Claims

IMPORTANT! Click on a topic below to go to that page in the chapter.

Contents

Contents (continued)

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Scope of chapter

Hyperlinks to authorization and referral information

Authorization and referral requirements affect the payment of claims. Providers should be aware of authorization and referral requirements for the services they provide.

Providers can access information about those requirements at the following locations:

- BCN's **Authorizations / Referrals** page in Provider Secured Services (BCN Provider Publications and Resources)
- **Care Management chapter** of the *BCN Provider Manual*
- **BCN Referral and Authorization Requirements** document
- **Authorization Requirements & Criteria** page at **ereferrals.bcbsm.com**
- **ereferrals.bcbsm.com** > **BCN**

Products this chapter applies to

The instructions in this chapter apply to BCN HMO℠ (commercial) and BCN Advantage℠ products for groups and individuals, including self-funded products.

BCN Advantage℠ products

The instructions in this chapter do not constitute a complete set of information related to members enrolled in BCN Advantage℠ HMO-POS (group options and Basic, Elements, Classic and Prestige individual options), BCN Advantage℠ HMO ConnectedCare, BCN Advantage℠ HMO MyChoice Wellness, BCN Advantage℠ HMO HealthySaver and BCN Advantage℠ HMO HealthyValue, all of which are Blue Care Network's Medicare Advantage products.

For additional instructions specific to BCN Advantage claims, providers should refer to the BCN Advantage chapter of this manual.

Note: In this chapter, references to "BCN Advantage" include both BCN Advantage HMO-POS and BCN Advantage HMO products, unless otherwise indicated.

Blue Cross Complete

Information about Blue Cross Complete claims is located in the *Blue Cross Complete Provider Manual*, which is available at **MiBlueCrossComplete.com/providers**.*

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Scope of chapter

BCN 65 and MyBlue Medigap

The instructions in this chapter also apply to BCN 65, which is an HMO product that is secondary to Medicare. They also apply to MyBlue Medigap℠, which is a Medicare supplement product that is not an HMO.

Medicare is the primary carrier for all BCN 65 and MyBlue Medigap members and must be billed first. Medicare automatically forwards claims to BCN for payment, with the exception of the following types of claims:

- Claims from providers outside the state of Michigan
- Claims paid at 100% by Medicare
- Claims paid at more than 100% by Medicare
- Claims denied 100% by Medicare
- Medicare secondary payer claims
- National Council for Prescription Drug claims

For the claim types listed here, providers should submit them to BCN along with the Medicare Remittance Advice statement.

Note: When a BCN 65 member receives hearing or dental services, no Medicare Remittance Advice statement is required.

In all other respects, BCN 65 and MyBlue Medigap claims follow the billing guidelines described in this section. In addition, providers may find the following information useful:

- BCN 65 members have an XYF prefix on their ID card. MyBlue Medigap members have an XYJ prefix on their ID card. At the time of service, these members will present two ID cards: their Medicare card and their BCN 65 or MyBlue Medigap card.
- Providers who have not received payment from BCN within 30 days of the Medicare payment should submit to BCN a copy of the claim with the Medicare Remittance Advice statement attached.

- Providers can also submit claims electronically by following the guidelines at **bcbsm.com/providers** > FAQs > Help > **How to exchange information with us electronically**.
- Payments for hearing services require a member to have a hearing rider with his or her contract. (This applies to BCN 65 only. For MyBlue Medigap, hearing services are not a benefit.)
- An authorization is required for payment of traumatic dental services. (This applies to BCN 65 only. MyBlue Medigap pays the remaining balance for traumatic dental services only when Medicare pays first; in that case, no authorization is required.)

Scope of chapter

Health reimbursement arrangement claims

The instructions in this chapter apply to health reimbursement arrangement claims. At the time of service, the provider should collect the member's fixed-dollar copayment. Fixed-dollar copayments are not eligible for reimbursement under the health reimbursement arrangement. The provider then submits the claim information to BCN.

When health reimbursement arrangement claims are processed, providers are reimbursed with two checks: one processed through the regular medical claims process and the other processed using health reimbursement arrangement dollars, as available. Both checks are run in the same payment cycle.

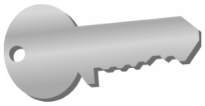
Additional information on health reimbursement arrangement claims is found later in this chapter.

Collecting copayments, coinsurance and deductible

For general information on collecting copayment, coinsurance and deductible amounts from members, providers should refer to the **Member Eligibility chapter** of this manual.

Resources for providers

web-DENIS



Web-DENIS is Blue Cross Blue Shield of Michigan's user-friendly electronic inquiry tool that provides up-to-the-minute online information about a member's eligibility, benefits and claim status.

For information on how to get connected to web-DENIS, providers should take one of the following steps:

- Go to **bcbsm.com/providers** > Help Center > **How to get access to Provider Secured Services**
- Call 1-877-BLUE-WEB (1-877-258-3932)

BCN's Billing / Claims page

BCN's Billing / Claims page in Provider Secured Services is a resource for providers and billers. It contains hyperlinks to several documents useful for billing purposes.

The BCN Billing / Claims page can be accessed by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > **Billing / Claims**.

The information available on BCN's Billing / Claims page is regularly updated, so providers and billers should check to make sure they are accessing the most current information.

Other resources on the BCN Provider Publications and Resources site

Several other resources to assist physicians can be located by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking **BCN Provider Publications and Resources**.

These include the following:

- BCN's provider newsletter, *BCN Provider News*
- *BCN Provider Manual*
- *BCN Provider Resource Guide*
- *BCN Provider Resource Guide At a Glance*

Submitting claims to BCN — the basics

Scope of section

This section applies, in general, to both BCN HMO (commercial) and BCN Advantage claims.

However, providers should also refer to the **BCN Advantage chapter** of this manual to find information and instructions specific to BCN Advantage, which may be different from the information found in this section. Look in the section titled "BCN Advantage claims processing."

Follow contract requirements

Physicians should always follow the requirements listed in their BCN provider contract. If any information in this manual differs from the provider contract, the contract language prevails**.**

Timely filing limits for claims

The filing limits for BCN HMO (commercial) claims are as follows, unless the claim qualifies as an eligible exception as identified by CMS:

- New claims must be submitted within 12 months of the date of service or discharge date.
- Replacement claims (TOB xxx7 or frequency 7) or void claims (TOB xxx8 or frequency 8) must be submitted within 24 months of the date of service or discharge date.

Claims that receive a front-end rejection, either electronically or on a paper-submitted claim, are not considered submitted or clean claims. To be considered submitted, a claim must contain all required data elements in the appropriate format. Claims that receive a front-end rejection must be corrected and resubmitted within the standard filing limit time frames. A copy of a front-end rejection is not acceptable documentation of a claim submission for payment reconsideration purposes.

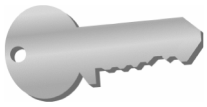
For claims from noncontracted providers, BCN follows applicable federal and state regulations.

BCN 65 and MyBlue Medigap Coordination of Benefits claims:

- Claims for members with primary coverage through Medicare or another health plan that were initially submitted to the primary plan will be processed if they are received within 18 months after the date of service or date of discharge.
- Requests for claim corrections or resubmissions must be received within 24 months of the date of service or date of discharge. Requests received after 24 months will be denied.
- BCN will not override a filing limit edit unless BCN is paying as the secondary plan or unless there is a valid claim history indicating the claim was received and processed within one year from the date of service or the date of discharge.

Submitting claims to BCN — the basics

Encounter submission



Under BCN's managed care system, primary care physicians are prepaid for a number of different services. The claim form is the way primary care physicians let BCN know of the services provided for each member. A claim form must be submitted for every member visit and every date of service.

Encounter submissions help BCN monitor the care provided to members. Such monitoring is mandated by state HMO regulations. Encounter submissions also help BCN determine capitation rates. BCN bases capitation on the number of members providers see and the types of services they provide.

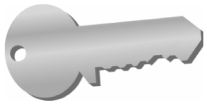
An encounter submission is the same as a claims submission except that the physician has been prepaid for the service. Throughout this chapter, the term "claim" refers to both a claim and an encounter submission.

National Provider Identifier

Electronic claims must contain only the National Provider Identifier. Claims received with legacy provider identifiers such as Bill PINs will be rejected.

Providers should look for updates in *BCN Provider News* and on web-DENIS or contact their Blue Cross/BCN provider consultant for more information.

Electronic claims



Electronic billing is faster, easier and more accurate than filing paper claims. The main options for the electronic handling of claims are as follows:

- The HIPAA 837 electronic standard transaction is used for submitting a new claim and for correcting or replacing a claim already submitted.
- The HIPAA 835 electronic standard transaction is the electronic Remittance Advice, which shows how the claim was paid.

Providers who wish to learn more about filing claims electronically should contact the Blue Cross Blue Shield of Michigan Electronic Data Interchange department at 1-800-542-0945.

Providers can also follow the guidelines for electronic billing that are available in the reference documents at **bcbsm.com/providers** > Help > FAQs > **How to exchange information with us electronically**.

