January 2014

Articles in this issue…

This is your last printed edition of *The Record*

As we've been telling you over the past few months, the January issue of *The Record* is the last printed edition we will send you. *The Record* will only be available electronically via email or through **bcbsm.com** and web-DENIS starting in February.

Moving to an all-electronic *Record* is part of our commitment to give you access to the news and information you need as quickly as possible. The email version of *The Record* arrives in your inbox on the last business day of the month prior to the issue date. That means that current email subscribers should have received this issue on Dec. 31 — several days before print edition subscribers received the issue in the mail.

If you haven't yet subscribed to the electronic *Record*, it's easy to do.

- 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 all the required information and select *The Record*.
- Be sure to scroll down and click on the *Subscribe* button.

Note: The newsletter will be sent to whatever email address you provide — and multiple staff members within an organization can subscribe.

Current and archived issues of the electronic version of *The Record* also can be easily accessed from **bcbsm.com/providers**. Simply click on the *Newsletters* tab and then *The Record Archive*.

We hope this transition will support you in your efforts to streamline your business operations and make it easier for you to do business with us.

If you have questions about this change, please contact your provider consultant. If you encounter any technical issues when subscribing, send an email to ProvComm@bcbsm.com.

BCBSM coverage decisions on 2014 HCPCS codes available online

The 2014 Current Procedural Terminology codes were released in mid-October. We have begun working to implement these new and revised codes in our claims processing systems. You may begin using these new codes on or after Jan. 1.

BCBSM will publish coverage decisions in PDF format on web-DENIS:

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- Under the *What's New* section, click on *2014 HCPCS update*

  or
- Click on *Newsletters Past Issues and Indexes*.
- Click on *The Record*.
- Click on *2014 HCPCS update*.

To request a copy of the PDF, please send an email to ProvComm@bcbsm.com.

We will also identify codes deleted for 2014. As you know, a 90-day grace period is no longer observed for any procedure code deleted as part of the update.

Due to this fall's federal government shut-down, the Centers for Medicare & Medicaid Services delayed its release of the 2014 Healthcare Common Procedure Coding System codes. So, those codes are not yet included in the *HCPCS News* document on web-DENIS. The current document includes only CPT codes from the American Medical Association. We will add the 2014 HCPCS codes as soon as our coverage determinations for them are available.

BCBSM's claims processing systems use HCPCS codes to allow health care providers to report services they performed. HCPCS is a two-level coding system. Providers should use the following resources to find the code that best describes the service provided:

- Level I codes are published in the *Physicians' Current Procedural Terminology, CPT 2014* maintained by the American Medical Association. For a comprehensive list of 2013 changes, refer to Appendix B. The CPT 2014 manual may be purchased from the AMA over the phone or by ordering online.
  - 1-800-621-8335
  - **amapress.com***
- Level II codes are the Centers for Medicare & Medicaid Services codes and apply to professional services, procedures, items and supplies. For a comprehensive list of CMS Level II code changes, refer to the *HCPCS Level II Code Book*. A hard-copy file for these codes can be ordered from:

  U.S. Government Printing Office
  Superintendent of Documents
  P.O. Box 371954
  Pittsburgh, PA 15250-7954

  202-512-1800

*Blue Cross Blue Shield of Michigan does not control this website or endorse its general content.

Coverage expanded for licensed medical practitioners in 2014 FEP benefits

New coverage for medical practitioners and BRCA mutation testing are among the Federal Employee Program® benefit changes for 2014. We've outlined other benefit changes for FEP members below.

The following changes apply to both the Standard and Basic Option benefit plans for services provided on or after Jan. 1, 2014:

- Any licensed medical practitioner is eligible for benefit coverage for his or her services if those services are performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act. This coverage is subject to documented criteria. Previously, benefits for certain medical practitioners were limited to services performed in medically underserved areas.
- New preventive care benefits are available for BRCA mutation testing for adult females when certain criteria are met. Benefits for both preventive and diagnostic testing are limited to one BRCA test per lifetime.
- Two tiers of specialty drugs are now available: Tier 4 includes preferred specialty drugs, and Tier 5 includes non-preferred specialty drugs. Previously, all specialty drugs were included in Tier 4.
- Benefits will be provided in full for Vitamin D supplements for adults age 65 and older. These supplements must be prescribed by a physician and obtained from a preferred retail pharmacy.

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FEP BENEFITS continued from Page 2

- Insulin and diabetic supplies must be obtained from a retail pharmacy or, for Standard Option only, from the Mail Service Prescription Drug Pharmacy Program. This requirement does not apply to members who have Medicare Part B as their primary insurance.
- Benefits are available for cancer patients to purchase wigs if they've experienced hair loss due to their treatments. This benefit is limited to a maximum of $350 for one wig per lifetime. (Previously this benefit only applied to hair loss due to chemotherapy for the treatment of cancer.)
- When a non-participating provider bills for drugs, we will consider the Medicare Part B Average Sale Price in the calculation to determine our plan allowance.
- Benefits are no longer available for heart-lung transplants when performed at Blue Distinction Centers for Transplants®.

