



Blue Cross Blue Shield of Michigan

Medicare Plus Blue PPOSM Manual

Revised April 1, 2012

For use by Michigan providers only.
Many of the provisions do not apply to
providers in other states.

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



Blue Cross Blue Shield of Michigan

Table of Contents

- Medicare Plus Blue PPO overview1**
- ID card1**
 - Overview 1
- Eligibility and coverage2**
 - Web-DENIS..... 2
 - CAREN..... 3
 - Verifying eligibility and coverage for out-of-area members 3
- Billing members3**
 - Collecting deductible and copayments at time of service..... 3
 - Balance billing is not allowed..... 3
 - Refund over-billed members 3
 - Coordination of benefits 3
 - Non-covered services 3
 - Referral for non-covered services..... 4
- DME/P&O, medical suppliers and pharmacists4**
 - DMEnson Benefit Management 4
 - DME benefits, billing and CMS jurisdiction list..... 4
- Lab services5**
- AIM Specialty Health6**
 - Radiology management program 6
 - AIM Specialty Health..... 6
 - Radiology preauthorization 6
- Benefits.....6**
- Hospice services7**
- Access to care7**
 - Compliance with access standards..... 8
- Advance directives.....8**
- Medical management, quality, cost and safety initiatives9**
 - Case and disease management 9
 - Quality improvement program..... 11
 - Healthcare Effectiveness Data and Information Set..... 11
 - CMS Quality Star Ratings program 13
 - BCBSM’s new Medicare Advantage tool Health e-BlueSM 13
 - How do providers sign-up? 13
 - Healthy Advantage Rewards 14
 - Cost and safety management 14

- Prior notification and utilization management.....14**
 - Prior notification 14
 - Utilization management 14
 - Prior authorization of prescription drugs 15
 - Prior authorization of behavioral health services 16
 - Precertification 16
- Clinical criteria for skilled nursing facility, long-term acute care hospitals, and inpatient rehabilitation admissions20**
- Providing members with notice of their appeals rights21**
- Getting an advance coverage determination.....21**
- Reimbursement.....22**
- Claim filing.....23**
- Provider dispute resolution process.....24**
 - Appeals of claim denials and/or medical necessity denials (not related to retrospective audits) 24
 - Payment level appeals (not related to claim denials or retrospective audits)..... 24
 - Appeal of retrospective audit findings..... 26
- Medical records27**
 - Medical record audits and reviews..... 29
- Other Medicare Plus Blue PPO requirements29**
 - Settlement 29
 - Serious adverse events and present on admission 30
 - Clinical research study..... 32
 - Swing beds 32
- Network participation.....32**
 - Overview 32
 - Qualifications and requirements 33
 - Participation agreements 34
- Network information and affiliation.....34**
 - Overview 34
 - Network sharing with other Blue plans’ PPO programs 34
 - Affiliation 34
- Disaffiliation.....36**
- Questions, additional information and contacts37**

Provider Manual Chapter for Medicare Plus Blue PPOSM

**NOTE: This manual is for use by Michigan providers only.
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**If you are an out-of-state provider, for more information, please visit:
bcbsm.com/pdf/ma/2011/Fact-Sheet-No-Ntwk-Sharing-MAPPO-2-18-11.pdf.**

Medicare Plus Blue PPOSM 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. BCBSM will offer Medicare Plus Blue PPO coverage to Medicare-eligible Michigan residents and Medicare-eligible members of BCBSM groups.

Medicare Plus Blue PPO 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 BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit.

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 PPO plan.

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 which will eventually enable us to provide easier access to eligibility and benefit information.

Providers must include the three-character alpha prefix found on the member's ID card when submitting paper and electronic claims. The alpha 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.

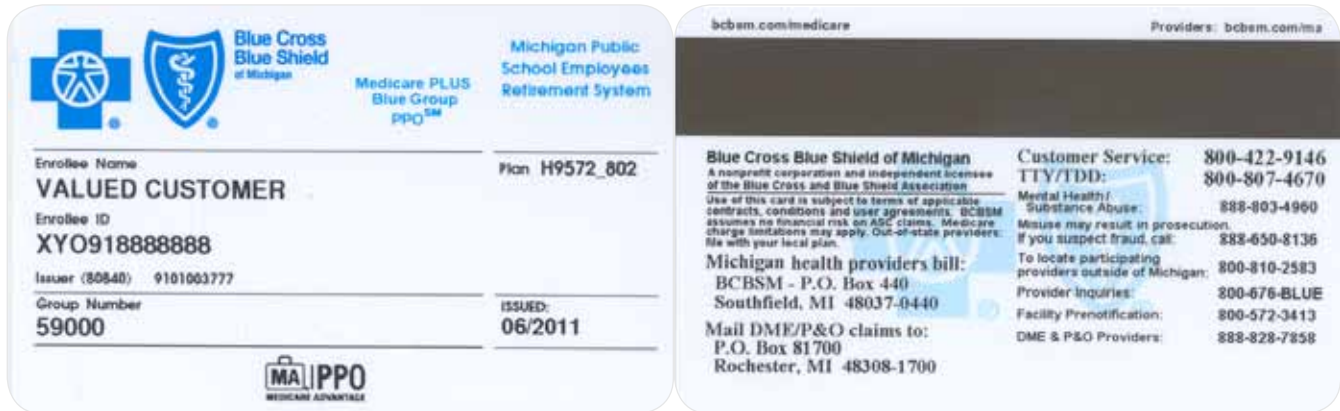
 Blue Cross Blue Shield of Michigan	Medicare PLUS Blue PPOSM	Members: bcbsm.com/medicare	Providers: bcbsm.com/ma
Enrollee Name <VALUED CUSTOMER>	Plan <H9572_001>	Blue Cross Blue Shield of Michigan A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association Use of this card is subject to terms of applicable contracts, conditions and user agreements. Medicare charge limitations may apply. Out-of-state providers: file with your local plan. Michigan health providers bill: BCBSM - P.O. Box 440 Southfield, MI 48037-0440 Mail DME/P&O claims to: P.O. Box 81700 Rochester, MI 48308-1700 Mail pharmacy claims to: P.O. Box 14712 Lexington, KY 40512	
Enrollee ID <XYO888888888>	RxBIN 610014 RxPCN MEDDPRIME RxGrp BCBSMAN		
Issuer (80840) 9101003777	Issued: <06/2011>		
Group Number 50802			
		Customer Service: 877-241-2583 TTY/TDD: 800-579-0235 Mental Health/ Substance Abuse 888-803-4960 Misuse may result in prosecution. If you suspect fraud, call: 888-650-8136 To locate participating providers outside of Michigan: 800-810-2583 Provider Inquiries: 800-676-BLUE Facility Prenotification: 800-572-3413 DME & P&O Providers: 888-828-7858 Providers: Rx Prior Authorizations/ Rx benefits and eligibility: 800-437-3803 Pharmacists/Rx Claims: 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 BCBSM 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 (BCBSM 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 "XYO" alpha prefix, they have Catalyst Rx 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 BCBSM's 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.

