January 2014

Medicare Advantage deductibles rule clarified

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

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

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

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

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January 2014

Medicare Plus Blue℠ launches Blue Care Connect℠ in January

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

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

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

Key features include:

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

The care manager will encourage the member to complete the standard Medicare Advantage health assessment, address gaps in care and identify and suggest appropriate interventions depending on the member’s needs.
A subset of goals, if appropriate, will be considered high priority, and care managers will address these first. All other identified goals or guidelines will be addressed by the care manager during the program’s course.

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

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

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January 2014

**BCBSM’s Medicare Plus Blue® Group PPO gains members in Michigan for 2014**

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

**ID cards**

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

**Eligibility**

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

**Precertification**

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

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

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

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

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

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

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

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

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

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

High-tech diagnostic radiology pre-authorizations can be obtained from AIM℠ Specialty Health as directed in the [Medicare Plus Blue PPO Provider Manual](http://www.bcbsm.com/newsletter/therecord/record_0114/Record_0114t.shtml).

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
1. CMS revises 2014 Medicare Physician Fee Schedule

**Category:** Commercial and Medicare Advantage

**Title:** CMS revises 2014 Medicare Physician Fee Schedule

**Start Date:** January 2, 2014    **End Date:** February 2, 2014

In a related web-DENIS communication in December 2013, we mentioned that the 2014 Medicare Physician Fee Schedule effective for dates of service on and after Jan. 1, 2014, was available on the Centers for Medicare & Medicaid Services website. We also shared that the proposed physician reimbursement reduction was under much debate in Congress. We promised we would notify you if we learned of new circumstances.

On Dec. 27, 2013, CMS published a new 2014 Medicare Physician Fee Schedule effective for dates of service Jan. 1, 2014. This resulted from President Barack Obama signing into law the Pathway for Sustainable Growth Rate Reform Act of 2013. This law prevents the scheduled payment reduction for physicians and other practitioners who treat Medicare patients. There is a 0.5 percent update for services provided by such providers from Jan. 1, 2014, through March 31, 2014, under this law.

Blue Cross Blue Shield of Michigan is currently updating its systems to reflect the new law’s requirements. We will continue to pay 2013 rates until such updates are complete for the following services:

- Clinical labs reported by an independent laboratory
- Physical therapy
- Cardiology
- Ophthalmology

When we’ve completed the necessary system updates to reflect new 2014 rates for the above services, BCBSM will adjust 2014 paid claims accordingly. We will notify you via web-DENIS when this becomes effective.

Thank you for your patience as we await possible further communications on this important issue. If you have any questions, please contact your provider consultant.
2. Old CMS 1500 claim forms to be discontinued soon

   Category: Claims

   Title: Old CMS 1500 claim forms to be discontinued soon

   Start Date: January 2, 2014    End Date: January 16, 2014

   As of Jan. 31, 2014, you’ll no longer be able to order the old CMS-1500 paper claim form (version 08/05) or the Michigan Status Claim Review Form by using the BCBSM Facility and Professional Supply Requisition form. Providers who are submitting a paper claim form should use the revised CMS-1500 claim form (version 02/12). For information about the new form, see the January Record.

3. Electronic Funds Transfer Vouchers

   Category: January 2, 2014 Vouchers Unavailable

   Title: Electronic Funds Transfer Vouchers

   Start Date: January 7, 2014    End Date: January 10, 2014

   NASCO/MOS facility vouchers for check date 1/2/14 are currently not available in web-DENIS.

   We apologize for the inconvenience and are working to restore these vouchers.

4. New BCN Advantage fee schedule in effect Jan. 27, 2014

   Category: BCN Advantage

   Title: New BCN Advantage fee schedule in effect Jan. 27, 2014

   Start Date: January 2, 2014    End Date: January 31, 2014

   On Dec. 26, 2013, President Obama signed into law the Pathway for SGR Reform Act of 2013. This new law prevents a scheduled payment reduction of 20.1 percent for physicians and other practitioners who treat Medicare patients from taking effect on Jan. 1, 2014. The new law provides for a 0.5 percent update for services rendered by such providers through March 31, 2014. While the new law does provide for some increases, the 2 percent sequestration reduction has been extended through 2023.
Although CMS published this revision on Dec. 27, BCN Advantage will not be able to implement the new fee schedule until Jan. 27, 2014. BCN Advantage claims for services rendered on or before Dec. 31, 2013, are unaffected and will be processed and paid under normal procedures and time frames. Outpatient facility, ambulatory surgery center and physician 2014 claims will begin processing the week of Jan. 27. For questions, please contact your provider representative.

5. BCBSM electronic provider manuals — December 2013 changes

Category: Online manuals

Title: BCBSM electronic provider manuals — December 2013 changes

Start Date: January 2, 2014    End Date: January 16, 2014

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

- **Blue Pages Directory** (12/19/2013)
  - "Claims and status inquiries" — Added a note about the effective dates for using the new CMS-1500 claim (02/12).
  - "Optum" (formerly "OptumHealth – profiles for chiropractors") — Updated the name of the entity and the phone extension for speaking to a clinician.
  - "Prescription drugs" — Changed the name Medco to Express Scripts.

- **Cardiac Rehabilitation Services** (12/9/2013)
  - “Conditions and limitations” — In the “Program criteria” section, added more diagnoses for Phase II patients.
  - “Noncovered services” section — Added “Intensive cardiac rehabilitation.

- **Claims** (12/1/2013)
  - “Guidelines for completing paper claims” — In the “Where to send paper claims” section, added a link to “Other BCBS Plan Claim Addresses” on web-DENIS for DME suppliers and independent labs.
  - "Completing the CMS-1500 claim (08/05 version)" — In the "Line-by-line instructions" section, updated the instructions for maternity and prenatal care in field 24A. DATES OF SERVICE.

- **Documentation Guidelines for Physicians and Other Professional Providers** (12/1/2013)
  - “Physical therapy” — Updated the entire section, which includes a change to the expiration date for physician orders, and a change to the number of days required for obtaining the physician signature and date based on verbal orders.
  - "Speech and language pathology services" - Made a few minor changes to this section.

- **Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services** (12/1/2013)
  - “Durable medical equipment” — In the “How to decide which Blue plan to submit claims to” subsection of the “Billing guidelines” section, revised based on Record
article and added a link to “Other BCBS Plan Claim Addresses” on web-DENIS.

• **Hospice Services (12/1/2013)**
  - “Legibility in medical records” — Added a link to the *Documentation Guidelines* chapter.

• **Hospital (12/1/2013)**
  - “Reconstructive surgery” — In the “Definition” section, updated the current definition; in the “Conditions and limitations” subsection of the “Coverage” section, clarified the “massive weight loss” bullet based on new guidelines.
  - “Urgent care and clinic services” — In the “Definitions” section, removed the word “clinic” from the definition.

• **Introduction (12/19/2013)**
  - “Prescription coverage” — In the "Specialty Pharmacy program” section, changed the name Medco to Express Scripts.

• **Medical-Surgical Services (12/1/2013)**
  - “Reconstructive surgery” — In the “Definition” section, updated the current definition; in the “Conditions and limitations” subsection of the “Coverage” section, clarified the “massive weight loss” bullet based on new guidelines.

• **Outpatient Diabetes Management Program (12/19/2013)**
  - “Conditions and limitations” — In the “Diabetic testing supplies (lancets and test strips)” section, changed the name Medco to Express Scripts.

• **Pathology & Laboratory Services: Billing and Reimbursement (12/1/2013)**
  - “General Billing guidelines” — Updated the table to indicate where to file claims.

• **Physical Therapy, Occupational Therapy, and Speech Therapy Services (12/11/2013)**
  - Throughout the chapter, changed “physical therapy assistant” and “PT assistant” to “physical therapist assistant.”
  - Throughout the chapter, removed references to SLPs being certified. As of 12/7/2013, they must be licensed.

• **PPO Policies (12/1/2013)**
  - “Utilization management” — Throughout this section, changed “Optum Health” to “Optum.”

• **Serious Adverse Events Policy (12/5/2013)**
  - “Nonreimbursable serious adverse events and their diagnosis codes” — Added new ICD 9 codes.

*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.*
6. We’re missing benefit links on web-DENIS for some members

**Category:** Benefits

**Title:** We’re missing benefit links on web-DENIS for some members

**Start Date:** January 3, 2014    **End Date:** January 20, 2014

We’re currently experiencing issues with missing benefit links for some members. Please verify that the member has benefits by doing the following:

- Log in to Provider Secured Services.
- Click on web-DENIS.
- Click on Subscriber Info.
- Click on Eligibility/COB.
- Enter the member’s contract/enrollee ID number.
- Click on the Blue Benefits button located to the right of the ID card. This will take you to Explainer where you can verify the benefits.
- To view the needed steps [Click Here]

We apologize for the inconvenience and wanted to let you know we’re working to resolve this issue as quickly as possible.

Please note that benefits can also be verified through our CAREN IVR system. Professional providers can call CAREN at 1-800-344-8525, while facility providers can call CAREN at 1-800-249-5103.

7. All professional electronic submitters

**Category:** Processing delay for professional 837 claims reporting specialty pharmacy services

**Title:** All professional electronic submitters

**Start Date:** January 3, 2014    **End Date:** January 17, 2014

Due to a technical issue, some professional claims containing specialty pharmacy services will not make this week’s check writing cycle. Impacted claims were submitted between 9:00 am on Thursday, 01/02/2014 and 9:00 am on Friday, 01/03/2014.

Delayed claims will be processed by Monday, 01/06/2014 and will be included in check date 01/10/2014.

We apologize for any inconvenience this may cause.
8. Centers for Medicare & Medicaid Services releases 2014 facility pricing updates

**Category:** Medicare Advantage

**Title:** Centers for Medicare & Medicaid Services releases 2014 facility pricing updates

**Start Date:** January 3, 2014  **End Date:** February 28, 2014

CMS has released 2014 facility pricing updates for the following services:

- Home Health Prospective Payment System Low Utilization Payment Adjustment Add-On Factor
- Hospital Outpatient Prospective Payment System
- End Stage Renal Dialysis – Non-participating MA PPO providers only
- Skilled nursing facilities
- Ambulatory surgical centers

We’ll continue to pay the 2013 rates until we’ve completed updating our systems to reflect the 2014 pricing. When those system updates are complete, we’ll adjust any 2014 paid claims accordingly. We’ll notify you via web-DENIS when this becomes effective.

Thank you for your patience as we work to respond to these changes. If you have any questions, please contact your provider consultant.

9. We’re recertifying all P&O providers

**Category:** Prosthetics and orthotics

**Title:** We’re recertifying all P&O providers

**Start Date:** January 6, 2014  **End Date:** January 20, 2014

Blue Cross Blue Shield of Michigan is currently in the process of recertifying all providers currently in our P&O network. BCBSM requests that all P&O providers submit their CMS certification letter as well as a current copy of their site and practitioner accreditation (A.B.C. Certification). Please include your BCBSM PIN and NPI number on all correspondence. For providers with multiple sites, please note that documentation should be submitted for all of the separately billed locations.

All supporting documents should be faxed to 877- 492-1763 no later than March 31, 2014. If you are unable to locate your CMS letter a copy can be requested from the National Supplier Clearinghouse website at palmettogba.com/nsc. It generally takes seven to10 business days by mail. Pursuant to your contract with BCBSM, please note that failure to submit these documents could result in termination of your BCBSM contract, audit or recoveries.
10. Processing delay for professional 837 claims reporting specialty pharmacy services

Category: All professional electronic submitters

Title: Processing delay for professional 837 claims reporting specialty pharmacy services

Start Date: January 6, 2014    End Date: January 20, 2014

On 1/3/14, we notified you that due to a technical issue, some professional claims containing specialty pharmacy services would not make last week’s check writing cycle. Impacted claims were submitted between 9:00 am on Thursday, 01/02/2014 and 9:00 am on Friday, 01/03/2014.

Delayed claims were processed today, 01/06/2014 and will be included in check date 01/10/2014.

We apologize for any inconvenience this may have caused.

11. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: January 6, 2014    End Date: January 20, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 6, 2014

- Professional
  - Injection
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

These and other fee change schedules are available on web-DENIS under *BCBSM Provider Publications and Resources*, by selecting *Entire Fee Schedules and Fee Changes*. 
12. Wrong benefit information being displayed at contract level

Category: Benefits

Title: Wrong benefit information being displayed at contract level

Start Date: January 7, 2014    End Date: January 21, 2014

We’re currently experiencing issues with some contracts that have more than one active group. The benefits being displayed are incorrectly showing the same benefits for multiple groups. We are working to resolve this issue as quickly as possible.

In the meantime, you can verify benefits by using the links located next to the member’s name. Follow these steps:

• Log in to Provider Secured Services.
• Click on web-DENIS.
• Click on Subscriber Info.
• Click on Eligibility/COB.
• Enter the member’s contract/enrollee ID number.
• Click on the benefit links that are located to the right of the members name. (These are identified by HOSP, MED etc.) This will take you to Explainer where you can verify the benefits.

We apologize for any inconvenience this has caused.

13. BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Category: New professional front-end edits

Title: BCBSM Electronic Trading Partners, Vendors and Clearinghouses

Start Date: January 7, 2014    End Date: February 7, 2014

Effective Jan 21, 2014 BCBSM EDI will implement a new edit for all professional claims. The edit will trigger when a Claim Adjustment Group Code of CO, OA, PI or PR has been duplicated within a single CAS segment in Loop 2430.

This edit will be returned using a R277CAH report or 277CA transaction:

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A3 696</td>
<td>P952</td>
<td>Duplicate Claim Adjustment Group Code Reported</td>
</tr>
</tbody>
</table>

As a reminder, all edited claims must be corrected and resubmitted.
If you have any questions regarding the edit, or require additional information, contact the EDI help desk at 1-800-542-0945.

14. All Blue Cross Complete electronic submitters

  Category: Delayed Blue Cross Complete 835 remittance files

  Title: All Blue Cross Complete electronic submitters

  Start Date: January 8, 2014   End Date: January 22, 2014

Due to a systems issue, some Blue Cross Complete 835 remittance files for check date 1/2/14 are delayed.

All files will be distributed as soon as possible.

We apologize for any inconvenience.

15. Providers should bill appropriate codes for preventive visits

  Category: Medicare codes

  Title: Providers should bill appropriate codes for preventive visits

  Start Date: January 8, 2014   End Date: January 22, 2014

Effective immediately, Blue Care Network will no longer pay claims for commercial members billed with the following Medicare codes: G0402, G0438 and G0439. These Medicare codes are for preventive visits and should be reported for Medicare primary patients only. Providers should be reporting an appropriate E&M or preventive services code for commercial members if supported by the documentation.

If you have questions about appropriate coding, please contact your BCN provider representative

16. Oncology Pathways Program claims reimbursed incorrectly

  Category: Claims

  Title: Oncology Pathways Program claims reimbursed incorrectly

  Start Date: January 8, 2014   End Date: January 22, 2014

We’ve discovered that our Oncology Pathways Program health care providers are being reimbursed incorrectly, at the physician fee schedule rather than oncology fee schedule.
The program’s uplift reimbursement is not being applied when claims are reported with a group provider identification number.

This issue only affects claims reporting one of the 13 J codes with dates of service on or after Nov. 15, 2013. Claims reporting E and M codes are not affected.

Please do not resubmit these claims, as our system will automatically restore the correct payments when the problem is corrected. We will post another web-DENIS message here when we know the date this will happen. We apologize for the inconvenience this may cause.

17. Electronic Funds Transfer Vouchers

Category: Jan. 2, 2014 vouchers are now available

Title: Electronic Funds Transfer Vouchers

Start Date: January 10, 2014    End Date: January 13, 2014

NASCO and MOS facility vouchers for checks dated Jan. 2, 2014 are now available on Provider Secured Services. However, the check date now reflects Jan. 6, 2014. When searching for these vouchers, please use the new date of Jan. 6, 2014.

18. 2014 BCBSM Medicare Advantage PPO Performance Recognition Program materials are available on BCBSM Medicare Advantage Health e-BlueSM

Category: Medicare Advantage

Title: 2014 BCBSM Medicare Advantage PPO Performance Recognition Program materials are available on BCBSM Medicare Advantage Health e-BlueSM

Start Date: January 10, 2014    End Date: January 24, 2014

This month, Blue Cross Blue Shield of Michigan launches the 2014 Medicare Advantage PPO Performance Recognition Program for primary care providers.

The program, which mirrors Blue Care Network’s initiative, recognizes physician efforts in helping BCBSM improve its Medicare Advantage members’ health and Healthcare Effectiveness Data and Information Set Scores.

Program materials are available on the BCBSM Medicare Advantage Health e-Blue portal for participating providers. Materials include a booklet with detailed descriptions of the program components, Pay As You Go, Base and Bonus measures and opportunities, as well as exhibits.
Please visit the BCBSM Medicare Advantage Health e-Blue home page for all 2014 Performance Recognition Program information. Health e-Blue is a secure, online tool that provides easy data access for both HEDIS and PRP measures. Registered BCBSM Medicare Advantage PPO providers will see timely patient data, like health registry data, utilization and pharmacy information, and current treatment closure opportunities. Using Health e-Blue will allow providers to see their performance toward provider incentive payment opportunities. Providers are encouraged to enter data in Health e-Blue to close any treatment opportunities for their patients.

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

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

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

**West Region**
Kathy Grinsteiner
Phone: 616-389-8141
Email: grinsteiner@bcbsm.com

**Upper Peninsula Region**
Michael Fedrizzi
Phone: 906-228-5457
Email: mfedrizzi@bcbsm.com

19. **Informational calls for EPO opportunity rescheduled for Jan. 16**

**Category:** Contracting

**Title:** Informational calls for EPO opportunity rescheduled for Jan. 16

**Start Date:** January 10, 2014  **End Date:** January 17, 2014

BCBSM will host conference calls Jan. for health care practitioners interested in participating in a new local exclusive provider organization network for individual members in Southeast Michigan (Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties). The calls were originally scheduled for Jan. 14. Interested practitioners need to sign and return the contract signature document by Jan. 31, 2014, in order to participate in the EPO.
BCBSM will host the informational calls from 7:30 to 8 a.m. and 5 to 5:30 p.m. on Jan. 16 to answer frequently asked questions. To join either call, please dial 1-800-462-5837 and enter one of the following codes: 735 438 752 for the morning call or 731 037 585 for the evening call. If calling from a land line, please then press the “#” key twice. The content will be the same for both calls.

BCBSM mailed contracts to Southeast Michigan practitioners in the fall. If you need additional copies, please contact your provider consultant.

20. Verify new Aspirus Keweenaw Hospital members’ coverage through Provider Inquiry

Category: Eligibility

Title: Verify new Aspirus Keweenaw Hospital members’ coverage through Provider Inquiry

Start Date: January 15, 2014  End Date: January 31, 2014

A system problem has been identified causing some Aspirus Keweenaw Hospital members’ records to appear as though they do not have coverage. As a result of this error, web-DENIS shows that the members are not eligible for services. Aspirus Keweenaw Hospital members are covered effective Jan. 1, 2014.

Please call Provider Inquiry for eligibility and benefit information while we work to resolve the issue. We apologize for any inconvenience this may have caused and will update you as soon as we have resolved this issue.

21. Professional drug quantity reporting changes

Category: Professional drug claims

Title: Professional drug quantity reporting changes

Start Date: January 14, 2014  End Date: January 28, 2014

Previously, BCBSM required professional practitioners to split National Drug Code drug quantities between multiple lines on professional claims when the total was greater than 9,999 units. We have now extended the drug quantity field to accept a quantity up to 99,999,999.999 units (eight places before the decimal and three places after the decimal). This will allow you to report the NDC quantity on one line.

However, when you are reporting the same drug, but a different vial size or NDC, please continue to report and bill these services on a separate line with the correct quantity used for each NDC for that drug.
BCBSM has also extended the HCPCS drug field from 999 units to 9,999.9 units.

The NDC quantity fields are in loop 2410 of the electronic claim and the shaded area above fields 24A through 24G of the paper claim. Please reference the September 2013 Record for more information.

22. Update: Wrong contract-level benefit information issue level resolved

Category: Benefits

Title: Update: Wrong contract-level benefit information issue level resolved

Start Date: January 13, 2014    End Date: January 21, 2014

We have resolved the issue of wrong benefit information displaying on web-DENIS for some contracts that have more than one active group. The benefits were displayed incorrectly and showing the same benefits for multiple groups. The correct benefits are now being displayed.

We apologize for any inconvenience this may have caused.

23. Update: Missing benefit links issue on web-DENIS for some members resolved

Category: Benefits

Title: Update: Missing benefit links issue on web-DENIS for some members resolved

Start Date: January 13, 2014    End Date: January 20, 2014

We have resolved the issue of missing benefit links on some members’ web-DENIS coverage information.

We apologize for the inconvenience this caused and appreciate your patience as we worked through the issue

24. All Medicare Advantage Submitters

Category: Medicare Advantage 835 remittance advice files distribution

Title: All Medicare Advantage Submitters

Start Date: January 13, 2014    End Date: January 27, 2014

Effective January 18, 2014, Medicare Advantage 835 remittance file distribution will occur once per week on Saturday. This is a change from the previous schedule of Wednesday and Saturday.
BCBSM EDI is implementing this new Saturday-only distribution to align with CAQH/CORE EFT ERA Operating Rule requirements for delivery of an 835/ERA within three business days of electronic funds transfer. Medicare Advantage electronic funds transfer occurs on the Tuesday following the Saturday 835 release.

For questions regarding 835 files, contact the EDI help desk at 1-800-542-0945.

25. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes  

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

**Start Date:** January 16, 2014   **End Date:** February 3, 2014  

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 21, 2014

a. Professional  
   • Traditional, TRUST & Blue Preferred Plus℠  
   • Injection  
   • Independent Lab  
   • DME  

b. Facility  
   • Outpatient Hospital  
   • Ambulatory Surgery Facility  

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

26. Blue Care Network 835 remittance advice file distribution

**Category:** BCN Claims  

**Title:** Blue Care Network 835 remittance advice file distribution  

**Start Date:** January 17, 2014   **End Date:** January 31, 2014  

Effective January 21, 2014, BCN 835 remittance file distribution will occur on Tuesday evenings after 8:00 p.m. This is a change from the previous schedule of Monday evenings.

BCBSM is implementing this new Tuesday evening distribution to align with CAQH/CORE EFT ERA Operating Rule requirements for delivery of an 835/ERA within
three business days of electronic funds transfer. BCN electronic funds transfer occurs on the Friday following the Tuesday 835 release.

For questions regarding 835 files, contact the EDI help desk at 1-800-542-0945.

27. New procedure code authorized for outpatient hospital clinic visits

**Category:** Medicare Advantage and Commercial

**Title:** New procedure code authorized for outpatient hospital clinic visits

**Start Date:** January 17, 2014    **End Date:** January 31, 2014

Starting Jan. 1, 2014, the Centers for Medicare & Medicaid Services eliminated the use of evaluation and management Current Procedural Terminology codes *99201-*99205 and *99211-*99215 for hospital outpatient clinic visits for all Medicare patients. CMS now requires health care providers to bill the new Health Care Procedure Coding System code G0463 for E&M hospital outpatient clinic visits for all Medicare patients. The *99201-*99205 and *99211-*99215 are still appropriate and valid for place of service.

**Commercial**
Blue Cross Blue Shield of Michigan will continue to accept the E&M CPT codes for clinic visits for outpatient hospital services on the CMS-1500 claim form. BCBSM will not reimburse facilities or professional providers for procedure code G0463 for clinic services for commercial business in Michigan. However, we will reimburse G0463 for Medicare secondary claims.

For more information about billing for clinic E&M services, see the related article in the March 2013 issue of The Record or contact your provider consultant.

**Medicare Advantage**
BCBSM’s Medicare Advantage PPO will comply with the CMS requirement. Please continue to use E&M CPT codes *99201-99205, and *99211-*99215 for clinic visits for E&M outpatient hospital services until we notify you that our system has been updated. The implementation date will be shared as soon as available. Once BCBSM’s Medicare Advantage PPO system has been updated, we will not reimburse facilities who bill using these codes.

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28. Additional fee schedule added to web-DENIS

**Category:** Fee Schedules

**Title:** Additional fee schedule added to web-DENIS
Resulting from the National Uniform Billing Committee addition of Revenue Code 0691, BCBSM added the following facility fee schedule to web-DENIS, showing the Pre-Hospice Phase I Service Visit revenue code 0691 in place of 0650, effective January 1, 2014:

a. Hospice Rate Schedule 1/1/14

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

For more information, contact your BCBSM provider consultant.

29. All Institutional providers

Category: UPDATE: New edit for non-scheduled transportation claims

Title: All Institutional providers

On January 10, 2014 we communicated that effective April 7, 2014, BCBSM will implement a new edit for all institutional non-scheduled transportation claims.

As clarification, the new edit will trigger when:

a. Revenue Code 054x is reported in Loop 2400 SV201, and
b. HCPCS Codes A0425, A0427, A0428 are reported in SV202-3, SV202-4, 0SV202-5, or SV202-6 with a QL modifier, or
c. HCPCS Codes A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0888, or A0436 are reported in Loop 2400 SV202-2, and
d. Attending physician information is present in Loop 2310A.

This edit will be returned using a R277CAI report or 277CA transaction:

<table>
<thead>
<tr>
<th>Transaction Report</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A3 21 71 F701</td>
<td>ATTENDING PHYSICIAN INFORMATION IS NOT VALID ON NON-SCHEDULED TRANSPORTATION CLAIM</td>
</tr>
</tbody>
</table>

As a reminder, all edited claims must be corrected and resubmitted.
30. All Blue Care Network trading partners

Category: Delayed BCN 277CA transactions/reports and 835 non-EFT check date issue

Title: All Blue Care Network trading partners

Start Date: January 21, 2014    End Date: February 4, 2014

Due to a system issue, BCN 277CA reports and transactions from Jan. 18, 2014 through current have been delayed. All delayed 277CAs will be distributed as soon as possible.

In addition, an issue has been identified with the non-EFT check dates returned in BCN 835 remittance advice files. The check date is erroneously reflected as a Friday. This issue is impacting all non-EFT 835s distributed since the beginning of Jan. 2014. BCN is working to correct this issue as quickly as possible.

We will provide an update when these issues are resolved. We apologize for any inconvenience.

31. ICD-10 webinar scheduled for Monday, Jan. 27, from 1-2 p.m.

Category: Professional

Title: ICD-10 webinar scheduled for Monday, Jan. 27, from 1-2 p.m.

Start Date: January 21, 2014    End Date: January 28, 2014

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind. In this session, Precyse University will focus on physicians’ offices – “Breaking the Code, ICD-10’s Impact on a Physician Office.” This webinar will focus on the impacts ICD-10 has on this setting. Precyse will also focus on the pervasiveness of ICD-10 and the education that needs to be completed within each office or practice prior to the Oct. 1, 2014, deadline. This webinar will include:

a. The largest impacts on the physician office or practice that ICD-10 brings and the steps you should be taking
b. Strategies to drive roll out, adoption and urgency
c. Best practices on how to implement an education plan and the populations needing education
Our next call is scheduled for Monday, Jan. 27 from 1 to 2 p.m. Eastern Time. To register for this webinar, click here and you will receive a confirmation email with instructions for joining the session.

Meeting information
Topic: Precyse University will focus on physicians’ offices – “Breaking the Code, ICD-10’s Impact on a Physician Office”
Host: Cynthia Slajus
Date: Monday, Jan. 27, 2014
Time: 1-2 p.m., Eastern Standard Time
Session Number: 733 117 001
Registration password: This session does not require a registration password.

Send an email to ICD-10providerreadiness@bcbsm.com if:

d. You would like us to cover a specific topic in a future webinar, or you have questions related to ICD-10.0.
e. Your organization would like to participate in a future webinar.
f. You are having issues with the link above or logging into the call.
g. You are unable to participate in the webinar and would like a copy of the presentation.

A link to the recorded webinar will be provided after the webinar has been conducted.

32. BCBSM Medicare Advantage End Stage Renal Disease claims paid incorrectly

Category: Medicare Advantage

Title: BCBSM Medicare Advantage End Stage Renal Disease claims paid incorrectly

Start Date: January 21, 2014    End Date: February 4, 2014

We discovered that between Sept. 24 and Oct. 22, 2013, end stage renal disease treatment claims were paid incorrectly. The system has been updated, and claims have been reprocessed in the Jan. 14, 2014, check run. As a result, some providers may see a payment recovery on their provider vouchers.

We apologize for any inconvenience and confusion this error may have caused. If you have any questions, please call your provider consultant.
33. MESSA members’ chiropractic manipulation claims paying at 100 percent in error

Category: Professional claims

Title: MESSA members’ chiropractic manipulation claims paying at 100 percent in error

Start Date: January 22, 2014    End Date: February 7, 2014

A system issue has been identified with chiropractic manipulation claims for some MESSA members. These claims are processing and paying at 100 percent of the approved amount in error. We appreciate your patience as we work to resolve the issue. Please continue to bill your claims and check web-DENIS for updates pertaining to this issue.

34. BCBSM electronic trading partners, vendors and clearinghouses

Category: UPDATE - New professional front-end edit for duplicate CAS codes

Title: BCBSM electronic trading partners, vendors and clearinghouses

Start Date: January 23, 2014    End Date: February 6, 2014

On Jan. 21, 2014 BCBSM implemented a new edit of P952 Duplicate Claim Adjustment Group Code Reported for all professional claims. The edit triggers when a Claim Adjustment Group Code of CO, OA, PI or PR is duplicated within a single CAS segment in Loop 2430.

Due to a systems issue, the edit is erroneously rejecting some tertiary claims. Effective immediately, this edit will temporarily be applied only to BCBSM and commercial claims - Loop 2000B SBR09 source of pay indicators ‘BL’ and ‘CI’ – until the issue is resolved. Once corrected, the edit will be reapplied for all sources of payment.

Tertiary claims that received this edit in error can be resubmitted.

We will provide an update when the edit is corrected. If you have questions, contact the eBIG/EDI Business Helpdesk at 1-800-542-0945.
35. All Blue Care Network trading partners

**Category:** UPDATE - Delayed BCN 277CA transactions/reports and 835 non-EFT check date issue

**Title:** All Blue Care Network trading partners

**Start Date:** January 23, 2014    **End Date:** February 6, 2014

The delayed BCN 277CA report and transaction files from Jan. 18 through current have been distributed. Electronic submitters can anticipate short-term sporadic delays in receipt of new 277CA files until normal processing/distribution resumes.

BCN continues to work to correct the BCN 835 non-EFT check date issue as quickly as possible.

We will provide additional updates when available. We appreciate your patience and apologize for any inconvenience.

36. BCN Care Management provider call volumes high

**Category:** Care Management

**Title:** BCN Care Management provider call volumes high

**Start Date:** January 24, 2014    **End Date:** February 14, 2014

BCN Care Management is experiencing high call volumes. To avoid waiting on the phone line, providers should use BCN’s e-referral system to submit or check the status of referrals or requests for clinical review. We encourage providers to call the Medical Information Specialist line at 1-800-392-2512 with urgent requests only.

37. Mirvaso® excluded from BCBSM commercial drug coverage

**Category:** Prescription Drugs

**Title:** Mirvaso® excluded from BCBSM commercial drug coverage

**Start Date:** January 27, 2014    **End Date:** February 10, 2014

We have determined that the newly approved drug Mirvaso, a topical gel used to treat redness associated with rosacea, is a cosmetic drug. Therefore, this drug is no longer covered through most Blue Cross Blue Shield of Michigan prescription drug plans.

Some members filled this drug under their BCBSM pharmacy coverage before we made our determination. We are allowing Mirvaso refills for those members until Feb. 1, 2014.
Beginning Feb. 1, if members choose to continue using Mirvaso, they will be responsible for the full cost of the drug. This change is in accordance with our prescription drug certificates, which exclude cosmetic drugs.

We will notify affected members of these changes and encourage them to contact their physicians to discuss other treatment options.

38. Member Care Alerts on web-DENIS change from 2013 to 2014 data

Category: BCN and BCBSM Member Care Alerts

Title: Member Care Alerts on web-DENIS change from 2013 to 2014 data

Start Date: January 27, 2014   End Date: February 28, 2014

The Blues are transitioning from 2013 to 2014 data in Health e-BlueSM. As a result, there will be a period of time where Member Care Alert buttons in web-DENIS will all appear gray, as though the member has no gaps in care. This will occur as follows:

a. BCN – From Jan. 27 through Feb. 23, 2014, all BCN members will appear to have no gaps in care. Beginning Feb. 24, 2014, BCN gaps in care for 2014 will be viewable through the Member Care Alerts buttons on the web-DENIS eligibility screens.

b. BCBSM Medicare Advantage – Through Jan. 30, Member Care Alerts in web-DENIS will reflect 2013 gaps in care for BCBSM Medicare Advantage patients. Beginning Jan. 31, 2014, 2014 gaps in care will be viewable through the Member Care Alerts.

Thank you for your patience as we transition data from 2013 to 2014.

39. EPO practitioner contract will be amended to remove initial four-year term

Category: Contracting

Title: EPO practitioner contract will be amended to remove initial four-year term

Start Date: January 27, 2014   End Date: February 1, 2014

Based on feedback and on-going discussion with the physician community, BCBSM has determined that the duration of the local exclusive provider organization contract should match that of the TRUST agreement. Therefore, the EPO contract will not require a four-year term as stated in the contract language physicians received.

BCBSM has initiated the standard update process (including necessary regulatory filings) to amend the EPO contract to remove references to a four-year term.
Practitioners interested in participating in this new BCBSM local exclusive provider organization network for individual members in Southeast Michigan (Lenawee, Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne counties) need to sign and return the contract signature document by January 31, 2014.

You can expect additional communication in coming weeks once this term change has been made official in the contract. You do not need to wait to submit your contract, as this amendment will apply to all EPO practitioner contracts.

BCBSM mailed contracts to Southeast Michigan practitioners. If you need additional copies, or have questions, please contact your provider consultant.

40. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: January 28, 2014    End Date: February 11, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Jan. 28, 2014

a. Professional
   i. Traditional, TRUST & Blue Preferred Plus SM
   ii. Independent Lab
   iii. DME

b. Facility
   i. Outpatient Hospital
   ii. Ambulatory Surgery Facility

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

41. Additional fee schedules added to web-DENIS

Category: Claims

Title: Additional fee schedules added to web-DENIS

Start Date: January 28, 2014    End Date: February 10, 2014

BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective February 1, 2014:
Professional: Injection Fee Schedule
   a. Injections minimum fee schedule (02/01/2014)

Note: Effective for dates of service on or after February 1, 2014, professional providers must provide the national drug code when submitting an injection HCPCS code for accurate payment at the NDC level. Otherwise, the claim will be priced at the minimum fee, which is displayed in the professional fee schedule listed above.

Facility: Hospital Outpatient
   b. Drug fees effective 2/01/14

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

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

For more information, contact your BCBSM provider consultant.

42. URMBT and UAW staff members’ COB claims

   Category: Professional Claims
   Title: URMBT and UAW staff members’ COB claims
   Start Date: January 29, 2014    End Date: February 12, 2014

   UAW Retiree Medical Benefits Trust and UAW staff members’ coordination of benefit claims are taking longer than normal to process. We are aware of the issue and are working diligently to correct the problem. Please continue to check web-DENS and the Critical Provider Issues log for updates to this issue.

43. All BCBSM trading partners

   Category: Delayed processing of electronic claim files
   Title: All BCBSM trading partners
   Start Date: January 29, 2014    End Date: February 12, 2014

   Due to a systems issue, some files received yesterday morning between 8:00am and 9:00am were delayed and will be processed today. We will distribute 999 transactions when the files have completed processing.
We apologize for any inconvenience.

If you have questions, contact the eBIG EDI Business Helpdesk at 1-800-542-0945.

44. Blue Cross Complete Primary Care Physicians receive CSHCS payment

**Category:** Blue Cross Complete

**Title:** Blue Cross Complete Primary Care Physicians receive CSHCS payment

**Start Date:** January 29, 2014  **End Date:** February 12, 2014

On February 1, 2014, Blue Cross Complete is making payment on the Children’s Special Health Care Services Program to primary care physicians. The payment is for each Blue Cross Complete CSHCS member assigned to primary care physician panels from July 1, 2013 to December 31, 2013. On the remittance advice, a manual adjustment line will indicate the CSHCS payment amount.

This program was developed to ensure CSHCS patients receive the care they need from quality primary care providers.

- CSHCS Temporary Assistance for Needy Families: $4 per member per month
- CSHCS Aged, Blind and Disabled: $8 per member per month

We appreciate the care and service you and your staff provide to Blue Cross Complete members. If you have questions regarding your payment amount, please contact your provider representative, or call 1-888-312-5713.

45. Michigan Quality Improvement Consortium clinical practice guidelines

**Category:** Clinical practice guidelines

**Title:** Michigan Quality Improvement Consortium clinical practice guidelines

**Start Date:** January 30, 2014  **End Date:** February 17, 2014

The MQIC has released updated clinical practice guidelines and guideline update alerts on the following topics:

a. Advance Care Planning
b. Primary Care Diagnosis and Management of Adults with Depression
c. Management and Prevention of Osteoporosis
Please visit mqic.org to access the guidelines.

46. Recovery underway for NASCO hospital groups claims

**Category:** Recoveries

**Title:** Recovery underway for NASCO hospital groups claims

**Start Date:** January 31, 2014    **End Date:** February 14, 2014

On Jan. 29, 2014, NASCO began conducting a recovery for hospital groups claims for
dates of service June 28, through Sept. 30, 2013.

Professional claims processed with the incorrect provider tax identification numbers,
causing claims to process at the incorrect benefit level.

This payment replaces the incorrect one we sent you. When you adjust patients’ accounts
to reflect the correct payment the subscriber’s liability may change.
February 2014

CMS implements 2014 inpatient rule changes

You may have heard that the Centers for Medicare & Medicaid Services will be implementing new inpatient rule changes for 2014. After April 1, 2014, BCBSM will follow CMS’ lead in handling the 2014 inpatient rule changes as outlined in this article.

These changes do not affect current HealthDataInsights audit processes. Current HDI audits and processes will remain effective until April 1, 2014. These include:

- Two complex audit categories
  - Diagnosis-related group validation
  - Short-stay hospitalizations
  - Two-step appeal process

Hospitals can rebill claims for certain Part B ancillary services. These must be billed with:

- Paper claims
- Type of bill 121
- Original claim number in the remarks box

Payment is made after the original claim is offset.

After April 1, 2014, BCBSM will follow CMS guidance for the following 2014 inpatient rule changes:

Two-midnight rule

- Bill reasonable and necessary hospital stays that include two or more midnights as inpatient stays.
- Bill hospital stays that include fewer than two midnights as outpatient stays. (There are some exceptions to this rule, which are listed in the CMS admission guidelines.)
- Continue to follow CMS admission guidelines, physician orders and documentation for hospital stays.
Hospital self-audits
BCBSM encourages hospitals to audit themselves and adjust claims according to the new rules. If a hospital does adjust claims after a self-audit, it would be reimbursed for observation stays on any rebilled claims with dates of service after April 1, 2014.

Condition code 44
BCBSM will waive condition code 44 that requires hospitals to conduct a utilization committee review to convert short stay cases from inpatient to outpatient to ease the burden on our hospital partners. We will require use of condition code W2 on outpatient rebilled claims.

CMS-1455-R
BCBSM will allow for the billing of and payment for Part B observation services when an inpatient claim is denied. Prior to this, hospitals could only rebill for certain ancillary services when an inpatient claim was denied. Hospitals may continue to bill separately for the Part B outpatient services furnished during the three days prior to the inpatient admission.

Timely filing on rebilled claims
We’ll begin to implement timely filing limits in accordance with CMS guidelines, which is one year from the date of service. Hospitals can submit claims through EDI whenever the case is still within filing limits. This includes most Part B services when an admission is not reasonable or necessary (as determined by HDI or a hospital self-audit).

Hospitals must comply with all applicable CMS laws, regulations, program instructions and payment rules. For more information, please visit the CMS website** or call your provider consultant.

If CMS delays the implementation of any of these rules, BCBSM will also adjust its implementation timeline.

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February 2014

HEDIS® medical record reviews begin in March

Blue Cross Blue Shield of Michigan conducts Healthcare Effectiveness Data and Information Set medical record reviews each year. Inovalon™ will perform the HEDIS reviews from March through May on behalf of PPO and Medicare Advantage PPO members who received services in Michigan.

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

Inovalon will contact you to schedule an appointment for a HEDIS review or request that you fax the necessary records. HEDIS requires proof of service documentation for data collected from a medical record. BCBSM will reimburse you $5 for each chart requested and received.

Inovalon will continue to perform the risk adjustment medical record review on behalf of BCBSM’s Medicare Advantage PPO members who received services in Michigan.

These reviews are conducted in addition to the risk adjustment and HEDIS medical record review process performed by Verisk on behalf of the Blue Cross and Blue Shield Association.

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The Record - HEDIS(R) medical record reviews begin in March

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
February 2014

New procedure code authorized for outpatient hospital clinic visits

Starting Jan. 1, 2014, the Centers for Medicare & Medicaid Services eliminated the use of evaluation and management Current Procedural Terminology codes *99201-*99205 and *99211-*99215 for hospital outpatient clinic visits for all Medicare patients. CMS now requires health care providers to bill the new Health Care Procedure Coding System code G0463 for E&M hospital outpatient clinic visits for all Medicare patients. The *99201-*99205 and *99211-*99215 codes are still appropriate and valid for place of service.

Commercial
Blue Cross Blue Shield of Michigan will continue to accept the E&M CPT codes for clinic visits for outpatient hospital services on the CMS-1500 claim form.

BCBSM will not reimburse facilities or professional providers for procedure code G0463 for clinic services for commercial business in Michigan. However, we will reimburse G0463 for Medicare secondary claims.

For more information about billing for clinic E&M services, see the related article in the March 2013 issue of The Record or contact your provider consultant.

Medicare Advantage
BCBSM’s Medicare Advantage will comply with the CMS requirement. The implementation date will be shared as soon as available. Medicare Advantage PPO will not reimburse facilities that bill using E&M CPT codes *99201-*99205 and *99211-*99215 for clinic visits for E&M outpatient hospital services after the system is modified. Adjustments will be made once the change is made.

This change applies to outpatient hospital services only and does not affect professional services provided at the point of service.

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Cross Blue Shield of Michigan, except that BCBSM participating health care providers may make copies for their personal use. In no event may any portion of this publication be copied or reprinted and used for commercial purposes by any party other than BCBSM.

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1. All Medicare Advantage trading partners

   Category: Delayed Medicare Advantage 835 remittance files

   Title: All Medicare Advantage trading partners

   Start Date: February 3, 2014    End Date: February 17, 2014

   Medicare Advantage 835 remittance files for check date 1/30/14 have been delayed. All files will be distributed as soon as possible.

   We apologize for any inconvenience

2. Specialty medical drug prior authorization requirement delayed for seven drugs

   Category: Specialty drugs

   Title: Specialty medical drug prior authorization requirement delayed for seven drugs

   Start Date: February 3, 2014    End Date: February 28, 2014

   We told you in the January issue of The Record that seven additional specialty drugs administered by health care practitioners will require BCBSM prior authorization under members’ medical benefits, starting March 1, 2014. This requirement will be delayed one month.

   Prior authorization will be required starting April 1, 2014, for these drugs that we’re adding to the specialty drug prior authorization program:

<table>
<thead>
<tr>
<th>HCPS code</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0638</td>
<td>Canakinumab (Ilaris®)</td>
</tr>
<tr>
<td>J1300</td>
<td>Eculizumab (Soliris®)</td>
</tr>
<tr>
<td>J1602</td>
<td>Golumumab (Simponi® Aria™)</td>
</tr>
<tr>
<td>J2357</td>
<td>Omalizumab (Xolair®)</td>
</tr>
<tr>
<td>J2507</td>
<td>Pegloticase (Krystexxa®)</td>
</tr>
<tr>
<td>J2562</td>
<td>Plerixafor (Mozobil®)</td>
</tr>
<tr>
<td>J2796</td>
<td>Romiplostim (Nplate®)</td>
</tr>
</tbody>
</table>
You may continue to submit claims without prior authorization for these drugs until April 1. Please refer to the January Record for more information.

3. Update: MESSA members’ chiropractic manipulation claims issue resolved

   Category: Professional claims

   Title: Update: MESSA members’ chiropractic manipulation claims issue resolved

   Start Date: February 4, 2014    End Date: February 14, 2014

   We have resolved the issue of chiropractic manipulation claims for some MESSA members. These claims were processing and paying at 100 percent of the approved amount in error. The claims are processing correctly, effective Jan. 24, 2014.

   A recovery will be initiated within the next month for claims that were paid incorrectly.

   We apologize for any inconvenience this may have caused.

4. BCN 2014 Behavioral Health Incentive Program documents available

   Category: BCN Behavioral Health

   Title: BCN 2014 Behavioral Health Incentive Program documents available

   Start Date: February 5, 2014    End Date: February 19, 2014

   Blue Care Network is proud to announce the launch of its new Behavioral Health Incentive Program, a novel and unprecedented incentive program designed exclusively for behavioral health providers. BHIP is effective January 1, 2014. Materials regarding the program can be accessed on web-DENIS for all contracted BCN behavioral health providers. To access the documents, click on the links below or click on BCN Provider Publications and Resources and then, under Resources, click on Behavioral Health.

   - BHIP Booklet
   - BHIP Self Reported Measure Specifications
   - BHIP BCN Assessed Measure Specifications

5. FEP – System downtime for Feb. 8, 2014

   Category: System downtime notification

   Title: FEP – System downtime for Feb. 8, 2014
The Federal Employee Program application will be unavailable on Saturday, 02/08/2014 until approximately 3 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through Web-DENIS during that period.

6. Blues begin Medicare Advantage Risk Adjustment Data Validation audits

Category: Medicare Advantage

Title: Blues begin Medicare Advantage Risk Adjustment Data Validation audits

Start Date: February 5, 2014    End Date: March 5, 2014

The Blues are conducting a 2012 National Risk Adjustment Data Validation Medicare Advantage audit, beginning Feb. 5 and continuing through May 30, 2014. The audit helps obtain medical records to support diagnosis information submitted to the Centers for Medicare & Medicaid Services.

Thank you for your cooperation during this important initiative and your continued commitment to providing quality health care.

7. BCBSM Optical Character Recognition software issues

Category: Medicare Advantage

Title: BCBSM Optical Character Recognition software issues

Start Date: February 5, 2014    End Date: February 19, 2014

Blue Cross Blue Shield of Michigan’s Medicare Plus Blue℠ team has identified two issues with the Optical Character Recognition processing software:

i. The OCR reader is, at times, dropping the second digit in the place of service field on the CMS-1500 claim. For example, place of service 11 may be read as one. This can cause incorrect denials for an invalid place of service.

ii. The OCR reader is, at times, misreading some modifiers, which can cause denials and incorrect payments. For instance, a third billed modifier KX is read as EX.