These changes apply only to Standard Option members for services incurred on or after Jan. 1, 2014:

- The maximum number of home nursing care visits allowed has increased to 50 visits per calendar year.
- The copayment for Tier 2 preferred, brand-name drugs purchased through the FEP Mail Service Prescription Drug Program is $80 per prescription for up to a 90-day supply.
- The copayment for Tier 3 non-preferred brand-name drugs purchased through the FEP Mail Service Prescription Drug Program is $105 per prescription for up to a 90-day supply.
- New prescriptions of Tier 4 or Tier 5 specialty drugs may be filled at a preferred retail pharmacy or through the FEP Specialty Drug Pharmacy Program. Members must use the FEP Specialty Drug Pharmacy Program for any refills of the same specialty drug. FEP will cover supplies of up to 30 days for the first three fills of the same Tier 4 or Tier 5 prescription. The member may receive supplies of up to 90 days beginning with the fourth fill.
- The copayment for Tier 4 preferred specialty drugs dispensed by the FEP Specialty Drug Pharmacy Program is $35 for up to a 30-day supply, and $95 for a 90-day supply.
- Members pay 30 percent of the FEP plan allowance for Tier 5 non-preferred specialty drugs dispensed by a preferred retail pharmacy.
- The copayment for Tier 5 non-preferred specialty drugs dispensed by the FEP Specialty Drug Pharmacy Program is $55 for up to a 30-day supply, and $155 for up to a 90-day supply.

The following changes apply only to Basic Option members for services incurred on or after Jan. 1, 2014:

- Coinsurance for non-preferred, brand-name drugs purchased at preferred retail pharmacies will apply toward the out-of-pocket maximum for the annual catastrophic protection.
- The copayment for surgical procedures performed outside the office setting is $200 per performing surgeon.
- The copayment for an inpatient admission to a preferred facility is $175 per day, up to a maximum of $875 for unlimited days.
- The copayment for a maternity inpatient admission to a preferred facility is $175.
- The copayment for diagnostic tests such as EEGs, ultrasounds and X-rays performed by a preferred professional provider is $40.
- The copayment for diagnostic tests and radiological services is $100 when performed by a preferred professional provider. These services include bone density tests, CT scans, MRIs, PET scans, angiographies, genetic tests, nuclear medicine and sleep studies.
- The copayment for outpatient diagnostic testing and treatment services is $150 when performed at a preferred, member or non-member facility. These services include angiographies, bone density tests, CT scans, MRIs, PET scans, genetic testing, nuclear medicine and sleep studies.
- The copayment for outpatient diagnostic testing services such as EEGs, ultrasounds and X-rays is $40 per day per preferred, member or non-member facility.
- Benefits for up to 10 acupuncture visits per year are now available. These services must be performed by preferred providers acting within the scope of their license or certification in the state where the services are provided. Previously, benefits for acupuncture were only available when provided by a physician.
- The copayment for neurological testing is $40 when performed by a preferred professional provider.
- The FEP copayment for Tier 2 preferred, brand-name drugs purchased at a preferred retail pharmacy is $45 for up to a 30-day supply.

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FEP BENEFITS continued from Page 3

- Members pay 50 percent of the FEP plan allowance or a minimum $55 copayment for Tier 3 non-preferred, brand-name drugs purchased at a preferred retail pharmacy for up to a 30-day supply.
- New prescriptions of Tier 4 or Tier 5 specialty drugs may be filled at a preferred retail pharmacy or through the FEP Specialty Drug Pharmacy Program. The member must use the FEP Specialty Drug Pharmacy Program for any refills of the same specialty drug. FEP will cover up to a 30-day supply for the first three refills of the same Tier 4 or Tier 5 prescription. The member may receive up to a 90-day supply beginning with the fourth refill.
- The FEP copayment for Tier 4 preferred specialty drugs dispensed by a preferred retail pharmacy is $60. Benefits are limited to one purchase of up to a 30-day supply for each prescription filled.
- The FEP copayment for Tier 5 non-preferred specialty drugs dispensed by a preferred retail pharmacy is $80. Benefits are limited to one purchase of up to a 30-day supply for each prescription filled.
- The FEP copayment for Tier 4 preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is $50 for up to a 30-day supply and $140 for up to a 90-day supply.
- The copayment for Tier 5 non-preferred specialty drugs dispensed through the FEP Specialty Drug Pharmacy Program is $70 for up to a 30-day supply and $195 for up to a 90-day supply.

Blue Cross Blue Shield of Michigan changes its board committee structure

As part of its transition process to a mutual insurance company, the BCBSM Board of Directors has redefined and approved its new board committee structure, which will be in place Jan. 1, 2014, and reflected in health care provider participation agreements April 1, 2014.

The changes outlined in the chart below affect all health care providers, except for hospitals.

Old committee structure	New committee structure
Provider Relations Committee **+** Health Care Delivery and Cost Committee	Health Care Delivery Committee
Physician and Professional Provider Contract Advisory Committee	Professional Provider Relations Advisory Committee

All references to PRC and PPPCAC in provider agreements will be changed to HCDC and PPRAC, respectively.

For the health care providers listed below, provider agreements have also been updated to include the revised committee names in the appeals process. These agreements can be found in the provider manuals on web-DENIS:

- Ambulance
- Certified registered nurse anesthetist
- End-stage renal disease facility (Traditional contract)
- End-stage renal disease facility (TRUST contract)
- Hearing specialist
- Hospice
- Long-term acute care hospital
- Practitioners (M.D., D.O., chiropractors, fully-licensed psychologists and podiatrists)
- Vision specialists (ophthalmologists and optometrists)
- Freestanding and hospital-based substance abuse facility
- Skilled nursing facility

Providers not listed above should check their online provider manuals beginning April 1, 2014, for the latest appeals process.

