December 2013

Articles in this issue…

Here's what you need to know about Diagnosis Closure Incentive and Performance Recognition Program

Blue Cross Blue Shield of Michigan and Blue Care Network are nearing the conclusion of this year's incentive programs for primary care physicians who close diagnosis and treatment opportunity gaps for their Blues Medicare Advantage patients. Here are the details you need to know.

Diagnosis Closure Incentive Program

All of the diagnosis gaps included in the 2013 Diagnosis Closure Incentive for the period of Jan. 1 through Sept. 30, 2013, are listed on Health e-Blue℠ under *Panel – Diagnosis Evaluation*. In order to earn incentives, physicians must close **all** the diagnosis gaps (identified through Sept. 30, 2013) that exist for a patient through a face-to-face visit before the end of this calendar year. Alternatively, they can notify the Blues that the patient doesn't have the suspected or previously reported diagnosis.

Schedule patient visits by end of year

Be sure to see your Blues Medicare Advantage patients before the end of the year to document and close diagnosis and treatment opportunity gaps. Information about gap closures should be submitted via Health e-Blue℠ under *Panel – Diagnosis Closure* and *Treatment Opportunities by Condition/Measure Panel* by Jan. 24, 2014. You may also submit a claim as part of your documentation. In addition, if you received a paper *Member Diagnosis Closure and Treatment Opportunities* report in the mail, you should fax it to 1-866-707-4723.

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Diagnosis gaps will continue to appear on Health e-Blue Oct. 1 through Dec. 31, 2013. While new gaps will continue to be displayed after September, physicians are responsible for closing diagnosis gaps identified prior to Oct. 1 for purposes of earning an incentive.

More information is available in the *Resources* section of Health e-Blue by clicking on *2013 Diagnosis Closure Incentive Program and FAQ*. A fact sheet can also be found on web-DENIS within *BCN Provider Publications and Resources* by clicking on *BCN Advantage*.

Performance Recognition Program
Treatment opportunity gaps included in the 2013 PRP incentive for the period Jan. 1 through Dec. 31, 2013, are listed on Health e-Blue under the *Treatment Opportunities by Condition/Measure Panel.* In order to earn incentives, physicians must close treatment opportunities that exist for a patient before the end of this calendar year.

More information is available in the *Resources* section of Health e-Blue by clicking on *2013 BCBSM MA PPO PRP Booklet and Exhibits* or *BCN 2013 BCN Advantage Incentive Program booklet and specifications.*

Diagnosis and treatment opportunity closures must be submitted to the Blues by the dates in the table at right.

Method	Deadline
Claim submission	Received by Feb. 28, 2014
Health e-Blue	Entered by Jan. 24, 2014
Paper *Member Diagnosis Evaluation and Treatment Opportunities* report (for BCBSM out-of-state physicians and in-state physicians without access to Health e-Blue)	Faxed or postmarked by Jan. 31, 2014
Paper medical record (for BCBSM physicians)	Faxed or postmarked by Jan. 31, 2014

If you don't have access to Health e-Blue, sign up today at **bcbsm.com/providers/help/faqs/sign-into-secured-services/track-and-share-patient-data.html**. If you have questions, please contact your provider consultant or provider representative.

Details about next year's PRP Incentive will be announced soon while information about the Diagnosis Closure Incentive program will be announced next year. In the meantime, physicians are encouraged to continue to check Health e-Blue for patient conditions, schedule face-to-face office visits and close historical or suspected patient diagnosis and treatment opportunity gaps in the coming year.

ALL PROVIDERS

Electronic version of *The Record* features many benefits

As we move closer to the time when the print version of *The Record* is discontinued, we want to make sure you understand the many benefits of the electronic version of the newsletter.

The Record provides critical updates on changes in billing, reimbursement, patient eligibility, medical criteria, benefit policy and more. Currently available in either print or electronic formats, the print version of the monthly newsletter will be discontinued beginning with the February 2014 issue.

Benefits of electronic *Record*
Benefits to an electronic version include:

- It provides the same information you've come to expect. but you get it earlier each month.
- It includes links to helpful sites and additional information.
- It comes directly to whatever email address you provide — and more than one person within a work area can subscribe.
- Information is customized according to your area of interest. For example, if you indicate you're primarily interested in information related to facilities, that information will appear first in the newsletter.

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- You can print the articles you need, rather than retaining and filing the entire newsletter.
- You can easily access the current or archived versions of the newsletter from **bcbsm.com/providers**. Click on the *Newsletters* tab.

Subscribing is easy

- Go to **bcbsm.com/providers**.
- Click on *Newsletters* in the box at right. Click on the *subscribe* link at the top of the screen.
- Fill out the required information, selecting *The Record*.
- Scroll down and click on the *Subscribe* button.

If you experience any technical difficulties when subscribing to *The Record*, send an email to ProvComm@bcbsm.com. If you have any other questions about the transition to an all-electronic format, please contact your provider consultant.

Certain tests should be billed as medically necessary for members with individual plans

Among the many changes brought about by the Affordable Care Act is the number of different health plans that members have to choose from, as well as the required benefit levels for those plans. In an article in the August *Record*, we discussed the topic of essential health benefits — benefits for such things as screenings for cancer and diabetes, vaccinations and chronic condition management. A plan's coverage of essential health benefits is one factor in determining if it's a qualified health plan under the Affordable Care Act.

It's important to keep in mind that the type of health plan a member has often determines how a benefit is processed. For example, here are several services that are commonly performed during health maintenance exams:

- Chest X-rays
- Complete blood counts
- Prostate-specific antigens
- Electrocardiograms
- Urinalysis

Sometimes, these services will be coded as preventive, when billed with associated screening diagnosis codes. However, for members in BCBSM's 2014 individual plans purchased on or off the marketplace, they should be coded as medically necessary diagnostic tests in order to be covered and paid, subject to cost-sharing. The diagnostic tests should be billed with the related medical diagnosis codes.

Note: These requirements apply to all individual market BCBSM products, including non health care-compliant plans and plans purchased on the Marketplace. Additionally, documentation of medical necessity must be included in the medical record to support this information, according to national coding guidelines.

How would you know that a member has an individual plan purchased on or off the marketplace? Members with this coverage have an alpha prefix of JXI, XYE or XYG on their BCBSM ID card.

These particular services have different billing requirements based on which plan a member has, so it's extremely important that you continue to check your patients' benefits and eligibility on web-DENIS or CAREN.

For more information about these changes, contact your BCBSM provider consultant.

Reminder: List of preventive medications available at no copayment expands Jan. 1

Under the Women's Preventive Services mandate of the Affordable Care Act, the Blues currently provide generic oral and injectable prescription contraceptives with no copayment requirement for our female members with commercial pharmacy coverage.

Beginning Jan. 1, 2014, preventive drug coverage with no member copayment will expand to include additional preventive medications as recommended by the U.S. Preventive Services Task Force under the Affordable Care Act.

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These include select over-the-counter female contraceptives and other mandated preventive medications. Prescriptions are required for both prescription and OTC products. For details, see the article in the November *Record*.

Some group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. In addition, there are some nonprofit employer groups that were granted a delay on the implementation of this benefit until their first plan year on or after Aug. 1, 2013, based on their religious beliefs.

The information in this article is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. If you have any legal questions about this information, you should consult your attorney or other professional legal services provider. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.

Changes made to autism benefits for 2014

Blue Cross Blue Shield of Michigan and Blue Care Network will be making some changes to benefits covering autism spectrum disorder beginning in 2014.

The current $50,000 per member, per calendar year limit for applied behavior analysis will be replaced with a new limit of up to 25 hours of direct line therapy for ABA per member, per seven calendar days (procedure code H2019). The frequency limits take effect for members when the plan year begins. The current $50,000 per year limit will still apply to some members in 2014 until their new plan year begins.

Remember to check member eligibility and benefits before providing services to ensure the member has autism coverage and to determine which of the limits applies for ABA treatment.

ABA authorizations
For those BCBSM members whose ABA benefit requires authorization from Magellan, please be aware that Magellan authorizes ABA services based on medical necessity. They do not review frequency or dollar limits. An authorization from Magellan is not a guarantee of payment. A service authorized by Magellan could be denied for payment due to the member exceeding a frequency or dollar limit, or due to a coverage or benefit change. Always check eligibility and benefits at each visit.

PT, OT and ST visit limits in 2014 for autism
Physical, occupational and speech therapy visits for most BCBSM group members with an autism diagnosis will be subject to visit limits specified by the member's plan, beginning with their new plan year that starts on Jan. 1, 2014, or later. Due to the differences in visit limits among group plans, providers should be sure to check member benefits and eligibility.

More information about billing for ABA services
Providers should bill for ABA in units based on 15-minute increments. If a member received four-and-a-half hours of ABA treatment, for example, it should be billed as 18 units. More information is available in the Applied Behavior Analysis Billing Guidelines and Procedure Codes document on web-DENIS.

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters & Resources*.
- Click on *Clinical Criteria & Resources*.
- Click on *Autism*.

New Electronic Provider Access Tool gives you access to other Blue plans' provider portals

As we told you in the October *Record*, we're preparing to launch a new tool Jan. 1, 2014, that will make it easier for you to conduct preservice reviews for the out-of-state members you treat.
The Electronic Provider Access Tool will give you access to other Blue plan provider portals to conduct electronic preservice reviews, including prenotification, precertification, preauthorization and prior approval. The tool is part of a Blue Cross and Blue Shield Association requirement, and it will also allow providers outside of Michigan access to BCSM's Provider Secured Services site for preservice reviews.

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The availability of the tool next month will vary, depending on the capabilities of each out-of-state member's Blue plan. Some plans may have fully implemented the tool's capabilities by Jan. 1, 2014, others may only allow preservice review for certain services and others may not have implemented any electronic preservice review capabilities. Also, Blue Care Network will not launch the tool until later in 2014.

Following is a quick look at how to use the tool.

- Go to **bcbsm.com/providers** and log in.
- Select the *Conduct Pre-Service Review for Out-of-Area Members (includes notification, pre-certification, pre-authorization and prior approval)* menu option.
- Enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member's ID number.
- You'll be automatically routed to the home plan's Electronic Provider Access landing page. This page will welcome you to the Blue plan portal and indicate that you have left BCBSM's portal. The landing page will allow you to connect to the available electronic preservice review processes.

Because the screens and functionality of a plan's preservice review processes vary widely, home plans may include instructional documents or e-learning tools on the landing page with instructions on how to conduct an electronic preservice review. The page will also include instructions for conducting preservice review for services that can't be submitted electronically.

Determining whether precertification is required
You can determine whether precertification is required by the member's home plan by sending a request through BlueExchange℠ or accessing the home plan's precertification requirements pages by using the medical policy router.

