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of the provisions
don't apply to
providers in other
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Blue Cross Blue Shield of Michigan

Medicare Private Fee for Service Manual

This provider manual is subject to change by Blue Cross on an ongoing basis. To ensure providers review the most current version, Blue Cross strongly discourages providers from relying upon printed versions.

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Provider Manual Chapter for Blue Cross Medicare Private Fee for Service

NOTE: This manual is for use by Michigan providers only. Many of the provisions do not apply to providers in other states.

Blue Cross Medicare Private Fee for Service overview

Blue Cross Blue Shield of Michigan is an authorized Medicare Advantage Organization that contracts with Centers for Medicare & Medicaid Services to offer the Blue Cross Medicare Private Fee for Service insurance plan in the senior market. Blue Cross will offer Medicare Private Fee for Service coverage to Medicare-eligible Michigan residents and Medicare-eligible members of Blue Cross groups.

Medicare Private Fee for Service plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options. You can find these benefit policies on our website at <http://www.bcbsm.com/provider/ma> under Blue Cross Medicare Private Fee for Service/Provider Toolkit/Coverage Details/ Enhanced Benefits.

ID card

Overview

Our member identification cards contain basic information you will need when providing covered services to our members. The Blue Cross Medicare Private Fee for Service ID card indicates the member is enrolled in a Medicare Private Fee for Service plan. Our Blue Cross Medicare Private Fee for Service members only need to show our ID card to receive services. A member doesn't need to show his/her Original Medicare ID card to obtain services.

All Blue Cross and Blue Shield Association (the national organization for all Blue plans) cards have a similar look and feel, which promotes nationwide ease of use. The cards include a magnetic stripe on the back to provide easier access to eligibility and benefit information.

Providers must include the three-character prefix found on the member's ID card when submitting paper and electronic claims. The prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm member coverage. It is critical for the electronic routing of specific transactions to the appropriate Blue Cross and Blue Shield plan.

Below is a sample of the members' ID card.



As with other Blue Cross products, members should provide their ID cards when requesting services from you.

The front of the card may include:

- The subscriber name, also called the enrollee or member, who is the contract holder.
- The member ID, also called the contract number, which is made up of randomly chosen characters, either alpha-numeric or all numeric.
- The issuer ID number just below the member information. This number identifies which Blue plan issued the card (Blue Cross or another plan.)
- A logo in the lower right corner of many cards identifies the member's prescription drug claims processor (for use by pharmacists).
- The group number
- Our website address
- A magnetic stripe at the top
- Phone numbers
- An address showing where to send claims



Eligibility and coverage

Each time your patient receives care, check to see if there have been any coverage changes.

- Ask to see the patient's Blue Cross Medicare Private Fee for Service ID card or acknowledgement letter at every encounter
- Verify eligibility and coverage
- Call 1-800-676-BLUE (2583)
- Michigan providers can verify eligibility and coverage online through web-DENIS

Web-DENIS

Web-DENIS is Blue Cross web-based information system for providers. Web-DENIS is a great tool because it's:

- **Complete** — web-DENIS tells you what the patient is required to pay for services, including the:
 - Total deductible amount
 - Remaining amount of the deductible
 - Copayments required for covered services
 - Out-of-pocket maximums or the highest dollar amount that the patient is required to pay
 - Remaining amount of the out-of-pocket maximum
- **Fast** — giving you the information you need quickly
 - Available 24 hours a day, seven days a week
 - User-friendly

If you need access to web-DENIS, we can help you get the information you need to use the system. Web-DENIS login and other information is available at bcbsm.com/provider/provider_secured_services/index.shtml.

PARS

PARS (Provider Automated Response System), formerly known as CAREN, is an interactive voice response system that allows providers to check claim status or verify members' high-level benefit and cost-share information. For claims, PARS provides:

- Claims status
- Claims payment and denial details
- Check information

For benefit and cost-share information, PARS provides:

- The deductible and coinsurance amounts
- Remaining amount of the deductible
- Out-of-pocket maximums
- Remaining amount of the out-of-pocket maximum
- High-level benefit information such as office visits and preventive care services
- Copayments required for covered services

Providers can request a copy of the PARS information by fax or email.

To access PARS, call 1-866-309-1719. Once you have listened to a benefit on PARS, you have the option of transferring to a customer service representative during business hours. Please call 1-888-826-8152 for PARS Dental MA information.

Dental Electronic Inquiry System

Secure Track by INMEDIATA is no longer the tool for Blue Dental membership and eligibility. The new website is <http://onlineservices.bcbsm-dental.com> and can be used for patient benefit and eligibility information, claims submission, recent communications as well as claim and payment status. In order to access the information on the new system, you must first register at <http://dentaquest.com/selfreg/bcbsm/>.

For dental provider servicing and automated information, call 1-844-876-7917 Monday – Friday, 8am - 5pm EST. Automated information is available 24/7.

Verifying eligibility and coverage for out-of-area members

To determine eligibility and cost-sharing amounts for out-of-area members, call the BlueCard line at 1-800-676-BLUE (2583) and provide the member's three digit prefix located on the ID card. You may also submit electronic eligibility requests for Blue Cross Medicare Private Fee for Service members.

Billing members

Collect deductible, copayments or coinsurance at time of service

Providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost-sharing refers to a fixed-dollar copayment, a percentage coinsurance or a deductible. You can only collect the appropriate Blue Cross Medicare Private Fee for Service cost-sharing amounts from the member. After collecting these amounts, bill your local Blue plan for covered services.

Balance billing is not allowed

You may only collect applicable cost-sharing from Blue Cross Medicare Private Fee for Service members for covered services and may not otherwise charge or bill them.

Cost-sharing for Qualified Medicare Beneficiaries (QMB) is not allowed

The Qualified Medicare Beneficiary (QMB) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. As mandated by CMS, providers who inappropriately bill individuals enrolled in QMB are potentially subject to sanctions. Any wrongfully collected

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deductibles should be refunded to the patient. Providers needing to verify a Medicare Plus Blue member's QMB status should contact Servicing.

Refund over-billed members

If you collect more from a member than the applicable cost-sharing, you must refund the difference.

Coordination of benefits

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we will pay depends on the amount paid by the primary plan. We follow all Medicare secondary-payer laws.

Providing Medicare Outpatient Observation Notice (MOON)

The Medicare Outpatient Observation Notice (MOON) is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are in the emergency department or an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH). Blue Cross follows CMS guidance for the MOON. Hospitals and Critical Access Hospitals (CAH) are required to furnish the MOON to Medicare beneficiaries in the circumstances listed below:

- When a member is in the emergency department, and is being considered for inpatient admission. Specifically:
 - Any member considered for inpatient admission should be given the Medicare Outpatient Observation Notice form
- When a member is in observation setting for 24 hours or more, if the member has not already received the form prior to being admitted for observation.

For our Medicare Advantage members in these circumstances, hospitals must present the member with a completed Medicare Outpatient Observation Notice. This is a Centers for Medicare & Medicaid Services requirement.

The MOON is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are in the emergency department or an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH). The notice must be provided no later than 36 hours after emergency department or observation services are initiated or, if sooner, if the member is transferred, discharged or admitted.

The MOON notice informs beneficiaries of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Provider compliance with this notification requirement is mandatory.

- The standard language for the MOON notice and instructions can be accessed at the following link: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/>.

Non-covered services and referrals for non-covered services — provider responsibilities

Sometimes you and your patient may decide that a service, treatment or item is the best course of care, even though it isn't covered by Blue Cross Medicare Private Fee for Service or may be supplied by another provider or practitioner.

You are responsible for determining which items, services or treatments are covered. If you believe that a service, item or treatment won't be covered, you must tell the member before the service or treatment is performed or item obtained. If the member acknowledges that the item, service or treatment won't be covered by Blue Cross Medicare Private Fee for Service and agrees that he or she will be solely responsible for paying you, must obtain an advance coverage determination before the non-covered service, treatment or item is provided.

If you provide an item, treatment or service that is not covered and have not obtained an advance coverage determination to provide the patient with prior notice that the item, treatment or service is not (or may not be) covered by the plan, you may not bill the patient for such non-covered items, treatments or services.

If you believe that an item, service or treatment won't be covered and the provider supplying the service, treatment or item is not contracted with Blue Cross Medicare Private Fee for Service, you must tell the member before you refer them. If the member acknowledges that the item, service and/or treatment won't be covered by Medicare Private Fee for Service, understands that you referring them to a non-contracted provider and would like to continue with the treatment plan, either the prescribing, referring or treating physician must obtain an advance coverage determination before providing the service.

There is a process for requesting an advance coverage determination. Please see below.

Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before providing a service or item.

All of Blue Cross Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, it will be covered by Medicare Private Fee for Service.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To obtain an advance coverage determination, fax your request to 1-877-348-2251 or submit your request in writing to:

Grievance and Appeals Department
Attn: Org Determination
Blue Cross Blue Shield of Michigan
P.O. Box 2627
Detroit, MI 48231-2627

Blue Cross will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Blue Cross justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, fax your request to 1-877-348-2251. We will notify you of our decision within 72 hours, unless a 14-day extension is requested by the member or the plan justifies a 14-day extension is in the best interest of the member.

Durable medical equipment, diabetic supplies, and prosthetic & orthotic Northwood and J&B Medical Supply Benefit Management

Blue Cross Medicare Plus Blue leases the Northwood provider network and contracted fees for durable medical equipment, prosthetic and orthotics from Northwood and diabetic supplies from J&B Medical Supply. Our claim system processes these claims for Blue Cross MA. Medicare Plus Blue reimburses in-network providers based on the vendor fee schedules. If a service does not have a network fee available, Medicare's allowed-amount will be used. Out-of-network claims for Medicare Plus Blue PPO members will be reimbursed using the Medicare fee schedule with the potential for higher level of cost-sharing to be applied.

DME benefits

All Medicare Plus Blue plans include DME/P&O, medical supplies and Part B drugs that are covered under Original Medicare.

Lab services

Medicare Private Fee for Service Lab Network — We've established a laboratory network with Quest Diagnostics and Joint Venture Hospital Laboratories to provide non-patient clinical and pathology lab services to Blue Cross Medicare Private Fee for Service members. Non-patient services as defined by the JVHL Managed Care Contract Terms include specimens that are either couriered to a lab or are drawn at patient service centers, including those located on hospital campuses — *if no concurrent diagnostic services are rendered by a physician or non-physician practitioner*. Blue Cross Medicare Private Fee for Service providers must use the Blue Cross Medicare Private Fee for Service lab network for all lab and pathology services (facilities – nonpatient only) to receive payment. Use of the Blue Cross Medicare Private Fee for Service lab network minimizes out-of-pocket costs for members.