We’re updating the system to correct these issues, but we do not have an estimated date of completion yet. We’re identifying impacted claims and will adjust them appropriately. Please expect to see most of your previously billed OCR claims corrected within the next 60 days.

We encourage our providers to submit the new CMS-1500 claim form. Using this new version will reduce these types of errors and delays in processing your claims. If you do
use a paper claim form, please make sure the right information is included in the correct boxes.

Thank you for your patience and your continued dedication to great patient care. If you have any further questions, please contact your provider consultant.

8. Update: Hospital Outpatient Pricing Strategy II update regarding “C” codes

Category: Facility Claims

Title: Update: Hospital Outpatient Pricing Strategy II update regarding “C” codes

Start Date: February 6, 2014    End Date: February 28, 2014

As previously communicated, BCBSM does not routinely accept Level III “C” codes. We are aware that ancillary services (revenue codes 027X) when reported with procedure codes in the CXXXXX range are rejecting as noncovered services and causing member liability. Since these ancillary services are reimbursed as part of the surgery, we should not be rejecting the ancillary claim lines.

We are working to allow the system to ignore the “C” codes when reported with an ancillary revenue code on a surgery claim. We will notify you in a future web-DENIS message when the change is made.

9. Update: Hospital Outpatient Pricing Strategy II update for HBOT claims

Category: Facility Claims

Title: Update: Hospital Outpatient Pricing Strategy II update for HBOT claims

Start Date: February 6, 2014    End Date: February 28, 2014

Last November we notified you of an issue identified with the HOPS II changes and hyperbaric oxygen therapy claims reporting revenue code 0413 with procedure code C1300.

10. We have now made changes to our claims processing system to accept procedure code C1300 when reported with revenue code 0413 for HBOT services. This code is payable effective Oct. 1, 2013. Although BCBSM does not routinely accept Level III “C” codes, it is acceptable when reporting HBOT with revenue code 0413. Providers can now rebill rejected claims with this procedure and revenue code combination Recovery underway for all URMBT claims

Category: Recoveries

Title: Recovery underway for all URMBT claims

The group requested a retroactive benefit change for ambulance benefits to no longer reject as “not eligible for ambulance service” when billed with modifiers, but instead reject as “not a covered benefit.”

This payment replaces the incorrect one we sent you. When you adjust patients’ accounts to reflect the correct payment the subscriber’s liability may change.

11. All BCBSM electronic trading partners

Category: Conversion of informational edits effective May 1, 2014

Title: All BCBSM electronic trading partners

On August 19, 2013, BCBSM implemented informational edits for claims reporting NPI/submitter ID combinations that do not match our EDI enrollment files. The informational edits, P001i, P002i, P003i and F001i, alert submitters of inconsistencies in their EDI setup for a particular payer without rejecting their claims. Effective May 1, 2014, these informational edits will convert to ‘hard edits’ that reject the claims.

Claims receiving informational edits appear on 277CAX and 277CAZ reports. Beginning May 1, claims rejected with hard edits will appear on 277CAP transactions or 277CAH/277CAI reports:

Professional - Returned on a 277CAH report

- A3 24 P001 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR BL OR HM
- A3 24 P002 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR MB
- A3 24 P003 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR CI

Institutional - Returned on a 277CAI report

- A3 24 F001 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR ELEC BILLING

Rejected claims must be resubmitted. Prior to resubmission, providers must update their Provider Authorization Form to the correct billing NPI/submitter ID combination. Providers should validate their setup for all sources of payment (BL, HM, MA, MB, or CI).
Communication of the new edits was published in the July edition of The Record and a web-DENIS broadcast message on August 19, 2013.

For questions about claim edits, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945, Opt. 1. For assistance with updating your Provider Authorization form, select Opt. 3.

12. All institutional providers

**Category:** CMS H24391 denial of some institutional crossover claims

**Title:** All institutional providers

**Start Date:** February 10, 2014  **End Date:** April 1, 2014

We have been alerted by the Centers for Medicare and Medicaid Services that some institutional crossover claims submitted to Medicare Administrative Contractors (MACs) during January 2014 have been rejected in the crossover process. The rejected claims were not routed to the patient’s supplemental insurer for payment.

If you received a letter from your MAC referencing error code H24391, you will need to send a supplemental claim directly to BCBSM for payment. This error code identifies that the claim did not crossover.

To avoid unnecessary rejections, please ensure that you wait 30 days from the Medicare remittance/paid date before submitting your claims to BCBSM for supplemental payment.

13. Medicare Plus Blue SM electronic fund transfer

**Category:** Medicare Advantage

**Title:** Medicare Plus Blue SM electronic fund transfer

**Start Date:** February 10, 2014  **End Date:** February 24, 2014

**Here are answers to questions about Medicare Plus BlueSM electronic fund transfers**

In December 2013, Blue Cross Blue Shield of Michigan Medicare Advantage PPO began offering electronic fund transfer as a payment option for our providers. Provider vouchers are also now distributed electronically. However, as we implemented this new system, we received some feedback from health care practitioners and are working to address your comments.

Here are some frequently asked questions that we hope will make this new process more convenient and user-friendly for you.
**How do I enroll in EFT?**
Enrolling is easy. Log in at [bcbsm.com](http://bcbsm.com), click on *Register Provider* and follow the instructions. You also can call our help desk at 1-877-258-3932 or your provider consultant for help with enrolling.

**How do I change my financial institution information?**
- Visit [bcbsm.com](http://bcbsm.com) and log in.
- Under *Electronic Funds Transfer*, click on *Update provider*.
- Enter the required information and click on *submit*.

Please allow three to five weeks for the system to update. You’ll receive paper checks and vouchers until that update occurs.

**What if the money isn’t in my account when it’s supposed to be?**
You’ll need to verify the following:
- You received your EFT registration confirmation letter.
- You haven’t changed your financial institution since you registered.
- The account on the registration form is open and active.
- Your financial institution hasn’t changed its policy on fund availability.
- You’ve submitted claims and they’re scheduled for payment.

If you’ve confirmed all of the above information and you still haven’t received a payment for a BCBSM MA PPO product, email us at [providereft@bcbsm.com](mailto:providereft@bcbsm.com).

**How do I tell if a check was issued using EFT?**
Right now, MA PPO electronic transfers are incorrectly displaying *NON-EFT*. We expect to have this issue resolved by mid-February, 2014. In the interim, you can identify electronically deposited funds by the check number. A check number that begins with a six indicates electronic funds. If the check number begins with any other number, the check will be delivered by postal mail.

**How do I find out where my EFT payment was deposited?**
Send an email to [providereft@bcbsm.com](mailto:providereft@bcbsm.com), and we’ll get back to you as soon as we can.

**When are funds transferred to my account?**
Providers will receive the “835” record every Saturday, and funds should be deposited every Tuesday.

**I can’t access my vouchers electronically. What should I do?**
Call our web support help desk at 1-877-258-3932 and we’ll be happy to help you.

You’ll also find a helpful frequently-asked-questions document about EFT when you log in at [bcbsm.com](http://bcbsm.com). A general guideline document will soon be posted at [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma).
For more information or questions, please contact your provider consultant.

14. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

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

**Start Date:** February 10, 2014    **End Date:** February 24, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Feb.10, 2014

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

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

15. AIM starts Feb. 17, 2014

**Category:** Radiology Preauthorization

**Title:** AIM starts Feb. 17, 2014

**Start Date:** February 11, 2014    **End Date:** February 21, 2014

**AIM starts Feb. 17, 2014**

The AIM preauthorization review start date has been delayed until Feb. 17. We advised in a November 2013 Record article that the Advanced Cardiac Imaging Consortium would be retired on Jan. 31.

For CCTA review authorizations prior to AIM start date, contact your provider consultant. Your consultant will help you with the review procedures.

On Feb. 17, you may call AIM at 1-800-728-8008 or visit their website, aimspecialtyhealth.com, for preauthorization requests.

Contact your provider consultant for any other questions.

16. EFT for MA PPO and BIP Hospitals
Reminder: Medicare Advantage PPO facilities and BIP hospitals can enroll in Electronic Fund Transfer

Facilities and hospitals that receive Blue Cross interim payments began enrolling for electronic funds transfer through Blue Cross Blue Shield of Michigan’s Provider Secured Services in December.

Please be aware of the following:

- **Medicare Advantage PPO funds for BIP facilities currently receive mailed checks. MA PPO facility funds will not be available electronically until approximately mid-March 2014. We apologize for any inconvenience this causes.**
- BIP hospitals currently enrolled in EFT do not need to re-enroll to receive EFT for Medicare Advantage.
- Non-BIP facilities currently enrolled in EFT with Blue Care Network need to re-enroll to obtain EFT for BCBSM (including Medicare Advantage).
- To enroll in EFT, you must be registered to access Provider Secured Services. Once access is granted, you can register for EFT to begin receiving electronic payments from the Blues.
- Every BCBSM PIN associated with your National Provider Identifier should be set up correctly. If a BCBSM PIN is not registered on your Secured Services ID, you will not be able to enroll that NPI for EFT.
- The processing of your EFT enrollment can take three to five weeks. You will continue to receive payment by check until you are successfully enrolled for EFT.

Thank you for your commitment to providing high quality care to our members and your patients. For questions, call 1-877-258-3932.

17. Cost-sharing start-over date change for City of Detroit retirees covered by Blue Cross Blue Shield of Michigan Medicare Plus Blue℠ PPO, BCN Advantage℠, Community Blue PPO℠ and BCN HMO℠

**Category:** Medicare Advantage, Community Blue PPO and BCN HMO

**Title:** Cost-sharing start-over date change for City of Detroit retirees covered by Blue Cross Blue Shield of Michigan Medicare Plus Blue℠ PPO, BCN Advantage℠, Community Blue PPO℠ and BCN HMO℠

**Start Date:** February 11, 2014  **End Date:** March 3, 2014
The City of Detroit has delayed changes to its retirees’ health care coverage until March 1, 2014. Their current coverage remains in effect until that date. Members have been informed. City of Detroit retirees’ annual cost-sharing requirements will start over on March 1, 2014.

<table>
<thead>
<tr>
<th>Cost-sharing start-over date</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 1, 2014</td>
<td>Retirees with Medicare Plus Blue</td>
</tr>
<tr>
<td></td>
<td>Retirees with BCN Advantage</td>
</tr>
<tr>
<td></td>
<td>Retirees with BCBSM Community Blue</td>
</tr>
<tr>
<td></td>
<td>Retirees with BCN HMO</td>
</tr>
</tbody>
</table>

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

18. 2014 Michigan Hospital Networking sessions scheduled

**Category:** Hospital

**Title:** 2014 Michigan Hospital Networking sessions scheduled

**Start Date:** February 12, 2014  **End Date:** February 26, 2014

Blue Cross Blue Shield of Michigan is hosting a series of networking sessions to provide hospitals with the information they need to do business with us.

The networking sessions will present information about hospital billing, medical policy, Medicare Advantage, BlueCard® and more. Blue Care Network and Medicaid information will also be represented at the sessions.

The sessions are from 9 a.m. to noon with registration beginning at 8:30 a.m. Coffee and continental breakfast will be served. Here are the 2014 scheduled dates:
– Tuesday, March 25, 2014
– Tuesday, June 17, 2014
– Wednesday, September 17, 2014
– Wednesday, December 3, 2014

The sessions will be in the auditorium at the Blue Care Network Commons building, 20500 Civic Center Dr., Southfield. There will be designated provider parking available in the back lot.

To register for the sessions, send an email to sefacilityeducationregistration@bcbsm.com. When registering, please take the opportunity to provide suggestions for future topics for presentation at these meetings.

19. All Blue Cross Complete electronic submitters

Category: Delayed Blue Cross Complete 835 remittance files
Title: All Blue Cross Complete electronic submitters
Start Date: February 13, 2014   End Date: February 27, 2014

Due to a system issue, Blue Cross Complete 835 remittance files for check date 2/10/14 have been delayed. The files will be distributed on 2/13/14 after 8 p.m.

We apologize for any inconvenience the delay may have caused.

20. BCBSM Medicare Advantage PPO implements new CARC code

Category: Medicare Advantage
Title: BCBSM Medicare Advantage PPO implements new CARC code
Start Date: February 13, 2014   End Date: February 27, 2014

BCBSM Medicare Advantage PPO implements new Centers for Medicare & Medicaid Services sequestration claim adjustment reason code

A new CARC code to identify claims in which payment is reduced due to sequestration was implemented by BCBSM Medicare Advantage PPO:

- Claims processed prior to Dec. 30, 2013 will reflect the old CARC code PI*223 on your remittance.
- Claims processed on Dec. 30, 2013 and after will reflect the new CARC code OA*253 on your remittance.

If you have any questions, contact your provider consultant.
21. Delayed Medicare Advantage 835 remittance files

**Category:** All Medicare Advantage electronic trading partners

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

**Start Date:** February 17, 2014    **End Date:** March 3, 2014

Medicare Advantage 835 remittance files for check date 2/18/14 have been delayed. All files will be distributed on 2/17/14 after 8 p.m.

We apologize for any inconvenience.

22. Behavioral health codes processing update

**Category:** Professional and Facility claims

**Title:** Behavioral health codes processing update

**Start Date:** February 17, 2014    **End Date:** April 1, 2014

On Dec. 13, 2013, we began making changes to our claims processing system to ensure behavioral health claims are processing in accordance with our members’ benefits. Claims affected by these changes will be released for processing as our system is updated or the claim will be manually processed. We are expediting internal processes to speed up claims processing; however, you may still experience some delays in claims processing for the next few weeks.

We expect to complete more system changes throughout February and have all changes completed by April 30, 2014.

If you have questions or experience any problems, contact Provider Inquiry or your BCBSM provider consultant. Thank you for your continued patience as we work to correct these issues.

23. Jan. 1, 2014 HCPCS Update Corrections fee change schedules added to Web-DENIS

**Category:** Fee Changes

**Title:** Jan. 1, 2014 HCPCS Update Corrections fee change schedules added to Web-DENIS
BCBSM recently added Jan. 1, 2014 HCPCS Update corrections fee change schedules to web- DENIS, for the week beginning 02-17-2014:

- Facility
  - Hospital Outpatient
  - Ambulatory Surgery Facility
  - Freestanding Outpatient Physical Therapy

The above listed fee change schedules include new codes and corrections for the 1/1/14 annual HCPCS update. Some of the new codes do not yet have fees established and are indicated as TBD. As soon as fees have been established for these codes, we will publish them in future weekly fee change schedules. Also, included in the above fee change schedules are previously published HCPCS codes and Service category combinations which were published in error.

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

24. Oncology Pathways Program claims reimbursed incorrectly

**Category:** Claims

**Title:** Oncology Pathways Program claims reimbursed incorrectly

**Start Date:** February 18, 2014   **End Date:** March 4, 2014

We’ve discovered that our Oncology Pathways Program health care providers are being reimbursed incorrectly, at the physician fee schedule rather than oncology fee schedule. The program’s uplift reimbursement is not being applied when claims are reported with a group provider identification number.

This issue only affects claims reporting one of the 13 J codes with dates of service on or after Nov. 15, 2013. Claims reporting E and M codes are not affected.

Please do not resubmit these claims, as our system will automatically restore the correct payments when the problem is corrected. We will post another web-DENIS message here when we know the date this will happen. We apologize for the inconvenience this may cause.

25. BCBSM Medicare Advantage PPO implements evaluation and management codes

**Category:** Medicare Advantage
Blue Cross Blue Shield of Michigan’s Medicare Advantage PPO has implemented the changes for evaluation and management Current Procedural Terminology codes *99201-*99205 and *99211-*99215 for outpatient hospital clinic visit services.

Effective Feb. 5, 2014, claims received with these E&M CPT codes will be denied for dates of service on or after Jan. 1, 2014. Providers should report E&M procedure code G0463 as instructed by the Centers for Medicare & Medicaid Services in place of the above codes.

If you submit a claim with CPT codes (*99201-*99295 and *99211-*99215) instead of G0463, it will trigger an event code 10Z. The 10Z code indicates we won’t pay for the procedure code used. Please resubmit your claim using the G0463 code and we will reprocess the claim.

If you used the new procedure code for a date of service on or after Jan. 1, 2014 (and submitted prior to the Feb. 5 implementation date), your BCBSM Medicare Advantage PPO claim will automatically be adjusted for payment.

As reported in a January web-DENIS message, CMS eliminated the use of evaluation and management codes *99201-*99205 and *99211-*99215 for hospital outpatient clinic visits for all Medicare patients.

CMS now requires health care providers to bill the new code G0463 for E&M hospital outpatient clinic visits for all Medicare patients.

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

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

26. Reminder: BCBSM Medicare Advantage PPO acute detoxification admissions

Category: Medicare Advantage

Title: Reminder: BCBSM Medicare Advantage PPO acute detoxification admissions

Start Date: February 18, 2014  End Date: March 4, 2014

Please follow the appropriate medical prenotification protocol for inpatient admissions. This includes acute detoxification admissions to a medical unit. Please do not contact Blue Cross Blue Shield of Michigan Medicare Advantage PPO behavioral health for preauthorization for these patients.
Thank you for your cooperation and please call your provider consultant with any questions.

27. ICD-10 webinar scheduled for Monday, Feb. 24 from 1-2 p.m.

Category: All Providers

Title: ICD-10 webinar scheduled for Monday, Feb. 24 from 1-2 p.m.

Start Date: February 19, 2014   End Date: February 25, 2014

ICD-10 is coming and it will affect how we all work together. Blue Cross Blue Shield of Michigan is committed to working with our health care providers on the ICD-10 transition. From now until the Oct. 1, 2014, implementation of ICD-10, BCBSM will host ICD-10 conference calls for our health care providers.

These calls are designed with you in mind. In this session, Complete Practices Resources and Availity will focus on the “Five Things to Jump Start Your ICD-10 Transition.”

Our next call is scheduled for Monday, Feb. 24 from 1 to 2 p.m. Eastern Time. To register for this webinar, click here. You will receive a confirmation email with instructions for joining the session.

Send an email to ICD-10providerreadiness@bcbsm.com if:

- You would like us to cover a specific topic in a future webinar, or you have questions related to ICD-10.0
- Your organization would like to participate in a future webinar.
- You are having issues with the link above or logging into the call.
- You are unable to participate in the webinar and would like a copy of the presentation.

A link to the recorded webinar will be provided after the webinar has been conducted.

28. BCBSM Medicare Advantage PPO facility inpatient DRG error

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO facility inpatient DRG error

Start Date: February 20, 2014   End Date: March 6, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO identified a potential pricing error in the calculation of the diagnosis-related group rate of hospital inpatient claims. The affected claims were scheduled to be paid with the Feb. 18, check run. The
potential issues have been resolved and those payments will be issued in next week’s check run.

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

29. Autism updates: A change to applied behavior analysis procedure codes starting April 1 and a reminder about billing guidelines

Category: Procedure Codes, Utilization

Title: Autism updates: A change to applied behavior analysis procedure codes starting April 1 and a reminder about billing guidelines

Start Date: February 20, 2014    End Date: March 6, 2014

**Autism procedure codes**

We’re letting you know that there will be three additional procedure codes that providers can bill for applied behavior analysis services with autism diagnoses for dates of service starting on or after April 1, 2014. The new codes are:

<table>
<thead>
<tr>
<th>New Code</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2014</td>
<td>Skills training</td>
</tr>
<tr>
<td>S5108</td>
<td>Supervision</td>
</tr>
<tr>
<td>S5111</td>
<td>Caregiver training</td>
</tr>
</tbody>
</table>

Note: Procedure code G9012 (supervision) that is currently used when billing for ABA services cannot be used for dates of service after March 31, 2014.

We’ve also changed the activity details for procedure codes H0031 and H0032 to align with the state of Michigan guidelines for reimbursable autism codes. This change will be effective for claims that you submit for dates of service on or after April 1, 2014. See the table below.

<table>
<thead>
<tr>
<th>Code</th>
<th>On or After April 1, 2014</th>
<th>Before April 1, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>Initial assessment</td>
<td>Reassessment</td>
</tr>
<tr>
<td>H0032</td>
<td>Reassessment</td>
<td>Initial assessment</td>
</tr>
</tbody>
</table>
Reminder about autism billing guidelines
Please remember that when you submit claims, you should bill for ABA services in whole units only. Also, BCN claims must include the HO modifier.

Additional information
For more details, refer to the Applied Behavior Analysis Billing Guidelines and Procedure Codes document.

- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters & Resources.
- In the left-hand navigation under Other Resources, click on Clinical Criteria & Resources.
- Under Resources, click on Autism.

This information is also available in BCN Provider Publications and Resources by clicking on Autism.

For additional information, please contact Provider Inquiry or your provider consultant.

30. MESSA Choices and ABC plan members’ claims paying at 100 percent in error

Category: Professional claims

Title: MESSA Choices and ABC plan members’ claims paying at 100 percent in error

Start Date: February 20, 2014   End Date: March 6, 2014

A new system issue has been identified with MESSA Choices and ABC plan members’ professional claims. Claims are processing and paying at 100 percent of the approved amount in error. We appreciate your patience as we work to resolve the issue. Please continue to bill your claims and check web-DENIS for updates pertaining to this issue.

31. BCN reminder: Check PCP assignment and follow referral guidelines

Category: BCN claims

Title: BCN reminder: Check PCP assignment and follow referral guidelines

Start Date: February 21, 2014   End Date: March 21, 2014

BCN providers are reminded of the following:

- BCN primary care physician offices should always check to ensure the appropriate physician is assigned as the BCN member’s PCP before providing services. This information is available in web-DENIS on the member eligibility screen. If you find the
member does not have a PCP or has a different PCP, request PCP assignment by doing one of the following:
  o Calling BCN Provider Inquiry
  o Having the member call the Customer Service phone number on the back of the BCN ID card

• BCN providers should always follow BCN referral and authorization requirements. Read more in the Care Management chapter of the BCN Provider Manual. BCN’s Referral and Clinical Review Program chart is available on our e-referral website.

32. BCBSM electronic provider manuals — January 2014 changes

Category: Online manuals

Title: BCBSM electronic provider manuals — January 2014 changes

Start Date: February 21, 2014   End Date: March 7, 2014

These are the chapters we revised in January 2014, along with the revision date and a brief statement of the main changes for each.*

• Ambulance Services (1/1/2014)

  “Reimbursement” — Deleted the link to the now-outdated Ambulance Provider Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement

• Anesthesia Services (1/1/2014)

  “Reimbursement” — Deleted the links to the now-outdated Certified Registered Nurse Anesthetist Participating Agreement and the Practitioner Traditional Participating Agreement, leaving the links to the current (1/1/14) agreements in place; and added links to the future (4/1/14) agreements.

• Appeals (1/1/2014)

  - Overhauled the entire chapter.

• Blue Pages Directory (1/1/2014)

  - "BlueCard" — Added information about pre-service reviews.

  - “Forms and supplies" — Added a note under the chart explaining effective dates
for use of the old (08/05) and new (02/12) CMS-1500.

- "General Motors and Delphi" — Updated the two DME sections.
  
  “Magellan Behavioral Health Medical Necessity Criteria" — Updated the behavioral health criteria sets to include Blue Cross Blue Shield of Michigan Behavioral Health Criteria Application Guidelines.

• Blue Preferred Plus (1/6/2014)

  “Billing guidelines” — Added information about the new CMS-1500 (02/12) claim.

• BlueCard Program (1/1/2014)

  "Precertification and preauthorization" — Added information and a link to the Electronic Provider Access tool.

• Chiropractic Services: Billing and Reimbursement (1/13/2014)

  “Reimbursement” — Deleted the link to the now-outdated Practitioner Traditional Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

• Claims (1/15/2014)

  “UB-04 claim examples” — Added a line for “0710 – Recovery Room” to two claim examples: “Outpatient Surgery” and “Hospital Outpatient Bilateral Surgery on the Same Day.”

  “Completing the CMS-1500 claim (08/05 version) effective only through 3/31/2014)” — Added the “effective” wording to the title.

  “Completing the CMS-1500 claim (02/12 version) effective 1/6/2014” — Added this new section to address the instructions for the redesigned CMS-1500 claim.

  “Claims follow-up (effective through 3/31/2014)” — Added the ”effective” wording to the title.

  “Claims follow-up (effective through 3/31/2014)” — Added the ”effective” wording to the title.

• Dialysis Services (1/15/2014)
- “Noncovered services” — Added a bullet for services not provided by the employees of the ESRD facility.

“Reimbursement” — Deleted the link to the now-outdated End Stage Renal Disease Facility Participation Agreement and TRUST End Stage Renal Disease Facility Network Affiliation Agreement, leaving the links to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

Documentation Guidelines for Physicians and Other Professional Providers
(1/29/2014)

Pre-service and audit determination processes” — Updated the behavioral health criteria sets to include reference to the Blue Cross Blue Shield of Michigan Behavioral Health Criteria Application Guidelines

• Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services
(1/1/2014)

“Coverage” — Deleted the now-outdated reference to Public Act 350.

• Hearing Services (1/30/2014)

“Reimbursement” — Deleted the link to the now-outdated Hearing Specialist Provider Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

• Home Health Care Services (1/21/2014)

“Noncovered services” — Added “home therapy” and “enteral nutrition” to list

“Conditions and Limitations” — Changed the word “current” to “applicable” when referring to the use of InterQual criteria.

• Hospice (1/1/2014)

“Reimbursement” — Deleted the link to the now-outdated Hospice Provider Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the (4/1/14) future agreement.

• Hospital Services (1/29/2014)

“Newborn care” — In the “Billing guidelines” section, clarified the first sub-bullet in the “Sick-baby” bullet by removing the reference to well babies
“Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link to the current (1/1/14) agreement in place and added a link to the future (4/1/14) agreement.

• **ID Card** (1/1/2014)

  - “ID Card” — Updated the card images and information based on National Health Care Reform mandates.

• **Long-Term Acute Care Hospital Services** (1/1/2014)

  - “Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link (1/1/14) to the current agreement in place; and added a link to the future (4/1/14) agreement.

• **Participation** (1/20/2014)

  - “Per-claim participation” — Deleted the now-outdated reference to Public Act 350.

  “Participation agreements” — Deleted links to these 11 now-outdated agreements, leaving the links to the current (1/1/14) agreements in place; and added links to future (4/1/14) agreements:

  • Ambulance Provider Participation Agreement
  • CRNA Direct Reimbursement Participation Agreement
  • *End Stage Renal Disease Facility Participation Agreement (Traditional)*
  • *End Stage Renal Disease Facility Network Affiliation Agreement (TRUST)*
  • Hearing Specialist Provider Participation Agreement
  • Hospice Provider Participation Agreement
  • *Long-Term Acute Care Hospital Participation Agreement*
  • Practitioner Traditional Participation Agreement
  • Skilled Nursing Facility Freestanding and Hospital-Based) Participation Agreement
  • Substance Abuse Facility (Freestanding and Hospital-Based) Participation Agreement
Agreement

• Vision Specialist Provider Participation Agreement

• Physical Therapy, Occupational Therapy, and Speech Therapy Services (1/15/2014)
  “Physical therapy services” — In the “Covered services” section, added a bullet for development of cognitive skills to improve attention, memory and problem solving; in the “Noncovered services” section, removed the bullet and note about treatment that is solely to improve cognition.

• Physician Assistant Services (1/6/2014)
  "Coverage" — Updated the names of groups for which PA-rendered services are excluded from reimbursement.
  “Supervision requirements” — In the “Rural and underserved areas” section, deleted the now-outdated reference to Public Act 350.

• PPO Policies (1/6/2014)
  “Disaffiliation” — In both the “Appeals policy” and the “Continuity-of-care guidelines” sections, deleted now-outdated references to Public Act 350.
  “Completing the referral form” — Added information about how to submit the new CMS 1500 (02/12) claim.

• Preapproval of Services (1/28/2014)
  “Precertifying members of other Blues plans” — Deleted the steps and left the link to the BlueCard Program chapter, where detailed information is given.
  "Magellan Behavioral Health Medical Necessity Criteria" — Updated the behavioral health criteria sets to include Blue Cross Blue Shield of Michigan Behavioral Health Criteria Application Guidelines.

• Psychiatric Care Services (1/1/2014)
  “Reimbursement” — In the “Professional providers” section, deleted the link to the now-outdated Practitioner Traditional Participating Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement

• Radiology Management Program Procedure Codes (1/1/2014)
- "Radiology privileging" — In the “Nuclear medicine (specialty code 36)” chart, added procedure codes 78071 and 78072 to the privileging chart.

- "Radiology privileging" — In the "Neurology (specialty code 13)" chart, added procedure code 76942 to the privileging chart.

• Skilled Nursing Facility Services (1/21/2014)
  - “Conditions and limitations” — Changed the word “current” to “applicable” when referring to the use of InterQual criteria.
  - “Reimbursement” — Deleted the link to the now-outdated Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

• Substance Abuse Treatment Services (1/1/2014)
  - “Reimbursement” — Deleted the link to the now-outdated Freestanding and Hospital-Based Substance Abuse Facility Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

• Technical Surgical Assistant Services (01/06/2014)
  - Throughout the chapter — Made changes based on the new CMS-1500 (02/12) claim.

• Vision Care Program: Billing and Reimbursement(01/06/2014)
  - Throughout the chapter — Made changes based on the new CMS-1500 (02/12) claim.
  - “Reimbursement” — Deleted the link to the now-outdated Vision Specialist Provider Participation Agreement, leaving the link to the current (1/1/14) agreement in place; and added a link to the future (4/1/14) agreement.

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

33. BCN Care Management provider call volumes high

  Category: Care Management
Title: BCN Care Management provider call volumes high

Start Date: February 21, 2014   End Date: March 31, 2014

BCN Care Management continues to experience high call volumes. To avoid waiting on the phone line, providers should use BCN’s e-referral system to submit or check the status of referrals or requests for clinical review. We encourage providers to call the Medical Information Specialist line at 1-800-392-2512 with urgent requests only. We apologize for any inconvenience as we work to improve our telephone response time.

34. BCBSM Medicare Advantage PPO Precertification Services experiencing high processing volumes

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO Precertification Services experiencing high processing volumes

Start Date: February 21, 2014   End Date: March 6, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO Precertification Services is experiencing delays in processing care requests due to a high fax submission volume. We are working to increase our staff as soon as possible to address this situation.

A critical access line is available at 313-448-3619 for immediate requests or inquiries.

We apologize for any inconveniences that this may cause.

35. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: February 24, 2014   End Date: March 10, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Feb.24, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - Independent Lab
  - Injections
  - DME/P&O
- Facility
  - Outpatient Hospital
These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes

36. National drug code pricing webinar scheduled for Wednesday, Feb. 26, from 3-5 p.m.

Category: Professional

Title: National drug code pricing webinar scheduled for Wednesday, Feb. 26, from 3-5 p.m.

Start Date: February 26, 2014    End Date: February 27, 2014

BCBSM is hosting a webinar today from 3 to 5 p.m. on national drug code pricing basic billing information.

To join the webinar, click here. Be sure to click on the More Info link for the meeting number, password and teleconference information.

Please see the information below for the webinar call-in and meeting information.

Meeting information
Topic: NDC Pricing
Date: Wednesday, February 26, 2014
Time: 2:45 pm, Eastern Standard Time
Meeting Number: 733 911 833
Meeting Password: drugs

Teleconference information
- Please call one of the following numbers:
  Toll-Free: 1-800-462-5837
  Local: 313-225-4000
- Follow the instructions that you hear on the phone.
  Meeting ID: 733 911 833

37. Additional fee schedule added to web-DENIS

Category: Claims

Title: Additional fee schedule added to web-DENIS
Start Date: February 26, 2014    End Date: March 12, 2014

BCBSM recently replaced the 2/1/2014 Injections minimum fee schedule with the following revised 2/1/2014 Injections minimum fee schedule on web-DENIS, reflecting fee updates effective February 1, 2014:

Professional: Injection Fee Schedule

- Injections minimum fee schedule (02/01/2014, revised 2/26/2014)
- The fee schedule has been revised to correct the fee for J9266 and to add “NDC Billable Unit”, “AWP minus/plus x%” and “Start date for NDC”. This additional information was added to show:
  - the unit of measurement for corresponding NDC code (GR, ML or UN), when applicable
  - the percent or amount below or above the Average Wholesale Price, when applicable
  - the start date for NDC billing

Note: Effective for dates of service on or after 2/1/14, professional providers must provide the NDC when submitting an injection HCPCS code for accurate payment at the NDC level. Otherwise, the claim will be priced at the minimum fee, which is displayed in the professional fee schedule listed above.

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

For more information, contact your BCBSM provider consultant.

38. Billing hospital outpatient laboratory services for BCN Advantage SM members

Category: BCN Advantage Claims

Title: Billing hospital outpatient laboratory services for BCN Advantage SM members

Start Date: February 26, 2014    End Date: March 17, 2014

Effective Jan. 1, 2014, CMS changed the way laboratory services are paid in an outpatient hospital setting. CMS now packages outpatient hospital laboratory services when billed as integral, ancillary, supportive dependent or adjunctive to a primary service or procedure.

BCN Advantage outpatient hospital claim processing mirrors Medicare methodology. Hospitals (including provider-based designations) are reminded that laboratory services
denied as packaged may not be submitted to JVHL, BCN’s laboratory services vendor, for payment. Sending those claims to JVHL is considered unbundling.

Laboratory tests may be billed on a TOB 014x claim and submitted to JVHL in the following instances:

- Non-patient laboratory specimen tests
- Laboratory-only services when no other service is rendered during the same encounter
- Unrelated tests rendered with other hospital services during the same encounter, but only if the other hospital services were ordered by a different ordering physician

The CMS guidelines are found in the CMS *MLN Matters* article MM8572.

It is the hospital’s responsibility to determine when laboratory tests may be separately billed on a 014x claim under the limited exceptions outlined by CMS. In addition, molecular pathology tests represented by CPT codes *81200 through *81383, *81400 through *81408, and *81479 should be billed using a 013x type of bill.

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39. Additional counties to transition out of MIChild Blue Cross PPO coverage on March 1

*Category:* MIChild

*Title:* Additional counties to transition out of MIChild Blue Cross PPO coverage on March 1

*Start Date:* February 26, 2014  *End Date:* March 21, 2014

The following counties will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for their medical, pharmacy and vision benefits on March 1, 2014.

**Two counties transitioning on March 1, 2014**

- Hillsdale
- Missaukee

As we announced in the September 2013 issue of *The Record*, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.
First transition happened on Oct. 1, 2013, and included these 34 counties:

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

Second transition happened on Nov. 1, 2013, and included these 13 counties:

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
<tr>
<td>Crawford</td>
<td>Ogemaw</td>
<td>Tuscola</td>
</tr>
<tr>
<td>Gratiot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Third transition happened on Dec. 1, 2013, and included these four counties:

<table>
<thead>
<tr>
<th>Clinton</th>
<th>Ingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eaton</td>
<td>Isabella</td>
</tr>
</tbody>
</table>
For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit [michigan.gov/michild](michigan.gov/michild)*. Click on Information for MIChild Providers then click on MI Child Health Plan Service Contacts and Service Areas Listing.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

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**BCBSM Medicare Plus BlueSM PPO manual to be updated in April 2014**

**Category:** Medicare Advantage

**Title:** BCBSM Medicare Plus BlueSM PPO manual to be updated in April 2014

**Start Date:** February 27, 2014    **End Date:** March 15, 2014

Blue Cross Blue Shield of Michigan will update its Medicare Plus BlueSM PPO manual for April 2014. Key changes include:

- Michigan Public School Employees Retirement System members have Catamaran as their pharmacy benefits manager (clarification only).
- Updated primary care physician listings and high-level benefit language
- Added eye exams as an example for our provider Performance Recognition Program and made program overview more high-level
- Added reminder that acute detoxification admissions should be processed as a medical service and should follow the prenotification guidelines for inpatient admission
- Updated source for the Diagnostic and Statistical Manual, fifth edition/p>o
- Deleted proton beam therapy as a treatment for prostate cancer
- Added that effective July 1, 2014, the Blue Cross and Blue Shield Association issued a mandate that requires all participating providers to be responsible for obtaining preservice reviews for inpatient facility services provided to Medicare Advantage members from other states. The BCBSM Medicare Advantage PPO provider agreement and hospital attachment will be updated accordingly on our website July 1, 2014. The following guidelines are also outlined in the April manual:

  ✓ Preservice reviews should be obtained prior to admission for inpatient facility services when such a review is required under the member’s plan.
  Out-of-state members will be held harmless if a preservice review is required
  ✓ and not performed prior to admission for inpatient facility services. You cannot bill or collect from a member for covered services where you failed to
perform preservice review as required. Specified time frames for preservice review may apply. These include: 48
✓ hours to notify the host plan of a change in the preservice review and 72 hours in the case of an emergency or urgent care notification.
✓ Providers can use the Electronic Provider Access tool to determine whether
✓ provider portals for the purpose of conducting preservice reviews. For more
✓ information about the tool, see the article in the December 2013 Record.

- Updated involuntary disaffiliation language: Depending on the reasons for this type of disaffiliation, you may be able to reapply for affiliation two years after the disaffiliation date.

You can obtain the most current version of the manual at bcbsm.com/provider/ma.

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

40. Blue Cross Complete embraces Medicaid expansion - The Healthy Michigan Plan

Category: Blue Cross Complete

Title: Blue Cross Complete embraces Medicaid expansion - The Healthy Michigan Plan

Start Date: February 27, 2014    End Date: March 14, 2014

On April 1, 2014, Michigan’s newly approved bill authorizing the expansion of the state’s Medicaid program to nearly 2.5 million people will take effect. The new Healthy Michigan Plan also includes reforms that expect to increase cost-sharing through new health care accounts and healthy behavior incentives. Blue Cross Complete will experience an increase of members for this new plan in our service area including Washtenaw, Livingston and Wayne counties.

Blue Cross Complete has published the March edition of their Complete Update newsletter which includes an overview of the plan and what to expect as a provider. Questions can also be directed to Blue Cross Complete provider representatives.

41. Some BCBSM Medicare Advantage PPO ambulatory surgery facility claims processing incorrectly

Category: Medicare Advantage
Some BCBSM Medicare Advantage PPO ambulatory surgery facility claims processing incorrectly

Start Date: February 27, 2014    End Date: March 13, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO ambulatory surgery facility claims for providers in Lapeer, Livingston, Macomb, Oakland and St. Clair counties are processing with incorrect fees.

These claims are being held until the problem is corrected. A few claims were paid prior to the discovery of this error. Any paid claims affected by this issue will be adjusted once this problem is fixed.

We are working to fix this issue as quickly as possible, and we thank you for your patience. If you have any questions, please contact your provider consultant.

Proton beam therapy requires clinical review effective March 1

Category: BCN Advantage Care Management

Start Date: February 28, 2014    End Date: March 21, 2014

BCN is revising and formalizing clinical review criteria for proton beam radiation therapy effective March 1, 2014, for both BCN HMOSM (commercial) and BCN AdvantageSM members. This affects procedure codes *77520, *77522-*77523 and *77525.

The BCN Referral / Clinical Review Program is updated with these requirements.

Providers should continue to submit clinical review requests for these procedures, either through BCN’s e-referral system or by calling BCN Care Management at 1-800-392-2512. As is currently the case, the requests will be pended for review and BCN Care Management will require additional information.

For additional details on these changes, refer to the news item Proton beam therapy requires clinical review effective March 1 available at ereferrals.bcbsm.com.

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All BCBSM electronic trading partners

Category: BCBSM to return new electronic pended claim transactions on Mar. 1, 2014
On Oct. 24, 2013, Blue Cross Blue Shield of Michigan announced development of a new 277x228 Health Care Claim Pending Status Information electronic transaction and report. The new 277s will identify pended claims for Advance Premium Tax Credit eligible members during the 31-90 day grace period of premium delinquency.

Effective March 1, BCBSM EDI will automatically distribute the following 277x228 reports, transactions or both based on trading partner set up. Submitter trading partners do not need to enroll with EDI or complete any forms.

- **BCBSM reports:**
  - Professional = R277CAE
  - Institutional = R277CAG

- **BCN reports:**
  - Professional = R277CAJ
  - Institutional = R277CAQ

The report and transaction format is very similar to the BCBSM R277CA and 277CAP files distributed today. Trading partners can identify pended claims by the claim status and category codes returned in the STC segment of Loop 2200D of the transaction, or by the codes and message shown on the report. For example:

**Transaction:**

```
STC*P5:734~
```

**Report:**

```
P5 734 Pending – verifying premium payment
```

We are in the process of finalizing 277x228 examples to include in our 5010 Acknowledgements reference document. Watch for updates and additional details in future communications.

Providers can read more about the Advance Premium Tax Credit grace period in the February 2014 edition of *The Record*.

If you have questions about a submitter set up or require assistance, email us at EDICustMgmt@bcbsm.com.

March 2014

Here are answers to questions about Medicare Plus Blue℠ electronic fund transfers

In December 2013, Blue Cross Blue Shield of Michigan Medicare Advantage PPO began offering electronic fund transfer as a payment option for our providers. Provider vouchers are also now distributed electronically. However, as we implemented this new system, we received some feedback from health care practitioners and are working to address your comments as soon as possible.

Here are some frequently asked questions that we hope will make this new process more convenient and user-friendly for you. This information was also shared in a February web-DENIS message.

**How do I enroll in EFT?**
Enrolling is easy. Log in at [bcbsm.com](http://www.bcbsm.com), click on Register Provider and follow the instructions. You also can call our help desk at 1-877-258-3932 or your provider consultant for help with enrolling.

**How do I change my financial institution information?**

- Visit [bcbsm.com](http://www.bcbsm.com) and log in.
- Under Electronic Funds Transfer, click on Update provider.
- Enter the required information and click on submit.

Please allow three to five weeks for the system to update. You’ll receive paper checks and vouchers until that update occurs.

**What if the money isn’t in my account when it’s supposed to be?**
You’ll need to verify the following:
You received your EFT registration confirmation letter.
You haven’t changed your financial institution since you registered.
The account on the registration form is open and active.
Your financial institution hasn’t changed its policy on fund availability.
You’ve submitted claims and they’re scheduled for payment.

If you’ve confirmed all of the above information and you still haven’t received a payment for a BCBSM Medicare Advantage PPO product, email us at providereft@bcbsm.com.

How do I tell if a check was issued using EFT?
A check number that begins with a six indicates electronic funds. If the check number begins with any other number, the check will be delivered by postal mail.

How do I find out where my EFT payment was deposited?
Send an email to providereft@bcbsm.com, and we’ll get back to you as soon as we can.

When are funds transferred to my account?
Providers will receive the “835” record every Saturday, and funds should be deposited every Tuesday.

I can’t access my vouchers electronically. What should I do?
Call our Web support help desk at 1-877-258-3932 and we’ll be happy to help you.

You’ll also find a helpful frequently-asked-questions document about EFT when you log in at bcbsm.com. A general guideline document will soon be posted at bcbsm.com/provider/ma.

For more information or questions, please contact your provider consultant.

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Web-DENIS messages March 2014
1. BCBSM electronic provider manuals — February 2014 changes

Category: Online manuals

Title: BCBSM electronic provider manuals — February 2014 changes

Start Date: March 3, 2014    End Date: March 17, 2014

These are the chapters we revised in February 2014, along with the revision date and a brief statement of the main changes for each.*

- **Ambulatory Surgery Facility Services** (2/5/2014)
  - "Incomplete (canceled) surgery" — Updated billing instructions about ICD diagnosis codes.

- **Appeals** (2/20/2014)
  - "Utilization management decisions" — Added a fax number to the Pharmacy row of the contact-information chart.
  - “Claim disputes” — Updated the section for hospitals.
  - "Audit disputes" — Updated the "Internal review" and the "External peer review" sections for hospitals by adding more detail.

- **Blue Pages Directory** (2/1/2014)
  - "Michigan Conference of Teamsters Welfare Fund" — Deleted "pet scans" from the list of items requiring prior authorization directly from MPSERS.

- **Blue Preferred Plus** (2/1/2014)
  - "Contact information" — Changed the contact information for DME and P&O services for the following groups: Chrysler Corporation, Chyrsler URMBT, Ford Motor Company, and Ford URMBT.

- **BlueCard Program** (2/4/2014)
  - “Precertification and preauthorization” — Added directions for accessing the Electronic Provider Access tool.
  - “Replacement claims” — Added instructions for using the SCCF# in FL 80.
- “Void claims” — Added instructions for using the SCCF# in FL 80.

**Chiropractic Benefit (2/7/2014)**

- "Covered services" — Added more information to the “Mechanical traction therapy” bullet.
- "Conditions and limitations” — In the “Mechanical traction therapy” section, added information about benefit limitations.

**Claims (2/24/2014)**

- “UB-04 claim examples” — Updated 65 claim examples and deleted 16 claim examples that were made obsolete by the HOPS II project.
- “Completing the CMS-1500 claim (08/05 version) effective only through 3/31/2014” — In the "Line-by-line instructions" section, for field 24A, added instructions for billing a 90-day quantity of medical supplies.
- “Completing the CMS-1500 claim (02/12 version) effective 1/6/2014” — In the "Line by line instructions" section, for field 24A, added instructions for billing a 90-day quantity of medical supplies.
- “Coordination of benefits secondary and tertiary balance claims” — Updated seven claim examples.

**Hospice (2/1/2014)**

- "Phase 1 (prehospice care)" — In the "Coverage" section, replaced revenue code 0650 with revenue code 0691.
- "General classification for hospice services (revenue code 0650)" — Replaced two occurrences of revenue code 0650 with revenue code 0691.

**Medical-Surgical Services (2/24/2014)**

- “Allergy testing and allergen immunotherapy” — Moved “Leukocyte histamine release test (LHRT)” from the “Covered services” section to the “Noncovered services” section. Also added the following covered services:
  - Survey, including history, physical exam and diagnostic laboratory studies
  - Allergy immunotherapy by injection (allergy shots)
• Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

  “Chemotherapy” — In the “Billing guidelines” section, updated the billing instructions about ICD diagnosis codes.

• Patient Eligibility (2/12/2014)

  “Overview” — Added a clarification note saying that covered services are eligible for reimbursement only when the patient is listed on the BCBSM contract and has active coverage on the date of service.

• Physical Therapy, Occupational Therapy, and Speech Therapy Services (2/11/2014)

  “Coverage” — Added a note to explain that visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward the visit maximum for all outpatient visits for PT, OT and ST.

  “Occupational therapy services” — In the “Noncovered services” section, added a bullet for “Services received from other facilities independent of a hospital, such as an independent sports medicine clinic.”

  “Speech and language pathology therapy services” — In the “Conditions and limitations” section, amended the second bullet to add “or to optimize the development potential of the patient and maintain the patient’s level of functioning” to the “Given for a condition” statement. Also added a bullet to the same section to cover the “Given by” situation.

  “Speech and language pathology therapy services” — In the “Noncovered services” section, added two bullets.

• Physician Office Laboratory List (2/21/2014)

  “POLL codes” — Added code 83861 to the list of payable laboratory services allowed to be performed in the physician office setting.