- Log in to Provider Secured Services.
- Go to the *Conduct Pre-Service Review for Out of Area Members* section of the page.
- Click on *Medical Policy & Pre-Cert/Pre-Auth Router.*

For more details, see the October *Record* article. If you have any questions, please contact your provider consultant.

We've made some changes to MPSERS LivingWell program for 2014

In 2014, Michigan Public School Employees Retirement System Medicare members will be automatically enrolled in LivingWell and receive a lower deductible. Non-Medicare members who follow the steps below will be enrolled in LivingWell and will have a lower deductible for 2014.

About LivingWell
Introduced in 2009, LivingWell is a voluntary program that gives members an opportunity to lower their cost share if they completed an annual health assessment. The program has been updated with additional requirements.

2014 LivingWell program requirements

1. **Complete a health assessment.** Non-Medicare members will receive their health assessments in December 2013. Medicare members will receive the Medicare Advantage Health Assessment in February. BCBSM will send members a health report based on their responses. We're encouraging members to bring these reports to their doctor to discuss any health questions or concerns.
2. **Select a primary care physician.** The LivingWell health assessment will include a space for members to enter the name of their primary care doctor.
3. **Complete an annual wellness visit by March 31, 2014.** Effective Oct. 1, 2013, routine physicals are a covered benefit for non-Medicare MPSERS members. The following procedure codes are now payable for MPSERS non-Medicare members:
   - *99385 Preventive visit for new patient (18-39)
   - *99386 Preventive visit for new patient (40-64)
   - *99395 Preventive visit for established patient (18-39)
   - *99396 Preventive visit for established patient (40-64)

An annual wellness visit is already covered for Medicare members.

4. **Bonus step: Choose a patient-centered medical home.** Non-Medicare MPSERS members who select a PCMH doctor and complete other program requirements receive an additional discount on their deductible. To learn more about becoming a PCMH

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practice, go to **valuepartnerships.com** and click on the *Patient-Centered Medical Home* tab or send an email to providerpartnerships@bcbsm.com.

We hope these LivingWell program enhancements will support your ongoing efforts to improve your patients' health.

If you have any questions about LivingWell, please call MPSERS Member Services at 1-800-422-9146, 8:30 a.m. to 5 p.m., Monday through Friday.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.

Documentation guidelines updated for speech and language pathology services

The Blue Cross Blue Shield of Michigan documentation guidelines for speech and language pathology services have been updated. Listed below are the guidelines to follow when providing these services:

- When speech and language pathology services are provided in a physician's office, the physician must document the medical necessity for those services in the patient's medical record.
- When speech services are provided in a location other than the physician's office, the medical necessity for those services must be documented in the physician's patient medical record. They also must be documented on the appropriate referral form from the physician to the speech-language pathologist.

The physician's referral for therapy must be maintained in the speech pathologist's patient medical record. The physician's referral form must contain:

- Date of referral
- Date of onset of the condition (if appropriate)
- Medical diagnosis
- Physician's signature and signature date

Note: Physician referrals expire after 120 days, even those that say "ongoing" or indicate a period longer than 120 days. In all cases, after 120 days, a new referral, signed and dated by the physician, must be obtained. (The date of the first treatment is the start of the 120-day period.)

We require the following information in the patient's treatment record when speech pathology services are performed:

- Identifying information
  - Patient's name and address
  - Patient's contract number (including alpha prefix) and group number
  - Patient's date of birth
  - Facility name and address (if applicable)
  - Facility case number (if applicable)
  - Location where services are provided
  - Physician's name and address
- Diagnosis and history
  - Primary and all pertinent secondary diagnoses, with dates of onset (Diagnoses must be recognized medical diagnoses, not symptoms.)
  - Diagnoses for which treatment is being provided, with onset dates
  - Prior hospitalization and surgeries, with dates
  - Other relevant patient history — such as exacerbation of a chronic illness, accidental injury, complicating medical problems, past treatment received — with onset dates and references to cause where relevant

Documenting the initial evaluation

For an initial evaluation, the certified or state-licensed speech-language pathologist must document the following information in the patient's medical record, as is appropriate:

- Date of evaluation
- Date of injury or onset and description of exacerbation of a chronic condition
- Current status of the following:
  - Diagnosis
  - Age
  - Functional level
  - Level of speech intelligibility (with an objective measure and description of the level of severity of condition)
  - Degree of language usage

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  - Indication of voice quality
  - Swallowing ability
  - Assessment of cognitive dysfunction
- Functional level prior to the onset of the current illness, injury or exacerbation
- Mental status and ability to participate in the treatment program (with reference to orientation, motivation, short-term memory, ability to follow directions, etc.)
- Pain level (as reported by the patient), type and the possible effect on the treatment program
- Treatment plan, including reference to the following:
  - Communication disorders to be treated
  - Treatment techniques and activities to be provided
  - Frequency of treatments
  - Duration of procedures
  - Patient and family education (if applicable)
  - Home treatment program
- Rehabilitation potential (a realistic evaluation of the patient's potential for rehabilitation or restoration, in objective language)
- Treatment goals (therapeutic goals that are appropriate for the patient, the diagnoses, rehabilitation potential and the treatment to be provided)
- Anticipated duration of therapy (for example, three sessions per week for six weeks)
- Signature and credentials of the speech pathologist performing the evaluation

Documenting individual services or sessions
For each treatment session billed to BCBSM, the speech pathologist must document certain information in the patient's treatment record. The following information may be documented in progress notes, a flow chart or a grid system of record keeping:

- Date of service
- Time of service if treatments are performed more than once per day (the use of a.m. or p.m. is acceptable)
- Treatment techniques and activities provided at the treatment session
- Patient's response to the treatment
- Signature and credentials of the clinician providing treatment

Note: If the services are provided and documented by another person, the supervising speech-language pathologist or physician must co-sign the documentation.

Re-evaluating the response to treatment
The speech-language pathologist must write a treatment summary or progress note summarizing the patient's response to treatment at least once every 60 days if treatment continues beyond a 60-day period**.**

Every treatment summary and progress note in the medical record must contain the following, as appropriate**:**

- Date of summary or progress note and the dates of service covered by the summary or progress note
- Specific and objective evaluation of the patient's progress and response to treatment during the period
- Changes in medical status, which must be documented in clear, concise, objective statements
- Changes in mental status and level of cooperation, which must be documented in clear, concise, objective statements
- Change in treatment plan with rationale for the changes and reference to the patient's readiness for discharge from treatment
- Signature and credentials of the clinician assessing the patient's progress

The physician must also periodically evaluate and document the patient's response to treatment. This can be accomplished through review of treatment summaries and recertification of the treatment plan**.** The requirements for physician involvement are as follows:

- When services are performed in a hospital inpatient setting, the physician must evaluate the patient at least once every 30 days.
- When services are performed in the hospital outpatient setting, freestanding outpatient therapy facility, physician office setting, hospice, skilled nursing facility or in the patient's home, the physician must evaluate and recertify the treatment plan every 60 days.
- For speech pathology services beyond 60 days, the physician must evaluate and recertify the treatment plan every 60 days to determine whether continued therapy is needed and document the medical necessity for continuing the treatment.

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Note: The period for recertification for long-term treatment plans is every 60 days. The previous requirement for a face-to-face physician visit for treatment-plan recertification is no longer in place.

Establishing ongoing communication
The physician and the speech-language pathologist must communicate every 16 visits or 60 days, whichever comes first. Communication may be in person, by phone or in writing.

The communication must be documented, including the date of communication, and must demonstrate ongoing communication between the referring physician and speech pathologist:

- Both the physician and the speech-language pathologist must document the substance of the verbal or written communication in the patient's medical record.
- If the communication is in writing, such as in the form of a progress note or summary letter from the speech-language pathologist, the physician must include that document in the patient's record and document that the information was reviewed and the plan for ongoing therapy approved.
- If the physician believes that further evaluation is required or that the treatment plan must be changed or discontinued, then the physician must communicate directly with the speech-language pathologist. Both the physician and the speech-language pathologist must document the discussion in their respective patient medical record.

You can review these changes in the "Documentation Guidelines for Physicians and Other Professional Providers" chapter of your online provider manual. To view the provider manual:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Provider Manual.*

Documentation guidelines updated for mental health, substance abuse services

We've updated the documentation guidelines for mental health and substance abuse services.

Here are some of the key changes:

- In the section titled "Office or outpatient psychiatric care — general guidelines," we've added a note to the "Initial visit" subsection. The note explains that if this service is provided by a psychiatrist, a medical history must be documented. The medical history must include all prescriptions, over-the-counter medications, and holistic and natural supplements.
- In the "Inpatient and outpatient individual psychotherapy" section, we've added a note to the "Progress notes" subsection. The note explains that if a psychiatrist performs psychotherapy and medication management in the same visit, he or she must document the patient's response to the medication. The documentation should include side effects, as well as a treatment plan related to the medication.
- In the section titled "Inpatient and outpatient group or family therapy," we've added information about inpatient services. We outline what must be documented when a patient from the inpatient unit is able to participate only minimally — or not at all — in psychotherapy.
- In the "Psychological testing services" section, we've expanded a bullet point that discusses "the rationale for the referral." It now mentions that the patient record must contain either a letter from the referring physician or psychologist, or a notation that documents a conversation between the referring physician and the provider of testing services. We've also added information on what must be documented if the psychologist is referring the testing to be done by him or her.

For more information, please see the "Documentation Guidelines for Physicians and Other Professional Providers" chapter in your online provider manual. To view the provider manual:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Provider Manual.*

Mental health medical necessity criteria updated for 2014

The *Magellan Behavioral Health Medical Necessity Criteria* and *Blue Cross Blue Shield of Michigan Behavioral Health Criteria Application Guidelines* have been updated. Both will go into effect and be available on web-DENIS starting Jan. 1, 2014.

Keep in mind that the medical necessity criteria, along with the application criteria, must be met.

The new medical necessity criteria encompasses psychiatric and substance abuse treatment. This includes acute medical detoxification, which is considered a behavioral health benefit. Acute medical detoxification is considered a **medical** benefit for Federal Employee Program® members.

Health care providers may view and print the 2014 guides directly from web-DENIS. Go to web-DENIS and click on:

- *BCBSM Provider Publications and Resources*
- *Newsletters and Resources*
- *Clinical Criteria and Resources*
- *2014 updated Magellan Behavioral Health Medical Necessity Criteria* under Resources

Call Mental Health Behavioral Services at 313-448-7745 if you have any questions or comments.

Members have power to compare provider treatment costs and quality with redesigned feature

The newly redesigned *Find a Doctor* feature at **bcbsm.com** integrates a doctor and hospital search, treatment cost estimates and provider quality data into one, all-inclusive search feature.

