

Revised
January 1, 2018

For use by Michigan
providers only. Many
of the provisions
don't apply to
providers in other
states.



Blue Cross Blue Shield of Michigan

Medicare Plus BlueSM PPO 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.

[GROUP HEALTH PLANS](#) | [INDIVIDUAL PLANS](#) | [DENTAL](#) | [VISION](#) | [BCBSM.COM](#)

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

Table of Contents

- Medicare Plus Blue PPO overview1**
- ID card1**
 - Overview 1
- Eligibility and coverage2**
 - Web-DENIS.....2
 - PARS3
 - Dental electronic inquiry system3
 - Verifying eligibility and coverage for out-of-area members3
- Billing members3**
 - Collect deductible, copayments or coinsurance at time of service 3
 - Balance billing is not allowed.....3
 - Dental billing3
 - Refund over-billed members3
 - Coordination of benefits4
 - Providing Medicare Outpatient Observation Notice (MOON).....4
 - Non-covered services and referrals for non-covered services — provider responsibilities4
 - Getting an advance coverage determination 4
- DME/P&O, medical suppliers and pharmacists5**
 - Northwood and J&B Medical Supply Benefit Management.....5
 - DME benefits.....5
- Lab services5**
- Benefits6**
- Hospice services8**
 - Medicare Advantage member cost-share for hospice services 8
- Access to care9**
 - After-hours access 9
 - Appointment access.....9
 - In office waiting room times.....10
 - Compliance with access standards.....10
- Advance directives.....10**
- Medical managemet and quality improvement.....11**
 - Case and disease management11
 - Quality improvement program.....13
 - Healthcare Effectiveness Data and Information Set.....13
 - What is the CMS Quality Star Ratings Program?15
 - What are CMS star ratings?.....15
 - Star clinical performance16
 - Classification of clinical measures.....16
 - 2018 CMS quality star measures16
 - Blue Cross Medicare Advantage tool, Health e-Blue.....18
 - How do providers sign up?19
 - Provider Performance Recognition Program19

- New Medicare Part D prescriber prerequisite20**
 - Enrolling in Medicare Part D 20
- Medication Therapy Management Program.....20**
- Pharmacy treatment improvement opportunities21**
 - Medication adherence..... 21
 - Statin use in diabetes 21
 - Opioid overutilization 21
- Immunization22**
 - Billing guidelines for roster bills 23
- Utilization management.....23**
 - Preauthorization of Prescription Drugs Covered under the Pharmacy Benefit-Medicare Part D 24
 - Preauthorization of Prescription Drugs Covered Under the Medical Benefit- Medicare Part B..... 25
 - Preauthorization of high-technology radiology and echocardiography services..... 26
 - Preauthorization of lumbar spinal fusion surgery, outpatient interventional pain management..... 26
 - Short and long term changes to outpatient physical and occup
occupational therapy prior to authorization process 28
 - Categorization of outpatient physical and occupational providers 28
 - Preauthorization of behavioral health services..... 30
 - Preauthorization of acute care admissions to hospitals 31
 - Preauthorization of other medical/surgical services..... 31
 - Preauthorization of skilled nursing facility, long term acute care, and inpatient rehabilitation stays 32
 - Preauthorization process for Michigan MA PPO members to Michigan post-acute care facilities 32
 - Preauthorization process for MA PPO members with a non-Michigan permanent address..... 34
 - Providing notices of appeal rights and responding to appeals 35
 - Hospitals 35
 - Post acute care facilities and home health agencies..... 35
- Reimbursement.....36**
- Claim filing.....36**
 - Ancillary claims 38
- Provider dispute resolution process.....38**
 - Appeals of claim denials and/or medical necessity denials (not related to retrospective audits) 38
 - Payment level appeals (not related to claim denials or retrospective audits)..... 39
 - Appeal of retrospective audit findings..... 41
- Medical records41**
 - Medical record audits and reviews 43
 - Retrospective audits and appeals 43
 - CMS risk-adjustment validation audits 44
 - Blue Cross risk-adjustment medical record reviews 44
 - HEDIS medical record reviews 44
- Other Medicare Plus Blue PPO requirements45**
 - Settlements..... 45
 - Hospital Settlement..... 45
 - Federally Qualified Health Centers Vaccine Settlement 46
 - Serious adverse events and present on admission 46

Clinical research study	48
Swing beds	48
Network participation.....	48
Overview	48
Qualifications and requirements	48
Participation agreements	49
Network information and affiliation.....	50
Overview	50
Network sharing with other Blue plans' PPO programs	50
Affiliation	50
Disaffiliation.....	53
Obligations of recipients of federal funds	53
Fraud, waste and abuse	53
Detecting and preventing fraud, waste and abuse.....	53
What is fraud?.....	53
Examples of fraud.....	53
What is waste?.....	54
Examples of waste.....	54
What is abuse?	54
Examples of abuse	54
Providers and vendors are required to take CMS compliance training on Medicare fraud, waste and abuse.....	54
Medicare Part D program.....	54
Repayment rule	55
Questions, additional information and contacts	55

Provider Manual Chapter for Medicare Plus Blue PPO

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

If you are an out-of-state provider, for more information, please visit:

<http://www.bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/medicare-plus-blue-ppo-fact-sheet.pdf>

Medicare Plus Blue PPO overview

Blue Cross Blue Shield of Michigan is an authorized Medicare Advantage Organization that contracts with Centers for Medicare & Medicaid Services to offer Medicare Plus Blue PPO and Part D prescription drug insurance plans in the senior market. Blue Cross will offer Medicare Plus Blue coverage to Medicare-eligible Michigan residents and Medicare-eligible members of Blue Cross groups.

Medicare Plus Blue 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, including a Part D prescription drug benefit. You can find these benefit policies on our website at <http://www.bcbsm.com/provider/ma> under Medicare Plus Blue PPO/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 Medicare Plus Blue PPO ID card indicates the member is enrolled in a Medicare Plus Blue plan. Our Blue Cross Medicare Plus Blue 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.

	Medicare PLUS BlueSM PPO
Enrollee Name VALUED CUSTOMER	Plan XXXXX-XXX
Enrollee ID XYL918888888	RxBIN 610014
Health Plan (80840) 9101003777	RxPCN MEDDPRIME
Group Number XXXXX	RxGrp BCBSMAN
	Issue 08/2017
VISION, HEARING & PREVENTIVE DENTAL	
	

Members: bcbsm.com/medicare	Providers: bcbsm.com/provider/ma
	
Blue Cross Blue Shield of Michigan A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association	Customer Service: 877-241-2583 TTY/TDD: 711
Use of this card is subject to terms of applicable contracts, conditions and user agreements. Medicare limiting charges apply. Providers outside of Michigan, file claims with your local plan.	Misuse may result in prosecution. If you suspect fraud, call: 888-650-8136
	To locate participating providers outside of Michigan: 800-810-2583
	Provider Services: 800-676-BLUE
Mail Provider claims to: BCBSM - P.O. BOX 32593 Detroit, MI 48232-0593	Facility Prenotification: 800-572-3413
	Rx Prior Authorizations: 800-437-3803
Mail Pharmacy claims to: P.O. BOX 14712 Lexington, KY 40512	Pharmacy Services: 800-922-1557

The “MA” in the suitcase indicates a member who is covered under the Medicare Advantage PPO network sharing program. 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

Please note that our Michigan Public School Employees Retirement System members have a slightly different ID card. While they share the “XYL” prefix, they have Catamaran for their pharmacy benefits administrator.



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 Medicare Plus Blue PPO 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 the 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
 - Applicable prior authorization and certification requirements
- **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 claims 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.

For dental provider servicing and automated information, call 1-844-876-7917 Monday – Friday, 8am - 5pm EST. Automated information is available 24/7. The fax number for provider servicing is 1-262-834-3450.

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 Medicare Plus Blue PPO 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 Medicare Plus Blue PPO 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 Medicare Plus Blue PPO members for covered services and may not otherwise charge or bill them.

Dental billing

Dentists may refuse to accept assignment on a claim and direct Blue Cross payments to members. In this case, Blue Cross pays the approved amount, minus any applicable copayment and/or deductible directly to the member. Members are responsible for the difference between out payment and the submitted charge.

Refund over-billed members

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

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

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)

Blue Cross follows CMS guidance for the Medicare Outpatient Observation Notice (MOON). Hospitals and Critical Access Hospitals (CAH) are required to furnish the MOON, to any Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. The MOON is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are 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 observation services are initiated or, if sooner, upon release.

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/BNL/>.

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 Medicare Plus Blue PPO 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 Medicare Plus Blue and would like to pursue the non-covered course of treatment, then the provider would need to submit a pre-service organization determination (also known as an advanced coverage determination).

If you provide an item, treatment or service that is not covered and have not provided 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 item, service or treatment is not contracted with Medicare Plus Blue PPO, 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 Plus Blue, understands that you are referring them to a non-contracted provider and agrees that he or she will be solely responsible for paying for the service, then you or the rendering provider must obtain an advance coverage determination before the service or item is provided.

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 PPO 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 Plus Blue.

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:

Grievances 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.

DME/P&O, medical suppliers and pharmacists

Northwood and J&B Medical Supply

Blue Cross Medicare Plus Blue leases the provider network and pays contracted fees for durable medical equipment, prosthetic and orthotics and diabetes supplies from Northwood and J&B Medical Supply. Blue Cross's claim system processes these claims for Blue Cross Medicare Advantage providers. The plan will reimburse in-network providers in accordance with the applicable vendor fee schedule. If a service does not have a network fee available on the vendor fee schedule, providers will be reimbursed using Medicare's allowed amount. Out-of-network claims for Medicare Plus Blue PPO members will be reimbursed using the Medicare fee schedule with the potential for higher out-of-network cost-sharing to be applied.

