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Blue Cross Complete of Michigan is contracted by the Michigan Department of Health and Human Services to provide health care coverage to eligible Medicaid beneficiaries. Blue Cross Complete arranges for the provision of comprehensive and cost-effective coverage to Medicaid members in 32 counties in Michigan.

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JANUARY 2016

NOTE: Changes to the Blue Cross Manual occurring since the previous version are marked with a Blue Dot and are explained in the list of Blue Dot Changes to the Blue Cross Complete Provider Manual, available at MiBlueCrossComplete.com/providers.
A. Overview: Blue Cross Complete

**What is Blue Cross Complete?**

Blue Cross Complete of Michigan is an independent licensee of the Blue Cross and Blue Shield Association. It is a health maintenance organization and is a joint venture between Blue Cross Blue Shield of Michigan and AmeriHealth Caritas Family of Companies. Blue Cross Complete is not contracting as the agent of the Association. No person, entity or organization other than Blue Cross Complete will be held accountable or liable for any of Blue Cross Complete’s obligations created under the contract. Blue Cross Complete is solely responsible for its own debts and other obligations.

Blue Cross Complete is contracted with the Michigan Department of Health and Human Services to provide health care coverage to eligible Medicaid beneficiaries.

Note: Effective April 1, 2014, Blue Cross Complete enrolls eligible individuals into the Healthy Michigan Plan, which offers health care coverage to an expanded pool of Medicaid beneficiaries. This includes Adult Benefit Waiver beneficiaries. Providers may access additional information about who is eligible for this plan at [michigan.gov/healthymichiganplan](https://michigan.gov/healthymichiganplan) > Healthy Michigan Plan Frequently Asked Questions. Click Eligibility.

Blue Cross Complete provides administrative services and arranges for the provision of covered services to all Blue Cross Complete members within the Blue Cross Complete service area. Blue Cross Complete providers offer preventive and wellness care (for example, an annual physical exam) and Blue Cross Complete encourages the Medicaid population to use medical services for preventive care.

Blue Cross Complete, not Medicaid, is the payer for covered health services rendered to a Blue Cross Complete member.

Payments shall be made in accordance with the terms of the agreement between Blue Cross Complete and MDHHS.

**What Blue Cross Complete does**

Blue Cross Complete of Michigan is a Medicaid managed care plan that contracts with physicians, hospitals and other health care providers to deliver care and provide service to Blue Cross Complete members.

In addition to providing basic health care coverage and customer services, Blue Cross Complete helps promote the delivery of high-quality care in a cost-effective manner by supporting the efforts of Blue Cross Complete-affiliated providers with programs such as care management and chronic condition management.

**Blue Cross Complete geographic area**

Blue Cross Complete services members in Michigan, in the following 32 counties:

- Allegan
- Barry
- Clinton
- Eaton
- Genesee
- Hillsdale
- Huron
- Ingham
- Ionia
- Jackson
- Kent
- Lake
- Lapeer
- Lenawee
- Livingston
- Macomb
- Mason
- Mecosta
- Monroe
- Montcalm
- Muskegon
- Newaygo
- Oakland
- Osceola
- Ottawa
- Sanilac
- St. Clair
- Tuscola
- Wayne
- Washtenaw
- Shiawassee
Blue Cross Complete mission
In support of the Blue Cross Blue Shield of Michigan mission to offer access to health care coverage to everyone regardless of circumstance, Blue Cross Complete will excel in providing health care coverage to Medicaid beneficiaries. Blue Cross Complete’s commitment to this population is demonstrated by the provision of comprehensive and cost-effective coverage by Michigan’s leading health insurance company.

Blue Cross Complete values
Blue Cross Complete’s values are:
- Integrity and honesty
- Family and personal life
- Personal accountability and empowerment
- Helping and caring
- Quality and excellence
- Diversity and inclusiveness
- Community involvement

Blue Cross Complete confidentiality standards
Blue Cross Complete upholds the right to privacy of members and providers. All documents, data and knowledge of business and health care matters are maintained in a confidential manner, and strict standards are adhered to concerning the release of member or provider records and information. Blue Cross Complete employees may not discuss these matters with anyone outside the organization, except as may be required in the normal course of business, with appropriate authorization, or by law.

Blue Cross Complete educates members
Because knowledge is an important part of prevention, member education is vital to the Blue Cross Complete system of managed care. Blue Cross Complete educates members about managed care philosophy and health-related issues in various ways:
- Through MiBlueCrossComplete.com, members can access valuable health information.
- My Blue Health newsletter, sent three times a year, contains information about benefits, advice on healthy self-care practices and the latest news about Blue Cross Complete programs.

B. How to use this manual

How to search the Blue Cross Complete Provider Manual
To search the manual, providers should complete the following steps:
1. Open the manual.
2. In the Edit menu, select Search or Find.
3. Enter the word or phrase that is being searched for.
4. Press Enter.

Blue Dot changes identify revisions to the manual
Significant revisions to the Blue Cross Complete Provider Manual are identified on the affected pages by means of a Blue Dot.

A cumulative list of all Blue Dot changes made during the year is available on MiBlueCrossComplete.com/providers.
Each January, a new edition of the Blue Cross Complete Provider Manual is published. In the new edition, all Blue Dot changes from the previous year are incorporated into the manual and are no longer visible as Blue Dot changes. New Blue Dot changes are added to the new edition during the upcoming year.

Providers should watch for manual revisions and read the Complete Update and the Blue Cross Complete provider news, for the latest information.

C. Other electronic resources for providers

Blue Cross Complete’s electronic systems

Providers are encouraged to use Blue Cross Complete’s electronic systems to do business with Blue Cross Complete. Providers can sign up for access to the following electronic systems:

- NaviNet®, Blue Cross Complete’s secure provider portal. Providers can use NaviNet to:
  - Verify a member’s eligibility and benefits and see the history
  - Access the primary care provider panel roster and other reports
  - Check the status of claims
  - Submit and check the status of authorization requests
  - Access Care Gap reports for medical and pharmacy services

Providers who are not already NaviNet users can sign up at NaviNet.net > Sign up.

- web-DENIS, the Blue Cross user-friendly electronic inquiry tool. Providers can use web-DENIS to:
  - Verify a member’s eligibility
  - Locate a Remittance Advice
  - Providers can sign up for Provider Secured Services and web-DENIS at bcbsm.com/providers > Help Center > How to sign up for Provider Secured Services, or call 1-877-BLUE-WEB (1-877-258-3932).

Note: Providers must use their user ID within 14 days after they receive it. After that, providers are encouraged to log in to Provider Secured Services on a monthly basis. Providers must log in at least once every six months to keep their account active. If the account becomes disabled or is no longer active, providers should call the Web Support Help Desk at 1-877-258-3932 to reactivate their account.

- Blue Cross Provider Enrollment and Change Self-Service (available only to practice group administrators for professional groups and allied providers)

Providers can also access additional information on Blue Cross Complete’s public website at MiBlueCrossComplete.com/providers.

Other resources on the Web

Providers can also access the following resources online at MiBlueCrossComplete.com/providers:

- Blue Cross Complete Provider Manual
- Blue Cross Complete Provider Resource Guide At-a-Glance, a quick reference for phone and fax numbers
- Blue Cross Complete Provider Newsletter - Connections
- Complete Update, a bi-monthly publication that offers summaries of current Blue Cross Complete information

Each of these resources is an important source of information about doing business with Blue Cross Complete.
Forms
Providers can access Blue Cross Complete forms at MiBlueCrossComplete.com/providers.

The electronic version of a form can be saved to a computer hard drive and printed.

The forms are opened with Adobe® Reader®. A free copy of Adobe Reader is available at get.adobe.com/reader.

Providers who use the forms they download over time should check back periodically to make sure they have the latest version of the form. They should use the effective date or revision date of the form to determine whether they have the most current version. These dates are typically shown at the lower right on each page of the form.

For some of the forms, an interactive version is available. An interactive form can be opened using Adobe Reader version 7.0 or later, completed electronically, saved and printed. In some cases, the form can also be submitted electronically once it has been completed.

D. Provider communications

Blue Cross Complete providers receive an orientation
Blue Cross Complete providers receive a visit from a provider account executive who familiarizes them with things they’ll need to know about Blue Cross Complete, including the following:

- Member ID card
- Checking eligibility and benefits
- Culturally and Linguistically Appropriate Services
- Information about the service area
- Contact phone numbers
- Drug coverage
- Utilization management requirements and systems (NaviNet and Jiva™)
- Member transportation resources
- Submitting claims

Providers receive information in other ways
Providers also receive updates on Blue Cross Complete information through the following:

- NaviNet
- web-DENIS (Direct Eligibility Network Information System) messages
- Blue Cross Complete Provider Manual
- Blue Cross Complete Provider Newsletter - Connections
- Complete Update, a one-page summary of information pertinent to Blue Cross Complete providers published every other month
- Training for providers and their office staff by provider account executives

Providers can contact Provider Inquiry
Providers can contact Blue Cross Complete Provider Inquiry for assistance. Blue Cross Complete Provider Inquiry hours are 8 a.m. to 5 p.m., Monday through Friday.

The Blue Cross Complete Provider Inquiry phone and fax numbers are:

- Phone: 1-888-312-5713
Fax: 1-888-987-6395

Providers should be ready to supply the following information when calling Provider Inquiry:

- Caller’s name and direct phone number
- Provider’s NPI
- Member’s contract number, name and date of birth
- The information being requested

E. Assistance in working with Blue Cross Complete

Providers can request assistance through Provider Outreach

Providers may request individual assistance by calling their Blue Cross Complete provider account executive. The Blue Cross Complete provider account executive can help with the following:

- Enrollment and credentialing questions
- Contractual issues
- Recurring or unresolved problems
- Education and training on Blue Cross Complete policies, procedures and programs
- Discussion of medical care group administration
- Changes in primary care physician acceptance codes
- Requests for coverage / on-call providers
A. Blue Cross Complete provider network

What is the Blue Cross Complete provider network?

The Blue Cross Complete provider network includes primary care physicians, specialists, hospitals and providers who are licensed or certified by the state of Michigan and authorized to provide Medicaid health care services.

Providers who wish to enroll in the Blue Cross Complete provider network should complete the appropriate Blue Cross Complete enrollment form (for practitioners or facilities), located at MiBlueCrossComplete.com/providers, under the “Change and Enrollment Forms” heading. Submit the form according to the instructions outlined on the form. Providers may call Blue Cross Complete Provider Inquiry at 1-888-312-5713 with any questions.

Effective January 1, 2018, all providers furnishing services to Michigan Medicaid beneficiaries, including providers participating in a managed care organization's provider network, are required to be screened and enrolled in the Michigan Medicaid program. The State of Michigan’s Community Health Automated Medicaid Processing System is the state’s web-based Medicaid enrollment and billing system.

Beginning March 1, 2018, MDHHS will prohibit Blue Cross Complete from making payments to all typical rendering, referring, ordering and attending providers not enrolled in CHAMPS. Effective for dates of service on and after May 1, 2018, MDHHS will prohibit payment for prescription drug claims written by a prescriber who is not enrolled in CHAMPS.

This requirement applies to all individuals who provide services of any type to Medicaid beneficiaries, including but not limited to, health care providers, social services workers, pharmacies, and even family members who provide home care services to Medicaid recipients. This requirement also applies to those providers who do not bill directly to Medicaid Fee-for-Service but receive payment through a Medicaid managed care plan.

For instructions on how to enroll in CHAMPS, log on to www.michigan.gov/medicaidproviders > Provider Enrollment.

Providers who have questions about affiliation with Blue Cross Complete or about coordinating the care of a patient within the Blue Cross Complete network should contact their provider account executive.

How to access information about the Blue Cross Complete provider network

Information on all providers in the Blue Cross Complete provider network can be accessed through the following:

- The online Blue Cross Complete provider search at MiBlueCrossComplete.com > Find a Provider.
- Blue Cross Complete Provider Inquiry at 1-888-312-5713 between 8 a.m. and 5 p.m., Monday through Friday

Mental health services are provided through the network

- Mental health services are provided through the Blue Cross Complete mental health provider network.

Note: Treatment for substance use disorders is not covered by Blue Cross Complete. Members must contact the Substance use Disorder Coordinating Agency for their county.
• Blue Cross Complete covers unlimited outpatient mild to moderate mental health intervention services and treatment. There are no referrals or authorizations required.

Members who have severe and persistent mental illness should contact their local PHIP in their county located at Michigan.gov/mdhhs.

Note: The Michigan Department of Health and Human Services has made available a standard consent form for sharing behavioral health and substance abuse treatment information. Here is some additional information about this form:

• The form complies with Public Act 129 of 2014.
• Although providers are not required to use this form, they are required to accept it.

Providers should visit michigan.gov/bhconsent to access the DCH-3927 behavioral health consent form and to read more about it.

PerformRx is the pharmacy benefit manager
PerformRx, the pharmacy benefit manager for Blue Cross Complete:

• Processes prescription claims
• Manages the Blue Cross Complete Clinical Pharmacy Help Desk
• Provides coverage reviews for prior authorization after normal business hours
• Provides specialty pharmacy services

Preferred vendors for outpatient laboratory services, DME and diabetic supplies
The table below shows the vendors preferred by Blue Cross Complete that provide covered services involving outpatient laboratory services; durable medical equipment / prosthetics and orthotics; and diabetic supplies for providers affiliated with Blue Cross Complete.

<table>
<thead>
<tr>
<th>Type of service (outpatient)</th>
<th>Preferred vendors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td>JVHL, which provides the statewide network and third-party administration for outpatient laboratory services. Providers should refer to the “Blue Cross Complete claims processing” section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims for exclusions to the JVHL laboratory management agreement. Quest Diagnostics, provides statewide network and third-party administration for outpatient laboratory services. Providers should refer to the “Blue Cross Complete claims processing” section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims for exclusions to Quest Diagnostic management agreement.</td>
</tr>
</tbody>
</table>
| DME, P&O and nondiabetic medical supplies | Northwood, Inc., which provides the statewide network and third-party administration for most DME and P&O covered services and is contracted by Blue Cross Complete to authorize and pay for all DME and P&O covered services
Note: As a general rule, outpatient diabetic supplies are not provided through the Northwood network. |
| Diabetic and incontinence supplies | J&B Medical Supply, which provides the statewide network for outpatient diabetic supplies |

Providers should use Blue Cross Complete’s preferred only vendors, when possible
Here are Blue Cross Complete’s guidelines related to vendors:
Providers should use Blue Cross Complete’s preferred vendors, when possible. When a preferred vendor is not available, providers should use another vendor that is contracted with Blue Cross Complete. Providers should refrain from referring members to vendor providers who are not contracted with Blue Cross Complete, including those who operate exclusively outside of Michigan.

Providers who feel that a Blue Cross Complete-contracted vendor cannot meet a need should contact the vendor or call the Blue Cross Complete Utilization Management department at 1-888-312-5713 (press 1) to submit a request for a service provided by a noncontracted vendor. This should occur prior to the service being rendered, unless it is an emergency.

**Members may arrange for transportation**

Blue Cross Complete members may arrange for transportation for medically necessary medical exams and treatment, including picking up prescriptions and durable medical equipment. Members should call 1-888-803-4947 to arrange transportation. (TTY users should call 1-800-649-3777.)

Members should call to arrange transportation in advance of their appointment. Patients who are pregnant, or have a need for an urgent appointment can obtain same day transportation. Patients can arrange for transportation for appointments that are scheduled for multiple days with just one phone call. They can consult their *Blue Cross Complete Member Handbook* for more specific information on this requirement.

Additional information on transportation services for Blue Cross Complete members is found at the following locations:

- **MiBlueCrossComplete.com > Resources > Transportation Services**
- In the brochure *We can help you get there*

Note: Dual-eligible members who have transportation benefits through both BCN Advantage and Blue Cross Complete should exhaust their BCN Advantage benefit before arranging transportation under their Blue Cross Complete benefit.

Members living in Wayne County who need transportation for dental care, substance abuse services, some types of mental health services and other services provided by the state of Michigan should call LogistiCare® at 1-866-569-1902 between 8 a.m. and 5 p.m. Monday through Friday.

**Specialty care services do not require authorization**

Blue Cross Complete members may access specialty care services without an authorization from providers affiliated with Blue Cross Complete. Services rendered by providers not affiliated with Blue Cross Complete, including those outside the state of Michigan, must be preauthorized by calling 1-888-312-5713 (press 1).

**Specialty network access**

The Michigan Department of Health and Human Services, the Michigan Medicaid health plans and several public entities have worked on a joint initiative to increase access to specialty care services to Michigan Medicaid recipients. Blue Cross Complete does offer a comprehensive provider network, but should a provider determine an in-network specialist is unavailable, the provider can request a referral to access a specialty care provider affiliated with one of the public entities Blue Cross Complete does not contract with (Central Michigan University and Western Michigan University). The following table shows the hospital systems that would require authorization before a member is seen there.
### Table: System of Managed Care

<table>
<thead>
<tr>
<th>Public entity</th>
<th>Hospital system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Michigan University</td>
<td>• Covenant Healthcare</td>
</tr>
<tr>
<td></td>
<td>• St. Mary’s of Michigan</td>
</tr>
<tr>
<td>Western Michigan University</td>
<td>• Borgess Health</td>
</tr>
</tbody>
</table>

To request assistance with obtaining an authorization, providers can contact Blue Cross Complete’s Utilization Management department at 1-888-312-5713 (press 1).

**Some services are available through unique providers**

Blue Cross Complete also covers services provided by unique providers, such as for services from Federally Qualified Health Centers, Rural Health Clinics, local health departments, family planning clinics and child-adolescent health center services (immunizations, etc.).

**Guidelines for out-of-state providers**

Emergency services rendered by out-of-state providers are covered.

Other services rendered by out-of-state providers must be authorized by Blue Cross Complete prior to the service being rendered.

**Primary care physicians coordinate care**

A primary care physician is a medical doctor or a doctor of osteopathic medicine licensed in the state of Michigan or a nurse practitioner or physician assistant whose practice is primarily in family practice, general practice, internal medicine, internal medicine/pediatrics or pediatrics.

The primary care physician provides and coordinates medical care and services for members.

Members must select a participating primary care physician as soon as they join Blue Cross Complete. Members can use the online provider search to find a physician. These resources provide information on primary care physicians, specialists and other providers across the state.

Every primary care physician listed in the online search must meet Blue Cross Complete’s affiliation and credentialing requirements.

### B. Role/responsibilities of practitioners

**Primary care physician’s central role**

Each Blue Cross Complete-affiliated provider is valued for the key contributions he or she makes in providing members with the highest quality care in the most effective manner. The primary care physician, in particular, plays a central role.

Each Blue Cross Complete member must select a primary care physician, but members of the same family do not have to have the same physician.

**Primary care physician provides access to care**

The responsibilities of the primary care physician in providing access to care include but are not limited to:

- Providing telephone access 24 hours a day, seven days a week with a triage mechanism directing members to an appropriately trained health professional
- Accepting a minimum number of Blue Cross Complete members and giving 60 days’ written notice of a change in acceptance status

**Primary care physician provides care**
The primary care physician is responsible for providing primary care services to members within the scope of the physician’s medical specialty, including:

- Office visits for sick and well care
- Health maintenance exams
- Preventive care services
- Health education
- Inpatient consultations

**Primary care physician arranges for care from other providers**

The primary care physician’s office is also responsible for coordinating care that must be rendered through other providers, including specialty and ancillary services in or out of the hospital, as medically indicated. Examples include:

- Specialty treatment
- Hospitalization
- Post-hospital care
- Ancillary and specialty services using Blue Cross Complete-contracted vendors
- Referrals to chronic condition and care management programs
- Prescription medications, following the Blue Cross Complete custom formulary, as appropriate
- Referrals to health education programs
- Providing or referring for habilitative care (only for Healthy Michigan Plan members)
- Referring for hearing aids (for members under 21 with standard Blue Cross Complete and for Healthy Michigan Plan members 21 and over)

Pediatric and obstetrician-gynecologist services are accessed by Blue Cross Complete members without a referral from their primary care physician.

**Guidelines related to practitioners covering for primary care physicians**

The primary care physician must provide for member care at all times and ensure that covering or on-call medical personnel are of like or similar specialty and are Blue Cross Complete-affiliated providers who understand the procedures for managing Blue Cross Complete members.

**Specialists have responsibilities**

It is the responsibility of the specialist to:

- Provide services in a manner commensurate with the standards of practice for the physician’s specialty
- Provide a timely written report to the member’s primary care physician for inclusion in the member’s medical record
- Use Blue Cross Complete-contracted agencies and facilities for tests or services provided to members, except as authorized by Blue Cross Complete
- Allow primary care physicians access to the Blue Cross Complete member’s medical record upon request
Specialists expected to share information with primary care physician

As part of Blue Cross Complete’s continuing commitment to ensure that members receive the highest quality and safest care possible, specialists, including OB/GYNs and behavioral health practitioners, are expected to share members’ clinical information with members’ primary care physicians.

Blue Cross Complete medical record standards and National Committee for Quality Assurance standards require evidence of continuity and coordination of care. In addition, provider contracts specify that the specialist’s timely communication with the referring physician is essential to effectively manage the member’s care. This requires providing information to the member’s PCP about the episodes of care rendered in different settings. Documentation should be sent to and received by the primary care physician within 30 days of service.

Note: Behavioral health specialists are permitted by law to share behavioral health information without signed written consent from the member. A signed written consent from the member is required by law before the release of information related to the treatment of substance abuse or HIV.

Guidelines related to practitioners covering for specialists

It is the responsibility of the specialist to provide for member care at all times and ensure that covering or on-call medical personnel are of like or similar specialty and are Blue Cross Complete-affiliated providers who understand the procedures for managing Blue Cross Complete members.

C. General responsibilities of all contracted providers

General responsibilities of all providers who contract with Blue Cross Complete

Providers who affiliate with Blue Cross Complete sign an applicable provider agreement that outlines their responsibilities. The following is a summary of what Blue Cross Complete expects from contracted providers:

Note: This summary applies to all providers, including primary care physicians, specialists and hospital and ancillary providers.

- Providers will cooperate with all Blue Cross Complete programs as outlined in the Blue Cross Complete Provider Manual and Blue Cross Complete policies.

- Providers will comply with applicable authorization procedures set forth by Blue Cross Complete for the validation and payment of covered services. Providers are responsible for verifying the current and proper authorization of all nonemergency services prior to providing such services. Providers will seek appropriate authorization for any proposed additional services or for services for which the initial authorization period has expired at the time of service.

- Physicians will utilize Blue Cross Complete’s network of contracted providers unless services cannot be provided by the in-network providers.

- Providers will maintain adequate medical and general liability coverage as prescribed in each provider’s Blue Cross Complete affiliation agreement and all licenses, certifications, accreditations and practice privileges required by law. Providers will furnish proof of such credentials upon Blue Cross Complete request. Providers will fully comply with applicable Blue Cross Complete credentialing requirements and will immediately notify Blue Cross Complete of any material changes in the provider’s licensure, certification, accreditation or practice privileges. Providers will furnish covered services in accordance with each provider’s legal qualifications and professional capabilities in a manner consistent with professionally recognized standards of health care.