When members log in to **bcbsm.com**, the *Find a Doctor* feature allows them to gain more information about participating doctors and hospitals in Michigan and across the country. Members can compare doctors and hospitals within their specific health plan, access treatment costs by facility for nearly 400 different health services (PPO only) and see extensive hospital quality information across the nation.

This enhanced feature makes finding a doctor easier and more convenient because members can find care based on criteria that's important to them, while bringing your office additional patients as well as those more suited to your specialty.

Members can also discover which doctors offer extended office hours, read patient reviews about a particular doctor's services or even leave a review of their own.

In addition, members can take their search on the go with their mobile device or tablet, and if members forget to bring their ID card to an appointment, they can access their own virtual ID card right in your office from a mobile device.

Our *Find a Doctor* feature provides members with confidence knowing they can find the information they need to make more informed decisions.

Stay tuned as we continue to release more improvements.

Keep in mind these coding tips to improve medical record documentation

In previous editions of *The Record*, we've reminded you of the importance of documentation and proper ICD-9 coding to ensure appropriate insurance reimbursement. This month we'll focus on coding tips related to heart failure.

Heart failure: an overview
Heart failure is a challenge for all providers and affects all different specialties. Heart failure occurs when the heart muscle doesn't pump blood to the body as effectively as it should. It can be an acute condition, but most of the time it occurs slowly and becomes a chronic condition. Heart failure often develops after other conditions have damaged or weakened the heart.

Congestive heart failure is a specific type of heart failure that occurs when blood backs up — and becomes congested — into other organs such as the liver, abdomen, lower extremities and lungs. CHF is often mistakenly used interchangeably with heart failure. Congestion is one feature of heart failure, but it doesn't occur in all patients.

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Causes of heart failure include coronary artery disease, cardiomyopathy and other arrhythmias, hypertension, myocarditis and faulty heart valves, and may contribute to kidney disease, diabetes, pulmonary embolism, endocarditis, anemia and other conditions

Heart failure can involve the left, right or both sides of the heart, but usually begins on the left side.

Type of heart failure	Description
Right-sided (right ventricular)	Includes left-sided heart failure. Fluid may back up into abdomen, legs and feet, causing swelling (edema). It is classified as Congestive Heart Failure 428.0
Left-sided	This is the most common type of heart failure. Fluid may back up in lungs, causing shortness of breath. There are two types of left-sided heart failure: • Systolic — Occurs when the ability of the heart to contract decreases with the result of blood coming from the lungs into the heart may backing up. • Diastolic — Occurs when the left ventricle can't relax fully between contractions. The heart cannot properly fill with blood, which may lead to fluid accumulation in the legs, ankles and feet.

Symptoms of heart failure include:

- Shortness of breath
- Dizziness, fatigue and weakness
- Fluid and water retention
- Rapid or irregular heartbeats
- Cough or wheezing with white or pink blood-tinged phlegm
- Chest pain

Coding for heart failure
Coding and documentation of heart failure and congestive heart failure present additional challenges. The types of heart failure referenced above should be documented in order to correctly assign ICD-9 codes. Systolic heart failure uses codes in the 428.2x series, while diastolic heart failure uses codes in the 428.3x series. There's also a category for combined systolic and diastolic heart failure: 428.4x. A fifth digit can be used to further specify whether the heart failure is unspecified, acute, chronic or acute on chronic.

When documenting only "congestive heart failure," use ICD-9 code 428.0: congestive heart failure, unspecified.

Left heart failure is coded as 428.1 and includes associated conditions such as dyspnea, orthopnea, bronchospasm and acute pulmonary edema. Do not assign additional codes for these conditions. If both right and left heart failure exist, code only 428.0, which includes both conditions.

Systolic, diastolic and combined systolic and diastolic heart failure require a fifth digit, as indicated below:

- Systolic heart failure — 428.2x
- Diastolic heart failure — 428.3x
- Combined systolic and diastolic heart failure — 428.4x

The fifth digits for heart failure include:

0	Unspecified
1	Acute
2	Chronic
3	Acute on chronic

Using the above information, you would code acute diastolic heart failure as 428.31.

When the diagnostic statement lists congestive heart failure along with either systolic or diastolic heart failure, two codes are required. For example, a diagnosis of acute combined systolic and diastolic congestive heart failure would be assigned two codes — 428.41 (combined systolic and diastolic heart failure, acute) and 428.0 (congestive heart failure, unspecified). Both codes are needed to report the specific type of heart failure — congestive, diastolic and systolic. Congestive heart failure is not an inherent component of systolic or diastolic heart failure, so CHF must be specifically documented.

If a patient has hypertensive heart disease with CHF, report a code for the hypertensive heart disease (402.01, 402.11 or 402.91). The code for CHF (428.0) should be added. However, a causal relationship between the two conditions must be documented by the practitioner in order to be coded. A coder can't assume a cause-and-effect relationship, and the correct way to document a causal relationship is by stating "CHF due to benign hypertension." A patient with congestive heart failure and hypertension without a documented causal relationship

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is assigned separate ICD-9 codes for CHF (428.0) and hypertension (401.9). Documentation simply stating "heart failure" codes to 428.9.

Documentation of diastolic or systolic dysfunction without mention of heart failure codes to 429.9: heart disease, unspecified. Do not assume that a patient is in heart failure if only "diastolic dysfunction" or "systolic dysfunction" is documented. Other terms for this code include "Heart disease, unspecified" and "Organic heart disease NOS."

If you have any questions, please contact your provider consultant.

The information in this article is not intended to impart legal advice. If you have any legal questions about this information, you should consult your attorney or other professional legal services provider.

Follow these guidelines for revisions to bariatric surgeries

We'd like to remind providers about the bariatric surgery revision requirements and guidelines as published in the BCBSM medical policy titled "Bariatric Surgery."

In cases where a revision of a bariatric procedure is planned, the following must be document in the patient's medical record:

- Date and type of previous procedure
- The factor(s) that precipitated the resulting failure
- Complications resulting from the previous procedure
- If the reason for the revision is a failure of the patient to lose a desired amount of weight, then the patient must meet all of the initial preoperative criteria. Previous procedures that failed for anatomic or technical reasons (e.g., obstruction, staple dehiscence, etc.) are considered medically appropriate for revision without consideration of the initial preoperative criteria.

The BCBSM bariatric surgery policy document is accessible through Benefit Explainer and web-DENIS.

Please remember that group-specific rules and variations may apply. Please verify patient-specific benefits and eligibility coverage accordingly.

Reminder: Retrieving encrypted audit emails

Since 2009, the Utilization Review department has been sending audit appointment and reporting letters to providers via encrypted email. This allows us to properly share protected health information in a secure environment while complying with all applicable regulations. Due to provider staffing changes, we have been asked to again share the information regarding the encrypted mail process.

Here are some instructions:

1. When the audit letters are sent, you will receive a generic message stating: "You have a Blue Cross Blue Shield of Michigan and Blue Care Network Message from <name> @ bcbsm.com." This notification contains a link to the BCBSM/BCN Message Center website. You will simply need to click on the link to retrieve the secure email.
2. If this is your first time to go to the site, you will be required to register and set a password. Password rules will be identified on the registration page.
3. Once you are registered, log in to retrieve messages.
4. When you log in, you will be directed to your "Inbox." Click on the message title to open the message.

Please remember that the encrypted mail will only be stored for 30 days. The recipient must read their notification email prior to the designated expiration date. If the recipient does not retrieve the message before the expiration date, you will receive an expiration notification email. The original message will be deleted from the secure website. If this occurs, contact your designated auditor to request that the letter be re-sent.

The audit letters may contain attachments in a PDF format.

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AUDIT EMAILS continued from Page 11

Some providers have indicated that, when they receive the encrypted email, they are unable to forward the audit letter to additional internal personnel. Providers are considered "external users" to the system and cannot forward emails to another email address through the secured site. If you choose to forward the audit letter and attachments, please save the letter and attachments from the secured BCBSM email and create your own email and attach the saved documents.

As always, be sure to follow the applicable privacy regulations when sending PHI.

If you have problems with accessing the audit letters, contact your designated auditor.

Reminder: Elimination of paper remittance advices, changes to Electronic Remittance Advice and Electronic Funds Transfer

Elimination of paper remittance advices
Blue Cross Blue Shield of Michigan recently published several communications about the implementation of changes that align with the Affordable Care Act-mandated EFT Standard and CAQH/CORE EFT-ERA Operating Rules, which take effect Jan. 1, 2014.

As part of our efforts to align with these mandates, BCBSM and Blue Care Network will eliminate paper remittance advices (also known as vouchers), effective Dec. 6, 2013.

The only paper remittance advices that will continue to be mailed will be for:

- BCBSM local facilities
- Out-of-state providers paid through the Medicare crossover process
- BCN out-of-state providers (through mid-2014)

If a provider identification number is not registered with your Provider Secured Services ID, you will not see online remittance advices for those affiliated claims. This applies to both paper and electronic claims submissions.

Providers can complete one of the following forms to add PINs:

- *Authorization to Modify BCBSM and or BCN Provider codes on Your Provider Secured Service ID*
- *Addendum "B" Authorization for Representative Access*

All providers in the state of Michigan and those outside the state that have a contract with BCBSM or BCN have the ability to access online remittance advices for the Blues. Professional providers, hospitals or facilities that do not have access to Provider Secured Services need to enroll to obtain access before enrolling for Electronic Funds Transfer or to view online remittance advices (vouchers).

More information about the discontinuation of paper remittance advices is available in the article titled "Changes to Electronic Remittance Advice and Electronic Funds Transfer take effect Jan. 1, 2014" in the November *Record*.

Changes to electronic remittance advice and electronic funds transfer

- CORE 382 ERA Enrollment Data Rule mandates that health plans are required to offer electronic enrollment for 835/ERA at a minimum and must use standardized templates to collect data for these enrollments
- CORE 360 standardizes the use of adjustment reason and remark codes in the 835/ERA transaction into four different business scenarios
  - The new listing of codes, organized by business scenario, is available on the CAQH/CORE website at **caqh.org/ORMandate_EFT.php**.
- CORE 370 EFT and ERA Reassociation (CCD+/835) Rule mandates delivery of an ERA and EFT within three business days of each other if you're set up for both.
- CORE 380 EFT Enrollment Data Rule mandates that health plans offer EFT to all providers and must use standardized templates to collect data for these enrollments.
  - BCBSM and BCN require all professional providers to use electronic funds transfer. If you're not, please follow these instructions to begin receiving electronic payments from the Blues.
    - Go to **bcbsm.com/providers**.
    - Click on *Provider Secured Services*.
    - Click on *Online payments and electronic vouchers*.

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All BCBSM PINs associated with the NPIs for which you submit claims must be registered for EFT.