For claims submitted electronically, the BCN facility payer ID is 00210; the BCN professional payer ID is 00710.

Submitting claims to BCN — the basics

Professional claims: electronic or paper submission

Physicians who are not facility based can submit claims electronically or on a paper form, using the CMS-1500 claim form.

Note: When submitted electronically, all claims must include the prefix of the member's enrollee ID number. Electronic claims submitted without the prefix receive a front-end edit and are returned.

The CMS-1500 and UB-04 forms, produced by the Centers for Medicare & Medicaid Services, are used nationally. Guidelines for completing these forms can be accessed as follows:

- For instructions for completing the CMS-1500 form, visit **bcbsm.com/providers**, log in to Provider Secured Services and click BCN Provider Publications and Resources > **Billing / Claims**.
- For assistance with completing a UB-04, providers should refer to the *National Uniform Billing Committee Official Data Specifications Manual* and see the facility claim examples on BCN's BIlling / Claims page in Provider Secured Services. These documents are available as follows:
  - To access the *National Uniform Billing Committee Official Data Specifications Manual*, go to **nubc.org** > **Official UB-04 Data Specifications Manual 2017**.*
  - To access BCN's Billing / Claims page, visit **bcbsm.com/providers**, log in to Provider Secured Services and click BCN Provider Publications and Resources > **Billing / Claims**.

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Facility claims: electronic submission with some exceptions

Facility claims should be submitted electronically with the exception of human organ transplant claims, which should be submitted on paper.

The addresses to which human organ transplant claims should be sent are found in the "Where to send paper claims" subsection of the "Guidelines for submitting claims" section of this manual.

Submitting claims to BCN — the basics

The ASC X12 Health Care Information Status Notification (277) electronic standard transaction

Blue Cross EDI selected the ASC X12 Health Care Information Status Notification (277) as the acknowledgement of v5010 837 claim transaction(s). Claims that did not reach the processing system due to receiving a Blue Cross EDI front-end edit are identified on either a 277CAP transaction or an R277CAF report. Claims that receive 277CA edits must be corrected and resubmitted.

The 277CAP transaction. The 277CAP is the electronic claim acknowledgement in ASC X12N 5010 x214 format. The transaction identifies which claims have been edited and will not continue on for processing. The transaction is generally used by clearinghouses, software vendors or submitters with practice management systems that can translate the information into a report readable by humans.

The R277CAF report. In addition to or in place of the 277CAP transaction, Blue Cross EDI returns an R277CAF edit report. The report provides detailed information about claims that have received edits. The report also contains a summary of all accepted and rejected claims together with the total charges.

Providers may refer to the Blue Cross V5010 Acknowledgements document available online for additional information and examples.

Tips for using the 277CAP transaction

On the 277CAP transaction, providers can distinguish between an edit for "member not found" and one for "contract not found" as follows:

- An edit for member not found returns as A3:26:QC.
  - A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
  - 26 – Entity not found. Note: This code requires use of an entity code.
  - QC – Patient
- An edit for contract not found returns as A3:164:HK.
  - A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
  - 164 – Entity's contract/member number. Note: This code requires use of an entity code.
  - HK – Subscriber

Information required when submitting claims

Information required for all claims

The information required to complete electronic and paper claims is the same; however, field formats may vary. Software vendors have instructions for entering the information for electronic claims.

Place of Service codes

A Place of Service code must be provided on each CMS-1500 claim. A list of the Place of Service codes is available on the CMS website at **cms.gov** > Medicare > **Place of Service Codes*** (under the Coding heading).

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Submit with the correct member information

For both electronic and paper claims, the following member match criteria rules are in effect:

- BCN does not look for the subscriber if the contract (enrollee ID) number submitted is not found. Claims without a valid contract (enrollee ID) number are rejected as contract number not found.
- BCN does not match if a Social Security number is submitted as the contract (enrollee ID) number. These claims are rejected as contract number not found.
- An exact match on the date of birth is not required. A match on six characters is considered a match for the date of birth.

  Example: If the date of birth in BCN's system is 09141954 and it is submitted as:

  - 09151953, it matches on 6 and is accepted
  - 08151954, it matches on 6 and is accepted
  - 10141954, it matches on 6 and is accepted
  - 10141964, it does not match on 6 and is rejected
- BCN's hierarchy for matching is:
  - Date of birth (6), last name (first 4 characters) and first name (first 3 characters)
  - Date of birth (6) and last name (first 4 characters)
  - Date of birth (6) and first name (first 3 characters)
  - Date of service will be used when there is more than one group that matches on a member.
- BCN uses enhanced logic if there is more than one match (twin logic). The full first name will be used. If there are still two matches, the relationship code will be used.
- Spaces, hyphens and other special characters are ignored when matching on name.

Information required when submitting claims

Standard medical codes

Claims must be billed with valid procedure and/or revenue codes, modifiers and diagnosis codes. If any of these data elements is missing or invalid, the claim may be denied. Physicians should ensure that any procedure code and modifier combinations submitted are appropriate and that multiple modifiers are used when applicable. The following table summarizes the standard medical code sets.

Code set	Use	Website or contact information
Documentation guidelines — for evaluation and management services	Definitions / documentation guidelines for the three key components of E/M services and for visits that consist predominantly of counseling or coordination of care. BCN providers should choose to use either the 1995 or 1997 guidelines and then use those guidelines consistently.	• **1995 CMS guidelines*** • **1997 CMS guidelines*** • **MLN EdWeb***
ICD-9-CM — *International Classification of Diseases,* 9th Revision, *Clinical Modifications,* Vols. 1, 2 and 3	For dates of service prior to Oct. 1, 2015. **Vols. 1 and 2:** Diseases, injuries, impairments, other health problems and their manifestations; causes of injury, disease, impairment or other health problem. **Vol. 3:** Inpatient hospital services, including prevention, diagnosis, treatment and management	**cms.hhs.gov***
ICD-10 – CM/PCS — *International Classification of Diseases,* 10th Revision	For dates of service on or after Oct. 1, 2015. **ICD-10-CM** is a replacement for ICD-9-CM, Vols.1 and 2. **ICD-10-PCS** is a replacement for ICD-9-CM, Vol. 3.	**cms.gov/Medicare/Coding/ICD10/index.html***
HCPCS Level 1 (CPT-4) — *Current Procedural Terminology,* fourth edition	Physician services (evaluation and management, anesthesiology, surgery, radiology, pathology and laboratory, medicine)	**catalog.ama-assn.org/Catalog***
HCPCS Level II — *Centers for Medicare & Medicaid Services Level II Common Procedure Coding System*	All other health care services not included in CPT-4 (substances, durable medical equipment, medical supplies, orthotic and prosthetic devices)	**cms.hhs.gov***
CDT-3 — *Code on Dental Procedures and Nomenclature,* fourth edition	Dental services	Available by calling 1-800-947-4746
NDC — National drug codes	Drugs, biologics	**www.fda.gov/cder/ndc***
CPT modifiers — *Current Procedural Terminology,* fourth edition	Identify circumstances that alter or enhance the description of a service	**catalog.ama-assn.org/Catalog***

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(continued on next page)

Information required when submitting claims

Standard medical codes (continued)

Code set	Use	Website or contact information
HCPCS or national modifiers — *Centers for Medicare & Medicaid Services Level II Common Procedure Coding System*	Identify circumstances that alter or enhance the description of a service or supply	**cms.hhs.gov***
Revenue codes — National Uniform Billing Committee Revenue Codes	Identify a specific accommodation and/or ancillary service or billing calculation	**nubc.org***

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Specific revenue codes to be billed with five-digit procedure codes

For BCN commercial outpatient claims from hospitals and ambulatory surgery facilities, BCN requires that certain revenue codes be billed with a five-digit CPT* or HCPCS procedure code.

Hospitals and ambulatory surgery facilities can access a complete list of revenue codes that need to be billed with five-digit procedure codes on BCN's Billing / Claims page by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Specific revenue codes to be billed with five-digit procedure codes**.

***CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.**

Tips for coding COPD diagnoses

Providers can find tips for coding diagnoses related to chronic obstructive pulmonary disease in the article titled **Medical record documentation for COPD and associated respiratory conditions**, which starts on page 38 of the January-February 2018 issue of *BCN Provider News*.

Include the proper taxonomy

BCN requires that providers include the proper taxonomy on claims for certain services to BCN HMO (commercial) and BCN Advantage members, to facilitate correct reimbursement.

This applies to the following types of claims:

- For home infusion therapy claims, use taxonomy 251F00000X.
- For ambulatory infusion center claims, use taxonomy 261QI0500X.
- For limited-distribution pharmacy claims, use taxonomy 3336S0011X.

Providers who do not use proper taxonomy when submitting these claims to BCN may have their claims denied.

Information required when submitting claims

Online training available

Providers may take advantage of a 30-minute online training module, complete with a 10-question assessment, to learn more about accurate documentation and coding.

Professional coders on staff can earn one continuing education unit credit from the American Academy of Professional Coders when they complete the course and score 80% or better on the 10-question assessment.

