January 2013

Medicare Advantage contract numbers include new alpha prefix

All Blue Cross Blue Shield of Michigan’s Medicare Plus Blue PPO℠ and Medicare Plus Blue Group PPO℠ member identification cards will have the new alpha prefix of XYL, starting Jan. 1, 2013.

Remember to include this prefix as part of the contract number on claims and other records submitted to BCBSM. If a member gives you an ID card with the old prefix of XYO, please ask the member for his or her new ID card that shows the XYL prefix.

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

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January 2013

Medicare Advantage durable medical equipment coverage changes

Medicare Advantage Medicare Plus Blue PPO<sup>SM</sup> members will have a combined out-of-pocket maximum for durable medical equipment and medical and surgical benefits, effective Jan. 1, 2013. Claims will be processed at the in-network level for members that receive services from in-network DME providers.

**Claims**
Please send DME paper claims to:

Medicare Plus Blue  
Blue Cross Blue Shield of Michigan  
P.O. Box 32593  
Detroit, MI 48232-0593

Please visit our website at [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma) for information on BCBSM’s electronic billing processes. Call DMEnsion Benefit Management at 1-888-828-7858 from 8:30 a.m. to 5 p.m. Monday through Friday for questions related to dates of service prior to Jan. 1, 2013.

Medicare Advantage claims payment checks are sent once a week.

**Eligibility**
To verify eligibility or for information related to dates of service Jan. 1, 2013, and after, please call BCBSM Medicare Advantage Provider Inquiry at 1-866-309-1719. You can also access DME information, including member eligibility, online via web-DENIS. Go to [bcbsm.com](http://bcbsm.com) and click on *Providers*, then select *web-DENIS*.

**Billing**
Prescriptions must be written and submitted prior to the member obtaining the DME item, or the member may be subject to pay for that item out of pocket. Please encourage your patients to wait to obtain any DME items until they receive a prescription.
There are times when a Michigan Medicare Advantage member or provider may receive DME equipment or supplies from an out-of-state provider. The out-of-state DME provider will be responsible for submitting claims to BCBSM for processing.

Some DME requires a Certificate of Medical Necessity. A Certificate of Medical Necessity is a form the physician must complete and submit with the DME prescription. It certifies the member’s condition is such that the DME being prescribed is medically necessary.

If a DME supplier bills for items requiring a Certificate of Medical Necessity, the supplier must bill with the KX modifier to indicate a certificate is on file. Current equipment that requires this certificate includes:

- Bone growth (or osteogenesis) stimulators
- Home oxygen equipment and supplies
- Lymphedema pumps and pneumatic compression devices
- Patient lifts
- Transcutaneous electronic nerve stimulators
- Continuous positive airway pressure machines

**Special exception items**

Some equipment may be covered under certain conditions, even though it does not meet the definition of DME. The following items are covered when it is clearly established that they serve a therapeutic purpose in an individual case:

- Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who has bed sores or when there is medical evidence the patient is highly susceptible to ulceration
- Heat lamps for a medical, rather than a soothing or cosmetic, purpose (such as heat therapy)

In establishing medical necessity for these items, evidence must show that the item is required as part of the physician’s course of treatment and that a physician is supervising its use.

**Note:** The above items represent special exceptions and no extension of coverage to other items should be inferred.

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January 2013

**Medicare Advantage Part D benefits change for 2013**

The following Medicare Part D changes for Blue Cross Blue Shield of Michigan Medicare Advantage members are effective Jan. 1, 2013.

**Prescription drug tier coverage**
The following tiers have changed designations:

- Tier 1: Preferred generic drugs
- Tier 2: Nonpreferred generic drugs
- Tier 3: Preferred brand drugs
- Tier 4: Nonpreferred brand drugs

All specialty drugs remain in Tier 5. Non-self-administered injectable drugs are available in Tiers 1, 2, 3 and 4.

**Initial coverage limit charge**
The initial coverage limit has decreased from $2,930 to $2,800 for Prescription Blue PDP Option A. The initial coverage limit for Prescription Blue PDP Option B, Vitality, Signature and Assure is now $2,970.

**Deductible change**
Medicare Advantage Part D Essential and Vitality plans have a $325 standard Medicare deductible. PDP Option A has a $125 deductible for Tiers 3, 4 and 5.

**Coverage gap discount increase**
In 2012, members in the coverage gap paid 86 percent of the price (plus the dispensing fee) of generic drugs. In 2013, members will be responsible for 79 percent of these prescription drug costs. In 2012, members in the coverage gap paid 50 percent of the price (plus the dispensing fee) of brand drugs. In 2013, members will be responsible for 47.5 percent of these prescription drug costs.
Out-of-pocket threshold change
The out-of-pocket maximum for BCBSM Medicare Advantage members has increased from $4,700 to $4,750.

Catastrophic coverage limit change
The catastrophic portion after the coverage gap will require members to pay the greater amount of a $2.65 copayment for generic drugs (including brand drugs treated as generic), a $6.60 copay for all other drugs or 5 percent coinsurance.

For more information, contact your provider consultant.

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January 2013

New Blues Medicare Advantage Health Assessment requires your action

You now have another tool to support you in talking to your Medicare Advantage patients about their health risks and conditions during their annual wellness visits.

Our new *Blues Medicare Advantage Health Assessment* is for Blue Cross Blue Shield of Michigan and Blue Care Network members with Medicare Plus Blue PPOS, Medicare Plus Blue Group PPOS, BCN Advantage HMO-POS and BCN Advantage HMO coverage.

We are offering the *Blues Medicare Advantage Health Assessment* to all Medicare Advantage members via mail and telephone beginning in January 2013. Members who complete the health assessment and return it will receive a letter identifying health topics they may want to discuss with their physicians.

We encourage them to bring the letters to their next visits with their physicians. Some members may need your support. If your patient hasn’t already completed a *Blues Medicare Advantage Health Assessment* in the past year, we ask you to assist him or her in completing it during the annual exam.

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services require providers to conduct a health assessment during a member’s annual wellness visit. But, more than that, it is a key opportunity for you and your patients to discuss their past and current health status, including health risks, medical conditions, medications and activities of daily living.

The *Blues Medicare Advantage Health Assessment* form is available to you via web-DENIS. To download it:

- Log in to web-DENIS.
- In the left-hand navigation, click on *BCBSM Provider Publications and Resources.*
Then click on Newsletters & Resources.
Click on MA Resources on the left side of the screen.
Scroll down to Frequently Used MA Forms and click on Medicare Advantage Health Assessment Form.

A set of instructions for use, including the fax number, will appear on the first page of each Blues Medicare Advantage Health Assessment printed from here.

We’ll provide you with results of completed member health assessments beginning in spring 2013 through the Blues’ Health e-BlueSM online tool. Health e-Blue tracks the health status of your Medicare Plus Blue PPO members and is available by logging in to Provider Secured Services on bcbsm.com.

If you have any questions about the Medicare Advantage health assessment, contact your provider consultant.

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January 2013

New Medicare Advantage Diagnosis Gap Closure incentive program for primary care physicians for 2013
Replaces Physician Assessment Form reimbursement

Blue Cross Blue Shield of Michigan and Blue Care Network are pleased to announce a new primary care physician Medicare Advantage Diagnosis Gap Closure incentive program in 2013. The new incentive applies to Blues Medicare Advantage patients, including those with BCN Advantage HMO-POS\textsuperscript{SM}, BCN Advantage HMO Focus\textsuperscript{SM} and BCBSM Medicare Plus Blue PPO\textsuperscript{SM} coverage.

The new Diagnosis Gap Closure incentive program replaces reimbursement for completion of the Physician Assessment Form effective for dates of service Jan. 1, 2013, or later.

**Here’s how it works**
The Diagnosis Gap Closure incentive rewards physicians for having annual face-to-face visits with Blues Medicare Advantage patients during which diagnoses are evaluated, documented and coded according to standards set by the Centers for Medicare & Medicaid Services. Physicians will receive a financial incentive for closing diagnosis code gaps identified by the Blues.

Primary care physicians will be able to view a report of their Medicare Advantage patients who have diagnosis code gaps on Health e-Blue\textsuperscript{SM} in the first quarter of 2013. The new Medicare Diagnosis Evaluation Form on Health e-Blue will list Blues Medicare Advantage patients who are suspected of having a condition based on pharmacy claims, medical claims, other...
supplemental data sources or prior year diagnoses, but the diagnosis has not been submitted to the
Blues yet in the current year on a claim, through Health e-Blue, on an electronic medical record or
a paper version of the Diagnosis Evaluation Form.

A suspected or historic condition that has not been accurately documented and coded in the
current year is considered a “gap”. Medicare Advantage patients with one or more gaps will be
identified on the primary care physician’s Health e-Blue Diagnosis Evaluation Form.

The report will be refreshed monthly so physicians can track their progress in closing these
identified diagnosis code gaps. The Blues will pay physicians $100 for each Medicare Advantage
member with one or more gaps identified between January and October 10, 2013, for whom all
gaps are closed during a face-to-face encounter by Dec. 31, 2013 and reported to the Blues by Jan.
31, 2014 following CMS guidelines.

An identified gap can only be closed following a face-to-face visit with the patient in 2013 during
which the diagnosis is documented in the patient’s medical record following CMS guidelines.
Then the gap must be closed through one of the following methods:

- Confirming the diagnosis code
  - By submitting a claim with the diagnosis code
  - Through Health e-Blue
  - By submitting a paper Diagnosis Evaluation Form*
  - Through an EMR interface (available after May 2013)
- Notifying the Blues that the patient does not have the suspected condition
  - Through Health e-Blue
  - By submitting a paper Diagnosis Evaluation Form*
  - Sending a delete record on an EMR file (available after May 2013)

Gaps that are closed by Inovalon™, formerly MedAssurant, will not result in an incentive
payment.

Tip: As you conduct face-to-face annual wellness visits with Blues Medicare patients, make sure
you address every chronic or previously diagnosed condition or past diagnosis that is still relevant
to the patient, including transplant or amputation status. Then document this in the patient’s
medical record following coding guidelines and include all of the diagnoses in your claim
submission.

More information about this new incentive program will be mailed to Blues Medicare Advantage
primary care physicians in early 2013. If you do not have access to Health e-Blue, sign up today on
bcbsm.com/provider. Please contact your provider consultant for assistance.

Learn more about documentation, coding and closing gaps

The Blues have staff available who can provide training to physicians and their office staff on
proper documentation and coding guidelines and the importance of closing gaps for Medicare
Advantage patients. Contact your provider consultant for more information.

If you would like a Blues speaker to address a large provider group on this topic, please contact
Laurie Latvis at LLatvis@bcbsm.com.

**The new paper Diagnosis Evaluation Form will be available in January on web-DENIS in BCBSM Provider Publications and Resources. Click on Newsletters & Resources and then click on Medicare Advantage Resources.

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Web-DENIS messages December 2012
1. NASCO recovery for Master Medical claims underway

Category: Recoveries

Title: NASCO recovery for Master Medical claims underway

Start Date: December 3, 2012  End Date: December 17, 2012

NASCO began conducting a recovery Nov. 28, 2012, of Major Medical and Master Medical claims for all accounts, excluding the Federal Employee Program®, for dates of service Jan. 3, 2011, through July 31, 2012.

Professional Major and Master Medical claims were paying in error during that time. When you adjust patients’ accounts, their balances may change.

2. NASCO recovery of Ascension Health pediatric office visit claims underway

Category: Recoveries

Title: NASCO recovery of Ascension Health pediatric office visit claims underway

Start Date: December 3, 2012  End Date: December 17, 2012


The group requested a retroactive benefit change for these office visits to process at a different benefit and copayment level. When you adjust patients’ accounts, their balances may change.

3. NASCO recovery of Ascension Health pre-, postnatal claims underway

Category: Recoveries

Title: NASCO recovery of Ascension Health pre-, postnatal claims underway

Start Date: December 3, 2012  End Date: December 17, 2012


The group requested a retroactive benefit change for these services, effective Jan. 1, 2012, to change member copayments. When you adjust patients’ accounts, their balances may change.
4. **Use correct post office box for live claims**

   **Category:** Medicare Advantage

   **Title:** Use correct post office box for live claims

   **Start Date:** December 4, 2012   **End Date:** December 18, 2012

   To receive quicker service, please be certain to use the post office box listed below for live claims:

   Blue Cross Blue Shield of Michigan  
P.O. Box 32593  
Detroit, MI 48232-0593

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

5. **New provider home page on bcbsm.com**

   **Category:** Providers and Electronic Submitters

   **Title:** New provider home page on bcbsm.com

   **Start Date:** December 7, 2012   **End Date:** December 31, 2012

   On Friday, Dec. 7, MiBCN.com and bcbsm.com will be combined into one website. With the redesigned look and feel, providers may wonder where to locate certain information.

   When visiting the new bcbsm.com, providers and electronic submitters can now select the Providers link above the blue banner section of the home page. Once on the Provider page, a Quick Links box located in the bottom right-hand corner will provide the navigation to all frequently accessed resources. For example:

   **Where is the log in for the TPA (Trading Partner Agreement) and Provider Authorization?** From the Quick Links page, select the *Electronic Connectivity (EDI)* link. The TPA and Provider Authorization information will be on the right-hand side under *Are you a returning user?*

   **Where is the Professional Commercial payer list?** From the Quick Links page, select the *Electronic Connectivity (EDI)* link and then click *EDI reference documents*. The Commercial Payer List is located under the heading *Physicians and other professional providers.*
**Where can I find NPI information?** From the Quick Links page, select the link for *NPI*. This link will route visitors directly to the National Provider Identifier (FAQ) page.

We encourage providers and electronic submitters to explore all of the Quick Link options. If you need assistance in finding electronic connectivity information, please call our EDI helpdesk 1-800-542-0945.

6. **Blues announce changes for Medicare Advantage DME benefits**

   **Category:** Medicare Advantage  
   **Title:** Blues announce changes for Medicare Advantage DME benefits  
   **Start Date:** December 7, 2012  **End Date:** December 31, 2012

   Effective Jan. 1, 2013, Medicare Advantage PPO members will have a combined out-of-pocket maximum for durable medical equipment, medical and surgical benefits. Claims will be processed at the in-network level for members who live in Michigan, if they receive services from an in-network DME provider.

   **Claims**  
   Beginning Jan. 1, 2013, please send DME paper claims to:

   Medicare Plus Blue  
   Blue Cross Blue Shield of Michigan  
   P.O. Box 32593  
   Detroit, MI 48232-0593

   Please visit our [website](#) for information on BCBSM’s electronic billing processes. Providers should call DMEnsion Benefit Management for questions related to dates of service prior to Jan. 1, 2013, at 1-888-828-7858 from 8:30 a.m. to 5 p.m. Monday through Friday.

   Medicare Advantage claim payment checks are sent once a week.

   **Eligibility**  
   To verify eligibility, please call BCBSM Medicare Advantage Provider Inquiry at 1-866-309-1719. You can also access DME information online, including member eligibility, via web-DENIS.

   Please watch for more details in the January 2013 issue of *The Record* or call your provider consultant with any questions.

7. **AIM Specialty Health expands BCBSM Medicare Advantage radiology utilization management program**
AIM Specialty Health expands BCBSM Medicare Advantage radiology utilization management program

On Dec. 17, 2012, BCBSM’s radiology partner, AIM Specialty HealthSM, expands the current advanced diagnostic imaging services included in the Medicare Advantage radiology utilization management program to include cardiac services for Medicare Plus Blue PPO\textsuperscript{SM} and Medicare Plus Blue Group PPO\textsuperscript{SM} members. Prior authorizations will be required for dates of service on or after Jan. 1, 2013, for services including stress echocardiography, transesophageal echocardiography and resting transthoracic echocardiography. Servicing providers’ claims will be processed based on the results of the prior authorization review.

Prior authorization requirements will continue for those cardiac and other diagnostic imaging services that are currently included in this program. A list of all MA PPO cardiology services that require a prior authorization review can be found in the December edition of The Record.

Also, beginning Dec. 17, 2012, ordering providers may begin requesting prior authorization for SE, TEE or TTE for dates of service on or after Jan. 1, 2013, through AIM. For more information and details on pre-exam questions, please see the December Record article.

These changes to BCBSM’s radiology utilization management program will help us provide a clinically appropriate, consistent and efficient case review process.

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

BCBSM announces 2013 Medicare Advantage product changes

BCBSM introduces a new Medicare Plus Blue PPO\textsuperscript{SM} option, the Essential plan, for 2013. Highlights of this new plan include:

- Low premiums
- Part D prescription drug coverage included
- Safety bars
- Lasik coverage
Emergency coverage worldwide

2013 Medicare Plus Blue PPO changes include:
Elective LASIK and radial keratotomy surgeries to reduce refractive error (in network) and coverage for one set of chiropractic X-rays annually (up to three views) performed by a chiropractor.

New deductibles and copayments apply for all Medicare Advantage PPO and Prescription Blue PDP^SM^ plans.

2013 Medicare Advantage Part D benefit changes
These Medicare Part D changes for Blue Cross Blue Shield of Michigan Medicare Advantage members also begin Jan. 1, 2013:

**Prescription drug tier change**
In 2013, the tiers have changed designations:
Tier 1: Preferred generic drugs
Tier 2: Nonpreferred generic drugs
Tier 3: Preferred brand drugs
Tier 4: Nonpreferred brand drugs
All specialty drugs remain in Tier 5.

Non self-administered drugs that are injected are available in Tiers 1, 2, 3 and 4.

**Initial coverage limit change**
The initial coverage limit has decreased from $2,930 to $2,800 in 2013 for Prescription Blue PDP^SM^ Option A. The initial coverage limit for Prescription Blue PDP Option B, Vitality, Signature and Assure in 2013 is $2,970.

**Deductible change**
MAPD Essential and Vitality plans have $325 standard Medicare deductible. PDP Option A has a $125 deductible for Tiers 3, 4 and 5.

**Catastrophic coverage limit change**
The catastrophic portion after the coverage gap will require members to pay the greater of a $2.65 copay for generic drugs (including brand-name drugs treated as generic) or a $6.60 copay for all other drugs, or 5 percent coinsurance.

For more information, contact your provider consultant or look for more information in the January 2013 edition of *The Record*. Additional details on coverage, out-of-pocket threshold changes and coverage gap increases will be included.
9. Medicare Advantage members’ alpha prefix changes

Category: Medicare Advantage

Title: Medicare Advantage members’ alpha prefix changes

Start Date: December 7, 2012   End Date: February 1, 2013

All Blue Cross Blue Shield of Michigan Medicare Plus Blue PPO and Medicare Plus Blue Group PPOSM member identification cards will show the new alpha prefix of XYL, starting Jan. 1, 2013. Remember to include the alpha prefix as part of the contract number on claims and other records submitted to BCBSM.

The new XYL ID cards do not go into effect until Jan. 1, so please be certain to use contract numbers with the XYO alpha prefix until then.

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

10. BCBSM e-prescribing

Category: Sponsored licenses

Title: BCBSM e-prescribing

Start Date: December 10, 2012   End Date: January 4, 2013

The BCBSM e-prescribing program will be ending at the end of your current sponsorship. Any sponsored licenses that are expected to expire before March 31, 2013, will be extended through at least March 31, 2013.

To keep the transition smooth, BCBSM will begin assigning new log in credentials through the DrFirst electronic prescription management system, beginning in January.

You will see no change other than how you log in to the e-prescribing system. Interfaces and data will not be affected. Your BCBSM e-prescribing team is available to answer questions and support your transition.

If you have any questions, please don’t hesitate to call us at (248) 446-3803 or email us at eprescribing@bcbsm.com.
11. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes  
**Title:** Additional fee change schedules added to web-DENIS  
**Start Date:** December 10, 2012  
**End Date:** December 24, 2012

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Dec. 10, 2012:

- Professional
  1. Traditional, TRUST & Blue Preferred PlusSM
  2. Independent Lab
- Facility
  1. Outpatient Hospital
  2. Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.*

12. Out-of-state alpha prefix list available

**Title:** Out-of-state alpha prefix list available  
**Start Date:** December 10, 2012  
**End Date:** December 24, 2012

An updated list of out-of-state alpha prefixes is now available on web-DENIS in the BCBSM Newsletters & Resources section. The list includes non-Michigan alpha prefixes for out-of-state groups that have members residing in Michigan.

To access the list:

- Click on *BCBSM Provider Publication and Resources.*
- Click on *BCBSM Newsletters and Resources.*
- Click on *Clinical Criteria and Resources.*
- Scroll to the section *Alpha prefixes.*
- Click on Out of state *alpha prefixes.*
13. Internet Claim Submission Tool is unavailable

Category: Internet Claim Submission Tool

Title: Internet Claim Submission Tool is unavailable

Start Date: December 10, 2012  End Date: December 20, 2012

The Internet Claim Tool is currently unavailable. We are working towards a resolution.

We apologize for the inconvenience.

14. Delayed Blue Care Network 835 remittance files

Category: Blue Care Network electronic submitters

Title: Delayed Blue Care Network 835 remittance files

Start Date: December 11, 2012  End Date: December 25, 2012

Due to a BCN systems issue, professional and institutional 835 remittance advice files for check date December 10, 2012 have been delayed. The files will be distributed upon receipt.

We apologize for any inconvenience.

15. Medicare Eligibility


Title: Medicare Eligibility

Start Date: December 11, 2013  End Date: December 17, 2012

There is a scheduled outage for Medicare Eligibility application. The outage window will begin at 7:00 AM EST on Saturday, December 15, 2012. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. CMS estimates that the outage will be complete by 4:00 PM EST on Saturday, December 15, 2012.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315
16. Pay As You Go Provider Recognition Program checks delayed

Category: Medicare Advantage

Title: Pay As You Go Provider Recognition Program checks delayed

Start Date: December 12, 2012   End Date: January 12, 2013

BCBSM previously reported that Pay As You Go Provider Recognition Program payments would be delayed until December 2012. Unfortunately, we continue to experience data issues that need to be corrected to ensure the accuracy of these payments. The correction and associated testing is more complicated than originally anticipated and, therefore, will take more time to complete.

We want to ensure the accuracy of the incentive payments and the Health e-Blue Web tool.

In order to ensure that incentives due to health care providers for the October Pay as You Go Payment are accurately paid, we will combine the two Pay as You Go payments into a single incentive payment in June 2013. As part of that payment, BCBSM will pay interest on any money owed as part of the delayed October payment. We apologize for these issues and the resulting delay in incentive payments. We appreciate the great work that you have done for our members with this new program, and we ask for your patience while we implement and test the system fixes.

If you have additional questions please contact your provider consultant.

17. Internet Claim Tool is now available

Category: Internet Claim Tool

Title: Internet Claim Tool is now available

Start Date: December 13, 2012   End Date: December 27, 2012

The Internet Claim Tool is now available.

We apologize for the inconvenience and appreciate your patience as we worked to resolve the issue.
18. Benefit Configurator

Category: System unavailable on Sunday 12/16/2012 at 5:00 AM through 2:00 PM

Title: Benefit Configurator

Start Date: December 13, 2012   End Date: December 17, 2012

There is scheduled maintenance on the Benefit Configurator System. Access to Benefit Configurator will be unavailable on Sunday 12/16/2012 at 5:00 AM through 2:00 PM.

We apologize for any inconvenience.

19. Submit 2012 Medicare Advantage claims quickly

Category: Medicare Advantage

Title: Submit 2012 Medicare Advantage claims quickly

Start Date: December 14, 2012   End Date: December 31, 2012

As the end of the year is quickly approaching, Blue Cross Blue Shield of Michigan asks its Medicare Advantage health care providers to please submit claims for dates of service through Dec. 31, 2012, in a timely manner to help ensure accurate and timely processing.

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

20. Blues introduce new Medicare Advantage member initiatives in January

Category: Medicare Advantage

Title: Blues introduce new Medicare Advantage member initiatives in January

Start Date: December 14, 2012   End Date: December 31, 2012

BCBSM introduces three Medicare Advantage member initiatives in January 2013:

- Blues’ Medicare Advantage Health Assessment
- Blue Advantage RewardsSM (formerly Healthy Advantage Rewards)
- Benefit QuickStart guide and preventive planner
Next month, we’ll mail the new health assessment to all 2013 eligible Medicare Plus Blue PPO℠ and Medicare Plus Blue Group PPO℠ members in compliance with the Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services. The Medicare Advantage Health Assessment replaces the current assessment and contains questions required by CMS about a member’s past and current health status to identify health risks and conditions.

Members may request assistance from their physicians to complete the assessment at their scheduled annual wellness visits. You can find the form on web-DENIS, and we ask you to help members complete their assessments if they have not already done so. Providers should return the Medicare Advantage Health Assessment via fax if completed with a member at the annual visit. Instructions for faxing the form appear on the first page of the version you’ll find on web-DENIS. Based on their answers, members will receive follow-up letters identifying their health risks and conditions and will be encouraged to discuss those with their physicians. In the spring, primary care physicians will you’ll be able to access member assessments via Health e-Blue Web℠ secure provider portal. Please check future issues of The Record for more information.

BCBSM will continue to offer a member incentive program, Blue Advantage Rewards (formerly known as “Healthy Advantage Rewards”), for its Medicare Plus Blue PPO℠ individual and group members (Prescription Blue PDP℠ only members are not eligible) to encourage long-term health. Members will receive 2013 program information in late January. BCBSM will continue to encourage members to make appointments with their primary care physicians for health assessments. The Blue Advantage Rewards program rewards members for taking proactive steps to stay healthy. These initiatives include:

- Member health evaluation
- Cholesterol screening
- Glaucoma screening
- Mammogram
- Flu vaccine
- Retinal eye exam
- Colorectal cancer screening
- Diabetes screening

BCBSM will also mail members a QuickStart Guide and a preventive planner in January. The guide provides members with a brief and simple introduction to their plan. The planner encourages members to get preventive care and gives them a tool they can use to track medical services, tests, screenings, medications and appointments.

If you have any questions, please contact your provider consultant.
21. CMS delays 2012 PC Pricer release

**Category:** Medicare Advantage

**Title:** CMS delays 2012 PC Pricer release

**Start Date:** December 14, 2012  **End Date:** December 27, 2012

Please be advised that CMS anticipates delays for all of the fiscal year 2012 PC Pricer releases, including inpatient psychiatric services, inpatient rehabilitation, skilled nursing facilities and long-term care facilities. This delay will affect all fourth quarter specialty facility pricing.

We will process all claims received for fourth quarter via the current rates. Once the fourth quarter fees have been loaded, we will adjust all affected claims.

CMS is transitioning to new software to support the back-end development of all PC Pricers. Executable files will be made available once the transition is complete, which is expected between Jan. 1 and March 31, 2013.

We apologize for any inconvenience this may cause. If you have any questions, please contact your provider consultant.

22. Some payments reprocessed for codes E0424, E0439, E1390, E1391

**Category:** Claims

**Title:** Some payments reprocessed for codes E0424, E0439, E1390, E1391

**Start Date:** December 14, 2012  **End Date:** December 28, 2012

Payments we sent for checks dated July 4, 2012, for codes E0424, E0439, E1390 and E1391 may have been incorrect. Deductible and copayment amounts we deducted may not have been correct.

These services were reprocessed on Dec. 11, 2012, and, where applicable, valid cost-sharing deductions were taken.
23. Prior authorization to be required for 13 specialty drugs

**Category:** Specialty drugs

**Title:** Prior authorization to be required for 13 specialty drugs

**Start Date:** December 14, 2012   **End Date:** January 31, 2013

Thirteen specialty drugs administered by health care practitioners will require prior authorization by BCBSM in order to be covered under members’ medical benefits, starting Jan. 22.

The Blues have delayed the expansion of its specialty drug prior authorization requirement to cover 12 additional drugs. We told you in the October issue of *The Record* that the new requirement would start Jan. 1.

The following drugs will be added to the prior authorization program:

- J0129  Abatacept (Orencia®)
- J0490  Belimumab (Benlysta®)
- Jo585  Onabotulinumtoxin A (Botox®, Botox® Cosmetic)
- J0586  Abobotulinumtoxin A (Dysport®)
- J0587  Rimabotulinumtoxin B (Myobloc®)
- J0588  Incobotulinumtoxin A (Xeomin®)
- J0755  Collagenase clostridium histolyticum (Xiaflex®)
- J0800  Repository corticotropin injection (Acthar HP® gel)
- J0897  Denosumab (Xgeva®, Prolia®)
- J3262  Tocilizumab (Actemra®)
- J3357  Ustekinumab (Stelara®)
The following drug continues to require prior authorization:

J1725  Hydroxyprogesterone caproate (Makena™)

Members currently receiving the six drugs listed below are authorized to continue treatment until the date listed. Continuation of therapy beyond that date will require a renewal prior authorization. The patient will need to meet the Medical Policy clinical requirements for each drug.

<table>
<thead>
<tr>
<th>Code</th>
<th>Grandfather Drug</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0129</td>
<td>Abatacept (Orencia®)</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td>J0490</td>
<td>Belimumab (Benlysta&lt;SUP&gt;®&lt;/SUP&gt;)</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td>J3262</td>
<td>Tocilizumab (Actema®)</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td>J3357</td>
<td>Ustekinumab (Stelara®)</td>
<td>July 1, 2013</td>
</tr>
<tr>
<td>J0897</td>
<td>Denosumab (Xgeva®)</td>
<td>September 1, 2013</td>
</tr>
<tr>
<td>J0897</td>
<td>Denosumab (Prolia®)</td>
<td>September 1, 2013</td>
</tr>
</tbody>
</table>

You can find the Medication Authorization Request Forms on the web-DENIS BCBSM Newsletters and Resources page. Click on Physician administered medications on the right side of the screen, under “Frequently Used Forms.”

BCBSM will begin accepting the request forms Jan. 10 for medication therapy start dates of Jan. 22 and later.

A prior authorization approval is not a guarantee of payment. The prior authorization is a clinical review. Health care providers must still verify eligibility and benefits for members, or members will be responsible for the full cost of medications that are not covered.

The following groups are excluded from this prior authorization process: Medicare, Federal Employee Program®, State of Michigan, MPSERS, Michigan Conference of Teamsters Welfare Fund, United Food and Commercial Workers, UAW Retiree Medical Benefits Trust, General Motors, Ford and Chrysler.
24. Medicare Advantage Access

Category: System Outage

Title: Medicare Advantage Access

Start Date: December 14, 2012  End Date: December 17, 2012

BCBSM will be performing a maintenance/upgrade on the Medicare Advantage system. The maintenance will begin on Friday December 14, 2012 at 8:00PM EST and will be completed Saturday December 15, 2012 at 9:00PM EST.

You may experience errors when accessing Medicare Advantage Eligibility and Medicare Claims during this time.

We apologize for any inconvenience

25. All Blue Care Network trading partners

Category: UPDATE: Delayed 835 remittance files for check date 12/10/12

Title: All Blue Care Network trading partners

Start Date: December 14, 2012  End Date: December 28, 2012

All BCN professional and institutional 835 remittance advice files for check date 12/10/12 have now been distributed.

We apologize for any inconvenience this delay may have caused.

26. BCN Database Maintenance

Category: Scheduled Outage from Saturday 10:00 PM EST to Sunday 8:00 AM EST

Title: BCN Database Maintenance

Start Date: December 14, 2012  End Date: December 17, 2012

There is scheduled maintenance on the BCN System. The BCN system will be unavailable starting Saturday December 15 at 10:00 PM EST and will be available after Sunday December 16, 2012 at 8:00 AM EST. Access to BCN services during the outage will result in errors.

We apologize for any inconvenience.
27. Additional fee schedules added to web-DENIS

Category: Fee Schedules

Title: Additional fee schedules added to web-DENIS

Start Date: December 17, 2012   End Date: January 31, 2013

BCBSM recently added these additional facility fee schedules to web-DENIS, for new fee-based services, effective April 1, 2013:

- Outpatient Hospital
  1. New HCPCS fees effective 04/01/13 (includes newly fee- based AOR, DMP, ERT, OBR, THE, THV & TXR category codes)
  2. New Dialysis rates effective 04/01/13 (includes newly fee-based Revenue Code / Condition Code rates)
- Ambulatory Surgery Facility: EKG fees effective 04/1/13 (includes newly fee-based EKG category codes)

BCBSM also added the following additional facility fee schedules to web-DENIS, for updates effective April 1, 2013:

1. LTACH: Long Term Acute Care Hospital rate schedule - Effective 04/01/2013
2. SNF: Per Diem rates effective 04/01/2013
3. ESRD: Freestanding ESRD Facility 4/1/13 (to add new codes)

These and other fee schedules and fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

28. Blues closed four days for holidays

Category: Provider services

Title: Blues closed four days for holidays

Start Date: December 17, 2012   End Date: January 2, 2013

Blue Cross Blue Shield of Michigan and Blue Care Network will be closed for four days in observance of the Christmas and New Year’s Day holidays. The Blues will be closed Dec. 24, 25 and 26 and Jan. 1.

We apologize for any inconvenience this may cause. If you have any questions, please contact your provider consultant.
29. All ICT users

Category: REMINDER: Do not upgrade to Internet Explorer 10 (IE10)

Title: All ICT users

Start Date: December 17, 2012   End Date: December 31, 2012

Please be advised that the Internet Claims Tool is not yet compatible with Internet Explorer version 10. At this time, we are requesting that ICT users not upgrade to IE10 until further notice. Although some ICT users have been successful in accessing the tool after upgrading to IE9, BCBSM EDI remains unable to support incompatibility issues that may be encountered.

If you have already upgraded and are receiving error messages when logging into the ICT, please visit Microsoft.com for instructions on reverting to IE8.

We will inform you in a future message when you can proceed with an upgrade to either IE9 or IE10. We apologize for any inconvenience this may cause.

30. Procedure code Q0091 is payable when reported with G0101

Category: BCBSM Payment Policy

Title: Procedure code Q0091 is payable when reported with G0101

Start Date: December 18, 2012   End Date: January 25, 2013

Blue Cross Blue Shield of Michigan has identified that claims reporting procedure code Q0091 are erroneously being denied when reported with pelvic and clinical breast examination procedure code G0101.

Our claims processing system is currently being updated to accommodate this combination. In the interim, we’ve implemented a manual process to pay Q0091 when reported with G0101. If you have experienced problems with this procedure code combination, you do not need to resubmit your claims. As soon as the system is corrected, we will reprocess these claims.

Please continue to use Clear Claim Connection through web-DENIS to validate appropriate coding relationships.
31. Jan. 1, 2013, HCPCS update fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Jan. 1, 2013, HCPCS update fee change schedules added to web-DENIS

**Start Date:** December 18, 2012    **End Date:** January 15, 2013

BCBSM recently added Jan. 1, 2013, HCPCS update fee change schedules to web-DENIS, for the week beginning Dec. 17, 2012:

- **Professional**
  1. Traditional, TRUST & Blue Preferred Plus℠
  2. Independent Lab
  3. Injections
  4. DME/P&O
  5. Hearing
- **Facility**
  1. Hospital Outpatient
  2. Ambulatory Surgery Facility
  3. Outpatient Psychiatric Care Facility

The above listed fee change schedules include all new codes for the Jan. 1, 2013, annual HCPCS update. Many of the new codes do not yet have fees established and are indicated as “TBD.” As soon as fees have been established for these codes, we will publish them in future weekly fee change schedules.

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

For more information, contact your BCBSM provider consultant.

32. BCBSM updates DRG weights, adjusts hospital rates to neutralize payments

**Category:** Hospital Inpatient Claims

**Title:** BCBSM updates DRG weights, adjusts hospital rates to neutralize payments

**Start Date:** December 19, 2012    **End Date:** January 21, 2012

BCBSM will begin using the updated MS-DRG Grouper 30 weights effective with BCBSM inpatient admissions on or after Jan. 1, 2013.
The MS-DRG Grouper 30 weights were recalibrated based on a more current claims set: calendar year 2011. The previous versions of MS-DRG weights were based on a fiscal year 2004 claims set.

Due to the age of the claims and the change in clinical practices since 2004, the DRG weights changed significantly more than in previous years, when the same 2004 claims were used. The significant weight change made it necessary to adjust individual hospital prices in order to maintain budget neutrality in payments.

A letter describing this change will be included with the budget neutral header file rate revision. We will also send an email to your facility’s chief financial officer, or other primary contact, with a secured workbook containing your facility’s 2011 claims used to recalibrate the new DRG weights. These claims, along with the Grouper 28 and Grouper 30 DRG weights, are also the basis of the budget neutral inpatient price adjustment.

For security purposes, we’ll send the password to open the encrypted workbook separately from the email with the file. You can also find the password in the detailed letter included with the header file rate revision.

The Grouper 30 MS-DRG weights are posted on the web-DENIS BCBSM Provider Publications and Resources page, under BCBSM Newsletters and Resources, and then BCBSM DRG Weights.

33. Blue Cross Complete of Michigan provider affiliation agreements amended

Category: Blue Cross Complete

Title: BlueCross Complete of Michigan provider affiliation agreements amended

Start Date: December 20, 2012   End Date: January 5, 2012

Pursuant to the Mandated Amendment section in the Blue Cross Complete of Michigan Affiliation Agreements, this publication serves as notice of amendment. The Blue Cross Complete Affiliation Agreements listed below are hereby amended to incorporate the indicated changes, effective February 18, 2013. The contractual language updates are related to language clarifications and Michigan Department of Community Health requirements, none of which impact the rate of reimbursement. Please click on the respective links below to obtain a copy of the amendment applicable to each provider type.

Blue Cross Complete of Michigan Medical Service Affiliation Agreement

Blue Cross Complete of Michigan Hospital Affiliation Agreement

Blue Cross Complete of Michigan Ancillary Provider Affiliation Agreement

Category: System downtime notification


Start Date: December 21, 2012   End Date: January 2, 2013

The Federal Employee Program® application will be unavailable Sunday, Dec. 30 through Tuesday, Jan. 1 due to system maintenance.

This means health care providers won’t be able to check FEP member benefits and eligibility through web-DENIS during that time.

We apologize for the inconvenience.

35. Some MESSA claims rejected erroneously

Category: Claims

Title: Some MESSA claims rejected erroneously

Start Date: December 21, 2012   End Date: February 23, 2013

Claims for MESSA members reporting procedure codes *10040, *36468 and *36469 are erroneously being denied in some circumstances. Our claims processing system is being updated and should begin processing these procedure codes correctly for MESSA members by Feb. 22, 2013.

Please do not resubmit your claims or bill the MESSA member. We will reprocess these claims as soon as the system is corrected. We apologize for the inconvenience.
36. Institutional HOST 835 remittance advice files

**Category:** Institutional Trading Partners

**Title:** Institutional HOST 835 remittance advice files

**Start Date:** December 21, 2012  **End Date:** January 11, 2013

On Dec 28, 2012, BCBSM will implement a fix to 835 remittance files for institutional HOST replacement (XX7 bill type) claims. Starting with check date Jan 3, 2013 forward, 835 files will now return the replacement (XX7) charges rather than the original claim charge.

If you have questions regarding the original or corrected claims, please contact Provider Inquiry. If you have questions regarding the 835 files, contact the EDI Helpdesk at 1-800-542-0945.

37. Quality measures added to provider directory

**Category:** Provider Directory

**Title:** Quality measures added to provider directory

**Start Date:** December 21, 2012  **End Date:** January 7, 2013

We’ve added measurable information to the *Find a Doctor* directory accessed from Member Secured Services. These enhancements to the physician and hospital profiles will help members find a doctor or hospital they feel will suit their health care preferences or needs.

Physician profile enhancements include physician quality measures for 12 HEDIS measures and a Blue Physician Recognition graphic icon.

Hospital profiles will show CMS Quality Hospital Compare data, Patient Experience (HCAHPS) and Leapfrog Quality surveys. The quality data included in each hospital’s profile in the secure, online directory can be found on each of these data organization’s public websites. We’re including the data for the convenience of our members.

For details on these enhancements, see the December 2012 issue of *The Record* or the November 2012 issue of *Physician Update.*
38. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: December 21, 2012  End Date: January 31, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Dec. 26, 2012:

- Facility
  1. Ambulatory Surgical Facility
  2. Freestanding Outpatient Physical Therapy Facility
  3. Hospital Outpatient

The above noted fee change schedules are adding additional procedure codes to existing fee-based service categories as follows:

- Ambulatory Surgical Facility: Laboratory, Radiology & Surgery
- Freestanding Outpatient Physical Therapy Facility: PT, OT & SLP Evaluations & PT, OT & SLP Visits
- Hospital Outpatient: Drug, Drug admin., Laboratory, Radiology & Surgery

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, and selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

39. Autism treatment billing guidelines change; BCBSM partners with Magellan Behavioral Inc.

Category: Autism treatment

Title: Autism treatment billing guidelines change; BCBSM partners with Magellan Behavioral Inc.

Start Date: December 21, 2012  End Date: January 15, 2013

In the December issue of The Record, we provided the billing and procedure information pertinent to behavior analysts who participate with the Blues to provide autism treatment. We want to update you on a change to the detailed billing guidelines for supervision quantity limits.
Behavior analysts should report supervision code G9012 in quantities **per 15 minutes**, with a quantity limit of 12. A board-certified behavior analyst may bill up to three hours of supervision per tutor per patient per week. A BCBA may bill for the supervision of the parent- and educator-tutors under this code.

We previously stated the quantity limit was calculated **per hour**.

For details, please see the [billing guidelines](#) on the BCBSM Autism Resources page.

**BCBSM partners with Magellan Behavioral Inc.**
BCBSM has partnered with Magellan Behavioral Inc. to provide utilization and care management, including preauthorization, of applied behavior analysis, or ABA, therapy. For more information, please see [A supplement to Your Guide to the Blues for board certified behavior analysts](#), on the BCBSM Autism Resources page.

40. Certain Medicare Advantage lab claims rejecting incorrectly

Category: Medicare Advantage

**Title:** Certain Medicare Advantage lab claims rejecting incorrectly

**Start Date:** December 21, 2012  **End Date:** January 21, 2013

Electronically billed Medicare Advantage claims for lab service procedure codes *80047 through *89356 with more than one unit in the “days/units” field are being rejected incorrectly. Until we’ve corrected this problem, please submit a paper claim if you receive an E30 rejection for these procedure codes for all dates of service prior to Jan. 1, 2013.

We are aware of the issue and are working to correct the situation. This does not affect paper claim submissions. Electronic claim submissions for dates of service after Dec. 31, 2012, should not be affected.

We apologize for the inconvenience and will update you as soon as we have resolved this issue.
41. Deadline extended for 2012 Performance Recognition Program credit

Category: Medicare Advantage

Title: Deadline extended for 2012 Performance Recognition Program credit

Start Date: December 21, 2012   End Date: January 18, 2013

Jan. 18, 2013, is now the last day for Blues Medicare Advantage health care providers to enter 2012 dates of service into Health e-Blue for inclusion in the Performance Recognition Program. This applies to BCBSM’s Medicare Plus Blue PPOS, BCN Advantage HMO-POSSM and BCN Advantage HMOSM.

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

42. CMS releases new claims-based data collection requirement for outpatient therapy

Category: Medicare Advantage

Title: CMS releases new claims-based data collection requirement for outpatient therapy

Start Date: December 21, 2012   End Date: January 21, 2013

CMS introduced a new claims-based data collection requirement for outpatient therapy services, which will become effective Jan. 1, 2013. CMS announced 42 new nonpayable functional G codes and seven new modifiers for physical therapy, occupational therapy and speech-language pathology services. Two “Sometimes Therapy” codes were also added for 2013.

These reporting requirements apply to therapy services from the following providers: hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and home health agencies (when the member is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice, physicians and nonphysician providers as noted above.

This claims-based data collection system is effective for therapy services with dates of service on or after Jan. 1, 2013. However, a testing period will be in effect from Jan. 1, 2013, through June 30, 2013, during which claims without the required G codes and modifiers will be processed to allow providers to use the new coding requirements in order to ensure that their systems work. A separate instruction will be issued regarding the editing required for claims with therapy services furnished on or after July 1, 2013.
Please see the links below for a list of G codes and more information. If you have additional questions, please contact your provider consultant. More detailed information will also be available in the February edition of The Record.

- CMS MLN MM 8005: Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services

- CMS Transmittal - CR 8005: Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services

- CMS MLN MM8126: 2013 Annual Update to the Therapy Code List

- CMS Transmittal - CR 8126: 2013 Annual Update to the Therapy Code List

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43. Report numeric amount in charge field of Medicare Advantage claims

**Category:** Medicare Advantage

**Title:** Report numeric amount in charge field of Medicare Advantage claims

**Start Date:** December 21, 2012  **End Date:** January 15, 2012

The Centers for Medicare & Medicaid Services require a numeric amount in the charge field of both the UB-04 and CMS-1500 claims. Blue Cross Blue Shield of Michigan is not allowed to correct claims that are not reported this way.

Below are links to information explaining CMS’ claims guidelines:

UB-04 – Field 47 overview of total charges required by Medicare:

Medicare Claims Processing Manual, Chapter 25, Page 23, details field 47 specifically:

CMS-1500 – Field 24F overview of total charges required by Medicare:
Medicare Claims Processing Manual, Chapter 26, Page 14, details how Field 24F requires this charge for each listed service:


Home health and skilled nursing facility medical claim forms are, at times, mistakenly completed with blank charges. Zeros should be reported instead.

CMS recently discovered its instructions regarding the total charges field for home health claims is in conflict with the HIPAA standard 837 institutional claim format. The 837 requires that the total charges filed (SV203) must always be reported and that zero is an acceptable value. The link below provides additional instructions and clarification:


For skilled nursing facilities, total charges should be zero for revenue code 0022. The link below provides additional guidance:


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

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44. CMS announces 2013 therapy cap

Category: Medicare Advantage

Title: CMS announces 2013 therapy cap

Start Date: December 21, 2012   End Date: January 15, 2013

CMS released updated information for its outpatient therapy caps for calendar year 2013. The cap will be $1,900 for physical therapy and speech-language therapy combined. Occupational therapy’s cap is also $1,900.
For more information, please review the CMS Web pages below or contact your provider consultant:

- CMS MLN MM 8129: 2013 Therapy CAP Values for Calendar Year 2013
- CMS Transmittal - CR 8129: 2013 Therapy CAP Values for Calendar Year 2013

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45. Medicare Advantage Health e-Blue health measures received

**Category:** Medicare Advantage

**Title:** Medicare Advantage Health e-Blue health measures received

**Start Date:** December 21, 2012  **End Date:** January 15, 2013

You may have noticed that many of the member health measures you have entered in Health e-Blue are now listed as “rejected.” Please be assured that the data you have entered has been received and will be utilized to calculate your payments for the Physician Recognition Program.

This issue is triggered by the timing of data exchanges, and we are working to fix this for 2013. If you have any questions, please use the feedback link in the upper right corner of the Health e-Blue screen or send an email to MAHealtheblue@bcbsm.com.

We apologize for the inconvenience. Thank you for your patience.

46. All Medicare Part B submitters

**Category:** Delayed WPS 835 remittance files

**Title:** All Medicare Part B submitters

**Start Date:** December 27, 2012  **End Date:** January 10, 2013

Medicare Part B 835 remittance files from WPS for check dates 12/26/12 and 12/27/12 were delayed. We anticipate that all files will be distributed by this evening.

We apologize for any inconvenience.
47. All BCBSM professional trading partners

Category: Delayed 835 remittance files for check date 12/26/2012

Title: All BCBSM professional trading partners

Start Date: December 28, 2012    End Date: January 26, 2012

Due to a systems issue, some professional 835 remittance advice files for check date 12/26/2012 were delayed. The issue has now been resolved and the files will be distributed today.

We apologize for any inconvenience.

48. Internet Claim Tool intermittent outages

Category: All Internet Claim Tool users

Title: Internet Claim Tool intermittent outages

Start Date: December 28, 2012    End Date: January 11, 2013

BCBSM EDI is aware that some ICT users are encountering a blank screen when logging into the claim tool. We are investigating the issue and encourage users to try logging in again at a later time. Currently, the issue is sporadic and only affecting a small number of users.

We will update this message when additional information is available. Please contact the EDI helpdesk at 800-542-0945 on Monday, Dec. 31, 2012, if you continue to experience this issue.

We apologize for any inconvenience.

49. FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Category: FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Title: FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Start Date: March 29, 2012    End Date: TBD

The Federal Employee Program (FEP) eligibility information does not currently indicate if Medicare or another carrier is primary.

Please use the web-DENIS Medicare Eligibility feature to determine if Medicare is the primary carrier for your patient.
50. The Centers for Medicare and Medicaid Services gives recommendation to hold claims paid under the 2013 Medicare Physician Fee Schedule

**Category:** BCN Advantage Claims

**Title:** The Centers for Medicare and Medicaid Services gives recommendation to hold claims paid under the 2013 Medicare Physician Fee Schedule

**Start Date:** December 28, 2012  **End Date:** January 11 2013

Please read the notice from CMS regarding the holding of 2013 date-of-service claims for services paid under the 2013 Medicare Physician Fee Schedule. We have posted the notice under the BCN Provider Publications and Resources home page under What’s New.

51. Reminder: Global referrals for BCN commercial and Blue Cross Complete members should be written for a minimum of 90 days beginning Jan. 1

**Category:** BCN Referrals

**Title:** Reminder: Global referrals for BCN commercial and Blue Cross Complete members should be written for a minimum of 90 days beginning Jan. 1

**Start Date:** December 31, 2012  **End Date:** January 14, 2013

The Blue Care Network global referral process will be simpler for both providers and members beginning Jan. 1, 2013. The process for BCN commercial and Blue Cross Complete members includes these changes:

- Write global referrals for a minimum of 90 days.
- For three chronic conditions — oncology, rheumatology and renal management — write global referrals for one year.

For more information, please read the article on Page 51 of the Nov.-Dec. 2012 BCN Provider News or contact your BCN provider representative.
52. Accumulators temporarily not displayed on web-DENIS for Blue Care Network Metro Health members

Category: BCN - Metro Health

Title: Accumulators temporarily not displayed on web-DENIS for Blue Care Network Metro Health members

Start Date: January 1, 2013   End Date: January 15, 2013

Effective January 1, 2013, for Blue Care Network Metro Health members only, tier 3 deductible and coinsurance accumulators will temporarily not be displayed on web-DENIS. Providers will need to call Provider Inquiry at 1-800-255-1690.

53. Internet Claim Tool intermittent outages

Category: All Internet Claim Tool users

Title: Internet Claim Tool intermittent outages

Start Date: December 31, 2012   End Date: January 14, 2013

BCBSM EDI is aware that some ICT users are encountering a blank screen when logging into the claim tool. We are investigating the issue and encourage users to try logging in again at a later time. Currently, the issue is sporadic and only affecting a small number of users.

We will update this message when additional information is available. Please contact the EDI helpdesk at 800-542-0945 on Wednesday, Jan. 2, 2013, if you continue to experience this issue.

We apologize for any inconvenience.

54. Include rendering practitioner NPI on group provider claims

Category: Medicare Advantage

Title: Include rendering practitioner NPI on group provider claims

Start Date: December 31, 2012   End Date: January 15, 2013

Please be certain to include the rendering practitioner’s national provider identifier on any claims originating with group health care providers, including clinics, multispecialty groups and physicians providing durable medical equipment or supplies.
Enter the NPI in field 24J on the CMS-1500 paper claim or in field 2310B/2420A on the 5010 electronic claim. All applicable fields will require verification with EDI.

Inclusion of the NPI will help us to more quickly process claims. Failure to provide this information may result in claims processing delays or denials.

If you have any questions, please contact your provider consultant. Thank you for your continued partnership.

55. Some Medicare Advantage PPO provider manual links not working

Category: Medicare Advantage

Title: Some Medicare Advantage PPO provider manual links not working

Start Date: December 31, 2012   End Date: January 21, 2013

As a result of the recent Blues website redesign, some hyperlinks in the January 2013 Medicare Advantage PPO provider manual may not function correctly. We are working to correct the issue. In the meantime, please use our provider website search tool, at bcbsm.com/provider/ma, to find the information you need or call your provider consultant.

We apologize for this inconvenience. Thank you for your patience.

56. Some Medicare Advantage ID cards missing alpha prefix

Category: Medicare Advantage

Title: Some Medicare Advantage ID cards missing alpha prefix

Start Date: December 31, 2012   End Date: January 15, 2013

Blue Cross Blue Shield of Michigan recently began mailing new 2013 Medicare Plus Blue PPOSM ID cards to members. For billing purposes, the alpha characters preceding the contract numbers have changed to XYL. In some instances, this alpha prefix was not printed on the ID card.

We have identified this issue and will reissue new ID cards to those members. Members can use the ID cards without the alpha prefix until the corrected ID card is received. Please use the XYL prefix in conjunction with the member’s contract number for any 2013 claims.

If you have any questions, please contact your provider consultant. We appreciate your patience and apologize for any inconvenience this may cause.
57. Professional and facility fee change schedules removal

**Category:** Fee Changes

**Title:** Professional and facility fee change schedules removal

**Start Date:** December 31, 2012    **End Date:** January 15, 2013

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published.

Entire fee schedules effective July 1, 2012, were published on web-DENIS March 28, 2012. Therefore, fee change schedules published prior to March 28, 2012, have been removed from web-DENIS, as the fee changes are either incorporated in or superseded by the new entire fee schedule effective July 1, 2012.

Specifically, the fee change schedules published before March 28, 2012, that have been removed are:

- **Professional**
  1. Traditional, TRUST & Blue Preferred Plus℠
  2. Independent Lab
  3. Injections
  4. Hearing

- **Facility**
  1. Ambulatory Surgery Facility
  2. Outpatient Psychiatric Care
  3. Home Infusion Therapy

Entire fee schedules and fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.
February 2013

Centers for Medicare & Medicaid Services
announce 2013 therapy caps

The Centers for Medicare & Medicaid Services released updated information on change request 8129 for its outpatient therapy caps for 2013. The 2013 therapy cap is $1,900 for physical therapy and speech-language therapy combined. The occupational therapy cap is also $1,900.

For more information, visit the CMS website to download the MLN Matters® (PDF) overview of the 2013 therapy caps or the related CMS Manual System alert* (PDF). You can also contact your provider consultant.

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February 2013

**HEDIS medical record reviews begin in February**

Each year, Blue Cross Blue Shield of Michigan conducts Healthcare Effectiveness Data and Information Set medical record reviews. Inovalon™ will perform the HEDIS reviews from February through May on behalf of PPO and Medicare Advantage PPO members beginning this month.

These reviews don’t replace the risk adjustment medical record review process also performed by Inovalon on behalf of BCBSM’s Medicare Advantage PPO.

For the HEDIS reviews, Inovalon looks for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results, cholesterol and colorectal screenings, and body mass index. This information helps us enhance our member quality improvement initiatives.

Inovalon will contact you to either schedule an appointment for a HEDIS review or request that you fax the necessary records. BCBSM will reimburse you $5 for each requested medical chart.

The chart below outlines the reviews and when they will be performed:

<table>
<thead>
<tr>
<th>Review</th>
<th>Reviews scheduled</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>February through May 2013</td>
</tr>
<tr>
<td>Medicare Advantage Risk Adjustment Review Process 1 (FRO 1)</td>
<td>January through March 2013</td>
</tr>
<tr>
<td>Medicare Advantage Risk Adjustment Review Process</td>
<td>April through May 2013 and October 2013 through</td>
</tr>
</tbody>
</table>
If you have any questions, please contact your provider consultant.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Reminder: Include rendering practitioner NPI on group provider claims

Please include the rendering practitioner’s national provider identifier on any claims originating with group health care providers, including clinics, multi-specialty groups and **physicians providing durable medical equipment or supplies.**

Enter the NPI in field 24J on the CMS-1500 paper claim or in field 2310B/2420A on the 5010 electronic claim. All applicable fields will require verification with EDI.

Inclusion of the NPI will help us to more quickly process claims. Failure to provide this information may result in claims processing delays or denials.

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

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February 2013

Reminder: Report numeric amounts in Medicare Advantage claims charge fields

The Centers for Medicare & Medicaid Services require a numeric amount in the charges field of both UB-04 and CMS-1500 claims. Blue Cross Blue Shield of Michigan is not allowed to correct claims.

Home health and skilled nursing facility claims are, at times, submitted with blank charges. Zeros should be included when the forms are completed to initiate a procedure.

Below are links to information on the CMS website explaining each form’s guidelines:


CMS recently discovered that Medicare’s instruction regarding the total charges field report for home health is in conflict with the HIPAA standard 837 institutional claim format. This link below provides additional instructions and clarification: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7660.pdf*. The 837 requires that the total charges filed (SV203) must always be reported. Zero is an acceptable value.

For skilled nursing facilities, total charges should be zero for revenue code 0022. This link

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

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Reminder: Submit 2012 Medicare Advantage claims

To help ensure accurate and timely claims processing, be sure to submit all claims for Medicare Advantage members with dates of service through Dec. 31, 2012, as soon as possible.

Your assistance in this matter is appreciated. If you have any questions, please contact your provider consultant.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Web-DENIS messages January 2013
These are the chapters we revised in December 2012, along with the revision date and a brief statement of the main changes for each.*

**Ambulance Services** (12/3/2012)
- Overhauled the entire chapter, which replaces two previously published chapters — *Ambulance Benefit* and *Ambulance Services: Billing and Reimbursement*.

**Blue Pages Directory** (12/12/2012)
- "AIM Specialty Health" — Added information about the availability of AIM’s clinical criteria.
- "Human Organ Transplant Program" — Added information about how to review the medical criteria and a link to the criteria manual.
- "InterQual criteria" — Added a section about criteria availability and a link to the BCBSM modifications to InterQual criteria (local rules).
- "Provider Consulting Services" — Updated the “West Michigan – professional consultants" chart.

**Blue Preferred Plus** (12/10/2012)
- "Contact information” — In the “Ford UAW Retiree Medical Benefits Trust (URMBT)” section, changed the contact information for laboratory from Capitated Laboratory Program to PLUS Lab.