- Providers must provide all identifying information (phone numbers, group affiliations, National Provider Identifier, tax identification number, billing address, etc.). When that information changes, providers must update the information at least 60 days in advance of the change, when possible.
This also applies to information about changes in physician staffing; after-hours and vacation coverage; and practice locations. This also applies to other types of changes.

Note: Changes should be submitted using the Blue Cross Complete Provider Change Form, located at MiBlueCrossComplete.com/providers, under the “Change and Enrollment Forms” heading. Submit the form according to the instructions outlined on the form. Providers may call Blue Cross Complete Provider Inquiry at 1-888-312-5713 with any questions.

- Providers will treat Blue Cross Complete members in the same manner and with the same quality and promptness as other patients are treated. In providing covered services, providers will refrain from discriminating against any Blue Cross Complete member on the basis of his or her Blue Cross Complete membership, source of payment, sex, ethnicity, age, race, color, religion, national origin, ancestry, marital status, sexual preference or any factor related to health status, including but not limited to medical condition (including conditions arising out of domestic violence), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or handicap, or any other basis prohibited by federal law.

- Providers will look solely to Blue Cross Complete for payment of covered services and will accept Blue Cross Complete payment as payment in full for all covered services. The only exception is that providers will pursue payments from other responsible payers when appropriate.

- Providers will maintain accurate and timely medical records for Blue Cross Complete members for at least ten years in accordance with all federal and state laws, ensure the confidentiality of those records and afford access to those records by authorized Blue Cross Complete representatives, peer reviewers and government representatives upon request.

- Providers will, to the extent possible, comply with federal standards designed to promote the use of health information technology.

- Providers will allow Blue Cross Complete to use provider performance data for quality improvement activities.

- Providers will submit claims for covered services in accordance with Blue Cross Complete-specified formats and using Blue Cross Complete-designated claim forms and the provider’s NPI.

- Providers will comply with all applicable state and federal legislative, regulatory and legal requirements.

- Other than the appropriate discharge of a patient, providers are expected to refrain from withholding care, appointment access, medication, prescriptions or treatment of any kind or for any reason.

- Providers will comply with and adhere to the American Medical Association Principles of Medical Ethics (Code of Medical Ethics and Conduct) in the care and treatment of Blue Cross Complete patients.

- Neither Blue Cross Complete nor its providers shall use any financial incentive or accept any reimbursement that either directly or indirectly is an inducement to deny, reduce, limit or delay specific medically necessary and appropriate services.

- Providers will comply with all obligations outlined in their provider contracts and in the amendments to those contracts.

Physicians expected to comply with AMA Code of Medical Ethics

Blue Cross Complete expects physicians to comply with the American Medical Association Code of Medical Ethics, which encourages physicians to select a personal physician for their regular health care and refrain from treating themselves or their immediate family members.

In addition, physicians shall not bill Blue Cross Complete for covered services provided to themselves or to their immediate family members.

The following Blue Cross Complete Quality Management policies and procedures also apply:
Section 2: System of Managed Care

- Practitioners found to have selected themselves as their own primary care physician or as the primary care physician for their immediate family members are notified that they are not eligible to do so and are asked to select another appropriately qualified practitioner. If the practitioner fails to select another appropriately qualified practitioner, Blue Cross Complete will make the reassignment.

- Practitioners who have provided billable medical services to themselves or to their immediate family members will be notified that they are not eligible to do so and will be asked to select another appropriately qualified practitioner for medical services.

- Practitioners who have provided billable medical services for themselves or for their immediate family members will be contacted by Blue Cross Complete’s regional chief medical officer or his or her designee.

- These activities are tracked in accordance with Blue Cross Complete’s Quality Management policies and procedures.

D. Responsibilities of hospital/ancillary providers

Responsibilities of hospital and ancillary providers

It is the responsibility of hospital and ancillary providers to:

- Accept Blue Cross Complete members and, except in emergencies, provide only authorized services

- Coordinate with the member’s primary care physician or with Blue Cross Complete, if necessary, in the following situations:
  - When additional treatment or tests are needed
  - When the treatment will exceed the dates on the initial authorization

  - Use Blue Cross Complete-affiliated providers and facilities for tests or services provided to members unless services cannot be provided by in-network providers

E. Provider termination

Blue Cross Complete notifies members when a provider terminates

When a primary care physician stops affiliating with Blue Cross Complete for any reason, Blue Cross Complete will endeavor to provide timely written notice of the physician’s termination to all of the physician’s members within 30 days of the date of notification.

If the terminating provider is a primary care physician, all members assigned to that physician will receive written notification.

If the terminating provider is a specialty care provider, members with a recent claim with that provider will receive written notification.

Providers wishing to terminate must notify Blue Cross Complete

Providers are required under their affiliation agreements to provide written notification 60 days in advance to Blue Cross Complete when they wish to terminate their Blue Cross Complete provider affiliation. Providers must terminate their Blue Cross Complete affiliation in accordance with the terms and conditions of their provider agreement and continue to provide covered services to members. Providers should refer to their contract for the proper notification time period and any additional requirements for termination. Timely notification of provider termination assures proper payment to providers and assures continuity of care for Blue Cross Complete members.

Providers are reminded that timely notification to the members is facilitated by the notification that providers must give to Blue Cross Complete.
Blue Cross Complete assigns a new primary care physician

Blue Cross Complete notifies members of their primary care physician termination and assigns a new primary care physician. Members can call Blue Cross Complete Customer Service at 1-800-228-8554 between 8 a.m. and 7 p.m. Monday through Friday, to change their primary care physician if they so choose. (TTY users should call 1-888-987-5832.)

Members receive additional information from Blue Cross Complete to assist them in the transition, if the Blue Cross Complete network is modified. Members who are pregnant or have a terminal illness and who want to continue their care with their current provider, even though the provider has terminated his or her Blue Cross Complete affiliation, should contact Blue Cross Complete Customer Service.

Blue Cross Complete notifies members when a specialist terminates

When a specialist or specialty group has requested termination of Blue Cross Complete affiliation, Blue Cross Complete notifies the affected members about the termination and will assist affected members in transferring to the care of another affiliated provider. Blue Cross Complete will inform affected members of the financial consequences of continuing care with the provider after disaffiliation — specifically, that although the provider cannot bill the members, the members also cannot continue to see a nonparticipating provider. Affected members are those members who have been under the ongoing care of the specialist or specialty group.

Note: Members may continue to see disaffiliated providers in certain circumstances.

As part of the process, the Blue Cross Complete care manager also works with the member’s primary care physician to arrange for new referrals.

The provider is expected to notify any Blue Cross Complete member who seeks services after the termination that the provider is no longer affiliated with Blue Cross Complete.

Where to submit termination notices

Termination notices should be submitted in accordance with the notice requirements of the provider agreement. Providers should submit termination notices for Blue Cross Complete to:

Director, Provider Network Management
Blue Cross Complete
100 Galleria Officentre
Suite 210
Southfield, MI 48034

F. Blue Cross Complete’s commitment to providers

What providers can expect from Blue Cross Complete

Primary care and specialty physicians and hospital and ancillary providers can expect Blue Cross Complete to:

- Process and pay claims for covered and authorized services in a timely fashion and in accordance with state and federal law
- Provide active quality management, utilization management and care management programs
- Maintain a credentialing program for providers
- Respond to provider inquiries in a timely manner
Section 2: System of Managed Care

- Inform providers about changes to Blue Cross Complete’s programs, policies and procedures in a timely manner
- Inform providers about how Blue Cross Complete coordinates interventions with treatment plans for individual members
- Inform providers about how to contact the Blue Cross Complete staff responsible for providing care management services to members
- Support providers to make decisions interactively with members regarding their health care
- Treat providers with courtesy and respect
- Inform providers about how to contact the Blue Cross Complete staff responsible for providing care management services to members
- Carry out other responsibilities as outlined in the provider contracts and in the amendments to those contracts.

Processes for appeals or complaints

Blue Cross Complete has specific appeal processes for providers who disagree with a decision regarding credentialing, quality concerns, pharmacy, care management or claims. These processes are described as follows:

- For information on credentialing processes, go to (Provider Secured Services) web-DENIS > BCN Provider Publications and Resources > Provider Manual > Affiliation (under BCN Provider Manual chapters)
- For information on addressing quality concerns, see the “Monitoring quality of care” section of this manual.
- For information about appealing decisions on authorization requests related to medications, see the “Pharmacy Services” section of this manual.
- For information on appealing claims denials, see the “Blue Cross Complete claims processing” section of this manual.
- For information about appeals related to the temporary increased payment rate for primary care services, see the “Blue Cross Complete claims processing” section of this manual.

Providers who have a general complaint regarding Blue Cross Complete programs, services or staff should contact the appropriate Blue Cross Complete provider account executive.

Credentialing – Healthcare professional and provider rights

Healthcare professional and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information.
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application.
- Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval.
G. Obligations of recipients of federal funds

Providers obliged to comply with requirements

Providers affiliated with Blue Cross Complete are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990.

Blue Cross Complete is prohibited from issuing payment to a provider or entity that is debarred from any federal or state agency. To comply with this requirement, Blue Cross Complete will not issue payment to any provider who appears in any of the following lists:

- Social Security Administration’s Death Master File
- National Plan and Provider Enumeration System
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- Medicare Exclusion Database
- MDHHS /Medical Services Administration Sanctioned Provider List
- Licensing and Regulatory Affairs Disciplinary Action Reports

A possible exception to this prohibition is payment for emergency services under certain circumstances.

In addition, providers are prohibited from employing directors, officers, managing partners, agents, employees or persons with beneficial ownership of more than 5 percent who appear on any of these databases. Providers must check the databases when hiring and must also check their staff against the LEIE and SAM no less frequently than monthly.

A code of conduct, as referred to by CMS guidelines, is a set of values and ethical standards that both Blue Cross Complete and providers should adhere to in order to prevent, stop or correct noncompliance.

Providers are expected to adhere to the Blue Cross Complete code of conduct and also to create one for their office that best fits the culture in their office. The code of conduct should be a written document, easily accessible by employees.

Effective lines of communication

CMS emphasizes the importance of open and effective lines of communication as an integral part of a compliance program. Having effective lines of communication means that Blue Cross Complete, providers, and their employees are made aware of the following through training and management:

- What is expected of them regarding ethics and compliance based on the code of conduct
- That compliance is everyone’s responsibility
- How to report instances of suspected fraud, waste, abuse and noncompliance

It is important that employees are comfortable with reporting noncompliant activities within their own organizations. CMS emphasizes that effective communication not only means that employees may report noncompliant activities anonymously, but also that employees understand they are legally protected from retaliation when they report suspected noncompliance in good faith.
H. Electronic health records

**Use electronic health records**

Blue Cross Complete encourages the use of electronic instead of paper medical records for maintaining members' health information. Some advantages of electronic health records are:

- Availability of accurate and complete information anytime the member presents to health care providers to aid in diagnoses and treatment
- Enhanced ability to coordinate a member's care among various health care providers
- Reduced paperwork and increased efficiency for members and providers

**Get help making the change to electronic health records**

The Michigan Center for Effective IT Adoption is dedicated to assisting providers in making the transition to electronic health records. M-CEITA provides education, outreach and technical assistance for providers in developing digitized patient information, physician order entry and decision support mechanisms.

Providers may contact M-CEITA by telephone at 1-888-MICH-EHR (1-888-642-4347). Providers may access additional information about M-CEITA's services at mceita.org.

**EHR incentive programs are available**

Information on EHR incentive programs is available at the following locations:

- Information on programs offered by the Centers for Medicare & Medicaid Services, including a timeline for incentive payments, is available at [cms.gov > Regulations & Guidance > EHR Incentive Programs](https://www.cms.gov/Regulations-Guidance/EHRIncentivePrograms).
- Other information is available at “Electronic Health Record (EHR) Incentive Program” section of the General Information for Providers chapter of the [MDHHS Medicaid Provider Manual](https://www.michigan.gov/health).
A. About the guidelines

**Purpose of the guidelines**

Blue Cross Complete promotes the development, approval, implementation, monitoring and revision of uniform evidence-based clinical practice and preventive care guidelines for practitioners. Such guidelines promote the delivery of quality care and reduce variability in physician practice. Evidence-based guidelines are ones that are known to be effective in improving health care outcomes.

All guidelines are intended as a general resource to assist the practitioner and are not meant as a substitute for the practitioner’s medical judgment. They are based on current medical literature, including existing guidelines and practice standards within the community.

**Encouraging adherence to the guidelines**

Adherence to the clinical practice and preventive care guidelines is encouraged by Blue Cross Complete. This encouragement is provided through interventions focusing on improving health outcomes for Blue Cross Complete members, which include the following:

- Member and provider incentives
- Reminder mailings
- Telephone reminders
- Newsletter articles
- Educational materials

Ongoing monitoring of compliance with the preventive health guidelines is conducted through medical record reviews and quality studies.

B. Reporting blood lead tests

**Blue Cross Complete providers must report blood lead analysis results**

Providers must report to MDHHS the blood lead analysis results of children who are Blue Cross Complete members.

To view the testing plan and get additional information about the MDHHS lead poisoning prevention program, providers can:

- Go to [michigan.gov/leadsafe](http://michigan.gov/leadsafe)
- Call 517-335-8885

Forms related to the collection and submission of blood samples and the reporting of test results are available at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers).

C. Other applicable guidelines

**MQIC guidelines**

Blue Cross Complete endorses the clinical proactive and preventive care guidelines developed by the Michigan Quality Improvement Consortium. The guidelines are designed to improve the consistent delivery of services to members and to establish a core set of clinical practice guidelines and performance measures. The MQIC guidelines can be accessed at [mqic.org > Current guidelines](http://mqic.org > Current guidelines).
Note: The MQIC guidelines can be accessed on iOS and Android mobile devices through applications developed by MQIC that can be found in the Apple App Store and at Google play.

**Blue Cross Complete guidelines**

In addition to the MQIC guidelines, Blue Cross Complete maintains the following two internal guidelines:

- Diagnosis and Management of Chronic Obstructive Pulmonary Disease (COPD)
- Diagnosis and Management of Attention Deficit Hyperactivity Disorder (ADHD)

These guidelines can be accessed at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers).
Section 4: Managing the Quality of Care

A. Monitoring the quality of care

Providers should identify quality concerns
Blue Cross Complete encourages all areas of the corporation as well as external sources to identify concerns regarding quality of care or service. These quality issues are reviewed and investigated.

Member satisfaction is the goal
The Blue Cross Complete Quality Management department reviews all member reports of quality of care issues. Quality Management staff tracks and trends quality of care concerns. All potential quality of care concerns are submitted to the designated Blue Cross Complete medical director officer review.

Blue Cross Complete conducts member satisfaction surveys that include an assessment of the member’s perception of the quality of health care provided.

Providers notify Blue Cross Complete about quality concerns
Blue Cross Complete encourages all providers to actively participate in its continuous quality improvement process. Providers are invited to write to Blue Cross Complete about quality of care concerns. Providers should send letters to:

Blue Cross Complete
Quality Management
Suite 210
100 Galleria Officentre
Southfield, MI 48034

For additional information, providers can call Blue Cross Complete Provider Inquiry at 1-888-312-5713.

B. Peer review process

Description of peer review process
Blue Cross Complete uses a formal peer review process to evaluate a practitioner’s performance for identified quality of care concerns. The policy applies to all affiliated Blue Cross Complete practitioners and independent licensed practitioners.

The peer review process is used to identify, investigate, analyze, monitor and resolve all potential quality of care issues. The involved physician is notified when an issue is identified.

Activities are confidential
All peer review activities are confidential, in compliance with legal requirements and state statutory standards. The dissemination of practitioner-specific information is limited to the involved practitioner or to those individuals who require the data in order to perform any recommended corrective action.

Examples of quality issues
The following are examples of quality of care issues:

- Deviations from standards and guidelines that can be measured but have no direct impact on the practitioner/patient relationship
- Deviations from medical practice or from generally accepted community medical standards that have the potential to adversely affect the member
Substandard care that results in or has the potential to result in a significant adverse effect on the member

**Steps in the peer review process**

The peer review process follows these steps:

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<th>Step</th>
<th>Action</th>
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<tbody>
<tr>
<td>1</td>
<td>If the medical director determines there is evidence of a potential quality of care or service issue, he or she assigns a tentative severity category and forwards the case to the QM staff for action. If the medical director determines that further action is warranted, he or she initiates appropriate action or forwards the matter to the relevant committee for review and decision. The committees include the Credentialing Committee or the Quality Management Committee</td>
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<tr>
<td>2</td>
<td>The practitioner is sent a certified letter to advise of the potential quality of care issue, the pending peer review and the right to comment or submit additional documentation for review by the peer committee. In the event the committee schedules a meeting to review the case, the practitioner is notified by certified letter and offered the option to attend the meeting.</td>
</tr>
<tr>
<td>3</td>
<td>The relevant committee reviews the case and makes a decision.</td>
</tr>
<tr>
<td>4</td>
<td>The committee chairperson forwards the committee’s decision to the medical director and Quality Management staff. This decision must be submitted in writing to the medical director within 30 calendar days of the meeting. The medical director, along with the appropriate Quality Management staff, implements the decision of the committee. The corporate committee decision must be carried out, subject to whatever appeal process is applicable.</td>
</tr>
<tr>
<td>5</td>
<td>The practitioner is advised of any recommended corrective action/quality improvement plan via certified letter. The practitioner may request a personal conference with the designated Blue Cross Complete chief medical officer to discuss the plan, which may include:</td>
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<td></td>
<td>• Medical record review to determine whether the identified quality issue is an isolated incident or is representative of the practitioner’s practice patterns</td>
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<td></td>
<td>• Prescribed education activities</td>
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<td>• Restriction of new member assignment</td>
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<td></td>
<td>• Termination of affiliation</td>
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<td>6</td>
<td>The Quality Management staff monitors and reports the results of the practitioner’s corrective action/quality improvement plan to the medical director and the Quality Management director on a monthly basis, or as necessary. A status report is submitted to the committee that initiated or authorized the plan on request.</td>
</tr>
<tr>
<td>7</td>
<td>If the medical director determines the expectations of the plan are met, the corrective action process is closed. The practitioner is notified in writing of this action via certified mail.</td>
</tr>
<tr>
<td>8</td>
<td>Additional corrective measures, further disciplinary action or contract termination may follow if the corrective action plan is not met.</td>
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</table>

If the medical director determines the expectations of the plan are not met, he or she reviews the case in its entirety and determines if additional corrective measures, further disciplinary action or contract termination or affiliation are appropriate. All terminations for quality reasons are coordinated between the medical director, the Credentialing Committee and the Quality Management Committee.

**C. Disciplinary action or termination**

**Physician discipline or termination process**

When quality of care issues are severe enough to warrant contract termination rather than corrective action, the practitioner or independent licensed practitioner termination process will be followed, as outlined here.
Blue Cross Complete has an established procedure to initiate disciplinary action or termination of an affiliated practitioner or independent licensed practitioner. The cause of such action may include but is not limited to:

- Quality of care concerns
- Lack of cooperation
- Unsatisfactory utilization management
- Behavior inconsistent with Blue Cross Complete managed care objectives
- Failure to comply with recredentialing standards
- Evidence of fraud
- Exclusion or debarment from Medicare or Medicaid participation
- Other appropriate reasons

**Steps in physician discipline or termination process**

A practitioner may be terminated by Blue Cross Complete for any reason not prohibited by law. Termination may occur by Blue Cross Complete’s declining to recredential an affiliated practitioner, not renewing a time-limited contract or notifying the practitioner of termination during the term of the contract.

The formal steps of the process for termination relating to quality issues are:

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<th>Step</th>
<th>Action</th>
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<tbody>
<tr>
<td>1</td>
<td>The medical director and the Quality Management staff assess the validity and seriousness of concerns about a practitioner's performance, behavior, conduct or attitude. Their findings are documented.</td>
</tr>
<tr>
<td>2</td>
<td>The involved practitioner is notified of the concern and provided an opportunity for the practitioner to respond in writing within 30 calendar days of the date of the letter.</td>
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</table>
| 3    | After reviewing all documentation, the designated Blue Cross Complete chief medical officer makes one of the following decisions:  
  - No discipline is warranted  
  - Performance improvement plan required  
  - Committee review recommended  
  - Termination  
  If the case is forwarded to a committee, the committee reviews the case and requests that a corrective action/performance improvement plan is developed. The plan specifies exceptions for change including time frames, whether the practitioner is allowed to accept new patients or referrals, consequences of noncompliance, and plan for follow-up monitoring and feedback. |
| 4    | The designated Blue Cross Complete chief medical officer sends a certified letter to the practitioner with a copy of the improvement plan or decision. The letter also notifies the practitioner that he/she has the right to request a personal conference with the appropriate plan medical director. If the corrective action/performance improvement plan is related to the quality of patient care provided by the practitioner and the plan reduces or restricts the practitioner's clinical practice for more than 15 days, the appropriate plan medical director follows the practitioner appeal process |
| 5    | Compliance with the corrective action/performance improvement plan is monitored by Blue Cross Complete staff and reported to the appropriate plan medical director. Noncompliance or unsatisfactory compliance with the plan or other terms of discipline may result in termination initiated by Blue Cross Complete or the practitioner group. Termination is pursued in accordance with the practitioner’s contract, where applicable. |
**Expeditied procedure**

When Blue Cross Complete identifies a concern about a practitioner that may jeopardize member health or safety, the appropriate plan medical director intercedes promptly to assure that appropriate care is arranged for members.

If deemed appropriate, the disciplinary steps may be completed on an expedited basis or the appropriate plan medical director, after consultation with the senior vice president and chief medical office may initiate termination of contractual agreement at any point in the proceedings.

**Medical boards and data bank must be notified**

When, based on quality of care issues, Blue Cross Complete terminates affiliation, rejects an application for affiliation or takes action resulting in restriction or regulation of clinical practice for a period greater than 30 days, Blue Cross Complete is obligated to make an appropriate report to the National Practitioner Data Bank. The credentialing department has responsibility for reporting quality of care concerns to the National Practitioner Databank. Action resulting in restriction or regulation of clinical practice for a period greater than 15 days obligates Blue Cross Complete to make an appropriate report to the State Licensing Board.

**Additional information about termination**

The practitioner is informed in writing via certified mail of the plan’s decision to terminate and the reason(s) for it.

An effective and consistent appeal process for use by practitioners is followed based on certain administrative issues and quality of care issues.

**D. Appealing physician discipline or termination**

**Physicians can appeal Blue Cross Complete actions**

Blue Cross Complete offers an appeal process for practitioners in response to disciplinary action taken or recommended by Blue Cross Complete regarding the quality of their patient care.

An effective and consistent practitioner appeal process is available for when a relevant corporate committee or a plan medical director recommends discipline or termination based on certain administrative issues and quality of care issues.

The appeal process is available for:

- **Administrative issues**: Refers to issues that are determined by Blue Cross Complete to warrant denial of an application for affiliation or continued affiliation and that may be based on legal and nondiscriminatory business or contract issues or requirements; or upon regulatory issues or requirements and aren’t quality of care related.