DME benefits

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

Lab services

Medicare Plus Blue 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 Medicare Plus Blue 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*. Medicare Advantage PPO providers must use the Medicare Advantage PPO lab network for all lab and pathology services (facilities – nonpatient only) to receive payment. Use of the Medicare Advantage PPO 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). No or minimal cost sharing is applied when Medicare Plus Blue members have lab services performed within the Medicare Advantage PPO lab network. For lab services performed at a Medicare Advantage network hospital that does not participate with JVHL, a copayment will apply. Coinsurance is applied when members go outside of the network. 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.

Medicare Plus Blue PPO plan	In-network services	Services performed at a network hospital that is non-par with JVHL	Out-of-network services
Essential	\$0 after deductible	\$40 copay after deductible	50% coinsurance after deductible
Vitality	\$0 after deductible	\$40 copay after deductible	40% coinsurance after deductible
Signature	\$0	\$30	40% coinsurance after deductible
Assure	\$0	\$20	30% coinsurance after deductible
Medicare Plus Blue PPO Group	Refer to the group's summary of benefits for cost sharing information.		

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

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 Medicare Advantage PPO lab network provider. These procedures are limited to those on the Blue Cross provider website. Simply visit bcbsm.com/provider/ma and select *Medicare Plus Blue PPO/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 Medicare Advantage PPO physician office lab list may not be reimbursed. The Medicare Advantage PPO POLL is intended for use only by in-network providers. Blue Cross MA PPO 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 Plus Blue individual PPO 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 Medicare Plus Blue PPO members can be viewed on our provider website, bcbsm.com/provider/ma under *Medicare Plus Blue PPO/Provider Toolkit/Coverage Details/Medicare Plus Blue PPO Benefit Summaries*.

Three individual Medicare Plus Blue PPO plan options — Vitality, Signature and Assure — offer supplemental coverage for vision, hearing and select preventive dental.

These plans offer vision coverage administered by Vision Service Plan (VSP). When members obtain covered services from a VSP network provider, they receive the maximum level of coverage available under their plan. For information about VSP®, visit their website at <http://vsp.com>*.

Individual Medicare Plus Blue PPO members with Vitality, Signature or Assure also have coverage for diagnostic hearing exams, routine hearing tests and hearing aids and receive the maximum level of coverage when they obtain services from a hearing provider who participates with the Blue Cross Medicare Advantage PPO network. If you have questions about the Medicare Plus Blue PPO hearing benefit, please call our Provider Inquiry department at 1-866-309-1719.

Furthermore, Vitality, Signature and Assure offer coverage with no cost sharing for select preventive dental services obtained in-network. Members will be responsible for significant cost sharing for preventive dental services obtained out-of-network. Eligibility can be verified and claims can be submitted through SecureTrack electronic inquiry system by logging on <https://www.securedi.com/securetrack/Default.aspx>*.

Medicare Plus Blue PPO Essential offers supplemental vision exams; however, Essential does not offer supplemental coverage for eyewear, hearing, or dental benefits.

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

Additionally, Essential, Vitality, Signature and Assure offer a fitness benefit known as the SilverSneakers® Fitness Program. The Michigan Blues support physical fitness at any age, and hope that you will encourage your Medicare Plus Blue PPO patients to enroll in the program, which offers a complimentary membership to any participating location. SilverSneakers also includes a self-directed program for members who are unable to leave the home. More information about this fitness benefit is available online at <http://silversneakers.com/>*.

Medicare Plus Blue plans include benefits that may be in addition to Original Medicare benefits. You can find those benefit policies on our website, <http://bcbsm.com/provider/ma> under *Medicare Plus Blue/Provider Toolkit/Coverage Details/Enhanced Benefits*.

Note: Group coverage may not include the vision, hearing, preventive dental or fitness benefits described above. The Medicare Plus Blue PPO plan, Essential, has Medicare-covered services only for dental and hearing cost-share applies. Depending on the plan option, members may have cost-sharing for Medicare-covered dental benefits.

MPSERS hearing services

Starting Jan. 1, 2018, Blue Cross will provide routine hearing care benefits and hearing aids for MSPERS members exclusively through TruHearing, an independent company that provides hearing services. TruHearing doesn't provide Blue Cross-branded products or services. But our arrangement allows them to work with us to administer the MSPERS hearing care and hearing aids benefit.

We've let all MSPERS members know about this benefit change through our various member communications. Our members won't receive a new ID card from TruHearing. An ID card isn't necessary, because TruHearing will coordinate services directly between the member and provider.

Benefit highlights MSPERS members can have:

- An audiometric hearing exam once every 36 months with a \$45 copay
- Three provider visits
- Up to two TruHearing Flyte 770 hearing aids (\$499 copayment per aid) or Flyte 990 hearing aids (\$799 copay per aid) every 36 months
- A 45-day trial with the purchase of each Flyte hearing aid
- A three-year manufacturer warranty
- 48 batteries per aid

Tips for providers

- Routine hearing services and hearing aids are only covered for MSPERS members when they call TruHearing at 1-855-205-6305 and follow the directions provided.
- Give MSPERS members the opportunity for a trial with Flyte to give the members the best opportunity to use the benefit.
- Ask members who decide to waive their hearing benefit (whether it's their preference or a medical necessity) to complete a TruHearing Select Non-covered Services form.
 - Providers will need to submit these forms directly to TruHearing.
 - Members who waive their benefits can then use the TruHearing Choice discount program, which includes 100-plus hearing aid models from five manufacturers at prices ranging from \$695 to \$2,250.
- Collect member hearing exam copayments through the TruHearing provider portal, Echo.
 - TruHearing will remit the allowable amount for the exam to providers approximately 10 days after the exam copay has been collected in Echo.
- Collect full TruHearing Flyte hearing aid copayments through Echo.
 - TruHearing will remit the professional fee to providers after the member's 45-day trial period.

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

- Providers can get more details about Flyte hearing aids at http://TruHearing.com/flyte**, which offers providers Flyte spec sheets, a fitting guide, a reference guide and other information about the Flyte product line. There are also training courses available to providers on Audiology online (https://www.audiologyonline.com**).
- In December 2017, the Flyte website will be updated with the new Flyte 770/990 information.
- For more information about training or tools needed to ensure successful Flyte fittings or partnering with TruHearing, providers should contact TruHearing Provider Outreach at 1-855-286-0550 or <mailto:Provider.outreach@truhearing.com>.
- Financing is available for MPSERS members through AllWell Financing, if interested.

MPSERS vision services

Starting Jan. 1, 2018, Medicare Advantage and commercial retirees with MPSERS coverage will transition from Blue Cross' Blue VisionSM plan to EyeMed Vision Care.

In December 2017, EyeMed will mail members a separate welcome kit detailing their 2018 vision benefits. The kit will also include the member's new EyeMed vision ID card. Retirees who share a vision policy with a dependent or spouse will receive two identical ID cards with the retiree's name on it.

Providers should continue to contact Blue Vision at 1-800-877-7195 if they have any questions about dates of service between Jan. 1, 2014, and Dec. 31, 2017. If providers have questions about dates of service beginning Jan. 1, 2018, they should contact EyeMed at **1-888-581-3648**.

Primary Care Physicians

Blue Cross MA PPO 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

Some plans have a higher copayment for specialists.

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 Medicare Plus Blue PPO members who elect hospice care. Claims for services provided to a Medicare Plus Blue PPO 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 Medicare Plus Blue PPO 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 MA PPO 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 access and 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 Plus Blue 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

Blue Cross Blue Shield has delegated the responsibility to assess and monitor compliance with the standards to Blue Care Network. 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 Advantage PPO 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 Medicare Plus Blue PPO 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 Plus Blue offers enhanced care management programs to members. Our care management strategy begins with the Care Transition to Home team reaching out to assist in discharge planning for members and coordinating short-term care management. Members may be identified for programs including Blue Care Connect (integrated care management), case management, remote monitoring or chronic condition management. Blue Cross may contact you, as the primary provider, to inform and coordinate care for these members if warranted.

- **Blue Care Connect**

BCC 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 Transition to Home**

The Care Transition to Home 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 signs of worsening symptoms
- Identifying the need and coordinating with physician offices for follow-up care
- Triage for referral to other Blue Cross health management programs

Predictive modeling is used to identify members at the highest risk for emergency room visits and hospital readmissions for this intervention. The Care Transition to Home team also acts as a triage area for members who may benefit from an advanced intensity programs such as case management or chronic condition management. If the member has ongoing needs that meet criteria for one of the advanced intensity programs, the team will refer that member accordingly. All other members are provided with assistance to ensure the member receives comprehensive self-management information for a smooth transition home.

- **Care Transition to Home Onsite**

The Care Transition to Home program includes an onsite component for engaging members through face to face interactions. The CTH Onsite program is delivered to Medicare Advantage PPO members of Blue Cross in selected Michigan hospitals (with high readmission rates). Initial member engagement is conducted at the bedside, rather than telephonically. CTH telephonic intervention is provided for post discharge. Members receive education, support and resources to assist with the transition from the acute setting to home. RN nurse coordinators address, medication compliance, gaps in care and facilitate physician follow-up within seven days of discharge to decrease the potential for readmissions.