**Claims** (12/15/2012)
- "UB-04 claim examples” — Updated the “Inpatient Medical Rehab” claim example.

**Coordination of Benefits** (12/21/2012)
- Overhauled the entire chapter.

**Home Infusion Therapy Services** (12/1/2012)
- “Billing guidelines” — In the “Electronic billing” section, added the claims filing time limit

**Hospital Services** (12/10/2012)
- "IV therapy” — In the “Billing guidelines” section, deleted revenue codes 0270, 0271 and 0272 from the outpatient hospital manual.
- "Substance abuse - acute care” — In the "Covered services" section, changed the diagnosis codes that are payable for acute care services.

**Mental Health Substance Abuse Managed Care Program** (12/10/2012)
- Overhauled the entire chapter.
Participation (12/18/2012)

• “Participation agreements” — Added a link to the future Outpatient Psychiatric Care Facility Participation Agreement, which is effective April 1, 2013.

Preapproval of Services (12/28/2012)

- “Preauthorization” — In the “Required preauthorization” section, added information to the “Note” bullets.
- “Additional guidelines for human organ transplant benefits” — Added information on how to review HOT criteria and a link to the criteria manual.
- “InterQual criteria” — Added information about Long Term Acute Care criteria; added a link to the BCBSM modifications to InterQual criteria.

Psychiatric Care Services (12/18/2012)

• “Reimbursement” — In the “Outpatient Psychiatric Care facilities” section, added a link to the future Outpatient Psychiatric Care Facility Participation Agreement, which is effective April 1, 2013.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

2. All Internet Claim Tool users

Category: Erroneous editing for diagnosis codes

Title: All Internet Claim Tool users

Start Date: January 4, 2013  End Date: January 18, 2013

BCBSM is aware that the ICT is erroneously editing some claims. At this time, the issue is limited to claims reporting diagnosis codes in the 839.00 – 839.08 range, together with 2013 dates of service. We are in the process of determining whether additional diagnosis codes are affected.

We are working to correct this issue and will provide an update when it has been resolved.
3. All Institutional Trading Partners

Category: Institutional HOST 835 remittance

Title: All Institutional Trading Partners

Start Date: January 4, 2013    End Date: January 18, 2013

On Dec. 28, 2012, BCBSM implemented a fix to 835 remittance files for institutional HOST replacement (XX7 bill type) claims. Starting with check date Jan. 3, 2013 forward, 835 files will now return the replacement (XX7) charges rather than the original claim charge.

Please review your 835s and contact the EDI Helpdesk at 1-800-542-0945, if you encounter any issues.

4. Some member ID cards delayed

Category: Benefits and eligibility

Title: Some member ID cards delayed

Start Date: January 7, 2013    End Date: February 22, 2013

Some new Blue Cross Blue Shield of Michigan members have not yet received BCBSM health insurance cards. Please use the web-DENIS name search feature to obtain a member’s contract number, if one of your patients doesn’t yet have an ID card.

If a member is still not found in web-DENIS using the name search feature, please follow the current process of inquiry to Customer/Provider servicing and for BCBSM Employee contact the Ombudsman office at 877 258-0167.

We anticipate that ID cards will be mailed to these members in February. We apologize for any inconvenience this may cause.
5. Additional fee change schedules added to web-DENIS

   **Category:** Fee Changes
   
   **Title:** Additional fee change schedules added to web-DENIS
   
   **Start Date:** January 7, 2013    **End Date:** January 21, 2013
   
   BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 07, 2013:
   
   - Professional
     - Traditional, TRUST & Blue Preferred Plus℠
     - DME
   - Facility
     - Outpatient Hospital
     - Ambulatory Surgery Facility
   
   These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, click on Entire Fee Schedules and Fee Changes.

6. 2013 Medicare physician, facility fee schedules released

   **Category:** Medicare Advantage
   
   **Title:** 2013 Medicare physician, facility fee schedules released
   
   **Start Date:** January 8, 2013    **End Date:** January 31, 2013
   
   The Centers for Medicare & Medicaid Services has released the 2013 Medicare Physician Fee Schedule and inpatient facility pricer and will be used for claims processing. However, CMS has yet to release the 2013 outpatient facility pricer.
   
   As a result of this delay, Blue Cross Blue Shield of Michigan will process affected claims using the 2012 pricer and adjust the claims accordingly once the 2013 pricer is loaded.
   
   As more information becomes available, we will publish it via web-DENIS. If you have any questions, please contact your provider consultant. Thank you.
7. Facility inpatient claims rejecting in error R194

Category: Facility Claims

Title: Facility inpatient claims rejecting in error R194

Start Date: January 10, 2013    End Date: January 31, 2013

We have identified an issue with facility inpatient claims rejecting in error when the statement “from” date is prior to the “admission” date. Claims are rejecting with reason code R194 in error. We will notify you in another broadcast message when the issue is corrected and claims will be reprocessed.

8. UA Local 190 claims being reprocessed

Category: Claims

Title: UA Local 190 claims being reprocessed

Start Date: January 10, 2013    End Date: February 15, 2013

We have identified an error made in benefit information for UA Local 190 Health Plan, group number 007004717, when it migrated to our Michigan Operating System Oct. 1. As a result, incorrect cost-sharing amounts were applied to several facility and professional claims.

We are working to correct the benefit information and reprocess these claims. Please allow additional time before billing these members for cost-sharing amounts. We will notify you on web-DENIS when this issue has been resolved.

We apologize for any inconvenience this may cause. Thank you for your patience.
9. Deductible and coinsurance amounts temporarily not displayed on web-DENIS for Blue Care Network Metro Health members

**Category:** BCN - Metro Health

**Title:** Deductible and coinsurance amounts temporarily not displayed on web-DENIS for Blue Care Network Metro Health members

**Start Date:** January 11, 2013    **End Date:** February 8, 2013

Due to technical difficulties, the out-of-pocket dollar amounts are not displaying correctly on web-DENIS for Metro Health members. The Deductible/Copay screen is erroneously showing that the member has no out-of-pocket costs. While we work to resolve the issue, we encourage providers to collect the applicable copayment at the time of service and wait for the remittance advice from Blue Care Network to determine any applicable member deductibles or coinsurance. You may also call Provider Inquiry at 1-800-255-1690. We apologize for the inconvenience.

10. All professional BCBSM electronic submitters

**Category:** New NDC code edit for BCBSM MIChild claims

- Group #007004505 (new group number effective October 2012)
- Group #31295 (group number prior to October 2012)

**Title:** All professional BCBSM electronic submitters

**Start Date:** January 13, 2013    **End Date:** March 13, 2013

Effective Feb. 18, 2013, BCBSM will edit professional claims for MIChild group 007004505 that do not follow Medicaid Drug Rebate Program requirements. The Drug Rebate Program is a partnership between CMS, State Medicaid Agencies, and participating drug manufacturers that helps to offset the Federal and State costs of most outpatient prescription drugs dispensed to Medicaid patients. As part of the program, claims that contain professional procedure codes that indicate a drug was submitted must also contain a national drug code (NDC) and the associated quantity.

The new edit P099 A3 454 PROCEDURE CODE/NDC CODE MISSING/INVALID will be returned on BCBSM R277CAH reports. Edited claims will require correction and resubmission.

To avoid this edit, applicable 837 claims for MIChild Group 007004505 should contain NDC codes and associated quantities as follows:

- Loop 2410 LIN02 – report qualifier N4
- Loop 2410 LIN03 – report the 11 digit NDC code without spaces or special characters
Loop 2410 CTP04 – report the associated numeric drug quantity
Loop 2410 CTP05 – report the unit of basis of measurement qualifier as applicable

For more information about the MDRP, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html.

If you need assistance with reporting of procedure or NDC code information in your software or practice management system, please contact your vendor or clearinghouse.

11. All professional BCBSM electronic submitters

Category: New NDC code edit for BCBSM MIChild claims
  Group #007004505 (new group number effective October 2012)
  Group #31295 (group number prior to October 2012)

Title: All professional BCBSM electronic submitters

Start Date: January 13, 2013   End Date: March 13, 2013

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For more information about the MDRP, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html.

If you need assistance with reporting of procedure or NDC code information in your software or practice management system, please contact your vendor or clearinghouse.
12. All institutional trading partners

**Category:** Institutional outpatient reporting changes

**Title:** All institutional trading partners

**Start Date:** January 14, 2013    **End Date:** May 5, 2013

Effective April 1, 2013 BCBSM will implement reporting changes on all outpatient institutional claims. These changes are for Blue Cross claims only (Claim filing indicator BL).

The changes include:

- Reporting appropriate revenue codes for each date of service.
- Reporting of HCPCS procedure codes for each date of service. (Loop 2400, SV202-2).
- Dialysis claims containing Revenue Codes 0821, 0841 and 0851 must have the appropriate condition code for each date of service.
- Freestanding Outpatient Physical Therapy Facilities can no longer report Revenue Code 420, 430 and 440. (Loop 2400, SV201).
- Value Code 80 is no longer required on outpatient therapy claims. (Loop 2300, HI01-1 BE qualifier).
- If a drug does not have a corresponding HCPCS code, it should be billed with revenue code 0250.
This chart provides the billing information that will be in effect April 1, 2013.

<table>
<thead>
<tr>
<th>Description</th>
<th>Revenue codes that require HCPCS codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (including maternity)</td>
<td>0360, 0361, 0369, 0490, 0499, 0700, 0750, 0769, 0790</td>
</tr>
<tr>
<td></td>
<td>Codes that require a surgical HCPCS if surgery is performed in this room: 0450, 0451, 0452, 0456, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0519, 0761</td>
</tr>
<tr>
<td>Laboratory – clinical/anatomical</td>
<td>0300, 0301, 0302, 0303, 0304, 0305, 0306, 0307, 0309, 0310, 0311, 0312, 0314, 0319, 0923, 0924, 0925</td>
</tr>
<tr>
<td>Other</td>
<td>0270, 0271, 0272, 0279, 0280, 0289, 0370, 0379, 0380, 0381, 0382, 0383, 0384, 0385, 0386, 0387, 0389, 0390, 0391, 0392, 0399, 0410, 0412, 0413, 0419, 0450, 0451, 0452, 0456, 0459, 0460, 0469, 0470, 0471, 0472, 0479, 0480, 0481, 0482, 0483, 0489, 0500, 0509, 0510, 0511, 0512, 0514, 0515, 0516, 0517, 0519, 0530, 0531, 0539, 0540, 0545, 0621, 0622, 0623, 0730, 0731, 0732, 0739, 0740, 0780, 0920, 0921, 0922, 0929, 0940, 0942, 0943, 0949, 0951, 0952, 2101, 2105, 2106</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>0274, 0291, 0292, 0293, 0946, 0947</td>
</tr>
<tr>
<td>Prosthetic &amp; Orthotic</td>
<td>0260, 0331, 0332, 0335, 0771</td>
</tr>
<tr>
<td>Drug Administration</td>
<td>0250, 0251, 0252, 0253, 0254, 0255, 0256, 0257, 0258, 0259, 0262, 0631, 0632, 0633, 0634, 0635, 0636, 0637</td>
</tr>
<tr>
<td>Drug/Pharmacy</td>
<td>0255, 0343, 0349</td>
</tr>
<tr>
<td>Radiopharmaceutical</td>
<td>0255, 0320, 0321, 0322, 0323, 0324, 0329, 0330, 0333, 0339, 0340, 0341, 0342, 0343, 0344, 0349, 0350, 0351, 0352, 0359, 0400, 0401, 0402, 0403, 0404, 0409, 0610, 0611, 0612, 0614, 0615, 0616, 0618, 0619, 0860, 0861</td>
</tr>
<tr>
<td>Radiology</td>
<td>0450, 0451, 0452, 0459, 0681, 0682, 0683, 0684, 0689</td>
</tr>
<tr>
<td>Emergency Room &amp; Trauma</td>
<td>Refer to “Surgery”</td>
</tr>
<tr>
<td>Surgery (Maternity)</td>
<td>Refer to “Surgery”</td>
</tr>
<tr>
<td>Treatment Room</td>
<td>0761</td>
</tr>
<tr>
<td>Observation Room</td>
<td>0762</td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy, Speech and Language Pathology Evaluation</td>
<td>0424, 0434, 0444</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy, Speech and Language Pathology Visit</td>
<td>0421, 0431, 0441</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenue codes</th>
<th>Condition codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0821</td>
<td>71</td>
<td>In Facility Hemodialysis</td>
</tr>
<tr>
<td>0821</td>
<td>73</td>
<td>Hemodialysis Training/Home</td>
</tr>
<tr>
<td>0821</td>
<td>74</td>
<td>Hemodialysis Session/Home</td>
</tr>
<tr>
<td>0841</td>
<td>73</td>
<td>Continuous Ambulatory Peritoneal Dialysis (CAPD) Training/Treatment</td>
</tr>
<tr>
<td>0841</td>
<td>74</td>
<td>Continuous Ambulatory Peritoneal Dialysis (CAPD) Supplemental Day</td>
</tr>
<tr>
<td>0851</td>
<td>73</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) Training Treatment</td>
</tr>
<tr>
<td>0851</td>
<td>74</td>
<td>Continuous Cycling Peritoneal Dialysis (CCPD) Supplemental Day</td>
</tr>
</tbody>
</table>

Additional information is available in the November and December 2012 editions of *The Record*.

If you questions about accommodating these changes in your electronic claims, contact the BCBSM EDI helpdesk at 800-542-0945. Billing and reimbursement inquiries should be directed to your provider consultant.
13. Cotterman Company-Conveyor Components Company changes its name

Category: Medicare Advantage

Title: Cotterman Company-Conveyor Components Company changes its name

Start Date: January 14, 2013    End Date: January 28, 2013

Cotterman Company-Conveyor Components Company has legally changed its name to Material Control, Inc., effective immediately.

Please contact your provider consultant with any questions.

14. Clarification: CMS new claims-based data collection requirement for outpatient therapy does not apply to Medicare Advantage

Category: Medicare Advantage

Title: Clarification: CMS new claims-based data collection requirement for outpatient therapy does not apply to Medicare Advantage

Start Date: January 14, 2013    End Date: January 31, 2013

Blue Cross Blue Shield of Michigan recently reported that the new, CMS claims-based data collection requirement for outpatient therapy services, effective Jan. 1, 2013, applies to Medicare Advantage. Based on further clarification from CMS, it was determined that the new codes and modifiers apply only to Original Medicare, not Medicare Advantage.

We apologize for any confusion. If you have any questions, please contact your provider consultant.

15. Transition to BCN 277CA reports and transactions

Category: All Blue Care Network trading partners

Title: Transition to BCN 277CA reports and transactions

Start Date: January 15, 2013    End Date: March 31, 2013

Effective Mar. 1, 2013, BCBSM EDI will return 277CA reports and transactions for Blue Care Network claims. The new versions will be:

R277CAF – replaces the BCN U277F report
277CAP – replaces the 4010 version 277P transaction. The 277CAP transaction will display ‘Blue Care Network’ as the payer name in Loop 2100.
The new versions will return the same claim detail and acknowledgement information as found in all other 277CAs distributed by BCBSM. BCN submitters will receive their regular reports and transactions until the transition.

Please note that BCBSM continues to receive 277P transactions from other payers. This change to BCN reports will not impact the distribution or naming convention of other payer 277P files.

If you have any questions regarding the new BCN reports, please contact the EDI helpdesk 1-800-542-0945.

16. Some professional psychiatric claims on hold

Category: Professional Claims

Title: Some professional psychiatric claims on hold

Start Date: January 15, 2013    End Date: February 15, 2013

BCBSM placed a stop on professional claims billed with the new psychiatric procedure codes *90785, *90791, *90792, *90832-*90834, *90836-*90838, *90839, *90840 and *90863 until the system is updated to process these procedures.

After the system has been updated, the claims will be released and processed for reimbursement. There is no need for providers to hold claims, as BCBSM will stop them from rejecting and hold them until the system is able to process them.

Thank you for your patience.

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17. Professional fee change schedules

Category: Fee Changes

Title: Professional fee change schedules

Start Date: January 16, 2013    End Date: January 30, 2013

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published.

We inadvertently removed a hearing fee change schedule, which has now been republished.
Specifically, the fee change schedule that has been republished is:

- Professional
  - Hearing

Entire fee schedules and fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

For more information, contact your BCBSM provider consultant.

18. Reminder: BCN changes minimum length for global referrals. Please make sure your referral coordinator is aware of these important changes.

Category: Blue Care Network referrals

Title: Reminder: BCN changes minimum length for global referrals. Please make sure your referral coordinator is aware of these important changes.

Start Date: January 16, 2013    End Date: February 13, 2013

Because Blue Care Network is committed to improving the referral experience for our members, the BCN global referral process has changed. We told providers beginning last October about these changes, which are effective Jan. 1, 2013:

- Global referrals should now be written for a minimum of 90 days.
- For three chronic conditions — oncology, rheumatology and renal management — global referrals should be written for one year.

In order to keep this new process on track, BCN will manually change the end dates of any referrals written for less than the minimum 90 days, or less than the minimum 365 days for oncology, rheumatology and renal management. This manual intervention will take time and could slow our response to your referral requests. We are notifying members of end-date extensions as they arise. If the end date of a global referral is changed, you will see this on the e-referral system.

19. All Blue Care Network trading partners

- Category: All Blue Care Network trading partners
- Title: All Blue Care Network trading partners
- Start Date: January 22, 2013    End Date: February 4, 2013
- Due to a BCN systems issue, professional and institutional 835 remittance advice files for check date Jan. 22, 2013 have been delayed. The files will be distributed this evening.
- We apologize for any inconvenience
20. Fee change schedule correction added to web-DENIS
   - **Category:** Fee Changes
   - **Title:** Fee change schedule correction added to web-DENIS
   - **Start Date:** January 22, 2013  **End Date:** February 5, 2013
   - BCBSM added a fee change schedule for outpatient psychiatric care to web-DENIS, with an effective date of Jan. 1, 2013, as of Nov. 26, 2012. However, the schedule was not correct and it has been removed. If you had used the “as of 11/26/2012” outpatient psychiatric care fee change schedule, please disregard it. It has been replaced with a corrected fee change schedule effective April 1, 2013, as of Jan. 22, 2013:
     - Facility
       1. Outpatient Psychiatric Care
   - This and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.
   - For more information, contact your BCBSM provider consultant.

21. Additional fee change schedules added to web-DENIS
   - **Category:** Fee Changes
   - **Title:** Additional fee change schedules added to web-DENIS
   - **Start Date:** January 22, 2013  **End Date:** February 5, 2013
   - BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 22, 2013:
     - Professional
       1. Traditional, TRUST & Blue Preferred Plus℠
       2. Injections
       3. DME
     - Facility
       1. Outpatient Hospital
       2. Ambulatory Surgical Facility
   - These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

22. All Medicare Advantage trading partners
   - **Category:** Transition to Medicare Advantage 277CA reports and transactions
   - **Title:** All Medicare Advantage trading partners
   - **Start Date:** January 23, 2013  **End Date:** February 6, 2013
   - Beginning in February, BCBSM EDI will transition to new 277CA reports and transactions for Medicare Advantage. Going forward, submitters will receive one or more of the following responses depending upon the service dates included in the claim:
     - Reports:
R277CAK – report format for 2013 dates of service.

Transactions:
277P – transaction format for 2012 dates of service.
277CAP transaction format for 2013 dates of service. The 277CAP transaction will display ‘Medicare Advantage’ as the payer name in Loop 2100.

The new versions will return the same claim detail and acknowledgement information as found in all other 277CAs distributed by BCBSM.

Please note that BCBSM continues to receive U277 reports and 277P transactions from other payers. This change to our Medicare Advantage reports will not impact the distribution or naming convention of other payer files.

We will provide an update when the release date for the new report and transaction is determined.

If you have any questions regarding the new formats, please contact the EDI helpdesk 1-800-542-0945.

23. Additional fee schedules added to web-DENIS

Category: Claims
Title: Additional fee schedules added to web-DENIS
Start Date: January 23, 2013  End Date: February 6, 2013

BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective Feb. 1, 2013:

Professional: Injection Fee Schedule
   1. Injections fee schedule 2/01/13

Facility: Hospital Outpatient
   1. Drug fees effective 2/01/13

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will be removed.

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.
24. Medicare Eligibility

**Category:** System Outage Notifications – January 25-26, 2013

**Title:** Medicare Eligibility

**Start Date:** January 24, 2013    **End Date:** January 28, 2013

There is scheduled maintenance on the Medicare Eligibility system for the weekend of Friday-Saturday, January 25-26, 2013. The maintenance window will begin at 9:00 PM ET on Friday, January 25, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to Medicare Eligibility will result in errors. CMS estimates that the maintenance will be completed by 1:00 PM ET on Saturday, January 26, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

25. All Medicare Advantage submitters

**Category:** Delayed Medicare Advantage 835 remittance files

**Title:** All Medicare Advantage submitters

**Start Date:** January 25, 2013    **End Date:** February 8, 2013

BCBSM has not yet received some Medicare Advantage 835 remittance files for this week’s check cycle. We are working to obtain the missing files. The files will be distributed upon receipt.

We apologize for any inconvenience

26. Update: Some professional and OPC psychiatric claims on hold

**Category:** Professional and Facility claims

**Title:** Update: Some professional and OPC psychiatric claims on hold

**Start Date:** January 25, 2013    **End Date:** February 15, 2013

We previously told you that BCBSM placed a stop on professional claims billed with the new psychiatric procedure codes *90785, *90791, *90792, *90832-*90834, *90836-*90838, *90839, *90840 and *90863 until the system is updated to process these procedures. BlueCard host claims billed with procedure codes *90832, *90837 and *90834 are now processing.
We are aware of the OPC claim rejections for evaluation and management procedure codes used to report pharmacologic management. We are aware of several other issues, and we are working diligently to resolve them. We’ll provide updates as they become available.

After the system has been updated, the claims will be released and processed for reimbursement. There is no need for you to hold claims, as BCBSM will stop them from rejecting and hold them until the system is able to process them.

Thank you for your patience. We apologize for the inconvenience.

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27. Clarification: CMS new claims-based data collection requirement for outpatient therapy does not apply to Medicare Advantage

Category: Medicare Advantage

Title: Clarification: CMS new claims-based data collection requirement for outpatient therapy does not apply to Medicare Advantage

Start Date: January 28, 2013    End Date: February 15, 2013

Blue Cross Blue Shield of Michigan recently reported that the new, CMS claims-based data collection requirement for outpatient therapy services, effective Jan. 1, 2013, applies to Medicare Advantage. Based on further clarification from CMS, it was determined that the new codes and modifiers apply only to Original Medicare, not Medicare Advantage.

**Update: If providers choose to submit claims to Blue Cross Blue Shield Medicare Advantage using the new therapy codes and modifiers, it will not affect or delay payment.**

28. Medicare Advantage PPO provider manual links now working

Category: Medicare Advantage

Title: Medicare Advantage PPO provider manual links now working

Start Date: January 28, 2013    End Date: February 15, 2013

The non-working hyperlinks in the January 2013 Medicare Advantage PPO provider manual have been corrected. You can find the most current version of the manual on our website at bcbsm.com/provider/ma.

Thank you for your patience as we worked to correct this issue.
29. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: January 28, 2013    End Date: February 11, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 28, 2013:

- Professional
  - Traditional, TRUST &Blue Preferred Plus℠
  - Independent Lab
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

30. BCN to stop mailing paper remittance advice statements

Category: BCN Miscellaneous

Title: BCN to stop mailing paper remittance advice statements

Start Date: January 29, 2013    End Date: March 15, 2013

Effective March 1, 2013, BCN will stop mailing paper remittance advice statements (vouchers) to facilities reimbursed through the bi-weekly interim payment (BIP) process. Other facilities and professional providers stopped receiving paper vouchers when they moved to electronic funds transfer payment. This change will save money and reduce our use of paper.

Provider Secured Services at bcbsm.com began storing remittance advice statements (or vouchers) beginning July 15, 2012. Facilities will have access to three years of searchable BCN remittance advices by July 15, 2015. There are two ways to look up an electronic facility voucher:

Finding a voucher by check number, EFT trace number or period of time:

- Within Provider Secured Services, under Electronic Vouchers Facility, click on View Electronic Vouchers.
Enter the billing NPI and click Submit.

When searching for a specific check number or EFT trace number, keep in mind that the system began storing the vouchers July 15, 2012. You will be able to search back three years by July 15, 2015.

If you want to find all remittance advices for a specific check date or span of time, input the billing NPI and then select one of these choices:

- Type in the “from” and “to” dates for a span of time up to one year. Note that the system can only go back up to three years.
- Search for all remittance advices in the last week.
- Search for all remittance advices in the last four weeks.
- Search for all remittance advices in the last 12 weeks.

Finding a remittance advice for a specific patient:

- Within web-DENIS click on Facility Claims.
- Click on BCN Facility Claims Tracking and complete the information requested on the form, including contract number, NPI and date of service.
- Click Enter.
- In the search results, you can click on the EFT trace number link to view the remittance advice.

If you need assistance, contact your BCN provider representative or, for technical assistance, call our help desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.

31. Michigan Conference of Teamsters Welfare Fund claims temporarily suspended

Category: Claims

Title: Michigan Conference of Teamsters Welfare Fund claims temporarily suspended

Start Date: January 29, 2013   End Date: February 8, 2013

Claims processing for the Michigan Conference of Teamsters Welfare Fund moved from our local claims system to the NASCO system Sept. 22, 2012. Claims processing is suspended while we complete post conversion validation.

Please allow us time to process these claims. Please be aware the payments will be delayed so do not bill the member for claims that are still on stop.

Thank you for your patience.
32. All Medicare Advantage submitters

Category: UPDATE - Delayed Medicare Advantage 835 remittance files have been distributed

Title: All Medicare Advantage submitters

Start Date: January 30, 2013    End Date: February 13, 2013

On 1/25/13, BCBSM EDI identified that Medicare Advantage 835 remittance files for that week were delayed. The issue has been resolved and all 835 files have been distributed.

We apologize for any inconvenience this delay may have caused.

33. BCBSM facility precertification request process moving to fax and email only

Category: BCBSM Precertification Services

Title: BCBSM facility precertification request process moving to fax and email only

Start Date: January 30, 2013    End Date: March 29, 2012

All requests for precertification and recertification of BCBSM member inpatient admissions (acute hospital, skilled nursing facility and acute rehab) must be submitted by fax or email, starting March 1, 2013. Blue Cross Blue Shield of Michigan’s Precertification Services department will no longer accept precertification requests by phone.

Facilities should complete the appropriate facility request form located on BCBSM’s provider website at bcbsm.com/providers/quick-links.html and fax or email to:

- **Acute inpatient hospital requests:**
  1. Fax 1-866-411-2585
  2. Email acuteprecertification1@bcbsm.com

- **Skilled nursing facility requests:**
  1. Fax 1-866-411-2573
  2. Email continuumofcaresnfandacuterehab@exchange.bcbsm.com

- **Acute inpatient rehabilitation requests:**
  1. Fax 1-866-411-2573
  2. Email continuumofcaresnfandacuterehab@exchange.bcbsm.com

Please begin using these options as soon as possible. The departmental phone lines will remain open until Thursday, Feb. 28, 2013. Over the next 30 days, we plan to restructure our staffing resources to ensure one-day turnaround during regular business hours to all precertification requests received by fax.
Facilities attempting to reach Precertification Services by phone on or after Thursday, Feb. 28, will receive an automated message outlining the appropriate fax submission process and related resources.

Soon you will be able to access submission forms and instructions on web-DENIS by clicking BCBSM Provider Publications and Resources, then Newsletters & Resources. The submission forms and instructions are also available on our BCBSM provider website at bcbsm.com/providers/quick-links.html.

34. Incorrect benefit information on Explainer for Michigan Laborers Health Care Fund

Category: Benefits

Title: Incorrect benefit information on Explainer for Michigan Laborers Health Care Fund

Start Date: January 30, 2013    End Date: February 13, 2013

Benefit information for Michigan Laborers Health Care Fund, group number 007004429, suffixes 0000 through 0020, is not correct on Benefit Explainer. Key benefits affected are:

- This group has no deductible (Explainer shows $100 individual/$200 family deductible)
- Office, home, outpatient and urgent care visits are subject to a $20 flat copayment (Explainer shows 20 percent copayment after deductible)
- Chiropractic spinal manipulation is subject to a $20 flat copayment – maximum of 27 services (Explainer shows 38 visits payable at 100 percent)
- Mental health and substance abuse services have a 20 percent copayment (Explainer shows 50 percent copayment)

We apologize for this issue and will have it resolved soon. We will notify you in a web-DENIS alert when the issue is corrected.
February 2013 Web-DENIS messages
1. 270/271 response files for Teamsters PPO contracts

**Category:** 270/271 Eligibility Benefit Inquiry and Response

**Title:** 271 response files for Teamsters PPO contracts

**Start Date:** February 1, 2013   **End Date:** February 15, 2013

BCBSM EDI had identified an issue with 271 responses files returning a contract number that does not match the 270 request. This issue only impacted MI Conference of Teamsters Welfare Fund PPO contracts with alpha prefix KMT.

EDI is working to correct this issue and will implement a fix on Feb. 11, 2013. In the interim, submitters can contact EDI Support via email with questions or for assistance.

We apologize for any inconvenience.

2. Physician fee uplifts for BlueCard® host claims

**Category:** Claims

**Title:** Physician fee uplifts for BlueCard® host claims

**Start Date:** February 1, 2013   **End Date:** March 1, 2013

Physician fee uplifts are not being applied to BlueCard host claims. We are working to update the claims system and will reprocess all the impacted claims. We expect this process to be completed within 90 days.

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

3. Michigan Quality Improvement Consortium special announcement and clinical practice guidelines

**Category:** Clinical practice guidelines

**Title:** Michigan Quality Improvement Consortium special announcement and clinical practice guidelines

**Start Date:** February 4, 2013   **End Date:** February 17, 2013

The Michigan Quality Improvement Consortium is pleased to announce that an MQIC app for iOS (iPhone and iPad) and Android devices is now available. Please access your mobile app store and search for “MQIC” to download the app today.
The MQIC has released updated clinical practice guidelines on the following topics:

- Acute Pharyngitis in Children 2-18 Years Old
- Adults with Systolic Heart Failure

Please visitmqic.org to access the guidelines.

4. Important reminders for Healthy Blue Outcomes℠ patients

**Category:** Miscellaneous

**Title:** Important reminders for Healthy Blue Outcomes℠ patients

**Start Date:** February 4, 2013   **End Date:** February 18, 2013

Blue Cross Blue Shield of Michigan’s outcomes-based PPO, Healthy Blue Outcomes, ties a financial incentive to positive behavioral outcomes. You may have patients with this coverage, so we put together some helpful reminders about the Healthy Blue Outcomes program.

See the related article in the February 2013 Record for further details.

5. Blues conduct medical record reviews

**Category:** Medicare Advantage and Professional

**Title:** Blues conduct medical record reviews

**Start Date:** February 4, 2013   **End Date:** February 18, 2013

Each year, Blue Cross Blue Shield of Michigan conducts Healthcare Effectiveness Data and Information Set medical record reviews. Inovalon™ will perform the HEDIS reviews from February through May on behalf of PPO and Medicare Advantage PPO members beginning this month.

These reviews do not replace the risk adjustment medical record review process also performed by Inovalon on behalf of BCBSM’s Medicare Advantage PPO.

For more information, see the related article in the February Record.
6. Medicare Advantage preventive care planner mailed to patients

Category: Medicare Advantage

Title: Medicare Advantage preventive care planner mailed to patients

Start Date: February 4, 2013   End Date: February 18, 2013

Blue Cross Blue Shield of Michigan Medicare Advantage patients will receive the BCBSM 2013 preventive care planner this week, encouraging them to get preventive care. The planner also can help them track medical services, tests, screenings, medications and appointments. We ask that you encourage your patients to bring the planner with them to their visits, and use it throughout the year to support them in managing and tracking their health care needs.

BCBSM values the quality patient care Blues’ providers consistently demonstrate. We hope this tool will both support physicians’ health care efforts and enhance patient-doctor dialogue.

To view the preventive planner and learn more, please visit our Medicare Advantage resources page in Provider Secured Services. If you have questions, please contact your provider consultant or the Provider Relations manager for your area:

Southeast Region
Laurie Latvis
Phone: 313-225-7778
Email: llatvis@bcbsm.com

Central (Mid/East) Region
Kate Simon
Phone: 517-325-4590
Email: ksimon@bcbsm.com

West Region
Shaun Raleigh
Phone: 616-389-8141
Email: sraleigh@bcbsm.com

Watch for more information in the March issue of The Record.

7. BCBSM electronic provider manuals — January 2013 changes

Category: Online Manuals

Title: BCBSM electronic provider manuals — January 2013 changes

Start Date: February 5, 2013   End Date: February 19, 2013

These are the chapters we revised in January 2013, along with the revision date and a brief statement of the main changes for each.*

- Blue Pages Directory (1/1/2013)
  - "Chrysler – Bargaining BPP, PPO and SCN" — Updated the information about calling the Chrysler Help-Line.
  - "Provider Consulting Services" — Updated the "West Michigan – professional
consultants" chart and the "West Michigan – facility consultants" chart.

- **Blue Card Program** (1/1/2013)
  - “Status claim process” — Added this new section.

- **Hemophilia Treatment Services** (1/7/2013)
  - “Coverage” — Added a link to the "specialty pharmaceuticals requirement" section in the Medical-Surgical Services chapter.

- **Medical-Surgical Services** (1/1/2013)
  - “Pharmaceuticals - specialty” — In the “Preauthorization for specialty pharmaceuticals” section, revised the language.

- **Participation** (1/31/2013)
  - “Participation agreements” — Added a link to the future Home Infusion Therapy Facility Participation Agreement (effective 5/1/13).

- **Physician Office Laboratory List** (1/3/2013)
  - “POLL codes” — Added code 86386 to the chart.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.*

8. Additional fee change schedule added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedule added to web-DENIS

**Start Date:** February 5, 2013 **End Date:** February 20, 2013

BCBSM recently added this additional fee change schedule to web-DENIS, for the week beginning Feb. 4, 2013:

- Professional
  - Traditional, TRUST & Blue Preferred Plus

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

9. BCBSA vendor calling some providers to validate addresses

**Category:** Miscellaneous

**Title:** BCBSA vendor calling some providers to validate addresses

**Start Date:** February 5, 2013 **End Date:** February 19, 2013
We wanted to make sure you are aware that the national Blue Cross and Blue Shield Association hired a vendor to randomly call providers throughout the year to validate their information. Thoroughbred Research may contact Michigan providers to validate provider information (such as name, address, phone number, and specialty) that is currently published on the National Blue Doctor & Hospital Finder website and the FEP Online Provider Directory website.

If your office is contacted by Thoroughbred Research, please verify your provider information to ensure we have valid data for our members.

10. All Internet Claim Tool users

Category: System performance and planned outage

Title: All Internet Claim Tool users

Start Date: February 6, 2013  End Date: February 13, 2013

The Internet Claim Tool will be unavailable beginning at 4:00 PM this afternoon to correct system wide performance and intermittent connectivity issues. Users will be unable to access the claim tool until after 6:00 PM.

We apologize for any inconvenience.

11. Medicare Eligibility

Category: System Outage Notification – February 9, 2013

Title: Medicare Eligibility

Start Date: February 6, 2013  End Date: February 11, 2013

There is scheduled maintenance for the Medicare Eligibility system on Saturday, February 9, 2013. The maintenance window will begin at 8:00 AM ET on Saturday, February 9, 2013. The Medicare Eligibility System will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will
result in errors. The maintenance will be completed on the same day by 3:00 PM ET on Saturday, February 9, 2013.

Please contact the Help Desk if you have questions or comments

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

12. FEP System downtime for February 9

Category: System downtime notification

Title: FEP System downtime for February 9

Start Date: February 6, 2013    End Date: February 12, 2013

The Federal Employee Program application will be unavailable Saturday, Feb. 9, 2013, until approximately 12 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through web-DENIS during that period.

13. Update: Some professional and OPC psychiatric claims on hold

Category: Professional and Facility claims

Title: Update: Some professional and OPC psychiatric claims on hold

Start Date: February 8, 2013    End Date: February 28, 2013

We previously told you that BCBSM placed a stop on professional claims billed with the new psychiatric procedure codes *90785, *90791, *90792, *90832-*90834, *90836-*90838, *90839, *90840 and *90863 until the system is updated to process these procedures. This stop included professional claims billing evaluation and management procedure codes with the new psychiatric add-on procedure codes *90833, *90836 and *90838.

Effective Jan. 31, 2013, all claims were removed from stop and are currently processing.

Now that these psychiatric procedure codes are processing, we have identified the following issues and are working diligently to correct them:

- Two copayments may be applied incorrectly to claims billed with an E&M procedure code and a psychotherapy add-on procedure code when billed with a primary psych diagnosis. The E&M procedure code will apply an office visit copay, and the psychotherapy procedure code will apply a psychiatric copay. When this occurs, the
provider or member may call BCBSM to request an adjustment of the claim. The payment to providers will be based on our current fee schedule.

Claims may reject for members who do not have office visit coverage if an E&M procedure code is billed with a psychiatric diagnosis. When this occurs, the provider or the member may call BCBSM to request an adjustment to the claim. If the member has psychiatric coverage, the claim will be reprocessed based on the member’s psychiatric benefits. If the member does not have psychiatric coverage, the rejection will be maintained.

Claims may reject for psychotherapy procedure codes *90785, *90791, *90832, *90834, *90837, *90839 and *90840 when billed by a clinical licensed master's social worker. When this occurs, the provider or member may call BCBSM to request an adjustment to the claim. If the member has psychiatric benefits, the claim will be adjusted. If the member does not have psychiatric benefits, the rejection is correct, and the claim will not be adjusted.

If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant.

Thank you for your continued patience as we work to implement these new changes.

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14. Facility inpatient claims rejecting in error R194

Category: Facility Claims

Title: Facility inpatient claims rejecting in error R194

Start Date: February 8, 2012    End Date: February 28, 2013

We previously identified an issue with facility inpatient claims rejecting in error when the statement “from” date is prior to the “admission” date. Claims were rejecting with
reason code R194 in error. The claims system has been corrected and claims will only reject with R194 when the statement ‘from’ date is more than seven days prior to the admission date. We will soon begin reprocessing the claims that rejected incorrectly.

15. BCN therapy claims payments temporarily halted due to system problem

Category: Blue Care Network miscellaneous

Title: BCN therapy claims payments temporarily halted due to system problem

Start Date: February 11, 2013    End Date: February 25, 2013

A configuration change in our system has caused some therapy providers to receive overpayments and multiple copayments for services. As a result, Blue Care Network began pending physical therapy, speech therapy and occupational therapy claims on Feb. 6 for BCN commercial and BCN AdvantageSM members. This temporary measure will continue until the end of February when a system fix will be in place. This action excludes inpatient and BlueCard claims.

BCN will adjust claims that were processed incorrectly prior to Feb. 6. Providers will not need to resubmit claims. We apologize for this inconvenience.

16. Duplicate Medicare Advantage 835 remittance files distributed in error

Category: All Medicare Advantage trading partners

Title: Duplicate Medicare Advantage 835 remittance files distributed in error

Start Date: February 11, 2013    End Date: February 25, 2013

Please be advised that duplicate Medicare Advantage 835 remittance files were distributed in error on Feb. 8, 2013. The files were duplicates of the 835s previously distributed for check date Feb. 6, 2013. Submitters can disregard the duplicate files.

We apologize for any inconvenience.

17. Fee schedules and fee change schedules removed from web-DENIS

Category: Fee Schedules

Title: Fee schedules and fee change schedules removed from web-DENIS

Start Date: February 11, 2013    End Date: February 25, 2013

BCBSM added facility entire fee schedules to web-DENIS for Hospital Outpatient and Ambulatory Surgery Facility with an effective date of April 1, 2013.
We also added fee changes to web-DENIS for Hospital Outpatient, Ambulatory Surgery Facility and Freestanding Outpatient Physical Therapy with an effective date of April 1, 2013. However, as the schedules were part of the Hospital Outpatient Pricing Strategy II project that has been postponed until Oct. 1, 2013, they have been removed. Please see the March 2013 article in *The Record* titled “Changes to hospital outpatient services reimbursement delayed” for more information.

The specific fee schedules that have been removed are as follows:

- **Facility**
  - **Hospital Outpatient:**
    - New HCPCS rates effective 04/01/13
    - New Dialysis rates effective 04/01/13
  - **Ambulatory Surgical Facility:**
    - EKG fees effective 04/1/13

The specific fee change schedules that have been removed, published for the week beginning Dec. 26, 2012, are as follows:

- **Facility**
  - **Hospital Outpatient**
  - **Ambulatory Surgical Facility**
  - **Freestanding Outpatient Physical**

Replacement fee schedules and fee change schedules effective Oct. 1, 2013, will be published by July 1. Other fee schedules and fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

For more information, contact your BCBSM provider consultant.

18. **Pro Care Health Plan claim rejections**

   **Category:** All commercial claim submitters

   **Title:** Pro Care Health Plan claim rejections

   **Start Date:** February 11, 2013   **End Date:** February 25, 2013

   On Feb. 6, 2013, BCBSM’s commercial clearinghouse partner discontinued accepting electronic claims for Pro Care Health Plan (Payer ID 38329). As a result, claims
received for this payer and payer ID are rejecting with a front-end edit of P017 COMMERCIAL PAYER ID AND OR CLAIM OFFICE NUMBER IS INVALID.

Effective immediately, claims for Pro Care Health Plan will need to be submitted hard copy directly to the payer.

BCBSM did not receive advance notice of this change. We will immediately remove Pro Care Health Plan from our electronic professional commercial payer list available on www.bcbsm.com.

We apologize for any inconvenience.

19. Benefit Configurator system upgrade scheduled for the weekend of Feb. 16

   Category: Benefits Unavailable

   Title: Benefit Configurator system upgrade scheduled for the weekend of Feb. 16

   Start Date: February 11, 2013    End Date: February 19, 2013

   During the weekend of Feb. 16, 2013, the Benefit Configurator system will undergo an update. This update will not result in any new functionality within the Benefit Explainer tool.

   As a result of this release, all Benefit Configurator tools, including Explainer, will be unavailable from 5 p.m. Saturday, Feb. 16, through 7 a.m. Monday, Feb. 18.

   Benefit Configurator is a system of various applications serving as the single source for benefit information. The most common tool used is Explainer.

20. Some services denied or cost-sharing applied in error for Medicare Advantage colorectal cancer screening claims

   Category: Medicare Advantage

   Title: Some services denied or cost-sharing applied in error for Medicare Advantage colorectal cancer screening claims

   Start Date: February 14, 2013    End Date: February 28, 2013
Blue Cross Blue Shield of Michigan recently identified an error with Medicare Advantage colorectal cancer screening claims billed with procedure code G0105 and processed from January 2012 through February 2013. This screening should have been paid at 100 percent, if applicable.

BCBSM will reprocess the affected claims within the next 60 days. As a result, it is probable that affected members’ cost-sharing will be reduced. If the members’ cost-sharing is reduced, the billing provider is responsible for reimbursing the member for any higher amounts he or she already paid.

The Centers for Medicare & Medicaid Services expanded its list of approved diagnosis codes for high-risk colorectal cancer screening: 555.0-555.2, 555.9, 556.0-556.3, 556.8, 556.9, 558.2, 558.9, V10.00, V10.03-V10.07, V12.72, V16.0 and V19.8. CMS said this list is not all-inclusive. Other diagnosis codes may be applicable and would also not be subject to deductibles.

Please watch for more information on web-DENIS as it becomes available. If you have any questions, please contact your provider consultant. Thank you for your assistance.

21. 270/271 response file issue for Teamsters PPO contracts

Category: 270/271 Eligibility Benefit Inquiry and Response

Title: 270/271 response file issue for Teamsters PPO contracts

Start Date: February 14, 2013    End Date: February 28, 2013

BCBSM EDI previously identified an issue with 271 responses files returning a contract number that did not match the 270 request. The issue was only impacting MI
Conference of Teamsters Welfare Fund PPO contracts with alpha prefix KMT, This issue was corrected on Feb. 11, 2013 and submitters should no longer encounter a mismatch.

Submitters who have questions or continue to experience contract number inconsistencies can contact EDI Support via email for assistance.

We apologize for any inconvenience.

22. Please submit Medicare Advantage 2012 and 2013 claims separately

Category: Medicare Advantage

Title: Please submit Medicare Advantage 2012 and 2013 claims separately

Start Date: February 14, 2013   End Date: February 28, 2013

As a reminder, please submit any Blue Cross Blue Shield of Michigan Medicare Advantage claims with a combination of 2012 and 2013 service dates as separate claims. This method will help ensure the accuracy and timeliness of claim processing.

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

Thank you for your assistance.

23. Changes to freestanding outpatient physical therapy billing delayed

Category: Facility

Title: Changes to freestanding outpatient physical therapy billing delayed

Start Date: February 15, 2013   End Date: March 1, 2013
BCBSM is delaying the changes in how freestanding OPTs should report physical therapy, occupational therapy and speech therapy services until Oct. 1, 2013. Those changes were communicated in the November 2012 Record. Until Oct. 1, 2013, freestanding OPTs should report PT, OT and ST services as follows:

- Revenue codes 0421, 0424, 0431, 0434, 0441 and 0444 and appropriate HCPCS codes should be reported.
- Revenue codes 0420, 0430 and 0440 should continue to be used to report therapy specific visits.
- Value code 80 should still be reported and series billing rules will also apply.

24. Changes to hospital outpatient services reimbursement delayed

**Category:** Facility

**Title:** Changes to hospital outpatient services reimbursement delayed

**Start Date:** February 15, 2013    **End Date:** March 1, 2013

Since July 2012, BCBSM has published several articles about reporting of services for the Hospital Outpatient Pricing Strategy II (HOPS II) project effective April 1, 2013. While these reporting guidelines should still be applied effective April 1, 2013, BCBSM’s payment for the services will continue on the current methodology and not be converted to a fee basis until Oct. 1, 2013.

Two important exceptions to reporting services, however, are for physical therapy, occupational therapy and speech therapy services and for emergency and trauma services.

- Hospital outpatient – Claims should continue to be reported as they are today, using only revenue codes 0421, 0424, 0431, 0434, 0441 and 0444. Value code 80 should still be reported and series billing rules will also apply.
- Emergency room and trauma E&M services will continue to bundle with surgical services on the claim as they do today.

25. BCBSM Electronic Trading Partners, Vendors and Clearinghouses

**Category:** Validator Self-Testing Tool Maintenance

**Title:** BCBSM Electronic Trading Partners, Vendors and Clearinghouses

**Start Date:** February 15, 2013    **End Date:** February 22, 2013
The BCBSM HIPAA Validator online self-testing tool will be unavailable on Saturday, 02/16/13, between 7:00 AM and 4:00 PM, in order to perform system maintenance.

We apologize for any inconvenience

26. Beginning April 1, use diagnosis code set in place at time of discharge

Category: Facility

Title: Beginning April 1, use diagnosis code set in place at time of discharge

Start Date: February 15, 2013    End Date: March 1, 2013

As part of our ICD-10 transition, BCBSM has determined that we must change our facility guidelines for reporting the diagnosis code on inpatient claims. Effective April 1, 2013, we are asking our facilities to begin using the diagnosis code sets in place of the date of discharge (instead of the date of admission) for inpatient claims.

This change not only meets the mandated requirement for the ICD-10 transition, but it also aligns our billing guidelines with those of other payers and makes us consistent with the Centers for Medicare & Medicaid Services. Even though the ICD-10 implementation is scheduled for next year, we are making this change now to allow time for our facilities to make the necessary adjustments.

We’ve heard from some of our facilities that being consistent in which diagnosis code set to use would make it easier to do business with us and help as we all transition to the new code sets. For more information about billing, check your provider manual on web-DENIS. For more information about the ICD-10 transition, go to bcbsm.com/icd10.

27. Internet Claim Tool intermittent connection issues

Category: All Internet Claim Tool users

Title: Internet Claim Tool intermittent connection issues

Start Date: February 16, 2013    End Date: February 23, 2013
BCBSM is experiencing intermittent connection issues with the internet claim tool. We are investigating the cause and encourage users to try logging in again at a later time.

We will update this message when additional information is available.

We apologize for any inconvenience.

28. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: February 18, 2013    End Date: March 4, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Feb. 18, 2013:

- Professional
  - Traditional, TRUST &Blue Preferred Plus℠
  - Independent Lab
  - DME
- Facility
  - Outpatient Hospital
  - Outpatient Psychiatric Services
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

29. BCBSM launched new Concurrent Review Program for UAW Retiree Medical Benefits Trust members

Category: Benefits

Title: BCBSM launched new Concurrent Review Program for UAW Retiree Medical Benefits Trust members
The UAW Retiree Medical Benefits Trust requested BCBSM implement concurrent review for its members identified as having excessive length of stay in acute hospital, skilled nursing facility or acute rehab settings. An excessive length of stay is defined as:

- More than seven days in an acute inpatient hospital
- More than 14 days in a skilled nursing facility
- More than seven days in an acute rehab facility

BCBSM launched a new URMBT Concurrent Review Program Jan. 7, 2013, enhancing utilization management services for Trust members in Michigan. The Trust member groups impacted are: 71400, 71434, 71435, 71436 and 71472.

The main objectives of the concurrent review process are for BCBSM concurrent review nurses to work collaboratively with hospital case managers and discharge planners to:

- Monitor appropriateness of setting that warrants longer length of stay
- Identify patient-specific barriers to care and offer intervention where appropriate
- Facilitate moving patients from an acute setting to a lower level of care
- Make referrals to case management and care transition to home resources as needed

For Michigan hospitals under the diagnosis-related group arrangement, BCBSM will not deny days that exceed the DRG indicated on the prenotification. Rather, BCBSM’s concurrent review nurses will discuss patient stays with acute hospital case managers and discharge planners on a case-by-case basis to facilitate transitional care planning. For those Trust members identified who could safely move to a lower level of care, BCBSM’s concurrent review nurses will expedite that process by completing the precertification.

Facilities can assist in this process by notifying BCBSM when a Trust member has been discharged from its facility by:

- Emailing the discharge date to ConcurrentReviewFax@BCBSM.com
- Faxing the discharge date to 1-866-915-9811
- Calling BCBSM’s Concurrent Review Department at 1-888-417-3464 to discuss the discharge date

Michigan Conference of Teamsters Welfare Fund claims temporarily suspended
Category: Claims

**Title:** Michigan Conference of Teamsters Welfare Fund claims temporarily suspended

**Start Date:** February 19, 2013    **End Date:** TBD

Claims processing for the Michigan Conference of Teamsters Welfare Fund moved from our local claims system to the NASCO system Sept. 22, 2012. Claims processing is suspended while we complete post conversion validation.

Please allow us time to process these claims. Please be aware the payments will be delayed so do not bill the member for claims that are still on stop.

Thank you for your patience

31. **Blues reprocessing claims for mammograms**

**Category:** Claims

**Title:** Blues reprocessing claims for mammograms

**Start Date:** February 20, 2013    **End Date:** March 31, 2013

We have started to reprocess some mammogram and newborn screening claims for individual and group members whose service was either rejected or had cost-sharing applied in error. This applies to claims with dates of service between Sept. 23, 2010, and Dec. 31, 2012. Reprocessing will continue through early March. You’ll receive payment for covered services after claims are reprocessed. The new payment will indicate if the deductibles and copayments should not have been applied.

If a member paid you directly for your services, please issue a refund. The member may still have to pay the deductibles and copays.

**Affected claims**

Specifically, routine mammogram screenings that resulted in a medical diagnosis (where a medical finding is combined with a preventive screening code) are being reprocessed and are listed below:

<table>
<thead>
<tr>
<th>Procedure Codes*</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>77052 Screening Mammography (list separately in</td>
<td></td>
</tr>
</tbody>
</table>
addition to code for primary procedure

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77057</td>
<td>Screening Mammography, bilateral (2 view film study of each breast)</td>
</tr>
<tr>
<td>0403</td>
<td>Screening mammography facility charges</td>
</tr>
<tr>
<td>G0202</td>
<td>Screening mammography, digital, bilateral all views</td>
</tr>
</tbody>
</table>

Newborn screenings with the following procedure codes* are being reprocessed:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82017</td>
<td>82776</td>
</tr>
<tr>
<td>82136</td>
<td>83498</td>
</tr>
<tr>
<td>82261</td>
<td>83516</td>
</tr>
<tr>
<td>82544</td>
<td>83615</td>
</tr>
<tr>
<td>82760</td>
<td>83630</td>
</tr>
<tr>
<td>83788-83789</td>
<td>83918-83919</td>
</tr>
<tr>
<td>83890-83894</td>
<td>86355</td>
</tr>
<tr>
<td>83898</td>
<td>86357</td>
</tr>
<tr>
<td>83904</td>
<td>86359</td>
</tr>
<tr>
<td>83912</td>
<td>88233</td>
</tr>
</tbody>
</table>

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

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32. 2013 BCBSM Provider Performance Recognition Program materials will be posted to Medicare Advantage PPO Health e-Blue℠

Category: Medicare Advantage

Title: 2013 BCBSM Provider Performance Recognition Program materials will be posted to Medicare Advantage PPO Health e-Blue℠

Start Date: February 20, 2013    End Date: March 8, 2013

This month, Blue Cross Blue Shield of Michigan introduces the 2013 Medicare Plus Blue PPOSMSM Performance Recognition Program for primary care providers. BCBSM will post Medicare Advantage PPO program materials on its Health e-Blue portal for participating providers. The program, which mirrors Blue Care Network’s initiative, recognizes physician efforts in helping BCBSM improve its Medicare Advantage members’ health and Healthcare Effectiveness Data and Information Set Scores.

The 2013 program design remains unchanged from 2012. Materials will include a booklet with detailed descriptions of the program components, Pay As You Go, Base and Bonus measures and opportunities, as well as exhibits and Bonus measure specs.

Please visit the Medicare Plus Blue Health e-Blue home page for all 2013 physician recognition information. Health e-Blue is a secure, online tool that provides easy data access for both HEDIS and PRP measures. Registered Medicare Advantage PPO providers will see timely patient data, like health registry data, utilization and
pharmacy information and current treatment closure opportunities. Using Health e-Blue will allow providers to see their performance toward provider incentive payment opportunity. Providers are encouraged to enter data in HEB to close any treatment opportunities for their patients.

If you do not have access to Health e-Blue, please contact your provider consultant who will facilitate immediate access. You may also contact your provider consultant or Provider Relations manager below and they will assist in answering any questions you may have about the program.

Please watch for more details in the March edition of The Record.

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### 33. Medicare Advantage lab claims issue fixed

**Category:** Medicare Advantage  
**Title:** Medicare Advantage lab claims issue fixed  
**Start Date:** February 20, 2013  
**End Date:** March 17, 2013

We previously reported a problem with Medicare Advantage claims rejecting incorrectly with front-end edit E30 when more than one unit was reported for lab service procedure codes *80047 through *89356. This problem only affected claims with dates of service prior to Jan. 1, 2013.

The issue has been corrected. It is no longer necessary to submit the affected claims as paper claims. You can now submit them electronically.

Thank you for your patience as we worked to resolve this issue.

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### 34. DME/P&O fee schedule update postponed
Category: Fee Schedules

Title: DME/P&O fee schedule update postponed

Start Date: February 21, 2013    End Date: March 7, 2013

The June 2013 DME/P&O fee schedule update has been postponed until July 2013. As such, new DME/P&O fees will not be published until April 1, 2013.

35. Some Blue Cross Complete behavioral health claims being denied due to system error

Category: Blue Cross Complete (Medicaid)

Title: Some Blue Cross Complete behavioral health claims being denied due to system error

Start Date: February 21, 2013    End Date: March 7, 2013

Blue Cross Complete behavioral health claims that involve CPT procedure code *90837 are being denied in error for 2013 dates of service. BCN is correcting the configuration issues that resulted in these denials and the claims will be adjusted. We are sorry for this inconvenience.

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36. Recovery underway for Faurecia USA claims

Category: Recoveries

Title: Recovery underway for Faurecia USA claims

Start Date: February 22, 2013    End Date: March 8, 2013

NASCO is conducting an overpayment recovery for the Faurecia USA group for dates of service Jan. 1 through Dec. 28, 2012.

The group requested a retroactive benefit change to apply deductible amounts toward out-of-pocket maximums for in-network and out-of-network claims.

We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscribers’ liability may change.

37. Physician fee uplifts for BlueCard® host claims
Category: Claims

Title: Physician fee uplifts for BlueCard® host claims

Start Date: February 22, 2013    End Date: May 1, 2013

Physician fee uplifts are not being applied to BlueCard host claims. The system fix is targeted for completion at the end of March. When the issue is corrected, we will reprocess all the impacted claims within 60 days.

If you have any questions, please contact your provider consultant

38. Medicare Eligibility

Category: System Outage Notification – February 24, 2013

Title: Medicare Eligibility

Start Date: February 20, 2013    End Date: February 25, 2013

There is scheduled maintenance on the Medicare Eligibility application on Sunday, February 24, 2013. The maintenance window will begin at 8:00 AM ET on Sunday, February 24, 2013. Medicare Eligibility will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors.

The maintenance will be completed on the same day by 3:00 PM ET on Sunday, February 24, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

39. Cotinine testing not required, but optional, for Consumer’s Energy members with Blue Care Network Healthy Blue LivingSM coverage

Category: BCN Miscellaneous

Title: Cotinine testing not required, but optional, for Consumer’s Energy members with Blue Care Network Healthy Blue LivingSM coverage

Start Date: February 26, 2013    End Date: March 31, 2013
We told you that effective Jan. 1, 2013, a cotinine screening test would be required for Consumer’s Energy members with Healthy Blue Living coverage, and their qualification form could not be submitted without the cotinine values. Effective immediately, cotinine testing for Consumer’s Energy members is optional, not mandatory. This policy only applies to Healthy Blue Living members in the Consumer’s Energy and Meijer Premier Health Network plans.