Note to Blue Care Network hospitals and facilities: If you enrolled for EFT directly with BCN, you'll need to enroll with BCBSM through Provider Secured Services.

Note to BCBSM Medicare Advantage and Medicare Plus Blue providers: In the November *Record* article on this topic, we should have noted that if you use the same NPI or PINs for both BCBSM and Medicare Advantage and are already registered for BCBSM EFT, you don't need to register separately for Medicare Advantage to begin to receive payment via EFT.

Providers should work with BCBSM and their software vendor or clearinghouse before Jan. 1 to ensure that they are properly registered, enrolled and electronically capable of handling the changes.

For more information on EFT and ERA, see the article on these topics in the November *Record.*

Corrections to November *Record* article:

- The CORE 382 ERA Enrollment Data Rule was incorrectly reported as the rule for *both* ERA and EFT enrollment. The correct rule for EFT is the CORE 380 EFT Enrollment Data Rule.
- The "Note for Blue Care Network providers" should have read: "Note for Blue Care Network hospitals and facilities."

Need help?

- If you need help accessing online remittance advices or signing up for Provider Secured Services or Electronic Funds Transfer, contact your BCBSM provider consultant or BCN provider representative.

  For technical assistance, you also can call the BCBSM Web Support Help Desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.
- For questions or help with 835/ERA, contact the BCBSM EDI Help Desk at 1-800-542-0945, Monday through Friday from 8 a.m. to 4:30 p.m.

Express Scripts to fill Ford employee prescription drugs

Express Scripts will fill prescription drug orders for Ford salaried employees, starting Jan. 1, 2014.

All mail order prescriptions placed after that date must be sent to Express Scripts Home Delivery. Call Express Scripts at 1-800-922-1557 for prior authorization requests.

Members affected by this change will receive a new ID card.

To check benefits or verify eligibility for all members, log in to web-DENIS or call the appropriate CAREN number.

Blues highlight medical, benefit policy changes

You'll find the latest information about procedure codes and Blue Cross Blue Shield of Michigan billing guidelines in the following chart.

This billing chart is organized numerically by procedure code. Newly approved procedures will appear under the *New Payable Procedures* heading. Procedures for which we have changed a billing guideline or added a new payable group will appear under *Updates to Payable Procedures*. Procedures for which we are clarifying our guidelines will appear under *Policy Clarifications*. New procedures that are not covered will appear under *Experimental Procedures.*

You will also see that descriptions for the codes are no longer included. This is a result of recent negotiations with the AMA on use of the codes.

We will publish information about new BCBS groups or changes to group benefits under the *Group Benefit Changes* heading.

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For more detailed descriptions of the BCBSM policies for these procedures, please check under the *Medical/Payment Policy* tab in Explainer on web-DENIS. To access this online information:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications & Resources*.
- Click on *Benefit Policy* for a Code.
- Click on *Topic*.
- Under *Topic Criteria*, click the drop-down arrow next to *Choose Identifier Type* and then click on *HCPCS Code*.
- Enter the procedure code.
- Click on *Finish*.
- Click on *Search*.

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, 81401, 81406, S3833, S3834	**Basic Benefit and Medical Policy** The criteria for genetic testing For Lynch syndrome and other inherited intestinal polyposis syndromes policy has been updated. This policy is effective Nov. 1, 2013. **Inclusionary Guidelines** These guidelines refer to the different types of genetic tests available for colorectal cancer. **A.** Genetic testing of the adenosis polyposis coli gene is established in patients with one of the following: • Patients with greater than 20 colonic polyps • First-degree relatives (e.g., siblings, parents and offspring) of patients with FAP or AFAP or a known APC mutation. • Genetic testing for MYH (MUTYH) gene mutations is established in any of the following: - Individuals with personal history of adenomatous polyposis who have negative APC mutation testing and a negative family history for adenomatous polyposis, or - Individuals with personal history of adenomatous polyposis whose family history is consistent with recessive inheritance (e.g., family history is positive only for sibling(s)), or - Asymptomatic siblings of individuals with known MYH polyposis • Genetic testing for *MLH1* and MSH2 gene mutations to determine the carrier status of Lynch syndrome is established in any of the following: - Patients with colorectal cancer to test for the diagnosis of Lynch syndrome, or **Continued on next page**

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NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, 81401, 81406, S3833, S3834 ***Continued***	- Patients with endometrial cancer and one first-degree relative diagnosed with a Lynch-associated cancer for the diagnosis of Lynch syndrome - Patients without colorectal cancer, but who have a first- or second-degree relative with a known MMR mutation, or - At-risk relatives of patients with Lynch syndrome with a known MMR mutation, or - Patients without colorectal cancer but with a family history meeting the Amsterdam or Revised Bethesda criteria, when no affected family members have been tested for MMR mutations. In cases when testing is proposed for an individual without a personal history of colorectal cancer, the Revised Bethesda or Amsterdam II criteria would be applicable to that individual's first- or second-degree relatives. • Amsterdam II criteria: Must meet **all** of the following: - Three or more relatives with a histologically-verified Lynch syndrome-associated cancer (colorectal cancer or cancer of the endometrium, small bowel, ureter or renal pelvis), one of whom is a first-degree relative of the other two - HNPCC-associated cancer involving at least two successive generations - Cancer in one or more affected relatives diagnosed before 50 years of age - Familial adenomatous polyposis excluded in any cases of colorectal cancer - Tumors should be verified by pathologic examination whenever possible • Revised Bethesda guidelines: Patients must meet **any** of the following: - Individuals diagnosed with colorectal cancer under the age of 50 - Individuals with Lynch syndrome-related cancer, including synchronous and metachronous colorectal cancers or associated extracolonic cancers,* regardless of age **Continued on next page**

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NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, 81401, 81406, S3833, S3834 ***Continued***	- Individuals with colorectal cancer with the MSI-H histology diagnosed in a patient younger than age 60 - Individuals with colorectal cancer and one or more first-degree relatives with colorectal cancer or Lynch syndrome-related extracolonic cancer* if one of the cancers was diagnosed at age <50 years - Individuals with colorectal cancer and colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch syndrome-related tumors,* regardless of age *Extracolonic cancers include stomach, bladder, ureter and renal pelvis, biliary tract, brain (usually glioblastoma), pancreas, sebaceous gland adenomas, keratoacanthomas, carcinoma of the small bowel and endometrial or ovarian cancer. MSH6 or PMS2 gene sequence analysis is established in patients meeting the Bethesda criteria for genetic testing for Lynch syndrome: • Who do not have mutations in either the MLH1 or MSH2 genes • Who meet the first Amsterdam II criteria that describes the relatives • Single site MSH6 or PMS2 testing is established for testing family members of persons with Lynch syndrome with an identified MSH6 or PMS2 gene mutation. • Patients with endometrial cancer and one first-degree relative diagnosed with a Lynch-associated cancer who do not have mutations in either the MLH1 or MSH2 genes for the diagnosis of Lynch syndrome Genetic testing for EPCAM mutations is established in any of the following: • Patients with colorectal cancer, for the diagnosis of Lynch syndrome when all of the following three criteria are met: - Tumor tissue shows a high level of microsatellite instability - Tumor tissue shows lack of MSH2 expression by immunohistochemistry - Patient is negative for a germline mutation in MSH2, MLH1, PMS2 and MSH6 **Continued on next page**

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NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, 81401, 81406, S3833, S3834 ***Continued***	• At-risk relatives of patients with Lynch syndrome with a known EPCAM mutation • Patients without colorectal cancer but with a family history meeting the Amsterdam or Revised Bethesda criteria, when no affected family members have been tested for MMR mutations, and when sequencing for MMR mutations is negative. In cases when testing is proposed for an individual without a personal history of colorectal cancer, the revised Bethesda criteria would be applicable to that individual's first and second-degree relatives. Pre- and post-test genetic counseling should be provided as an adjunct to genetic testing.
84376-84379, 84999	**Basic Benefit and Medical Policy** Saccharide testing is established for the diagnosis of carbohydrate malabsorption. It may be considered a useful diagnostic option when indicated, effective Sept. 1, 2013. The 1,5-anhydroglucitrol testing does not provide additional clinically relevant information in the monitoring of diabetes over available tests or procedures. It has not been definitively shown to impact patient outcomes. The 1,5-anhydroglucitrol testing is not established for these indications. **Group Variations** Not covered for Chrysler, Ford, GM, Delphi and URMBT groups **Inclusionary Guidelines** Saccharide testing is indicated for the diagnosis of carbohydrate malabsorption when any of the following conditions are present: • Prolonged diarrhea, steatorrhea or a pre-existing condition that may predispose to malabsorption • Abdominal symptoms, such as distention, colic, loud peristaltic sounds or increased flatulence after ingesting saccharides • Infants and young children exhibiting signs of failure to thrive • Clinical signs of weight loss, anemia, edema, osteopathies or neuropathies. **Exclusionary Guidelines** The 1,5-anhydroglucitrol testing is excluded for the diagnosis and monitoring of diabetes.

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NEW PAYABLE PROCEDURES	
A9584	**Group Variations** Dopamine transporter imaging with single photon emission computed tomography is a payable service for GM hourly and salaried members when specific clinical criteria are met. This change is effective Sept. 20, 2013. **Inclusionary Guidelines** • To aid in the diagnosis of a Parkinsonian syndrome (e.g., essential tremor versus Parkinson's disease) • To distinguish drug-induced Parkinsonism versus degenerative Parkinsonism or idiopathic Parkinson's disease • To discriminate psychogenic Parkinsonism from neurologically based Parkinsonism • To be used prior to DBS surgery for intractable tremor of uncertain etiology to determine the appropriate site of DBS stimulation (e.g., VIM stimulation for essential tremor versus STN or GPi stimulation for Parkinson's disease) • DaTscan should only be prescribed by a board-certified neurologist who has evaluated the patient. **Exclusionary Guidelines** • As a screening or confirmatory test and for monitoring disease progression or response to therapy. • Serial DaTscan studies.
K0008, K0013	**Group Variations** Effective July 1, 2013, procedure codes K0008 and K0013 are payable for the Federal Employee Program®.
UPDATES TO PAYABLE PROCEDURES	
11100, 11101, 20220	**Payment Policy** Effective Aug. 1, 2013, procedure codes *11100, *11101 and *20220 are no longer payable to dentists or oral surgeons.
15271-15278	**Basic Benefit and Medical Policy** Procedure codes *15271, *15272, *15273, *15274, *15275, *15276, *15277 and *15278 are now reimbursable to a podiatrist.
17340, 17360	**Basic Benefit and Medical Policy** These procedures will no longer be payable in an inpatient hospital location, effective Aug. 1, 2013. The codes are payable when performed in an outpatient hospital, ambulatory surgical facility and office setting only.