Locations of patient service centers are available on the JVHL (jvhl.org*) and Quest Diagnostics (questdiagnostics.com*) websites, or by calling their administrative offices at 1-800-445-4979 (JVHL) or 1-866-MY-QUEST (1-866-697-8378) (Quest Diagnostics). A deductible may be applied when Medicare Private Fee for Service members have lab services performed. The member may visit JVHL online at jvhl.org* to view the complete list of JVHL hospital labs or call JVHL at 1-800-445-4979 for the provider directory of hospital labs that par with JVHL.

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Blue Cross Medicare Private Fee for Service plan	In-network services	Services performed at a network hospital that is non-par with JVHL	Out-of-network services
Medicare Private Fee for Service	\$0 after deductible	\$0 after deductible	\$0 after deductible

When you, or other qualified members of your office staff, obtain laboratory specimens in your office, Quest Diagnostics or JVHL can arrange for a courier to pick up the specimen. If you prefer, direct your patients to have their laboratory specimens collected at Quest Diagnostics or JVHL patient service centers or participating hospitals, which may be located on or off the hospital's campus. JVHL participating hospitals must bill JVHL for non-patient laboratory services rather than submitting claims directly to Blue Cross. Claims submitted directly to Blue Cross will not be reimbursed.

We also cover pathology services associated with the lab services provided by JVHL participating hospitals or by Quest Diagnostics, and the test specimens registered by a JVHL participating hospital lab or by Quest Diagnostics and sent to an external reference laboratory.

In-network practitioners may perform certain lab procedures in the office location without referring the patient or the specimen to a Blue Cross Medicare Private Fee for Service lab network provider. These procedures are limited to those on Blue Cross provider website. Simply visit bcbsm.com/provider/ma and select *Blue Cross Medicare Private Fee for Service/Provider Toolkit/Coverage Details/Medicare Advantage PPO Lab Network*. The procedures on this list are those that Blue Cross has determined to be appropriately provided in an office setting by in-network practitioners when the test:

- Results are needed at the time of service to support making real time therapeutic decisions
- Can be performed economically and accurately
- Is medically necessary

Note: Procedures performed in the office location that are not listed on the Blue Cross Medicare Private Fee for Service physician office lab list may not be reimbursed. The Medicare Advantage POLL is intended for use only by in-network providers. Blue Cross MA Private Fee for Service regularly reviews and periodically updates the POLL based on the Centers for Medicare & Medicaid Services guidelines.

Benefits

For basic Medicare benefits, refer to www.cms.gov.*

Medicare Private Fee for Service individual members will be assessed out-of-network cost sharing for non-urgent or emergency services received out of network. Out-of-network cost share will apply to a separate out-of-pocket maximum for out-of-network services. Summaries of benefits for Blue Cross Medicare Private Fee for Service members can be viewed on our provider website, bcbsm.com/provider/ma under *Provider Toolkit/Coverage Details/Blue Cross Medicare Private Fee for Service Benefit Summaries*.

Medicare Private Fee for Service plans include benefits that may be in addition to Original Medicare benefits. You can find those benefit policies on our website, bcbsm.com/provider/ma under *Provider Toolkit/Coverage Details/Enhanced Benefits*.

Primary Care Physicians

Blue Cross Medicare Private Fee for Service recognizes the following practitioner specialties as personal or primary care physicians:

- Family practice
- General practice
- Geriatrician
- Pediatric medicine
- Internal medicine
- Certified nurse practitioner – primary care focus
- Physician assistant – primary care focus
- Obstetrics and gynecology

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Hospice services

Federal regulations require that Medicare fee-for-service contractors (Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier) maintain payment responsibility for Blue Cross Medicare Private Fee for Service members who elect hospice care. Claims for services provided to a Blue Cross Medicare Private Fee for Service member who has elected hospice care should be billed to the appropriate Medicare contractor.

- If the member elects hospice care and the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.
- If the member elects hospice care and the service is not related to the member's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.
- If the service is provided during a lapse in hospice coverage, submit the claim to the local Blue plan.
Note: Original Medicare is responsible for the entire month that the member is discharged from hospice.
- If the service is not covered under Original Medicare but offered as an enhanced benefit under the member's Blue Cross Medicare Private Fee for Service plan (for example, vision), submit the claim to the local Blue plan.

Medicare Advantage member cost-share for hospice services

As provided in 42 CFR § 422.320, an MA organization must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare hospice program is located within the plan's service area; or (2) it is common practice to refer patients to hospice programs outside the MAO's service area.

An MA enrollee who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive (through the MA plan) any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the enrollee and the MAO, providers, and suppliers for other Medicare-covered services furnished to the enrollee.

The table below summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Type of Services	Enrollee Coverage Choice	Enrollee Cost-sharing	Payments to Providers
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice ¹ , Parts A & B	MA plan or Original Medicare	MA plan cost-sharing, if enrollee follows MA plan rules ³	Original Medicare ²
		Original Medicare cost-sharing, if enrollee does not follow MA plan rules ³	Original Medicare
Non-hospice ¹ , Part D	MA plan (if applicable)	MA plan cost-sharing	MAO
Supplemental	MA plan	MA plan cost-sharing	MAO

Notes:

- 1) The term "hospice care" refers to Original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term "non-hospice care" refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.
- 2) If the enrollee chooses to go to Original Medicare for non-hospice, Original Medicare services, and also follows plan requirements, then, as indicated, the enrollee pays plan cost-sharing and Original Medicare pays the provider. The MA plan must pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable.
- 3) Note: A Blue Cross Medicare Private Fee for Service enrollee who receives services out-of-network and has followed plan rules is only responsible for plan cost-sharing. The enrollee doesn't have to communicate to Blue Cross in advance regarding his/her choice of where services are obtained.

Access to care

Accessibility of services is measured by after-hours and access, appointment access.

After-hours access

CMS requires that the hours of operation of its practitioners are convenient for and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, seven days a week with a published after-hours telephone number (to a practitioner's home or other relevant location), pager or answering service, or a recorded message directing members to a physician for after-hours care instruction. Note: Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening are not acceptable.

In addition, primary care physicians must provide appropriate backup for absences.

Appointment access

Each practitioner must, at a minimum, meet the following appointment standards for all Medicare Private Fee for Service members.

Appointment accessibility will be measured and monitored using the following standards:

- Regular and routine care appointments (includes complete history and physical and physical annual gynecologic examinations, immunizations and other preventive care appointments) – service is provided within 30 business days.
- Urgent medical care appointment routine primary and specialty care, includes appointments for acute non-life-threatening conditions – service is provided within 48 hours.

Behavioral health service accessibility will be measured using the following standards:

- Initial visit for routine behavioral health services - service is provided within 10 business days.
- Follow-up routine behavioral health services - service is provided within 30 business days.
- Urgent behavioral health care appointments - service is provided within 48 hours.
- Emergency non-life threatening behavioral health care - service is provided within 6 hours.

In-office waiting room times

- Acceptable office waiting room time for all practitioners should be no more than 30 minutes from the scheduled time of appointment. Members should be advised of delays as soon as possible. If a delay occurs, the member should be advised of the estimated time at which the appointment will begin. If the member is unable to wait, an alternate appointment should be offered consistent with appointment access standards

Compliance with access standards

If it is determined that a practitioner does not meet access to care standards, the non-compliant practitioner must submit a corrective action plan within 30 days of notification.

If...	Then...
The practitioner's corrective action plan is approved	The practitioner is notified and the provider's office will be called approximately 14 days after receipt of the corrective action plan to reassess compliance with the corrective action plan.
The corrective action plan is not approved	A request will be made that the practitioner submit an acceptable corrective action plan within 14 days.
A reply is not received within 14 days	The practitioner will be sent a second letter, signed by the appropriate medical director. Copies of the letter will be forwarded to the Blue Cross Medicare Advantage Quality Improvement Department.
A reply to the second letter is not received within 14 days	A third letter, signed by an appropriate medical director, will be sent to inform the practitioner that termination will occur within 60 days.

Blue Cross encourages Medicare Private Fee for Service practitioners (or their office staff) to assist members whenever possible in finding an in-network practitioner who can provide necessary services. If assistance is needed in arranging for specialty care (in- or out-of-network), please call our Provider Inquiry department at 1-866-309-1719.

Blue Cross network providers must ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds.

Providers and their office staff are not allowed to discriminate against members in the delivery of health care services consistent with benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as end stage renal disease, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. It is necessary that a provider's office can demonstrate they accept for treatment any member in need of health care services they provide.

Advance directives

Blue Cross provides Blue Cross Medicare Private Fee for Service members information on their right to complete an advance directive. Advance directive means a written instruction, recognized under state law, relating to how to provide health care when an individual is incapacitated. As part of the medical record content requirements for Blue Cross Blue Shield of Michigan, physicians must document discussion in the medical record of whether a member has or does not have an advance directive. If a member has completed and presents an advance directive, then the provider must include it in the member's medical record.

Medical management and quality improvement

Case and disease management

Medicare Private Fee for Service offers enhanced care management programs to members. Our care management strategy includes a variety of programs of different intensity and length to ensure that all members have a program that fits their needs. All care management programs are fully integrated with medical, behavioral health and pharmacy professionals working to assist members with complex needs. Members may be identified for programs including chronic condition management, complex care management or case management. Blue Cross may contact you, as the primary provider, to inform and coordinate care for these members if warranted.

- **Blue Care Connect**

Blue Care Connect is an integrated care management program to improve the continuity and quality of care and reduce benefit costs for high-risk members. The purpose of the program is to use a high touch approach focused on behavioral, social, and environmental aspects of care management to reduce the burden of disease and overall benefit cost. To improve continuity of care, members who are identified will be managed by one care manager and the case will remain open indefinitely. If a member needs to be referred to external programs, the identified care manager will remain the member's primary point of contact and follow-up. BCC is delivered internally by Blue Cross care managers and is available to members nationwide.

The member's care manager will encourage the member to complete a health assessment, address gaps in care, and identify and address appropriate intervention pathways depending on the member's needs. A subset of goals are considered "high priority" and care managers will address these first as appropriate. All other identified goals/guidelines are expected to be addressed by the care manager during the course of the program. Even after acute episodes and immediate goals have been addressed, the care manager will continue to support the member and monitor the case due to the complexity of these members.

- **Care Transitions**

The Care Transitions Program is designed to ensure members a safe transition home from the hospital. The program targets members who are being discharged from an acute hospital setting and assist with coordinating services and follow-up care that can help to improve the recovery period and reduce the likelihood of a readmission. Some of the services provided within the program are:

- Post-discharge care coordination calls which may include DME and home health
- Post-discharge education about medication and signs of worsening symptoms
- Identifying the need and coordinating with physician offices for follow-up care

Predictive modeling is used to identify members at the highest risk for emergency room visits and hospital readmissions for this intervention. The Care Transitions provides members with intensive services at discharge that slowly decrease based on the member's needs. If the member has a chronic condition and would benefit from continued education and support, the team will refer that member to the Chronic Condition Management Program accordingly. All members are provided with assistance to ensure the member receives comprehensive self-management information for a smooth transition home.