40. Managers in West Michigan Blue Care Network-affiliated provider offices invited to town hall meetings in March.

Category: BCN Miscellaneous

Title: Managers in West Michigan Blue Care Network-affiliated provider offices invited to town hall meetings in March.

Start Date: February 26, 2013   End Date: March 21, 2013

Blue Care Network is hosting town hall meetings for provider office managers in West Michigan on March 12 (Muskegon), 13 (Kalamazoo), 14 (Grand Rapids) and 21 (Traverse City). For the agenda, meeting times, locations and RSVP information, click on the links to the invitations in BCN Provider Publications and Resources under What’s New. If you have questions, please contact your BCN provider representative.

41. Medicare Eligibility

Category: System Outage Notification – March 2, 2013

Title: Medicare Eligibility

Start Date: February 27, 2013   End Date: March 4, 2013

There is scheduled maintenance for the Medicare Eligibility system on Saturday, March 2, 2013. The maintenance window will begin at 8:00 AM ET on Saturday,
March 2, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed on the same day by 10:00 AM ET on Saturday, March 2, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

42. Transition to BCN 277CA reports and transactions

Category: All Blue Care Network trading partners

Title: Transition to BCN 277CA reports and transactions

Start Date: February 28, 2013    End Date: March 31, 2013

Transition to 277CA reports and transactions for Blue Care Network claims has been delayed. We anticipate implementation will occur in the next few weeks. We will provide an effective date as soon as possible.

As a reminder, the new BCN 277 versions will be:

R277CAF – replaces the BCN U277F report.

277CAP – replaces the 4010 version 277P transaction. The 277CAP transaction will display ‘Blue Care Network’ as the payer name in Loop 2100.

The new versions will return the same claim detail and acknowledgement information as found in all other 277CAs distributed by BCBSM. BCN submitters will receive their regular reports and transactions until the transition.

Please note that BCBSM continues to receive 277P transactions from other payers. This change to BCN reports will not impact the distribution or naming convention of other payer 277P files.

If you have any questions regarding the new BCN reports, please contact the EDI helpdesk 1-800-542-0945.

43. Update: Some professional and OPC psychiatric claims on hold

Category: Professional and Facility claims
We previously told you that BCBSM placed a stop on professional claims billed with the new psychiatric procedure codes *90785, *90791, *90792, *90832-*90834, *90836-*90838, *90839, *90840 and *90863 until the system is updated to process these procedures. This stop included professional claims billing evaluation and management procedure codes with the new psychiatric add-on procedure codes *90833, *90836 and *90838.

Effective Jan. 31, 2013, all claims were removed from stop and are currently processing.

Now that these psychiatric procedure codes are processing, we have identified the following issues and are working diligently to correct them:

- Two copayments may be applied incorrectly to claims billed with an E&M procedure code and a psychotherapy add-on procedure code when billed with a primary psych diagnosis. The E&M procedure code will apply an office visit copay, and the psychotherapy procedure code will apply a psychiatric copay. When this occurs, the provider or member may call BCBSM to request an adjustment of the claim. The payment to providers will be based on our current fee schedule.

- Claims may reject for members who do not have office visit coverage if an E&M procedure code is billed with a psychiatric diagnosis. When this occurs, the provider or the member may call BCBSM to request an adjustment to the claim. If the member has psychiatric coverage, the claim will be reprocessed based on the member’s psychiatric benefits. If the member does not have psychiatric coverage, the rejection will be maintained.

- Claims may reject for psychotherapy procedure codes *90785, *90791, *90832, *90834, *90837, *90839 and *90840 when billed by a clinical licensed master’s social worker. When this occurs, the provider or member may call BCBSM to request an adjustment to the claim. If the member has psychiatric benefits, the claim will be adjusted. If the member does not have psychiatric benefits, the rejection is correct, and the claim will not be adjusted.

If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant.

Thank you for your continued patience as we work to implement these new changes.

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44. FEP Eligibility Alert and Medicare or other Current Carrier Coverage
The Federal Employee Program (FEP) eligibility information does not currently indicate if Medicare or another carrier is primary.

Please use the web-DENIS Medicare Eligibility feature to determine if Medicare is the primary carrier for your patient.
March 2013

Clarification: Certificate of medical necessity required for only seat lift mechanism

In the January issue of The Record, in the article titled “Medicare Advantage durable medical equipment coverage changes,” we reported that a certificate of medical necessity was required for patient lifts. The CMN requirement is only for the seat lift mechanism portion of what is commonly referred to as a lift chair.

A CMN is a form the physician must complete and submit with a DME prescription. It certifies the member’s condition is such that the DME being prescribed is medically necessary. If a DME supplier bills for items requiring a certificate of medical necessity, the supplier must bill with the KX modifier to indicate a certificate is on file.

We apologize for any confusion this may have caused. If you have any questions, please contact your provider consultant.

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March 2013

Medicare Advantage preventive care planner mailed to patients

We’ve developed a preventive care planner for Blue Cross Blue Shield of Michigan Medicare Advantage patients to help them plan their preventive care and make time for wellness. We ask that you encourage your patients to bring the planners to their visits and use them throughout the year for support in managing and tracking health care needs.

The BCBSM 2013 preventive care planner was recently mailed, and will help Medicare Advantage patients track medical services, tests, screenings, medications and appointments.

The planner includes a checklist that reminds patients to schedule preventive tests focused on such areas as:

- Blood pressure
- Bone mass measurement
- Cholesterol
- Glaucoma
- Glucose
- Pelvic or prostate health

The planner reminds patients that only their doctors can help them determine the appropriate test options and frequency. The planner also includes vaccine reminders for flu, hepatitis B, pneumonia and shingles, and encourages patients to talk with their physicians about:

- Exercise and physical activity
- Body mass index
- Memory and mental health
- Bladder control
- Risks of slipping and falling
- Age-related medication risks
- Diabetes
Angiotensin converting enzyme inhibitors and angiotensin receptor blocker drugs for controlling blood pressure

BCBSM values the quality patient care that Blues’ participating physicians consistently demonstrate. We hope this new tool will support physicians’ efforts to improve the health of their patients and enhance the patient-doctor dialogue.

To view the preventive planner and learn more, log in to web-DENIS:

- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters & Resources.*
- Click on *Medicare Advantage Resources.*

If you have questions, please contact your provider relations manager:

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**West Region**  
Shaun Raleigh  
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**Upper Peninsula Region**  
Michael Fedrizzi  
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March 2013

New report to help primary care physicians achieve new Diagnosis Closure incentive

A new Blues Medicare Advantage Diagnosis Closure incentive program for primary care physicians was announced in the January issue of The Record. A new report is expected to be available on Health e-BlueSM by the beginning of March.

The new report will be called Panel - Diagnosis Evaluation and will include Medicare Advantage patients who have historical or suspected conditions but the diagnosis has not been submitted to the Blues yet in the current year. Watch for an update on Health e-Blue with more information.

The report will include:

- Reported diagnoses in the current year, including all diagnoses reported to the Blues for each patient in the calendar year
- A list of all historical diagnoses reported in prior years and suspected conditions based on pharmacy claims, medical claims or other supplemental data sources
- The report allows the physician to submit additional diagnoses, along with the date the patient was seen in the office, or to indicate that the patient does not have a suspected diagnosis
- A section for the physician’s electronic signature

All diagnoses reported must be:

- Based on a face-to-face visit with the patient in 2013
- Addressed with the patient during the face-to-face visit

Obtaining access to Health e-Blue

If your primary care office does not have access to Health e-Blue, apply today. Go to bcbsm.com/provider, then:

1. Click on web-DENIS
2. Click on Provider Secured Services
3. Under Solutions available through Provider Secured Services, click on Health e-Blue for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data.
- Documented in the patient’s medical record following the Centers for Medicare & Medicaid Services guidelines

This information may be audited by the Blues or by CMS.

Note: The Blues will not provide a paper Diagnosis Evaluation form on web-DENIS as previously communicated. The form will be available solely on Health e-Blue as part of the report described in this article.

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March 2013

**Performance Recognition Program for Medicare Advantage PPO providers continues in 2013**

BCBSM is continuing the Medicare Plus Blue PPO\(^{SM}\) Performance Recognition Program for 2013. The program design remains unchanged from 2012.

The program recognizes your efforts to improve Medicare Advantage members’ health. Furthermore, it encourages your patients to take more active roles in their health and wellness. The Performance Recognition Program uses the Health e-Blue\(^{SM}\) online tool that gives you easy access to member data related to the program’s performance measures.

This tool allows viewing of the health registry, utilization of services and pharmacy information for our members. This enables you to remind and encourage your patients to obtain preventative services such as mammograms or eye exams.

The program has three main components:

**Base PRP** — The base PRP is a target based on certain preventive screenings and disease management measures. The measurement period runs January 2013 through December 2013. You receive the base PRP payment in July 2014.

**Pay As You Go** — This component focuses on Healthcare Effectiveness Data and Information Set measures. The measurement period is January 2013 through December 2013. You receive payments in October 2013 and June 2014 for services completed during 2013.

**PRP Bonus** — Bonuses are based on HEDIS measures within a specified measurement period. This bonus is paid once a year in June 2014.

Please visit the Health e-Blue home page (log in through [Provider Secured Services](http://www.bcbsm.com/newsletter/therecord/record_0313/Record_0313s.shtml)) for all 2013
physician recognition information, including the specific metrics for each PRP component.

If you do not have access to Health e-Blue, contact your provider consultant who will facilitate immediate access. Please contact your provider consultant or Provider Relations manager below and they will assist in answering any questions you may have about the program.

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1. Benefits currently incorrect for UA Local 190 group
   
   **Category:** Benefits  
   **Title:** Benefits currently incorrect for UA Local 190 group  
   **Start Date:** March 1, 2013  
   **End Date:** March 31, 2013  

   The benefit changes for the UA Local 190 group, group number 007004717, planned for March 1, 2013, have been suspended. Benefits for this group are not changing. We are working to correct the system to reflect the correct benefits. You can access the correct benefits by using the CAREN system and entering a date of service between Oct. 1, 2012, and Feb. 28, 2013.

   All affected claims are being held. After the system has been updated, the claims will be released and processed.

   We apologize for this inconvenience.

2. Clarification: Submit Medicare Advantage 2012 and 2013 **professional** claims separately  
   
   **Category:** Medicare Advantage  
   **Title:** Clarification: Submit Medicare Advantage 2012 and 2013 **professional** claims separately  
   **Start Date:** March 1, 2013  
   **End Date:** March 18, 2013  

   As a reminder, please submit any Blue Cross Blue Shield of Michigan Medicare Advantage professional claims with a combination of 2012 and 2013 service dates as separate claims. This method will help ensure the accuracy and timeliness of claim processing.

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

   Thank you for your assistance.
3. Medicare Plus Blue PPO℠ manual will be updated on April 1, 2013

**Category:** Medicare Advantage

**Title:** Medicare Plus Blue PPO℠ manual will be updated on April 1, 2013

**Start Date:** March 1, 2013    **End Date:** April 1, 2013

Blue Cross Blue Shield of Michigan will update the Medicare Plus Blue PPOSM manual for April 2013. Key changes are bolded below:

- **Due to a transition with claims vendors, BCBSM asks that providers please submit 2012 claims quickly.**
- **Updated embedded out-of-state provider fact sheet on page one.**
- BCBSM Medicare Advantage PPO recognizes non-physician practitioners with a specialty designation of nurse practitioner, clinical nurse specialist or physician assistant in addition to the standard following practitioner specialties as personal or primary care physicians:
  - Family practice
  - General practice
  - Internal medicine
- Medicare Advantage assessment forms for skilled nursing facilities, long-term acute care and inpatient rehabilitation can be found on BCBSM’s provider website: [bcbsm.com/providers/quick-links.html](http://bcbsm.com/providers/quick-links.html).
- Providers should contact DMEnsion Benefit Management for appeals or questions related to dates of service prior to Jan. 1, 2013 at 1-888-828-7858 from 8:30 a.m. to 5 p.m.
- The bolded phrase below regarding the diagnosis related group for serious adverse events was deleted from the April edition:
  - “The policy on serious adverse events is administered as follows:
    - For DRG-reimbursed hospitals — BCBSM uses the Medicare severity diagnosis-related groups (MS-DRG). **Grouper version 26 to administer the policy, incorporating the POA indicator into the DRG assignment.**”
- The General Services Administration list of debarred contractors can be found at [sam.gov](http://sam.gov).*

You can obtain the most current version of the manual at [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma).

This message serves as notice of these changes to the Medicare Plus Blue PPO manual per the terms of the **MA PPO Provider Agreement**, available online at [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma).

* **BCBSM does not control this website or endorse its general content.**
4. Claims reported with modifier 59 or site-specific modifiers E1-E4, FA, F1-F9, TA or T1-T9 are processing incorrectly

Category: Professional Claims

Title: Claims reported with modifier 59 or site-specific modifiers E1-E4, FA, F1-F9, TA or T1-T9 are processing incorrectly

Start Date: March 4, 2013    End Date: March 30, 2013

Blue Cross Blue Shield of Michigan has identified that services billed with modifier 59 or site-specific modifiers E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, TA, T1, T2, T3, T4, T5, T6, T7, T8 and T9 are processing incorrectly. This error will be corrected by March 30, 2013.

Please do not resubmit your claims for correction. The system will automatically reprocess the claims.

Thank you for your patience as we work to resolve this issue.

5. Additional facility fee schedule added to web-DENIS

Category: Fee Schedules

Title: Additional facility fee schedule added to web-DENIS

Start Date: March 4, 2013    End Date: March 18, 2013

BCBSM recently added an additional fee schedule to web-DENIS that includes newly payable evaluation and management codes effective Jan. 1, 2013, and other changes in the Jan. 1, 2013, HCPCS code update:

- **Outpatient Psychiatric Care Facility**
  - OPC Traditional and Mental Health Managed Care Program Fees (1/1/2013)

Please note that BCBSM normally publishes an entire fee schedule only when there is a fee update. For OPCs, these updates generally occur effective July 1. However, due to the numerous and significant changes to the HCPCS codes affecting OPCs, BCBSM is publishing an entire OPC fee schedule for Jan. 1, 2013. In conjunction with this, we are also removing the previously published fee change schedule that included fee changes effective Jan. 1, 2013, or before.

Entire fee schedules and fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*. 
For more information, contact your BCBSM provider consultant.

6. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: March 4, 2013   End Date: March 18, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning March 4, 2013:

- Professional
  - Traditional, TRUST & Blue Preferred Plus℠
  - Independent Lab
  - Injection
  - DME

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

7. Subscribe to BCN Provider News to read new series on patient satisfaction

Category: Miscellaneous

Title: Subscribe to BCN Provider News to read new series on patient satisfaction

Start Date: March 4, 2013   End Date: March 18, 2013

Subscribe to BCN Provider News to read new series on patient satisfaction

Read the new series of articles on patient satisfaction in BCN Provider News. See the March-April issue, Page 32, to read about how patient communication helps patients get involved in their care.

To get other important information about billing and claims, referral requirements, clinical practice guidelines and chronic condition management programs, subscribe today, click on Subscribe,” and check the box next to BCN Provider News and BCN Alerts.
8. BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Category: New professional and institutional front-end edits

Title: BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Start Date: March 4, 2013    End Date: April 30, 2013

Effective April 15, 2013, BCBSM EDI will implement new edits for Medicare Advantage claims. All of the new edits are triggered by incorrect reporting of billing provider contact information. Submitters may avoid receiving one or more of the edits by ensuring that they report telephone numbers and fax numbers in the correct format – 10 numeric only, without spaces or special characters.

<table>
<thead>
<tr>
<th>277 CA Transaction</th>
<th>Edit Code on 277CA Report</th>
<th>Description</th>
<th>Trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td>A3 85 127</td>
<td>F906 (Institutional) P940 (Professional)</td>
<td>BILLING PROVIDER COMMUNICATION NUMBER IS MISSING OR INVALID</td>
<td>Two scenarios trigger this edit: (i) Billing provider contact information (PER segment) is present in Loop 2010AA without a telephone number, fax number or email address; or (ii) Telephone or fax number format reported in Loop 2010AA PER04 is invalid.</td>
</tr>
<tr>
<td>A3 85 127</td>
<td>F907 (Institutional) P941 (Professional)</td>
<td>BILLING PROVIDER COMMUNICATION NUMBER IS MISSING OR INVALID</td>
<td>This edit is triggered by reporting of an invalid telephone or fax number format in Loop 2010AA PER06.</td>
</tr>
<tr>
<td>A3 85 127</td>
<td>F908 (Institutional) P942 (Professional)</td>
<td>BILLING PROVIDER COMMUNICATION NUMBER IS MISSING OR INVALID</td>
<td>This edit is triggered by reporting of an invalid telephone or fax number format in Loop 2010AA PER08.</td>
</tr>
</tbody>
</table>

In the future, these edits will apply for all other lines of business. We will distribute a new broadcast message once the implementation date has been finalized.

As a reminder, all edited claims must be corrected and resubmitted.

If you have any questions regarding the edits or require additional information, contact the EDI help desk at 1-800-542-0945.
9. BCBSM electronic provider manuals — February 2013 changes

Category: Online Manuals

Title: BCBSM electronic provider manuals — February 2013 changes

Start Date: March 5, 2013    End Date: March 19, 2013

These are the chapters we revised in February 2013, along with the revision date and a brief statement of the main changes for each.*

- **Blue Pages Directory (2/1/2013)**
  - “Magellan Behavioral Health Medical Necessity Criteria Adapted for BCBSM” —
    - Updated the name of the Behavioral Health Service department and the phone number.

- **Blue Preferred Plus (2/1/2013)**
  - “Overview” — In the "Members' rights and responsibilities" section, changed the name of
    - the section to "PPO program policies, responsibilities" and changed link from the brochure
    to online information.

- **BlueCard Program (2/1/2013)**
  - “Medical records” — In the “Additional information requests” section, deleted the paragraph
    that told what information to send for medical record requests.

- **BlueHealthConnection (2/1/2013)**
  - This new chapter was added to all provider manuals.

- **Dialysis Services (2/1/2013)**
  - “Billing guidelines” — In the “All-inclusive payment” section, revised the revenue codes.

- **Home Infusion Therapy Services (2/1/2013)**
  - “Reimbursement” — Added a link to the future participation agreement (effective
    - 5/1/2013).

- **Hospital Services (2/1/2013)**
  - “Inpatient medical rehabilitation” — Added this new section.

- **Mental Health and Substance Abuse Managed Care Program (2/1/2013)**
  - "Precertification" — In the "Where to send appeal requests" subsection of the
    - "Precertification appeals" section, changed the contact information for UAW-Ford - BPP.

- **Participation (2/13/2013)**
  - “Participation agreements” — For skilled nursing facilities, replaced links to the separate
    - freestanding and hospital-based participation agreements with links to the combined
    - (freestanding and hospital-based) agreement. Did the same for links to participation
    - agreements for substance abuse treatment facilities.

- **Physician Office Laboratory List (2/7/2013)**
  - Overhauled the entire chapter.
• **Skilled Nursing Facility Services (2/12/2013)**
  - “Conditions and limitations” — Revised the bulleted information about precertification of SNF admissions.

• **Substance Abuse Treatment Services (2/13/2013)**
  - “Conditions and limitations” — Revised the bulleted information about precertification of SNF admissions.

• **Valid Modifiers (2/1/2013)**
  - “Valid modifiers: pathology and laboratory services” — Added modifier GS.
  - “Valid modifiers: surgery” — Added modifiers LM and RI.

• **Value Partnerships (2/1/2013)**
  - "Value Partnerships programs and initiatives" — In the "Hospital Collaborative Quality Initiatives (CQIs)" section, added the Michigan Urological Surgery Improvement Collaborative (MUSIC) to the list of current initiatives..

Provider type “Outpatient mental health facility” has been renamed “Outpatient psychiatric care facility (OPC).”

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

10. Behavioral health codes processing update

**Category:** Professional and Facility claims

**Title:** Behavioral health codes processing update

**Start Date:** March 5, 2013    **End Date:** TBD

This update is to give you a status on how Blue Cross Blue Shield of Michigan is handling the new 2013 psychiatric procedure code changes. In a previous message, we informed you that BCBSM had some processing issues when the 2012 CPT codes were replaced with a new set of codes for 2013. BCBSM’s claims system has been updated to process claims for psychotherapy procedure codes *90785, *90791, *90832, *90834, *90837, *90839 and *90840 for the majority of our members. These services represent the largest volume of behavioral health claims we receive. We are working on solutions to process the rest of the codes more efficiently.

The following scenarios have been identified as issues, and we are working to resolve them.

- Two copayments may be applied incorrectly to claims billed with an evaluation and management procedure code and a psychotherapy add-on code (when billed with primary psychiatric diagnosis). The E&M procedure code will apply an office visit copay, and the psychotherapy procedure code will apply a psychiatric
copay. Only one copay should apply. When this occurs, the provider or member should call BCBSM to request an adjustment of the claim to apply a copay to only the E&M procedure code.

- Claims may reject for members who do not have office visit coverage if an E&M procedure code is billed with a psychiatric diagnosis. When this occurs, the provider or member should call BCBSM to request an adjustment of the claim. If the member has psychiatric benefits, the claim will be adjusted. If the member does not have psychiatric benefits, the rejection is correct, and the claim will not be adjusted.

Also, please note that with psychotherapy benefits that are carved out, all claims need to be billed to the appropriate vendor.

If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant. Thank you for your continued patience as we work to correct these issues.

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11. Error causing BlueCard® claims processing delay

**Category:** Medicare Advantage

**Title:** Error causing BlueCard® claims processing delay

**Start Date:** March 5, 2013 **End Date:** March 19, 2013

Blue Cross Blue Shield of Michigan recently identified an error with a BlueCard® claims issue that resulted in a processing delay for out-of-state, Medicare Advantage ITS host claims.

BCBSM is working to resolve the issue and anticipates it should be corrected by March 5, 2013.

Please watch for more information on web-DENIS as it becomes available. If you have any questions, please contact your provider consultant. Thank you for your patience.

12. Claims authorization error identified and corrected

**Category:** Medicare Advantage

**Title:** Claims authorization error identified and corrected

**Start Date:** March 6, 2013 **End Date:** March 20, 2013
A claims processing prior authorization error was identified that affected approximately 500 Blue Cross Blue Shield of Michigan Medicare Advantage claims between Jan. 16 and Jan. 31, 2013. The error has been corrected. We will evaluate and reprocess any affected claims.

We apologize for any inconvenience and thank you for your patience. If you have any questions, please contact your provider consultant.

13. 2013 Michigan hospital networking sessions scheduled

Category: Facility training

Title: 2013 Michigan hospital networking sessions scheduled

Start Date: March 6, 2013    End Date: March 28, 2013

Blue Cross Blue Shield of Michigan is hosting a series of networking sessions to provide hospitals with the information they need to do business with us.

The networking sessions will present information about hospital billing, medical policy, Medicare Advantage, BlueCard® and more. In addition to BCBSM, Blue Care Network and Medicaid information will also be represented at the sessions.

The sessions are from 9 a.m. to noon with registration beginning at 8:30 a.m. Coffee and continental breakfast will be served. Here are the scheduled dates for the sessions in 2013:

– Wednesday, March 27, 2013
– Wednesday, June 26, 2013
– Wednesday, Sept. 25, 2013
– Friday, Dec. 6, 2013

The sessions will be in the auditorium at the Blue Care Network Commons building, 20500 Civic Center Dr., Southfield. There will be designated parking available.

To register for the sessions, send an email to sefacilityeducationregistration@bcbsm.com.

14. Save the date for hospital forum in Frankenmuth

Category: Forums

Title: Save the date for hospital forum in Frankenmuth

Start Date: March 6, 2013    End Date: March 20, 2013
The annual hospital forum, sponsored by the Benefit Administration Committee, is scheduled for Wednesday, May 1, 2013, for all hospital billing staff, managers and directors. This year’s forum will once again be held at the Frankenmuth Bavarian Inn and lunch will be served.

Look to the April issue of *The Record* and future web-DENIS broadcasts for registration information.

15. Medicare Advantage Health e-Blue treatment opportunities data being updated

**Category:** Medicare Advantage

**Title:** Medicare Advantage Health e-Blue treatment opportunities data being updated

**Start Date:** March 11, 2013  **End Date:** March 13, 2013

We’re updating the 2013 treatment opportunities data on Health e-Blue, which will be available on March 12, 2013.

Health e-Blue is a secure, online tool that provides easy data access for HEDIS measures. The tool shows treatment opportunities for their patients based on data that physicians enter.

Thank you for your patience.

16. Reminder: Submit Blue Cross Blue Shield of Michigan Medicare Advantage 2012 claims

**Category:** Medicare Advantage

**Title:** Reminder: Submit Blue Cross Blue Shield of Michigan Medicare Advantage 2012 claims

**Start Date:** March 11, 2013  **End Date:** April 11, 2013
Beginning with 2013 service dates, BCBSM transitioned all Medicare Advantage claims processing to a new claims vendor. We encourage providers to submit claims with 2012 service dates as quickly as possible to avoid any processing delays.

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

17. All BCBSM professional trading partners

Category: Some BCBSM and FEP claims delayed until Mar. 20, 2013 check writing

Title: All BCBSM professional trading partners

Start Date: March 12, 2013   End Date: March 26, 2013

Due to a systems issue, some professional claims submitted between Mar. 7 and Mar. 8, 2013 missed the check writing cutoff for Mar. 13, 2013. The claims have been processed and will appear in check date Mar. 20, 2013.

We apologize for any inconvenience.

18. Medicare Eligibility

Category: System Outage Notification – March 16, 2013

Title: Medicare Eligibility

Start Date: March 13, 2013   End Date: March 18, 2013

There is scheduled maintenance on the Medicare Eligibility application on Saturday, March 16, 2013. The maintenance window will begin at 8:00 AM ET on Saturday, March 16, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors.
The maintenance will be completed on the same day by 4:00 PM ET on Saturday, March 16, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315

19. New valuable webinar available for professional billers and coders to assist in proper coding and documentation

Category: Webinar

Title: New valuable webinar available for professional billers and coders to assist in proper coding and documentation

Start Date: March 15, 2013  End Date: March 29, 2013

BCBSM and BCN are pleased to announce a new training webinar that gives professional billers and coders valuable information about proper claim coding and documentation.

You can now access this training through web-DENIS or from your smart phone or tablet. To access the presentation, log in to web-DENIS and:

- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- The BCBSM coding initiative presentation can be found under “What’s New” and “Provider Training.”

The presentation is also available within BCN Provider Publications and Resources on the Learning Opportunities page.

You can also access the training directly without going through web-DENIS by going to brainshark.com/bcbsm/codinginitiative.

Please take advantage of this new method of provider training. Contact your BCBSM provider consultant or BCN provider representative to share your thoughts about this new training approach. We value your opinion.

20. Second Amendment to BCN Advantage℠ Amendment to Individual Provider, Provider Group, Ancillary Provider and Hospital Affiliation Agreements

Category: BCN Advantage℠ contract amendments

Title: Second Amendment to BCN Advantage℠ Amendment to Individual Provider, Provider Group, Ancillary Provider and Hospital Affiliation Agreements
Start Date: March 15, 2013    End Date: April 1, 2013

Pursuant to the Mandated Amendment section in the various Blue Care Network of Michigan Affiliation Agreements, this publication serves as notice of amendment. The BCN Advantage amendments listed below are hereby amended to incorporate the indicated changes, effective May 1, 2013. The contractual language updates are related to new and/or revised compliance requirements mandated by the Centers for Medicare & Medicaid Services for “First Tier” entities (which include providers of medical services) contracted with Medicare Advantage organizations.

Please click on the respective links below to obtain a copy of the amendment applicable to each provider type.

- BCN Advantage Amendment to Individual Provider Affiliation Agreement formerly titled “BCN Advantage Amendment to Individual Practitioner Affiliation Agreement”
- BCN Advantage Amendment to Provider Group Affiliation Agreement (formerly titled “BCN Advantage Amendment to Practitioner Group Agreement”)
- BCN Advantage Amendment to Ancillary Provider Agreement (formerly titled “BCN Advantage Amendment to Provider Agreement”)
- BCN Advantage Amendment to Hospital Affiliation Agreement

21. BCBSM Medicare Advantage consultation services provided by clinical psychologist – no longer payable effective immediately

Category: Medicare Advantage

Title: BCBSM Medicare Advantage consultation services provided by clinical psychologist – no longer payable effective immediately

Start Date: March 18, 2013    End Date: March 28, 2013

For its Medicare Plus Blue Group PPO℠ members, Blue Cross Blue Shield of Michigan has determined evaluation and management consultation services (procedure codes *99201 – *99499) aren’t within a clinical psychologist's scope of practice because clinical psychologists aren’t licensed to perform E&M services. Effective immediately, we have retired this Medicare Advantage enhanced benefit policy. New groups with effective dates of July 1, 2013, or later will no longer have this as an enhanced benefit.

We currently have approximately 50 groups with this enhanced benefit and will continue to provide coverage to them through Dec. 31, 2013. You can view a list of these groups by clicking on BCBSM Provider Publications and Resources, then Newsletters and Resources and then Medicare Advantage Resources.

There will be no retroactive adjustments or recoveries for claims with 2012 dates of service.
Additional information regarding clinical psychologist requirements and services that may be covered can be found on the Centers for Medicare & Medicaid Services website under the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services section 160 – Clinical Psychologist Services**.

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

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

22. Advantage Rewards℠ program vendor issue

Category: Medicare Advantage

Title: Advantage Rewards℠ program vendor issue

Start Date: March 18, 2013  End Date: April 1, 2013

Entertainment Promotions LLC, the Blues’ vendor partner for its Blue Advantage Rewards℠ program, has filed for Chapter 7 bankruptcy. Medicare Plus Blue PPO℠, Medicare Plus Blue Group PPO℠, BCN Advantage HMO-POS℠ and BCN Advantage HMO℠ members were sent Entertainment booklets as part of the Blue Advantage Rewards program.

Should a patient have questions, please let them know that they can continue to obtain their services and send in their reward forms. Their existing coupons may still be honored, although some merchants may choose to discontinue their participation in the program.

The Blues are working quickly to determine the next steps for this member incentive program and will keep you informed via future web-DENIS messages. We remain committed to working with you and our members to improve and maintain their overall health.
If you have any questions, please contact your BCBSM provider consultant or BCN provider representative.

23. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: March 18, 2013    End Date: April 1, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning March 18, 2013:

- Professional
  - Traditional, TRUST & Blue Preferred PlusSM
  - Independent Lab
  - Injections
  - DME
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

24. March 14, 2013 Wisconsin Physicians Service system issue

Category: All Medicare Part B electronic claim submitters

Title: March 14, 2013 Wisconsin Physicians Service system issue

Start Date: March 19, 2013    End Date: April 2, 2013

WPS encountered a system issue on March 14, 2013 requiring them to rerun some Medicare Part B claims. If you submitted claims via BCBSM EDI on Mar. 14 between 10:00 AM and 2:00 PM, your claims may have been affected.

As a result, providers may receive an additional 277CA transaction and/or R277CAW report from BCBSM dated Mar. 19 that contains claim information for the Mar. 14 submissions.

If you have questions, please contact the EDI helpdesk at 1-800-542-0945.
25. Blue Cross Blue Shield of Michigan begins transition process following Gov. Snyder’s signature on health insurance reform legislation

**Category:** All Providers

**Title:** Blue Cross Blue Shield of Michigan begins transition process following Gov. Snyder’s signature on health insurance reform legislation

**Start Date:** March 19, 2013    **End Date:** April 2, 2013

Today begins a process that will lead BCBSM into a new era, following the Governor’s signature on landmark legislation—Senate Bills 61 and 62—that will regulate all health insurers in our state. As we communicated previously, this legislation regulates all health insurers in our state under consistent guidelines and enables the BCBSM Board of Directors to transition BCBSM to a nonprofit mutual insurance company. The new regulatory system is critical as the health insurance industry undergoes significant transformation under national health care reform. These regulations will ensure fair and balanced competition as the insurance industry adjusts to tremendous changes.

While the legislation modernizes the state regulations under which BCBSM operates, there are several key aspects of our business that do not change. We retain our core values as a nonprofit and our commitment to Michigan and our customers. Our current health care coverage to your patients, our provider networks, and our ongoing partnerships with physicians and hospitals to improve the quality of care do not change as we transition to a mutual. Your patients can continue to use their Blue Cross cards to receive care.

As a nonprofit mutual insurer, BCBSM will be regulated by the state insurance code as are other health insurers. We have begun identifying operational changes that will be necessary to conform with Insurance Code regulations and implement process, policy and procedure changes over the course of 2013. We anticipate receiving board approval in the summer as we move through these process steps, and to finish the full transition to a mutual by January 2014.

As with any change, we understand that you may have questions and we are committed to communicating to you prior to changes that would affect our interactions with providers.

26. Facility claims tracking error identified and corrected

**Category:** Facility Providers

**Title:** Facility claims tracking error identified and corrected
Facility Claims Tracking by contract number was corrected on March 15.

An error was identified when providers were using this web-DENIS feature to search by contract number for out-of-state claim history between Feb. 28 and March 14, 2013. We apologize for any inconvenience this may have caused.

27. Benefit Explainer updated to improve search performance

Category: Benefit Explainer

Title: Benefit Explainer updated to improve search performance

We’ve updated Benefit Explainer with a new navigational step when you perform a Benefit Package Report search in the Coverage Limitations section. The “Topic Criteria” window will prompt you to provide additional information to narrow the search for rules pertaining to your search.

To help reduce slow response time and timeouts, please follow these helpful hints:

- Search for topics using the hyperlinks on the Quickview Report whenever possible.
- When completing a query, click on the “Reset All” button to clear the previous search information.

28. Reminder: Claims must be submitted by filing limits

Category: Claims

Title: Reminder: Claims must be submitted by filing limits

We will systematically enforce claims filing limits, effective May 24, 2013.

If you submit a claim after your filing limits, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

We’ve reminded you since April 2012 that it’s imperative that you submit your claims on time. As we continue to improve and enhance our claims processing operations, it’s critical that you follow submission deadlines for all claims.
Deadline submissions for original claims remain the same – 180 days for professional health care providers and 12 months for facility providers, from the date of service. All health care providers must also submit secondary claims, status inquiries and adjustments within 24 months of the date of service.

For more information, see the related article in the April 2013 Record.

29. 13 specialty drugs require prior authorization for some General Motors members

**Category:** Specialty drugs

**Title:** 13 specialty drugs require prior authorization for some General Motors members

**Start Date:** March 21, 2013    **End Date:** April 4, 2013

BCBSM’s prior authorization program for certain specialty drugs will apply to some General Motors employees, starting April 1, 2013.

Thirteen specialty drugs administered by health care practitioners require prior authorization by BCBSM in order to be covered under members’ medical benefits. The program started for most members Jan. 22.

The following drugs require prior authorization:

- J0129 Abatacept (Orencia)
- J0490 Belimumab (Benlysta®)
- J0585 Onabotulinumtoxin A (Botox®, Botox® Cosmetic)
- J0586 Abobotulinumtoxin A (Dysport®)
- J0587 Rimabotulinumtoxin B (Myobloc®)
- J0588 Incobotulinumtoxin A (Xeomin®)
- J0755 Collagenase clostridium histolyticum (Xiaflex®)
- J0800 Repository corticotropin injection (Acthar HP® gel)
- J0897 Denosumab (Xgeva®)
- J0897 Denosumab (Prolia®)
- J3262 Tocilizumab (Actemra®)
- J3357 Ustekinumab (Stelara®)
- J1725 Hydroxyprogesterone caproate (Makena™)

GM recently approved the program for hourly (excluding UAW), salaried, retired and manufacturing subsystem employees in the following group numbers:

- 83200 – sections 0044, 0045, 0046, 0047, 0052, 0053, 8141, 8142, 8146, 8147, 8152 and 8153; package codes 035, 045, 131, 141, 231 and 241
30. Medicare Eligibility

Category: Maintenance on Saturday, March 23, 2013

Title: Medicare Eligibility

Start Date: March 22, 2013   End Date: March 25, 2013

Due to a system error, some claims for knee arthroscopy and lumbar spine surgery for dates of service from January 1 through March 1, 2013, were denied for no authorization incorrectly. The requirement to obtain prior authorization for these services did not start until March 1, 2013. We have corrected our system and will adjust any claim denied incorrectly. Providers do not need to resubmit the claims.

We apologize for this inconvenience to you and appreciate your patience.

31. Knee arthroscopy and lumbar spine surgery claims for 2013 to be reprocessed

Category: Blue Care Network claims

Title: Knee arthroscopy and lumbar spine surgery claims for 2013 to be reprocessed
Due to a system error, some claims for knee arthroscopy and lumbar spine surgery for dates of service from January 1 through March 1, 2013, were denied for no authorization incorrectly. The requirement to obtain prior authorization for these services did not start until March 1, 2013. We have corrected our system and will adjust any claim denied incorrectly. Providers do not need to resubmit the claims.

We apologize for this inconvenience to you and appreciate your patience.

32. Change in 2013 HEDIS® specifications for LDL-C medical record documentation

Category: BCN and BCBSM medical record documentation

Title: Change in 2013 HEDIS® specifications for LDL-C medical record documentation

Start Date: March 22, 2013    End Date: April 5, 2013

The 2013 HEDIS specifications for LDL-Cs have changed for Cholesterol Management for Patients with Cardiovascular Conditions and Comprehensive Diabetes Care. This includes both BCN Health e-Blue and BCBSM Health e-Blue entries and data received from electronic medical records and disease management registries, as well as paper medical records.

Following are the 2013 documentation requirements for the above measures:

- Include in the medical record, at a minimum, a note indicating the date when the LDL-C test was performed and the result.
- Calculate LDL-C levels from total cholesterol, HDL-C and triglycerides using the Friedewald equation if the triglycerides are less than or equal to 400 mg/dL.
  \[(\text{LDL-C}) = (\text{total cholesterol}) – (\text{HDL}) – (\text{triglycerides}/5)\]
- If measuring lipoprotein (a), use the following calculation:
  \[(\text{LDL-C}) = (\text{total cholesterol}) – (\text{HDL}) – (\text{triglycerides}/5) – 0.3 \times [\text{lipoprotein (a)}]\]

These formulas are used when all levels are expressed in mg/dL and cannot be used if triglycerides are greater than 400 mg/dL. Do not use the Friedewald equation if a direct or calculated result is present in the medical record for the most recent LDL-C test.

33. Physician fee uplifts for BlueCard® host claims

Category: Claims

Title: Physician fee uplifts for BlueCard® host claims

Start Date: March 22, 2013    End Date: May 1, 2013
Physician fee uplifts are not being applied to BlueCard host claims. The system fix will be in place March 23, 2013. We will reprocess all the impacted claims within 60 days.

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

34. Professional and Facility Claims Tracking for Michigan Conference of Teamsters Welfare Fund and United Food Commercial Workers claims

**Category:** web-DENIS Claims Tracking/Status

**Title:** Professional and Facility Claims Tracking for Michigan Conference of Teamsters Welfare Fund and United Food Commercial Workers claims

**Start Date:** March 22, 2013    **End Date:** TBD

To retrieve Michigan Conference of Teamsters Welfare Fund and United Food Commercial Workers claims using the Claims Tracking feature in web-DENIS, please reference the contract number on the member’s ID card. If the contract number is 12 characters long (alpha and numeric), you must enter both the alpha prefix and the nine digits to obtain claim detail responses for both of these groups.

Thank you for using the Claims Tracking feature on web-DENIS.

35. Web-DENIS e-prescribing system access ends March 31

**Category:** E-prescribing

**Title:** Web-DENIS e-prescribing system access ends March 31

**Start Date:** March 25, 2013    **End Date:** April 30, 2013

Web-DENIS portal access for e-prescribing will be turned off on March 31, 2013. All BCBSM e-prescribing users will no longer have access to e-prescribing through web-DENIS starting that day.

As we explained in December, BCBSM has ended sponsorship of e-prescribing licenses and assigned users new log in credentials directly to the DrFirst electronic prescription management system.

If you have not had your log-in credentials reset to access drfirst.com*, please contact the DrFirst™ helpdesk at 1-866-263-6512.

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36. BCBSM Medicare Advantage has identified a problem with the electronic data interchange codes

Category: Medicare Advantage

Title: BCBSM Medicare Advantage has identified a problem with the electronic data interchange codes

Start Date: March 25, 2013    End Date: April 10, 2013

As you know, when BCBSM Medicare Advantage claims are finalized, an EDI message is assigned to each line on the claim explaining how the line of service was paid or why it was rejected. Once this process is complete, an 835 record (electronic reply) is generated and transmitted to our providers. We’ve identified a system error that is triggering incorrect message claim codes. Although the claims are processing correctly, the incorrect message codes may be confusing.

We’re working to correct the problem and anticipate this will be completed within 30 days. In the meantime, please refer to the paper remittance you receive with your check. The paper remittance will display the proper message codes.

We apologize for any confusion this inconvenience has caused and value your patience as we work toward a resolution. If you have any questions, please contact your provider consultant.

37. Second Amendment to BCN AdvantageSM Amendment to Primary Care Practitioner Agreement

Category: BCN AdvantageSM contract amendments

Title: Second Amendment to BCN AdvantageSM Amendment to Primary Care Practitioner Agreement

Start Date: March 26, 2013    End Date: April 15, 2013

Pursuant to the Mandated Amendment section in the Blue Care Network of Michigan Primary Care Practitioner Agreement, this publication serves as notice of amendment. The BCN Advantage amendment listed below is hereby amended to incorporate the indicated changes, effective May 1, 2013. The contractual language updates are related to new and/or revised compliance requirements mandated by the Centers for Medicare & Medicaid Services for “First Tier” entities (which include providers of medical services) contracted with Medicare Advantage organizations.

Please click on the respective links below to obtain a copy of the amendment applicable to this provider type.
38. Centers for Medicare & Medicaid Services transitions to new PC Pricer software

**Category:** Medicare Advantage  

**Title:** Centers for Medicare & Medicaid Services transitions to new PC Pricer software  

**Start Date:** March 26, 2013    **End Date:** April 16, 2013

Fourth quarter PC Pricer executable files including inpatient psych services, inpatient rehabilitation, skilled nursing facilities and long-term care facilities were expected between Jan. 1 and March 31, 2013, but are delayed. CMS is transitioning to new software, and this process has taken longer than anticipated. Fourth quarter executable files will be made available once the transition is complete, sometime between April 1 and May 31, 2013.

This delay affects all fourth quarter specialty facility pricing and has also delayed the FY 2013 PC Pricer (IPPS, IRF, IPF, LTCH, SNF, ESRD and HH) releases until CMS completes its software transition. Please reference the following link for more details: [cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index.html*](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index.html).

We will process all claims received for fourth quarter 2012 using the third quarter 2012 rates. Once the fourth quarter fees have been loaded, we will adjust all affected claims. If there was an increase in fees, BCBSM may make additional provider payments. If there is a decrease in fees, BCBSM may undertake a provider recovery.

We apologize for any inconvenience this may cause. If you have any questions, please contact your provider consultant.

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

39. Amendment to Blue Cross Blue Shield of Michigan Medicare Advantage PPO Provider Agreement

**Category:** Blue Cross Blue Shield of Michigan contract amendments  

**Title:** Amendment to Blue Cross Blue Shield of Michigan Medicare Advantage PPO Provider Agreement  

**Start Date:** March 27, 2013    **End Date:** June 30, 2013

Pursuant to the General Modifications section 7.3 in the Blue Cross Blue Shield of Michigan Medicare Advantage PPO Provider Agreement, this publication serves as
notice of amendment. The Medicare Advantage PPO Agreement is hereby amended to incorporate the indicated changes, effective July 1, 2013. The contractual language updates are related to new or revised compliance requirements mandated by the Centers for Medicare & Medicaid Services for “First Tier” entities (which include providers of medical services) contracted with Medicare Advantage Organizations.

More specifically, there are new and enhanced requirements regarding: monitoring, auditing and identifying compliance risks (including monitoring federal exclusion data bases, creating a more robust compliance program and increased monitoring of “Downstream Entities,” as defined by CMS); and effective training and education related to compliance and fraud, waste and abuse.

Please click on the links below to obtain a red-lined and a clean copy of the revised Medicare Advantage PPO Agreement.

- MA-PPO Agreement (red-line)
- MA-PPO Agreement (clean)

40. Sequestration fee reductions for Medicare Advantage providers

Category: Medicare Advantage

Title: Sequestration fee reductions for Medicare Advantage providers

Start Date: March 28, 2013   End Date: April 30, 2013

Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan have been monitoring the sequestration impacts to Medicare reimbursement. The Centers for Medicare & Medicaid Services has announced the sequestration fee reductions are effective for original Medicare claims with dates of service April 1, 2013 and after.

BCBSM and BCN are providing notice that reimbursement based on Medicare payment methodology will have the same two-percent sequestration reduction applied to the paid amount for both network and non-network providers. As set out in the applicable provider network agreements, this is the timeline for the effective date of the reimbursement reduction:

- BCBSM Medicare Plus Blue PPO℠ and Medicare Plus Blue Group PPO℠ Professional Providers – July 1, 2013
- BCBSM Medicare Plus Blue PPO and Medicare Plus Blue Group Facility and Ancillary Providers – April 1, 2013
BCBSM and BCN will apply the claims payment adjustment consistent with CMS, meaning the adjustment will be applied to claims after determining any applicable member deductible, copayment or other member liability.

Questions about this reimbursement reduction can be directed to your BCBSM provider consultant or BCN provider representative.

41. Reminder: Claims must be submitted by filing limits

Category: Claims

Title: Reminder: Claims must be submitted by filing limits

Start Date: March 28, 2013    End Date: April 11, 2013

We will systematically enforce claims filing limits, effective May 24, 2013.

If you submit a claim after your filing limits, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

We’ve reminded you since April 2012 that it’s imperative that you submit your claims on time. As we continue to improve and enhance our claims processing operations, it’s critical that you follow submission deadlines for all claims.

Deadline submissions for original claims remain the same – 180 days for professional health care providers and 12 months for facility providers, from the date of service. All health care providers must also submit secondary claims, status inquiries and adjustments within 24 months of the date of service.

For more information, see the related article in the April 2013 Record.

42. Additional facility fee schedules added to web-DENIS

Category: Claims

Title: Additional facility fee schedules added to web-DENIS

Start Date: March 28, 2013    End Date: April 30, 2013
BCBSM recently added these additional fee schedules to web-DENIS resulting from fee updates effective July 1, 2013:

**Ambulatory Surgery Facility**
- Laboratory, radiology & surgery fees effective 7/1/13

**Freestanding Outpatient Physical Therapy Facility**
- OPT Rates effective 7/1/13

**Hospice Rates**
- Hospice Revenue Code 0657 CPT Code Fee Schedule (to include the 7/1/13 CPT fees)

**Hospital Outpatient Fee Schedules**
- HCPCS fees effective 7/1/13
- Physical therapy benefit rates effective 7/1/13

**Outpatient Psychiatric Care Facility**
- OPC Traditional and Mental Health Managed Care Program Fees (7/1/13)

In addition, entire fee schedules that are over three years old have been removed, as well as selected fee change schedules. As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. Therefore, fee change schedules published prior to March 28, 2013, have been removed from web-DENIS, as the fee changes are either incorporated in or superseded by the new entire fee schedule effective July 1, 2013.

Entire fee schedules and fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, and selecting *Entire Fee Schedules and Fee Changes*.

For more information, contact your BCBSM provider consultant.

43. Additional professional fee schedules added to web-DENIS

Category: Claims

Title: Additional professional fee schedules added to web-DENIS

Start Date: March 28, 2013   End Date: April 30, 2013

BCBSM recently added these additional fee schedules to web-DENIS resulting from fee updates effective July 1, 2013:
Independent LAB Fee Schedule
- Independent Lab Fee Schedule (7/1/13)

Traditional (External) Fee Schedule (PCTMP)
- Traditional Fee Schedule (7/1/13) (Excel)
- Traditional Fee Schedule (7/1/13) (PDF)
- Traditional Fee Schedule (7/1/13) Anesthesia Page

TRUST PPO (External) Fee Schedule
- TRUST PPO Fee Schedule - Full (7/1/13) (Excel)
- TRUST PPO Fee Schedule – Full (7/1/13) (PDF)
- TRUST PPO Fee Schedule (7/1/13) Anesthesia Page

BPP Fee Schedule (External) Fee Schedule
- BPP Fee Schedule – Full (7/1/13) (Excel)
- BPP Fee Schedule – Full (7/1/13) (PDF)
- BPP Fee Schedule (7/1/13) Anesthesia Page

DME/P&O Fee Schedule
- DME/P&O Fee Schedule (effective 7/1/13)

In addition, entire fee schedules that are over three years old have been removed, as well as selected fee change schedules. As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. Therefore, fee change schedules published prior to March 28, 2013, have been removed from web-DENIS, as the fee changes are either incorporated in or superseded by the new entire fee schedule effective July 1, 2013.

Entire fee schedules and fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, and selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

44. FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Category: FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Title: FEP Eligibility Alert and Medicare or other Current Carrier Coverage

Start Date: March 29, 2012    End Date: TDB

The Federal Employee Program (FEP) eligibility information does not currently indicate if Medicare or another carrier is primary.
Please use the web-DENIS Medicare Eligibility feature to determine if Medicare is the primary carrier for your patient.
May 2013

New compliance language added to Medicare Advantage provider agreement

Please read the new compliance language in your Medicare Advantage PPO Provider Agreement. The language, required by the Centers for Medicare & Medicaid Services, takes effect July 1, 2013. BCBSM alerted you March 26 through web-DENIS about this change.


Blue Cross Blue Shield of Michigan must comply with the new guidelines. Your provider agreement requires you and your vendors to also comply with all CMS rules, regulations and guidelines. The new CMS guidelines aim to reduce Medicare fraud, waste and abuse through key compliance requirements.

Complying with the new guidelines also aligns you with future requirements of Section 6401 of the Patient Protection and Affordable Care Act. It requires Medicare, Medicaid and the Children’s Health Insurance Program (MIChild in Michigan) to create compliance programs as a condition of enrollment.

Questions? Contact your provider consultant.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
May 2013

Reminder: Medicare Advantage Diagnosis Closure Incentive program replaces assessment form reimbursement

Blue Cross Blue Shield of Michigan and Blue Care Network have a new primary care physician Medicare Advantage Diagnosis Closure Incentive program for 2013. The new incentive applies to Blues Medicare Advantage patients, including those with BCN Advantage HMO-POS\textsuperscript{SM}, BCN Advantage HMO\textsuperscript{SM}, BCBSM Medicare Plus Blue PPO\textsuperscript{SM} and BCBSM Medicare Plus Blue Group PPO\textsuperscript{SM} coverage.

The new Diagnosis Closure Incentive program replaces reimbursement for completing the \textit{Physician Assessment Form}, effective for dates of service Jan. 1, 2013, or later. The Diagnosis Evaluation reports are now available on Health e-Blue\textsuperscript{SM}.

Need access to Health e-Blue?

If your primary care office does not have access to Health e-Blue, apply today. Go to \url{bcbsm.com/provider}, then:

\begin{itemize}
  \item Click on Provider Secured Services.
  \item Under Solutions available through Provider Secured Services, click on Health e-Blue for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data.
  \item Complete all fields on both the Health e-Blue Application and the Use and Protection Agreement and return to the address on the form.
\end{itemize}

Please be sure to sign in to Health e-Blue at least every six months to maintain your access to the system.

Tips for signing up for Health e-Blue

\begin{itemize}
  \item All applications need to be completed and signed by a primary care physician or PCP manager (Pages 5 and 6).
  \item The practice name has to match across the application.
  \item Provide state license number (can send additional pages if you are out of space).
  \item Include any previously created web-DENIS ID to help the Health e-Blue team provide faster service. (Web-DENIS IDs usually start with D or F.)
  \item Use your full legal name on the application.
\end{itemize}
See the *January issue of The Record* for details.

Health care providers may use the reports on Health e-Blue to document that diagnosis gaps have been closed. See "Need access to Health e-Blue?" above for instructions on how to apply for enrollment in Health e-Blue.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Web-DENIS messages April 2013
1. New message for daily quantity maximums

   Category: Professional and Facility claims

   Title: New message for daily quantity maximums

   Start Date: April 1, 2013   End Date: April 15, 2013

   Starting as early as this June, providers will receive a new message when a submitted
   HCPCS or CPT procedure code reaches or exceeds its recommended daily quantity
   maximum.

   This maximum determines the number of times a procedure can be billed on a single
   claim line for a particular date. Currently, there is no message when this daily maximum
   is reached or exceeded.

   When a maximum quantity is reached, this message will alert providers that they only
   will be reimbursed for the daily maximum quantity. For example, if the maximum is five
   per day for a reported HCPCS or CPT code, but 15 are submitted, the message will state
   that there’s been an adjustment in the reimbursement. Payment will be made for the first
   five only.

   Web-DENIS will display claims information with both the paid and maximum quantities.

   Look for more detailed articles and updates in upcoming issues of The Record.

2. Additional fee change schedules added to web-DENIS

   Category: Fee Changes

   Title: Additional fee change schedules added to web-DENIS

   Start Date: April 1, 2013   End Date: April 15, 2013

   BCBSM recently added these additional fee change schedules to web-DENIS, for the
   week beginning April 1, 2013:

   - Professional
     - Traditional, TRUST & Blue Preferred Plus℠
     - Injections
   - Facility
     - Outpatient Hospital
     - Ambulatory Surgery Facility
     - Outpatient Psychiatric Care
These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

3. New message for daily quantity maximums

**Category:** Professional and Facility claims

**Title:** New message for daily quantity maximums

**Start Date:** April 1, 2013    **End Date:** April 15, 2013

Starting as early as this June, providers will receive a new message when a submitted HCPCS or CPT procedure code reaches or exceeds its recommended daily quantity maximum.

This maximum determines the number of times a procedure can be billed on a single claim line for a particular date. Currently, there is no message when this daily maximum is reached or exceeded.

When a maximum quantity is reached, this message will alert providers that they only will be reimbursed for the daily maximum quantity. For example, if the maximum is five per day for a reported HCPCS or CPT code, but 15 are submitted, the message will state that there’s been an adjustment in the reimbursement. Payment will be made for the first five only.

Web-DENIS will display claims information with both the paid and maximum quantities.

Look for more detailed articles and updates in upcoming issues of The Record.

4. Outpatient facility services benefit policy change coming

**Category:** Facility claims

**Title:** Outpatient facility services benefit policy change coming

**Start Date:** April 1, 2013    **End Date:** April 15, 2013

Effective July 2013, BCBSM plans to make member benefit determinations by processing outpatient facility claims at the procedure code level, for services that must be reported with a HCPCS procedure code.

Currently, benefits are determined at the revenue code level for all hospital outpatient services. Starting in July 2013, when a HCPCS code is not payable based on the group benefits, condition code or occurrence code, the nonpayable service will be rejected and become the member’s liability.
We do not anticipate any changes in the way outpatient facilities need to report services.

Look for more information in upcoming issues of *The Record*.

### 5. BCBSM electronic provider manuals — March 2013 changes

**Category:** Online Manuals

**Title:** BCBSM electronic provider manuals — March 2013 changes

**Start Date:** April 3, 2013  **End Date:** April 17, 2013

These are the chapters we revised in March 2013, along with the revision date and a brief statement of the main changes for each.*

- **Blue Pages Directory** (3/12/2013)
  - “Chrysler – Bargaining BPP, PPO and SCN” — Updated the precertification information.
  - "Michigan Education Special Services Association" — Updated the precertification contact information.
  - “Precertification – admissions” — Updated the entire section.
  - “Precertification – mental health and substance abuse admissions” — Separated this information from the “Precertification – admissions” section.
  - “UAW-Ford” — Updated the mental health and substance abuse precertification information for NPP and BPP members.

- **Claims** (3/1/2013)
  - “UB-04 Claim examples” — Added two new claim examples: “Hospital Outpatient – Medical Emergency and Observation Room Spanning More Than 48 Hours” and “Hospital Outpatient – Direct Admit to Observation Room.”

- **Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services** (3/1/2013)
  - "Durable medical equipment" — In the "Covered services" section, updated the wording about aligning to CMS medical policy and gave directions on finding BCBSM medical policy.

- **Hospice Services** (3/22/2013)
  - "Hospice care" — In the "Coverage" section, deleted the names of groups that have fifth level of care coverage because this information changes and is better obtained from Benefit Explainer when checking a member’s eligibility and coverage.

- **Hospital Services** (3/22/2013)
  - “Observation bed” — In the “Billing guidelines” section, updated the two claim examples.

- **Physical Therapy, Occupational Therapy, and Speech Therapy Services** (3/6/2013)
  - “Billing guidelines” — In both the “Evaluations and re-evaluations in an office setting” and
the “Reporting therapy services in an office setting” sections, added a link to “Valid modifiers: Rehabilitative therapy.”

- **PPO Policies (3/1/2013)**
  - “Affiliation” — In the “Requirements” section, deleted part of the third bullet.

- **Psychiatric Care Services (3/1/2013)**
  - “Autism spectrum disorders” — Replaced most of the content with a link to the information online and added a link to the list of AAECs.
  - “Billing guidelines” — In the “Autism disorders” section, added some detailed billing guidelines for BCBAs.

- **Valid Modifiers (3/6/2013)**
  - “Valid modifiers: Rehabilitative therapy” — Added this new section.
  - Added this chapter to the IPT, IOT and IST manuals.