• PPO Policies (2/13/2014)

  “Overview” — Moved “physician assistant” from the list of TRUST PPO network providers to the list of providers not included in the PPO network.

  “Radiology management” — Added a new section titled “Retroactive preauthorization” to the section.
• Psychiatric Care Services (2/11/2014)

"Outpatient psychiatric care program – facility" — Added a new bullet to the "Covered services" section to include ancillary services for patients who are admitted and discharged on the same day of treatment. Also added two sub-bullets to the "Individual psychotherapy" bullet in the same section.”

"Outpatient psychiatric care program – professional" — Added two sub-bullets to the "Individual psychotherapy" bullet in the "Covered services" section. Also added the word "program" to the title of this section.

• Radiology Management Program Procedure Codes (2/1/2014)

- “Preauthorization” — Added codes *75572-*75574 to the chart.

• Valid Modifiers (2/1/2014)

- “Valid modifiers: ambulance services” — Added modifier QL to the “Other applicable modifiers” chart.

- “Valid modifiers: evaluation and management” — Added modifier PM to the “Level II modifiers” chart.

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

2. ICD-10 readiness information

Category: All providers

Title: ICD-10 readiness information

Start Date: March 4, 2014   End Date: March 18, 2014

As we continue to get ready for the Oct. 1, 2014, implementation of ICD-10, BCBSM wants to bring you potential educational opportunities for you and your staff. As a reminder, BCBSM is not sponsoring these events and there may be an associated cost with these sessions.

Anatomy and Physiology Refresher courses

Sponsored by the Michigan Health Information Management Association and Davenport University
March 29, 2014 – Grand Rapids (Click here* to register securely online)

April 19, 2014 – Livonia (Click here* to register securely online)

In addition to this information, also be sure to check cms.gov/icd10* frequently for updates on the implementation from the Centers for Medicare & Medicaid Services. We also have information available at bcbsm.com/icd10. Also check web-DENIS often for notices about our ICD-10 webinars, which occur monthly.

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3. Qualification form cotinine testing

Category: Professional

Title: Qualification form cotinine testing

Start Date: March 4, 2014   End Date: March 18, 2014

Blue Cross Blue Shield of Michigan has received numerous questions about the cotinine test requirement on the 2014 qualification form.

Cotinine testing is required only for certain members. As of March 3, 2014, cotinine testing is required only for the following group numbers:

<table>
<thead>
<tr>
<th>Group Number 1</th>
<th>Group Number 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>71312</td>
<td>7015548</td>
</tr>
<tr>
<td>7000499</td>
<td>7016936</td>
</tr>
<tr>
<td>7002256</td>
<td>7016948</td>
</tr>
<tr>
<td>7002929</td>
<td>7017015</td>
</tr>
<tr>
<td>7003223</td>
<td>7023156</td>
</tr>
<tr>
<td>7003715</td>
<td>7034273</td>
</tr>
<tr>
<td>7006324</td>
<td>7034883</td>
</tr>
<tr>
<td>7009486</td>
<td>7039587</td>
</tr>
</tbody>
</table>
Remember these rules:

- If the cotinine test box is **checked**, order the test.
- If the cotinine test box is **not checked** on the qualification form, do not order the test.
- You **do not** need to run the test if the member admits to being a tobacco user.

*Cotinine tests are typically not a covered benefit, so please do not order the test for a patient who does not need it.*

4. Some BCBSM Medicare Advantage PPO ophthalmological evaluation and management codes denying in error

**Category:** Medicare Advantage

**Title:** Some BCBSM Medicare Advantage PPO ophthalmological evaluation and management codes denying in error

**Start Date:** March 5, 2014    **End Date:** March 19, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO has identified an error in processing ophthalmological E&M procedure codes. These CPT codes were denying in error when a routine diagnosis was billed on the claim for another service. The following procedure codes have been affected: *92002, *92004, *92012 and *92014.

This error was corrected in the claims system Feb. 26, 2014. We’ll adjust claims that were denied in error.

We are working to fix this issue as quickly as possible and thank you for your patience. If you have any questions, please contact your provider consultant.

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5. Update: MESSA ABC Choices members’ chiropractic manipulation claims issue resolved

**Category:** Professional claims
Title: Update: MESSA ABC Choices members’ chiropractic manipulation claims issue resolved

Start Date: March 5, 2014    End Date: March 19, 2014

We have resolved the issue of chiropractic manipulation claims for some MESSA members. These claims were processing and paying at 100 percent of the approved amount in error. The claims are processing correctly, effective Jan. 24, 2014.

We are working on a recovery for claims that were paid incorrectly and apologize for any inconvenience this may have caused.

6. Blue Cross Complete reminder – no authorization for home health services

Category: Blue Cross Complete

Title: Blue Cross Complete reminder – no authorization for home health services

Start Date: March 5, 2014    End Date: March 19, 2014

Blue Cross Complete does not require authorization for home health services. For plan notification and clinical review requirements related to other services, refer to the Blue Cross Complete Plan Notification and Clinical Review Requirements document, located on the Blue Cross Complete for Providers website under the Benefit, authorization and clinical resources section.

7. Blue Cross Blue Shield of Michigan retiring its local system

Category: All providers

Title: Blue Cross Blue Shield of Michigan retiring its local system

Start Date: March 6, 2014    End Date: March 20, 2014

As a result of the migration of local groups to the NASCO platform, which was completed in 2012, there’s no longer a need for the local system. Therefore, the Blues will retire the local system, effective Oct. 31, 2014, and claims will no longer be processed on that system.

All claims filed on the local system must be submitted and received by Sept. 15, 2014, in order to be processed.

For more information, see the article in the March Record.

8. Molecular pathology codes updated
Based on requests received from hospitals and physician offices, we’re providing a list of genetic testing procedure codes that had policy revisions or system updates in recent months. The following codes are processing as payable in our claims system. Be sure to also check member benefits prior to performing the service.

<table>
<thead>
<tr>
<th>Code*</th>
<th>Status</th>
<th>Effective date of status change</th>
</tr>
</thead>
<tbody>
<tr>
<td>81206</td>
<td>Payable (Note: Payable with revenue code 0310)</td>
<td>Jan. 1, 2013</td>
</tr>
<tr>
<td>81207</td>
<td>Payable (Note: Payable with revenue code 0310)</td>
<td>Jan. 1, 2013</td>
</tr>
<tr>
<td>81208</td>
<td>Payable (Note: Payable with revenue code 0310)</td>
<td>Jan. 1, 2013</td>
</tr>
<tr>
<td>81211</td>
<td>Payable (Note: Diagnostic edits removed)</td>
<td>May 1, 2013</td>
</tr>
<tr>
<td>81212</td>
<td>Payable (Note: Diagnostic edits removed)</td>
<td>May 1, 2013</td>
</tr>
<tr>
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<td>Payable (Note: Diagnostic edits removed)</td>
<td>May 1, 2013</td>
</tr>
<tr>
<td>81214</td>
<td>Payable (Note: Diagnostic edits removed)</td>
<td>May 1, 2013</td>
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<td>Payable (Note: Diagnostic edits removed)</td>
<td>May 1, 2013</td>
</tr>
<tr>
<td>81216</td>
<td>Payable (Note: Diagnostic edits removed)</td>
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</tr>
<tr>
<td>81217</td>
<td>Payable (Note: Diagnostic edits removed)</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>81222</td>
<td>Payable</td>
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<tr>
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<td>Code</td>
<td>Description</td>
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<td>81228</td>
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<td>81235</td>
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<td>81254</td>
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<td>81267</td>
<td>Payable (Note: Payable with revenue code 0310)</td>
<td>Jan. 1, 2013</td>
</tr>
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<td>Payable (Note: Payable with revenue code 0310)</td>
<td>Jan. 1, 2013</td>
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<td>81374</td>
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<td>Jan. 1, 2013</td>
</tr>
<tr>
<td>G0452</td>
<td>Payable (Professional claims only)</td>
<td>Jan. 1, 2013</td>
</tr>
</tbody>
</table>

If you have any questions or need more information, please contact your provider consultant.

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9. Additional fee change schedules added to web-DENIS

Category: Fee Changes
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Mar. 10, 2014

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

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility
  - Freestanding Outpatient Physical Therapy

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


**Category:** Behavior health criteria

**Title:** Behavioral Health Criteria Application Guidelines updated with clarifications

**Start Date:** March 10, 2014  **End Date:** March 24, 2014

We posted 2014 Behavioral Health Criteria Application Guidelines earlier this year. There have been clarifications made to Admission Intensity and Quality of Services for Residential Treatment Substance Related Disorder, Adult, Geriatric, Child and Adolescent, (page A-16, section A) regarding when a patient must be seen by a physician and the Intensity and Quality of Services: Partial Hospitalization Eating Disorders, (page A-23, section B) regarding frequency of visits. These clarifications are effective March 10, 2014. The Behavioral Health Criteria Application Guidelines document is updated.

To access the Behavioral Health Criteria Application Guidelines document:

- Login to web-DENIS
- Click on BCBSM Provider Publication and Resources
- Click on BCBSM Newsletters and Resources
- Click on Clinical Criteria and Resources
- Scroll to the section Magellan Behavior Health Clinical Criteria
11. All Medicare Advantage trading partners

Category: Delayed Medicare Advantage 835 remittance files

Title: All Medicare Advantage trading partners

Start Date: March 10, 2014    End Date: March 23, 2014

Medicare Advantage 835 remittance files for check date 3/11/14 have been delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience

12. All BCBSM electronic trading partners

Category: Conversion of informational edits effective May 1, 2014

Title: All BCBSM electronic trading partners

Start Date: February 10, 2014    End Date: May 1, 2014

On August 19, 2013, BCBSM implemented informational edits for claims reporting NPI/submitter ID combinations that do not match our EDI enrollment files. The informational edits, P001i, P002i, P003i and F001i, alert submitters of inconsistencies in their EDI setup for a particular payer without rejecting their claims. Effective May 1, 2014, these informational edits will convert to ‘hard edits’ that reject the claims.

Claims receiving informational edits appear on 277CAX and 277CAZ reports. Beginning May 1, claims rejected with hard edits will appear on 277CAP transactions or 277CAH/277CAI reports:

Professional - Returned on a 277CAH report

- A3 24 P001 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR BL OR HM
- A3 24 P002 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR MB
- A3 24 P003 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR CI

Institutional - Returned on a 277CAI report

- A3 24 F001 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR ELEC BILLING

Rejected claims must be resubmitted. Prior to resubmission, providers must update their Provider Authorization Form to the correct billing NPI/submitter ID combination.
Providers should validate their setup for all sources of payment (BL, HM, MA, MB, or CI).

Communication of the new edits was published in the July edition of The Record and a web-DENIS broadcast message on August 19, 2013.

For questions about claim edits, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945, Opt. 1. For assistance with updating your Provider Authorization form, select Opt. 3.

13. ICD-10 webinar now available

**Category:** Professional

**Title:** ICD-10 webinar now available

**Start Date:** March 10, 2014   **End Date:** October 1, 2014

If you’d like to listen to a recording of the January ICD-10 Michigan Mondays webinar in which Precyse University focuses on physicians’ offices, “Breaking the Code, ICD-10’s Impact on a Physician Office,” please click on this link.

Precyse talks about the impacts ICD-10 has physician offices in addition to providing an overview of ICD-10 as it relates to documentation and coding. Precyse also focuses on the pervasiveness of ICD-10 and the education that needs to be completed within each office prior to the Oct. 1, 2014, deadline.

This recorded webinar includes:

- The largest impacts on the physician office or practice that ICD-10 brings and the steps you should be taking
- Strategies to drive roll out, adoption and urgency
- Best practices on how to implement an education plan
- The populations needing education

14. All BCBSM institutional trading partners

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

**Title:** All BCBSM institutional trading partners

**Start Date:** March 12, 2014   **End Date:** April 11, 2014
On February 24, 2014, BCBSM began editing institutional claims for MIChild groups 31295 and 007004505 that do not follow Medicaid Drug Rebate Program requirements.

The new edit is returned on BCBSM institutional R277CAI reports or R277CAP transactions. Edited claims must be corrected and resubmitted.

Transaction Report

A3 218 F910 INVALID/MISSING NDC CODE/QUANTITY REPORTED ON MICHILD CLAIM.

To avoid this edit, institutional electronic 837 claims should report NDC codes and associated quantities as follows:

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

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

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

15. Claims billed with HCPCS code T1015 are rejecting in error

**Category:** Professional Claims

**Title:** Claims billed with HCPCS code T1015 are rejecting in error

**Start Date:** March 12, 2014 **End Date:** April 11, 2014

A system issue has been identified for professional claims billed with HCPCS code T1015. Claims are either pending or rejecting in error, indicating T1015 is not a payable code. T1015 should process as a benefit for most groups with office visit coverage.

Please do not resubmit these claims as our claims system will automatically reprocess the services for payment when the problem is corrected. We will post another web-DENIS message when this happens.
We appreciate your patience as we work to resolve the issue, and we apologize for any inconvenience caused by this error. If you have any questions, please contact your provider consultant.

16. Update: Abortion Insurance Opt-Out Act

**Category:** Claims

**Title:** Update: Abortion Insurance Opt-Out Act

**Start Date:** March 13, 2014    **End Date:** March 27, 2014

As you read in the *March Record* and the March-April *BCN Provider News*, the Abortion Insurance Opt-Out Act goes into effect today and could impact abortion claims you submit.

As we work to implement system changes to comply with the law, it’s especially important to check your patients’ benefits and eligibility before submitting a claim for any abortion services.

Please remember to check benefits on web-DENIS or CAREN to verify whether a patient has elective abortion (voluntary abortion) coverage. If you do not see elective abortion coverage on web-DENIS or CAREN, you should call Provider Inquiry to determine if the patient has coverage for the specific circumstance.
17. Some individual billed member claims rejecting as no coverage

**Category:** All providers

**Title:** Some individual billed member claims rejecting as no coverage

**Start Date:** March 17, 2014    **End Date:** March 31, 2014

On March 1, 2014, we automatically terminated some individual billed contracts where no premium payment was received for January coverage. Unfortunately, we incorrectly voided out the previous coverage that was paid. As a result, this may impact new claim submissions and adjustment processing for dates of service that fall under the previous months’ coverage until the issue is corrected. These claims will reject with the explanation that the member has no coverage.

We are working to resolve this issue by Friday, March 21. We apologize for any inconvenience this may cause.

If you see these incorrect rejections after March 21, 2014, please contact Provider Inquiry.

18. New voucher edit message for daily quantity maximums

**Category:** Professional and Facility claims

**Title:** New voucher edit message for daily quantity maximums

**Start Date:** March 17, 2014    **End Date:** March 28, 2014

Starting in April, health care providers will receive a new message on vouchers when the submitted HCPCS or CPT procedure codes reach or exceed their recommended daily quantity maximum on outpatient facility and professional claims.

Quantity maximum determines the number of times a procedure can be billed on a single claim line for a particular date. Currently, there is no message when this daily maximum is reached or exceeded.

When a maximum quantity is reached, this message will alert providers that they only will be reimbursed for the daily maximum quantity. For example, if the maximum is five per day for a reported HCPCS or CPT code, but 15 are submitted, the message will state that there’s been an adjustment in the reimbursement. Payment will be made for the first five only.

Web-DENIS will display claims information with both the allowed quantity and maximum quantity for the code.
19. ICD-10 webinar scheduled for Monday, March 24 from 1-2 p.m.

Category: Post-acute providers

Title: ICD-10 webinar scheduled for Monday, March 24 from 1-2 p.m.

Start Date: March 17, 2014    End Date: March 25, 2014

Precyse University will host an ICD-10 webinar focused on post-acute care providers, called “ICD-10 and the Impact on the Post-Acute Setting.” This webinar will provide an overview of the change to ICD-10 diagnosis coding and its impacts on the post-acute setting, including home health, hospice, rehab, skilled nursing facilities, behavioral health, long-term care therapies, long term acute care and others.

In addition to providing an overview of ICD-10’s impacts in these settings, this free webinar will also focus on the education your organization and personnel will need to complete before the Oct. 1, 2014, deadline. This webinar will include:

- The largest ICD-10 impacts on post-acute settings and the steps you should be taking now
- Who in your organization needs education
- Best practices for implementing an education plan
- Strategies to emphasize urgency and drive rollout and adoption

This webinar is scheduled for Monday, March 24 from 1 to 2 p.m. Eastern Time. To register, click here and you will receive a confirmation email with instructions for joining the session. Send an email to, ICD-10providerreadiness@bcbsm.com if:

- You would like us to cover a specific topic in a future webinar, or you have questions related to ICD-10
- Your organization would like to participate in a future webinar
- You are having issues with the link above or logging into the call

A link to the recorded webinar will be provided after the session has been conducted.

20. Claims for individual business members could reject as a result of duplicate coverage

Category: All providers

Title: Claims for individual business members could reject as a result of duplicate coverage

Start Date: March 17, 2014    End Date: March 31, 2014
At the end of last year, in response to requirements of the Affordable Care Act, BCBSM automatically transferred some individual business members into a pre-reform plan to make sure that they did not lose coverage. In doing so, some members accidentally had duplicate coverage (where they were enrolled in more than one plan at a time), which caused membership and billing issues. In several cases, the individuals have chosen coverage from another carrier, and, therefore, BCBSM is not the carrier that should be billed.

We began processing these claims this week. If you receive a rejection for an individual business member (from KeepFit or a qualified health plan) for a claim submitted in January 2014, please verify the patient’s coverage and submit the claim to the appropriate carrier. If the carrier of record is BCBSM and you feel that the claim was rejected in error, please appeal the rejection as needed.

We apologize for any inconvenience this may cause.

21. Important information about CMS-1500 and status claim review forms

**Category:** BCBSM and BCN claims

**Title:** Important information about CMS-1500 and status claim review forms

**Start Date:** March 17, 2014    **End Date:** March 31, 2014

Effective April 1, 2014, BCBSM and BCN providers should submit professional claims and status inquiries using the new CMS-1500 (02-12) claim form.

**For BCBSM claims:** The old CMS-1500 claim form (08-05 version) and the *Michigan Status Claim Review Form* will be returned if submitted after March 31, 2014. Beginning April 1, 2014, BCBSM will accept only the new CMS-1500 (02-12) form. When submitting status inquiries for BCBSM claims, providers should use the new CMS 1500 (02-12) form and do the following:

- Complete Field 22 by entering the original reference number for the resubmitted claim and the appropriate bill frequency code — either a “7” (to replace a prior claim) or an “8” (to void or cancel a prior claim).
- Complete Field 19 by entering additional information, such as the reason for the resubmission.

For additional details about using the new CMS 1500 form for BCBSM claims, see the *January Record*.

**For BCN claims:** The old paper forms — the CMS 1500 (08-05 version) and the *Status Claim Review Form* — will not be returned if used after March 31, 2014. Providers are nevertheless encouraged to submit new BCN claims and status inquiries using the new CMS-1500 (02-12) form. To submit a status inquiry for a BCN claim using the CMS-
1500 (02-12) form, providers should complete Field 22 by entering the original reference number for the resubmitted claim and the appropriate bill frequency code — either a “7” (to replace a prior claim) or an “8” (to void or cancel a prior claim). For BCN claims, providers do not need to complete Field 19.

22. Amendment to BCN Advantage HMO-POS<sup>SM</sup> Amendments for Ancillary, Practitioner, and Provider Group Agreements for Radiology Providers

Category: BCN Advantage SM contract amendments

Title: Amendment to BCN Advantage HMO-POS<sup>SM</sup> Amendments for Ancillary, Practitioner, and Provider Group Agreements for Radiology Providers

Start Date: March 17, 2014  End Date: March 31, 2014

Pursuant to the Financial Terms Amendment section of the Blue Care Network of Michigan Provider/Practitioner/Provider Group Affiliation Agreements, this publication serves as notice of amendment. The BCN Advantage Amendment is hereby amended to incorporate the indicated changes effective July 1, 2014. Reimbursement for services will be paid in accordance with the applicable BCN Advantage Professional Fee Schedule. Should you have any questions regarding this language, please contact your provider consultant.

Please click on the respective links below to obtain a copy of the amendment applicable to each provider type.

- BCN Advantage Ancillary Provider Affiliation Amendment
- BCN Advantage Practitioner Affiliation Amendment
- BCN Advantage Provider Group Affiliation Amendment

23. Amendment to Blue Care Network of Michigan Ancillary Provider Affiliation Agreement and BCN Advantage Amendment for Dialysis Providers

Category: BCN miscellaneous

Title: Amendment to Blue Care Network of Michigan Ancillary Provider Affiliation Agreement and BCN Advantage Amendment for Dialysis Providers

Start Date: March 17, 2014  End Date: March 31, 2014

Pursuant to the Generally Applicable Amendments section of the Blue Care Network of Michigan Provider Affiliation Agreement, this publication serves as notice of amendment. The Agreement is hereby amended to incorporate the indicated changes effective June 1, 2014. The contractual language updates are related to claim submission requirements which do not impact the rate of reimbursement. Should you have any questions regarding any of this language, please contact your provider consultant.
Please click on the link below to obtain a copy of the amendment.

- Blue Care Network of Michigan Ancillary Provider Affiliation Agreement and BCN Advantage Amendment for Dialysis Providers

24. All ICT Users

**Category:** System Enhancements: New claim forms, filters and navigation

**Title:** All ICT Users

**Start Date:** March 18, 2014    **End Date:** April 1, 2014

On April 6, 2014, many of the filters and lists of the Internet Claim Tool will be enhanced to provide greater usability and navigation. The changes include:

- Enhancements to the Claims List Filter Pages
  - Regrouped criteria
  - Color coded claim status values
- Enhancements to the Claims List Pages
  - New sort options
  - New action options
- Claim Form Navigation Enhancements
  - A new claim navigation bar replaces the Webpage Dialog box
  - New one-click icons
  - Easier location of errors on claim forms
- Claim Form: Professional Form Enhancements
  - Professional claim form has been updated to the CMS-1500 (02/12) version
- Claim Form: Institutional Form Enhancements
  - Institutional claim form is now a UB-04
- Claim Form: Electronic Fields Enhancements
  - Electronic fields redesign

Detailed information about these changes is located in the Internet Claim Tool Enhancements Quick Reference Guide available in the Knowledge Center.

25. All BCBSM electronic trading partners

**Category:** Distribution of new electronic 277x228 pended claim transaction delayed

**Title:** All BCBSM electronic trading partners

**Start Date:** March 20, 2014    **End Date:** April 3, 2014
Due to a systems issue, 277x228 pended claims transactions and reports are not being released at this time. Blue Cross Blue Shield of Michigan originally communicated that distribution would begin on March 1, 2014.

We will provide an update when the issue is resolved. Electronic submitters should continue to use CAREN and web-DENIS to check marketplace member delinquency status.

As a reminder, the new 277s will identify pended claims for Advance Premium Tax Credit eligible members during the 31-90 day grace period of premium delinquency. BCBSM will automatically distribute the following 277x228 reports, transactions or both based on trading partner set up. Submitter trading partners do not need to enroll with EDI or complete any forms.

**BCBSM reports:**
- Professional = R277CAE
- Institutional = R277CAG

**BCN reports:**
- Professional = R277CAJ
- Institutional = R277CAQ

**BCBSM/BCN Transaction:** 277x228

Trading partners can identify pended claims by the claim status and category codes returned in the STC segment of Loop 2200D of the transaction, or by the codes and message shown on the report. For example:

**Transaction:** STC*P5:734

**Report:** P5 734 Pending – verifying premium payment

Providers can read more about the Advance Premium Tax Credit grace period in the February 2014 edition of *The Record*.

If you have questions about a submitter set up or require assistance, email us at EDICustMgmt@bcbsm.com.

26. BCBSM Medicare Advantage PPO program ending its contract with CarePlus, effective June 13, 2014

**Category:** Medicare Advantage

**Title:** BCBSM Medicare Advantage PPO program ending its contract with CarePlus, effective June 13, 2014

**Start Date:** March 20, 2014 **End Date:** April 3, 2014
Effective June 13, 2014, Blue Cross Blue Shield of Michigan’s Medicare Advantage PPO will end the CarePlusSM home-based care management program that was provided for select members.

Current CarePlus members will be notified by the CarePlus vendor that the program will end in June. We are developing a transition plan for those who may still need home visits after June 13 and will advise you when we have further details.

You may receive phone calls from the CarePlus vendor regarding members who are currently enrolled with CarePlus.

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

27. Provider Enrollment and Change Self-Service unavailable this weekend

   Category: Miscellaneous
   Title: Provider Enrollment and Change Self-Service unavailable this weekend

   Start Date: March 21, 2014    End Date: March 24, 2014

   The Provider Enrollment and Change Self-Service application will be unavailable beginning at 9 p.m. on Friday, March 21, through 7 p.m. Saturday, March 22, for system maintenance. This means you won’t be able to access Provider Enrollment and Change Self Service during this time.

   We apologize for this inconvenience.

28. Possible fee reduction for BCN AdvantageSM providers

   Category: BCN Advantage
   Title: Possible fee reduction for BCN AdvantageSM providers

   Start Date: March 21, 2014    End Date: April 15, 2014

   On December 26, 2013, President Obama signed into law the Pathway for SGR Reform Act of 2013. This new law prevented a scheduled payment reduction of 20.1 percent for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. The new law also provided for a 0.5 percent increase for such services through March 31, 2014.

   The current fee schedule will expire on March 31. Effective April 1 the fee schedule reverts to the old formula with the flawed sustainable growth rate factor resulting in a 23.7 percent reduction from current rates. BCN anticipates that Congress will take the appropriate action by mid April with another temporary fix by extending the current fee
schedule as they’ve done in the past. BCN Advantage claims will be held through the month of April as Congress works through this issue. More information will be posted here once it is available.

29. Oncology Pathway Program claims payment adjusted

**Category:** Oncology Pathway Program claims

**Title:** Oncology Pathway Program claims payment adjusted

**Start Date:** March 21, 2014    **End Date:** April 4, 2014

We are starting to adjust incorrect payments made on Oncology Pathway Program claims from Nov. 15, 2013, through Jan. 31, 2014. Affected health care providers will see these adjustments on their vouchers in the coming weeks.

We previously notified you of incorrect payments for these claims, which were paid according to the physician fee schedule instead of the oncology fee schedule. We also asked that you not submit status claims because we would automatically recover the incorrect payments.

We apologize for any inconvenience this may have caused.

30. Out-of-state alpha prefix list

**Category:** Claims

**Title:** Out-of-state alpha prefix list

**Start Date:** March 21, 2014    **End Date:** April 4, 2014

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

To access the list:
- Log onto web-DENIS
- Click on *BCBSM Provider Publication and Resources*
- Click on *BCBSM Newsletters and Resources*
- Click on *Clinical Criteria and Resources*
- Scroll to the section *Alpha prefixes*
- Click on *Out of state alpha prefixes*
31. BCBSM Medicare Advantage PPO claims system updated for post-cataract surgery glasses and contacts services

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO claims system updated for post-cataract surgery glasses and contacts services

Start Date: March 21, 2014   End Date: April 4, 2014

We updated our claims system on Jan. 22, 2014, to process claims for glasses and contacts provided after cataract surgery as in-network benefits. Claims prior to this update were processed as out-of-network.

For claims processed after Jan. 22, members’ Explanation of Benefits statements will show providers’ true network status, but member cost-sharing will reflect the in-network rate.

We’re adjusting claims that were processed before Jan. 22, 2014, reporting these services provided after cataract surgery.

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

32. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: March 24, 2014   End Date: April 7, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Mar. 24, 2014

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

These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources, by selecting Entire Fee Schedules and Fee Changes.
33. Headline: BCBSM commercial Health e-Blue delayed

Category: Headline: BCBSM commercial Health e-Blue delayed

Title: Headline: BCBSM commercial Health e-Blue delayed

Start Date: March 25, 2014    End Date: April 30, 2014

BCBSM continues to conduct system testing and quality checks for the new BCBSM commercial version of Health e-BlueSM. Due to this effort, BCBSM Health e-Blue will not go live on April 1, 2014 as previously communicated. Watch here for a future alert when the BCBSM commercial Health e-Blue application goes live.

34. Precertification Services experiencing high processing volumes

Category: Precertification

Title: Precertification Services experiencing high processing volumes

Start Date: March 25, 2014    End Date: April 14, 2014

BCBSM’s Medicare Advantage PPO and commercial Precertification Services department is experiencing delays in processing care requests due to a high fax submission volume.

A critical access line is available at 313-448-3619 for immediate requests or inquiries.

We apologize for any inconvenience that this may cause. Thank you for your patience.

35. All institutional trading partners

Category: Correction to F129 edit for institutional claims

Title: All institutional trading partners

Start Date: March 25, 2014    End Date: April 25, 2014

On May 19, 2014, BCBSM will implement a correction to edit F129 OPERATING PHYSICIAN INFORMATION MISSING/INVALID. The edit will now apply to institutional claims when surgical procedures are reported.

Going forward, an operating physician name and NPI must be reported in Loop 2310B Segments NM102 and NM109 when:

- A principal procedure is reported on inpatient claims in Loop 2300 with a ‘BR’ qualifier in Segment HI01-1, or
HCPCS Codes in the range of 10,000-35,414 and 36,416-69,999 are reported in Loop 2400 with a ‘HC’ qualifier in Segment SV2.

Institutional claims not following these guidelines will receive the F129 edit on a R277CAI report or 277CA transaction. All edited claims must be corrected and resubmitted.

If you have questions regarding the edit or require additional information, contact the EDI help desk at 1-800-542-0945.

36. All institutional trading partners

**Category:** Correction to F129 edit for institutional claims

**Title:** All institutional trading partners

**Start Date:** March 25, 2014    **End Date:** April 25, 2014

On May 19, 2014, BCBSM will implement a correction to edit F129 OPERATING PHYSICIAN INFORMATION MISSING/INVALID. The edit will now apply to institutional claims when surgical procedures are reported.

Going forward, an operating physician name and NPI must be reported in Loop 2310B Segments NM102 and NM109 when:

- A principal procedure is reported on inpatient claims in Loop 2300 with a ‘BR’ qualifier in Segment HI01-1, or
- HCPCS Codes in the range of 10,000-35,414 and 36,416-69,999 are reported in Loop 2400 with a ‘HC’ qualifier in Segment SV2.

Institutional claims not following these guidelines will receive the F129 edit on a R277CAI report or 277CA transaction. All edited claims must be corrected and resubmitted.

If you have questions regarding the edit or require additional information, contact the EDI help desk at 1-800-542-0945.

37. BCBSM Medicare Advantage begins provider medical record requests for Post Encounter Morbid Obesity Initiative

**Category:** Medicare Advantage

**Title:** BCBSM Medicare Advantage begins provider medical record requests for Post Encounter Morbid Obesity Initiative
Blue Cross Blue Shield of Michigan’s Medicare Advantage PPO will mail letters requesting medical records to health care providers beginning March 28, 2014. The letters will request selected medical records for dates of service from Jan. 1, 2013, to Dec. 31, 2013.

The Centers for Medicare & Medicaid Services requires Medicare Advantage plans to submit detailed, ongoing documentation about each member. Requested medical records should include patient history and physical exam, physician progress notes, consultations and procedures.

We ask that you please return the needed documents within two weeks. BCBSM will reimburse you $5 for each medical record. Records can be submitted to us by fax or mail as detailed in the request letter. A reimbursement request form will also be included in this mailing.

Thank you in advance for your cooperation. If you have any questions, please contact your provider consultant.

38. BCBSM Medicare Advantage electronic funds transfer payment issue

Category: Medicare Advantage

Title: BCBSM Medicare Advantage electronic funds transfer payment issue

Start Date: March 26, 2014    End Date: April 14, 2014

We’ve identified a claims system issue that affects this week’s electronic funds transfer payments for our Medicare Advantage providers. Due to this issue, if you normally receive payments via the EFT process, you may receive paper checks for the March 27, 2014, payment.

We’re working to resolve this issue before the next EFT payment cycle and will keep you updated if that changes. Once this issue is fixed, you will once again receive your payments via the normal EFT process.

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

39. BCBSM electronic trading partners, vendors and clearinghouses

Category: UPDATE – Correction to professional edit P952 for duplicate CAS codes

Title: BCBSM electronic trading partners, vendors and clearinghouses
On Jan 23, 2014 BCBSM communicated that professional edit P952 ‘Duplicate Claim Adjustment Group Code Reported’ was erroneously rejecting some tertiary claims. In response, we temporarily revised the edit to apply to BCBSM and commercial claims only.

The edit issue is now resolved. Effective April 7, 2014, edit P952 will be applied to all sources of payment (BL, CI, MB, MC, FI or HM) when a Claim Adjustment Group Code of CO, OA, PI or PR is duplicated within a single CAS segment in Loop 2430.

This edit will be returned using a R277CAH report or 277CA transaction:

Transaction: A3 696
Report: P952 Duplicate Claim Adjustment Group Code Reported

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

If you have any questions regarding the edits or require additional information, contact the EDI help desk at 1-800-542-0945.

40. Additional counties to transition out of MIChild Blue Cross PPO coverage on April 1

Category: MIChild

Title: Additional counties to transition out of MIChild Blue Cross PPO coverage on April 1

Start Date: March 27, 2014   End Date: April 10, 2014

The following counties will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for their medical, pharmacy and vision benefits on April 1, 2014.

Three counties transitioning on April 1, 2014
- Clare
- Gladwin
- Roscommon

As we announced in the Sept. 2013 issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.
First transition happened on Oct. 1, 2013, and included these 34 counties:

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

Second transition happened on Nov. 1, 2013, and included these 13 counties:

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
<tr>
<td>Crawford</td>
<td>Ogemaw</td>
<td>Tuscola</td>
</tr>
<tr>
<td>Gratiot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Third transition happened on Dec. 1, 2013, and included these four counties:

<table>
<thead>
<tr>
<th>Clinton</th>
<th>Ingham</th>
</tr>
</thead>
</table>
Fourth transition happened on March 1, 2013, and included these two counties:

<table>
<thead>
<tr>
<th>Eaton</th>
<th>Isabella</th>
</tr>
</thead>
</table>

Hillsdale          Missaukee

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit [michigan.gov/michild](http://michigan.gov/michild). Click on *Information for MIChild Providers* then click on *MI Child Health Plan Service Contacts and Service Areas Listing*.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email *ProviderSupport@michigan.gov* for this information or with any questions you may have.

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

41. Proton beam therapy requires prior authorization

**Category:** Professional and Facility claims

**Title:** Proton beam therapy requires prior authorization

**Start Date:** March 27, 2014  **End Date:** August 1, 2014

Effective July 1, 2014, Blue Cross Blue Shield of Michigan will require preauthorization for both in-state and out-of-state providers for proton beam therapy services. This affects procedure codes *77520, *77522, *77523, *77525 and revenue code 0333.

The referring health care provider needs to submit a written request and include the following: dates of service, radiology report and rationale to support medical necessity, diagnosis codes, procedure codes, charges and planned duration of treatment.

Mail or fax preauthorization requests to:

**Write:**
Preauthorization, Provider Inquiry Services
Blue Cross Blue Shield of Michigan
P.O. Box 2227
Detroit, MI 48231-2227

**Fax:**
1-866-311-9603
Attn: Preauthorization, Provider Inquiry Services.

BCBSM Provider Inquiry will review the requests and respond to the provider with a letter explaining what preauthorization covers. The provider must adhere to the terms of the letter.

Note: In-state services will only be approved as facility services.

Please copy and paste the following URL in your Internet browser to review the inclusionary and exclusionary guidelines for Charged-Particle (Proton or Helium Ion) Radiation Therapy:

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

42. BCBSM to update claims system when Medicare fee schedule and pricer updates are released

Category: Medicare Advantage

Title: BCBSM to update claims system when Medicare fee schedule and pricer updates are released

Start Date: March 27, 2014    End Date: April 11, 2014

The Centers for Medicare & Medicaid Services will update its quarterly Medicare fee schedule and pricer, effective April 1, 2014. Blue Cross Blue Shield of Michigan will update its system accordingly for Medicare Advantage PPO.

As we prepare for these CMS updates, there are two potential situations that may impact how and when claims with dates of service April 1 or later will be paid:

- If CMS does not publish the complete updated fee schedule and pricers by April 1, BCBSM will continue to pay Medicare Advantage PPO claims at the current rate and automatically make adjustments later.

  Once we get the information from CMS to update the pricer, we’ll publish a follow-up web-DENIS message.

- If CMS does publish the updated fee schedule and pricers by April 1, BCBSM’s Medicare Advantage system still requires some time to make the update. In this situation, BCBSM will hold claims until the systems update to match the CMS fee schedule and pricer are complete.
We will publish information here on web-DENIS when we have more details about the fee schedule and pricer updates.

43. All institutional trading partners

Category: Correction to F129 edit for institutional claims

Title: All institutional trading partners

Start Date: March 27, 2014    End Date: April 25, 2014

This message was posted on March 25, 2014 with an incorrect HCPCS code range of 10,000-35,414. The message should have stated ‘HCPCS Codes in the range of 10,000-36,414 and 36,416-69,999’. The message below is now correct:

On May 19, 2014, BCBSM will implement a correction to edit F129 OPERATING PHYSICIAN INFORMATION MISSING/INVALID. The edit will now apply to institutional claims when surgical procedures are reported.

Going forward, an operating physician name and NPI must be reported in Loop 2310B Segments NM102 and NM109 when:

- A principal procedure is reported on inpatient claims in Loop 2300 with a ‘BR’ qualifier in Segment HI01-1, or
- HCPCS Codes in the range of 10,000-36,414 and 36,416-69,999 are reported in Loop 2400 with a ‘HC’ qualifier in Segment SV2.

Institutional claims not following these guidelines will receive the F129 edit on a R277CAI report or 277CA transaction. All edited claims must be corrected and resubmitted.

If you have questions regarding the edit or require additional information, contact the e-BIG EDI Business help desk at 1-800-542-0945.

44. Presentations from Michigan Hospital Network session in Southfield now available

Category: Forums

Title: Presentations from Michigan Hospital Network session in Southfield now available

Start Date: March 28, 2014    End Date: April 11, 2014

The presentations made at the Michigan Hospital Network session in Southfield on Tuesday, March 25, 2014 are now available on web-DENIS to all hospitals that weren’t
able to make the event. To access the presentations given during the session, log in to web-DENIS:

1. Click on *BCBSM Provider Publications and Resources*.

2. Click on *Newsletters and Resources*.

3. In the “What’s New” section, find Presentations from **03/25/14** Michigan Hospital Networking session. Click on the presentation to open.

All the presentation from forums and provider fairs in the past year can also be found on the Provider Training page.

Thank you to all who attended.

45. All professional electronic submitters

   **Category:** Processing delay for professional 837 claims reporting specialty pharmacy services

   **Title:** All professional electronic submitters

   **Start Date:** March 28, 2014    **End Date:** April 11, 2014

   Due to a technical issue, some professional claims containing specialty pharmacy services will not make this week’s check writing cycle. Impacted claims were submitted between 9:00 am on Thursday, 03/27/2014 and 9:00 am on Friday, 03/28/2014.

   Delayed claims will be processed by Monday, 03/31/2014 and will be included in check date 04/04/2014.

   We apologize for any inconvenience this may cause.

46. BCN EFT payment error

   **Category:** BCN EFT

   **Title:** BCN EFT payment error

   **Start Date:** March 28, 2014    **End Date:** April 11, 2014

   BCN providers who had claims with a payment date of March 24, 2014 received their payments via electronic funds transfer on March 28. However, these providers will see three transactions in their accounts. BCN experienced a problem with the first transaction file. Thus, a second transaction was necessary to reverse the first transaction. The third
transaction was the accurate payment. We apologize for any confusion caused by the additional transactions in your accounts.

47. All professional electronic trading partners

**Category:** Correct reporting of National Drug Code quantities in professional claims

**Title:** All professional electronic trading partners

**Start Date:** March 28, 2014  **End Date:** April 25, 2014

Blue Cross Blue Shield of Michigan recently announced that we can accept professional claims with NDC quantities up to 99,999,999.999 and HCPCS drug units up to 9,999.9 on a single service line. These changes allow professional practitioners to submit claims without having to split NDC quantities between multiple service lines.

There has been some confusion about how to report the expanded quantities on electronic 837 claims. To clarify, professional claims must follow these requirements:

- **HCPCS units** are reported at service line level in **Loop 2400** Segment SV1-04. This includes Drug Service Line HCPCS quantities. HCPCS unit quantities cannot exceed 8 digits, excluding the decimal (xxxxx.xxx).

  For example, if the HCPCS is for one injection, the quantity reported in SV1-04 is 1: **SV1*HC>Jxxxx*8*UN*1***1~

- **NDC quantities** are reported at service line level in **Loop 2410** Segment CTP-04, together with the Unit of Measurement Code in CTP-05. NDC quantities cannot exceed 11 digits, excluding the decimal (xxxxxxxx.xxx).

  For example, if the NDC quantity for the J code injection is 60 milligrams, the quantity reported in CTP-04 is 60 and the value in CTP-05 is **ME:**

    **CTP****60*ME~

  Acceptable unit of measurement values for CTP-05 are F2 (international unit), GR (gram), ME (milligram), ML (milliliter) or UN (unit).

- **Claims for compound drugs** must follow ANSI 837P Technical Report Type 3 guidelines (Section 1.11.2). The TR3 requires reporting of a SV1 segment in Loop 2400 and a LIN segment and CTP segment in Loop 2410 for each ingredient in the compound drug.

- As a reminder, all claims reporting an NDC quantity must include the 11 digit NDC code (5-4-2 format) in Loop 2410 Segment LIN-03, with qualifier N4 in LIN-02.

For questions regarding 837 reporting requirements, call the EDI Helpdesk at 1-800-542-0945. For hardcopy claim questions, contact your Provider Consultant.

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

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

Start Date: March 29, 2013    End Date: TBD

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

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

49. Additional facility fee schedules added to web-DENIS

Category: Claims

Title: Additional facility fee schedules added to web-DENIS

Start Date: March 31, 2014    End Date: April 30, 2014

BCBSM recently added these additional fee schedules to web-DENIS resulting from fee updates effective July 1, 2014:

Ambulatory Infusion Center

- Ambulatory Infusion Center fees effective 7/01/14

Ambulatory Surgery Facility

- ASF HCPCS fees effective 7/1/14

Freestanding Outpatient Physical Therapy Facility

- OPT fees effective 7/1/14

Hospice Rates

- Hospice Revenue Code 0657 CPT Code Fee Schedule (to include the 7/1/14 CPT fees)

Hospital Outpatient Fee Schedules

- HCPCS fees effective 07/01/14

Outpatient Psychiatric Care Facility
• OPC Traditional and Mental Health Managed Care Program Fees (7/1/14)

In addition, entire fee schedules that are over 3 years old have been removed.

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

For more information, contact your BCBSM provider consultant.

50. Additional professional fee schedules added to web-DENIS

Category: Claims

Title: Additional professional fee schedules added to web-DENIS

Start Date: March 31, 2014   End Date: April 30, 2014

BCBSM recently added these additional fee schedules to web-DENIS resulting from fee updates effective July 1, 2014:

**Independent LAB Fee Schedule**

• Independent Lab Fee Schedule (7/1/14)

**Traditional Fee Schedule**

• Traditional Fee Schedule (7/1/14) (Excel)
• Traditional Fee Schedule (7/1/14) (PDF)
• Traditional ANESTHESIA MAXIMUM PAYMENT SCHEDULE (7/1/14) (Excel)

**TRUST PPO Fee Schedule**

• TRUST PPO Fee Schedule (7/1/14) Excel
• TRUST PPO Fee Schedule (7/1/14) (PDF)
• TRUST PPO ANESTHESIA MAXIMUM PAYMENT SCHEDULE (7/1/14) (Excel)

**BPP Fee Schedule Fee Schedule**
• BPP Fee Schedule (7/1/14) (Excel)
• BPP Fee Schedule (7/1/14) (PDF)
• BPP ANESTHESIA MAXIMUM PAYMENT SCHEDULE (7/1/14) (Excel)

State of Michigan Mental Health Managed Care Program Professional Fee Schedule
• SOM Mental Health Managed Care Program (7/1/14) (Excel)
• SOM Mental Health Managed Care Program (7/1/14) (PDF)

DME/P&O Fee Schedule
• DME/P&O Fee Schedule (effective 7/1/14)

In addition, entire fee schedules that are over 3 years old have been removed.

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

For more information, contact your BCBSM provider consultant.
Web-DENIS messages April 2014
1. Prior authorization to be required for additional specialty drugs

**Category:** Specialty drugs for professional medical drug claims

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

**Start Date:** April 1, 2014   **End Date:** August 1, 2014

Thirteen additional specialty drugs administered by health care practitioners will require prior authorization by BCBSM in order to be covered under members’ medical benefits, starting July 1, 2014.

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bivigam™</td>
<td>J1556</td>
</tr>
<tr>
<td>Carimune® NF</td>
<td>J1566</td>
</tr>
<tr>
<td>Febogamma® DIF</td>
<td>J1572</td>
</tr>
<tr>
<td>Gammagard® Liquid or S/D</td>
<td>J1569</td>
</tr>
<tr>
<td>Gammaplex®</td>
<td>J1557</td>
</tr>
<tr>
<td>Gamunex® (IV and SubQ)</td>
<td>J1561</td>
</tr>
<tr>
<td>Hizentra® (SubQ only)</td>
<td>J1559</td>
</tr>
<tr>
<td>Octagam®</td>
<td>J1568</td>
</tr>
<tr>
<td>Privigen®</td>
<td>J1459</td>
</tr>
<tr>
<td>Ig, IV injection, NOS</td>
<td>J1599</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90283</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90284</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90399</td>
</tr>
</tbody>
</table>

Please refer to the opt-out list for the groups that do not require members to participate in the program.

**The following drugs continue to require prior authorization**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actemra®</td>
<td>J3262</td>
</tr>
<tr>
<td>Acthar® gel</td>
<td>J0800</td>
</tr>
<tr>
<td>Benlysta®</td>
<td>J0585</td>
</tr>
<tr>
<td>Botox®</td>
<td>J0586</td>
</tr>
<tr>
<td>Dysport®</td>
<td>J0638</td>
</tr>
<tr>
<td>Ilaris®</td>
<td>J2507</td>
</tr>
<tr>
<td>Nplate®</td>
<td>J2796</td>
</tr>
<tr>
<td>Ocrevus®</td>
<td>J0129</td>
</tr>
<tr>
<td>Prolia®</td>
<td>J0897</td>
</tr>
<tr>
<td>Simponi®</td>
<td>J1602</td>
</tr>
<tr>
<td>Aria™</td>
<td>J1300</td>
</tr>
<tr>
<td>Soliris®</td>
<td>J3357</td>
</tr>
<tr>
<td>Stelara®</td>
<td>J0588</td>
</tr>
</tbody>
</table>
You can find the Medication Authorization Request Forms on the web-DENIS BCBSM Newsletters and Resources page. Click on Physician administered medications on the right side of the screen, under “Frequently Used Forms.”