To access this training module, visit bcbsm.com/providers, log in to Provider Secured Services and click BCN Provider Publications and Resources > Patient Care Reporting for Risk Adjustment > **New online training: Best Practices for Medical Record Documentation (October 2015)**.

The training module provides helpful information about medical record documentation according to the Centers for Medicare & Medicaid Services, including:

- How to demonstrate the condition of the patient
- Principles of sound documentation
- Tips for maintaining quality medical records

Guidelines for submitting claims

Filing electronically

Follow these steps before filing claims electronically:

Step	Action
1	Each provider should decide whether to submit his or her own claims or use a service bureau or billing agency. Either way, providers should review the information provided at **bcbsm.com/providers** > Help > FAQs > **How to exchange information with us electronically**.
2	Providers should call the Blue Cross Electronic Data Interchange department at 1-800-542-0945. An EDI Help Desk agent will help each provider navigate the process and confirm that the provider's software vendor is approved to bill Blue Cross/BCN electronically. Each provider will: • Receive a billing location code • Complete a Trading Partner Agreement, if applicable • Update the *Provider Authorization Form*, as needed • Receive applicable user guide manuals

Internet claims submission tool

For smaller provider offices currently submitting paper claims who would like to submit claims electronically but without the expense of purchasing software, BCN provides a free Internet claims tool that allows electronic submission of professional (including vision and hearing) and facility claims.

Additional information about this tool is available at **bcbsm.com/providers** > Help > FAQs > How to exchange information with us electronically > I'm a provider and I submit my own claims > **Make the switch to electronic billing**.

For more information about this tool, providers should visit **bcbsm.com/providers** > Help > FAQs > **How to exchange information with us electronically**.

For more information

For more information on filing electronic claims, providers should contact the Blue Cross EDI department at 1-800-542-0945.

Guidelines for submitting claims

Filing paper claims

For claims that may be filed on paper, providers should follow these guidelines:

- File claim on a red and white CMS-1500 or UB-04 form.
- Use 12-point readable type (Arial or Times New Roman).
- Do not submit handwritten claims.
- Use black ink that produces a clear impression. Each character must be distinct.
- Do not use highlighters or any other markers on the claim or on any attachments to the claim. They make the claim impossible to process.
- Do not use an imprinter to complete any portion of the claim form. The forms are not designed for use with an imprinter.
- Use a six-digit format with no spaces or punctuation for all dates; for example, enter May 3, 2008 as 050308.
- Securely staple all attachments. Paper clips and tape tend to fall off. Send only Medicare or coordination of benefits information. No other attachments are necessary.
- Use large, flat envelopes (instead of folding claims into letter-size number 10 envelopes). This significantly improves BCN's processing time and reduces the chance of damage to the paper form.
- Complete all required data fields on the form. Incomplete claims will be returned. Leave the field blank if there is no information to populate that field.
- Use only code sets required by HIPAA regulations.
- Ensure data are enclosed within field or box perimeters, including the provider signature. Claims with text or data outside field or box perimeters will be returned for alignment rejection.
- Include the name and the NPI for the billing provider in Field 33a. Claims will be returned if the NPI is missing from Field 33a of the CMS-1500 form.
- Include the NPI of the rendering physician in Field 24j (unshaded) on the CMS-1500 form. This is particularly important if the NPI in box 33a is for a group.
- Always include the tax identification number in box 25.
- Report the member's correct BCN contract (enrollee ID) number, as shown on the member's ID card. Include the suffix and the date of birth.

  Note: The enrollee ID number is not the member's Social Security number.
- Report any other insurance information when submitting the claim.

Guidelines for submitting claims

Where to send paper claims

Sending a claim to the appropriate mailing address is one of the most useful ways to minimize delays in payment. Most paper claims should be submitted to the appropriate office at:

Blue Care Network Claims
P.O. Box 68710
Grand Rapids, MI 49516-8710

BCN Advantage Claims
P.O. Box 68753
Grand Rapids, MI 49516-8753

Additional information on where to send paper claims is available by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Where to send paper claims for BCN HMO and BCN Advantage members**.

Note: Information about Blue Cross Complete claims can be found in the *Blue Cross Complete Provider Manual*, which is available at **MiBlueCrossComplete.com/providers**.*

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Prompt pay

Prompt payment legislation

Claims received by BCN will be processed in accordance with prompt payment legislation (Public Act 28 of 2004). This means that BCN is required to pay simple interest at 12% per year on all "clean claims" that are not paid within 45 days of receipt.

What is a clean claim?

Public Act 28 defines clean claims as claims that:

- Identify the provider of services (BCN requires the provider's NPI(s) and tax identification number as the identifiers.)
- Identify the member and subscriber
- List the date and place of service
- Bill for covered services for eligible members
- Substantiate the medical necessity and appropriateness of care, when necessary
- Contain prior authorization or precertification information, when necessary
- Identify services rendered using proper procedure and diagnosis codes
- Include any necessary additional information as required by BCN

BCN's claims payment process for paper claims that are not clean

If BCN's screening process determines that a paper claim is not clean, the claim will be returned with a BCN claim return letter indicating the area or areas needing to be addressed. Providers have 45 days after receiving the claim return letter to correct the defects in the original claim. In order for the corrected claim to be considered a resubmission (and subject to the original 45-day period for clean claims), the provider must:

- Return the BCN claim return letter to BCN along with the corrected information on an original claim form
- Ensure that BCN receives it within 48 days of the date on the BCN claim return letter. (The three additional days allow for mail delivery time from the time BCN mails the BCN claim return letter to the providers.)

The 45-day payment period begins on the date that BCN receives the original claim. It is tolled (suspended) from the date the provider or facility receives the BCN claim return letter requesting corrections to the claim until the date that BCN receives a response. If the response makes the claim clean, BCN has 45 days to pay the claim from the date of its original receipt, excluding any time that was tolled. If the resubmitted claim is still not clean, BCN will send an adverse determination notice within the 45-day payment period, excluding any time that was tolled.

Note: Refer to the BCN Advantage chapter of this manual for information about the BCN Advantage claims payment process for paper claims that are not clean.

Prompt pay

Electronic claims that are not clean

The claim payment process does not change for claims filed electronically through the Blue Cross clearinghouse. The 999 Functional Acknowledgment must be reviewed to determine whether the file was accepted for processing or rejected for compliance issues. The 277CA transaction or report should be reviewed to determine whether 837 claims have been returned due to edits (Claim Status Category Code of A3).

When will BCN pay interest?

If BCN fails to pay a clean claim within the 45-day time period, BCN is required to pay simple interest of 12% per claim to the provider or facility. It is important to note that BCN will pay interest only to providers who are eligible according to 2004 PA 28. This includes providers licensed or registered under Article 15 of the Public Health Code and facilities licensed under Article 17 of the Public Health Code, as well as durable medical equipment providers and home health care providers. Pharmacies are not included. Providers and facilities that do not fit the criteria specified in 2004 PA 28 will not be paid interest. **BCN hospitals that receive payment via the Blue Cross Interim Payment are not eligible for interest payment.**

Claims submitted more than 365 days from the date of service will not be eligible for late payment interest as defined in 2004 PA 28. Providers should note that claims are still subject to BCN payment policies and may not be paid if they exceed the timely filing limits specified in the *BCN Provider Manual*.

Note: Refer to the BCN Advantage chapter of this manual for information about when BCN Advantage will pay interest.

When to resubmit a claim

Providers should resubmit a claim for the following reasons:

- The paper claim was returned with a BCN claim return letter describing claim defects that must be corrected.
- The electronic claim was listed in the 277CA transaction or report with Claim Status Category of A3.

Providers should not automatically resubmit claims without investigating one of these situations. This description of the Prompt Pay Act is not intended and should not be construed as legal advice. BCN recommends providers consult with their attorneys or read 2004 PA 28 in its entirety. The law can be accessed at **michiganlegislature.org**.*

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Pricing and fees

Diagnosis-specific pricing

In determining the fees paid to providers for select procedures, BCN uses diagnosis-specific pricing. This means that BCN takes into account the effectiveness of new technology as compared to existing approaches to care.

The following apply to fees paid for certain procedures:

- When Blue Cross/BCN medical policy indicates that a procedure performed is "established" for a particular diagnosis, the fee is in line with the procedure performed.
- When Blue Cross/BCN medical policy indicates that a procedure performed is not medically necessary for that diagnosis, the fee is in line with the alternative, equally effective and less costly treatment approach.

Fee schedules

The fee schedules for the payment of commercial professional claims are reviewed and updated at least annually. This applies to all professional fee schedules representing services for BCN commercial members.

Providers with questions about BCN's fee schedules should contact their provider consultant.

Payment by capitation

For contracted primary care physicians, BCN reimburses some providers through monthly capitation payments instead of through individual claims. Through capitation payments, a capitated primary care physician provider or a provider group is paid a fixed amount for each assigned member regardless of the actual services provided.