- **Quality of care issues**: Refers to actions or inactions of a practitioner determined by Blue Cross Complete to warrant review under the Blue Cross Complete peer review process, and which are based on a practitioner’s professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a Blue Cross Complete member. Quality of care issues subject to appeal are those that result in rejection of an application for participation, termination of a contract with Blue Cross Complete or restriction or regulation of clinical practice.

The appeal process is a two-level process.

**Level 1 appeal process**

The following are the steps for Level 1:
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<th>Action</th>
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| 1    | The practitioner has 30 days following receipt of the written disciplinary notice restricting the practice or terminating the contract to file an appeal. The practitioner sends the appeal to the following address:  
    Blue Cross Complete  
    P.O. Box 5043  
    Southfield, MI 48076-5043  
    ATTN: Corporate Manager, Quality Management  
    Mail Code C330  
    Practitioners who fail to request an appeal in writing within 30 calendar days following receipt of the notice waive any right to Blue Cross Complete’s appeal process. |
| 2    | Blue Cross Complete’s Clinical Quality Committee reviews the appeal within 30 days of receiving the request. The practitioner or independent licensed practitioner (appealing practitioner) will be advised of the committee’s meeting date and his or her right to appear in person at the appeal hearing:  
    ▶ Administrative issues that are determined to fall into the nonemergent appealable category are forwarded to the Credentialing Committee for a first level appeal. The Committee makes a determination and notifies the practitioner within seven days by certified letter.  
    ▶ Administrative issues which result in a practitioner termination and fall into the administrative emergent category and are reviewed by the Emergent Administrative and Quality Appeal Panel which makes a decision on action to be taken. Notification to the practitioner is sent by certified mail within seven calendar days of the decision.  
    ▶ Quality of care issues that are determined to fall into nonemergent category may be appealed and are reviewed by the Quality Appeals Committee within 30 calendar days of receipt of the practitioner’s letter requesting a hearing. The Quality Appeals Committee decision is communicated to the practitioner in writing and sent by certified mail within 60 calendar days of the decision.  
    Quality issues that are determined to fall into the emergent category may be appealed and are reviewed by the Emergent Administrative and Quality Appeals Panel. The panel reviews the case and makes a decision on action to be taken. Notification to the practitioner is sent by certified letter within seven calendar days of the decision. |
| 3    | Within 14 days of receiving the committee’s decision, the appealing practitioner may challenge the committee’s decision by making a written request for a Level 2 appeal. |
**Level 2 appeal process**

The appealing practitioner may proceed to a Level 2 appeal and request a review of Blue Cross Complete’s decision.

The process is outlined as follows:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
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</table>
| 1    | The practitioner sends a request for a Level 2 appeal along with any additional information to the following address:  
Blue Cross Complete  
P.O. Box 5043  
Southfield, MI 48076-5043  
ATTN: Corporate Manager, Quality Management  
Mail Code C330 |
| 2    | The appeal is forwarded to Blue Cross Complete’s chief medical officer, who reviews and makes the final decision. |
| 3    | Within 14 calendar days, Blue Cross Complete’s chief medical officer issues a written decision to the practitioner that includes a brief description of the underlying rationale. For non-emergent terminations, a written decision is provided within 30 days.  
The decision is final. |
| 4    | Blue Cross Complete is obligated to notify the appropriate state licensing board of cases that involve quality of care issues that will restrict or regulate a practitioner’s clinical practice for more than 15 days.  
Blue Cross Complete is obligated to make a report to the National Practitioner Data Bank when one of the following actions is taken based on issues related to a practitioner’s quality of care:  
- A practitioner’s affiliation is terminated  
- A practitioner’s application for affiliation is rejected  
- An action is taken that results in the restriction or regulation of clinical practice for a period greater than 30 days |

**E. Facility onsite reviews**

**Blue Cross Complete conducts facility onsite reviews**

Blue Cross Complete will conduct a facility site review and a medical record review for all network practitioners as a result of the following:

- Member complaints
- Deficiencies identified when a site visit is being conducted for another reason, for example, a HEDIS® review, a quality management study or audit, a disease-specific medical record review, or a medical record review audit
- Member surveys
- Reports from Provider Outreach
- Executive inquiries
- Suspicion of fraud, waste and/or abuse

The Blue Cross Complete quality management coordinator will continue to monitor the facility and/or medical records of the practitioner at least every six months, to detect deficiencies and institute actions for improvement until the performance goals established by Blue Cross Complete are met.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance.*
Blue Cross Complete conducts onsite reviews for nonaccredited facilities

Facility reviews are also conducted for nonaccredited facilities. These facilities include but are not limited to freestanding surgical centers; home health care agencies; hospices; nursing homes; radiation oncology centers; retail clinics; skilled nursing facilities; urgent care centers; freestanding radiology centers that conduct CT, PET scans and MRIs; and mental health and substance abuse facilities that provide care in inpatient, residential, outpatient or ambulatory settings. These facilities are considered “organizational providers.”

Purpose of facility onsite reviews

The facility onsite review process ensures conformity to Blue Cross Complete criteria for safe and sanitary conditions and complies with requirements established by Michigan’s Department of Insurance and Financial Services.

What Blue Cross Complete looks for in a facility review

Blue Cross Complete representatives look for the following certificates as part of the onsite facility review:

- A current Clinical Laboratory Improvement Amendments certificate, if applicable
- Compliance with sterilization procedures, as specified in the Blue Cross Complete facility review criteria
- A current Medical Waste Certificate

Blue Cross Complete requires access to practitioners’ offices

Blue Cross Complete quality management representatives and authorized regulatory representatives must have access to practitioners’ offices during normal business hours to inspect the facility and to review and copy member medical and mental health records, as required by law and as authorized by the member upon enrollment. These representatives should provide identification upon arrival at the facility.
A. Access to appointments

Appointment access standards for medical services

Primary care and obstetrician-gynecologist practitioners should provide appointments to members for medical services according to the guidelines in the following table:

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Definition</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care</td>
<td>Complete history and physical, including:</td>
<td>Within 30 business days of member's request</td>
</tr>
<tr>
<td></td>
<td>- Annual gynecologic examinations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Immunizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Other preventive care appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For adults, preventive care should comply with all screenings indicated in the Michigan Quality Improvement Consortium preventive care guidelines as appropriate for the member.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: The MQIC preventive care guidelines are available at <a href="http://mqic.org">mqic.org</a> &gt; Current Guidelines.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For children, preventive care should comply with the Early and Periodic Screening, Diagnosis, and Treatment/Well Child Care requirements.</td>
<td></td>
</tr>
<tr>
<td>Emergency Care (Arising Suddenly and unexpectedly)</td>
<td>Medical care that directly addresses threats to life, limb, or eyesight that requires immediate judgment such as:</td>
<td>Immediate</td>
</tr>
<tr>
<td></td>
<td>- Heart attack</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Stroke</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Open fractures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Appendicitis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe allergic reaction that make it difficult to breath</td>
<td></td>
</tr>
<tr>
<td>Routine primary care (symptomatic, non-urgent)</td>
<td>Appointments for members</td>
<td>Within 10 business days of member's request</td>
</tr>
<tr>
<td></td>
<td>- Who were previously seen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- With conditions that are not life threatening but that keep recurring, such as rashes and joint or muscle pain</td>
<td></td>
</tr>
<tr>
<td>Urgent medical care (acute, symptomatic)</td>
<td>Appointments for acute conditions that are not life threatening, such as:</td>
<td>Within 48 hours of member's request</td>
</tr>
<tr>
<td></td>
<td>- Fever over 101 degrees Fahrenheit over 24 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Persistent vomiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mild, persistent diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- New-onset skin rashes</td>
<td></td>
</tr>
</tbody>
</table>
Section 5: Standards and Ratings

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Definition</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-urgent symptomatic care</strong></td>
<td>Symptomatic Care: Non-acute symptoms that are not life- or limb-threatening and not interfering with function. Symptoms are of milder nature or longer duration (e.g., intermittent headaches, fatigue, colds, minor injuries, or joint/muscle pain).</td>
<td>Within 7 days of member’s request</td>
</tr>
<tr>
<td><strong>Specialty care</strong></td>
<td>Expert knowledge to optimize treatment in unique or complicated courses of care. Focuses on a particular area of care in which the provider has extensive training and education.</td>
<td>Within 6 weeks of member’s request</td>
</tr>
</tbody>
</table>
| **Acute specialty care** | Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to:  
  - Sprains,  
  - Flu symptoms  
  - Minor cuts and wounds  
  - Sudden onset of stomach pain  
  - Severe, non-resolving headache. | Within 5 days of member’s request              |

**Dental health appointment access standards**

Dental health practitioners should provide appointments to members according to the following guidelines:

<table>
<thead>
<tr>
<th>Dental Appointment type</th>
<th>Definition</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency dental services</strong></td>
<td>Requires immediate treatment in order to save a tooth, stop ongoing tissue bleeding or alleviate severe pain. A severe infection or abscess in the mouth can be life-threatening.</td>
<td>Immediately 24 hours/day 7 days per week</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Includes replacement of tooth/teeth; treatment of cracked or broken tooth/teeth; treats individuals who experience acute dental pain</td>
<td>Within 48 hours of member’s request</td>
</tr>
<tr>
<td><strong>Routine care</strong></td>
<td>Includes a professional cleaning, exam and possibly X-rays.</td>
<td>Within 21 days of member’s request</td>
</tr>
<tr>
<td><strong>Preventative services</strong></td>
<td>Include oral evaluations, routine cleaning x-rays and fluoride treatments</td>
<td>Within 6 weeks of member’s request</td>
</tr>
<tr>
<td><strong>Initial appointment</strong></td>
<td>Evaluation of overall health and oral hygiene, risk of tooth decay, root decay and gum or bone disease. Evaluation of need to tooth restoration or tooth replacement; check bit and jaws for problems.</td>
<td>Within 8 weeks of member’s request</td>
</tr>
</tbody>
</table>
Mental health appointment access standards

Mental health practitioners should provide appointments to members according to the following guidelines:

<table>
<thead>
<tr>
<th>Mental health appointment access standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases in which no acute danger is detected and the member’s condition is not likely to worsen significantly</td>
</tr>
<tr>
<td>Within 10 business days of member’s request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent mental health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditions that are not life threatening, but for which face-to-face evaluation is necessary within a short period of time (for example, acutely worsening symptoms accompanied by significant environmental change such as discontinuation of attendance at school or work). Examples:</td>
</tr>
<tr>
<td>A member calls the provider reporting she was recently discharged from inpatient psychiatric care and is uncertain about how to manage current symptoms and how to transition back to work and home.</td>
</tr>
<tr>
<td>A member was recently discharged from inpatient care after a suicide attempt and calls his provider stating he is compliant with medications but is experiencing a decrease in appetite and problems sleeping through the night. He reports he has strong family support and family members are available to stay with him. He reports being fearful of suicidal ideation returning; he denies being actively suicidal.</td>
</tr>
<tr>
<td>Within 48 hours of member’s request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency mental health care: conditions that are not life threatening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conditions that require rapid intervention to prevent deterioration of the member’s state of mind that, left untreated, could jeopardize the member’s safety. Example:</td>
</tr>
<tr>
<td>A member in treatment for substance abuse calls Monday morning to report he has relapsed and binged all weekend and can’t stop. He states “I can’t go on like this.” He reports his wife has kicked him out of the house and won’t let him see his children and his sponsor is away.</td>
</tr>
<tr>
<td>Within 6 hours of member’s request</td>
</tr>
</tbody>
</table>

Monitoring appointment access

The information about monitoring appointment access found here applies to primary care, obstetrician-gynecologist and mental health practitioners.

Blue Cross Complete conducts appointment access reviews annually. Reviews are conducted more frequently for practitioners who do not meet access standards.

Blue Cross Complete contacts the practitioner’s office to determine access and records the next available appointment for each of the designated appointment types. Physician-specific member complaints related to access are also analyzed.

The expected performance level for each appointment type is 100 percent within the specified time frame.

Blue Cross Complete provides practitioners with a copy of their individual access performance results within four weeks of their assessment. This may include recommendations for actions for improvement, when applicable. Practitioner-specific access monitoring results are considered at recredentialing.

Blue Cross Complete publishes a summary of the results in the newsletters and other publications.
Monitoring timeliness of appointment

Blue Cross Complete will monitor for complaints to ensure providers offer hours of operations that are no less than the hours of operations offered to commercial enrollees or hours of operations are comparable to the Medicaid Fee For Service, if the provider services only Medicaid enrollees.

Compliance with appointment access standards

If Blue Cross Complete determines a practitioner does not meet appointment access standards, the noncompliant practitioner is reassessed for compliance. If continued noncompliance is found, the practitioner must submit a corrective action plan to the Blue Cross Complete Quality Management department within 30 days of notification.

Follow-up monitoring will occur within 90 days.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practitioner’s corrective action plan is approved</td>
<td>Blue Cross Complete will notify the practitioner.</td>
</tr>
<tr>
<td>The corrective action plan is not approved</td>
<td>Blue Cross Complete will request that the practitioner submit an acceptable corrective action plan within 14 days.</td>
</tr>
<tr>
<td>A reply is not received within 14 days</td>
<td>Blue Cross Complete will send a second letter, signed by the Blue Cross Complete chief medical officer. Blue Cross Complete will forward copies of the letter to the medical care group administrator, the Blue Cross Complete Provider Network Management director and the Corporate Credentialing Department</td>
</tr>
</tbody>
</table>

B. Waiting room time

Standards for waiting room time

All Blue Cross Complete members should have appropriate and timely access to their practitioners.

The acceptable office waiting room time is no more than 30 minutes from the scheduled time of appointment. Because situations arise in the practice of medicine beyond the practitioner’s control, waiting times may extend periodically beyond the 30-minute time frame. In such cases, the member must be advised of any delay and, whenever possible, provided with an estimated time at which the appointment will begin.

If the member is unable to wait until the practitioner is available, an alternate appointment should be offered consistent with Blue Cross Complete’s appointment access standards and according to the member’s clinical status.

Monitoring waiting room time

Blue Cross Complete monitors primary care physicians, mental health practitioners and other specialists, for compliance with waiting room guidelines.

C. Access to after-hours care

Standards for access to after-hours care

All Blue Cross Complete members should have appropriate and timely access to their practitioners.
Practitioners must provide their patients with access to care 24 hours a day, seven days a week. Practitioner compliance with these standards helps to ensure that Blue Cross Complete members receive timely service.

**Achieving compliance with standards for access to after-hours care**

After-hours access compliance can be achieved by one of the following methods:

- Answering service
- On-call pager
- Call forwarding to practitioner’s home or other location
- Recorded telephone message with instructions that direct the member to a practitioner for instruction in after-hours care

  Note: Recorded messages instructing members to obtain treatment via the emergency room for conditions that are not life threatening are not acceptable.

**Monitoring access to after-hours care**

On an annual basis, Blue Cross Complete monitors primary care providers pediatrician for access to after-hours care by calling practitioners’ offices after normal business hours and documenting compliance with standards.

Blue Cross Complete publishes a summary of the results in the newsletters and other publications.

**Corrective action plan required for noncompliance**

If Blue Cross Complete determines a practitioner does not meet standards for access to after-hours care, the following steps are taken:

1. A letter is sent to the noncompliant practitioner, which indicates the practitioner must submit a corrective action plan to the Blue Cross Complete Provider Network Management department within 14 days of receipt of the letter.

2. A Blue Cross Complete provider account executive attempts to contact the practitioner by telephone to assist in expediting submission of the corrective action plan.

The remaining steps are outlined in the following table:

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practitioner’s corrective action plan is approved</td>
<td>The practitioner is notified, and the office will be called approximately 14 days after receipt of the corrective action plan to reassess compliance with the corrective action plan.</td>
</tr>
<tr>
<td>The corrective action plan is not approved</td>
<td>Blue Cross Complete will request that the practitioner submit an acceptable corrective action plan within 14 days.</td>
</tr>
<tr>
<td>A reply is not received within 14 days</td>
<td>Blue Cross Complete will send a second letter, signed by the Blue Cross Complete chief medical officer. Blue Cross Complete will forward copies of the letter to the medical care group administrator, the Blue Cross Complete Provider Network Management director, and the Corporate Credentialing Department.</td>
</tr>
<tr>
<td>A reply to the second letter is not received within 14 days</td>
<td>A third letter, signed by the Blue Cross Complete chief medical officer, will be sent informing the practitioner that termination will occur within 60 days.</td>
</tr>
</tbody>
</table>
D. CAHPS survey

**CMS monitors providers through the CAHPS survey**

CMS monitors health care providers through the Consumer Assessment of Healthcare Providers and Systems, which is a survey randomly given to members on an annual basis.
Section 6: Multicultural Health Care

A. Accommodating providers’ and members’ needs

Program objective
The objective of Blue Cross Complete’s multicultural health care program is to ensure that health care services are delivered in ways that accommodate the cultural and linguistic needs of Blue Cross Complete providers and members. This objective is accomplished through the following:

- Improving the collection of provider and member data
- Providing access to translation and interpretive services
- Reducing health care disparities
- Improving health plan services

Terms and definitions
Providers should be aware of the following terms and their definitions:

- Cultural competence: the ability of an individual to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population and to translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations
- Limited English proficiency: a designation referring to a member who primarily communicates in a language other than English and has a limited ability to communicate in English
- Low literacy proficiency: In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.
- Sensory impaired: a person who is deaf or visually impaired

B. Aspects of culturally competent care

Translation services
Certified translation services are available to all Blue Cross Complete providers and to eligible Blue Cross Complete members whose primary language may not be English or who have limited English proficiency or low literacy proficiency. Providers are encouraged to use these services to ensure all information is accurately communicated to members.

Members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-8554 for assistance with any or all of the following:

- Interpreting conversations with providers or other health care staff
- Translating health plan documents
- Obtaining health plan documents in alternative formats

Translation and interpretive services are available in over 200 languages. Providers and members can call 1-800-228-8554 to:

- Obtain these services immediately over the telephone
- Schedule an appointment for services to be delivered either by telephone or in person
Blue Cross Complete will provide translation and interpretive services after it has been verified that the physician’s office does not have their own services for their patients. After verification, Blue Cross Complete will contact member services to complete a *Blue Cross Complete Interpreter Request* form. The request should be complete within 48 hours of services, however, if there is an immediate need for a visit the request can be completed as soon as possible.

TTY and TTD services are also available for both providers and members who are sensory impaired. To obtain these services, providers and members should call 1-888-987-5832.

**Education in support of culturally competent care**

Health care services that are respectful of and responsive to the health beliefs and practices and cultural and linguistic needs of diverse patient populations are more effective at improving the quality of life of Blue Cross Complete members.

For some Blue Cross Complete members, language is the first barrier to health care. But along with language barriers, the culture of different ethnic groups may influence the following:

- An individual member’s health, healing and wellness belief systems
- How a member perceives an illness or a disease and its causes
- The behaviors of members who are seeking health care and their attitudes toward health care providers

To help providers take the first step in serving diverse populations the Office of Minority Health, part of the U.S. Department of Health & Human Services, offers the following accredited continuing education programs:

- A Physician's Practical Guide to Culturally Competent Care, accredited for physicians, physician assistants and nurse practitioners. Providers may register for this course at [Think Cultural Health](#).
- Culturally Competent Nursing Care: A Cornerstone of Caring, accredited for nurses and social workers. Providers may register for this course at [Office of Minority Health](#).

Both programs offer continuing education credits and are available online at no cost to participants.

Providers may also visit the [Think Cultural Health home page](#) and the [Office of Minority Health home page](#) for more information on these programs and for more resources to enhance the cultural competency of their health care practices.

**C. Enhancing cultural competency in health care settings**

**Reporting provider information**

Blue Cross Complete encourages providers and their staff to report their race and ethnicity and the languages they speak. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or [CAQH](#).

Provider and member information is analyzed to identify opportunities for improvement so Blue Cross Complete can provide the best possible service to its providers and members.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.
Additional resources
The following additional resources are available:

- HHS Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency
- Health Literacy Innovations™
- The Health Literacy & Plain Language Resource Guide
SECTION 7: MEMBER ELIGIBILITY

A. Membership ID cards

**Medicaid ID card**

All Blue Cross Complete members are enrolled in either the Healthy Michigan Plan or in another Michigan Medicaid plan. They, along with other Medicaid beneficiaries, receive a state-issued Medicaid ID card, after their eligibility is determined by the Michigan Department of Human Services.

Note: Eligibility for Medicaid is determined by the Michigan Department of Human Services. The administration of the Medicaid managed care programs is carried out by the Michigan Department of Health and Human Services.

The Medicaid ID card is also known as the *mihealth card*. Additional information on the mihealth card is available in the *March 2014 issue of Complete Update*.

**Medicaid Beneficiary ID number**

The Medicaid ID card includes a unique Medicaid Beneficiary ID number for the individual identified on the card. This number identifies the individual as eligible for Medicaid and may be used by providers to verify eligibility with the state of Michigan, via the magnetic stripe that providers can swipe.
Medicaid Beneficiary ID numbers are 10 digits, in line with the Michigan Department of Human Services system known as Bridges.

**Blue Cross Complete member ID card**

Each Blue Cross Complete member also receives a Blue Cross Complete member ID card, as follows:

- Members enrolled in the Healthy Michigan Plan receive a Blue Cross Complete member ID card with Healthy Michigan Plan dental services information on the back of the card. Healthy Michigan Plan ID cards issued starting May 1, 2015, also show the Healthy Michigan Plan label on the front of the card.

  Note: For Healthy Michigan Plan members enrolled prior to May 1, 2015, the Healthy Michigan Plan label is not shown on the front of the card, but providers can look for the Healthy Michigan Plan dental services information on the back of the card.

- Other members receive a standard Blue Cross Complete member ID card.

Each Blue Cross Complete member ID card shows:

- The member’s name
- The member’s Blue Cross Complete ID number (a de-identified contract number)
- The member’s Medicaid Beneficiary ID number
- A phone number the member can call for mental health care
- The pharmacy BIN and PCN numbers, to facilitate prescription claims processing

Providers should use the member’s Blue Cross Complete de-identified contract number to verify Blue Cross Complete eligibility and to submit claims. To verify member eligibility with the state of Michigan, as required, providers should use the Medicaid Beneficiary ID number, which is also located on the front of the Blue Cross Complete member ID card.

Possession of the Blue Cross Complete member card confers no right for benefits under this Certificate. To be entitled to such benefits, the holder of the card must meet and maintain all MDHHS requirements.

If a member permits the use of his or her member ID card by any other person, the card may be reclaimed by Blue Cross Complete or its providers, and all rights of that member and other members of his or her family can be terminated immediately.