2. BCBSM electronic provider manuals — March 2014 changes

Category: Online Manuals

Title: BCBSM electronic provider manuals — March 2014 changes

Start Date: April 1, 2014   End Date: April 15, 2014

These are the chapters we revised in March 2014, along with the revision date and a brief statement of the main changes for each.*

• **Blue Pages Directory** (3/6/2014)
  - “Changing your name, address or other information” — Added new info to the "Physician and other professional providers" section.
  - "Claims, status inquiries and claim resubmissions - paper" — Added "claim resubmissions" to the title and in the section’s contents.
  - "Federal Employee Program" — To the "paper claims" section, added "claim resubmission."
  - "Physician Ombudsman" — Added "claim resubmission" as part of the second step for resolving issues.

• **Hospital** (3/4/2014)
  - “Overview” — Created a section for general hospital definitions.
  - “Emergency treatment” — Added a definition for “accidental injury.”
  - “Maternity care and delivery” — Updated the definition for “maternity care.”

• **Medical-Surgical Services** (3/6/2014)
  - “Emergency treatment” — Added a definition for “accidental injury.”
  - “Injectable drugs” — Added a definition for “biological.”
  - “Maternity care and delivery” — Updated the definition for “maternity care.”
  - “Private duty nursing” — Added the stipulation that skilled care must be ordered by the attending physician.

• **Mental Health and Substance Abuse Managed Care Program** (3/4/2014)
  - “Definitions” — Added a definition for “psychiatric care.”

• **Outpatient Diabetes Management: Billing and Reimbursement** (3/5/2014)
  - “Progress notes” — Updated billing instructions about ICD diagnosis codes.
  - “Supplies and equipment” — Updated billing instructions about ICD diagnosis
codes.
- **Outpatient Diabetes Management Program** (03/07/2014)
  - “Coverage” — Added a note about the diabetes diagnosis requirement for services to be covered under the state mandate.

- **Physical Therapy, Occupational Therapy, and Speech Therapy Services** (3/4/2014)
  - “Overview” — In the “Definitions” section, added a new definition for “developmental condition” and updated the definition for “freestanding outpatient physical therapy.”
  - “Physical therapy services” — In the “Covered services” section, added EMGs and nerve conduction tests to the list of items in the initial evaluation to develop a treatment plan.

- **PPO Policies** (3/5/2014)
  - "Overview" — Deleted physician assistants from the list of provider types not included in the PPO network and added PAs to the list of provider types in the "TRUST Practitioner Network."

- **Problem Resolution** (3/5/2014)
  - "Channels of inquiry" — In the “Provider Inquiry” section, added information about claim resubmission.

- **Psychiatric Care Services** (3/4/2014)
  - “Definitions” — Added definitions for “advanced practice psychiatric nurse” and “clinical licensed master’s social worker.”

- **Serious Adverse Events Policy** (3/6/2014)
  - Overhauled the entire chapter.

- **Vision Care Program: Billing and Reimbursement** (03/05/2014)
  - “Glaucoma staging diagnosis codes” — Updated billing instructions about ICD diagnosis codes.

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

3. All Blue Cross Complete electronic submitters

**Category:** Delayed Blue Cross Complete 835 remittance files

**Title:** All Blue Cross Complete electronic submitters

**Start Date:** April 2, 2014  **End Date:** April 16, 2014

Blue Cross Complete 835 remittance files for check date 04/01/2014 have been delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience.
4. BCBSM Medicare Advantage PPO claims for clinical lab and physical therapy services incorrectly paid at 2013 rates

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO claims for clinical lab and physical therapy services incorrectly paid at 2013 rates

Start Date: April 3, 2014    End Date: April 18, 2014

We’ve identified that recent BCBSM Medicare Advantage PPO claims for clinical lab and physical therapy services have been paid at 2013 Centers for Medicare & Medicaid Services rates, instead of 2014 rates.

We will automatically reprocess claims that were paid incorrectly by the April 8, 2014, check run.

We apologize for any inconvenience this issue has caused. Thank you for your patience. If you have any questions, please contact your provider consultant.

5. BCBSM will hold claims to be paid under the Medicare physician fee schedule, following CMS instructions

Category: Medicare Advantage

Title: BCBSM will hold claims to be paid under the Medicare physician fee schedule, following CMS instructions

Start Date: April 4, 2014    End Date: April 18, 2014

Blue Cross Blue Shield of Michigan will hold claims to be paid under the Medicare physician fee schedule, following Centers for Medicare & Medicaid Services instructions.

The Pathway for Sustainable Growth Rate Reform Act of 2013 that delayed the reimbursement reduction for claims paid at the Medicare physician fee schedule ended March 31, 2014. CMS instructed Medicare administrative contractors like BCBSM to hold any related claims paid under that fee schedule for the first 10 business days of April to allow for congressional action that may prevent the reduction. President Barack Obama has signed this legislation into law. We have no further information about April 1 fee updates and, therefore, will continue to hold claims, as CMS previously instructed.

This hold only affects claims paid at Medicare physician fee schedule rates with dates of service April 1, 2014, and later. All claims for services delivered on or before March 31, 2014, will be processed and paid under normal procedures.
Thank you for your patience. We will update you when we receive further instructions from CMS.

6. Save the date for hospital forum in Frankenmuth

Category: Forums

Title: Save the date for hospital forum in Frankenmuth

Start Date: April 7, 2014    End Date: April 25, 2014

The annual hospital forum, sponsored by the Benefit Administration Committee, is scheduled for Tuesday, June 10, 2014, for all hospital billing staff, managers and directors. This year’s forum will once again be held at the Frankenmuth Bavarian Inn Lodge.

The event includes information on web-DENIS, BlueCard®, Medicare Advantage and ICD-10. Look to the May issue of The Record for registration information.

7. 2014 BCN AdvantageSM Ambulatory Surgery Center payment issue

Category: BCN Advantage

Title: 2014 BCN AdvantageSM Ambulatory Surgery Center payment issue

Start Date: April 7, 2014    End Date: April 21, 2014

This communication is intended for Ambulatory Surgery Centers who submit claims on behalf of BCN Advantage members only.

The 2014 reimbursement amount to some Ambulatory Surgery Centers is incorrect. Initially, there was a delay in adding the 2014 rates to our software. That issue was corrected in March; however there is a new issue in that the wage index factor is incorrect for some facilities. This will be corrected in early May.

BCN Advantage will automatically adjust claims paid incorrectly approximately the third week in May.

8. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: April 7, 2014    End Date: April 21, 2014
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Apr. 7, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
- Facility
  - Outpatient Hospital
  - Outpatient Psychiatric Care

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

9. BRCA testing now available locally

Category: Laboratory services for Blue Care Network HMO SM and Blue Care Network Advantage SM members

Title: BRCA testing now available locally

Start Date: April 8, 2014    End Date: April 22, 2014

A full complement of BRCA testing is now available locally through the Molecular Genetics Laboratory, part of the MLabs TM Michigan Medical Genetics Laboratories. For BCN HMO (commercial) and BCN Advantage members, the testing must be authorized through Joint Venture Hospital Laboratories prior to the service being rendered.

The following test options are available:

<table>
<thead>
<tr>
<th>Test</th>
<th>Order Code</th>
<th>CPT code</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRCA1 Gene Sequencing</td>
<td>BRCA1</td>
<td>*81214</td>
</tr>
<tr>
<td>BRCA2 Gene Sequencing</td>
<td>BRCA2</td>
<td>*81216</td>
</tr>
<tr>
<td>BRCA1 Deletion/Duplication Analysis</td>
<td>BRC1D</td>
<td>*81213</td>
</tr>
<tr>
<td>BRCA2 Deletion/Duplication Analysis</td>
<td>BRC2D</td>
<td>*81213</td>
</tr>
<tr>
<td>BRCA1 and BRCA2 Gene Sequencing (Tier 1)</td>
<td>BRC1</td>
<td>*81211</td>
</tr>
<tr>
<td>BRCA1 Targeted Sequencing, Familial</td>
<td>BR1F</td>
<td>*81215</td>
</tr>
<tr>
<td>BRCA2 Targeted Sequencing, Familial</td>
<td>BR2F</td>
<td>*81217</td>
</tr>
<tr>
<td>BRCA Ashkenazi Jewish Founder Mutations</td>
<td>BRAJ</td>
<td>*81212</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>BRCP Panel (includes Tier 1 and Tier 2)</td>
<td>BRCP1</td>
<td>*81211 and *81213</td>
</tr>
</tbody>
</table>

Here is some important information about ordering:

- For test descriptions and guidelines for specimen collection and handling, visit the [MLabs website](https://www.mlabs.com).
- For instructions for transporting specimens, call 1-800-862-7284 or visit the [MLabs Submit Specimens Web page](https://submit.mlabs.com).
- For a sample test requisition form, visit the [MLabs Test Requisitions Web page](https://www.mlabs.com/test-requisitions).
- For a sample MLabs informed consent form, click on the [Request and Consent to Genetic Testing](https://www.mlabs.com/consent).

For questions about the BRCA testing options or processes for ordering, please contact the MLabs Client Services Center at 1-800-862-7284.

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10. Reminder: Reconciling mental health claims

    **Category:** Professional and Facility OPC claims
    **Title:** Reminder: Reconciling mental health claims
    **Start Date:** April 8, 2014  **End Date:** April 22, 2014

    When you’re reconciling mental health claims, keep in mind that some members have psychiatric managed care. These claims are reimbursed at Blue Preferred Plus rates—a different rate than other mental health claims.

11. Blues’ Medicare Advantage Health Assessment

    **Category:** BCBSM and BCN Medicare coverage
    **Title:** Blues’ Medicare Advantage Health Assessment
    **Start Date:** April 8, 2014  **End Date:** April 22, 2014

    The Patient Protection & Affordable Care Act and the Centers for Medicare & Medicaid Services require providers to review results of a health assessment and other medical techniques to create a personalized prevention plan for all Medicare beneficiaries. The PPACA and CMS require that an effort to have a health assessment, customized for older
adults, completed before or during a member’s annual wellness visit be made. The *Blues’ Medicare Advantage Health Assessment*, introduced in 2013, is a key opportunity for you and your patients to discuss their past and current health status, including potential health risks, medical conditions, medications, activities of daily living, and suggested services.

The *Blues’ Medicare Advantage Health Assessment* is for Blue Cross Blue Shield of Michigan and Blue Care Network members with Medicare Plus Blue PPO℠, Medicare Plus Blue Group PPO℠, BCN Advantage℠ HMO-POS, BCN Advantage℠ HMO Local and BCN Advantage℠ HMO MyChoice Wellness coverage.

Members are offered the health assessment via mail, telephone, online, and at your office. Physicians may assist members in completing the assessment by accessing a blank copy via Web DENIS. Members who complete and return it will receive a personalized letter identifying health topics they are encouraged to discuss with their physicians. BCN Advantage providers can access completed Blues Medicare Advantage Health Assessment responses for their BCN Advantage patients on Health e-Blue℠.

For additional details about this health assessment, see the [January 2013 Record](#).

12. All Internet Claim Tool Users

**Category:** System Enhancements/Internet Explorer IE8

**Title:** All Internet Claim Tool Users

**Start Date:** April 9, 2014    **End Date:** April 23, 2014

System enhancements were implemented on 4/6/2014. As a result some users accessing the ICT with IE8 are unable to view all Icons on the new Navigation Bar. The following action is recommended:

Turn off compatibility mode in the IE window. The icon is usually contained in the address bar and appears like a broken page. After compatibility mode is off when viewing a claim hold down the CTRL & F5 keys at the same time. This should resolve the issue if compatibility mode is off.

If this does not resolve your issue we recommend you upgrade to IE9.

13. Reminder: How to use Outpatient Prospective Payment System 13X, 14X type-of-bill codes for BCBSM Medicare Advantage PPO claims

**Category:** Medicare Advantage

**Title:** Reminder: How to use Outpatient Prospective Payment System 13X, 14X type-of-bill codes for BCBSM Medicare Advantage PPO claims
As of Jan. 1, 2014, the payment for most laboratory tests is processed through the Outpatient Prospective Payment System. Here’s a reminder of how to bill for services and the exceptions to keep in mind:

<table>
<thead>
<tr>
<th>Type of bill</th>
<th>Service</th>
<th>Exceptions</th>
</tr>
</thead>
</table>
| 13x          | Lab tests   | Hospitals and other providers can bill separately for lab tests outlined in the [Centers for Medicare & Medicaid Services guidelines*](https://www.cms.gov/).  
In addition, laboratory tests for molecular pathology tests, CPT codes **81200 through **81383, **81400 through **81408 and **81479 are not packaged in the OPPS and should be billed with type-of-bill code 13X. |
| 14x          | Clinical lab| Hospitals and other providers can only use type-of-bill code 14X for the excluded scenarios found in the CMS hyperlink above to allow for billing and payment at the clinical laboratory fee schedule rate.  
Use type-of-bill code 14X if the hospital only provides lab tests (either directly or under arrangement) and the patient doesn’t receive other hospital outpatient services during that same encounter.  
There is one scenario that can change the normal 14X billing process. This process, outlined below, was effective Jan. 1, 2014.  
In the following scenario, if all conditions are met, the lab test should be billed with type-of-bill code 14X and other hospital outpatient services should be billed with type-of-bill code 13X.  
   - The lab test is provided during the same encounter as the other hospital... |
<table>
<thead>
<tr>
<th>14x</th>
<th>Non-patient laboratory specimen tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use type-of-bill code 14X and bill Joint Venture Hospital Laboratories directly.</td>
<td></td>
</tr>
<tr>
<td>(Note: Only JVHL contracted providers should bill JVHL directly.)</td>
<td></td>
</tr>
</tbody>
</table>

It is the hospital’s responsibility to determine when laboratory tests may be separately billed with type-of-bill code 14X under these limited exceptions.

<table>
<thead>
<tr>
<th>14x</th>
<th>Non-patient laboratory specimen tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use type-of-bill code 14X and bill Joint Venture Hospital Laboratories directly.</td>
<td></td>
</tr>
<tr>
<td>(Note: Only JVHL contracted providers should bill JVHL directly.)</td>
<td></td>
</tr>
</tbody>
</table>

- The lab test is clinically unrelated to the other hospital outpatient services and
- The lab test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services.

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

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14. Updated BCN Behavioral Health forms now available

Category: Behavioral health services for Blue Care Network HMO<sup>SM</sup> and Blue Care Network Advantage<sup>SM</sup> members

Title: Updated BCN Behavioral Health forms now available

Start Date: April 11, 2014    End Date: April 25, 2014

Updated forms for use by BCN’s behavioral health providers are now available on the e-referral Behavioral Health Web page as follows:

- Behavioral Health Initial Outpatient Authorization Request Form
- Behavioral Health Continuing Outpatient Treatment Request Form
- Behavioral Health IP/PHP/IOP Concurrent Review Form

These forms are to be used with BCN HMO (commercial) and BCN Advantage members.

The revisions to the forms include:
Field for the DSM-5 diagnosis and reminder that authorization is not a guarantee of payment (Continuing Outpatient Treatment Request Form and IP/PHP/IOP Concurrent Review Form)

Fields for discharge date and number of additional outpatient sessions requested (Continuing Outpatient Treatment Request Form)

Updated examples for goals and objectives (Continuing Outpatient Treatment Request Form)

BCN Behavioral Health fax number changed to 1-866-364-7145 (all forms)

The forms are also available on the web-DENIS BCN Provider Publications and Resources page under the Behavioral Health and Forms sections, but providers can readily access them on the e-referral website under Behavioral Health without having to sign in.

15. Blue Cross Blue Shield of Michigan Medicare Advantage PPO claims adjusted for the 2013 sequestration show multiple Claim Adjustment Reason Codes on 835 remittance transmittal

Category: Medicare Advantage

Title: Blue Cross Blue Shield of Michigan Medicare Advantage PPO claims adjusted for the 2013 sequestration show multiple Claim Adjustment Reason Codes on 835 remittance transmittal

Start Date: April 11, 2014    End Date: April 25, 2014

Beginning in January 2014, claims that were processed in 2013 but required an adjustment due to the sequestration should have been communicated to providers through the 835 remittance transmittal with the Claim Adjustment Reason Code (CARC) of OA*253.

We have received calls that you are seeing multiple CARC codes on adjusted 2013 claims.

When the original claim was backed out and reprocessed due to the sequestration, you will see the old codes on the adjustment claim. In addition to the old codes that were valid at the times the claims were processed, the following are also listed:

PI*104             PI*223             OA*253

These codes indicate the claims were adjusted due to the sequestration. Approximately 10,000 claims have been affected by this issue.

Moving forward for 2014 dates of service, only code OA*253 will appear on the 835 remittance transmittal.
We apologize for any confusion this has caused. We are currently investigating this issue. If you have any questions, please contact your provider consultant.

16. Update: Blue Cross Blue Shield of Michigan Medicare Advantage PPO claims for clinical lab and physical therapy services incorrectly paid at 2013 rates

**Category:** Medicare Advantage

**Title:** Update: Blue Cross Blue Shield of Michigan Medicare Advantage PPO claims for clinical lab and physical therapy services incorrectly paid at 2013 rates

**Start Date:** April 11, 2014    **End Date:** April 25, 2014

On April 3, 2014, we advised providers that the clinical lab and physical therapy services claims that were paid at the 2013 rate would be reprocessed for the April 8, 2014 check run.

Due to unforeseen circumstances, this was not completed. Claims are now expected to be reprocessed by April 22, 2014.

We apologize for any inconvenience and thank you for your patience. If you have any questions, please contact your provider consultant.

17. Manufacturer recalls metformin XR extended release tablets, 500 mg

**Category:** Blue Cross Complete drug recall notification

**Title:** Manufacturer recalls metformin XR extended release tablets, 500 mg

**Start Date:** April 11, 2014    **End Date:** April 25, 2014

Sun Pharmaceutical, Inc. has announced a voluntary recall of one lot of metformin XR 500 mg tablets, lot number JKM2433A expiring 03/2016.

The recall is due to customer reports that bottles of Sun’s metformin XR 500 mg tablets contained gabapentin tablets in addition to the metformin XR tablets. Metformin XR is an anti-diabetic medication. Gabapentin is an anticonvulsant and is also used for neuralgia.

One or more of your Blue Cross Complete patients may have had a prescription filled for the affected metformin XR 500 mg tablets. If your patient is not taking this medicine, you do not have to take any action.

If you have questions about this recall, please call Caraco Drug Safety and Quality Complaints at 1-800-818-4555 ext. 4239. For more information, visit the FDA recall enforcement report website for the week of March 5, 2014.
18. All Blue Cross Complete trading partners

Category: Delayed Blue Cross Complete 277CA transactions/reports

Title: All Blue Cross Complete trading partners

Start Date: April 14, 2014    End Date: April 28, 2014

Due to a system issue, some Blue Cross Complete 277CA reports and transactions from March 28, 2014 through current have been delayed. All delayed 277CAs will be distributed by the end of the week.

We will provide an update when this issue has been resolved.

We apologize for any inconvenience.

19. BCBSM to require prior authorization for all prescriptions for hospice patients

Category: Medicare Advantage

Title: BCBSM to require prior authorization for all prescriptions for hospice patients

Start Date: April 16, 2014    End Date: May 16, 2014

Beginning May 1, 2014, all prescriptions for hospice patients will require prior authorization, to ensure hospice patients’ drug claims are paid under the correct plan.

When a patient enters hospice, drugs related to managing the terminal illness and its related conditions are covered under Part A. Prescriptions for conditions unrelated to the terminal illness may be covered under Part D.

If a hospice patient attempts to fill a prescription at a pharmacy, the claim will be rejected with the indication that prior authorization is required.

You can obtain prior authorization for hospice patients through the Pharmacy Services Clinical help desk at 1-800-437-3803.

If you’re not affiliated with your patient’s hospice program, we encourage you to coordinate care with that provider. This makes it easier for your patient to get future fills of their medications.

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

20. All Internet Claim Tool users

Category: Scheduled System Maintenance – April, 26 and 27, 2014
Title: All Internet Claim Tool users

Start Date: April 17, 2014   End Date: May 1, 2014

BCBSM will be performing system maintenance on Saturday, April 26th from 12:00 pm EST until Sunday, April 27th, 2014 6:00 am EST. You will be unable to access the internet claim tool system during this time period.

We apologize for any inconvenience this may cause.

21. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: April 21, 2014   End Date: May 5, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Apr.21, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus<sup>SM</sup>
  - Independent Lab
  - Injection
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

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

22. All BCBSM electronic trading partners

Category: Edits effective May 1, 2014 -BILLING NPI SUBMITTER ID COMBO NOT ON FILE (EDI Authorization file)

Title: All BCBSM electronic trading partners

Start Date: April 22, 2014   End Date: June 30, 2014

Informational edits F001i, P001i, P002i and P003i will convert to 'hard edits' that will reject the claims if the billing NPI is not authorized and linked to the submitter ID.
Beginning May 1, claims rejected with hard edits will appear on 277CAP transactions or 277CAH/277CAI reports:

Professional - Returned on a 277CAH report
- **A3 24 P001** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR BL OR HM
- **A3 24 P002** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR MB
- **A3 24 P003** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR CI

Institutional - Returned on a 277CAI report
- **A3 24 P001** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR ELEC BILLING

Rejected claims must be resubmitted. Prior to resubmission, providers must update their Provider Authorization Form to the correct billing NPI/submitter ID combination. Providers should validate their setup for all sources of payment (BL, HM, MA, MB, or CI).

Communication of the new edits was published in the July edition of The Record and a web-DENIS broadcast message on August 19, 2013.

For questions about claim edits, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945, Opt. 1. For assistance with updating your Provider Authorization form, select Opt. 3.

23. Some home health care claims not paying correctly for BCBSM Medicare Advantage PPO members

**Category:** Medicare Advantage

**Title:** Some home health care claims not paying correctly for BCBSM Medicare Advantage PPO members

**Start Date:** April 22, 2014  **End Date:** May 6, 2014

We’ve identified a system issue that is paying some home health care claims at a higher level than the Centers for Medicare & Medicaid Services approved amount. This issue affects dates of service Feb. 1, 2014, and after.

This error primarily affects in-state claims but may affect some out-of-state claims. The affected claims are currently being held until the issue is corrected.

Once the problem is fixed, we will automatically adjust the affected claims. There is no need to resubmit them. We will notify you in a web-DENIS alert when the issue is corrected.
We apologize for any inconvenience this may cause. Thank you for your patience. If you have any questions, please contact your provider consultant.

24. ICD-10 webinar scheduled for Monday, April 28 from 1-2 p.m.

Category: All Providers

Title: ICD-10 webinar scheduled for Monday, April 28 from 1-2 p.m.

Start Date: April 22, 2014   End Date: April 29, 2014

Now that the ICD-10 implementation has been postponed, health care providers can take advantage of the delay to ensure they’re ready for the switch to the new diagnosis code set. A complimentary webcast, “Use the ICD-10 Delay to Your Advantage,” delves into the top five important steps to focus on in the months ahead.

Education alone is not enough to ensure continued productivity. Other critical focus areas include implementing a clinical documentation improvement program, utilizing technology, code auditing and dual coding.

**Learning Objectives**

In this webcast, you will:

- Come to understand the impact of ICD-10 with productivity estimates
- Learn how to prepare for ICD-10
- Hear specific examples and real world experiences of successful ICD-10 preparations
- Understand why these steps significantly reduce your risk,

This webinar is scheduled for Monday, April 28 from 1 to 2 p.m. Eastern Time. To register for this webinar, click here. You will receive a confirmation email with instructions for joining the session.

Send an email to ICD-10providerreadiness@bcbsm.com if:

- You would like us to cover a specific topic in a future webinar, or you have questions related to ICD-10.
- Your organization would like to participate in a future webinar.
- You are having issues with the link above or logging into the call.

A link to the recorded webinar will be provided on web-DENIS after the session has been conducted. You can also view previously recorded Preeyse University ICD-10 webinars from January and March there.
25. BCBSM Medicare Advantage PPO physician office lab list updated, effective Jan. 1, 2013

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO physician office lab list updated, effective Jan. 1, 2013

Start Date: April 23, 2014   End Date: May 15, 2014

Blue Cross Blue Shield of Michigan is updating the physician office lab list to ensure claims are paid properly.

We’re removing procedure code *80101, as it is no longer recognized as a payable code by Medicare. Procedure code G0431 is being added to the physician office lab list to replace it.

We will identify all claims that were denied with dates of service between Jan. 1, 2013, and April 30, 2014, and reprocess these claims under procedure code G0431. This will ensure that you receive the appropriate payment and that the member is not liable.

Claims billed with procedure code *80101 for dates of service on or after May 1, 2014, will be denied, since this procedure code is no longer valid.

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

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26. FEP – System downtime for April 26, 2014

Category: System downtime notification

Title: FEP – System downtime for April 26, 2014

Start Date: April 23, 2014   End Date: April 29, 2014

There is scheduled maintenance on the Federal Employee Program (FEP) application. The maintenance will begin on Saturday April 26 at 1:30 am. Attempts to access the system to view FEP benefits or eligibility will result in errors. The maintenance will be completed on Saturday April 26, 2014 at 5:00 pm.

We apologize for any inconvenience this may cause.
27. Send requested medical records to the correct address for BCBSM Medicare Advantage PPO claims

**Category:** Medicare Advantage

**Title:** Send requested medical records to the correct address for BCBSM Medicare Advantage PPO claims

**Start Date:** April 25, 2014    **End Date:** May 10, 2014

There is some confusion about the correct address to send medical records to when requested by Blue Cross Blue Shield of Michigan for Medicare Advantage PPO claims.

To ensure timely processing, please send all requested medical records to:

Medicare Advantage PRS — Appeals
Attn: First Level Appeal
Blue Cross Blue Shield of Michigan
P.O. Box 33842
Detroit, MI 48232-5842

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

28. BCBSM Medicaid Eligibility Access

**Category:** System Maintenance on April 27, 2014

**Title:** BCBSM Medicaid Eligibility Access

**Start Date:** April 25, 2014    **End Date:** April 28, 2014

The real-time 270/1 BCBSM Eligibility Transactions may experience an outage on Sunday April 27, 2014 from 1:00 am to 1:00 pm EDT due to system maintenance. Medicaid, Medicare Advantage and Blue Care Network eligibility transactions should not be impacted.

We apologize for any inconvenience this might cause you.

Please email us at **Realtimesupport@bcbsm.com** if you have any questions or concerns.

29. Pharmacologic management procedure code M0064 no longer required, effective Aug. 1, 2014

**Category:** Professional and Facility OPC claims
In previous web-DENIS messages, we informed you of an interim solution for claims processing issues associated with billing evaluation and management procedure codes with behavioral health diagnosis codes. These messages told you to report pharmacologic management claims using procedure code M0064.

We now have updated our claims processing system to accept E&M procedure codes for behavioral health claims. These claims will process using the member’s mental health or medical cost-sharing benefits based on diagnosis reported.

Please note: Some of our members have behavioral health benefits that do not process through BCBSM. These claims will reject if billed to BCBSM. The appropriate vendor should then be billed.

30. Additional counties to transition out of MIChild Blue Cross PPO coverage on May 1

Category: MIChild

Title: Additional counties to transition out of MIChild Blue Cross PPO coverage on May 1

Start Date: April 28, 2014 End Date: May 22, 2014

The following counties will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for their medical, pharmacy and vision benefits on May 1, 2014.

Twelve counties transitioning on May 1, 2014:

<table>
<thead>
<tr>
<th>Allegan</th>
<th>Emmet</th>
<th>Manistee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>Grand Traverse</td>
<td>Mecosta</td>
</tr>
<tr>
<td>Branch</td>
<td>Leelanau</td>
<td>St. Joseph</td>
</tr>
<tr>
<td>Cheboygan</td>
<td>Lenawee</td>
<td>Wexford</td>
</tr>
</tbody>
</table>

As we announced in the September 2013 issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will
happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

Second transition happened on Nov. 1, 2013, and included these 13 counties:

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
</tbody>
</table>

31. Additional fee schedules added to web-DENIS

**Category:** Claims

**Title:** Additional fee schedules added to web-DENIS

**Start Date:** April 28, 2014  **End Date:** May 12, 2014
BCBSM recently added the following “entire fee schedules” to web-DENIS, reflecting fee updates effective May 1, 2014:

Professional: Injection Fee Schedule

- Injections minimum fee schedule (05/01/2014)

Note: Effective for dates of service on or after 2/1/14, professional providers must provide the NDC when submitting an injection HCPCS code for accurate payment at the NDC level. Otherwise, the claim will be priced at the minimum fee, which is displayed in the professional fee schedule listed above.

Facility: Hospital Outpatient

- Drug fees effective 5/01/14

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

32. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: April 28, 2014   End Date: May 12, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning Apr.28, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - DME

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

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

33. Eligibility Access

Category: Scheduled System Maintenance May 4, 2014
Title: Eligibility Access

Start Date: April 29, 2014   End Date: May 5, 2014

There is scheduled maintenance on our Eligibility file system. The maintenance will begin Sunday May 4, 2014 at 5:00PM. There will be intermittent availability during this time. The Maintenance will be complete Monday, May 5, 2014 at 1:00 AM.

We apologize for any inconvenience this may cause.

34. We’re adjusting BCBSM Medicare Advantage PPO ambulatory surgery facility claims that were paid incorrectly

Category: Medicare Advantage

Title: We’re adjusting BCBSM Medicare Advantage PPO ambulatory surgery facility claims that were paid incorrectly

Start Date: April 29, 2014   End Date: May 30, 2014

At the beginning of 2014, the ambulatory surgery facility pricing files were not loaded properly. As a result, claims were processed according to the 2013 fee schedules until the error was corrected on Feb. 14, 2014. We’ll be adjusting the affected claims to pay the correct amount.

In-state ASF claims received Jan. 1 through Feb. 13, 2014, will be processed prior to the April 29 check run.

Out-of-state ASF claims received Jan. 1 through Feb. 13, 2014, will be processed prior to May 23, 2014. The adjustments will appear on the provider vouchers.

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

35. All BCBSM electronic trading partners

Category: Update: distribution of new electronic 277x228 pended claim transaction

Title: All BCBSM electronic trading partners

Start Date: April 29, 2014   End Date: May 11, 2014

On April 30, 2014, Blue Cross Blue Shield of Michigan will return the first 277x228 pended claim transactions and reports (Professional: R277CAE, Institutional: R277CAG). This first distribution will contain all claims that are currently pended for
delinquency. Beginning May 1, 2014, the daily transactions and reports will contain claims that pended on that processing date only.

The 277x228 transactions and reports for BCN (Professional: R277CAJ, Institutional: R277CAQ) are delayed at this time. We will provide an update when the issue is resolved.

If you have questions, contact the e-BIG/EDI Helpdesk at 1-800-542-0945.

36. We’re no longer accepting *Michigan Status Claim Review Form*

**Category:** BCBSM claims

**Title:** We’re no longer accepting *Michigan Status Claim Review Form*

**Start Date:** April 29, 2014  **End Date:** May 31, 2014

As you read in previous issues of *The Record*, the *Michigan Status Claim Review Form* will no longer be accepted at BCBSM. These forms, if submitted, will be returned.

There are two fields on the new CMS1500 form (version 02-12) that, when completed, take the place of the *Michigan Status Claim Review Form*. When resubmitting a claim, providers should complete the new CMS 1500 form (version 02-12), including the following fields:

- Complete Field 22 by entering the original reference number for the resubmitted claim and the appropriate bill frequency code — either a “7” (to replace a prior claim) or an “8” (to void or cancel a prior claim).
- Complete Field 19 by entering additional information, such as the reason for the resubmission.

For additional details about using new CMS 1500 form, see the [January Record](#).

37. All professional electronic submitters

**Category:** Processing delay for professional 837 claims reporting specialty pharmacy services

**Title:** All professional electronic submitters

**Start Date:** April 30, 2014  **End Date:** May 14, 2014

Due to a system issue, some professional claims containing specialty pharmacy services will not be included in this week’s check writing cycle. Impacted claims were submitted between 9 a.m. Friday, April 25, 2014 and 9 a.m. Sunday, April 27, 2014.
Impacted claims will be processed the week of May 5, 2014.

We apologize for any inconvenience this delay may cause.

38. All professional electronic submitters

Category: Subscriber information on some professional remittances

Title: All professional electronic submitters

Start Date: April 30, 2014   End Date: May 14, 2014

Some professional claims containing specialty pharmacy services processed incorrectly. Providers and electronic submitters may receive erroneous 835 files and vouchers for check date May 2, 2014 that contain de-identified and unrecognizable subscriber/patient information. Please disregard the erroneous information.

All affected claims will be reprocessed and included in the check writing cycle for May 9, 2014. New 835 files and vouchers will be distributed at that time.

We apologize for any inconvenience this may cause.

39. Error in BCBSM Medicare Advantage PPO claims payment system will delay May 1 check run

Category: Medicare Advantage

Title: Error in BCBSM Medicare Advantage PPO claims payment system will delay May 1 check run

Start Date: April 30, 2014   End Date: May 12, 2014

A system issue has been identified for all Blue Cross Blue Shield of Michigan Medicare Advantage PPO claims. Checks did not process as scheduled on April 29, 2014. We are working to resolve this issue as quickly as possible.

At this time, we are unable to confirm when the May 1 checks will run.

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

40. BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error

Category: Medicare Advantage
Title: BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error

Start Date: April 30, 2014   End Date: May 14, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO local and BlueCard® claims billed with procedure code *97530 were rejecting as a component when billed with procedure code *97140 and modifier 59.

We corrected this issue in February. Impacted claims were adjusted April 11, 2014.

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

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

41. All Blue Care Network trading partners

Category: Delayed BCN 277CA transactions/reports

Title: All Blue Care Network trading partners

Start Date: April 30, 2014   End Date: May 14, 2014

Due to a system issue, BCN R277CAF reports and 277CAP transactions for April 30, 2014 are delayed. We will distribute the files as soon as possible.

We apologize for any inconvenience.

42. Medicare Eligibility

Category: Upcoming System Outages May 3 and May 4, 2014

Title: Medicare Eligibility

Start Date: April 30, 2014   End Date: May 5, 2014

May 3, 2014 Scheduled Outage

There is a scheduled maintenance scheduled for the Medicare Eligibility application. The maintenance will begin at 9:30 AM ET on Saturday, May 3, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Saturday, May 3, 2014.

May 4, 2014 Scheduled Outage
There is an additional maintenance scheduled for the Medicare Eligibility application. The maintenance will begin at 12:00 AM (Midnight) ET on Sunday, May 4, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance will be completed by 12:00 PM (Noon) ET on Sunday, May 4, 2014.

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

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk
1-866-324-7315
1. BCN outpatient high tech radiology providers must obtain an authorization of services performed on or after July 1, 2014 from CareCore National

   **Category:** Outpatient high tech radiology referrals

   **Title:** BCN outpatient high tech radiology providers must obtain an authorization of services performed on or after July 1, 2014 from CareCore National

   **Start Date:** May 1, 2014   **End Date:** May 31, 2014

   Effective for services performed on or after July 1, 2014, all freestanding diagnostic facilities, outpatient hospital settings, and ambulatory surgery centers as well as any physician’s office that provides MRI, CT, and Nuclear Scans who are BCN participating providers will be required to visit carecorenational.com or call 1-855-774-1317 for prior authorizations.

   If a treating physician does not receive a Medical Necessity Determination and Authorization number from CareCore National prior to performing radiology procedures, claims may not be reimbursed.

   For more information, please visit the Radiology Management section of e-referral for FAQs, a Quick Guide, and an updated Outpatient high-tech radiology procedure code summary.

2. Manufacturer recalls clindamycin palmitate HCl oral solution, 75 mg/5 mL

   **Category:** Blue Cross Complete drug recall notification

   **Title:** Manufacturer recalls clindamycin palmitate HCl oral solution, 75 mg/5 mL

   **Start Date:** May 1, 2014   **End Date:** May 15, 2014

   Perrigo® has announced a recall of clindamycin palmitate HCl, 75 mg/5 mL, **100 mL size bottles with National Drug Code 0574-0129-01.** The NDC is found on the medicine label.

   One or more of your Blue Cross Complete patients may have had a prescription filled for the affected clindamycin palmitate HCl, 75 mg/5 mL, **100 mL size bottles.** If your patient is not taking this medicine, you do not have to take any action.

   If you have questions about this recall, please call Perrigo Consumer Affairs at 1-800-538-9543 from 8 a.m. to 5 p.m. Monday through Friday. For more information, visit the FDA recall enforcement report website for the week of March 26, 2014.

3. Manufacturer recalls ranitidine tablets, 150 mg
Glenmark Generics, Inc. has announced a recall of ranitidine tablets, 150 mg. Ranitidine is the generic name for Zantac®. This medicine is for several gastrointestinal or stomach disorders.

This solution is being recalled because another medicine may have been packaged in bottles of ranitidine 150 mg.

One or more of your Blue Cross Complete patients may have had a prescription filled for the affected ranitidine tablets, 150 mg. If your patient is not taking this medicine, you do not have to take any action.

If you have questions about this recall, please call Glenmark Drug Safety Group at 1-888-721-7115 from 8 a.m. to 5 p.m. Monday through Friday. For more information, visit the [FDA recall enforcement report](https://www.fda.gov) website for the week of April 16, 2014.

4. BCBSM electronic provider manuals — April 2014 changes

These are the chapters we revised in April 2014, along with the revision date and a brief statement of the main changes for each.*

- **Ambulance Services** *(4/1/14)*
  - “Reimbursement” — Deleted the link to the now-outdated
  - *Ambulance Provider Participation Agreement*, leaving the
  link to the current (4/1/14) agreement in place.
- **Ambulatory Infusion Center Services** *(4/1/2014)*
  - “Electronic billing” — Changed reference for “status inquiry
  claim” to “resubmission claim.”
- **Anesthesia Services** *(4/1/14)*
  - “Reimbursement” — Deleted the link to the now-outdated
  - *Practitioner Traditional Participation Agreement*, leaving the
  link to the current (4/1/14) agreement in place.
  - “Reimbursement” — Deleted the link to the now-outdated
Certified Registered Nurse Anesthetist Direct Reimbursement Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Blue Pages Directory (4/1/2014)**
  - “Audits” — Updated the readmissions phone number.
  - “Billing seminars” — Deleted the phone and fax numbers; updated themail code.
  - “CAREN” — Updated the information you need to have ready when you call.
  - “CAQH Universal Provider Datasource” — Added “nurse practitioners” to the example of those who use the UPD.
  - “Claims and claim resubmissions” — paper — Updated the topic name and content based on use of the new CMS-1500 (02/12) claim form.
  - “Clinical Laboratory Improvement Amendments” — Updated all the contact information for inquiries about CLIA regulations and reviews.
  - “Federal Employee Program” — Updated the content based on use of the new CMS-1500 (02/12) claim form.
  - “Forms and supplies” — Deleted the note explaining effective dates for use of the old (08/05) and new (02/12) CMS-1500 claim forms.
  - “Physician Ombudsman” — Updated the content based on use of the new CMS-1500 (02/12) claim form.
  - “Provider Consulting Services” — Updated several phone numbers in the “Mid Michigan – professional consultants” chart.
- **Blue Preferred Plus (4/1/2014)**
  - “Billing guidelines” — Deleted all references to the old (08/05) CMS-1500 claim.
- **BlueCard Program (4/1/2014)**
  - “Verifying coverage and eligibility” — Added a new section for “BCBS of Illinois – fax process for hospitals to have additional inpatient days approved.”
- **Claims (4/7/2014)**
  - Throughout the chapter, deleted all references to the old (08/05) CMS-1500 claim and the paper status claim inquiry.
  - “Completing the CMS-1500 claim” — In the “Line-by-line instructions” section, revised fields 1, 21, 22, 24 A-H, 24C, 24I, 24J.
  - “Filing status inquiries electronically” — Added back the instructions for filing electronically, which had been inadvertently deleted from the previous version of this chapter.
• **Coordination of Benefits (4/4/2014)**
  - "Coordination period" — Revised dates in examples 1 and 2.
  - "Dual entitlement" — Revised dates in the first and second examples.

• **Dialysis Services (4/1/2014)**
  - "Reimbursement" — Deleted links to the now-outdated *End Stage Renal Disease Facility Participating Agreement* and the *TRUST End Stage Renal Disease Facility Network Affiliation Agreement*, leaving the links to the current (4/1/14) agreements in place.

• **Hearing Care Services (4/1/14)**
  - "Reimbursement" — Deleted the link to the now-outdated *Hearing Specialist Provider Participation Agreement*, leaving the link to the current (4/1/14) agreement in place.

• **Home Infusion Therapy Services**
  - (4/1/2014)
    - “Electronic billing” — Changed reference for “status inquiry claim” to “resubmission claim.”

• **Hospice Services (4/1/2014)**
  - “Reimbursement” — Deleted the link to the now-outdated *Hospice Provider Participation Agreement*, leaving the link to the now-current (4/1/14) agreement in place.

• **Hospital Services (4/15/2014)**
  - “Polysomnography” — Overhauled this subsection.
    - “Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link to the now-current (4/1/14) agreement in place.

• **Long-Term Acute Care Hospital Services (4/1/2014)**
  - “Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link to the now-current (4/1/14) agreement in place.

• **Medical-Surgical Services (4/15/2014)**
  - “Chemotherapy” — Added a “Reimbursement” subsection.
    - "Immunizations” — Added to the list of immunizations for members with National Health Care Reform coverage: Measles, mumps, rubella (MMR); hepatitis A; Immune globulin (IgIv), human, for intravenous use; inactivated polio; and pneumococcal and deleted varicella; also added a “Reimbursement” subsection.
  - “Injectable drugs” — Added a “Reimbursement” subsection.
- “Medication” — Added this new section for members with NHCR coverage.
- “Polysomnography” — Overhauled this subsection.
- “Preventive care services” — In the section for members with NHCR coverage, added the following: prenatal pediatrician visits; BRCA testing; mutation testing; breastfeeding support, supplies and counseling; and domestic violence counseling.
- “Substance abuse treatment” — Added this new section.

**Participation (4/1/2014)**

- “Participation agreements” — Deleted links to these 11 now-outdated participation agreements, leaving the links to the current (4/1/14) agreements in place:
  - *Ambulance Provider Participation Agreement*
  - *CRNA Direct Reimbursement Participation Agreement*
  - *End Stage Renal Disease Facility Participation Agreement (Traditional)*
  - *End Stage Renal Disease Facility Participation Agreement (TRUST)*
  - *Hearing Specialist Provider Participation Agreement*
  - *Hospice Provider Participation Agreement*
  - *Long-Term Acute Care Hospital Participation Agreement*
  - *Practitioner Traditional Participation Agreement*
  - *Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement*
  - *Substance Abuse Facility (Freestanding and Hospital-Based) Participation Agreement*
  - *Vision Specialist Provider Participation Agreement*

**Patient Eligibility (4/16/2014)**

- "Electronic standard transaction 270/271" — Added this new section.

**Physical Therapy, Occupational Therapy, and Speech Therapy Services (4/1/2014)**

- “Physical therapy services” — In the “Covered services” section, deleted hot and cold packs because they are bundled with other services and not payable separately.
- “Physical therapy services” — In the “Conditions and limitations” section, changed “physician orders are valid for 30 days” to say that they are valid for 90 days.

**PPO Policies (4/1/2014)**

- “Billing guidelines” — Deleted all references to the old (08/05) CMS-1500 claim.

**Problem Resolution (4/1/2014)**

- “Channels of inquiry” — In the “Provider Inquiry”
section, deleted references to “status inquiries,” leaving only the concept of “claim resubmission.”

- **Psychiatric Care Services (4/1/2014)**
  “Reimbursement” — Deleted the link to the now-outdated
  Practitioner Traditional Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Skilled Nursing Facility Services (4/1/14)**
  “Reimbursement” — Deleted the link to the now-outdated
  Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Substance Abuse Treatment Services (4/1/2014)**
  “Reimbursement” — Deleted the link to the now-outdated
  Freestanding and Hospital-Based Substance Abuse Facility Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Vision Care Program: Billing and Reimbursement (4/1/14)**
  “Reimbursement” — Deleted the link to the now-outdated
  Vision Specialist Provider Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

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

1. **Facility providers**

   **Category:** Web-DENIS not displaying rejection descriptions

   **Title:** Facility providers

   **Start Date:** May 2, 2014  **End Date:** May 16, 2014

   We are working to resolve an issue on web-DENIS that is preventing you from seeing the rejection descriptions for rejected facility claims. Until the issue is resolved, if you need immediate assistance with the rejection description please contact Provider Inquiry. We apologize for the inconvenience and are working to resolve the issue as quickly as possible.

2. **National drug code billing requirement delayed**

   **Category:** Medical drug billing

   **Title:** National drug code billing requirement delayed
Start Date: May 2, 2014          End Date: May 16, 2014

BCBSM has created a temporary solution to address health care provider concerns about billing medical drugs with national drug code information, due to billing software limitations and other billing issues. The solution changes the Blues’ new NDC quantity and unit of measurement billing requirements for these claims until November 1, 2014.

For six months starting April 28, 2014, BCBSM will use the HCPCS code and quantity in conjunction with a matching and valid NDC code to calculate the NDC quantity for medical drug claims. BCBSM will pay average wholesale prices based on that quantity, plus or minus the drug discount, as listed in the Injections Fee Schedule.

BCBSM will pay the lowest or minimum fee listed in the Injections Fee Schedule if claims are submitted with:

- No national drug code
- Invalid national drug codes
- NDC and HCPCS codes that don’t match

Claims submitted with not-otherwise-classified drug codes (J3490, for example) still require accurate national drug codes and NDC quantities, as they have in the past.

The Blues began requiring NDC quantities February 1, 2014, on medical drug claims that are reimbursed according to the Injections Fee Schedule. BCBSM created the alternative pricing solution in answer to provider concerns, allowing time to update billing software and to adjust to the new pricing requirements.

BCBSM will reinstitute the requirement to bill a matching and valid HCPCS and NDC combination, along with valid and accurate HCPCS and NDC quantities and NDC units of measures, on November 1. BCBSM will no longer calculate the NDC quantity for medical drug claims at that time. If the information is missing or invalid, we’ll reimburse the claim at the lowest average wholesale price or minimum fee.

During this six-month transition period, you may continue to report the NDC quantity to become familiar with the combination process.

This change is not applicable to the following provider types. They must bill the correct NDC and NDC quantity on all claims today:

- Home infusion therapy providers
- Ambulatory infusion centers
- Limited distribution drug specialty pharmacies
- Walgreens Specialty Pharmacy
- Hemophilia network providers

If you have any questions, please provide your provider consultant.
3. All Medicare Advantage trading partners

Category: Delayed Medicare Advantage 835 remittance files

Title: All Medicare Advantage trading partners

Start Date: May 5, 2014   End Date: May 19, 2014

Medicare Advantage 835 remittance files for check date 5/6/14 have been delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience.

4. Reminder: Blues retiring local system

Category: All providers

Title: Reminder: Blues retiring local system

Start Date: May 5, 2014   End Date: May 19, 2014

The Blues will retire the local system on Oct. 31, 2014. Since we will no longer process claims on that system, all claims filed on the local system must be submitted and received by Sept. 15, 2014, in order to be processed.