Payment of health reimbursement arrangement claims

Health reimbursement arrangement claims paid with two checks

Health reimbursement arrangement claims are paid with two checks processed in the same payment cycle. One check is from the member's health plan; the other check is from the member's health reimbursement arrangement account. The amounts in the two checks total the amount owed for the claim.

If the checks are not received in the provider's office on the same day, it is usually because of a delay in the mail delivery. The provider should wait a few days before contacting Provider Inquiry.

For guidelines related to collecting from members with a health reimbursement arrangement, providers should refer to the Member Eligibility chapter of this manual, in the section titled "Collecting deductible, copayments and coinsurance for HRA members."

BCN claim form letters

Claim return letters

When claims cannot be processed, BCN sends a claim return letter stating the reason. Physicians should follow the instructions in the letter. Providers should contact Provider Inquiry if they have questions about the content of the letter or the instructions contained in the letter.

Providers can call Provider Inquiry using the appropriate phone number as shown on the *Provider Inquiry Contact Information* list, which is available at **ereferrals.bcbsm.com** > BCN > Quick Guides > **BCN Provider Inquiry Contact Information**.

This list is also available on BCN's Quick Guides page in Provider Secured Services.

E-visits and telemedicine visits

Description of e-visits and telemedicine visits

Clinical visits can be completed in the form of e-visits and telemedicine visits. E-visits and telemedicine visits are structured, real-time (synchronous), two-way health encounters using secure, HIPAA-compliant, audio-visual online communication technology to virtually connect a physician or other health care provider in one location to a patient in another location for the purpose of diagnosing and providing medical or other health treatment.

Note: For information specific to telepsychiatry services, refer to the subsection titled “Behavioral health telemedicine visits” later in this section.

Description of e-visits

E-visits (also called “online visits”) are described as follows:

- E-visits are for low-complexity conditions:
  - The e-visit is a low-complexity, straightforward decision-making encounter that addresses urgent but not emergency clinical conditions, such as a cold, sore throat or gastrointestinal issue. It is not anticipated that a follow-up encounter is required.
  - The discussion during the e-visit should reflect an algorithmic question and answer approach. At the points of making decisions regarding diagnosis and/or treatment, the provider does not require face-to-face contact to make an optimal decision.
  - An e-visit does not involve ongoing treatment (typically requiring more than three to five visits) without the expectation of a face-to-face visit with the same treating clinician or provider group.
- E-visits may be covered for BCN HMO (commercial) members only.
- The e-visit must be initiated by the patient.
- There is no originating site requirement. The patient does not need to be located at a specific type of site at the time the service occurs.

E-visits and telemedicine visits

Description of telemedicine visits

Telemedicine visits are described as follows:

- Telemedicine visits are for higher-complexity conditions:
  - A telemedicine service is for the ongoing treatment of a condition that is chronic and/or is expected to take more than three to five sessions before the condition resolves or stabilizes. A hosted visit or a face-to-face encounter may be required during the active treatment period.
  - Services are available to all clinicians but may not be the preferred method of delivery in certain clinical scenarios — for example, with chronic suicidal ideation or unstable angina. A hosted visit may be necessary due to the complexity of the clinical situation.

  Note: A hosted visit is a telemedicine consult with a remote health care provider hosted by a provider who is face to face with the patient. Certain clinical scenarios will dictate the use of a hosted visit, so as to minimize risk to the patient and maximize the clinical outcome. For example, when a patient presents to the emergency room with acute stroke symptoms and the neurology specialist is not on site, the emergency room physician hosts a consult with the remote neurologist in a real-time encounter.
- Telemedicine visits may be covered for both BCN HMO (commercial) and BCN Advantage members.
- Either the patient or the provider can initiate a telemedicine visit.
- There is an originating site requirement. The member needs to be located at one of the following locations at the time the service occurs:
  - Physician or practitioner office
  - Hospital or critical access hospital
  - Rural health clinic or federally qualified health center
  - Hospital or CAH-based renal dialysis center including satellite
  - Skilled nursing facility
  - Community mental health center

  In addition, for BCN Advantage members, the originating site for the telemedicine visit must be in one of the following:
  - A rural Health Professional Shortage Area located either outside of a Metropolitan Statistical Area or in a rural census tract
  - A county outside of an MSA

  This additional site restriction is in place because BCN Advantage coverage mirrors that for Original Medicare. More information on Original Medicare coverage is found in the **MLN for Telehealth Services*** published by CMS.

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E-visits and telemedicine visits

Criteria for reimbursement of e-visits and telemedicine visits

For e-visits and telemedicine visits, the following criteria must be met for the visit to be eligible for reimbursement by BCN:

- The visit must be real-time (synchronous) between the patient and health care professional.
- The visit is conducted over a HIPAA-compliant secured channel, as outlined in BCN's medical policies.
- The provider must be licensed to practice in Michigan but does not need to be physically located in Michigan.
- The provider must be contracted with BCN.
- The services must be within the provider's scope of practice.
- All referral and authorization requirements that apply to the service must be met.

E-visits and telemedicine visits

Additional reimbursement guidelines for e-visits and telemedicine visits

Claims for e-visits and telemedicine visits may be submitted electronically or via a CMS-1500 form.

The following procedure codes are eligible for reimbursement:

- **E-visits.** E-visits are reimbursable for both BCN HMO (commercial) and BCN Advantage members, using procedure code * 99421, *99422 or *99423. No modifier is used. Note: Self-funded plans may opt out of the e-visit benefit.
- **Telemedicine visits.** Most telemedicine visits are reimbursable for both BCN commercial members and BCN Advantage members, as outlined in the following list of procedure codes:

• *90791	• *90961	• *99201	• *99355	• G0421
• *90792	• *90963	• *99202	• *99356	• G0425
• *90832	• *90964	• *99203	• *99357	• G0426
• *90833	• *90965	• *99204	• *99406	• G0427
• *90834	• *90966	• *99205	• *99407	• G0438†
• *90836	• *90967	• *99211	• *99495	• G0439†
• *90837	• *90968	• *99212	• *99496	• G0442
• *90838	• *90969	• *99213	• *99497†	• G0443
• *90845†	• *90970	• *99214	• *99498†	• G0444
• *90846	• *96116	• *99215	• G0108	• G0445
• *90847	• *96150	• *99231	• G0109	• G0446
• *90951	• *96151	• *99232	• G0270	• G0447
• *90952	• *96152	• *99233	• G0396	• G0459†
• *90954	• *96153	• *99307	• G0397	• G0508
• *90955	• *96154	• *99308	• G0406	• G0509
• *90957	• *97802	• *99309	• G0407	• Q3014
• *90958	• *97803	• *99310	• G0408	
• *90960	• *97804	• *99354	• G0420	

†Reimbursable for BCN Advantage members only

Important! Providers must add modifier GT to the normal code for the telemedicine visit. In addition, telemedicine visits must be billed using place of service 02 (the location where health services and health-related services are provided or received, through telecommunication technology). Refer to **CMS Transmittal 3586**** for more information.

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Updates are added to show that effective Jan. 1, 2020, e-visits can be billed with procedure code *99421, *99422 and *99423 for BCN Advantage members as well as for BCN HMO members.

E-visits and telemedicine visits

Service that are not reimbursable

The following services are not eligible for reimbursement for BCN commercial or BCN Advantage members:

- Storing and forwarding information
- Telemonitoring
- Email-only, telephone-only and text-only communication
- Facsimile transmission
- Request for medication refills
- Reporting of normal test results
- Provision of educational materials
- Scheduling of appointments and other health care-related issues
- Registration or updating billing information
- Reminders for health care-related issues
- Referrals to other providers
- Any visit encounter resulting in an office visit, urgent care or emergency care encounter on the same day for the same condition
- Any visit encounter for the same condition originating from an office visit, urgent care or emergency care encounter within the previous seven days
- Any visit encounter occurring during the postoperative period

Note: Telephone, text and email communication can be considered an enhancement to a visit. However, if they are done independently, they are not considered as meeting the criteria for a visit to be reimbursable.

Providers strongly encouraged to contact BCN before offering e-visits or telemedicine visits

Before offering e-visits or telemedicine visits, providers and medical care groups are strongly encouraged to notify BCN that they will begin providing these services. Notifying BCN ahead of time allows time for BCN's online provider search to be updated to show that the provider offers these services.

To notify BCN, providers should update their information using the enrollment and change forms accessed by visiting **bcbsm.com/providers** and clicking Join Our Network > **Provider enrollment form**. Follow the prompts to complete the correct forms.

E-visits and telemedicine visits

Behavioral health telemedicine visit

Behavioral health telemedicine visits, also called telepsychiatry visits, offered by BCN behavioral health providers must follow the guidelines outlined in this section for telemedicine visits.

In addition, telepsychiatry visits are eligible for reimbursement only if the following conditions are met:

- Services must be delivered only by the following providers who are credentialed and contracted with BCN:
  - MD/DO psychiatrists
  - Psychiatric nurse practitioners
  - Clinical nurse specialists (also referred to as clinical nurse specialists-certified) who have a certification in adult gerontology, adult psychiatric mental health or gerontology). CNSs can provide medication reviews and assessments via telepsychiatry.