Contact your provider consultant if you have any questions.

Physical therapy services guidelines updated

We've updated the medical record documentation requirements for physical therapy services. The updates include:

Expiration of physician orders
Unless the ordering physician specifies an earlier date, orders expire after 90 days, even those marked "ongoing" or indicating a period of time longer than 90 days. In all cases, after 90 days, a recertification order (signed and dated by the physician) must be obtained. The date of the first treatment is the start of the 90-day period.

Previously, physician orders expired after 30 days.

For verbal orders, the request for physician signature and date must be initiated within 10 days of receipt of the verbal order, and obtained within 30 days. Previously, the physician signature and date had to be obtained within 10 days of the verbal order.

Treatment plan
Physical therapists must submit treatment plans to physicians for approval and signature. Physician certification of the plan (by signature or verbal order) must be dated within 30 days of the first day of treatment (including evaluation) and documented in the patient medical record. Payment may be denied if physician certification is not obtained.

Discharge summary
Physical therapists must write a discharge summary when their services end. The summary must contain details about the response to treatment, achievement or lack of achievement of goals, and any related recommendations for follow-up or self care.

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

- From web-DENIS, click on *BCBSM Provider Publications and Resources.*
- Click on *Provider Manual.*
- Click on *Provider Type* and select yours from the "Make Selection" box.
- Click on the *Search* button and then on the "Documentation Guidelines for Physicians and Other Professional Providers" chapter.

Anesthesia services guidelines updated

We've updated the medical record documentation requirements for anesthesia services as follows:

- To the list of facts that must be included in the "anesthesia record," we've added the wording shown in bold:

  Route of anesthetic and medication administered (for example, IV, mask, endotracheal, **laryngeal mask airway,** regional)

- To the list of items the anesthesiologist's medical record must include, we've added the wording shown in bold:

  Documentation of a pre-anesthesia evaluation of the patient within the 30-day period prior to the administration of anesthesia (including a complete history, physical examination **with specific inclusion of a Mallampatti Score and notes regarding oral and dental hygiene**, review of systems, personal and relevant family **medical** and social history, and review of pertinent diagnostic tests sufficient to document the safety of the planned surgical procedure and anesthetic)

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

- From web-DENIS, click on *BCBSM Provider Publications and Resources.*
- Click on *Provider Manual.*
- Click on *Provider Type* and select yours from the "Make Selection" box.
- Click on the *Search* button and then on the "Documentation Guidelines for Physicians and Other Professional Providers" chapter.

Process for obtaining an autism evaluation updated

Effective Jan. 1, 2014, BCBSM is discontinuing the accelerated process for obtaining an autism evaluation. Members seeking an autism evaluation after Jan. 1 will need to contact an approved autism evaluation center if they're seeking a recommendation for applied behavioral analysis treatment.

If a BCBSM member obtained an autism diagnosis using the accelerated process prior to Jan. 1, 2014, the diagnosis will be accepted by BCBSM for a period of three years from the date the diagnosis was made.

The number of approved autism evaluation centers has more than doubled since the Blues began covering autism in October of 2012, and it's expected to continue to grow. Receiving an accurate autism diagnosis and the correct treatment plan is crucial to ensuring high-quality patient care, and it's becoming easier to obtain an evaluation through an approved autism evaluation center.

Members can find an approved autism evaluation center at **bcbsm.com/content/dam/public/Common/Documents/approved-autism-evaluation-centers.pdf**.

Reminder: Keep your CAQH® information current

To ensure that your affiliation with the Blues isn't interrupted, be sure you reattest with the Council for Affordable Quality Healthcare every 120 days. You'll also want to update your CAQH information if you change your practice location.

Blue Cross Blue Shield of Michigan uses CAQH to gather and coordinate our practitioner credentialing information. All health care practitioners, including hospital-based health care providers and nurse practitioners, need to be registered with CAQH.

If you do not regularly attest to your information on CAQH, you will not appear in our provider directories or online search tool. Also, if your affiliation with us is interrupted, it can affect the claims you submit.

If you have any questions about CAQH, call the CAQH help desk at 1‑888-599-1771. For questions about the credentialing process, contact your provider consultant.

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.

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*.

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Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
UPDATES TO PAYABLE PROCEDURES	
76942	**Basic Benefit and Medical Policy** The PPO Radiology Management Program has added procedure code *76942 to the program for provider specialty neurologist, effective Sept. 1, 2013.
B4185	**Basic Benefit and Medical Policy** CLINOLIPID injection (lipid injectable emulsion, for intravenous use) is covered for adult patients, effective Oct. 4, 2013.
J7199	**Basic Benefit and Medical Policy** RIXUBIS (Coagulation Factor IX [Recombinant]) is covered for routine prophylactic treatment, control of bleeding episodes and perioperative management in people who are 16 or older with hemophilia B when reported with J7199, effective June 28, 2013.
POLICY CLARIFICATIONS	
96150-96154	**Basic Benefit and Medical Policy** Clinical licensed master's social workers are considered payable providers for these procedures.
99201-99205, 99211-99215, 99217-99223, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350	**Payment Policy** The procedure codes listed at left are not payable to a psychologist, effective Oct. 1, 2013. This change does not apply to the Federal Employee Program®.
Revenue code 0960	**Payment Policy** Payable locations: Inpatient, outpatient, residential substance abuse facility and outpatient substance abuse facility.
Revenue codes 1001, 1002	**Payment Policy** The National Uniform Billing Committee has clarified the behavioral health residential accommodations language by removing the word "treatment" from the descriptions of revenue codes 1001 and 1002. The revenue code category is intended for use on 086X type of bills.
EXPERIMENTAL PROCEDURES	
81500, 81503	**Basic Benefit and Medical Policy** Proteomics-based testing for the evaluation of ovarian (adnexal) masses (e.g., OVA1® and ROMA™ tests) is considered experimental. The use of this testing has not been scientifically demonstrated to improve patient clinical outcomes. This policy is effective Sept. 1, 2013.