- **Value Partnerships (3/6/2013)**
  - Made changes throughout the entire chapter.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

6. Blue Cross Blue Shield of Michigan Medicare Advantage ambulance claims rejecting in error

**Category:** Medicare Advantage

**Title:** Blue Cross Blue Shield of Michigan Medicare Advantage ambulance claims rejecting in error

**Start Date:** April 3, 2013  **End Date:** April 15, 2013

You may have received a rejection in error for ambulance claims with 2013 dates of service because we incorrectly loaded the ZIP code file used to determine pricing for all ambulance claims. We have corrected the ZIP code file and are working quickly to identify any rejected claims that require reprocessing.

We apologize for any inconvenience this error may have caused and appreciate your patience as we review the affected claims.

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

7. HEDIS® medical record reviews have begun

**Category:** Medicare Advantage
Title: HEDIS® medical record reviews have begun

Start Date: April 5, 2013    End Date: April 17, 2013

Blue Cross Blue Shield of Michigan will conduct Healthcare Effectiveness Data and Information Set® medical record reviews through May. Currently, Inovalon™ is performing the HEDIS reviews on behalf of BCBSM Commercial PPO and Medicare Advantage PPO members.

These reviews **do not** replace the risk adjustment medical record review process, also performed by Inovalon on behalf of BCBSM’s Medicare Advantage PPO.

For the HEDIS reviews, Inovalon will look for details that may not have been captured in claims data, such as blood pressure readings, eye exams, HbA1c lab results, cholesterol and colorectal screenings and body mass index. This information helps us enhance our member quality improvement initiatives.

Inovalon will contact you to either schedule an appointment for a HEDIS review or request that you fax the necessary records. Inovalon will also request to scan the records they retrieve. If you have questions regarding this process, please contact your provider consultant. BCBSM will reimburse you $5 for each requested chart.

The chart below outlines the reviews and when they will be performed:

<table>
<thead>
<tr>
<th>Review</th>
<th>Reviews Scheduled</th>
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<tbody>
<tr>
<td>HEDIS</td>
<td>March through May 2013</td>
</tr>
<tr>
<td>Medicare Advantage risk adjustment record review phase one</td>
<td>April through May 2013 and October 2013 through January 2014</td>
</tr>
<tr>
<td>Medicare Advantage risk adjustment record review phase two</td>
<td>June through September 2013</td>
</tr>
</tbody>
</table>

Thank you for your continued support and assistance.

8. Register **now** for hospital forum in Frankenmuth

Category: Forums

Title: Register **now** for hospital forum in Frankenmuth

Start Date: April 5, 2013    End Date: April 26, 2013
The Blues invite you to the annual hospital forum sponsored by the Benefit Administration Committee. This year’s forum is scheduled for Wednesday, May 1, 2013, for all hospital billing staff, managers and directors.

The event includes information on web-DENIS, ICD-10, BlueCard®, Medicare Advantage and the Federal Employee Program®. The forum starts with an information fair during registration, followed by classroom-style presentations on a variety of important topics.

Where: Bavarian Inn Lodge
1 Covered Bridge Lane
Frankenmuth, Michigan
1-888-775-6343

Who: All hospital billing managers, directors and staff

Schedule: Program: 9 a.m.
Lunch: 12 p.m.

RSVP to jholzhausen@bcbsm.com by Friday, April 26. In the subject line, indicate “BAC Forum” and list your name, facility and the total number of people attending from your facility. Your response is also an RSVP for lunch.

9. Recovery underway for some national and auto account claims

Category: Recoveries

Title: Recovery underway for some national and auto account claims

Start Date: April 8, 2013    End Date: April 22, 2013

NASCO is conducting an overpayment recovery for multiple national and auto account groups, excluding the Federal Employee Program® and UAW Retiree Medical Benefits Trust groups, for dates of service Jan. 4, through Jan. 18, 2013.

In-network and out-of-network claims were applying cost-sharing incorrectly for all services.

We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscriber’s liability may change.

10. All ICT users

Category: REMINDER: Do not upgrade to Internet Explorer version 9 or 10

Title: All ICT users
Start Date: April 8, 2013   End Date: May 8, 2013

BCBSM EDI recommends that ICT users not upgrade to IE9 or IE10 until further notice. Although some ICT users have been successful in accessing the tool after upgrading to IE9, we are unable to support incompatibility issues that may be encountered. If you have already upgraded and are receiving error messages when logging into the ICT, please visit Microsoft.com for instructions on reverting to IE8.

We will inform you in a future message when you can proceed with an upgrade to either IE9 or IE10. We apologize for any inconvenience this may cause.

11. Additional BCBSM Healthy Advantage Rewards Medicare Advantage PPO provider payments coming in June

Category: Medicare Advantage

Title: Additional BCBSM Healthy Advantage Rewards Medicare Advantage PPO provider payments coming in June

Start Date: April 8, 2013   End Date: June 3, 2013

The BCBSM Revenue Management Operations team received numerous inquiries from providers regarding missing payments for submitted 2012 Healthy Advantage Rewards Physician Assessment forms. Upon final review of the 2012 Healthy Advantage Rewards Medicare Advantage PPO provider payments, we identified additional BCBSM physician assessment reimbursements that weren’t included in the initial payment cycle.

We can appreciate how this error may be frustrating to you and to correct this issue, another check run will be processed the first week of June 2013. Please expect your reimbursement checks to arrive by mid-June 2013.

We apologize for this inconvenience and thank you for your continued patience.

If you have any questions or for more information, please contact the Revenue Management Operations team via email at MARevenueMgtOps@bcbsm.com.
12. Some Blue Cross Blue Shield Medicare Advantage radiology claims rejecting in error

Category: Medicare Advantage

Title: Some Blue Cross Blue Shield Medicare Advantage radiology claims rejecting in error

Start Date: April 8, 2013   End Date: April 22, 2013

Approximately 300 BCBSM Medicare Advantage radiology claims were processed incorrectly, with dates of service beginning Jan. 1, 2013.

Our claims system checks for a prior authorization if one or more high-tech radiology services are billed. When no prior authorization is found, the claim is held for manual review. Due to a processing error, these claims are incorrectly rejecting all lines of services instead of rejecting only the non-authorized high-tech radiology service.

We will reprocess all affected claims and send a new provider remittance voucher to affected providers.

We apologize for the inconvenience this error has caused and appreciate your patience as we correct it.

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

13. Blues offer webinars on professional coding services

Category: Webinar

Title: Blues offer webinars on professional coding services

Start Date: April 9, 2013   End Date: April 30, 2013

Blue Cross Blue Shield of Michigan is offering a series of webinars to support the new BCBSM coding initiative and computer-based training that was recently released on web- DENIS.

The upcoming webinars will cover the information in the computer-based training session and allow the opportunity to ask questions of certified coders.

Here are webinar opportunities that BCBSM is hosting throughout May 2013:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
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<td>Date</td>
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<tr>
<td>Tuesday, April 30</td>
<td>12 to 1 p.m.</td>
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<tr>
<td>Thursday, May 9</td>
<td>12 to 1 p.m.</td>
</tr>
<tr>
<td>Wednesday, May 15</td>
<td>9 to 10 a.m.</td>
</tr>
<tr>
<td>Wednesday, May 22</td>
<td>9 to 10 a.m.</td>
</tr>
<tr>
<td>Wednesday, May 29</td>
<td>12 to 1 p.m.</td>
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</tbody>
</table>

To register, send an email to SE-professionaleducationregistration@bcbsm.com and include the date and time of the class you wish to attend. You will receive a confirmation within 72 hours of registering.

For a full list of webinars throughout 2013, see the related article in the May 2013 Record. Please contact your provider consultant with questions related to the webinars or computer-based training.

14. Recovery underway for all URMBT claims

Category: Recoveries

Title: Recovery underway for all URMBT claims

Start Date: April 10, 2013    End Date: April 24, 2013

NASCO is conducting an overpayment recovery for all UAW Retiree Medical Benefits Trust groups, for dates of service Jan. 4, through Jan. 18, 2013.

In-network and out-of-network claims were applying cost-sharing incorrectly for all services.

This payment replaces the incorrect one we sent with a different amount for the member to pay. When you adjust patients’ accounts, the subscriber’s liability might change.

15. Recovery underway for Autocam Corporation claims

Category: Recoveries

Title: Recovery underway for Autocam Corporation claims
Start Date: April 11, 2013   End Date: April 25, 2013

Beginning April 1, 2013, we are conducting an overpayment recovery for Autocam Corporation member claims for dates of service Jan. 1, 2011, through Jan. 17, 2013. The group requested a retroactive benefit change to combine in- and out-of-network cost-sharing accumulations for its single and family PPO high-deductible health plan health savings account, effective Jan. 1, 2011.

When you adjust patients’ accounts, the subscribers’ balances may change.

16. All Internet Claim Tool users

Category: Scheduled system maintenance –April 20 and 21, 2013

Title: All Internet Claim Tool users

Start Date: April 15, 2013   End Date: April 22, 2013

BCBSM will be performing system maintenance on the internet claim tool from 12:00 p.m. EST on Saturday, April 20th through 6:00 a.m. on April 21st. Claim tool users will be unable to access the system during this time period.

We apologize for any inconvenience this may cause.

17. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: April 15, 2013   End Date: April 29, 2013
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning April 15, 2013:

- **Professional**
  - Traditional, TRUST & Blue Preferred Plus<sup>SM</sup>
  - Independent Lab
- **Facility**
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

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18. **Centers for Medicare & Medicaid Services initiates 50 percent multiple procedure payment reduction on selected therapy services**

**Category:** Medicare Advantage

**Title:** Centers for Medicare & Medicaid Services initiates 50 percent multiple procedure payment reduction on selected therapy services

**Start Date:** April 17, 2013  **End Date:** May 1, 2013

In accordance with CMS regulations, BCBSM is reducing payments on selected Medicare Advantage therapy services rendered in both the facility and professional settings by 50 percent effective for claims with dates of service on or after April 1, 2013. These reductions are based on the current physician fee schedule.

The CMS Multiple Procedure Payment Reduction applies to the practice expense when more than one unit or procedure is offered to the same patient on the same day.

If therapy services are provided by a physician organization or as a supplement to a doctor’s normal services, the MPPR applies to all services, regardless of whether the services represent one or more types of therapy, such as physical, occupational or speech-language pathology.
Please see the *MLN Matters* article for additional details or contact your provider consultant for more information.

We appreciate your understanding that we must follow CMS guidelines. Thank you for working with BCSBM.

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

19. Medicare Eligibility Submitters

**Category:** System Outage Notifications – April 19-21, 2013

**Title:** Medicare Eligibility Submitters

**Start Date:** April 17, 2013  **End Date:** April 22, 2013

There is scheduled maintenance on the weekend of Friday, April 19 - Sunday, April 21, 2013. The maintenance window will begin at 9:00 PM ET on Friday, April 19, 2013.

The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 5:00 PM ET on Sunday, April 21, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315

20. All BCBSM trading partners
Category: Submission of electronic Federal Employee Program status inquiry, replacement and void claims

Title: All BCBSM trading partners

Start Date: April 17, 2013  End Date: May 15, 2013

BCBSM has updated our 837 Professional and Institutional companion documents to remove FEP professional status inquiry and facility void and replacement claims from the list of electronic exclusions. FEP claims may now be submitted electronically with a claim frequency code/third digit bill type of XX7 (replacement) or XX8 (void) in Loop 2300 CLM05-3.

In order for the claims to process, the Original Reference Number (ICN/DCN) of the previously adjudicated claim must be reported in Loop 2300 Segment REF02, with a qualifier of F8. This requirement is the same as is in place for BCBSM status inquiry, replacement or void claims.

Please contact your software vendor or clearinghouse for assistance with adapting your practice management system to create FEP status inquiry, void or replacement claims.

Additional information is located in our BCBSM 837 companion documents available online.

21. Remember to submit claims on time

Category: Claims

Title: Remember to submit claims on time

Start Date: April 19, 2013  End Date: May 3, 2013

It’s critical that you follow submission deadlines for all claims. Starting May 24, 2013, filing limits will be strictly enforced.

If you submit a claim after your filing limits, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber. If you haven’t submitted a claim because you’re having difficulty identifying a member’s contract number, log in to web-DENIS and use the Subscriber Name Search feature.

Deadline submissions for original claims remain the same — 180 days from the date of service for professional providers and 12 months from the date of service for facility providers. If you’re submitting a Master Medical claim that will be paid to the subscriber, the filing limit will be two years. Claims for dates of service prior to the contract
migrating to MOS are pay-subscriber, after MOS migration, the provider is paid and regular filing limits apply.

Health care providers must also submit secondary claims, status inquiries and adjustments within 24 months of the date of service.

For more information about this requirement, see the related article in the April 2013 issue of *The Record* or contact your provider consultant.

22. Join BCBSM for an informational ICD-10 conference call, April 29

**Category:** All providers

**Title:** Join BCBSM for an informational ICD-10 conference call, April 29

**Start Date:** April 19, 2013  **End Date:** April 30, 2013

Have you heard about ICD-10? Do you know how it will affect your business? Are you sure of when ICD-10 goes into effect?

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind – giving you and your practice or facility a chance to discuss topics of interest to the health care provider community, to hear about the ICD-10 transition from a payer perspective, to learn about the latest ICD-10 news and updates, to get valuable ICD-10 preparation tips and to have a chance to ask questions about the transition.

Our first call will focus on the ICD-10 basics and an overview of ICD-10 testing.

The call is scheduled for Monday, April 29, 2013, from 1 to 2 p.m., Eastern time. The call-in number is 1-800-462-5837. When you are asked for a meeting ID number, enter 938541.

The call will be on a first-come, first-serve basis and we have the capacity for 75 participants. If you try to dial-in, but cannot join, send an email to icd-10providerreadiness@bcbsm.com and we will make sure that you get a copy of the presentation and anything discussed during the Q&A session.

Also, feel free to send an email to icd-10providerreadiness@bcbsm.com if:

- you want a copy of the presentation associated with the conference call. We will send out the presentation on April 29, just before the meeting begins.
• You would like to join the online webinar that goes along with the conference call (this may require a download of software to your computer). We will email you a link and suggest you attempt to log in about 15 minutes prior to the meeting time.
• You would like us to cover a specific topic on a future call or have questions related to ICD-10.

23. Blue Cross Blue Shield of Michigan Health e-BlueSM temporarily down

Category: Medicare Advantage

Title: Blue Cross Blue Shield of Michigan Health e-BlueSM temporarily down

Start Date: April 19, 2013    End Date: April 23, 2013

BCSBM’s Medicare Advantage Health e-Blue website is experiencing data issues and as a result, we’ve temporarily disabled the system to fix the issue. This issue does not affect Blue Care Network’s Health e-Blue.

Currently, there is no alternative entry option for Health e-Blue. We’re working to correct the system and hope to have Health e-Blue operational as soon as possible. We’ll update you when the system has been restored.

We apologize for any inconvenience this may cause and appreciate your patience.

If you have any questions, please MAHealtheBlue@bcbsm.com or contact your provider consultant

24. ICD-10 system changes impacts

Category: All providers

Title: ICD-10 system changes impacts

Start Date: April 19, 2013    End Date: May 18, 2013

As BCBSM continues to prepare for the ICD-10 transition on Oct. 1, 2014, we will need to update some of our systems. During those update periods, there may be impacts to the tools you use for a period of time. From now through May 17, 2013, accumulated deductible information for members in the following groups may not be current when viewed online - HP Pelzer (group number 71337) and The Bartech Group (group number 72222). If you need to identify the correct deductible accumulated to date for these members, call the provider service center. We apologize for this temporary issue.

25. Some Medicare Advantage facility claims that span the 2012 and 2013 calendar year aren’t processing correctly
Title: Some Medicare Advantage facility claims that span the 2012 and 2013 calendar year aren’t processing correctly

Start Date: April 19, 2013    End Date: May 6, 2013

Blue Cross Blue Shield of Michigan received some Medicare Advantage group facility claims that spanned 2012 and 2013. These facility claims aren’t processing correctly and we’re working to correct the issue.

The two affected groups are:

- BCBSM and Blue Care Network nonbargaining unit
- Sheet Metal Workers Local 80

Some members in these two groups were admitted to the hospital in 2012 and discharged in 2013. The claims system should have processed this as one complete claim and applied the appropriate benefits at the time of admission, not discharge.

Once the system is corrected, the claims will be reprocessed and pay according to the 2012 benefit structure.

We apologize for the inconvenience this system error has caused and appreciate your patience as we work to resolve the issue. If you have any questions, please contact your provider consultant.

26. Blue Care Network hosting open house for Southeast primary care provider offices in May

Title: Blue Care Network hosting open house for Southeast primary care provider offices in May

Start Date: April 22, 2013    End Date: May 11, 2013

Blue Care Network Provider Affairs is hosting an open house for its affiliated Southeast Michigan primary care offices on Thursday, May 16, 2013, in Southfield. An RSVP is requested by May 10. If representatives from your office would like to attend, download the invitation to your hard drive and fax or email the completed form to BCN. For more information, please contact your BCN provider representative.

27. Additional fee schedules added to web-DENIS
Category: Claims

Title: Additional fee schedules added to web-DENIS

Start Date: April 22, 2013   End Date: May 5, 2013

BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective May 1, 2013:

Professional: Injection Fee Schedule

Injections fee schedule 05/01/13

Facility: Hospital Outpatient

Drug fees effective 05/01/13

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will been removed.

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

28. Recovery underway for Trinity Health St. Mary Mercy facility claims

Category: Recoveries

Title: Recovery underway for Trinity Health St. Mary Mercy facility claims

Start Date: April 23, 2013   End Date: May 7, 2013

NASCO is conducting a recovery for Trinity Health St. Mary Mercy facility claims for dates of service Sept. 1, 2012, through Feb. 8, 2013.

Facility claims for Trinity Health St. Mary Mercy were processed and checks were erroneously sent, when our payment should have appeared on an interim payment voucher. We’re taking back our checks and replacing them with the correct voucher.

29. Out-of-state alpha prefix list
Category: Claims

Title: Out-of-state alpha prefix list

Start Date: April 24, 2013   End Date: May 8, 2013

An updated list of out-of-state alpha prefixes is now available on web-DENIS on the BCBSM Newsletters & Resources page under Clinical Criteria & Resources. The list includes non-Michigan alpha prefixes for out-of-state groups that have members residing in Michigan.

To access the list:

Log in to web-DENIS

Click on BCBSM Provider Publication and Resources

Click on BCBSM Newsletters and Resources

Click on Clinical Criteria and Resources

Scroll to the section Alpha prefixes

Click on Out of state alpha prefixes

30. Recovery underway for TK USA claims

Category: Recoveries

Title: Recovery underway for TK USA claims

Start Date: April 24, 2013   End Date: May 8, 2013

NASCO is conducting a recovery for TK USA, group number 71486, for dates of service Jan. 1, through Feb. 8, 2013.

Facility and professional claims processed with the incorrect enrollment date.

This payment replaces the incorrect one we sent you. When you adjust patients’ accounts, the subscriber’s liability may change.

31. FEP System downtime for April 27

Category: System downtime notification
Title: FEP System downtime for April 27

Start Date: April 24, 2013    End Date: April 30, 2013

The Federal Employee Program application will be unavailable Saturday, April 27, 2013, until approximately 5 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through web-DENIS during that period.

32. Blue Advantage RewardsSM program vendor update

Category: Medicare Advantage

Title: Blue Advantage RewardsSM program vendor update

Start Date: April 25, 2013    End Date: May 15, 2013

Entertainment Promotions LLC, the Blues’ vendor partner for its Blue Advantage RewardsSM program, is back in business. Medicare Plus Blue PPOSM, Medicare Plus Blue Group PPOSM, BCN Advantage HMO-POSSM and BCN Advantage HMOSSM members who have completed their BAR forms and submitted them for 2013 will begin receiving Entertainment coupon booklets in May.

Should a patient have questions, please let them know that they can continue to obtain their services and send in their reward forms. They will continue to receive coupon booklets after submitting completed forms for the eligible services.

We remain committed to working with you and our members to improve and maintain their overall health. We appreciate everything you do to help keep our members healthy.

If you have any questions, please contact your BCBSM provider consultant or BCN provider representative.

33. Benefit Configurator System upgrade scheduled for the weekend of May 4

Category: Benefits Unavailable

Title: Benefit Configurator System upgrade scheduled for the weekend of May 4

Start Date: April 29, 2013    End Date: May 6, 2013

During the weekend of May 4, 2013, the Benefit Configurator system will undergo an update. This update will not result in any new functionality within the Benefit Explainer tool.

As a result of this release, all Benefit Configurator tools, including Explainer, will be unavailable from 5 p.m. Saturday, May 4, through 7 a.m. Monday, May 6.
Benefit Configurator is a system of various applications serving as the single source for benefit information. The most common tool used is Explainer.

34. Hospital Forum in Frankenmuth is Wednesday, May 1

Category: Forums

Title: Hospital Forum in Frankenmuth is Wednesday, May 1

Start Date: April 29, 2013   End Date: May 2, 2013

There is some confusion on the date of the annual hospital forum in Frankenmuth. Please note that the event is indeed Wednesday, May 1. See you Wednesday in Frankenmuth.

35. Additional fee schedules added to web-DENIS

Category: Claims

Title: Additional fee schedules added to web-DENIS

Start Date: April 29, 2013   End Date: May 13, 2013

BCBSM recently added the following revised “entire fee schedules” to web-DENIS, reflecting fee updates effective May 1, 2013:

Professional: Injection Fee Schedule

- Injections fee schedule 05/01/13 (revised 4/24/2013)

Facility: Hospital Outpatient

- Drug fees effective 05/01/13 (revised 4/24/2013)

New information became available after initial publication of the above noted fee schedules. Therefore, the originally published fee schedules have been revised and republished.
As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will be removed.

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

36. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: April 29, 2013    End Date: May 13, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning April 29, 2013:

- Professional
  - Traditional, TRUST & Blue Preferred PlusSM
  - Injections
  - DME

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility
  - Outpatient Psychiatric Care
These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

37. FEP Eligibility Alert and Medicare or other Current Carrier Coverage

**Category:** FEP Eligibility Alert

**Title:** FEP Eligibility Alert and Medicare or other Current Carrier Coverage

**Start Date:** March 29, 2012   **End Date:** TBD

The Federal Employee Program (FEP) eligibility information does not currently indicate if Medicare or another carrier is primary.

Please use the web-DENIS Medicare Eligibility feature to determine if Medicare is the primary carrier for your patient.
38. Precertify detox treatment for State of Michigan employees

Category: Benefits

Title: Precertify detox treatment for State of Michigan employees

Start Date: April 30, 2013    End Date: May 14, 2013

Acute care hospitals must submit a precertification request when admitting State of Michigan employees for substance abuse detoxification treatment (including alcohol withdrawal).

Please follow this process:

- Determine if the patient is a State of Michigan employee (BCBSM group number 007000562, alpha prefixes: MIG – Non-Medicare, XYR – Medicare).
- If the patient is a State of Michigan employee, fill out the Acute Inpatient Fax Assessment Form (PDF).
- Fax the form to 1-866-411-2585 or email it to acuteprecertification1@bcbsm.com.

Please remember that if the incoming patient is not a State of Michigan employee, please call Magellan Behavioral at 1-800-762-2382 for precertification.

If you have questions, please contact your provider consultant.

39. Delayed Medicare Advantage 835 remittance files

Category: All Medicare Advantage submitters

Title: Delayed Medicare Advantage 835 remittance files

Start Date: April, 30, 2013    End Date: May 05, 2013

BCBSM EDI has not yet received all of the Medicare Advantage 835 remittance files for the week of Apr. 22, 2013. We are working to obtain the missing files and will distribute them upon receipt.

We apologize for any inconvenience this may cause.
June 2013

**Blues give instructions for Medicare Part D coverage determination process**

For our Medicare Advantage health care providers, we’ve created an instruction guide for the Blue Cross coverage determination process for Medicare Part D. The *Blue Cross Blue Shield of Michigan Medicare Advantage Part D drug coverage guidelines* are available in [Provider Secured Services](bcbsm.com) and includes the following resources:

- An explanation of when and how to request a coverage determination
- The timeline for receiving a decision
- Links to our formularies

Our Part D formularies and drug-use guidelines encourage you to choose options that are low-cost as well as safe and effective.

In some cases, you may need to use a nonformulary drug or have the restrictions to the drug removed (e.g., quantity limit, prior authorization or step therapy requirements). In those situations, the Centers for Medicare & Medicaid Services requires that Medicare Part D plans provide patients and prescribers with a process to bypass these restrictions when medically necessary.

That process is also included in the instruction guide. It’s located in Provider Secured Services:

- Go to [bcbsm.com](bcbsm.com).
- Log in to Provider Secured Services.
- In the left-hand navigation, click on *BCBSM Publications and Resources*.
- Click on *Medicare Advantage Resources*.
- Under *What’s New*, click on *Medicare Advantage provider coverage determination job aid*.

If you have any questions about coverage determination, please call our Clinical Pharmacy Help Desk at 1-800-437-3803 or your provider consultant.
The Record - Blues give instructions for Medicare Part D coverage determination process

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Web-DENIS messages May 2013
1. All BCBSM Professional Claim Submitters

Category: Commercial Payer Table Updates

Title: All BCBSM Professional Claim Submitters

Start Date: May 1, 2013    End Date: July 1, 2013

BCBSM’s Commercial Payer Table contains a combination of payers that are electronic (Type D and E) and Print and Mail (Type X). Print and Mail claims are sent to the BCBSM clearinghouse electronically in the 837 X12 5010A1 format, however because there is no electronic connection to these payers the claims are printed to a 1500 paper claim form and mailed to that Payer by a third party vendor. While this process is not a significant cost to BCBSM, it can delay receipt of the claim by the intended payer. These delays can be avoided by a submitter or provider mailing the claim form directly to the payer.

Over the next few months, we will be updating our Commercial Payer Table to remove a large number of Print and Mail payers. Our recent update removed payers that had little or no activity during 2012. Effective June 1, 2013, we will be removing an additional 65 Print and Mail payers. The payer table has been updated to highlight the payers that will be deleted from the list. The Professional Commercial Payer Listing document is located on our EDI Connectivity web page:

Before submitting a commercial claim electronically, please check the updated payer table to ensure a payer is still listed. Claims for payers no longer listed on the table will need to be submitted on paper directly to the payer.

Going forward, BCBSM will reject electronic claims received on or after June 1 that contain the Payer IDs and Claim Office numbers of the deleted Print and Mail payers. Submitters will receive an edit of P017 COMMERCIAL PAYER ID AND OR CLAIM OFFICE NUMBER IS INVALID on a R277CAH report.

If you have any questions regarding this information, please call our Electronic Data Interchange department at 1-800-542-0945.

2. Ambulatory surgery centers receiving denied claims in error

Category: Medicare Advantage

Title: Ambulatory surgery centers receiving denied claims in error
Start Date: May 1, 2013   End Date: May 16, 2013

Due to an error in Blue Cross Blue Shield of Michigan’s Medicare Advantage claims system, ambulatory surgery centers claims for dates of service Jan. 1, 2012, through April 17, 2013, were denied, indicating global surgery modifiers were required. However, ambulatory surgery centers are not required to bill this modifier.

The system error has now been fixed, and we will adjust all affected claims.

Please note: Per the Centers for Medicare & Medicaid Services guidelines, physicians are still required to use global surgery modifiers when performing certain services during the post-operative period.

We apologize for any inconvenience this issue may have caused. If you have any questions, please contact your provider consultant.

3. NaviNet coming for Blue Cross Complete providers

Category: Blue Cross Complete (Medicaid)

Title: NaviNet coming for Blue Cross Complete providers

Start Date: May 1, 2013   End Date: May 31, 2013

We’re making changes to prepare for and support our growth as a Michigan Medicaid health plan. We are pleased to announce that effective July 1, 2013, Blue Cross Complete of Michigan providers will have access to NaviNet.

NaviNet will provide Blue Cross Complete provider offices with access to a variety of transactions and features that can simplify your work day. You will be able to perform the following functions for Blue Cross Complete:

- Verify member eligibility
- Access primary care provider panel roster
- Access member benefits and history information
- Submit and status authorizations
- Status claims
- Access Gaps in Care reports for medical and pharmacy services

All Blue Cross Complete historical eligibility, authorization and claims information will be available in NaviNet. We will offer NaviNet training for your office in June. If you have questions, please contact your provider representative.
4. Blue Cross Blue Shield of Michigan Medicare Advantage announces revised sequestration reduction claim code

**Category:** Medicare Advantage

**Title:** Blue Cross Blue Shield of Michigan Medicare Advantage announces revised sequestration reduction claim code

**Start Date:** May 2, 2013    **End Date:** May 17, 2013

We’ve identified a claims system error that is triggering an incorrect claim code message regarding sequestration reduction. Claims are processing correctly but the electronic remit advice incorrectly lists claim adjustment reason code 104, “reduced paid by provider withhold.”

The Centers for Medicare & Medicaid Services advised plans to use claim adjustment reason code 223, – “withhold is due to Medicare sequestration”– to report the sequestration reduction on the electronic remit advice. A system error is preventing us from using this code but we’re working to correct the problem and anticipate this will be completed within 30 days.

In the meantime, please refer to the paper remittance you receive with your check. The paper remittance will display the proper message codes.

We apologize for the confusion this may have caused and appreciate your patience as we work to resolve this issue. We’ll notify you via web-DENIS once the issue is fixed.

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

5. MESSA members’ office visits processing incorrectly

**Category:** Professional claims

**Title:** MESSA members’ office visits processing incorrectly

**Start Date:** May 2, 2013    **End Date:** May 28, 2013

We are aware of the issue with many Michigan Education Special Services Association members’ office visit claims processing without a member copayment, and resolution is under development. If you have collected a copayment from the member and have been reimbursed at 100 percent, please refund the copay amount collected. We anticipate this issue will be corrected by the end of June. A recovery will not be requested.

We apologize for any inconvenience this may cause.

6. BCBSM electronic provider manuals — April 2013 changes
These are the chapters we revised in April 2013, along with the revision date and a brief statement of the main changes for each.*

- **Blue Pages Directory** (4/1/2013)
  - "CAQH Universal Provider Datasource" map: Added information about hospital-based practitioners and 120-day re-attestation requirement.
  - "Michigan Conference of Teamsters Welfare Fund" — Updated the precertification contact information for mental health and substance abuse services
  - “Precertification – behavioral health admissions” — Renamed this formerly called “Precertification – medical admissions” section. Also added more information to the section.
  - “Precertification – medical admissions” — Renamed this formerly called “Precertification – medical admissions” section.
  - “UAW-Ford” — Updated the mental health and substance abuse precertification information for NPP and BPP members.

- **Blue Preferred Plus** (4/1/2013)
  - “Contact information” — Deleted from each table the phone number for precertification and replaced it with a link to the “Precertification” section of the “Blue Pages Directory” chapter.
  - “Affiliation” — In the “Access standards” section, updated the two tables.
  - “Referrals” — In the “Referral process” section, updated the process.
  - “Billing guidelines” — Added this new section.

- **Claims** (4/12/2013)
  - "CMS-1500 Claim examples" — Added three new claim examples: “Outpatient Psychiatric Care Facility,” “Outpatient Psychiatric Care Facility-Partial Hospitalization” and “Outpatient Psychiatric Care Facility with COB.”
  - “Completing the CMS-1500 claim (08/05 version)” — In field 24J, added “Leave blank for OPCs.”
  - “Claims follow-up” — In the “Completing the Status Claim Review Form” section, deleted field 23 for OPCs and added “Leave blank for OPCs” to fields 24, 44 and 45.

- **Hospital Services** (4/1/2013)
  - “Dialysis” — In the “Billing guidelines” section, revised the revenue codes.

- **Human Organ Transplant Benefit** (4/2/2013)
  - “Overview” — Added information about claims submission and follow-up.
• **Long-Term Acute Care Hospital Services** (4/1/2013)
  - “Billing guidelines” — Added a section named "Diagnosis codes."

• **Mental Health and Substance Abuse Managed Care Program** (4/12/2013)
  - Throughout the chapter, made modifications to the OPC information.
  - Reordered topics.
  - "Precertification" — Added the “Emergency situations” section.
  - “Precertification appeals” — Updated the precertification appeals process.
  - “Discharge planning” — Added this section.

• **Participation** (4/26/2013)
  "Participation agreements" — Deleted the link to the now-outdated 11/1/07 Outpatient Psychiatric Care Facility Participation Agreement, leaving only the link to the 4/1/13 agreement.
  - Overhauled the entire chapter.

• **PPO Policies** (4/1/2013)
  - “Affiliation” — In the “Access standards” section, updated both tables.

• **Preapproval of Services** (4/1/2013)
  - “Precertification” — Added a Note about precertification for Mental Health and Substance Abuse Managed Care Program services and psychiatric care services.

• **Psychiatric Care Services** (4/12/2013)
  - Throughout the chapter, made modifications to the OPC information.

• **Radiology Management Program Procedure Codes** (4/25/2013)
  - “Radiology privileging” — Updated two specialty charts: "ENT physicians (specialty codes 04 and 17)," and "Ophthalmologists (specialty code 18)."

• **Skilled Nursing Facility Services** (4/1/2013)
  - “Diagnosis code sets” — Added this topic.

• **Valid Modifiers** (4/11/2013)
  - “Valid modifiers: durable medical equipment” — Added four new modifiers to this section.
  - “Valid modifiers: prosthetics and orthotics” — Added three new modifiers to this section.
  - "Valid modifiers: surgery” — Added modifier 63 to this section.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.*

7. Additional fee schedule added to web-DENIS

Category: Fee Schedules
Title: Additional fee schedule added to web-DENIS

Start Date: May 6, 2013    End Date: May 20, 2013

BCBSM recently added this additional facility fee schedule to web-DENIS:

- Ambulatory Infusion Centers - Rate Schedule effective 8/1/13

This and other fee schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*. For more information, contact your BCBSM provider consultant.

7. Recovery underway for Crittenton Hospital claims

Category: Recoveries

Title: Recovery underway for Crittenton Hospital claims

Start Date: May 8, 2013    End Date: May 22, 2013

NASCO is conducting an overpayment recovery for Crittenton Hospital for dates of service Sept. 1, 2012, through Feb. 7, 2013.

The group requested a retroactive benefit change for mental health services performed in an office setting, effective Sept. 1, 2012.

We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscriber’s liability may change.

8. Recovery underway for TK USA claims

Category: Recoveries

Title: Recovery underway for TK USA claims

Start Date: May 8, 2013    End Date: May 22, 2013

NASCO is conducting an overpayment recovery for the TK USA group for dates of service Jan. 1 through Feb 10, 2013.

The group requested copayment changes for specific services to accommodate 2013 benefit changes. The affected services are allergy testing, clinic visits, outpatient mental health and substance abuse care, office visits for accidental injuries, medical emergencies, consultations, pre- and postnatal visits and urgent care services.
We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscriber’s liability may change.

9. Blue Cross Blue Shield of Michigan begins hospital chart review requests

   **Category:** Medicare Advantage

   **Title:** Blue Cross Blue Shield of Michigan begins hospital chart review requests

   **Start Date:** May 8, 2013    **End Date:** May 29, 2013

   The Centers for Medicare and Medicaid Services requires Medicare Advantage plans to submit detailed, ongoing documentation about each Medicare Advantage member. Plans must document each member’s specific diagnosis according to ICD-9-CM standards and as supported by the patient’s medical record. We need this important documentation to clarify each specific medical condition.

   As part of this process, BCBSM will mail letters to hospitals requesting copies of providers’ medical records beginning May 9, 2013. The information can be submitted to BCBSM via fax or mail. A provider reimbursement request form will also be included.

   Providers are asked to return the necessary information within four weeks of the letter’s date and will be reimbursed $10 per medical record within 45 days of receiving the documentation.

   For more information, please call Lori Harris at 313-225-6458.

   Thank you for your support and partnership in providing quality health care.

10. Follow your filing limits and submit claims on time

   **Category:** Claims

   **Title:** Follow your filing limits and submit claims on time

   **Start Date:** May 8, 2013    **End Date:** May 31, 2013

   Over the last few months, we’ve reminded you that starting May 24, 2013, filing limits will be strictly enforced.

   If you submit a claim after your filing limits, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

   For more details on this requirement and important guidelines that you need to follow, see the related article in the [May 2013 Record](#).
11. Blue Cross Blue Shield of Michigan Medicare Advantage begins long-term care facility requests

Category: Medicare Advantage

Title: Blue Cross Blue Shield of Michigan Medicare Advantage begins long-term care facility requests

Start Date: May 8, 2013  End Date: May 29, 2013

BCBSM Medicare Advantage will mail letters to approximately 60 long-term acute care facilities on May 9, 2013, requesting selected physician documentation. The Centers for Medicare & Medicaid Services requires Medicare Advantage plans submit detailed, ongoing documentation about each Medicare Advantage member.

Physician documentation includes patient progress notes, history, physical exams, consults and procedures for selected BCBSM Medicare Advantage members. Affected dates of service range from June 1, 2012, to Dec. 31, 2012.

We ask that providers please return the needed documents within four weeks. Providers will be reimbursed $10 for each medical record returned to BCBSM. Medical records can be submitted to us by fax or mail. A provider reimbursement request form will also be included.

Thank you in advance for your cooperation. If you have any questions, please contact your provider consultant.

12. Presentations from hospital forum in Frankenmuth now available

Category: Forums

Title: Presentations from hospital forum in Frankenmuth now available

Start Date: May 8, 2012  End Date: May 22, 2013

The presentations made at the BAC Hospital Forum in Frankenmuth on May 1 are now available on web-DENIS to all hospitals that weren’t able to make the event. To access the presentations given during the forum, log in to web-DENIS:

2. Click on BCBSM Provider Publications and Resources.
3. Click on Newsletters and Resources.
4. In the “What’s New” section, click on Presentations from the 05/01/2013 Hospital Informational BAC Forum in Frankenmuth.

Thank you to all who attended. This year we had record attendance, and the feedback has been fantastic. We’re looking forward to seeing you at next year’s event.
13. Facility claims editing for missing units

Category: Facility Claims

Title: Facility claims editing for missing units

Start Date: May 13, 2013    End Date: May 28, 2013

You may be experiencing a high volume of claims editing in Provider Claims Correction from entry date May 10, 2013. We are investigating an issue with facility claims editing with message code R259, “The units of service are equal to zero or blank.”

We are working to resolve this issue. An updated message will be posted if any action is needed on your part. We apologize for any inconvenience this may cause.

14. Billing high-risk and non-obstetric conditions for maternity patients

Category: Professional claims

Title: Billing high-risk and non-obstetric conditions for maternity patients

Start Date: May 13, 2013    End Date: May 31, 2013

Our system is currently being updated to allow you to enter an evaluation and management procedure code with modifier 25 when billing for maternity patient visits for high-risk conditions or conditions unrelated to the pregnancy during the 270-day antepartum period.

The diagnosis code and documentation should support the patient’s high-risk condition or other condition unrelated to the pregnancy for the purposes of post-audit review.

If you receive a claim rejection before our system update is complete, you may request reconsideration of services rendered by sending documentation to be reviewed through the appeals process.

We will notify you when the system is updated.

15. Recovery underway for Chrysler nonbargaining and Delphi hourly claims

Category: Recoveries

Title: Recovery underway for Chrysler nonbargaining and Delphi hourly claims
Start Date: May 13, 2013   End Date: May 28, 2013

NASCO is conducting an overpayment recovery for Chrysler nonbargaining and Delphi hourly groups for dates of service Jan. 1, 2012, through Dec. 27, 2012.

The group requested a retroactive benefit change for outpatient mental health and substance abuse services, effective Jan. 1, 2012.

We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscriber’s liability may change.

16. Validator Self-Testing Tool Maintenance

Category: BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Title: Validator Self-Testing Tool Maintenance

Start Date: May 13, 2013   End Date: May 20, 2013

The BCBSM HIPAA Validator online self-testing tool and Provider Authorization application will be unavailable on Thursday, 05/16/13, from 9:00pm - 11:00pm, in order to perform system maintenance.

We apologize for any inconvenience.

17. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: May 13, 2013   End Date: May 28, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 13, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
Injections
- Independent Lab
  - Facility
    - Outpatient Hospital

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

18. Michigan Conference of Teamsters claims processing delayed

Category: Claims

Title: Michigan Conference of Teamsters claims processing delayed

Start Date: May 15, 2013   End Date: May 31, 2013

We are having technical difficulties processing Michigan Conference of Teamsters Welfare Fund claims. We are working with MCTWF to process these claims as quickly as possible.

Payments will be delayed, so please do not bill members for these claims.

Thank you for your patience while we work to correct this processing issue. We apologize for any inconvenience this may cause.

19. Claims editing for missing units

Category: Facility and Professional Claims

Title: Claims editing for missing units

Start Date: May 14, 2013   End Date: May 29, 2013
You may be experiencing a high volume of claims editing in Provider Claims Correction from entry date May 10, 2013. We are investigating an issue with claims editing with message code R259, “The units of service are equal to zero or blank.”

All impacted claims will be reprocessed. Thank you for your patience while we work to correct this processing issue. We apologize for any inconvenience this may cause.

20. Discontinue accessing web-DENIS using a saved URL link or Favorites bookmark

Category: Web-DENIS upgrade

Title: Discontinue accessing web-DENIS using a saved URL link or Favorites bookmark

Start Date: May 14, 2013   End Date: May 28, 2013

BCBSM is upgrading its servers May 16. The upgrade means that web-DENIS users will not be able to access the system using a saved URL link or Favorites bookmark. Please access web-DENIS via Provider Secured Services by logging in at bcbsm.com and navigating to the provider login page.

21. Reminder: Michigan Department of Corrections’ prisoners processing rules

Category: Claims

Title: Reminder: Michigan Department of Corrections’ prisoners processing rules

Start Date: May 14, 2013   End Date: TBD

Please bill all claims for Michigan Department of Corrections’ prisoners, group numbers 71499, 71564, 71563 and 7003516, to Blue Cross Blue Cross Blue Shield of Michigan.

For inpatient services only, if you receive a rejection notice from BCBSM stating that there is other coverage available, Medicaid should be billed.

Report claims with the prisoner’s BCBSM contract number. All prisoner contract numbers begin with UZW994 or NOG994, followed by a six-digit inmate number that should be provided at the time of service.

22. REVISED: Validator Self-Testing Tool Maintenance

Category: BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Title: REVISED: Validator Self-Testing Tool Maintenance

Start Date: May 15, 2013   End Date: May 24, 2013
System maintenance for the BCBSM HIPAA Validator online self-testing tool and Provider Authorization application has been rescheduled until Wednesday, 05/22/13, from 9:00pm - 11:00pm. Users will be unable to access the application during this time period.

We apologize for any inconvenience.

23. Delayed Medicare Advantage 835 remittance files

**Category:** All Trading Partners

**Title:** Delayed Medicare Advantage 835 remittance files

**Start Date:** May 16, 2013  **End Date:** May 30, 2013

Due to a systems issue, Medicare Advantage 835 remittance files have been delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience.

24. Update: Claims editing for missing units

**Category:** Facility and Professional Claims

**Title:** Update: Claims editing for missing units

**Start Date:** May 20, 2013  **End Date:** June 7, 2013

The high volume of claims editing in Provider Claims Correction from entry date May 10, 2013, has been resolved and all claims have reprocessed as of May 20, 2013.

We apologize for any inconvenience this may have caused. If you have any claims that were not finalized, please contact your provide consultant.

25. Behavioral health codes processing update

**Category:** Professional and Facility claims

**Title:** Behavioral health codes processing update

**Start Date:** May 21, 2013  **End Date:** TBD

This update is to inform you of several recent changes on how Blue Cross Blue Shield of Michigan is handling the new 2013 psychiatric procedure code changes. In a previous message, we communicated that the following scenarios were identified as issues. We now have interim solutions in place to allow processing of these claims:
Effective March 26, 2013, claims are processing correctly and applying only one copayment instead of two, to claims billed with an evaluation and management procedure code and a psychiatric add-on code (when billed with primary psychiatric diagnosis). Claims impacted are E&Ms billed with psychiatric add-on procedure codes *90833, *90836 and *90838. Providers may experience a delay in claims processing.

Provider types M.D. and D.O. were added as “payable” when billed with procedure code *90791, effective March 12, 2013. Allowing these provider types will stop inappropriate rejections for this procedure code. Providers need to resubmit claims that rejected prior to March 12, 2013.

We began a claims recovery May 16, 2013, for dates of service Jan. 1 to Feb. 27, 2013, for procedure codes *90832, *90834 and *90837 that were incorrectly processed. Not all claims with these procedures codes were processed incorrectly. Providers will see adjustments on the affected claims.

26. Ambulatory infusion centers can now enroll with BCBSM and BCN

**Category:** Claims

**Title:** Ambulatory infusion centers can now enroll with BCBSM and BCN

**Start Date:** May 24, 2013    **End Date:** June 24, 2013

As we reported in the February Record, Ambulatory infusion centers can now apply to contract with the Blues. BCBSM and BCN decided to contract with qualified ambulatory infusion centers to provide members with additional safe, convenient, cost-effective locations to receive infusion therapy.

AICs must participate with BCBSM and BCN to receive reimbursement. Enrollment applications are available on [bcbsm.com](http://bcbsm.com).

- Click on the Providers tab:
- Click on Sign up today:
- Click on Provider Enrollment:
- Select Hospitals and Facilities:
- Follow the prompts to access the application form for ambulatory infusion centers.

You’ll complete the form online, print it and fax it according to the instructions on the form.
To ensure that your application is processed in time for the Aug. 1, 2013, effective date, please submit your enrollment form as soon as possible. If you have any questions, contact your provider consultant.

Participating AICs that will submit claims electronically need to register with BCBSM EDI after July 1, 2013. For additional questions on electronic billing registration, please contact the EDI Helpdesk at 1-800-542-0945.

27. Crestor® moved to nonpreferred on the BCBSM and BCN Custom Drug List

Category: Prescription Drugs

Title: Crestor® moved to nonpreferred on the BCBSM and BCN Custom Drug List

Start Date: May 24, 2013    End Date: July 8, 2013

Crestor® will become nonpreferred on the Blue Cross Blue Shield of Michigan and Blue Care Network Custom Drug List (formulary) effective July 1, 2013. This change does not apply to BCN Advantage, BCBSM Medicare Part D or Blue Cross Complete members.

As a result, BCBSM members with a two-tier closed drug benefit must obtain medical necessity authorization before they can receive Crestor. Members enrolled in a three-tier drug benefit will have to pay a nonpreferred brand (Tier 3) copayment.

BCN members currently on Crestor can continue to get Crestor, but will be required to pay a higher copay, depending on their drug benefits. **For members who switch from Crestor to a generic statin, BCN is offering their first 90-day supply for free if filled on or before Oct. 31, 2013.** Any BCN members with a new Crestor prescription will have to meet step-therapy requirements.

We will notify affected members of these changes, and we’ll encourage them to contact their physicians to discuss other treatment options.

If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant. Thank you for your continued patience as we work to correct these issues.

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28. All BCBSM Professional Claim Submitters

Category: All BCBSM Professional Claim Submitters

Title: All BCBSM Professional Claim Submitters
As a reminder, effective June 1, 2013, BCBSM will be removing 65 Print and Mail payers from the Commercial Payer Table. The payer table was updated earlier this month to highlight the payers that will be deleted from the list.


Before submitting a commercial claim electronically, please check the updated payer table to ensure a payer is still listed. Claims for payers no longer listed on the table will need to be submitted on paper directly to the payer.

Going forward, BCBSM will reject electronic claims received on or after June 1 that contain the Payer IDs and Claim Office numbers of the deleted Print and Mail payers. Submitters will receive an edit of P017 COMMERCIAL PAYER ID AND OR CLAIM OFFICE NUMBER IS INVALID on a R277CAH report.

If you have any questions regarding this information, please call our Electronic Data Interchange department at 1-800-542-0945.

29. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedules added to web-DENIS

**Start Date:** May 28, 2013  **End Date:** June 11, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 28, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility
  - Outpatient Psychiatric Care

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

30. Medical policy change for Proteomics-based testing
Category: Benefits

Title: Medical policy change for Proteomics-based testing

Start Date: May 30, 2013    End Date: July 1, 2013

Effective Sept. 1, 2013, Proteomics-based testing for the evaluation of ovarian (adnexal) masses, procedure codes *81500 and *81503, is considered experimental and no longer payable. The use of this testing has not been scientifically demonstrated to improve patient clinical outcomes; therefore, it is considered experimental.

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31. Medicare Plus Blue PPO℠ manual will be updated for July 2013

Category: Medicare Advantage

Title: Medicare Plus Blue PPO℠ manual will be updated for July 2013

Start Date: May 30, 2013    End Date: July 1, 2013

Blue Cross Blue Shield of Michigan will update the Medicare Plus Blue PPO℠ manual for July 2013. Key changes are outlined below, but please review the manual in its entirety.

- Updated out-of-state fact sheet.
- Reminder: BCBSM Medicare leases the DMEnsion provider network and contracted fees. Our claims processor manages these claims for BCBSM Medicare Advantage. DMEnsion no longer processes claims for durable medical equipment, prosthetic and orthotic devices, medical supplies and Part B drugs.
- Added obstetrics-gynecology as a recognized BCBSM Medicare Advantage PPO practitioner specialty.
- Updated compliance terms for in-office waiting times.
- Changed the compliance with access standards notification days:

  If it’s determined a practitioner doesn’t meet access to care standards, the non-compliant practitioner must submit a corrective action plan within **30 days** of notification.
o Added information regarding the Advanced Illness @HOM Support program.

o Changed Health e-Blue℠ access hyperlinks. Providers no longer need to complete an updated Use and Protection Agreement for Health e-Blue access if the office has one on file under the practice name.

o Updated the Medical Therapy Management Program annual drug expense projections and member outreach through the University of Arizona’s College of Pharmacy Medicine.

o Added a new section on member outreach for pharmacy treatment improvement opportunities, including high-risk medications, angiotensin converting enzyme inhibitor and angiotensin receptor blocker treatment for diabetes and hypertension, and opioid overuse.

o Updated prenotification system changes (applicable after August 2013):

- 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 admittance and the necessary treatment.
- Hospitals will be required to reference the 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.

o Updates to utilization management including:

- If the service is not a benefit under your patient’s BCBSM contract or if it’s not medically necessary, there is no reason to request prior authorization. The service will not be covered.
- Patients must be made aware of the possibility of increased cost-sharing they may incur when receiving non-network services. Preauthorization must be requested before the service is performed with the exception of emergency and urgent care settings or emergent clinical settings.
- How we notify you of the results: Our medical staff will review all preauthorization requests and respond to you verbally or by mail. If your request is approved, we’ll give you a preauthorization number, which you’ll later need when completing a claim form to bill for the service. For more information, see Claim filing. If your request is denied, we’ll explain why. You may appeal our decision; see Provider dispute resolution process.
Deleted the following precertification requirement:

After-hours, weekend or holiday admissions — The facility must submit a request via fax or email on the first business day following the after-hours, weekend, or holiday admission to obtain certification.

Access the CMS Inpatient only list — Addendum E


Updated EDI links

Updated Medicare Advantage PPO provider agreement

Updated the following affiliation information for professional and facility enrollment:

Requirements are no longer listed in the application but can now be found in a separate general information sheet on this Web page along with the application. Additional eligible practitioner categories were added including clinical nurse specialist and physician assistant.

You can obtain the most current version of the manual at bcbsm.com/provider/ma.

This message serves as notice of these changes to the Medicare Plus Blue PPO manual per the terms of the MA PPO Provider Agreement, available online at bcbsm.com/provider/ma.

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

32. Additional fee schedule added to web-DENIS

Category: Claims

Title: Additional fee schedule added to web-DENIS

Start Date: May 30, 2013    End Date: June 13, 2013

BCBSM recently added the following revised fee schedule to web-DENIS reflecting corrections and revisions to the DME / P&O fee schedule effective July 1, 2013:

Professional:

o  DME/P&O Fee Schedule (effective 7/1/13, revised 05/29/2013)

New information became available after initial publication of the above noted fee schedule. Therefore, the originally published fee schedule has been revised and republished. Please reference the tab called “Explanation for Revised Fee Sch” in the
above noted fee schedule for a detailed explanation of why the revised fee schedule was published.

This and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

33. 2013 InterQual® criteria implemented

Category: InterQual

Title: 2013 InterQual® criteria implemented

Start Date: May 30, 2013   End Date: July 1, 2013

Blue Cross Blue Shield of Michigan will implement InterQual acute care, rehabilitation, skilled nursing, long-term acute care and home health criteria July 1, 2013. This is one month earlier than BCBSM traditionally implements the criteria. BCBSM modifications to InterQual are now posted to web-DENIS.

InterQual criteria should be applied to all elective or emergency hospital admissions.

BCBSM will offer training sessions around the state. Look to the July Record for upcoming training dates.

The BCBSM modifications, or local rules, of the InterQual criteria are now on web-DENIS. To access them:

  o Log in to web-DENIS.
  o Click on BCBSM Provider Publications and Resources in the left column.
  o Click on Newsletters and Resources in the left column or at the top of the page.
  o Click on Clinical Criteria and Other Resources.
  o Scroll down to BCBSM modifications to InterQual criteria at the bottom of the page.
  o Click on 2013 BCBSM Modifications to InterQual® criteria.

34. BlueCard® medical records

Category: BlueCard Claims

Title: BlueCard® medical records

Start Date: May 30, 2013   End Date: June 13, 2013
Please remember these helpful tips when submitting medical records for BlueCard claims:

- If you receive a letter requesting medical records from the Blues, please return the records with the letter attached.
- If you receive a rejection on your claim requesting medical records, please go to web-DENIS and print the Medical Records Routing Form and attach it to the medical records with the SCCF serial number written on the form.

To access the form on web-DENIS:

- Click on BCBSM Provider Publications and Resources
- Click on Newsletters and Resources
- Click on Clinical Criteria and Resources
- Click on Medical Records Routing Form, located under the "Clinical criteria" section
- Please do not send in unsolicited medical records for rejected claims, such as emergency room reports sent with claims that were rejected as not being benefits. The medical records will not be sent to the home plan. Rejected claims need to be appealed through Provider Inquiry or your provider consultant.
- Do not send questions about record requests on the cover sheet. The claims automation process will forward records to the home plan. Questions sent on the cover sheet won’t get answered, and it delays the process.

35. Provider Self-Service unavailable this weekend

Category: Miscellaneous

Title: Provider Self-Service unavailable this weekend

Start Date: May 30, 2013    End Date: June 3, 2013

The Provider Self-Service application will not be available from Friday, May 31 at 5 p.m. through Monday, June 3 at 7a.m. We apologize for any inconvenience this may cause.

36. Blues’ Medicare Advantage offers Centers for Medicare & Medicaid Services fraud, waste and abuse training

Category: Medicare Advantage

Title: Blues’ Medicare Advantage offers Centers for Medicare & Medicaid Services fraud, waste and abuse training

Start Date: May 31, 2013    End Date: June 16, 2013
The Blues are committed to preventing, identifying and reducing Medicare fraud, waste and abuse. CMS requires the Blues to ensure that first tier, downstream and related entities such as providers and pharmacies complete fraud, waste and abuse training annually.

For your convenience, we’ve uploaded the most recent CMS Medicare fraud, waste and abuse training to our provider website, bcbsm.com/provider/ma. The training can be found on our Medicare Plus Blue PPOSM page under What’s New and on our BCN Advantage HMO-POS page landing page.

Please complete this training each year to be in compliance with CMS requirements. Afterward, you may sign and date the last slide of the presentation for your records as evidence that you completed the training.

The Blues encourage health care providers and pharmacists to report any suspected fraud, waste and abuse to our Corporate and Financial Investigations department, corporate compliance officer, Medicare compliance officer or through our anti-fraud hotline at 1-800-482-3787. The reports may be made anonymously.

Thank you for your commitment to providing quality health care and services.

37. Blue Cross Blue Shield of Michigan Medicare Advantage begins new inquiry process for human organ transplants

Category: Medicare Advantage

Title: Blue Cross Blue Shield of Michigan Medicare Advantage begins new inquiry process for human organ transplants

Start Date: May 31, 2013     End Date: June 30, 2013

Beginning June 1, 2013, please contact the Medicare Advantage Provider Inquiry department for any questions regarding human organ transplants for Medicare Plus Blue PPOSM and Medicare Plus Blue Group PPOSM members:

Phone number: 1-866-309-1719
Hours: 8:30 a.m. to 4:30 p.m., Monday through Friday

Prior authorization for human organ transplants isn’t required for covered transplant services, but hospitals must be a Medicare-approved human organ transplant facility to perform the procedure. BCBSM follows all Original Medicare guidelines for human organ transplants, and BCBSM won’t approve claims for organ transplants the facility isn’t authorized to perform.
Please watch for more information in the July edition of The Record. Thank you for understanding as we transition this process to better serve you and our members. If you have any questions, please contact your provider consultant.
July 2013

Contact Medicare Advantage Provider Inquiry regarding human organ transplant procedures

We’re providing you with a new contact for questions about Blue Cross Blue Shield of Michigan human organ transplant procedures covered by our Medicare Plus Blue PPOSM and Medicare Plus Blue Group PPOSM products.

Our Human Organ Transplant Program is no longer managing transplant benefits for our Medicare Advantage members. If you have questions about the benefit, you should now call the Blue Cross Medicare Advantage Provider Inquiry department at 1-866-309-1719. This transition occurred on June 1, 2013.

It’s also important to note:

- Each relevant transplant procedure must be performed in a Medicare-approved facility.
- Medicare Advantage members aren’t required to use Blue Distinction Centers® for Transplant. Also, that designation doesn’t guarantee Medicare approval.
- Preauthorization isn’t required for transplant procedures covered by Original Medicare or by optional, enhanced Medicare Plus Blue Group PPO benefits.
- For case management help, transplant facilities should refer Medicare Advantage members to the Blue Cross Case Management Program by calling 1-800-845-5982.