- **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, licensed master level social worker and physician consultants. In addition, behavioral health and medical 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 telephonic 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 and education and support to increase self-management skills.

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 members' home, transmits biometric and/or other symptom data daily. When this data falls 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 members' 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 Advantage members and providing them with intensive care management services to improve quality of life and increase their care cost-efficiency. This model

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

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 stop smoking. 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** screen 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 Medicare Advantage PPO members. Medicare Plus Blue PPO 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 Medicare Plus Blue PPO 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. Medicare Plus Blue PPO 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 Medicare Plus Blue PPO focuses on include:

- Adults access to preventive/ambulatory health services
- Adult body mass index assessment (document weight, height and BMI value in the medical record)
- Acute Hospital Utilization
- 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
- 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
 - Confirmed diagnosis of hypertension (documented in the medical record prior to June 30)
 - Adequate control of hypertension <140/90 (members 18–59 years of age)
 - Adequate control of hypertension <140/90 (members 60–85 years of age with diagnosis of diabetes)
 - Adequate control of hypertension <150/90 (members 60–85 years of age without a diagnosis of diabetes)
- 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 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

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

- 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
- Transition of care
- Tobacco cessation – medical assistance
- 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

What is the CMS quality star ratings program?

CMS evaluates Medicare Advantage health plans and issues star ratings each year. The ratings may change from year to year. The methodology used by CMS is subject to change and final guidelines are released each spring after the measurement 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 their 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

What are CMS star ratings?

Star measurement is comprised of approximately 40 measures and is assessed across clinical, member perception and operational measures:

1. Clinical - HEDIS and Pharmacy
 - Staying healthy, including screenings, tests, and vaccines
 - Managing chronic (long-term) conditions
2. Member Perception - CAHPS and HOS surveys
 - The Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey measures how customers feel about their health plan, its network providers and the care they receive.
 - The Health Outcome Survey, or HOS, assesses the physical and mental health of customers.

3. Operations

- Member complaints, handling of member appeals and members choosing to leave the plan
- Plan performance improvement

4. Performance is converted to star ratings, based on CMS specifications, as one through five stars, where five stars indicate higher performance. This rating system applies to all Medicare Advantage lines of business: health maintenance organizations, preferred provider organizations and prescription drug plans. In addition, the ratings are posted on the CMS consumer website, <http://www.medicare.gov>, to help beneficiaries choose a Medicare Advantage plan offered in their area.

Star clinical performance

Star clinical performance is determined by who in the eligible population received appropriate services/care as defined by the measure.

Numerator: Eligible population that met the criteria

= % Compliant

Denominator: Eligible population for the measure

CMS determines the thresholds of performance required to achieve a star rating.

Classification of clinical measures

Administrative: Transaction data or other administrative data are used to identify the eligible population and the numerator. The reported rate is based on all members who meet the eligible population and who are found through administrative data to have received the service required.

Hybrid: Administrative data is used to identify the eligible population. A combination of administrative data and medical record review data is used to calculate the numerator. An exception to this is the measure for Controlling Blood Pressure, for which the numerator is completely collected from medical record review data.

2018 CMS quality star measures

Area	Measure	Description
Clinical	Adult body mass index assessment	Percent of plan members aged 18-74 with an outpatient visit who had their BMI calculated and documented in their medical record along with their weight.
Clinical	Breast cancer screening	Percent of plan members aged 52-74 who had a mammogram to screen for breast cancer.
Clinical	Colorectal cancer screening	Percent of plan members aged 50-75 who had a colonoscopy, sigmoidoscopy or FOBT to screen for colon cancer.
Clinical	Controlling blood pressure	Percent of plan members aged 18-85 with high blood pressure who received treatment and were able to maintain a healthy pressure <ul style="list-style-type: none"> • With a diagnosis of diabetes <140/90 mm Hg • Without a diagnosis of diabetes <150/90 mm Hg
Clinical	Diabetes care – eye exam	Percent of plan members aged 18-75 with diabetes who had an eye exam to check for damage from diabetes during the year.
Clinical	Diabetes care – kidney disease monitoring	Percent of plan members aged 18-75 with diabetes who were monitored for kidney disease during the year via a visit with a nephrologist, ACE/ARB treatment, microalbuminuria testing, or macroalbuminuria testing.
Clinical	Diabetes care – blood sugar controlled	Percent of plan members aged 18-75 with diabetes who had an A1c lab test during the year that showed their average blood sugar is under control (<9%).
Clinical	Hospitalization for Preventable Complication	The rate of hospitalization for plan members aged 67 years and older related to complications of chronic and acute ambulatory care sensitive conditions.

Clinical	Medication Reconciliation Post Discharge	Percent of plan members aged 66 years and older who were discharged from an acute or non-acute inpatient facilities and had medications reconciled within 30 days of discharge.
Clinical	Osteoporosis management in women who had a fracture	Percent of female plan members aged 67-85 who broke a bone and received screening or treatment for osteoporosis within six months.
Clinical	Plan all-cause readmissions	Percent of senior plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.
Clinical	Rheumatoid arthritis management	Percent of plan members with rheumatoid arthritis who received one or more prescription(s) for an anti-rheumatic drug.
Clinical	Statin therapy for patients with cardiovascular disease	Percent of male plan members aged 21-75 and female plan members aged 40-75 who were identified as having clinical atherosclerotic cardiovascular disease and dispensed at least one high or moderate-intensity statin medication and remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.
Clinical pharmacy	Part D medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical pharmacy	Part D medication adherence for hypertension (ACE or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical pharmacy	Part D medication adherence for cholesterol (statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.
Clinical pharmacy	Statin use in persons with diabetes	Percent of members aged 40 to 75 years who were dispensed a medication for diabetes that receive a statin medication.
Clinical operations	Part D Medication Therapy Management	Percent of plan members 18 and older who were enrolled in the MTM program for at least 60 days during the reporting period.
Member survey	Annual flu vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.
Member survey	Improving or maintaining physical health	Percent of all plan members whose physical health was the same or better than expected after two years.
Member survey	Improving or maintaining mental health	Percent of all plan members whose mental health was the same or better than expected after two years.
Member survey	Monitoring physical activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.
Member survey	Improving Bladder Control	Percent of plan members experiencing urinary incontinence and talked to their doctor about treatment approaches.
Member survey	Getting needed care	Percent of the best possible score the plan earned on how easy it is for members to get needed care, including care from specialists.
Member survey	Getting appointments and care quickly	This case-mix adjusted composite measure is used to assess how quickly the member is able to get appointments and care.
Member survey	Rating of health care quality	Percent of the best possible score the plan earned from members who rated the quality of the health care they received.
Member survey	Getting needed prescription drugs	Percent of the best possible score the plan earned on how easy it is for members to get the prescription drugs they need using the plan.
Member survey	Care coordination	Percent of the best possible score the plan earned on how well the plan coordinates members' care

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

Please note that the methodology used by CMS is subject to change and final guidelines are released each spring after the measurement year.

Provider tips

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Understand the metrics included in the CMS rating system, as some of them are part of our provider Performance Recognition Program and you may be eligible to participate.
- Review the gap in care files listing members with open gaps.
- Ensure documentation includes assessment of cognitive and functional status.
- Identify opportunities for you or your office to have an impact.
- Leverage Health e-Blue, a clinical support tool (please see the next section).

To learn more about the:

For more information:

- 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 Medicare Plus Blue 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 Medicare Plus Blue patients.

Blue Cross partners with our Medicare Plus Blue providers by identifying their Blues Medicare Advantage patients who need specific medical services so providers can contact those patients and schedule necessary services. 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.

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

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

Addiction Medicine – Family Practice	Gastroenterology	Pediatrics
Addiction Medicine	Geriatric Medicine – Family Practice	Pediatric Endocrinology
Adolescent Medicine	Geriatric Medicine – Internal Medicine	Pediatric Infectious Disease
Adolescent Medicine – Pediatrics	General Practice	Pediatric Nephrology
Allergy/Immunology	Hematology – Internal Medicine	Pediatric Gastroenterology
Allergy/Immunology – Internal Medicine	Hematology/Oncology	Public Health / General Preventive Medicine
Cardiology	Interventional Cardiology	Pediatric Hematology/Oncology
Critical Care Medicine	Infectious Disease	Pediatric Pulmonology
Critical Care Medicine – Internal Medicine	Internal Medicine	Preventive Medicine
Critical Care Medicine – Pediatrics	Internal Medicine Pediatrics	Pediatric Rheumatology
Cardiovascular Disease	Nephrology	Pulmonary Disease
Endocrinology, Diabetes / Metabolism	Neuromusculoskeletal Medicine	Rheumatology
Endocrinology	Oncology	Sports Medicine – Family Practice
Family Practice	Pediatric Allergy/Immunology	Sports Medicine – Internal Medicine
	Pediatric Cardiology	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

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 (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.

Provider Performance Recognition Program

The Provider Performance Recognition Program was developed to reward our Medicare Plus Blue providers for encouraging patients to get preventive screenings and procedures (such as colonoscopies), and for achieving certain disease management measures such as HbA1c control.

Both BCN and Medicare Plus Blue providers are eligible to participate in the Provider Performance Recognition program for Medicare Plus Blue providers. Both programs reward their primary care physicians for performance measures that are based on HEDIS benchmarks related to preventive screenings and procedures.

Providers can use Health e-Blue to identify patients' treatment opportunities for HEDIS and Provider Performance Recognition Program measures and enter data to close gaps. If you have questions on how, contact your provider consultant.

