Blue Cross Blue Shield of Michigan and Blue Care Network Updates 4th Quarter 2017

Michigan Osteopathic Association
Practice Managers Conference
November 3, 2017

PAs must re-enroll with Blue Cross and BCN, starting October 2017

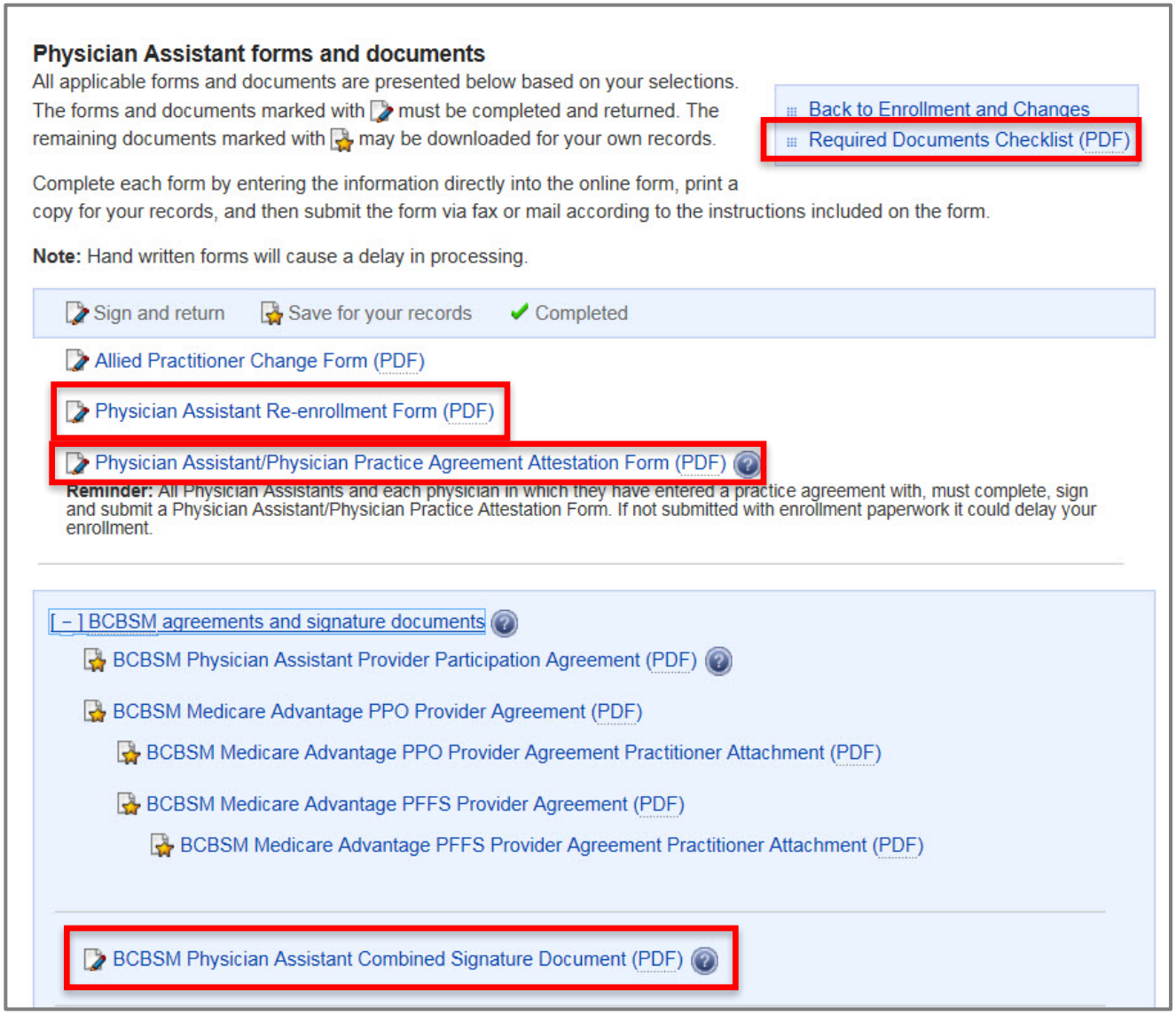
Blue Cross Blue Shield Blue Care Network of Michigan

- Physician assistants must re-enroll and be credentialed with Blue Cross and BCN, including for our Medicare Advantage programs, by Feb. 1, 2018.

- Upon re-enrollment, be sure your CAQH data is current and consistent with the information you provide on the re-enrollment form. Current reimbursement arrangements will be terminated for dates of service after Jan. 31, 2018. Physician assistants may begin re-enrolling in October 2017.