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UPDATES TO PAYABLE PROCEDURES	
33361, 33362	**Basic Benefit and Medical Policy** Transcatheter aortic valve replacement performed via the transfemoral approach with a device approved by the U.S. Food and Drug Administration is established for patients with aortic stenosis who meet medical policy guidelines. **Group Variations** Payable for URMBT members, effective Jan. 1, 2013. Payable for Delphi hourly and salaried enrollees, effective March 1, 2013.
43644, 43645, 43770- 43775, 43842, 43843, 43845-43848, 43886- 43888, 43999, 44130, 96101- 96103, S2083	**Basic Benefit and Medical Policy** The safety and effectiveness of laparoscopic and open gastric restrictive procedures, including, but not limited to, gastric-band, Roux-en-Y, gastric bypass, sleeve gastrectomy and biliopancreatic diversion have been established. They may be considered useful therapeutic options when specified criteria are met. Criteria have been updated, effective Jan. 1, 2014. **Note:** Please check web-DENIS for BCBSM-specific plan criteria. Please check the BCN benefit page at the end of the policy for BCN- specific plan criteria. **Inclusionary Guidelines** The surgical procedures for severe obesity, including sleeve gastrectomy, are considered established treatment options if all the following criteria are met: • The patient has a BMI >40 or a BMI of >35 with one or more comorbid conditions including, but not limited to: – Degenerative joint disease (including degenerative disc disease) – Hypertension – Hyperlipidemia, coronary artery disease – Presence of other atherosclerotic diseases – Type 2 diabetes mellitus – Sleep apnea – Congestive heart failure • Bariatric surgery may be indicated for patients 18 to 60 years of age. Requests for bariatric surgery for patients younger than 18 years of age should include documentation that the primary care physician has addressed the risk of surgery on future growth, the patient's maturity level and the patient's ability to understand the procedure and comply with postoperative instructions, as well as the adequacy of family support. Patients older than 60 may be considered if it is documented in the **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
43644, 43645, 43770- 43775, 43842, 43843, 43845-43848, 43886- 43888, 43999, 44130, 96101- 96103, S2083 ***Continued***	medical record that the patient's physiologic age and co-morbid condition(s) result in a positive risk-benefit ratio. • The patient has been clinically evaluated by an M.D. or D.O. (or their authorized delegate (e.g., physician assistant, etc.). The physician has documented failure of non-surgical management including a structured, professionally supervised (physician or non-physician) weight loss program for a minimum of one of the following: – Six full, consecutive months (180 days) within the last four years prior to the recommendation for bariatric surgery (for BCBSM patients) – Six full, consecutive months (180 days) within the last two years prior to the recommendation for bariatric surgery (for BCN patients) The six full consecutive month (180 days) weight loss program listed above is waived for super morbidly obese individuals who have a BMI ≥50. Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated. • Documentation that the primary care physician and the patient have a good understanding of the risks involved and reasonable expectations that the patient will be compliant with all post-surgical requirements. • A psychological evaluation must be performed as a pre-surgical assessment by a contracted mental health professional in order to establish the patient's emotional stability, ability to comprehend the risk of surgery and to give informed consent and ability to cope with expected post-surgical lifestyle changes and limitations. Such psychological consultations may include one unit total of psychological testing for purposes of personality assessment (e.g., the MMPI-2 or adolescent version, the MMPI-A). • The physician needs to be aware and follow up with individuals who have had gastric surgery for any long-term complications. • In cases where a revision of the original procedure is planned because of failure due to anatomic or technical reasons (e.g., obstruction, staple dehiscence, etc.) or excessive weight loss of 20% or more below ideal body weight, the revision is determined to be medically appropriate without **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
43644, 43645, 43770- 43775, 43842, 43843, 43845-43848, 43886- 43888, 43999, 44130, 96101- 96103, S2083 ***Continued***	consideration of the initial preoperative criteria. The medical records should include documentation of: – The date and type of the previous procedure – The factor(s) that precipitated the failure or the nature of the complications from the previous procedure that necessitate the takedown • If the indication for the revision is a weight gain **or** a failure of the patient to lose a desired amount of weight due to patient non-adherence, then the patient must re-qualify for the subsequent procedure and meet all the initial preoperative criteria. **Exclusionary Guidelines** The following surgical procedures are considered experimental because their safety or effectiveness has not been proven: • Loop gastric gastroplasty, also known as mini gastric bypass • Stomach stapling • Endoscopic procedures (e.g., insertion of the StomaphyX™ device) as a primary bariatric procedure or as a revision procedure, (e.g.,, to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches). • Any bariatric surgery for patients with Type 2 diabetes who have a BMI of less than 35 • Vertical-banded gastroplasty • Gastric bypass using a Billroth II type of anastomosis (mini-gastric bypass) • Biliopancreatic bypass without duodenal switch • Long-limb gastric bypass procedure (e.g., >150 cm)
78607, A9584	**Basic Benefit and Medical Policy** The safety and effectiveness of dopamine transporter imaging with single photon emission computed tomography have been established for patients meeting specified criteria. It may be considered a useful diagnostic option when specific clinical criteria are met. This policy is effective July 1, 2013. **Inclusionary Guidelines** • To aid in the diagnosis of a Parkinsonian syndrome (e.g., essential tremor versus Parkinson's disease) • To distinguish drug-induced Parkinsonism versus degenerative Parkinsonism or idiopathic Parkinson's disease **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
78607, A9584 ***Continued***	• To discriminate psychogenic Parkinsonism from neurologically-based Parkinsonism • To be used prior to DBS surgery for intractable tremor of uncertain etiology to determine the appropriate site of DBS stimulation (e.g., VIM stimulation for essential tremor versus. STN or GPi stimulation for Parkinson's disease) • DaTscan should only be prescribed by a board-certified neurologist who has evaluated the patient. **Exclusionary Guidelines** • As a screening or confirmatory test and for monitoring disease progression or response to therapy. • Serial DaTscan studies
81500, 81503, 84999	**Basic Benefit and Medical Policy** The safety and effectiveness of proteomics-based testing for the evaluation of ovarian (adnexal) masses (e.g., OVA1 and ROMA tests) have been established. It may be considered a useful diagnostic option for women meeting the patient selection criteria. **Group Variations** Payable for Delphi hourly and salaried members, effective March 1, 2013.
92526	**Basic Benefit and Medical Policy** Effective May 1, 2013, procedure code *92526 is payable to independent occupational therapists.
G0249	**Payment Policy** BCBSM will allow procedure code G0249 to process with a maximum of three units every 85 days.
G0460	**Group Variations** This procedure is payable for Federal Employee Program® members, effective July 1, 2013.
J7665	**Basic Benefit and Medical Policy** The safety and effectiveness of inhaled dry powder mannitol in the diagnosis and management of bronchial hyperresponsiveness have been established. It may be considered a useful diagnostic option when indicated. **Group Variations** Not payable for Delphi hourly and salaried members, effective July 1, 2012

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POLICY CLARIFICATIONS

Established procedures
33215-33218, 33220, 33223, 33230, 33231, 33240, 33241, 33243, 33244, 33249, 33262-33264, 93282-93284, 93287, 93289, 93295, 93296

Experimental procedures
0319T-0328T

Medical Policy
The exclusionary coverage criteria for Implantable Cardioverter Defibrillator have been updated. This policy is effective Nov. 1, 2013.

Adults
The use of the automatic implantable cardioverter defibrillator may be considered established in adults who meet the following criteria:

Primary Prevention
Inclusionary Guidelines
Must meet one of the following criteria:

- Ischemic cardiomyopathy with New York Heart Association functional Class II or Class III symptoms, a history of myocardial infarction at least 40 days before ICD treatment and left ventricular ejection fraction of 35% or less
- Ischemic cardiomyopathy with NYHA functional Class I symptoms, a history of myocardial infarction at least 40 days before ICD treatment and left ventricular ejection fraction of 30% or less
- Nonischemic dilated cardiomyopathy and left ventricular ejection fraction of 35% or less, after reversible causes have been excluded, and the response to optimal medical therapy has been adequately determined
- Hypertrophic cardiomyopathy with one or more major risk factors for sudden cardiac death (history of premature HCM-related sudden death in one or more first-degree relatives younger than 50 years; left ventricular hypertrophy greater than 30 mm; one or more runs of nonsustained ventricular tachycardia at heart rates of 120 beats per minute or greater on 24-hour Holter monitoring; prior unexplained syncope inconsistent with neurocardiogenic origin) and judged to be at high risk for sudden cardiac death by a physician experienced in the care of patients with HCM

Exclusionary Guidelines
The use of the ICD is considered experimental in primary prevention patients who meet one of the following criteria:

- Have had an acute myocardial infarction (e.g., less than 40 days before ICD treatment)
- Have New York Heart Association class IV congestive heart failure (unless patient is eligible to receive a combination cardiac resynchronization therapy ICD device)

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POLICY CLARIFICATIONS	
Established procedures **33215-33218, 33220, 33223, 33230, 33231, 33240, 33241, 33243, 33244, 33249, 33262-33264, 93282-93284, 93287, 93289, 93295, 93296** **Experimental procedures** **0319T-0328T** ***Continued***	• Have had a cardiac revascularization procedure in past 3 months (coronary artery bypass graft [CABG] or percutaneous transluminal coronary angioplasty [PTCA]) or are candidates for a cardiac revascularization procedure • Have non-cardiac disease that would be associated with life expectancy less than 1 year **Secondary Prevention** **Inclusionary Guidelines** • Patients with a history of a life-threatening clinical event associated with ventricular arrhythmic events such as sustained ventricular tachyarrhythmia. **Exclusionary Guidelines** • The use of the ICD is considered experimental for all other indications secondary prevention patients. **Pediatrics** **Inclusionary Guidelines** The use of the ICD may be considered **established** in children who meet any of the following criteria: • Survivors of cardiac arrest, after reversible causes have been excluded. • Symptomatic, sustained ventricular tachycardia in association with congenital heart disease in patients who have undergone hemodynamic and electrophysiologic evaluation • Congenital heart disease with recurrent syncope of undetermined origin in the presence of either ventricular dysfunction or inducible ventricular arrhythmias **Exclusionary Guidelines** The use of the ICD is considered **experimental** for all other indications in pediatric patients. **Adult and Pediatrics** The use of a subcutaneous ICD is considered experimental for all indications.
38204-38206, 38208-38215, 38220, 38221, 38230, 38232, 38240-38242, S2140, S2142, S2150	**Basic Benefit and Medical Policy** The criteria for the BMT-Hematopoietic Stem-Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome medical policy have been updated. This policy is effective Jan. 1, 2014. **Continued on next page**