CAREN

If you don't have computer access, you can call CAREN to verify your patient's cost-sharing requirements. CAREN tells you the:

- Total amount of the deductible
- 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

Call CAREN and follow the prompts for your specialty, or stay on the line to connect with a customer service representative during business hours. You may access CAREN by calling 1-800-344-8525.

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 alpha 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.

Refund over-billed members

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

Coordination of benefits

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

Non-covered services – Provider Responsibility

Sometimes you and your patient may decide that a service or treatment is the best course of care, even though it isn't covered by Medicare Plus Blue PPO.

If you believe that a service won't be covered, you must tell the member before the service is performed. If the member acknowledges that it won't be covered by Medicare Plus Blue and agrees that he or she will be solely responsible for paying you, you may perform and bill the member for the non-covered service.

This decision is between you and your patient, and the process is called advanced beneficiary notification or notification of non-coverage (for skilled nursing, home health care, or comprehensive outpatient rehabilitation facility services). The intent of advance notification is to provide the patient with sufficient information for them to make an informed decision about whether or not to obtain the item/service for which they may have to pay out-of-pocket.

You are required to give the notification and obtain acknowledgement from the patient or their authorized representative in writing and maintain that documentation in your medical records. Although CMS does not require documentation on the standard ABN form for Medicare Advantage plans, BCBSM requires you to obtain a written acknowledgement notifying the member that you do not expect the plan to pay for the services, and indicating the member agrees to be responsible for payment of the non-covered items and/or services.

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If a written acknowledgement does not exist, you will be required to hold the member harmless for the charges. BCBSM will take appropriate action if you fail to obtain these written notifications or hold the member harmless.

Referral for Non-covered Services – Provider Responsibility

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

If you believe that a service won't be covered and the provider supplying the service is not contracted with Medicare Plus Blue PPO, you must tell the member before you refer them for the service. If the member acknowledges that the item and / or service won't be covered by Medicare Plus Blue, understands that you referring them to a non-contracted provider and agrees that he or she will be solely responsible for paying for the service, you may refer the member to the non-contracted provider for the non-covered service.

This decision is between you and your patient, and the process is called advanced beneficiary notification or notification of non-coverage (for skilled nursing, home health care, or comprehensive outpatient rehabilitation facility services). The intent of advance notification is to provide the patient with sufficient information for them to make an informed decision about whether or not to obtain the item / service for which they may have to pay out of pocket.

You are required to give the notification and obtain acknowledgement from the patient or their authorized representative in writing and maintain that documentation in your medical records. Although CMS does not require documentation on the standard ABN form for Medicare Advantage plans, BCBSM requires you to obtain a written acknowledgement notifying the member that you do not expect the plan to pay for the services, that the services will be provided by a non-contracted provider and indicating the member agrees to be responsible for payment of the non-covered items and/or services.

BCBSM will take appropriate action if you fail to obtain these written notifications.

DME/P&O, medical suppliers and pharmacists

DMEnson Benefit Management

DMEnson Benefit Management processes claims for durable medical equipment, prosthetic and orthotic devices, medical supplies and Part B drugs subject to the DME regional carrier jurisdiction list for all Medicare Plus Blue PPO services. DMEnson Benefit Management reimburses providers based on the DMEnson fee schedule. If a service does not have a network fee available, Medicare's allowed-amount will be used. Out-of-network claims for Medicare Plus Blue PPO members will be reimbursed using the CMS fee schedule with a higher level of cost sharing applied.

The local Blue plan processes all DME and P&O claims with local carrier jurisdiction. Reimbursement for services with local carrier jurisdiction is consistent with Original Medicare rates.

DME benefits, billing and CMS jurisdiction list

All Medicare Plus Blue plans include DME/P&O, medical supplies and Part B drugs that are covered under Original Medicare. All providers should follow the CMS jurisdiction list to determine where to send claims for services provided to BCBSM Medicare Plus Blue PPO members. The CMS jurisdiction list can be referenced at cms.gov/transmittals/downloads/R2132CP.pdf*

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Lab services

Medicare Advantage PPO Lab Network — We've established a Medicare Advantage PPO 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.

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

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 BCBSM. Claims submitted directly to BCBSM 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 BCBSM's [Medicare Advantage PPO physician office lab list](#). The procedures on this list are those that BCBSM 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
- Are 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.

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AIM Specialty Health

Radiology management program

The Medicare Advantage PPO radiology management program is a provider utilization management program for outpatient high-tech diagnostic radiology services.

Specialty Health

AIM Specialty Health administers the preauthorization requirements of the Medicare Advantage PPO Radiology Management Program for BCBSM. BCBSM is responsible for the administrative oversight and contract administration. Providers can contact AIM Specialty Health to request preauthorization by calling 1-800-728-8008 or via the internet at www.aimspecialtyhealth.com.*

Please note: This program applies only to BCBSM Medicare Advantage PPO members receiving services from contracted providers. Members enrolled with other Blues MA plans, non-contracted providers, emergency room, urgent care, observation room, inpatient services and secondary coordination of benefits are not included in this program.

The Medicare Advantage PPO radiology management program includes preauthorization of non-emergency or non-urgently needed outpatient CT scans, MRIs, MRAs, nuclear cardiology procedures and PET scans.

Radiology preauthorization

All contracted Medicare Advantage PPO physicians are required to contact AIM Specialty Health before ordering select high technology, select diagnostic imaging studies to be performed in office, outpatient hospital or freestanding centers for a BCBSM Medicare Advantage PPO member. (Preauthorization is not required in the hospital inpatient or emergency room or urgent care setting.) The RMP helps to 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 as needed.

The ordering physician should obtain preauthorization because he or she is more familiar with the member's clinical condition and indications for special imaging. However, the rendering physician should verify that the preauthorization has been obtained. Prior to any high-technology radiological exam or service being rendered, an approved preauthorization must be obtained in order 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 level one and level two appeal rights.

Outpatient high-technology radiological procedures requiring preauthorization can be accessed on our [Medicare Advantage PPO website](#).

Benefits

For basic Medicare benefits, refer to the [CMS website](#).*

Structurally, Medicare Plus Blue PPO members will have member cost sharing for non-urgent or emergency services received out of network and a separate out-of-pocket maximum for out-of-network services. Summaries of benefits for Medicare Plus Blue PPO members can be viewed at bcbsm.com/provider/ma/2012/ppo/benefit-summaries.shtml.

All three individual Medicare Plus Blue PPO plan options offer coverage for vision, hearing, and preventive dental.

Our individual Medicare Plus Blue PPO plans will offer vision coverage administered by Vision Service Plan®. 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 vsp.com*.