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

New Medicare Part D prescriber prerequisite

As an update to the new CMS mandate, health care professionals who write prescriptions for Medicare Part D members are required to enroll in Medicare for an approved prescriber status or submit a valid-opt-out affidavit no later than January 1, 2019, to allow CMS time to process your application before the implementation date. This is required of health care professionals who write prescriptions to ensure continued prescription coverage under Medicare Part D. Those who have previously applied to meet this requirement and have received confirmation of their registration from CMS are not required to take additional action to fulfill this requirement. CMS has also issued an interim final rule that exempts pharmacists from the enrollment requirement; however, other prescribers remain subject to the final rule. Additionally, the new rule deems the new requirements, will be enforced beginning January 1, 2019. Providers should have submitted their completed Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors no later than January 1, 2019, to prevent their patients' prescription drug claims from being denied by their Part D plans beginning January 1, 2019.

Beginning January 1, 2019, Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. Part D plans will only cover up to one 3-month provisional supply of a drug, if prescribed by a provider who has not enrolled in or validly opted out of Medicare. If you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

In addition, in order for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) registry. You can search <https://npiregistry.cms.hhs.gov/registry/> to verify the taxonomy code(s) associated with your NPI. The taxonomy code is an element Express Scripts® uses to determine whether or not a claim may be paid based on eligibility to prescribe.

For more information on the Part D enrollment requirements, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>*

If you have any questions, please contact your MAC at its toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>*

Enrolling in Medicare Part D

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System located at <https://pecos.cms.hhs.gov/pecos/login.do>* or by completing the paper CMS-855I or CMS-855O application, which is available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>*. Note that an application fee is not required as part of your application submission.

Medication Therapy Management Program

To be eligible for participation in a Medication Therapy Management program, a member must meet the following criteria:

- Have at least three chronic medical conditions
- Be on at least eight Part D maintenance medications
- Be reasonably expected to incur \$3,919 worth of drug expenses in one calendar year (for 2017)

Our MTM program is coordinated by SinfoniaRx and Outcomes MTM. All members eligible for the MTM program receive a welcome packet that explains the program, and invites the member to complete a comprehensive medication review. The CMR is an interactive consultation between the member or the member's representative and a pharmacist. SinfoniaRx handles CMRs telephonically, while OutcomesMTM uses a network of pharmacies to provide face-to-face services in addition to a telephonic model. The CMR lasts approximately 30 minutes and reviews any medications the patient takes (including prescription, over-the-counter, supplements, herbals, physician samples), for potential drug interactions, adherence problems, etc. The pharmacist asks open-ended questions to ensure the patient understands their personal medication regimen.

The patient receives a written summary of the CMR, with a complete updated medication list and an explanation of any medication issues that were discussed. If any issues were identified during the CMR, the pharmacist may contact the member's prescriber by phone and/or fax to address these issues. Per CMS, everyone who is eligible for the MTM program must be offered a CMR at least once a year. In addition to the mailing, identified members may be called to encourage their participation. CMR completion rate factors into our Star rating scores as a single weighted Star measure.

Per CMS, all MTM program-eligible members must also receive a targeted medication review at least once every quarter. This is a computer review of members' claims by the pharmacist. If the pharmacist notices any issues, they may contact the member and the member's prescriber. This is another way the pharmacist can engage the member to participate in a CMR if they have been unsuccessful in contacting the member previously.

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.

Opioid overutilization

Because of the risks involved with opioid and acetaminophen use, both Blue Cross and CMS urge physicians to prescribe opioids with caution and carefully monitor patients using these medications. CMS requires Blue Cross to actively monitor claims data for potential opioid and/or acetaminophen overuse. If our analysis suggests potential overuse, we send a letter to the prescriber detailing our concerns and ask them to complete and return a questionnaire about the patient's condition and treatments. If the physicians verify that the current opioid therapy is medically necessary, safe, and appropriate for their patient, we'll follow up with a letter of confirmation and report our findings to CMS.

If the physicians fail to respond to our request for information or agree that the current opioid therapy is not appropriate, Blue Cross may stop or limit coverage for the patient's opioid medication and notify the member, prescribers, and report our findings to CMS.

Our analysis looks at:

- Safety risks, such as instances when a patient receives a daily dosage of opioids — either from a single prescription, or multiple prescriptions – that's higher than established safety levels.
- High utilization patterns, where a patient may have opioid prescriptions from multiple physicians within the same time period.
- Potential fraud, waste or abuse, when a patient visits multiple physicians to expand their access to these painkillers, a practice known as "doctor shopping."

Effective January 1, 2017, plans are required to implement a point-of-sale (POS) safety edit on the below identified opioid drug list for a daily cumulative Morphine Equivalent Dose (MED).

Butorphanol products	Hydromorphone products	Opium products
Buprenorphine products	Levorphanol products	Oxycodone products
Codeine products	Meperidine products	Oxymorphone products
Dihydrocodeine products	Methadone products	Pentazocine products
Fentanyl/Fentanyl Citrate products	Morphine products	Tapentadol products
Hydrocodone products	Nalbuphine products	Tramadol products

Point of Sale (POS) Edit

This edit will identify and place a stop to a claim at the POS that causes the daily MED to exceed 250 mg. This daily cumulative MED will be calculated using a patient look back on opioid claims within the pharmacy claims adjudication system. Using the calculation methodology, any particular claim exceeding the 250mg MED threshold level will be stopped at the POS for clinical review.

The edit can be resolved by the submission of a prior authorization (PA) request by the prescriber or their delegate. Please keep in mind that the physician prescribing the dose, that results in the member exceeding the daily threshold, will be the same physician that will be required to resolve the PA requirement.

Documentation of medical necessity and acknowledgement of the significant clinical circumstance must be submitted for clinical review. The physician must demonstrate that the warranted amount of the opioid medication prescribed is needed to adequately manage the patients' pain while being safe and appropriate.

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 all charges 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 Plus Blue — Roster Billing
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
P.O. Box 32593
Detroit, MI 48226

Utilization management

Blue Cross has developed processes and guidelines for providers to proactively communicate and obtain authorization or certification for anticipated services or admissions. In addition to providing a means of determining whether the patient's symptoms meet criteria for the level of care you've planned, authorization requirements provide Blue Cross with the information needed to identify members that may benefit from the assistance of one of our care management programs.

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*.

The information below outlines the program guidelines for prescription drugs, specialty services such as high tech radiology, echocardiography, radiation oncology, spinal fusion, outpatient interventional pain management, outpatient physical and occupational therapy, behavioral health services, and inpatient admissions to acute care hospitals, long term acute care and inpatient rehabilitation facilities, and skilled nursing facilities.

Effective July 2017, additional services require prior authorization. These services include:

- Select specialty medications covered under the Medicare Part B medical benefit
- Select surgical procedures including:
 - Arthroplasty (hip, knee, shoulder)
 - Correction of hammertoe
 - Nasal/sinus endoscopy
 - Endovascular intervention, peripheral artery

- Radiofrequency ablation and transarterial embolization
- Vagus nerve stimulation
- Intrathecal catheter/pump placement
- Spinal cord stimulator insertion
- Gastric stimulation

Details of the services included and how to submit a prior authorization can be found under the *Preauthorization of prescription drugs and Prior authorization of other medical/surgical services* sections of this Manual.

Preauthorization of Prescription Drugs Covered under the Pharmacy Benefit – Medicare Part D

To help ensure our members receive high-quality, cost-effective pharmaceutical care, we require preauthorization for certain medications and clinical criteria must be met before coverage is approved. Clinical criteria are based on current medical information and the recommendations of the Blue Cross and/or Blue Care Network Pharmacy and Therapeutics Committee. Drugs that are subject to step therapy may require previous treatment with one or more formulary agents prior to coverage. You can view our formularies online at http://www.bcbsm.com/provider/pharmacy_services to find out if a medication is covered by our plan and what drugs require preauthorization or step therapy.

To request preauthorization you can call, fax or mail preauthorization or exceptions requests. Calling is the preferred method. Providers will be asked for specific information that substantiates the request. Providers are encouraged to have the member's chart readily available when calling. To request preauthorization or an exception request, the provider should contact the Blue Cross Clinical Pharmacy Help Desk at 1-800-437-3803, Monday through Friday, 8 a.m. to 6 p.m.

For requests by fax:

1-866-601-4428

For requests by mail:

Blue Cross Blue Shield of Michigan
Pharmacy Help Desk — 1610
P.O. Box 32877
Detroit, MI 48232-0877

The provider should alert the Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the member's life, health or ability to regain maximum function would be jeopardized or that, in the opinion of the prescriber with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. The provider should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

Determinations

The Pharmacy Clinical Help Desk calls every member with the outcome for a coverage determination.

Approvals:

Preauthorization is entered into the system and notification is provided to the prescriber and member in writing.

Denials:

Written notification will be provided to the prescriber and member including the reason for denial and suggested alternatives as well as a copy of the appeal process.

If you have any questions about this process, forms or to make a request, please call the Pharmacy Clinical Help Desk at 1-800-437-3803.

Preauthorization of Prescription Drugs Covered under the Medical Benefit – Medicare Part B

Select Part B medications require preauthorization when administered by a health care professional in the provider office setting. We want providers to use the most effective procedures with an understanding of CMS coverage guidelines for medical necessity, safety and efficacy. A list of medications requiring preauthorization will be updated periodically and can be found on the Provider Secured Services homepage.