All health care providers must follow claim-filing deadlines. If you submit a claim after the filing limits, BCBSM will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

For more information about this change, please refer to the March 2014 Record.

5. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: May 5, 2014   End Date: May 19, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 05, 2014

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

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

6. Update: Revised ICD-10 training schedule and ICD-10 webinars

**Category:** All Providers

**Title:** Update: Revised ICD-10 training schedule and ICD-10 webinars

**Start Date:** May 7, 2014  **End Date:** December 31, 2014

Now that the ICD-10 implementation has been postponed until Oct. 1, 2015, BCBSM will offer ICD-10 training once a month instead of twice a month in 2014. If you previously registered for a training date not listed below, we will notify you to reschedule for one of these dates.

- All classes will be held in the Midnight Training Room at the Lyon Meadows Conference Center, 53200 Grand River, New Hudson.
- The sessions are from 9 a.m. to noon, with registration at 8:30 a.m.

Here are the 2014 ICD-10 training dates:

- Thursday, May 8
- Wednesday, May 21
- Thursday, June 19
- Wednesday, July 23
- Wednesday, Aug. 27
- Thursday, Sept. 25
- Thursday, Oct. 9

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date and time of the class that you wish to attend. You’ll receive a confirmation within 72 hours of registering. The Blues will provide continuing education credits for billers and office managers who qualify for certain education sessions.

**BCBSM ICD-10 webinars:** If you’d like to listen to a recording of the ICD-10 Michigan Mondays webinars provided by Precyse University, please click on this link.

- January webinar: “Breaking the Code, ICD-10’s Impact on a Physician Office”
- March webinar: “ICD-10 and the Impact on the Post Acute Setting”
- April webinar: “Using the ICD-10 Delay to Your Advantage”
- Sept. 22 webinar (the topic and registration link will be provided on web-DENIS the week before the webinar)
- Dec. 8 webinar (the topic and registration link will be provided on web-DENIS the week before the webinar)

If you have any questions or need help to get started on implementing ICD-10 you can contact us at ICD-10providerreadiness@bcbsm.com.

7. Medicare Eligibility Access

   Category: System Maintenance Friday May 9 to Sunday May 11
   Title: Medicare Eligibility Access
   Start Date: May 8, 2014   End Date: May 12, 2014

   There is scheduled maintenance on the Medicare eligibility application. The maintenance window will begin at 9:00 PM ET on Friday, May 9, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Sunday, May 11, 2014.

   Please contact the Help Desk if you have any questions.

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

8. BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error

   Category: Medicare Advantage
   Title: BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error
   Start Date: May 8, 2014   End Date: May 22, 2014

   We previously reported that BCBSM Medicare Advantage PPO local and BlueCard® claims billed with bilateral procedure code *97530 were adjusted because they were rejecting as a component when billed with procedure code *97140 and modifier 59.

   We adjusted all bilateral procedures billed with modifier 59 to pay appropriately, not just those claims related to codes *97530 and *97140.

   All claims were adjusted and reprocessed as of April 15, 2014.
We apologize for the confusion this may have caused. If you have any questions, please contact your provider consultant.

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9. Additional fee schedules added to web-DENIS new

Category: Claims

Title: Additional fee schedules added to web-DENIS new

Start Date: May 8, 2014   End Date: May 27, 2014

BCBSM recently added the following Revised Hospital Outpatient drug fee schedule to web-DENIS, reflecting fee updates effective May 1, 2014:

Facility: Hospital Outpatient

   o Drug fees effective 05/01/14 (Revised 5/7/2014)

This revised version of the Hospital Outpatient drug fee schedule includes codes that were inadvertently omitted (J7310 and Q4100-Q4149) from the originally published fee schedule, which has been removed.

10. Evaluation and management claims process according to diagnosis

Category: Professional and Facility OPC claims

Title: Evaluation and management claims process according to diagnosis

Start Date: May 9, 2014   End Date: September 1, 2014

BCBSM has updated its claims processing system to process evaluation and management procedure codes based on the primary diagnosis.

We’ll process claims billed with a behavioral health diagnosis using the member’s mental health benefits. Please bill behavioral health visits with a corresponding diagnosis code as the primary diagnosis to ensure correct processing of the claim.

We previously told you that the American Medical Association released new procedure codes for behavioral health, effective Jan. 1, 2013. Some codes were replaced with new codes and some of the codes that were previously bundled to include both evaluation and management with therapy were unbundled.

To summarize:
Evaluation and management procedures can be billed with either a primary medical or primary mental health diagnosis and should process in accordance with the member’s benefits. This means if an E&M procedure code is billed by a primary care physician with a behavioral health diagnosis, the claim will process against the member’s behavioral health cost share.

Throughout 2013 and into the second quarter of 2014, we updated, tested and validated the new unbundled behavioral health procedure codes and the E&M codes with psychiatric diagnosis codes. Due to the complexities in our systems, it took longer than anticipated to update them.

Some members may have a different cost-sharing experience between 2013 and 2014 and beyond. For example, in 2013 the member may have paid a flat dollar copay for a service, and in 2014 may need to pay a deductible and coinsurance for that same service. This is because the member’s cost-sharing may be different for medical and mental health benefits.

Please note: Please bill the appropriate vendor for members whose mental health benefits are not provided by BCBSM. If you bill BCBSM for these members, a message on your voucher will indicate where to send the claim.

Please see the June 2014 Record for more information.

11. U.P. BCN providers invited to town hall

Category: BCN U.P. town hall

Title: U.P. BCN providers invited to town hall

Start Date: May 9, 2014  End Date: May 17, 2014

Blue Care Network invites its Upper Peninsula providers to attend an upcoming town hall to be held on Tuesday, June 17 at the Holiday Inn in Marquette. The town hall will discuss e-referral, reimbursement, contracting and enrollment, Behavioral Health and more.

For more information, please contact Laura Voght at 906-228-6214.

12. Additional specialty drugs require prior authorization starting July 1

Category: Specialty drug professional billing

Title: Additional specialty drugs require prior authorization starting July 1

Start Date: May 12, 2014  End Date: May 27, 2014

We previously told you that we’re adding more specialty drugs to the list of those that require prior authorization by BCBSM in order to be covered under members’ medical
benefits, starting July 1, 2014. We inadvertently missed naming the drug Gammaked™ on the list.

Gamunex® and Gammaked share the same HCPCS code, J1561, which was on our previous list. The revised list is below:

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Procedure code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bivigam™</td>
<td>J1556</td>
</tr>
<tr>
<td>Carimune® NF</td>
<td>J1566</td>
</tr>
<tr>
<td>Febogamma® DIF</td>
<td>J1572</td>
</tr>
<tr>
<td>Gammagard® Liquid or S/D</td>
<td>J1569</td>
</tr>
<tr>
<td>Gammaplex®</td>
<td>J1557</td>
</tr>
<tr>
<td>Gamunex® C/Gammaked™ (IV and SubQ)</td>
<td>J1561</td>
</tr>
<tr>
<td>Hizentra® (SubQ only)</td>
<td>J1559</td>
</tr>
<tr>
<td>Octagam®</td>
<td>J1568</td>
</tr>
<tr>
<td>Privigen®</td>
<td>J1559</td>
</tr>
<tr>
<td>Immune globulin, IV injection, NOS</td>
<td>J1599</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90283</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90284</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90399</td>
</tr>
</tbody>
</table>

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

13. BCBSM encourages providers to submit Medicare Advantage PPO claim inquiries as soon as possible

Category: Medicare Advantage
Title: BCBSM encourages providers to submit Medicare Advantage PPO claim inquiries as soon as possible

Start Date: May 13, 2014       End Date: May 27, 2014

Send Blue Cross Blue Shield of Michigan Medicare Advantage PPO claim inquiries as soon as possible for claims incorrectly processed with dates of service prior to Jan. 1, 2013. We will review the requests and make appropriate adjustments in a timely manner.

Call Provider Inquiry at 1-866-309-1719 to discuss your claim concerns.

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

14. Recovery underway for Hurley Medical Center member claims

Category: Recoveries

Title: Recovery underway for Hurley Medical Center member claims

Start Date: May 13, 2014       End Date: May 27, 2014

Beginning May 13, 2014, NASCO began conducting a recovery for Hurley Medical Center member claims for dates of service Jan.1 through April 3, 2014.

Professional and facility claims were processed without applying cost-sharing in error.

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

15. Use of the laboratory services modifier

Category: Modifiers, billing

Title: Use of the laboratory services modifier

Start Date: May 13, 2014       End Date: May 27, 2014

When reporting laboratory services, it is important to use the correct modifiers to indicate repeat tests. With few exceptions modifier 91 should be used to indicate repeat laboratory services.

Some surgical pathology services, *88104-*88199 and *88300-*88399, may be reported with modifier 76. Reporting lab services with other modifiers to indicate additional testing may result in an edit.
16. Correct reporting of add-on codes

**Category:** Add-on codes, Billing  
**Title:** Correct reporting of add-on codes  
**Start Date:** May 13, 2014  **End Date:** May 27, 2014

Add-on codes are *CPT or HCPCS codes that indicate services performed as part of or in conjunction with another service. The other service is typically referred to as the primary service.

For add-on codes to be reimbursed, they need to be reported with an appropriate primary service as indicated by the corresponding CPT or HCPCS code. If the primary code is not found, the add-on code will most likely receive an edit.

Blue Care Network follows this policy for both its commercial and BCN AdvantageSM lines of business. BCN utilizes the National Correct Coding Initiative listing as a basis for determining appropriate primary codes for add-on codes.

To minimize your chance of receiving an edit, please observe the following:

- Report an appropriate primary procedure code when billing an add-on code.
- Don’t split claims. Report the primary and add-on codes on the same claim. An add-on code being reported without a primary code on the same claim may result in an edit.

17. Medicare Eligibility Access

**Category:** System Maintenance on Saturday May 17, 2014, from 7:30 AM to 5:00 PM  
**Title:** Medicare Eligibility Access  
**Start Date:** May 14, 2014  **End Date:** May 19, 2014

There is scheduled maintenance on the Medicare Eligibility application. The maintenance window will begin at 7:30 AM ET on Saturday, May 17, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Saturday, May 17, 2014.
Please contact the Help Desk if you have any questions.

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

18. All professional electronic submitters

**Category:** Processing delay for professional 837 claims reporting specialty pharmacy services

**Title:** All professional electronic submitters

**Start Date:** May 16, 2014 **End Date:** May 29, 2014

Due to a system issue, some professional claims containing specialty pharmacy services will not be included in this week’s check writing cycle. Impacted claims were submitted between 9 a.m. Thursday, May 15, 2014 and 9 a.m. Friday, May 16, 2014.

Impacted claims will be processed the week of May 19, 2014.

We apologize for any inconvenience this delay may cause.

19. All BCBSM electronic trading partners

**Category:** Conversion of informational edits effective May 1, 2014

**Title:** All BCBSM electronic trading partners

**Start Date:** May 16, 2014 **End Date:** May 30, 2014

On May 1, 2014, Blue Cross Blue Shield of Michigan implemented hard edits for claims reporting NPI/submitter ID combinations that do not match our EDI enrollment files for a particular payer. As of May 1, BCBSM EDI began seeing large numbers of claims rejecting with these edits:

**Professional - Returned on a 277CAH report**

- A3 24 P001 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR BL OR HM
- A3 24 P002 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR MB
- A3 24 P003 BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR CI

**Institutional - Returned on a 277CAI report**
Electronic submitters should review their 277CA reports or transactions daily. Rejected claims will not process and must be resubmitted. Prior to resubmission, you should take one or more of the following steps to correct your EDI enrollment:

- New submitters must complete a Trading Partner Agreement and a Provider Authorization form.
- Providers who have obtained a new billing NPI must update their Provider Authorization Form prior to submitting claims.
- Validate your EDI setup for all sources of payment (Blue Cross Blue Shield (BL), Blue Care Network (HM), Medicare / Medicare Advantage (MA or MB), or Commercial (CI)).
- Update your Provider Authorization Form to the correct billing NPI/submitter ID combination.
- Submitters who have switched clearinghouses must update their Provider Authorization Form with the new submitter ID.
- Work with your vendor or clearinghouse to ensure that the right combination is included in your 837 electronic claim files.

For assistance with updating your Trading Partner Agreement or Provider Authorization form, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945, Opt. 3 or email us at EDISUPPORT@BCBSM.COM include in subject “NPI SUBMITTER AUTHORIZATION”.

20. New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

Category: Provider Training

Title: New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

Start Date: May 16, 2014 End Date: June 6, 2014

BCBSM and BCN are pleased to offer web-based eLearning modules that give professional billers and coders in-depth training about proper claim coding and documentation.

The two new interactive eLearning training modules are enriched with multimedia elements, examples and case studies. When you finish each of the modules, your understanding of the material will be assessed. You will receive a Certificate of Completion for the training if you answer 90 percent of the questions correctly. Here’s how to access the training:
21. Autism diagnosis code changes to 299.0 under DSM-5

**Category:** Autism diagnosis codes

**Title:** Autism diagnosis code changes to 299.0 under DSM-5

**Start Date:** May 16, 2014  **End Date:** May 30, 2014

Effective May 2014, Blue Cross Blue Shield of Michigan and Blue Care Network will accept only DSM-5 codes for the diagnosis of autism, in accordance with the American Psychiatric Association.

In DSM-5, Asperger’s Disorder, Pervasive Developmental Disorder, Childhood Disintegrative Disorder and Rhett’s Disorder no longer exist as diagnoses. They are variants of the Autism Spectrum Disorder and are not individual diagnoses in and of themselves.

ASD is the diagnosable disorder and is the only current accurate diagnosis to be used. The code 299.0 is the current accurate diagnosis that should be used. The other disorders previously outlined by DSM-IV can still be treated and will be covered through the more general ASD diagnosis.

Providers may continue to bill utilizing ICD-9 codes where you have an authorization in place for codes used under DSM-IV.
22. Colorectal screening guidelines for HEDIS®

Category: HEDIS®

Title: Colorectal screening guidelines for HEDIS®

Start Date: May 16, 2014 End Date: May 30, 2014

HEDIS® identifies a colorectal cancer screening as one of the following:

- Fecal occult blood test yearly
- Flexible sigmoidoscopy every five years
- Colonoscopy every 10 years

Please do not count a digital rectal exam as evidence of a colorectal cancer screening. It is not specific or comprehensive enough to screen for colorectal cancer. A specimen collected via rectal exam is not accepted. The FOBT should be from a passed stool only.

23. New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

Category: Provider Training

Title: New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

Start Date: May 19, 2014 End Date: June 6, 2014

BCBSM and BCN are pleased to offer web-based eLearning modules that give professional billers and coders in-depth training about proper claim coding and documentation.

The two new interactive eLearning training modules are enriched with multimedia elements, examples and case studies. When you finish each of the modules, your understanding of the material will be assessed. You will receive a Certificate of Completion for the training if you answer 90 percent of the questions correctly. Here’s how to access the training:

- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- The Documentation and Coding Accuracy eLearning modules can be found under What’s New and Provider Training.

The training modules are also available within BCN Provider Publications and Resources on the Learning Opportunities page.
These new training modules are a great add-on to the documentation and coding webinars and presentations offered by the Blues in 2013. If you missed last year’s webinars, you can still view the coding initiative presentation online. Follow the above instructions to get to the BCBSM Provider Training page, and then scroll down to eLearning (web-based training) resources. The same training is also available on the BCN Learning Opportunities page.

Contact your BCBSM and BCN provider consultant to share your thoughts on the new training or you may email us at ProviderTraining@bcbsm.com. We value your opinion.

24. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: May 19, 2014 End Date: June 2, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 19, 2014

- Professional
  1. Traditional, TRUST & Blue Preferred Plus
  2. Independent Lab
- Facility
  1. Outpatient Hospital
  2. Ambulatory Surgery Facility
  3. Freestanding Outpatient Physical Therapy Facility

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

25. Recovery underway for Valassis member claims

Category: Recoveries

Title: Recovery underway for Valassis member claims

Start Date: May 20, 2014 End Date: June 3, 2014

NASCO began conducting a recovery May 16 for Valassis member claims for dates of service Jan. 1, through April 8, 2014.

In- and out-of-network professional and facility claims were applying cost-sharing incorrectly for the group’s single Traditional and family PPO members.
We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscribers’ balance may change.

26. Medicare Eligibility

**Category:** Medicare Eligibility System Maintenance scheduled for Tuesday May 20

**Title:** Medicare Eligibility

**Start Date:** May 20, 2014 **End Date:** May 21, 2014

System Maintenance will occur tonight, Tuesday, May 20, 2014. The maintenance window will begin at 9:00 PM ET on Tuesday, May 20, 2014. Medicare Eligibility will be unavailable during this period. Attempts to access Medicare Eligibility will result in errors. The maintenance window will be completed by 11:00 PM ET on Tuesday, May 20, 2014.

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk

1-866-324-7315

27. All BCBSM trading partners

**Category:** Clarification for reporting emergency room date spans

**Title:** All BCBSM trading partners

**Start Date:** May 20, 2014 **End Date:** June 3, 2014

In May 2014, Blue Cross Blue Shield of Michigan published an article in *The Record* titled *Visits to ER spanning more than one day*. To avoid rejection of other services in your electronic claims, follow these reporting requirements:

- When the emergency room visit spans more than one day, report the dates at claim level in Loop 2300.
  1. Report qualifier ‘434’ in Segment DTP01, and
  2. Report qualifier ‘RD8’ in DTP02, and
  3. Report the statement from and to date in DTP03.
- In addition, report the date span on the ER revenue code line in Loop 2400.
  1. Report qualifier ‘472’ in Segment DTP01, and
  2. Report qualifier ‘RD8’ in DTP02, and
  3. Report the range of dates in DTP03.
Contact your software vendor or clearinghouse if you need assistance with your practice management system. If you have questions about 837 electronic claims, call the e-BIG/EDI Business helpdesk at 1-800-542-0945.

28. All institutional trading partners

**Category:** Institutional edit F129 reminder

**Title:** All institutional trading partners

**Start Date:** May 21, 2014 **End Date:** June 4, 2014

Effective May 19, 2014, institutional claims with surgical procedures that do not follow these guidelines will edit:

An operating physician name and NPI must be reported in Loop 2310B Segments NM102 and NM109 when:

- A principal procedure is reported on inpatient claims in Loop 2300 with a 'BR' qualifier in Segment HI01-1, or
- HCPCS Codes in the range of 10,000-36,414 and 36,416-69,999 are reported in Loop 2400 with a 'HC' qualifier in Segment SV2.

Claims not following these guidelines will receive the edit of F129 OPERATING PHYSICIAN INFORMATION MISSING/INVALID on a R277CAI report or 277CA transaction. All edited claims must be corrected and resubmitted.

If you have questions regarding the edit or require additional information, contact the e-BIG EDI Business help desk at 1-800-542-0945.

29. Medicare Part B trading partners

**Category:** Delayed Medicare Part B 835 remittance files

**Title:** Medicare Part B trading partners

**Start Date:** May 23, 2014 **End Date:** June 6, 2014

Medicare Part B 835 remittance files from Wisconsin Physician Services for check date 05/27/14 were delayed. BCBSM has distributed all of the delayed WPS files.

We apologize for any inconvenience.
30. Ambulatory surgery center claims processing issue for individual members and Michigan Catholic Conference Lay Clergy groups

Category: Medicare Advantage

Title: Ambulatory surgery center claims processing issue for individual members and Michigan Catholic Conference Lay Clergy groups

Start Date: May 23, 2014 End Date: June 6, 2014

BCBSM incorrectly applied copayments for individual Medicare Advantage PPO members and Michigan Catholic Conference Lay Clergy groups that mirror individual plans, for ambulatory surgery center claims processed Jan. 1, through Sept. 18, 2013.

There is no cost-sharing for professional services rendered in place of service 24, ambulatory surgery center facilities, for all individual plans.

We identified the affected claims and are in the process of making the necessary adjustments. We expect to adjust the affected claims by July 25, 2014.

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

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

Category: FEP Eligibility Alert

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

Start Date: March 29, 2013 End Date: TBD

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

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

32. Additional fee schedule added to web-DENIS

Category: Claims

Title: Additional fee schedule added to web-DENIS

Start Date: May 28, 2014 End Date: June 11, 2014
BCBSM recently added the following revised DME/P&O fee schedule to web-DENIS, reflecting fee updates effective July 1, 2014:

**DME/P&O Fee Schedule**

- DME/P&O Fee Schedule (effective 7/1/14, Revised 5/23/2014)

This revised version of the fee schedule includes information related to DME injections subject to NDC pricing. Please refer to the October 2013 Record article “Report national drug code number on professional drug claims for accurate processing” for additional information on NDC pricing.

33. One county to transition out of MIChild Blue Cross PPO coverage on June 1

**Category:** MIChild

**Title:** One county to transition out of MIChild Blue Cross PPO coverage on June 1

**Start Date:** May 30, 2014  **End Date:** June 25, 2014

The following county will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for its medical, pharmacy and vision benefits on June 1, 2014:

- Monroe

As we announced in the September 2013 issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.

**First transition happened on Oct. 1, 2013, and included these 34 counties:**

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

**Second transition happened on Nov. 1, 2013, and included these 13 counties:**

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
<tr>
<td>Crawford</td>
<td>Ogemaw</td>
<td>Tuscola</td>
</tr>
<tr>
<td>Gratiot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Third transition happened on Dec. 1, 2013, and included these four counties:**

<table>
<thead>
<tr>
<th>Clinton</th>
<th>Ingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eaton</td>
<td>Isabella</td>
</tr>
</tbody>
</table>

**Fourth transition happened on March 1, 2014, and included these two counties:**

<table>
<thead>
<tr>
<th>Hillsdale</th>
<th>Missaukee</th>
</tr>
</thead>
</table>

**Fifth transition happened on April 1, 2014, and included these three counties:**

<table>
<thead>
<tr>
<th>Clare</th>
<th>Roscommon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gladwin</td>
<td></td>
</tr>
</tbody>
</table>
Sixth transition happened on May 1, 2014 and included these 12 counties:

<table>
<thead>
<tr>
<th>Allegan</th>
<th>Emmet</th>
<th>Manistee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>Grand Traverse</td>
<td>Mecosta</td>
</tr>
<tr>
<td>Branch</td>
<td>Leelanau</td>
<td>St. Joseph</td>
</tr>
<tr>
<td>Cheboygan</td>
<td>Lenawee</td>
<td>Wexford</td>
</tr>
</tbody>
</table>

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit michigan.gov/michild*. Click on Information for MIChild Providers then click on MI Child Health Plan Service Contacts and Service Areas Listing.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

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34. CareCore National training webinars available

**Category:** BCN outpatient high-tech radiology services

**Title:** CareCore National training webinars available

**Start Date:** May 30, 2014  **End Date:** June 30, 2014

Effective for dates of service on or after July 1, 2014, BCN will require clinical review for non-emergent, outpatient high-tech radiology services through CareCore National. In preparation for this new process, BCN will host several upcoming training webinars. To learn how to register with CareCore, request clinical review, verify the status of the review and more, providers are invited to attend one of the upcoming one-hour training webinars:

- June 10 — 8 to 9 a.m.
- June 11 — 11 a.m. to noon
- June 12 — 4 to 5 p.m.
- June 17 — 5 to 6 p.m.
- June 18 — 9 to 10 a.m.
- June 19 — noon to 1 p.m.
- June 24 — 11 a.m. to noon
- June 25 — 4 to 5 p.m.
June 26 — 8 to 9 a.m.

For more information and to register, download the invitation.

For more information about CareCore, please visit the Radiology Management section of e-referral for FAQs, a Quick Guide, and an updated Outpatient high-tech radiology procedure code summary.

35. NASCO Access

Category: Scheduled Maintenance Sunday June 1, 2014

Title: NASCO Access

Start Date: May 30, 2014 End Date: June 2, 2014

There is a scheduled maintenance on our NASCO system. The maintenance will begin on Sunday June 1, 2014 at 1:00 AM. Attempts to view NASCO information during this time could result in access errors. The maintenance window will be completed by Sunday, June 1 at 12:00 PM.

We apologize for any inconvenience.

36. BCBSM Medicare Plus BlueSM PPO manual to be updated in July 2014

Category: Medicare Advantage

Title: BCBSM Medicare Plus BlueSM PPO manual to be updated in July 2014

Start Date: May 30, 2014 End Date: June 25, 2014

Blue Cross Blue Shield of Michigan will update its Medicare Plus BlueSM PPO manual for July 2014. Key changes include:

- Added information regarding the Centers for Medicare & Medicaid Services two-midnight rule
- Deleted information about the CarePlus program, as program was discontinued
- Updated the CMS Star ratings information

You can obtain the most current version of the manual at bcbsm.com/provider/ma.

This message serves as notice of these changes to the Medicare Plus Blue PPO manual, per the terms of the MA PPO Provider Agreement, available online at bcbsm.com/provider/ma.
37. Some General Motors claims rejecting in error

**Category:** Professional Claims

**Title:** Some General Motors claims rejecting in error

**Start Date:** May 30, 2014 **End Date:** August 11, 2014

We’re changing the way we handle General Motor’s mental health claims to improve coordination with GM’s mental health benefits carrier, Value Options.

BCBSM will process these members’ office visit claims that are submitted with mental health diagnoses. Currently, these claims are rejecting when submitted by non-psychiatric providers. The rejection message directs providers to bill ValueOptions®, GM’s mental health carrier. Claims processed on or after Dec. 15, 2013, were affected.

We’re working to make system changes to ensure that these claims are processed by BCBSM. Once the changes are made, we’ll automatically reprocess the rejected claims for payment. Please do not bill members for these rejected claims.

We apologize for any inconvenience this may have caused.
June 2014

All prescriptions for hospice patients require prior authorization

To ensure drug claims for hospice patients are paid under the correct plan, as of May 1, 2014, all prescriptions for hospice patients require prior authorization. You can obtain prior authorization for hospice patients through the usual process with the Pharmacy Clinic Help Desk. You can access the phone directory with the appropriate help desk numbers by clicking here.

There may be some medications used before the patient’s hospice enrollment that will continue as part of the hospice plan of care. Prior to hospice enrollment, these drugs were paid under Medicare Part D. When the patient enters hospice, coverage switches to Part A as part of the hospice’s bundled per-diem payment.

Prescriptions for conditions unrelated to the terminal illness and its related conditions may be covered under Part D. For Part D payment, in addition to prior authorization, we require supporting documentation confirming that the treatment is unrelated to the terminal illness.

If a hospice patient attempts to fill a prescription at a pharmacy, the claim will be rejected and indicate that prior authorization is required. We notified pharmacies and affected members of this change in mid-April.

If you’re providing health care services to a hospice patient for a nonrelated condition and are not affiliated with the hospice provider, we encourage you to coordinate care with the hospice. This makes it easier for your patient to fill their prescription at a pharmacy in the future.

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The Record - All prescriptions for hospice patients require prior authorization

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June 2014

Do you have a Medicare Advantage claim from 2012 or before that you think was processed incorrectly?

If a health care provider believes that a Medicare Advantage claim with a date of service in 2012 or before was processed incorrectly, he or she should submit an inquiry as soon as possible.

The first step the provider should take is to call Provider Inquiry at 1-866-309-1719. If the issue is not resolved to the provider’s satisfaction, he or she may submit an appeal in writing to:

Medicare Plus Blue PPO
Provider Inquiry
P.O. Box 33842
Detroit, MI 48232-5842

We appreciate your cooperation in this matter. We want to ensure that we make appropriate adjustments in a timely manner.

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June 2014

**Medicare Advantage PPO lab network saves money for members**

BCBSM has partnered with Quest Diagnostics® and Joint Venture Hospital LaboratoriesSM to create a nonpatient clinical pathology lab network that will help our Medicare Plus Blue PPOSM members decrease out-of-pocket lab costs.

When these members have lab services performed within the Medicare Advantage PPO lab network, services are paid in full.

You can arrange for a Quest Diagnostics or JVHL courier to pick up a lab specimen in your office obtained by a qualified member of your staff. To contact a physician representative at Quest Diagnostics, call 1-866-MY-QUEST (1-866-697-8378) or use their website contact form. To contact JVHL, call 1-800-445-4979 or use their website contact form.

If you prefer, you may direct your Medicare Plus Blue PPO patients to have their laboratory specimens collected at a Quest Diagnostics or JVHL patient service center. You can find a patient service center on [Quest Diagnostics’ website**](http://www.questdiagnostics.com) or on [JVHL’s website**](http://www.jvhl.org).

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Web-DENIS messages May 2014
1. BCN outpatient high tech radiology providers must obtain an authorization of services performed on or after July 1, 2014 from CareCore National

Category: Outpatient high tech radiology referrals

Title: BCN outpatient high tech radiology providers must obtain an authorization of services performed on or after July 1, 2014 from CareCore National

Start Date: May 1, 2014   End Date: May 31, 2014

Effective for services performed on or after July 1, 2014, all freestanding diagnostic facilities, outpatient hospital settings, and ambulatory surgery centers as well as any physician’s office that provides MRI, CT, and Nuclear Scans who are BCN participating providers will be required to visit carecorenational.com or call 1-855-774-1317 for prior authorizations.

If a treating physician does not receive a Medical Necessity Determination and Authorization number from CareCore National prior to performing radiology procedures, claims may not be reimbursed.

For more information, please visit the Radiology Management section of e-referral for FAQs, a Quick Guide, and an updated Outpatient high-tech radiology procedure code summary.

2. Manufacturer recalls clindamycin palmitate HCl oral solution, 75 mg/5 mL

Category: Blue Cross Complete drug recall notification

Title: Manufacturer recalls clindamycin palmitate HCl oral solution, 75 mg/5 mL

Start Date: May 1, 2014   End Date: May 15, 2014

Perrigo® has announced a recall of clindamycin palmitate HCl, 75 mg/5 mL, 100 mL size bottles with National Drug Code 0574-0129-01. The NDC is found on the medicine label.

One or more of your Blue Cross Complete patients may have had a prescription filled for the affected clindamycin palmitate HCl, 75 mg/5 mL, 100 mL size bottles. If your patient is not taking this medicine, you do not have to take any action.

If you have questions about this recall, please call Perrigo Consumer Affairs at 1-800-538-9543 from 8 a.m. to 5 p.m. Monday through Friday. For more information, visit the FDA recall enforcement report website for the week of March 26, 2014.

3. Manufacturer recalls ranitidine tablets, 150 mg
Glenmark Generics, Inc. has announced a recall of ranitidine tablets, 150 mg. Ranitidine is the generic name for Zantac®. This medicine is for several gastrointestinal or stomach disorders.

This solution is being recalled because another medicine may have been packaged in bottles of ranitidine 150 mg.

One or more of your Blue Cross Complete patients may have had a prescription filled for the affected ranitidine tablets, 150 mg. If your patient is not taking this medicine, you do not have to take any action.

If you have questions about this recall, please call Glenmark Drug Safety Group at 1-888-721-7115 from 8 a.m. to 5 p.m. Monday through Friday. For more information, visit the FDA recall enforcement report website for the week of April 16, 2014.

4. BCBSM electronic provider manuals — April 2014 changes

These are the chapters we revised in April 2014, along with the revision date and a brief statement of the main changes for each.*

- **Ambulance Services** (4/1/14)
  “Reimbursement” — Deleted the link to the now-outdated
  - Ambulance Provider Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Ambulatory Infusion Center Services**
  (4/1/2014)
  - “Electronic billing” — Changed reference for “status inquiry claim” to “resubmission claim.”

- **Anesthesia Services** (4/1/14)
  “Reimbursement” — Deleted the link to the now-outdated
  - Practitioner Traditional Participation Agreement, leaving the link to the current (4/1/14) agreement in place.
  - “Reimbursement” — Deleted the link to the now-outdated
Certified Registered Nurse Anesthetist Direct Reimbursement Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Blue Pages Directory (4/1/2014)**
  - “Audits” — Updated the readmissions phone number.
  - “Billing seminars” — Deleted the phone and fax numbers; updated themail code.
  - “CAREN” — Updated the information you need to have ready when you call.
  - “CAQH Universal Provider Datasource” — Added “nurse practitioners” to the example of those who use the UPD.
  - “Claims and claim resubmissions” — paper — Updated the topic name and content based on use of the new CMS-1500 (02/12) claim form.
  - “Clinical Laboratory Improvement Amendments” — Updated all the contact information for inquiries about CLIA regulations and reviews.
  - “Federal Employee Program” — Updated the content based on use of the new CMS-1500 (02/12) claim form.
  - “Forms and supplies” — Deleted the note explaining effective dates for use of the old (08/05) and new (02/12) CMS-1500 claim forms.
  - “Physician Ombudsman” — Updated the content based on use of the new CMS-1500 (02/12) claim form.
  - “Provider Consulting Services” — Updated several phone numbers in the “Mid Michigan – professional consultants” chart.

- **Blue Preferred Plus (4/1/2014)**
  - “Billing guidelines” — Deleted all references to the old (08/05) CMS-1500 claim.

- **BlueCard Program (4/1/2014)**
  - “Verifying coverage and eligibility” — Added a new section for “BCBS of Illinois – fax process for hospitals to have additional inpatient days approved.”

- **Claims (4/7/2014)**
  - Throughout the chapter, deleted all references to the old (08/05) CMS-1500 claim and the paper status claim inquiry.
  - “Completing the CMS-1500 claim” — In the “Line-by-line instructions” section, revised fields 1, 21, 22, 24 A-H, 24C, 24I, 24J.
  - “Filing status inquiries electronically” — Added back the instructions for filing electronically, which had been inadvertently deleted from the previous version of this chapter.
• **Coordination of Benefits (4/4/2014)**
  - "Coordination period" — Revised dates in examples 1 and 2.
  - "Dual entitlement" — Revised dates in the first and second examples.
• **Dialysis Services (4/1/2014)**
  "Reimbursement" — Deleted links to the now-outdated *End Stage Renal Disease Facility Participating Agreement* and the *TRUST End Stage Renal Disease Facility Network Affiliation Agreement*, leaving the links to the current (4/1/14) agreements in place.
• **Hearing Care Services (4/1/14)**
  “Reimbursement” — Deleted the link to the now-outdated *Hearing Specialist Provider Participation Agreement*, leaving the link to the current (4/1/14) agreement in place.
• **Home Infusion Therapy Services (4/1/2014)**
  - “Electronic billing” — Changed reference for “status inquiry claim” to “resubmission claim.”
• **Hospital Services (4/15/2014)**
  - “Polysomnography” — Overhauled this subsection.
  - “Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link to the now-current (4/1/14) agreement in place.
• **Long-Term Acute Care Hospital Services (4/1/2014)**
  “Reimbursement” — Deleted the link to the now-outdated *Long-Term Acute Care Hospital Participation Agreement*, leaving the link to the now-current (4/1/14) agreement in place.
• **Medical-Surgical Services (4/15/2014)**
  - “Chemotherapy” — Added a “Reimbursement” subsection.
  - “Immunizations” — Added to the list of immunizations for members with National Health Care Reform coverage:
    - Measles, mumps, rubella (MMR); hepatitis A; Immune globulin (IgGv), human, for intravenous use; inactivated polio; and pneumococcal and deleted varicella; also added a “Reimbursement” subsection.
  - “Injectable drugs” — Added a “Reimbursement” subsection.
- “Medication” — Added this new section for members with NHCR coverage.
- “Polysomnography” — Overhauled this subsection.
- “Preventive care services” — In the section for members with NHCR coverage, added the following: prenatal pediatrician visits; BRCA testing; mutation testing; breastfeeding support, supplies and counseling; and domestic violence counseling.
- “Substance abuse treatment” — Added this new section.

- Participation (4/1/2014)
  - “Participation agreements” — Deleted links to these 11 now-outdated participation agreements, leaving the links to the current (4/1/14) agreements in place:
    - Ambulance Provider Participation Agreement
    - CRNA Direct Reimbursement Participation Agreement
    - End Stage Renal Disease Facility Participation Agreement (Traditional)
    - End Stage Renal Disease Facility Participation Agreement (TRUST)
    - Hearing Specialist Provider Participation Agreement
    - Hospice Provider Participation Agreement
    - Long-Term Acute Care Hospital Participation Agreement
    - Practitioner Traditional Participation Agreement
    - Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement
    - Substance Abuse Facility (Freestanding and Hospital-Based) Participation Agreement
    - Vision Specialist Provider Participation Agreement

- Patient Eligibility (4/16/2014)
  - "Electronic standard transaction 270/271" — Added this new section.

- Physical Therapy, Occupational Therapy, and Speech Therapy Services (4/1/2014)
  - “Physical therapy services” — In the “Covered services” section, deleted hot and cold packs because they are bundled with other services and not payable separately.
  - “Physical therapy services” — In the “Conditions and limitations” section, changed “physician orders are valid for 30 days” to say that they are valid for 90 days.

- PPO Policies (4/1/2014)
  - “Billing guidelines” — Deleted all references to the old (08/05) CMS-1500 claim.

- Problem Resolution (4/1/2014)
  - “Channels of inquiry” — In the “Provider Inquiry”
section, deleted references to “status inquiries,” leaving only the concept of “claim resubmission.”

- **Psychiatric Care Services (4/1/2014)**
  
  
  “Reimbursement” — Deleted the link to the now-outdated 
  
  Practitioner Traditional Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Skilled Nursing Facility Services (4/1/14)**
  
  “Reimbursement” — Deleted the link to the now-outdated 
  
  Skilled Nursing Facility (Freestanding and Hospital-Based) Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Substance Abuse Treatment Services (4/1/2014)**
  
  “Reimbursement” — Deleted the link to the now-outdated 
  
  Freestanding and Hospital-Based Substance Abuse Facility Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

- **Vision Care Program: Billing and Reimbursement (4/1/14)**
  
  “Reimbursement” — Deleted the link to the now-outdated 
  
  Vision Specialist Provider Participation Agreement, leaving the link to the current (4/1/14) agreement in place.

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

1. Facility providers

   **Category:** Web-DENIS not displaying rejection descriptions

   **Title:** Facility providers

   **Start Date:** May 2, 2014  **End Date:** May 16, 2014

   We are working to resolve an issue on web-DENIS that is preventing you from seeing the rejection descriptions for rejected facility claims. Until the issue is resolved, if you need immediate assistance with the rejection description please contact Provider Inquiry. We apologize for the inconvenience and are working to resolve the issue as quickly as possible.

2. National drug code billing requirement delayed

   **Category:** Medical drug billing

   **Title:** National drug code billing requirement delayed
BCBSM has created a temporary solution to address health care provider concerns about billing medical drugs with national drug code information, due to billing software limitations and other billing issues. The solution changes the Blues’ new NDC quantity and unit of measurement billing requirements for these claims until November 1, 2014.

For six months starting April 28, 2014, BCBSM will use the HCPCS code and quantity in conjunction with a matching and valid NDC code to calculate the NDC quantity for medical drug claims. BCBSM will pay average wholesale prices based on that quantity, plus or minus the drug discount, as listed in the Injections Fee Schedule.

BCBSM will pay the lowest or minimum fee listed in the Injections Fee Schedule if claims are submitted with:

- No national drug code
- Invalid national drug codes
- NDC and HCPCS codes that don’t match

Claims submitted with not-otherwise-classified drug codes (J3490, for example) still require accurate national drug codes and NDC quantities, as they have in the past.

The Blues began requiring NDC quantities February 1, 2014, on medical drug claims that are reimbursed according to the Injections Fee Schedule. BCBSM created the alternative pricing solution in answer to provider concerns, allowing time to update billing software and to adjust to the new pricing requirements.

BCBSM will reinstitute the requirement to bill a matching and valid HCPCS and NDC combination, along with valid and accurate HCPCS and NDC quantities and NDC units of measures, on November 1. BCBSM will no longer calculate the NDC quantity for medical drug claims at that time. If the information is missing or invalid, we’ll reimburse the claim at the lowest average wholesale price or minimum fee.

During this six-month transition period, you may continue to report the NDC quantity to become familiar with the combination process.

This change is not applicable to the following provider types. They must bill the correct NDC and NDC quantity on all claims today:

- Home infusion therapy providers
- Ambulatory infusion centers
- Limited distribution drug specialty pharmacies
- Walgreens Specialty Pharmacy
- Hemophilia network providers

If you have any questions, please provide your provider consultant.
3. All Medicare Advantage trading partners

   **Category:** Delayed Medicare Advantage 835 remittance files
   
   **Title:** All Medicare Advantage trading partners
   
   **Start Date:** May 5, 2014  **End Date:** May 19, 2014

   Medicare Advantage 835 remittance files for check date 5/6/14 have been delayed. All files will be distributed as soon as possible.

   We apologize for any inconvenience.

4. Reminder: Blues retiring local system

   **Category:** All providers
   
   **Title:** Reminder: Blues retiring local system
   
   **Start Date:** May 5, 2014  **End Date:** May 19, 2014

   The Blues will retire the local system on Oct. 31, 2014. Since we will no longer process claims on that system, all claims filed on the local system must be submitted and received by Sept. 15, 2014, in order to be processed.

   All health care providers must follow claim-filing deadlines. If you submit a claim after the filing limits, BCBSM will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

   For more information about this change, please refer to the [March 2014 Record](#).

5. Additional fee change schedules added to web-DENIS

   **Category:** Fee Changes
   
   **Title:** Additional fee change schedules added to web-DENIS
   
   **Start Date:** May 5, 2014  **End Date:** May 19, 2014

   BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 05, 2014

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

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

6. Update: Revised ICD-10 training schedule and ICD-10 webinars

Category: All Providers

Title: Update: Revised ICD-10 training schedule and ICD-10 webinars

Start Date: May 7, 2014  End Date: December 31, 2014

Now that the ICD-10 implementation has been postponed until Oct. 1, 2015, BCBSM will offer ICD-10 training once a month instead of twice a month in 2014. If you previously registered for a training date not listed below, we will notify you to reschedule for one of these dates.

- All classes will be held in the Midnight Training Room at the Lyon Meadows Conference Center, 53200 Grand River, New Hudson.
- The sessions are from 9 a.m. to noon, with registration at 8:30 a.m.

Here are the 2014 ICD-10 training dates:

- Thursday, May 8
- Wednesday, May 21
- Thursday, June 19
- Wednesday, July 23
- Wednesday, Aug. 27
- Thursday, Sept. 25
- Thursday, Oct. 9

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date and time of the class that you wish to attend. You’ll receive a confirmation within 72 hours of registering. The Blues will provide continuing education credits for billers and office managers who qualify for certain education sessions.

BCBSM ICD-10 webinars: If you’d like to listen to a recording of the ICD-10 Michigan Mondays webinars provided by Precyse University, please click on this link.

- January webinar: “Breaking the Code, ICD-10’s Impact on a Physician Office”
- March webinar: “ICD-10 and the Impact on the Post Acute Setting”
- April webinar: “Using the ICD-10 Delay to Your Advantage”
o Sept. 22 webinar (the topic and registration link will be provided on web-DENIS the week before the webinar)

o Dec. 8 webinar (the topic and registration link will be provided on web-DENIS the week before the webinar)

If you have any questions or need help to get started on implementing ICD-10 you can contact us at ICD-10providerreadiness@bcbsm.com.

7. Medicare Eligibility Access

**Category:** System Maintenance Friday May 9 to Sunday May 11

**Title:** Medicare Eligibility Access

**Start Date:** May 8, 2014  **End Date:** May 12, 2014

There is scheduled maintenance on the Medicare eligibility application. The maintenance window will begin at 9:00 PM ET on Friday, May 9, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Sunday, May 11, 2014.

Please contact the Help Desk if you have any questions.

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

8. BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error

**Category:** Medicare Advantage

**Title:** BCBSM adjusted Medicare Advantage PPO claims affected by modifier 59 error

**Start Date:** May 8, 2014  **End Date:** May 22, 2014

We previously reported that BCBSM Medicare Advantage PPO local and BlueCard® claims billed with bilateral procedure code *97530 were adjusted because they were rejecting as a component when billed with procedure code *97140 and modifier 59.

We adjusted all bilateral procedures billed with modifier 59 to pay appropriately, not just those claims related to codes *97530 and *97140.

All claims were adjusted and reprocessed as of April 15, 2014.
We apologize for the confusion this may have caused. If you have any questions, please contact your provider consultant.

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9. Additional fee schedules added to web-DENIS new

Category: Claims

Title: Additional fee schedules added to web-DENIS new

Start Date: May 8, 2014  End Date: May 27, 2014

BCBSM recently added the following Revised Hospital Outpatient drug fee schedule to web-DENIS, reflecting fee updates effective May 1, 2014:

Facility: Hospital Outpatient

- Drug fees effective 05/01/14 (Revised 5/7/2014)

This revised version of the Hospital Outpatient drug fee schedule includes codes that were inadvertently omitted (J7310 and Q4100-Q4149) from the originally published fee schedule, which has been removed.

10. Evaluation and management claims process according to diagnosis

Category: Professional and Facility OPC claims

Title: Evaluation and management claims process according to diagnosis

Start Date: May 9, 2014  End Date: September 1, 2014

BCBSM has updated its claims processing system to process evaluation and management procedure codes based on the primary diagnosis.

We’ll process claims billed with a behavioral health diagnosis using the member’s mental health benefits. Please bill behavioral health visits with a corresponding diagnosis code as the primary diagnosis to ensure correct processing of the claim.

We previously told you that the American Medical Association released new procedure codes for behavioral health, effective Jan. 1, 2013. Some codes were replaced with new codes and some of the codes that were previously bundled to include both evaluation and management with therapy were unbundled.

To summarize:
Evaluation and management procedures can be billed with either a primary medical or primary mental health diagnosis and should process in accordance with the member’s benefits. This means if an E&M procedure code is billed by a primary care physician with a behavioral health diagnosis, the claim will process against the member’s behavioral health cost share.

Throughout 2013 and into the second quarter of 2014, we updated, tested and validated the new unbundled behavioral health procedure codes and the E&M codes with psychiatric diagnosis codes. Due to the complexities in our systems, it took longer than anticipated to update them.

Some members may have a different cost-sharing experience between 2013 and 2014 and beyond. For example, in 2013 the member may have paid a flat dollar copay for a service, and in 2014 may need to pay a deductible and coinsurance for that same service. This is because the member’s cost-sharing may be different for medical and mental health benefits.

Please note: Please bill the appropriate vendor for members whose mental health benefits are not provided by BCBSM. If you bill BCBSM for these members, a message on your voucher will indicate where to send the claim.

Please see the June 2014 Record for more information.

11. U.P. BCN providers invited to town hall

   Category: BCN U.P. town hall

   Title: U.P. BCN providers invited to town hall

   Start Date: May 9, 2014   End Date: May 17, 2014

   Blue Care Network invites its Upper Peninsula providers to attend an upcoming town hall to be held on Tuesday, June 17 at the Holiday Inn in Marquette. The town hall will discuss e-referral, reimbursement, contracting and enrollment, Behavioral Health and more.

   For more information, please contact Laura Voght at 906-228-6214.