Helping members manage transplant procedures
The following information will help you talk with patients about Blue Cross human organ transplant procedures:

- Members with coverage questions about transplant procedures should call the Customer Service number on the back of their ID cards.
- Medicare Advantage groups have the option of purchasing enhanced organ transplant

coverage that involves diagnoses and procedures that may not be covered in Original Medicare. Medicare Advantage group members should refer to their *Evidence of Coverage* or contact Customer Service to find out if they have expanded coverage.

- Some Medicare Advantage group members have coverage for travel and lodging related to transplant services. Customer Service can also provide information about that benefit.
- A member’s cost-sharing amount is determined by the group. All services must be provided during the benefit period, except for anti-rejection drugs and other transplant-related prescription drugs. The benefit period begins five days before the transplant and ends one year after the transplant.

When directly related to a covered transplant, Medicare Advantage will pay for anti-rejection drugs and other transplant-related prescription drugs — during and after the benefit period. For noncovered transplants, the member’s prescription drug plan is responsible for anti-rejection drugs and other transplant-related prescription drugs.

If you would like more information about procedures included in the enhanced transplant benefit, visit BCBSM’s Newsletters & Resources Medicare Advantage Resources page.

Here’s how to find it:

1. Go to [bcbsm.com](http://bcbsm.com).
2. Click on LOGIN and select *Provider*.
3. Log in to *Provider Secured Services*.
4. Click on *web-DENIS*.
5. Click on *BCBSM Provider Publications and Resources*.
6. Click on *Newsletters & Resources*.
7. Click on *Medicare Advantage*.
8. Click on *Human organ transplants: Enhanced benefit transplant procedures*.

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July 2013

Health e-BlueSM offers new Diagnosis Evaluation tool

As announced in the May 2013 Record, a new Diagnosis Evaluation report is available on Health e-BlueSM. We urge primary care physicians to review this report for their Blues Medicare Advantage patients and take action to close any diagnosis gaps.

More information is available in the Resources section of Health e-Blue by clicking on 2013 Diagnosis Closure Incentive Program.

Frequently asked questions
A new Medicare Advantage Diagnosis Closure Incentive Program frequently asked questions document is available in the Resources section of Health e-Blue, as well as within web-DENIS. Here’s how to find the new FAQ in web-DENIS:

1. Click on BCBSM Provider Publications and Resources.
2. Click on Newsletters and Resources.
3. Click on Medicare Advantage Resources.
4. Look under What’s New.

If you have any questions about the new incentive program or the new Health e-Blue report, please contact your BCBSM provider consultant.

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Web-DENIS messages June 2013
1. BCBSM electronic provider manuals - May 2013 changes

Category: Online Manuals

Title: BCBSM electronic provider manuals - May 2013 changes

Start Date: May 31, 2013    End Date: June 14, 2013

• **Blue Preferred Plus** (5/21/2013)
  - “PPO program policies, responsibilities”— In the “Groups with BPP coverage” chart, updated the group numbers
  - “Contact information” — In the “Ford Motor Company“ chart, added “Quest Diagnostics” in the Laboratory row.

• **Claims** (5/1/2013)
  - “(Professional providers only) “Guidelines for completing paper claims” — In the “When to file claims” section, added a note to indicate that filing limits are being strictly enforced as of May 24, 2013.
  - "Completing the CMS-1500 claim (08/05 version)" — In the "Line-by-line instructions" section, added instructions for billing an NDC in field 24A - H (shaded).
  - “Special claim types” — In the "Master Medical claims" section, clarified differences between "pay subscriber" and "pay provider" claim filing limits.
  - (Facility providers only) “Filing limit” — Added a note to indicate that filing limits are being strictly enforced as of May 24, 2013.

• **Dialysis Services** (5/1/2013)
  - “Billing guidelines” — In the “All-inclusive payment” section, add the fact that “With the exception of revenue code 0880, all revenue codes must be billed with a condition code for outpatient dialysis.”

• **Home Infusion Therapy Services** (5/15/2013)
  - "Documentation requirements for clinical records" — Clarified the wording of the "Nursing orders" sub-bullet that explains what must be included in the CNM.
  - “Reimbursement” — Deleted the link to the now-outdated 4/1/07 Home Infusion Therapy Provider Participation Agreement, leaving only the link to the 5/1/13 agreement.

• **Hospital Services** (5/1/2013)
  - “Substance abuse – acute care” — In the “Conditions and limitations” subsection of the “Covered services” section, revised the diagnosis codes for acute detoxification.

• **Participation** (5/10/2013)
  - "Participation agreements" — Deleted the link to the now-outdated 4/1/07 Home Infusion Therapy Provider Participation Agreement, leaving only the link to the 5/1/13 agreement.

• **Pathology and Laboratory Services: Billing and Reimbursement** (5/1/2013)
  - "Chemistry (82000-84999)" — Added several rows to the chart.

• **Psychiatric Care Services** (5/10/2013)
  - "Billing guidelines" — Updated the "Autism disorders" billing chart.
  - “Radiology privileging” — Updated the “Oral surgeons (specialty code 97)” chart.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.*

2. **All Medicare Part B trading partners**

   **Category:** Delayed WPS claims

   **Title:** All Medicare Part B trading partners

   **Start Date:** June 3, 2013    **End Date:** June 17, 2013

   Due to a BCBSM systems issue, some Medicare Part B claims were delayed in their transmission to Wisconsin Physicians Service. Affected claims were received by BCBSM EDI on 5/31/13 between 10:30 a.m. and 2:00 p.m.

   The impacted claims will be processed today.

   We apologize for any inconvenience this may cause.

3. **All Medicare Part B trading partners**

   **Category:** Delayed WPS 277CA Reports

   **Title:** All Medicare Part B trading partners

   **Start Date:** June 3, 2013    **End Date:** June 17, 2013

   BCBSM has not yet received Wisconsin Physicians Service (WPS) 277CA reports for some Part B claims. The delayed reports would include claims submitted to BCBSM between 7:30 p.m. on 5/29/13 through 10:00 a.m. on 5/30/13. We are working with WPS to obtain the files and will distribute them upon receipt.

   We apologize for any inconvenience.

4. **Some members may need new prescriptions for diabetic supplies**

   **Category:** Diabetic Supplies Prescriptions
Some members may need new prescriptions for diabetic supplies

Start Date: June 3, 2013   End Date: June 17, 2013

BCBSM recently learned that Wright & Filippis® sold its diabetic supply business to US MED on May 17, 2013. US MED is a participating BCBSM provider, effective May 20, 2013. BCBSM members currently using Wright & Filippis for their diabetic supplies will be transitioned to US MED or will need to go to another participating provider.

In most cases, US MED will honor members’ current prescriptions, but some members may need to get a new prescription, such as when Medicare is their primary payer or if their current prescription is expiring. This change potentially impacts all BCBSM members with durable medical equipment coverage needing diabetic supplies, including the UAW Retiree Medical Benefits Trust, General Motors, Ford, Chrysler, State of Michigan and Michigan Public School Employees Retirement System accounts whose claims are processed by DMEnsion for their customer-specific networks (SUPPORT, HMENN, NNPN).

For more information, please contact Provider Inquiry or your BCBSM provider consultant.

5. All Medicare Advantage trading partners

Category: Duplicate 835 remittance files distributed in error

Title: All Medicare Advantage trading partners

Start Date: June 4, 2013   End Date: June 18, 2013

Please be advised that duplicate Medicare Advantage 835 remittance files were distributed in error on May 30, 2013. The files were duplicates of the 835s previously distributed 5/29/2013. Submitters can disregard the duplicate files.

We apologize for any inconvenience.

6. All Medicare Part A and Medicaid trading partners

Category: Duplicate 835 remittance files distributed in error

Title: All Medicare Part A and Medicaid trading partners

Start Date: June 5, 2013   End Date: June 19, 2013
Please be advised that some duplicate 835 remittance files were distributed in error on 5/31/13. The duplicate files include Medicare Part A check date 5/8/13 and professional and institutional Medicaid check date 5/9/13.

The files were duplicates of the 835s previously distributed on 5/9/13. Submitters can disregard the duplicate files.

We apologize for any inconvenience.

7. Important reminder: Follow your filing limits and submit claims on time

Category: Claims

Title: Important reminder: Follow your filing limits and submit claims on time

Start Date: June 5, 2013   End Date: June 19, 2013

We’ve reminded you over the last few months that starting May 24, 2013, filing limits will be strictly enforced.

If you submit a claim after your filing limits, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

For more details on this requirement and important guidelines that you need to follow, see the related article in the June 2013 Record.

8. Quantity limits on opioid and APAP combination products

Category: Prescription Drugs

Title: Quantity limits on opioid and APAP combination products

Start Date: June 7, 2013   End Date: June 21, 2013

On June 1, 2013, Blue Cross Blue Shield of Michigan and Blue Care Network began limiting the use of the drugs listed below and their generic equivalents to a total of four grams of acetaminophen for some commercial members (non-Medicare), based on their prescription drug benefits. The total grams of acetaminophen contained in all drugs filled will count toward the listed limit.

We are committed to working with you to provide high-quality drug therapy. If you have questions, please call the Pharmacy Services Clinical Help Desk at 1-800-437-3803.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Category</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anexsia®</td>
<td>Percocet®</td>
<td></td>
</tr>
<tr>
<td>Ceta-Plus®</td>
<td>Primlev®</td>
<td></td>
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<tr>
<td>Cocet®</td>
<td>Roxicet®</td>
<td></td>
</tr>
<tr>
<td>Co-Gesic®</td>
<td>Roxilox®</td>
<td></td>
</tr>
<tr>
<td>Endocet®</td>
<td>Stagesic®</td>
<td></td>
</tr>
<tr>
<td>Hydrocel®</td>
<td>T-Gesic®</td>
<td></td>
</tr>
<tr>
<td>Hydrogesic®</td>
<td>Tylenol w/Codeine®</td>
<td></td>
</tr>
<tr>
<td>Hy-Phen®</td>
<td>Tylox®</td>
<td></td>
</tr>
<tr>
<td>Lorcate Plus®</td>
<td>Vicodin®</td>
<td></td>
</tr>
<tr>
<td>Lortab®</td>
<td>Vopac®</td>
<td></td>
</tr>
<tr>
<td>Magnacet®</td>
<td>Xodol®</td>
<td></td>
</tr>
<tr>
<td>Maxidone®</td>
<td>Xolox®</td>
<td></td>
</tr>
<tr>
<td>Norco®</td>
<td>Zydone®</td>
<td></td>
</tr>
</tbody>
</table>

Opioid analgesic and acetaminophen combination products 4 gm. acetaminophen/day

9. Reminder to TTY users

Category: Miscellaneous
Title: Reminder to TTY users
Start Date: June 7, 2013  End Date: June 21, 2013

If you are a TTY user, you can reach any phone number included in Blues publications by first dialing 711.

10. Blue Cross Blue Shield of Michigan answers frequently asked Medicare Advantage physician attestation questions

Category: Medicare Advantage
Title: Blue Cross Blue Shield of Michigan answers frequently asked Medicare Advantage physician attestation questions
Start Date: June 7, 2013  End Date: June 21, 2013
Blue Cross Blue Shield of Michigan has posted a Medicare Advantage frequently asked questions document about provider attestation on its Newsletters & Resources MA Resources page. To access this FAQ:

- Go to bcbsm.com.
- Click on LOGIN and select Provider.
- Log in to Provider Secured Services.
- Click on web-DENIS.
- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters & Resources.
- Click on Medicare Advantage Resources.

Attestations are necessary when a medical record signature doesn’t meet the Centers for Medicare & Medicaid Services signature requirements.

We appreciate your help in ensuring our compliance with CMS.

If you have any questions, please contact marevenumgtops@bcbsm.com.

11. All Internet Claim Tool users

**Category:** Scheduled System Maintenance

**Title:** All Internet Claim Tool users

**Start Date:** June 7, 2013    **End Date:** June 17, 2013

BCBSM will be performing system maintenance on June 15, 2013, from 6:00 a.m. through 6:00 a.m. on June 16, 2013. You will be unable to access the system during this time period.

We apologize for any inconvenience this may cause.

12. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedules added to web-DENIS

**Start Date:** June 10, 2013    **End Date:** June 24, 2013
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning June 10, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - Injections
  - Independent Lab
  - DME
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

13. Explainer outage scheduled for Sunday morning

Category: Benefit Explainer

Title: Explainer outage scheduled for Sunday morning

Start Date: June 13, 2013    End Date: June 17, 2013

Benefit Explainer will be unavailable from 7 a.m. to noon, Sunday, June 16, for a software upgrade.

Thank you for your patience during this service improvement. Normal operations resume at noon on Sunday, June 16.


Category: Clinical practice guidelines

Title: Michigan Quality Improvement Consortium clinical practice guidelines

Start Date: June 13, 2013    End Date: June 28, 2013

The MQIC has released updated clinical practice guidelines and guideline update alerts on the following topics:

- Management of Diabetes Mellitus
Diagnosis and Management of Adults with Chronic Kidney
Adult Preventive Services (Ages 18-49)
Adult Preventive Services (Ages 50-65+)
In Office Use of Sedation
Management of Overweight and Obesity in the Adult
Routine Preventive Services for Infants and Children (Birth to 24 months)
Routine Preventive Services for Children and Adolescents (Ages 2-21)

Please visit mqic.org to access the guidelines.

15. MESSA members’ inpatient behavioral health services require preauthorization

Category: Benefits

Title: MESSA members’ inpatient behavioral health services require preauthorization

Start Date: June 14, 2013   End Date: July 31, 2013

Effective July 1, 2013, Magellan Behavioral of Michigan will perform inpatient behavioral health preauthorization for Michigan Education Special Services Association members. MESSA members can be identified by group numbers 71452-71455 on their ID cards. Please continue to call the phone number on the back of the members’ cards, 1-800-336-0022, for these requests.

16. MESSA members’ autism services require preauthorization

Category: Benefits

Title: MESSA members’ autism services require preauthorization

Start Date: June 14, 2013   End Date: July 31, 2013

Effective July 1, 2013, applied behavioral analysis services for autism provided to Michigan Education Special Services Association members requires preauthorization. Providers need to call Magellan Behavioral of Michigan at 1-800-762-2382. MESSA members can be identified by group numbers 71452-71455 on their ID cards.

17. Recovery underway for procedure code Q0091 when billed with G0101 claims

Category: Recoveries
Title: Recovery underway for procedure code Q0091 when billed with G0101 claims

Start Date: June 14, 2013    End Date: June 28, 2013

NASCO is conducting a recovery for all accounts, including the Federal Employee Program®, for Pap smear and clinical breast and pelvic exam claims for dates of service Sept. 21, 2012, through Feb. 10, 2013.

Claims reporting procedure code Q0091 were being denied when reported with procedure code G0101. Blue Cross Blue Shield of Michigan established a new benefit payment policy for claims billed with these two procedure codes to correct this problem.

This payment replaces the incorrect one we sent you. When you adjust patients’ accounts to reflect the correct payment the subscriber’s liability may change.

18. All BCBSM institutional trading partners

Category: New BCBSM EDI front-end edit

Title: All BCBSM institutional trading partners

Start Date: June 14, 2013    End Date: August 30, 2013

Effective August 19, 2013, BCBSM EDI will implement a new front-end edit for institutional claims reporting a Federal Employee Program contract number and an incorrect source of payment code.

The new edit A3 116 F909 CLAIM SUBMITTED TO INCORRECT PAYER will be returned on R277CAI reports. Edited claims will require correction and resubmission.

To avoid this edit, report a claim filing indicator of 'FI' in loop 2000B SBR09 when the member ID/contract number reported in loop 2010BANM109 is 'R' followed by eight digits.

Additional information is located in BCBSM's Institutional 837 Companion Guide available on www.bcbsm.com.

19. Additional fee schedules added to web-DENIS

Category: Fee Schedules

Title: Additional fee schedules added to web-DENIS
Start Date: June 17, 2013  End Date: July 31, 2013

BCBSM recently added these additional facility fee schedules to web-DENIS, for newly fee-based services, effective October 1, 2013:

- Outpatient Hospital
  - New HCPCS fees effective 10/01/13 (includes newly fee-based AOR, DMP, ERT, OBR, THE, THV & TXR category codes)
  - New Dialysis rates effective 10/01/13 (includes newly fee-based Revenue Code / Condition Code rates)
- Ambulatory Surgery Facility: EKG fees effective 10/1/13 (includes newly fee-based EKG category codes)

These and other fee schedules and fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

20. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: June 17, 2013  End Date: July 14, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning June 17, 2013.

- Facility
  - Outpatient Hospital
  - Freestanding Outpatient Physical Therapy Facility
  - Ambulatory Surgery Facility

The above noted fee change schedules are adding additional procedure codes to existing fee-based service categories, effective 10/1/13, as follows:

a) Ambulatory Surgical Facility: Laboratory, Radiology & Surgery
b) Freestanding Outpatient Physical Therapy Facility: PT, OT & SLP Evaluations & PT, OT & SLP Visits
c) Hospital Outpatient: Drug, Drug admin., Laboratory, Radiology & Surgery
These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

21. All BCN Professional and Institutional trading partners

*Category:* Duplicate Blue Care Network 835 remittance files distributed in error

*Title:* All BCN Professional and Institutional trading partners

*Start Date:* June 18, 2013   *End Date:* June 25, 2013

Due to a systems issue, BCN institutional and professional 835 remittance files dated 6/17/13 contain duplicate payment information. The claims were not processed twice. Submitters can disregard the duplicate information.

We apologize for any inconvenience this may cause.

22. Sign up now for important professional billing and coding classes

*Category:* Training

*Title:* Sign up now for important professional billing and coding classes

*Start Date:* June 18, 2013   *End Date:* July 2, 2013

Blue Cross Blue Shield of Michigan is offering important information to every professional service biller at no charge. The training material covers changes needed for BCBSM and the Centers for Medicare & Medicaid Services on coding and documentation, diagnostic evaluation incentive program and changes to web-DENIS that support these initiatives.

For your convenience, these classes are being offered around the state. Space is limited, so sign up now. Lunch will be served at all sites. Registration begins at 8:30 a.m. and classes begin at 9 a.m. To accommodate driving distances in the Upper Peninsula, registration in the U.P. only begins at 9:30 a.m. with classes beginning at 10 a.m.

<table>
<thead>
<tr>
<th>Class Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Joseph – Silver Beach Hotel, 100 Main St.</td>
<td>Tuesday, July 16, 2013</td>
</tr>
<tr>
<td>Kalamazoo – Radisson Kalamazoo, 100 West Michigan Ave.</td>
<td>Wednesday, July 17, 2013</td>
</tr>
<tr>
<td>Location</td>
<td>Venue Details</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>Crowne Plaza Grand Rapids, 5700 28th St. S.E.</td>
</tr>
<tr>
<td>Port Huron</td>
<td>McMorran Place, 701 McMorran Blvd.</td>
</tr>
<tr>
<td>Mt. Pleasant</td>
<td>Soaring Eagle Casino, 6800 Soaring Eagle Blvd.</td>
</tr>
<tr>
<td>Frankenmuth</td>
<td>Bavarian Inn Lodge, One Covered Bridge Lane</td>
</tr>
<tr>
<td>Sterling Heights</td>
<td>Best Western Sterling Inn, 34911 Van Dyke Ave.</td>
</tr>
<tr>
<td>Ann Arbor</td>
<td>Weber’s Inn, 3050 Jackson Road</td>
</tr>
<tr>
<td>Southgate</td>
<td>Holiday Inn Southgate – Banquet &amp; Conference Center, 17201 Northline Road</td>
</tr>
<tr>
<td>Houghton</td>
<td>Magnuson Hotel Franklin Square Inn, 820 Shelden Ave.</td>
</tr>
<tr>
<td>Marquette</td>
<td>Holiday Inn Marquette, 1951 U.S. 41 West</td>
</tr>
<tr>
<td>Escanaba</td>
<td>Quality Inn &amp; Suites, 2603 N. Lincoln Road</td>
</tr>
<tr>
<td>Alpena</td>
<td>Sanctuary Inn &amp; Conference Center (formerly the Alpena Holiday Inn), 1000 U.S. 23 North</td>
</tr>
<tr>
<td>Gaylord</td>
<td>Treetops Resort, 3962 Wilkinson Road</td>
</tr>
<tr>
<td>Traverse City</td>
<td>Holiday Inn West Bay, 615 East Front St.</td>
</tr>
</tbody>
</table>

To register, send an email to Jeff Holzhausen at jholzhausen@bcbsm.com. In the subject line, write “Professional” and the city where you wish to attend the class. Include the class date and the names and number of attendees expected from your facility. You will receive a confirmation within 72 hours of registering. Additional information is available in the June 2013 issue of The Record.

23. Reminder: Please request current health care ID cards  

Category: Medicare Advantage

Title: Reminder: Please request current health care ID cards
As commercial groups transition into a Medicare Advantage product for their Medicare-eligible members, you may find occasional situations when it appears the member may have both commercial and Medicare Advantage coverage.

In these cases, please make sure to ask the member for their current health care ID card and process claims according to the current card. Our members should be aware of this process, but we appreciate that you follow your normal practice of always asking for any health care coverage changes and requesting copies of any updated ID cards.

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

24. Medicare Eligibility

Category: System Outage Sunday June 23, 2013

Title: Medicare Eligibility

Start Date: June 19, 2013    End Date: June 24, 2013

There is scheduled maintenance on the Medicare Eligibility System. The maintenance window will begin at 12:00 AM (Midnight) ET on Sunday, June 23, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 2:00 PM ET on Sunday, June 23, 2013.

Please contact the Help Desk if you have questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315

25. Sequestration error occurred on Medicare Advantage facility claims

Category: Medicare Advantage

Title: Sequestration error occurred on Medicare Advantage facility claims

Start Date: June 20, 2013    End Date: July 8, 2013
Due to an error in our Medicare Advantage claims processing system, the 2 percent sequestration withholding reduction of health care provider payments wasn’t applied on some facility claims. This system error affects approximately 4,000 facility claims.

We’ve corrected the issue and will load the file before the next check run. All affected claims will reprocess to include the 2 percent sequestration reduction and adjusted to show the appropriate reimbursement. This will result in a payment recovery for claims with an overpayment greater than $10.

We apologize for the inconvenience and confusion this issue may have caused. If you have any questions, please contact your provider consultant.

26. Behavioral health codes processing update for pharmacologic management

Category: Professional and Facility OPC claims

Title: Behavioral health codes processing update for pharmacologic management

Start Date: June 20, 2013   End Date: TBD

BCBSM has created an interim solution for the claims processing issues associated with billing evaluation and management procedure codes with behavioral health diagnosis codes used to report pharmacologic management.

Effective June 19, 2013, procedure code M0064 should be reported to BCBSM in place of the 2012 procedure code *90862 for behavioral health diagnoses. Claims for pharmacologic services reported under M0064 will process with correct cost-sharing according to the member’s benefits.

This interim process will be effective until BCBSM’s claims systems are updated to process pharmacologic services under the appropriate E&M procedure code. Please do not bill an E&M and M0064 procedure code together.

An updated web-DENIS message will be posted when the interim process is no longer needed. If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant. Thank you for your continued patience as we work to correct these issues.

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27. Michigan Medical Billers Association ICD-10 classes

Category: Training
Title: Michigan Medical Billers Association ICD-10 classes

Start Date: June 21, 2013    End Date: July 8, 2013

The Michigan Medical Billers Association will host a two-day class focusing on the guidelines and documentation principles for ICD-10 in September 2013. This event will be held at two locations and is open to members and non-members.

Dates and locations:

Sept. 11-12, 2013
Soaring Eagle Casino
6800 Soaring Eagle Blvd.
Mt. Pleasant

Sept. 18-19, 2013
Ukrainian Cultural Center
26601 Ryan Road
Warren

For more details, please go to mmbaonline.org/the-guidelines-and-principles-of-icd-10-cm-for-coders/*. If you have any questions, call MMBA at 1-888-314-2025 or send an email to info@mmbaonline.org.

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

28. All Medicare trading partners

Category: New BCBSM front-end edits

Title: All Medicare trading partners

Start Date: June 24, 2013    End Date: October 1, 2013

The Blue Cross Blue Shield Association requires a 30 day wait period before Blues Plans can accept or process provider submitted Medicare supplemental claims. Medicare automatically crosses the secondary portion of claims over to BCBSM for processing. Therefore, BCBSM cannot accept provider submitted supplemental claims until 30 days after the Medicare adjudication date.
Effective Sept. 16, 2013, BCBSM will edit provider submitted supplemental claims received before this 30 day period has lapsed. Providers can identify Medicare crossover claims that have been sent to BCBSM by remark codes MA18 and N89 returned on the Medicare Remittance Advice and electronic remittance (835).

The new BCBSM edits will be returned on 277CAP transactions and R277CAH and R277CAI edit reports:

P951 A3 516 SUPPLEMENTAL CLM RECD WITHIN 30 DAYS OF MEDICARE PROC DATE

F716 A3 516 SUPPLEMENTAL CLM RECD WITHIN 30 DAYS OF MEDICARE PROC DATE

Edited claims cannot be resubmitted until the 30 days have lapsed.

If you have any questions regarding the new edits, please contact the EDI helpdesk 1-800-542-0945.

29. All Medicare Advantage trading partners

Category: Delayed 835 remittance files for check date June 26, 2013

Title: All Medicare Advantage trading partners

Start Date: June 27, 2013    End Date: July 11, 2013

Professional and institutional 835 remittance advice files for check date June 26, 2013 have been delayed. The files will be distributed as soon as they are received.

We apologize for any inconvenience.

30. Medical policy for serum biomarker Human epididymis protein 4

Category: Benefits

Title: Medical policy for serum biomarker Human epididymis protein 4

Start Date: June 27, 2013    End Date: August 1, 2013
Effective Oct. 1, 2013, Human epididymis protein 4 (HE4), procedure code *86305, is considered experimental and not payable. HE4 is a potential new biomarker that has been cleared by the U.S. Food and Drug Administration for monitoring patients with epithelial ovarian cancer. HE4 is proposed as a replacement for or a complement to CA-125 for monitoring disease progression and recurrence. HE4 has also been proposed as a test to screen for ovarian cancer in asymptomatic women.

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31. Reminder: New InterQual® criteria effective July 1

Category: Training

Title: Reminder: New InterQual® criteria effective July 1

Start Date: June 27, 2013    End Date: July 12, 2013

As we’ve reported, Blue Cross Blue Shield of Michigan will implement InterQual acute care, rehabilitation, skilled nursing, long-term acute care and home health criteria July 1, 2013. This is one month earlier than BCBSM traditionally implements the criteria. BCBSM modifications to InterQual are now posted to web-DENIS.

InterQual criteria should be applied to all elective or emergency hospital admissions.

BCBSM will offer training sessions around the state. Look to the July Record for upcoming training dates.

The BCBSM modifications, or local rules, of the InterQual criteria are now on web-DENIS. To access them:

- Log in to web-DENIS.
- Click on BCBSM Provider Publications and Resources in the left column.
- Click on Newsletters and Resources in the left column or at the top of the page.
- Click on Clinical Criteria and Other Resources.
- Scroll down to BCBSM modifications to InterQual criteria at the bottom of the page.
- Click on 2013 BCBSM Modifications to InterQual® criteria.

32. Additional specialty types to become eligible for fee uplifts

Category: Miscellaneous
As part of the continuing development of our Physician Group Incentive Program and Organized Systems of Care, 17 additional specialty types will be eligible for fee uplifts Feb. 1, 2014. This brings the number of eligible specialty types to 24.

Here’s a complete list of eligible specialty types:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Oncology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>Orthopedics</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>Critical care</td>
<td>Pain management</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Physical medicine</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>Psychology</td>
</tr>
<tr>
<td>Neonatal care</td>
<td>Pulmonology</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Neurology</td>
<td>Sports medicine</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>Urology</td>
</tr>
</tbody>
</table>

Only specialists in one of these categories who are members of PGIP are eligible. The specialist practice units must be nominated by their member physician organization and, in some cases, another PO.

Information on the amount of the fee uplifts and the associated procedure codes will be provided in the coming months.

PGIP members with questions about the fee uplifts should consult with their PO; non-PGIP members should talk to their provider consultant.
33. St. Joseph, Kalamazoo and Grand Rapids: Important professional classes in your area

**Category:** Training

**Title:** St. Joseph, Kalamazoo and Grand Rapids: Important professional classes in your area

**Start Date:** June 27, 2013    **End Date:** July 12, 2013

Blue Cross Blue Shield of Michigan is offering free important information to every professional service biller. The training material covers changes needed for BCBSM and the Centers for Medicare & Medicaid Services on coding and documentation, diagnostic evaluation incentive program and changes to web-DENIS that support these initiatives.

The training agenda includes national health care reform, coding and collaboration, a BCBSM informational session, coding specifics and Health e-BlueSM.

Complete details on classes in July and August are available in the June issue of *The Record*.

For your convenience, these classes are being offered around the state. **Space is limited, so sign up now.** Lunch will be served at all sites. Registration begins at 8:30 a.m. and classes begin at 9 a.m. To accommodate driving distances in the Upper Peninsula, **registration in the U.P. only begins at 9:30 a.m. with classes beginning at 10 a.m.**

To register, send an email to Jeff Holzhausen, JHolzhausen@bcbsm.com. In the subject line, write “Professional” and the city where you wish to attend the class. Include the class date and the names and number of attendees expected from your facility. You will receive a confirmation within 72 hours of registering.

34. Upper Peninsula hospitals: Important facility classes in your area

**Category:** Trainings

**Title:** Upper Peninsula hospitals: Important facility classes in your area

**Start Date:** June 27, 2013    **End Date:** July 12, 2013

Blue Cross Blue Shield of Michigan is offering free important information to every hospital biller. For your convenience, classes are being offered in Houghton, Marquette and Escanaba.
The classes will include BCBSM billing and policy changes in the morning and web-DENIS and Medicare Advantage information in the afternoon. To accommodate driving distances in the Upper Peninsula, registration begins at 9:30 a.m. with the classes beginning at 10 a.m.

<table>
<thead>
<tr>
<th>Class Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houghton – Magnuson Hotel</td>
<td>Tuesday, Aug. 6, 2013</td>
</tr>
<tr>
<td>Franklin Square Inn, 820 Shelden Ave.</td>
<td></td>
</tr>
<tr>
<td>Marquette – Holiday Inn</td>
<td>Wednesday, Aug. 7, 2013</td>
</tr>
<tr>
<td>Marquette, 1951 U.S. 41 West</td>
<td></td>
</tr>
<tr>
<td>Escanaba – Quality Inn &amp; Suites</td>
<td>Thursday, Aug. 8, 2013</td>
</tr>
<tr>
<td>Escanaba, 2603 N. Lincoln Road</td>
<td></td>
</tr>
</tbody>
</table>

To register, send an email to Jeff Holzhausen, JHolzhausen@bcbsm.com. In the subject line, write “Facility” and the city where you wish to attend the class. Include the class date and the names and number of attendees expected from your facility. You will receive a confirmation within 72 hours of registering. Additional information is available in the June issue of The Record.
August 2013

Blue Cross Blue Shield of Michigan issues Medicare Advantage claim overpayment reports

After reviewing its records, Blue Cross Blue Shield of Michigan determined that it overpaid some Medicare Advantage providers for services provided to BCBSM Medicare Advantage members. Providers who are affected will receive a letter with more details.

This overpayment occurred on our former claims processing system, PGBA, and will be transferred to our new claims processing system, ikaSystems. Affected providers will receive a PGBA claim overpayment information sheet that includes the recovery amount and the members who received services.

The ikaSystems remittance will deduct any claim overpayments, which may result in no payment or a reduced payment in the future. If any money is owed to you, it will be included in your notification or sent separately. We’ll also include a current remittance that details current claims payment information from ikaSystems.

We apologize for any inconvenience this may cause. If you have any questions, call our Medicare Advantage Provider Inquiry department at 1-866-309-1719 between 8 a.m. and 4:30 p.m., Monday through Friday.

To review our recovery and provider disputes process in more detail, visit the overpayment page on our provider website.

Following is a screen shot of the report and an overview of the information the report contains.
1. Tax ID: The Tax ID used to match the PGBA overpayment with the ikaSystems check
2. Provider name: The provider name associated with the overpayment
3. National provider identifier: The NPI associated with the overpayment
4. Claim number: PGBA claim number associated with the overpayment
5. Original amount owed: The original amount of the overpayment
6. Refund reason code: The reason for the overpayment
7. Subscriber name: Patient name related to the overpayment
8. Subscriber contract number: Patient contract number with BCBSM Medicare Advantage
9. Patient control number: Patient account number submitted by the provider
10. Begin date of service: Beginning date of service on the overpayment
11. End date of service: Ending date of service on the overpayment
12. Total charge: The total charged amount on the overpayment
13. Accounts receivable number: Unique number related to the overpayment
14. Date created: The date the overpayment was identified
15. Date received: The date the payment was offset or the check was received from the provider
16. Amount received: The amount applied to the overpayment
17. Check number: The check number of the offset amount or the check received from the provider
18. Check Source:
   a. Ika – New system offset
   b. PGBA – Old system offset
   c. Provider – Check received from the provider
19. Totals by tax ID:
   a. Total original amount owed – Total of all claims original amount overpaid
   b. Total amount received – Total of all amounts received as of the date of the statement
   c. Remaining balance owed – The balance of the overpayment the provider still owes
20. Total checks offset this statement:

http://www.bcbsm.com/newsletter/therecord/record_0813/Record_0813t.shtml

8/1/2013
a. Check number – Check number used for the overpayment
b. Check amount – Total check amount
c. Check date – The date of the check
d. Check source – The system the check was generated from
e. Amount offset for Accounts Receivable – Amount of check taken for overpayments
f. Remaining check balance – Any amount of the check due to the provider

21. Refund reason code description – Detailed description of the overpayment

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Reminder: Qualified Medicare beneficiaries can’t be balance-billed for Medicare services

Keep in mind that qualified Medicare beneficiaries do not pay coinsurance or copayments for Medicare-covered services received from Medicare or Medicaid participating providers.

The state Medicaid program may pay for all or part of these cost-sharing amounts. All Medicare or Medicaid payments are considered full payments to providers.

Qualified Medicare beneficiaries are entitled to Medicare Part A and eligible for Medicare Part B. They have incomes below 100 percent of the federal poverty level and must be deemed eligible by their state Medicaid agency.

According to the August 2012 issue of MLN Matters, all Medicare physicians and suppliers who offer services or supplies to qualified Medicare beneficiaries cannot balance-bill those beneficiaries. This is explained in Section 1902 (n)(3)(B) of the Social Security Act as modified by Section 4712 of the Balanced Budget Act of 1997. Providers or suppliers who bill beneficiaries for Medicare cost-sharing are subject to sanctions.

No portion of this publication may be copied without the express written permission of Blue Cross Blue Shield of Michigan, except that BCBSM participating health care providers may make copies for their personal use. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than BCBSM.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.
1. BCBSM electronic provider manuals — June 2013 changes

Category: Online Manuals

Title: BCBSM electronic provider manuals — June 2013 changes

Start Date: July 1, 2013   End Date: July 15, 2013

These are the chapters we revised in June 2013, along with the revision date and a brief statement of the main changes for each.*

• **Blue Pages Directory** (6/1/2013)
  - "Enrollment" — Updated some of the instructions.
  - “Provider Enrollment and Change Self-Service" — Added more information.

• **Claims** (6/3/2013)
  - "Claim eligibility requirements" — Added several exclusions with regard to payment of interest.

• **Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services** (6/1/2013)
  - “Billing guidelines" — Added a "Inhalation medications" section.

• **Hospice Services** (6/1/2013)
  - “Noncovered services" — Updated the first bullet item to read: Services provided to cure or diagnose a patient's terminal illness or to cure conditions related to the terminal diagnosis.

• **Medical-Surgical Services** (6/1/2013)
  - “Maternity care and delivery” — In the “Billing guidelines” section, added a subsection titled “Multiple births.”

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

2. Tower Automotive mental health claims recovery underway
Category: Recoveries

Title: Tower Automotive mental health claims recovery underway

Start Date: July 1, 2013    End Date: July 15, 2013

NASCO is conducting a recovery (overpayment) for Tower Automotive member claims for dates of service Jan. 1, 2012, through Feb. 14, 2013.

The group has requested a retroactive benefit change for all in- and out-of-network mental health and substance abuse services, effective Jan. 1, 2012. Applicable member cost-sharing will now be applied to these claims.

We’re taking back the excess amounts from our original payments. When you adjust these patients’ accounts, the subscribers’ balances may change.

3. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: July 1, 2013    End Date: July 15, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 01, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus℠
  - Independent Lab
  - Hearing
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

4. BCBSM issues Medicare Advantage claim overpayment reports

Category: Medicare Advantage

Title: BCBSM issues Medicare Advantage claim overpayment reports
Start Date: July 2, 2013    End Date: July 16, 2013

In reviewing our records, we discovered that we’ve overpaid some professional and facility health care providers for services provided to our Medicare Advantage members. We will send letters with more details to those providers who are affected.

This overpayment occurred on our former claims processing system (PGBA) and now will be transferred to our new claims processing system (ikaSystems). Affected providers will receive PGBA claim overpayment information sheets that include the recovery amounts and the members’ names.

Any claim overpayment will be deducted from the current ikaSystems remittance owed to the provider and may result in no payment or a reduced payment. If there is any money owed on the new claim, it will be included on the ikaSystems voucher or reimbursed to you separately.

We apologize for any inconvenience this may cause. If you have any questions, please call our Medicare Advantage Provider Inquiry department at 1-866-309-1719 between 8 a.m. and 4:30 p.m., Monday through Friday.

To review our recovery and provider disputes process in more detail, please visit the Overpayment page on our website.

5. BCBSM NASCO and BCBSM MOS 835 enhancements for COB claims

Category: All Trading Partners

Title: BCBSM NASCO and BCBSM MOS 835 enhancements for COB claims

Start Date: July 2, 2013    End Date: October 1, 2013

Beginning the week of Sept. 3, 2013, BCBSM NASCO and BCBSM MOS 835 remittance transactions will more accurately reflect the adjudication and reimbursement of professional and institutional coordination of benefits) (COB) claims.

The enhancements being implemented are:

1. The 835s will now correctly report balance dollars for Other Insurance Allowed amounts with OA23.
2. Changed PR23 to PR70 to reflect the Cost Outlier Adjustment for additional costs when reporting Sub-Liability along with other insurance dollars.

3. Enhanced claim balancing, when applicable, by utilizing CARC A7 to reflect the Presumptive Payment Adjustment.

4. Corrected reporting of BCBSM sanction amount when subscriber has waived Medicare B primary coverage.

If you have questions regarding this information, please call our helpdesk at 800-542-0945.

6. Training available for prenotification system’s new features

   Category: Hospital prenotification

   Title: Training available for prenotification system’s new features

   Start Date: July 3, 2013    End Date: August 30, 2013

   BCBSM will add new features to the hospital prenotification system the weekend of Aug. 9. Click here to view a training presentation about the new and existing features at your own pace.

   You may also follow the steps below to access the training presentation through the BCBSM Newsletters and Resources page on web-DENIS:

   - Log into web-DENIS.
   - Click on BCBSM Provider Publications and Resources in the left navigation bar.
   - Click on Newsletters and Resources.
   - In the What’s New section, click on Prenotification System Overview web presentation (audio capability required).

   BCBSM will host two webinars to answer questions you may have about the new prenotification system functions. We’ll announce the dates for the webinars in a web-DENIS message the week of July 8.

7. Hospital outpatient pricing questions answered

   Category: Hospital outpatient services
Title: Hospital outpatient pricing questions answered

Start Date: July 3, 2013   End Date: August 3, 2013

BCBSM plans to complete its conversion to fee-based pricing for hospital outpatient services effective Oct. 1, 2013. In addition to the pricing changes, there will be changes in billing requirements. Click here to see a list of answers to the most common billing questions BCBSM has received.

You may also follow the steps below to access the document through the BCBSM Newsletters and Resources page on web-DENIS:

1. Log into web-DENIS.
2. Click on BCBSM Provider Publications and Resources in the left navigation bar.
3. Click on Newsletters and Resources.
4. In the What’s New section, click on Hospital Outpatient Pricing Strategy (HOPS II) Frequently asked questions.

This document may also be found on the Provider Training page, along with other health care provider training resources.

8. Presentations from Michigan Hospital Network session in Southfield now available

Category: Forums

Title: Presentations from Michigan Hospital Network session in Southfield now available

Start Date: July 3, 2013   End Date: July 19, 2013

The presentations made at the Michigan Hospital Network session in Southfield on June 26 are now available on web-DENIS to all hospitals that weren’t able to make the event. To access the presentations given during the session, log in to web-DENIS:

- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- In the “What’s New” section, find Presentations from 06/26/2013 Michigan Hospital Networking session. Click on the presentation to open.

All the presentation from forums and provider fairs in the past year can also be found on the Provider Training page. Thank you to all who attended.

9. All facility trading partners

Category: FEP void (bill type ‘XX7’) and replacement (bill type ‘XX8’) processing delay
Title: All facility trading partners  

Start Date: July 3, 2013  End Date: July 17, 2013

BCBSM recently announced that Federal Employee Program void and replacement facility claims could be submitted electronically. Due to special handling procedures FEP is required to follow, the processing of type of bill XX7 and XX8 FEP claims has a thirty day backlog. Every effort is underway to resolve the backlog as quickly as possible.

We appreciate your patience and apologize for any inconvenience.

10. All Institutional BCBSM trading partners

Category: Delayed 835 remittance files for check date July 9, 2013

Title: All Institutional BCBSM trading partners

Start Date: July 8, 2013  End Date: July 15, 2013

BCBSM LOCAL institutional 835 remittance advice files for check date July 9, 2013 have been delayed. The files will be distributed this evening.

We apologize for any inconvenience.

11. Explainer outage starting Saturday afternoon

Category: Benefit Explainer

Title: Explainer outage starting Saturday afternoon

Start Date: July 9, 2013  End Date: July 16, 2013

Benefit Explainer will be unavailable from 5 p.m. Saturday, Jul 13 to 7 a.m. Monday, July 15, for a system upgrade.

Thank you for your patience during this service improvement. Normal operations resume at 7 a.m. on Monday, July 15.

12. Behavioral health claims for OPC providers are processing incorrectly

Category: Professional and Facility OPC claims
Behavioral health claims for OPC providers are processing incorrectly

Start Date: July 10, 2013  End Date: July 31, 2013

We have identified an issue with behavioral health claims processing incorrectly when billed with procedure code M0064. These OPC claims are paying an incorrect provider fee or rejecting in error with reason code B357, “Your health care coverage doesn’t pay for this service when performed in the reported location. The subscriber is liable for your charge.”

We are aware of the problem and are working diligently to correct the situation.

We apologize for the inconvenience and will update you as soon as we have resolved this issue. If you have any questions, please contact Provider Inquiry.

Medicare Eligibility

Category: System Outage for Saturday July 13

Title: Medicare Eligibility

Start Date: July 10, 2013  End Date: July 15, 2013

There is scheduled maintenance on the Medicare Eligibility application. The maintenance window will begin at 8:30 AM ET on Saturday, July 13, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 11:30 AM ET on Saturday, July 13, 2013.

Please contact the Help Desk if you have any questions or comments.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk

1-866-324-7315

FEP – System downtime for July 13

Category: System downtime notification
Title: FEP – System downtime for July 13

Start Date: July 10, 2013    End Date: July 16, 2013

The Federal Employee Program application will be unavailable Saturday, July 13, 2013, until approximately 5 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through web-DENIS during that period.

15. BCBSM Medicare Advantage has updated electronic data interchange codes

Category: Medicare Advantage

Title: BCBSM Medicare Advantage has updated electronic data interchange codes

Start Date: July 11, 2013    End Date: July 25, 2013

When BCBSM Medicare Advantage claims are finalized, an EDI message is assigned to each line on the claim explaining how the line of service was paid or why it was rejected. Once this process is complete, an 835 (Electronic Remittance Advice) is generated and transmitted to our providers.

We’ve updated the EDI codes to be more aligned with Medicare’s guidelines and to better explain how codes are processed. These updates include:

- Minimizing the use of code CO:45 (charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement), which caused provider files to write off charges in error.
- Using code CO:96 (non-covered charge) on the 835 record when necessary (see below). This code requires at least one accompanying remark code.

Providers should receive the updated denial messages beginning with remits dated June 28, 2013, and after.

If you receive code CO:96 with a remark N386 on your 835 record, please be sure to check your paper remit for a detailed description of why the service was denied. The paper remit will fully describe the denial message.

Thank you for your continued cooperation. If you have any questions, please contact your provider consultant.

16. All Internet Claim Tool users

Category: Scheduled System Maintenance –July 13 and 14, 2013
Title: All Internet Claim Tool users

Start Date: July 11, 2013   End Date: July 15, 2013

BCBSM will be performing system maintenance from 6:00 a.m. EST on Saturday, July 13th through 6:00 a.m. EST on Sunday, July 14th, 2013. You will be unable to access the internet claim tool system during this time period.

We apologize for any inconvenience this may cause.

17. ICD-10 webinar, July 15, from 1 to 2 p.m. EST

Category: ICD-10

Title: ICD-10 webinar, July 15, from 1 to 2 p.m. EST

Start Date: July 12, 2013   End Date: July 16, 2013

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 webinars for our health care providers.

The next webinar is scheduled for Monday, July 15, 2013, from 1 to 2 p.m., Eastern time. The topic is ICD-10 and barriers to readiness.

This will be a web presentation. To join us, click here to register:

You will receive login and dial in information once you register through the link above. Send an email to icd10providerreadiness@bcbsm.com if:

- You want a copy of the presentation associated with the conference call (available on July 15, 2013)
- You would like us to cover a specific topic on a future call or have questions related to ICD-10.
- You are having issues with the link above or logging into the call

18. EDI sequestration message code will update on July 22, 2013

Category: Medicare Advantage
Title: EDI sequestration message code will update on July 22, 2013

Start Date: July 12, 2013   End Date: July 29, 2013

We’ve fixed our Medicare Advantage claims processing system to correctly process electronic claims in accordance with sequestration guidelines from the Centers for Medicare & Medicaid Services.

As identified in a previous web-DENIS message, Blue Cross Blue Shield of Michigan has reduced payments to providers by two percent as required by the Centers for Medicare & Medicaid Services. In updating our system to adjust for sequestration, the system had triggered an incorrect claim adjustment reason code for claims submitted electronically.

Providers should reference the current message of Claim Adjustment Reason Code 104 (withhold is due to Medicare Sequestration) for the period of April 1, 2013, through July 21, 2013.

Effective July 22, 2013, we will change to the new CARC code PI 223 (reduction is due to Medicare Sequestration).

In the interim, please continue to refer to the paper remittance that accompanies your check. The paper remittance will display the appropriate message codes.

Thank you for your patience as we worked to resolve this issue. If you have any questions, please contact your provider consultant.

19. NaviNet registration for Blue Cross Complete delayed

Category: Blue Cross Complete (Medicaid)

Title: NaviNet registration for Blue Cross Complete delayed

Start Date: July 12, 2013   End Date: July 26, 2013

We told you in our special edition Blue Cross Complete Provider News that NaviNet would be available for early registration beginning July 15, 2013. Early registration is now delayed until further notice so we can ensure that providers have a positive experience with the transition to NaviNet. We will announce a new date soon.

We apologize for this inconvenience and appreciate your patience.

20. PCMH fee uplifts error identified and corrected

Category: Professional claims
Title: PCMH fee uplifts error identified and corrected

Start Date: July 12, 2013   End Date: July 31, 2013

Due to a claims system error, we incorrectly applied the PCMH fee uplift percentages for some evaluation and management services processed from June 14, 2013, through July 11, 2013.

Many PCMH-practitioners received a lesser percentage than they were due, while others received no fee uplift at all. Claims will begin processing correctly on July 12, 2013. Claims which processed incorrectly for the June and July dates will be held for reprocessing at a later date.

We apologize for any inconvenience this may have caused. If you have any questions, please contact your provider consultant.

21. Prenotification system enhancements: Frequently asked questions

Category: Hospital prenotification

Title: Prenotification system enhancements: Frequently asked questions

Start Date: July 12, 2013   End Date: August 30, 2013

BCBSM will add new features to the hospital prenotification system the weekend of Aug. 9. Click here to view a training presentation about the new and existing features at your own pace.

Click here to view FAQs about the new features.

You may also follow the steps below to access FAQs through the BCBSM Newsletters and Resources page on web-DENIS:

- Log into web-DENIS.

- Click on **BCBSM Provider Publications and Resources** in the left navigation bar.

- Click on **BCBSM Provider Publications and Resources** in the left navigation bar.

  In the What’s New section, click on **Hospital Prenotification system enhancements: Frequently asked questions**.

In addition BCBSM will host two webinars to answer questions you may have about the new functionality in the prenotification system:
7. July 30, 2013, from 2 to 3 p.m.
8. August 1, 2013, from 9 to 10 a.m.

Stay tuned for the sign up information.

22. Laboratory fee increases for select physician office lab tests

**Category:** Medicare Advantage, BCBSM PPO and Traditional coverage

**Title:** Laboratory fee increases for select physician office lab tests

**Start Date:** July 15, 2013    **End Date:** August 1, 2013

Effective July 15, 2013, BCBSM will pay providers an additional $5 per billing for LDL-C and HbA1c screening lab services performed in a physician office setting for members with Medicare Advantage PPO, BCBSM PPO and Traditional plans when billed with the correct CPT® Category II codes.

This increase impacts LDL-C screening procedure codes *83721 and *80061 (PPO and Traditional only) and HbA1c screening procedure code *83036. Please see the table below for the associated CPT Category II codes. CPT Category II codes must be reported on the same claim as the service to receive the additional reimbursement.

CPT Category II codes describe components usually included in evaluation and management of clinical services, such as test results. When used, these codes may decrease the number of charts requested for review for Healthcare Effectiveness Data and Information Set** purposes.

The following table lists the select lab tests with physician office-billable CPT Category I codes and the associated CPT Category II codes.

---

Select lab services with BCBSM-required use of CPT Category II codes:
<table>
<thead>
<tr>
<th>Laboratory test</th>
<th>CPT code*</th>
<th>CPT II code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C screening</td>
<td>83721 80061 (PPO and Traditional only)</td>
<td>3048F 3049F 3050F</td>
</tr>
<tr>
<td>HbA1c screening</td>
<td>83036</td>
<td>3044F 3045F 3046F</td>
</tr>
</tbody>
</table>

**Please note:** On or after Oct. 15, 2013, BCBSM will no longer reimburse the selected laboratory services (*83721, *80061 and *83036) from physician offices without submission of the associated CPT Category II code. Please look for future BCBSM communications regarding this date.

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

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23. InterQual® classes scheduled for Grand Rapids, Novi, Traverse City and Marquette

**Category:** Training

**Title:** InterQual® classes scheduled for Grand Rapids, Novi, Traverse City and Marquette

**Start Date:** July 15, 2013  **End Date:** July 31, 2013

Please join us for a free, in-person training session regarding the use of the new InterQual criteria, which were effective July 1, 2013, for Blue Cross Blue Shield of Michigan. We will provide training and answer questions for all five InterQual criteria sets – acute care, rehabilitation, skilled nursing, long-term acute care and home health.

BCBSM-specific modifications to the criteria are now posted to web-DENIS.

Complete details on classes in July and August are available in the July issue of The Record.

Please be sure to sign-up in advance for these classes.
24. Houghton, Marquette and Escanaba: Important professional and facility classes in your area

Category: Training

Title: Houghton, Marquette and Escanaba: Important professional and facility classes in your area

Start Date: July 15, 2013    End Date: July 31, 2013

Blue Cross Blue Shield of Michigan is offering free important information to every professional and hospital biller.

The professional material covers changes needed for BCBSM and CMS on coding and documentation, diagnostic evaluation incentive program, and changes to web-DENIS that supports these initiatives. The facility classes will include BCBSM billing and policy changes in the morning and web-DENIS and Medicare Advantage information in the afternoon.

To accommodate driving distances in the Upper Peninsula, registration begins at 9:30 a.m., with the classes beginning at 10 a.m.

<table>
<thead>
<tr>
<th>Class Location</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Houghton</strong> – Magnuson Hotel Franklin Square Inn, 820 Shelden Ave.</td>
<td>Tuesday, Aug. 6, 2013</td>
</tr>
<tr>
<td><strong>Marquette</strong> – Marquette – Holiday Inn Marquette 1951 U.S. 41 West</td>
<td>Wednesday, Aug. 7, 2013</td>
</tr>
<tr>
<td><strong>Escanaba</strong> – Quality Inn &amp; Suites 2603 N. Lincoln Road</td>
<td>Thursday, Aug. 8, 2013</td>
</tr>
</tbody>
</table>

To register, send an email to Jeff Holzhausen, click here. In the subject line, write “Professional” or “Facility” and the city where you wish to attend the class. Include the class date and the names and number of attendees expected from your facility. You will receive a confirmation within 72 hours of registering.

Additional information is available in the June 2013 Record articles, *Summer training opportunities scheduled across the state* and *Upper Peninsula facility training scheduled for August*. 
25. Member Care Alert buttons on web-DENIS eligibility screen

**Category:** Web-DENIS update

**Title:** Member Care Alert buttons on web-DENIS eligibility screen

**Start Date:** July 15, 2013    **End Date:** July 29, 2013

BCN Commercial, BCN Medicare and Blue Cross Blue Shield of Michigan Medicare Advantage web-DENIS users will notice new Member Care Alert buttons on the web-DENIS eligibility screens this month. The new alert buttons will be color-coded to help providers identify patient needs quickly.

The new Member Care Alert buttons will appear on the initial web-DENIS contract eligibility screen in a new column to the right and on the individual member’s eligibility screen.

There are three color-coded alerts providers may see:

<table>
<thead>
<tr>
<th>Red member care alert</th>
<th>This member has an open diagnosis gap or treatment opportunity that requires action.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green member care alert</td>
<td>This member has a pending or closed diagnosis gap or treatment opportunity. No action is required.</td>
</tr>
<tr>
<td>Grey member care alert</td>
<td>This member doesn’t have a diagnosis gap or treatment opportunity at this time. No action is required.</td>
</tr>
</tbody>
</table>

For more details, see the related article in the July Record and July-August *BCN Provider News*.

26. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedules added to web-DENIS

**Start Date:** July 15, 2013    **End Date:** July 29, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 15, 2013:
o Professional
  ▪ Traditional, TRUST & Blue Preferred Plus SM
  ▪ Injections
o Facility
  ▪ Outpatient Hospital

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

27. Medicare 2 percent sequestration reduction

Category: Medicare Advantage

Title: Medicare 2 percent sequestration reduction

Start Date: July 16, 2013   End Date: July 31, 2013

The Centers for Medicare & Medicaid Services is reducing payments by 2 percent for certain services as a result of the Budget Control Act of 2011, which requires mandatory across-the-board reductions in federal spending, also known as sequestration. The American Taxpayer Relief Act of 2012 postponed sequestration for two months.

Please be aware that BCBSM will not make up the difference by paying providers the 2 percent that CMS is cutting.

The following will incur a 2 percent reduction in Medicare payments:

  o Medicare fee-for-service program (i.e., Part A and Part B)
  o Medicare fee-for-service claims with dates of service or dates of discharge on or after April 1, 2013

The following will be reduced by 2 percent based on whether the date of service or the start date for rental equipment or multi-day supplies is on or after April 1, 2013:

  o Durable medical equipment
  o Prosthetics
  o Orthotics
  o Supplies
  o Claims under the DME Competitive Bidding Program
28. Recovery underway for Iron Workers claims

Category: Recoveries

Title: Recovery underway for Iron Workers claims

Start Date: July 16, 2013   End Date: July 31, 2013


We incorrectly applied cost-sharing for some professional preventive services now covered at 100 percent under health care reform.

When you adjust patients’ accounts to reflect the correct payments, the subscribers’ liability may change.

29. Chrysler’s Autism and Autism Spectrum Disorder Pilot Program

Category: Benefits

Title: Chrysler’s Autism and Autism Spectrum Disorder Pilot Program

Start Date: July 17, 2013   End Date: August 2, 2013

Effective July 1, 2013, Chrysler Group LLC established an Autism and Autism Spectrum Disorder Pilot Program for salaried employees and their eligible dependents. The program applies to workers who are Michigan residents enrolled in Chrysler’s Blue Cross Blue Shield of Michigan Healthy Blue ChoicesSM.

Applied behavior analysis treatment and other services for autistic patients now qualify for benefit coverage, if they are administered by a Michigan-based provider. Please note that the Chrysler employees will still be responsible for copayments, as well as deductibles and coinsurance.

The program will also cover physical, occupational and speech therapies used to treat ASD and congenital and severe developmental disorders. But there are a few provisions:

- Eligible dependents can only receive speech therapy services until the end of the month in which they turn 7.
- A maximum of 100 speech therapy visits will be covered for ASD and congenital and severe developmental disorders.
- There is no limit on physical and occupational therapy sessions.
- Claims for physical, speech and occupational therapies that date back to Jan. 1, 2013, will be reprocessed.
ValueOptions is coordinating Chrysler’s benefits. ABA providers who currently have Chrysler clients should call 1-800-346-7651 to set up a discussion with ValueOptions’ Provider Relations department.

30. Medicare Eligibility

**Category:** System Unavailable on Sunday July 21, 2013

**Title:** Medicare Eligibility

**Start Date:** July 17, 2013  **End Date:** July 22, 2013

There is a scheduled maintenance for Medicare Eligibility. The maintenance will begin at 2:00 AM ET on Sunday, July 21, 2013. The system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 4:00 AM ET on Sunday, July 21, 2013.

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

31. Continue to use current CMS-1500 claim form

**Category:** Claims

**Title:** Continue to use current CMS-1500 claim form

**Start Date:** July 18, 2013  **End Date:** August 1, 2013

On July 2, 2013, the National Uniform Claim Committee approved a revised version of the CMS-1500 Health Insurance Claim Form (version 02/12). Blue Cross Blue Shield of Michigan will continue to accept only the current version of the CMS-1500 (version 08/05) claim form until the final transition timeline is announced by the NUCC.