- **Case management**

The Case Management Program was created to improve the quality of life for members with high-risk chronic and acute conditions, as well as those who are at high risk for incurring high costs in the future. Through collaboration with the member's family and physician, the member will be provided with education, care coordination, and psychosocial interventions to assist them in understanding their complex health issues and to provide health coaching and promote completion of advance directives. Nurse case managers or licensed masters level social workers may contact providers directly to coordinate care and services. The program extends an average of three months and is staffed by registered nurses, a social worker and physician consultants. In addition, behavioral and medical health initiatives can be implemented collaboratively for members with co-occurring conditions to identify and treat the member holistically.

- **Chronic condition management**

The Chronic Condition Management Program is a comprehensive program designed to aid members in managing their chronic condition.

The program targets high risk members with coronary artery disease, chronic obstructive pulmonary disease, diabetes, and heart failure. Members in the program receive education about their health status, personalized information regarding their treatment options, self-management materials and monitoring, maintenance and management of their condition.

When a member is engaged in the program, the member will identify their primary provider and that provider will receive notification of the member's engagement in the program. The provider then has the opportunity to opt out of having their patient participate in the program.

- **Remote monitoring**

The Remote Monitoring Program targets high risk members with a diagnosis of Heart Failure (HF) or HF with diabetes. Members receive a symptom appropriate monitor for their condition(s) and are provided with the support needed to operate it. A monitor, placed in member's home, transmits biometric and/or other symptom data daily. When these data readings fall outside of usual parameters a nurse care manager will call the member to validate the information and confirm the symptoms.

The member's primary provider will receive notification of the member's engagement in the program and will have the opportunity to opt out of having their patient participate in the program. The provider will also be contacted by the nurse manager whenever biometric data is outside of usual parameters and follow up may be needed.

- **Behavioral health case management**

Blue Cross provides case management services to assist members who may benefit from additional support due to complex behavioral health care issues or co-existing behavioral and medical health conditions.

Members are identified for case management interventions using a variety of triggers based on utilization, health risk assessment information and targeted diagnoses.

Identified members are contacted telephonically and following the member's consent to participate in the case management program, the case manager completes a behavioral health-specific assessment, develops a plan of care that identifies targeted interventions and long-and short-term goals, and notes any barriers to achieving the expected outcomes. The frequency and type of case management intervention varies based on the individual member's needs. Case management services are provided until the identified goals are met, the member declines further case management or no further benefit from case management can be identified.

- **Provider delivered care management**

The Provider Delivered Care Management program is a comprehensive array of patient education, coordination and other support services delivered face-to-face and over the telephone by ancillary health care professionals who work collaboratively with the patient, the patient's family, and the patient's primary physician. These professionals perform PDCM services within the context of an individualized care plan

designed to help patients with chronic and complex care issues address medical, behavioral, and psychosocial needs. PDCM helps patients meet personal health care goals that contribute to optimal health outcomes and lower health care costs.

PDCM is integrated into the clinical practice setting functions as a key component of the patient-centered medical home care model fostered by Blue Cross in its efforts to transform health care delivery in Michigan.

- **High intensity care management program**

The HICM program is currently a pilot program with select physician organizations in southeast and west Michigan. It enables patients to receive care management services from a trained clinical care management team in the physician's office and at home. This program extends the Provider-Delivered Care Management program by identifying the highest-risk Medicare Private Fee For Service members and providing them with intensive care management services to improve quality of life and increase their care cost-efficiency. This model provides services to patients based on their chronic conditions and level of health care need, and may include psycho-social support, care coordination, goal-setting, self-management support, care transitions, remote patient monitoring, and comprehensive care planning. Services are delivered in-person, in the home or practitioner's office, and also by phone.

- **Tobacco Cessation Coaching**

Tobacco Cessation Coaching is a telephone-based program provided by WebMD, designed to support members in their efforts to quit tobacco. The program's goal is to improve the members' quality of life as well as reduce costs and hospital utilization for conditions associated with tobacco use.

- **24-Hour NurseLine**

The 24-Hour NurseLine is a 24/7 telephone triage and health information service.

Nurses maintain client confidentiality while providing support, and if necessary, referring members to appropriate sources for further information. Support is provided on symptom management, provider searches, clinical support, education and referral to community resources.

- **Health and wellness**

Our health promotion and wellness programs give members health information to help them understand their health care issues, address their concerns, and work more closely with their providers. Members can view online articles, tools and quizzes that provide information on thousands of topics. Providers may refer members to this resource, when appropriate, by having them click on the **Health & Wellness** tab at bcbsm.com. Information obtained is used to support continuity of care through care management program identification and Blue Cross program development.

For questions about our care management programs or if you feel your patient would benefit from one of our programs, call our Provider Inquiry department at 1-866-309-1719. Nurse case managers may contact you directly to coordinate care and services.

Quality improvement program

Blue Cross Blue Shield of Michigan is committed to improving the quality of health care for our Blue Cross Medicare Private Fee for Service members. Blue Cross Medicare Private Fee for Service maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services members receive and routinely measure the results to ensure members are satisfied and expectations are met.

The Blue Cross Medicare Private Fee for Service Quality Improvement unit develops an annual quality improvement program that includes specific quality improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Member satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Medical record documentation compliance
- Quality improvement projects

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Provider and Systems Survey and Health Outcomes Survey
- Regulatory compliance

Healthcare Effectiveness Data and Information Set

HEDIS is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. Blue Cross Medicare Private Fee for Service follows HEDIS reporting requirements established by the National Committee for Quality Assurance and the Centers for Medicare & Medicaid Services. Audited HEDIS reports will be used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures that Blue Cross Medicare Private Fee for Service focuses on include:

- Acute hospital utilization
- Adults access to preventive/ambulatory health services
- Adult body mass index assessment (document weight, height and BMI value in the medical record)
- Ambulatory care (outpatient visits and emergency department visits)
- Alcohol and other drug abuse or dependence treatment – initiation and engagement
- Antibiotic utilization
- Antidepressant medication management
 - Effective acute phase treatment
 - Effective continuation phase treatment
- Acute hospital utilization
- Breast cancer screening (women 50–74 years of age)
- Board certification
- Colorectal cancer screening (members 50–75 years of age)
- Comprehensive diabetes care
 - Blood pressure control <140/90
 - Dilated retinal eye examination
 - HbA1c testing, poor and good control
 - Medical attention for nephropathy
- Controlling high blood pressure
 - Adequate control of hypertension <140/90 (members 18–85 years of age)
- Disease-modifying anti-rheumatic drug therapy in rheumatoid arthritis
- Emergency department utilization
- Fall risk management
- Follow-up after emergency department visit for alcohol and other drug dependence (within seven and 30 days)
- Follow-up after emergency department visit for mental illness (within seven and 30 days)
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions (within seven days)
- Flu vaccinations for adults
- Follow-up after hospitalization for mental illness (within seven and 30 days)
- Frequency of selected procedures
- Hospitalization following discharge from a skilled nursing facility
- Hospitalization for potentially preventable complications
- Identification of alcohol and other drug services
- Inpatient utilization – general hospital/acute care
- Management of urinary incontinence in older adults
- Medication reconciliation post-discharge
- Mental health utilization

- Non-recommended PSA-based screening in older men
- Osteoporosis testing in older women
- Osteoporosis management in women who had a fracture (women age 67–85)
- Persistence of beta-blocker treatment after a heart attack
- Pharmacotherapy management of COPD exacerbation
 - Systemic corticosteroid
 - Bronchodilator
- Physical activity in older adults
- Plan all-cause re-admissions
- Pneumonia vaccination status for older adults
- Potentially harmful drug-disease interactions in the elderly
- Standardized healthcare-associated infection ratio
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Tobacco cessation – medical assistance
- Transition of care
- Use of high-risk medications in the elderly
- Use of opioids at high dosage
- Use of opioids from multiple providers
- Use of spirometry testing in the assessment and diagnosis of COPD

CMS Quality Star Ratings Program

CMS evaluates Medicare Advantage health plans and issues star ratings each year.

The CMS plan rating uses quality measurements that are widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services Blue Cross offers. CMS compiles its overall score for quality of services based on measures such as:

- How Blue Cross helps members stay healthy through preventive screenings, tests and vaccines and how often our members receive preventive services to help them stay healthy.
- How Blue Cross helps members manage chronic conditions
- Member satisfaction with Blue Cross and their experience with the provider
- How often members filed a complaint against Blue Cross
- How well Blue Cross handles calls from members

In addition, because Blue Cross offers prescription drug coverage, CMS also evaluates Blue Cross prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

To learn more about the:

- Star quality rating system, visit <https://www.medicare.gov/find-a-plan/staticpages/rating/planrating-help.aspx>.
- HOS, visit <http://www.hosonline.org/en/survey-instrument/>.
- CAHPS survey, visit <http://www.ahrq.gov/cahps/index.html>.
- HEDIS, visit <http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx>.

Blue Cross Medicare Advantage tool, Health e-Blue

Health e-Blue is a clinical support tool that helps track members' health and offers our Blue Cross Medicare Private Fee for Service providers consistent and timely data like health registry, utilization and pharmacy information.

We routinely request certain data from providers. With Health e-Blue, providers have the convenience of entering patient services, lab results and vaccine information online as well as diagnosis codes for their Blue Cross Medicare Private Fee for Service patients.

Blue Cross partners with our Blue Cross Medicare Private Fee for Service providers by identifying their Blue Cross Medicare Advantage patients who need specific medical services so providers can contact those patients and schedule necessary services. Our Medicare Advantage tool, Health e-Blue, helps physicians identify gaps in care and receive information about their patients through enhanced encounter facilitation. Health e-Blue is designed to enable providers to get the information on patients for necessary services (such as mammograms) and helps them to take action toward providing those services.

The following provider specialties can register for our Medicare Advantage Health e-Blue:

Addiction Medicine - Family Practice Addiction Medicine	Gastroenterology	Pediatric Endocrinology
<ul style="list-style-type: none"> • Addiction Medicine – Family Practice Addiction Medicine • Adolescent Medicine • Adolescent Medicine – Pediatrics • Allergy/Immunology Allergy/Immunology – Internal Medicine • Cardiology • Critical Care Medicine • Critical Care Medicine – Internal Medicine • Critical Care Medicine – Pediatrics Cardiovascular Disease Endocrinology, Diabetes / Metabolism • Endocrinology Family Practice 	<ul style="list-style-type: none"> • Geriatric Medicine – Family Practice • Geriatric Medicine – Internal Medicine • General Practice • Hematology – Internal Medicine Hematology/Oncology • Interventional Cardiology Infectious Disease • Internal Medicine • Internal Medicine Pediatrics Nephrology Neuromusculoskeletal Medicine Oncology • Pediatric Allergy/Immunology Pediatric Cardiology Pediatrics 	<ul style="list-style-type: none"> • Pediatric Endocrinology • Pediatric Infectious Disease • Pediatric Nephrology Pediatric Gastroenterology • Public Health / General Preventive Medicine • Pediatric Hematology/Oncology Pediatric Pulmonology Preventive Medicine • Pediatric Rheumatology Pulmonary Disease Rheumatology • Sports Medicine – Family Practice Sports Medicine – Internal Medicine Sports Medicine – Pediatric

How do providers sign-up?