Individual Medicare Plus Blue PPO members 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 BCBSM's Medicare Advantage PPO network. If you have questions about the Medicare Plus Blue PPO hearing benefit, please call our Provider Inquiry department at 1-800-309-1719.

Furthermore, our individual Medicare Plus Blue PPO plan options offer coverage with no cost sharing for preventive dental services obtained in-network. Depending on the plan option, members may have in-network cost-sharing for Medicare-covered dental benefits. Members will have significant cost sharing for obtaining preventive and comprehensive dental services out-of-network.

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Additionally, all our individual Medicare Plus Blue PPO plans 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 silversneakers.com*.

Note: Group coverage may not include the vision, hearing, preventive dental and fitness benefits described above.

Primary care physicians

BCBSM Medicare Advantage PPO recognizes the following practitioner specialties as personal or primary care physicians:

- Family practice
- Geriatricians
- General practice
- Obstetrics and gynecology
- Internal medicine
- Pediatrics

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. Some exceptions apply.

- If the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.
- If 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.

Access to care

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.

Accessibility of services is measured by the timeliness of appointments and in-office waiting times for routine, urgent and emergency care. Each practitioner must, at a minimum, meet the following standards of access and availability for all Medicare Plus Blue PPO members.

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

- Preventive care appointment (routine primary and specialty care) — service is provided within 30 calendar days.
- Routine care appointment (non-urgent, symptomatic) — service is provided within four calendar days.
- Urgent medical care appointment (acute, symptomatic) — service is provided within two calendar days.
- Emergency medical care appointment— immediate treatment is provided.
- Average waiting time in the office is equal to or less than 30 minutes.

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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 after-hours standards, the non-compliant practitioner must submit a corrective action plan within 14 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 BCBSM Medicare Advantage Quality Improvement Department.
A reply to the second letter is not received within 14 days	A third letter, signed by Blue Care Network's clinical quality medical director or the regional medical director, will be sent to inform the practitioner that termination will occur within 60 days.

Medicare Plus Blue PPO allows all members direct access to primary care and specialty practitioners for in-network routine, preventive and specialty services. Medicare Plus Blue PPO members can choose to receive care from out-of-network providers as long as the provider participates with Medicare. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, members may have significantly higher cost sharing when obtaining services from an out-of-network provider.

BCBSM 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.

BCBSM 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 ESRD, 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 Blue Shield of Michigan 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, quality, cost and safety initiatives

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 chronic condition disease management, complex chronic condition management, case management or oncology management. BCBSM may contact you, as the primary provider, to inform and coordinate care for these members if warranted.

- **Care Transition to Home**

The Care Transition to Home Program is designed to ensure members a safe transition home from the hospital, and to avoid readmissions within 30 days of discharge from the hospital. The program seeks to identify and assist members who are being discharged from an acute hospital setting with services such as:

- 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 BCBSM health management programs

The team uses predictive modeling to identify members at highest risk for emergency room visits and hospital readmissions for intense intervention or post acute care. 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 a smooth transition to home as well as information on self-management.

- **Case management**

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

- **Oncology case management**

The Oncology Case Management Program, delivered by KePro[®] supports members who have been diagnosed with a cancer-related condition. This program has been tailored to target and support the needs of members with cancer, to ensure quality of care, symptom and pain management, access to care and treatment options, advanced illness counseling and education and care coordination with the member's providers. Nurse case managers may contact providers directly to coordinate care and services.

- **Complex chronic condition management**

The Complex Chronic Condition Management Program is a hybrid case management and disease management program customized to support members with multiple chronic conditions or complex care needs for members with coronary artery disease, chronic obstructive pulmonary disease, diabetes and heart failure. In addition to delivering a telephonic chronic condition management intervention, members may receive additional support with care coordination and psychosocial issues. Nurse case managers may contact providers directly to coordinate care and services.

- **Chronic condition management**

The Chronic Condition Management Program is a comprehensive program designed to aid members in managing their chronic condition. The program focuses on these conditions: coronary artery disease, chronic obstructive pulmonary disease, diabetes, and heart failure. Members in the program receive education about their health status, personalized information regarding their treatment options, self-management materials and monitoring, maintenance and management of their condition.

When a member is engaged in the program, delivered by Alere®, 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 as the physician will receive alerts regarding their members' health which may include biometric data for members who may have a remote monitoring device. Outreach services may occur by phone, through an in-home biometric device, and the Internet. The chronic condition management team will provide health coaching, symptom management, proactively identify and close care gaps, and assist members with becoming self-sufficient at managing their condition. High risk members may also receive remote monitoring as part of their intervention which incorporates daily monitoring of symptoms or biometric data, timely identification of clinical changes, and teachable moments between nurses and members.

- **Behavioral health case management**

Blue Cross Blue Shield of Michigan has partnered with Blue Care Network to provide 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.

- **Quit the Nic**

Quit the Nic is a telephone-based tobacco cessation program designed to support members in their efforts to stop smoking. Members have access to counseling by registered nurses. 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 visit the *Health Assessment & Wellness* screen at bcbsm.com. Members are encouraged to access this site and complete the confidential Health Assessment within 90 days of initial enrollment with Medicare Plus Blue. Information obtained is used to support continuity of care through care management program identification and BCBSM 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 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. Quality improvement activities include:

- Appointments, and after hours access monitoring
- Investigating quality of care complaints
- Member and provider satisfaction
- Chronic care management
- Utilization management
- Improving health outcomes
- Medical record review standards
- Quality improvement projects
- Perform, analyze, and report Healthcare Effectiveness Data and Information Set (HEDIS)
- Administration of the Consumer Assessment of Healthcare Provider and Systems (CAHPS) Survey and Health Outcome Survey (HOS)
- Annually evaluating the quality improvement program
- Ensuring compliance with all regulatory standards

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 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:

- Adult access to preventive/ambulatory health services
- Adult body mass index assessment
- Ambulatory care (outpatient visits and emergency department visits)
- Alcohol and other drug dependence treatment – initiation and engagement
- Antibiotic utilization
- Antidepressant medication management
 - Effective acute phase treatment
 - Effective continuation phase treatment
- Annual monitoring for patients on persistent medications
- Breast cancer screening (women 40-69 years of age)
- Board certification
- Cholesterol management for patients with cardiovascular conditions
 - LDL-C screening after an acute cardiovascular condition
 - LDL-C controlled (<100 mg/dl)
- Colorectal cancer screening (members 50-75 years of age)
- Comprehensive diabetes care
 - Blood pressure control <140/90
 - Blood pressure control <140/80
 - Dilated retinal eye examination
 - HbA1c testing, poor and good control
 - LDL-C screening and lipid control
 - Medical attention for nephropathy