12. Additional specialty drugs require prior authorization starting July 1

   Category: Specialty drug professional billing

   Title: Additional specialty drugs require prior authorization starting July 1

   Start Date: May 12, 2014   End Date: May 27, 2014

   We previously told you that we’re adding more specialty drugs to the list of those that require prior authorization by BCBSM in order to be covered under members’ medical
benefits, starting July 1, 2014. We inadvertently missed naming the drug Gammaked™ on the list.

Gamunex® and Gammaked share the same HCPCS code, J1561, which was on our previous list. The revised list is below:

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Procedure code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bivigam™</td>
<td>J1556</td>
</tr>
<tr>
<td>Carimune® NF</td>
<td>J1566</td>
</tr>
<tr>
<td>Febogamma® DIF</td>
<td>J1572</td>
</tr>
<tr>
<td>Gammagard® Liquid or S/D</td>
<td>J1569</td>
</tr>
<tr>
<td>Gammaplex®</td>
<td>J1557</td>
</tr>
<tr>
<td>Gamunex® C/Gammaked™ (IV and SubQ)</td>
<td>J1561</td>
</tr>
<tr>
<td>Hizentra® (SubQ only)</td>
<td>J1559</td>
</tr>
<tr>
<td>Octagam®</td>
<td>J1568</td>
</tr>
<tr>
<td>Privigen®</td>
<td>J1559</td>
</tr>
<tr>
<td>Immune globulin, IV injection, NOS</td>
<td>J1599</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90283</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90284</td>
</tr>
<tr>
<td>Immune globulin</td>
<td>*90399</td>
</tr>
</tbody>
</table>

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13. BCBSM encourages providers to submit Medicare Advantage PPO claim inquiries as soon as possible

Category: Medicare Advantage
Title: BCBSM encourages providers to submit Medicare Advantage PPO claim inquiries as soon as possible

Start Date: May 13, 2014          End Date: May 27, 2014

Send Blue Cross Blue Shield of Michigan Medicare Advantage PPO claim inquiries as soon as possible for claims incorrectly processed with dates of service prior to Jan. 1, 2013. We will review the requests and make appropriate adjustments in a timely manner.

Call Provider Inquiry at 1-866-309-1719 to discuss your claim concerns.

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

14. Recovery underway for Hurley Medical Center member claims

Category: Recoveries

Title: Recovery underway for Hurley Medical Center member claims

Start Date: May 13, 2014          End Date: May 27, 2014

Beginning May 13, 2014, NASCO began conducting a recovery for Hurley Medical Center member claims for dates of service Jan.1 through April 3, 2014.

Professional and facility claims were processed without applying cost-sharing in error.

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

15. Use of the laboratory services modifier

Category: Modifiers, billing

Title: Use of the laboratory services modifier

Start Date: May 13, 2014          End Date: May 27, 2014

When reporting laboratory services, it is important to use the correct modifiers to indicate repeat tests. With few exceptions modifier 91 should be used to indicate repeat laboratory services.

Some surgical pathology services, *88104-*88199 and *88300-*88399, may be reported with modifier 76. Reporting lab services with other modifiers to indicate additional testing may result in an edit.
16. Correct reporting of add-on codes

Category: Add-on codes, Billing

Title: Correct reporting of add-on codes

Start Date: May 13, 2014   End Date: May 27, 2014

Add-on codes are *CPT or HCPCS codes that indicate services performed as part of or in conjunction with another service. The other service is typically referred to as the primary service.

For add-on codes to be reimbursed, they need to be reported with an appropriate primary service as indicated by the corresponding CPT or HCPCS code. If the primary code is not found, the add-on code will most likely receive an edit.

Blue Care Network follows this policy for both its commercial and BCN AdvantageSM lines of business. BCN utilizes the National Correct Coding Initiative listing as a basis for determining appropriate primary codes for add-on codes.

To minimize your chance of receiving an edit, please observe the following:

- Report an appropriate primary procedure code when billing an add-on code.
- Don’t split claims. Report the primary and add-on codes on the same claim. An add-on code being reported without a primary code on the same claim may result in an edit.

17. Medicare Eligibility Access

Category: System Maintenance on Saturday May 17, 2014, from 7:30 AM to 5:00 PM

Title: Medicare Eligibility Access

Start Date: May 14, 2014   End Date: May 19, 2014

There is scheduled maintenance on the Medicare Eligibility application. The maintenance window will begin at 7:30 AM ET on Saturday, May 17, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Saturday, May 17, 2014.
Please contact the Help Desk if you have any questions.

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

18. All professional electronic submitters

**Category:** Processing delay for professional 837 claims reporting specialty pharmacy services

**Title:** All professional electronic submitters

**Start Date:** May 16, 2014 **End Date:** May 29, 2014

Due to a system issue, some professional claims containing specialty pharmacy services will not be included in this week’s check writing cycle. Impacted claims were submitted between 9 a.m. Thursday, May 15, 2014 and 9 a.m. Friday, May 16, 2014.

Impacted claims will be processed the week of May 19, 2014.

We apologize for any inconvenience this delay may cause.

19. All BCBSM electronic trading partners

**Category:** Conversion of informational edits effective May 1, 2014

**Title:** All BCBSM electronic trading partners

**Start Date:** May 16, 2014 **End Date:** May 30, 2014

On May 1, 2014, Blue Cross Blue Shield of Michigan implemented hard edits for claims reporting NPI/submitter ID combinations that do not match our EDI enrollment files for a particular payer. As of May 1, BCBSM EDI began seeing large numbers of claims rejecting with these edits:

**Professional - Returned on a 277CAH report**

- A3 24 **P001** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR BL OR HM
- A3 24 **P002** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR MB
- A3 24 **P003** BILLING NPI SUBMITTER ID COMBO NOT ON FILE FOR CI

**Institutional - Returned on a 277CAI report**
Electronic submitters should review their 277CA reports or transactions daily. Rejected claims will not process and must be resubmitted. Prior to resubmission, you should take one or more of the following steps to correct your EDI enrollment:

- New submitters must complete a Trading Partner Agreement and a Provider Authorization form.
- Providers who have obtained a new billing NPI must update their Provider Authorization Form prior to submitting claims.
- Validate your EDI setup for all sources of payment (Blue Cross Blue Shield (BL), Blue Care Network (HM), Medicare / Medicare Advantage (MA or MB), or Commercial (CI).
- Update your Provider Authorization Form to the correct billing NPI/submitter ID combination.
- Submitters who have switched clearinghouses must update their Provider Authorization Form with the new submitter ID.
- Work with your vendor or clearinghouse to ensure that the right combination is included in your 837 electronic claim files.

For assistance with updating your Trading Partner Agreement or Provider Authorization form, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945, Opt. 3 or email us at EDISUPPORT@BCBSM.COM include in subject “NPI SUBMITTER AUTHORIZATION”.

20. New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

**Category:** Provider Training

**Title:** New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

**Start Date:** May 16, 2014 **End Date:** June 6, 2014

BCBSM and BCN are pleased to offer web-based eLearning modules that give professional billers and coders in-depth training about proper claim coding and documentation.

The two new interactive eLearning training modules are enriched with multimedia elements, examples and case studies. When you finish each of the modules, your understanding of the material will be assessed. You will receive a Certificate of Completion for the training if you answer 90 percent of the questions correctly. Here’s how to access the training:
- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- The Documentation and Coding Accuracy eLearning modules can be found under “What's New” and “Provider Training.”

The training modules are also available within BCN Provider Publications and Resources on the Learning Opportunities page.

These new training modules are a great add-on to the documentation and coding webinars and presentations offered by the Blues in 2013. If you missed last year’s webinars, you can still view the coding initiative presentation online. Follow the above instructions to get to the BCBSM Provider Training page, and then scroll down to eLearning (web-based training) resources. The same training is also available on the BCN Learning Opportunities page.

Contact your BCBSM and BCN provider consultant to share your thoughts on the new training or you may email us at ProviderTraining@bcbsm.com. We value your opinion.

21. Autism diagnosis code changes to 299.0 under DSM-5

**Category:** Autism diagnosis codes

**Title:** Autism diagnosis code changes to 299.0 under DSM-5

**Start Date:** May 16, 2014  **End Date:** May 30, 2014

Effective May 2014, Blue Cross Blue Shield of Michigan and Blue Care Network will accept only DSM-5 codes for the diagnosis of autism, in accordance with the American Psychiatric Association.

In DSM-5, Asperger’s Disorder, Pervasive Developmental Disorder, Childhood Disintegrative Disorder and Rhett’s Disorder no longer exist as diagnoses. They are variants of the Autism Spectrum Disorder and are not individual diagnoses in and of themselves.

ASD is the diagnosable disorder and is the only current accurate diagnosis to be used. The code 299.0 is the current accurate diagnosis that should be used. The other disorders previously outlined by DSM-IV can still be treated and will be covered through the more general ASD diagnosis.

Providers may continue to bill utilizing ICD-9 codes where you have an authorization in place for codes used under DSM-IV.
22. Colorectal screening guidelines for HEDIS®

**Category:** HEDIS®

**Title:** Colorectal screening guidelines for HEDIS®

**Start Date:** May 16, 2014  **End Date:** May 30, 2014

HEDIS® identifies a colorectal cancer screening as one of the following:

- Fecal occult blood test yearly
- Flexible sigmoidoscopy every five years
- Colonoscopy every 10 years

Please do not count a digital rectal exam as evidence of a colorectal cancer screening. It is not specific or comprehensive enough to screen for colorectal cancer. A specimen collected via rectal exam is not accepted. The FOBT should be from a passed stool only.

23. New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

**Category:** Provider Training

**Title:** New valuable eLearning modules for professional billers and coders to assist in proper coding and documentation

**Start Date:** May 19, 2014  **End Date:** June 6, 2014

BCBSM and BCN are pleased to offer web-based eLearning modules that give professional billers and coders in-depth training about proper claim coding and documentation.

The two new interactive eLearning training modules are enriched with multimedia elements, examples and case studies. When you finish each of the modules, your understanding of the material will be assessed. You will receive a Certificate of Completion for the training if you answer 90 percent of the questions correctly. Here’s how to access the training:

- Click on *BCBSM Provider Publications and Resources*.
- Click on Newsletters and Resources.
- The Documentation and Coding Accuracy eLearning modules can be found under *What’s New* and *Provider Training*.

The training modules are also available within *BCN Provider Publications and Resources* on the *Learning Opportunities page*. 
These new training modules are a great add-on to the documentation and coding webinars and presentations offered by the Blues in 2013. If you missed last year’s webinars, you can still view the coding initiative presentation online. Follow the above instructions to get to the BCBSM Provider Training page, and then scroll down to eLearning (web-based training) resources. The same training is also available on the BCN Learning Opportunities page.

Contact your BCBSM and BCN provider consultant to share your thoughts on the new training or you may email us at ProviderTraining@bcbsm.com. We value your opinion.

24. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: May 19, 2014 End Date: June 2, 2013

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning May 19, 2014

- Professional
  1. Traditional, TRUST & Blue Preferred Plus SM
  2. Independent Lab
- Facility
  1. Outpatient Hospital
  2. Ambulatory Surgery Facility
  3. Freestanding Outpatient Physical Therapy Facility

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

25. Recovery underway for Valassis member claims

Category: Recoveries

Title: Recovery underway for Valassis member claims

Start Date: May 20, 2014 End Date: June 3, 2014

NASCO began conducting a recovery May 16 for Valassis member claims for dates of service Jan. 1, through April 8, 2014.

In- and out-of-network professional and facility claims were applying cost-sharing incorrectly for the group’s single Traditional and family PPO members.
We’re taking back the excess amount from our original payment. When you adjust patients’ accounts, the subscribers’ balance may change.

26. Medicare Eligibility

**Category:** Medicare Eligibility System Maintenance scheduled for Tuesday May 20

**Title:** Medicare Eligibility

**Start Date:** May 20, 2014  **End Date:** May 21, 2014

System Maintenance will occur tonight, Tuesday, May 20, 2014. The maintenance window will begin at 9:00 PM ET on Tuesday, May 20, 2014. Medicare Eligibility will be unavailable during this period. Attempts to access Medicare Eligibility will result in errors. The maintenance window will be completed by 11:00 PM ET on Tuesday, May 20, 2014.

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk

1-866-324-7315

27. All BCBSM trading partners

**Category:** Clarification for reporting emergency room date spans

**Title:** All BCBSM trading partners

**Start Date:** May 20, 2014  **End Date:** June 3, 2014

In May 2014, Blue Cross Blue Shield of Michigan published an article in *The Record* titled *Visits to ER spanning more than one day*. To avoid rejection of other services in your electronic claims, follow these reporting requirements:

- When the emergency room visit spans more than one day, report the dates at claim level in Loop 2300.
  1. Report qualifier ‘434’ in Segment DTP01, and
  2. Report qualifier ‘RD8’ in DTP02, and
  3. Report the statement from and to date in DTP03.

- In addition, report the date span on the ER revenue code line in Loop 2400.
  1. Report qualifier ‘472’ in Segment DTP01, and
  2. Report qualifier ‘RD8’ in DTP02, and
  3. Report the range of dates in DTP03.
Contact your software vendor or clearinghouse if you need assistance with your practice management system. If you have questions about 837 electronic claims, call the e-BIG/EDI Business helpdesk at 1-800-542-0945.

28. All institutional trading partners

**Category:** Institutional edit F129 reminder

**Title:** All institutional trading partners

**Start Date:** May 21, 2014 **End Date:** June 4, 2014

Effective May 19, 2014, institutional claims with surgical procedures that do not follow these guidelines will edit:

An operating physician name and NPI must be reported in Loop 2310B Segments NM102 and NM109 when:

- A principal procedure is reported on inpatient claims in Loop 2300 with a 'BR' qualifier in Segment HI01-1, or
- HCPCS Codes in the range of 10,000-36,414 and 36,416-69,999 are reported in Loop 2400 with a 'HC' qualifier in Segment SV2.

Claims not following these guidelines will receive the edit of F129 OPERATING PHYSICIAN INFORMATION MISSING/INVALID on a R277CAI report or 277CA transaction. All edited claims must be corrected and resubmitted.

If you have questions regarding the edit or require additional information, contact the e-BIG EDI Business help desk at 1-800-542-0945.

29. Medicare Part B trading partners

**Category:** Delayed Medicare Part B 835 remittance files

**Title:** Medicare Part B trading partners

**Start Date:** May 23, 2014 **End Date:** June 6, 2014

Medicare Part B 835 remittance files from Wisconsin Physician Services for check date 05/27/14 were delayed. BCBSM has distributed all of the delayed WPS files.

We apologize for any inconvenience.
30. Ambulatory surgery center claims processing issue for individual members and Michigan Catholic Conference Lay Clergy groups

**Category:** Medicare Advantage

**Title:** Ambulatory surgery center claims processing issue for individual members and Michigan Catholic Conference Lay Clergy groups

**Start Date:** May 23, 2014  **End Date:** June 6, 2014

BCBSM incorrectly applied copayments for individual Medicare Advantage PPO members and Michigan Catholic Conference Lay Clergy groups that mirror individual plans, for ambulatory surgery center claims processed Jan. 1, through Sept. 18, 2013.

There is no cost-sharing for professional services rendered in place of service 24, ambulatory surgery center facilities, for all individual plans.

We identified the affected claims and are in the process of making the necessary adjustments. We expect to adjust the affected claims by July 25, 2014.

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

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

**Category:** FEP Eligibility Alert

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

**Start Date:** March 29, 2013  **End Date:** TBD

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

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

32. Additional fee schedule added to web-DENIS

**Category:** Claims

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

**Start Date:** May 28, 2014  **End Date:** June 11, 2014
BCBSM recently added the following revised DME/P&O fee schedule to web-DENIS, reflecting fee updates effective July 1, 2014:

DME/P&O Fee Schedule
  o DME/P&O Fee Schedule (effective 7/1/14, Revised 5/23/2014)

This revised version of the fee schedule includes information related to DME injections subject to NDC pricing. Please refer to the October 2013 Record article “Report national drug code number on professional drug claims for accurate processing” for additional information on NDC pricing.

33. One county to transition out of MIChild Blue Cross PPO coverage on June 1

Category: MIChild

Title: One county to transition out of MIChild Blue Cross PPO coverage on June 1

Start Date: May 30, 2014 End Date: June 25, 2014

The following county will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for its medical, pharmacy and vision benefits on June 1, 2014:
  o Monroe

As we announced in the September 2013 issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.

**First transition happened on Oct. 1, 2013, and included these 34 counties:**

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

**Second transition happened on Nov. 1, 2013, and included these 13 counties:**

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
<tr>
<td>Crawford</td>
<td>Ogemaw</td>
<td>Tuscola</td>
</tr>
<tr>
<td>Gratiot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Third transition happened on Dec. 1, 2013, and included these four counties:**

<table>
<thead>
<tr>
<th>Clinton</th>
<th>Ingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eaton</td>
<td>Isabella</td>
</tr>
</tbody>
</table>

**Fourth transition happened on March 1, 2014, and included these two counties:**

<table>
<thead>
<tr>
<th>Hillsdale</th>
<th>Missaukee</th>
</tr>
</thead>
</table>

**Fifth transition happened on April 1, 2014, and included these three counties:**

<table>
<thead>
<tr>
<th>Clare</th>
<th>Roscommon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gladwin</td>
<td></td>
</tr>
</tbody>
</table>
Sixth transition happened on May 1, 2014 and included these 12 counties:

<table>
<thead>
<tr>
<th>Allegan</th>
<th>Emmet</th>
<th>Manistee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>Grand Traverse</td>
<td>Mecosta</td>
</tr>
<tr>
<td>Branch</td>
<td>Leelanau</td>
<td>St. Joseph</td>
</tr>
<tr>
<td>Cheboygan</td>
<td>Lenawee</td>
<td>Wexford</td>
</tr>
</tbody>
</table>

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit michigan.gov/michild*. Click on Information for MIChild Providers then click on MI Child Health Plan Service Contacts and Service Areas Listing.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

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

34. CareCore National training webinars available

Category: BCN outpatient high-tech radiology services

Title: CareCore National training webinars available

Start Date: May 30, 2014 End Date: June 30, 2014

Effective for dates of service on or after July 1, 2014, BCN will require clinical review for non-emergent, outpatient high-tech radiology services through CareCore National. In preparation for this new process, BCN will host several upcoming training webinars. To learn how to register with CareCore, request clinical review, verify the status of the review and more, providers are invited to attend one of the upcoming one-hour training webinars:

- June 10 — 8 to 9 a.m.
- June 11 — 11 a.m. to noon
- June 12 — 4 to 5 p.m.
- June 17 — 5 to 6 p.m.
- June 18 — 9 to 10 a.m.
- June 19 — noon to 1 p.m.
- June 24 — 11 a.m. to noon
- June 25 — 4 to 5 p.m.
June 26 — 8 to 9 a.m.

For more information and to register, download the invitation.

For more information about CareCore, please visit the Radiology Management section of e-referral for FAQs, a Quick Guide, and an updated Outpatient high-tech radiology procedure code summary.

35. NASCO Access

Category: Scheduled Maintenance Sunday June 1, 2014

Title: NASCO Access

Start Date: May 30, 2014 End Date: June 2, 2014

There is a scheduled maintenance on our NASCO system. The maintenance will begin on Sunday June 1, 2014 at 1:00 AM. Attempts to view NASCO information during this time could result in access errors. The maintenance window will be completed by Sunday, June 1 at 12:00 PM.

We apologize for any inconvenience.

36. BCBSM Medicare Plus Blue℠ PPO manual to be updated in July 2014

Category: Medicare Advantage

Title: BCBSM Medicare Plus Blue℠ PPO manual to be updated in July 2014

Start Date: May 30, 2014 End Date: June 25, 2014

Blue Cross Blue Shield of Michigan will update its Medicare Plus Blue℠ PPO manual for July 2014. Key changes include:

- Added information regarding the Centers for Medicare & Medicaid Services two-midnight rule
- Deleted information about the CarePlus program, as program was discontinued
- Updated the CMS Star ratings information

You can obtain the most current version of the manual at bcbsm.com/provider/ma.

This message serves as notice of these changes to the Medicare Plus Blue PPO manual, per the terms of the MA PPO Provider Agreement, available online at bcbsm.com/provider/ma.
37. Some General Motors claims rejecting in error

**Category:** Professional Claims

**Title:** Some General Motors claims rejecting in error

**Start Date:** May 30, 2014  **End Date:** August 11, 2014

We’re changing the way we handle General Motor’s mental health claims to improve coordination with GM’s mental health benefits carrier, Value Options.

BCBSM will process these members’ office visit claims that are submitted with mental health diagnoses. Currently, these claims are rejecting when submitted by non-psychiatric providers. The rejection message directs providers to bill ValueOptions®, GM’s mental health carrier. Claims processed on or after Dec. 15, 2013, were affected.

We’re working to make system changes to ensure that these claims are processed by BCBSM. Once the changes are made, we’ll automatically reprocess the rejected claims for payment. Please do not bill members for these rejected claims.

We apologize for any inconvenience this may have caused.
BCBSM Medicare Advantage PPO home health care and skilled nursing facility audits begin this month

Starting this August, independent contractors will audit Blue Cross Blue Shield of Michigan Medicare Advantage home health care and skilled nursing facility claim payments.

These audits will be performed at the vendor’s office and modeled after the Centers for Medicare & Medicaid Services home health and skilled nursing facility audits. The contractors that will be performing the audits are HealthDataInsights and SCIO Health Analytics.

Home health care and skilled nursing facility services are defined as home health care services that occur within a BCBSM Medicare Advantage member’s home and are provided by home health care companies, including caregiver services, home health nursing, aides and therapists.

A skilled nursing facility provides health and therapeutic services to patients who require residential and continual nursing care. A licensed physician supervises each patient’s care and a nurse or other medical professional is almost always on the premises. Skilled nursing can be made available 24 hours a day.

Additional information will be included in letters sent to facilities.

If you have questions, contact your provider consultant or send an email to efoster@bcbsm.com.

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Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Blues Medicare Advantage website redesigned to improve customer experience

The Blues recently launched its redesigned Medicare website, bcbsm.com/medicare, to enhance the customer experience for people who shop for Medicare plans.

**Key improvements include:**

- A new contemporary user interface
- Information about Blue Cross Blue Shield of Michigan and Blue Care Network Medicare plans on one site
- Simplified site navigation that makes it easier to find information about our Medicare plans
- Easy-to-understand content
- Faster and more effective search tools
- A new Medicare 101 tutorial and help center that provide answers to the most commonly asked questions

The site’s helpful tools include:

- The search tool on the home page. Just enter a simple keyword or phrase in the bar in the upper-right corner
- The bottom of each page provides direct links to all the pages on the site.
- The “contact us” link on each page has contact information for both group and individual members.

Over the next few months, the Blues’ Digital Experience team will work with Medicare business units to update the site in time for the 2015 enrollment period.

Site access is available to Medicare insurance shoppers, including those who are aging in, potential Medicare group customers, current members, providers, employers, agents and the general public.
If you have any problems accessing the site, call 1-877-258-3932.

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August 2014

**My Advocate™ appointment scheduling underway**

Member outreach initiatives are underway to encourage select Blue Cross Medicare Advantage members to schedule wellness visits with their physicians. Provider offices should expect an influx of calls from our members and the My Advocate appointment scheduling service.

My Advocate is a suite of member services offered by Altegra Health, an independent company that contracts with BCBSM to provide these services free of charge to our Medicare Advantage members.

These services include locating community programs that may save our members money on various health care needs, such as medical supplies, medications and everyday living expenses. The My Advocate program also provides education to our members on specific health issues and how to effectively communicate health concerns with their doctors.

We also encourage our members to visit their doctor regularly, take medications as prescribed and alert the appropriate doctor when issues arise. It’s our goal to provide our Medicare Advantage members with a quality service to aid them in maintaining their health without any additional out-of-pocket expenses.

**What you need to know:**

- My Advocate will schedule appointments directly with your office staff while they have the member on the phone.
- A confirmation fax will be sent to your office 24 to 48 hours prior to the member’s visit. The confirmation fax will include the member’s gaps in care and basic medical history.

Please notify your staff members of this outreach initiative in order to better prepare them for the increasing volume of calls and to create a pleasant experience for your patients over the next several weeks.
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August 2014

Reminder: Submiting CMS-1500 claim forms for Medicare Advantage patients

To submit paper claims and avoid processing delays, BCBSM Medicare Advantage providers should send their CMS-1500 claim forms to:

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

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

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Web-DENIS messages July 2014
1. BCBSM Medicare Advantage PPO follows government lead for modifier L1

   Category: Medicare Advantage

   Title: BCBSM Medicare Advantage PPO follows government lead for modifier L1

   Start Date: July 1, 2014   End Date: July 15, 2014

   The Centers for Medicare & Medicaid Services added modifier L1 (separately payable lab test) as a valid modifier, effective July 1, 2014. Please include modifier L1 on facility claims using type of bill 13X for laboratory services as appropriate.

   We will update our claims processing system by July 7, with an effective date of July 1, 2014. Claims billed with modifier L1 will be held until our claims processing system is updated. At that time, the claims will be released and processed accordingly.

   Thank you for your cooperation.

2. Blue Cross Complete Performance Recognition Program payments for July-Dec. 2013

   Category: Blue Cross Complete PRP

   Title: Blue Cross Complete Performance Recognition Program payments for July-Dec. 2013

   Start Date: July 1, 2014   End Date: July 14, 2014

   Blue Cross Complete is pleased to make payment on the Performance Recognition Program on July 2, 2014, for the reporting period of July through December 2013. On the remittance advice there will be a manual adjustment line indicating the amount of the Performance Recognition Program payment. If you have questions regarding your payment amount, please contact your provider representative, or call 1-888-312-5713.

   This program was developed to ensure Blue Cross Complete members receive the care they need.

   We appreciate the care and service you and your staff provide to Blue Cross Complete members.
3. 2014 InterQual® criteria effective August 4

Category: Training

Title: 2014 InterQual® criteria effective August 4

Start Date: July 1, 2014 End Date: August 8, 2014

Blue Cross Blue Shield of Michigan and Blue Care Network are implementing 2014 InterQual® criteria on August 4, 2014. Here’s how to find more information. For BCBSM:

- InterQual article in the July 2014 issue of The Record
- 2014 BCBSM modifications to InterQual® criteria

For BCN:

- InterQual article in the July-August 2014 issue of BCN Provider News (includes link to Blue Care Network 2014 Local Rules)

BCBSM will offer comprehensive InterQual training webinars this year. Schedules for the webinars will be published in The Record and posted to web-DENIS.
4. BCBSM electronic provider manuals — June 2014 changes

**Category:** Online manuals

**Title:** BCBSM electronic provider manuals — June 2014 changes

**Start Date:** July 1, 2014  **End Date:** July 15, 2014

These are the chapters we revised in June 2014, along with the revision date and a brief statement of the main changes for each.*

* Ambulatory Surgery Facility Services (06/16/2014)
  - Overhauled the entire chapter.

* Blue Pages Directory (06/13/2014)
  - "Changing your name, address or other information" — Added more information for nonhospital facilities.
  - "Claims and claim resubmissions - paper" — Updated the mailing address for pharmacy’s paper claims.
  - "Enrollment" — To the "questions about enrollment forms," section, added email and mail options. Also updated the “Hospitals” and "Nonhospital facilities" sections.
  - Hospital P4P Program — Updated the entire section, including contact information.
  - “InterQual criteria — Updated the information.
  - “Landmark Connect – profiles for physical therapists” — Updated the Web address.
  - "Medicare Advantage" — Updated the link name.
  - "Michigan Education Special Services Association" — Updated the list of inquiry phone numbers from nonparticipating providers.
  - "Michigan Public School Employees Retirement System" — Updated the Vision row with new contact information and phone number.

* Claims (06/01/2014)
  - “Filing status inquiries electronically” — Modified the time limit from “24 months from the date the claim was paid or rejected” to “24 months from the date of service.”

* Hospice Services (06/13/2014)
  - Overhauled entire chapter.

* Hospital Services (06/1/2014)
  - “Reimbursement” — Deleted the link to the now-outdated Participating Hospital Agreement, leaving only the link to the current (6/1/14) agreement.

* ID Card (06/10/2014)
  - Overhauled entire chapter.

* Medical-Surgical Services (06/1/2014)
  - Added instructions on documenting the NDC codes for the person administering the medication in the following sections: “Chemotherapy,” “Immunizations,” “Injectable drugs,” and “Pharmaceuticals - specialty.”

* Participation (06/01/2014)
  - "Participation agreements" — Deleted the link to the now-outdated Participating
Hospital Agreement, leaving only the link to the current (6/1/14) agreement.

• **Problem Resolution (06/30/2014)**
  - "Provider Inquiry" — Updated the information Provider Inquiry will ask for when Michigan providers call in.

• **Radiology Management Program Procedure Codes (06/03/2014)**
  - "Preauthorization" — Added 76376 to this table.

• **Service Reviews (06/01/2014)**
  - “Purpose of audits” — Added documentation and coding accuracy audits to the list.

• **Skilled Nursing Facility Services (06/02/2014)**
  - “Reimbursement” — In the “Hospital-based SNF” section, deleted the link to the now-outdated Participating Hospital Agreement, leaving only the link to the current (6/1/14) agreement.

• **Value Partnerships (06/12/2014)**
  - Overhauled entire chapter.

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

5. All Medicaid trading partners

**Category:** Reminder for BCBSM clearinghouse submitters

**Title:** All Medicaid trading partners

**Start Date:** July 2, 2014 **End Date:** August 2, 2014

If you submit Medicaid claims through Blue Cross Blue Shield of Michigan, remember these items when completing your CHAMPS Provider Enrollment:

- Use BCBSM Billing Agent ID 1200009 for professional claims.
- Use BCBSM Billing Agent ID 1200018 for facility claims.
- Select ‘State of Michigan Data Exchange Gateway (DEG)’ as the method of retrieval when enrolling to receive electronic remittance (835) files.

If you need assistance completing MDCH enrollment information, contact the CHAMPS Provider Support help desk at 1-800-292-2550.

For questions about submitting 837 claims through BCBSM, contact our EDI help desk at 1-800-542-0945.

6. All Blue Cross Complete electronic submitters
Category: Delayed Blue Cross Complete 835 for check date 07/01/14

Title: All Blue Cross Complete electronic submitters

Start Date: July 2, 2014 End Date: July 17, 2014

Due to a systems issue, professional and institutional BCC 835 remittance files for check date 07/01/14 are delayed. BCBSM will distribute the files as soon as possible.

We apologize for any inconvenience.

7. New Individual and Small Group member care alerts display on web-DENIS — alerts will appear grey until commercial Health e-Blue℠ launches later this year

Category: BCBSM and BCN Individual and Small Group Member Care Alerts

Title: New Individual and Small Group member care alerts display on web-DENIS — alerts will appear grey until commercial Health e-Blue℠ launches later this year

Start Date: July 2, 2014 End Date: August 4, 2014

New member care alerts for Individual and Small Group (commercial*) members will display on the web-DENIS member eligibility screen beginning June 26, 2014. For a period of time, these alert buttons will appear grey as though the member has no gaps in care.

When commercial BCBSM and BCN Health e-Blue℠ functionality goes live later this year, the member care alerts will be color-coded to indicate whether the member has an open, closed or pending diagnosis gap or treatment opportunity. At that time, clicking on a member diagnosis gap or treatment opportunity will take you to the commercial BCBSM or BCN Health e-Blue home page where you’ll have the ability to close patient gaps.

Existing BCN and Medicare Advantage PPO Health e-Blue users will receive automatic access to commercial BCBSM Health e-Blue once it is live. If you don’t have current access to Health e-Blue, sign up today, or contact your provider consultant for more information.

Watch this page for future announcements about BCBSM and BCN Health e-Blue for Individual and Small Group members.

*Commercial refers to all business other than Medicare Advantage and Medicaid.

8. Formulary names now displayed in web-DENIS for BCN members
Beginning July 2, 2014, when you check member eligibility in web-DENIS for a Blue Care Network or BCN AdvantageSM member, you can see which drug formulary applies to the member. This will help you determine the most cost-effective drug choice for your patient.

When you open the Member Eligibility/Coverage screen, look under Current Product Summary. If the member has drug coverage, you will see the name of the formulary listed rather than the generic “Drugs” indicator. The name will appear as an active link. The link is not currently functional, but is expected to be fixed by July 10. Once active, the link will take you to a list of BCN formularies where you can click on the member’s drug list and review the member’s drug coverage.

9. Prior authorization to be required for additional specialty drugs

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berinert®</td>
<td>J0597</td>
</tr>
<tr>
<td>Cinryze®</td>
<td>J0598</td>
</tr>
<tr>
<td>Firazyr®</td>
<td>J1744</td>
</tr>
<tr>
<td>Kalbitor®</td>
<td>J1290</td>
</tr>
<tr>
<td>Synagis®</td>
<td>*90378</td>
</tr>
</tbody>
</table>
**Note:** We’re removing the requirement of prior authorization on the following drug as of Oct. 1, 2014:

<table>
<thead>
<tr>
<th>Drug</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mozobil®</td>
<td>J2562</td>
</tr>
</tbody>
</table>

Click [here](#) to find a list of medications that require prior authorization on web-DENIS. Then click on the medication for the prior authorization request form.

Please refer to the opt-out list for the groups that do not require members to participate in the program.

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

**Note:** The prior authorization requirement does not apply to Medicare, Medicare Advantage or Federal Employee Program® members.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

10. All Medicare Advantage trading partners

   **Category:** Delayed Medicare Advantage 835 remittance files
   
   **Title:** All Medicare Advantage trading partners
   
   **Start Date:** July 8, 2014 **End Date:** July 22, 2014
   
   Medicare Advantage 835 remittance files for check date 7/8/14 have been delayed. All files will be distributed as soon as possible.
   
   We apologize for any inconvenience.

11. Domestic line incorrectly displaying on member deductible, copay screen

   **Category:** Web-DENIS
   
   **Title:** Domestic line incorrectly displaying on member deductible, copay screen
We are currently experiencing an issue on the Deductible/Copay screen on web-DENIS. A domestic line is displaying for many contracts in error. Please disregard this line unless there are dollar amounts present. We expect this issue to be corrected later this week.

12. Update: BCBSM Medicare Advantage PPO modifier L1

**Category:** Medicare Advantage

**Title:** Update: BCBSM Medicare Advantage PPO modifier L1

**Start Date:** July 9, 2014  **End Date:** July 31, 2014

Blue Cross Blue Shield of Michigan Medicare Advantage PPO recently published a web-DENIS message about the Centers for Medicare & Medicaid Services adding modifier L1 (separately payable lab test) as a valid modifier for hospital bill type 13X.

We are aware of an issue with claims rejecting due to this newly implemented modifier.

We are researching this issue and apologize for the confusion this change has caused. We will update you via a web-DENIS message as soon as we have more information.

Thank you for your patience.

13. All Blue Care Network electronic trading partners

**Category:** Erroneous BCN 277x228 pended claim transaction distributed

**Title:** All Blue Care Network electronic trading partners

**Start Date:** July 9, 2014  **End Date:** July 23, 2014

Due to a systems issue on July 7, 2014, test BCN 277x228 pended claims transactions and reports were distributed erroneously in production.

The file name for the Transaction: 277x228188

The file name for the Reports:

- Institutional = R277CAQ188
- Professional = R277CAJ188

Please disregard these files.
At this time BCN is not in production with the 277x228 transactions and reports (Professional: R277CAJ, Institutional: R277CAQ). An updated broadcast message will be provided when BCN is ready to go to production.

We apologize for any inconvenience.

14. Reminder: Where to send Medicare Advantage CMS-1500 paper claim forms

Category: Medicare Advantage

Title: Reminder: Where to send Medicare Advantage CMS-1500 paper claim forms

Start Date: July 10, 2014 End Date: August 8, 2014

To submit paper claims and avoid processing delays, please send BCBSM Medicare Advantage CMS-1500 paper claim forms to:

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

Please continue to submit your claims electronically. Only use the above address for any necessary paper claims.

15. Materials from June Michigan Hospital Networking session available

Category: Hospitals

Title: Materials from June Michigan Hospital Networking session available

Start Date: July 10, 2014 End Date: July 25, 2014

The presentations made at the Michigan Hospital Networking session in Southfield on Tuesday, June 17, 2014 are now available on web-DENIS to all hospital providers that weren’t able to make the event. To access the presentations given during the session:

- Click on BCBSM Provider Publications and Resources.
- Click on Newsletters and Resources.
- In the “What’s New” section, find Presentations from June 17, 2014 Michigan Hospital Networking session.

All the presentations from forums and provider fairs in the past year can also be found on the Provider Training page.
Thank you to all who attended.

16. We’re aligning BCBSM Medicare Advantage PPO with CMS fee schedule and pricer updates

Category: Medicare Advantage

Title: We’re aligning BCBSM Medicare Advantage PPO with CMS fee schedule and pricer updates

Start Date: July 10, 2014 End Date: July 24, 2014

We’ve received the Centers for Medicare & Medicaid Services fee schedule and pricer updates and are aligning our claims system accordingly. The changes will show an effective date of July 1, 2014, with an implementation date of July 7, 2014.

Here is BCBSM’s action plan:

• **Medicare Ambulatory Surgical Centers Prospective Payment System and Outpatient Prospective Payment System**
  
  o We plan to align with CMS and have the Ambulatory Surgical Centers PPS and OPPS pricer updates in production by July 7, 2014, with reimbursements to be paid no later July 15, 2014.

• **Skilled nursing facilities and end stage renal disease**
  
  o BCBSM will reimburse these two claim categories using the current pricer. We will then automatically adjust claims affected by the July 1, 2014, pricer updates after those updates are implemented.

We will communicate additional information regarding the fee schedule and pricer updates as they become available.

17. All Medicare Advantage trading partners

Category: Delayed Medicare Advantage 835 remittance files

Title: All Medicare Advantage trading partners

Start Date: July 14, 2014 End Date: July 28, 2014

Medicare Advantage 835 remittance files for check date 7/15/14 are delayed. All files will be distributed as soon as possible.
18. Webinar on mental health parity alignment scheduled

**Category:** Mental health parity

**Title:** Webinar on mental health parity alignment scheduled

**Start Date:** July 14, 2014  **End Date:** July 22, 2014

Webinar on mental health parity alignment scheduled

A webinar on mental health parity alignment is set for July 22, 2014, from 10 a.m. to noon.

We’ll be providing an overview of the behavioral health authorization process changes that become effective Sept. 1, 2014. Utilization Review directors and staff who are involved in the authorization process are encouraged to attend.

Registration is required; to register click [here](#).

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

19. Correction: BCBSM Medicare Advantage PPO updates system for L1 modifier

**Category:** Medicare Advantage

**Title:** Correction: BCBSM Medicare Advantage PPO updates system for L1 modifier

**Start Date:** July 14, 2014  **End Date:** July 31, 2014

BCBSM Medicare Advantage PPO recently shared information via web-DENIS about how The Centers for Medicare & Medicaid Services added modifier L1 (separately payable lab test) as a valid modifier, effective July 1, 2014.

We’ve updated our system to correct an effective date error associated with the L1 modifier. Our system now recognizes dates of service for Jan. 1, 2014, and after.

Claims submitted between June 30, 2014, through July 11, 2014, that were wrongly processed with MF10 or MP04 were reprocessed late last week.

BCBSM Medicare Advantage PPO will reprocess claims that denied inappropriately with modifier L1 for dates of service Jan. 1, 2014 and after within the next few weeks.

Please include modifier L1 on facility claims, using type of bill 13X for laboratory services as appropriate.
Thank you for your cooperation and we apologize for any confusion.

20. **Additional fee change schedules added to web-DENIS**

*Category:* Fee Changes

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

**Start Date:** July 14, 2014  **End Date:** July 28, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 14, 2014

- **Professional**
  - Traditional, TRUST & Blue Preferred Plus SM
  - Injection
  - Independent Lab
- **Facility**
  - Outpatient Hospital

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

21. **Recovery underway for durable medical equipment claims billed with BiPAP procedures**

*Category:* Recoveries

**Title:** Recovery underway for durable medical equipment claims billed with BiPAP procedures

**Start Date:** July 15, 2014  **End Date:** July 29, 2014


Professional durable medical equipment claims billed with bilevel positive airway pressure procedure codes A9901, E0470-E0472 were rejecting X366 and X368 in error.

When you adjust patients' accounts to reflect the correct payments, the subscribers’ liability may change.

22. **Totals not displaying for some contracts on member deductible, copay screen**

*Category:* Web-DENIS
23. Update: Domestic line error on member deductible, copay screen resolved

Category: Web-DENIS

Title: Update: Domestic line error on member deductible, copay screen resolved

Start Date: July 16, 2014 End Date: July 23, 2014

We have resolved the issue on the Deductible/Copay screen on web-DENIS. A domestic line was displaying for many contracts in error.

We apologize for any inconvenience this may have caused.

24. Medicare Eligibility

Category: System Maintenance for July 18 and July 19, 2014

Title: Medicare Eligibility

Start Date: July 16, 2014 End Date: July 21, 2014

There is scheduled maintenance for Medicare Eligibility. The maintenance window will begin at 9:30 PM ET on Friday, July 18, 2014. The Medicare Eligibility application system will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 5:00 PM ET on Saturday, July 19, 2014.

Please contact the Help Desk if you have any questions.

25. Register now for live webinar on the use of estrogen utilization in the 65 and older population

Category: Professional Providers

Title: Register now for live webinar on the use of estrogen utilization in the 65 and older population
BCBSM is hosting a webinar Wednesday, Aug. 27, from 8 to 8:30 a.m., for professional providers, on the use of estrogen utilization in the 65 and older population. The speaker for the webinar is Patricia A. Ferguson, M.D., F.A.C.O.G.

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date, time and title of the class you wish to attend, as well as your national provider identifier. You’ll receive a confirmation within 72 hours of registering. Instructions on how to access the webinar will be sent with the confirmation email or prior to the webinar.

26. Register for Upper Peninsula training classes

Category: Training

Title: Register for Upper Peninsula training classes

Start Date: July 18, 2014 End Date: August 13, 2014

There’s still time to register for BCBSM professional and facility training sessions in the Upper Peninsula. The sessions will be Aug. 19 and 20 at the Holiday Inn in Marquette. Additional information is available in the June Record.

To accommodate driving times across the U.P., we will begin our classes one hour later than usual, with registration beginning at 9:30 a.m. and class starting at 10 a.m.

We are training professional office staff on Tuesday, Aug. 19. The class will cover documentation and coding, ICD-10, national health care reform and a BCBSM informational session.

We are training hospital staff on Wednesday, Aug. 20. The facility class will cover general billing tips, web-DENIS and a Q&A session. To register, email Jeff Holzhausen at jholzhausen@bcbsm.com. If you are registering for the professional class, please put “Prof RMRA Marquette” in the subject line. If you are registering for the facility class, please put “Facility Marquette” in the subject line.

We look forward to seeing you at these free classes.

27. New accumulator solution to roll out displaying used amount for limited number of groups

Category: Web-DENIS cost sharing

Title: New accumulator solution to roll out displaying used amount for limited number of groups
Start Date: July 21, 2014  End Date: August 4, 2014

A new accumulator solution will be used to display benefit accumulations and maximums on the *Deductible/Copay* screen on web-DENIS. This will be a pilot for a small number of Blue Cross Blue Shield of Michigan MOS groups. For all other groups, you will continue to see the current screens. To view a demo of the new feature, follow the steps below:

1. Log in to web-DENIS.
2. Click on *BCBSM Provider Publications and Resources*.
3. Click on *Newsletters and Resources*.
4. The Provider hot tip clip for the new accumulator solution can be found under *What’s New* and *Provider Training*.

Contact your BCBSM and BCN provider consultant to share your thoughts on the new training or email us at providertraining@bcbsm.com. We value your opinion.

28. Additional fee schedules added to web-DENIS

**Category:** Fee Changes

**Title:** Additional fee schedules added to web-DENIS

**Start Date:** July 21, 2014  **End Date:** August 4, 2014

Professional

**State of Michigan Mental Health Managed Care Program Professional Fee Schedule**

- SOM Mental Health Managed Care Program (7/1/14) (Excel) (Revised 7/11/14)
- SOM Mental Health Managed Care Program (7/1/14) (PDF) (Revised 7/11/14)
- SOM Mental Health Managed Care Program (7/1/13) (Excel)
- SOM Mental Health Managed Care Program (7/1/13) (PDF)
- SOM Mental Health Managed Care Program (1/1/13) (Excel)
- SOM Mental Health Managed Care Program (1/1/13) (PDF)

Facility

**Outpatient Psychiatric Care Facility (OPC)**

- OPC Traditional and Mental Health Managed Care Program Fees (7/1/14) (Revised 7/11/14)
- OPC Traditional and Mental Health Managed Care Program Fees (7/1/13) (Revised 7/11/14)
The previously published (as of 06/02/2014) facility Outpatient Psychiatric Care fee change schedule includes additional Evaluation & Management codes payable effective 1/1/13. The newly published or revised entire fee schedules also have the additional Evaluation & Management codes listed. The June 2014 Record article titled “Here’s an update on how we’re processing behavioral health claims” includes information regarding the addition of Evaluation & Management codes due to CPT coding changes that became effective 1/1/13.

Furthermore, the above noted Record article also includes information that effective Aug. 1, 2014; we will no longer allow M0064 to be reimbursed. Instead, an appropriate Evaluation & Management code must be billed.

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

29. Update: Totals not displaying error on member deductible, copay screen resolved

Category: Web-DENIS

Title: Update: Totals not displaying error on member deductible, copay screen resolved

Start Date: July 21, 2014 End Date: August 4, 2014

We have resolved the issue on the Deductible/Copay screen on web-DENIS. All member’s paid copay and deductible totals are now displaying at the patient level. We apologize for any inconvenience this may have caused.

30. EPA access unavailable

Category: Scheduled Maintenance

Title: EPA access unavailable

Start Date: July 23, 2014 End Date: July 28, 2014

The Electronic Provider Access tool will be unavailable beginning at 4 p.m. on Saturday, July 26, through 2 a.m. Sunday, July 27, due to scheduled maintenance. Attempts to access EPA information during this time will result in errors.

The Electronic Provider Access tool gives you access to other Blue plan provider portals for the out-of-state members you treat.

We apologize for any inconvenience this may cause.
31. Blue Exchange access unavailable

**Category:** Scheduled Maintenance

**Title:** Blue Exchange access unavailable

**Start Date:** July 23, 2014 **End Date:** July 28, 2014

The Blue Exchange application will be unavailable from 6 p.m. Sunday, July 27, until approximately 1 a.m. on Monday, July 28, due to scheduled maintenance. Attempts to access the Blue Exchange application during this time will result in errors.

We apologize for any inconvenience this may cause.

32. All Blue Cross Complete electronic submitters

**Category:** Delayed Blue Cross Complete 835s for check date 07/22/14

**Title:** All Blue Cross Complete electronic submitters

**Start Date:** July 24, 2014 **End Date:** August 7, 2014

Due to a systems issue, professional and institutional BCC 835 remittance files for check date 07/22/2014 are delayed. We will distribute the files this evening.