How to request a preauthorization (organization determination):

1. Please submit preauthorization requests through the NovoLogix® online tool by following the steps below.
 - Access the Provider Secured Services homepage at <https://provider.bcbsm.com> or login at <http://www.bcbsm.com/providers.html> BCBSM.com/providers (LOGIN is located at the upper right corner of the page).
 - Click on the link “Medicare Advantage PPO Medical Benefit – Medication Prior Authorization” and follow login instructions.
 - If you cannot access Provider Secured Services or are not registered to use NovoLogix please call 1-877-258-3932, Monday through Friday, 8 a.m. to 8 p.m., Eastern time.
2. If you have any questions about this process or to make a request, you may call the Pharmacy Clinical Help Desk at 1-800-437-3803, Monday through Friday, 8 a.m. to 4:30 p.m., Eastern Time.

Determinations

The provider will receive written notification via fax of the pre-service organization determination

Approvals:

Preauthorization is entered into the system and notification is provided to the prescriber and member in writing.

Denials:

Written notification will be provided to the prescriber and member including the reason for denial as well as a copy of the appeal process.

Retrospective Review: BCBSM will conduct a retrospective review if requested within 90 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless (providers may not bill members for these services). Please call the Pharmacy Clinical Help Desk at 1-800-437-3803 to request a retrospective review.

Pre Service Appeals (Appeal of a denied preauthorization): If a service is denied, an appeal may be filed to have the request reviewed again. Refer to your denial letter for the appeal process.

How to request an appeal (reconsideration):

- Directly through the NovoLogix® online tool. Using the search function, locate the denied authorization and select the appeal icon to initiate your appeal.
- By calling the Pharmacy Clinical Help Desk at 1-800-437-3803 or faxing the information to 1-866-392-6465, Monday through Friday, 8 a.m. to 4:30 p.m., Eastern Time and we will initiate the appeal on your behalf.

Post Service Appeals (Appeal of a denied claim): Once a claim has been denied, a first level appeal must be filed in order to have the request re-reviewed. Please reference the **Provider dispute resolution process** section for your appeal rights.

Note: Original Medicare benefit coverage rules and benefit exclusions/limitations on the member’s plan will apply. Providers must obtain preauthorization approval and also verify the member’s benefits to be eligible for claim payment on the date of service. Providers may be held financially liable if services are rendered without a preauthorization approval. Providers may not bill members for services that required, but did not receive preauthorization.

Resources:

You can find a drug list, NovoLogix® user guide, NovoLogix® tutorial video and FAQ document here:

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

- Provider Secured Services homepage at <https://provider.bcbsm.com/> under the link “Medicare Advantage PPO Medical Benefit – Medication Prior Authorization”.

In addition to the above resources, you can also find our Medical Policies and Request Forms here:

- Provider tool-kit for Medicare Advantage PPO at <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit.html> and click on the link “Medicare Advantage PPO medical drug policies and forms- Medication prior authorization request forms”

Preauthorization of high-technology radiology and echocardiography services

All contracted Medicare Plus Blue PPO physicians are required to contact AIM Specialty Health before ordering select radiology and echocardiography imaging studies to be performed in office, outpatient hospital or freestanding centers for a Medicare Plus Blue PPO member. (Preauthorization is not required in the hospital inpatient, emergency room or urgent care setting.) The program is designed to help ensure the most appropriate test is utilized for the diagnosis in question. This comprehensive approach to managing outpatient diagnostic imaging utilization provides an interface for new technology procedures and helps to clarify radiological procedures.

Either the ordering or rendering physician may obtain preauthorization. However, the rendering physician should verify that the preauthorization has been obtained prior to performing the service.

Prior to any high-technology radiology, or echocardiography exam or service being rendered, an approved preauthorization must be obtained to receive reimbursement. Without preauthorization, claims will be denied with no member liability.

Members will receive preauthorization approval letters. Providers and members will also receive written notification of preauthorization denials with all applicable appeal rights.

Outpatient high-technology radiology and echocardiography procedures requiring preauthorization can be accessed on our website, <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/aim-radiology-mgt.pdf>.

Preauthorization of lumbar spinal fusion surgery, outpatient interventional pain management, outpatient radiation oncology services and outpatient physical and occupational therapy

Blue Cross Blue Shield of Michigan’s preauthorization program requires all Medicare Plus Blue providers to obtain preauthorization for medical necessity for lumbar spinal fusion surgery, outpatient interventional pain management, and outpatient radiation oncology for Medicare Plus Blue PPO members who reside in Michigan and use Michigan providers. Providers are also required to obtain preauthorization for physical and occupational therapy for Medicare Plus Blue PPO members who reside in Michigan and use Michigan providers.

Preauthorization for these services is administered by eviCore healthcare. eviCore is a national specialty benefit management company that focuses on managing quality and use for individual patients. The preauthorization program is intended to eliminate the unnecessary use of certain procedures to improve patient care and manage health care costs. Services performed without preauthorization may be denied for payment, and you may not seek reimbursement from members.

There are two ways to request a preauthorization and to locate clinical worksheets and the list of CPT codes that require preauthorization:

- Access the eviCore implementation site at <https://www.carecorenational.com/page/bcbsm-implementation.aspx>*
- Go to the Blue Cross website at <http://www.bcbsm.com/providers.html> click on Provider Secured Services, then log in into web-DENIS and click on the prior authorization link to find the list of procedure codes subject to prior authorization and the link to eviCore’s portal to submit your preauthorization request.

These portals are available 24/7, 365 days per year. The clinical worksheets will help guide you with the necessary information to request a preauthorization. The eviCore implementation site also includes Frequently Asked Questions, a Quick Reference Guide, and national guidelines.

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

To ensure the preauthorization process is as quick and efficient as possible, the following is required when submitting a preauthorization request:

- Member name, date of birth, plan name and plan ID number.
- Ordering Physician's name, National Provider Identifier (NPI), Tax Identification Number (TIN), Fax number
- Place of service
- Rendering facility's name, NPI, TIN, street address, fax number
- Service being requested (CPT codes and diagnosis codes)
- All relevant clinical notes; imaging/X-ray reports, patient history, physical findings
- Preauthorization requests must be submitted to eviCore before any of the services listed below are rendered. Additional instructions follow.
- Lumbar spinal fusion surgery and outpatient interventional pain management requests may be made by telephone, fax, or web portal
- Outpatient radiation oncology requests may only be made by telephone or web portal
- Outpatient physical and occupational therapy requests may be made only via web portal

Approved preauthorization requests may have differing time spans.

- Lumbar spinal fusion surgery
- Outpatient interventional Pain Management
- Outpatient physical and occupational therapy

If approved, each of the above service preauthorizations is valid for 45 days.

- Outpatient radiation Oncology: varies

If an authorization is going to be denied, the provider may request a peer-to-peer conversation. If the service isn't performed within the valid date span of the issued preauthorization, a new preauthorization must be requested.

The recommended and quickest way to obtain preauthorizations is online. If a preauthorization isn't obtained for the above services, claims will be denied and providers will be responsible for the costs and the member must be held harmless.

We recommend that the ordering physicians secure the required preauthorizations and provide the preauthorization numbers to the rendering facilities or providers at the time of scheduling. Authorization records will contain preauthorization numbers and one or more CPT/HCPCS codes specific to the services authorized. Services performed in conjunction with 23-hour observation or emergency room visits are not subject to preauthorization requirements. Inpatient hospital admissions require separate preauthorization via e-Referral.

Preauthorizations will be excluded for:

- Facility claims for emergency/trauma, observation, urgent care, treatment room, other labor room, VA hospitals
- Professional claims for emergency/trauma, inpatient (except spinal fusion surgery)
- Radiation oncology patients under 18 years of age

When a service requiring preauthorization is medically urgent, the provider must call eviCore at 1-877-917-2583 (BLUE) for preauthorization. Expedited or urgent requests must contain a doctor's attestation the services are necessary for a condition that is jeopardizing the member's life or health and is deemed life threatening. Expedited or urgent requests will be processed within four hours and will be processed by the end of the business day.

For all services, if there is not enough information to grant a medical necessity approval, eviCore will reach out to providers prior to denying a request to allow them to provide pertinent information. Providers must call 1-877-917-2583 (BLUE) to schedule a peer-to-peer review. Providers have one business day to schedule a peer-to-peer review. If there is no response within one business day, the request will result in a formal denial. After a peer-to-peer review, the request will be formally approved or denied. Written denial notices will be sent to the

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

member as well as the requesting provider(s). Once a service has been denied, an appeal must be filed to have the request re-reviewed. Please reference the **Provider dispute resolution process** section for your appeal rights.

eviCore will conduct a retrospective review if requested within 90 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless.

Short and long term changes to the outpatient physical and occupational therapy prior authorization process

Effective Oct. 1, 2017 an interim solution was implemented for members undergoing post-surgical physical therapy as part of their treatment plan. In such circumstances, the member is entitled to receive a minimum of 12 visits within 45 days. This approach is intended to provide two visits per week over the course of six weeks and give providers more time to request approvals for any additional visits to the member's treatment plan without creating a lapse in care.

Effective Jan. 1, 2018 eviCore will implement its new authorization model called corePathSM. The corePath model is designed to streamline the authorization process and will be easier for the Medicare Advantage provider community to follow. Highlights of the program changes include:

- Reducing the administrative burden on providers and their staff
- Empowering providers with the ability to identify attributes that are unique to a specific member's condition
- Allowing providers to submit and receive same day authorizations in real time
- Eliminating provider tiers as a factor in the utilization management process
- Applying the authorization to the initial course of treatment only
- Granting approvals for additional physical therapy visits with confirmation that a member's condition is progressing as expected

The ability of providers to go online to schedule peer-to-peer reviews will also be included as part of the program changes effective Jan. 1, 2018. Additional information on the model and answers to frequently asked questions (including scheduling peer-to-peer reviews) are available through the e-referral website ereferrals.bcbsm.com/bcbsm-managed-procedures.shtml.