- Controlling high blood pressure
 - Confirmed diagnosis of hypertension
 - Adequate control of hypertension (<140/90)
- Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis
- Fall risk management
- Flu shots for adults
- Follow-up after hospitalization for mental illness (within seven and 30 days)
- Frequency of selected procedures
- Glaucoma screening in older adults (members age 65 and older)
- Identification of alcohol and other drug services
- Inpatient utilization – general hospital/acute care
- Management of urinary incontinence in older adults
- Mental health utilization
- Osteoporosis testing in older women
- Osteoporosis management in women who had a fracture (women age 67 and older)
- Persistence of beta-blocker treatment after a heart attack
- Pharmacotherapy management of COPD exacerbation
- Physical activity in older adults
- Plan all-cause re-admissions
- Pneumonia vaccination status for older adults
- Potentially harmful drug-disease interactions in the elderly
- Tobacco cessation – medical assistance
- Use of high-risk medications in the elderly
- Use of spirometry testing in the assessment and diagnosis of COPD

CMS Quality Star Ratings program

★★★★☆ Medicare Plus Blue PPOSM received 3.5 stars for 2012

The Centers for Medicare & Medicaid Services evaluates health insurance plans and issues star ratings each year; these ratings may change from year to year. The star rating system 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 BCBSM offers. CMS compiles its overall score for quality of services based on measures such as:

- How BCBSM helps members stay healthy through preventive screenings, test and vaccines and how often our members receive preventive services to help them stay healthy.
- How BCBSM helps members manage chronic conditions
- Scores of member satisfaction with BCBSM
- How often members filed a complaint against BCBSM
- How well BCBSM handles calls from members

In addition, because BCBSM offers prescription drug coverage, CMS also evaluates BCBSM's plan 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

CMS uses information from many different sources to compile its overall star rating for BCBSM. Some of these sources include member surveys administered by Medicare-approved vendors, information from doctors, information BCBSM reports to CMS and results from Medicare's regular monitoring activities.

BCBSM works with providers and members to make sure members received appropriate and timely care, that chronic conditions are well managed, that members are pleased with the level of service from their health plan and care providers and that health plans follow CMS operational and marketing requirements. BCBSM uses mailings and personal and automated phone calls to remind members about needed care and to help maintain optimal health.

Additionally, BCBSM partners with our Medicare Advantage PPO providers by identifying which of their Blues Medicare Advantage patients need what medical services so that they can contact those patients and schedule those services. The 2012 availability of BCBSM's new Medicare Advantage tool, Health e-BlueSM, will help 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 they need on how many and which patients haven't had certain needed services (such as mammograms) and enable them to take action toward providing those services.

BCBSM's new Medicare Advantage tool, Healthy e-BlueSM

Beginning in spring 2012, some BCBSM providers will have phased access to BCBSM Medicare Advantage PPO patient data by using the new Health e-Blue web tool. Health e-Blue is a clinical support tool that helps track members' health. The tool will begin to offer Medicare Advantage PPO providers consistent and timely data for BCBSM's Medicare Plus Blue PPO members like health registry, utilization and pharmacy information.

BCBSM routinely requests certain data from its providers. Historically, providers completed various paper forms and returned them to BCBSM. However, with Health e-Blue, providers will have the added convenience of entering patient services, lab results and vaccine information online as well as diagnosis codes for Medicare Advantage patients.

Only the following provider specialties can register for BCBSM's Medicare Advantage Health e-Blue tool:

- Adult medicine
- Family medicine
- Family practice
- General practice
- Geriatric medicine
- Health clinic practice
- Internal medicine
- Nurse practitioner
- Obstetrics and gynecology
- Osteopathy
- Physician assistant

Registration for BCBSM's Medicare Advantage Health e-Blue is limited to provider specialties to which members are attributed. Once registered, providers can access information about members who are attributed to them. Attribution is a process in which a BCBSM member is assigned to only one physician based on the members' medical claims activity reflecting a primary relationship.

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's website at http://www.bcbsm.com/provider/provider_secured_services/index.shtml 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 BCBSM's Health e-Blue tool.

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.

Healthy Advantage Rewards

In January 2012, BCBSM reached out to its Medicare Plus Blue PPO individual and group members (Prescription BlueSM only members are not eligible) to encourage long-term health through the Healthy Advantage Rewards program. This program also recognizes physicians and physician groups for their efforts in helping BCBSM achieve its goals in improving member health and our HEDIS[®] scores. BCBSM will continue to encourage its Medicare Plus Blue PPO members to make an appointment with their primary care physician to obtain a health assessment.

The Healthy Advantage Rewards program rewards members for taking proactive steps to stay healthy. These initiatives include:

- **Physician assessment***
- **Cholesterol screening**
- **Glaucoma screening**
- **Mammogram**
- **Flu vaccine**
- **Pneumococcal vaccine**
- **Smoking cessation**

* Blue Cross Blue Shield of Michigan will reimburse the physician \$40 for completing and returning this assessment. Physicians can choose to either return the paper form by mail or complete the form electronically through BCBSM's new Medicare Advantage tool, Health e-BlueSM, beginning spring 2012.

Cost and safety management

We work together with our network providers to ensure that:

- Patients receive quality services
- Benefits are administered appropriately and efficiently
- Services are billed and paid correctly
- Utilization is appropriately managed

Overview

BCBSM has developed the following processes and guidelines for providers to proactively communicate and obtain authorization or certification for anticipated services or admissions. The information below outlines the program guidelines for acute hospital admissions, as well as specialty services such as high-tech radiology, and admissions to skilled nursing, long-term acute care, and inpatient rehabilitation facilities.

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

In addition to providing a means of determining whether the patient's symptoms meet criteria for the level of care you've planned, the prior notification, authorization, and certification requirements provide BCBSM with the information needed to identify members for post-acute hospitalization support, and the pre-approval process helps identify cases that may benefit from the assistance of one of our care management programs.

Prior notification and utilization management

Prior notification

For acute care admissions to hospitals, providers are required to use web-DENIS to notify BCBSM of the admission. While pre-approval of hospital admissions is not required, it is highly recommended that hospitals utilize InterQual[®] criteria to assess the medical necessity of the admission. InterQual criteria should be applied prior to executing the prenotification process, but it will not be reviewed to accept or modify the admission.

Utilization management

Prior authorization enables contracted physicians and other professional and facility providers to request our review of a medical procedure or treatment before it is performed.

Preauthorization of services is based on the information you provide at the time of your request. An approval is not a guarantee of payment. Your claim must still meet our eligibility, billing, benefit and medical guidelines to be paid.

Note: If the service is not a benefit under your patient's BCBSM contract, or if it is not medically necessary, there is no reason to request prior authorization; the service will not be covered. Additionally, prior authorization is not given for non-participating physicians and facilities at this time. Patients must be made aware of the possibility of increased cost sharing they may incur when receiving non-network services.