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GROUP BENEFIT CHANGES	
Alta Equipment Company	Alta Equipment Company, group number 71582, will join the Blues, effective Jan. 1, 2014. The group will offer a PPO plan with medical-surgical coverage and a prescription drug plan. Member ID cards will indicate alpha prefix GLT.
Aspirus-Keweenaw Hospital	Aspirus-Keweenaw Hospital is a hospital group currently housed on the NASCO platform, but it will be moving to the MOS platform, effective Jan. 1, 2014. The new MOS group number will be 007004132. Member ID cards will continue to retain the existing alpha prefix of KEW. Aspirus Keweenaw Hospital employees will be offered medical, drug, dental and vision benefits.
City of Grosse Pointe Park	Effective Jan. 1, 2014, Medicare-eligible retirees of the City of Grosse Pointe Park 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 51567 with suffixes 601 and 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 PPO plan, go to **bcbsm.com/provider/ma.**
City of Huntington Woods	Effective Jan. 1, 2014, Medicare-eligible retirees of the City of Huntington Woods 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 60480 with suffix 600. 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.**
City of Pontiac	Effective Jan. 1, 2014, Medicare-eligible retirees of the City of Pontiac 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 60418 with suffixes 600-605. 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	
County of Wayne	Effective Jan. 1, 2014, Medicare-eligible retirees of the County of Wayne will have Blue Cross Blue Shield of Michigan's Medicare Advantage PDP plan, Prescription Blue℠, for their prescription drug benefits. The group number is 60456 with suffixes 600, 601 and 602. You can identify members by the XYA 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.**
Dickinson County Health System	Dickinson County Health System is a hospital group currently housed on the NASCO platform, but it will be moving to the MOS platform, effective Jan. 1, 2014. The new MOS group number will be 007003630. Member ID cards will continue to retain the existing alpha prefix of DHE. Dickinson County Health System employees will be offered medical and dental benefits.
Frankenmuth Insurance	Effective Jan. 1, 2014, Medicare-eligible retirees of Frankenmuth Insurance 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 60423 with suffix 600. 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.**
Henniges Automotive	Effective Jan. 1, 2014, Henniges Automotive, group number 71325, members have Catamaran as their prescription drug carrier, instead of Express Scripts. Members will receive a new BCBSM card that will no longer have a prescription drug phone number on it. They will also receive Catamaran cards with information regarding their new prescription drug plan.
Huron Clinton Metropolitan Authority	Effective Jan. 1, 2014, Medicare-eligible retirees of the Huron Clinton Metropolitan Authority 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 67228 with suffix 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	
Local 4911 VEBA Trust	Effective Jan. 1, 2014, Medicare-eligible retirees of Local 4911 VEBA Trust 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 60426 with suffix 600. 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.**
Michigan Electrical Employees Health Plan	Effective Jan. 1, 2014, Medicare-eligible retirees of the Michigan Electrical Employees Health Plan 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 60447 with suffix 600. 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.**
Neogen Corporation	Neogen Corporation, group number 71578, will transition from local MOS to NASCO, effective Jan. 1, 2014. The group offers four PPO plans with medical-surgical coverage and two prescription drug plans. Member ID cards will show alpha prefixes DMM.
Severstal North America Hourly	Claims processing for Severstal North America Hourly, group number 72730, will move from our local MOS to NASCO processing system Jan. 1, 2014. The group is offering one PPO plan with hearing, dental and Traditional vision coverage and one prescription drug plan. Member ID cards will show the following alpha prefixes: GVJ – for PPO plans GVL – for Medicare PPO
Sturgis Hospital Inc.	Sturgis Hospital Inc., group number 71580, will join the Blues Jan. 1, 2014. The group will offer two PPO plans, a health savings account (being managed outside BCBSM) and two prescription drug plans. Member ID cards will show alpha prefix AIB.

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GROUP BENEFIT CHANGES	
UAW Retiree Trust	Effective Jan. 1, 2014, Medicare-eligible retirees of the UAW Trust 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, expanding coverage to group members in Michigan, Florida, Missouri and West Virginia. The plan ID number for Michigan is 2040165. 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.**
Wacker Chemical	Effective Jan. 1, 2014, Medicare-eligible retirees of Wacker Chemical 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 60156 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.**

New wellness incentive plan Healthy Blue Achieve℠ PPO rewards members for making better health choices

Blue Cross Blue Shield of Michigan's Healthy Blue Achieve PPO is a new wellness incentive product that goes into effect Jan. 1, 2014. The Blues will offer two benefit levels for this product: enhanced and standard. Members with the enhanced benefit level will have lower out-of-pocket costs compared to the standard benefit level.