BCBSM will provide training to make the transition smoother. BCBSM will also continue to evaluate the eviCore program and work to improve its operational effectiveness.

Categorization of outpatient physical and occupational therapy providers

The Practitioner performance summary (PPS) and network categorization of providers:

- Insight into practice patterns and how they compare with your network peers
- Timely access to information to monitor performance over time and by condition
- Patient visits are adjusted for factors that account for variation in visit usage
- Risk-adjusted visits are comparable across member populations and conditions

Separate peer group networks are established for independent providers and/or groups and for hospital based outpatient physical therapy practices. Both peer groups consist of three Utilization Management categories (A, B, and C) that are based on the risk-adjusted visits per episode (RAVE) score that is used to establish each category.

The networks are assessed every six months with a new Utilization Management category developed in January and July and effective in April and October respectively.

- eviCore will mail letters designating your assigned Utilization Management category at the end of January and July
- Your assigned Utilization Management category is posted in the PPS Dashboard 60 days before the effective date (April and October).
- If you believe there are unusual circumstances adversely affecting your utilization data, you have 15 days from the date of your letter to initiate a Utilization Management category reconsideration.

The Utilization Management category ranges for each peer group are as follows:

Physical therapy peer group (IPTs and OPTs):

- Category A practices average a RAVE, up to 80 percent of the IPT/OPT peer group mean.
- Category B practices average a RAVE between 80 to 120 percent of the IPT/OPT peer group mean.
- Category C practices average a RAVE above 120 percent of the IPT/OPT peer group mean.

Hospital outpatient physical therapy peer group:

- Category A hospitals average a RAVE up to 80 percent of the hospital outpatient physical therapy peer group mean.
- Category B hospitals average a RAVE between 80 to 120 percent of the hospital outpatient physical therapy peer group mean.
- Category C hospitals average a RAVE above 120 percent of the hospital outpatient physical therapy peer group mean.

Outpatient physical therapy centers and hospitals follow the preauthorization process for their assigned Utilization Management category (A, B or C) for both PT and OT.

Therapists who aren't therapy centers and hospitals follow the preauthorized eviCore Basic Care Management Program – and will default to a category B for:

- IPTs and OPTs who didn't have at least 10 treatment episodes in the Practitioner Performance Summary reporting period
- IPTs and OPTs who are added as new in-network providers
- Independent occupational therapists

Category A Automatic approval	Category B Basic care	Category C Comprehensive care
<p>Category A providers are required to notify eviCore of new treatment episodes, but aren't required to submit clinical information for medical necessity review.</p> <ul style="list-style-type: none"> • Notify eviCore of new a treatment episode within seven days of the patient's initial visit. • The notification requires patient demographics and minimal clinical information. • eviCore will issue an immediate approval up to the patient's maximum benefit, or for a block of visits (e.g., 20 visits), for you to provide medically necessary care. 	<p>Category B physical therapists and all independent occupational therapists follow eviCore's basic care management process:</p> <ul style="list-style-type: none"> • Notify eviCore of new a treatment episode within seven days of the patient's initial visit. • eviCore will typically waive the requirement to submit clinical information for medical necessity review for six to 10 visits (depending on condition and acuity). • The clinical review waiver may be available for new conditions and for existing conditions if the patient hasn't had therapy services in the previous 90 days. • To request additional care after using the approved waiver visits, send eviCore a request for continuing care. Current clinical information will be required. 	<p>Category C providers are required to notify eviCore of new treatment episodes and to submit clinical information for medical necessity review.</p> <ul style="list-style-type: none"> • Notify eviCore of new a treatment episode within seven days of the patient's initial visit. • eviCore will prompt you to provide clinical information and will issue a medical necessity determination. • To request additional care after using approved visits, send eviCore a request for continuing care. Updated clinical information will be required.

Preauthorization of behavioral health services

All mental health and substance abuse inpatient, partial hospital, and intensive outpatient treatment, admissions or concurrent reviews require preauthorization. This process excludes acute detoxification admissions. Acute detoxification admissions should be processed as a medical service and should follow the preauthorization requirements for in-patient admission.

Beginning October 16, 2017 all mental health and substance abuse inpatient, partial hospital, and intensive outpatient treatment, admissions or concurrent reviews should be submitted using e-referral. Services that require authorization through the e-referral system include:

- Initial admissions for inpatient, partial hospitalization and intensive outpatient treatment for members who have been admitted to inpatient care or to a treatment program
- Extensions of inpatient, partial hospitalization or intensive outpatient treatment

Outpatient behavioral health services for MAPPO members do not require prior authorization. Discharges should also be communicated through e-referral.

The Behavioral Health department can be reached at 1-888-803-4960 for general assistance with behavioral health services including:

- Arranging services or requesting authorization for services
- Obtaining criteria used to make an authorization decision (both InterQual® and local criteria).

Note: If you're not an e-referral user already, you can sign up on the <http://ereferrals.bcbsm.com/home/signup>. Sign Up or Change a User page on the <http://ereferrals.bcbsm.com/index.shtml> website. The page contains information providers need to sign up for access to the e-referral system. **The Blue Cross page of the e-referral website** also contains resource materials that can assist providers in managing behavioral health service such as:

- The behavioral health e-referral user guide (pdf) Medicare Plus Blue PPO Manual 28 Revised October 1, 2017.
- Frequently asked questions for behavioral health providers for MAPPO (pdf)
- Behavioral health discharge summary (pdf). This document is to be attached to the case in the e-referral system

Our Behavioral Health Services case managers are available 24 hours per day, seven days a week for inpatient admissions and member emergencies.

Note: If you fail to submit your authorization request, submit an untimely request, or your request is denied and you still execute the service, the member must be held harmless.

Providers who fail to obtain authorization for these services may receive denials for all claims that do not have an associated authorization, and may incur complete financial responsibility for all services rendered without authorization.

Blue Cross Blue Shield of Michigan has partnered with Blue Care Network to administer its Behavioral Health Services program for our Medicare Plus Blue members. Effective Jan. 1, 2016 BCN began utilizing InterQual criteria to assess the medical necessity of all Behavioral Health inpatient, partial and intensive outpatient admissions for psychiatric or chemical dependency treatment. It is highly recommended that hospitals utilize InterQual criteria to assess the medical necessity of the admission prior to calling for authorization. BCN will maintain its local coverage criteria for the following:

- Transcranial Magnetic Stimulation
- Neurofeedback Training for ADD/ADHD
- Autism Spectrum Disorder–Applied Behavioral Analysis
- Residential Mental Health Services

Providers may obtain a copy of the criteria used to render all decisions and speak with the behavioral health medical director regarding medical necessity decisions by calling MA PPO Behavioral Health Services at 1-888-803-4960.

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

Preauthorization of acute care admissions to hospitals

As of July 31, 2017, BCBSM moved from the prenotification system to e-referral. All other conditions remain in place as to the timeframe for preauthorization, sanctions, and holding the member harmless for the failure of the provider to request preauthorization.

e-referral requests are required for members when moving from observation to inpatient status. Failure to obtain a timely authorization may result in payment sanctions. Members must be held harmless and cannot be billed for any amount remaining on the claim due to the application of a payment sanction.

Note: If you're not an e-referral user already, you can sign up on or change a user on the e-Referral website <http://ereferrals.bcbsm.com/bcbsm-landingPage.shtml>. The page contains information providers need to sign up for access to the e-referral system. The e-Referral page also contains information on authorization and referral criteria as well as other services that are subject to prior authorization. Effective Jan. 1, 2016, Blue Cross began reducing payments for acute care hospital claims through the application of payment sanctions if the facility does not notify Blue Cross of an admission or the notification is not received timely.

1. If an acute care admission notification is received within 60 days from date of admission, then Blue Cross will not apply a payment sanction.
2. If an acute care admission notification is received after 60 days from the date of admission, then Blue Cross will apply a 30% payment sanction.
3. If an acute care admission notification is not received or received but rejected, then Blue Cross will apply a 100% payment sanction.

Members must be held harmless and cannot be billed for any amount remaining on the claim due to the application of a payment sanction.

Payment sanctions for failure to comply with notification processes do not impact the behavioral health, (covered in the previous Utilization Management section)-skilled nursing facility, inpatient rehabilitation, or long term acute care admissions, which are covered in the sections below.

The preauthorization e-referral system requires information as outlined below.

- Hospitals are required to reference InterQual® criteria for inpatient admissions and indicate which subset was referenced and met. If a doctor is overriding InterQual inpatient criteria, then the hospital must provide the doctor's name and phone number.

For retrospective audit purposes, if the admitting physician reasonably expects the patient to require a hospital stay that crosses two midnights based on the InterQual® criteria, the medical record documentation must also support that expectation.

- Hospitals are required to attach clinical information from the medical record to validate the InterQual® criteria for pended and concurrent reviews.
- Hospitals are required to reference the CMS inpatient surgical list for Medicare Plus Blue PPO inpatient surgical procedures that are considered elective.

Please note: Facility review programs are generally initiated by staff of the relevant facilities; however, physicians are expected to support these programs as needed by providing appropriate clinical information and other needed data. See also the Billing Members-Providing Medicare Outpatient Observation Notice (MOON) section of this manual for information on prior authorization for members moving from observation to inpatient status.