A member must report loss or theft of the member ID card to Blue Cross Complete immediately upon discovery of the loss or theft.
## Blue Cross Complete member ID card: Standard card

<table>
<thead>
<tr>
<th>No.</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enrollee Name: Each member gets an ID card in his or her own name.</td>
</tr>
<tr>
<td>2</td>
<td>Enrollee ID: Providers should use this number, the member’s de-identified Blue Cross Complete contract number, to check eligibility. The Blue Cross Complete contract number begins with the XYU code.</td>
</tr>
<tr>
<td>3</td>
<td>Issuer ID number: This number identifies which plan issued the card.</td>
</tr>
<tr>
<td>4</td>
<td>Medicaid Beneficiary ID: This is a number issued by the state of Michigan that identifies the member as eligible for Medicaid. Providers may use this number to verify eligibility with the state of Michigan.</td>
</tr>
<tr>
<td>5</td>
<td>Group Number: The Blue Cross Complete group number</td>
</tr>
<tr>
<td>6</td>
<td>Pharmacy information: Prescription drug coverage under Blue Cross Complete</td>
</tr>
<tr>
<td>7</td>
<td>Magnetic stripe: In the future, this stripe will allow the provider to swipe the card and view eligibility and benefit information on the computer. Note: The ID card readers are not yet available.</td>
</tr>
</tbody>
</table>
Blue Cross Complete member ID card: Healthy Michigan Plan

No. | Explanation
--- | ---
1 | Enrollee Name: Each member gets an ID card in his or her own name.
2 | Enrollee ID: Providers should use this number, the member’s de-identified Blue Cross Complete contract number, to check eligibility. The Blue Cross Complete contract number begins with the XYU code.
3 | Issuer ID number: This number identifies which plan issued the card.
4 | Medicaid Beneficiary ID: This is a number issued by the state of Michigan that identifies the member as eligible for Medicaid. Providers may use this number to verify eligibility with the state of Michigan.
5 | Group Number: The Blue Cross Complete group number.
6 | The Healthy Michigan Plan label appears on the front of ID cards issued starting May 1, 2015.
7 | Pharmacy information: Prescription drug coverage under Blue Cross Complete.
8 | Magnetic stripe: In the future, this stripe will allow the provider to swipe the card and view eligibility and benefit information on the computer. Note: The ID card readers are not yet available.
9 | Phone number for dental coverage: Blue Cross Complete members enrolled through the Healthy Michigan Plan have dental coverage.
B. Checking member eligibility

Always check a member’s eligibility

It is essential to check each member’s eligibility prior to performing services. Providers should use the standard Blue Cross Complete resources for checking eligibility, including:

- NaviNet, at NaviNet.net > Login
- web-DENIS, at bcbsm.com/providers > Login > Provider. Enter your user name and password and click Login. Then click web-DENIS.
- Blue Cross Complete Provider Inquiry, at 1-888-312-5713 between 8 a.m. and 5 p.m. Monday through Friday
- HIPAA 270/271 electronic standard transaction

Note: For information on the HIPAA 270/271 transaction, providers should email the Blue Cross Electronic Data Interchange support staff at EDICustMgmt@bcbsm.

- CHAMPS, the MDHHS Community Health Automated Medicaid Processing System

For Healthy Michigan Plan members, providers must verify that the member is covered by the Healthy Michigan Plan using the member’s mihealth (Medicaid) and Blue Cross Complete ID cards. This verification must take place prior to services being rendered. Providers can also verify eligibility for Healthy Michigan via the NaviNet Eligibility Details screen. On that screen, the Healthy Michigan product name is displayed in the Plan Name field, for Healthy Michigan members.

Note: The additional dental benefit for Healthy Michigan members is reflected in the NaviNet benefits section (270/271). The hearing aid benefit is not shown.

C. Member eligibility data files

Blue Cross Complete members identified in eligibility data files

Through their medical care group or practice administrators, primary care physicians can access monthly electronic member eligibility data files that identify Blue Cross Complete members.

Note: On the monthly panel roster, Healthy Michigan members show HM# after the member’s name.

D. Member eligibility, enrollment, disenrollment, effective date

Blue Cross Complete may request member termination for cause

Blue Cross Complete may request special disenrollment (termination for cause) of a member from MDHHS under certain circumstances. When special disenrollment is requested, Blue Cross Complete will notify the member by letter.

MDHHS will review the request; if approved, MDHHS will determine the termination date and will notify Blue Cross Complete. The member has 90 days within which to request a hearing. If a hearing is not requested, MDHHS will provide Blue Cross Complete with an electronic termination record. If a hearing is requested, the member will remain active until a decision is rendered. Once a decision has been made, Blue Cross Complete will receive a notice from MDHHS indicating either that the member will be terminated (with the termination date) or that the member will not be terminated.

Special disenrollment requests may be made in cases of violent, urgent or life-threatening situations involving physical or verbal threats or acts of violence made against Blue Cross Complete providers, staff or the public at Blue Cross Complete locations; or stalking situations.
Special disenrollments will occur only to the extent consistent with the rules and regulations of MDHHS. All rights to benefits cease as of the effective date of the disenrollment. Claims for services provided prior to the effective date of the disenrollment are still eligible for reimbursement.

**Retroactive member terminations may occur**

Retroactive member terminations may occur, resulting in the recovery of monies paid by Blue Cross Complete when the member was ineligible for coverage through Blue Cross Complete.

Subject to the terms of the Blue Cross Complete provider agreement, Blue Cross Complete may collect any overpayments made to a provider in error, including any payments made for services provided to a member after the retroactive termination. Overpayments on facility claims will be recovered up to six months from the date paid or the end date of the member’s eligibility, whichever occurs sooner. This applies to both professional and facility payments. When there is fraud involved, payments can be recovered without a time limit. When the member is no longer considered eligible, the provider may bill the member's new insurance carrier.

Providers who have questions regarding payments that are taken back should contact Blue Cross Complete Provider Inquiry at 1-888-312-5713 between 8 a.m. and 5 p.m., Monday through Friday.

### E. Dual-eligible members

**What is a dual-eligible member?**

A dual-eligible member is one who qualifies for both Medicare and Medicaid. Dual-eligible members are those enrolled in either Original Medicare, BCN Advantage HMO-POS (Basic, Elements, Classic or Prestige option), BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan.

Note: In this manual, “BCN Advantage” refers to both BCN Advantage HMO-POS and BCN Advantage HMO products unless otherwise noted.

For dual-eligible members, the Medicare plan — either Original Medicare, BCN Advantage or Medicare Plus Blue PPO — is always the primary plan. Blue Cross Complete is secondary.

Note: Dual-eligible members are enrolled by MDHHS as voluntary members and may opt out of the dual-eligible program later if they choose to.

**Blue Cross Complete provides secondary coverage**

As the secondary plan, Blue Cross Complete covers the copayments, coinsurance and deductible — the member’s out-of-pocket expenses — that are not covered by the primary plan. In general, Blue Cross Complete pays the lesser of the member’s liability under the primary plan or the amount Blue Cross Complete would have paid as the primary plan less any payments made by the Medicare primary plan. Providers must hold the member harmless for any remaining sums.

Note: This applies to medical services. Blue Cross Complete does not pay copayments, coinsurances and deductible for Medicare-covered Part D (pharmacy) services.

**Blue Cross Complete assigns the primary care physician**

When an individual is enrolled as a dual-eligible member, the Blue Cross Complete secondary plan selects a primary care physician affiliated with Blue Cross Complete and sends the member a notification letter. The primary care physician selected by Blue Cross Complete may or may not be the physician the member is used to seeing under the primary Medicare plan.

Dual-eligible members are not required to see the primary care physician selected by Blue Cross Complete. These members may continue to receive Medicare-covered services from their current physician.
Note: If the physician the member is used to seeing under Medicare is affiliated with Blue Cross Complete, Blue Cross Complete will select that physician as the member’s primary care physician of record for Blue Cross Complete. If the physician the member is used to seeing under Medicare is not affiliated with Blue Cross Complete, Blue Cross Complete will select another physician as the member’s primary care physician of record for Blue Cross Complete.

**The primary plan determines the rules for referrals and authorizations**

For referrals and authorization requests related to dual-eligible members, providers should follow the rules of the member’s primary plan.

**Additional information about dual-eligible members**

Additional information about dual-eligible members is available as follows:

- Information about transportation services is available in the “Blue Cross Complete provider network” section of this manual.
- Information on review of readmissions for dual-eligible members is available in the “Review of inpatient admissions and discharge planning” section of this manual.
- Information on medications for dual-eligible members is available in the “Pharmacy Services” section of this manual.
- Information on billing for dual-eligible members is available in the “Blue Cross Complete claims processing” section of this manual.

Providers can also access a document titled *What you should know when serving dual-eligible members* at [MiBlueCrossComplete.com/providers > Dual-eligible Blues members – Provider Q&A](https://www.mibluecrosscomplete.com/providers/dual-eligible-blues-members-provider-qa).
SECTION 8: MEMBER BENEFITS

A. Blue Cross Complete primary care physician services

Process for primary care physician selection or assignment

Each Blue Cross Complete member may select his or her primary care physician from among those affiliated with Blue Cross Complete. Blue Cross Complete members can get assistance with the selection of a primary care physician from Blue Cross Complete Customer Service by calling 1-800-228-8554 between 8:00 a.m. and 7:00 p.m. Monday through Friday. (TTY users should call 1-888-987-5832.)

Adult Blue Cross Complete members may change their primary care physician or that of their minor dependent for any reason by calling Blue Cross Complete Customer Service. Changes in primary care physicians become effective the day of the request.

Note: Foster care parents who want to change the child’s primary care physician must contact the child’s caseworker in the state’s Department of Human Services.

If a beneficiary does not choose a Blue Cross Complete pediatrician to be a child’s primary care physician, the child can still be taken to a Blue Cross Complete pediatrician or family practitioner for pediatric services without a referral from the primary care physician.

Blue Cross Complete reserves the right to choose a primary care physician for the member in the event that the member does not indicate a physician selection.

Sending medical records to a new primary care physician

When a member changes to another primary care physician, regardless of who requested the change, the current primary care physician must provide copies of the member’s medical records to the new primary care physician at no charge. This is to facilitate continuity of the member’s care.

Primary care physicians responsible for managing care

Primary care physicians manage their Blue Cross Complete members’ medical care. Responsibilities include the following:

- Being available for patient care a minimum of 20 hours per week at each practice location
- Encouraging members to receive needed preventive care
- Monitoring specialty use and making appropriate referrals for required medical care
- Referring members to care management, as appropriate
- Coordinating inpatient admissions
- Directing patients to Blue Cross Complete network physicians for all care
- Prescribing appropriate medications using the Blue Cross Complete Preferred Drug List and monitoring for potential harmful interactions; discussing the member’s list of medications with the member
- Using Blue Cross Complete resources to link members to necessary support services
- Regularly accessing and reviewing available reports for important information related to member care
- Educating members on the appropriate use of the emergency room (For access and availability standards, see Section 5A, page 25).

Note: Healthy Michigan Plan members are required to schedule an appointment with their assigned primary care physician within 60 days of enrollment. Primary care physicians are encouraged to assist in
getting the appointment scheduled. Blue Cross Complete can also assist in coordinating appointment scheduling. The primary care physician is required to complete the appointment within 150 days of the member’s effective date with the plan. During the appointment, the primary care physician must complete a health risk assessment. Additional information on the health risk assessment required for Healthy Michigan members is found in the “Healthy Michigan plan members must have a health risk assessment” subsection of this section of the manual.

Healthy Michigan plan members must have a health risk assessment

For Healthy Michigan members, the primary care physician must complete a health risk assessment within 150 days of the member’s effective date with the plan and submit a Health Risk Assessment form with the results. Providers may use one of the following forms:

- The form that the Healthy Michigan member brings to the first appointment (The member receives a copy of the form in the welcome packet received shortly after enrollment.)
- The Blue Cross Complete Health Risk Assessment form that is available on MiBlueCrossComplete.com/providers and NaviNet.net. The form can also be accessed on BCN’s web-DENIS Blue Cross Complete page.
- The form available at michigan.gov/healthymiplan > After enrollment > Health Risk Assessment form (DCH-1315) PDF, which is not plan specific

Providers should complete and submit one of the health risk assessment forms with the following guidelines in mind:

- The form must be completed legibly.
- When completing Section 4, Member Results, be sure to include all required information for any diagnosis checked “yes.”
- A form completed by a member of the clinical team must be signed by the primary care physician.
- The entire form (all four pages) must be faxed to 1-888-287-7886 within five business days of the member’s appointment.
- A claim must also be submitted to indicate that a health risk assessment was completed. The claim should reflect procedure code *96160 with modifier 25 and will reimburse an incentive payment of $15.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2015 American Medical Association. All rights reserved.

If the form is not received within 30 days of receipt of the claim, Blue Cross Complete will complete outreach activities.

Members who complete a Health Risk Assessment and who agree to maintain healthy behaviors or address at least one healthy behavior may qualify for a reduction in required cost-sharing to their mihealth account.

For a Healthy Michigan Health Risk Assessment to be accepted as complete for the member incentive, the following minimum data elements must be completed:

- Member identification
- Survey date
- Healthy behavior chosen
- NPI
- Physician signature and date

The Healthy Risk Assessments can be submitted to 1-855-287-7886. Providers may call 1-888-312-5713 to inquire about the status of the member’s health risk assessment.
Online training for providers about the Health Risk Assessment is available through MDHHS. To access the training, providers should visit michigan.gov/mdhhs > Popular Links > Medicaid Hot Topics > Healthy Michigan Plan > Health Risk Assessment > Health Risk Assessment Training.

**Providing Early and Periodic Screening, Diagnosis, and Treatment/ Well Child Care services**

Primary care physicians must abide by the terms and conditions of their Blue Cross Complete provider affiliation agreement in providing Early and Periodic Screening, Diagnosis, and Treatment/Well Child Care services for their Blue Cross Complete members.

Note: Resources for carrying out responsibilities related to the EPSDT Program are available at the website of the Michigan State University Institute for Health Care Studies as follows:

- Access EPSDT Program information at ihp.msu.edu > Quality Improvement > Early Periodic Screening, Diagnosis and Treatment.
- Access the EPSDT Clinician Toolkit at ihp.msu.edu > Quality Improvement > EPSDT Clinician Toolkit.

**Primary care physicians must communicate with members**

Primary care physicians can communicate effectively with members by:

- Sending introduction letters asking new members to come in for a visit
- Discussing current and ongoing health care needs
- Discussing the care members are receiving from other providers
- Discussing their expectations of members (coordinating care, emergency room use, affiliated specialists, affiliated hospitals, etc.)
- Showing sensitivity to member needs (literacy concerns, cultural needs, social support, etc.)

**Blue Cross Complete provides primary care physicians with necessary support**

Blue Cross Complete will make available to network providers the needed support materials to serve Blue Cross Complete members. This support includes:

- Care management services
- Complex care management services
- Chronic condition management programs
- Reports

Information on these topics is found in subsequent sections of this manual.

In addition, Blue Cross Complete providers may refer to Blue Care Network’s Best Practices Web page, which can be accessed at bcbsm.com/providers > Newsletters > The archive (under BCN Provider News) > Visit the library.

**Vaccines for Children Program is available**

Protecting children from diseases that can be prevented by vaccination is a primary goal of Blue Cross Complete and MDHHS. Blue Cross Complete encourages providers to participate in the federally funded Vaccines for Children Basic (VFC-Basic) Program and Vaccines for Children Expanded (VFC-Expanded) Program, which are cooperatively run by local and state public health departments. These programs provide certain vaccines at no charge for children who are enrolled in Medicaid, have no insurance, are American Indian or Alaskan Native or are underinsured.

Providers must be enrolled in the VFC Program in order to receive VFC vaccines. Providers who want to sign up as a VFC Program provider or who want to learn more about the VFC Program can contact the
VFC Coordinator at the MDHHS Division of Immunization at 517-335-9646 or visit michigan.gov/mdhhs > Pregnant Women, Children & Families > Children & Families > Immunization Info for Families & Providers.

For more detailed information on what the VFC Program involves, including a list of the vaccines that are covered, providers may access the MDHHS VFC Resource Book online at michigan.gov/mdhhs > Pregnant Women, Children & Families > Children & Families > Immunization Info for Families & Providers > Health Care Professionals / Providers > Vaccines for Children (VFC) Resource Book.

Additional information can also be found in the “Immunizations” section of this manual.

B. Blue Cross Complete benefits

Overview of benefits

Blue Cross Complete members are entitled to receive services covered according to the Medicaid coverage guidelines established by MDHHS.

The member’s primary care physician will provide services or, when necessary, will coordinate the member’s care with a specialty provider affiliated with Blue Cross Complete.

Authorization may be required

Some services are covered only when the primary care physician or other plan provider has obtained an authorization for care (advance approval) from Blue Cross Complete.

Providers should refer to the Blue Cross Complete Plan Notification and Authorization Requirements for details. This document can be accessed at MiBlueCrossComplete.com/providers.

Benefits are explained in the Blue Cross Complete Member Handbook

The details about Blue Cross Complete benefits are available in the Blue Cross Complete Member Handbook, which can be accessed at MiBlueCrossComplete.com > Benefits > Blue Cross Complete Member Handbook.

Members can get discounts

Blue Cross Complete members have access to some discounts, as follows:

- Injury prevention items through BlueSafe™. By showing their ID card, Blue Cross Complete members can save 20 percent on the following:
  - Safety items, at Michigan Dunham’s Sports stores
  - Home medical equipment not covered by Blue Cross Complete, at Michigan Wright & Filippis stores

- Weight Watchers® memberships. Blue Cross Complete members who show their ID card can get a discount on the initial membership fee.

- Healthy Blue Xtras™ savings program. Blue Cross Complete members can take advantage of discounts on a variety of healthy products and services from Michigan merchants. Members may do the following:
  - Visit bcbsm.com/xtras to view the offers and learn how to get the discounts
  - Visit the merchants in person and show their ID card to get discounts

Members are not responsible for costs except through Healthy Michigan Plan

Blue Cross Complete members have no medical copayments and no pharmacy copayments, no deductible or coinsurance and no annual plan dollar maximums.
Exception: Blue Cross Complete members who have their coverage through the Healthy Michigan Plan may have cost-sharing requirements. These requirements and collections may be satisfied through the member’s mihealth accounts. The mihealth account is a unique health care savings vehicle through which copayments and additional contributions can be monitored and communicated to the member through a quarterly statement.

While primary care physician offices should not collect copayments from these members, providers are required to give Healthy Michigan Plan members a notice of potential copayments at the time of service. To this end, providers should access the following documents:


Note: For conditions exempted from copayments, the diagnosis must reflect the condition on the claim submitted. For institutional invoices, the condition diagnosis must be included in the claim header. For professional and dental claims, the condition diagnoses must be shown on the claim line.

Many services are supplied by the state

For information on services supplied directly by the state, including on billing (for services not related to Blue Cross Complete), and for copies of state Medicaid forms, providers can contact the Medical Services Administration Medicaid Information Line at 1-800-292-2550. Services supplied directly by the state include:

- Women, Infants and Children program (through MDHHS)
- **Dental care.**
  - Blue Cross Complete members who are covered by the Healthy Michigan Plan have some dental care coverage through Blue Cross Complete. Dental exams, cleanings and extractions are covered. Members get dental care through Blue Cross Complete’s network of dental providers.
  
  Note: Members can locate a dentist by calling Blue Cross Complete’s Dental Customer Service at 1-844-320-8465. (TTY users should call 711.) The business hours for Dental Customer Service are 9 a.m. to 5 p.m., Monday through Thursday, and 9 a.m. to 3:30 p.m. on Friday.
  
  - Dental coverage has been expanded to Blue Cross Complete members who reside in Kent, Oakland and Wayne counties. Eligible members who are age 13 through 20 years will receive Healthy Kids Dental benefits through Delta Dental Plan of Michigan. Covered benefits include diagnostic, preventative, restorative, endodontic and prosthodontics services. Some members may not qualify for Healthy Kids Dental due to spend-down status or other living arrangements.
  
  Note: Eligible members are automatically enrolled in Healthy Kids Dental. It is essential that dental providers verify the member’s eligibility and enrollment prior to each appointment to ensure payment. Eligibility can be verified using the MDHHS CHAMPS system.
  
  - For Blue Cross Complete members who are not covered by the Healthy Michigan Plan, the state of Michigan’s Medicaid program pays for emergency, diagnostic, preventive and therapeutic services for dental disease which if left untreated would result in acute dental problems or cause irreversible damage to teeth or supportive structures.
  
  Note: For these members, routine dental exams, cleanings, fillings, dentures and other non-emergency dental services are not a covered Blue Cross Complete benefit.

- **Developmental disabilities.** Blue Cross Complete primary care physicians must screen for developmental disabilities as part of the required EPSDT visit(s). If a developmental disability is
suspected (whether autism or another developmental disability), the Community Mental Health service provider can provide additional evaluation and treatment.

- **Nursing home services.** Blue Cross Complete pays for short-term rehabilitative services at a nursing or rehabilitation facility. Medicaid pays for long-term nursing home services. Additional information is available through the Medical Services Administration Medicaid Information Line at 1-800-292-2550.

- **Help with drug and alcohol problems.** Members who believe that they or a family member has a problem with drugs or alcohol should contact their local substance abuse coordinating agency listed below:
  - For residents of Washtenaw and Livingston counties: Washtenaw Community Health Organization at 734-544-3050 or 1-800-440-7548
  - For residents of western Wayne county outside of the city of Detroit: Southeast Michigan Community Alliance, at 1-800-686-6543
  - For residents of the city of Detroit: Institute for Population Health, Behavioral Health Division, at 1-800-467-2452

- **Maternal Infant Health Program.** Pregnant Blue Cross Complete members and infants get their primary maternal/infant health services through the Blue Cross Complete Bright Start program or through a certified MIHP provider. These preventive health services are intended to supplement regular prenatal and infant care and help providers manage the member's health and well-being. MIHP services are billed directly to Blue Cross Complete. Services may extend 60 days after delivery.

  It is the objective of MDHHS and Blue Cross Complete to enroll all pregnant women in an MIHP. For information on how to access MIHP services, providers should call Blue Cross Complete Provider Inquiry at 1-888-312-5713. In addition:
  - MIHP providers must be certified by the Michigan Department of Health and Human Services.
  - MIHP services include psychosocial and nutritional assessment; professional services rendered by a multidisciplinary team that includes a social worker, nurse and nutritionist; transportation; childbirth (including midwife and nurse practitioner services, if billed as an obstetrics benefit); parenting education; referral to community services; and coordination with medical care providers.
  - Care Management staff will contact eligible pregnant members and direct them to appropriate MIHP providers for service.

  Providers should refer to the “Pregnancy resources” section of this manual for information on the Blue Cross Complete Bright Start program.

- **Tobacco cessation**

  Blue Cross Complete supports members efforts for Healthy Living. For Tobacco Cessation, Blue Cross Complete has a tobacco quit program which covers group and individual counseling or coaching to help members quit.

  The tobacco quit program is a free phone–based support program which helps members make a plan to quit using tobacco and offers support and encouragement to members to assist them with sticking to their plan.

  The toll free tobacco quit phone number is: 1-800 784-8669 from 8:00 a.m. to 1:00 a.m. seven days a week.