Preauthorization may be mandatory for any of a number of reasons, such as:

- The contract benefit under which the proposed service falls requires preauthorization (such as high-tech radiology or mental health).
- The BCBSM program under which the proposed service falls requires preauthorization.
- The employer group that offers coverage to your patient requires preauthorization.

Preauthorization must be requested before the service is performed with the exception of emergency and urgent care settings.

How we notify you of the results: Our medical staff will review all preauthorization requests and respond to you verbally and/or by mail. If your request is approved, we'll give you a preauthorization number, which you'll later need when completing a claim form to bill for the service. For more information, see *Claim filing*. If your request is denied, we'll explain why. You may appeal our decision; see *Provider dispute resolution process*.

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.

Prior authorization of prescription drugs

To help ensure our members receive high-quality, cost-effective pharmaceutical care, BCBSM requires prior authorization 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 BCBSM/BCN's 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 bcbsm.com/provider/pharmacy_services/medicare_plus_blue_formulary.shtml to find out if a medication is covered by our plan and what drugs require prior authorization or step therapy.

To request prior authorization

You can call, fax or mail prior authorization 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 prior authorization or an exception request, the provider should contact the BCBSM 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 – C303
P.O. Box 807
Southfield, MI 48037

Responses to requests for prior authorizations or exceptions are made within 72 hours. 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: Prior authorization 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.

Prior authorization of behavioral health services

As of Oct. 1, 2011, all mental health and substance abuse inpatient, partial hospital, and intensive outpatient treatment admissions or extensions require prior authorization and concurrent review.

Acute care hospitals and behavioral health facilities that need to arrange for an inpatient admission, partial hospital admission, intensive outpatient admission or concurrent review for psychiatric or chemical dependency treatment must obtain prior authorization by calling MA PPO Behavioral Health Services at 1-888-803-4960 or by faxing 1-866-315-0442.

Medicare Advantage PPO 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 prior authorization for these services will receive denials for all claims that do not have an associated authorization, and will incur complete financial responsibility for all services rendered without prior authorization.

Blue Cross Blue Shield of Michigan has partnered with Blue Care Network to administer its Behavioral Health Services program for our Medicare Advantage members. BCN has developed criteria which will be used to make utilization management decisions. National experts, clinical advisory committees and providers have contributed to the development of these criteria. BCN reviews, assesses and revises its clinical criteria at least annually. Scientific resources for the internal criteria include:

- Diagnostic and Statistical Manual IV.
- Peer-reviewed scientific literature.
- Available nationally-recognized clinical guidelines.

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.

Precertification

Precertification is a review of a patient's current clinical condition and proposed treatment plan. We use precertification to determine, in advance, whether the patient meets nationally recognized clinical screening criteria for SNF, LTAC, and IP rehab admission and the level of care planned.

All Michigan contracted Medicare Advantage PPO providers are required to submit a prior certification request to the BCBSM Precertification Services department 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. Medical criteria will be utilized to assess the patient's severity of illness, the intensity of service, and discharge readiness.

The precertification process works best when hospitals and physicians have a standard procedure for communicating with each other to ensure that precertification information is sent timely. Please be aware that if you fail to submit your prior certification request, submit an untimely 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.

The precertification program is designed for the purpose of obtaining certification **prior** to admission. Please refer to the list below to ensure that you submit a timely prior certification request and execute compliant discharge procedures:

- **Standard business day admissions** — The facility must submit a request via fax or email on or before the date of admission in order to obtain certification.
- **After-hours, weekend or holiday admissions** — The facility must submit a request via fax or email on the first business day following the after-hours, weekend, or holiday admission in order to obtain certification.
- **Late precertification requests** — The Medicare Plus Blue precertification program does not allow late certifications. If the member has been admitted and you submit a request via fax or email after the admission date as outlined above, then BCBSM will evaluate from the date of the request forward. You will be responsible for the days outside of the approved length of stay and you may not bill the member for the days not covered by the plan. Please reference the *Provider dispute resolution process* section for your applicable appeal rights.

Recertification

- **Standard recertification requests** — You must submit a request via fax or email the BCBSM Precertification Services department no later than two days prior to the last covered day approved by the plan in order to request recertification of any continued stay. If the request is denied, Medicare-certified facilities must issue the appropriate CMS documentation and allot the applicable timeframe as outlined under the manual section, *Providing members with notice of their appeal rights*.
- **Late recertification requests** — Facilities that need additional days but submit a request via fax or email after the last covered day approved by the plan will have their request evaluated from the date of request forward. Please reference the *Provider dispute resolution process* section for your applicable appeal rights. If the request is denied, then the facility must issue the appropriate CMS documentation and allot the applicable discharge timeframe, as outlined under the manual section, *Providing members with notice of their appeal rights*. Facilities who fail to submit a request via fax or email no later than two days prior to the last covered day approved by the plan risk having to cover the days that will need to be allocated to support appropriate discharge planning.

Retroactive precertification and recertification requests

- The Medicare Plus Blue precertification program does not allow retroactive precertification or recertification. Facilities that fail to certify all or part of a member's stay prior to discharge will be responsible for any days not previously certified and approved by the plan. You may not bill the member for days not covered by the plan. No certification requests will be accepted once the member has been discharged from the facility. Please reference the *Provider dispute resolution process* section for your applicable appeal rights.

Submitting a request

As of July 14, 2011 Blue Cross Blue Shield of Michigan's Precertification Services department accepts requests for Medicare Advantage precertification or recertification only by fax or email. All skilled nursing, long-term acute care and inpatient rehabilitation facility requests for admission and recertification for Medicare Plus Blue PPO and Medicare Plus Group PPO members must now be submitted via fax or email.

Facilities are required to complete the appropriate facility request form (either the Skilled Nursing Facility and Acute Rehabilitation Facility Assessment Form or the Long-Term Acute Care Facility Form) and submit the request via fax to 1-866-464-8223. Facilities can also email their requests to MedicarePlusBlueFacilityFax@bcbsm.com.

Our Precertification Services department will process cases upon receipt of submission within the same business day. **Note:** Requests received after 4 p.m. on a business day will be processed the next business day. Any requests received over a weekend or holiday will be processed on the next business day. Cases pended to the medical consultant will be processed within two business days.

If we receive incomplete documentation, we will call and send a face sheet to the facility indicating the missing documentation. The request will not be processed until receipt of complete documentation.

Upon receipt of completed documentation, our Precertification Services staff will review the clinical documentation provided and apply InterQual criteria to determine the appropriateness of the admission. If we approve the admission (precertification or recertification), BCBSM will call the facility and fax a face sheet listing the authorization number, approved length of stay and last covered day (as applicable). If the request requires additional review by a medical consultant, we will notify the facility of the status via telephone and fax.

Our medical consultant reviews each request against Medicare guidelines.