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POLICY CLARIFICATIONS	
38204-38206, 38208-38215, 38220, 38221, 38230, 38232, 38240-38242, S2140, S2142, S2150 ***Continued***	The safety and efficacy of specified bone marrow or hematopoietic stem cell transplants for plasma cell dyscrasias, including multiple myeloma and POEMS syndrome, have been established. They may be considered useful therapeutic options for patients meeting patient selection criteria. **Contraindications** Absolute and relative contraindications represent situations where proceeding with transplant may not be advisable in the context of limited organ or tissue availability. Contraindications may evolve over time as transplant experience grows in the medical community. Clinical documentation supplied to the health plan must demonstrate that attending staff at the transplant center have considered all contraindications as part of their overall evaluation of potential organ transplant recipients and have decided to proceed. **Relative Contraindications** The selection process for approved tissue transplants is designed to obtain the best result for each patient. Therefore, relative contraindications to HSCT may include, but are not limited to: • Poor cardiac function: Ejection fraction should be greater than 45% with no overt symptoms of congestive heart failure. • Poor pulmonary function: Pulmonary function tests must be greater than or equal to 50% of predicted value. • Poor renal function: Renal creatinine clearance should be greater than 40 ml/min or creatinine must be less than or equal to 2mg/dl. • Poor liver function: There should be no history of severe chronic liver disease. • Presence of HIV or an active form of hepatitis B, hepatitis C or human T-cell lymphotropic virus (HTLV-1). **Multiple Myeloma** **Inclusionary Guidelines** The following hematopoietic stem-cell transplantations for multiple myeloma are considered established: • Single or second (salvage) autologous hematopoietic stem-cell transplantation • Tandem autologous-autologous hematopoietic stem-cell transplantation for patients who fail to achieve at least a near-complete or very good partial response after the first transplant in the tandem sequence. **Continued on next page**

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POLICY CLARIFICATIONS	
38204-38206, 38208-38215, 38220, 38221, 38230, 38232, 38240-38242, S2140, S2142, S2150 ***Continued***	[A near complete response, as defined by the European Group for Blood and Marrow Transplant is the disappearance of M protein at routine electrophoresis, but positive immunofixation. (12) A very good partial response has been defined as a 90% decrease in the serum paraprotein level. (13)] • Tandem transplantation with an initial round of autologous hematopoietic stem-cell transplantation followed by a non-marrow-ablative conditioning regimen and allogeneic hematopoietic stem-cell transplantation for the treatment of newly diagnosed multiple myeloma patients. **Exclusionary Guidelines** • Allogeneic hematopoietic stem-cell transplantation, myeloablative or nonmyeloablative, as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered experimental. • More than two tandem transplants, two single transplants, or a single and a tandem transplant per patient for the same condition. • The routine harvesting or storage of an individual's umbilical cord blood for possible use at some unspecified time in the future. **POEMS Syndrome** **Inclusionary Guidelines** Autologous hematopoietic stem-cell transplantation to treat disseminated POEMS syndrome. **Exclusionary Guidelines** Allogeneic and tandem hematopoietic stem-cell transplantation are to treat POEMS syndrome.
Payable Code **81225** **Nonpayable Codes** **81226, 81227**	**Basic Benefit and Medical Policy** **Genetic Testing for Cytochrome P450 Polymorphisms** BCBSM Medical Policy has determined that the safety and effectiveness of CYP450 genotyping for CYP2C19 *2 and *3 alleles have been established. It may be considered a useful diagnostic option for patients who meet specific patient selection criteria. This policy is effective Jan. 1, 2013. **Inclusionary Guidelines** One of the following criteria must be met: • CYP450 genotyping for the purpose of aiding in the choice of clopidogrel versus alternative anti-platelet agents **Continued on next page**

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POLICY CLARIFICATIONS	
Payable Code **81225** **Nonpayable Codes** **81226, 81227** ***Continued***	• CYP450 genotyping for the purpose of aiding in decisions on the optimal dosing for clopidogrel **Exclusionary Guidelines** CYP450 genotyping for the purpose of aiding in the choice of drug or dose to increase efficacy or avoid toxicity for all other drugs. This includes, but is not limited to, CYP450 genotyping for the following applications: • Selection or dosing of selective serotonin reuptake inhibitors • Selection or dosing of antipsychotic drugs • Deciding whether to prescribe codeine for nursing mothers • Selection and dosing of selective norepinephrine reuptake inhibitors including atomoxetine HCL (for treatment of attention-deficit hyperactivity disorder) • Selection and dosing of tricyclic antidepressants • Dosing of efavirenz (common component of highly active antiretroviral therapy for HIV infection) • Dosing of immunosuppressant for organ transplantation • Selection or dose of beta blockers (e.g., metoprolol)
84999	**Basic Benefit and Medical Policy** Measurement of antibodies to either infliximab or adalimumab in a patient receiving treatment with either infliximab or adalimumab, whether alone or as a combination test that includes the measurement of serum infliximab or adalimumab levels, is considered experimental. The use of these tests has not been clinically proven to improve patient clinical outcomes or alter patient management. This policy is effective Jan. 1, 2014.
93797, 93798, S9472	**Basic Benefit and Medical Policy** The criteria for the Cardiac Rehabilitation, Outpatient policy have been updated. This policy is effective Jan. 1, 2014. **Inclusionary Guidelines** Must meet all: • Phase II cardiac rehabilitation • Member must be medically stable and able to tolerate exercise for 20-40 minutes. • Must have a least one diagnosis listed below: – Acute myocardial infarction with documented diagnosis within the 12 preceding months – Coronary artery bypass graft surgery – Current stable angina pectoris **Continued on next page**

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POLICY CLARIFICATIONS	
93797, 93798, S9472 ***Continued***	– Percutaneous transluminal coronary angioplasty or coronary stenting – Heart valve surgery – Heart or heart-lung transplant – Compensated heart failure **Exclusionary Guidelines** • Phase I cardiac rehabilitation (performed during inpatient stay) • Phase III cardiac rehabilitation • Phase IV cardiac rehabilitation • Intensive cardiac rehabilitation • Does not meet diagnostic criteria • Repeat participation in an cardiac rehabilitation program in the absence of another qualifying cardiac event
EXPERIMENTAL PROCEDURES	
0336T, 58578, 58999	**Basic Benefit and Medical Policy** Laparoscopic and percutaneous techniques of myolysis as a treatment of uterine fibroids are considered experimental. There is insufficient published evidence to assess the safety or impact on health outcomes in the treatment of uterine fibroids. This policy is effective Jan. 1, 2014.
GROUP BENEFIT CHANGES	
Ascension Fully Insured Plan for Medical and Prescription Drug Benefits	The Ascension Fully Insured Plan for Medical and Prescription Drug Benefits will become effective Jan. 1, 2014. The group number is 71579 and the alpha prefix is HNZ. There will be four medical (three-tier) plans, which will also include prescription drug and hearing coverage.
Ascension SmartHealth	Effective Jan. 1, 2014, all Ascension SmartHealth's benefit plans will be migrating to the NASCO/FlexLink system. The new group number assigned to Ascension SmartHealth is 71574 and the alpha prefix is ASY. Please note that Ascension members will be receiving new ID cards. You may refer to the provider telephone numbers listed on the back of the ID card.
City of Ypsilanti	Effective Dec. 1, 2013, Medicare-eligible retirees of the City of Ypsilanti will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue℠ Group PPO, for their medical, surgical and prescription drug benefits. The group number is 60008 with suffixes 600 and 601. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PPO plan, go to **bcbsm.com/provider/ma.**

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GROUP BENEFIT CHANGES	
Delphi	Effective Jan. 1, 2014, Delphi is offering a new CDH plan to its salaried members. The group number is 72240. This plan is referred to as Healthy Blue Medical Plan. This replaces the previous Delphi PPO plan. The new CDH plan offers medical, hearing and prescription coverage integrated into the medical cost-sharing. Express scripts will remain the carrier for prescription drugs. There are cost-sharing increases, as this is a high-deductible health plan. The new Delphi CDH plan has a health savings account through Health Equity. BCBSM ID cards will only be sent to members new to BCBSM, but all members will receive a debit card from Health Equity before Jan. 1, 1014. This plan also offers transitional care for members who meet the criteria for continued care. Member ID cards will show alpha prefix DEH. Only new to Blue members will receive ID cards. Existing Blue members will use their current cards.
K.S. Kolbenschmidt	**Correction:** Effective Dec. 1, 2013, Medicare-eligible retirees of the K.S. Kolbenschmidt will have Blue Cross Blue Shield of Michigan's Medicare Advantage prescription drug plan, Prescription Blue℠ for its prescription drug benefits. The group number is 60388 with suffix 602. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PDP plan, go to **bcbsm.com/provider/ma**.
Perrigo Company	Effective Jan. 1, 2014, Perrigo Company, group number 71350, will be adding a new segment to its current benefit plans. The new plan will be a high-deductible health plan with a health savings account. Perrigo will refer to this plan as its consumer-directed health plan. This option will be available to both active and COBRA employees. There are no retirees for this account. It will include medical benefits along with the existing hearing plan and will be designated by package codes 100 and 101.
Spartan Stores Inc.	For this group, the group number is 71575, effective Jan. 1, 2014. The group will offer four PPO plans (Regular, Core and Select through a health reimbursement arrangement and a high-deductible health plan compatible with a health savings account through Health Equity), two prescription drug plans and one hearing plan. Member ID cards will show alpha prefix NSS for PPO coverage. Customer service line for Spartan Stores: 1-877-752-1233.

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ALL PROVIDERS

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GROUP BENEFIT CHANGES	
Truven Health Analytics	Truven Health Analytics, group number 71577, will join the Blues Jan. 1, 2014. The group will offer one PPO plan for its medical and surgical benefits and one hearing care plan. Member ID cards will show alpha prefix RTH for PPO coverage.

FACILITY

Utilization Review department to conduct audit survey

The Utilization Review department performs post-payment audits of facility providers. These audits are usually conducted onsite at the provider's location, on the Internet or as a desk audit. When the audit is completed, we would like to send you a short audit survey to tell us your opinion of the review process.

Beginning in January 2014, the hospital contact person will receive an email from the lead auditor with a link to access the survey. We will provide directions for completing the survey. Please complete your responses for the type of audit conducted at your facility. We request that the survey be completed within two weeks.

Your feedback is very important to us and will help us improve our service to you.

If you have any problems accessing the link, please contact your lead auditor.

Joint Venture Hospital Laboratories network now offers electronic funds transfer

Many health care providers who receive checks from JVHL for certain services for our Medicare Advantage members have indicated that they would prefer to receive payments electronically. That's why we're pleased to let you know that JVHL is now offering electronic funds transfer.