  Drug Benefits include over the counter and prescription medicines. See Section 12: Pharmacy Services for additional coverage information.
• **Additional services** not covered by Blue Cross Complete that may be available to members include:
  - Services provided by a school district
  - Mental health services: inpatient psychiatric services and outpatient psychiatric care for persons with severe and persistent mental illness
  - Substance abuse services: screening and assessment, detoxification, intensive outpatient counseling and methadone treatment
  - Long-term care in the home, through the home and community-based program services
  - Home help services
  - Transportation for services not covered by Blue Cross Complete

Additional information on how to access these services is available through Blue Cross Complete Provider Inquiry at 1-888-312-5713 from 8 a.m. to 5 p.m., Monday through Friday.

**Use the Medicaid telephone number to get additional information about services**

Additional information about services available through Medicaid can be accessed through Medicaid’s Helpline at 1-800-642-3195.

**Special-needs members can get assistance through Customer Service**

Blue Cross Complete members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-8554 (TTY users should call 1-888-987-5832) for assistance with any or all of the following:

- Language translation services
- Interpreting Blue Cross Complete services or written information
- Obtaining written materials in alternative formats

Refer to the “Multicultural health care” section for additional information.

### Care within Michigan outside the service area

**Limited scope of coverage outside of Michigan**

Coverage within Michigan but outside the Blue Cross Complete service area is limited to medical emergencies, urgently needed care and care that cannot be provided by an in-network provider.

**Emergent care is covered and does not require a referral**

Blue Cross Complete members do not need referrals to access emergency, lifesaving care. In a medical emergency, members should go directly to the closest hospital. The facility should notify the member’s primary care physician within 24 hours of the emergency admission.

Blue Cross Complete covers post-stabilization care according to Medicaid guidelines. Blue Cross Complete Care Management staff and the primary care physician will arrange for providers affiliated with Blue Cross Complete to take over the member’s care as soon as the member’s medical condition and the circumstances allow.

**Urgent care is covered**

Blue Cross Complete covers needed care provided by in-network and out-of-network providers in an urgent care setting.
D. Blue Cross Complete member rights and responsibilities

Member rights and responsibilities are outlined in member handbook

Blue Cross Complete members have rights, which will be honored by all Blue Cross Complete staff and affiliated providers.

Blue Cross Complete members also have responsibilities.

Member rights and responsibilities are outlined in the “Member rights and responsibilities” section of the Blue Cross Complete Member Handbook.

The entire member handbook can be accessed online at MiBlueCrossComplete.com > Benefits > Blue Cross Complete Member Handbook.
SECTION 9: MANAGING NONCOMPLIANT CARE

A. Assisting practitioners in managing noncompliant care

Care management assistance is available for managing noncompliant care

Blue Cross Complete offers care management evaluation services to assist primary care physicians in managing members who are noncompliant with care. Noncompliant behavior may be categorized as follows:

- Drug-seeking behavior
- Fraudulent behavior
- Inappropriate use of outpatient services
- Inappropriate use of the emergency room
- Multiple missed appointments
- Noncompliance with treatment plan

For assistance in managing noncompliant care, practitioners should contact the Blue Cross Complete Integrated Healthcare Management team at 1-888-288-1722 to refer a member for care management evaluation. The following information should be available at the time of the referral:

- Member’s name
- Member’s phone number
- Member’s Medicaid ID
- Reason for referral
- Primary care physician’s name
- Primary care physician’s office contact name and number

The Care Management team develops an evaluation and will perform a plan of care. This plan is shared with both the primary care physician and the member.

B. Special disenrollment from the Medicaid Health Plan

Requests for special disenrollment of a member from the Medicaid Health Plan

Blue Cross Complete may request special disenrollment (termination for cause) of a member from MDHHS under certain circumstances.

Note: Providers do not have the option of disenrolling or removing a member from their practice.

Providers may contact Blue Cross Complete to request the special disenrollment of a member in the following instances:

- In cases of violent, urgent or life-threatening situations involving physical or verbal threats or acts of violence made against Blue Cross Complete providers or staff, or against members of the public at Blue Cross Complete locations

Note: Before seeking special disenrollment of a member who exhibits violent or threatening behavior, providers must make contact with law enforcement, as appropriate.

- In stalking situations
When special disenrollment is requested, these steps are followed:

1. Blue Cross Complete notifies the member by letter.
2. MDHHS reviews the request.
3. If MDHHS approves the request, MDHHS determines the termination date and notifies Blue Cross Complete.
4. The member has 90 days within which to request a hearing.
5. If a hearing is not requested, MDHHS provides Blue Cross Complete with an electronic termination record. If a hearing is requested, the member remains active until a decision is rendered.

Once a decision has been made, Blue Cross Complete receives a notice from MDHHS indicating either that the member will be terminated (with the termination date) or that the member will not be terminated.

Special disenrollments occur only when they are consistent with the rules and regulations of MDHHS.

All the member’s rights to benefits cease as of the effective date of the disenrollment.

Claims for services provided prior to the effective date of the disenrollment are still eligible for reimbursement.
SECTION 10: MANAGING UTILIZATION

A. Review of services

Review of services promotes appropriate care

Blue Cross Complete’s Utilization Management department carries out the review of select services to promote high-quality, cost-effective and medically appropriate care.

Some services require authorization, which typically involves the submission of clinical information along with the request for review. Some services require only that the plan be notified. Other services require neither authorization nor plan notification.

Providers should refer to the Blue Cross Complete Plan Notification and Authorization Requirements document to see which services require plan notification or authorization and to access information on preferred vendors. This document is available at MiBlueCrossComplete.com/providers.

Utilization Management contact information and hours of operation

Providers can contact Blue Cross Complete’s Utilization Management department for plan notification or authorization requests at the toll-free phone number 1-888-312-5713 (press 1) during normal business hours, which are Monday through Friday, 8:00 a.m. to 5:00 p.m.

After-hours requests

For urgent or emergent requests after normal business hours (Monday through Friday from 8:00 a.m. to 5:00 p.m.) and on weekends and holidays), a physician and nurse are available to review requests.

Providers should call 1-888-312-5713 (press 1) to request an urgent review with the reviewer on call.

Providers can request criteria for decisions

Blue Cross Complete’s Utilization Management department responds to authorization requests within the following guidelines:

- Decision-making related to authorization requests is based only on the existence of coverage and on the appropriateness of the care and service.
- Practitioners and other individuals are not rewarded for issuing denials of coverage.
- Decision-makers for authorization requests do not receive financial incentives for decisions that result in underutilization.

Providers have the right to request the information used to make a decision. This includes benefit guidelines or other criteria. To request this information, providers should call the Utilization Management department or write the Appeals Coordinator at the following address:

Appeals Coordinator
Blue Cross Complete of Michigan
P.O. Box 40849
Charleston, SC 29423
B. Guidelines for authorization

Steps to take before rendering services that are not or may not be covered
When a service is not or may not be covered by Blue Cross Complete but the member is still interested in getting the service, providers should request an authorization for the service. The request should be submitted through the normal channels.

Blue Cross Complete will review the authorization request and make a decision. If the request is approved, the provider may provide the service and bill Blue Cross Complete. If the request is denied, Blue Cross Complete will send written notification of the denial to both the provider and the member.

How to notify the plan or request authorization
For services that require plan notification or authorization, the following guidelines apply:

Plan notifications can be given up to the following business day.

Non-urgent Preservice requests for services that require prior authorization, including the required clinical information, must be submitted at least 14 days prior to providing the service.

Urgent Preservice requests for services that require prior authorization, including the required clinical information, must be submitted at least 3 days prior to providing the service.

Blue Cross Complete recommends that providers use the NaviNet provider portal to submit plan notification and authorization requests. Providers are able to view the status of requests they input into the portal.

The required clinical information can also be called in or faxed as follows:

- Phone: 1-888-312-5713 (press 1, then 4 to request authorization)
- Fax: 1-888-989-0019
<table>
<thead>
<tr>
<th>Issue</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing for notifying Blue Cross Complete</td>
<td>Hospitals must notify Blue Cross Complete within 24 hours (one business day) of admission. If the member is admitted on the weekend or on a holiday, hospitals must notify Blue Cross Complete on the next business day.</td>
</tr>
<tr>
<td>Information required when notifying Blue Cross Complete</td>
<td>Blue Cross Complete requires that hospitals submit all pertinent clinical information.</td>
</tr>
</tbody>
</table>
| Blue Cross Complete contact information for submissions | Hospitals can submit the required information in one of the following ways:  
  - Call 1-888-312-5713 (press 1 then 4)  
    Note: Hospitals can use this number either during or after normal business hours. Normal business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.  
  - Fax to 1-888-989-0019                                                                                                                                 |
| Blue Cross Complete response time                   | Blue Cross Complete responds with a determination within the timeframes addressed previously in this section.                                                                                               |
| Action to take after initial notification           | Blue Cross Complete requests that hospitals complete concurrent reviews on the next review date communicated by the Blue Cross Complete Clinical Care Review Nurse. It is also requested that all current discharge plans be communicated with concurrent reviews. |
| What to do if the stay is denied.                   | If denied for medical necessity the attending physician may request peer-to-peer review within three business days. Please follow the peer to peer request process as indicated in section 10 B. |
| Notification to the member's primary care physician | Hospitals should notify the member’s primary care physician when admitting a member through the emergency room. This notification should take place prior to the member’s admission. |
| Transfer of a member to another facility            | Blue Cross Complete will review all requests for transfers to other facilities based on medical necessity.                                                                                             |

**Members may also request authorization**

Blue Cross Complete members may submit requests for authorization of medical care or services. The requests must be submitted either in writing or by telephone.

**Standard time frames for all requests for authorization**

Blue Cross Complete conducts timely reviews of all requests for authorization according to the type of service requested. Decisions are made according to the following time frames:
### Type of Request

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Definition</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice urgent</td>
<td>A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member’s psychological state or In the opinion of a practitioner with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.</td>
<td>Within 3 days from receipt of request</td>
</tr>
<tr>
<td>Urgent concurrent</td>
<td>Within 24 hours of receipt of request</td>
<td>Within 24 hours of receipt of request</td>
</tr>
<tr>
<td>Preservice non-urgent</td>
<td>A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.</td>
<td>Within 14 days of receipt of request</td>
</tr>
<tr>
<td>Post-service requests</td>
<td>A request for coverage of medical care or services that have been received.</td>
<td>Within 30 calendar days of receipt of request</td>
</tr>
</tbody>
</table>

Note: Providers are asked to submit completed clinical documentation upon the initial request. Utilization Management will attempt to reach out to the provider if information is missing – will make determination based on the table above.

Prior authorization is not a guarantee of payment for the service authorized. Blue Cross Complete reserves the right to adjust any payment made following a review of the medical record and determination of the medical necessity of the services provided.

Post-service requests are addressed within 30 calendar days of the receipt of request. Requests received later than 180 calendar days from the date of service will be denied for late notification. The attending or treating health care Practitioner, institutional Provider and/or Member are notified of the decision and the reason for the decision.

### Inpatient admissions and discharge planning

Blue Cross Complete’s Utilization Management department reviews inpatient admissions and discharge planning to promote high-quality, cost-effective and medically appropriate care.

Blue Cross Complete will respond to verbal requests from emergency departments about post-stabilization services, including emergency admissions to inpatient care, in one hour or less or the service will be deemed authorized.

The following table provides important information for hospitals notifying Blue Cross Complete about an urgent or emergent inpatient admission.

### Readmissions that occur within 15 days of discharge

Blue Cross Complete’s Utilization Management department reviews inpatient readmissions that occur within 15 days of discharge from a facility that is reimbursed by diagnosis-related groups (DRGs), when the member has the same or a similar diagnosis for each admission.

Blue Cross Complete reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
• A lack of a discharge plan or inadequate discharge planning
• A planned readmission
• Surgical complications

In some instances, Blue Cross Complete will combine two admissions into one for the purposes of the DRG reimbursement. This is in line with Medicaid policies.

The facility’s discharge planning process is a key factor in determining whether the two admissions can be reimbursed separately.

In general, if the facility carried out adequate discharge planning, the patient was stable at discharge and all standards of care were met during the first admission, both the first and second admissions may be deemed separately reimbursable.

Facilities may appeal a decision to combine admissions for payment purposes.

**Blue Cross Complete may extend the standard time frames**

An extension of the standard time frames is allowed if Blue Cross Complete needs more information to make a decision about the request for authorization. For preservice non-urgent and post-service requests, an extension of up to 14 calendar days is allowed if requested by the requesting provider or member. Blue Cross Complete notifies the provider about the specific information required to make the decision.

An extension of the standard time frames is also allowed if the member requests it.

Members can request an extension by phone by contacting Blue Cross Complete Customer Service at:

• 1-800-228-8554 between 8:00 a.m. and 7:00 p.m. Monday through Friday. (TTY users should call 1-888-987-5832.)

• Members can submit the request in writing to:
  Blue Cross Complete Medical Records
  PO Box 40849
  Charleston, SC 29423

**Submit hysterectomy claims with required form**

A hysterectomy is reimbursable by Blue Cross Complete only when the service is preauthorized and a copy of the **Acknowledgement of Receipt of Hysterectomy Information** form (MSA-2218) signed by the member is submitted to the health plan when authorization is requested.

The member must be informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The signed form serves as the written acknowledgement that the member has been informed.

The member is not required to sign the form in the following circumstances:

• The member was already sterile before the hysterectomy.
• The member required a hysterectomy due to a life-threatening emergency situation and it was not possible to inform her in advance.
• The hysterectomy was performed (in accordance with federal regulations) during a period of retroactive eligibility.

Note: Federal regulations prohibit coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes, even when there are medical indications that alone do not indicate a hysterectomy.
Providers can access this form at MiBlueCrossComplete.com/providers.

Submit consent forms for other procedures that require them

Consent forms must be submitted when authorization is requested for sterilization and abortion procedures:

- Sterilization procedure claims must be submitted with either:
  - An MDHHS Consent for Sterilization form (MSA-1959)
  - An HHS Consent for Sterilization form (HHS-687)
- Abortion procedure claims must be submitted with both:
  - A Certification for Induced Abortion form (MSA-4240)
  - A Beneficiary Verification of Coverage form (MSA-1550)

Peer-to-Peer Requests for Denied Services

If a request for inpatient or outpatient authorization is denied, a peer to peer discussion may be requested with the Blue Cross Complete medical director who issued the adverse determination. This request must be from a medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant. The provider requesting can be an ordering provider, treating provider, or a provider familiar with the case. A Peer to Peer request will be accepted up to three business days from the date of the original denial. All Peer to Peer requests received within the required timeframe will be returned within one business day.

C. Appealing authorization decisions

Appeal of utilization management decisions

A member or a health care professional or provider acting on behalf of the member, with the member’s written consent may submit an appeal of an action or service denial by Blue Cross Complete, (based on a medical necessity or appropriateness determination).

Appeals will be handled and processed within the timeframes listed below:

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Timeframe to File</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Appeal</td>
<td>Sixty (60) calendar days from the date of the denial notification letter</td>
<td>Within 30 calendar days from Plan receipt of appeal request</td>
</tr>
<tr>
<td>Expedited Appeal</td>
<td>Ten (10) calendar days from the date of the denial notification letter</td>
<td>Within seventy-two (72) hours of Plan receipt of appeal request</td>
</tr>
</tbody>
</table>

Filing an extension

Blue Cross Complete may extend the timeframes for Standard Appeals and Expedited Appeals resolution for up to 14 calendar days if the member or member’s authorized representative requests the extension, or if Blue Cross Complete shows, (to the satisfaction of MDHHS, upon request) that there is need for additional information and how the delay is in the member’s interest.

State fair hearing

The State Fair Hearing process must be requested by the member, or the provider on behalf of the member with the member’s written consent, within 120 calendar days of the Blue Cross Complete appeal determination.
External review
The member, or provider on behalf of the member with the member’s written consent, has the right to request an external review by the Department of Insurance and Financial Services. The request must be submitted to DIFS no later than sixty (60) days following the receipt of Blue Cross Complete’s determination.

Filing an appeal
The appeal should be submitted as follows:

- By calling Blue Cross Complete Customer Service at 1-800-228-8554
- By writing to:
  Member Medical Appeals
  Blue Cross Complete
  P.O. Box 41789
  North Charleston, SC 29423
- By faxing to 1-866-900-4482

State appeal
Write to:

Department of Insurance and Financial Services
Healthcare Appeals Section
Office of General Council
P.O. Box 30220
Lansing, MI 8909-7720

- By fax: 517-241-4168

D. Utilization monitoring
Blue Cross Complete’s Utilization Management department monitors utilization to promote high-quality, cost-effective and medically appropriate care.

Blue Cross Complete uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that Blue Cross Complete members receive the medical services required for health promotion and diagnosis, as well acute and chronic illness management. Examples of these mechanisms include:

- Review of Healthcare Effectiveness Data and Information Set (HEDIS) data
- Results of member satisfaction surveys
- Rate of inpatient admissions
- Primary care physician and specialty utilization patterns
- Use of non-generic pharmaceuticals
- Mental health utilization data
A. Managing members with an integrated approach

Overview of Integrated Health Care Management services

Blue Cross Complete offers an Integrated Care Management program that provides specialized services in comprehensive disease management and complex case management. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

Blue Cross Complete members are eligible for the program if they have specific health risks due to complex health conditions, require a high level of care coordination and typically access medical services from multiple providers’ sites. Members with the following identified issues or diagnoses may be referred to the program:

- Asthma
- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Depression management
- Diabetes
- Ischemic heart disease
- Kidney management
- Pregnancy – high risk
- Sickle cell anemia
- Transplants – bone marrow and human organ

Note: This list is not all inclusive.

Both adult and pediatric members are eligible for the program and are automatically enrolled unless they choose to opt out.

The Integrated Health Care Management Program is designed to help members understand their condition and achieve and maintain control of their disease. Care Management works collaboratively with the member and the member’s primary care physician to promote optimal outcomes of care. Providers who serve members participating in the Integrated Health Care Management Program receive a letter containing information on the member’s participation and an explanation of how the program can assist in the collaborative coordination of care.

Members work with a care management nurse

Members who require the services of the Integrated Healthcare Management Program are assigned a nurse who performs both a comprehensive assessment and a disease-specific assessment. Based on these assessments, the nurse identifies the member’s problems, goals and barriers to care and develops a collaborative plan of care with the member and the provider. The care manager works in collaboration with the member, the member’s family and the physician and the other members of the health care team to address and resolve the issues the member is facing, to create a care plan and to follow the member’s care. Physicians are encouraged to participate in the member’s care coordination.

The services provided by the care management team include but are not limited to:

- Contact with the member’s providers
Section 11: Managing Care

- Help in setting and keeping track of appointments
- Help in arranging transportation
- Facilitation of member-practitioner communication
- Help in navigating the health care system
- Psychosocial support and connection with various community resources
- Care coordination
- And self-management skills

Goals of the Integrated Health Care Management Program

The goals of the Blue Cross Complete Integrated Care Management program are:

- Ensure members have access to the appropriate health care services, health plan benefits and community resources
- Decrease the burden of disease complication through early identification and intervention
- Improve member self-management by providing education and self-management tools
- Increase member compliance with treatment plans through education about the disease process through self-monitoring interventions
- Improve the member’s functional status and quality of life
- Coordinate and facilitate health care services
- Assist in communication with the member’s primary care physician
- Promote evidence-based treatment guidelines
- Encourage participation in the tobacco use cessation program, as applicable, at no cost to the member

How to refer members to the Integrated Health Care Management Program

Providers can refer members for disease, case and complex case management services by calling 1-888-288-1722. When calling to make a referral, providers should have the following information available:

- Member’s name, date of birth and enrollee ID number
- Member’s address and current phone number
- Reason for member referral
- Name of contact person at the provider office
- Provider phone and fax numbers
- If the office prefers to be contacted by phone or fax with follow up on member outreach activities

B. Collaboration with practitioners

Services offered in collaboration with practitioners

The focus of Blue Cross Complete’s Integrated Health Care Management program is the promotion of health and wellness through member education and through collaboration with the member’s practitioner.

Based on the types and severity of illness of their members, practitioners may be contacted about referring members for participation in Blue Cross Complete integrated care management.

Blue Cross Complete’s Integrated Health Care Management program is carried out as a collaboration between the Blue Cross Complete care manager and the member’s practitioner. The nurse or care manager works within the practitioner’s existing treatment plans for the members involved.
A member’s participation in Blue Cross Complete’s Integrated Healthcare Management program is not expected to limit the practitioner’s autonomy in providing care to the member enrolled in the programs.

**Provider rights and responsibilities when members receive complex case management services**

Providers treating members who are participating in Blue Cross Complete’s Integrated Care Management Program has the right to:

- Obtain information about Blue Cross Complete, including its programs and services, its staff and its staff qualifications
- Be informed about how Blue Cross Complete coordinates the interventions and plan of care for individual members
- Know how to contact the nurse or care manager responsible for managing the case and for communicating with the provider’s patients
- Be supported by Blue Cross Complete and work collaboratively in decision-making with members regarding their health care
- Receive courteous and respectful treatment from Blue Cross Complete staff and know how to communicate complaints to Blue Cross Complete

Providers are responsible for participating in a member’s integrated care management program by:

- Providing relevant clinical information as requested
- Taking action to follow up on reported information
- Participating in the member’s plan of care

**C. Pregnancy resources**

**Educational materials for expectant mothers**

Blue Cross Complete offers expectant mothers educational materials about caring for themselves and their new infant.

Blue Cross Complete members can request educational materials on pregnancy, postpartum care and infant care by calling Blue Cross Complete at 1-888-288-1722.

A packet with educational materials is mailed to all identified pregnant members.

Blue Cross Complete members can access additional educational materials on pregnancy, postpartum care and infant care at [MiBlueCrossComplete.com](http://MiBlueCrossComplete.com) > Your health > Programs for parents and guardians.

**Bright Start program**

The Bright Start pregnancy management program promotes healthy behaviors and assists members in controlling risk factors during pregnancy. The ultimate outcome for members is the delivery of healthy, full-term infants who will have a bright start in their lives.

The goals of the Bright Start program are:

- Early identification of pregnant members
- Early and continual intervention throughout pregnancy
- Provision of services designed to encourage members to seek care and follow prenatal protocols
- Care coordination (including transportation) and referral for Maternal Infant Health Program (MIHP)

The Bright Start program is Blue Cross Complete’s core maternity management program. Through this program, pregnant members are identified according to their health risk, as follows:
Section 11: Managing Care

- Low-risk pregnancy management: Members will receive pregnancy-related educational materials that encourage good prenatal care.

- Moderate- and high-risk pregnancy management: Pregnant members identified as being at risk for preterm labor pregnancy complications or social barriers affecting their prenatal care are assigned a nurse case manager to provide ongoing supervision, coordination of care, education and addressing of various issues throughout the pregnancy. A letter is sent to the member’s physician to notify him or her of the member’s enrollment in the program.

Provider referral to Blue Cross Complete’s pregnancy management services

Providers should call 1-888-288-1722 to refer a Blue Cross Complete member for pregnancy management services through the Bright Start program.

D. Rapid Response and Outreach Team

The Blue Cross Complete Rapid Response and Outreach Team addresses the urgent needs of members and supports Blue Cross Complete providers and their staff. The RROT team consists of registered nurses, social workers and care connectors.

Case managers are also part of the RROT; they provide care management services for members with urgent health concerns that are clinical in nature. Calls are triaged by care connectors and referred to case managers when indicated by an urgent needs assessment or when case management services are requested.