If the request is...	BCBSM will...
Approved	Telephone the facility and fax a face sheet indicating the authorization number, approved length of stay and last covered day (as applicable).
Denied	Notify the facility via telephone and fax a face sheet indicating the appropriate next steps.

Facilities can access submission forms and instructions on web-DENIS by clicking *BCBSM Provider Publications and Resources*, then *Newsletters & Resources*. Additionally, the submission forms and instructions can be found on the *Prior notification and utilization management* of our MA provider website, bcbsm.com/provider/ma/2012/ppo/prior-notification-utilization-management.shtml.

Before you submit a request

For precertification to be approved, the proposed service must be a benefit under the member's active contract. The precertification or recertification request should be facilitated by a knowledgeable clinician who is familiar with the member's condition. Please ensure that all applicable fields contain comprehensive information as requested on the assessment form.

Note: Incomplete submissions will not be processed and returned for completion.

Category	Necessary information
Member	<ul style="list-style-type: none"> • Subscriber's first and last names as shown on the BCBSM ID card • Contract or ID number: usually a three-letter alpha prefix and nine digits • Subscriber's street address, city, state and ZIP code • Patient's name as shown on the contract • Patient's age • Patient's sex • Date of admission or first visit for this condition (day, month, year) • Primary diagnosis: reason for treatment. Use ICD-9-CM diagnosis code • The number of days remaining on the patient's contract
Facility SNF, IP rehab and LTAC services (as applicable)	<ul style="list-style-type: none"> • Facility name and telephone number • Facility NPI and five-digit facility code • Admitting physician's name, phone number and PIN (inpatient rehab and LTAC only)

Category	Necessary information
Clinical and treatment plans	<ul style="list-style-type: none"> • Patient’s current clinical and functional status • Patient’s diagnosis, reason for hospital admission, complications, surgical procedures and date of medical history • Duration, frequency, intensity of symptoms <p>Pre-certification should be facilitated by a knowledgeable clinician who is familiar with the member’s condition. The following information may be required to complete a certification request, but is not intended to be an all-inclusive summary.</p> <p>Therapy Admissions</p> <ul style="list-style-type: none"> • Assessments must be current (within 24-48 hours; within 24 hours for orthopedic patients) <p>Physical Therapy</p> <ul style="list-style-type: none"> • Previous level of function • Height and weight • Weight bearing status • Bed mobility • Transfers • Ambulation • Range of motion for orthopedic • Stairs • Wheelchair propulsion • Balance • Muscle strength • Endurance • Long-term goals <p>Occupational Therapy</p> <ul style="list-style-type: none"> • Feeding • Grooming • Bathing (upper/lower) • Dressing (upper/lower) • Toileting (hygiene/transfers) • Long-term goals <p>Speech Therapy</p> <ul style="list-style-type: none"> • Date of assessment • Orientation (Rancho level if applicable) • Swallow deficits, dysphagia evaluation, modified barium swallow • Cognitive deficits • Speech deficits • Ability to follow commands <p>Nursing</p> <ul style="list-style-type: none"> • Any nursing issues impacting the patient’s ability to participate in therapy (such as IVs, wounds [provide measurement and treatments], tube feedings, respiratory, etc). • Primary care giver support/status • Style of home with how many steps to enter home/ramp • Estimated length of stay • Changes/updates to discharge plan (needed for recertification) <p>Medical Admissions</p> <p>Medical/Nursing</p> <ul style="list-style-type: none"> • IVs and IV medications, including start and stop dates • Tube feedings • Wounds — description, measurements, treatments • Respiratory — oxygen therapy, suctioning, tracheotomy, vent <p>Mandatory discharge planning upon admission</p> <ul style="list-style-type: none"> • Primary care giver support/status • Style of home with how many steps to enter home/ramp • Estimated length of stay • Changes/updates to discharge plan (needed for recertification)

Requests and inquires can be emailed to MedicarePlusBlueFacilityFax@bcbsm.com or faxed to 1-866-464-8223. In situations other than medical emergencies, precertification should be requested before the SNF, LTAC, or IP rehab admission is executed.

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 PPO while admitted to a SNF, you will need to submit a request to BCBSM to precertify any continued stay within seven business days of the Medicare Plus Blue coverage effective date. If you fail to meet the seven business day timeframe, then BCBSM will evaluate the submission from the date of the request forward. You will be responsible for any non-approved 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 **Notice of Medicare Noncoverage (NOMNC)** two days prior to the last covered day if the member had a previous approved length of stay under their PPO coverage during this episode of care. If the member's entire length of stay in this episode of care was non-approved, facilities should issue the **Notice of Denial of Medicare Coverage (NDMC)**.

For LTACs and IRs: When a member's coverage changes from Original Medicare or another Medicare Advantage plan to Medicare Plus Blue PPO while admitted to a LTAC or IR, then Original Medicare or the prior Medicare Advantage plan will be responsible for the entire inpatient admission. For discharge planning, you must issue the appropriate inpatient discharge documentation outlined by CMS two days prior to the last covered day.

Members will receive precertification approval letters. Providers and members will also receive written notification of precertification denials with all applicable appeal rights. For additional information on the Precertification program, refer to "Medicare Advantage precertification program frequently asked questions", available by logging into web-DENIS, clicking *BCBSM Provider Publications and Resources* and then *Newsletters & Resources*.

Clinical criteria for skilled nursing facility, long-term acute care hospitals, and inpatient rehabilitation admissions

BCBSM has instituted a precertification program to:

- Review admissions, monitor continued stays and for discharge screening
- Determine the appropriateness of the setting

We utilize InterQual criteria to complete first level skilled nursing, inpatient rehabilitation, and long term acute care precertification and recertification requests. Medicare appropriate chapter guidance are applied to all certification requests that do not meet criteria at first level and require a second level review by a medical consultant.

Acute inpatient hospitalization facilities use the criteria for first-level review. Your non-physician utilization management staff should use the criteria to ensure that the level of care is appropriate based on the clinical findings for the patient. BCBSM uses the InterQual criteria along with the Medicare appropriate chapter guidance to support precertification and recertification decisions.

Criteria sets: We've contracted with McKesson Corporation to provide you with the following current InterQual Level of Care criteria sets:

- InterQual's current acute care criteria for adults and children (called *InterQual Level of Care Criteria – Acute Care Adult & Pediatric*) relate to acute-care hospitalization. This book can be utilized as a guide for determining whether the member meets inpatient admission or observation criteria.
- InterQual's Acute Care book also includes a list of surgical procedures for which an inpatient setting is appropriate.
- InterQual's current rehabilitation criteria for adults and children relate to inpatient rehabilitative services. Precertification is required for every rehabilitation admission. When you submit a request, our nurses review the admission to determine whether it meets InterQual criteria. If the nurse's determination is inconclusive, the request will be pended to a physician for closer review against Medicare appropriate chapter guidance.
- InterQual's current skilled nursing facility criteria for adults relate to skilled nursing services. Precertification and recertification are required for every skilled nursing admission. When you submit a request, our nurses review admissions to determine whether they meet InterQual criteria. If the nurse's determination is inclusive, the request will be pended to a physician for closer review against Medicare appropriate chapter guidance.