  Note: Any medical services delivered at the originating site can also be billed, as appropriate.
- The services billed can be with any E&M code or with procedure code *90792, with or without a crisis code or interactional complexity code, based on clinical appropriateness, but without add-on psychotherapy codes. In addition, the GT modifier needs to accompany the codes billed.

  Note: No psychotherapy services can be billed as telemedicine visits.

Also, a hosted visit (with a medical practitioner in the room with the patient) is preferred for most psychiatri c patients due to the additional clinical information that can be gathered and the potential clinical complexity of the patient's condition, which may require timely medical intervention.

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The information about telepsychiatry visits is updated to show that these services can be delivered by clinical nurse specialists who are certified in certain areas of work and who are credentialed and contracted with BCN. This is effective Jan. 1, 2020.

Additional information about e-visits and telemedicine visits

Additional information about e-visits and telemedicine visits is available in BCN's medical policies, as follows:

- "eVisits" medical policy
- "Telemedicine" medical policy

These policies can be accessed by by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > **Medical Policy Manual**.

E-visits and telemedicine visits

E-visits also available through American Well®

When their primary care physician is not available, members can obtain health care for low-complexity conditions (procedure code *99422) through the American Well online health service. This service offers members the option to connect with a practitioner by online video 24 hours a day, seven days a week.

Online visits through American Well are not intended to replace a member's relationship with his or her primary care physician. These visits are an alternative way to seek treatment for acute illness when the member's primary care physician is not available or when it is not convenient for the member to visit an urgent care center. Members are encouraged to follow up with their primary care physician after an online visit with American Well.

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The information about e-visits through American Well is updated to show that these visits are represented by procedure code *99422, effective Jan. 1, 2020.

Preventive services billing guidelines

BCN has established guidelines

BCN has established billing guidelines for providers to follow when performing preventive services, to comply with the provisions of the Patient Protection and Affordable Care Act effective for plan years beginning on or after September 23, 2010. These guidelines ensure that no member cost-sharing (deductibles, copayments or coinsurance) are charged for preventive services when this law applies.

Providers can find additional information on how to determine whether the Patient Protection and Affordable Care Act applies to a member's coverage in the "Collecting copayments, coinsurance and deductibles for preventive services" section of the Member Eligibility chapter of this manual.

General guidelines

Some general guidelines aimed at ensuring accurate member cost-sharing when billing preventive services include the following:

- For participating or network providers, if the primary purpose of the office visit is the delivery of the preventive service, the member may not be charged any cost-sharing (copayment, coinsurance or deductible) for the office visit. However, the member may be responsible for cost-sharing for the office visit if the visit's primary purpose is to diagnose or treat an illness or injury and preventive services are rendered secondarily.
- In some cases, BCN has frequency restrictions for coverage of preventive office visits. These frequency restrictions have not changed.
- Providers affiliated with BCN may not balance bill for the difference between the BCN-approved amount and the charge for the service.

Use of certain procedure codes helps ensure accurate member cost-sharing

When the primary reason for the visit is a preventive service and it is reported using one of the specific evaluation and management preventive service codes (*99381 through 99397), no member cost-sharing applies, even when a preventive visit or screening leads to a diagnosis.

The majority of evaluation and management (E&M) codes will continue to apply member cost-sharing because they are not set up in BCN's system to be recognized as preventive codes.

Nonpreventive medical services provided during the same visit are subject to applicable cost-sharing if billed as a separate line item on the claim.

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Preventive services billing guidelines

Diagnosis code exceptions to cost-sharing

While BCN typically applies cost-sharing to procedure codes, there are a few diagnosis code exceptions. These include:

- For the Woman's Choice program, E&M codes* 99201 through 99215 will not have member cost-sharing applied only when reported with either Z01.411 or Z01.419 as a primary diagnosis. Use of the diagnosis code indicates that the service is a preventive visit. When other diagnoses are reported with these E&M codes, the service will not be considered preventive and member cost-sharing will apply.
- For colonoscopies or sigmoidoscopies, when a patient is scheduled for a screening colonoscopy or sigmoidoscopy but during the procedure it is determined that another procedure is needed (polyp removal or biopsy of lesion, for example) and a standard colonoscopy or sigmoidoscopy code needs to be reported, the primary diagnosis must be reported as Z12.11 to avoid patient cost-sharing. Use of this diagnosis code indicates that the service was planned as a screening procedure. Providers should add a secondary diagnosis if applicable.
- For pregnant members, a separate service for counseling about breastfeeding is covered without any cost-sharing to the member. This service may be reported anytime during the antepartum or postpartum period. Up to three visits per calendar year are allowed for the mother. An additional three counseling visits per calendar year may be allowed for a baby under the age of 2, if needed. To distinguish this service from a regular pregnancy visit and to eliminate the cost-sharing for the member, providers should report the service with procedure codes *99401 through *99404 and diagnosis code Z39.1. Reporting the counseling with any other procedure or diagnosis code combination may result in cost-sharing for the member.

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Additional information

Providers may access additional information about preventive services under the provisions of the Patient Protection and Affordable Care Act at the following locations:

- In the "Collecting copayments, coinsurance and deductibles for preventive services" section of the **Member Eligibility chapter** of this manual
- Visit **bcbsm.com/providers**, log in to Provider Secured Services and click BCN Provider Publications and Resources > **Health Reform**
- At **bcbsm.com/healthreform**

Billing guidelines for PAs, CNSs, NPs, CNMs and CRNAs

Billing options for PAs, CNSs, NPs, CNMs and CRNAs

The services of physician assistants, clinical nurse specialists (also referred to as clinical nurse specialists-certified), nurse practitioners, certified nurse midwives and certified registered nurse anesthetists may be billed as outlined in the following table. In all cases, payment is made to the Tax ID number shown on the claim.

Note: Information on billing options for practitioners delivering behavioral health services is found in the Behavioral Health chapter of this manual.

Billing/reimbursement option	Practitioner type		
	PA/CNS	NP	CNM/CRNA
Incident to a physician's services	Yes[1]	Yes[1]	No
As part of a contracted practice group	Yes[2]	Yes[2]	Yes[2]
Directly, through an individual contract	No[3]	Yes[3]	As applicable[3]

[1]When billing incident to a physician's services, report the supervising physician's name in box 31 and the supervising physician's NPI in box 24j of the CMS-1500 form. The name of the PA , NP or CNS is not shown on the claim and no modifiers are used. For electronic claims, report the billing provider (supervising physician) in Loop 2010AA, NM109.

[2]When billing as part of a group on a paper CMS-1500 form, report the practitioner's NPI in box 24j, the servicing practitioner's name and degrees or credentials in box ~~Field~~ 31 and the group's NPI in box ~~Field~~ 33a of the CMS-1500 form. When submitting electronically (837P), report the group practice billing information in the Loop 2010AA NM1 segment (group NPI in the 2010AA NM109 data element) and report the rendering practitioner's information the in Loop 2310B segment (rendering practioner NPI in the NM109 data element). Note: For CNSs, a a physician must be part of the contracted practice group.

[3]Only primary care practitioners are contracted directly, through an individual contract. NPs who are primary care practitioners can bill directly, with the appropriate modifier. PAs and CNSs are not contracted directly, as they cannot be primary care practitioners.

This section is updated to include billing information related to clinical nurse specialists. Starting Jan. 1, 2020, CNSs are eligible to participate in BCN HMO and BCN Advantage networks. In addition, the information about how to bill is clarified.

Billing guidelines for PAs employed by hospitals or facilties

For physician assistants employed by hospitals or facilities, professional services may not be billed if the compensation for the physician assistant is included in the employer's operating expenses.

Services that are covered under the inpatient DRG and are provided by hospital- or facility-owned physician assistants may not be billed separately.

If a hospital- or facility-employed physician assistant provides clinical services independent of the duties associated with that employment and the compensation for the physician assistant is not included in the employer's operating expenses, the physician assistant must register with BCN and follow the billing guidelines found in this section of this chapter of the *BCN Provider Manual*.

Billing guidelines for outpatient laboratory services

General guidelines for outpatient laboratory services

BCN contracts with JVHL to provide all outpatient laboratory services. Claims for all outpatient laboratory services are eligible for payment only if the service provider is affiliated with BCN or with JVHL, BCN's approved laboratory vendor, or proper authorization is obtained from JVHL for out-of-network services.

Referring providers should use JVHL network laboratories. To obtain a service that is not provided by a JVHL laboratory, the provider must first submit the request for clinical review to JVHL.

It is the responsibility of the physician who orders the laboratory services to know whether the laboratory is in network and whether the laboratory procedure is covered by BCN. This information can be verified by JVHL.

In addition, the procedure must also be properly authorized before the service is provided, especially when the specimen will be directed to an out-of-network laboratory.

BCN will deny claims for outpatient toxicology laboratory services provided by an out-of-network laboratory without authorization from JVHL. This applies to BCN HMO (commercial) claims. A BCN member whose toxicology laboratory services are denied as out of network may not be balance-billed.