The RROT team offers the following services:

- Inbound call service. Blue Cross Complete members and providers may request RROT support via a direct, toll-free line. The RROT toll-free number is 1-888-288-1722. Referrals to the RROT are also received through the Customer Service department, pharmacy staff, utilization review staff, the retention unit, provider relations staff and other sources. The RROT toll-free number is used as a contact number in all member mailings and automated messaging, when members are encouraged to call for additional support or information. Authorization request are managed by the Utilization Management department (see section 10B – Guidelines for authorization).

- Outreach service. Outreach activities include telephone surveys, assessment completion and support of special projects or quality initiatives. RROT associates also place outreach follow-up calls to members who have called the 24-hour Nurse Help line and who require additional assistance from case management staff.

- Clinical and nonclinical case management support. Care connectors support case managers in care coordination by providing administrative support to members. This support includes appointment scheduling and reminders, help with transportation arrangements, educational mailings and similar activities.

E. Children’s Special Health Care Services

Services available to members enrolled in CSHCS

Blue Cross Complete members who are also enrolled in the MDHHS Children’s Special Health Care Services program are eligible to receive coverage for the following medical care and treatment through Blue Cross Complete:

- For children under 21 years old: subspecialty care, therapies and specialized medical equipment and medications for certain diagnoses

- For adults 21 and older: care for cystic fibrosis or for hereditary coagulation defects (hemophilia)
The MDHHS CSHCS program provides community-based services for these members that are over and above the services provided by Blue Cross Complete. Information about these services is available at michigan.gov/mdhhs > Providers > Providers > Children’s Special Health Care Services.

The CSHCS program services children and some adults who have special health care needs. The program covers more than 2,700 physical conditions with a specialty referral - regardless of income.

**Which providers serve CSHCS members**

A subnetwork of Blue Cross Complete primary care providers offers services to the Blue Cross Complete CSHCS population. Providers who qualify to serve these members are selected because they meet the following criteria:

- Provider currently serves children or youth with complex chronic health conditions.
- Provider’s practice has a procedure in place to identify children and youth with chronic health conditions.
- Provider’s practice offers expanded appointments when the child or youth has complex needs and requires more time.
- Provider’s practice coordinates care for children and youth who receive services from multiple professionals (for example, pediatric subspecialists, physical therapists, or mental health professionals).
- Provider’s practice is open to new patients (children and youth) with complex chronic health conditions.

Practitioners who serve as the primary care provider for the Blue Cross Complete CSHCS population are reimbursed for these additional services on a per-member-per-month basis; $4 to each primary care provider serving a Temporary Assistance for Needy Families (TANF) CSHCS enrollee or $8 to each primary care provider serving an Aged, Blind and Disabled (ABAD) CSHCS enrollee.

**F. Immunizations**

**Providers must report child and adult immunizations**

Blue Cross Complete requires practitioners to participate in the Michigan Care Improvement Registry, a nationally recognized electronic statewide immunization registry that collects reliable immunization information in Michigan and makes it accessible to authorized users online. Specifically:

- Practitioners are required to report childhood immunizations for children from birth through 19 years of age to the MCIR within 72 hours of administration.

Note: Practitioners are also required to report childhood immunizations to MDHHS.

- Blue Cross Complete practitioners are highly encouraged but are not required to report adult immunizations to the MCIR.

**Accessing information and other benefits of reporting to the MCIR**

Providers can take advantage of the many benefits that accompany reporting to the MCIR. One of these advantages is that practitioners may access up-to-date information on their patients’ immunization histories directly from the MCIR.

Other advantages of reporting immunizations to the MCIR include the following:

- Notifications of immunizations that are coming due and recommendations for future dose dates
- Reminder and recall notices for due or overdue immunizations
- Help with tracking and managing office vaccine supplies, including simplification of the complex immunization requirements and schedules of different manufacturers and combination vaccines
- Official, printer-friendly immunization records for child care and school requirements
- Profiles of practice and patient immunization coverage
- Access to lead screening results and opportunities
- Opportunities for influenza vaccine exchange
- Tracking for immunization hazards and emergency preparedness
- Access to body mass index information

**How to register for the MCIR**

To access information available through the MCIR, a practitioner must register to become an authorized user. To register for the MCIR, practitioners should contact their MCIR regional office.

Training materials on how to use the MCIR are available at [mcir.org > Providers](http://mcir.org). The locations of the MCIR regional offices are also available at that location.

**Blue Cross Complete uses MCIR information**

Blue Cross Complete receives immunization data from the MCIR and uses them along with data from other sources, including other physician-reported data and medical claims, to supplement the reports to providers available through NaviNet, a clinical support tool for primary care physicians.

**Participating providers assist in outreach**

When individual practitioners participate fully in reporting both childhood and adult immunizations to the MCIR, they are assisting with the public health all-hazard tracking system that supports emergency preparedness on a local and national basis. Through the MCIR, local health departments are able to do population-based assessments of immunization levels and focus outreach efforts where they are most needed.

**Additional information about the MCIR**

Additional information about the MCIR is available at [mcir.org](http://mcir.org).

**Vaccination waivers**

The State of Michigan’s Joint Commission on Administrative Rules approved waiver rules for parents who want an exception from vaccinations for their children.

The rules require parents who want a nonmedical waiver to receive education regarding the benefits of vaccination from a county health department before obtaining the waiver.

Additional information about the requirements is available at [michigan.gov > State Departments > Health and Human Services > Pregnant Women, Children & Families > Children & Families > Immunization Info for Families & Providers > Health Care Professionals/Providers > Immunization Waiver Information](http://michigan.gov).

**G. Nurse Help line (for members)**

**All members can use the Nurse Help line**

All Blue Cross Complete members have access to a 24-hour toll-free Nurse Help line at 1-888-288-1724.
A. Prescription drug program overview

Description of pharmacy coverage

Blue Cross Complete members have pharmacy coverage as follows:

- Blue Cross Complete participates in the Michigan Managed Care Common Formulary. Additional information regarding the common formulary can be found on our website at www.mibluecrosscomplete.com and at www.michigan.gov/mcopharmacy.

- Drugs that are excluded from coverage by the state of Michigan’s Medicaid program are not covered for Blue Cross Complete members. These excluded drugs include drugs used for cosmetic purposes, infertility, weight loss, sexual dysfunction and symptomatic relief of cough and cold; bulk powders for compounded products; food supplements; and certain vitamin preparations.

- Drugs that are part of the Medicaid Health Plan Carve-Out (Michigan Medicaid) must be processed through Magellan and are not payable through Blue Cross Complete. These include anticonvulsants, antidepressants, monoamine oxidase inhibitors, anti-anxiety agents, sedative/hypnotics, CNS stimulants, antiretrovirals, antivirals for Hepatitis C, disulfiram, naltrexone HCL, acamprosate calcium, buprenorphine HCL, and other drugs.

- Note: The full list of drugs included in the Medicaid Health Plan Carve-Out (Michigan Medicaid) can be accessed at michigan.fhsc.com > Providers > Drug Information > Medicaid Health Plan Carveout.

- Covered drugs that are available as generics will be dispensed as the generic version.

- All prescriptions are limited to a 34-day supply

- A pharmacy affiliated with Blue Cross Complete must be used

- Medications included on the common formulary are preferred. Before approving any non-formulary medication, members must first try and fail treatment with preferred medications. Exceptions may be made if preferred medications are inappropriate for treating the member’s condition

- Specialty medications are available through the mail from a UMHS pharmacy, from a pharmacy affiliated with Blue Cross Complete, from a retail pharmacy or from PerformRx Specialty Pharmacy

- No mail-order drug benefit is available for Blue Cross Complete members for nonspecialty drugs

- Some drugs require prior authorization before they are covered by Blue Cross Complete. These drugs are identified on the Blue Cross Complete Preferred Drug List. The Blue Cross Complete prior authorization form is available at MiBlueCrossComplete.com/providers

These criteria may change from time to time. Drugs that require prior authorization are covered only if Blue Cross Complete authorizes coverage. To request prior authorization for these medications, providers should contact the PerformRx Clinical Pharmacy Help Desk at 1-888-989-0057.

About the Blue Cross Complete Preferred Drug List

The Blue Cross Complete Preferred Drug List and the associated Preferred Drug List Quick Reference identify drugs that are covered for Blue Cross Complete members. Although the Preferred Drug list is comprehensive, the Quick Reference does not include all covered drugs.

The MDHHS MCO Common Formulary Workgroup and, when compliant with the Common formulary requirements, the Blue Cross Complete Pharmacy and Therapeutics Committee may add or delete drugs from the Blue Cross Complete Preferred Drug List during the year. These changes are published as part of a Pharmacy Formulary Update document posted under the Pharmacy heading at MiBlueCrossComplete.com/providers.
The Blue Cross Complete Preferred Drug List and Quick Reference are available online at MiBlueCrossComplete.com/providers in PDF form. The pharmacy documents are reviewed and updated monthly or as necessary. Providers can also access the Online Drug Search Tool linked to this website.

Blue Cross Complete encourages physicians to refer to the Blue Cross Complete Preferred Drug List when considering drug therapy for Blue Cross Complete members.

Additional information regarding the MDHHS MCO Common Formulary may be accessed by visiting www.michigan.gov/mcopharmacy. Plan information, prior authorization criteria, and step therapy criteria are also available on this site.

**Over-the-counter coverage**

Select over-the-counter pharmaceuticals are covered with a prescription. Covered over-the-counter items include pain relievers (acetaminophen and aspirin), laxatives and antacids, antihistamines, calcium, condoms, contraceptive gel products, iron and generic prenatal vitamins. Blue Cross Complete also provides coverage for selected diabetic medical supplies in the retail pharmacy, including disposable insulin needles and syringes, lancets, test strips and alcohol swabs. For details, providers should refer to the Blue Cross Complete Preferred Drug List.

**Coverage for tobacco use cessation products**

Over-the-counter agents (patches, gum and lozenges) and non-nicotine medications used to promote tobacco use cessation are included on the Blue Cross Complete Preferred Drug List. Members may also call the Tobacco Quitline program at 1-800-784-8669 for additional support.

**Generic substitutions**

A generic substitution is required when an equivalent generic drug is available and appropriate. Prior authorization is required for coverage of brand-name products for which generic equivalents are available.

**Coverage for brand-name drugs**

Brand-name drugs that are available as generics but that physicians prescribe, or members request to be dispensed as written (DAW), are non-formulary and are not covered.

DAW requests may be considered for coverage if a serious event or a quality issue occurred while trying the covered generic version. The request must be determined to be medically necessary by the physician and approved by Blue Cross Complete. The physician must submit a completed MedWatch form to the FDA to document serious adverse events or a quality issue with the covered generic. A copy of the completed MedWatch form must also be included with the Blue Cross Complete Medication Prior Authorization Request form, found at MiBlueCrossComplete.com/providers.

Information regarding the FDA’s MedWatch Program and the related online forms are available at the FDA’s MedWatch Program website at www.fda.gov/medwatch.

**Coverage for drugs not included on the Blue Cross Complete Preferred Drug List**

The Blue Cross Complete Preferred Drug List is an abbreviated list and does not include all covered drugs. Drugs not included may be non-formulary or may be excluded from coverage by the state of Michigan and not covered. Some drugs may be considered for coverage based on medical necessity, as determined by the physician and Blue Cross Complete. To request coverage for a non-formulary drug, providers should contact the PerformRx Clinical Pharmacy Help Desk at 1-888-989-0057.
B. Drug authorization guidelines

Prior authorization requirements for drugs

Drugs that require prior authorization are identified as such on the Blue Cross Complete Preferred Drug List. Prior authorization helps ensure that safe, high-quality, cost-effective drug therapy is prescribed prior to the use of more expensive agents that may not have proven value over the current formulary medications. The criteria for approval are based on current medical information and are approved by the MDHHS MCO Common Formulary Workgroup and the Blue Cross Complete Pharmacy and Therapeutics Committee. If a drug requires prior authorization, either certain clinical criteria must be met, including previous treatment with formulary agents, or other information must be provided before coverage is approved.

How to request prior authorization for drugs

Blue Cross Complete considers requests for prior authorization based on medical necessity. To request prior authorization or an override of one of Blue Cross Complete’s drug utilization management tools, Blue Cross Complete providers may use one of the following methods:

- Complete and submit the Blue Cross Complete Medication Prior Authorization Request form found at MiBlueCrossComplete.com/providers

Note: The fax number is shown on the form.

- Contact the PerformRx Clinical Pharmacy Help Desk at 1-888-989-0057.

Note: This number is available to providers 24 hours a day, seven days a week, including holidays.

Providers will need to provide documentation regarding the reason a formulary alternative is not appropriate for the member. If the request is for a higher quantity of a medication than Blue Cross Complete allows, the provider must provide documentation showing that the allowed quantity is not adequate for the member’s condition.

Authorization requests that do not include documentation of medical necessity or failure of or intolerance to formulary alternatives will not be considered for coverage.

Responses to requests for coverage determinations are made within 14 days.

How to make urgent requests for prior authorization for drugs

Providers should alert the Blue Cross Complete Clinical Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the member’s life, health or ability to regain maximum function would be jeopardized or the member would be subjected to severe pain that cannot be adequately managed, in the opinion of the prescriber with knowledge of the member’s condition.

Providers should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 72 hours.

C. Appealing a decision to deny authorization of drugs

Providers can appeal a decision to deny authorization of drugs

When a request for prior authorization of formulary drugs or approval of nonformulary drugs is denied, providers can submit an appeal on behalf of the member that is specific to the denial being appealed, with the written permission of the member. Pharmacy appeals will follow the same timeline and process as the UM appeals referenced in section 10B. The appeal should be submitted as follows:

- By calling Blue Cross Complete Customer Service at 1-800-228-8554
- By writing to:
Blue Cross Complete
P.O. Box 41789
North Charleston, SC  29423

- By faxing to 1-866-900-4482

D. Drug exclusions

Which drugs are not covered

Drugs that are not covered by Blue Cross Complete include the following:

- Over-the-counter drugs that are not on the *Michigan Pharmaceutical Product List*
- Drugs used for the symptomatic relief of cough and colds. (Select Codeine- and non-narcotic-containing products are covered.)
- Cosmetic drugs or drugs used for cosmetic purposes
- Drugs used for infertility
- Drugs used for sexual dysfunction
- Drugs used for anorexia or weight loss.
- Food supplements and standard infant formulas
- Drugs that are not approved by the FDA
- Drugs used for experimental or investigational purposes
- Drugs prescribed specifically for medical studies
- Prescriptions filled after a member is no longer enrolled in Blue Cross Complete
- Prescriptions that extend more than 34 days beyond a member's Blue Cross Complete termination date
- Drugs included as a health care benefit and other injectable drugs that are normally administered in a physician’s office. Note: Seasonal Influenza Vaccines are covered at participating retail pharmacies.
- Drugs covered by another plan, including Medicare Part D
- New drugs not yet reviewed by the Michigan Common Formulary Workgroup and the Blue Cross Complete Pharmacy and Therapeutics Committee
- Drugs recalled by the manufacturer and discontinued drugs
- Drugs acquired without cost to the providers or included in the cost of other services or supplies
- Durable medical equipment and supplies, such as certain blood glucose monitors and ostomy supplies. (These are covered under the medical certificate.)
- Drugs shown on the *Medicaid Health Plan Carve-Out (Michigan Medicaid)* list at michigan.fhsc.com > Providers > Drug Information > Medicaid Health Plan Carveout. (Coverage is provided by the state of Michigan.) This includes drugs used in the treatment of substance abuse disorders.
- Compounded products that contain bulk powders
- Prescriptions that have been adulterated or are fraudulent

E. Additional pharmacy information

Blue Cross Complete pharmacy network

Members are encouraged to use a Blue Cross Complete network pharmacy which participates in the Blue Cross Complete pharmacy network.
Members are encouraged to use a Blue Cross Complete pharmacy network. The Blue Cross Complete pharmacy network is available online at mibluecrosscomplete.com. A Blue Cross Complete pharmacy network is available online at MiBlueCrossComplete.com/providers.

**Prescribers must use tamper-resistant prescription pads with NPI**

Prescribers affiliated with Blue Cross Complete are required to include their NPI on prescriptions for Blue Cross Complete members. The use of these pads helps avoid service delays at the point of sale when dispensing pharmacies ask for the prescriber’s NPI. The pharmacies are required to include the prescriber’s NPI on prescription claims submitted for Blue Cross Complete members. Dispensing pharmacies may require that all prescriptions for Blue Cross Complete members be written on tamper-resistant prescription pads in order to process them.

The requirements for tamper-resistant prescription pads and inclusion of the NPI are associated with federal and state regulations that affect prescriptions written for Blue Cross Complete members. The requirement for tamper-resistant prescription pads does not apply to prescriptions ordered via telephone or fax, or to electronic prescriptions.

**Only specialty medications are available by mail**

There is no mail-order drug benefit for Blue Cross Complete members other than for specialty drugs.

**Medications for dual-eligible members**

For dual-eligible members (those members with Original Medicare, BCN Advantage or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), providers should consult the applicable Medicare Part D formulary first.

If a medication is not covered under the Medicare plan’s formulary, it may be covered under the Blue Cross Complete formulary, with the exception of some medications included in the Medicaid Health Plan Carve-Out (Michigan Medicaid) list.

**Additional information about pharmacy services**

Additional information about the Blue Cross Complete Pharmacy program is available at MiBlueCrossComplete.com/providers.
SECTION 13: CLAIMS

A. Claims overview

Claims processing overview
Information specific to Blue Cross Complete claims is found in this section of the *Blue Cross Complete* manual.

Regular updates on processing information are available via NaviNet and web-DENIS messages and in the *Blue Cross Complete Provider News*.

Members cannot be held liable
Blue Cross Complete members are not to be held liable for claims related to covered Blue Cross Complete services.

Reimbursement follows Medicaid fee schedules
Blue Cross Complete reimbursement follows the Medicaid fee schedules, which can be accessed at [michigan.gov/providers > Providers > Medicaid > Billing and Reimbursement > Provider Specific Information](https://michigan.gov/providers).

Claims from out-of-network providers, if authorized, are paid according to the established Medicaid fee schedule in effect on the date of service.

Resources for providers
The following resources are available to providers for verifying a member’s eligibility and claims status:
- NaviNet (for checking member eligibility and claims status)
- web-DENIS (for checking member eligibility and viewing Remittance Advice statements)

Note: Blue Cross Complete Remittance Advice statements are posted in Provider Secured Services under the *View Electronic Vouchers* page; they are not with the NASCO statements. The links to the Remittance Advice statements do not show “EFT” or “NON-EFT.”

Follow contract requirements
Physicians should always follow the requirements listed in their Blue Cross Complete provider contract. If any information in this manual differs from the provider contract, the contract language prevails.

Time limit for filing claims
- **Claims**: The filing limit for submitting a new claim is 12 months from the date of service or discharge date.
- **Resubmissions**: Blue Cross Complete follows MDHHS guidelines for Resubmitted and corrected claims. A replacement claim can be resubmitted within 12 months of the last date of service.

Claims over one year old must have continuous active review to be considered for reimbursement. Active review means the claim was received and acknowledged by Blue Cross Complete within 12 months from the date of service. In addition, claims with a date of service over 1 year old must be billed within 120 days from the date of the last rejection.

Claims that receive a front-end rejection, whether submitted electronically or on paper, are not considered submitted or clean claims. To be considered submitted or clean, a claim must contain all required data elements in the appropriate format. Claims that receive a front-end rejection must be corrected and resubmitted within the standard filing limit time frames. A copy of a front-end rejection is not acceptable documentation of a claim submission for payment reconsideration purposes.
Exceptions can be made to the timely filing billing limitation policy in the following circumstances:

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from Blue Cross Complete staff
  - Blue Cross Complete staff failed to enter (or entered erroneous) authorization, level of care, or restriction in the system
  - Other administrative errors by Blue Cross Complete that can be documented

Retroactive provider enrollment is not considered an exception to the timely filing billing limitation.

- Medicaid beneficiary eligibility/authorization was established retroactively:
  - Beneficiary eligibility/authorization was established more than 12 months after the DOS; and
  - The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.

Submit encounters for prepaid claims

An encounter submission is the same as a claims submission except that the physician has been prepaid for the service. Throughout this chapter, the term “claim” refers to both a claim and an encounter submission.

B. General guidelines for filing claims

Professional and facility claims: How to file

- Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. It has also been proven to reduce claim re-work (adjustments). Therefore, it is preferred that all claims be submitted electronically.

- Physicians can bill on the CMS-1500, Facilities on the UB-04 claim form, as appropriate. These forms, produced by the Centers for Medicare & Medicaid Services, are used nationally.

Information required for all claims

Field formats may vary. Software vendors have instructions for entering the information for electronic claims.

- A Place of Service code must be provided on each CMS-1500 claim. A list of the Place of Service codes is available on the CMS website at [cms.gov](http://cms.gov) > Medicare > Place of Service Codes (under the Coding heading).

- Claims must be billed with valid procedure and/or revenue codes, modifiers and diagnosis codes. If any of these data elements is missing or invalid, the claim may be denied. Physicians should ensure that any procedure code and modifier combinations submitted are appropriate and that multiple modifiers are used when applicable.

- The National Drug Code (NDC), Unit of Measure and Units supplied are required for all drugs as indicated by MDHHS policies.

- Claims must be submitted with the correct member information. For both electronic and paper claims, the following member match criteria rules are in effect:
  - Claims can be submitted with either the member’s Blue Cross Complete ID number or the member’s Medicaid ID number.
  - Blue Cross Complete does not match if a Social Security number is submitted as the contract number. These claims are rejected as contract number not found.
  - An exact match on the date of birth is required.
  - Blue Cross Complete uses enhanced logic if there is more than one match (twin logic). The full first name will be used. If there are still two matches, the relationship code will be used.
  - Spaces, hyphens and other special characters are ignored when matching on name.
C. Filing claims electronically

Preparing to file claims electronically

Electronic billing is faster, easier and more accurate than filing paper claims. The main options for the electronic handling of claims are as follows:

- The HIPAA 837 electronic standard transaction is used for submitting a new claim and for correcting or replacing a claim already submitted.
- The HIPAA 835 electronic standard transaction is the electronic Remittance Advice, which shows how the claim was paid.

Before filing electronically, providers should call the Blue Cross Electronic Data Interchange department at 1-800-542-0945. An EDI Help Desk agent will help each provider navigate the process and confirm that the provider’s software vendor is approved to bill Blue Cross electronically.

Each provider will:

- Receive a billing location code
- Complete a Trading Partner Agreement, if applicable
- Receive applicable user guide manuals

Providers who wish to learn more about filing claims electronically or obtain information about Blue Cross-approved vendors who do electronic billing should contact the Blue Cross Electronic Data Interchange department at 1-800-542-0945. Providers can also follow the guidelines for electronic billing that are available in the reference documents at [bcbsm.com/providers](http://bcbsm.com/providers) > Quick Links > Electronic Connectivity (EDI). Click the pertinent link under the “Reference library” heading.