- InterQual’s current Long Term Acute Care criteria for adults relates to LTAC services. Precertification and recertification are required for every long-term acute care facility admission. When you submit a request, our nurses review admissions to determine whether they meet InterQual criteria. If the nurse’s determination is inconclusive, the request will be pended to a physician for closer review against Medicare appropriate chapter guidelines.
- InterQual’s current home care criteria for adults and children relate to home health services. Although we require that home health care agencies apply InterQual criteria for admissions and patient management, we do not require precertification and recertification for home care services.

In addition to the level-of-care criteria, McKesson provides you with current InterQual Procedures Criteria. InterQual’s current procedures criteria are available in your hospital; you’re welcome to review them. Although we don’t use these criteria for precertification at this time, we may use them as screening criteria during audits. You may also access the CMS website at www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx for a current listing of Medicare-approved inpatient procedures.*

Providing members with notice of their appeals rights

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp*.

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, including the time frames for delivery. For copies of the notice and the notice instructions, go to: www.cms.gov/BNI/Downloads/NOMNCForm.zip*.

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

Home health agencies, comprehensive outpatient rehabilitation facilities and skilled nursing facilities can obtain the Detailed Explanation of Non-Coverage at cms.hhs.gov/MMCAG/Downloads/DENCIInstructions.pdf*.

Hospitals can obtain the Detailed Notice of Discharge at www.cms.gov/BNI/Downloads/Detailed_Notice_English_and_Spanish.zip*.

Failure to provide the requested forms violates the terms and conditions of your contract. Please reference your contract under the section titled *Member Notice of Termination of Certain Covered Services*.

Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Medicare Plus Blue. To obtain an advance coverage determination, call us at 1-866-309-1719, fax your request to 1-877-348-2251 or submit your request in writing to:

Grievance and Appeals Department
 Attn: Org Determination
 Blue Cross Blue Shield of Michigan
 P.O. Box 2627
 Detroit, MI 48244-2627

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

BCBSM 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 BCBSM's 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. In the absence of an advance coverage determination, BCBSM can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

Reimbursement

BCBSM 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.

BCBSM 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. BCBSM 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 PPO plan.

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

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

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code you must supply all applicable digits.
- National coding guidelines are accessible at cdc.gov/nchs/data/icd9/icdguide10.pdf*
- Medicare Part B supplier number, national provider identifier and federal tax identification number
- The member's Medicare Plus Blue number, including the alpha 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 (08/05) claim form.

Providers affiliated with the Medicare Advantage PPO network agree to BCBSM reimbursement policies outlined in the agreement. These include:

- Accepting the applicable Medicare Plus Blue PPO reimbursement as payment in full for covered services, except for cost sharing, which is the member's responsibility
- Billing BCBSM, 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 BCBSM based upon our credentialing or privileging policy for the particular service rendered

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

Claim filing

Medicare Plus Blue billing guidelines and unique billing requirements may be accessed at bcbsm.com/ma/ppo/submitting_claims.shtml.

Where to submit a claim:

For claims with local carrier jurisdiction —

- 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 440
Southfield, MI 48037-0440

For claims with DME MAC jurisdiction —

- For paper claim submission, send claims to:
DMEnson Benefit Management
P.O. Box 81700
Rochester, MI 48308-1700
- 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 bcbsm.com/pdf/edi_userGuide.pdf.

Non-Michigan providers bill your local Blue plan. Report the alpha 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 bcbsm.com/pdf/edi_userGuide.pdf .	
Non-Michigan providers — Your local Blue plan.	
Paper Claims	
Services with CMS local carrier jurisdiction	Michigan providers — Provider Inquiry at 1-866-309-1719 Non-Michigan providers — Your local Blue plan
Services with CMS DME MAC jurisdiction	All providers — DMEnson Benefit Management at 1-888-828-7858

If you have questions about plan payments:

Services with CMS local carrier jurisdiction	
Michigan providers	Provider Inquiry — 1-866-309-1719
Non-Michigan providers	Your local Blue plan
Services with CMS DME MAC jurisdiction	
All providers	Call DMEnson Benefit Management — 1-888-828-7858

To perform a status inquiry on a Medicare Plus Blue PPO 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.

Provider dispute resolution process

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

Contracted providers with 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, Medicare Advantage PPO providers should follow these guidelines when submitting an appeal.

Usually, 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:

Grievance and Appeals Department
Attn: First Level Appeal
Blue Cross Blue Shield of Michigan
P.O. Box 441160
Detroit, MI 48244-1160

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

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

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

Grievance and Appeals Department Second Level Appeal
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.**

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.

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

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

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

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

Services with CMS DME MAC jurisdiction		
All providers	Write to: Medicare Plus Blue PPO DMension Benefit Management P.O. Box 81700 Rochester, MI 48308-1700	Or call: 1-888-828-7858

Dental Services		
	Write to: BCBSM Provider Appeals Dept P.O. Box 4168 Scranton PA 18505-6168	

Second level appeals (medical and dental)

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

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

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

Grievance and Appeals Department
Attn: Second Level Payment Dispute
Blue Cross Blue Shield of Michigan
P.O. Box 441160
Detroit, MI 48244-1160

For secondary level MA provider appeals for dental, write to:

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

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, BCBSM, 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 the Center for Medicare and Medicaid Services and BCBSM to assess compliance with standards which includes, but not limited to:

1. Complaints from members and/or providers;
2. Conduct Health Effectiveness Data and Information Set (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;
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 advanced 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, 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, 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-IV 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 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.

Retrospective audits and appeals

BCBSM conducts audits in accordance with Medicare laws, rules and regulations. BCBSM will conduct audits as needed, including, but not limited to Diagnosis Related Group (DRG) 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 BCBSM risk-adjustment medical reviews. BCBSM may require providers and practitioners to submit medical records for these audits.

CMS risk-adjustment validation audits

CMS makes advance monthly payments to Medicare Plus Blue PPO plans for coverage of Original fee-for-service benefits for an individual in a Medicare Plus Blue PPO payment area for a month. CMS may require MAOs and their providers to submit medical records for the validation of risk adjustment data. There may be penalties for submission of false data.

BCBSM risk-adjustment medical record reviews

From time to time, BCBSM may require providers to make records available for on-site review or submission to ensure claims submitted are consistent with the chronic conditions documented in the medical record. For HEDIS, members' medical records are reviewed to confirm information not captured in claims data. BCBSM may contract with a vendor to perform these reviews. All vendors are required to have a Business Associates Agreement with BCBSM and are required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996. BCBSM will reimburse providers a specified amount, determined annually, for administrative costs related to these audits and reviews.