Members automatically receive enhanced benefits at the start of the plan. In order to maintain enhanced benefits, members must do the following within 90 days of their plan's effective date:

- **Complete a health assessment** — Members must visit **bcbsm.com** and complete the Succeed® online health assessment.
- **Submit the qualification form** — BCBSM has updated its qualification form. Members will bring their pre-populated qualification form to your office and ask you to complete the form, sign it and fax it to the number listed on the form.
- **Meet specific health targets** — If a member doesn't meet the blood pressure, blood sugar or cholesterol targets, they'll lose enhanced benefits unless they commit to work with you to improve the missed measure. For these three health targets, please use the check boxes on the qualification form to indicate the member has agreed to follow your plan.
  - If a member doesn't meet the tobacco use target, he or she will be required to enroll in BCBSM's tobacco cessation program for the remainder of their plan year, or until tobacco use has stopped.
  - If a member doesn't meet the Body Mass Index target, he or she will be required to participate in BCBSM's walking program and walk an average of 5,000 steps per day for the remainder of their plan year or until their BMI falls below 30.

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If a member has a medical condition that makes it inadvisable for him or her to meet the health measure or activity requirements, you can request a medical waiver on their behalf. You must complete and submit a *Physician Verification Form* to request a medical waiver for the member. You can access the *Physician Verification Form* in two different ways as follows.

1) From web-DENIS by logging in to Provider Secured Services:
   - Visit **bcbsm.com** and log in as a provider.
   - Click on the *Provider Publication and Resources* link.
   - Click on *Newsletters and Resources*.
   - Click on *Physician Verification Form*, located under Frequently Used Forms on the right side of the screen.

2) From the provider section of our website:
   - Visit **bcbsm.com** and click on the *Providers* tab.
   - Click on *Quick Links*.
   - Click on *Healthy Blue Achieve*.
   - Click on the *Physician Verification Form*.

For your Healthy Blue Achieve patients, the *Physician Verification Form* can be used to:

- Request that a member is waived from meeting a health measure due to a medical condition.
- Request that a member is waived from the walking requirement and the member will alternatively be required to participate in BCBSM's food journaling program.
- Notify BCBSM when your patient has met a health measure he or she previously missed.

If you have any questions regarding the Healthy Blue Achieve product, contact your provider consultant.

New *Physician Verification Form* replaces *Medical Waiver Request form*

When members are enrolled in a Blues wellness plan and they're unable to meet a required health measure or activity due to a medical condition, you may request a medical waiver on their behalf.

We've updated the medical waiver form to accommodate each wellness plan. The previous *Medical Waiver Request* form will no longer be accepted. When a medical waiver is appropriate, please complete the medical waiver portion of the new *Physician Verification Form* on the patient's behalf.

Similar to the old form, the new verification form is still a separate document from the qualification form. You can download it from web-DENIS by logging in to Provider Secured Services at **bcbsm.com**:

- Visit **bcbsm.com** and log in as a provider.
- Click on *Provider Publication and Resources*.
- Click on *Newsletters and Resources*.
- Click on *Physician Verification Form*, located on the right side of the screen.

You also can download the *Physician Verification Form* from the provider section of our website:

- Visit **bcbsm.com** and select the *Providers* tab.
- Click on *Quick Links*.
- Click on *Healthy Blue Achieve*.
- Click on *Physician Verification Form*.

After you've completed the form, be sure to sign it and fax it to the number listed on the form by the date provided in your patient's enrollment materials. Your patient may have alternative activities to complete. Please refer your patient to the enrollment materials for additional information.

Here's a summary of how the new *Physician Verification Form* will apply to your patients in BCBSM's two standard wellness products.

Healthy Blue Achieve℠ PPO
If your patient is enrolled in Healthy Blue Achieve, the *Physician Verification Form* can be used the following ways:

- To waive your patient from one or more health measure requirements. Healthy Blue Achieve members will be waived from the health measure you identify on the form and won't be required to complete the respective alternative activity, such as the walking program, food journaling program or tobacco cessation program.

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Note: If your patient is pregnant or in hospice, use the *Physician Verification Form* to indicate this.

- To waive your patient from the walking requirement. If your patient doesn't meet the body mass index target, and you feel they're unable to meet the alternative walking requirement (walk an average of 5,000 steps per day), please complete the medical waiver section of the form to waive them from walking, and they'll be required to participate in the food journaling program instead.
- To report newly met health measures to BCBSM after your patient's initial qualification form has been submitted. If your patient originally missed one or more health measure requirements and they've been participating in an alternative wellness program, you can use the new health measure section of the form to notify us of their newly met health measure.

Healthy Blue Outcomes℠
If your patient is enrolled in Healthy Blue Outcomes and you're requesting a medical waiver on his or her behalf, please complete the medical waiver portion of the *Physician Verification Form.* Your patient will be required to complete the following alternate compliance activities:

- Two online digital coaching modules
- A follow-up visit with you to review the member's health improvement plan, found on the back of the qualification form

You'll also need to complete and fax the *Medical Waiver Follow Up* form indicating whether your patient has met expectations from the health improvement plan.

Members must complete these alternate compliance activities within 210 days of their benefit effective dates.

If you have questions about the new *Physician Verification Form*, contact your provider consultant.

New CMS-1500 claim form to replace *Michigan Status Claim Review Form*

As you've read in previous issues of *The Record,* BCBSM will begin accepting the revised CMS-1500 claim form (version 02/12) on **Jan. 6, 2014**. It replaces version 08/05, as well as the *Michigan Status Claim Review Form*.

We'll no longer accept the 08/05 version of the CMS-1500 claim or the *Michigan Status Claim Review Form* as of April 1, 2014.