The committee has not yet finalized the transition timeline.

32. Hospital Prenotification system enhancements: Sign up for a Q &A webinar

**Category:** Hospital Prenote

**Title:** Hospital Prenotification system enhancements: Sign up for a Q &A webinar

**Start Date:** July 18, 2013  **End Date:** August 2, 2013

BCBSM will host two webinars to answer your questions regarding the new features to the hospital prenotification system rolling out the weekend of Aug. 9.
The dates for the two webinars are:

- Prenote Q & A Webinar #1 – July 30, 2013 from 2:00 p.m. to 3:00 p.m.
  RSVP for Webinar #1 and submit your additional questions Click Here
- Prenote Q & A Webinar #2 – August 1, 2013 from 9:00 a.m. to 10:00 a.m.
  RSVP for Webinar #2 and submit your additional questions Click Here

Please send your RSVP and any additional questions for these webinars by July 25, 2013.

In addition, Click here to view the Prenotification training presentation previously posted on web-DENIS for the new and existing features prior to these Q & A webinars.

Click here to view frequently asked questions about the new features.

33. All Internet Claim Tool Users

  Category: ICT system slowness
  
  Title: All Internet Claim Tool Users
  
  Start Date: July 19, 2013    End Date: August 2, 2013

  BCBSM is aware that the Internet Claim Tool is experiencing slower than normal response times. We are working with our technical team to address the issue.

  We appreciate your patience as we work to correct the problem.

34. All institutional Internet Claim Tool Users

  Category: Secondary Billing for Facilities
  
  Title: All institutional Internet Claim Tool Users
  
  Start Date: July 19, 2013    End Date: August 8, 2013

  Due to a system issue, institutional claims are currently encountering an issue with the Source of Payment Payer A field when reporting secondary payer information. We are working to resolve the issue as quickly and possible. We will provide an update when the system has been corrected.

  We apologize for any inconvenience.
35. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedules added to web-DENIS

**Start Date:** July 22, 2013    **End Date:** August 5, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 22, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - Injection
- Facility
  - Outpatient Hospital

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

36. BCBSM issues Medicare Advantage claim overpayment reports

**Category:** Medicare Advantage

**Title:** BCBSM issues Medicare Advantage claim overpayment reports

**Start Date:** July 22, 2013    **End Date:** August 16, 2013

In reviewing our records, we discovered that we’ve overpaid some professional and facility health care providers for services provided to our Medicare Advantage members. We will send letters with more details to those providers who are affected.

This overpayment occurred on our former claims processing system (PGBA) and now will be transferred to our new claims processing system (ikaSystems). Affected providers will receive PGBA claim overpayment information sheets that include the recovery amounts and the members’ names.

Any claim overpayment will be deducted from the current ikaSystems remittance owed to the provider and may result in no payment or a reduced payment. If there is any money owed on the new claim, it will be included on the ikaSystems voucher or reimbursed to you separately.
We apologize for any inconvenience this may cause. If you have any questions, please call our Medicare Advantage Provider Inquiry department at 1-866-309-1719 between 8 a.m. and 4:30 p.m., Monday through Friday. To review our recovery and provider disputes process in more detail, please visit the Overpayment page on our website.

37. Request for a Medicare statement

Category: Facility claims

Title: Request for a Medicare statement

Start Date: July 22, 2013   End Date: September 1, 2013

Effective immediately, if you receive a request from BCBSM for an Explanation of Medicare Benefits statement, please disregard the letter and follow the steps below. BCBSM is in the process of removing these letters from our automated letter generation system.

We do not require the EOMB to process a supplemental claim. These letter requests are generated when the Medicare crossover claim or the BCBSM supplemental claims billed to BCBSM are not coded correctly.

Steps to follow

1. If the claim does not have the appropriate CAS code or value code reported, please correct the claim and resubmit the claim.
2. If the claim is coded correctly, contact Provider Inquiry to have the claim adjusted.

If you require further assistance, please contact your provider consultant. We appreciate your continued patience as we work to improve this process.

38. Recovery underway for Faurecia USA Holdings member claims

Category: Recoveries

Title: Recovery underway for Faurecia USA Holdings member claims

Start Date: July 23, 2013   End Date: August 6, 2013

NASCO is conducting a recovery of claims for Faurecia USA Holdings FIS/FAE Sterling Heights Union members for dates of service April 1, 2013, through June 13, 2013.

The group requested a retroactive change to copayments for in- and out-of-network claims, effective April 1, 2013.
We’re taking back the excess amount from our original payment. When you adjust patient accounts, the subscribers’ balances may change.

39. We’re re-credentialing DME network providers

Category: Durable medical equipment

Title: We’re re-credentialing DME network providers

Start Date: July 23, 2013    End Date: August 6, 2013

We want to let our durable medical equipment providers know that Blue Cross Blue Shield of Michigan is currently in the process of re-credentialing all providers currently in our DME network. As part of this effort, we’re asking DME providers to submit the certification letter they received from the Centers for Medicare & Medicaid Services, as well as a current copy of their site accreditation. Be sure to include your BCBSM PIN and NPI number on all correspondence.

For providers with multiple sites, please note that documentation should be submitted for all of the separately billed locations. Documents should be faxed to 1-866-587-6920 no later than Sept. 30, 2013. If you have supplied this information to your BCBSM provider consultant on or after July 1, 2013, you do not have to submit a second copy.

If you are unable to locate your CMS letter, a copy can be requested from the National Supplier Clearinghouse website at www.palmettogba.com/nsc. It generally takes seven to 10 business days to receive it by mail. As explained in your contract with BCBSM, failure to submit these documents could result in termination of your BCBSM contract, audit and/or recoveries.

40. All Medicare Part B trading partners

Category: Delayed WPS 277CA Reports

Title: All Medicare Part B trading partners

Start Date: July 23, 2013    End Date: August 6, 2013

All delayed Wisconsin Physicians Service 277CA reports for Part B claims submitted to BCBSM between 10AM and 2PM on 7/19/13 have been received and distributed.

We apologize for any inconvenience this delay may have caused.
41. Facility Claims Tracking Revenue Tab enhancement

**Category:** Web-DENIS

**Title:** Facility Claims Tracking Revenue Tab enhancement

**Start Date:** July 24, 2013  **End Date:** August 23, 2013

BCBSM web-DENIS users can find new modifier fields on the web-DENIS Facility Claims Tracking Revenue Tab.

The new modifier fields display the first three modifiers billed on a revenue line of a facility claim. The information was added to web-DENIS July 12.

42. All BCBSM electronic trading partners

**Category:** New BCBSM informational 277CA edits reports for NPI/submitter ID

**Title:** All BCBSM electronic trading partners

**Start Date:** July 25, 2013  **End Date:** September 25, 2013

The July 2013 edition of *The Record* announced new informational front-end edits for professional and institutional claims. As a reminder to electronic submitters, effective August 19, 2013, BCBSM will begin issuing the new edits and distributing new informational 277CA reports.

The new reports (277CAX - Professional and 277CAZ – Institutional) will return informational edits for claims submitted to BCBSM with a NPI/submitter ID combination that does not match our EDI enrollment files. **Note:** The informational edits will only be returned on 277CAX and 277CAZ reports, not in 277CAP transactions.

The informational edits will not cause a claims’ rejection, but they do require submitters to take action:

**Professional – Returned on a 277CAX informational report**

- A2 24 85 P001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR BCBSM/BCN
- A2 24 85 P002i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR MEDB/MED ADV
- A2 24 85 P003i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR COMMERCIAL

**Institutional – Returned on a 277CAZ informational report**

- A2 24 85 F001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED
It’s critical that trading partners correct these inconsistencies by the end of 2013. In early 2014, the informational edits will convert to the following “hard edits,” and claims will be rejected:

**Professional – Returned on a 277CAH report**

- A3 24 85 P001 BCBSM OR BCN BILLING PROV UNAUTHORIZED FOR ELEC BILLING
- A3 24 85 P002 MED B/MEDADV BILLING PROV CODE UNAUTHORIZED
- A3 24 85 P003 COMMERCIAL BILLING PROV CODE UNAUTHORIZED

**Institutional – Returned on a 277CAI report**

- A3 24 85 F001 NPI UNAUTHORIZED FOR ELECTRONIC BILLING

Questions about the informational edits or hard edits can be directed to the EDI Helpdesk at 1-800-542-0945.

43. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedules added to web-DENIS

**Start Date:** July 29, 2013    **End Date:** August 12, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 29, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus℠
  - Injections
  - Durable Medical Equipment
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

44. Behavioral health codes processing update for pharmacologic management

**Category:** Professional and Facility OPC claims
Behavioral health codes processing update for pharmacologic management

Start Date: July 31, 2013   End Date: TBD

BCBSM has created an interim solution for the claims processing issues associated with billing evaluation and management procedure codes with behavioral health diagnosis codes used to report pharmacologic management.

Effective June 19, 2013, procedure code M0064 should be reported to BCBSM in place of the 2012 procedure code *90862 for behavioral health diagnoses. Claims for pharmacologic services reported under M0064 will process with correct cost-sharing according to the member’s benefits.

- Please do not bill an E&M procedure code and M0064 procedure code together.
- Please do not bill psychiatric add-on procedure codes *90833, *90836 or *90838 with M0064.
- If the psychiatric add-on procedure codes are billed, they should be billed with the appropriate E&M procedure code.

An updated web-DENIS message will be posted when the interim process is no longer needed. If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant. Thank you for your continued patience as we work to correct these issues.

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45. ICD-10 webinar, Aug. 5, from 1 to 2 p.m. EST

Category: ICD-10

Start Date: July 31, 2013   End Date: August 6, 2013

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 webinars for our health care providers.

The next webinar is scheduled for Monday, Aug. 5, from 1 to 2 p.m., Eastern time. The topic is ICD-10 testing.

This will be a web presentation. To join us, click here to register.
You will receive login and dial in information once you register through the link above. Send an email to ICD-10ProviderReadiness@BCSBM.com if:

- You want a copy of the presentation (available on Aug. 5, 2013) associated with the conference call.
- You would like us to cover a specific topic on a future call or have questions related to ICD-10.
- You are having issues with the link above or logging into the call.

46. Additional fee schedules added to web-DENIS

**Category:** Claims

**Title:** Additional fee schedules added to web-DENIS

**Start Date:** July 31, 2013    **End Date:** August 7, 2013

BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective August 1, 2013:

**Professional: Injection Fee Schedule**

- Injections fee schedule 08/01/13

**Facility: Hospital Outpatient**

- Drug fees effective 08/01/13

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will been removed.

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.
September 2013

BCBSM adds 2 codes to Medicare Advantage PPO Physician Office Laboratory List

On Aug. 5, 2013, Blue Cross Blue Shield of Michigan Medicare Advantage added two new codes to its MA Physician Office Laboratory List: codes *83037 and *80061.

The addition of these two codes allows our providers to bill and be reimbursed for providing these two services in an office setting and lab environment.

The procedures listed on the Medicare Advantage PPO Physician Office Lab List are services that are appropriate in an office setting. If lab services are provided and are not on this list, then they’re not considered payable, and members can’t be balance-billed for those services.

Remember to also use the appropriate CPT II code on the claims to communicate the results of these screening tests. See article titled “Laboratory fee increases for select physician office lab tests” also in this issue of The Record.

For more details, see the Aug. 5, 2013, web-DENIS message on the MA PPO Physician Office Laboratory List. If you have any questions, contact your provider consultant.

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September 2013

Diagnosis Closure Incentive Program

**Deadline approaches for closing diagnosis gaps**

In order to earn an incentive as part of the Diagnosis Closure Incentive Program, physicians must close all the diagnosis gaps that exist for a patient through a face-to-face visit before the end of this calendar year or notify the Blues that the patient does not have the suspected diagnosis.

Through the program, Blue Cross Blue Shield of Michigan and Blue Care Network provide an incentive to primary care physicians who close diagnosis gaps for their Blues Medicare Advantage members. The diagnosis gaps are listed on Health e-Blue℠ under Panel – Diagnosis Evaluation.

All of the diagnosis gaps included in the 2013 incentive will be identified on Health e-Blue by the end of September.

Diagnosis gap closures must be submitted to the Blues by the following dates:

<table>
<thead>
<tr>
<th>Method</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim submission</td>
<td>Received by Jan. 31, 2014</td>
</tr>
<tr>
<td>Health e-Blue</td>
<td>Input by Jan. 24, 2014</td>
</tr>
<tr>
<td>Electronic medical record</td>
<td>Received by Feb. 28, 2014</td>
</tr>
<tr>
<td>Paper Member Diagnosis Evaluation and Treatment Opportunities report submission (for BCBSM out-of-state providers and in-state BCBSM providers without access to Health e-Blue)</td>
<td>Faxed or postmarked by Jan. 31, 2014</td>
</tr>
<tr>
<td>Paper medical record submission</td>
<td>Faxed or postmarked by Jan. 31, 2014</td>
</tr>
</tbody>
</table>
More information about the incentive program is available in the Resources section of Health e-Blue by clicking on 2013 Diagnosis Closure Incentive Program and 2013 Diagnosis Closure Program FAQ. Also, a fact sheet can be found on web-DENIS within BCBSM Provider Publications and Resources. Click on Newsletters & Resources, then click on Medicare Advantage Resources.

If you do not have access to Health e-Blue, sign up today.

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

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September 2013

**Medicare Advantage enhanced benefit fee schedule to be updated in October**

The Blue Cross Blue Shield of Michigan Medicare Advantage enhanced benefit fee schedule will be updated in October to show BCBSM allowed amounts for both facility and non-facility locations.

These changes will affect health care providers’ payments for enhanced benefit services related to physician services performed in a facility location. The fee schedule will not include incentive amounts.

Physician payments for MA enhanced benefits will be reduced, starting Oct. 6, 2013. The enhanced benefit fee schedule on our provider website, [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma), will be updated on this date.

For more information, see the Aug. 6, 2013, web-DENIS message.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Medicare Advantage HCC model is changing

Upcoming revisions to the Medicare Advantage Hierarchical Condition Categories model will impact members’ risk scores.

The HCCs are being modified to reflect changes in ICD-9-CM codes that have occurred since the late 1990s, when the current HCCs were created. ICD-9-CM codes are the national standard coding language used to translate a patient’s clinical condition into three- to five-digit codes.

The Centers for Medicare & Medicaid Services announced the revisions on April 1, 2013, and changes will affect the 2014 payment year.

Features of the new model include:

- Major changes in several areas, including chronic kidney disease, diabetes, polyneuropathy, morbid obesity and neurological and metabolic disorders
- Diseases previously included in an HCC with other related conditions will have their own HCCs. These conditions include quadriplegia, cerebral palsy, amyotrophic lateral sclerosis and other motor neuron diseases, as well as atherosclerosis of the extremities with ulceration or gangrene.
- Seventy-nine HCCs — compared with 70 in the previous model
- It removes 129 ICD-9-CM codes that were in the previous model. These codes mapped to condition categories such as kidney disease, major complications of medical care, neurological diseases and cardio-respiratory failure and shock.

CMS is also introducing 224 new ICD-9-CM codes related to condition categories such as morbid obesity, lung disorders, hematological disorders and spinal cord disorders and injuries.

For more information about changes to the Medicare Advantage HCC model, visit hccublog.scanhealthplan.com/2013/04/risk-adjustment-changes-for-2014.html** or contact your Blue Cross Blue Shield of Michigan provider consultant or Blue Care Network provider representative.
September 2013

Medicare Advantage Risk Adjustment Model adding HCC for morbid obesity

Morbid obesity has been assigned its own Hierarchical Condition Categories code as part of the changes to the Medicare Advantage Risk Adjustment Model. These changes will take effect with 2013 dates of service and the 2014 payment year.

“Morbid obesity has become such a prevalent problem in our country that the Centers for Medicare & Medicaid Services has this year elevated morbid obesity to be its own HCC in the Medicare Advantage Risk Adjustment Model,” said Thomas Ruane, M.D., medical director, Federal Business Division, Blue Cross Blue Shield of Michigan.

Proper coding and documentation for morbid obesity will ensure an accurate member risk score and appropriate reimbursement. It will also help guarantee that patients receive the best and most affordable care possible.

Dr. Ruane pointed out that simply documenting the patient’s weight isn’t enough information for complete specificity.

When documenting morbid obesity in a patient’s medical records, it’s important to note his or her body mass index and weight. If a physician documents a patient’s BMI but doesn’t state that the obesity is severe or morbid, then the condition can’t be reported to the Centers for Medicare & Medicaid Services.

Adult BMI is a Healthcare Effectiveness Data and Information Set measure, making it an

---

Documenting BMI

The degree of obesity and the BMI should be documented to indicate morbid obesity for adults 20 and older. The BMI categories, with their ICD-9-CM codes in parentheses, are:

- Normal BMI, 19 to 24
- Overweight (278.02), BMI 25 to 29.9 (V85.21 to V85.25)
- Obese (278.00), BMI 30 to 39.9 (V85.30 to V85.39)
- Morbid obesity (278.01), BMI 40 to 49.9 (V85.41 to V85.42)
- Super morbidly obese (278.01), BMI 50-plus (V85.43 to V85.45)
An important indicator in effectively treating patients for obesity.

Once a patient has been diagnosed as morbidly obese, a complete treatment plan should be recommended. The plan may include the following:

- Dietary consult
- Describing how the condition impacts the patient’s health
- Recommendation of exercise
- Weight loss medication
- Physician and patient discussions about concerns
- Monitoring patients’ weight gain or loss
- Bariatric consultation
- A diet consisting of 1,800 calories per day

For more information on the morbidly obese HCC, visit [hccublog.scanhealthplan.com/2013/04/risk-adjustment-changes-for-2014.html](http://hccublog.scanhealthplan.com/2013/04/risk-adjustment-changes-for-2014.html).

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1. BCBSM electronic provider manuals — July 2013 changes

Category: Online manuals

Title: BCBSM electronic provider manuals — July 2013 changes

Start Date: August 1, 2013   End Date: August 15, 2013

These are the chapters we revised in July 2013, along with the revision date and a brief statement of the main changes for each.*

• Appeals (7/10/2013)
  - Throughout the chapter — Replaced all occurrences of "Office of Financial and Insurance Regulation" with "Department of Insurance and Financial Services."

• Blue Preferred Plus (7/18/2013)
  “Overview” — In the “Networks” section, added PAs to the list of providers who are included in the BPP network, and added AICs and HIT providers to the list of providers not included in the BPP network
  “Affiliation” — Replaced this section with a link to the “Affiliation” chapter of the BCN provider manual.

• Claims (7/1/2013)
  For hospice providers only:
  “UB-04 claim examples" — Added "Fifth Level of Care" wording to name of the two claim-example links having to do with Nursing Home Care with Hospice Support.
  "Coordination of benefits secondary and tertiary balance claims" — Deleted the claim examples because they do not pertain to hospice providers.

• Documentation Guidelines for Physicians and Other Professional Providers (7/24/2013)
“Medical record documentation – general guidelines” — In the “Completeness” section, (1) updated the "Medical record entry" and "Medical record page" topics, and (2) added a topic called “Electronic medical record data submission.”

"Physical therapy, occupational therapy, and speech and language pathology services" — Updated the entire "Speech and language pathology services" section, which includes a change to the required frequency related to periodic re-evaluation.

• Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services (7/22/2013)

  “Medical supplies” — In the “Billing guidelines” section, clarified exceptions to medical supplies that are billed monthly.

• Home Health Care Services (7/17/2013)

  “Definitions” — “Skilled nursing care” paragraph — Deleted information referring to unskilled services

• Home Infusion Therapy Services (7/18/2013)

  “Billing guidelines” — In the “Electronic billing” section, changed the filing limit for clean claims from 15 months to 180 days per the 5/1/13 Home Infusion Therapy Facility Participation Agreement.

• Medical-Surgical Services (7/11/2013)

  “Allergy testing and allergen immunotherapy” — Updated the “Covered services,” the “Noncovered services” and the “Billing guidelines sections per new benefit policy.

  “Maternity and delivery” — In the “Billing guidelines” section, added a subsection called “High-risk and non-obstetric conditions.”

• Participation (7/30/2013)

  "Participation agreements" — Added a link to the future Participating Hospital Agreement (effective 9/1/13).

• Physical Therapy, Occupational Therapy, and Speech Therapy Services (7/1/2013)

  "Physical therapy services" — In the "Conditions and limitations" section’s "Incident to therapy services" subsection, added a bullet about who does the billing when a physical therapist who is an IPT works in an OPT facility.
Physician Assistant Services (7/1/2013)

- "Definitions" — In the "Physician assistants" definition, updated the types of services PAs can prescribe.

PPO Policies (7/18/2013)

- “Overview” — Added PAs to the list of providers who are included in the PPO network, and AICs to the list of providers not included in the PPO network.
- “Affiliation” — Replaced this section with a link to the “Affiliation” chapter of the BCN provider manual.
- “Utilization management” — In the “Therapy services management” section, added a section titled “Reconsideration of category assignment.”

Preapproval of Services (7/1/2013)

- "InterQual criteria" — In the "General information" section, updated the example of an InterQual question.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

Home Infusion Therapy Services manual (7/9/2013)

- Deleted the PPO chapter because HIT providers are not part of the PPO network.

2. Blues begin contracting with ambulatory infusion centers

Category: Facility providers

Title: Blues begin contracting with ambulatory infusion centers

Start Date: August 5, 2013  End Date: August 19, 2013

Physicians now have another option to consider when deciding where to refer patients for infusion therapy: ambulatory infusion centers. Blue Cross Blue Shield of Michigan began formally contracting with AICs on Aug. 1, 2013. AICs provide our members with additional safe, convenient, cost-effective locations to receive infusion therapy.

Ambulatory infusion centers will be included in the BCBSM provider search tool as part of the next provider search tool upgrade later this summer. Currently, we’re providing a
list of participating AICs on the Find a Doctor or Hospital homepage. To find it, simply scroll down to the “Additional Directories” section of the page.

Note: Ford Motor Company and the UAW Retiree Medical Benefits Trust members currently do not include coverage for services provided by AICs. These members can continue to receive infusion therapy through participating home infusion therapy providers, hospitals or physician office infusion therapy.

If you have any questions, contact your provider consultant.

3. Please reregister for the ICD-10 webinar today, Aug. 5, from 1 to 2 p.m. EST

Title: Please reregister for the ICD-10 webinar today, Aug. 5, from 1 to 2 p.m. EST

Start Date: August 5, 2013    End Date: August 6, 2013

Due to a technical issue with our webinar provider, you must register again for the ICD-10 webinar today. This web presentation is on ICD-10 testing. To join us, click here to register. Be sure to click on the More Info link for the meeting number, password and teleconference information.

Meeting information
Topic: ICD-10 Provider Testing
Date: Monday, Aug. 5, 2013
Time: 1 p.m., Eastern Daylight Time
Meeting Number: 735 789 743
Meeting Password: 12345

Teleconference information
1. Please call one of the following numbers:
   Toll-Free Number: 1-800-462-5837
   Local Number: 313-225-4000
2. Follow the instructions that you hear on the phone.
Meeting ID: 859332

Send an email to ICD-10ProviderReadiness@BCSBM.com if:

- You want a copy of the presentation (available on Aug. 5, 2013) associated with the conference call.
- You would like us to cover a specific topic on a future call, or you have questions related to ICD-10.
- You are having issues with the link above or logging into the call.
4. Training available for prenotification system’s new features

Category: Hospital prenotification

Title: Training available for prenotification system’s new features

Start Date: July 3, 2013    End Date: August 30, 2013

BCBSM will add new features to the hospital prenotification system the weekend of Aug. 9. [Click here](#) to view a training presentation about the new and existing features at your own pace.

You may also follow the steps below to access the training presentation through the BCBSM Newsletters and Resources page on web-DENIS:

- Log into web-DENIS.
- Click on [BCBSM Provider Publications and Resources](#) in the left navigation bar.
- Click on [Newsletters and Resources](#).
  - In the What’s New section, click on [Prenotification System Overview web presentation](#) (audio capability required).

BCBSM will host two webinars to answer questions you may have about the new prenotification system functions. We’ll announce the dates for the webinars in a web-DENIS message the week of July 8.

5. All Medicaid trading partners

Category: Duplicate 835 remittance files distributed in error

Title: All Medicaid trading partners

Start Date: August 5, 2013    End Date: August 19, 2013

Please be advised that some duplicate 835 remittance files were distributed in error on 8/1/13. The duplicate files include Medicaid check date 7/18/13. The files were duplicates of the 835s previously distributed on 7/17/13. Submitters can disregard the duplicate files.

We apologize for any inconvenience.

6. BCBSM changes way it provides DME services to our auto customers
Blue Cross Blue Shield of Michigan is changing the way it provides DME services to our auto customers, beginning Jan. 1, 2014. Instead of using one of our current DME vendors, BCBSM will be handling claims processing and customer service for these customers.

This will give auto members in Michigan and other states (and Michigan auto members when they travel to other states) access to an expanded DME network made up of providers who participate with Blue plans across the country. This change also aligns our DME servicing with the way we deliver physician and hospital services.

As noted in an article in *Crain's Detroit Business* Aug. 4, 2013, Blue Cross will not renew a contract for the durable medical equipment claims processing service for autoworkers conducted by Binson’s Home Health Care Centers and Wright & Filippis. However, both companies will continue to be participating providers with BCBSM.

We’ll be sharing more details about this change through *The Record* as the implementation date draws nearer. If you have any questions, please contact your provider consultant.

### 7. Additional groups added to specialty drug prior authorization program

Additional groups now participate in the prior authorization program for specialty drugs administered by health care professionals and covered under members’ medical benefits.

Some General Motors Company members were covered by the program requirements starting April 1, 2013, and others will be included starting Sept. 1, 2013. Denso members were included starting Aug. 1, 2013.

We told you in January, in *The Record* and on web-DENIS, that this program was nationwide and that it did not apply to members of certain groups. Here are some of the group exceptions: Medicare, Federal Employee Program®, State of Michigan, MPSERS, Chrysler, Ford, UAW Retiree Medical Benefits Trust, Michigan Conference of Teamsters Welfare Fund and United Food and Commercial Workers members. These groups are not subject to this prior authorization program.
Prior authorization is also not required for coordination of benefit claims when Medicare is the primary payer or when BCBSM is not the primary payer.

We’ll continue to update you as new drugs and groups are added to the prior authorization requirement. You can find a complete list of these 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).

For more information about specific groups or benefits, please contact Provider Inquiry.

8. All Blue Cross Complete trading partners

Category: Blue Cross Complete EDI processing

Title: All Blue Cross Complete trading partners

Start Date: August 6, 2013    End Date: November 1, 2013

Beginning Sept. 1, 2013, Blue Cross Complete (BCC) professional and institutional claims processing will no longer be adjudicated by Blue Care Network (BCN). This change will not affect submission of electronic claims to BCBSM EDI. BCC claims will still require: i) a Source of Payment ‘HM’ in Loop 2000B SBR09 and, ii) the Member contract number with alpha-prefix ‘XYU’ in the Subscriber Loop 2010BA NM109.

Submitters will see minor changes in the acknowledgements they receive. In addition to the standard EDI front- end edit reports and/or transaction, additional edits for BCC claims will be returned in one of following ways:

- U277F BCN report (professional and institutional): BCN will still verify member eligibility. Therefore, this report will return a BCN edit:
  - A3 26 QC B26QC MEMBER NOT FOUND. This edit indicates that the claim was submitted without an alpha prefix, or the member name, date of birth or other identifiers do not match BCN’s records.
- R277CAA (professional) or R277CAB (institutional) report: These reports return edits of:
  - A3 21 MISSING OR INVALID INFORMATION and A3 33 MEMBER NOT FOUND. These paired edits indicate that the Subscriber Name or contract number was not found, or was invalid for the dates of service reported.
  - A3 24 BCBSM OR BCN BILLING NPI UNAUTHORIZED FOR ELEC BILLING. This edit indicates that the Billing Provider NPI reported in
Loop 2010AA NM109 is not on file with BCBSM EDI for electronic claims submission.

- 277CAP transaction. The transaction will return edits of:
  - STC*A3:21*20130000*U*53******A3:33**MEMBER NOT FOUND~
  - STC*A3:24:PR*20130000*U*000~ (Provider not authorized for electronic billing)

Blue Cross Complete 277CAP transactions will be distributed as they are received from the new processing system and are identified by the Payer Name displayed in Loop 2100A NM103:

- NM1*PR*2*BLUE CROSS COMPLETE*****PI*00210~ (institutional)
- NM1*PR*2*BLUE CROSS COMPLETE*****PI*00710~ (professional)

The BCC 835 changes include:

- The Payer Name returned in Loop 1000A N102 of the new 835s will be ‘Blue Cross Complete of Michigan’. 835s for claims processed prior to Sept. 1, 2013 will report the current Payer Name of ‘BLUECAID’.
- Electronic submitters can expect to receive a weekly 835 remittance advice file

Electronic submitters experiencing issues with posting or processing of 835 files should contact the EDI Helpdesk at 1-800-542-0945. Providers that want to receive EFT (Electronic Funds Transfer) for Blue Cross Complete claims must enroll with Emdeon by using their website: www.emdeon.com/epayment/

9. Reminder: Sequestration fee reductions for Medicare Advantage providers

**Category:** Medicare Advantage

**Title:** Reminder: Sequestration fee reductions for Medicare Advantage providers

**Start Date:** August 6, 2013   **End Date:** September 1, 2013

Per The Centers for Medicare & Medicaid Services requirements, Blue Cross Blue Shield of Michigan and Blue Care Network of Michigan have implemented the 2-percent sequestration reduction effective for Original Medicare claims with dates of service April 1, 2013, and after.

This 2-percent sequestration reduction applies to the paid amount for both network and non-network providers. As detailed in the applicable provider network agreements, timelines for the effective date of the reimbursement reduction included:

- BCBSM Medicare Plus Blue PPO and Medicare Plus Blue Group Facility and Ancillary Providers – April 1, 2013
The Blues will continue to apply the claims payment adjustment consistent with CMS requirements. The adjustment will be applied to claims after determining any applicable member deductible, copayment or other member liability.

Questions about this reimbursement reduction can be directed to your BCBSM provider consultant or BCN provider representative.

10. Our Medicare Advantage enhanced benefit fee schedule will be updated Nov. 6, 2013

Category: Medicare Advantage enhanced benefit fee schedule

Title: Our Medicare Advantage enhanced benefit fee schedule will be updated Nov. 6, 2013

Start Date: August 6, 2013    End Date: August 31, 2013

Blue Cross Blue Shield of Michigan’s Medicare Advantage enhanced benefit fee schedule will be updated in November 2013. It will indicate BCBSM allowed amounts for both facility and non-facility locations and will not include incentive amounts. These changes will affect the providers’ payments for enhanced benefit services related to physician services performed in a facility location.

In the past, because of system limitations, BCBSM only used the non-facility allowed amounts when processing claims for physician services provided in a facility.

The new claims processing system can now accommodate multiple allowed amounts. It will identify enhanced benefit physician services performed in both facility and non-facility locations. As a result, the allowed amounts will now be different for services performed in a facility location when billed on the professional CMS-1500 claim form.

Our research showed that the Medicare Advantage enhanced benefit fee schedule amounts for physician services previously included payments that didn’t apply to Medicare Advantage.

Because this error is now fixed, providers will see a reduction in their physician services’ payments for Medicare Advantage enhanced benefits, effective Nov. 6, 2013. The enhanced benefit fee schedule on bcbsm.com/provider/ma, will be updated on this date.
Following are the procedure codes affected by these changes:

<table>
<thead>
<tr>
<th>BCBSM Medicare Advantage Enhanced Benefit Fee Schedule</th>
<th>Physician Service Procedure Codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>43842</td>
<td>99394</td>
</tr>
<tr>
<td>58300</td>
<td>99395</td>
</tr>
<tr>
<td>80050</td>
<td>99396</td>
</tr>
<tr>
<td>92015</td>
<td>99397</td>
</tr>
<tr>
<td>99381</td>
<td>99601</td>
</tr>
<tr>
<td>99382</td>
<td>99602</td>
</tr>
<tr>
<td>99383</td>
<td>A4261</td>
</tr>
<tr>
<td>99384</td>
<td>S0800</td>
</tr>
<tr>
<td>99385</td>
<td>S2083</td>
</tr>
<tr>
<td>99386</td>
<td>S4981</td>
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<tr>
<td>99387</td>
<td>S4989</td>
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<tr>
<td>99391</td>
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<tr>
<td>99392</td>
<td></td>
</tr>
<tr>
<td>99393</td>
<td></td>
</tr>
</tbody>
</table>

Please note: Medicare Advantage providers **will not** be asked to refund overpayments made in error.

Thank you for your understanding and we apologize for any inconvenience this may have caused. If you have any questions, please contact your provider consultant.

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11. All Medicare trading partners

   **Category:** New BCBSM front-end edits
On June 24, 2013 we communicated information about implementation of new front end edits for provider submitted supplemental claims. Based on feedback from our submitters, we would like to provide additional clarification.

In certain situations, claims may not crossover from Medicare and the corresponding 835 or voucher would not report MA18 or N89. The MA18 or N89 identifies that the claims were crossed over by Medicare.

Provider submitted secondary claims for this type of instance are not subject to the edits. They can be submitted as a supplemental claim to BCBSM at the time you receive the finalized claim from Medicare. You do not have to wait the 30 days.

The new BCBSM edits will be returned on 277CAP transactions and R277CAH and R277CAI edit reports:

P951 A3 516 SUPPLEMENTAL CLM RECD WITHIN 30 DAYS OF MEDICARE PROC DATE
F716 A3 516 SUPPLEMENTAL CLM RECD WITHIN 30 DAYS OF MEDICARE PROC DATE
In addition the implementation date for these new edits has changed from Sept. 16, 2013, to Oct 13, 2013. If you have questions about this please contact our EDI helpdesk at 1-800-542-0945.

12. Training available for prenotification system’s new features

Category: Hospital prenotification

Title: Training available for prenotification system’s new features

Start Date: July 3, 2013  End Date: August 30, 2013

BCBSM will add new features to the hospital prenotification system the weekend of Aug. 9. Click here to view a training presentation about the new and existing features at your own pace.

You may also follow the steps below to access the training presentation through the BCBSM Newsletters and Resources page on web-DENIS:

- Log into web-DENIS.
- Click on BCBSM Provider Publications and Resources in the left navigation bar.
- Click on Newsletters and Resources.
- In the What’s New section, click on Prenotification System Overview web
presentation (audio capability required).

BCBSM will host two webinars to answer questions you may have about the new prenotification system functions. We’ll announce the dates for the webinars in a web-DENIS message the week of July 8.

13. Laboratory fee increase now includes procedure code *80061 for Medicare Advantage PPO and changes submission requirements

Category: Medicare Advantage, BCBSM PPO and Traditional coverage

Title: Laboratory fee increase now includes procedure code *80061 for Medicare Advantage PPO and changes submission requirements

Start Date: August 7, 2013    End Date: November 30, 2013

On July 15, 2013, a web-DENIS message informed providers of reimbursement increases for select lab services.

Because procedure code *80061 has now been added to the Medicare Advantage PPO Physician Office Laboratory List, the lab reimbursement increase now applies to this service for Medicare Advantage PPO members.

Effective Aug. 7, 2013, Blue Cross Blue Shield of Michigan will pay providers an additional $5 per billing for LDL-C screening lab services performed in a physician office setting for members with Medicare Advantage PPO when billed with the correct CPT® Category II codes. The reimbursement applies to procedure code *80061.

The increase, effective on July 15, impacted procedure codes *83721, *80061 and *83036 for BCBSM PPO and Traditional plans. The increase for procedure codes *83721 and *83036 also became effective on July 15 for Medicare Advantage PPO. Please see the table below for the associated CPT Category II codes. CPT Category II codes must be reported on the same claim as the service to receive the additional reimbursement.

Please note:
On or after Nov. 7, 2013, BCBSM will no longer reimburse physician offices for laboratory service *80061 for Medicare Advantage PPO members without submission of the associated CPT Category II codes.

On or after Oct. 15, 2013, BCBSM will no longer reimburse physician offices for laboratory services *83721 and *83036 for Medicare Advantage PPO members without submission of the associated CPT Category II codes. This effective date also applies to
BCBSM PPO and Traditional plans for procedure codes *83721, *80061 and *83036. These details can be found in a July 15, 2013, web-DENIS message.

**Please look for future BCBSM communications regarding this subject.**

CPT Category II codes describe components usually included in evaluation and management of clinical services, such as test results. When used, these codes may decrease the number of charts requested for review for Healthcare Effectiveness Data and Information Set** purposes.

The following table lists the select lab tests with physician office-billable CPT Category I codes and the associated CPT Category II codes.

**Select lab services with BCBSM-required use of CPT Category II codes:**

<table>
<thead>
<tr>
<th>Laboratory test</th>
<th>CPT code*</th>
<th>CPT II code*</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C screening</td>
<td>83721&lt;br&gt;80061 <em>(Now includes Medicare Advantage PPO BCBSM PPO and Traditional)</em></td>
<td>3048F&lt;br&gt;3049F&lt;br&gt;3050F</td>
</tr>
<tr>
<td>HbA1c screening</td>
<td>83036</td>
<td>3044F&lt;br&gt;3045F&lt;br&gt;3046F</td>
</tr>
</tbody>
</table>

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

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14. All BCBSM electronic trading partners

**Category:** Reminder: New BCBSM informational 277CA edits effective Aug. 19, 2013

**Title:** All BCBSM electronic trading partners

**Start Date:** August 12, 2013 **End Date:** September 30, 2013

As a final reminder to all electronic submitters, BCBSM will begin issuing new edits on new informational 277CA reports effective **August 19, 2013.** An announcement of the new edits and reports was published in the July edition of **The Record.**

The new reports (277CAX - Professional and 277CAZ - Institutional) will return informational edits for claims submitted to BCBSM with a NPI/submitter ID combination.
that does not match our EDI enrollment files. **Note:** The informational edits will only be returned on 277CAX and 277CAZ reports, not in 277CAP transactions.

The informational edits will not cause a claims' rejection, but they do require submitters to take action:

**Professional - Returned on a 277CAX informational report**
- A2 24 85 P001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR BCBSM/BCN
- A2 24 85 P002i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR MEDB/MED ADV
- A2 24 85 P003i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR COMMERCIAL

**Institutional - Returned on a 277CAZ informational report**
- A2 24 85 F001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED

It's critical that trading partners correct these inconsistencies by the end of 2013. In early 2014, the informational edits will convert to the following "hard edits," and claims will be rejected:

**Professional - Returned on a 277CAH report**
- A3 24 85 P001 BCBSM OR BCN BILLING PROV UNAUTHORIZED FOR ELEC BILLING
- A3 24 85 P002 MED B/MEDADV BILLING PROV CODE UNAUTHORIZED
- A3 24 85 P003 COMMERCIAL BILLING PROV CODE UNAUTHORIZED

**Institutional - Returned on a 277CAI report**
- A3 24 85 F001 NPI UNAUTHORIZED FOR ELECTRONIC BILLING

Questions about the informational edits or hard edits can be directed to the EDI Helpdesk at 1-800-542-0945.

15. Fee change schedules revised or removed on web-DENIS

**Category:** Fee Changes

**Title:** Fee change schedules revised or removed on web-DENIS

**Start Date:** August 12, 2013  **End Date:** August 26, 2013

BCBSM recently revised or removed these fee change schedules on web-DENIS, for the week beginning Aug. 05, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM (revised)
  - Independent Lab (removed)
- Facility
The revised fee change schedules no longer show 86305. The removed fee change schedule listed 86305 only. 86305 remains payable and was listed as non-payable erroneously. We apologize for any inconvenience this may have caused.

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

16. NASCO conducting recovery for Hurley Medical Center

Category: Benefits

Title: NASCO conducting recovery for Hurley Medical Center

Start Date: August 12, 2013    End Date: August 26, 2013


The group had requested a retroactive benefit change for in-network and Tier II (domestic) claims to apply combined cost share accumulations, effective Jan. 1, 2013.

We’re taking back the excess amount from our original payment. When you adjust this patient’s account, the subscriber’s balance may change.

17. Hospital Prenotification: We’ve revised the frequently asked questions document

Category: Hospital Prenotification

Title: Hospital Prenotification: We’ve revised the frequently asked questions document

Start Date: August 12, 2013    End Date: August 31, 2013

BCBSM has added new features to the hospital Prenotification system. Click here to view a training presentation about the new and existing features.

Click here to view the revised version of FAQs.

You may also follow the steps below to access FAQs through the BCBSM Newsletters and Resources page on web-DENIS:

- Log in to web-DENIS.
- Click on BCBSM Provider Publications and Resources in the left-hand navigation bar.

- Click on Newsletters and Resources.

- In the “What’s New” section, click on Hospital Prenotification system enhancements: Frequently asked questions.

18. Medicare Eligibility

Category: System Outage Scheduled for August 17 - 18, 2013

Title: Medicare Eligibility

Start Date: August 13, 2013   End Date: August 19, 2013

The Medicare Eligibility application will be unavailable due to scheduled maintenance. The maintenance window will begin at 2:00 AM ET on Saturday, August 17, 2013. The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 2:00 PM ET on Sunday, August 18, 2013.

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk 1-866-324-7315

19. NASCO conducting recovery for Magna

Category: Benefits

Title: NASCO conducting recovery for Magna

Start Date: August 13, 2013   End Date: August 27, 2013


Cost sharing and copayments for professional and facility claims were being incorrectly applied.

We’re taking backing the excess amount from our original payment. When the provider adjusts the accounts of affected patients, subscriber balances may change.

20. BCBSM issues Medicare Advantage claim overpayment reports
Category: Medicare Advantage

Title: BCBSM issues Medicare Advantage claim overpayment reports

Start Date: August 14, 2013    End Date: September 30, 2013

In reviewing our records, we discovered that we’ve overpaid some professional and facility health care providers for services provided to our Medicare Advantage members. We will send letters with more details to those providers who are affected.

This overpayment occurred on our former claims processing system (PGBA) and now will be transferred to our new claims processing system (ikaSystems). Affected providers will receive PGBA claim overpayment information sheets that include the recovery amounts and the members’ names.

Any claim overpayment will be deducted from the current ikaSystems remittance owed to the provider and may result in no payment or a reduced payment. If there is any money owed on the new claim, it will be included on the ikaSystems voucher or reimbursed to you separately.

We apologize for any inconvenience this may cause. If you have any questions, please call our Medicare Advantage Provider Inquiry department at 1-866-309-1719 between 8 a.m. and 4:30 p.m., Monday through Friday. To review our recovery and provider disputes process in more detail, please visit the Overpayment page on our website.

21. Outpatient psychiatric care claims processing corrected

Category: Outpatient psychiatric care claims

Title: Outpatient psychiatric care claims processing corrected

Start Date: August 15, 2013    End Date: September 15, 2013

The issue with behavioral health claims processing incorrectly when billed with procedure code M0064 has been corrected. If you billed claims prior to Aug. 1 and received a rejection with reason code B357, please call Provider Inquiry to have these claims adjusted.

We apologize for the inconvenience. If you have any questions about these claims, please contact Provider Inquiry or your provider consultant.

22. Blues Medicare Advantage program continues risk adjustment interventions

Category: Medicare Advantage

Title: Blues Medicare Advantage program continues risk adjustment interventions
Start Date: August 15, 2013    End Date: September 15, 2013

To close member diagnosis gaps, Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with several vendors. These member interventions are part of the Blues’ annual risk adjustment program. There are three primary member outreaches for 2013.

SMART appointment scheduling:
- Risk Adjustment/Healthcare Effectiveness Data and Information Set/Stars program
- Targets BCBSM Medicare Advantage members who haven’t received all their preventive care or those having one or more open diagnosis gaps. Members are contacted by telephone and interactive voice response programs, with the option of scheduling a doctor’s appointment. BCN Advantage℠ members are not included in this program.
- Goal is to encourage members to visit their physicians and discuss closing possible gaps in care.
- Runs June 2013 through December 2013

In-home assessments:
- Risk adjustment program
- Targets specific BCBSM and BCN Medicare Advantage members with chronic conditions who are likely to benefit from an in-home visit from a licensed physician or practitioner.
- Goal is to assess the member’s health status and complete an assessment to help close the member’s applicable diagnosis gaps.
- Providers who have patients selected for this program will receive a copy of the assessment and the patient will be encouraged to follow-up with their regular doctor.
- Runs May 2013 through December 2013

Skilled nursing facility assessments:
- Risk Adjustment program
- Targets specific BCBSM and BCN Medicare Advantage members who are confined to a skilled nursing facility or basic nursing home.
- Goal is to conduct a member health assessment and capture, address and close suspected gaps.
- Blues Medical Management staff reviews precertification criteria. This criteria helps to determine which members (currently in a SNF) would benefit most from this assessment. Members residing in a basic nursing home are selected to participate in this health assessment during a review of a biannual Centers for Medicare & Medicaid Services record.
- Runs May 2013 through December 2013

These programs are meant to support your efforts and not replace your care. The Blues appreciate your continued support and the quality care you provide our members and your patients.
For more information, please contact your BCBSM provider consultant or BCN provider representative.

23. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes  
**Title:** Additional fee change schedules added to web-DENIS  
**Start Date:** August 16, 2013  **End Date:** September 2, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Aug. 19, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus \(^{SM}\)
  - Independent Lab
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under **BCBSM Provider Publications and Resources**, by selecting **Entire Fee Schedules and Fee Changes**.

24. NaviNet registration opens August 19

**Category:** Blue Cross Complete  
**Title:** NaviNet registration opens August 19  
**Start Date:** August 19, 2013  **End Date:** September 30, 2013

Starting August 19, NaviNet early registration will be available for Blue Cross Complete providers. Providers must register for NaviNet prior to September 1, when they will begin using it for a variety of transactions and features including checking member eligibility and benefits, authorization requests, claims status and more.

Instructions on how to register for NaviNet can be found on the back of this NaviNet invitation or on page 4 of the **Blue Cross Complete Provider News**.

Please contact your Blue Cross Complete provider representative for more information.
25. Physical exam tips for BCN pediatricians

**Category:** BCN pediatricians

**Title:** Physical exam tips for BCN pediatricians

**Start Date:** August 19, 2013  **End Date:** September 3, 2013

BCN has created a flier to help you understand the HEDIS measure of weight assessment and counseling for nutrition and physical activity for children and adolescents. It is available in the “Helpful HEDIS hints” section of the HEDIS page in the BCN Provider Publications and Resources section of web-DENIS.

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26. All BCBSM trading partners

**Category:** Distribution of blank R277CAX and R277CAZ reports

**Title:** All BCBSM trading partners

**Start Date:** August 20, 2013  **End Date:** September 3, 2013

Due to a systems issue, some BCBSM informational edit reports were distributed in error. Electronic submitters may receive blank professional R277CAX or institutional R277CAZ reports dated Aug. 20, 2013 that do not contain claim or edit information. The erroneous blank reports can be disregarded and no action is required.

We apologize for any inconvenience.

27. All BCBSM trading partners
Category: Delayed BCBSM 277CA Reports

Title: All BCBSM trading partners

Start Date: August 20, 2013    End Date: September 3, 2013

Due to a systems issue, distribution of all BCBSM professional (R277CAH) and institutional (R277CAI) edit reports has been delayed. The delayed reports will be distributed as quickly as possible.

We apologize for any inconvenience.

28. Critical Provider Issues identified on new web-DENIS site

Category: Critical Provider Issues

Title: Critical Provider Issues identified on new web-DENIS site

Start Date: August 20, 2013    End Date: September 3, 2013

Blue Cross Blue Shield of Michigan would like to inform health care providers of outstanding claims issues that we are working to resolve. The new *Critical Provider Issues* page on web-DENIS identifies the outstanding issue and provides progress updates, estimated completion date and direction on what to do with claims in the interim. We encourage you to check this page before calling Provider Inquiry, as your answer may be there.

The information is now available on the first page of web-DENIS by clicking on the *Critical Provider Issues* link at the left side of the screen.

You'll also hear announcements for all critical issues when you select that option while on hold for Provider Inquiry.

29. Reminder: Change to benefit policy for outpatient facility services is here

Category: Facility claims

Title: Reminder: Change to benefit policy for outpatient facility services is here

Start Date: August 21, 2013    End Date: September 21, 2013

In July 2013, BCBSM began implementing member benefit determinations at the procedure code level for outpatient facility services that must be reported with a procedure code.
Previously, benefits were determined at the revenue code level for all hospital outpatient services. Starting in July 2013, you may see claim benefit rejections when a procedure code is not payable based on the group benefits, condition code or occurrence code. Members will become liable for nonpayable outpatient facility services. Claims processed prior to July 2013 will not be affected by this change.

There are no changes in the way that outpatient facilities need to report services.

Please determine members’ benefits at the procedure code level. More information will be provided in a future Record article.

30. National Health Care Reform

**Category:** Subscribe to BCN Provider News

**Title:** National Health Care Reform

**Start Date:** August 22, 2013    **End Date:** October 22, 2013

The September-October issue has important information providers need to know about health care reform. Don’t miss these articles:

- The Health Insurance Marketplace
- A look at essential health benefits
- Additional preventive medications available at $0 cost-sharing, effective Jan. 1

To subscribe [Click Here](#), by Aug. 27 to get the email for the next issue. Click on “Subscribe” and check the box next to BCN Provider News and BCN Alerts.

31. BCN clarifies blood pressure check requests

**Category:** BCN

**Title:** BCN clarifies blood pressure check requests

**Start Date:** August 26, 2013    **End Date:** September 23, 2013

Blue Care Network has two current quality initiatives relating to blood pressure. We want to clarify how to report blood pressure measurements for each initiative.

We mailed letters in early August to providers with one or more patients who need a blood pressure check. The letter included the names of BCN and BCN AdvantageSM patients who are due for a blood pressure check. Providers were encouraged to schedule visits for members to have their blood pressure checked before Dec. 31, 2013.
Providers may record the visit and member blood pressure in the patient’s medical record. Providers are not required to enter the data in Health e-BlueSM although they may do so if they wish. (Directions for entering blood pressure appear below.)

A separate mailing was sent earlier this year to medical care groups to share information with their physicians who have BCN Advantage patients. They were notified about our 2013 CMS Million Hearts Incentive program. One of the measures eligible for payment in this program is blood pressure control. Providers can earn the incentive by submitting data through a claim with an appropriate CPT II code, through a Health e-Blue entry or through an electronic medical record interface.

Here’s how to enter blood pressure in Health e-Blue.

- Log in to Health e-Blue and click on “Treatment Opportunities by Condition / Measure” panel
- Click on “Search Records”
- Click on the member contract number to get to the Patient Detail- Patient Treatment History screen. If the member is not listed in this panel, select the Patient Eligibility panel. Select the Advance Patient Search checkbox. Enter either the patient name (first and last names) or their 11 digit contract number. Click on Search Records. Click on the member contract number.
- Click on the “Add New Service” hyperlink. The Service/Treatment Opportunity Details – View/Edit data entry screen will appear.
- In the “Service Sub-type” drop down menu, select Diastolic Blood Pressure. Enter the service date in the Service Date 1 field.
- In “Result/ Days Supply” field, enter the value for diastolic blood pressure
- Click “Save.”
- Repeat by clicking again on “Add New Service”
- In the “Service Sub-Type” drop down box, select Systolic Blood Pressure.
- Enter the service date in the Service Date 1 field. (It must be the same date for which you entered the diastolic measure.)
- Enter the value of the systolic blood pressure.
- Click “Save.”

If you have any questions about the HEDIS measures or the Million Hearts Incentive program, contact your BCN provider representative.

32. All Blue Cross Complete trading partners

Category: Blue Cross Complete electronic claim requirements

Title: All Blue Cross Complete trading partners

Start Date: August 26, 2013    End Date: October 1, 2013

As a reminder to all Blue Cross Complete (BCC) submitters, BCC electronic claims must follow the same guidelines as Blue Care Network HMO claims. Here are some things to keep in mind:
• Report the Member contract number, including alpha-prefix ‘XYU’ in the Subscriber Loop 2010BA NM109.
  ▪ BCC claims submitted without the ‘XYU’ prefix will receive a rejection of “B26QC MEMBER NOT FOUND”. Claims receiving this rejection must be resubmitted with the ‘XYU’ alpha prefix and Enrollee ID number found on the front of the member’s ID card.
• Report a Source of Payment indicator of ‘HM’ in Loop 2000B SBR09
  ▪ Claims submitted with an incorrect source of payment indicator will receive a rejection. Rejected claims must be resubmitted with an indicator of ‘HM’.

If you have questions regarding electronic claims submission, please contact the EDI Helpdesk at 1-800-542-0945.

33. Additional fee change schedule added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedule added to web-DENIS

Start Date: August 26, 2013  End Date: September 9, 2013

BCBSM recently added this additional fee change schedule to web-DENIS, for the week beginning Aug. 26, 2013:

• Facility
  ▪ Outpatient Hospital

This and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*.

For more information, contact your BCBSM provider consultant.

34. Hospital outpatient ERT - Emergency Room & Trauma Fee Corrections

Category: Hospital outpatient services

Title: Hospital outpatient ERT - Emergency Room & Trauma Fee Corrections

Start Date: August 26, 2013  End Date: September 9, 2013

BCBSM is making corrections to the previously published ER and trauma HCPCS fees for hospital outpatient facility reimbursement, effective October 1, 2013. Although the fees will be lower than what were previously published, BCBSM will make the hospital outpatient payments budget neutral for the first year of implementation of the Hospital Outpatient Pricing Strategy project. The corrected fees are included in the “Hospital Outpatient Fee Changes as of 8/26/2013”, available on web-DENIS under *BCBSM*
Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.”

For more information, contact your BCBSM provider consultant.

35. Updated medical necessity criteria for TENS unit now posted

Category: Medical necessity criteria

Title: Updated medical necessity criteria for TENS unit now posted

Start Date: August 27, 2013    End Date: September 9, 2013

Effective March 1, 2013, Blue Cross Blue Shield of Michigan aligned its medical necessity criteria for use of a transcutaneous electrical nerves stimulation unit with the criteria used by the Centers for Medicare & Medicaid Services. Applicable procedure codes are E0720 E0730 and E0731.

We’ve updated our inclusionary and exclusionary guidelines and posted them in the Clinical Criteria and Resources section of Web Denis. Scroll down and click on E0720, E0730, E0731 – Medical necessity criteria for transcutaneous electrical nerves stimulation (TENS) units.

36. All commercial trading partners

Category: Erroneous edit for Aetna commercial claims

Title: All commercial trading partners

Start Date: August 27, 2013    End Date: September 10, 2013

Please be advised that some Aetna claims submitted on Aug. 20 and 21, 2013 may have received an erroneous edit of:

'A3 122 YOUR ORGANIZATION (CUSTOMER ID 48544) REQUIRE ENROLLMENT IN AVAILITY ADVANCED CLEARINGHOUSE TO SUBMIT TO PAYER ID 60054. PLEASE CONTACT YOUR SOFTWARE VENDOR TO UPGRADE'.
The original claims were processed today and no action is required. Submitters may disregard the erroneous edit.

We apologize for any inconvenience.

37. Medicare Eligibility

**Category:** System Unavailable  
**Title:** Medicare Eligibility  
**Start Date:** August 28, 2013  **End Date:** September 2, 2013

There is scheduled maintenance on the Medicare Eligibility application. The maintenance window will begin at 8:00 AM EST on Sunday, September 1, 2013.

The Medicare Eligibility system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 12:00 PM (Noon) EST on Sunday, September 1, 2013.

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315

38. BCN notifies BCN Advantage hypertensive diabetic members of the importance of ACEI or ARB

**Category:** BCN Advantage  
**Title:** BCN notifies BCN Advantage hypertensive diabetic members of the importance of ACEI or ARB  
**Start Date:** August 28, 2013  **End Date:** September 13, 2013

In response to the Centers for Medicare & Medicaid Services System for Tracking Audit & Reimbursement (STAR) measure regarding the use of angiotensin converting enzyme inhibitors (ACEI) or angiotensin II receptor blockers (ARB) in diabetes, Blue Care Network will be notifying BCN Advantage diabetic members who have one claim for a hypertensive medication regarding the importance of taking an ACEI or ARB.
The benefits of ACEI/ARB therapy include: • Inhibited renal function decline • Decreased cardiovascular risk • Decreased mortality • Decreased microvascular diabetic complications

While ACEI or ARB’s may not be appropriate in some patients due to adverse effects, most side effects can be managed by using an alternative ACEI or ARB, dose reduction, or close monitoring during the initiation of therapy.

Your patients may be contacting you regarding this matter. An open dialogue weighing the risks versus benefits for each individual is necessary to determine if an ACEI or ARB is best for them. Additional information can be found on pages 14 and 15 of the May/June BCN Provider News and on page 46 of the September/October BCN Provider News.

39. Additional fee change schedule added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedule added to web-DENIS

Start Date: August 29, 2013   End Date: September 17, 2013

BCBSM recently added this additional fee change schedule to web-DENIS, for the week beginning Sept. 03, 2013:

- Professional
  - Traditional, TRUST & Blue Preferred Plus \textsuperscript{SM}
  - Independent Lab
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

This and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

40. Double-check demographic information when submitting claims

Category: Claims

Title: Double-check demographic information when submitting claims

Start Date: August 29, 2013   End Date: September 12, 2013
A high volume of claims are being rejected with code X118* due to incorrect patient demographics. For example, some providers are submitting data for a spouse or dependent when the patient is the subscriber. Please be sure to validate that patient information, such as the date of birth, gender and relationship code, are correct before submitting claims.

*Voucher message for X118: When we considered this claim for payment, we couldn’t find this patient in our files with the reported data. If you can correct the contract number, patient’s first or last name, data of birth gender or relationship, please send us a new claim. If the reported data is correct, the subscriber is liable for your charge.