Because Health e-Blue is a web-based tool, providers will need access to Provider Secured Services.

To register for Provider Secured Services, providers should visit Blue Cross website at bcbsm.com/provider/provider_secured_services/index.html to learn how to get a user ID and password. To register for Health e-Blue, providers should:

- Complete the Health e-Blue Application and the Use and Protection Agreement for Health e-Blue access only <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/health-e-blue-application.pdf> (PDF). It may take a moment for this document to appear

Providers must **complete both the Health e-Blue Application and the Use and Protection Agreement** to access Health e-Blue. This documentation will ensure that Medicare Advantage member protected health information is shared only with the appropriate providers. Note: If you have current Health e-Blue access through Blue Care Network, you do not have to complete another Health e-Blue Application and Use and Protection Agreement to access Blue Cross Health e-Blue.

It's important that providers complete all fields on the Health e-Blue Application and the Use and Protection Agreement by providing name, office name, details, state license number and proper, authorized signature. Otherwise, the forms will be returned for completion and access will be delayed.

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Medicare Diabetes Prevention Program

Beginning April 1, 2018, your patients with Medicare Part B coverage and who are at risk for Type 2 diabetes may be eligible for the Medicare Diabetes Prevention Program (MDPP). It's offered at no cost to the member. This is a one-time, life-time benefit.

In a random controlled trial, the program was proven by the National Institutes of Health to greatly reduce the progression of prediabetes to Type 2 diabetes. Program services are delivered by lifestyle coaches in community settings. The coaches are trained by organizations that are certified by the Centers for Disease Control and Prevention.

Medicare criteria for MDPP eligibility are:

- Enrollment in Medicare Part B
- Blood value (one of the following):
 - Fasting plasma glucose of 100-125 mg/dl
 - A1c value between 5.7-6.4
 - Oral glucose tolerance test between 140-199 mg/dl
- Body mass index greater than 25 (if Asian, greater than 23)

No diagnosis of end-stage renal disease, Type 1 or Type 2 diabetes; previous gestational diabetes isn't an exclusion to participation. Medicare beneficiaries with certain risk factors for pre-diabetes will need a glucose test within the last year (12 months) to confirm they meet the criteria. The following tests can be ordered with no co-pays or deductibles:

- HCPCS/CPT 8294 Glucose; quantitative, blood (except reagent strip)
- HCPCS/CPT 82950 Glucose; post glucose dose (includes Glucose)
- HCPCS/CPT 82951 Glucose; tolerance test (GTT), 3 specimens (includes glucose)

Medicare allows one screening every 6 months for Medicare beneficiaries diagnosed with pre-diabetes and one screening every 12 months if previously tested but not diagnosed with pre-diabetes or if never tested.

Information about how eligible members can enroll in the MDPP by calling Blue Cross's program administrator, Solera Health, at (866) 653-3837 or by visiting bcbsm.com/prevent-diabetes.

If you are a MDPP provider with full or partial certification from the CDC, please contact Solera for information on being included in the MDPP network.

Pharmacy treatment improvement opportunities

In addition to our formularies, prescribing limits and restrictions, we promote quality of care by monitoring claims to improve outcomes and patient safety. CMS requires us to identify certain treatment opportunities and proactively address them with providers and members. Some of these medication issues factor into our Star rating scores.

Medication adherence

We pay close attention to medication adherence for disease states such as diabetes, hypertension and hypercholesterolemia. We monitor medication adherence rates by reviewing pharmacy claims data, and if a member is non-adherent to their medications, we will address this with the member to see why the member is not taking his/her medication as prescribed.

Statin use in diabetes

The guidelines of several medical societies state that diabetics should be on a statin, regardless of whether they have high cholesterol or not, in order to prevent cardiac events such as heart attacks. We will alert prescribers when they have members with diabetes that are not on a statin.

Immunization

Medicare Part B and Part D both cover immunizations. Although the delineation of coverage is fairly clear, there are some exceptions where a vaccine could be covered under either plan.

When billing for prophylactic immunizations, the following always applies:

- **Influenza and pneumonia immunizations are always paid under Part B.**
(These are never covered under Part D.)
- **Shingles immunizations are always paid under Part D.**
(These are never covered under Part B.)

Part B covers two categories of immunizations (prophylactic and injury/disease-related) and the benefit pays everything associated with the vaccination in a single claim, including ingredient cost, dispensing fee, and injection or administration fee. Medicare will pay for immunizations in various venues: at a pharmacy, a clinic or a physician's office.

Activity associated with administering Part D vaccinations are also bundled into a single claim. However, incidental activity, such as an office visit, may involve additional cost-share to the patient.

Type of immunization	Part A covers	Part B covers	Part D covers
Prophylactic immunizations associated with a senior population: <ul style="list-style-type: none"> • Seasonal influenza • Pneumococcal pneumonia • Hepatitis B 		Covers flu, pneumonia and hepatitis B for patients at high- or intermediate risk of contracting the disease.	Hepatitis B vaccine may be covered if the patient does not meet Medicare's Part B criteria.
Vaccines administered by a health care provider for treatment of an injury, or as a result of direct exposure to a disease or condition.	Covers vaccines administered during an inpatient stay.	Covers limited vaccines administered on an outpatient basis. Some vaccines subject to review of clinical criteria to determine Part B or Part D coverage.	Covers shingles vaccination, and other Part D vaccines. Some vaccines (other than shingles) subject to review of clinical criteria to determine Part B or Part D coverage.

Medicare Part B covers flu shots in full and some organizations provide the flu shot free of charge while others may charge for a flu shot. Because not all venues will file the Part B claim on the patient's behalf, the patient may have to pay cash for the flu shot, and then seek reimbursement from Medicare Part B.

It's important to remind these patients that Medicare Part B covers annual flu shots at 100 percent (no copay or deductible) and that they must submit a completed claim form and receipt to their Medicare Part B insurance plan to obtain reimbursement. The claim must be submitted under Part B because flu shots and pneumonia vaccinations are never paid under Part D.

Although shingles vaccinations are a prophylactic measure, these vaccinations are always covered under Part D. There is no coverage for this vaccination under Part B.

Billing guidelines for roster bills

Providers who are mass immunizers, and/or providers who chose to bill using the roster billing method, must submit immunization claims on a roster bill and accept assignment under Original Medicare on both the administration and vaccine. Physicians and other health care providers enrolled in the Medicare program should follow the billing guidelines below when submitting roster bills to Blue Cross Blue Shield of Michigan:

- At this time, Blue Cross can only accommodate roster billing on paper claims.
- Providers may submit up to three rosters on a single CMS-1500 claim form for each type of vaccination.
- Rosters may include information regarding multiple patients.
- Typed rosters are preferred. If it is not typed, the roster information must be in blue or black ink and legible.
- Do not fold your claim or roster forms.

Mail your CMS-1500 claims and attached roster bills to the following address:

Medicare Private Fee for Service — Roster Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
P.O. Box 32593
Detroit, MI 48226

Utilization management

All medical procedures are subject to Blue Cross' claim processing rules and post-payment audits. Providers risk possible recovery of funds by Blue Cross during post-payment audits if clinical criteria are not met or if documentation is not maintained in the patient's medical records in accordance with CMS and Blue Cross specifications as outlined in the section of this Manual titled *Medical record audits and reviews*.

Transitional period for members changing coverage

SNF: When a Medicare beneficiary's coverage changes from Medicare Private Fee for Service while admitted to a SNF, the SNF must submit a request within seven business days of the Medicare Private Fee for Service to BCBSM Medicare Plus Blue PPO coverage effective date to preauthorize any continued stay. For details on how to submit a preauthorization request refer to the MAPPO provider manual. For members who are Michigan residents and are being admitted to an in-state facility refer to the section entitled **Preauthorization process for Michigan MA PPO members admitted to Michigan post-acute care facilities**. For members who are not Michigan residents refer to the section entitled **Preauthorization process for MA PPO members with a non-Michigan permanent address**.

Providing notices of appeal rights and responding to appeals

Hospitals

Hospitals are required to deliver the Important Message from Medicare (IM, CMS-R-193) to all MA PFFS enrollees who are hospital inpatients following all CMS guidelines. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. For beneficiaries with stays of greater than two days the follow-up copies of the Important Message from Medicare must also be delivered.

Beneficiaries who choose to appeal a discharge decision must also receive the Detailed Notice of Discharge (DND, Form CMS 10066) from the hospital on behalf of the plan within the timeframes specified by law.

The detailed explanation must be issued to the beneficiary and a copy returned to the Quality Improvement Organization, along with the requested supporting documentation, within the established timeframe set forth by the QIO in the notification to the provider of the appeal.

When a beneficiary files a timely review of the discharge (no later than midnight of the day of discharge) the beneficiary is not financially responsible for inpatient services, other than applicable coinsurance and deductibles, furnished before noon of the day after the beneficiary receives notice of the QIO determination. Beneficiary liability for additional days of service is dependent on the decision of the QIO. For additional information see **CMS 100-16 Chapter 13 §150.4.1**. The facility may not balance bill the beneficiary for these services.

The latest versions of the Important Message from Medicare (IM Form CMS-R-193), and the Detailed Notice of Discharge (DND, Form CMS-10066) can be obtained at <https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html>*

Post acute care facilities responsibilities to deliver notices of appeal rights and respond to expedited appeal notices

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage form (NOMNC CMS form 10123-NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>*

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The failure to deliver a valid NOMNC may result in the provider being held financially liable for the continued services until two days after the beneficiary receives a valid notice, or until the effective date of the valid notice, whichever is later per **CMS 100-04 Chapter 30 §260.3.6**. Providers may not balance bill the beneficiary for these services.

Home health agencies, comprehensive outpatient rehabilitation facilities, and skilled nursing facilities must provide both beneficiaries and the Quality Improvement Organization with a detailed explanation on behalf of the plan when contacted by the Quality Improvement Organization about an appeal of a termination of home health agency, comprehensive outpatient rehabilitation facility, and/or skilled nursing facility services within the time frames specified by law.

The detailed explanation must be issued to the beneficiary and returned to the Quality Improvement Organization, along with the requested supporting documentation, within the established timeframe set forth by the QIO in the notification to the provider of the appeal.

Post acute care providers can obtain a copy of the Detailed Explanation of Non-Coverage (DENC, CMS Form 10124-DENC) and instructions at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>.

Home health agencies, comprehensive outpatient rehabilitation facilities and skilled nursing facilities can obtain the Detailed Explanation of Non-Coverage at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>*.