For issues related to inpatient admissions of MAPPO members please call 1-866-807-4811.

Preauthorization of other medical/surgical services

Effective July 31, 2017, select medical/surgical procedures require preauthorization for members who reside in Michigan and use contracted Medicare Plus Blue PPO physicians. The preauthorization program is intended to eliminate the unnecessary use of certain procedures to improve patient care and manage health care costs. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members. Preauthorization is not required for procedures performed in an emergency room or urgent care setting.

Requests for preauthorization should be submitted via e-referral at least 14 days in advance of the procedure. For expedited or urgent requests, the provider must call Blue Cross at 1-800-392-2512. Expedited requests will be handled within 72 hours.

Clinical information will be required for all requests. If clinical information is not received, the provider will be contacted by phone and/or in writing to request the necessary information. If documentation is not received within the designated timeframe, the service will be denied.

When an organization determination is made, the member and provider will be notified of the decision via letter. If the service is denied, the letter will explain the reason for denial, instructions for filing an appeal and information on how to reach the plan medical director who made the decision. Providers can also view the status of the request on e-referral.

BCBSM will conduct a retrospective review if requested within 60 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless (providers may not bill members for these services). These requests may be submitted through e-referral.

A complete code listing, the clinical criteria and required information for each requested service can be accessed at ereferrals.bcbsm.com>Blue Cross>Blue Cross Authorizations/Referrals.

Preauthorization of skilled nursing facility, long term acute care, and inpatient rehabilitation stays

Utilization Management reviews a patient's current clinical condition and proposed treatment plan. The preauthorization program is designed to determine, in advance of an admission, whether the patient meets nationally recognized clinical screening criteria for SNF, LTAC and IP rehabilitation admission and the level of care planned.

All Michigan contracted Medicare Plus Blue PPO providers are required to submit a preauthorization request before admitting a Medicare Plus Blue PPO member into these facilities. It is our expectation that a clinician will provide the appropriate clinical information and documentation regarding the member's condition. InterQual criteria is utilized to complete first level review of skilled nursing, inpatient rehabilitation, and long-term acute care initial preauthorization and extension requests. Medicare-appropriate chapter guidance is applied to all preauthorization requests that do not meet first level InterQual criteria and require a second level review by a Medical Consultant.

The preauthorization process works best when hospitals and physicians have a standard procedure for communicating with each other to ensure that preauthorization information is sent timely. The preauthorization program is designed for obtaining certification prior to admission; requests for post-acute care (PAC) facility admissions should be submitted by the hospital case management/discharge planning teams or ordering physician a minimum of 48 hours prior to anticipated discharge. Please be aware that if you fail to submit your preauthorization request, submit a late request, or your request is denied and you still admit the member, all or part of your claim submission may be rejected. The member must be held harmless.

Preauthorization process for Michigan MA PPO members admitted to Michigan post-acute care facilities

eviCore healthcare manages preauthorization and service extension requests for inpatient admissions to skilled nursing facilities, long-term, acute care facilities and inpatient rehabilitation facilities for Medicare Plus Blue members living in Michigan who will receive services from Michigan post-acute care facilities. eviCore healthcare is a national specialty benefit management company that focuses on ensuring each individual patient receives the appropriate care, in the appropriate setting, for the appropriate duration.

Please refer to the list below to ensure that you submit a timely preauthorization request and execute compliant discharge procedures:

- Business hours (Monday through Friday, 7 a.m. to 8 p.m., Eastern time), weekends and holidays from 10 a.m. to 4 p.m. Eastern time.
- Requests for prior authorization for skilled nursing facility, long-term acute care or inpatient rehabilitation facility admissions in the state of Michigan may be submitted as follows:

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

- via the eviCore Provider Portal at www.evicore.com
- via AllScripts at www.entendedcare.com
- via fax to 844-407-5293
- via phone at 1-877-917-2583 (BLUE)

The following information is required for all preauthorization and service extension requests:

- eviCore healthcare authorization form located at www.carecorenational.com/page/bcbsm-implementation.aspx
- history and physical
- consult notes
- PT/OT/ST progress notes – include prior and current levels of function
- Medications
- If available, include Discharge summary and Social Work/Psychosocial Consult.
- eviCore determinations may be communicated in the following ways:
 - Allscripts: eviCore will communicate authorization determinations via Allscripts to providers that use Allscripts
 - Telephone: an outbound call will be placed by one of eviCore’s clinical support specialists to providers who do not use Allscripts communications
 - Fax: once the determination is communicated to the provider, eviCore will fax the authorization and/or denial letter to the requesting provider
 - Web Portal: providers may also visit <https://www.evicore.com/pages/providerlogin.aspx> to view the authorization determination
 - If a post-acute care admission or length of stay extension does not meet clinical criteria in accordance with the member’s health benefit plan, eviCore healthcare will reach out telephonically to offer a Peer-to-Peer discussion prior to a denial. It is important to provide additional clinical information needed or to take advantage of the Peer-to-Peer discussion prior to a final determination being made. Once a decision to deny had been rendered, an appeal must be filed.
 - Written denial notices will be sent to the member and requesting provider. All appeals will be managed by Blue Cross. Please reference the section for your appeal rights.
 - Standard recertification requests – If a request is denied, Medicare certified facilities must issue the appropriate CMS appeal rights documentation and provide the applicable timeframe to the member as outlined under the manual section *Providing notices of appeal rights and responding to appeals*. Failure to follow this process per CMS guidelines may result in an Administrative Denial of Payment. Administrative Denials of Payment may not be billed to the member.
- The initial PAC facility admission authorization will allow the member to be admitted to a participating facility any time within 10 days from the date of approval. If the member is not admitted within 10 days of the approval, it will expire and a new authorization request will need to be submitted.
- Approved PAC facility admissions will be authorized for an initial length-of-stay of three days. Once the facility has assessed the patient and performed all required evaluations, please contact eviCore healthcare for additional days. eviCore will then create the care plan and authorize additional days needed based on the clinical condition. eviCore will provide both written and telephonic notification regarding the number of days authorized and medical necessity determination.
- Standard recertification requests — If a request is denied, Medicare-certified facilities must issue the appropriate CMS appeal rights documentation and provide the applicable timeframe to the member as outlined under the manual section, **providing notices of appeal rights and responding to appeals**.

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

- eviCore will accept a retrospective requests for authorization as long as the request is submitted prior to a patient's discharge from the PAC facility. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless.

Preauthorization process for MA PPO members with a non-Michigan permanent address

Effective June 1, 2016, **Blue Cross Blue Shield of Michigan Utilization Management department will continue to provide** preauthorization for inpatient admissions to skilled nursing facilities, long-term, acute care facilities and inpatient rehabilitation facilities for Medicare Plus Blue members with a non-Michigan permanent address.

Please refer to the list below to ensure that you submit a timely preauthorization request and execute compliant discharge procedures:

- All skilled nursing, long-term acute care and inpatient rehabilitation facility requests for initial admission and extension for Medicare Plus Blue members with a non-Michigan permanent address must be submitted via fax or email.
- Facilities are required to complete the appropriate facility request form (either the SNF, acute rehab facility assessment or LTAC form) and submit the request via fax to: 1-866-464-8223 or via e-fax requests to MedicarePlusBlueFacilityFax@bcbsm.com.
- If incomplete documentation is received, Blue Cross will call or send a fax to the facility indicating the missing documentation. A lack of information denial will be issued if complete documentation is not received timely.
- Blue Cross will fax the facility with the authorization number, approved length of stay and last covered day (as applicable).
- Business hours are Monday through Friday, 8 a.m. to 6 p.m., (EST). The facility must submit a request via fax or email on or before the member's date of admission to obtain authorization from Blue Cross.
- Preauthorization requests received Saturdays, Sundays or holidays will be processed the next business day.
- Requests received in or outside of normal business hours will be processed within one to two full business days. Cases pended to the medical consultant will require longer processing times, up to three business days.
- Expedited/urgent care requests must contain a physician's attestation that an urgent admission is necessary for a condition that is jeopardizing the member's life or health and is deemed life-threatening. This care request will be processed within 72 hours. Please submit the request to along with the physician attestation to 866-464-8223 or email <mailto:MedicarePlusBlueFacilityFax@bcbsm.com>.
- BCBSM will conduct a retrospective review if requested within 90 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless (providers may not bill members for these services). Please reference the *Provider dispute resolution* process section for your appeal rights.

Extension of approved stays

- An extension request for an approved stay must be submitted via fax or email to the Blue Cross Utilization Management department no later than two days prior to the last covered day approved by Blue Cross. If a request is denied, Medicare-certified facilities must issue the appropriate CMS appeal rights documentation and provide the applicable timeframe to the member as outlined under the manual section, **Providing notices of appeal rights and responding to appeals**.

Access to all Post-Acute Care Submission forms

Facilities can access all eviCore and Blue Cross submission forms and instructions on web-DENIS by clicking Blue Cross Provider Publications and Resources, Newsletters & Resources, then Medicare Advantage. The submission forms and instructions can also be found in the Pre-notification and Utilization Management section of our Medicare Plus Blue provider website at <http://www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/prior-notification-and-utilization-management.html>.