41. We’re changing the wording on Eligibility/Coverage/COB screen

Category: Eligibility

Title: We’re changing the wording on Eligibility/Coverage/COB screen

Start Date: August 29, 2013    End Date: TBD

Effective Sept. 3, 2013, we’ll be changing the wording on the Eligibility/Coverage/COB screen in web-DENIS. We’ll be replacing the word “thru” with “expires.” Currently, the “Current Coverage Dates From” field is displayed with the date range of MM/DD/YYYY Thru MM/DD/YYYY. Once the change is complete, it will be displayed as MM/DD/YYYY Expires MM/DD/YYYY.

Note: A member’s contract expires at 12 a.m. EST on the date that the coverage “expires.” This means the member is no longer covered on that date.

42. All BCBSM trading partners


Title: All BCBSM trading partners

Start Date: August 29, 2013    End Date: September 14, 2013

BCBSM will be performing system maintenance beginning at 8:00 PM on Saturday, Sept. 14, 2013 through 8:00 AM on Sunday, Sept. 15, 2013. The maintenance will require a complete EDI network outage. BCBSM trading partners will be unable to connect with our claims or eligibility systems during this time period.

Attempts to log into web-DENIS, the Internet claim tool, or connect to our EDDI or 270/271 applications will fail. Normal system operations will resume after 8:00 AM on Sunday.
Claim, enrollment, status and eligibility files will not be processed during the outage.

We apologize for any inconvenience this may cause.

43. Medicare Plus BlueSM PPO manual will be updated on Oct. 1, 2013

Category: Medicare Advantage

Title: Medicare Plus BlueSM PPO manual will be updated on Oct. 1, 2013

Start Date: August 30, 2013    End Date: September 15, 2013

Blue Cross Blue Shield of Michigan will update the Medicare Plus Blue PPO manual for October 2013. Key changes include:

- Adding BCBSM Medicare Advantage enhanced benefit website
- Adding new hospice information
- Updating HEDIS® breast cancer age range
- Updating information regarding the Centers for Medicare & Medicaid Services integrated denial notice
- Updating advanced coverage determination section
- Adding a new HEDIS® section
- Adding detail for malpractice screening
- Clarifying after-hours, holiday and weekend precertification fax processes

Please note: As of Jan. 1, 2014, BCBSM will end its contract with KePro®, an independent company that delivered the Oncology Management Program, for BCBSM. As more information is available, we'll be certain to communicate it. You’ll also see this notation in the October edition of the Medicare Advantage PPO manual.

You can obtain the most current version of the manual at bcbsm.com/providers/ma.

This message serves as notice of these changes to the Medicare Plus Blue PPO manual per the terms of the MA PPO Provider Agreement, available online at bcbsm.com/providers/ma.
@HOMe Support Program pilot begins for Medicare Advantage members

Medicare Plus Blue℠ PPO members living in southeast Michigan and BCN Advantage℠ members living in the Saginaw, Flint, Bay City or Midland areas who have been diagnosed with advanced or terminal illness may participate in a pilot program designed to provide them with specialized health care services and support.

The @HOMe (At Home) Support Program pilot started in August 2013 and ends December 2015.

A subsidiary of Hospice of Michigan, the program focuses on supporting members with advanced illness, their families and caregivers in the home by providing home-based clinical services, including coordination of care, assessment and counseling associated with advanced illness, informed decision-making and 24/7 phone access to a registered nurse.

@HOMe support staff members have extensive training in palliative management. Copayments for members receiving home care service by @HOMe Support are waived.

Disease-specific criteria include the following:

- Cancer: Any Stage IV disease
- CHF: New York Heart Association Stage III or IV
- COPD: GOLD Stage III or IV
- Debility: Multiple comorbid conditions contributing to declining status and limited life expectancy

The Blues identifies members based on claims and pharmacy data. Members may opt out of the program.

While there are no direct physician referrals to this program, if you have a Medicare Plus Blue PPO member who may benefit from this program, you may encourage them to call the servicing number on the back of their ID card to request more information.
October 2013

Clarification: Medicare Advantage enhanced benefit fee schedule to be updated in November

An article that appeared in the September issue of The Record should have said that the Blue Cross Blue Shield of Michigan Medicare Advantage enhanced benefit fee schedule will be updated in November to show BCBSM allowed amounts for both facility and non-facility locations.

These changes will affect health care providers’ payments for enhanced benefit services related to physician services performed in facility and non-facility locations. The fee schedule will not include incentive amounts.

Physician payments for Medicare Advantage enhanced benefits will be reduced, starting Nov. 6, 2013. The enhanced benefit fee schedule on bcbsm.com/provider/ma will be updated on this date.

For more information, see the Aug. 6, 2013, web-DENIS message on this topic.

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Web-DENIS messages September 2013
1. BCN professional and institutional trading partners

**Category:** Blue Care Network 835 remittance files with missing check numbers

**Title:** BCN professional and institutional trading partners

**Start Date:** September 3, 2013  **End Date:** September 17, 2013

Due to a systems issue, BCN institutional and professional 835 remittance files distributed on Sept. 3, 2013 are missing check number information. The erroneous 835s can be identified by file name 835P5010245.

BCN has corrected the issue and will distribute new 835 files as soon as possible. Submitters can disregard the erroneous files.

We apologize for any inconvenience this may cause.

2. BCBSM electronic provider manuals — August 2013 changes

**Category:** Online manuals

**Title:** BCBSM electronic provider manuals — August 2013 changes

**Start Date:** September 3, 2013  **End Date:** September 17, 2013

These are the chapters we revised in August 2013, along with the revision date and a brief statement of the main changes for each.*

- **BlueCard Program** (8/1/2013)
  - Using BlueCard" — In the “Verifying coverage and eligibility” section, added a subsection called “The state of Tennessee, alpha prefix ZEC.”

- **Blue Pages Directory** (8/1/2013)
  - "General Motors and Delphi" — Updated the "outpatient and office physical therapy services" section.

- **Documentation Guidelines for Physicians and Other Professional Providers** (8/20/2013)
  - "Overview," "Medical record documentation - general guidelines" and "Diagnostic and therapeutic services" — Added more detail.
  - "Mental health and substance abuse services" — In the "Office or outpatient psychiatric care — general guidelines" section, under the "Initial visit" subsection, updated the "DSM IV" reference to "DSM-5."

- **General Limitations and Exclusions** (08/19/2013)
  - “Overview” — In the “We do not pay for” section, added more detail to the
“experimental or investigational” bullet.

- **Hospice Services (8/14/2013)**
  - "Phase 1 (prehospice)" — In the “Coverage” section, added the fact that services should be reported with RC 0650.
  - "Hospice care" — In the “Coverage” section, added the fact about the benefit maximum for the hospice benefit is defined at the time the patient is admitted into the hospice program.
  - "Covered services" — Added examples of home health aide services and homemaker services to the sub-bullet on that topic.

- **Mental Health and Substance Abuse Managed Care Program (8/1/2013)**
  - "Precertification" — In the “Precertification process” section and the “Emergency situations” section, changed “DSM-IV” to “DSM-5.”

- **Physical Therapy, Occupational Therapy, and Speech Therapy Services (8/6/2013)**
  - “Billing guidelines” — In the "Reporting therapy visits in freestanding OPTs" section’s "Value codes and occurrence codes" subsection, deleted the UB-04 claim-example clip. Will replace it soon with updated information.

- **Psychiatric Care Services (8/14/2013)**
  - Throughout the chapter, modifications were made to the BCBA information.
  - "Precertification" — In the "Precertification process" section and the "Emergency situations" section, changed "DSM-IV" to "DSM-5."
  - "Prior authorization for applied behavior analysis" — Added this new section.
  - "Prior authorization appeals for applied behavior analysis" — Added this new section.
  - "Billing guidelines" — In the "Autism disorders" section, replaced the chart with a link to the billing chart on web-DENIS.

- **Valid Modifiers (8/14/2013)**
  - "Valid modifiers: medicine" — Added modifier JE to the Level II modifiers per code update on July 1, 2013.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.*

**New manual (8/1/2013)**

- **Ambulatory Infusion Center Services**
3. Claims processing change for Medicare Advantage independent laboratories billing automated multi-channel chemistry tests

   **Category:** Medicare Advantage

   **Title:** Claims processing change for Medicare Advantage independent laboratories billing automated multi-channel chemistry tests

   **Start Date:** September 4, 2013    **End Date:** September 18, 2013

Prior to Aug. 6, 2013, when an independent clinical lab billed automated multi-channel chemistry tests, payment for the test was split between all lines of service.

Because of an update to our current processing system, all AMCC test claims processed after Aug. 6 will process under only one of the AMMC test lines of service. Your payment will remain unchanged but it will be bundled under one claim line.

Any additional AMCC tests claim lines will be denied with the following messages:

   a. **Paper remit denial message:** 38I-Payment bundled with other AMCC test.
   b. **835 electronic remit denial message:** CO:45 Remark code; M75- Multiple automated multi-channel tests performed on the same day combined for payment

Thank you for your patience during this update. If you have any questions, please contact your provider consultant.

4. Replacement (bill type ‘XX7’) and void (bill type ‘XX8’) claims for FEP contracts experience processing delays

   **Category:** Facility Claims

   **Title:** Replacement (bill type ‘XX7’) and void (bill type ‘XX8’) claims for FEP contracts experience processing delays

   **Start Date:** September 4, 2013    **End Date:** September 18, 2013

Replacement (bill type 'XX7') and void (bill type 'XX8') claims for FEP contracts continue to experience a claims processing delay of approximately 30 days. Although both void and replacement facility claims can be submitted to BCBSM electronically, the claims processing has been delayed due to special handling procedures that FEP is required to follow.

We’re making continual efforts to resolve the backlog and expect that the problem will be resolved within 30 days. **Please do not resubmit claims for these bill types that have been submitted but have not yet been processed.** We’re working to process them.
Once the backlog has been resolved, we’ll let you know via web-DENIS. If you have any questions, please contact your provider consultant.

5. Blue Cross Complete member treatment opportunity information available in Health e-BlueSM through September 22

Title: Blue Cross Complete member treatment opportunity information available in Health e-BlueSM through September 22

Start Date: September 6, 2013    End Date: October 4, 2013

Providers can continue to find treatment opportunities (also known as Gaps in Care reports) for Blue Cross Complete members in Health e-Blue through September 22. Effective October 1, these reports can be found in NaviNet. (It was previously announced these would be available in NaviNet on September 1.)

An announcement regarding the migration from Health e-Blue to NaviNet can be found on page 5 of the Blue Cross Complete Provider News. Submitting electronic medical record data is a functionality still being developed on NaviNet and will be announced as soon as it is available.

Please contact your Blue Cross Complete provider representative if you have further questions.

6. BCBSM electronic trading partners, vendors and clearinghouses

Category: Validator self-testing tool maintenance

Title: BCBSM electronic trading partners, vendors and clearinghouses

Start Date: September 6, 2013    End Date: September 20, 2013

The BCBSM HIPAA Validator online self-testing tool and Provider Authorization application will be unavailable on Saturday, 09/07/13, from 7:00 am – 4:00 pm, in order to perform system maintenance. Users will be unable to access the application during this time period.

We apologize for any inconvenience.
7. All Blue Care Network trading partners

Category: UPDATE – October 1, 2013 transition to BCN 277CA reports and transactions

Title: All Blue Care Network trading partners

Start Date: September 9, 2013    End Date: November 9, 2013

The new Blue Care Network 277CA reports and transactions are scheduled for implementation on Oct. 1, 2013.

As a reminder, the new versions will be:

- R277CAF – replaces the BCN U277F report
- 277CAP – replaces the 4010 version 277P transaction. The 277CAP transaction will display ‘Blue Care Network’ as the payer name in Loop 2100.

The new versions will return the same claim detail and acknowledgement information as found in all other 277CAIs distributed by BCBSM. BCN submitters will receive their regular reports and transactions until the transition.

Please note that BCBSM continues to receive 277P transactions from other payers. This change to BCN reports will not impact the distribution or naming convention of other payer 277P files.

If you have any questions regarding the new BCN reports, please contact the EDI helpdesk 1-800-542-0945.

8. All BCBSM institutional trading partners

Category: Reminder – NUBC changes approved for bill types 032x, 033x, and 034x

Title: All BCBSM institutional trading partners

Start Date: September 9, 2013    End Date: November 9, 2013

As a reminder to home health service providers, the National Uniform Billing Committee approved the following changes effective Oct. 1, 2013:

<table>
<thead>
<tr>
<th>TOB Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>032x</td>
<td>REVISED: Home Health Services under a Plan of Treatment</td>
</tr>
<tr>
<td>033x</td>
<td>DISCONTINUED: Home Health outpatient (includes HHA visits under a Part A plan of treatment including DME under Part A)</td>
</tr>
<tr>
<td>034x</td>
<td>REVISED: Home Health Services not under a Plan of Treatment</td>
</tr>
</tbody>
</table>
Home health claims submitted with dates of service on or after Oct. 1, 2013 and a bill type of 033x in FL 04, will reject.Rejected claims must be resubmitted with the correct type of bill code.

For information about completing any of the locators on the claim form, please refer to your UB-04 Manual.


Category: Clinical practice guidelines

Title: Michigan Quality Improvement Consortium clinical practice guidelines

Start Date: September 11, 2013    End Date: September 25, 2013

The MQIC has released updated clinical practice guidelines and guideline update alerts on the following topics:

   a. Routine Prenatal and Postnatal Care
   b. Prevention of Unintended Pregnancy in Adults 18 Years and Older
   c. Medical Management of Adults with Hypertension
   d. Screening and Management of Hypercholesterolemia
   e. Screening, Diagnosis and Referral for Substance Use Disorders

Please visit mqic.org to access the guidelines.

10. Correction: Blue Cross Complete phone number

Category: Blue Cross Complete

Title: Correction: Blue Cross Complete phone number

Start Date: September 12, 2013    End Date: September 26, 2013

The Sept.-Oct. issue of BCN Provider News included an incorrect phone number for Blue Cross Complete. If you need authorization for services that require plan notification, call 1-888-312-5713 and select prompt 1. The number has been corrected and the issue has been reposted.

Other information you need for the Blue Cross Complete transition can be found in Blue Cross Complete Provider News.

If you have any questions, call your provider representative.
11. All professional BCBSM trading partners

Category: BCBSM clearinghouse will begin accepting HealthPlus of Michigan electronic claims

Title: All professional BCBSM trading partners

Start Date: September 12, 2013    End Date: October 12, 2013

Effective Oct. 1, 2013, the Blue Cross Blue Shield of Michigan EDI clearinghouse will accept and route professional electronic claims for HealthPlus of Michigan.

To submit HealthPlus claims electronically, trading partners must first complete two enrollment processes. Existing commercial claim submitters must only complete step #2.

a. Register your billing NPI with the BCBSM clearinghouse.
   i. If you are a new submitter or do not currently submit commercial claims through BCBSM, you will need to complete a Provider Authorization Form online. Provider Authorization instructions and information are located on the login screen: [https://editest.bcbsm.com/tpalogon.html](https://editest.bcbsm.com/tpalogon.html). Contact the EDI helpdesk at 1-800-542-0945, Opt. #3, if you require additional assistance.
   ii. If you do not register the billing NPI with BCBSM EDI, your claims will reject with an edit of ‘A3 24 85 P003 COMMERCIAL BILLING PROV CODE UNAUTHORIZED’.

b. Register with HealthPlus of Michigan.
   i. To receive error reports and electronic remittance information you will need to contact HealthPlus of Michigan at 810-230-2084 or 800-345-9956 x 2084 or edicoordinator@healthplus.org.

Once enrolled, trading partners can submit electronic professional 837 claims following these guidelines:

- Report Source of payment code ‘CI’ in Loop 2000B SBR09
- Report Payer Name ‘HealthPlus of MI’ in Loop 2010BB NM103
- Report Payer ID ‘38216’ in Loop 2010BB NM109

If you have any questions regarding submission of 837 electronic claims, please contact the BCBSM EDI helpdesk at 1-800-542-0945.

12. All commercial claim submitters

Category: Payers removed from the BCBSM commercial payer list

Title: All commercial claim submitters
On September 12, 2013, BCBSM’s commercial clearinghouse partner discontinued accepting electronic claims for three payers. BCBSM did not receive advance notice of this change. Effective immediately, we will be removing the following payers from our electronic professional commercial payer list:

PRINCIPAL MUTUAL LIFE INS (Payer ID 61271 Claim Office NOCD)
PRINCIPAL FINANCIAL GROUP (Payer ID 61271 Claim Office 0002)
JF MOLLOY & ASSOCIATES (Payer ID 61271 Claim Office 0003)

Claims received for these payers and payer IDs will reject with a front-end edit of ‘P017 COMMERCIAL PAYER ID AND OR CLAIM OFFICE NUMBER IS INVALID’. Claims for these payers must now be submitted hard copy directly to the payer.

We apologize for any inconvenience.

13. All Blue Care Network trading partners

Category: New edits for missing alpha prefix

Title: All Blue Care Network trading partners

Beginning Oct. 21, 2013, BCBSM EDI will assign front-end edits to all electronic BCN claims submitted without the entire member contract number, including alpha prefix.

The edits will be returned on R277CAH and R277CAI reports or 277CAP transactions:

   Professional: A3 164 IL P615 CONTRACT ALPHA PREFIX IS REQUIRED
   Institutional: A3 164 IL F607 CONTRACT ALPHA PREFIX IS REQUIRED

Claims receiving either edit must be corrected and resubmitted.

If you have questions about these changes, please call the EDI helpdesk at 1-800-542-0945.
14. All BCBSM trading partners

Category: EDI system outage update

Title: All BCBSM trading partners

Start Date: September 16, 2013   End Date: September 30, 2013

BCBSM performed system maintenance on Sept. 14 and 15, 2013. As an update, all systems have resumed normal operation. Claim, enrollment, status and eligibility files are being processed.

In addition, trading partners can connect with our claims and eligibility systems, log into web-DENIS and the Internet claim tool, and connect with the EDDI application.

If you encounter connection issues with web-DENIS, please contact the Web Support helpdesk at 1-877-258-3932.

Connection issues with the Internet claim tool or EDDI can be directed to the EDI helpdesk at 1-800-542-0945.

15. Additional fee change schedule added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedule added to web-DENIS

Start Date: September 16, 2013   End Date: September 30, 2013

BCBSM recently added this additional fee change schedule to web-DENIS, for the week beginning Sep. 16, 2013:

a. Professional
   i. Traditional, TRUST & Blue Preferred Plus SM

This and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

16. Inpatient coding initiative Web presentation now available

Category: Training

Title: Inpatient coding initiative Web presentation now available

Start Date: September 17, 2013   End Date: October 7, 2013
An important computer-based training opportunity is now available for our hospital partners. This online training assists with inpatient documentation and coding accuracy. We want to help our hospitals by aligning their documentation with reportable diagnoses in accordance with Centers for Medicare & Medicaid Services’ requirements.

These improvements in documentation and coding accuracy will ensure better quality peer comparisons, population management, risk scores, reimbursement and incentive distribution.

To access the training:

• Log in to web-DENIS

• Click on *BCBSM Provider Publications and Resources*

• Click on *Newsletters and Resources*

  Under *Provider Training* link or the ”What’s New” section, click on your preferred format under “Inpatient Coding Initiative presentation.”

For your convenience, we’ve also enabled the presentation to be viewed from a smartphone or tablet or by printing a PDF of the presentation.

17. **InterQual® criteria updates now available**

**Category:** InterQual

**Title:** InterQual® criteria updates now available

**Start Date:** September 17, 2013    **End Date:** October 7, 2013

Updates are available to the 2013 pediatric acute and adult acute InterQual criteria. These updates will be effective Nov. 4, 2013.

To access the updates:

• Log in to web-DENIS.

• Click on *BCBSM Provider Publications and Resources.*

• Click on *Newsletters and Resources.*

• Click on *Clinical Criteria & Resources* in the left navigation bar.
• Scroll to the section “BCBSM modifications to InterQual criteria,”

• Click on *Pediatric Acute Nov. 4, 2013 update and Adult Acute Nov. 4, 2013 update.*

18. **AIM guidelines updated**

   **Category:** Clinical guidelines

   **Title:** AIM guidelines updated

   **Start Date:** September 17, 2013    **End Date:** November 4, 2013

   AIM Specialty Health, our radiology partner, has updated its *Clinical Appropriateness Guidelines*. The new guidelines will be effective Nov. 4, 2013.

   We’ve posted the updated guidelines on web-DENIS. To access the guidelines:

   • Log in to web-DENIS.

   • Click on *BCBSM Provider Publications and Resources.*

   • Click on *Newsletters and Resources.*

   • Click on *Clinical Criteria & Resources* in the left navigation bar.

   • Click on *AIM Specialty Health 2013 diagnostic imaging clinical guidelines (effective Nov 4, 2013).*

19. **Medicare Eligibility Access**

   **Category:** System Maintenance from September 20, 2013 to September 22, 2013

   **Title:** Medicare Eligibility Access

   **Start Date:** September 17, 2013    **End Date:** September 23, 2013

   There is scheduled maintenance on the Medicare Eligibility System this weekend. The maintenance window will begin at 9:00 PM ET on Friday, September 20, 2013. The Medicare Eligibility system will be unavailable during this period.

   Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 10:00 AM ET on Sunday, September 22, 2013.
Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315.

20. ICD-10 webinar offered to providers

**Category:** All providers

**Title:** ICD-10 webinar offered to providers

**Start Date:** September 18, 2013   **End Date:** September 24, 2013

ICD-10 is coming and it *will* affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014 implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind. In this session, BCBSM will be focusing on provider implementation, the top volume professional ICD-9 codes mapped to ICD-10 and coding tips for these new codes.

Our next call is scheduled for Monday, Sept. 23, from 1 to 2 p.m., Eastern time. To register, click on [this link](#).

**Meeting information**

**Topic:** ICD-10 Provider Implementation and Coding Tips  
**Date:** Monday, Sept. 23, 2013  
**Time:** 1 p.m., Eastern Daylight Time  
**Meeting Number:** 920 636 264

Send an email to [ICD-10ProviderReadiness@BCBSM.com](mailto:ICD-10ProviderReadiness@BCBSM.com) if:

a. You want a copy of the presentation (available on Sept. 23, 2013) associated with the conference call.
b. You would like us to cover a specific topic on a future call, or you have questions related to ICD-10.
c. You are having issues with the link above or logging into the call.
21. All BCBSM institutional trading partners

Category: NASCO 835 remittance files with incorrect data

Title: All BCBSM institutional trading partners

Start Date: September 19, 2013    End Date: October 3, 2013

Due to a systems issue, NASCO institutional 835 remittance files distributed from Aug. 30 through Sept. 12, 2013, contained erroneous CAS*OA*204 data. NASCO corrected this problem on September 13, 2013.

If you would like a recreate for an affected 835 file, contact the EDI helpdesk at 1-800-542-0945.

We apologize for any inconvenience this may cause.

22. All professional BCBSM trading partners

Category: Change in Payer IDs for McLaren Health Plan Claims

Title: All professional BCBSM trading partners

Start Date: September 19, 2013    End Date: October 30, 2013

Effective Sept. 30, 2013, McLaren Health Plan will implement new payer identification numbers for certain lines of business. Accordingly, all McLaren claims must report one of these IDs in Loop 2010BB, NM109:

<table>
<thead>
<tr>
<th>Line of business</th>
<th>Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHP Medicaid</td>
<td>3833C</td>
</tr>
<tr>
<td>MHP Commercial</td>
<td>38338</td>
</tr>
<tr>
<td>McLaren Health Advantage</td>
<td>3833A</td>
</tr>
<tr>
<td>McLaren Advantage</td>
<td>3833R</td>
</tr>
<tr>
<td>Northern Health Plan</td>
<td>3833N</td>
</tr>
<tr>
<td>Tencon Health Plan</td>
<td>3833T</td>
</tr>
</tbody>
</table>
Claims received with an incorrect Payer ID on or after Sept. 30 will be rejected by McLaren Health.

23. Magellan will begin authorizing rTMS for the treatment of major depressive disorder beginning Oct. 1, 2013, for select members only

   Category: Mental Health

   Title: Magellan will begin authorizing rTMS for the treatment of major depressive disorder beginning Oct. 1, 2013, for select members only

   Start Date: September 20, 2013    End Date: October 1, 2013

   Transcranial magnetic stimulation may be a benefit for a select subset of patients that meet all of BCBSM’s medical necessity criteria. The benefit applies only to BCBSM underwritten groups, Michigan Education Special Services Association, Michigan Public School Employee Retirement Systems and State of Michigan groups. Auto and national groups are excluded. Refer to members’ certificates for benefit-specific coverage guidelines.

   **BCBSM will not pay claims for rTMS unless prior authorization has been obtained.**

   Magellan Behavioral of Michigan Inc. will begin reviewing requests for this procedure Oct. 1, 2013. Call Magellan at 1-800-762-2382 with these requests. For State of Michigan members, call 1-866-503-3158.

   Medical necessity criteria will be forthcoming on web-DENIS.


   Category: All professional trading partners

   Title: New National Drug Code edit for electronic MIChild claims

   Start Date: September 20, 2013    End Date: November 15, 2013

   In Feb. 2013, BCBSM began editing MIChild claims that did not follow Medicaid Drug Rebate Program requirements. The edit returned for claims with errors was P099 A3 454 PROCEDURE CODE/NDC CODE MISSING/INVALID.

   Effective Oct. 21, 2013, claims for MIChild groups 31295 and 007004505 will begin receiving a new front-end edit when NDC code reporting errors are present. The new edit, P909 A3 218 INVALID/MISSING NDC CODE/QUANTITY REPORTED ON MICHILD CLAIM, will be returned on BCBSM professional R277CAH or R277CAP transactions.
The original P099 edit will remain in place for all other professional claims (BCBSM, BCN, etc.) reporting procedure codes and NDC codes do not meet format requirements.

To avoid either of the edits, electronic claims should report NDC codes and associated quantities as follows:

- Loop 2410 LIN02 - report qualifier N4
- Loop 2410 LIN03 - report the 11 digit NDC code without spaces or special characters
- Loop 2410 CTP04 - report the associated numeric drug quantity
- Loop 2410 CTP05 - report the unit of basis of measurement qualifier as applicable

For more information about the MDRP, visit *medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html.

If you need assistance with reporting of procedure or NDC code information in your software or practice management system, please contact your vendor or clearinghouse.

25. Reminder: Check eligibility

**Category:** Web-DENIS Eligibility

**Title:** Reminder: Check eligibility

**Start Date:** September 20, 2013    **End Date:** October 31, 2013

Before treating a patient, always check the web-DENIS eligibility screen to verify the member’s coverage and benefits are active for the services they are receiving.

If you have questions regarding submission of commercial claims, contact our EDI Helpdesk at 1-800-542-0945.

26. NASCO System Maintenance

**Category:** NASCO Maintenance on Sunday September 29, 2013

**Title:** NASCO System Maintenance

**Start Date:** September 23, 2013    **End Date:** September 30, 2013

There is scheduled maintenance on the NASCO Processing System. The maintenance testing will occur Sunday, September 29th, beginning at 5:00 a.m. EST and is expected to end at 1:00 p.m. EST., but could last longer if any issues arise. The NASCO system will
NOT be available during this time. Any person or application accessing NASCO Production during this time will NOT have access to current data.

We apologize for any inconvenience this may cause.

27. Vision benefit changes for State of Michigan members

**Category:** Benefits

**Title:** Vision benefit changes for State of Michigan members

**Start Date:** September 23, 2013    **End Date:** October 25, 2013

Effective Oct. 1, 2013, Blue Cross Blue Shield of Michigan has partnered with VSP to administer vision benefits for State of Michigan employees and retirees.

As a result of this partnership, State of Michigan employees and retirees are encouraged to utilize a VSP Choice Network provider to reduce their out-of-pocket costs. State of Michigan employees and retirees who choose to obtain services from a non-VSP Choice Network provider will pay higher out-of-pocket costs.

If you are interested in becoming a VSP provider, please go to [vspglobal.com*](http://vspglobal.com) and fill out the provider form. To access the form, click on *Become A VSP Doctor*, located under the “VSP Doctors” section. For additional information, call 1-800-615-1883.

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

28. Web-DENIS deductible, copay screen changes for BCBSM coverage

**Category:** Web-DENIS

**Title:** Web-DENIS deductible, copay screen changes for BCBSM coverage

**Start Date:** September 24, 2013    **End Date:** October 31, 2013

In preparation for health care reform, we will change the “Deductible /Copay” screen on web-DENIS.

Currently, for Blue Cross Blue Shield of Michigan coverage, we display yearly copay and remaining copay required. We will change this to “Out of Pocket Maximum Used” and “Out of Pocket Maximum Remaining” on Sept. 27, 2013.
29. Use new referral form for Upper Peninsula Blue℠ members

**Category:** Upper Peninsula Blue

**Title:** Use new referral form for Upper Peninsula Blue℠ members

**Start Date:** September 24, 2013    **End Date:** October 8, 2013

We revised the *U.P. Blue Referral Form* and now offer a simple single-page form and a new fax number for submitting it. Please immediately discontinue using the *TRUST PPO/POS Program Referral Form and UP Blue Out-of-State Preauthorization Form*.

Remember to follow these procedures when referring a UP Blue member to an out-of-state provider:

a. Complete the referral before the member receives services from an out-of-state provider.

b. Complete the *U.P. Blue Referral Form* for applicable UP Hospital Blue members within the tier networks.

c. Retrospective referrals will not be approved without documentation from the patient’s medical record indicating the referral was initiated prior to the UP Blue member receiving the services.

d. Fax the *U.P. Blue Referral Form* and supportive documentation to Upper Peninsula Health Plan at 906-225-9268. **Note:** This is a new fax number.

e. UPHP will notify the decision or need for additional information to the referring provider by fax within 48 hours.

f. UPHP will fax the final decision about the referral to the BCBSM Marquette office to send the member a letter notifying him or her of the decision.

g. It is the member’s responsibility to monitor and request his or her claims be reprocessed at his or her plan’s designated PPO benefit level.

To download and print the *U.P. Blue Referral Form*:

h. Click on [bcbsm.com/providers](http://bcbsm.com/providers).

i. Under the “Help” tab, click on *Plan Documents and Forms*.

j. Scroll down and click on *Referrals*.

k. Click on *BCBSM U.P. Blue Referral Form*.

You can also find the form on web-DENIS:

l. Click on *BCBSM Provider Publications and Resources*.

m. Click on *Newsletters and Resources*.

n. Under “Frequently Used Forms” or in the “What’s New” section, click on *U.P. Blue referral form*. 
30. New procedure code added to Medicare Advantage physician office lab list

**Category:** Medicare Advantage

**Title:** New procedure code added to Medicare Advantage physician office lab list

**Start Date:** September 25, 2013  **End Date:** October 25, 2013

Blue Cross Blue Shield of Michigan has added procedure code *83861 to our Medicare Advantage Physician Office Laboratory List. This procedure code is payable in an office setting when performed by an optometrist or ophthalmologist. We hope this addition will support your patient care.

This test is covered by Medicare and other third-party payers when medically necessary and ordered by a licensed provider. It’s covered and reimbursed as a lab service under the federal Clinical Laboratory Improvement Amendments Act.

BCBSM is in the process of quantifying impacted claims billed on or after Jan. 23, 2013, and will adjust them as payable when billed with modifier QW along with a valid, current CLIA certificate.

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

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31. Second Amendment to BCN AdvantageSM Amendment to Medical Service Agreement, Medical Service Agreement MCG Practitioner Affiliation Acknowledgement and Medical Service Agreement MCG Group Practitioner Affiliation Acknowledgement

**Category:** BCN AdvantageSM contract amendments

**Title:** Second Amendment to BCN AdvantageSM Amendment to Medical Service Agreement, Medical Service Agreement MCG Practitioner Affiliation Acknowledgement and Medical Service Agreement MCG Group Practitioner Affiliation Acknowledgement

**Start Date:** September 25, 2013  **End Date:** October 12, 2013

Pursuant to the Mandated Amendment section in the various Blue Care Network of Michigan Affiliation Agreements, this publication serves as notice of amendment. The BCN Advantage amendments listed below are hereby amended to incorporate the indicated changes, effective December 1, 2013. The contractual language updates are related to new and/or revised compliance requirements mandated by the Centers for Medicare & Medicaid Services for “First Tier” entities (which include providers of medical services) contracted with Medicare Advantage organizations.
Please click on the respective links below to obtain a copy of the amendment applicable to each provider type.

a. [BCN Advantage Amendment to Medical Service Agreement](#)
b. [BCN Advantage Amendment to Medical Service Agreement MCG Practitioner Affiliation Acknowledgement for BCN Advantage](#)
c. [BCN Advantage Amendment to Medical Service Agreement MCG Group Practitioner Affiliation Acknowledgement on behalf of Member Practitioners](#)


**Category:** System downtime notification

**Title:** FEP – System downtime for September 28, 2013.

**Start Date:** September 25, 2013  **End Date:** October 1, 2013

The Federal Employee Program application will be unavailable on Saturday, 09/28/2013 until approximately 5 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through Web-DENIS during that period.

33. FEP Eligibility Alert and Medicare or other Current Carrier Coverage

**Category:** FEP Eligibility Alert

**Title:** FEP Eligibility Alert and Medicare or other Current Carrier Coverage

**Start Date:** March 29, 2013  **End Date:** TBD

**The Federal Employee Program (FEP) eligibility information does not currently indicate if Medicare or another carrier is primary.**

Please use the web-DENISMedicare Eligibility feature to determine if Medicare is the primary carrier for your patient.  

34. Transfusion medicine codes denying when submitted on 1500 professional claim forms

**Category:** Medicare Advantage

**Title:** Transfusion medicine codes denying when submitted on 1500 professional claim forms

**Start Date:** September 26, 2013  **End Date:** October 15, 2013
Please remember that transfusion medicine codes are only reimbursed through Outpatient Prospective Payment System and Inpatient Prospective Payment System pricers for Blue Cross Blue Shield of Michigan Medicare Advantage facility claims.

These codes aren’t payable under clinical lab or physician fee schedules. If it is billed on a 1500 claim form, the code will deny as services rendered in a non-payable place of service.

The denial will impact the following claims:

a. Michigan participating providers
b. Michigan non-participating providers
c. Inter-plan Teleprocessing System out-of-state, non-participating providers with local Blue Cross Blue Shield plans
d. ITS Michigan PPO providers servicing out-of-area members

Thank you for your diligence in following the correct billing procedures. If you have any questions, please contact your provider consultant.

35. System issue with physical, occupational and speech therapy claims

Category: Facility Claims

Title: System issue with physical, occupational and speech therapy claims

Start Date: September 30, 2013    End Date: October 31, 2013

BCBSM discovered a system problem with physical, occupational and speech therapy claims processing. We will hold affected claims for dates of service on or after Oct. 1, 2013, until the system is fixed. Once the system has been corrected, we will release the claims for processing.

We apologize for any inconvenience this may cause.

36. Changes to the Eligibility screen on web-DENIS

Category: Web-DENIS Eligibility

Title: Changes to the Eligibility screen on web-DENIS

Start Date: September 30, 2013    End Date: October 15, 2013

On Oct. 15, 2013, we will change the Eligibility screen on web-DENIS for Michigan Operating System contracts.
This change will allow providers to access benefit information at the member level. This change will also decrease confusion with contracts when the subscriber has different benefits than his or her dependants.

37. All Blue Cross Complete trading partners

Category: Blue Cross Complete 835 electronic remittance files

Title: All Blue Cross Complete trading partners

Start Date: September 30, 2013    End Date: October 14, 2013

On Aug. 8, 2013, we communicated that BCC professional and institutional claims processing would no longer be handled by Blue Care Network effective Sept. 1, 2013.

As a clarification, BCC 835 receivers will encounter the following changes:

a. The Payer Name returned in Loop 1000A N102 of the new 835s will be ‘Blue Cross Complete of Michigan’;
b. 835s for claims processed prior to Sept. 1, 2013 will report the Payer Name of ‘BLUECAID’;
c. The application sender code in GS02 has changed to ‘133052274’;
d. 835s for claims processed prior to Sept. 1, 2013 will report ‘FACETSHG’ in GS02;
e. The claim filing indicator code returned in CLP06 will be ‘HM’; and
f. Electronic submitters can expect to receive a weekly 835 remittance advice file.

Electronic submitters experiencing issues with posting or processing of 835 files should contact the EDI Helpdesk at 1-800-542-0945.

38. Web-DENIS enhancements help physicians identify patient gaps in care

Category: Medicare Advantage

Title: Web-DENIS enhancements help physicians identify patient gaps in care

Start Date: September 30, 2013    End Date: October 15, 2013

At the end of September, web-DENIS users will notice more enhancements to help identify gaps in patient care. Now, when clicking on a member care alert, users will be brought to a page in web-DENIS that will display a printable list of diagnosis gaps and treatment opportunities by patient.

Primary care physicians
By clicking on a diagnosis gap or treatment opportunity on the list, you’ll visit our Health e-BlueSM home page. Then:
a. Find your patient listed in your panel
b. Navigate to either the Diagnosis Evaluation panel or Treatment Opportunities by Condition/Measure panel to close patient gaps.

If you don’t have access to Health e-Blue, please download an application from bcbsm.com.

Specialists and other health care providers
If you aren’t eligible to access Health e-Blue, you can still close patient gaps by providing the service and billing on a claim. Please check our website, bcbsm.com/provider, for a list of provider types who are eligible for access.

Thank you for your continued dedication to quality patient care. If you have any questions, please contact your BCBSM provider consultant or BCN provider representative.

39. Additional fee and rate schedules added to web-DENIS

Category: Claims

Title: Additional fee and rate schedules added to web-DENIS

Start Date: September 30, 2013    End Date: October 14, 2013

BCBSM recently added these additional entire fee and rate schedules to web-DENIS, resulting from fee or rate updates, as follows:

a. Facility
   i. Freestanding ESRD Facility 1/1/14
   ii. HIT Rate Schedule effective 1/1/14
   iii. HHC Facility Rate Sheet effective 01/01/2014
   iv. Hospice Rate Schedule 10/1/13
   v. Hospital Outpatient Dialysis rates effective 01/01/14

b. Professional
   i. Ambulance Fee Schedule (1/1/14) (PDF)

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

40. Additional facility fee schedules added to web-DENIS

Category: Claims

Title: Additional facility fee schedules added to web-DENIS
BCBSM recently added additional hospital outpatient and ambulatory surgery facility fee schedules to web-DENIS which includes all fee-based procedure codes in effect on October 1, 2013 (excluding hospital outpatient IND-Drug codes, published quarterly). While all included fees have already been published, BCBSM is republishing in an all-inclusive fee schedule to provide all related codes and fees in one place.

**Hospital Outpatient Fee Schedules**

i. Special fee schedule – All HCPCS fees effective 10/01/13

**Ambulatory Surgery Facility Fee Schedules**

ii. Special fee schedule – All HCPCS fees effective 10/01/13

Normally, BCBSM would remove previously published fee change schedules in conjunction with the publishing of new entire fee schedules. As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. However, since this is a special entire fee schedule publication, the fee change schedules published prior to September 30, 2013, will remain on web-DENIS until we publish the next entire fee schedules resulting from the next fee update.

Entire fee schedules and fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, and selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

41. Additional fee change schedule added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee change schedule added to web-DENIS

**Start Date:** September 30, 2013  **End Date:** October 7, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Sep. 30, 2013:

a. Professional
   i. Traditional, TRUST & Blue Preferred Plus SM
   ii. Independent Lab

b. Facility
   i. Outpatient Hospital
ii. Ambulatory Surgery Facility
iii. Outpatient Physical Therapy

This and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

42. Sequestration fee reductions for Medicare Advantage professional providers

Category: Medicare Advantage

Title: Sequestration fee reductions for Medicare Advantage professional providers

Start Date: September 30, 2013   End Date: January 1, 2014

As a result of the Centers for Medicare & Medicaid Services’ reimbursement reductions due to sequestration, Blue Cross Blue Shield of Michigan will implement a 0.5 percent payment reduction effective Jan. 1, 2014. This is in addition to the current 2 percent payment reduction.

The original 2 percent sequestration reduction was planned for April 1, 2013. However our provider contractual agreements require BCBSM to provide a 90-day notice before initiating these types of changes. Therefore, our sequestration reduction wasn’t implemented until July 1, 2013.

To offset the 90-day delay in implementation, we will increase the sequestration reduction by 0.5 percent Jan. 1.

This sequestration reduction applies to the paid amount for both network and non-network providers. Further details are included in the applicable provider network agreements.

The 0.5 percent reduction will be discontinued Dec. 31, 2014, barring any changes in CMS guidance.

Questions about this reimbursement reduction can be directed to your BCBSM provider consultant.
Sequestration fee reductions for Medicare Advantage professional providers

As a result of the reimbursement reductions at the federal Centers for Medicare & Medicaid Services due to the budgetary sequestration, Blue Cross Blue Shield of Michigan will implement a 0.5 percent payment reduction effective Jan. 1, 2014. This is in addition to the current 2 percent payment reduction.

The original 2 percent sequestration reduction was planned for implementation by April 1, 2013. However, based on our provider contractual agreements, BCBSM is required to provide a 90-day notice before initiating these types of changes. Therefore, our sequestration reduction wasn’t implemented until July 1, 2013.

To offset the 90-day delay in implementation, we will increase the sequestration reduction by 0.5 percent, effective Jan. 1, 2014.

This sequestration reduction applies to the paid amount for both network and non-network providers. Further details are included in the applicable provider network agreements.

If there are no further changes in CMS guidance, the 0.5 percent reduction will be discontinued on Dec. 31, 2014.

This information was also detailed in a Sept. 30, 2013, web-DENIS message.

Questions about this reimbursement reduction can be directed to your BCBSM provider consultant.

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The Record - Sequestration fee reductions for Medicare Advantage professional providers

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
New procedure code added to Medicare Advantage physician office lab list

Blue Cross Blue Shield of Michigan has added procedure code *83861 to our Medicare Advantage Physician Office Laboratory list. This procedure code is payable in an office setting when it’s performed by an optometrist or ophthalmologist. We hope this addition will support your patient care.

This test is covered by Medicare and other third-party payers when it’s medically necessary and ordered by a licensed provider. It’s covered and reimbursed as a lab service under the federal Clinical Laboratory Improvement Amendments Act.

For more information, please see the Sept. 25 web-DENIS message on this topic or contact your provider consultant.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Web-DENIS messages October 2013
1. Second Amendment to Blue Care Network of Michigan Commercial Ancillary, Hospital, Medical Service Agreement, Practitioner, Provider Group and Primary Care Practitioner Agreements

**Category:** BCN miscellaneous

**Title:** Second Amendment to Blue Care Network of Michigan Commercial Ancillary, Hospital, Medical Service Agreement, Practitioner, Provider Group and Primary Care Practitioner Agreements

**Start Date:** October 1, 2013    **End Date:** October 16, 2013

Pursuant to the Generally Applicable Amendments section of the Blue Care Network of Michigan Provider/Practitioner Affiliation Agreements, this publication serves as notice of amendment. The Agreements are hereby amended to incorporate the indicated changes, effective December 1, 2013. The contractual language updates are related to regulatory requirements and language clarification, none of which impact rate of reimbursement. Should you have any questions regarding any of this language, please contact your provider representative.

Please click on the respective links below to obtain a copy of the amendment applicable to each provider type.

- Blue Care Network of Michigan Ancillary Provider Affiliation Agreement
- Blue Care Network of Michigan Hospital Affiliation Agreement
- Blue Care Network of Michigan Medical Service Agreement
- Blue Care Network of Michigan Practitioner Affiliation Agreement
- Blue Care Network of Michigan Provider Group Affiliation Agreement
- Blue Care Network of Michigan Primary Care Practitioner Agreement

2. BCBSM prepares to launch Electronic Provider Access Tool

**Category:** Electronic pre-service review

**Title:** BCBSM prepares to launch Electronic Provider Access Tool

**Start Date:** October 1, 2013    **End Date:** October 15, 2013

Blue Cross Blue Shield Association is requiring that all Blue plans implement the Electronic Provider Access for Pre-Service Review Mandate. Blue Cross Blue Shield of Michigan is set to conform with the mandate Jan. 1, 2014.

Under the terms of the mandate, each Blue plan must provide all other Blue plans with the same electronic pre-service review capabilities that they give to their local providers.
This will make it easier for providers to conduct electronic pre-service reviews, including prenotification, precertification, preauthorization and prior approvals for out-of-state members they treat.

BCBSM providers will use the Electronic Provider Access Tool to gain access to an out-of-state member’s home plan portal through a secure routing mechanism.

Please note that the availability of Electronic Provider Access on Jan. 1, 2014, will vary depending on the capabilities of each out-of-state member’s Blue plan at that time. Some plans may have fully implemented this tool’s capabilities, others may only allow pre-service review for certain services, and others may not have implemented any electronic pre-service review capabilities.

A comprehensive article on the tool is included in the October Record. Additional information will be shared with you as we move close to the implementation date. If you have any questions, please contact your provider consultant.

3. BCBSM electronic provider manuals — September 2013 changes

Category: Online manuals

Title: BCBSM electronic provider manuals — September 2013 changes

Start Date: October 1, 2013   End Date: October 15, 2013

These are the chapters we revised in September 2013, along with the revision date and a brief statement of the main changes for each.*

• **Ambulatory Infusion Center Services** (9/1/2013)
  - “Prescription information” — Added a bullet about AICs requiring a separate and complete medical record.
  - “Billing guidelines” — Made minor changes to wording in the “Electronic billing,” the “Administration component” and the “Pharmaceutical component” sections.

• **Blue Pages Directory** (9/1/2013)
  - "Human Organ Transplant Program" — Added a note to differentiate between HOT benefits and basic benefits
  - "UAW-Ford" — Updated the entire section.

• **BlueCard Program** (9/1/2013)
  - "Using BlueCard" — In the "Verifying coverage and eligibility" section, added a subsection called "Exclusive Provider Organization (EPO)."
  - “Occurrence code 55” — Added this new section
• **Claims (9/4/2013)**
  - "Electronic facility claims" — In the "Paper claim exceptions" section, deleted the "FEP type of bill frequency codes 7 and 8" bullet.
  - "Claims follow-up" — Replaced instructions to "submit a status inquiry claim" with "call Provider Inquiry." Also in this section, reworded "Situation 1."

• **Hearing Care Services (9/19/2013)**
  - “Billing guidelines” — In the “Miscellaneous or NOC procedure codes” section, added a bullet that includes instructions on what to include when reporting NOC codes.

• **Hemophilia Treatment Services (9/18/2013)**
  - "Billing guidelines" — In "Completing the claim" section, "Not otherwise classified code for AHF" subsection, added information about documentation requirements when NOC codes are billed.

• **Outpatient Diabetes Management: Billing and Reimbursement (9/01/2013)**
  - “Medical record documentation” — Added this new section.

• **Participation (9/1/2013)**
  - “Participation agreements” — Deleted the link to the now-outdated Participating Hospital Agreement, leaving only the link to the 9/1/13 agreement.

• **Physician Assistant Services (9/3/2013)**
  - "Definitions" — Updated the types of services PAs may write prescriptions to include infusion therapy services.
  - "Registration" — In the "Registering for a BCBSM PIN" section updated the information on PA network participation.

• **PPO Policies (9/11/2013)**
  - "Referrals" — In the “Out-of-state referrals for Upper Peninsula Blue members” section, updated instructions for the new UP referral form that is replacing two older forms.

• **Psychiatric Care Services (9/3/2013)**
  - "Reimbursement" — Added "minus any member deductibles and copayments" to the wording about our covered services being paid at the BCBSM approved amount.

• **Service Reviews (9/1/2013)**
  - “Audits” — In the “Provider selection” section, added a bullet for under- or overutilization.

• **Vision Care Program: Billing and Reimbursement (9/19/2013)**
  - “Billing guidelines” — In the “Miscellaneous or NOC procedure codes” section, added a bullet that includes instructions on what to include when reporting NOC codes.
*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

4. All BCBSM electronic trading partners

**Category:** 835 enhancements to more accurately report benefit maximums

**Title:** All BCBSM electronic trading partners

**Start Date:** October 1, 2013    **End Date:** December 1, 2013

Starting November 2013, Blue Cross Blue Shield Michigan will distribute enhanced NASCO 835 electronic remittance advice transactions. The enhancements will make it easier to identify a subscriber’s liability amount when the member’s benefit maximum has been exceeded. Professional and institutional 835s will now include a CAS segment in loop 2100 and/or loop 2110 reporting the liability amount:

- Current: PI*119 (PI = Payer Initiated)
- Future: PR*119 (Patient Responsibility)

To assist with patient account reconciliation, EOB’s will also include a line that identifies the benefit excess. Members will be responsible for paying the excess to the provider.

If you have questions regarding this information please call the EDI Help Desk at 1-800-542-0945.

5. Hospital Outpatient Pricing Strategy II project implemented Oct. 1

**Category:** Facility Claims

**Title:** Hospital Outpatient Pricing Strategy II project implemented Oct. 1

**Start Date:** October 2, 2013    **End Date:** October 16, 2013

On Oct. 1, 2013, the HOPS II project began. This means it’s important that providers remember to bill the appropriate revenue codes, as well as the correct Current Procedural Terminology and Health Care Common Procedure Coding System codes, for services provided to our members in a hospital outpatient location.

These changes also apply to BCBSM freestanding outpatient physical therapy facilities and to ambulatory surgery facilities (for services reported with revenue code 0730).
For more details, refer to previously published articles on this topic in The Record and BCN Provider News. You may want to check out the article titled, “Changes to hospital outpatient services reimbursement delayed,” which ran in the March Record.

6. Use new forms to promote discussion between PCPs and behavioral health specialists

Category: Behavioral health referrals

Title: Use new forms to promote discussion between PCPs and behavioral health specialists

Start Date: October 4, 2013   End Date: October 18, 2013

BCBSM’s Behavioral Health Interest Workgroup created a handy way for primary care physicians and behavioral health specialists to communicate with one another about the diagnosis or reason for referral, treatment goals, results and pertinent medical information, including medication lists for a particular patient.

We developed two optional forms to use as a tool to spark communication between PCPs and behavioral health specialists:

- The *Primary Care Behavioral Health Referral Form* may be completed by the primary care physician when initially referring the patient for behavioral health services. The form helps the PCP more clearly specify the reasons for the referral to the behavioral health specialist.
- The *Behavioral Health Provider Report to Primary Care Provider* may be completed by the behavioral health specialist to discuss treatment progress. The form helps the specialist respond to the PCP’s concerns that prompted the referral.

Both forms include a section to be signed by the patient, granting his or her consent for the health care providers to share information related to behavioral health. Providers may print the forms on their own letterhead or otherwise modify the forms to best meet their needs.

To access the forms, log in to web-DENIS:
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters and Resources.*
- On the right side of the screen, under “Frequently Used Forms,” click on *Primary Care Behavioral Health Referral Form* or *Behavioral Health provider report form to Primary Care Provider.*
7. BCBSM updates DRG weights to version 31

Category: Hospital Inpatient Claims

Title: BCBSM updates DRG weights to version 31

Start Date: October 4, 2013   End Date: October 18, 2013

BCBSM MS-DRG Grouper 31 weights for BCBSM inpatient discharges occurring on or after Oct. 1, 2013, through Sept. 30, 2014, are now available in a downloadable format on web-DENIS.

The Grouper 31 MS-DRG weights are posted on the web-DENIS BCBSM Provider Publications and Resources page, under BCBSM Newsletters and Resources, and then BCBSM DRG Weights.

8. All Blue Cross Complete electronic submitters

Category: Duplicate 835 remittance files distributed in error

Title: All Blue Cross Complete electronic submitters

Start Date: October 7, 2013   End Date: October 21, 2013

Due to a systems issue, duplicate 835 remittance files for check dates 9/30/13, 10/1/13 and 10/3/13 were distributed in error. Electronic submitters can disregard the duplicate files dated 10/4/13.

We apologize for any inconvenience

9. All BCBSM commercial trading partners

Category: HealthPlus of Michigan electronic claims now accepted

Title: All BCBSM commercial trading partners

Start Date: October 7, 2013   End Date: November 11, 2013

As a reminder, BCBSM can now accept HealthPlus of Michigan claims electronically. Commercial claim submitters are encouraged to convert from paper to electronic.

To submit HealthPlus claims electronically, trading partners must first complete two enrollment processes.
Existing commercial claim submitters must only complete step #2.

1. Register your billing NPI with the BCBSM clearinghouse.
If you are a new submitter or do not currently submit commercial claims through BCBSM, you will need to complete a Provider Authorization Form online. Provider Authorization instructions and information are located on the login screen: https://editest.bcbsm.com/tpalogon.html. Contact the EDI helpdesk at 1-800-542-0945, Opt. #3, if you require additional assistance.

If you do not register the billing NPI with BCBSM EDI, your claims will reject with an edit of ‘A3 24 85 P003 COMMERCIAL BILLING PROV CODE UNAUTHORIZED’.

2. Register with HealthPlus of Michigan.
   - To receive error reports and electronic remittance information you will need to contact HealthPlus of Michigan at 810-230-2084 or 1-800-345-9956 x 2084 or edicoordinator@healthplus.org.

Once enrolled, trading partners can submit electronic professional 837 claims following these guidelines:

   - Report Source of payment code ‘CI’ in Loop 2000B SBR09
   - Report Payer Name ‘HealthPlus of MI’ in Loop 2010BB NM103
   - Report Payer ID ‘38216’ in Loop 2010BB NM109

If you have any questions regarding submission of 837 electronic claims, please contact the BCBSM EDI helpdesk at 1-800-542-0945.

10. Update: Magellan authorizes rTMS for the treatment of major depressive disorder for select members only

   Category: Mental Health

   Title: Update: Magellan authorizes rTMS for the treatment of major depressive disorder for select members only

   Start Date: October 8, 2013   End Date: October 31, 2013

Transcranial magnetic stimulation may be a benefit for a select subset of patients who meet all of BCBSM’s medical necessity criteria. The benefit applies only to BCBSM underwritten groups, Michigan Education Special Services Association, Michigan Public School Employee Retirement Systems and State of Michigan groups. Auto and national groups are excluded. Refer to members’ certificates for benefit-specific coverage guidelines.

BCBSM will not pay claims for rTMS unless prior authorization has been obtained.
Magellan Behavioral of Michigan Inc. began reviewing requests for this procedure Oct. 1, 2013. Call Magellan at 1-800-762-2382 with these requests. For State of Michigan members, call 1-866-503-3158.

Medical necessity criteria are now available on web-DENIS in the “What’s New” section or under the “Clinical Criteria and other resources” section. To access the criteria:

- Log in to web-DENIS
- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- Under the “What’s New” section, click on *BCBSM Clinical Criteria utilized by Magellan Behavioural of Michigan for repetitive transcranial magnetic stimulation pre-authorization*, under the 2013 updated Magellan Behavioral Health Medical Necessity Criteria bullet.
  - or
- Click on Clinical Criteria & Resources.
- Scroll down to the “Resources” section.
- Click on *BCBSM Clinical Criteria utilized by Magellan Behavioural of Michigan for repetitive transcranial magnetic stimulation pre-authorization*, under the 2013 updated Magellan Behavioral Health Medical Necessity Criteria bullet.

11. Michigan Quality Improvement Consortium clinical practice guidelines

**Category:** Clinical practice guidelines

**Title:** Michigan Quality Improvement Consortium clinical practice guidelines

**Start Date:** October 8, 2013   **End Date:** October 22, 2013

The MQIC has released updated clinical practice guidelines and guideline update alerts on the following topics:

- Outpatient Management of Uncomplicated Deep Venous Thrombosis
- Tobacco Control

Please visit [mqic.org](http://mqic.org) to access the guidelines.
12. Use new revised forms for behavioral health admissions and discharges

**Category:** Facilities

**Title:** Use new revised forms for behavioral health admissions and discharges

**Start Date:** October 8, 2013  **End Date:** October 22, 2013

In an effort to address some provider concerns, we revised the Magellan facility admission and discharge notification form and Magellan individual case management referral form. The current forms are located on web-DENIS and should be used immediately. Remember to use the new forms since all previous versions of the form will not be accepted.

To download the forms:
1. Log in to web-DENIS.
2. In the left-hand navigation, click on *BCBSM Provider Publications and Resources*.
3. Click on *Newsletters & Resources*.
4. Under “Other Resources,” click on *Clinical Criteria & Resources*.
5. In the right-hand column under “Frequently Used Forms,” click on the *Magellan facility admission and discharge notification form or Magellan ICM referral form*.

For more details, see the related article in the [March Record](#).

13. Sequestration fee reduction issues Medicare Advantage claims

**Category:** Medicare Advantage

**Title:** Sequestration fee reduction issues Medicare Advantage claims

**Start Date:** October 10, 2013  **End Date:** October 25, 2013

Blue Cross Blue Shield of Michigan’s Medicare Advantage claims team is working to resolve two system sequestration claims issues:

- The 2-percent sequestration reduction is not automatically taken on some adjusted claims.
- The sequestration message isn’t populated on adjusted claims.

We’re researching claims in which the sequestration reduction is not being applied. Once we determine the number of impacted claims, we’ll schedule those claims for adjustments.
The second issue involves claims in which providers see a sequestration reduction, but the correct sequestration message on the Explanation of Payment and paper remittance voucher doesn’t appear. We plan to implement a new manual sequestration message, 602 (reduction due to Medicare Sequestration). This new message is mapped to CARC PI 223 and anticipated to go into effect by Oct. 31, 2013.

The original 314 automated message (reduction is due to Medicare Sequestration) is still applicable and will populate on claims that do not require an adjustment.

The impacted claim dates of service are:

- April 1, 2013, to present for facility claims
- June 1, 2013, to present for nonparticipating providers’ professional claims
- July 1, 2013, to present for participating providers’ professional claims

Please note that enhanced benefits are also subject to the 2-percent reduction. Claims for enhanced benefits are also impacted by the issues described above.