Blue Cross may request documentation proving notices were delivered within timelines required by CMS and Quality Improvement Organization.

Hospitals can obtain the Detailed Notice of Discharge at <https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html>.

Inquires can be emailed to MedicarePlusBlueFacilityFax@bcbsm.com.

In situations other than medical emergencies, precertification should be requested before the SNF, LTAC, or IP rehab admission is executed.

Reimbursement

Blue Cross reimburses network providers at the reimbursement level stated in the provider's Medicare Private Fee for Service Agreement minus any member required cost sharing, for all medically necessary services covered by Medicare or an enhanced Blue Cross Medicare Private Fee for Service benefit.

We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest in accordance with the Medicare Private Fee for Service Provider Agreement.

Blue Cross provides an **Evidence of Coverage** to all members following enrollment. This document provides general benefit information for members by plan option. It also describes member cost-sharing requirements that can be used by the provider to collect payment at the time the service is provided, rather than waiting for the claim to be processed and the member billed.

Original Medicare benefit coverage rules apply, except where noted. Blue Cross will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the member's Blue Cross Medicare Private Fee for Service.

Blue Cross must also comply with CMS' national coverage determinations, general coverage guidelines included in Original Medicare manuals and instructions, and written coverage decisions of the local Medicare Administrative Contractor.

Follow all Original Medicare billing guidelines and be sure to include the following on all claims:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- National coding guidelines are accessible at cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf*
- Medicare Part B supplier number, national provider identifier and federal tax identification number

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- The member's Medicare Private Fee for Service number, including the prefix, found on the member's ID card
- For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 (02/12) claim form.

Providers affiliated with the Medicare Advantage network agree to Blue Cross reimbursement policies outlined in the Medicare Private Fee for Service agreement. These include:

- Accepting the applicable Medicare Private Fee for Service reimbursement as payment in full for covered services, except for cost sharing, which is the member's responsibility
- Billing Blue Cross, not the patient, for covered services
- Not billing patients for covered services that:
 - Required but did not receive preapproval
 - Were not eligible for payments as determined by Blue Cross based upon our credentialing or privileging policy for the particular service rendered

Claim filing

Medicare Private Fee for Service billing guidelines and unique billing requirements may be accessed at <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit.html>. Claims, including revisions or adjustments, that are not filed by a provider prior to the claim filing limit of one calendar year from date of service or discharge will be the provider's liability.

The National Uniform Claim Committee approved a new version of the CMS-1500 Health Insurance Claim Form. Blue Cross Blue Shield of Michigan began accepting the revised CMS-1500 claim form (version 02/12) on **Jan. 6, 2014**. Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form(02/12).

The 1500 claim form is a paper claim form used by professional health care providers, while the Michigan Status Claim Review Form is used if a claim is rejected or if payment received is different from what was anticipated. The new claim form (version 02/12) can be used for both purposes. When submitting a corrected claim, providers are required to complete field 22 of the 1500 claim form. The provider must enter 7 for Replacement of a prior claim or 8 for Void/Cancel of a prior claim in the Resubmission portion of the field (found on the left hand side of the claim form).

The original claim number must be supplied in the Original Reference Number portion of the field (found on the right hand side of the claim form).

For more information, contact your provider consultant or visit NUCC.org.* The site includes instructions for completing the form.

Where to submit a claim:

- For electronic medical and dental claim submission, send claims to your local Blue plan.
- For paper medical claim submission, send claims to:
 - Blue Cross Medicare Private Fee for Service
 - Blue Cross Blue Shield of Michigan
 - P.O. Box 32593
 - Detroit, MI 48232-0593
- For **paper dental claims**, use the 2012 American Dental Association claim form and, send to:
 - New address:**
 - Blue Cross Blue Shield of Michigan
 - P.O. Box 491
 - Milwaukee, WI 53201, MI 48232-0593
- For electronic claim submission, please call the Electronic Data Interchange help desk at 1-800-542-0945. An EDI user guide is also available at <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>.
- For electronic dental claim submission, please work with your clearinghouse to submit claims electronically. The DentaQuest Payor ID is BBMDQ.

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Non-Michigan providers bill your local Blue plan. Please see the Ancillary section of this manual for more information. Report the prefix to ensure correct routing of the claim.

If you have problems submitting claims to us or have any billing questions, contact our technical billing resources at:

Electronic Claims
Michigan providers — Electronic Data Interchange help desk at 1-800-542-0945. An EDI user guide is also available at http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html .
Non-Michigan providers — Your local Blue plan.

Paper Claims
Michigan providers — Provider Inquiry at 1-866-309-1719
Non-Michigan providers — Your local Blue plan.

If you have questions about plan payments:

Michigan providers	Provider Inquiry — 1-866-309-1719
Non-Michigan providers	Your local Blue plan.

To perform a status inquiry on a **dental** claim, call 1-844-876-7917. To perform a status inquiry on a Blue Cross Medicare Private Fee for Service claim you have two options:

1. Call Provider Inquiry for this information at 1-866-309-1719 or write to the following address:
Blue Cross Medicare Private Fee for Service
Provider Inquiry Services
P.O. Box 33842
Detroit, MI 48232-5842
2. Use web-DENIS. Even though you can check the status of a claim, you cannot adjust or correct any Blue Cross Medicare Private Fee for Service claim. For facility claims click on the *Medicare Private Fee for Service/Medicare Advantage Claims Tracking*. For professional claims click on *Claims Tracking*.

Ancillary claims

The Blue Cross and Blue Shield Association has clarified its rules pertaining to how independent laboratories, durable medical equipment suppliers and specialty pharmacies should submit claims in certain circumstances.

These rules also impact referring practitioners.

Here are highlights:

- Independent labs should file claims with the plan in whose state the specimen was drawn (determined by where the referring physician is located).
- Durable medical equipment suppliers should file claims with the plan in whose state the equipment or supplies were shipped to (including mail order supplies) or purchased (if it was purchased at a retail store).
- Specialty pharmacies should file claims with the plan in whose state the ordering physician is located.

Keep in mind that Blue Cross doesn't have participation agreements with most providers located outside Michigan. To determine if a lab or DME supplier participates with Blue Cross, health care providers and members can go to bcbsm.com and click on the *Find Doctor* tab.

We encourage practitioners to refer all Blue Cross Medicare Private Fee for Service members to network providers whenever possible. Blue Cross Medicare Private Fee for Service members who receive services from an out-of-network lab, specialty pharmacy or DME supplier cannot be balance-billed. Labs, specialty pharmacies and DME suppliers may collect only applicable cost-sharing from these members and may not otherwise charge or bill them.

For more information, contact your provider consultant.

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Provider dispute resolution process

Appeals of claim denials and/or medical necessity denials (not related to retrospective audits)

Contracted providers with Blue Cross' Medicare Private Fee for Service have their own appeals rights. Providers may appeal decisions on denied claims, such as denial of a service related to medical necessity and appropriateness. Instead of following the member appeals process, Blue Cross' Medicare Private Fee for Service providers should follow these guidelines when submitting an appeal.

Calling Provider Inquiry Services at 1-866-309-1719 is the first step in addressing a concern. If you are still unhappy with the decision after speaking with a representative, you may submit an appeal in writing to:

Medicare Advantage PRS — Appeals
Attn: First Level Appeal
Blue Cross Blue Shield of Michigan
P.O. Box 33842
Detroit, MI 48232-5842

Note: Non-Michigan providers should submit appeals to their local Blue Cross Blue Shield plan.

Appeals must be submitted within 60 days of the denial from the date the provider receives the initial denial notice. Be sure to include complete documentation, including clinical rationale, to support your appeal. We will review your appeal and respond to you in writing within 60 days.

If you believe that we have reached an incorrect decision regarding your appeal, you may file a request for a secondary review of this determination by mailing it to:

Medicare Advantage PRS — Appeals
Attn: Second Level Appeal
Blue Cross Blue Shield of Michigan
P.O. Box 441160
Detroit, MI 48244-1160

A request for secondary review must be submitted in writing within 60 days of written notice of the first level decision from Blue Cross Medicare Private Fee for Service. We will review your appeal and respond to you within 60 days. Please provide appropriate documentation to support your appeal, including clinical rationale. **Decisions from this secondary review will be final and binding.**

Payment level appeals (not related to claim denials or retrospective audits)

First level appeals

Provider payment disputes include any decisions where there is a dispute that the payment amount made by the Medicare Private Fee for Service plan to contracted providers is less than the payment amount that would have been paid under the Medicare fee schedule.

If you believe that the payment amount you received for a service is less than the amount paid by Medicare, you have the right to dispute the payment amount by following our dispute resolution process.

Provide appropriate documentation to support your payment dispute, such as a remittance advice from a Medicare carrier. Claims must be disputed within **120 days** from the date payment is initially received.

We will review your dispute and respond to you within **60 days** from the time we receive notice of your dispute. If we agree with your position, then we will pay you the correct amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

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To file a payment dispute with Medicare Private Fee for Service, submit your dispute in writing or by telephone as shown below:

Michigan providers	Write to: Blue Cross Medicare Private Fee for Service Provider Inquiry P.O. Box 33842 Detroit, MI 48232-5842	Or call: 1-866-309-1719
Michigan Dental providers	Your local Blue plan Dental Services: Write to: DentaQuest, LLC ATTN: Blue Cross Provider Appeal 11100 W. Liberty Drive Milwaukee, WI. 53224	

Providers should contact Northwood for DME related questions:

- Mail: Provider Relations, 7277 Bernice, Center Line, MI 48015
- Fax: 1-586-261-0118
- Or, complete the provider application online at: <http://www.northwoodinc.com>.

Second level appeals (medical and dental)

After completing the Blue Cross Medicare Private Fee for Service dispute resolution process as described above, if you still believe that we have reached an incorrect decision regarding your payment dispute you may file a request for a secondary review of this determination within **60 days** of receiving written notice of our first level decision.

We will review your dispute and respond within 60 days of the date on which we received your request for a secondary review. **Decisions from this secondary review will be final and binding.**

You may file a request for a secondary review of this determination in writing to:

Medicare Advantage PRS – Appeals
Attn: Second Level Payment Dispute
Blue Cross Blue Shield of Michigan
P.O. Box 441160
Detroit, MI 48244-1160

For **Dental Second level appeals** submit requests for secondary review of this determination in writing to:

DentaQuest, LLC
Attn: Blue Cross Provider Appeal
11100 W. Liberty Drive
Milwaukee, WI 53224

Be sure to include the following information with your request for a secondary review:

- Provider or supplier contact information including name and address
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original pricing determination
- Copy of the plan's first level dispute pricing decision letter
- Documentation and any correspondence that supports your position that the plan's reimbursement was incorrect (including interim rate letters when appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

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Appeal of retrospective audit findings

For retrospective audit disputes, the appeals process contains the following steps:

1. Internal Review
2. External Peer Review

Internal Review

You may submit a written request that documents the cases being appealed for an internal review **within 50 calendar days** of receiving our audit determination. You may also submit additional information to support your position.