We apologize for any inconvenience.

33. Reminder to submit local claims by deadline

**Category:** All providers

**Title:** Reminder to submit local claims by deadline

**Start Date:** July 25, 2014 **End Date:** August 8, 2014

The deadline to file claims on the local system is Sept. 15, 2014. This will allow Blue Cross Blue Shield of Michigan to process and finalize all claims before the Oct. 31, 2014, local system retirement date.

For professional and facility claims, you'll be able to view these claims only on webDENIS until Oct. 31, 2014. As a reminder if local claims are submitted after the filing deadline of Sept. 15, 2014, BCBSM will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

For more information about this change, please refer to the [March 2014 Record](#).
34. Vaccine injection claims billed with procedure code *90715 paid incorrectly

**Category:** Professional Claims

**Title:** Vaccine injection claims billed with procedure code *90715 paid incorrectly

**Start Date:** July 28, 2014  **End Date:** August 11, 2014

Some BCBSM vaccine injection claims billed with procedure code *90715 were paid incorrectly for claims processed May 1 through July 18, 2014. We inadvertently applied and posted a minimum fee of $4.41 for vaccine code *90715 on the May 1, 2014, Injections Minimum Fee Schedule. We corrected the minimum fee to $44.60 on the July 28, 2014, injections minimum fee change schedule.

If you were paid the minimum fee of $4.41 (per 0.5 ML) for this vaccine for dates of service on or after May 1, 2014, you can resubmit your claim for the appropriate minimum payment. If you have the national drug code available for this vaccine, please submit this information to receive reimbursement of the actual service provided.

35. Commercial Health e-Blue℠ Training Dates

**Category:** BCBSM Health e-Blue℠ Training Dates

**Title:** Commercial Health e-Blue℠ Training Dates

**Start Date:** July 28, 2014  **End Date:** August 26, 2014

Health e-Blue℠ for BCBSM Individual and Group patients is scheduled to be operational on Aug. 7, 2014. This new BCBSM Health e-Blue portal will allow you to close diagnosis gaps and treatment opportunities online, creating an efficient process for gap closure.

BCBSM will offer informational webinars about the new Health e-Blue site for Individual and Group patients. If you are an existing user, the navigation and use of the site will be similar to the Medicare Advantage PPO and BCN Health e-Blue sites.

Webinars will be offered on the following dates:

- Wednesday, Aug. 6 – 8 to 10 a.m.
- Tuesday, Aug. 12 – Noon to 2 p.m.
- Wednesday, Aug. 20 – Noon to 2 p.m.
- Tuesday, Aug. 26 – 8 to 10 a.m.

To register, send an email to SEprofessionaleducationregistration@bcbsm.com and include the date and time of the class you wish to attend, as well as your national provider
identifier and your title or role within your office. You will receive confirmation within 72 hours of registering.

For more information, view Training available for BCBSM Health e-Blue (PDF).

36. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: July 28, 2014 End Date: August 11, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning July 28, 2014

1. Professional
   1. Traditional, TRUST & Blue Preferred Plus SM
   2. DME
   3. DME NDC
   4. Independent Lab
   5. Injection

2. Facility
   1. Outpatient Hospital
   2. Ambulatory Surgery Facility

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

37. BCBSM Medicare Advantage PPO will update its Physician Office Lab List

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO will update its Physician Office Lab List

Start Date: July 29, 2014 End Date: October 29, 2014

Blue Cross Blue Shield of Michigan will update its Medicare Advantage PPO Physician Office Lab List on or after Oct. 29, 2014, to most accurately reflect currently recognized codes and procedures provided in a Clinical Laboratory Improvement Amendments or a Provider Performed Microscopy Procedures certified office setting.

The Medicare Advantage POLL is housed on BCBSM’s provider website at bcbsm.com/provider/ma. To find the list:

1. Click on Medicare Plus Blue.
2. Click on Provider Toolkit.
3. Under Coverage Details, click Medicare Advantage PPO lab network.
4. The POLL list is mentioned near the bottom of that page.

Please note:

5. Providers who render lab services that aren’t on this list will not be paid.
6. BCBSM Medicare Advantage PPO members cannot be billed for a lab service that isn’t on this list.
7. Providers must have the appropriate complexity level of certification required to perform and bill several of the applicable procedures.

Among the key changes are:

8. 17 procedure codes will be deleted.
9. 40 procedure codes will be added.
10. Some of the new codes added will include select Provider-performed Microscopy Procedures and two stat complete blood count codes.

In the meantime, please continue to use the Medicare Advantage Physician Office Lab List on our provider website. If you have any questions, please contact your provider consultant.

Resources:
http://www.fda.gov/medicaldevices/deviceregulationandguidance/ivdregulatoryassistance/ucm124105.htm *

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

38. All Blue Cross Complete electronic submitters

Category: Delayed Blue Cross Complete 835s for check date 07/29/14

Title: All Blue Cross Complete electronic submitters

Start Date: July 30, 2014 End Date: August 13, 2014

Due to a systems issue, professional and institutional BCC 835 remittance files for check date 07/29/14 are delayed. We will distribute the files as soon as possible.
We apologize for any inconvenience.

39. All Medicare Part B trading partners

**Category:** WPS 277CA Reports

**Title:** All Medicare Part B trading partners

**Start Date:** July 30, 2014 **End Date:** August 13, 2014

A small number of Medicare Part B 277CA reports dated 7/30/14 were not distributed or were distributed with invalid information. We are working with Wisconsin Physician’s Service to resolve the issue. If you submitted claims on 7/29/14 and have not received a 277CA report, or you received a report without detail, you may be affected.

We will post an updated message when additional information is available.

We apologize for any inconvenience.

40. Blue Elect Plus Self-Referral Option℠ Details

**Category:** Blue Elect Plus Self-Referral Option℠

**Title:** Blue Elect Plus Self-Referral Option℠ Details

**Start Date:** July 30, 2014 **End Date:** August 30, 2014

Members of the Blue Elect Plus Self-Referral Option product must select a primary care physician from BCN’s provider network, but then may choose to self-refer to any in-network or out-of-network provider.

Members pay the lowest costs when their care is provided by their primary care physician or by another provider in the BCN network. Certain services are covered only when provided by a BCN provider.

Requirements for plan notification and benefit and clinical review apply whether services are performed by BCN or non-BCN providers. Providers do not need to give referrals to Blue Elect Plus Self-Referral Option members.

Additional information on Blue Elect Plus Self-Referral Option can be found in the *BCN Provider Manual*, specifically in [Chapter 8: Care Management, beginning on page 8-31](#) (PDF).

41. Reimburse UAW staff and URMBT members for incorrectly paid amounts

**Category:** Recoveries
Title: Reimburse UAW staff and URMBT members for incorrectly paid amounts

Start Date: July 30, 2014  End Date: August 31, 2014

NASCO is conducting a recovery of claims for all UAW staff and UAW Retiree Medical Benefits Trust members for claims processed Aug. 1, 2013, through March 1, 2014. We are paying health care providers for services that members may have already paid them for, and providers should reimburse members as needed.

The Blues rejected claims with cost-sharing under the primary coverage, which resulted in members paying health care providers for services that we should have paid. In some cases, UAW members were referred to a collection agency when BCBSM didn’t pay the cost-sharing amount.

We’re in the process of making payments to the providers as part of the recovery. Providers should reimburse UAW members for any amounts they incorrectly paid.

We apologize for any inconvenience this may cause.

42. Blue Cross Complete Home Health Providers: Claims with bill type 032x

Category: Blue Cross Complete claims

Title: Blue Cross Complete Home Health Providers: Claims with bill type 032x

Start Date: July 30, 2014  End Date: August 22, 2014

Blue Cross Complete is in the process of updating its claims processing system to accept bill type 032x. During this time, any claims billed with bill type 032x will be pended and not denied. The configuration is expected to be completed by the end of August 2014, at which time, we will notify providers via a web-DENIS broadcast message. Thank you for your patience.

43. Medicare Eligibility Maintenance


Title: Medicare Eligibility Maintenance

Start Date: July 30, 2014  End Date: August 4, 2014

There is scheduled maintenance for the Medicare Eligibility application. The maintenance will begin at 8:00 AM ET on Saturday, August 2, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility application will result in errors. The maintenance window will be completed by 9:00 AM ET on Sunday, August 3, 2014.
Please contact the Help Desk if you have any questions.

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

44. All Blue Care Network electronic trading partners

**Category:** Erroneous BCN 277CA distributed 7/24/14

**Title:** All Blue Care Network electronic trading partners

**Start Date:** July 31, 2014 **End Date:** August 14, 2014

Blue Care Network erroneously distributed two versions of some 277CA files dated 7/24/14 using the same file name. One version contains valid claim data. The other version contains invalid data and 2012 or earlier dates of service.

Please disregard the 277CAP205 transaction or R277CAF205 report that reflects invalid information.

We apologize for any inconvenience

45. Use revised NOMNC forms for BCN Advantage™ members starting Aug. 1, 2014

**Category:** BCN Advantage™

**Title:** Use revised NOMNC forms for BCN Advantage™ members starting Aug. 1, 2014

**Start Date:** July 31, 2014 **End Date:** August 15, 2014

Revised *Notice of Medicare Non-Coverage* forms are now available on [BCN’s e-referral Forms page](#). Contracted providers must use the revised NOMNC forms starting Aug. 1, 2014. Please discard any forms printed prior to Aug. 1, 2014.

The revised forms show that KEPRO is the Quality Improvement Organization for BCN Advantage members. KEPRO replaces MPRO, the previous QIO, effective Aug. 1, 2014.

The NOMNC form must be given to BCN Advantage members who are in a skilled nursing or comprehensive outpatient rehabilitation facility or who are receiving home health services at least two days before coverage for those services ends, whether or not the member agrees with the discharge plan.

Members may request a QIO review from KEPRO if they disagree with the decision to discharge. The NOMNC forms include detailed instructions about how the member can make an immediate appeal directly to KEPRO, including KEPRO’s address and phone number.
The forms are available in both Microsoft® Word® and Adobe® PDF formats.

The forms are also available on BCN’s web-DENIS BCN Advantage page and Forms page, but providers can readily access them on the e-referral website without having to log in.

Instructions for using the NOMNC form are available on the Web pages and in the BCN Advantage chapter of the BCN Provider Manual, which can be accessed from on BCN’s e-referral Provider Manual page.
1. BCBSM electronic provider manuals — July 2014 changes

**Category:** Online manuals

**Title:** BCBSM electronic provider manuals — July 2014 changes

**Start Date:** August 1, 2014  **End Date:** August 15, 2014

These are the chapters we revised in July 2014, along with the revision date and a brief statement of the main changes for each.*

- **Ambulatory Infusion Center Services** (07/25/2014)
  - Overhauled the entire chapter.
- **Appeals** (07/17/2014)
  - "Claim disputes" — Added more detail to this section (for hospitals only).
- **Blue Pages Directory** (07/01/2014)
  - "Blue Distinction Centers for Specialty Care" — Updated the phone and fax numbers.
    - “Chrysler – Bargaining BPP, PPO and SCN”— Replaced previous information with ValueOptions’ phone number for mental health and substance abuse services.
  - "Practice profiles for physicians (M.D.s and D.O.s)" — Updated the topic content and added an email option for requesting practice profiles.
  - "Provider Consulting Services" — For all regions' professional charts, replaced the detailed information with a link to the updated details on the public website at bcbsm.com/provider. **Note:** We’re working to update the facility consultant information and will replace the facility charts as soon as the updated information has been posted.
- **Blue Preferred Plus** (07/01/2014)
  - "Contact information" — In the "Chrysler corporation" table, changed the phone number for ValueOptions and deleted the word "Partial" before carve out in the "Mental health and substance abuse care" entry.
- **BlueCard Program** (07/01/2014)
  - Overhauled the entire chapter.
- **Claims** (07/01/2014)
  - “Filing limit” — In the facilities manuals, updated the time limit from 24 months to 12 months. Also added instructions and the time limit for adjustment claims.
- **Durable Medical Equipment, Medical Supplies, and Prosthetics and Orthotics Services** (07/01/2014)
  - “Conditions and limitations/Prescription and CMN” — In the DME, Medical supplies and P&O sections, added information about prescriptions for routine refills; also added a new subsection titled “Refills.”
- **Hearing Care Services** (07/09/2014)
  - “Noncovered services” — Added information about dispensing fees.
- **Home Infusion Therapy Services** (07/25/2014)
- Overhauled the entire chapter.

**Hospital Services (07/29/2014)**
- “Room and board” — In the “Billing guidelines” section, added clarification that the “admit” date may be after the “from” date.
- “Reimbursement” — Added information about the high-tech procedures in the fee schedule.

**Immunizations Administered at Pharmacies Program (07/01/2014)**
- Overhauled the entire chapter.

**Long-Term Acute Care Hospital Services (07/11/2014)**
- Overhauled the entire chapter.

**Medical-Surgical Services (07/22/2014)**
- "Newborn care" — In the "For members with National Health Care Reform coverage" section, updated the name of the advisory committee.

**Patient Eligibility (07/01/2014)**
- “Overview” — Added a reminder note that the checking of member eligibility and benefits is the provider’s responsibility rather than the member’s.

**PPO Policies (07/01/2014)**
- "Referrals" — Added information about which programs do not acknowledge PPO referrals.
- "Disaffiliation" — In the "Appeals policy" section, revised the table that explains first- and second-level appeals.
- "Disaffiliation" — In the "Continuity-of-care guidelines" section, deleted references to public acts 228 and 229, which no longer pertain.

**Preapproval of Services (07/01/2014)**
- "About clinical criteria" — Updated the "Questions about criteria" section.

**Problem Resolution (07/24/2014)**
- "Electronic standard transactions" — Added this section.

**Psychiatric Care Services (07/01/2014)**
- “Billing guidelines” — In the "Outpatient psychiatric care program – facility" section, revised the HO modifier’s list of provider types.

**Radiology Management Program Procedure Codes (07/22/2014)**
- Overhauled the entire chapter.

**Service Reviews (07/14/2014)**
- “Transfer policy” — Added this new section.

**Valid Modifiers (07/01/2014)**
- “Valid modifiers: pathology and laboratory services” — Added modifier LT.
- “Added modifier SZ to the following sections:
  • “Valid modifiers: durable medical equipment”
  • “Valid modifiers: evaluation and management”
  • “Valid modifiers: medical supplies”
  • “Valid modifiers: prosthetics and orthotics”

**Urgent Care Center Services (07/15/2014)**
- Overhauled the entire chapter.
*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

2. Correction: Fax number for BCBSM Medicare Advantage PPO patient-level data

Category: Medicare Advantage

Title: Correction: Fax number for BCBSM Medicare Advantage PPO patient-level data

Start Date: August 4, 2014 End Date: August 18, 2014

On July 30, 2014, we sent a letter to some of our providers asking for support to improve prescribing best practices for our members.

The letter provided an opportunity for you to ask us for patient-level data that would identify possible treatment gaps. **The toll-free area code of the fax number was wrong. The correct fax number is 1-877-277-1143.**

The letter also included a *Treatment Opportunity Scorecard* that provided a snapshot of where you stand with Blue Cross Blue Shield of Michigan Medicare Advantage PPO target goals. These goals are focused on five clinical measures aligned with the Centers for Medicaid & Medicare Services. The scorecard can help identify ways to align with CMS best practices and also alerts you to an opportunity to increase your payout through our *Provider Recognition Program*.

We apologize for any inconvenience this fax number error has caused and appreciate your patience. If you have any questions, please contact your provider consultant.

3. BCBSM Medicare Advantage PPO clarification on two-midnight rule and related changes

Category: Medicare Advantage

Title: BCBSM Medicare Advantage PPO clarification on two-midnight rule and related changes

Start Date: August 6, 2014 End Date: September 1, 2014

In the February 2014 Record, Blue Cross Blue Shield of Michigan announced its intent to closely match the Centers for Medicare & Medicaid Services in implementing the Medicare 2014 inpatient rule changes for Medicare Advantage PPO plans, including the two-midnight rule, effective April 1, 2014. Following that announcement, Blue Cross received numerous requests from providers for additional clarification.
We’ve created a detailed question and answer document that we hope will further assist our provider community. This Q&A will be published in the September Record and is also posted on web-DENIS by clicking on BCBSM Provider Publications and Resources, then Newsletters and Resources and then Medicare Advantage Resources.

4. BCBSM Medicare Advantage PPO adjusting rural health clinic preventive service claims

**Category:** Medicare Advantage

**Title:** BCBSM Medicare Advantage PPO adjusting rural health clinic preventive service claims

**Start Date:** August 7, 2014 **End Date:** August 21, 2014

Blue Cross Blue Shield of Michigan incorrectly applied cost-sharing for Medicare Advantage PPO preventive service claims from rural health clinics. The affected claims will be adjusted on Aug. 8, 2014, and providers can expect to see adjustments in their Aug. 14 payments.

We apologize for the inconvenience this error may have caused and thank you for your patience. If you have any questions, please contact your provider consultant.

5. BCBSM Commercial Health e-BlueSM is operational

**Category:** BCBSM and BCN Health e-BlueSM

**Title:** BCBSM Commercial Health e-BlueSM is operational

**Start Date:** August 7, 2014 **End Date:** August 21, 2014

The new instance of Health e-BlueSM for Individual and Group patients is operational as of Aug. 7, 2014. This new BCBSM Health e-Blue portal will allow you to close diagnosis gaps and treatment opportunities online, creating an efficient process for gap closure. A BCBSM Health e-Blue User Guide is available below under Help and Training Documents.

Please see **BCBSM Health e-Blue now available** for features and more information.

In addition, member care alerts that have been displaying as grey for BCBSM Individual and Small Group patients on the web-DENIS member eligibility screen will now be color-coded to indicate if a member has an open, closed or pending diagnosis gap or treatment opportunity. Clicking on a member diagnosis gap or treatment opportunity will link to the commercial BCBSM Health e-Blue home page where the member gaps can be closed.
There are three informational webinars about the new Health e-Blue site for Individual and Group patients remaining. If you are an existing user, the navigation and use of the site will be similar to the Medicare Advantage PPO and BCN Health e-Blue sites. View the training available for BCBSM Health e-Blue (PDF) here.


Category: Professional and Facility claims

Title: Preauthorization changes to Radiology Management Program, effective Jan. 1, 2015

Start Date: August 7, 2014   End Date: August 21, 2014

We’re notifying you of two upcoming changes to our PPO Radiology Management Program, administered through AIM Specialty Health. Starting Jan. 1, 2015, we will:

1. Require preauthorization for the following cardiac imaging procedures:
   - Stress echocardiography
   - Transesophageal echocardiography
   - Resting transthoracic echocardiography
   - These services do not require preauthorization today, either in the office or in a hospital outpatient location.

2. Enforce preauthorization for radiological procedures that are part of the Radiology Management Program and are performed in hospital outpatient locations.

For more information, see the article in the August 2014 Record.

7. Facilities should use accurate coding when billing for RhoGAM

Category: BCN billing for RhoGAM

Title: Facilities should use accurate coding when billing for RhoGAM

Start Date: August 7, 2014   End Date: August 20, 2014

Rho(D) immune globulin (for example, RhoGAM™) may be a required treatment for pregnant or postpartum women. This is determined by a blood test the physician orders during pregnancy to determine the Rh and ABO blood typing.

Blue Care Network does not require a referral for the Rho(D) immune globulin injection when performed by contracted providers.

To facilitate reimbursement, follow the few simple steps below:
• Identify the correct CPT or HCPCS code for the Rho(D) immune globulin being provided to the member.
• Report this CPT or HCPCS code under revenue code 0250.
• For the administration of the injection, use CPT code *96372.
• Report the administration CPT code under revenue code 0940.
• To identify the member as requiring the injection related to pregnancy, please report the diagnosis codes of 656.10, 656.11, or 656.13.

Reporting the services in any other manner may result in a delay or possible denial of services, such as for an authorization or referral.

Billing instructions for services associated with Rho(D) immune globulin are available on the web-DENIS BCN Provider Publications and Resources page under Billing.

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8. BCBSM adjusts Medicare Advantage PPO nerve block injection claims

**Category:** Medicare Advantage

**Title:** BCBSM adjusts Medicare Advantage PPO nerve block injection claims

**Start Date:** August 8, 2014 **End Date:** August 23, 2014

Effective Nov. 8, 2014, procedure code *64450 cannot be billed in an office setting with any of the following ICD-9 diagnosis codes:

<table>
<thead>
<tr>
<th>ICD-9 Code 1</th>
<th>ICD-9 Code 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>249.60</td>
<td>356.0-356.9</td>
</tr>
<tr>
<td>249.61</td>
<td>357.0-357.9</td>
</tr>
<tr>
<td>250.60-250.63</td>
<td>719.47</td>
</tr>
<tr>
<td>354.5</td>
<td>729.2</td>
</tr>
<tr>
<td>355.8</td>
<td>782.0</td>
</tr>
<tr>
<td>355.9</td>
<td></td>
</tr>
</tbody>
</table>

To avoid rejections and ensure your claims process smoothly, please follow the above chart.

Any claims that were incorrectly denied since June 17, 2014, will be adjusted.
If you have any questions, please contact your provider consultant.

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9. All Internet Claim Tool users

Category: Scheduled System Maintenance – August 16 and 17, 2014

Title: All Internet Claim Tool users

Start Date: August 11, 2014 End Date: August 18, 2014

BCBSM will perform system maintenance from 6:00 a.m. EST on Saturday, Aug. 16 until 6:00 a.m. EST on Sunday, Aug. 17, 2014. You will be unable to access the internet claim tool during this time period.

We apologize for any inconvenience.

10. Diagnosis Specific Pricing fee change schedules added to web-DENIS

Category: Fee Changes

Title: Diagnosis Specific Pricing fee change schedules added to web-DENIS

Start Date: August 11, 2014 End Date: August 25, 2014

BCBSM recently added these Diagnosis Specific Pricing fee change schedules to web-DENIS, for the week beginning August 11, 2014

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

As BCBSM communicated in our July 2014 The Record article titled “Preauthorization for proton beam therapy required”, “Proton beam therapy, used for prostate cancer, hasn’t been demonstrated to be superior to other forms of external beam radiation therapy. The benefit and payment terms are limited to the allowed amount equivalent to intensity-modulated radiation therapy services. For contracted providers, this level of payment is considered payment in full and balance billing the member is not permitted.”

The Diagnosis Specific Pricing fee change schedules noted above contain the following information for proton beam therapy HCPCS codes:
o Established Diagnosis Fee (the maximum fee for services subject to diagnosis specific pricing (e.g., proton beam therapy), when the service is established for the diagnosis reported)

o Not Medically Necessary Diagnosis Fee (the maximum fee for equally effective but less costly alternative, established services (e.g., the maximum fee for when proton beam therapy was provided, but not medically necessary for the diagnosis reported))

A fuller description of Diagnosis Specific Pricing will be published in The Record this fall.

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

For more information, contact your BCBSM provider consultant.

11. All Blue Care Network trading partners

Category: Delayed BCN 277CA transactions/reports

Title: All Blue Care Network trading partners

Start Date: August 12, 2014 End Date: August 26, 2014

Due to a system issue, BCN R277CAF reports and 277CAP transactions for August 12, 2014 are delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience.

12. BCBSM begins Medicare Advantage PPO provider medical record requests

Category: Medicare Advantage

Title: BCBSM begins Medicare Advantage PPO provider medical record requests

Start Date: August 12, 2014 End Date: September 15, 2014

Beginning the week of Aug. 10, 2014, Blue Cross Blue Shield of Michigan will mail letters to its Medicare Advantage PPO providers requesting medical records. The letter requests selected medical records for dates of service from Jan. 1, to Dec. 31, 2013.

The Centers for Medicare & Medicaid Services requires Medicare Advantage plans to submit detailed, ongoing documentation about each member. Requested medical records should include patient history and physical exam, physician progress notes, consultations and procedures.
Please return the needed documents within four weeks by fax or mail as detailed in the letter. BCBSM will reimburse you $5 for each medical record. A reimbursement request form will also be included in this mailing.

Thank you in advance for your cooperation. If you have any questions, please contact your provider consultant.

13. All Blue Care Network trading partners UPDATE

Category: BCN claim processing and 277CA delays

Title: All Blue Care Network trading partners UPDATE

Start Date: August 13, 2014 End Date: August 27, 2014

A Blue Care Network system issue delayed processing of claims received from late afternoon on 08/08/14 through 08/12/14. As of 8/14/14, the system issue was resolved and all delayed claims have been processed and corresponding reports have been distributed.

Thank you for your patience

14. All Blue Cross Complete electronic submitters

Category: Delayed Blue Cross Complete 835s for check date 08/12/14

Title: All Blue Cross Complete electronic submitters

Start Date: August 13, 2014 End Date: August 27, 2014

Due to a systems issue, professional and institutional BCC 835 remittance files for check date 08/12/14 are delayed. We will distribute the files as soon as possible.

We apologize for any inconvenience.

15. All Electronic Submitters

Category: BCBSM and FEP adjustment claim edits

Title: All Electronic Submitters

Start Date: August 13, 2014 End Date: November 11, 2014

BCBSM is working to fully automate the facility adjustment claim process by mid-2015. Adjustment claims are identified by the frequency type code/type of bill reported in Loop 2300, CLM05-3 of an 837 transaction:
- payment other than anticipated, corrected, or replacement claim
- void or cancel claim

As part of the transition, all TOB XX7 and XX8 claims will require the 14-or 17-digit Internal Control Number of the original claim. Effective Nov. 3, 2014, EDI will edit both professional and facility BCBSM and FEP adjustment claims not reporting this information.

Claims received without a valid ICN in Loop 2300, REF02 with qualifier F8, will reject on 277CA reports or transactions:

**Professional**

- P059 A3 464 CLAIM FREQUENCY TYPE REQUIRES ORIGINAL REFERENCE NUMBER
- P618 A3 464 ORIGINAL CLAIM REFERENCE NUMBER / ICN IS INVALID

**Institutional**

- F086 A3 464 CLAIM FREQUENCY TYPE REQUIRES ORIGINAL REFERENCE NUMBER
- F719 A3 464 ORIGINAL CLAIM REFERENCE NUMBER / ICN IS INVALID

If the claim was submitted with an ICN, it may still reject on a voucher if the processing system is unable to locate a match.

If you have questions regarding the edits, contact the EDI help desk at 1-800-542-0945. For assistance with reporting this information using your practice management system, contact your software vendor or clearinghouse.

16. Blue Care Network is making changes to its electronic claims system

**Category:** BCN electronic claims

**Title:** Blue Care Network is making changes to its electronic claims system

**Start Date:** August 14, 2014 **End Date:** October 1, 2014

Beginning October 2014, the criteria we use in our electronic claims system process will align more closely with our paper submission criteria.

Please keep the following changes in mind for member match criteria:

- We will no longer look for the subscriber if the contract number submitted is not found. Claims without a valid contract number will be rejected as contract number not found.
• We will no longer match if a social security number is submitted as the contract number. These claims will be rejected as contract number not found.

• An exact match on the date of birth is no longer required. A match on six characters will be considered a match for the date of birth.

Example: If the date of birth in our system is 09141954 and it is submitted as:
09151953 – Matches on 6: Accepted
08151954 – Matches on 6: Accepted
10141954 – Matches on 6: Accepted
10141964 – Does not match 6: Rejected

• We have implemented a new hierarchy for matching:
  o Date of birth (6), last name (first 4 characters) and first name (first 3 characters)
  o Date of birth (6) and last name (first 4 characters)
  o Date of birth (6) and first name (first 3 characters)
  o Date of service will be used when there is more than one group that matches on a member.

• We have implemented 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 and hyphens (and other special characters) will be ignored when matching on name.

Example: First name: JO ANN or JO-ANN = JOANN (first three logic will be applied).

Example: Last name: MC DONALD or MC-DONALD = MCDONALD (first four logic will be applied).

Changes will also be made to the 277CA. Today we don’t distinguish between “member not found” and “contract not found” and return only A3:26:QC (see below). The following codes will be returned with the new changes:

• Member not found
  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.

• Contract not found
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

17. New accumulator solution now displaying used amounts for a limited number of groups

**Category:** Web-DENIS cost sharing

**Title:** New accumulator solution now displaying used amounts for a limited number of groups

**Start Date:** August 15, 2014  **End Date:** August 30, 2014

A new accumulator solution will display benefit accumulations and maximums on the Deductible/Copay screen on web-DENIS for some groups.

This tool is a pilot for a small number of Blue Cross Blue Shield of Michigan MOS and NASCO groups. For all other groups, you will continue to see the current screens.

To view a demo of the new feature, follow the steps below:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*. Click on *Newsletters and Resources*.
- The [Provider hot tip clip for the new accumulator solution](#) can be found under *What’s New* and *Provider Training*.

Contact your BCBSM and BCN provider consultant to share your thoughts on the new training or email us at [providertraining@bcbsm.com](mailto:providertraining@bcbsm.com). We value your opinion.

18. Validator self-testing and Provider Authorization tool

**Category:** BCBSM electronic trading partners, vendors and clearinghouses

**Title:** Validator self-testing and Provider Authorization tool

**Start Date:** August 15, 2014  **End Date:** August 29, 2014

The BCBSM HIPAA Validator online self-testing tool and Provider Authorization application will be unavailable on August 16, 2014 from 7:00 a.m. through 4:00 p.m. due
to system maintenance. Users will be unable to access the application during this time period.

We apologize for any inconvenience.

19. All Blue Care Network trading partners

Category: UPDATE - BCN claim processing and 277CA delays

Title: All Blue Care Network trading partners

Start Date: August 15, 2014 End Date: August 29, 2014

The Blue Care Network system issue is resolved. All claims from 08/08/14 through 8/13/14 are processed and the corresponding R277CAF reports and 277CAP transactions have been distributed.

We apologize for any inconvenience.

20. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: August 18, 2014 End Date: September 1, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning August 18, 2014

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

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

21. Reminder: Preauthorization for abdomen and pelvis CT scans

Category: Medicare Advantage
Reminder: Preauthorization for abdomen and pelvis CT scans

Start Date: August 18, 2014 End Date: September 15, 2014

As part of Blue Cross Blue Shield of Michigan’s radiology management program, physicians must obtain preauthorization through AIM Specialty Health for any nonemergency outpatient CT scans. The performed procedure must match the preauthorized procedure for the imaging claim to be paid.

BCBSM recently received questions regarding CT abdomen (*74150, *74160, *74170), CT pelvis (*72192-*72194), and CT abdomen pelvis combination tests (*74176-*74178). It is important to note that these exams are distinct.

When the imaging service is performed and it’s determined that a procedure other than the one preauthorized is more appropriate, the imaging facility must contact the ordering physician to change the order. The ordering physicians’ staff should then withdraw the original request and obtain authorization for the new procedure. In these specific circumstances, we provide a 48-hour, post-procedure window for the ordering physician to obtain the new authorization.

Before rendering any imaging services, providers should validate the authorized exams from the ordering physician by calling AIM at 1-800-728-8008 or accessing this information online through AIM’s provider portal at aimspecialtyhealth.com.

These rules apply to Medicare Advantage and commercial members in Michigan. If you have any questions, please contact your provider consultant.

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Recovery underway for Trinity Health claims

Category: Recoveries

Title: Recovery underway for Trinity Health claims

Start Date: August 18, 2014 End Date: August 25, 2014


Facility claims were processed at the incorrect benefit level in error. Claims will be reprocessed.
When you adjust patients’ accounts to reflect the correct payments, the subscribers’ liability may change.

23. BCBSM chiropractic network re-tiering delayed

   **Category:** Miscellaneous

   **Title:** BCBSM chiropractic network re-tiering delayed

   **Start Date:** August 20, 2014 **End Date:** September 30, 2014

   Blue Cross Blue Shield of Michigan has delayed re-tiering of its chiropractic network until late September.

   BCBSM and Optum™ are currently evaluating how they exchange and process data, as well as looking for opportunities to improve efficiency. Optum administers certain aspects of the BCBSM chiropractic program. We’ve delayed re-tiering of the network until we complete the work on evaluating the transfer process.

   We anticipate this process will be completed by the end of September. Thank you for your patience.

   If you have any immediate questions, please call an Optum support clinician at 1-800-873-4575, ext. 53121 or a BCBSM profiling analyst at 313-448-7371.


   **Category:** System downtime notification

   **Title:** FEP – System downtime for Aug. 24, 2014

   **Start Date:** August 20, 2014 **End Date:** August 26, 2014

   The Federal Employee Program application will be unavailable on Sunday, Aug. 24, 2014, until approximately 1 p.m., due to system maintenance. This means providers won’t be able to check FEP benefits and eligibility through web-DENIS during that period.

25. Additional fee schedules and fee change schedule added to web-DENIS

   **Category:** Fee schedules

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

   **Start Date:** August 21, 2014 **End Date:** September 4, 2014
The following revised Outpatient Psychiatric Care Facility (OPC) fee schedules have been added to web-DENIS:

- OPC Traditional and Mental Health Managed Care Program (7/1/14) (Revised 8/4/14)
- OPC Traditional and Mental Health Managed Care Program (7/1/13) (Revised 8/4/14)

In addition, the following revised fee change schedule has been published on web-DENIS, for the week beginning August 4, 2014:

- Facility
  - Outpatient Psychiatric Care

The 7/1/13 and 7/1/14 Outpatient Psychiatric Care Facility entire fee schedules were recently revised (as of 7/11/14) to include additional Evaluation & Management (E&M) codes effective 1/1/13. However, the majority of these E&M codes (*99217-*99350 and *99356-*99377) should not have been published for Outpatient Psychiatric Care Facility. Similarly, the Outpatient Psychiatric Care fee changes as of 06/02/2014, included the same erroneous E&M codes.

Therefore, we removed the 7/1/13 (revised 7/11/14) and 7/1/14 (revised 7/11/14) entire fee schedules and the fee change schedule as of 06/02/2014 and replaced them with the 8/4/14 revised versions listed above.

The processing of Evaluation and Management codes is not changing from what was described in the 7/21/2014 Web-DENIS alert. As the 7/21/2014 alert previously stated:

“The June 2014 Record article titled “Here’s an update on how we’re processing behavioral health claims” includes information regarding the addition of Evaluation & Management codes due to CPT coding changes that became effective 1/1/13.

Furthermore, the above noted Record article also includes information that effective Aug. 1, 2014; we will no longer allow M0064 to be reimbursed. Instead, an appropriate Evaluation & Management code must be billed.”

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

For more information, contact your BCBSM provider consultant.

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26. BCBSM episode of care Medicare Advantage claims processing issue for individual and URMBT members

**Category:** Medicare Advantage

**Title:** BCBSM episode of care Medicare Advantage claims processing issue for individual and URMBT members

**Start Date:** August 22, 2014 **End Date:** September 3, 2014

We’ve identified a system issue that is not applying correct copayments for episode of care claims when services are billed on separate claims for the same date of service for the same member. This issue affects UAW Retiree Medical Benefits Trust and individual business members.

We have held affected claims for the past few weeks as we worked to correct the system, but we will release a large number of them for payment in the Aug. 19 check run.

We are working to resolve this issue as quickly as possible. Once a solution is in place, we will automatically adjust the affected claims. We apologize for any inconvenience this may have caused.

27. Medicare Advantage

**Category:** System Maintenance Scheduled

**Title:** Medicare Advantage

**Start Date:** August 22, 2014 **End Date:** August 25, 2014

There is scheduled maintenance for the Medicare Advantage application. The maintenance will begin Saturday, Aug. 23, 2014, at 3 p.m. Attempts to access Medicare Advantage information will result in errors. The maintenance will be completed by Saturday, Aug. 23, 2014, at 6 p.m.

We apologize for any inconvenience this may have caused and thank you for your patience.

28. BCBSM mailed Medicare Advantage “1st Quarter 2013 Incentive Payments” test prints in error

**Category:** Medicare Advantage

**Title:** BCBSM mailed Medicare Advantage “1st Quarter 2013 Incentive Payments” test prints in error
Start Date: August 22, 2014  End Date: September 3, 2014

The Blues recently mailed Medicare Advantage first quarterly incentive payment test letters and checks in error. If you receive one of the test checks, please destroy it. We will mail the real provider incentive payments within the next week or two.

On Aug. 19, 2014, we ran a test file of the “1st Quarter 2013 Incentive Payments” checks. The test run included:

- A cover letter dated Aug. 11
- A copy of the provider incentive check printed on stock paper dated Aug. 7
- A remittance

The test letter was signed by Mary Sue Coatsworth. The check copies were printed on stock paper and not regular check paper. There is no signature on the test checks.

We apologize for any inconvenience this may have caused and thank you for your patience. If you have any questions, please contact your provider consultant.

29. New BCN Health e-Blue functionality and web-DENIS member care alert updates

Category: BCN Health e-Blue and web-DENIS member care alerts

Title: New BCN Health e-Blue functionality and web-DENIS member care alert updates

Start Date: August 25, 2014  End Date: September 15, 2014

New functionality for BCN Health e-BlueSM allows providers to close diagnosis gaps for BCN individual and small group patients.

Health e-Blue now displays Commercial individual/small group as a dropdown box. Providers can see patient information and enter data the same way it is entered for BCN Advantage patients. Please make sure data is entered for the correct product line.

Member care alerts for BCN individual and small group patients on the web-DENIS member eligibility screen are now color-coded for both diagnosis gaps and treatment opportunities to indicate if a member has an open, closed or pending diagnosis gap or treatment opportunity. Clicking on a member diagnosis gap or treatment opportunity will take providers with access to Health e-Blue to the BCN Health e-Blue home page where the member gap(s) can be closed.

Contact your provider consultant with any questions or use the BCN Health e-Blue Feedback button within BCN Health e-Blue.

30. Additional fee change schedules added to web-DENIS
BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning August 25, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus℠
- Facility
  - Outpatient Hospital

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

31. Michigan Quality Improvement Consortium clinical practice guidelines

Category: Clinical practice guidelines

Title: Michigan Quality Improvement Consortium clinical practice guidelines

Start Date: August 25, 2014 End Date: September 7, 2014

MQIC has released the following updated clinical practice guidelines and guideline update alerts:

- Routine Prenatal and Postnatal Care
- Prevention and Identification of Childhood Overweight and Obesity
- Treatment of Childhood Overweight and Obesity
- Management of Diabetes Mellitus
- General Principles for the Diagnosis and Management of Asthma

Please visit mqic.org to access the guidelines.

32. BCBSM behavioral health authorization process changes effective Sept. 1

Category: Mental health

Title: BCBSM behavioral health authorization process changes effective Sept. 1

Start Date: August 25, 2014 End Date: September 5, 2014

Effective Sept. 1, 2014, Blue Cross Blue Shield of Michigan will enhance its behavioral health authorization process administered by Magellan Behavioral of Michigan Inc.
These changes are required to assure BCBSM’s alignment with federally mandated mental health parity regulations.

They apply to all psychiatric facilities and hospital-based substance abuse facilities that provide inpatient services to BCBSM’s members. We’re alerting these facilities so that they may make the necessary preparations before the changes take effect.

The changes will impact Blues members with Traditional and PPO coverage. The changes will not, however, apply to customer groups that have chosen a third party to administer their behavioral health benefits or services provided at freestanding substance abuse facilities. Certain Blue Choice PPO℠ and Federal Employee Program® members are also exempt from the prenotification process. These members will continue to require precertification and recertification on the first day of an admission, when applicable.

For admissions on or after Sept. 1, 2014:

- There will no longer be a facility designation program for behavioral health.
- All inpatient behavioral health facilities must fax a notification form for all admissions and discharges.
- All inpatient behavioral health facilities must fax, email or call for clinical review through discharge for all admissions exceeding four days.
- BCBSM and Magellan will no longer conduct retrospective non-acute day assessments for the purpose of establishing designation status. BCBSM will, however, retain the right to audit any particular provider or service to determine medical necessity or appropriateness.

For additional details about these changes, see the July Record.

If you have any questions, please call Magellan at 1-800-762-2382 or contact your provider consultant.

33. All Blue Care Network trading partners

Category: Delayed BCN 277CA transactions/reports

Title: All Blue Care Network trading partners

Start Date: August 27, 2014 End Date: September 12, 2014

Due to a system issue, BCN R277CAF reports and 277CAP transactions for August 26, 2014 are delayed. All files will be distributed as soon as possible.

We apologize for any inconvenience.

34. BCBSM Medicare Plus Blue℠ PPO manual to be updated in October 2014
Blue Cross Blue Shield of Michigan will update its Medicare Plus BlueSM PPO manual for October 2014. Key changes include:

- Changed interactive voice response system from CAREN to PARS (Provider Automated Response System)
- Added the following practitioner specialties: geriatrician, certified nurse practitioner (primary care focus) and physician assistant (primary care focus).
- Deleted family nurse practitioner specialty.
- Updated Blue Care ConnectSM information
- Added roster billing information
- Updated non-covered services and referrals provider responsibility sections
- Added Care Transition to Home Onsite program information
- Added Care Transition to Skilled Nursing Facility program information
- Updated HEDIS® measures
- Updated program participation criteria for BCBSM’s Medication Therapy Management Program as well as coordination is now offered by SinfoniaRx’s Medication Management Program
- Updated settlement information

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

35. Medicare Eligibility

**Category:** System Maintenance for Friday August 29 & Saturday August 30

**Title:** Medicare Eligibility

**Start Date:** August 28, 2014 **End Date:** September 1, 2014

There is scheduled maintenance on the Medicare Eligibility application. The maintenance will begin at 11:30 PM ET on Friday, August 29, 2014. The Medicare Eligibility application will be unavailable during this period. Attempts to open a connection to the Medicare Eligibility will result in errors. The maintenance window will be completed by 10:00 PM ET on Saturday, August 30, 2014.

Please contact the Help Desk if you have any questions.

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

36. Blue Care Network pays the lesser of our rate or your submitted charges for PT, OT, ST therapy

**Category:** BCN PT, OT, ST provider payments

**Title:** Blue Care Network pays the lesser of our rate or your submitted charges for PT, OT, ST therapy

**Start Date:** August 29, 2014  **End Date:** September 12, 2014

Blue Care Network is changing the way we pay for physical, occupational and speech therapy. Starting Oct. 1, 2014 for BCN commercial and Jan. 1, 2015 for BCN AdvantageSM, we will pay the lesser of our rate or your submitted charges. While this “lesser of” payment policy is already specified in provider contracts, BCN has previously paid our rate even when the provider has billed at a lower rate for these services.

The change applies to all providers who are reimbursed following the BCN professional fee schedule and the BCN Advantage physician fee schedule.

This change does not apply to PT, OT or ST for autism spectrum diagnoses.

37. Register now to attend webinar on ACE inhibitors, ARBs, use of nonbenzodiazepine hypnotics

**Category:** Webinars

**Title:** Register now to attend webinars on ACE inhibitors, ARBs, use of nonbenzodiazepine hypnotics

**Start Date:** August 29, 2014  **End Date:** September 24, 2014

As you read in The Record, Blue Cross Blue Shield of Michigan is conducting a series of educational webinars for health care providers to discuss two pharmacy-related Medicare star measures — high-risk medications in older adults and the use of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers in hypertensive diabetics.

BCBSM is hosting a webinar on Sept. 19 that will begin at 7:30 a.m. The topic is “ACE Inhibitors and ARBs, The Good, The Bad and The Ugly.” The speaker will be Joel Topf, M.D., a board-certified nephrologist.

The 30-minute webinars will be followed by question- and-answer sessions. There will also be an email address available to send in additional questions.
To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date, time and name of the class you wish to attend, as well as your national provider identifier. You’ll receive a confirmation email within 72 hours of registering. Instructions on how to access the webinar via WebEx will be sent in the confirmation email or prior to the webinar.

If you have questions about the content of the webinar or the registration process, contact Lawrence Beal at 313-225-8981.

If you have technical issues or questions, call the BCBSM Web support help desk at 1-877-258-3932.

Additional webinars in this series will be announced in future issues of The Record and on web-DENIS.
September 2014

**BCBSM Medicare Advantage PPO will update its physician office lab list**

Blue Cross Blue Shield of Michigan will update its Medicare Advantage PPO Physician Office Lab List on or after Oct. 29, 2014, to more accurately reflect currently recognized codes and procedures.

The list is housed on the Medicare Advantage section of BCBSM’s provider website at [bcbsm.com/provider/ma](http://bcbsm.com/provider/ma). To find the list:

- Click on *Medicare Plus Blue*.
- Click on *Provider Toolkit*.
- Under “Coverage Details,” click on *Medicare Advantage PPO lab network*.
- You can find the list near the bottom of the page.

Keep the following in mind:

- Providers who render lab services that aren’t on this list will not be paid.
- BCBSM Medicare Advantage PPO members cannot be billed for a lab service that isn’t on this list.
- Providers must have the appropriate complexity level of certification required to perform and bill applicable procedures.

Among the key changes are:

- Seventeen procedure codes will be deleted.
- Forty procedure codes will be added.
- Some of the new codes added will include select provider-performed microscopy procedures and two blood count codes.

In the meantime, you can continue to use the current Medicare Advantage Physician Office Lab List. If you have any questions, please contact your provider consultant.
The Record - BCBSM Medicare Advantage PPO will update its physician office lab list

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September 2014

Clarification: Two-midnight rule and related changes for BCBSM Medicare Advantage PPO

In the February 2014 Record, Blue Cross Blue Shield of Michigan announced its intent to align with the Centers for Medicare & Medicaid Services in implementing Medicare 2014 inpatient rule changes for Medicare Advantage PPO plans, including the two-midnight rule, effective April 1, 2014.

Following that announcement, Blue Cross received numerous requests from providers for additional information. The following are answers to the most frequently asked questions:

1. **Why do hospitals have to complete prenotification if the case meets criteria for medical necessity and the stay is greater than two midnights?**

   Blue Cross Medicare Advantage PPO plans contractually require participating Medicare Advantage providers to submit prenotification of all acute inpatient hospital admissions. The physician’s decision to admit a patient should be based on medical necessity and follow the CMS guidelines for an inpatient stay. Blue Cross Medicare Advantage PPO plans use the admission information supplied by the hospitals to promote the highest quality of care for members by referring appropriate cases to our wellness and care management programs when appropriate. This also helps ensure seamless transitions from the inpatient setting back home or to an alternate level of care.

2. **Should hospitals wait until the second day of a stay to review cases to ensure the patient stayed two midnights and met the InterQual criteria for an inpatient stay? Would waiting affect our prenote reporting?**

   Hospitals should continue to review cases according to their established schedule and process while providing Blue Cross with timely prenotification of medically necessary inpatient admissions. The expectation that providers use web-DENIS to promptly notify
Blue Cross of inpatient admissions has not changed.

As stated in the 2014 Inpatient Prospective Payment System final rule issued by CMS, if the order is not properly documented in the medical record, the hospital **should not** submit a claim for Part A payment (78 FR 50941). **Meeting the two-midnight benchmark does not, in itself, render a beneficiary an inpatient or qualify that beneficiary for payment under Part A.** Rather, as provided in CMS regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if that beneficiary is formally admitted pursuant to an order for inpatient admission by a physician or other appropriate practitioner.