To enroll online or by phone:

- If you have access to JVHL's Provider Resource Center, click on *Sign Up For EFT* on any page of their secured website to start the process.
- If you don't have access to JVHL's Provider Resource Center, apply at **jvhl.org*** and click on *Apply to Access*.
- Call JVHL Business Services at 1-800-445-4979 to initiate the enrollment process.

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PROFESSIONAL

Register and begin ICD-10 professional testing today

The ICD-10 transition is less than a year away and there's still much work that needs to be done. In order to help health care providers start thinking about and working with ICD-10 — and to give BCBSM an idea of ICD-10 readiness — we opened our ICD-10 testing tool for professional health care providers in October of this year.

Here are a few notes about the tool:

- The test tool is available through the ICD-10 implementation date of Oct. 1, 2014.

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- Testing is done through a web-based tool; no special software or lengthy test requirements will be needed (but you will need Internet access).
- It is "content based" and "specialty specific," which means that professional health care providers will be presented with several unique health care encounters and be able to code the encounters in ICD-10.
- Providers will need to register for each specialty they are interested in testing.

To register for the ICD-10 professional test tool, go to **bcbsmicd10providerregistry.highpoint-solutions.com**.

Our facility testing process will be introduced next month.

Mental health providers will be impacted by ICD-10

As we've been telling you about in previous issues of *The Record*, providers who submit claims with dates of service beginning Oct. 1, 2014, must use the ICD-10 code set.

Recently, we've received questions about how ICD-10 will impact mental health providers. The ICD-10 implementation applies to mental health professionals, even if they currently use the DSM-IV or the updated DSM-5.

For billing purposes, the ICD code sets are the only HIPAA compliant code set for claims and claim submissions. Claims with non-compliant codes will be rejected.

It's important to note, however, that the DSM-5 lists the ICD-10 codes for each entry in parentheses next to the code description. Health care providers can use these codes for claims with dates of service on or after Oct. 1, 2014.

To learn more about ICD-10, go to **cms.gov/icd10***. For more information about the DSM or guidance from the American Psychiatric Association, go to **psychiatry.org***. To find out more about BCBSM's implementation, go to **bcbsm.com/icd10**.

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BCBSM to begin accepting new CMS-1500 claim form Jan. 6, 2014

As you read in the November *Record*, Blue Cross Blue Shield of Michigan will begin accepting a revised CMS-1500 claim form (version 02/12) on Jan. 6, 2014. It will replace the current form (version 08/05) as well as the *Michigan Status Claim Review Form*.

You can continue to use the current CMS-1500 claim form through March 31, 2014. From Jan. 6, 2014, through March 31, 2014, health care providers can submit either version of the form. New claim forms (version 02/12) received prior to Jan. 6, 2014, will be returned.

Keep in mind that this form will be used for all lines of business and applies to BCBSM Medicare Advantage as well.

To help you prepare to use the new version of the form, we'll include line-by-line instructions for completing it in the "Claims" chapter of our online provider manual by Jan. 6. (The "Claims" chapter will include two sets of instructions for completing CMS-1500 claims — one for each version — until April 1, 2014.)

You'll be able to order the new form (version 02/12) after Jan. 1, 2014, by accessing the *Blue Pages Directory* chapter of your online provider manual on web-DENIS and completing the *Facility and Professional Supply Requisition Form*.

For more information, contact your provider consultant or visit **NUCC.org***.

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WebAssist chiropractic provider portal provides clinical resources

Blue Cross Blue Shield of Michigan is committed to helping clinicians provide care that is well-aligned with current, evidence-informed best practices. That's why BCBSM and its chiropractic partner, Optum™, want to ensure that you can maximize the value and resources found on the Optum chiropractic provider portal, WebAssist, at **myoptumhealthphysicalhealth.com**.

WebAssist contains a vast library of resources available to you 24 hours a day, seven days a week:

- BCBSM tiering criteria
- Your personalized clinical profile comparing your performance against same-specialty peers within the BCBSM network
- Evidence-based resources
- Peer-reviewed literature
- Clinical guidelines
- Patient education
- Clinical newsletters

Chiropractors participating in the TRUST network contractually agree to provide BCBSM members with efficient, cost-effective care. We monitor network and individual providers and understand unique aspects of your practice may impact your ability to perform within the averages established by your professional peers. However, unexplained high utilization and cost of care will change your tier category from "meets criteria" to "does not meet criteria." Unexplained variance from your peers may impact your continued participation in BCBSM's PPO. BCBSM may contact you at any time with concerns about your profile.

Regular use of the Optum provider portal will help you assess your current standing among your network peers and help you plan for a continued, successful participation in the BCBSM TRUST network.

You'll need your provider ID and password to access your data on the Optum WebAssist provider portal. If you haven't received your provider ID or password, or you need this information resent to you, call Optum at 1-800-873-4575.

If you have any questions about the information in this article or would like to discuss a BCBSM clinical case, please call an Optum support clinician at 1-800-873-4575, ext. 31413. If you have any other questions, call a BCBSM profile analyst at 313-448-7371.

Cosmetic and reconstructive surgery guidelines updated

The Cosmetic and Reconstructive Surgery medical policy guidelines have been updated and will become effective Jan. 1, 2014. Reconstructive surgery is an established service when a patient is restored to a normal functional status, or when surgery is used to repair a defect due to congenital defects, developmental abnormalities, trauma, infection, involutional defects, tumors or disease. Reconstructive surgery may also be a therapeutic option when recommended.

Cosmetic surgery is not considered a medical necessity because it's performed to preserve or enhance a patient's appearance or self-esteem.

Guidelines
In the absence of a functional deficit, reconstructive surgery may be used to restore a patient's appearance to a normal state that existed before the illness, traumatic injury or surgery.

A declaration of medical necessity to justify surgery should be supported by medical documentation. Condition categories may be incorporated as part of the contractual definition of reconstructive services, and include the following:

- Post-surgery (including breast reconstruction)
- Accidental trauma or injury
- Diseases
- Congenital anomalies
- Post-chemotherapy
- Massive weight loss causing functional impairment, including, but not limited to, severe rashes or intertrigo, skin ulceration or pain (such as backache due to a large panniculus) that doesn't respond to conventional therapy.

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COSMETIC RECONSTRUCTIVE continued from Page 32

The following procedures may be considered either cosmetic or reconstructive in nature, based on the indications for the surgery. **Note:** This list is not all-inclusive.

Procedure	Cosmetic versus reconstructive
Abdominoplasty Panniculectomy	• *Reconstructive* if patient meets policy guidelines. See joint policy "Abdominoplasty."
Blepharoplasty of lower lids	• *Cosmetic*
Blepharoplasty of upper lids	• *Cosmetic* when done to improve appearance only • *Reconstructive* if criteria are met. Refer to policy "Blepharoplasty and Repair of Brow Ptosis."
*Breast augmentation or reconstruction	• *Cosmetic* if done solely to improve appearance • *Reconstructive* if done following prophylactic mastectomy in high-risk patients. May also be considered reconstructive following medically necessary mastectomy. This would include reconstruction of the nipple and areolar complex. Reconstruction or revision of the contralateral breast may be necessary to provide symmetry between the breasts. *See medical policy "Reconstructive Breast Surgery/Management of Breast Implants" for tattooing the breast or nipple in conjunction with breast reconstruction.
Breast reduction	• *Cosmetic* if done to improve appearance in the absence of functional deficit • *Reconstructive* if policy guidelines are met. See joint policy "Breast Reduction Mammoplasty."
*Chemical peels	• *Cosmetic* when done for aging skin (e.g., skin damage due to overexposure to sun, etc.), wrinkles, acne scarring or when using chemical peel and hydrating agents that do not require physician supervision for application • *Reconstructive* when guidelines are met: Chemical peels performed no more than three to four times in a 12-month period are appropriate as follows: – Dermal (medium and deep) chemical peels, up to four times in a 12-month period, used to treat patients with numerous (>10) actinic keratoses or other premalignant skin lesions – Epidermal (superficial) peels, up to six times in a 12-month period, to treat active acne in patients who have failed other therapy ***Note:** Requests for chemical peels should be carefully evaluated to determine if the request is primarily cosmetic in nature. Refer to joint policy "Chemical Peels."
Cheek (malar) or chin (genioplasty) implants	• *Cosmetic*
Correction of telangiectasias or spider veins	• *Cosmetic*

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COSMETIC RECONSTRUCTIVE continued from Page 33

Procedure	Cosmetic versus reconstructive
Cryotherapy for skin conditions	• *Cosmetic* when used to treat acne scarring or other dermatologic conditions in which the primary purpose is to change or improve appearance when there is no specific functional deficit or imminent health risk. Cryotherapy is not recommended for the treatment of active acne vulgaris. • *Reconstructive* when used to treat actinic keratosis or other pre-cancerous skin lesions
Dermabrasion/ microdermabrasion	• *Cosmetic* when used for treatment of wrinkling, hyperpigmentation or acne scarring. Dermabrasion and microdermabrasion are not recommended for the treatment of active acne vulgaris. • *Reconstructive* when used to treat actinic keratosis or other pre-cancerous skin lesions
Dermal fillers	• *Cosmetic*-only used to improve appearance
Diastasis recti repair absent a true midline hernia	• *Cosmetic*
Electrolysis	• *Cosmetic*
Excision of excessive skin of the thigh, leg, hip, buttock, arm, forearm, hand, submental fat pad or other areas	• *Cosmetic* if the primary purpose is to change or improve appearance when there is no specific functional deficit (e.g., interference with activities of daily life) or imminent health risk (e.g., infection) that can be removed or improved by the procedure • *Reconstructive* if done to correct a functional problem, including, but not limited to, severe rashes or intertrigo, skin ulceration or pain that has not responded to conventional medical therapy (e.g., topical antifungals, topical or systemic corticosteroids and local or systemic antibiotics)
Excision of glabellar frown lines	• *Cosmetic*
Fat grafts.	• *Cosmetic*
Hairplasty for any form of alopecia.	• *Cosmetic*. Coverage may be available only for the treatment of the underlying condition only. Refer to joint policy “Alopecia Treatment.”
Insertion or injection of prosthetic material to replace absent adipose tissue	• *Reconstructive* only when used to repair a significant deformity from accidental injury, surgery or trauma
Laser resurfacing of the skin	• *Cosmetic* when done to treat wrinkling or aging skin, acne scars, telangiectasias, or other skin conditions in which the primary purpose is to change or improve appearance when there is no specific functional deficit or imminent health risk. Laser resurfacing is not recommended for the treatment of active acne vulgaris. • *Reconstructive* when done to treat patients with numerous (>10) actinic keratoses or other pre-malignant or nonmalignant skin lesions when treatment of the individual lesions would be impractical
Laser treatment of port wine stains	• *Reconstructive* if done due to functional impairment related to the port wine stain (e.g., bleeding)
Liposuction/suction-assisted lipectomy	• *Cosmetic* if it is the sole procedure done. Commonly performed on the abdomen (the "tummy"), buttocks ("behind"), hips, thighs and knees, chin, upper arms, back and calves