Other Medicare Plus Blue PPO requirements

Additional requirements pertaining to Medicare Plus Blue PPO programs are described below.

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 will attempt to make the interim payments as accurate as possible. After the hospital's fiscal year ends, the fiscal intermediary will settle 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. However BCBSM will conduct settlements on inpatient claims when requested where certain provisions of the Original Medicare reimbursement system (for example, disproportionate share, bad debt, capital for a new hospital for first two years, etc.) are not accounted for through the normal voucher system. Outpatient claims will be considered only for bad debt and critical access hospitals. All other outpatient reimbursement issues should be referred to your BCBSM 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 and submit their rate letter (or system equivalent) via fax to (248) 350-4534 or e-mail to MARateLetterSubmissions@bcbsm.com.

Once a cost settlement is requested, all claims payment for the fiscal years in question will be suspended based on corresponding discharge date including those in the Provider Payment Dispute Resolution Process. Once the settlement is concluded, all claims will be considered paid as final.

A settlement will be conducted only on a hospital's full fiscal year at the appropriate Medicare rate based on discharge date. For facilities with fiscal year-end that does not align with the hospital specific payment and federal specific payment effective dates of Oct. 1 through Sept. 30, a prorated review will be completed. BCBSM will review the Medicare Cost Report, specific claims requesting review, and interim rate letters gathered by BCBSM in determining the cost settlement.

The hospital will notify BCBSM on an annual basis in writing of the discrepancy. The information must be submitted to BCBSM within 180 days of the hospital's fiscal year-end and must include all of the following:

- 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 BCBSM claims list (a template will be provided)
 - Calculations showing how the impact amount was determined

BCBSM will review the information and give the hospital a written determination of funds owed the hospital from BCBSM or funds owed BCBSM from the hospital. If the discrepancy is expected to span multiple years into the future, BCBSM will consider adjusting the interim rates paid to the hospital in order to pay the amount in question through the normal voucher system.

For bad debt settlement, BCBSM will only reimburse for uncollected BCBSM Medicare Advantage PPO member liability. This does not include charges for non-covered services. The hospital must provide signed attestation that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The bad debt claims template, along with the attestation, will be provided upon request.

Critical access hospitals are paid on an interim basis using the per diems and percentage of charges stipulated in the fiscal intermediary's interim rate letter applicable to the date on which services are rendered. The cost based reimbursement rate used for the year under review will be compared to the rate calculated on the Medicare Cost Report and a settlement will be made based on the difference. Outpatient services under consideration will follow the payment method elected by the CAH.

Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

Serious adverse events and present on admission

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

The main provisions of the policy are as follows:

- BCBSM 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.
- BCBSM participating hospitals are required to report present on admission indicators on all claims.
- BCBSM participating hospitals are not to balance bill members for any incremental costs associated with the treatment of a serious adverse event that BCBSM has paid.
- BCBSM members who have been billed in error should report incidents to BCBSM 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 BCBSM participating hospital agreement.

BCBSM 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

- 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
- Extreme blood sugar derangement
- Diabetic ketoacidosis
 - Non-ketotic hypersolmar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity

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 BCBSM 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.

Certain code categories are exempt from POA indicator reporting requirements because either they are always present on admission or they represent circumstances related to the health care encounter or factors influencing health status that do not represent a current disease or injury. A detailed list of code categories that are exempt from POA indicator reporting requirements is available in the Serious Adverse Events Policy located in the BCBSM online *Hospital Manual*.

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	Provider is unable to determine clinically whether the condition was present at the time of inpatient admission
1	Exempt from POA reporting
Blanks	Exempt from POA reporting Note: Blanks are valid only on paper 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 or the letter X, 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.

The policy on serious adverse events is administered as follows:

- **For DRG-reimbursed hospitals** — BCBSM uses the Medicare severity diagnosis-related groups (MS-DRG) Grouper version 26 to administer the policy, incorporating the POA indicator into the DRG assignment.
- **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 BCBSM 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. Providers need to submit bills to carriers and fiscal intermediaries using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to BCBSM, and BCBSM will reimburse providers accordingly.

Swing beds

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

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

Qualifications and requirements

To be included in BCBSM's Medicare Advantage PPO network, providers must:

- Have a national provider identifier they use to submit electronic transactions to BCBSM (in accordance with HIPAA requirements) or to submit paper claims to BCBSM
- Meet all applicable licensure requirements in the state of Michigan and meet BCBSM's credentialing requirements pertaining to licensure
- Furnish services to a Medicare Plus Blue PPO 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 BCBSM
- Agree to bill us for covered services provided to Medicare Plus Blue PPO members
- Accept our reimbursement as full payment less any member cost sharing
- Receive payment directly from BCBSM
- Not be on the Department of Health and Human Services Office of Inspectors 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 BCBSM 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 appeals 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 BCBSM and meet and maintain all BCBSM credentialing requirements for network inclusion. Examples of being in good standing are:
 - Unrestricted license to practice
 - Not on prepayment utilization review or in the performance monitoring 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:

- [BCBSM Medicare Advantage PPO Provider Agreement](#)
- BCBSM 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 BCBSM 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 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 PPO 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.

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.

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 social worker
- Ambulance providers
- Independent speech language pathologists

Facility affiliation — Facilities eligible for affiliation in the Medicare Advantage PPO network are:

- Ambulatory surgical facilities (freestanding only)
- End stage renal disease facilities
- 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.

- **BCBSM registered** — must be or become registered with BCBSM 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 BCBSM, such as the American Board of Medical Specialties) at the time of credentialing, and maintain board certification throughout affiliation. (Exception: Current BCBSM 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 BCBSM prepayment utilization review program will be denied affiliation with the Medicare Advantage PPO network.
- **BCBSM departicipation** — An applicant with a current or significant history of formal departicipation action by BCBSM 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 is; one million dollars or more, paid 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:
 - National Practitioner Data Bank findings
 - No history of conduct that threatens patient safety or adversely affects BCBSM’s 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 BCBSM 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 BCBSM Medicare Advantage PPO Provider Agreement can be terminated by BCBSM 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 BCBSM or as otherwise provided in the Agreement
- **Involuntary** — Initiated by BCBSM in accordance with the terms of the Agreement and applicable internal policies.

Questions, additional information and contacts

BCBSM 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 (8:30 a.m. to 5 p.m.) or write to:

Medicare Plus Blue
Provider Inquiry
P.O. Box 33842
Detroit, MI 48232-5842

For questions relating to DME issues, call DMEnson Benefit Management at 1-888-828-7858 (8:30 a.m. to 5 p.m.) or write to:

DMEnson Benefit Management
Medicare Plus Blue
P.O. Box 81700
Rochester, MI 48308-1700

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).



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