For assistance in identifying a JVHL network laboratory, call the JVHL administrative offices at 1-800-445-4979. JHVL business hours are 8 a.m. to 4:30 p.m. Monday through Friday; they are closed during the lunch hour, from noon to 1 p.m. (All times are Eastern time.) Messages can be left 24/7 and a return call will be placed during business hours.

This section is updated to clarify providers' responsibilities related to outpatient laboratory services. JVHL must authorize all out-of-network outpatient laboratory services. Contact information is added for JVHL. Starting Jan. 1, 2020, BCN will deny claims for outpatient toxicology laboratory services provided to BCN HMO members by an out-of-network laboratory without authorization from JVHL. Providers may not balance-bill BCN members whose toxicology laboratory services are denied as out of network.

Billing guidelines for outpatient laboratory services

Most laboratory services are billed to JVHL

Providers should submit claims data for outpatient laboratory services to JVHL electronically. This includes claims for:

- Both draw-site services and home draw services
- Specimens obtained from physician offices
- Testing performed in conjunction with outpatient visits

The only laboratory services that are not billed to JVHL are:

- Certain designated laboratory services rendered in physician offices. See "In-office tests billable to BCN" in this section.
- Laboratory services rendered outside Michigan. See "Billing for laboratory services provided to members outside Michigan" in this section.
- Services listed as exclusions to the JVHL agreement. See "Exclusions to the JVHL agreement" in this section.

In-office tests billable to BCN

To facilitate patient care, BCN allows physicians who are certified under the Clinical Laboratory Improvement Amendments to submit claims for certain designated laboratory services performed in their offices.

The procedure codes for the in-office laboratory tests that these primary care physicians and specialists can bill to BCN are available by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **In-office laboratory procedures billable to BCN**.

Providers should submit in-office laboratory claims for BCN members to:

BCN Claims
P.O. Box 68710
Grand Rapids, MI 49546-8710

Billing for laboratory services provided to members outside Michigan

An independent laboratory that provided a service for a BCN member outside Michigan should file the claim with the Blue Cross plan in the service area in which the specimen was drawn. This practice is in line with billing rules outlined by the Blue Cross and Blue Shield Association for laboratory, DME and specialty pharmacy claims that cross state lines.

Note: These claims were previously submitted through BlueCard.

Billing guidelines for outpatient laboratory services

Exclusions to the JVHL agreement

Some laboratory services fall outside the scope of the JVHL arrangement. The following table lists outpatient laboratory services that are not covered by JVHL because BCN assumes responsibility for them.

The same rules and exclusions apply whether BCN coverage is primary or secondary.

Service	Details on what's excluded from the JVHL contract and, therefore, billable to BCN
Blood products	• The following services are billable to BCN (All laboratory lines pay, not just those for the blood service.): - CPT procedure codes *36430 through *36460, *86890, *86891 and *86927 through *86999 - Revenue codes 038X and 039X — blood products • It is important to report not only the appropriate revenue code but also the correct HCPCS or CPT code indicating the blood product transfused. Not reporting the correct revenue code and HCPCS / CPT code combination could result in the denial of the transfusion service. Note: Blood bank services with codes *86077, *86078 and *86079 are covered by JVHL and are not billable to BCN.
Dialysis services	• The following services are billable to BCN: - CMS-1500 place of service is 65 (or UB-04 bill type is 013X) with revenue codes 0820-0889 - UB-04 bill type is 072X (dialysis facility / centers) with diagnosis codes N181-N19 Note: Effective Jan. 1, 2016, BCN pays laboratory claims with a renal diagnosis only if the services are completed in a dialysis facility or hospital dialysis unit.
Health departments	Health departments may bill BCN for all in-office laboratory services for which physicians can bill BCN. Health departments must use place of service code 71 on all laboratory claims.
Inpatient services	Place of service code 21 (or UB-04 bill type 011X, 012X, 018X)
Emergency room and urgent care center services	Providers should bill BCN for laboratory services provided during emergency room and urgent care center visits for claims that meet the following criteria: • CMS-1500 place of service is 20 (or UB-04 bill type is 013X) with revenue code 045X, 0516 or 0526. • CMS-1500 place of service is 23 (or UB-04 bill type is 013X) with revenue code 045X
Observation stays	Providers should bill BCN for laboratory services provided during observation stays when the OB/GYN observation claim shows a UB-04 bill type 013x and revenue code 0729.

(continued on next page)

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Billing guidelines for outpatient laboratory services

Exclusions to the JVHL agreement (continued)

Service	Details on what's excluded from the JVHL contract and, therefore, billable to BCN
Skilled nursing facilities	Providers should bill BCN for skilled nursing facility laboratory services when the place of service code 31, 32, 33 or 34 (or UB-04 bill type 021X-023X, 033X or 034X).
Surgical services	Providers should bill BCN for laboratory services provided directly pursuant to outpatient ambulatory surgical procedures and included on the same UB-04 as the surgery with revenue code 036X or 0490. Bill BCN with value code 30 to avoid denials.
Other	Providers should bill BCN for other laboratory services as follows: • Procedure codes *8XX99 (not otherwise classified) unless they have been authorized prior to the service being completed or they have an established fee schedule • Laboratory tests billable with codes SXXXX

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Billing guidelines for DME for members outside Michigan

Billing for DME provided to members outside Michigan

A DME supplier that provided a service for a BCN member outside Michigan should submit the claim as follows:

- For equipment that was shipped (including mail-ordered supplies), the DME supplier should submit the claim to the Blue Cross plan in the service area to which the equipment was shipped.
- For equipment that was purchased at a retail store, the DME supplier should submit the claim to the Blue Cross plan in the service area in which the equipment was purchased.

This practice is in line with billing rules outlined by the Blue Cross and Blue Shield Association for laboratory, DME and specialty pharmacy claims that cross state lines.

Note: These claims were previously submitted through BlueCard.

Billing guidelines for observation stays

Guidelines for billing observation care

Hospitals and professional providers may bill for observation stays only when observation care is the medically appropriate level of care for the member.

When a member is admitted for inpatient care but the admission is denied, the following guidelines apply:

- If the member was actually in observation and observation care was the appropriate level of care for the member's condition at the time, the services the member received may be billed as observation.
- If the member did not spend time in observation, the services rendered during the member's stay should be billed as outpatient services. This applies to BCN HMO (commercial) members only.

Submitting claims for observation stays

Claims for observation stays should be submitted with a HCPCS code associated with observation on a single service line with the units reported in total hours.

Observation units should not be submitted with more than one service date and additional observation lines may not be reported for each "day" in observation.

Ancillary services rendered during a member's observation stay should be reported using appropriate revenue and HCPCS codes, as applicable.

Providers should refer to the billing instructions on observation care for information about how facilities should bill observation services. This example can be accessed by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Observation stay**.

Billing guidelines for observation stays

Routine reimbursement for observation claims

Claims for observation services provided during the initial 48 hours of the stay are eligible for reimbursement. Claims for observation services rendered beyond the initial 48 hours will not result in additional payment.

Observation care is payable in the following circumstances:

- When a member is admitted from the emergency room or an urgent care setting
- When a member is referred directly from a physician's office or skilled nursing facility

Observation care is not payable in the following situations:

- After outpatient surgery. Reimbursement for recovery room care is included in the outpatient surgical fees.
- For routine preparation and recovery for a diagnostic or therapeutic service that requires active monitoring of the member, such as chemotherapy or transfusions
- For monitoring of pregnancy-related conditions such as preterm labor, hyperemesis gravidarum and gestational diabetes. These services are billable in the outpatient setting using the labor room/delivery room revenue code, since they fall under the member's maternity benefits.

Additional reimbursement for observation stays for BCN Advantage claims

For BCN Advantage claims to be reimbursed at the higher rate associated with an observation ambulatory payment category (APC), the following conditions must be present:

- The observation code line should be billed with only one service date.
- A qualifying clinic, emergency room or critical care code must be reported in addition to the observation code.

  Note: Additional payment for the observation stay may be added to the qualifying clinic, emergency room or critical care code.

For additional information, providers may refer to the observation billing guidelines in the **CMS Internet Only Manual (IOM) Publication 100-04, Chapter 4, Section 290.5**.*

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Billing guidelines for transitional care management services

Overview of transitional care management services

BCN provides coverage for transitional care management services for both BCN HMO (commercial) and BCN Advantage members when services are medically necessary, criteria are met and Medicare guidelines are followed. Documentation should clearly support the services provided.

The goal of transitional care management is to manage the patient's care upon release from an inpatient or partial hospital setting, observation care or a skilled nursing facility and to avoid a readmission. The care members require is of moderate or high complexity due to their medical or psychological condition or both.

It includes the coordination and management of the patient's care and services for his or her medical conditions and psychosocial needs during the 30-day post-discharge time frame. Essentially, the provider reporting the transitional care management code is facilitating the patient's transition back into the home or other appropriate community setting from the facility.