COSMETIC RECONSTRUCTIVE continued on Page 35

COSMETIC RECONSTRUCTIVE continued from Page 34

Procedure	Cosmetic versus reconstructive
Liposuction/suction-assisted lipectomy	• *Reconstructive* if done in conjunction with covered reconstruction surgery. For example, if a covered breast reduction is done by conventional means, there may be a need for minor liposuction to smooth the edges of the incisions.
Otoplasty	• *Cosmetic* when done to treat psychological symptomatology or psychosocial complaints related to one's appearance • *Reconstructive* in following circumstances: when done to correct absent or deformed ears due to congenital deformity/absence, trauma or accidental injury
Poly-L-lactic acid injection (e.g., Sculptra®)	• *Cosmetic* for all indications, including HIV lipoatrophy
Reduction of labia majora and minora, or labiaplasty	• *Cosmetic.* In situations where there is discomfort from the condition, these symptoms can be managed with personal hygiene and avoidance of form-fitting clothes.
Rhinoplasty	• *Cosmetic* if done to improve appearance only • *Reconstructive* if done for repair of nasal deformity due to trauma, accidental injury or chronic condition affecting the nasal structures (e.g., Wegener's granulomatosis)
Salabrasion (a technique in which salt or a salt solution is used to abrade the skin, e.g., to remove the pigment from a tattoo or permanent makeup)	• *Cosmetic*
Scar revision	• *Cosmetic* if scars are asymptomatic • *Reconstructive* for the revision of symptomatic scars
Tattoo removal	• *Cosmetic* if done for the removal of decorative tattoos • *Reconstructive* if done for the removal of hyperpigmentation resulting from trauma, surgery or other procedures
Testicular prostheses	• *Reconstructive* for replacement of congenitally absent testes, or testes lost due to disease, injury or surgery

Reminder: Supporting documentation needed when billing unclassified or not-otherwise-classified procedure codes

Specific documentation is needed when you provide a service that is associated with an unclassified or not-otherwise-classified procedure code.

The supporting documentation is necessary to ensure that the claim can be reviewed in a timely manner to determine a procedure's medical appropriateness and service payment amount. When the necessary documentation isn't attached, claims will be denied.

Only services where an established Current Procedural Terminology or Health Care Procedure Coding System code doesn't exist should be reported with a NOC code. NOC codes must include a description of the service performed as well as the specified supporting documentation.

For more information on supporting documentation, see the articles on Page 7 of the January 2009 *Record* and Page 3 of the September 2009 *Record*.

For more information about claims or payable services, see your online provider manual on web-DENIS.

PROFESSIONAL

The reporting of urgent care codes clarified

We've made a correction to the online version of an October 2013 *Record* article about reporting codes for professional urgent care services

An additional location, location 22, can now be reported by health care providers for urgent care services provided in a hospital outpatient setting. Urgent care centers should continue to report location 20.

To access archived issues of the online version of *The Record*, go to **bcbsm.com/providers** and click on *Newsletters*.

University of Michigan Health System doctors join Blue Preferred® Plus Provider Network

As of Aug. 1, 2013, the doctors at UMHS became a part of the Blue Preferred Plus Provider Network. This means that BPP members will no longer require a BPP Program Referral Form to use UMHS services.

PROFESSIONAL, DME

Updates announced for how DME suppliers, independent labs should submit claims

When the Blue Cross and Blue Shield Association revised its rules for filing ancillary claims in certain situations, we discussed the changes in an article in the November 2012 edition of *The Record*.

Now, we'd like to inform you of updates to those guidelines for submitting claims. The changes affect independent laboratories and durable medical equipment suppliers.

You can use the table on the following page as a reference, and the changes are indicated with an asterisk.

Find out where to file ancillary claims
To assist independent laboratories, DME suppliers and specialty pharmacies with filing claims, we've posted a link on web-DENIS.

The link provides a directory of addresses where they can submit claims for various Blues plans.
To find the link:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters & Resources.*
- Under Operations and Training, select *Other BCBS Plan Claim Addresses.*

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Provider type	Where to file	Fields to use when filing a claim	Examples showing which Blue plan to submit claims to
Durable medical equipment supplier Types of service include hospital beds, oxygen tanks, crutches, diabetic supplies, etc.	File the claim with the plan in whose state the equipment or supplies were **shipped to or purchased in a retail store.** **Note:** For items purchased in a retail store, use place of service "11" for commercial claims. If your claim is rejected, please contact Provider Servicing. We are currently working to update our system to ensure that location 11 is accepted as a payable location. For Medicare primary and Medicare Advantage claims, CMS billing guidelines apply.	**Patient's address**: Make sure to indicate the address of where the DME is shipped to or purchased, using the following fields: • Field 5 on the CMS-1500 claim • Loop 2010CA on the 837 professional electronic claim **Ordering/referring provider**: • Field 17B on the CMS-1500 claim • Loop 2420E (line level) on the 837 professional electronic claim **Place of service**: • Field 24B on the CMS-1500 claim • Loop 2300, CLM05-1 on the 837 professional electronic claim **Service facility location information**: Be sure to include the address of the retail site where the equipment or supplies were purchased, using the following fields: • Field 32 on the CMS-1500 claim • Loop 2310C (claim level) on the 837 professional electronic claim	• Diabetic supplies are purchased from a DME supplier located in the Plan X service area and are shipped by that supplier to a member in the Plan Y service area. **File with:** Plan Y • Diabetic supplies are purchased at a DME supplier's retail store in the Plan X service area. **File with:** Plan X • Diabetic supplies are purchased from a DME supplier in the Plan X service area and shipped or mailed to a member in the Plan X service area. **File with:** Plan X
Independent clinical laboratory (place of service code 81) Types of service include analysis of blood, urine, etc.	File the claim to the state where the referring physician resides	**Referring provider**: • Field 17B on the CMS-1500 claim • Loop 2310A on the 837 professional electronic claim **Note:** Be sure to enter the national provider identifier of the referring physician in field 17B.	Referring physician resides in the Plan X service area. Blood analysis is done by an independent lab in the Plan Y service area. **File with:** Plan X **Note:** Claims for services performed by an independent lab must be filed with the plan in the state where the referring physician resides.

DME, AUTOS

DME/P&O billing changes for URMBT will take effect Jan. 1

As we discussed in the November edition of *The Record*, Blue Cross Blue Shield of Michigan will begin managing benefits for auto group and UAW Retiree Medical Benefits Trust members who use DME/P&O services provided by professional DME/P&O suppliers, starting Jan. 1, 2014. This change does not affect DME/P&O services that are rendered in and billed by a hospital or physician's office.

The URMBT benefit states that the payment policy for its members' durable medical equipment and prosthetics and orthotics services must follow Centers for Medicare and Medicaid Services guidelines.

To ensure that DME/P&O providers are following CMS guidelines for non-Medicare URMBT members, Blue Cross is requiring providers to bill with a KX modifier on all claims with dates of service on or after Jan. 1, 2014, for the HCPCS codes listed below. The KX modifier indicates that providers have all documentation needed to show compliance with CMS guidelines in the event of a claims audit.

DME/P&O claims billed with the following codes will be denied as a provider liability if they are missing the KX modifier:

Healthcare Common Procedure Coding System codes requiring KX modifier for URMBT members					
A4222	E0431	E0935	K0004	L1907	L5673
A6550	E0434	E1002	K0005	L1960	L5679
B4034	E0443	E1161	K0835	L1970	L5700
B4035	E0450	E1390	K0848	L2275	L5781
B4150	E0464	E1800	K0856	L3908	L5940
B4152	E0482	E1805	K0861	L4360	L5980
B4153	E0570	E1810	L0627	L4386	L5987
B4154	E0652	E1815	L0631	L5321	L5988
B4155	E0730	E1830	L0637	L5530	L7900
B4161	E0745	E2311	L1200	L5649	
E0143	E0784	K0001	L1832	L5651	
E0303	E0849	K0003	L1846	L5671	

Please contact your provider consultant if you have any questions.

VISION

MPSERS vision coverage changes from EyeMed to BlueVision℠

Effective Jan. 1, 2014, the Michigan Public School Employees Retirement System vision plan will change from EyeMed to BlueVision℠. This change applies to both Medicare and non-Medicare MPSERS members

Blue Cross Blue Shield of Michigan has partnered with Vision Service Plan to administer BlueVision. Members will receive a separate ID card for their vision coverage before Jan. 1, 2014.

For information on how to join the VSP network, go to **vspglobal.com/cms/doctors/be-a-vsp-doctor.html***. If you have any questions, please contact your provider consultant.

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BCBSM makes changes to Medicare Advantage formulary

To reduce 2014 plan year costs, our Medicare Advantage Pharmacy Services team made some significant changes to the Part D formulary.

Because of the extent of these changes, we notified current members in October during annual enrollment. We encouraged them to check our formulary to see if their current drugs will be affected by these changes.

Our members may reach out to you about these changes and may request an exception.

Beginning Jan. 1, 2014, please consult our formulary before prescribing a medication to our members. Here are the key changes:

- The changes affect your patients' cost-sharing and access to drugs they're currently using. Some drugs will not be covered, beginning in 2014.
- We're encouraging use of generic drugs when appropriate and focusing on drugs that provide the best treatment.
- We moved many drugs to a high drug tier, resulting in higher out-of-pocket costs for affected members, while other covered drugs will have new requirements for use, such as prior authorization or step therapy.
- To promote drug safety, we've removed many high-risk medications from our formulary and imposed higher cost-sharing on other high-risk medications by moving them into a different drug tier or placing additional restrictions on their use. In some cases, you may be required to check with us before prescribing these drugs. We're also encouraging members to talk with you to see if there's a lower-risk option that would still effectively treat their condition.
- Implemented quantity limits for certain drugs. If you believe your patient needs a larger quantity of a specific drug, the patient may be eligible for a transition supply for the first 90 days of 2014.

Tier exceptions will be available before Dec. 31, 2013, for our members. Members can call Member Services at the number on the back of their ID cards to request a tier exception.

Providers can request coverage determinations for members in advance of the new plan year.

Our 2014 formulary can be found online at **bcbsm.com/medicare**.

If you have any questions or concerns, please contact your provider consultant.

Corporate Communications – MC 0245

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

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Managing Editor .....Joe Lieblang
ProvComm@bcbsm.com

Layout.....Patsy A. Wheatley

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