The *Michigan Status Claim Review Form* was used when a claim was rejected or if the payment received was different from what was anticipated — issues you'll be able to address with the new CMS-1500 claim. Following are the fields that will need to be completed when submitting a claim status update:

Field 22: This field takes the place of the *Michigan Status Claim Review Form*. (If you're submitting a new claim, leave this field blank.) List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code left-justified on the left-hand side of the field.

Field 19: This is required on a resubmitted claim. If you complete Field 22, you must complete Field 19 as well, providing additional information.

As of Jan. 6, 2014, you can get more details about the above-mentioned fields or learn about other changes to the CMS-1500 claim in the "Claims" chapter of your provider manual.

You'll be able to order the new claim form (version 02/12) from us beginning Jan. 1, 2014, by completing the *Facility and Professional Supply Requisition Form.* There are two ways to access the form:

1) You can access it via your provider manual on Explainer.
   - From web-DENIS, click on *BCBSM Provider Publications and Resources.*
   - Click on *Provider Manual.*
   - Click on *Provider Type* and select yours from the "Make Selection" box.
   - Click on the *Search* button and then on the *Blue Pages Directory* chapter.
   - Click on *Forms and supplies* and then on *Facility and Professional Supply Requisition*.
   - Print and complete the form and mail it, along with a check for the total amount of your order, to the address provided on the form.

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2) You can access it via the *BCBSM Newsletters and Resources* page on **bcbsm.com/providers**.
   - From web-DENIS, click on *BCBSM Provider Publications and Resources.*
   - Click on *Newsletters & Resources.*
   - Click on *Facility and Professional Supply Requisition Form*, which you can access from the list of frequently used forms on the right side of the screen.
   - Print and complete the form and mail it, along with a check for the total amount of your order, to the address provided on the form.

For more information about the new CMS-1500 claim form, see the article titled "BCBSM to begin accepting new CMS-1500 claim form Jan. 6, 2014," in the December *Record*, contact your provider consultant or visit **NUCC.org***.

*BCBSM does not control this website or endorse its general content.

Practitioners must sign contracts soon to participate in the Southeast Michigan local network

Practitioners interested in participating in a new local exclusive provider organization network for Southeast Michigan individual members need to sign and return the contract signature document soon.

Blue Cross Blue Shield of Michigan is developing a local exclusive provider organization network for health insurance products to be marketed to individuals in selected Southeast Michigan counties: Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne. We plan to introduce these local products in 2015 for individual consumers on and off the Health Insurance Marketplace.

Contracts were distributed to practitioners in these counties in October and November. Additional copies are available from your BCBSM provider consultant, who can also answer any questions regarding this opportunity.

BCBSM requested that signature pages be returned by Dec. 31, 2013. Practitioners who are interested in joining the EPO network and have not yet responded should **immediately** fax the signature document to BCBSM at 1-866-915-1714 or email a scanned and signed copy to SE_Michigan_EPO@bcbsm.com. This will indicate your participation in the EPO network, pending final BCBSM approval.

Physicians (M.D. and D.O.), podiatrists, chiropractors, oral surgeons and fully licensed psychologists participating in our TRUST PPO network are eligible to participate in the new EPO. Practitioners must also meet network selection standards, which were published in the *Detroit Free Press* in August before physician contracting began.

How are these products different?
BCBSM is committed to providing solutions for the estimated 600,000 uninsured in Southeast Michigan and other consumers who want locally driven, quality health care at a reasonable price. The Michigan Blues are looking to create partnerships with health care providers who are willing to control costs in order to provide access to affordable coverage.

These EPO products will not offer out-of-network coverage (except for emergency services), and members who receive care from providers not in the EPO network will be required to pay in full for those services.

Participating in the EPO network will give practitioners an opportunity to provide services to members who purchase these products. **Services provided as a part of this network will be reimbursed in accordance with a published fee schedule that will be set 10 percent lower than TRUST payment rates.** Please note that information in a cover letter sent with the contract addendum to some physicians included an error in explaining this rate. We apologize for any confusion this may have caused.

Risk adjustment, HEDIS® medical record reviews begin in January

As the New Year begins, physician office staffs should monitor their mail for patient medical record requests.

Verisk Health has been selected by Blue Cross Blue Shield Association to gather medical records for review on behalf of Blue Cross and Blue Shield companies nationwide. Blue plans are using Verisk to retrieve medical records for members — or from providers in other plans' service areas — to support risk adjustment, Healthcare Effectiveness Data and Information Set measures and government requirements related to the Affordable Care Act.

Keep in mind that the medical record reviews are in addition to the risk adjustment and HEDIS medical record review processes performed by Inovalon on behalf of BCBSM.

Effective medical record retrieval services play a fundamental role in driving optimal quality reporting outcomes and ensuring appropriate risk scores — all of which contribute to enhanced health care delivery and affordability. Health plans are also required by the Department of Health and Human Services to accurately report members' health conditions. HHS will be auditing the plans' reported conditions.

As outlined in your Medicare Plus Blue℠ PPO manual, please respond to these medical record requests within the requested timeframe. Verisk Health is contractually bound to preserve the confidentiality of health plan members' protected health information obtained from medical records, in accordance with HIPAA regulations.

Patient-authorized information releases are not required in order for you to comply with these requests for medical records when both the provider and health plan had a relationship with the patient and the information relates to the relationship. For more information regarding privacy rules, please visit **hhs.gov/ocr/privacy**.