- For more information, including requirements to re-enroll, see the October 2017 and the August 2017 issues of *The Record* and the September–October 2017 *BCN Provider News*.

PAs must re-enroll with Blue Cross and BCN



Go to
bcbsm.com/providers

- Enrollment and Changes
- Provider Enrollment
- Physicians and Professionals
- Change an existing provider
- Physician Assistant

Paper Claim Reduction Initiative

- Prior to July 1, 2017, Blue Cross created 1.1 million claims using Optical Character Recognition when providers submitted paper claims on a UB04 or HCFA1500 form.

- Many of those submissions were unnecessary and could have otherwise been submitted electronically or not at all.

- The OCR Reduction initiative has significantly reduced the receipt and processing of paper claims.

- All providers that had electronic claims submittal capability are now required to bill electronically, with the exception of:
  - Out-of-state ancillary providers (laboratories, DME providers, etc.)
  - Medicare Advantage PPO, BCN and BCN Advantage, Vision, Dental and Blue Cross Complete
  - Claims submitted to Blue Cross as secondary

Correcting and Voiding claims

- Many of the paper claims fell into one of the following two categories:
  - Replacement claim
  - Void or cancel claim

Process to follow:

Send your electronic 837 transaction replacement or void claims with this information:

- In Loop 2300, CLM05-3, use frequency code 7 for a **replacement claim.**
- In Loop 2300, CLM05-3, use frequency code value 8 to **void or cancel a claim.**

Whether you submit a frequency code value of 7 or 8, you must report the internal control number of the original claim in Loop 2300, REF segment, along with qualifier F8.

CAQH ProView for physician attestation

Blue Cross Blue Shield Blue Care Network of Michigan

We're pleased to announce that Blue Cross and BCN have transitioned from the PRIME-Hub website to CAQH ProView for the quarterly attestation process. Health care providers and practice managers should use CAQH to review and confirm their demographic data instead of going to the Atlas PRIME-Hub website or submitting their electronic Big Group Audit or physician organization attestation roster to their assigned provider data analytics analyst.

New and existing users can access the CAQH ProView Provider portal to register, log in and validate existing information in their CAQH account.

Resources to help providers and their practice managers use CAQH ProView are available at caqh.org/solutions/caqh-proview. If you have questions or need support with completing your attestations, contact CAQH at 1-888-599-1771 or reach out to your provider consultant.

BCN and BCN Advantage referrals and authorizations refresher

Blue Cross Blue Shield Blue Care Network of Michigan

Who is responsible for submitting referrals and authorizations?

- Primary care physicians and specialists
- Just as a reminder, *referrals* are entered by the primary doctor's office to refer a patient to an out-of-network specialist.
- If specialists are ordering tests or procedures that require *authorizations*, their offices should request *authorizations* from BCN and BCN Advantage.