Within 50 calendar days of receiving your request, we will send you our determination. You may further appeal this determination by requesting an external appeal.

External Peer Review

You may submit a written request that documents the cases being appealed for an external peer review **within 20 calendar days** of receipt of our internal review determination. Only previously submitted information will be used for this review.

Within 50 calendar days after your submission of medical records, the review organization communicates its determination, which is binding for both of us.

If our decision is upheld, you pay the review cost. If our decision is reversed, then we absorb the cost. If our findings are partially upheld and partially reversed, we share the review cost with you in proportion to the results. This ends the appeal process.

Medical records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations (including prior consent when releasing any information contained in the medical record).

Blue Cross Medicare Private Fee for Service providers must maintain timely and accurate medical, financial and administrative records related to services they render to Blue Cross Medicare Private Fee for Service members, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts for 10 years from date of service.

The provider shall give without limitation, Blue Cross Blue Shield of Michigan, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation, maintained by the provider, which will be consistent with all federal, state and local laws. Such records will be used by CMS and Blue Cross to assess compliance with standards which includes, but not limited to:

1. Complaints from members and/or providers;
2. Conduct HEDIS reviews, quality studies/audits or medical record review audits;
3. CMS and Blue Cross Medicare Private Fee for Service reviews of risk adjustment data;
4. Blue Cross Medicare Private Fee for Service determinations of whether services are covered under the plan are reasonable and medically necessary and whether the plan was billed correctly for the service;
5. Making advance coverage determinations;
6. Medical Management specific medical record reviews;
7. Suspicion of fraud, waste and/or abuse;
8. Periodic office visits for contracting purposes; and
9. Other reviews deemed appropriate and/or necessary.

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Medical record content and requirements for all practitioners (for behavioral health practitioners see below) include, but may not be limited to:

- **Clinical record**
 - Patient name, identification number (**name and ID number must be on each page**), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.
- **Medical documentation**
 - History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services and other risk screening.
 - Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
 - Past medical, surgical and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
 - Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self exams.
- **Clinical record — progress notes**
 - Identification of all providers participating in the member’s care and information on services furnished by these providers.
 - Reason for visit or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed and follow-up report to referring practitioner (if applicable).
- **Clinical record — reports content** (all reviewed, signed and dated within 30 days of service or event)
 - Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from health care delivery organizations, such as skilled nursing facilities, home health care, free-standing surgical centers, and urgent care centers.

For behavioral health practitioners:

- Chief complaint, review of systems and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills
- At least one complete mental status examination, usually done at the time of initial evaluation and containing each of the items below:
 - Description of speech
 - Description of thought processes
 - Description of associations (such as loose, tangential, circumstantial, or intact)
 - Description of abnormal or psychotic thoughts
 - Description of the patient’s judgment
- Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect and other information relevant to the case.

- A DSM-V diagnosis, consistent with the presenting problems, history, mental status examination and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member's acceptance of the treatment goals. Formal signed consent is not required except where required by law.
- To ensure coordination of the member's care, the treatment records shall reflect continuity and coordination of care with the member's primary care practitioner and as applicable; consultants, ancillary practitioners and health care institutions involved in the member's care.
- Where it is required by law, proper documented written and signed consent for any release of information to outside entities has been obtained.
- Progress notes describe the member's strengths and limitations in achieving the treatment goals and objectives.
- Members who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

Other medical record requirements

The provider of service for all face-to-face encounters must be identified on the medical record, which includes: signature and credentials (can be located anywhere on record, including stationery) for each date of service.

Stamped signatures are not acceptable. Acceptable signatures include handwritten (initials can be used if the full name and credentials appear somewhere in the record or on stationery) or an electronic signature on electronic records if authenticated at the end of each note in accordance with CMS authentication requirements (examples include — "electronically signed by," "authenticated by," "approved by," "completed by," "finalized by" or "validated by" and includes practitioner's name, credentials, date and signature).

Medical record audits and reviews

All records related to services rendered to Blue Cross Medicare Private Fee for Service members can be audited and/or reviewed during the term of the provider's Blue Cross Medicare Private Fee for Service agreement and for a period of 10 years following termination or expiration of the agreement for any reason, or until completion of an audit, whichever is later. We will not use medical record reviews to create artificial barriers that would delay or deny rightful payments to providers.

Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements. Only when a member has paid for the full cost of services out-of-pocket will an authorization for release of information be required.

Retrospective audits and appeals

Blue Cross conducts audits in accordance with Medicare laws, rules and regulations. We will conduct audits as needed, including, but not limited to Diagnosis Related Group validation audits, site of care reviews, readmission audits, audits at skilled nursing facilities or other network providers, practitioners and suppliers, CMS risk-adjustment validation audits and Blue Cross risk-adjustment medical reviews. We may conduct audits on services to determine that care delivered was provided and billed in the most appropriate, reasonable, and cost-effective setting available. We may also conduct audits to assure that claims billing matches services actually provided according to claims payment rules and regulations. Blue Cross contracted providers and practitioners will be required to submit medical records for these audits.

CMS risk-adjustment validation audits

CMS makes advance monthly payments to Blue Cross Medicare Private Fee for Service plans for providing coverage of Original Medicare fee-for-service benefits for each individual enrolled in a Blue Cross Medicare Private Fee for Service plan per month. CMS may require Medicare Advantage organizations and their providers to submit medical records for the validation of risk adjustment data. There may be penalties for submission of false data.

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Section 1853(a)(3) of the Social Security Act requires that CMS risk adjust payments to Medicare Advantage organizations. In general, the current risk adjustment methodology relies on member diagnoses, to prospectively adjust capitation payments for a given member based on the health status of the member. Diagnosis codes submitted by MA organizations are used to determine beneficiary risk scores, which in turn determine the risk-adjusted reimbursement.

RADV audits determine whether the diagnosis codes submitted by MA organizations can be validated by supporting medical record documentation. This medical record documentation must meet certain criteria and standards as specified by CMS. Blue Cross may contract with a vendor to perform these reviews. All vendors are required to have a Business Associate Agreement with Blue Cross and are required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Blue Cross risk-adjustment medical record reviews

From time to time, Blue Cross will require providers to make records available for on-site review or submission to ensure claims submitted are consistent with the chronic conditions documented in members' medical record. Blue Cross may contract with a vendor to perform these reviews. All vendors are required to have a Business Associate Agreement with Blue Cross and are required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Blue Cross reimburses \$5 for each individual chart from a provider's office and \$5 per care episode at hospital facilities. Download a reimbursement form at bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/reimbursement.html or email us at marevenuemgtops@bcbsm.com to request this form. You may fax your invoice to us at 1-800-431-9451. Most requests are processed within 30 to 45 business days.

Note that a policy change effective May 1, 2015, indicating that Blue Cross would no longer reimburse in-network physicians for the administrative costs associated with medical record retrieval, has been discontinued. The previous risk adjustment policy, which reimbursed in-network, Medicare Advantage physicians for medical records remains in effect. See the web-DENIS message posted on June 23, 2015 for more information.

HEDIS medical record reviews

Blue Cross collects medical record data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records/data may be required to complete data collection.

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

A Blue Cross employee or designated vendor(s) will perform the HEDIS reviews. Provider offices are responsible for responding to the medical record request and providing the documentation requested in a timely manner. Blue Cross or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data requested. A patient list will be sent including the name and information being requested. If your office is selected for an onsite visit, please have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the Blue Cross employee or the designated vendor immediately. Blue Cross will not reimburse for copy house services. If a provider or an accountable care organization contracts with a copy house vendor they will be responsible for reimbursing that vendor.

We request that providers allow Blue Cross employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record.

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Other Blue Cross Medicare Private Fee for Service requirements

Additional requirements pertaining to Blue Cross Medicare Private Fee for Service programs are described below.

Settlements

Hospital Settlement

Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted which are at least partially reimbursed based on their reasonable costs rather than a fee schedule. The Medicare Fiscal Intermediary/Administrative Contractor will attempt to make the interim payments as accurate as possible.

After the hospital's fiscal year end, the fiscal intermediary settles with the providers for the difference between interim payments and actual reasonable costs.

CMS policy does not require plans to agree to settle with providers. Blue Cross conducts settlements on hospital claims for Blue Cross Medicare Private Fee for Service members, when requested, where certain provisions of the Original Medicare reimbursement system are not accounted for through the normal claims vouchering system (for example, disproportionate share, bad debt, capital for a new hospital for first two years, etc.) Bad debt and critical access hospital settlements include both inpatient and outpatient claims for Medicare Private Fee for Service members. All other outpatient reimbursement issues should be referred to your Blue Cross provider consultant.

To minimize financial impact of the settlement and to ensure proper reimbursement throughout the year, hospitals are expected to retrieve their current year rates from the Fiscal Intermediary/MAC and submit their rate letter (or system equivalent) to MARateLetterSubmissions@bcbsm.com.

Blue Cross conducts settlements on a hospital's full fiscal year at the appropriate Medicare rate based on discharge date. Blue Cross reviews the Medicare Cost Report, the specific claims submitted for review, and the interim rate letters to determine the cost settlement.

The hospital must request a settlement from Blue Cross in writing within 180 days of the hospital's fiscal year-end, and must include all of the following information:

- A description of the issue
- An estimate of the impact
- Supporting documentation including (as appropriate)
 - The filed Medicare Cost Report for the year in question
 - The Medicare interim rate letter (or system equivalent) for the applicable time period
 - A detailed Blue Cross claims list (a template will be provided)
 - Calculations showing how the impact amount was determined

Blue Cross reviews the information and gives a written determination of funds owed the provider from Blue Cross or funds owed Blue Cross from the provider. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

Blue Cross reimburses Bad Debt claims for only uncollected Blue Cross Medicare Private Fee for Service member liability. Charges for non-covered services are not included. The hospital must provide a signed attestation stating that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The Blue Cross Private Fee for Service bad debt claims template, along with the attestation, are provided upon receipt of the request for settlement.

Blue Cross pays Critical Access Hospital claims on an interim basis using the per diems and percentage of charges stipulated in the Fiscal Intermediary/MAC interim rate letter applicable to the date on which services are rendered. The cost based reimbursement rate and elected payment method used for the year under review are compared to the rate calculated on the Medicare Cost Report and a settlement is made based on the difference. Once a hospital elects to engage in the settlement process, all subsequent years will need to be settled.

Blue Cross reviews the information and gives a written determination of funds owed the provider from Blue Cross or funds owed Blue Cross from the provider. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

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Federally Qualified Health Centers Vaccine Settlement

Effective Oct. 1, 2014, Centers for Medicare and Medicaid Services changed the payment system for Federally Qualified Health Centers from an “all inclusive rate” system to a prospective payment system. Blue Cross Blue Shield will transition FQHCs to the PPS based on their cost reporting periods beginning Nov. 1, 2015. Previously flu and pneumococcal vaccines were paid on a claim by claim basis, but under the new payment rules Blue Cross will compensate FQHC’s for vaccines through an annual settlement process.