If you have any questions about the medical record requests, you may contact Verisk Health at 1-877-489-8437.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Additional specialty medical drugs require prior authorization starting March 1

Seven additional specialty drugs administered by health care practitioners will require prior authorization by BCBSM in order to be covered under members' medical benefits, starting March 1.

Ensuring proper utilization and addressing the potential safety issues of these high-cost medications will address concerns that many of our major group customers have expressed.

You can find a list of medications that require prior authorization on web-DENIS:

- Click on *BCBSM Provider Publications and Resources.*
- Click on *Commercial Pharmacy Prior Authorization and Step Therapy forms.*
- Click on *Physician administered medications* (on the right side under *Frequently Used Forms*).

Criteria for authorization of these medications are included on web-DENIS. We will not consider a request for coverage until we receive either a physician-signed medication request or an online request through the NovoLogix tool. Requests will follow BCBSM time frames for coverage determination.

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PROFESSIONAL, PHARMACY, DME

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The following drugs will require prior authorization starting March 1, 2014:

HCPCS code	Drug name
J0638	Canakinumab (Ilaris®)
J1300	Eculizumab (Soliris®)
J1602	Golimumab (Simponi® Aria™)
J2357	Omalizumab (Xolair®)
J2507	Pegloticase (Krystexxa®)
J2562	Plerixafor (Mozobil®)
J2796	Romiplostim (Nplate®)

Blue Cross Blue Shield of Michigan reserves the right to change this list at any time.

Please note that the prior authorization requirement does not apply to Medicare, Medicare Advantage or Federal Employee Program® members.

PROFESSIONAL, AUTO GROUP

Physician assistant, certified nurse practitioner group exclusion chart updated

Since the January 2011 issue of *The Record*, we've made some changes to the list of auto and TRW groups that exclude payment to physician assistants and certified nurse practitioners. Please see the revised chart below:

Group name	Group numbers	Excluded for PA and CNP reimbursement
Chrysler	82300 and 82500	"Non-Retiree Choice" retirees
TRW	71393	All

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

FACILITY

Blue Cross Blue Shield of Michigan launches 'SmartER' initiative

Routine cases of the flu, minor sprains or other minor conditions all need some medical attention, but they're usually not life-threatening. Yet people sometimes go directly to the hospital emergency room for such conditions when they should contact their primary care doctor first. According to a recent study by Truven Health Analytics, 50 percent of ER visits are potentially avoidable and could be treated in a primary care setting.

That's why the Blues recently kicked off an initiative called "SmartER." It's designed to help ensure that patients receive the right care in the right location.

Other key aspects of the initiative include:

- Stressing the importance of a doctor-patient relationship
- Focusing on quality of care, cost and wait time concerns

In addition, patients who regularly see their primary care doctor are better able to manage chronic conditions — conditions that may worsen and require an ER visit if not managed properly.

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Over the next several months, BCBSM will be communicating with our members to give them information that will help them select the best location to get care.

We encourage you to discuss with your patients what a real emergency is, along with their options for non-emergency situations. These can range from scheduling a same-day appointment with their primary care doctor to going to an urgent care center if it's after hours or if quick, non-emergent, medical attention is needed.

With your support, we can help reduce delays for people who are in need of immediate care in an ER setting and help ensure that all patients get high-quality care in the best location.

Reminder: Psychiatric, subacute detox facilities should not submit claims for acute medical detox

Recently, Blue Cross Blue Shield of Michigan has received incorrect claims from residential substance abuse rehab facilities.

The claims have inappropriately included the diagnostic codes for acute alcohol withdrawal (ICD-9 codes 291.XX or 292.XX series) for patients who are actually receiving subacute detoxification and rehabilitative services.

Detoxification is the process of withdrawing a patient from the dependence of one or more addictive substances. There are two categories of services for detox:

- **Acute detoxification** services are provided in an inpatient, acute-care hospital setting. These services are for patients who require treatment for physiological withdrawal symptoms that are severe or life-threatening.
- **Subacute detoxification** services are provided during residential or outpatient treatment. These services are for patients who suffer physiological withdrawal symptoms that are not life-threatening. Instead, the patients require a coordinated rehabilitation treatment program to assist them in attaining an unimpaired or improved level of physiological, psychological and social functioning.

Residential facilities are not licensed to provide acute medical detoxification. Therefore, those facilities should report subacute detox and rehab treatment services with the diagnosis code range of 303.XX, 304.XX and 305 series.

BCBSM may attempt to recover 100 percent of the reimbursements paid to providers when we identify claims that have been billed incorrectly.

MEDICARE ADVANTAGE

Medicare Plus Blue^{SM} launches Blue Care Connect^{SM} in January

BCBSM is launching Blue Care Connect, an integrated care management program based on best practices, in January 2014 for Medicare Plus Blue members at high risk for admissions.

The program aims to keep members out of the hospital or emergency room by helping them control their symptoms and by answering any questions they have about their diseases or conditions. It's also intended to help members and their caregivers navigate the health care system. The program is a high-intensity program, for members with the highest need for long-term care management services.

Select Medicare Plus Blue members will receive an introductory program letter that explains Blue Care Connect and how it can support their health care. It is a voluntary, free program.