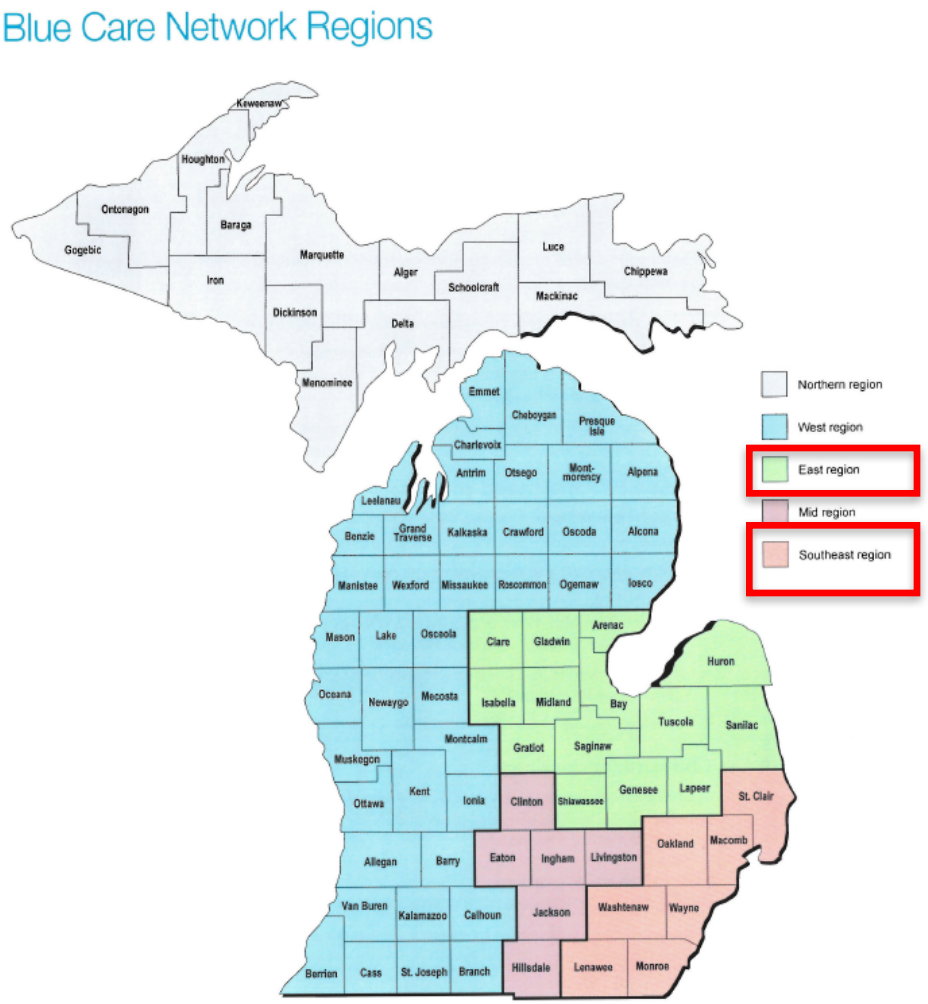
BCN referrals and authorizations

Blue Cross Blue Shield Blue Care Network of Michigan

General guidelines

- For BCN HMO members living in the Mid, West or Upper Peninsula region, no global referral is required as long as the contracted specialist is located in one of those regions.

- For BCN HMO members living in the East (Green) or Southeast (Orange) region, a referral is required.



eviCore

Blue Cross Blue Shield Blue Care Network of Michigan

•Providers must obtain clinical review from eviCore healthcare (formerly CareCore National)

•All BCN-participating freestanding diagnostic facilities, outpatient hospital settings, ambulatory surgery centers and physician offices are required to use.

•As of July 31, 2017, Medicare Advantage PPO also utilizes eviCore for the following:

- •Joint replacement (hip, knee, shoulder)
- •Hammertoe surgery
- •Nasal sinus endoscopy
- •Endovascular intervention, peripheral artery
- •Transcatheter placement of intravascular stents
- •Vascular embolization or occlusion (TACE, RFA or UAE)
- •Insertion or replacement of cranial neurostimulator pulse generator
- •Implantation of devices for intrathecal or epidural drug infusions
- •Percutaneous implantation of neurostimulators (epidural, sacral nerve or gastric)

•Requests for review must be submitted by visiting evicore.com or by calling 1-855-774-1317.

Upcoming authorization changes for Blue Cross Commercial

Blue Cross Blue Shield Blue Care Network of Michigan

- Preauthorization program launches in January
- Category: Commercial PPO

- Beginning Jan. 1, 2018, our fully insured and IBU commercial Blue Cross PPO plans will require pre-authorizations for the following programs:
  - Interventional pain management
  - Radiation therapy (oncology) services
  - Inpatient and outpatient lumbar spinal fusion surgery

- These programs will be administered by eviCore healthcare, a national specialty benefits management company that focuses on quality, cost and use of health care services.

- For more information, see the October *Record* article titled "Preauthorization program for commercial PPO plans coming in January." Look for more detailed information about the programs in future web-DENIS alerts and *Record* articles.

Prior authorization contact list for Blue Cross commercial PPO, Medicare Plus Blue℠, BCN HMO℠, BCN Advantage℠

Blue Cross Blue Shield Blue Care Network of Michigan

Post-acute care	
Blue Cross commercial PPO	mailto:Continuumofcaresnfandacuterehab@bcbsm.com?hipaaState=off Fax: 1-866-411-2573
Medicare Advantage Medicare Plus Blue PPO	**Facilities in Michigan:** eviCore Phone: 1-877-917-2583 Fax: 1-844-407-5293
	Out-of-state facilities: EPA system mailto:Medicareplusbluefacilityfax@bcbsm.com?hipaaState=off Fax: 1-866-464-8223
BCN HMO or BCN Advantage	**Home care facilities, for UAW Retiree Medical Benefits Trust members only:** Phone: 1-800-392-2512
BCN HMO or BCN Advantage	**Skilled nursing, rehabilitation or long-term acute care facilities** Fax the appropriate form to the number listed on the form. Click here to access the forms. Look under the "Transitional care services" heading.