We’ll update you as we have more information. We appreciate your patience as we work to find a solution.

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

14. ICD-10 provider conference call coming Monday, Oct. 14

Category: All Providers

Title: ICD-10 provider conference call coming Monday, Oct. 14

Start Date: October 10, 2013   End Date: October 15, 2013

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014 implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind. In this session, BCBSM will focus on hospital inpatient coding and results from the BCBSM hospital inpatient recoding project.

Our next call is scheduled for Monday, Oct. 14, from 1 to 2 p.m., Eastern Daylight Time.

To register, click on this link: Register, then enter your name and email address.

Send an email to ICD-10ProviderReadiness@BCBSM.com if:
15. Claims edit F548 not displaying correctly in Provider Claims Correction tool

**Category:** Facility Claims

**Title:** Claims edit F548 not displaying correctly in Provider Claims Correction tool

**Start Date:** October 14, 2013    **End Date:** October 31, 2014

We have identified an issue with facility claims editing with message code F548 and not displaying a description of the edit in Provider Claims Correction.

Edit code F548 should display this message: “An invalid revenue code and HCPCS code combination were billed.” If you receive edit code F548 on a claim without a description of the edit, please check the revenue code and HCPCS code combination.

If your hospital outpatient claim edits with message codes F548, F605 or F806, please remember to use the online Provider Claims Correction application to make corrections to those claims. This allows you to fix the claim and have it reprocessed for payment. If you need assistance with using the PCC tool, please contact your provider consultant.

We apologize for any inconvenience this issue may have caused and appreciate your patience while we work to get the edit code and description displayed in the PCC tool.
16. Update: Magellan authorizes rTMS for the treatment of major depressive disorder for select members only, SOM claims not handled by BCBSM

Category: Mental Health

Title: Update: Magellan authorizes rTMS for the treatment of major depressive disorder for select members only, SOM claims not handled by BCBSM

Start Date: October 14, 2013    End Date: October 31, 2013

Transcranial magnetic stimulation may be a benefit for a select subset of patients who meet all of BCBSM’s medical necessity criteria. The benefit applies only to BCBSM underwritten groups with outpatient psychiatric care benefits, Michigan Education Special Services Association and Michigan Public School Employee Retirement Systems groups. State of Michigan, auto and national groups are excluded. (State of Michigan member mental health claims are processed by a vendor). Refer to members’ certificates for benefit-specific coverage guidelines.

**BCBSM will not pay claims for rTMS unless prior authorization has been obtained.**

Magellan Behavioral of Michigan Inc. began reviewing requests for this procedure Oct. 1, 2013. Call Magellan at 1-800-762-2382 with these requests.

Medical necessity criteria are now available on web-DENIS in the “What’s New” section or under the “Clinical Criteria and other resources” section. To access the criteria:

- Log in to web-DENIS
- Click on **BCBSM Provider Publications and Resources**.
- Click on **Newsletters and Resources**.
- Under the “What’s New” section, click on **BCBSM Clinical Criteria utilized by Magellan Behavioural of Michigan for repetitive transcranial magnetic stimulation pre-authorization**, under the **2013 updated Magellan Behavioral Health Medical Necessity Criteria** bullet. 
  or
- Click on **Clinical Criteria & Resources**.
- Scroll down to the “Resources” section.
- Click on **BCBSM Clinical Criteria utilized by Magellan Behavioural of Michigan for repetitive transcranial magnetic stimulation pre-authorization**, under the **2013 updated Magellan Behavioral Health Medical Necessity Criteria** bullet.
17. BlueCard® claims processing changes

**Category:** BlueCard® claims

**Title:** BlueCard® claims processing changes

**Start Date:** October 14, 2013    **End Date:** October 31, 2013

BlueCard® claims processing will change on Oct. 13, 2013, due to the Inter-Plan Teleprocessing System 13.5 release. The Blue Cross and Blue Shield Association implements these BlueCard software releases twice each year.

If a claim is received with an invalid or missing code (patient status, source of admission, type of bill), that should be caught in our initial front-end edits. However, if that doesn’t happen and the claim is processed, it will be rejected. Providers will have to resubmit the claim with the correct code.

Outlined below are the key changes for this update.

**Patient Status Codes**
Beginning Oct. 13, a patient status code is now required on all institutional inpatient and outpatient claim types, per HIPAA requirements. The patient status code listing has also changed, adding some codes and deleting others.

**SOA Codes**
SOA codes (also known as point of origin) need to be edited for all claims to match industry standards. With this release, the system edits SOA for all claims with the exception of claims with type of bill code 14X (Hospital – Laboratory Services provided to non-patients). This enhancement provides a more accurate picture of all claims.

**TOB Changes**
The following TOB codes have been modified with this release: 32X, 34X, 84X and 89X. TOB code 33X will no longer be accepted.

For more information on these changes, please refer to the National Uniform Billing Committee UB-04 manual. We appreciate your help in accurately coding claims. It helps us process your claims more quickly and accurately. If you have any questions, please contact your provider consultant.
18. All professional electronic submitters

**Category:** New diagnosis code edit for BCBSM MIChild claims (Group #007004505 and Group #31295)

**Title:** All professional electronic submitters

**Start Date:** October 14, 2013    **End Date:** December 18, 2013

Effective Nov. 18, 2013, BCBSM will edit MIChild professional claims reporting an E code as the principal diagnosis. Claims submitted with a ‘BK’ qualifier in Loop 2300 HI01-1 and E code principal diagnosis in Loop 2300 HI01-2, will receive an edit of P953 A3 255 PRINCIPAL DIAGNOSIS CODE CANNOT BE AN E CODE. This new edit will apply to professional claims for MIChild groups 007004505 and 31295 only and be returned on a R277CAH report or 277CAP transaction.

Edited claims will require correction and resubmission.

If you have questions regarding this information or the submission of electronic claims, please contact the EDI Helpdesk at 1-800-542-0945.

19. All Internet claim tool users

**Category:** Payer Filter issues

**Title:** All Internet claim tool users

**Start Date:** October 15, 2013    **End Date:** October 29, 2013

BCBSM has identified that the error message “Changing payer option will reset provider to all” was caused by a Microsoft upgrade to Internet Explorer 10.

At this time, the ICT is not compatible with IE10. Affected ICT providers will need to revert to version IE8 or IE9 to resolve the issue.

Contact your IT administrator or visit [www.microsoft.com](http://www.microsoft.com) for assistance with a downgrade.
20. BCBSM wants to hear from office staff in satisfaction survey

Category: Professional

Title: BCBSM wants to hear from office staff in satisfaction survey

Start Date: October 16, 2013    End Date: December 2, 2013

Blue Cross Blue Shield of Michigan is requesting feedback from physician office and billing managers in the 2013 Physician Office Staff Satisfaction Survey. Participating M.D. and D.O. offices will receive the survey by mail in October and online survey completion will also be available.

BCBSM remains committed to improving our relationship with physician offices. The survey is one way for us to assess our progress and identify opportunities for providing you better service.

The information you provide is confidential, and your responses will be combined with those from other physician offices. An independent research firm is collecting and tabulating results on our behalf.

We appreciate the feedback we’ve received in past years. We hope to hear from your office again this year.

21. Changes to the Eligibility screen on web-DENIS

Category: Web-DENIS Eligibility

Title: Changes to the Eligibility screen on web-DENIS

Start Date: October 16, 2013    End Date: October 31, 2013

On Oct. 15, 2013, we changed the Eligibility screen on web-DENIS for Michigan Operating System contracts.

This change allows providers to access benefit information at the member level. This change also decreases confusion with contracts when the subscriber has different benefits than his or her dependants.

To verify the member’s coverage and benefits for the individual member:

1. Log in to web-DENIS.
2. Click on Subscriber Info in the left navigation bar.
3. Click on Eligibility/Coverage/COB.
4. Enter the member’s contract number.
5. Next to the member’s name, click on the link you wish to obtain benefits for. The benefit links are underlined in blue and to the left of the “COB” button.
6. When the next screen opens, click on the blue “Benefits” button.
7. You will then be able to access the benefits specific to the member you chose.

22. National drug code processing for specialty drug claims delayed to Nov. 15

Category: Specialty drugs

Title: National drug code processing for specialty drug claims delayed to Nov. 15

Start Date: October 16, 2013    End Date: November 15, 2013

BCBSM will delay the move to processing certain health care providers’ specialty drug claims at the national drug code level.

We told you in the September issue of The Record that we would begin this transition Oct. 15 for limited distribution drug specialty pharmacy network providers and for Walgreens’ Specialty Pharmacy. Instead, we will begin processing these claims at the national drug code level beginning Nov. 15.

Look for more information in future issues of The Record.

23. All Blue Cross Complete electronic submitters

Category: Delayed Blue Cross Complete 835 for 10/2/13 check date

Title: All Blue Cross Complete electronic submitters

Start Date: October 17, 2013    End Date: October 31, 2013

Due to a systems issue, professional and institutional BCC 835 remittance files for check date 10/2/13 were delayed. The files have now been received and will be distributed this evening.

We apologize for any inconvenience.
24. Blue Cross Complete denied claims

**Category:** Blue Cross Complete  
**Title:** Blue Cross Complete denied claims  
**Start Date:** October 17, 2013  **End Date:** December 1, 2013

Blue Cross Complete has identified a claims processing issue resulting in some claims being denied in error with the following claim denial reasons:

a. **Q41:** PLEASE SEND US A NEW CLAIM WITH THE CMS CPT OR HCPCS PROCEDURE CODE IN EFFECT ON THIS SERVICE DATE FOR REV CODES THAT DO NOT REQUIRE A HCPCS. (Impacts facility claims only.)

b. **P60:** THERE ARE ONE OR MORE EDITS PRESENT THAT CAUSE THE WHOLE CLAIM TO BE RETURNED TO THE PROVIDER.

Blue Cross Complete has identified the cause for the denials and is working on a fix. The claims affected by the denials will be adjusted; no further action is required by the provider of the service. We apologize for any inconvenience caused by these errors and appreciate your patience as we work to make these system changes. Please contact the Blue Cross Complete Provider Inquiry Line at 1-888-312-5713 with questions or concerns.

25. BCBSM removes compounded hormones from commercial drug coverage

**Category:** Pharmacy  
**Title:** BCBSM removes compounded hormones from commercial drug coverage  
**Start Date:** October 24, 2013  **End Date:** November 7, 2013

As part of our ongoing efforts to promote cost-effective, high-quality prescription drug therapy, we will no longer cover compounded hormone products for Blue Cross Blue Shield of Michigan commercial (non-Medicare) members, effective Nov. 1, 2013. Compounded drugs may expose members to risks from products that have not been tested for safety or effectiveness by the Food and Drug Administration.

This means that BCBSM commercial members will no longer have compounded hormone products covered under their drug benefits. These products include compounds containing any of the following ingredients:
• Estradiol
• Methyltestosterone
• Estrone
• Progesterone
• Hydroxyprogesterone caproate
• Testosterone

This does not apply to members who have Blue Care Network plans, BCBSM Michigan Education Special Services Association plans, BCBSM Medicare Advantage plans or Medicare Part D plans. We will notify affected members of these changes and encourage them to contact their physicians to discuss other treatment options, including commercially available, FDA-approved products on our drug lists.

If you have any questions about our pharmacy programs, call the Pharmacy Services Clinical help desk at 1-800-437-3803 and select Option 1.

26. NASCO ClaimsXTen (CXT)

Category: NASCO ClaimsXTen (CXT) Application will be unavailable on 10/26/13

Title: NASCO ClaimsXTen (CXT)

Start Date: October 25, 2013   End Date: October 28, 2013

There is scheduled maintenance on the NASCO Claims XTen application this weekend. CXT will be unavailable from 8:00p.m.ET on Saturday' 10/26/13 until 11:00p.m.ET on Sunday' 10/27/13.

It is strongly recommended to avoid logging into the CXT application as response time may be impacted. All access to CXT database components will be impacted during the above mentioned time frame.

We apologize for any inconvenience.
27. Claims edit F548 not displaying correctly in Provider Claims Correction tool and claims on hold

**Category:** Facility Claims

**Title:** Claims edit F548 not displaying correctly in Provider Claims Correction tool and claims on hold

**Start Date:** October 25, 2013  **End Date:** November 8, 2013

As previously communicated in a web-DENIS alert, we have identified an issue with facility claims editing with message code F548 and not displaying a description of the edit in Provider Claims Correction.

Currently, facility claims with edit code F548 are on hold in PCC, and hospitals are not able to see which claim line is causing the edit. These claims cannot be corrected in PCC at this time.

As we work to resolve the issue as quickly as possible, claims that edit with codes F548, F605 and F806 will no longer be held in PCC. If your claim is affected by one of these edits, the claim will process, and the revenue line causing the edit will reject. Please correct the claim and resubmit it to us as an adjustment claim for processing.

All claims pending since Oct. 1, 2013, will be moved from PCC and processed. The claim lines that have an invalid revenue code and HCPCS code combination will be rejected with the appropriate rejection message.

28. Blues to discontinue paper vouchers

**Category:** Paper Vouchers

**Title:** Blues to discontinue paper vouchers

**Start Date:** October 25, 2013  **End Date:** December 31, 2013

Blue Cross Blue Shield of Michigan and Blue Care Network will stop printing and mailing paper remittance advices, also known as vouchers, Dec. 6, 2013. BCBSM local facility remittance advices are an exception, which will continue to be mailed.

We’ll also continue to mail paper remittance advices until mid-2014 to out-of-state health care providers paid through the Medicare crossover process or those treating BCN patients.
Going forward, all Michigan health care providers and those outside of the state who have a contract with BCBSM or BCN will have the ability to access online remittance advices. To view them, providers must sign up for Provider Secured Services and ensure that their Blues provider identification numbers are loaded prior to Dec. 6.

In preparation for this change, please make sure that every PIN associated with your national provider identifier is set up appropriately. If a PIN is not on your Secured Services ID, you will not see online remittance advices for affiliated claims. This applies to both paper and electronic claims submissions.

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

a. BCBSM and BCN professionals, hospitals and facilities
b. Billing services

If you need help accessing online remittance advices or signing up for Provider Secured Services, contact your BCBSM provider consultant or BCN provider representative. For technical assistance, you can also call the BCBSM Web Support Help Desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.

29. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: October 28, 2013   End Date: November 11, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Oct. 28, 2013

a. Professional
   i. Traditional, TRUST & Blue Preferred Plus
   ii. Injections
   iii. Independent Lab
   iv. DME
b. Facility
   i. Outpatient Hospital
   ii. Ambulatory Surgery Facility
   iii. Outpatient Psychiatric Care

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.
30. Additional fee schedules added to web-DENIS

Category: Claims

Title: Additional fee schedules added to web-DENIS

Start Date: October 28, 2013   End Date: November 11, 2013

BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective November 1, 2013:

Professional: Injection Fee Schedule

  a. Injections fee schedule 11/01/13

Facility: Hospital Outpatient

  b. Drug fees effective 11/01/13

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will been removed.

These and other fee schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

31. Additional counties transition out of MIChild Blue Cross PPO coverage

Category: MIChild

Title: Additional counties transition out of MIChild Blue Cross PPO coverage

Start Date: October 28, 2013   End Date: November 18, 2013

The following counties will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for their medical, pharmacy and vision benefits on Nov. 1.
Thirteen counties transitioning on Nov. 1

Bay           Lapeer
Cass          Ogemaw
Charlevoix    Saginaw
Crawford      Shiawassee
Gratiot       St. Clair
Huron         Tuscola
Kalamazoo

As we announced in the September issue of *The Record*, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. The first transition involved 34 counties. Members residing in those counties transitioned to Medicaid-approved HMO plans on Oct. 1, 2013. See the September issue of *The Record* for a listing of those counties.

In addition, all MIChild members with Blue Dental℠ coverage transitioned to other dental carriers on Oct. 1.

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

a. Visit [michigan.gov/michild](http://michigan.gov/michild)*. Click on Information for MIChild Providers then click on *MI Child Health Plan Service Contacts and Service Areas Listing.*

b. You can call also contact MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov) for this information or with any questions you may have.

*Blue Cross Blue Shield of Michigan does not control this website or endorse its general content.*
32. Claims for diabetic education reported under G0108 and G0109 rejecting in error

Category: Facility Claims

Title: Claims for diabetic education reported under G0108 and G0109 rejecting in error

Start Date: October 28, 2013    End Date: TBD

Currently, facility claims for diabetic education reported with HCPCS procedure codes G0108 and G0109 are rejecting in error. G0108 and G0109 appropriately represent diabetic education when reported with revenue code 0942.

We apologize for the issue and appreciate your patience while we work to get the codes corrected in our system. We will notify you in a future broadcast message when the claims can be resubmitted for payment.

We apologize for any inconvenience this issue may have caused and appreciate your patience while we work to get the edit code and description displayed in the PCC tool.

33. InterQual® criteria updates now available

Category: InterQual

Title: InterQual® criteria updates now available

Start Date: October 29, 2013    End Date: November 15, 2013

Updates are available to the 2013 pediatric acute and adult acute InterQual criteria. These updates will be effective Nov. 4, 2013.

To access the updates:

a. Log in to web-DENIS.
   b. Click on BCBSM Provider Publications and Resources.
   c. Click on Newsletters and Resources.
   d. Click on Clinical Criteria & Resources in the left navigation bar.
   e. Scroll to the section “BCBSM modifications to InterQual criteria,”
   f. Click on Pediatric Acute Nov. 4, 2013 update and Adult Acute Nov. 4, 2013 update.
Medicare Advantage cardiology codes require preauthorization

Category: Medicare Advantage

Title: Medicare Advantage cardiology codes require preauthorization

Start Date: October 29, 2013    End Date: November 15, 2013

Specific Medicare Advantage radiology cardiology codes require preauthorization, and these claims will reject if the required preauthorization is not obtained.

As of Jan. 1, 2013, as detailed in the December 2012 Record and the Dec. 7, 2012, web-DENIS message, the following cardiology codes require preauthorization:

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BCBSM partners with AIM Specialty HealthSM for radiology utilization management program services. Last year, AIM’s scope was expanded to cardiac services. These services include stress echocardiography, transesophageal echocardiography and resting transthoracic echocardiography.

The following codes are echo add-on, or secondary, codes included in the grouper, but do not require preauthorization: *93320,*93321,*93325, *93352.
Thank you for continuing to follow the PPO utilization guidelines and preauthorization requirements so we can better process your claims. If you have any questions, please contact your provider consultant.

Providers may request prior authorizations for the services listed above in one of two ways:

a. Online via the provider portal at aimspecialtyhealth.com/goweb**
   b. Through the AIM call center at 1-800-738-8008

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35. Joint Venture Hospital Laboratories network now offers electronic funds transfer

Category: Medicare Advantage

Title: Joint Venture Hospital Laboratories network now offers electronic funds transfer

Start Date: October 29, 2013    End Date: November 12, 2013

Many of our health care providers who receive checks from JVHL for certain services for our Medicare Advantage member 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:

a. 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.
   b. If you don’t have access to JVHL’s Provider Resource Center, applyatjvhl.org* and click on Apply to Access.
   c. Call JVHL Business Services at 1-800-445-4979 to initiate the enrollment process.

*BCBSM does not control this website or endorse its general content.
36. BCN revises medical policy on measurement of HE4 effective January 1

**Category:** BCN medical policy

**Title:** BCN revises medical policy on measurement of HE4 effective January 1

**Start Date:** October 30, 2013   **End Date:** November 30, 2013

BCN has revised its medical policy on the measurement of human epididymis protein 4 (HE4). Effective January 1, 2014, the measurement of HE4 is a noncovered service for BCN members. The procedure code impacted is *86305.

HE4 is a potential new serum biomarker that has been cleared by the U.S. Food and Drug Administration (FDA) for monitoring patients with epithelial ovarian cancer. HE4 is proposed as a replacement for or a complement to CA-125 for monitoring disease progression and recurrence. HE4 has also been proposed as a test to screen for ovarian cancer in asymptomatic women.

Measurement of HE4 is experimental/investigational. The clinical utility for identifying disease progression or recurrence has not been established.

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37. Advanced Cardiac Imaging Consortium closing February 2014

**Category:** Professional and Facility claims

**Title:** Advanced Cardiac Imaging Consortium closing February 2014

**Start Date:** October 31, 2013   **End Date:** November 14, 2013

As of Feb, 1, 2014, we will retire the Advanced Cardiac Imaging Consortium, sponsored by Blue Cross Blue Shield of Michigan and Blue Care Network.

During the coming months, the Blues and the ACIC Coordinating Center will be winding down their activities. **Through Jan. 31, 2014, CCTA procedures will continue to be reimbursed at current ACIC CQI participating facilities.**

For more details, see the related article in the November Record.

If you have any questions, contact your provider consultant.
38. Electronic funds transfer for providers using Citizens Bank®

Category: Electronic Funds Transfer

Title: Electronic funds transfer for providers using Citizens Bank®

Start Date: October 31, 2013  End Date: November 15, 2013

Citizens Bank is now FirstMerit® Bank and has changed the routing number on its members’ bank accounts. This change requires no action by our providers for electronic funds transfer. However, if you are a FirstMerit customer, there will be an interruption in your electronic funds transfers for approximately seven to 10 business days while the routing number is updated at Blue Cross Blue Shield of Michigan.

During this time, we will mail you checks. Once the information is updated, we’ll switch your payments back to electronic funds transfer.

If you have any questions about this change, you should contact FirstMerit Bank.
December 2013

**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](http://bcbsm.com/medicare).

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

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December 2013

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-BlueSM 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-BlueSM 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.

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 following dates:

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

If you don’t have access to Health e-Blue, [sign up today](#). 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.

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December 2013

**MPSERS vision coverage changes from EyeMed to BlueVisionSM**

Effective Jan. 1, 2014, the Michigan Public School Employees Retirement System vision plan will change from EyeMed to BlueVisionSM. 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, click [here](http://www.bcbsm.com/newsletter/therecord/record_1213/Record_1213cc.shtml).* If you have any questions, please contact your provider consultant.

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Web-DENIS messages November 2013
1. BCBSM contract with oncology vendor ends Dec. 31, 2013

**Category:** Medicare Advantage

**Title:** BCBSM contract with oncology vendor ends Dec. 31, 2013

**Start Date:** November 14, 2013  **End Date:** December 2, 2013

Our contract with our Medicare Advantage Oncology Management Program vendor, KePRO ends on Dec. 31, 2013, and will not be renewed for 2014. As of July 31, 2013, BCBSM stopped referrals of any Medicare Advantage members to the program.

For those members who are currently enrolled in the program, our Wellness and Care Management team has developed a transition plan.

For current Oncology Management Program participants, if their condition no longer requires case management, their case will be closed. For those current members who need further case management after Dec. 31, 2013, they each will be reassigned to a BCBSM Case Management Program case manager. The case manager will continue to monitor the member’s condition and course of care.

If a BCBSM Medicare Advantage member was recently diagnosed or was previously in the program but his or her condition has deteriorated, providers can refer members to our Case Management Program at 1-800-845-5982. The case manager will review the case and determine if the member is eligible for a care management program.

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

2. BCN hosts Behavioral Health webinars

**Category:** BCN Behavioral Health webinars

**Title:** BCN hosts Behavioral Health webinars

**Start Date:** November 14, 2013  **End Date:** November 29, 2013

Blue Care Network has invited its behavioral health providers to attend an upcoming webinar to be held on December 2, 3, 4 and 6. The webinars will discuss the 2014 Behavioral Health Incentive Program, coding and authorization updates, and tools to make the job easier.

For more information, please contact Christina Caldwell by email or by phone at 734-332-2949.

3. CMS expects delay in release of 2014 HCPCS update and final coding decisions
Category: 2014 Procedure Codes and Fees

Title: CMS expects delay in release of 2014 HCPCS update and final coding decisions

Start Date: November 13, 2013   End Date: December 31, 2013

Recently the Centers for Medicare & Medicaid Services announced that the partial government shutdown is expected to impact completion of the 2014 Healthcare Common Procedure Coding System coding update. CMS intends to publish the 2014 annual HCPCS update file by Nov. 27, 2013 (based on the timing of the final rules), with new HCPCS codes effective Jan. 1, 2014, unless otherwise specified.

Because of the government delay, we anticipate a delay in our ability to implement the codes this year. This may delay our claims payments. This may also cause a delay in the publication of the Jan. 1, 2014, HCPCS update fee change schedules that will contain the newly added codes and related fees. These are normally published prior to Jan. 1.

We are preparing a contingency plan to ensure the new and revised HCPCS codes are accepted in our claims system. This means we will be ready to accept the new codes Jan. 1, but we anticipate a delay in claims processing.

The delayed release will also change our annual HCPCS News. We will publish this on web-DENIS by Jan. 1 as usual for the Current Procedural Terminology codes owned by the American Medical Association. We’ll update HCPCS News with the CMS HCPCS codes and our coverage decisions when that information is available.

4. Medicare Advantage durable medical equipment test strips claims

Category: Medicare Advantage

Title: Medicare Advantage durable medical equipment test strips claims

Start Date: November 13, 2013   End Date: November 30, 2013

BCBSM denied approximately 2,000 durable medical claims in error for diabetic test strips when reported with procedure codes A4253, A4256 and A4259. The claims were for a 90-day supply of diabetic supplies and were billed spanning two calendar years (e.g.: 2013 and 2014). The claims were rejected with code 034.

We’re currently holding these claims so they don’t process incorrectly and cause more confusion. We anticipate correcting the error by Dec. 6, 2013, and will then reprocess the affected claims.

Thank you for your patience as we work to fix this issue. If you have any questions, please contact your provider consultant.
5. Enter to win a $250 gift certificate – Take the 2013 BCN Care Management survey

**Category:** BCN Care Management

**Title:** Enter to win a $250 gift certificate – Take the 2013 BCN Care Management survey

**Start Date:** November 11, 2013   **End Date:** December 31, 2013

Blue Care Network Care Management Services wants to hear from you! How can we improve our services to better meet your needs and those of the BCN members you serve? Please take our [online survey](#) for a chance to win one of two $250 gift certificates. Survey responses must be submitted no later than December 31 to be eligible for the drawing. One entry per person. Winners will be chosen in January 2014.

A letter signed by Dr. Duane DiFranco has also been mailed to physician offices inviting them to participate in the survey.

6. Claims for diabetic education reported under G0108 and G0109 rejecting in error

**Category:** Facility Claims

**Title:** Claims for diabetic education reported under G0108 and G0109 rejecting in error

**Start Date:** November 8, 2013   **End Date:** November 22, 2013

Effective Nov. 1, 2013, procedure codes G0108 and G0109 have been loaded to process correctly when reported with revenue code 0942 for diabetic education. A recovery to reprocess claims that were rejected in error is planned, but the recovery date has not been determined. You may resubmit previously rejected claims, if you choose not to wait for the system recovery.

We appreciate your cooperation as we worked to resolve this issue. If you have any questions, please contact your provider consultant.

7. All Internet Claim Tool Users

**Category:** Internet claim Tool Offline November 7, 2013

**Title:** All Internet Claim Tool Users

**Start Date:** November 8, 2013   **End Date:** November 22, 2013
The BCBSM Internet Claim Tool was offline in the late afternoon of Thursday, November 7th. The downtime lasted for approximately three hours. The BCBSM Internet Claim Tool application is available for use.

We appreciate your patience as we worked to correct the problem and apologize for the inconvenience this may have caused.

8. Internet Claim Tool system is currently unavailable

Category: All ICT users

Title: Internet Claim Tool system is currently unavailable

Start Date: November 7, 2013   End Date: November 21, 2013

Please be advised that the BCBSM Internet Claim Tool application is offline this evening, November 7, 2013. We are working with our technical team to address the issue, but anticipate the site will be down for a minimum of two hours.

ICT users will be unable to access the site or transmit claims during the downtime. An update will be posted once the site is operational.

We appreciate your patience as we work to correct the problem.

9. Hospital Outpatient Pricing Strategy II update

Category: Facility Claims

Title: Hospital Outpatient Pricing Strategy II update

Start Date: November 7, 2013   End Date: November 21, 2013

We have identified some facility claims processing issues with the HOPSII changes that went into effect Oct. 1, 2013. We will notify you when we’ve made changes to our claims processing system.

Anesthesia services reported with revenue codes 0370 and 0379 are rejecting when a Current Procedural Terminology or Health Care Common Procedure Coding System code is not reported. We are working to remove the rejection that requires a procedure code for anesthesia in these instances.

Revenue codes 0251-0254 and 0256-0259 are also rejecting when a procedure code is not reported. BCBSM requests that you report the appropriate procedure code when one is available for these services. If ancillary pharmacy is reported and there is not a procedure code for the service, please report the ancillary pharmacy code under revenue code 0250.
Hyperbaric oxygen therapy reported with revenue code 0413 is appropriately rejecting when a procedure code is not reported. The only acceptable procedure code for HBOT services is C1300. Although BCBSM does not routinely accept Level III “C” codes, it will be acceptable when reporting HBOT with revenue code 0413 when the changes have been made.

We apologize for any inconvenience these reporting requirements may have caused you. If you have any questions, please contact your provider consultant.

10. NaviNet and Jiva system maintenance November 9 and 10

Category: System Outage

Title: NaviNet and Jiva system maintenance November 9 and 10

Start Date: November 6, 2013   End Date: November 11, 2013

NaviNet and Jiva will be unavailable this weekend from 9 p.m. on Saturday, November 9, until 6 a.m. on Sunday, November 10.

For assistance during this time, please call 1-888-312-5713.

We apologize for the inconvenience.

11. Revised fee schedule added to web-DENIS

Category: Claims

Title: Revised fee schedule added to web-DENIS

Start Date: November 5, 2013   End Date: November 19, 2013

BCBSM recently revised the Hospital Outpatient Drugs entire fee schedule to show the service category. The following entire fee schedule reflects fee update effective November 1, 2013:

Facility: Hospital Outpatient

- Drug fees effective 11/01/13 (Revised to include Service Category)

As noted in our Sept. 13, 2010, web-DENIS broadcast alert, fee change schedules will remain available on web-DENIS until the next entire fee schedule is published. In conjunction with the publication of the entire fee schedules, all previously published professional injection fee change schedules will been removed.
These and other fee schedules are available on web-DENIS under BCBSMProvider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

For more information, contact your BCBSM provider consultant.

12. Benefit Configurator

**Category:** Benefit Configurator Unavailable Saturday Nov. 9 until Sunday Nov. 11, 2013

**Title:** Benefit Configurator

**Start Date:** November 6, 2013  **End Date:** November 12, 2013

There is scheduled maintenance for the Benefit Configurator Service. The maintenance will begin on Saturday November 9 at 5:00PM and should be completed by Monday November 11, 2013 at 7:00 AM.

Attempts to access the Benefit Configurator Service will result in errors.

We appreciate your patience during this time.

13. ICD-10 conference call and presentation scheduled for Monday, Nov. 11

**Category:** Professional

**Title:** ICD-10 conference call and presentation scheduled for Monday, Nov. 11

**Start Date:** November 5, 2013  **End Date:** November 12, 2013

ICD-10 is coming and it **will** affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind. In this session, BCBSM will focus on ICD-10 Provider Readiness and Coding Tips for Medical Practices with a focus on internal medicine, family and general practices.

Our next call is scheduled for Monday, Nov. 11 from 1 to 2 p.m. Eastern Time. [Register](#) for the session on our website.

**Meeting information** Topic: ICD-10 Provider Readiness and Coding Tips for Medical Practices with a focus on internal medicine, family and general practices

**Date:** Monday, Nov. 11, 2013
**Time:** 1 p.m., Eastern Time
Session Number: 735 049 438 Registration password: This session does not require a registration password.

Send an email to ICD-10providerreadiness@BCBSM.com if:

- You would like us to cover a specific topic in a future webinar, or you have questions related to ICD-10.0
- Your organization would like to participate in a future webinar.
- You are having issues with the link above or logging into the call.
- You are unable to participate in the webinar and would like a copy of the presentation.

A copy of the presentation will be sent the day of the webinar to those who register.

14. Recovery underway for OSF St. Francis and West Branch Regional hospital claims

Category: Recoveries

Title: Recovery underway for OSF St. Francis and West Branch Regional hospital claims

Start Date: November 5, 2013   End Date: November 19, 2013


Facility claims for OSF St. Francis and West Branch Regional were processed and checks were erroneously sent, when our payment should have appeared on an interim payment voucher. We’re taking back our checks and replacing them with the correct voucher.

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

Category: Claims

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

Start Date: November 4, 2013   End Date: November 18, 2013

In accordance with Centers for Medicare & Medicaid Services guidelines, BCBSM will begin accepting a new version of the CMS-1500 Health Insurance Claim Form on Jan. 6, 2014.

You’ll be able to order the new form (version 02/12) after Jan. 1, 2014, by using the Blue Pages Directory on web-DENIS. The new form will replace the current form (version 08/05) as well as the Michigan Status Claim Review Form.
Please note if you submit the new CMS-1500 Health Insurance Claim Form (version 02/12) before Jan. 6, 2014, it will be returned. Also, you can continue to use the current form through March 31, 2014.

For more details, including a look at the new form and an overview of the transition timeline, see the November Record article.

16. BCBSM electronic trading partners, vendors and clearinghouses

**Category:** Validator self-testing tool maintenance

**Title:** BCBSM electronic trading partners, vendors and clearinghouses

**Start Date:** November 4, 2013  **End Date:** November 18, 2013

The BCBSM HIPAA Validator online self-testing tool and Provider Authorization application will be unavailable on Saturday, 11/09/13, from 7:30 AM – 9:30 AM, in order to perform system maintenance. Users will be unable to access the application during this time period.

We apologize for any inconvenience

17. BCBSM electronic provider manuals — October 2013 changes

**Category:** Online manuals

**Title:** BCBSM electronic provider manuals — October 2013 changes

**Start Date:** November 1, 2013  **End Date:** November 15, 2013

These are the chapters we revised in October 2013, along with the revision date and a brief statement of the main changes for each.*

• Ambulance Services (10/1/2013)
  
  “Reimbursement” — Added a link to the future Ambulance Provider Participation Agreement (effective 1/1/14).

• Appeals (10/1/2013)

  Throughout the chapter — Based on BCBSM’s transition to a nonprofit mutual insurer as of January 1, 2014, added future changes to this chapter and marked them “effective 1/1/14.”

• BlueCard Program (10/1/2013)
“Physical, occupational and speech therapy services: billing for BlueCard claims” — Deleted this section.

- “Occurrence code 55” — Changed the form locator from 15 to 18-28.

**Cardiac Rehabilitation Services (10/1/2013)**

“Billing guidelines” — Added this new section with an instruction to refer to the *HCPCS Payment Rule Information and Associated Revenue Codes* chart.

- “Reimbursement” — Added this new section.

**Claims (10/1/2013)**

“Claims examples” — Updated numerous claims examples based on HOPS II changes and type of bill changes for home health care.

**Dialysis Services (10/1/2013)**

“Reimbursement” — Added links to the future *End Stage Renal Disease Facility Participation Agreement* (effective 1/1/14) and the *TRUST End Stage Renal Disease Facility Network Affiliation Agreement* (effective 1/1/14).

*Documentation Guidelines for Physicians and Other Professional Providers* (10/10/2013)

- "Mental health and substance abuse services” — Updated the entire section.

**Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services (10/1/2013)**

“Durable equipment” — In the “Documentation requirements for claims” subsection of the “Documentation requirements” section, revised the note clarifying what to include when reporting NOC codes.

“Medical supplies” — In the “Documentation requirements for claims” subsection of the “Documentation requirements” section, revised the note clarifying what to include when reporting NOC codes.

“P&O” — In the “Documentation requirements for claims” subsection of the “Documentation requirements” section, revised the note clarifying what to include when reporting NOC codes.

**HCPCS Payment Rule Information and Associated Revenue Codes (10/9/2013)**
- Updated the chart based on the HOPS II project.

• *Hearing Care Services (10/1/2013)*

  “Reimbursement” — Added a link to the future *Hearing Specialist Provider Participation Agreement* (effective 1/1/14).

• *Home Health Care Services (10/4/2013)*

  - “Noncovered services” — Added medical supplies to the list.

• *Hospice (10/1/2013)*

  “Reimbursement” — Added a link to the future *Hospice Provider Participation Agreement* (effective 1/1/14).

• *Hospice Hospital Services (10/1/2013)*

  Made changes in the following sections:
  - Anesthesia
  - Blood
  - Cosmetic surgery
  - Dialysis
  - DME
  - Emergency treatment
  - Enteral and Parenteral nutrition
  - Maternity care and delivery
  - Observation bed
  - Urgent care services

  Added the following new sections:
  - Ambulance services
  - Pulmonary rehab and general therapeutic services
  - Treatment room services
  - Frequently asked questions

• *Introduction (10/1/2013)*

  - “Coverage” — Added information about the Affordable Care Act.
  - “PPO coverage” — Updated the content in the “MIChild” section.

• *Long-Term Acute Care Hospital Services (10/1/2013)*
“Reimbursement” — Added a link to the future Long-Term Acute Care Hospital Participation Agreement (effective 1/1/14).

- **Medical-Surgical Services (10/1/2013)**

  “Allergy testing and allergen immunotherapy” — In the “Noncovered services” section, deleted “investigational” from the term “investigational/experimental” now that “experimental” is our preferred term.

- **Outpatient Diabetes Management Services: Billing and Reimbursement (10/1/13)**

  “Diabetes education services” — Added this new section with an instruction to refer to the HCPCS Payment Rule Information and Associated Revenue Codes chart.

- **Participation (10/1/2013)**

  “Participation agreements” — Added links to 11 future participation agreements, all of which are effective 1/1/14:

  - Ambulance Provider Participation Agreement
  - CRNA Direct Reimbursement Participation Agreement
  - End Stage Renal Disease Facility Participation Agreement (Traditional)
  - End Stage Renal Disease Facility Network Affiliation Agreement (TRUST)
  - Hearing Specialist Provider Participation Agreement
  - Hospice Provider Participation Agreement
  - Long-Term Acute Care Hospital Participation Agreement
  - Practitioner Traditional Participation Agreement
  - Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement
  - Substance Abuse Facility (Freestanding and Hospital-Based) Participation Agreement
  - Vision Specialist Provider Participation Agreement
  - Physical Therapy, Occupational Therapy, and Speech Therapy Service (10/1/2013)
- Made changes in the following sections:
  
  • Billing guidelines: “Evaluations and re-evaluations”
  
  • Billing guidelines: “Reporting therapy visits”
  
  • Reimbursement
  
  - Updated the *HCPCS Payment Rule Information and Associated Revenue Codes* chart.

- *Psychiatric Care Services* (10/1/2013)
  
  Outpatient psychiatric care program - facility” — In the "Noncovered services" section, added a parenthetical statement to the "Biofeedback training" bullet describing instances where training is payable
  
  “Reimbursement” — In the “Professional providers” section, added a link to the future *Practitioner Traditional Participating Agreement* (effective 1/1/14).

- *Problem Resolution* (10/1/2013)
  
  “Web-DENIS” — Added a new bullet, "Critical Provider Issues page," to the list of things to which web-DENIS gives you access.

- *Radiology Management Program Procedure Codes* (10/2/2013)
  
  "Orthopedists (specialty code 20) - orthopedic surgery" — Added 11 codes to the privileging chart and deleted one code (77052).

  "Sports medicine physicians (specialty code 78)" — Added 21 codes to the privileging chart and deleted one code (77052).

- *Skilled Nursing Facility Services* (10/1/2013)
  
  "Noncovered services” — In the “Biofeedback training” bullet, added an exception.

  “Reimbursement” — Added a link to the future *Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement* (effective 1/1/14).

- *Substance Abuse Treatment Services* (10/1/2013)
  
  "Reimbursement” — Added a link to the future *Substance Abuse Facility (Freestanding and Hospital-Based) Participation Agreement* (effective 1/1/14).

- *Valid Modifiers* (10/1/2013)
Throughout the chapter — modified all sections to reflect the 2013 code updates.

• **Vision Care Program: Billing and Reimbursement** (10/1/2013)
  
  “Reimbursement” — Added a link to the future *Vision Specialist Provider Participation Agreement* (effective 1/1/14).

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

18. All institutional trading partners

**Category:** Changes to EDI setup for new institutional/facility electronic submitters

**Title:** All institutional trading partners

**Start Date:** November 27, 2013  **End Date:** January 27, 2014

Blue Cross Blue Shield of Michigan recently published several communications about implementing EFT and ERA changes that align with the Affordable Care Act-mandated Operating Rules. As part of these changes, BCBSM EDI will make minor changes to the way new facility trading partners register to submit electronically.

Effective immediately, NEW facility submitters will use a tax identification number as their unique trading partner ID when completing a Provider Authorization and ERA Enrollment form. The tax ID is now used for trading partner set up instead of a 5-character submitter code beginning with “S” or “F”. This effects new, first time enrollments or updates to current enrollments.

Going forward, facility providers will complete a Provider Authorization using these guidelines:

- Tax ID column: Key the tax identification number of the provider or facility.
- Submitter ID column: Key the tax identification number of the clearinghouse or entity that submits claims on your behalf. If you are a direct submitter, include the tax ID of your hospital, clinic or facility.
- Trading Partner ID column: Key the tax identification number of entity that will receive your 835 remittance files.

Facility submitters who previously completed a provider authorization using the BCBSM EDI assigned code of “Fxxxx” or “Sxxxx” as the trading partner ID will not need to re-register.

Contact the EDI Helpdesk at 1-800-542-0945, Opt. 3 with questions or for assistance.
19. Additional counties to transition out of MIChild Blue Cross PPO coverage on Dec. 1

Category: MIChild

Title: Additional counties to transition out of MIChild Blue Cross PPO coverage on Dec. 1

Start Date: November 27, 2013   End Date: December 20, 21013

The following counties will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for their medical, pharmacy and vision benefits on Dec. 1, 2013.

Four counties transitioning on Dec. 1

- Clinton
- Eaton
- Ingham
- Isabella

As we announced in the September issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1.

First transition happened on Oct. 1, and included these 34 counties:

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
</tbody>
</table>
Second transition happened on Nov. 1, and includes these 13 counties:

<table>
<thead>
<tr>
<th>Houghton</th>
<th>Mason</th>
<th>Washtenaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit [michigan.gov/michild](http://michigan.gov/michild). Click on Information for MIChild Providers then click on MI Child Health Plan Service Contacts and Service Areas Listing.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

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

20. Prior authorization to be required for additional specialty drugs

**Category:** Specialty drugs

**Title:** Prior authorization to be required for additional specialty drugs

**Start Date:** November 27, 2013    **End Date:** March 1, 2014

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.
The following drugs will be added to the prior authorization program:

<table>
<thead>
<tr>
<th>Drug</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilaris® (canakinumab)</td>
<td>J0638</td>
</tr>
<tr>
<td>Krystexxa® (pegloticase)</td>
<td>J2507</td>
</tr>
<tr>
<td>Mozobil® (plerixafor)</td>
<td>J2562</td>
</tr>
<tr>
<td>Nplate® (romiplostim)</td>
<td>J2796</td>
</tr>
<tr>
<td>Simponi® Aria™ (golimumab)</td>
<td>J3590</td>
</tr>
<tr>
<td>Soliris® (eculizumab)</td>
<td>J1300</td>
</tr>
<tr>
<td>Xolair® (omalizumab)</td>
<td>J2357</td>
</tr>
</tbody>
</table>

The following drugs continue to require prior authorization:

<table>
<thead>
<tr>
<th>Drug</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actemra® (tofacitinib)</td>
<td>J3262</td>
</tr>
<tr>
<td>Acthar® gel (repository corticotropin injection)</td>
<td>J0800</td>
</tr>
<tr>
<td>Benlysta® (belimumab)</td>
<td>J0490</td>
</tr>
<tr>
<td>Botox® (onabotulinumtoxin A)</td>
<td>J0585</td>
</tr>
<tr>
<td>Dysport® (abobotulinumtoxin A)</td>
<td>J0586</td>
</tr>
<tr>
<td>Makena® (hydroxyprogesterone caproate)</td>
<td>J1725</td>
</tr>
<tr>
<td>Myobloc® (rimabotulinumtoxin B)</td>
<td>J0587</td>
</tr>
<tr>
<td>Orencia® (abatacept)</td>
<td>J0129</td>
</tr>
<tr>
<td>Prolia® (denosumab)</td>
<td>J0897</td>
</tr>
<tr>
<td>Stelara® (ustekinumab)</td>
<td>J3357</td>
</tr>
<tr>
<td>Xeomin® (incobotulinumtoxin A)</td>
<td>J0588</td>
</tr>
<tr>
<td>Xiaflex® (collagenase clostridium histolyticum)</td>
<td>J0775</td>
</tr>
<tr>
<td>Xgeva® (denosumab)</td>
<td>J0897</td>
</tr>
</tbody>
</table>
You can find the Medication Authorization Request Forms on the web-DENIS BCBSM Newsletters and Resources page. Click on Physician administered medications on the right side of the screen, under “Frequently Used Forms.”

A prior authorization approval is not a guarantee of payment. The prior authorization is a clinical review. Health care providers must still verify eligibility and benefits for members, or members will be responsible for the full cost of medications that are not covered.

Please refer to the opt-out list of employer groups that are currently not included in the program and do not require prior authorization for these drugs.

21. All Blue Cross Complete electronic submitters

Category: Delayed Blue Cross Complete 835 remittance advice files for check date Nov. 20, 2013

Title: All Blue Cross Complete electronic submitters

Start Date: November 27, 2013  End Date: December 11, 2013

Due to a systems issue, professional and institutional BCC 835 remittance files for check date Nov. 20, 2013 have been delayed. BCBSM will distribute the files as soon as possible.

We apologize for any inconvenience.

22. Medicare Plus Blue℠ PPO manual will be updated Jan. 1, 2014

Category: Medicare Advantage

Title: Medicare Plus Blue℠ PPO manual will be updated Jan. 1, 2014

Start Date: November 26, 2013  End Date: December 15, 2013

Blue Cross Blue Shield of Michigan will update its Medicare Plus Blue PPO manual in January 2014. Key changes include:

- Adding CAREN Medicare Advantage dental phone number
- Clarifying durable medical equipment out-of-network claims
- Adding information on Blue Care Connect℠
- Deleting the information regarding the Oncology Management program (Our contract with the vendor has ended.)
- Deleting content on Blue Advantage Rewards (The program will be discontinued Dec. 31, 2013.)
- Clarifying preauthorization requirement for behavioral services
Adding claims filing information regarding the new version of the CMS-1500 claim
Adding detail regarding risk-adjustment medical record reviews
Adding an example under Qualifications and Requirements for those in good standing, with no license limitations

You can obtain the most current version of the manual at bcbsm.com/provider/ma.

This message serves as notice of these changes to the Medicare Plus Blue PPO manual per the terms of the MA PPO Provider Agreement, available online at bcbsm.com/provider/ma.

23. Don’t report national drug codes with medical drug administration procedure codes

Category: Medical drugs

Title: Don’t report national drug codes with medical drug administration procedure codes

Start Date: November 26, 2013   End Date: December 10, 2013

BCBSM has started processing claims for medical drugs administered by health care practitioners at the national drug code level. While we’ve asked you to report drug NDCs with procedures codes on your claims, please do not report the national drug code with the drug’s administration procedure code.

The NDC is not required on claim lines reporting drug administration services. But please continue to report the NDC on claim lines reporting medical drug procedure codes. This allows us to identify the exact drug and quantity for accurate payment.

For more information, please refer to the September issue of The Record.

24. Oxygen and oxygen equipment rental policy change

Category: Benefits

Title: Oxygen and oxygen equipment rental policy change

Start Date: November 26, 2013   End Date: January 1, 2014

In the October 2013 Record billing chart, we announced that effective Jan. 1, 2014, BCBSM would adopt Medicare’s coverage of oxygen and oxygen equipment rental for up to 36 months. At this time, the decision has been made to maintain our current oxygen and oxygen equipment rental policy.
We are continuing to evaluate the policy. We will update you regarding any changes in a future Record article.

25. Helpful hints for CMS-1500 claim, Field 19

Category: Medicare Advantage

Title: Helpful hints for CMS-1500 claim, Field 19

Start Date: November 22, 2013   End Date: December 6, 2013

Field 19 on the CMS-1500 claim can be used to provide additional information you would like us to consider during the claim’s processing. It can also be used to indicate you’re correcting a claim, if you insert “correct claim” with the claim number in Field 19.

Here are some more helpful hints:

- Enter the statement "homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub.100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services"; Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers"; and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5,"Definitions" respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)
- Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a nonparticipating physician or supplier who accepts assignment on a claim. In this case, payment can only be made directly to the subscriber.
- Enter the statement "Testing for hearing aid" when billing services involving the testing of a hearing aid is used to obtain intentional denials when other payers are involved.
- When billing a dental examination, enter the specific surgery for which the exam is being performed.
- Enter the specific name and dosage when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.
- Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | YYYY) assumed or relinquished date for a global surgery claim when providers share postoperative care.
- Enter demonstration ID number "30" for all national emphysema treatment trial claims. Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.
- Enter the national provider identifier of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-
markup payment limitation. (See Pub. 100-04, Chapter 1, section 30.2.9 for additional information.)


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

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

26. HCPCS payment rule chart available on web-DENIS

Category: HCPCS Chart

Title: HCPCS payment rule chart available on web-DENIS

Start Date: November 22, 2013   End Date: December 13, 2013

The HCPCS payment rule chart, which includes a list of the revenue codes that must be reported with a procedure code, is available in the online outpatient provider manuals. Now you can also view the chart on the BCBSM Publications and Resource page on web-DENIS.

Please use this chart to determine the procedure code category and the associated revenue codes. Click here to view the chart.

You may also follow the steps below to access the document through the BCBSM Newsletters and Resources page on web-DENIS:

- Log in to web-DENIS.
- Click on BCBSM Provider Publications and Resources in the left navigation bar.
- Click on Newsletters and Resources.
- Click on Clinical Criteria and Resources in the left navigation bar.
- In the Resources section, click on HCPCS Payment Rule Information and Associated Revenue Codes chart.

27. Seasonal influenza vaccine claim issue for Medicare Advantage members

Category: Medicare Advantage

Title: Seasonal influenza vaccine claim issue for Medicare Advantage members

Start Date: November 21, 2013   End Date: December 5, 2013

We’re working to correct a claims processing error with seasonal influenza vaccine claims when a Medicare Advantage member receives more than one influenza
vaccination within the same calendar year. The second flu vaccination is incorrectly rejecting with code 347, “number of visits exceeded.”

The Centers for Medicare & Medicaid Services guidelines permit one flu vaccination per season. Medicare Advantage members are allowed to receive two flu vaccines within one calendar year, but each vaccine must be administered during different flu seasons.

We’re in the process of fixing this issue, allowing you to be paid for two flu vaccines administered during the same calendar year. Any denied claims will be adjusted; you don’t need to resubmit them.

We apologize for any inconvenience this issue may have caused and appreciate your patience as we work to correct it.

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

28. We’re clarifying how DME suppliers should file claims

Category: Durable medical equipment

Title: We’re clarifying how DME suppliers should file claims

Start Date: November 21, 2013   End Date: December 5, 2013

We’d like to clarify where a durable equipment medical supplier should file claims. As we reported in the November 2012 Record, DME suppliers should file claims with the plan in whose state the equipment or supplies were shipped to, if they’re mailed, or purchased at, if bought at a retail store.

For items purchased in a retail store, you would use place of service “11” for commercial claims only. (For Medicare primary and Medical Advantage claims, CMS billing guidelines apply.) Please note that some claims have been incorrectly rejected when place of service 11 is used, and we’re working to resolve this system issue. If your claim is rejected, please contact Provider Servicing.

For more details on how DME suppliers should submit claims, see the article titled, “Updates announced for how DME suppliers, independent labs should submit claims” in the December 2013 Record, which will be available online Nov. 27.

29. Reminder: BCBSM Medicare Advantage electronic funds transfer begins

Category: Medicare Advantage

Title: Reminder: BCBSM Medicare Advantage electronic funds transfer begins

Start Date: November 20, 2013   End Date: December 15, 2013
The BCBSM Medicare Advantage electronic funds transfer initiative will be implemented on Dec. 6, 2013.

All professional providers should already be signed up for electronic funds transfer. **EFT is already mandatory for commercial claims.** If you aren’t registered for the service, you must sign up for Provider Secured Services first. Then you can register for EFT to begin receiving electronic payments from the Blues. EFT gives you faster access to your payments, and there is no cost to participate.

If you need help accessing online remittance advices or signing up for Provider Secured Services or electronic funds transfer, contact your BCBSM provider consultant. For technical assistance, you can also call the BCBSM Web Support Help Desk at 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m.

These changes are part of the actions we are taking as a result of the federally mandated EFT-ERA Operating Rule requirements.

**How to search for remittance advices online**

All Michigan health care providers have the ability to access [online remittance advices](http://bcbsm.com/vouchers) for the Blues. To view them, providers must sign up for Provider Secured Services. Then go to [bcbsm.com/vouchers](http://bcbsm.com/vouchers) to find the steps for locating a voucher or remittance advice online. You can access up to three years of remittance advice history with the ability to search by check number, EFT trace number, period of time or specific patient.

30. MPSERS enhances LivingWell program

**Category:** Benefits

**Title:** MPSERS enhances LivingWell program

**Start Date:** November 20, 2013   **End Date:** January 5, 2014

Michigan Public School Employees Retirement System non-Medicare members have the option of completing the following steps to enroll in LivingWell and get a lower deductible for 2014:

- Complete a health assessment.
- Select a primary care physician.
- Complete a routine physical by March 31, 2014.
- Bonus Step: Choose a patient-centered medical home.

LivingWell is a voluntary program that was introduced in 2009, which gave members an opportunity to lower their cost-sharing by completing an annual health assessment.
Also, 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)

MPSERS Medicare members have no changes to their benefits. We do encourage them to complete the LivingWell requirements to support their good health.

For more information, please see the December issue of *The Record*.

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

31. All Medicare Part B trading partners

**Category:** UPDATE: WPS 277CA reports and transactions with totals only  

**Title:** All Medicare Part B trading partners

**Start Date:** November 19, 2013    **End Date:** December 2, 2013

On 11/18/13, we communicated that some Wisconsin Physician Services Medicare Part B 277CA reports and transactions distributed by BCBSM on 11/16/13 contained only rejected claim totals. This issue affected Part B claims submitted to BCBSM between 2:30 PM and 7:30 PM on 11/14/13.

As an update, BCBSM has received corrected 277CA transactions and reports from WPS. The corrected files will be distributed this evening.

If you received one of the erroneous 277CAs, please ignore the information.

We apologize for any inconvenience.

32. All electronic trading partners

**Category:** Reminder – Report entire contract number with alpha characters  

**Title:** All electronic trading partners

**Start Date:** November 19, 2013    **End Date:** December 19, 2013
For processing purposes, electronic 837 claims must contain a subscriber’s entire contract number, including alpha prefix or alpha character. Claims not following these requirements will reject:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Example</th>
</tr>
</thead>
</table>
| BCBSM*, includes MOS/NASCO, Auto National and MESSA                 | Three alpha/nine numeric: AAA000000000  
*Blue Card contract numbers contain three alpha with up to 15 additional alpha-numeric characters |
| Blue Care Network, includes Blue Cross Complete and BCN Advantage    | Three alpha/nine numeric: AAA000000000                                      |
| Federal Employee Program (FEP)                                       | R with eight numeric: R00000000                                             |
| Medicare Advantage, includes DME                                     | Three alpha/nine numeric: AAA000000000                                      |

If you have questions about electronic claim requirements, contact the EDI Helpdesk at 1-800-542-0945.

33. All Medicare Part B trading partners

Category: WPS 277CA reports and transactions with totals only

Title: All Medicare Part B trading partners

Start Date: November 18, 2013   End Date: December 2, 2013

Some Wisconsin Physician Services Medicare Part B 277CA reports and transactions distributed by BCBSM on 11/16/13 contained only rejected claim totals. This issue may affect Part B claims submitted to BCBSM between 2:30 PM and 7:30 PM on 11/14/13.

The erroneous 277CA versions were missing billing provider information and claim detail. The 277CA transaction contained an STC ‘A8’, error code ‘746’ and entity code ‘40’ at the submitter level. The R277CAW report contained rejected totals without a rejection code. If you received one of these erroneous 277CAs, please ignore the information.

We are working with WPS to investigate this matter further. An updated message will be posted when additional information is available.

We apologize for any inconvenience.

34. Additional fee change schedules added to web-DENIS

Category: Fee Changes
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Nov. 18, 2013

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - Injections
  - Independent Lab
  - DME
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.

35. BCN offers **$200 incentive** to primary care physicians for each BCN Advantage member with diabetes and hypertension started on an ACEI or ARB

**Category:** BCN Advantage

**Title:** BCN offers **$200 incentive** to primary care physicians for each BCN Advantage member with diabetes and hypertension started on an ACEI or ARB

**Start Date:** November 18, 2013   **End Date:** December 31, 2013

Blue Care Network of Michigan and the Centers for Medicare & Medicaid Services endorse angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy as a best practice in treating patients with diabetes and hypertension. CMS considers this therapy so important that it monitors adherence among Medicare Advantage patients.

BCN is offering a $200 incentive to primary care physicians for each member with diabetes and hypertension who starts on treatment with an ACEI or ARB between Sept. 1 and Dec. 31, 2013. The member must have one new pharmacy claim for an ACEI or ARB within the designated time frame for the PCP to qualify for the incentive. Payments will be made in the first quarter of 2014.

PCPs with one or more identified BCN Advantage members who might benefit from ACEI/ARB therapy will receive a letter identifying the members. As always, we would like to thank you for helping ensure optimal medication use for our BCN Advantage members. Additional information regarding the use of ACEI or ARBs in diabetes can be