3. **We have a patient who was admitted as an inpatient but did not meet the InterQual criteria for an inpatient stay. Our physician advisor reviewed the case and recommended observation status, but the attending physician would not change the order. What can we do?**

Blue Cross does not engage in the hospital’s management of disagreements between its physicians. The CMS regulations specify that the decision to admit should generally be based on the treating physician’s reasonable expectation of a length of stay spanning two or more midnights, taking into account complex medical factors that must be documented in the medical record. Because this is based upon the physician’s expectation, as opposed to a retroactive determination based on actual length of stay, unforeseen circumstances that result in a shorter stay than the physician’s reasonable expectation may still result in a hospitalization that is appropriately considered inpatient. In accordance with the Blue Cross Medicare Advantage PPO provider manual, if a doctor is overriding InterQual inpatient criteria, then the hospital must provide the doctor’s name and phone number in the prenote documentation.

If the physician is unable to determine, when the beneficiary arrives at the hospital, whether he or she will require two or more midnights of hospital care, the physician may order observation services and reconsider providing an order for inpatient admission at a later point in time.

In considering stays lasting less than two midnights following formal inpatient admission (i.e., those stays not receiving presumption of inpatient medical necessity), the reasonableness of the physician's expectation of the need for and duration of care must be clearly documented in the medical record. These reasons should be based on complex medical factors, such as history and comorbidities, the severity of signs and symptoms, current medical needs and the risk of an adverse event.

4. **Under the new CMS guidance, will all inpatient stays of less than two midnights after formal inpatient admission be automatically denied?**

No. Under the CMS guidelines, there will still be services payable under Part A in a number of instances for inpatient stays less than two total midnights after formal inpatient admission. Hospitals should focus their attention on short (0-1 total days) stays (without death, transfer, discharge against advice, an inpatient-only service or a preceding outpatient stay over midnight) to ensure that the physician clearly expected a longer stay, the discharge was unexpected, or some other rare and unusual circumstance supports that the
Part A claims represent appropriate, payable inpatient services. For example:

- There will be cases where the physician had a reasonable expectation of a two-midnight stay, but there was an unforeseen circumstance that resulted in a shorter stay than the physician’s reasonable expectation.
- If the beneficiary received a medically necessary service on the Inpatient-Only List and was able to be discharged before two midnights passed, those claims would be appropriately inpatient for Part A payment.
- Inpatient claims for patients who unexpectedly improved and were discharged in less than two midnights would be payable as long as the medical record clearly demonstrated that the admitting physician had reasonable expectation of a two-midnight stay and the improvement that allowed an earlier discharge was clearly unexpected.

For more information, please refer to Q4.9 on Page 14 of the CMS frequently-asked-questions document**.

5. **Are hospitals allowed to change an inpatient stay to observation status after discharge?**

Yes. In cases where a hospital determines that an inpatient admission does not meet the hospital’s inpatient criteria, prior to submission of a claim, the hospital may change the beneficiary’s status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all the following conditions are met:

- The hospital has not submitted a claim to Medicare for the inpatient admission.
- The practitioner responsible for the care of the patient (and the Utilization Review committee, if applicable) concur with the decision.
- The concurrence of the practitioner responsible for the care of the patient (and the UR committee, if applicable) is documented in the patient’s medical record.

This change in status is typically billed with condition code “44.” Blue Cross Medicare Advantage PPO plans have waived the requirement that the change in patient status from inpatient to outpatient must be made while the beneficiary is still a patient of the hospital, prior to discharge or release.

When an inpatient claim has already been denied by Medicare and the hospital loses an appeal, or decides not to appeal, it may rebill for Part B services which are medically necessary. The hospital can also bill for the services provided as an outpatient during the three-day window. Hospitals submitting Part B inpatient claims in these situations need to include condition code “W2” on the rebilled claim.

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September 2014

**Reminder: BCBSM Medicare Advantage PPO processing system for pre-2013 claims to shut down**

BCBSM’s Medicare Advantage PPO’s claim processing system for claims with dates of service before 2013 will shut down Dec. 31, 2014.

To avoid any claims processing problems, be sure to submit any adjustment requests for claims for services provided prior to Jan. 1, 2013, as soon as possible.

Also, if you discover an overpayment and the date of service is before Dec. 31, 2012, send a check with the applicable member and claims information to:

Senior Business Division  
Blue Cross Blue Shield of Michigan  
P.O. Box 441187  
Detroit, MI 48244-1187

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1. **BCBSM and BCN add residential psychiatric treatment benefits**

   **Category:** Mental Health

   **Title:** BCBSM and BCN add residential psychiatric treatment benefits

   **Start Date:** September 2, 2014  **End Date:** September 16, 2014

   Blue Cross Blue Shield of Michigan and Blue Care Network began covering residential psychiatric treatment, effective July 1, 2014.

   Residential psychiatric treatment takes place in a state-licensed facility (e.g., an adult or child foster care facility) with a multidisciplinary treatment team.

   For more detailed information, see the article in the *September Record* and the *September-October BCN Provider News*.

2. **BCBSM adjusts preventive mammogram claims for some UAW Trust Medicare Advantage PPO members**

   **Category:** Medicare Advantage

   **Title:** BCBSM adjusts preventive mammogram claims for some UAW Trust Medicare Advantage PPO members

   **Start Date:** September 2, 2014  **End Date:** September 16, 2014

   Blue Cross Blue Shield of Michigan identified a system issue with preventive mammogram claims for select, Michigan-only, UAW Trust members. We incorrectly applied cost-sharing and exceeded the member’s out-of-pocket maximum. The issue has been corrected. All affected claims were reprocessed and adjusted last week.

   We apologize for the inconvenience this system error may have caused. Thank you for your patience. If you have any questions, please contact your provider consultant.

3. **BCBSM electronic provider manuals — August 2014 changes**

   **Category:** Online Manuals

   **Title:** BCBSM electronic provider manuals — August 2014 changes

   **Start Date:** September 2, 2014  **End Date:** September 16, 2014

   These are the chapters we revised in August 2014, along with the revision date and a brief statement of the main changes for each.*
o Ambulatory Surgery Facility Services(08/11/2014)
   -“Reimbursement” — Added a note about fees for high-tech radiology procedures.

o Blue Pages Directory (08/01/2014)
   -“Preauthorization requests - written” — Updated the address information.
   -"Provider Consulting Services" — Reorganized the topic into two sections, professional consultants and facility consultants.

o BlueCard Program (08/01/2014)
   -“Precertification and preauthorization” — Reorganized this information.
   -“Appeals” — Moved the “Authorization appeals” subsection to this section.

o Claims (08/15/2014)
   -“UB-04 claim examples” — Added a claim example for inpatient hospitals in which the “from date” is prior to the “admit date.”
   -“CMS-1500” — In the “Line-by-line instructions” for field 24A-DATES OF SERVICE, updated the instructions for prenatal visits and delivery dates.

o Hemophilia Treatment Services (08/28/2014)
   -Overhauled the entire chapter.

o Hospital Services(08/11/2014)
   -“Reimbursement” — Revised the note about fees for high-tech radiology procedures.

o Introduction(08/27/2014)
   -“Individual Market Plans-PPO” — Added this new section.

o Service Reviews(08/01/2014)
   -Renamed this chapter “Audits and Other Post-Service Reviews.”
   -“Transfer policy” — Moved this section to the “Audits” section.
*Because we’ve customized our manual chapters to each provider type, the changes listed above may or may not affect the contents of your particular manual.

4. We’re shutting down the Exception Admission application

   Category: web-DENIS

   Title: We’re shutting down the Exception Admission application

   Start Date: September 3, 2014 End Date: October 31, 2014

   As we approach the two-year anniversary of the discontinuation of loading membership data to the local system, we want to let facility users know that we’ll be shutting down the Exception Admission application on web DENIS. Since membership information is no longer being loaded, the application is no longer needed. Exception Admission is only required for local contracts. The Exception Admission application will shut down at the end of October.

   If you have any questions, contact the BCBSM Web Support Help Desk at 1-877-258-3932.

5. Reminder: Change in September ICD-10 overview training schedule at Lyon Meadows

   Category: All Providers

   Title: Reminder: Change in September ICD-10 overview training schedule at Lyon Meadows

   Start Date: September 3, 2014 End Date: September 12, 2014

   Please remember that the ICD-10 training session scheduled for Tuesday, Sept. 9, at the Lyon Meadows conference center, has been cancelled.

   To see the remaining 2014 ICD-10 training schedule, see the article in the July 2014 Record.

   If you have any questions or need help to get started on implementing ICD-10, contact us at ICD-10providerreadiness@bcbsm.com.

6. 2014 Professional Update training presentations now available

   Category: Training

   Title: 2014 Professional Update training presentations now available
The presentations made at the 2014 Professional Update sessions given across the state are now available online. To access the presentations with valuable billing and coding information:

• Log in to web-DENIS.
• Click on BCBSM Provider Publications and Resources •
• Click on Newsletters and Resources.
• Click on 2014 summer Professional update in the “What’s New” section and also in the “Recently Uploaded” section on the Provider Training page.

7. CMS ICD-10 implementation resources and education for physicians
   - Category: Physicians
   - Title: CMS ICD-10 implementation resources and education for physicians
   - Start Date: September 4, 2014 End Date: September 11, 2014
   - Did you know that the Centers for Medicare and Medicaid Services has resources for physician practices?
   - The Centers for Medicare & Medicaid Services has released a new webcast introducing the “Road to 10” tool. Accessible through the “Road to 10” link on the CMS website, the webcast covers the history of the International Classification of Diseases and the benefits of ICD-10. This is the first in the new “Road to 10” webcast series. Five more webcasts will follow—all aimed at helping small practices get ready for ICD-10 by the October 1, 2015, compliance date.
   - Also available now is a brief video introduction to the “Road to 10” tool. Developed in collaboration with physicians, the “Road to 10” tool offers:
     - Clinical documentation tips
     - Coding concepts
     - Clinical scenarios
     - Training calendar
   - Go to the CMS ICD-10 website to get started on the “Road to 10” today.
   - Also, CMS will be in Mt. Pleasant, Michigan for the CMS Sponsored “Road to 10”: the Small Physician Practice’s Route to ICD-10:
     - What: ICD-10 educational session for physicians and practice managers
     - When: 4 to 6 p.m., Thursday, September 11, 2014
     - Where: Mt. Pleasant, MI
     - For all types of providers, keep Up to Date on ICD-10 Visit the CMS ICD-10 Industry Email Updates and follow CMS on Twitter.

8. All Blue Cross Complete electronic submitters
   - Category: Delayed Blue Cross Complete 835 for check date 09/02/14
   - Title: All Blue Cross Complete electronic submitters
Due to a systems issue, professional and institutional BCC 835 remittance files for check date 09/02/14 are delayed. BCBSM will distribute the files as soon as possible. We apologize for any inconvenience.

9. New date for September hospital networking session
   - Category: Hospital networking sessions
   - Title: New date for September hospital networking session
   - Start Date: September 5, 2014 End Date: September 19, 2014
   - In the March Record, we listed the dates for a series of hospital networking sessions in 2014. Due to a conflict, the Sept. 17 session has been cancelled and has been rescheduled for Thursday, Sept. 25.
   - Please make a note of this date change. If you had previously registered for this session, you should have received notification of this change.

10. The new BCN e-referral tool coming Sept. 29; training tools now available
    - Category: BCN e-referral tool
    - Title: The new BCN e-referral tool coming Sept. 29; training tools now available
    - Start Date: September 8, 2014 End Date: September 30, 2014
    - An e-referral message has been posted announcing the new BCN e-referral tool will be live on Monday, Sept. 29 at 7 a.m. In order to maintain access to e-referral without disruption, providers are asked to make sure their Provider Secured Services user ID and password (web-DENIS ID) are operational. This is required in order to complete the online training that will be live this week.
    - Several training tools have also been posted to prepare providers for the new e-referral tool. The Training Tools page on ereferrals.bcbsm.com now includes a new, comprehensive user guide, a quick guide to getting started and a flier. The user guide will be mailed to every active e-referral user.

11. BCBSM adjusts select Medicare Advantage PPO DME claims due to system issue
    - Category: Medicare Advantage
    - Title: BCBSM adjusts select Medicare Advantage PPO DME claims due to system issue
    - Start Date: September 8, 2014 End Date: September 22, 2014
    - We recently identified a problem with DME procedure codes Q0513 and Q0514 for pharmacy dispensing fees for inhalation drugs. Claims were being denied as not payable.
The system issue was fixed on Aug. 1, 2014, to allow payment to our DME providers. Approximately 2,700 local claims will be adjusted beginning the week of Sept. 8, 2014.

We apologize for the inconvenience. If you have any questions, contact your provider consultant.

12. Additional fee change schedules added to web-DENIS

**Category:** Fee Changes

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

**Start Date:** September 8, 2014  **End Date:** September 22, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning September 8, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus™
  - DME P&O
  - Independent Lab
  - Injections

- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility

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

13. All Medicare Part B trading partners

**Category:** Delayed WPS 277CA Reports

**Title:** All Medicare Part B trading partners

**Start Date:** September 10, 2014  **End Date:** September 24, 2014

BCBSM has not yet received Wisconsin Physicians Service (WPS) 277CA reports for Part B claims submitted on September 9, 2014. We are working with WPS to obtain the files and will distribute them upon receipt.

We apologize for any inconvenience.
14. Sept. 24 webinar postponed to Oct. 15; Sept. 19 webinar still taking place

*Category:* Webinars

*Title:* Sept. 24 webinar postponed to Oct. 15; Sept. 19 webinar still taking place

*Start Date:* September 10, 2014  *End Date:* September 20, 2014

The Sept. 24 webinar on “Clinical Considerations for the Use of Nonbenzodiazepine Hypnotics in Patients 65 and Older” has been postponed until Oct. 15 at 7:30 a.m. The speaker will be Karen E. Hall, M.D., Ph.D. Dr. Hall is board-certified in internal medicine, with subspecialties in geriatric medicine, and hospice and palliative medicine.

As you read in *The Record*, Blue Cross Blue Shield of Michigan is conducting a series of educational webinars for health care providers to discuss two pharmacy-related Medicare star measures — high-risk medications in older adults and the use of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers in hypertensive diabetics.

There’s still time to register for the webinar on Sept. 19 that will begin at 7:30 a.m. The topic is “ACE Inhibitors and ARBs, The Good, The Bad and The Ugly.” The speaker will be Joel Topf, M.D., a board-certified nephrologist.

Both 30-minute webinars will be followed by question-and-answer sessions. There will also be an email address available to send in additional questions.

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date, time and name of the class you wish to attend, as well as your national provider identifier. You’ll receive a confirmation email within 72 hours of registering.

Instructions on how to access the webinar via WebEx will be sent in the confirmation email or prior to the webinar.

If you have questions about the content of the webinar or the registration process, contact Lawrence Beal at 313-225-8981.

If you have technical issues or questions, call the BCBSM Web support help desk at 1-877-258-3932.

Additional webinars in this series will be announced in future issues of *The Record* and on web-DENIS.

15. Blue Exchange

*Category:* Blue Exchange Maintenance

*Title:* Blue Exchange
Start Date: September 10, 2014  End Date: September 15, 2014

There is scheduled maintenance for the Blue Exchange application. The maintenance will begin on Sunday September 14, 2014 at 1:00a.m.ET. Accessing Blue Exchange during this time could result in slow response time or time out errors. The maintenance will be completed on Sunday at 12:00p.m.ET

We apologize for any inconvenience.

16. ICD-10 webinar scheduled for Monday, Sept. 22 from 1-2 p.m.

Category: Professional Providers

Title: ICD-10 webinar scheduled for Monday, Sept. 22 from 1-2 p.m.

Start Date: September 12, 2014  End Date: September 23, 2014

Precyse University will host an ICD-10 webinar for professional providers, called “Don’t Stop Believing: How to Convince Physicians and Others to Prepare for ICD-10 amid Delay Fatigue.”

This webcast will highlight:

- Useful tips and ideas on how to engage physicians in ICD-10 preparedness programs to ensure a successful transition
- The far-reaching impact on every aspect of a physician’s practice, including patient encounters, clinical and financial workflow and compensation, reimbursement and future career opportunities
- The benefits to physicians and the health care organizations in which they practice, including more appropriate reimbursement, improved outcome indicators, reduced potential compliance issues and fewer claims denials
- The importance of obtaining the support and buy-in of physicians

This webinar is scheduled for Monday, Sept. 22, from 1 to 2 p.m. Eastern time.

To register, click here, and you will receive a confirmation email with instructions for joining the session.

Send an email to ICD-10providerreadiness@bcbsm.com if:

- You would like us to cover a specific topic in a future webinar or you have questions related to ICD-10
- Your organization would like to participate in a future webinar
- You are having issues with the link above or logging into the call

A link to the recorded webinar and a copy of the presentation will be provided on
web-DENIS after the session.

17. Blue Cross identifies Medicare Advantage PPO lab claim issue

**Category:** Medicare Advantage

**Title:** Blue Cross identifies Medicare Advantage PPO lab claim issue

**Start Date:** September 12, 2014  **End Date:** September 26, 2014

We’ve identified a system issue with Medicare national coverage determination code 190.15 causing lab claims to incorrectly be rejected when the service is billed with a not medically necessary diagnosis and procedure code *85004, *85007, *85008, *85013, *85014, *85018, *85025, *85027, *85032, *85048 or *85049. We are working to resolve the issue as quickly as possible. We will reprocess all affected claims. We apologize for any inconvenience this issue has caused.

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

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

18. Test your BCN e-referral user ID and password for online training

**Category:** BCN e-referral training

**Title:** Test your BCN e-referral user ID and password for online training

**Start Date:** September 15, 2014  **End Date:** September 30, 2014

Online training for BCN’s new e-referral tool is now live. In order to log into the training, as well as log into the new tool, you will be asked for your user ID. Please follow these steps to test your user ID:

- Check that you can get into Provider Secured Services. Go to [bcbsm.com/providers](http://bcbsm.com/providers) and click **LOGIN**. Make sure **Provider** is selected and type your username and password.
- If you can get into Provider Secured Services, congratulations — you are ready for the new e-referral tool.
- If your account is not active, please fax over a request on company letterhead to 1-800-495-0812 asking for your IDs to be reconnected. Please provide an email address for reconnection notification and have the fax signed by an authorized individual in the office. For additional help, please call the Web Support Help Desk at 1-877-258-3932.
- If you do not have a Provider Secured Services username and password, sign up now at bcbsm.com/providers and click on **Provider Secured Services**.
These instructions can be found in the e-referral Transition Information flier found on ereferrals.bcbsm.com.

19. New BCN e-referral online training now available

Category: BCN e-referral tool
Title: New BCN e-referral online training now available
Start Date: September 15, 2014 End Date: September 30, 2013

Online training for the new BCN e-referral tool is now available. Learn more by reading the latest e-referral message. The new system will be live on Sept. 29 at 7 a.m. The online training will prepare you for the new system and can be found on the Training Tools page of ereferrals.bcbsm.com. This was also announced in a BCN Alert that was emailed on Sept. 11 to BCN Provider News subscribers. If you are not already subscribed to receive these emails, please visit bcbsm.com/providernews to sign up and receive future information by email.

20. Log in to BCN Provider Secured Services through bcbsm.com

Category: URL for BCN Provider Secured Services
Title: Log in to BCN Provider Secured Services through bcbsm.com
Start Date: September 15, 2014 End Date: October 15, 2014

Blue Cross Blue Shield of Michigan and Blue Care Network are upgrading our internal systems supporting all of the Blues’ Provider Secured Web Services which includes access for web-DENIS features.

This update will not change the look and feel of the system and all navigation will remain the same. However, the Web address, or URL, will change.

The best way to log in to Provider Secured Services is to follow these steps:

- Visit bcbsm.com.
- Select LOGIN.
- Select Provider.
- Enter your user ID and password.

For a smooth transition, eliminate former bookmarks and save bcbsm.com as your favorite. For questions about this change, please contact the BCBSM Web Support Help Desk at 1-877-258-3932.
21. Blue Cross offers Medicare Advantage PPO and PDP member support for diabetes and cholesterol medication adherence

Category: Medicare Advantage

Title: Blue Cross offers Medicare Advantage PPO and PDP member support for diabetes and cholesterol medication adherence

Start Date: September 16, 2014 End Date: September 26, 2014

Blue Cross Blue Shield of Michigan is offering help to select Medicare Plus BlueSM and Prescription BlueSM members who may not be able to take their diabetes or cholesterol medications as directed. It’s included as two of the quality measures in your physician Medicare Part D quarterly scorecard. This outreach supports two important measures outlined by the Centers for Medicare & Medicaid Services.

We are conducting a quick telephone survey with these members to determine if there are any barriers that may prevent them from taking their medication regularly. Based on that conversation or a follow-up call with one of our clinical pharmacists, we offer suggestions or clinical interventions and encourage the member to share those with his or her doctor. This initiative is meant to support, not replace, the ongoing quality care you provide.

If you have any questions related to this outreach, please email mtm@bcbsm.com.

22. Use required form for all claims Blue Cross is expected to reject

Category: Professional

Title: Use required form for all claims Blue Cross is expected to reject

Start Date: September 16, 2014 End Date: September 30, 2014

As you read in The Record, physicians must present a written notice to Blue Cross Blue Shield of Michigan members before providing medical services or supplies that are expected to be rejected. This policy applies to all professional, non-Medicare claims that are billed with the modifiers GY or GZ, along with modifier GA. The Advance Notice of Member Responsibility form serves as this written notice, and it requires signatures from the provider and member to ensure that the member is informed and accepts financial responsibility.

To download the form on web-DENIS:

  o Click on BCBSM Provider Publications and Resources.
  o Click on Newsletters & Resources.
23. Recovery underway for all auto and URMBT member claims

**Category:** Recoveries

**Title:** Recovery underway for all auto and URMBT member claims

**Start Date:** September 16, 2014 **End Date:** September 30, 2014

NASCO began conducting a recovery Sept. 8, for all auto and UAW Retiree Medical Benefits Trust member claims for dates of service April 1, 2012, through July 11, 2014.

The group requested a retroactive benefit change for genetic testing procedures BRCA, MLH1 and MSH2 to be covered benefits with applicable diagnosis restrictions and cost-sharing requirements.

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

24. Blue Cross adjusts Medicare Advantage PPO Part B drug claims

**Category:** Medicare Advantage

**Title:** Blue Cross adjusts Medicare Advantage PPO Part B drug claims

**Start Date:** September 16, 2014 **End Date:** September 30, 2014

Blue Cross Blue Shield of Michigan identified a claims processing issue that affected Medicare Part B drug rates. We will adjust the affected claims for dates of service Oct. 1 to Nov. 13, 2013. The issue has been corrected.

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

25. All Internet Claim Tool users

**Category:** Scheduled System Maintenance – September 21, 2014

**Title:** All Internet Claim Tool users

**Start Date:** September 17, 2014 **End Date:** September 22, 2014
BCBSM will be performing system maintenance from 4:00 a.m. until 12:00 p.m. EST on Sunday, Sept. 21. You will be unable to access the internet claim tool system during this time period.

We apologize for any inconvenience this may cause.

26. Blue Cross Medicare Advantage PPO durable medical equipment claims issue

Category: Medicare Advantage

Title: Blue Cross Medicare Advantage PPO durable medical equipment claims issue

Start Date: September 18, 2014 End Date: October 2, 2014

Blue Cross Blue Shield of Michigan identified a system issue with some durable medical equipment supply claims. These claims are rejecting as medically unnecessary, based on unit fields that are set by the Centers for Medicare & Medicaid Services. The system issue affects all of our DME providers. We plan to fix this issue within 30 days and will then adjust any impacted claims.

We apologize for this inconvenience and thank you for your patience. If you have any questions, please contact your provider consultant.

27. Recovery underway for Portage Health member claims

Category: Recoveries

Title: Recovery underway for Portage Health member claims

Start Date: September 22, 2014 End Date: October 6, 2014

NASCO began conducting a recovery Sept. 18, for Portage Health member claims for dates of service Dec. 1, 2013, through Aug. 7, 2014.

The group requested a retroactive benefit change for facility services to waive cost-sharing requirements, effective Dec. 1, 2013.

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

28. Update: Oct. 1 webinar postponed to Oct. 29

Category: Webinars

Title: Update: Oct. 1 webinar postponed to Oct. 29
The Oct. 1 webinar titled “Is it Time to Stop Prescribing Glyburide” has been postponed until Oct. 29 at 7:30 a.m. The speaker will be Jeffrey A. Sanfield, M.D., F.A.C.P., C.D.E. Dr. Sanfield is board-certified in internal medicine with subspecialties in endocrinology and metabolism. He is the department chair of internal medicine at St. Joseph Mercy Hospital in Ann Arbor, the medical director of the St. Joseph Mercy Hospital Center for Diabetes and Nutrition, and president of the Ann Arbor Endocrinology and Diabetes. The 30-minute webinar will be followed by a question-and-answer session.

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date, time and name of the class you wish to attend, as well as your national provider identifier. You’ll receive a confirmation email within 72 hours of registering. Instructions on how to access the webinar via WebEx will be sent in the confirmation email or prior to the webinar.

If you have questions about the content of the webinar or the registration process, contact Lawrence Beal at 313-225-8981.

If you have technical issues or questions, call the BCBSM Web Support Help Desk at 1-877-258-3932.

29. All Blue Cross Complete trading partners

Category: Delayed 277CA transactions/reports

Title: All Blue Cross Complete trading partners

Start Date: September 22, 2014 End Date: October 6, 2014

Due to a system issue, Blue Cross Complete R277CAA and R277CAB reports and 277CAP transactions for Sept. 18, 2014 are delayed. We will distribute the files as soon as possible.

We apologize for any inconvenience.

30. Update: Sept. 24 webinar postponed to Oct. 15

Category: Webinars

Title: Update: Sept. 24 webinar postponed to Oct. 15

Start Date: September 22, 2014 End Date: October 16, 2104
The Sept. 24 webinar on “Clinical Considerations for the Use of Nonbenzodiazepine Hypnotics in Patients 65 and Older” has been postponed until Oct. 15 at 7:30 a.m. The speaker will be Karen E. Hall, M.D., Ph.D. Dr. Hall is board-certified in internal medicine, with subspecialties in geriatric medicine, and hospice and palliative medicine.

As you read in The Record, Blue Cross Blue Shield of Michigan is conducting a series of educational webinars for health care providers to discuss two pharmacy-related Medicare star measures — high-risk medications in older adults and the use of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers in hypertensive diabetics.

A 30-minute webinar will be followed by a question- and-answer session. There will also be an email address available to send in additional questions.

To register, email SEprofessionaleducationregistration@bcbsm.com. Include the date, time and name of the class you wish to attend, as well as your national provider identifier. You’ll receive a confirmation email within 72 hours of registering. Instructions on how to access the webinar via WebEx will be sent in the confirmation email or prior to the webinar.

If you have questions about the content of the webinar or the registration process, contact Lawrence Beal at 313-225-8981.

If you have technical issues or questions, call the BCBSM Web support help desk at 1-877-258-3932.

31. Additional fee change schedules added to web-DENIS

Category: Fee Changes

Title: Additional fee change schedules added to web-DENIS

Start Date: September 22, 2014 End Date: October 6, 2014

BCBSM recently added these additional fee change schedules to web-DENIS, for the week beginning September 22, 2014

- Professional
  - Traditional, TRUST & Blue Preferred Plus SM
  - DME P&O
  - Independent Lab
- Facility
  - Outpatient Hospital
  - Ambulatory Surgery Facility
These and other fee change schedules are available on web-DENIS under BCBSM Provider Publications and Resources selecting Entire Fee Schedules and Fee Changes

32. BCBSM Commercial Payer Submitters

Category: Required reporting changes for some commercial payer IDs

Title: BCBSM Commercial Payer Submitters

Start Date: September 23, 2014 End Date: October 7, 2014

Effective December 1, 2014, the 27 commercial payer IDs and claim office numbers listed in columns 1 and 2 below will be deleted from the BCBSM Commercial Payer Table and no longer accepted in electronic claims. When submitting claims for these payers, please ensure the correct ID listed in column 3 is reported.

Commercial claim submitters can report the correct IDs immediately. Please note these payer IDs no longer require use of a claim office number.
<table>
<thead>
<tr>
<th>Payer ID and Claim Office Numbers to be deleted</th>
<th>Correct Payer IDs</th>
<th>Name</th>
<th>Address</th>
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<th>Zip</th>
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<td>AKRON</td>
<td>OH</td>
<td>44309</td>
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<td>CHAMPVA INS COMPANY</td>
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<td>CO</td>
<td>802469064</td>
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<td>450 EAST RAMINGTON RD</td>
<td>SCHAUMBURG</td>
<td>IL</td>
<td>60173</td>
</tr>
<tr>
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<td>PROFESSIONAL BENEFIT ADM</td>
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<td>RICHARDSON</td>
<td>TX</td>
<td>75085</td>
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</tbody>
</table>
After Dec. 1, claims reporting the deleted IDs will reject with an edit of a ‘P017 Commercial Payer ID and or Claim Office Number is Invalid’. Rejected claims must be corrected and rebilled with the appropriate Payer ID.

If you have questions about these Payer IDs or submitting electronic commercial claims, call the EDI helpdesk at 1-800-542-0945.

33. Blue Cross adjusts multiple Medicare Plus BlueSM claims

**Category:** Medicare Advantage

**Title:** Blue Cross adjusts multiple Medicare Plus BlueSM claims

**Start Date:** September 23, 2014  **End Date:** October 7, 2014

Blue Cross Blue Shield of Michigan adjusted the following claims Sept. 19, 2014, for previously corrected claims processing issues:

- Some injection claims were processed under the wrong fee schedule in the fourth quarter of 2013.
- We underpaid some diabetic testing supply claims and will adjust additional claims in the future.
- The claims system applied an inappropriate edit to some facility lab claims, causing the claims to finalize without a payment amount.
- Claims for refractions for UAW Retiree Medical Benefits Trust members were initially denied.

We apologize for this inconvenience and appreciate your patience. If you have any questions, please contact your provider consultant.

34. Clarification: Advance Notice of Member Responsibility policy

**Category:** Modifiers

**Title:** Clarification: Advance Notice of Member Responsibility policy

**Start Date:** September 23, 2014  **End Date:** October 7, 2014

We’ve received some questions from health care providers since publishing an article on the Advance Notice of Member Responsibility form in the September Record. The following are key points to keep in mind about the appropriate use of the Advance Notice of Member Responsibility form and modifiers GY or GZ and GA:
The modifiers GY or GZ are **not** required for every claim.

- If you bill for professional services using the GY or GZ modifier, you must complete the *Advance Notice of Member Responsibility* form. (You **only** complete the form if you use the GY or GZ modifier.) Once the form is complete, providers are then required to report the GA modifier.
- Modifier GA acknowledges that the member has signed the form prior to any services rendered and has agreed to accept financial responsibility for the service.
- The form and the modifiers work together under this new policy. If the modifiers GY or GZ are not billed, the form is not required. The provider must keep the form in the member's file and provide a copy to the member.

The *Advance Notice of Member Responsibility* form **should not** be used and the modifiers should not be reported when it has been verified that a service is not contract benefit. Providers should follow the normal billing guidelines for a routine system rejection for non-covered group benefits. In addition, the form should not be used and the modifiers should not be reported if the member does not agree to accept financial responsibility.

The Advance Notice of Member Responsibility policy **does not** apply to the following:

- Any facility services
- Medicare primary or Medicare Advantage members
- MESSA group members
- Professional services that are not a contract benefit. (The system already has edits in place to reject claims that are not a benefit.)
- Instances where the member refuses to sign the form
- Instances where the provider did not verify coverage

The *Advance Notice of Member Responsibility* form only is required when modifiers GY or GZ and GA are used. All services reported with modifiers GY or GZ must be reported with a modifier GA in order for the claim to reject as the member responsibility. If the provider reports the GY or GZ modifier alone, the service will be reject as the provider responsibility.

**35. Submit Medicare Advantage professional claims electronically**

**Category:** All professional providers

**Title:** Submit Medicare Advantage professional claims electronically

**Start Date:** September 23, 2014 **End Date:** October 7, 2014

As a reminder, claims for Medicare Advantage patients may be submitted electronically along with your BCBSM, BCN and FEP claims. The benefits of electronic claims are faster claims processing, claims tracking and electronic remittance.
Medicare Advantage claims must be submitted:

- As Medicare claims following Medicare billing instructions;
- With a Payer Identification Number of 00710 in NM109 of Loop 2010BB;
- With a Source of Payment Code of MB in SBR09 of Loop 2000B; and
- With the BCBSM assigned contract number, including alpha prefix, reported as the Insured’s Primary Identification Number in NM109 of Loop 2010BA.

Contact your software vendor if you do not currently submit Medicare Advantage claims electronically. If you have questions about electronic claims, call the e-BIG/EDI Business Helpdesk at 1-800-542-0945.

36. Reminder to TTY users

Category: Miscellaneous

Title: Reminder to TTY users

Start Date: September 23, 2014 End Date: October 17, 2014

If you are a TTY user, you can reach any phone number included in Blues publications by first dialing 711.

37. BCN and BCBSM offer **$200 incentive** for each Medicare Advantage member with diabetes and hypertension started on an ACEI or ARB

Category: Medicare Advantage

Title: BCN and BCBSM offer **$200 incentive** for each Medicare Advantage member with diabetes and hypertension started on an ACEI or ARB

Start Date: September 24, 2014 End Date: October 31, 2014

Blue Care Network of Michigan, Blue Cross Blue Shield of Michigan, and the Centers for Medicare & Medicaid Services endorse angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy as a best practice in treating patients with diabetes and hypertension. CMS considers this therapy so important that it monitors adherence among Medicare Advantage patients.

The benefits of ACEI/ARB therapy in diabetics include:

- Inhibited renal function decline
- Decreased cardiovascular risk
- Decreased mortality
- Decreased microvascular diabetic complications
While ACEI/ARBs may not be appropriate in some patients due to adverse effects, most side effects can be managed using an alternative medication within one of the drug classes, dose reduction, or close monitoring during the initiation of therapy. An open dialogue weighing the risks versus benefits for each individual is necessary to determine if an ACEI or ARB is best for them.

The Blues are offering a $200 incentive to BCN Advantage primary care physicians and BCBSM Medicare Plus Blue PPO prescribing physicians for each member with diabetes and hypertension who starts on treatment with an ACEI or ARB between September 24, 2014, and December 31, 2014. The member must have one new pharmacy claim for an ACEI or ARB within the designated time frame to qualify for the incentive. Payments will be made in the first quarter of 2015.

Thank you for helping ensure optimal medication use for our BCN and BCBSM Medicare Advantage members.

38. Current BCN e-referral tool disconnected Sept. 25 at 12 noon

Category: BCN e-referral tool

Title: Current BCN e-referral tool disconnected Sept. 25 at 12 noon

Start Date: September 25, 2014 End Date: October 9, 2014

The current e-referral system has been disconnected today, Sept. 25, at 12 noon in preparation for the new BCN e-referral tool coming Monday, Sept. 29 at 7 a.m. An e-referral message has been posted as well as an e-referral transition information flier (PDF) regarding this transition period.

On Monday, Sept. 29 at 7 a.m. you may access the new e-referral system two ways:

a. Visit bcbsm.com/providers and click LOGIN. Make sure Provider is selected, then type your username and password.

b. Visit ereferrals.bcbsm.com and log in at the top of the page.

Online training is available to help you prepare for the new system. This training, plus a comprehensive User Guide, Quick Guide and frequently asked questions document can be found on the Training Tools page of ereferrals.bcbsm.com.

39. Blue Cross Blue Shield of Michigan identifies Medicare Advantage breath hydrogen claim defect

Category: Medicare Advantage

Title: Blue Cross Blue Shield of Michigan identifies Medicare Advantage breath hydrogen claim defect
We’ve identified a defect that’s causing claims to wrongly deny when the breath hydrogen service is billed with a payable diagnosis. The associated CPT code is *91065. Claims will be reprocessed.

We’re working as quickly as possible to resolve the issue and apologize for any inconvenience this issue has caused.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2013 American Medical Association. All rights reserved.

40. Presentations from Michigan Hospital Network session in Southfield now available

Category: Hospitals

Title: Presentations from Michigan Hospital Network session in Southfield now available

Start Date: September 26, 2014 End Date: October 10, 2014

The presentations made at the Michigan Hospital Network session in Southfield on Thursday, Sept. 25, 2014, are now available on web-DENIS to all hospitals that weren’t able to make the event. To access the presentations given during the session, log in to web-DENIS:

i. Click on BCBSM Provider Publications and Resources.
ii. Click on Newsletters and Resources.
iii. In the “What’s New” section, find Presentations from the September 2014 Michigan Hospital Networking session. Click on the presentations to open them.

All the presentations from forums and provider fairs in the past year can also be found on the Provider Training page.

Thank you to all who attended.

41. New BCN e-referral tool now live

Category: BCN e-referral tool

Title: New BCN e-referral tool now live

Start Date: September 29, 2014 End Date: October 13, 2014

The new e-referral tool is now live. For the latest e-referral issues and tips, please see the Referral News section on ereferrals.bcbsm.com. Online training, plus a comprehensive
42. One county to transition out of MIChild Blue Cross PPO coverage on Oct. 1

Category: MIChild

Title: One county to transition out of MIChild Blue Cross PPO coverage on Oct. 1

Start Date: September 29, 2014 End Date: October 13, 2014

The following county will transition from MIChild Blue Cross PPO coverage to Medicaid-approved HMO plans for its medical, pharmacy and vision benefits on Oct. 1, 2014: **Benzie**

As we announced in the September 2013 issue of The Record, MIChild members with Blue Cross PPO coverage are switching to Medicaid-approved HMOs. The transition will happen in stages by county. In addition, all MIChild members with Blue DentalSM coverage transitioned to other dental carriers on Oct. 1, 2013.

**First transition happened on Oct. 1, 2013, and included these 34 counties:**

<table>
<thead>
<tr>
<th>Alger</th>
<th>Kent</th>
<th>Newaygo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arenac</td>
<td>Keweenaw</td>
<td>Oakland</td>
</tr>
<tr>
<td>Baraga</td>
<td>Lake</td>
<td>Oceana</td>
</tr>
<tr>
<td>Chippewa</td>
<td>Livingston</td>
<td>Ontonagon</td>
</tr>
<tr>
<td>Delta</td>
<td>Luce</td>
<td>Osceola</td>
</tr>
<tr>
<td>Dickinson</td>
<td>Mackinac</td>
<td>Otsego</td>
</tr>
<tr>
<td>Genesee</td>
<td>Macomb</td>
<td>Ottawa</td>
</tr>
<tr>
<td>Gogebic</td>
<td>Marquette</td>
<td>Schoolcraft</td>
</tr>
<tr>
<td>Houghton</td>
<td>Mason</td>
<td>Washtenaw</td>
</tr>
<tr>
<td>Ionia</td>
<td>Menominee</td>
<td>Wayne</td>
</tr>
<tr>
<td>Iosco</td>
<td>Montcalm</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>Muskegon</td>
<td></td>
</tr>
</tbody>
</table>

**Second transition happened on Nov. 1, 2013, and included these 13 counties:**

<table>
<thead>
<tr>
<th>Bay</th>
<th>Huron</th>
<th>Saginaw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>Kalamazoo</td>
<td>Shiawassee</td>
</tr>
<tr>
<td>Charlevoix</td>
<td>Lapeer</td>
<td>St Clair</td>
</tr>
<tr>
<td>Crawford</td>
<td>Ogemaw</td>
<td>Tuscola</td>
</tr>
<tr>
<td>Gratiot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Third transition happened on Dec. 1, 2013, and included these four counties:**
Fourth transition happened on March 1, 2014, and included these two counties:

<table>
<thead>
<tr>
<th>Clinton</th>
<th>Ingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eaton</td>
<td>Isabella</td>
</tr>
</tbody>
</table>

Fifth transition happened on April 1, 2014, and included these three counties:

<table>
<thead>
<tr>
<th>Hillsdale</th>
<th>Missaukee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare</td>
<td>Roscommon</td>
</tr>
<tr>
<td>Gladwin</td>
<td></td>
</tr>
</tbody>
</table>

Sixth transition happened on May 1, 2014, and included these 12 counties:

<table>
<thead>
<tr>
<th>Allegan</th>
<th>Emmet</th>
<th>Manistee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>Grand Traverse</td>
<td>Mecosta</td>
</tr>
<tr>
<td>Branch</td>
<td>Leelanau</td>
<td>St. Joseph</td>
</tr>
<tr>
<td>Cheboygan</td>
<td>Lenawee</td>
<td>Wexford</td>
</tr>
</tbody>
</table>

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit michigan.gov/michild*. Click on Information for MIChild Providers then click on MI Child Health Plan Service Contacts and Service Areas Listing.
- You can also call MIChild’s Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

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

43. Additional fee and rate schedules added to web-DENIS

Category: Claims

Title: Additional fee and rate schedules added to web-DENIS

Start Date: September 29, 2014 End Date: October 13, 2014

BCBSM recently added these additional entire fee and rate schedules to web-DENIS, resulting from fee or rate updates, as follows:

- Facility
• Freestanding ESRD Facility 1/1/15
• HHC Facility Rate Sheet effective 01/01/2015
• HIT Rate Schedule effective 1/1/15 (see NOTE below)
• Hospice Rate Schedule 10/1/14
• Hospital Outpatient Dialysis rates effective 01/01/15

  o Professional
  • Ambulance Fee Schedule (1/1/15) (PDF)
  • Local Network (EPO) Fee Schedule (1/1/15) (Excel)
  • Local Network (EPO) Fee Schedule (1/1/15) (PDF)
  • EPO ANESTHESIA MAXIMUM PAYMENT SCHEDULE (1/1/15) (Excel)

Please note that fee and rate schedules older than 3 years have been removed.

**NOTE: HIT Per-Diem Reporting for continuous infusion pump billing**

In the April 2012 Record, BCBSM announced that daily billing of S codes related to continuous infusion for surgically implanted pump was not permitted. However, please note that effective January 2015, HIT providers will again be able to report the appropriate per-diem S code for continuous infusions through implanted pumps on a daily basis. This change will also be communicated in the November 2014 Record and included in the Home Infusion Therapy Provider Manual.

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

For more information, contact your BCBSM provider consultant.

### 44. Blue Cross Blue Shield of Michigan facility billing issues for Medicare Plus Blue℠

**Category:** Medicare Advantage

**Title:** Blue Cross Blue Shield of Michigan facility billing issues for Medicare Plus Blue℠

**Start Date:** September 30, 2014 **End Date:** October 14, 2014

To better service our facility providers, we have begun a monthly status on any identified billing issues related to Medicare Advantage facility claims. These rolling updates will detail the issues, dates problems are resolved or anticipated to be fixed and any new issues. They are organized from oldest to newest.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Issue status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue Description</td>
<td>Notes</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Positron emission tomography scans rejecting</td>
<td>· System testing continues. There is no estimated fix date yet.</td>
</tr>
<tr>
<td></td>
<td>· Claims can be manually corrected by Provider Inquiry until the system fix is completed.</td>
</tr>
<tr>
<td>Denials of Medicare Advantage radiology claims where a combination procedure code was authorized and only one component of the authorized order was performed</td>
<td>· This issue was resolved.</td>
</tr>
<tr>
<td></td>
<td>· A web-DENIS message was posted in August reminding providers of the existing policy.</td>
</tr>
<tr>
<td>Hospitals are experiencing struggles getting the referring physician to update authorizations when it’s determined that a procedure other than the one preauthorized is more appropriate</td>
<td>· An article will be published in <em>The Record</em> reminding physician offices of their responsibility.</td>
</tr>
<tr>
<td>Molecular lab procedure code *81479 is rejecting</td>
<td>· The current policy is under review by Blue Cross Blue Shield of Michigan’s Payment &amp; Policy Committee for Medicare Advantage.</td>
</tr>
<tr>
<td></td>
<td>· Claims are currently processing in accordance with the existing policy to pay 100 percent of claims that have a de-identified remittance advice on file and 25 percent for those that do not.</td>
</tr>
<tr>
<td>MRI procedure codes are rejecting stating a modifier is required</td>
<td>· This issue is resolved and a web-DENIS message was posted Sept. 12.</td>
</tr>
<tr>
<td></td>
<td>· Mass adjustments were completed, but we will monitor pended claims manually in the next 60 days.</td>
</tr>
<tr>
<td>Lab issue (*83036)</td>
<td>· This issue was resolved in July, and all adjustments were completed.</td>
</tr>
<tr>
<td></td>
<td>· The fix is planned for early October.</td>
</tr>
<tr>
<td></td>
<td>· All rejected claims will be reprocessed once the system</td>
</tr>
</tbody>
</table>
45. All BCBSM trading partners

**Category:** UPDATE - Delayed Blue Cross Blue Shield 835s

**Title:** All BCBSM trading partners

**Start Date:** September 30, 2014 **End Date:** October 14, 2014

All delayed professional and institutional 835 files for the week of 09/29/14 will be distributed this evening.

We apologize for any inconvenience.

46. Medicare Eligibility

**Category:** System Maintenance for Sunday October 5, and Monday October 6, 2014

**Title:** Medicare Eligibility

**Start Date:** September 30, 2014 **End Date:** October 6, 2014

The Medicare Eligibility application is scheduled for two maintenance updates.

The first maintenance update will begin Sunday October 5, 2014 at 12:01 AM ET. The Medicare Eligibility Application will be unavailable during this time. Attempts to access Medicare Eligibility will result in errors. The maintenance should be completed by 5:00 AM ET on Sunday October 5, 2014.

The second maintenance update will begin Sunday October 5, 2014 at 5:00 PM ET. The Medicare Eligibility application will be unavailable during this time. Attempts to access the Medicare Eligibility Application will result in errors. The second maintenance update should be completed by 6:00 AM ET on October 6, 2014

Please contact the Help Desk if you have any questions.

Medicare Customer Assistance Re: Eligibility (MCARE) Help Desk

1-866-324-7315
Blue Cross Complete partners with PerformRx to develop the Drug Therapy Management program

Category: Blue Cross Complete

**Title:** Blue Cross Complete partners with PerformRx to develop the Drug Therapy Management program

**Start Date:** September 30, 2014 **End Date:** October 14, 2014

Blue Cross Complete and PerformRx, a pharmacy benefits manager, have partnered to develop the Drug Therapy Management program. Through personalized consultations with patients and communication with their health care providers, this pharmacist-driven program optimizes a patient’s drug therapy and addresses drug safety concerns. Going forward, if your patient’s medication regimen is reviewed by a pharmacist, a summary of consultation and recommendations will be sent to you. We hope this program will help as you manage your patients’ care. For more information please refer to the **Drug Therapy Management program** Pharmacy Update PDF on the web-DENIS BCN Provider Publications and Resources page under Blue Cross Complete in the Blue Cross Complete pharmacy materials section. This will also be posted soon on mibluecrosscomplete.com/providers.