FQHC’s should continue to bill pneumococcal and flu vaccines as this information will be used at the end of the fiscal year to determine the settlement amounts. Settlement requests must be sent to fqhcsettlementrequests@bcbsm.com within 180 days of the fiscal year end to be eligible. Settlements will be conducted only on a complete fiscal year and only for claims that have been billed. The settlement calculations are made using the CMS Average Sale Price fee schedule.

If you would like further information on the vaccine settlement process, please submit your question(s) via email to fqhcsettlementrequests@bcbsm.com.

Serious adverse events and present on admission

Blue Cross Blue Shield of Michigan uses an enterprise-wide reimbursement policy. Blue Cross does not pay for medically unnecessary services, regardless of the cause. This policy is in keeping with Blue Cross reimbursement structure under the Participating Hospital Agreement and other provider contracts.

The main provisions of the policy are as follows:

- Blue Cross will no longer reimburse a hospital or physician whose direct actions result in a serious adverse event.
- Serious adverse events affected by this policy will be updated as needed to remain consistent with changes made by the Center for Medicare & Medicaid Services.
- Blue Cross participating hospitals are required to report present on admission indicators on all claims.
- Blue Cross participating hospitals are not to balance bill members for any incremental costs associated with the treatment of a serious adverse event that Blue Cross has paid.
- Blue Cross members who have been billed in error should report incidents to Blue Cross as appropriate.

The policy on serious adverse events applies to all acute care hospitals, exempt hospital units and critical access hospitals that have signed a Blue Cross participating hospital agreement.

Blue Cross developed the following list of events and conditions:

- Object left in the body after surgery
- Air embolism as a result of surgery
- Blood incompatibility
- Catheter-associated urinary tract infections
- Pressure sores (decubitus ulcers) — Stage 3 or 4
- Vascular catheter-associated infections
- Surgical site infections
 - Mediastinitis following a coronary artery bypass graft surgery
 - Gastric bypass
 - Orthopedic procedures
 - Cardiac Implantable Electronic Device
- Hospital-acquired injuries
 - Falls and fractures
 - Dislocations
 - Intracranial and crushing injury
 - Burns
- Deep vein thrombosis or pulmonary embolism following:
 - Total knee replacement
 - Total hip replacement
- Manifestations of poor glycemic control

- Diabetic ketoacidosis
 - Non-ketotic hypersolmar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity
- Iatrogenic pneumothorax with venous catheterization

Additionally, CMS further defined the following events for wrong surgeries for easier identification:

- Performance of procedure on patient not scheduled for operation (procedure) — formerly known as surgery on wrong patient
- Performance of correct procedure on wrong side or body part — formerly known as surgery on wrong body part
- Performance of wrong procedure on correct patient — formerly known as wrong surgery

Hospitals participating with Blue Cross are required to submit present-on-admission indicator information for all primary and secondary diagnoses, for both paper and electronic claims.

The POA indicator is used to identify conditions present at the time the admission occurs, including those that develop during an outpatient encounter in settings that include the emergency department, observation or outpatient surgery. The POA indicator is not required on secondary claims.

The following values should be used to indicate POA when submitting data:

Value	Definition
Y	Diagnosis was present at the time of inpatient admission
N	Diagnosis was not present at the time of inpatient admission
U	Documentation is insufficient to determine whether the condition was present at the time of inpatient admission
W	Clinically undetermined. Provider is unable to determine clinically whether the condition was present at the time of inpatient admission.
1	Exempt from POA reporting <ul style="list-style-type: none"> – Applies to paper claims
Blanks	Exempt from POA reporting <ul style="list-style-type: none"> – Applies to electronic claims

*Note: These values were established by CMS.

On electronic claims, the POA data element must contain the letters POA followed by a single POA indicator for every diagnosis reported, as follows:

- The POA indicator for the principal diagnosis should be the first indicator after the POA letters, followed by the POA indicators for the secondary diagnoses as applicable.
- The final POA indicator must be followed by either the letter Z to indicate the end of the data element.

For paper claims, the POA indicator is the eighth digit of the principal diagnosis field in Form Locator 67 on the UB-04 claim and the eighth digit of each of the secondary diagnoses in Form Locator 67, A-Q. Report the applicable POA indicator (Y, N, U, or W) for the principal diagnosis and any secondary diagnoses as the eight digit. Enter 1 if the diagnosis is exempt from POA .

The policy on serious adverse events is administered as follows:

- **For DRG-reimbursed hospitals** — Blue Cross uses the Medicare severity diagnosis-related groups (MS-DRG).
- **When the member is readmitted to the same hospital and the admissions are combined** — Hospitals should follow the current process for combining admissions:
 - If the POA indicator is correctly reported as Y (indicating the condition was present on admission), there is no financial reduction.
 - In cases in which the POA for the serious adverse event was N (indicating that the condition was not present on admission and that, therefore, the readmission was a direct result of the serious adverse event), the two cases are combined and only the first admission is reimbursed.

- **When the member is readmitted to the same hospital and the admissions are not combined** — Any readmission with diagnosis associated with a serious adverse event during the initial admission may be selected for audit review to validate its presence on admission.
- **When the member is admitted to a different hospital** — When an admission to a second hospital carries a POA indicator of Y but the treatment is that which is medically necessary to treat the adverse event, the second hospital is held harmless and is reimbursed for the admission.
- **When claims are submitted with an invalid POA** — Claims submitted with an invalid POA indicator are returned to the hospital for correction and are not entered into the Blue Cross claims system.
- **When treatment to correct the adverse event is rendered by a hospital or physician not responsible for the adverse event** — In all cases, the second hospital and the second physician correcting the adverse event are held harmless. Because the treatment is medically necessary, they are reimbursed.

Clinical research study

If a member with Blue Cross Medicare Private Fee for Service coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay the provider on behalf of the Blue Cross Medicare Private Fee for Service plan. The Blue Cross Medicare Private Fee for Service plan will pay for Medicare-covered services that are not affiliated with the clinical trial. **Therefore, providers must submit claims for Medicare-covered services related to the clinical trial to carriers and fiscal intermediaries, not to Blue Cross,** using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to Blue Cross, and Blue Cross will reimburse providers accordingly.

Swing beds

Swing beds in a critical access hospital are paid according to the critical access hospital methodology (101 percent of cost).

Swing beds located in non-critical access hospitals are paid using the Medicare skilled nursing facility prospective payment system, which is a per diem payment.

Network participation

Overview

Blue Cross will give select provider types an opportunity to apply for participation in the Medicare Private Fee for Service network. Network providers provide care to Medicare Private Fee for Service members and we reimburse them for covered services at the agreed upon payment rate. Network providers sign formal agreements with Blue Cross, agree to bill us for covered services provided to Medicare Private Fee for Service members, accept our reimbursement as full payment minus any member required cost sharing, and receive payment directly from Blue Cross.

Qualifications and requirements

To be included in Blue Cross Medicare Private Fee for Service, providers must:

- Have a national provider identifier they use to submit electronic transactions to Blue Cross (in accordance with HIPAA requirements) or to submit paper claims to Blue Cross
- Meet all applicable licensure requirements in the state of Michigan and meet Blue Cross credentialing requirements pertaining to licensure
- Furnish services to a Blue Cross Medicare Private Fee for Service member within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care
- Provide services that are covered by our plan and that are medically necessary by Medicare definitions
- Meet applicable Medicare approval or certification requirements
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- Sign formal agreements with Blue Cross
- Agree to bill us for covered services provided to Blue Cross Medicare Private Fee for Service members

- Accept our reimbursement as full payment less any member cost sharing
- Receive payment directly from Blue Cross
- Not be on the U.S. Department of Health and Human Services Office of Inspector General excluded and sanctioned provider lists
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members
- Agree to cooperate with Blue Cross to resolve any Blue Cross Medicare Private Fee for Service member grievance involving the provider within the time frame required under federal law
- For providers who are hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities, provide applicable member appeal notices
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy
- Provide certain special services to members only if approved by Medicare to provide such services (e.g., transplants, VAD distribution therapy, carotid stenting, bariatric surgery, PET scans for oncology, or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Be in good standing with Blue Cross and meet and maintain all Blue Cross credentialing requirements for network inclusion. Examples of being in good standing are:
 - Unrestricted license to practice
 - No license limitations
 - Not on prepayment utilization review, not in the performance monitoring program or not de-participated from the Traditional program
 - Not denied or disaffiliated from the TRUST program within a two-year period of application to Blue Cross Medicare Private Fee for Service
 - No Medicare or Medicaid exclusion, sanction, or debarment
 - Not opting out of Medicare
- Agree to accept all Blue Cross Medicare Private Fee for Service members unless practice is closed to all new patients (commercial or Medicare)

Participation agreements

The Blue Cross Medicare Private Fee for Service Provider Agreement includes a base agreement that applies to all providers and attachments specific to certain provider types which may be accessed on our website:

- **Blue Cross Medicare Private Fee for Service Provider Agreement**
- Blue Cross Medicare Private Fee for Service Provider Agreement Attachments
 - **Practitioner Attachment**
 - **Hospital Attachment (includes psychiatric hospitals)**
 - **Non-Hospital Facility Attachment**
 - **Rural Health Clinic Attachment**
 - **Federally Qualified Health Clinic Attachment**

Network information and affiliation

Overview

Medicare Private Fee for Service is a network of health care providers consisting of primary care physicians, specialists, hospitals and other health care providers who have agreed to provide services to Blue Cross Medicare Private Fee for Service members. Medicare Private Fee for Service focuses on delivering cost-effective and quality patient care. Network providers agree to accept Blue Cross reimbursement as payment in full for covered services (minus any member required cost sharing). Members with Blue Cross Medicare Private Fee for Service coverage receive services from a select network of providers. Medicare Private Fee for Service requirements apply only to providers in our Medicare Private Fee for Service network.

Network sharing with other Blue plans' Private Fee for Service programs

All Blue Medicare Private Fee for Service plans will participate in reciprocal network sharing. This network sharing will allow all Blue Medicare Private Fee for Service members to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Private Fee for Service Plan, as long as the member sees a contracted Medicare Private Fee for Service provider.

If you are a contracted Medicare Private Fee for Service provider for Blue Cross Medicare Private Fee for Service and you see Blue Cross Medicare Private Fee for Service members from other Blue plans, these members will be extended the same contractual access to care and you will be reimbursed in accordance with the rate for your Blue Cross Medicare Private Fee for Service contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted Medicare Private Fee for Service provider for Blue Cross Medicare Private Fee for Service and you provide services for any Blue Cross Medicare Private Fee for Service members, you will receive the Medicare-allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services, including renal dialysis services provided while the member was temporarily outside the plan's service area, will be reimbursed at the out-of-network benefit level.