Transitional care management sevices begin on the day of discharge from an inpatient or partial hospital setting, observation care or a skilled nursing facility and continue for an additional 29 days. If additional evaluation and management services are provided during the 30-day transitional care period on a date of service that's different from the transitional care management visit, those services can be reported separately,

Key components of transitional care management services

To report a transitional care management service, three key components are required. Appeals must include documentation that these services occurred and that they occurred in the time frames noted.

- An interactive contact — This contact must be made to the beneficiary or designated caregiver within two business days of discharge. The medical record must include documentation about this contact or about the attempts to reach the patient.
- Certain non-face-to-face services — Unless determined to be not medically necessary, these services should also be provided and documented in the medical record. Examples of these services can include medication review and reconciliation, review of the need for or follow-up on diagnostic testing, patient or caregiver education or coordination of referrals.
- A face-to-face visit with the patient within defined time frames — Depending on the medical needs of the patient, a face-to-face visit must be made within seven days for patients requiring complex care and decision-making or within 14 days if the decision-making is at the moderate level.

This information must be clearly documented in the member's medical record. These three components are included in the transitional care management code and are not separately reportable.

Billing guidelines for transitional care management services

Procedure codes to use

Transitional care management services are reported using procedure codes *99495 and *99496. Use the appropriate code to match the level of care required by the member.

The transitional care management visit should be reported using the date of the initial face-to-face contact. If you are reporting the high complexity code, this visit is to occur within seven days of discharge. If you are reporting the moderate complexity code, the initial face-to-face visit is to occur within 14 days of discharge. The transitional care management service can be reported on a claim as soon as it is provided. You do not need to wait until the end of the 30-day transitional care management period to report. If additional evaluation and management visits are needed for dates of service after the initial visit, they can be reported separately and are not considered bundled in the transitional care management service.

If documentation does not reflect a moderate or high level of complexity and care coordination, and the components of transitional care management are not met, it is not appropriate to report a transitional care management code. In this circumstance, follow-up care may be best reflected by reporting an evaluation and management code of the appropriate level.

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Appealing an edit to a claim for transitional care management services

The transitional care management code should be reported on the 30th day.

The BCN claims system looks for a discharge or for a professional evaluation and management claim performed in a facility location to relate the transitional care management services to a facility stay. If one is not found, the claim may receive an edit.

If the claim receives an edit but services were performed, providers should submit a clinical editing appeal with the required supporting documentation.

Additional information on the appeal process is found in the section titled “Clinical editing appeal process,” which is located in this chapter.

Billing guidelines for transitional care management services

Summary of key points about billing transitional care management services

Here are some key points to keep in mind about billing transitional care management services:

- Transitional care management services can be reported for members discharged from select facility locations to help the transition to the community setting and prevent readmission.
- Transitional care management services cover a 30-day period. They begin with the discharge day and continue for the next 29 days.
- Criteria must be met to report transitional care management services including, but not limited to:
  - An interactive contact must be made with the patient within two business days of discharge. Documentation of the contact or the attempts to contact must be in the medical record.
  - Non-face-to-face services identified as appropriate and necessary for the management of the patient should be documented in the medical record.
  - A face-to-face visit within seven days is required for a member requiring high-complexity transitional care management and within 14 days for a member requiring moderate-complexity transitional care management.

Additional information

For additional information, refer to the CMS Medical Learning Network publication titled **Transitional Care Management Services**.*

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Billing guidelines for living-donor-related services for basic organ transplants

Guidelines for billing living-donor-related services for basic organ transplants

BCN and BCN Advantage cover living-donor-related services under the recipient's medical policy when the donor is not a member and when BCN or BCN Advantage has approved the transplant for the recipient. The recipient's medical policy should be billed only for living donors who are donating to a member on the policy.

These guidelines apply as follows:

- They apply to both BCN HMO (commercial) and BCN Advantage members.
- They apply only to basic organ transplants, which include bone marrow, kidney, cornea and skin.
- They do not apply to self-donations or cadaveric donations.

These guidelines do not change any benefits; rather, they place the medical necessity and financial responsibility with the recipient. The donor is held harmless, financially. The donor's coverage for complications includes the postoperative care period.

(continued on next page)

Billing guidelines for living-donor-related services for basic organ transplants

Guidelines for billing living-donor-related services for basic organ transplants (continued)

The guidelines are outlined in the following table:

If...	Then...
The recipient and the donor are both eligible BCN or BCN Advantage members...	Submit claims under the recipient's contract with the appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for both the recipient and the donor. The donor is not charged. Note: If the recipient and the donor are family members with coverage under the same policy, submit the claims using both the recipient's and the donor's names and the applicable procedure and diagnosis codes for both the recipient and the donor.
The recipient has BCN or BCN Advantage coverage and the donor has other insurance...	Submit claims under the recipient's contract with the appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for both the recipient and the donor. The donor is not charged. Note: A nonplan member donor claim is identified by the donor diagnosis codes in the Z52 code section in the ICD-10-CM code set. The Z52 diagnosis codes should be listed as a principal diagnosis code. Providers may also submit an attachment that indicates the patient is a donor; however, this is not required.
The recipient has BCN or BCN Advantage coverage and the donor has no coverage...	Submit claims under the recipient's contract with the appropriate donor and recipient procedure and diagnosis codes. Coverage will be provided for both the recipient and donor. The donor is not charged. Note: A nonplan member donor claim is identified by the donor diagnosis codes in the Z52 code section in the ICD-10-CM code set. The Z52 diagnosis codes should be listed as a principal diagnosis code. Providers may also submit an attachment that indicates the patient is a donor; however, this is not required.
The recipient has other insurance and the donor has BCN or BCN Advantage coverage...	Submit claims under the recipient's contract with appropriate donor and recipient procedure and diagnosis codes. The recipient's plan is billed for the donor charges. If the BCN or BCN Advantage member's donor claim is rejected by the other carrier (not a benefit), then the donor services are charged against their BCN or BCN Advantage policy. The donor is responsible for his or her cost share.

Note: When the donor's services are charged to the recipient's BCN or BCN Advantage policy, they are charged up to the contract limits.

For information about organ transplants involving Blue Cross members, providers should refer to the Human Organ Transplant Program chapter of the Blue Cross Blue Shield provider manuals. To access those manuals, visit **bcbsm.com/providers**, log in to Provider Secured Services, click *Provider Manuals* (in the lower right part of the welcome page) and click *Blue Cross Blue Shield provider manuals*.

Reimbursement for multiple imaging procedures

Multiple imaging procedure reduction guidelines

For multiple imaging procedures, the reimbursement for the technical component of the services is subject to a reduction. There is no reduction on the professional component.

These guidelines apply to professional claims submitted for both BCN HMO (commercial) and BCN Advantage lines of business and for facility claims for the commercial line of business. BCN Advantage facility claims are processed in accordance with the CMS reduction methodology.

Specifically, for imaging procedures subject to the multiple procedure reduction, the technical component is reduced for the procedures with the lower relative value units when multiple procedures are reported on the same day by the same provider (or by providers within the same group).

Multiple imaging procedure reduction example

The table below shows some procedures codes that are subject to the multiple procedure reduction and indicates the level of reimbursement for the technical component on each code.

This example applies to the group of procedure codes shown. The complete list of codes subject to the multiple procedure reduction is in CMS Transmittal 3578, which can be accessed by clicking **R3578CP**.**

CPT code	Units	Revenue code	Subject to MPR?	Reimbursement
*70470	1	351	Yes	Half
*71260	1	352	Yes	Half
*74177	1	352	Yes	Full

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This section is updated to show that the complete list of codes subject to the multiple procedure reduction is reflected in CMS Transmittal 3578.

Present-on-admission indicator for hospitals

Required reporting of present-on-admission indicator information

Hospitals participating with BCN are required to submit POA indicator information for all principal and secondary diagnoses, for both paper and electronic claims. The reporting of POA indicators is required across all BCN products.

The POA indicator is used to identify any conditions present at the time the order for admission occurs, including those that develop during an outpatient encounter in settings that include the emergency department, observation or outpatient surgery.

Exemptions from POA indicator reporting

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 listing of code categories that are exempt from POA indicator reporting requirements is available on the CMS website at **https://www.cms.gov/HospitalAcqCond/** > **Coding**.*

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POA values

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

Note: These values were established by CMS.

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.
Leave blank.	Exempt from POA reporting.

Reporting POA indicators

All discharge claims involving an inpatient admission to an acute care general hospital reported on a UB-04 claim form or an 837I claim transaction must be submitted with POA indicators for all primary and secondary diagnoses.

The POA indicator is placed adjacent to the primary and secondary diagnoses as the sixth character after the diagnosis code.

When billing claims electronically, providers should submit the POA indicator in Loop 2300, elements HI01-9 through HI12-9, as applicable.

Never events and other preventable serious adverse events

Required reporting of events

Never events and other preventable serious adverse events must be reported on claims for all BCN products.