In addition, providers must take appropriate steps in order to begin receiving production 005010X221A1 835 transactions, including the completion of an EDI Trading Partner Agreement, a Provider Authorization Form and an 835 ERA Enrollment Form. To begin this process, receive more information or ask questions, providers should contact the EDI Help Desk at 1-800-542-0945 or visit [bcbsm.com/providers](http://bcbsm.com/providers) > Quick Links > Electronic Connectivity (EDI) and select the appropriate provider type and then the appropriate ANSI ASC X12N 835 Companion Document under the “Reference library” heading.

Internet claims submission tool

For smaller provider offices currently submitting paper claims who would like to submit claims electronically but without the expense of purchasing software, Blue Cross Complete provides a free Internet claims tool that allows electronic submission of professional (including vision and hearing) and facility claims.

Additional information about this tool is available at [bcbsm.com/providers](http://bcbsm.com/providers) > Quick Links > Electronic Connectivity (EDI) > I’m a provider and I submit my own claims > Make the switch to electronic billing. For more information about this tool or to obtain information about Blue Cross-approved vendors who do electronic billing, providers should contact the Blue Cross Electronic Data Interchange department at 1-800-542-0945.

Guidelines for filing claims electronically

The guidelines for submitting Blue Cross Complete claims electronically include:

- Providers may submit claims using the alpha prefix XYU. This prefix is found in front of the enrollee ID number on the member’s ID card.

Note: Claims submitted without the XYU prefix but with the member’s Medicaid ID number are routed for processing. Claims submitted without the XYU prefix and with only the member’s Blue Cross Complete ID number are rejected and must be resubmitted with either the XYU prefix or the member’s Medicaid ID number.
The Blue Cross Complete facility payer ID is 00210; the Blue Cross Complete professional payer ID is 00710.

Electronic claims must contain only the NPI, not legacy identifiers. Claims received with legacy provider identifiers such as Bill PINs will be rejected.

**Following up on EDI claims via the HIPAA 276/277 standard electronic transaction**

Providers who submit professional or facility claims electronically to Blue Cross Complete can register to receive a weekly 835 HIPAA-compliant transaction set. This file contains claims finalized during the weekly processing cycle. The instructions for registering are found in the “The Remittance Advice” section of the chapter.

Providers who submit claims electronically can use the HIPAA 276/277 standard electronic transaction (Claim Status Inquiry and Response) to check the status of a claim. For additional information about the HIPAA 276/277 standard electronic transaction, providers should email Electronic Data Interchange at EDICustMgmt@bcbsm.com.

**D. Filing paper claims**

**Guidelines for filing paper claims**

For claims that may be filed on paper, providers should follow these guidelines:

- File claim on a red and white CMS-1500 or UB-04 form.
- Use 12-point readable type (Arial or Times New Roman).
- Do not submit handwritten claims.
- Use black ink that produces a clear impression. Each character must be distinct.
- Do not use highlighters or any other markers on the claim or on any attachments to the claim. They make the claim impossible to process.
- Do not use an imprinter to complete any portion of the claim form. The forms are not designed for use with an imprinter.
- Use a six-digit format with no spaces or punctuation for all dates; for example, enter May 3, 2008 as 050308.
- Securely staple all attachments. Paper clips or tape tend to fall off. Send only Medicare or coordination of benefits information. No other attachments are necessary.
- Use large, flat envelopes (instead of folding claims into letter-size number 10 envelopes). This significantly improves Blue Cross Complete’s processing time and reduces the chance of damage to the paper form.
- Complete all required data fields on the form. Incomplete claims will be returned. Leave the field blank if there is no information to populate that field.
- Use only code sets required by HIPAA regulations.
- Ensure data are enclosed within field or box perimeters, including the provider signature. Claims with text or data outside field or box perimeters will be returned for alignment rejection.
- Include the name and the NPI for the billing provider in field 33a. Claims will be returned if the NPI is missing from field 33a of the CMS-1500 form.
- Include the NPI of the rendering physician in field 24j (unshaded) on the CMS-1500 form. This is particularly important if the NPI in box 33a is for a group.
- Always include the tax identification number in box 25.
- Report the member’s correct Medicaid ID number, as shown on the member’s ID card. Include the suffix and the date of birth.
● Report any other insurance information when submitting the claim.

● Submit paper claims to:
  Blue Cross Complete Claims  
  P.O. Box 7355  
  London, KY 40742-7355

E. Processing submitted claims

Prompt payment legislation
Claims received by Blue Cross Complete will be processed in accordance with prompt payment legislation (Public Act 28 of 2004). This means that Blue Cross Complete is required to pay simple interest at 12 percent per year on all “clean claims” that are not paid within 45 days of receipt.

What is a clean claim?
Public Act 28 defines clean claims as claims that:

● Identify the provider of services (Blue Cross Complete requires the provider’s NPI(s) and tax identification number as the identifiers.)

● Identify the member and subscriber

● List the date and place of service

● Bill for covered services for eligible members

● Substantiate the medical necessity and appropriateness of care, when necessary

● Contain prior authorization or precertification information, when necessary

● Identify services rendered using proper procedure and diagnosis codes

● Include any necessary additional information as required by Blue Cross Complete

Remittance advice statements
After Blue Cross Complete processes a claim, a remittance advice (also called a claim voucher) is issued that tells the provider about the claim’s payment status. The remittance advice is a detailed summary disposition of the claims. Blue Cross Complete claims are shown on a remittance advice that carries the Blue Cross Complete logo and reflects only Blue Cross Complete claims.

The ASC X12 Health Care Information Status Notification (277) electronic standard transaction
Blue Cross Electronic Data Interchange selected the ASC X12 Health Care Information Status Notification (277) as the format for returning the notification of v5010 837 claim transaction(s). Claims that did not reach the processing system due to receiving a Blue Cross EDI front-end edit are identified on either a 277CAP transaction or an R277CAF report. Claims that receive 277CA edits must be corrected and resubmitted.

● The 277CAP transaction. The 277CAP is the electronic claim acknowledgement in ASC X12N 5010 x214 format. The transaction identifies which claims have been edited and will not continue on for processing. The transaction is generally used by clearinghouses, software vendors or submitters with practice management systems that can translate the information into a report readable by humans.

● The R277CAF report. In addition to or in place of the 277CAP transaction, Blue Cross EDI returns an R277CAF edit report. The report provides detailed information about claims that have received edits. The report also contains a summary of all accepted and rejected claims together with the total charges. Providers may refer to the Blue Cross V5010 Acknowledgements document available online for additional information and examples.
Tips for using the 277CAP transaction

On the 277CAP transaction, providers can distinguish between an edit for “member not found” and one for “contract not found” as follows:

- An edit for member not found returns as A3:26:QC.
  - A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
  - 26 – Entity not found. Note: This code requires use of an entity code.
  - QC – Patient
    - An edit for contract not found returns as A3:164:HK.
  - A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
  - 164 – Entity’s contract/member number. Note: This code requires use of an entity code.
  - HK – Subscriber

Paper claims that do not meet HIPAA 5010 X12 format requirements

Blue Cross Complete will convert paper claims data into an electronic claim as set forth by the United States Department of Health and Human Services and HIPAA standards.

Note: Paper claims that are completed improperly will be rejected.

Please refer to the grids below for both the CMS-1500 and UB-04 required fields and billing guidelines for mandated 5010 837 formats to ensure your claims are submitted correctly.

<table>
<thead>
<tr>
<th>Field #</th>
<th>CMS-1500 Field/Data Element</th>
<th>&quot;Reject Statement&quot; (Reject Criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td>&quot;Member name is missing or illegible.&quot; (If first or last name are missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Date</td>
<td>&quot;Member date of birth is missing.&quot; (If missing month or day or year, the claim will be rejected.)</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Birth Sex</td>
<td>&quot;Member’s sex is required.&quot; (If no box is checked, the claim will be rejected.)</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>&quot;Insured’s name missing or illegible.&quot; (If first or last name is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address (number, street, city, state, zip) phone</td>
<td>&quot;Patient address is missing.&quot; (If street number, street name, city, state or zip are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>6</td>
<td>Patient Relationship to Insured</td>
<td>&quot;Patient relationship to insured is required.&quot; (If none of the four boxes is selected, the claim will be rejected.)</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address (number, street, city, state, zip) phone</td>
<td>&quot;Insured’s address is missing.&quot; (If street number, street name, city, state or zip are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>21</td>
<td>Information related to Diagnosis/Nature of Illness/Injury</td>
<td>&quot;Diagnosis code is missing or illegible.&quot; (The claim will be rejected.)</td>
</tr>
<tr>
<td>24</td>
<td>Supplemental Information</td>
<td>&quot;National Drug Code data is missing or incomplete or invalid.&quot; (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)</td>
</tr>
<tr>
<td>Field #</td>
<td>CMS-1500 Field/Data Element</td>
<td>&quot;Reject Statement&quot; (Reject Criteria)</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>24A</td>
<td>Date of Service</td>
<td>&quot;Date of service is missing or illegible.&quot; (The claim will be rejected if both the “From” and “To” DOS are missing. If both “From” and “To” DOS are illegible, the claim will be rejected. If only the “From” or “To” DOS is billed, the other DOS will be populated with the DOS that is present.)</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
<td>&quot;Place of service is missing or illegible.&quot; (Claim will be rejected.)</td>
</tr>
<tr>
<td>24D</td>
<td>Procedure, Services or Supplies</td>
<td>&quot;Procedure code is missing or illegible.&quot; (Claim will be rejected.)</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
<td>&quot;Diagnosis pointer is required on line ___” [lines 1-6]. (For each service line with a “From” DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>24F</td>
<td>Line item charge amount</td>
<td>&quot;Line item charge amount is missing on line ___” [lines 1-6]. (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)</td>
</tr>
<tr>
<td>24G</td>
<td>Days/Units</td>
<td>&quot;Days/units are required on line ___” [lines 1-6]. (For each line with a “From” DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider identification</td>
<td>&quot;National provider identifier of the servicing or rendering provider is missing or illegible.&quot; (If NPI is missing or illegible, claim will be rejected.)</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number SSN/EIN</td>
<td>&quot;Billing Provider Tax ID is missing or incomplete&quot; (If the provider tax ID is missing the claim will be rejected.)</td>
</tr>
<tr>
<td>26</td>
<td>Patient Account/Control Number</td>
<td>&quot;Patient Account/Control number is missing or illegible&quot; (If missing or illegible, claim will reject)</td>
</tr>
<tr>
<td>27</td>
<td>Assignment Number</td>
<td>&quot;Assignment acceptance must be indicated on the claim.&quot; (If “Yes” or “No” is not checked, the claim will be rejected.)</td>
</tr>
<tr>
<td>28</td>
<td>Total Claim Charge Amount</td>
<td>&quot;Total charge amount is required.&quot; (If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier including degrees or credentials</td>
<td>&quot;Provider name is missing or illegible.&quot; (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Information and Phone number</td>
<td>&quot;Billing provider name and/or address is missing or incomplete.&quot; (If the name and/or street number and/or street name and/or city and/or state and/or zip +4 are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Information and Phone number</td>
<td>&quot;Field 33 of the CMS1500 claim form requires the provider's physical service address.&quot; (If a PO Box is present, the claim will be rejected.)</td>
</tr>
<tr>
<td>Field #</td>
<td>UB-04 Field/Data Element</td>
<td>&quot;Reject Statement&quot; (Reject Criteria)</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Billing Provider Name, Address and Telephone Number</td>
<td>&quot;Billing provider name or address missing or incomplete.&quot; (If the name, street number, street name, city, state or zip +4 code is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>1</td>
<td>Billing Provider Name, Address and Telephone Number</td>
<td>&quot;Field 1 of the UB04 claim form requires the provider's physical service address.&quot; (If a PO Box is present, the claim will be rejected.)</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Account/ Control Number</td>
<td>&quot;Patient account/control number is missing or illegible.&quot; (If the number is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>5</td>
<td>Fed. Tax Number</td>
<td>“Billing Provider Tax ID is missing or incomplete” (If the provider tax ID is missing the claim will be rejected.)</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name</td>
<td>&quot;Member name is missing or illegible.&quot; (If first or last name are missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>9a-e</td>
<td>Patient Address</td>
<td>&quot;Patient address is missing.&quot; (If the name, street number, street name, city, state or zip +4 code is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birth Date</td>
<td>&quot;Member DOB is missing.&quot; (If month, day or year is missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex</td>
<td>&quot;Member's sex is required&quot; (If missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>&quot;Admission Date is missing or illegible.&quot; (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, the claim will not reject. If it is IP and a valid date is not billed, the claim will be rejected.)</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>&quot;Based on the date the claim was received, the admission date is a future date.&quot; (Use bill type table to identify if it is an IP or an OP claim. If it is OP, the claim will not reject. If it is IP and a future date is billed, reject the claim.)</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>&quot;Admission hour is required.&quot; (Use bill type table to identify if it is an IP or OP claim. If it is IP, the claim will not reject. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)</td>
</tr>
<tr>
<td>14</td>
<td>Admission Type</td>
<td>&quot;Admission type is required.&quot; (If a numeric value is not present, claim will be rejected.)</td>
</tr>
<tr>
<td>15</td>
<td>Source of Referral for Admission or Visit</td>
<td>&quot;Source of referral for admission or visit is missing.&quot; (If claim has any bill type except 14x and the field is blank, claim will be rejected.)</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>&quot;Discharge hour is required.&quot; (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status</td>
<td>&quot;Patient discharge status is required.&quot; (If left blank, claim will be rejected.)</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>&quot;Revenue code is missing or illegible.&quot; (If the revenue code is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description</td>
<td>&quot;Invalid NDC Code or Unit of Measure&quot; (In addition to the standard description of the Revenue Code, the NDC Code and Unit of Measure are required in accordance with MDHHS guidelines.)</td>
</tr>
<tr>
<td>Field #</td>
<td>UB-04 Field/Data Element</td>
<td>&quot;Reject Statement&quot; (Reject Criteria)</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>&quot;DOS is missing or illegible.&quot; (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)</td>
</tr>
<tr>
<td>45</td>
<td>Creation Date</td>
<td>&quot;Creation date is missing or illegible.&quot; (If the creation date is missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>46</td>
<td>Service Days/Units</td>
<td>&quot;Days/units are required on line ___.&quot; [lines 1-22]. (For each line with a &quot;From&quot; DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)</td>
</tr>
<tr>
<td>47</td>
<td>Line Item Charges</td>
<td>&quot;Line item charge amount is missing on line ___.&quot; [lines 1-22]. (If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>&quot;Total charge amount is missing.&quot; (If a value greater than or equal to zero is not present, the claim will be rejected.)</td>
</tr>
<tr>
<td>50</td>
<td>Payer</td>
<td>&quot;Payer name is required.&quot; (If left blank, the claim will be rejected.)</td>
</tr>
<tr>
<td>52</td>
<td>Release of Information</td>
<td>&quot;Release of information certification indicator is required.&quot; (If blank, the claim will be rejected.)</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits</td>
<td>&quot;Assignment of benefits certification indicator is required.&quot; (If left blank, the claim will be rejected.)</td>
</tr>
<tr>
<td>58</td>
<td>Insured's Name</td>
<td>&quot;Member name is missing or illegible.&quot; (If first and/or last name are missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>59</td>
<td>Patient’s Relationship</td>
<td>&quot;Patient’s relationship to insured is required.&quot; (If blank, the claim will be rejected.)</td>
</tr>
<tr>
<td>67A-Q</td>
<td>Other Diagnosis Codes and Present on Admission Indicator</td>
<td>&quot;Diagnosis codes are missing or illegible.&quot; (If diagnosis codes are missing or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code</td>
<td>&quot;Admitting diagnosis code is missing or illegible.&quot; (If it is an IP claim and field is blank or illegible, the claim will be rejected.)</td>
</tr>
<tr>
<td>70</td>
<td>Patient’s Reason for Visit</td>
<td>&quot;Patient’s reason for visit is missing.&quot; (If the claim is OP and field is blank, the claim will be rejected.)</td>
</tr>
<tr>
<td>74</td>
<td>Other/Procedure Date</td>
<td>&quot;Based on the date the claim was received, procedure date is a future date.&quot; (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)</td>
</tr>
<tr>
<td>74</td>
<td>Other/Procedure Date</td>
<td>&quot;Procedure date is missing or illegible.&quot; (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Identifiers: Name and NPI</td>
<td>&quot;Attending physician name and/or number is missing.&quot; (If attending physician name or NPI number are missing, the claim will be rejected.)</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Qualifier</td>
<td>&quot;Attending provider qualifier is missing/invalid.&quot; (The claim will be rejected if the “Other provider ID” is present and either: 1.) The ‘Qualifier’ box is blank or 2.) A qualifier other than 0B/1G/G2 is present.</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Other ID#</td>
<td>&quot;Attending Provider NPI is missing.&quot; (The claim will be rejected if qualifier is present and NPI box is blank.)</td>
</tr>
</tbody>
</table>
Claim return letters are sent for claims that cannot be processed

When claims cannot be processed, Blue Cross Complete sends a claim return letter stating the reason. Physicians should follow the instructions in the letter.

Providers should contact Blue Cross Complete Provider Inquiry at 1-888-312-5713 if they have questions about the content of the letter or the instructions contained in the letter.

Providers can check the status of a claim

Providers can check on the status of a claim at any time using NaviNet, at NaviNet.net > Login.

If the provider has a question about a claim, he or she should call Blue Cross Complete Provider Inquiry at 1-888-312-5713.

If the claim needs to be reprocessed, the reprocessing will be done during the phone call, if possible. In addition:

- If information on the claim was incorrect, a corrected claim may be submitted.
- If there is an issue with a medical necessity determination, the claim may be appealed.

Review electronic claims that are not clean

The claim payment process does not change for claims filed electronically through the Blue Cross clearinghouse. The 997 Functional Acknowledgment must be reviewed to determine whether the file was accepted for processing or rejected for compliance issues. The 277CA (Claim Status Category Code of A3 or A4) transaction or report should be reviewed to determine whether claims have been returned due to edits in the 837 claims transaction.

When to resubmit a claim

Providers should resubmit a claim for the following reasons:

- The paper claim was returned with a Blue Cross Complete claim return letter describing claim defects that must be corrected.
- The electronic claim was listed in the 277CA transaction or report with Claim Status Category of A3.

Providers should not automatically resubmit claims without first investigating the circumstances.

Guidelines for submitting corrected claims

Providers may submit corrected claims either on paper (using a CMS-1500 for professional claims or a UB-04 for facility claims) or via electronic data interchange.

Note: A corrected claim is one that is resubmitted with a specific change made, such as a different procedure code, diagnosis code or billed amount. Neither the Member ID nor the Billing Provider can be changed using a corrected claim. Providers must Void the original claim and submit a new claim with the correct Member ID and Billing Provider. A claim should not be submitted as corrected simply to review how the claim was processed during its initial submission.

Corrected claims should be submitted as follows:

- Corrected claims submitted on paper should comply with the following guidelines:
  - On the CMS-1500, Field 22 must contain “7” followed by the original claim ID. On the UB-04, the original claim ID must show in Field 64 and the bill type in Field 4 must end in “7”.
  - Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.
Original and corrected claims should be sent to:

Blue Cross Complete Claims
P.O. Box 7355
London, KY 40742-7355

- Corrected claims submitted electronically should comply with the following guidelines:
  - Use "7" for the replacement of a prior claim, for the type of bill or frequency type in loop 2300, CLM05-03 (837P or 837I). Include the claim number when submitting your claim with the 7.
    - Note: Do use these indicators for claims that were previously processed (approved or denied). Do not use these indicators for claims that contained errors and were not processed (were rejected up front).
  - Include the original claim number in segment REF01=F8 and REF02=the original claim number. Do not use dashes or spaces.
  - Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.

Corrected claims should not be submitted on paper and electronically at the same time.

**Reasons for negative balances**

Occasionally, the Remittance Advice will reference a negative balance. A negative balance is created when Blue Cross Complete pays a provider for services and later discovers this payment was incorrect. In most cases, the provider has already processed the Blue Cross Complete payment before the error is caught. When payment is made in error, Blue Cross Complete will take steps to recover the incorrect payment in accordance with terms contained in the provider agreement.

Among the more common reasons for incorrect payments are the following:

- Provider was overpaid for the service rendered due to billing or processing errors.
- Provider was paid in error because of member ineligibility, or the service provided was not authorized.
- It is determined that the member had other primary insurance.

A Negative Balance Report is system generated when the provider has a negative balance on the Remittance Advice.

**F. Billing laboratory services**

**General guidelines for billing laboratory services**

Claims for laboratory services are eligible for payment, following MDHHS Guidelines.

In addition, it is the responsibility of the physician who orders the laboratory services to know whether the laboratory is contracted with Blue Cross Complete and the laboratory procedure is covered by Medicaid and on the MDHHS fee schedule.

Non-participating laboratories will require a prior authorization before rendering services to Blue Cross Complete members.
G. Required reporting of events

Which events must be reported?

Never events and other preventable serious adverse events must be reported on claims for all Blue Cross Complete products.

What are these events?

A never event is a serious, preventable condition that results from health care management and that should never have occurred. A never event is defined as follows:

- A surgical or other invasive procedure performed on the wrong body part or the wrong site
- A surgical or other invasive procedure performed on the wrong member
- The wrong surgical or other invasive procedure performed on a member

A preventable serious adverse event other than a never event is one that meets all of the following criteria:

- It is reasonably preventable through the use of evidence-based guidelines or criteria.
- It is within the control of the facility or the providers practicing within the facility.
- It is the result of an error made in the facility. (That is, the condition was not present when the member entered the facility.)
- It results in serious or significant harm.
- It is clearly, unambiguously and precisely identified, reportable and measurable.

Note: In the terminology of government programs, never events and other preventable serious adverse events are known as provider-preventable conditions. Those PPCs that occur in an inpatient hospital setting are called health care-acquired conditions. Those that occur elsewhere are called other provider-preventable conditions. The list of hospital-acquired conditions published by CMS is available at [cms.gov](https://www.cms.gov/HospitalAcqCond/) > Medicare > Hospital-Acquired Conditions (Present on Admission Indicator) > Hospital-Acquired Conditions (on the left navigation bar) > FY 2013, FY 2014, and FY 2015 Final Hac List (no changes have been made during the past 3 years). This document is a list of hospital-acquired conditions with ICD-9 codes.

Information on hospital-acquired conditions with ICD-10 codes is available at [https://www.cms.gov/HospitalAcqCond/](https://www.cms.gov/HospitalAcqCond/) > ICD-10-CM/PCS HACs List.
How to report never events
Providers must comply with the following guidelines when reporting never events:

- **Facility services.** Hospitals are required to submit a no-pay claim (TOB 110) when an erroneous surgery related to a never event is reported. If there are covered services or procedures provided during the same stay as the erroneous surgery, hospitals are required to submit two claims:
  - One claim with covered services or procedures unrelated to the erroneous surgery(s) on a TOB 11X (with the exception of 110)
  - The other claim with the noncovered services or procedures related to the erroneous surgery or surgeries on a TOB 110 (no-pay claim). Within the first five diagnosis codes listed on the claim, the TOB 110 claim should also contain one of the diagnosis codes to indicate the type of preventable serious adverse event: E876.5 (wrong surgery), E876.6 (wrong patient) or E876.7 (wrong body part).