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Key features include:

- One care manager who manages all of the member's goals and oversees discharge planning, chronic condition management and social support interventions with limited referrals to other programs
- The member's case remains open unless the member will be managed by another high intensity program, such as BCBSM's Medicare Plus Blue CarePlus program.
- Comprehensive home assessment
- Integrated delivery of case management
- Care manager works collaboratively with the member's primary care physician and keeps the physician informed of the member's issues

The care manager will encourage the member to complete the standard Medicare Advantage health assessment, address gaps in care and identify and suggest appropriate interventions depending on the member's needs.

A subset of goals, if appropriate, will be considered high priority, and care managers will address these first. All other identified goals or guidelines will be addressed by the care manager during the program's course.

Even after the care manager handles acute episodes and immediate goals, he or she will continue to support the member and monitor the case.

For more information, please contact our Blue Care Connect case management specialists at 1-800-845-5982.

BCBSM's Medicare Plus Blue℠ Group PPO gains members in Michigan for 2014

Members of the UAW Retiree Medical Benefits Trust who live in Michigan may choose medical and surgical coverage through Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO.

ID cards
Members of the UAW Retiree Medical Benefits Trust who reside in Michigan will have new ID cards that reflect alpha prefix "XYL" for Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO. UAW Trust Medicare Advantage PPO members will have medical and surgical benefits as well as coverage for hearing, routine vision exams provided by VSP and the SilverSneakers® Fitness Program.

Eligibility
You can verify eligibility and coverage online through web-DENIS by using the alpha prefix located on the ID card. Information obtained regarding member eligibility is not a guarantee or a promise of payment. Payment determination only occurs after the claim is processed according to the member's benefits. **You can also verify eligibility and coverage using CAREN** by calling 1-866-309-1719.

Precertification
Precertification is required by BCBSM for its Medicare Advantage PPO members for certain services in Michigan. Providers should contact BCBSM to obtain precertification or recertification for:

- Skilled nursing facility, long term acute care and inpatient acute rehabilitation admissions
  - Facilities are required to complete the appropriate facility request form (either the *Skilled Nursing Facility and Acute Rehabilitation Facility Assessment* form or the *Long-Term Acute Care Facility* form) and submit it by fax to 1-866-464-8223. Facilities can also email requests to MedicarePlusBlueFacilityFax@bcbsm.com.
  - Expedited and urgent care requests must be attested to by the physician, indicating that this is an urgent admission for a condition jeopardizing the member's life or health and is deemed life-threatening. Please submit expedited and urgent requests to 1-866-225-4905 or email urgentinpatientprecertrequests@bcbsm.com for processing within 72 hours or as quickly as the patient's condition requires.

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- Behavioral health admissions and intensive outpatient behavioral health services
  - For inpatient, partial hospitalization and intensive outpatient behavioral health services, providers should contact Michigan Medicare Plus Blue PPO Behavioral Health at 1-888-803-4960.
  - SNF, acute rehabilitation, long-term acute care and expedited, urgent admission (for those admissions attested to by a physician as urgent) assessment forms are available online via BCBSM's provider website at **bcbsm.com/provider/ma**.

Pre-notification
For acute care admissions to hospitals, providers are required to use web-DENIS to notify BCBSM of the admission.

While pre-approval of hospital admissions is not required, we highly recommend that hospitals use InterQual® criteria to assess the medical necessity of the admission. InterQual criteria should be applied prior to executing the pre-notification process, but it will not be used to accept or modify the admission.

- Hospitals will be required to reference InterQual criteria for inpatient admissions and indicate which subset was referenced and met. If a doctor is overriding InterQual inpatient criteria, then the hospital must provide the doctor's name and phone number.
- Hospitals will be encouraged to enter symptoms exhibited at admission and the necessary treatment.
- Hospitals will be required to reference the U.S. Centers for Medicare & Medicaid Services inpatient surgical list for Medicare Advantage PPO inpatient surgical procedures that are considered elective. If a physician is overriding the CMS inpatient surgical list, then the hospital must provide the physician's name and phone number.
- Hospitals will be required to provide an ICD-9-CM narrative for admissions. We ask that hospitals also enter the ICD-9-CM diagnosis code that corresponds with the narrative.

Radiology Management Program preauthorization
The National Radiology Utilization Management Program requires preauthorization for outpatient advanced diagnostic services to ensure that the procedures are appropriate and medically necessary.

The preauthorization requirement includes the following outpatient advanced diagnostic imaging services:

- Computed tomography
- Magnetic resonance imaging
- Nuclear cardiology
- Positron emission tomography
- Stress echocardiography
- Resting transesophageal echocardiography
- Transthoracic echocardiography

Note: Imaging studies performed along with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers), urgent care centers and 23-hour observations are excluded from this requirement.

High-tech diagnostic radiology pre-authorizations can be obtained from AIM℠ Specialty Health as directed in the Medicare Plus Blue PPO Provider Manual: **bcbsm.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf**.

Medicare Advantage deductibles rule clarified

We want to make sure you're aware that employer or union group-sponsored health plans may apply a deductible for Medicare Part B services when provided to a Medicare Advantage member at a federally qualified health center.

To clarify, if a health care provider treats a member who has coverage through an employer or union group-sponsored health plan, the member is responsible for the deductible if the plan applies a deductible to the service.

For more information, see Chapter 9, Sections 20 and 20.1, of the *Medicare Managed Care Manual*, produced by the Centers for Medicare & Medicaid Services.

If you have any questions, call Medicare Advantage Provider Servicing from 8 a.m. to 4:30 p.m. Monday through Friday at 1-866-309-1719,

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