Effective July 1, 2014, the Blue Cross Blue Shield Association issued a mandate to all Association members, which requires all participating providers to be responsible for obtaining pre service reviews for inpatient facility services provided to Medicare Advantage members from other states. Keep the following guidelines in mind.

- Obtain pre-service reviews 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 pre-service 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 pre-service review as required.
- Specified timeframes for pre-service review may apply. These include: 48 hours to notify the host plan of a change in the pre-service 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 pre-service is required. The tool allows you access to other Blue plan provider portals for the purpose of conducting pre-service reviews. For more information about the tool, see the http://www.bcbsm.com/newsletter/therecord/record_1213/Record_1213c.shtml article in the *December 2013 Record*.

Affiliation

Professional and facility enrollment — Information on how to enroll is available in the provider enrollment section of bcbsm.com at bcbsm.com/provider/enrollment/index.shtml. Requirements are no longer listed in [the application](#) but can now be found in a separate general information sheet on this web page along with the application.

Eligible practitioners — Practitioners eligible for affiliation in the Medicare Private Fee for Service Network are:

- Medical doctors
- Doctors of osteopathy
- Doctors of podiatric medicine
- Doctors of dental surgery (oral surgeons only)
- Doctors of chiropractic medicine
- Anesthesia assistants
- Audiologists
- Certified nurse practitioners
- Certified nurse midwives
- Certified registered nurse anesthetists
- Independent physical therapists
- Occupational therapists
- Optometrists
- Hearing aid dealers
- Fully licensed psychologists
- Clinical licensed master's social worker
- Ambulance providers
- Independent speech language pathologists
- Clinical nurse specialist
- Physician assistant

Facility affiliation — Facilities eligible for affiliation in the Medicare Private Fee for Service network are:

- Ambulatory surgical facilities (freestanding only)
- End stage renal disease facilities (hemodialysis centers)
- Federally qualified health centers
- Home health care facilities
- Hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Rural health clinics
- Skilled nursing facilities

Affiliation requirements include:

Facility

Facilities must meet certain requirements to participate in the Medicare Private Fee for Service network. These requirements are available in the applications which can be found in the provider enrollment section of bcbsm.com at bcbsm.com/provider/enrollment/index.shtml.

Practitioner

Practitioners (except ambulance) who request affiliation in the Medicare Private Fee for Service Network must meet specific network requirements and complete an online application on the Council for Affordable Quality Health Care Universal Credentialing Datasource website. Typically, up to five years of history are reviewed during the initial credentialing process. We use the same review process to credential new applicants and to recredential network practitioners.

- **Blue Cross registered** — must be or become registered with Blue Cross and have an active identification number. To become registered, go to bcbsm.com, click on the “Provider” tab and follow the appropriate links.
- **Board certified** — MD, DO, DPM, and DDS/DMD (oral surgeons only) must be board certified or eligible for board certification (the board must be one recognized by Blue Cross, such as the American Board of Medical Specialties) at the time of credentialing, and maintain board certification throughout affiliation. (Exception: Current Blue Cross Medicare Private Fee for Service Network practitioners who are not board certified are excluded from this requirement as long as they have continued affiliation in the Blue Cross Medicare Private Fee for Service Network.)
- **Fully licensed** — must be fully licensed and free of any current disciplinary actions of suspension, revocation, surrender, limitation or probation. A provider who has any of these disciplinary actions imposed because of a criminal conviction related to payment or provision of health care will be restricted from applying to the network for a period of two years following the date the license restriction is lifted.
- **Malpractice coverage** — must have and maintain current malpractice coverage of \$100,000 per occurrence, and \$300,000 annual aggregate. The coverage must protect the provider from all liability, whether a claim is filed against the individual provider or jointly with a hospital. Liability insurance must cover all practice locations, unless the provider is directly employed by a hospital and practices exclusively at that hospital.
- **Professional certification bodies** — Non-physician providers must be in good standing with designated professional certification bodies applicable to their area of expertise.
- **Government sanctions** — must be free of any exclusions or sanctions from Medicare and Medicaid.
- **Opt out** — must not have opted out of participation in the Medicare program under §1802 (b) of the Social Security Act, unless providing emergency or urgently needed services.
- **Prepayment utilization review** — An applicant who is currently in or has a significant history in the Blue Cross prepayment utilization review program will be denied affiliation with the Medicare Private Fee for Service network.

- **Blue Cross deparicipation** — An applicant with a current or significant history of formal deparicipation action by Blue Cross will not be accepted in the Medicare Private Fee for Service network.
- **Malpractice case history** — must be reported with supporting details. These include the number of malpractice cases against the applicant that have been filed, adjudicated or settled within the five years prior to the application date. We review all cases against established screening criteria and may deny the application. The screening criteria for high volume specialties is in excess of \$500,000 within a five-year period and the screening criteria for other specialties is in excess of \$200,000 within a five-year period prior to application to the Medicare Private Fee for Service network.
- **Substance abuse or chemical dependency** — Current use or recent history of illegal drug use or substance abuse or dependence will result in a denied application. New applicants with history of chemical dependence or substance abuse must:
 - Provide proof of treatment
 - Be substance-free during the 24-month period before application
 - Attest that they have no current chemical dependence and are currently free of all illegal chemicals
- **Additional considerations** — We may use other information in credentialing and recredentialing review and decision-making, such as:
 - Data Bank (National Practitioner – Healthcare Integrity and Protection) findings
 - No history of conduct that threatens patient safety or adversely affects Blue Cross’ business interests

Affiliated provider agreement — As an affiliated provider, you agree to (among other things):

- Meet our recredentialing requirements every three years (includes facilities)
- Meet and maintain board certification requirements
- Abide by the Medicare Private Fee for Service Network agreement, policies and procedures (includes facilities)
- Bill only for professional services personally provided by the Medicare Private Fee for Service Network provider. This specifically prohibits billing for services provided by any subcontractor, or other provider, including a partner in a group practice.

Note: The only exception is when a physician personally supervises a provider who cannot bill Blue Cross directly.
- Provide complete care within the Medicare Private Fee for Service provider’s specialty and do not systematically refer or “share” the care of patients
- Provide safe, medically necessary and cost-effective care (includes facilities)
- Maintain a current and accurate CAQH UCD record — Update the CAQH UCD minimally once every 120 days and re-attest to the completeness and accuracy of the information.

Disaffiliation

The Blue Cross Medicare Private Fee for Service Provider Agreement can be terminated by Blue Cross or an affiliated provider, in accordance with the terms of the Agreement. When the agreement is terminated, the provider is no longer affiliated with the Medicare Private Fee for Service network. We call this activity “disaffiliation.”

There are two types of disaffiliation:

- **Voluntary** — Initiated by the provider at any time, except during the initial term of the Agreement, with 60 days written notice to Blue Cross or as otherwise provided in the Agreement
- **Involuntary** — Initiated by Blue Cross in accordance with the terms of the Agreement and applicable internal policies. Depending on the reason(s) for this type of disaffiliation, you may be able to re-apply for affiliation two years after the disaffiliation date

Obligations of recipients of federal funds

Providers participating in Blue Cross Medicare Private Fee for Service are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-kickback Statute (section 128B(b) of the Social Security Act).

Blue Cross Medicare Private Fee for Service is prohibited from issuing payment to a provider or entity that appears on the List of Excluded Individuals/Entities as published by the U.S. Department of Health and Human Service Office of Inspector General or on the list of debarred contractors as published by the U.S. General Services Administration (with the possible exception of payment for emergency services under certain circumstances). Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at oig.hhs.gov > **Exclusions** > **Online Searchable Database***.
- The General Services Administration list of debarred contractors can be found at sam.gov*. in the System for Award Management.

Fraud, waste and abuse

Detecting and preventing fraud, waste and abuse

Blue Cross is committed to detecting, mitigating and preventing fraud, waste and abuse. Providers are also responsible for exercising due diligence in the detection and prevention of fraud, waste and abuse as well, in accordance with the Blue Cross *Detection of Fraud, Waste and Abuse* policy.

Blue Cross encourages providers to report any suspected fraud, waste and/or abuse to the Blue Cross Corporate and Financial Investigations department, the corporate compliance officer, the Medicare compliance officer, or through the anti-fraud hotline, 1-800-482-3787. The reports may be made anonymously.

What is fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as Blue Cross Medicare Private Fee for Service) in order to get money or a benefit.

Examples of fraud

Examples of fraud include:

- Billing for services not rendered or provided to a member at no cost
- Upcoding services
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

What is waste?

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of waste

Example of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed
- Overuse, underuse and ineffective use of services

What is abuse?

Abuse include practices that result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of abuse

Examples of abuse include:

- Providing and billing for excessive or unnecessary services
- Routinely waiving member coinsurance, copayments or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

Providers and vendors are required to take CMS compliance training on Medicare fraud, waste and abuse

Providers are required by the Center for Medicare & Medicaid Services to take CMS-specific training about fraud, waste and abuse and compliance. Training is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

Providers and vendors should make sure that governing body members and any employees (including volunteers and contractors) and contractors providing health or administrative services in connection with the Blue Cross Blue Shield of Michigan Medicare Advantage program complete the training within 90 days of being hired and annually thereafter. Be sure to keep the certificate generated by the website as proof that you took the training and retain evidence of training for 10 years from the end date of your contract with Blue Cross. You need to be able to provide proof to Blue Cross or CMS if requested.

Repayment rule

Under the Patient Protection and Affordable Care Act, effective March 23, 2010, providers are required to report and repay overpayments to the appropriate Medicare administrative or other contractor (Fiscal Intermediary or Carrier) within the later of (a) 60 days after the overpayment is identified, or (b) the date of the corresponding cost report is due, if applicable.

Under the Affordable Care Act, a provider is obligated to report and return an overpayment by the later of (1) 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due (if applicable). Failure to do so may render the provider subject to liability and penalties under the False Claims Act.

Questions, additional information and contacts

Blue Cross does not prohibit network health care professionals from advising or advocating on behalf of patients. If you have general questions about Blue Cross Medicare Private Fee for Service, call Blue Cross Medicare Private Fee for Service Provider Inquiry at 1-866-309-1719 (8 a.m. to 4:30 p.m.) or write to:

Blue Cross Medicare Private Fee for Service
Provider Inquiry
P.O. Box 33842
Detroit, MI 48232-5842

Providers should contact Northwood for DME related questions:

- Mail: Provider Relations, 7277 Bernice, Center Line, MI 48015
- Fax: 1-586-261-0118

Or, complete the provider application online at: <http://www.northwoodinc.com>.

What if I suspect fraud? If you suspect fraud, please contact Blue Cross Blue Shield of Michigan Anti-Fraud Hotline at 1-888-650-8136 (24 hours a day/seven days a week).



**Blue Cross
Blue Shield
Blue Care Network**
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association