  Note: Both the covered and the noncovered claim must have Statement Covers Periods that match.

- **Professional services.** Any claim for an erroneous surgery or procedure rendered by a practitioner should be submitted using the CMS-1500 claim form or an 837P claim transaction. The claim must include the appropriate modifier appended to all lines that relate to the erroneous surgery or procedure using one of the following applicable National Coverage Determination modifiers:
  - PA – surgery wrong body part
  - PB – surgery wrong patient
  - PC – wrong surgery on patient

  Note: Physician claims associated with these events should be submitted with a charge of 1 cent.

Never events are not reimbursed
Blue Cross Complete will not reimburse a hospital or physician in the hospital setting for costs associated with direct actions that result in a never event.

In addition, all services provided in the operating room when an error occurs are considered related and are therefore not covered. No providers who are in the operating room when the preventable serious adverse event occurs and who could bill individually for their services are eligible for payment. All related services provided during the same hospitalization in which the error occurred are noncovered.

Note: Related services do not include performance of the correct procedure.

Policy is administered using APR-DRG Grouper
For DRG-reimbursed hospitals, Blue Cross Complete uses the most current version of the All Patient Refined Diagnosis-Related Groups (APR-DRG) Grouper to administer the policy, incorporating the POA indicator into the DRG assignment.

Note: Blue Cross Complete continues to require authorization for all inpatient services. Authorizations do not change any of the payment guidelines stated here.

H. Other guidelines for submitting claims

Evaluate readmissions to facilities (15-day Readmission)
If a member is readmitted within 15 days of a previous discharge, the hospital or facility should evaluate the admission to determine whether it should be billed separately or combined with the previous admission. All readmissions that occur within 15 days of the discharge date are subject to Blue Cross Complete review based on the following:
• **Premature discharge** – occurs when a member’s condition is not sufficiently stable at discharge, resulting in a readmission within 15 days

• **Planned readmission** – occurs when a member is discharged with a documented plan to readmit for additional services within 15 days without a medical reason for the delay in services

• **Continuation of care** – a readmission due to one of the following:
  - Findings of an acute disease process are documented but not addressed during the first admission.
  - Treatment is initiated but not monitored or evaluated before discharge.
  - There is no follow-up outpatient discharge plan.

**Report information on newborns**

Providers are required to report the following information on newborns:

• The appropriate priority (type) of admission or visit should be reported. For example, a newborn admission should be reported as type of admission 4 (newborn). When reporting with this type of admission, providers should report one of the following the special point of origin codes:
  - Code 5 (born inside this hospital)
  - Code 6 (born outside of this hospital)

• Birth weight should be reported in grams on all claims with a type of admission 4. Birth weight should be reported as a whole number.

• For cesarean sections or inductions related to gestational age, one of the following should be reported:
  - Condition code 81: C-sections or inductions performed at less than 36 weeks’ gestation for medical necessity
  - Condition code 82: Elective C-sections or inductions performed at less than 39 weeks’ gestation
  - Condition code 83: C-sections or inductions performed at 39 weeks’ gestation or greater

For additional information, providers should refer to **Bulletin MSA-14-34** (effective Oct. 1, 2014) from the Michigan Department of Health and Human Services.

**Use National Drug Code to bill physician-administered pharmaceutical products**

Providers must report the NDC on all Blue Cross Complete claims for physician-administered pharmaceutical products. The NDC is a unique 11-digit identifier assigned to a drug product by the manufacturer under FDA regulations. Claims will be rejected if the NDC is not reported or if the NDC reported is not valid.

The following information is required for each billed pharmaceutical product:

- NDC qualifier N4
- 11-digit NDC
- NDC unit qualifier (GR, ML or UN)
- NDC quantity

When submitting claims, providers should follow these guidelines:

- For professional claims submitted on paper, the required information must be entered into the shaded portion of the fields 24A through 24H on the CMS-1500 form.
- For facility claims submitted on paper, the required information must be entered into Form Locator 43 on the UB-04 form.
For professional and facility claims submitted electronically, the required information must be reported in the LIN and CTP segment within the 2410 service line loop.

**Guidelines for billing pharmacy claims**

For pharmacy claims:

- The pharmacy will use the member’s Blue Cross Complete de-identified ID number to process claims for regular prescriptions through PerformRx.

Note: The pharmacy can contact PerformRx at 1-888-989-0057 with any questions related to processing and member eligibility.

- The pharmacy will use the Magellan system and the member’s state-issued Medicaid Beneficiary ID number to process claims for prescriptions for AIDS and HIV infections and certain psychotropic medications.

**Report Medicaid encounter data on all Blue Cross Complete claims**

Providers submitting Blue Cross Complete claims must report the following Medicaid encounter data on those claims:

- All diagnosis codes (for every claim)
- All procedure codes (for every claim)
- Both admission and discharge dates (for inpatient services)
- Both revenue and procedure codes (for outpatient hospital services)
- NDCs for all physician-administered pharmaceutical products

Blue Cross Complete reports to MDHHS the encounter data received from providers.

**Use EX codes specific to Blue Cross Complete claims**

An EX code explains the reason a claim is denied. It is typically a three-character code composed of letters or numbers or both that represents the reason for the denial.

Some EX codes that pertain to Blue Cross Complete claims include:

- Reimbursement for the Vaccines for Children Program
- Consent form for sterilization, certification and verification forms for abortion and acknowledgement form for hysterectomy (For these services, the applicable form(s) must be submitted with the claim.)
- Age exceeds normal range for the procedure
- Mental health provider submitted without provider degree
- Eligibility denials without subscriber liability

**How to bill for dual-eligible members**

When billing for dual-eligible members (those members with either Original Medicare, BCN Advantage or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), providers should always bill the primary plan.

Additional information about billing dual-eligible members is in the document *What you should know when serving dual-eligible members* at MiBlueCrossComplete.com/providers > Dual-eligible Blues members – Provider Q&A.

For Blue Cross Complete members who are eligible for but not yet enrolled in either Original Medicare or a Medicare Advantage product, Blue Cross Complete may not cover the services that Medicare would
normally cover or the copayments, coinsurances and deductible that would have been left for the member to pay after Medicare covered the services.

Prospective claims editing policy

Blue Cross Complete claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider’s contract, and/or a member’s eligibility to receive covered health care services.

I. Coordination of benefits and subrogation

What is coordination of benefits?

Blue Cross Complete benefits are not provided to the extent that any amounts are paid or payable for expenses to or on behalf of the member under the provisions of any insurance, service benefit or reimbursement plan providing similar direct benefits without regard to fault, including by way of illustration and not limitation: Medicare, Workers’ Compensation, Employer's Liability Law or No Fault Automobile Insurance.

In establishing the order of carrier responsibility applicable to health plans covering Blue Cross Complete members, Blue Cross Complete will follow the coordination of benefits guidelines of MDHHS.

All medical bills must first be submitted to the primary insurance carrier. Blue Cross Complete is the payer of last resort.

If a Blue Cross Complete member is injured and requires treatment related to a motor vehicle accident, Blue Cross Complete will require a statement indicating the type of medical coverage carried on the member's automobile insurance.

How to resolve questions about a member’s coordination of benefits issues

To resolve a question about a member’s coordination of benefits status, providers may do the following:

- Call Blue Cross Complete Provider Inquiry at 1-888-312-5713.
- Write to:
  Blue Cross Complete Claims
  P.O. Box 7355
  London, KY 40742-7355

When to bill for coordination of benefits

Coordination of benefits is a process that defines which health carrier or insurance company pays as primary when a member has more than one source of coverage for health care benefits.

Providers should bill for coordination of benefits only when both of the following circumstances apply:

- The member is covered by more than one health plan and Blue Cross Complete is secondary.
The primary carrier has been billed and a remittance advice statement has been received showing a balance remaining.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>A claim is sent to Blue Cross Complete and requires coordination of benefits investigation</td>
<td>Payment may be delayed until the primary coverage is determined.</td>
</tr>
<tr>
<td>It is determined that Blue Cross Complete is the primary carrier</td>
<td>The claim is processed as usual.</td>
</tr>
<tr>
<td>It is determined that Blue Cross Complete is the secondary carrier</td>
<td>The claim will be rejected unless it is submitted with payment information from the primary carrier</td>
</tr>
</tbody>
</table>

As a Michigan Medicaid health plan, Blue Cross Complete is considered the payer of last resort.

**Coverage when another-party liability case is in litigation**

For members with other-party liability coverage (through Workers’ Compensation, etc.), Blue Cross Complete coordinates coverage with the OPL carrier. In instances in which an OPL case is in litigation, reimbursement for medical services is covered by Blue Cross Complete based on the member’s certificate. Once the case is settled, Blue Cross Complete works with the OPL carrier, as necessary, to reconcile any reimbursement owed to Blue Cross Complete.

**What is subrogation?**

If the member has a right of recovery from a person or organization for any benefits or supplies covered under this affiliation agreement (except from a member’s health insurance coverage, subject to the coordination of benefits provisions), the member, as a condition of receiving benefits under this contract, will either:

- Pay Blue Cross Complete all sums recovered by suit, settlement or otherwise, to the extent of the benefits provided by Blue Cross Complete and in an amount equal to the Blue Cross Complete payment for those benefits, but not in excess of monetary damages collected; or
- Authorize Blue Cross Complete to be subrogated to the member’s rights of recovery, to the extent only of the benefits provided, including the right to bring suit in the member’s name at the sole cost and expense of Blue Cross Complete.

In the event a suit instituted by Blue Cross Complete on behalf of the member results in monetary damages awarded in excess of the cash value of actual benefits provided by Blue Cross Complete, Blue Cross Complete shall have the right to recover the costs of suit and the attorney fees out of the excess, to the extent of the cost of such fees. If a member refuses to cooperate with Blue Cross Complete in its filing of a claim for reimbursement, Blue Cross Complete shall have the right (to be exercised at Blue Cross Complete’s sole discretion) to request disenrollment of the member and the member’s dependents. Such disenrollment shall be subject to the Member Appeals Program.

**Blue Cross Complete has the right to payment and recovery**

Whenever benefits have been provided by Blue Cross Complete under the contract and the responsibility for payment is with another plan, Blue Cross Complete shall have the right to deny payment or recover from the other plan the reasonable cash value of each service provided by Blue Cross Complete in a total amount necessary to satisfy the intent of this section.

**Blue Cross Complete has the right to receive and release necessary information**

For the purpose of determining the applicability of and implementing the terms of this section, Blue Cross Complete will be required from time to time to release or to obtain information with respect to a member that it deems to be necessary for such purposes. A member who is claiming benefits under the contract shall furnish to Blue Cross Complete such information as may be necessary to implement this section. This would include notifying Blue Cross Complete if there is any change in other insurance coverage.
In the event that a member refuses to give consent where reasonably required, thereby preventing Blue Cross Complete from pursuing its right under this section, then such refusal shall be considered a material breach of this contract and may constitute, at the discretion of Blue Cross Complete, grounds for member disenrollment from Blue Cross Complete by MDHHS. Such disenrollment shall be subject to the Member Appeals Program.
SECTION 14: PROVIDER APPEALS

A. Appealing utilization management decisions

Peer-to-Peer Requests for Denied Services
If a request for inpatient or outpatient authorization is denied, a peer to peer discussion may be requested with the Blue Cross Complete medical director who issued the adverse determination. This request must be from a medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant. The provider requesting can be an ordering provider, treating provider, or a provider familiar with the case. A Peer to Peer request will be accepted up to three business days from the date of the original denial.

All Peer to Peer requests received within the required timeframe will be returned within one business day.

Appeal of Utilization Management Decisions
A health care professional or provider may submit an appeal of an action or service denial by Blue Cross Complete, (based on a medical necessity or appropriateness determination). The appeal must be submitted with documentation to support medical necessity or appropriateness.

Appeals will be handled and processed within the timeframes listed below:

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Timeframe to File</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Appeal</td>
<td>Thirty (30) calendar days from the date of the denial notification letter</td>
<td>Within 30 calendar days from Plan receipt of appeal request</td>
</tr>
</tbody>
</table>

B. Appealing claim denials

Guidelines for appealing a denied claim
Blue Cross Complete claim denials may be appealed as follows:

- The appeal must be submitted within 30 business days of the decision on the claim.
- The documentation that must be submitted with each type of appeal is:

<table>
<thead>
<tr>
<th>Reason for denial</th>
<th>Documentation required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely filing</td>
<td>Supporting documentation must show the claim was filed in a timely manner.</td>
</tr>
<tr>
<td>Coding edit (CCI edit denial)</td>
<td>Supporting documentation and medical notes or reports must be submitted.</td>
</tr>
<tr>
<td>Payment amount</td>
<td>Supporting documentation must be submitted.</td>
</tr>
</tbody>
</table>

C. Appeals submission guidelines

All appeals must be submitted to:
Blue Cross Complete Claims Appeals
P.O. Box 7361
London KY 40742-7355

Blue Cross Complete responds to all appeals within 30 business days.
Note: Blue Cross Complete will expedite an appeal and render a decision within 72 hours of the request if a longer time frame could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is the subject of the request.

A practitioner may request that Blue Cross Complete furnish the following:

- All documents relevant to the member’s appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision is based
- The names, titles and qualifications of any medical experts whose advice was obtained on behalf of Blue Cross Complete in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision

D. How to appeal temporary rate increase for primary care services

During 2014, MDHHS will apply an increased payment rate for specific primary care services furnished by certain qualified primary care providers. This is in compliance with the Affordable Care Act.

Practitioners eligible for this temporary increased payment include physicians with a board-certified specialty designation in family medicine, internal medicine or pediatric medicine or any related subspecialties. To qualify for the increased rate payments, which will be mailed from Blue Cross Complete, these physicians must be affiliated with Blue Cross Complete and must be registered on the MDHHS CHAMPS system.

Services eligible for this temporary increased payment include those associated with evaluation and management procedure codes *99201 through *99499 and vaccine administration codes *90460, *90461 and *90471 through *90474 and their successor codes.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Appeals related to these temporary rates should be submitted in writing within 90 days of the payment to:

Blue Cross Complete
Suite 210
100 Galleria Officentre
Southfield, MI 48034

The appeal must include the following:

- Provider name
- Provider Tax ID
- Member name
- Member ID number
- Member date of birth
- Claim ID, if available
- Date of service
- Type of service
- Supporting documentation, such as Remittance Advice statements

Upon receipt of the appeal, Blue Cross Complete will investigate and will respond in writing within 30 business days.
MDHHS Rapid Dispute Resolution Process for hospitals

Note: This section does not apply to hospitals that are contracted with Blue Cross Complete.

Blue Cross Complete supports the MDHHS Rapid Dispute Resolution Process for hospitals not contracted with Blue Cross Complete that have signed the MDHHS Access Agreement. The purpose of this process is to ensure that provider disputes are processed in a timely and efficient manner with adherence to state and federal regulations. Provider disputes will be reviewed to determine the appropriate resolution.

The following providers do not have access to the MDHHS Rapid Resolution Process:

- Noncontracted hospital providers who have not signed the Hospital Access Agreement
- Nonhospital providers

When providers who do not have access to the MDHHS Rapid Resolution Process request arbitration, Blue Cross Complete is required to participate in a binding arbitration process. Providers must first exhaust the Blue Cross Complete’s provider appeal process before requesting arbitration.
A. Blue Cross Complete uses Change Healthcare for Electronic Funds Transfer

Blue Cross Complete uses Change Healthcare (formally Emdeon®) for EFT payments:

- Providers who already use Emdeon can select Blue Cross Complete using BCC Payer ID 32002.
- Providers who need to sign up for Change Healthcare should enroll at emdeon.com/epayment.

Providers who are not registered with Change Healthcare receive payments in the form of paper checks.

B. Benefits of Electronic Funds Transfer

The benefits of electronic funds transfer include:

- Faster payment and no cost to participate
- Elimination of problems associated with multiple mailings of checks and paper payment vouchers, including the incidental disclosure of protected health information by mail when addresses change and are not updated in Blue Cross Complete's system

C. Providers receive electronic remittance advice statements

Providers who are paid through EFT can view Blue Cross Complete remittance advice statements electronically on Emdeon.com. In order to receive your 835 remittance through Blue Cross Blue Shield of Michigan you will need to enroll on the Change Healthcare website and Select BCBSM as your receiver; by selecting BCBSM as your receiver, your electronic remittance advice will be available. Blue Cross Complete does not mail paper remittance advice statements to providers who are paid through EFT.

D. How to arrange for Electronic Funds Transfer

Providers who have questions about EFT or who would like assistance in arranging for EFT should contact Change Healthcare directly at 1-866-506-2830 (option 1) or their Blue Cross Complete provider account executive.
A. What is health care fraud?

Health care fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Fraud also includes any act that constitutes fraud under applicable state or federal law. (42 CFR § 455.2)

Currently, the cost of health care fraud represents $1 trillion in annual health care revenues.

B. What is health care waste?

Waste definition: Activities involving payment or the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent but the outcome of poor or inefficient billing or treatment methods causes unnecessary costs.

C. What is health care abuse?

Abuse definition: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. (42 CFR § 455.2)

Abuse also includes practices on the part of the beneficiary that result in unnecessary cost to the Medicaid program.

D. Fraud, abuse and the Special Investigations Unit

Blue Cross Complete receives state and federal funding for payment of services provided to our members. In accepting claims payment from Blue Cross Complete, health care providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the Medicaid program. As a provider, you are responsible to know and abide by all applicable state and federal regulations.

Blue Cross Complete is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including the Attorney General’s Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the Health and Human Services Office of Inspector General, as well as local authorities. As part of Blue Cross Complete’s responsibilities, the Payment Integrity department is responsible for identifying and recovering claim overpayments. The department performs several operational activities to detect and prevent fraudulent and/or abusive activities.

Examples of fraudulent/abusive activities include, but are not limited to:

- Billing for services not rendered or not medically necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not medically necessary
- Misrepresenting the services rendered
- Submitting a claim for provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement
Blue Cross Complete, through its Special Investigations Unit, investigates all reports of fraud and/or abuse committed by members and providers. Credible allegations of fraud or abuse will be reported to Blue Cross Complete’s partners within the government. Blue Cross Complete may also take any number of actions to resolve fraud or abuse allegations, including medical record audits, instituting prepayment review of a provider’s claims, provider education and/or demanding recovery for discovered overpayments. Moreover, depending on the severity of the fraud/abuse finding, Blue Cross Complete reserves the right to impose sanctions, including and up to terminating the provider from Blue Cross Complete’s network.

As stated above, Blue Cross Complete seeks recovery of all excess payments discovered as a result of its fraud and abuse operational efforts. In the event an overpayment is identified, Blue Cross Complete will begin its overpayment recovery process by sending written notification to the provider containing instructions for the process (“initial overpayment notification”). Any questions should be referred to the contact information provided in the letter to expedite a response to questions or concerns.

In the event the provider does not agree with the identified overpayment amount, the provider should send a notice of dispute with the overpayment determination and request a re-review of the findings. The provider’s dispute must be accompanied by any additional documentation relevant to the dispute to the address contained within the initial overpayment notification. Such additional documentation may include chart information accompanied by a written narrative outlining the significance of the provided records. The provider must respond to the written overpayment notification within 30 days of the date of the notification. Blue Cross Complete reserves the right to grant an additional 15-day extension if the provider gives a valid reason why he or she was not able to submit a timely dispute. Upon completion of its review of the provider’s submitted dispute materials, Blue Cross Complete will issue a new overpayment determination (“dispute determination notification”). Blue Cross Complete will issue the dispute determination notification within 30 days of receipt of the provider’s dispute.

If the provider remains unsatisfied upon receipt of the dispute determination notification, the provider may file a second-level dispute. The provider’s second-level dispute must be accompanied by new, additional information relevant to reconsideration of the dispute determination notification. The provider must file his or her second-level dispute within 30 days of the date of the notification. Upon completion of its review of the provider’s submitted second-level dispute materials, Blue Cross Complete will issue a second dispute determination notification. Blue Cross Complete will issue the second dispute determination notification within 30 days of receipt of the provider’s second-level dispute.

If Blue Cross Complete does not hear from the provider in 30 days from either the initial written overpayment notification or the dispute determination notification, the final overpayment amount will be offset from future claims payments. In cases where recovery through offsetting will take longer than six months, Blue Cross Complete reserves the right to seek additional legal recourse such as referral to a collection service. If the provider remains unsatisfied upon receipt of the second dispute determination notification, the provider should follow the dispute processes outlined within the Provider Agreement.

E. Waste identification and recoveries

The Payment Integrity Department is responsible for identifying and recovering claim overpayments. The department performs several operational activities to ensure the accuracy of providers’ billing submissions. The department utilizes internal and external resources to prevent the payment of claims associated with waste and to initiate recovery when overpaid claims are identified. Some examples of identified “waste” include:

- Overpayments due to incorrect setup or update of contract/fee schedules in the system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/procedure codes or retroactive third-party liability/eligibility

As a result of the department’s claims accuracy efforts, providers may receive an overpayment notification or may receive letters from Blue Cross Complete or on behalf of Blue Cross Complete.
requesting medical records for review. Any questions should be referred to the contact information provided in the letter to expedite a response to questions or concerns. More important, if providers do not agree with Payment Integrity’s findings, providers should follow the dispute process outlined within the overpayment notification or findings letter in order to ensure their dispute rights are preserved and appropriately addressed. Providers who remain unsatisfied upon resolution of the dispute should refer to the instructions outlined within the dispute determination letter.

F. False Claims Act

The federal False Claims Act (FCA) is a federal law that applies to fraud involving any contract or program that is federally funded, including Medicare and Medicaid. It prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contractors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. Health care entities that violate the federal FCA can be subject to imprisonment and civil monetary penalties ranging from $5,000 to $11,000 for each false claim submitted to the United States government or its contractors, including state Medicaid agencies, as well as possible exclusion from federal government health care programs.

The federal FCA contains a “qui tam” or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim or providing testimony for or assistance in a federal FCA action.

G. How to report health care fraud

Providers who suspect that another Blue Cross Complete provider, employer group, employee or member is committing fraud should notify the Blue Cross Complete Antifraud Unit as follows:

- By phone: Call 1-855-232-7640 (TTY users should call the National Relay Service at 711.)
- By fax to (215) 937-5303
- By email to fraudtip@mibluecrosscomplete.com
- By U.S. mail to:
  
  Blue Cross Complete Antifraud Unit
  
  P.O. Box 018
  
  Essington, PA 19029

All information that is referred to the Blue Cross Complete Antifraud Unit will be given in cooperation with MDHHS and the Michigan Office of the Attorney General, as required by the Medicaid contract and regulations. The Blue Cross Complete Antifraud Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud.

Reports of suspected fraud regarding Blue Cross Complete may also be made directly to MDHHS in one of the following ways:

- By calling toll free to 1-855-MI-FRAUD (1-855-643-7283)
- Online at michigan.gov/fraud
- By writing to:

  Office of Health Services Inspector General
  
  P.O. Box 30062
  
  Lansing, MI 48909

Information may be left anonymously.