Prior authorization contact list

Blue Cross Blue Shield Blue Care Network of Michigan

Inpatient acute care	
Blue Cross commercial PPO	**Facilities in Michigan:** Prenote system
	Out-of-state facilities: EPA system Email: mailto:acuteprecertification1@bcbsm.com?hipaaState=off Fax: 1-866-411-2585
Medicare Advantage **Medicare Plus Blue PPO**	**Facilities in Michigan:** Prenote system When admitting, hospitals must notify Blue Cross via web-DENIS.
	Out-of-state facilities: EPA system Email: mailto:medicareplusbluefacilityfax@bcbsm.com?hipaaState=off Fax: 1-866-464-8223
BCN HMO or BCN Advantage	Submit authorization requests through BCN's *e-referral system*. Click here for additional information.

Prior authorization contact list

Blue Cross Blue Shield Blue Care Network of Michigan

Other prior authorizations	
Blue Cross commercial PPO *Radiology, cardiology, sleep studies*	aimspecialtyhealth.com Phone: 1-800-728-8008
Medicare Advantage PPO *Radiology, cardiology*	aimspecialtyhealth.com Phone: 1-800-728-8008
Medicare Advantage PPO *Interventional pain management, lumbar spinal fusion surgery; beginning fourth-quarter 2016, radiation therapy*	eviCore via web-DENIS Phone: 1-877-917-2583
BCN HMO or BCN Advantage *Radiology, cardiology, interventional pain management, radiation therapy, physical, occupational and speech therapy, and physical medicine services provided by chiropractors*	Click here for guidelines on how to submit these authorization requests.
BCN HMO or BCN Advantage *Sleep studies, Spine surgery (lumbar, cervical) and other services*	Submit authorization requests through BCN's *e-referral system*. Click here for additional information. For urgent requests, call 1-800-392-2512.

Member transfer tip sheet

- BCN has published a more user-friendly *Member Transfer Tip Sheet* for primary care physicians to use when requesting the transfer of a BCN HMO℠ (commercial) or BCN Advantage℠ member assignment.

- The requirements for requesting a member transfer have not changed, but the document outlining them has been renamed and reorganized for easier use.

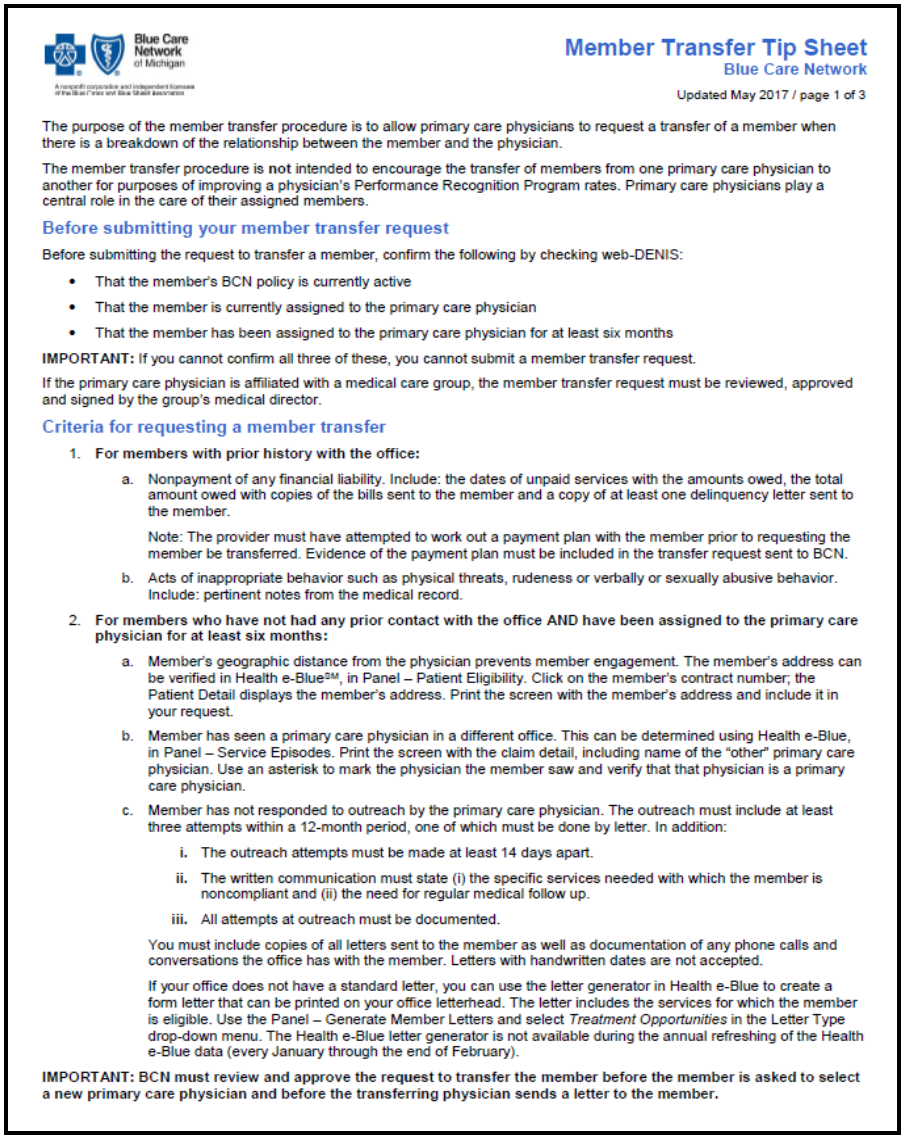
- The updated document includes an optional checklist providers can use to make sure they're sending all the required documentation in with their requests. The checklist does not need to be submitted with the request; it is for use in the provider's office only.