Transitional period for members changing coverage

SNF: When a member's coverage changes from Original Medicare or another Medicare Advantage plan to Medicare Plus Blue while admitted to a SNF, submit a request to Blue Cross within seven business days of the Medicare Plus Blue coverage effective date to preauthorize any continued stay. If you fail to meet the seven business day timeframe, we will evaluate the submission from the date of the request forward. You will be responsible for any non-covered days and you may not bill the member for the days not covered by the plan. If the member does not meet criteria, you must issue the member a Notice of Medicare Noncoverage (NOMNC) two days prior to the last covered day. <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>*

The NOMNC is not to be used when member services end based on the exhaustion of Medicare benefits, such as the 100-day SNF limit (for some benefit plans).

Facilities that fail to authorize all or part of a member's stay prior to discharge will be responsible for any days not previously authorized by the plan. You may not bill the member for days not covered by the plan. No authorization requests will be accepted once the member has been discharged from the facility. Please reference the **Provider dispute resolution** process section for your appeal rights.

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 Medicare Plus Blue PPO enrollees who are hospital inpatients following all CMS guidelines. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. For members with stays of greater than two days the follow-up copies of the Important Message from Medicare must also be delivered.

Members 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 in the specified format and within the timeframes specified by law.

The detailed explanation must be issued to the member 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 member files a timely review of the discharge (no later than midnight of the day of discharge) the enrollee is not financially responsible for inpatient services, other than applicable coinsurance and deductibles, furnished before noon of the day after the member receives notice of the QIO determination. Member 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 member 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 and home health agencies

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>*.

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 member 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 member for these services.

Home health agencies, comprehensive outpatient rehabilitation facilities, and skilled nursing facilities must provide both members 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 member 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>*.

Reimbursement

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

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 <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf>*
- Medicare Part B supplier number, national provider identifier and federal tax identification number
- The member's Medicare Plus Blue 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 Advantage PPO agreement. These include:

- Accepting the applicable Medicare Plus Blue 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 Plus Blue 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 claim submission, send claims to your local Blue plan.
- For paper claim submission, send claims to:
 Medicare Plus Blue
 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:
 Blue Cross Blue Shield of Michigan
 P.O. Box 491
 Milwaukee, WI 53201

 Fax for dental claims and payment issues: 1-262-834-3589.
- 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.

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 Medicare Plus Blue claim you have two options:

1. Call Provider Inquiry for this information at 1-866-309-1719 or write to the following address:
 Medicare Plus Blue Provider Inquiry Services
 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 Medicare Plus Blue PPO claim. For facility claims click on the *Medicare Plus Blue/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 Medicare Plus Blue PPO members to network providers whenever possible. Medicare Plus Blue PPO 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.

Provider dispute resolution process

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

Contracted providers with Blue Cross' Medicare Advantage PPO 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 Advantage PPO 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. We will review your appeal and respond to you in writing within 60 days.

Be sure to include the following information with your written request for a **first** level claim denial appeal:

- Provider or supplier contact information including name and address
- 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 claim determination
- Documentation and any correspondence that supports your position that the plan's original claim determination was incorrect (including any applicable medical notes (history, physical and operative notes, etc.) Medicare guidance, NCD or LCD when appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

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 Medicare Plus Blue PPO. 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.**

Be sure to include the following information with your written request for a **second** level claim denial appeal:

- Provider or supplier contact information including name and address
- 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 claim determination
- Copy of the first level appeal response letter
- Documentation and any correspondence that supports your position that the plan's **first level appeal review** claim determination was incorrect (including any applicable medical notes (history, physical and operative notes, etc.) Medicare guidance, NCD or LCD when appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

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 Advantage PPO 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.

Claims must be disputed within **120 days** from the date payment is initially received. Be sure to include the following information with your written request for a **first** level payment dispute:

- Provider or supplier contact information including name and address
- 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
- Documentation and any correspondence that supports your position that the plan's **original reimbursement** was incorrect (including interim rate letters when appropriate, pricer screen prints, etc.)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

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. We will inform you in writing if your payment dispute is denied.

To file a payment dispute with Medicare Plus Blue, submit your dispute in writing or by telephone as shown below:

Michigan providers	Write to: Medicare Plus Blue Provider Inquiry P.O. Box 33842 Detroit, MI 48232-5842	Or call: 1-866-309-1719
Non-Michigan providers	Your local Blue plan	

Dental Services		
	Write to: DentaQuest ATTN: BCBSM 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)

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. 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
P.O. Box 441160
Detroit, MI 48244-1160

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.** Be sure to include the following information with your written request for a **second** level claim denial appeal:

- Provider or supplier contact information including name and address
- 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 **first level reimbursement review** was incorrect (including interim rate letters when appropriate, pricer screen prints, etc.)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

For second level dental appeals, if you disagree with the decision made on your first appeal, you may request a managerial level review conference within 60 days of receiving the original decision. The address to request your managerial level review conference is:

Medicare Advantage Dental Provider Grievances & Appeals (second level)
600 E. Lafayette – Mail Code 517K
Detroit, MI 48226

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

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).

Medicare Plus Blue PPO providers must maintain timely and accurate medical, financial and administrative records related to services they render to Medicare Plus Blue PPO 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 Medicare Plus Blue PPO reviews of risk adjustment data;

4. Medicare Plus Blue PPO 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.

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 Medicare Plus Blue PPO members can be audited and/or reviewed during the term of the provider’s Medicare Advantage PPO 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 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. The presence of a prior authorization for a service or stay does not exempt the record or related claims from retrospective audits or documentation requirements (i.e., a valid inpatient order signed by a qualified provider prior to discharge of the patient as defined by CMS regulatory guidance). The lack of a valid inpatient order will result in a claim denial.

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

Additionally, prior authorization of services is not a guarantee that claims will be paid as billed. We may conduct audits on services to determine that care provided was delivered 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 Medicare Plus Blue PPO plans for providing coverage of Original Medicare fee-for-service benefits for each individual enrolled in a Medicare Plus Blue PPO 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.

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. 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.

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.

Other Medicare Plus Blue PPO requirements

Additional requirements pertaining to Medicare Plus Blue PPO 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 Advantage PPO 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 Advantage PPO 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 Medicare Advantage PPO member liability. Charges for non-covered services are not included. The hospital must provide a signed attestation that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The Blue Cross MA PPO 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.

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 - Applies to paper claims
Blanks	Exempt from POA reporting - 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 Medicare Plus Blue PPO coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay the provider on behalf of the Medicare Plus Blue PPO plan. The Medicare Plus Blue PPO 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 Plus Blue network. Network providers provide care to Medicare Plus Blue 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 Plus Blue 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 Advantage network, 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 Medicare Plus Blue 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 Medicare Plus Blue 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 Medicare Plus Blue PPO 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 Medicare Advantage PPO
 - No Medicare or Medicaid exclusion, sanction, or debarment
 - Not opting out of Medicare
- Agree to accept all Medicare Plus Blue PPO members unless practice is closed to all new patients (commercial or Medicare)

Participation agreements

The Medicare Advantage PPO 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 Advantage PPO Provider Agreement**
- Blue Cross Medicare Advantage PPO 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

A Medicare Advantage PPO 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 Medicare Plus Blue PPO members. The Medicare Advantage PPO 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 Medicare Plus Blue PPO coverage receive services from a select network of providers. Medicare Advantage PPO requirements apply only to providers in our Medicare Advantage PPO network.

Network sharing with other Blue plans' PPO programs

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

If you are a contracted Medicare Advantage PPO provider for Medicare Plus Blue PPO and you see Medicare Advantage PPO 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 Advantage PPO contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted Medicare Advantage PPO provider for Medicare Plus Blue and you provide services for any Blue Medicare Advantage PPO 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 Advantage PPO 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 Advantage PPO 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 Advantage PPO 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 Advantage PPO 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 PPO TRUST Network practitioners who are not board certified are excluded from this requirement as long as they have continued affiliation in the PPO TRUST 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 Advantage PPO network.
- **Blue Cross departicipation** — An applicant with a current or significant history of formal departicipation action by Blue Cross will not be accepted in the Medicare Advantage PPO 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 Advantage PPO 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 re-credentialing requirements every three years (includes facilities)
- Meet and maintain board certification requirements
- Abide by the Medicare Advantage PPO Network agreement, policies and procedures (includes facilities)
- Bill only for professional services personally provided by the Medicare Advantage PPO 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 Advantage PPO 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 Advantage PPO 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 Advantage PPO 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 Medicare Plus Blue PPO 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).

Medicare Plus Blue PPO 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*](https://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 Medicare Plus Blue PPO) 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 general 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) or 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.

Medicare Part D program

As part of an ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, CMS' program integrity contractor, the NBI MEDIC (Health Integrity, LLC), requests prescriber prescription verifications. The NBI MEDIC routinely mails prescriber prescription verification forms containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks the prescriber to check yes or no to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

A timely and complete response to prescription verification is important as it is likely to result in the elimination of an allegation of wrongdoing and/or prevent the payment of fraudulent prescriptions without need for further investigation.

Providers who are involved in the administration or delivery of the Medicare Part D prescription drug benefit are strongly encouraged to respond in a timely manner to prescription verifications when contacted by the NBI MEDIC.

Additionally, if you wish Part D to cover a prescription, not only must you have a valid NPI number, but you must also be either: (1) enrolled in Medicare or (2) validly opted-out of the program. Blue Cross Blue Shield of Michigan will reject an otherwise valid prescription, if it was written by a prescriber who is neither enrolled in Medicare nor validly opted-out of the program.

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 Medicare Plus Blue PPO, call Medicare Plus Blue Provider Inquiry at 1-866-309-1719 (8 a.m. to 4:30 p.m.) or write to:

Medicare Plus Blue
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