Member transfer tip sheet

- Providers can access the updated *Member Transfer Tip Sheet* on BCN's Health e-Blue℠ home page. Scroll down to the Resources section of the page and look under the Help Documents heading.

- A link to the *Physician Selection Form* is also located there; members can use it to change their primary care physician.

- Links to the updated *Member Transfer Tip Sheet* are also included in the following two chapters of the *BCN Provider Manual*:
  - BCN System of Managed Care
  - Member Rights and Responsibilities



Blue Care Network of Michigan

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Member Transfer Tip Sheet

Blue Care Network

The purpose of the member transfer procedure is to allow primary care physicians to request a transfer of a member when there is a breakdown of the relationship between the member and the physician.

The member transfer procedure is not intended to encourage the transfer of members from one primary care physician to another for purposes of improving a physician's Performance Recognition Program rates. Primary care physicians play a central role in the care of their assigned members.

Before submitting your member transfer request

Before submitting the request to transfer a member, confirm the following by checking web-DENIS:

- That the member's BCN policy is currently active
- That the member is currently assigned to the primary care physician
- That the member has been assigned to the primary care physician for at least six months

IMPORTANT: If you cannot confirm all three of these, you cannot submit a member transfer request.

If the primary care physician is affiliated with a medical care group, the member transfer request must be reviewed, approved and signed by the group's medical director.

Criteria for requesting a member transfer

1. **For members with prior history with the office:**
   a. Nonpayment of any financial liability. Include: the dates of unpaid services with the amounts owed, the total amount owed with copies of the bills sent to the member and a copy of at least one delinquency letter sent to the member.

      Note: The provider must have attempted to work out a payment plan with the member prior to requesting the member be transferred. Evidence of the payment plan must be included in the transfer request sent to BCN.

   b. Acts of inappropriate behavior such as physical threats, rudeness or verbally or sexually abusive behavior. Include: pertinent notes from the medical record.

2. **For members who have not had any prior contact with the office AND have been assigned to the primary care physician for at least six months:**
   a. Member's geographic distance from the physician prevents member engagement. The member's address can be verified in Health e-Blue℠, in Panel – Patient Eligibility. Click on the member's contract number; the Patient Detail displays the member's address. Print the screen with the member's address and include it in your request.

   b. Member has seen a primary care physician in a different office. This can be determined using Health e-Blue, in Panel – Service Episodes. Print the screen with the claim detail, including name of the "other" primary care physician. Use an asterisk to mark the physician the member saw and verify that that physician is a primary care physician.

   c. Member has not responded to outreach by the primary care physician. The outreach must include at least three attempts within a 12-month period, one of which must be done by letter. In addition:

      i. The outreach attempts must be made at least 14 days apart.

      ii. The written communication must state (i) the specific services needed with which the member is noncompliant and (ii) the need for regular medical follow up.

      iii. All attempts at outreach must be documented.

      You must include copies of all letters sent to the member as well as documentation of any phone calls and conversations the office has with the member. Letters with handwritten dates are not accepted.

      If your office does not have a standard letter, you can use the letter generator in Health e-Blue to create a form letter that can be printed on your office letterhead. The letter includes the services for which the member is eligible. Use the Panel – Generate Member Letters and select *Treatment Opportunities* in the Letter Type drop-down menu. The Health e-Blue letter generator is not available during the annual refreshing of the Health e-Blue data (every January through the end of February).

IMPORTANT: BCN must review and approve the request to transfer the member before the member is asked to select a new primary care physician and before the transferring physician sends a letter to the member.

Thank you!

Blue Cross Blue Shield Blue Care Network of Michigan

Questions?