Definitions

A never event is a serious, preventable condition that results from health and that should never have occurred. A never event is defined as follows:

- A surgical or other invasive procedure performed on the wrong body part or the wrong site
- A surgical or other invasive procedure performed on the wrong member
- The wrong surgical or other invasive procedure performed on a member

A preventable serious adverse event other than a never event is one that meets all of the following criteria:

- It is reasonably preventable through the use of evidence-based guidelines or criteria.
- It is within the control of the facility or the providers practicing within the facility.
- It is the result of an error made in the facility. (That is, the condition was not present when the member entered the facility.)
- It results in serious or significant harm.
- It is clearly, unambiguously and precisely identified, reportable and measurable.

Note: In the terminology of government programs, never events and other preventable serious adverse events are known as provider-preventable conditions. Those PPCs that occur in an inpatient hospital setting are called health care-acquired conditions. Those that occur elsewhere are called other provider-preventable conditions.

Never events and other preventable serious adverse events

Reporting of never events

Providers must comply with the following guidelines when reporting never events:

- **Facility services.** Hospitals are required to submit a no-pay claim (TOB 110) when an erroneous surgery related to a never event is reported. If there are covered services or procedures provided during the same stay as the erroneous surgery, hospitals are required to submit two claims:
  - One claim with covered services or procedures unrelated to the erroneous surgery(s) on a TOB 11X (with the exception of 110)
  - The other claim with the noncovered services or procedures related to the erroneous surgery or surgeries on a TOB 110 (no-pay claim). Within the first five diagnosis codes listed on the claim, the TOB 110 claim should also contain one of the diagnosis codes to indicate the type of preventable serious adverse event: Y65.51 (wrong surgery), Y65.52 (wrong patient) or Y65.53 (wrong body part).

  Note: Both the covered and the noncovered claim must have Statement Covers Periods that match.
- **Professional services.** Any claim for an erroneous surgery or procedure rendered by a practitioner should be submitted using the CMS-1500 claim form or an 837P claim transaction. The claim must include the appropriate modifier appended to all lines that relate to the erroneous surgery or procedure using one of the following applicable National Coverage Determination modifiers:
  - PA – surgery wrong body part
  - PB – surgery wrong patient
  - PC – wrong surgery on patient

  Note: Physician claims associated with these events should be submitted with a charge of 1 cent.

No reimbursement for never events

BCN will not reimburse a hospital or physician in the hospital setting for costs associated with direct actions that result in a never event.

In addition, all services provided in the operating room when an error occurs are considered related and are therefore not covered. No providers who are in the operating room when the preventable serious adverse event occurs and who could bill individually for their services are eligible for payment. All related services provided during the same hospitalization in which the error occurred are noncovered.

Note: Related services do not include performance of the correct procedure.

Never events and other preventable serious adverse events

Reporting of preventable serious adverse events other than never events

Preventable serious adverse events other than never events are identified by the diagnosis codes listed in the list of hospital-acquired conditions published by CMS. That list is available at **https://www.cms.gov/HospitalAcqCond/** > Hospital-Acquired Conditions (on the left navigation bar) > **FY 2013, FY 2014, and FY 2015 Final HAC List (no changes have been made during the past 3 years)**.* This document is a list of hospital-acquired conditions with ICD-9 codes.

Information on hospital-acquired conditions with ICD-10 codes is available at **https://www.cms.gov/HospitalAcqCond/** > **ICD-10 HAC List**.*

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Reduced reimbursement for preventable serious adverse events other than never events

BCN will reduce payment for preventable serious adverse events other than never events.

When any of the complicating or major complicating conditions associated with a preventable serious adverse event occur during an inpatient stay, payment will no longer reflect the higher-weighted Medicare Severity Diagnosis-Related Group (MS-DRG) rate for the condition.

Other aspects of reimbursement for never events and other preventable serious adverse events

Other aspects of BCN's reimbursement policy related to never events and other preventable serious adverse events include the following:

- The never events and other preventable serious adverse events covered under the policy are consistent with recent policy changes by CMS.
- Participating hospitals and physicians may not balance-bill members for any incremental costs associated with the treatment of never events and other preventable serious adverse events for which BCN has not paid. Members are encouraged to report these incidents to BCN, as appropriate.
- The policy cannot be changed by any customer.

Which providers are affected

The requirements related to serious adverse events apply to all acute care hospitals and exempt hospital units that have signed a Blue Cross Participating Hospital Agreement. This includes Peer Groups 1 through 6.

Policy is administered using MS-DRG Grouper

For DRG-reimbursed hospitals, BCN uses the most current version of the MS-DRG Grouper to administer the policy, incorporating the POA indicator into the DRG assignment.

Note: BCN continues to require authorization for all inpatient services. BCN's approval of an admission does not change any of the payment guidelines stated here.

Never events and other preventable serious adverse events

Additional information

Providers who want additional information about never events and other preventable serious adverse events should contact their Blue Cross/BCN provider consultant.

Readmission guidelines for facilities

Evaluate readmissions

If a member is readmitted within 14 days of a previous discharge, the hospital or facility should evaluate the admission to determine whether it should be billed separately or combined with the previous admission. All readmissions that occur within 14 days of the discharge date are subject to BCN review based on the following:

- **Premature discharge** − occurs when a member's condition is not sufficiently stable at discharge, resulting in a readmission within 14 days
- **Planned readmission** − occurs when a member is discharged with a documented plan to readmit for additional services within 14 days without a medical reason for the delay in services
- **Continuation of care** − a readmission due to one of the following:
  - Findings of an acute disease process are documented but not addressed during the first admission.
  - Treatment is initiated but not monitored or evaluated before discharge.
  - There is no follow-up outpatient discharge plan.

Guidelines for bundling admissions

In some instances, BCN will combine the two admissions into one for purposes of the DRG reimbursement. BCN's guidelines for bundling a readmission with the initial admission are available by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Guidelines for Bundling Admissions**.

How to bill for a combined admission

If the first admission was reported to BCN

Providers should submit a replacement claim with frequency code 7. The replacement claim should report the admit date of the first admission and the discharge date of the second admission. Total charges should equal the charges for both admissions. The days the member was not in the facility should be reported as revenue code 0180; no charges should be attached to this revenue code.

If the first admission was NOT reported to BCN

Providers should submit a new claim with frequency code 1. The new claim should report the admit date of the first admission and the discharge date of the second admission. The total charges should equal the charges for both admissions. The days the member was not in the facility should be reported as revenue code 0180; no charges should be attached to this revenue code.

Note: The frequency code differs depending on whether the first admission was previously reported.

Reimbursement of high-cost inpatient claims

BCN's process for handling high-cost inpatient claims

BCN's primary goal is to ensure that all claims are paid correctly the first time.

To achieve this goal for high-cost inpatient claims, BCN uses the following process:

- Equian reviews certain types of high-cost inpatient claims to detect and resolve errors before payment. Equian uses advanced analytics and a specific service delivery model to help ensure that their reviews are completed within five days using only an itemized bill for input.

  Note: BCN has developed a strategic relationship with Equian, a company that specializes in health care reimbursement analysis and payment integrity.
- BCN's internal claim-handling processes and approval workflows have been streamlined to save time in the reimbursement process.

BCN aims to achieve other goals with this approach, including:

- Reduction in administrative costs and in the need for multiple claim adjustments
- Speedier claim payments
- Reduction in post-payment audits and overpayment recoveries

Other billing and payment guidelines

Bill from contracted locations only

Providers should serve BCN members and bill for services only from locations at which they have a BCN contractual relationship.

If providers need to serve a BCN member from a noncontracted location, they must obtain authorization from BCN. BCN will deny claims for services that are not authorized and are billed from a noncontracted location and the claim will indicate the subscriber is liable.

Providers should be vigilant about complying with the contractual relationships designated for their different practice locations.

Reporting the National Drug Code on medical drug claims

For information on billing medical drug claims, refer to the Pharmacy chapter of this manual, in the section titled “Drugs covered under the medical benefit.”

Advanced Premium Tax Credit grace period

Providers should look in the Member Eligibility chapter of this manual for information on the Advanced Premium Tax Credit grace period. This applies to members who have purchased individual plans through the Health Insurance Marketplace and whose claims will be pended or paid depending on whether the member has paid his or her portion of the premiums.

Procedure codes for office visits after office hours or during extended office hours

For instructions on billing for office visits for members with BCN HMO (commercial) coverage that have occurred outside of regularly scheduled office hours, refer to **Billing instructions: After-hours care**.

These and other billing instructions are available by logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > **Billing / Claims**.

Guidelines for billing flu and other vaccines

For BCN HMO (commercial) members, providers may use all the standard CPT codes to bill flu vaccines, including CPT code *90658.

Note: Providers may opt to refer BCN members to participating pharmacies for certain vaccine services. Most-in-network pharmacies can bill flu, pneumonia, and zoster vaccines through their medical or pharmacy billing system. In-network pharmacies can also bill Tdap, HPV and quadrivalent meningitis (ACYW) vaccines.

For guidelines for billing flu vaccines for BCN Advantage members, providers should refer to the BCN Advantage chapter of this manual.

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Other billing and payment guidelines

Guidelines for ambulatory surgery facilities

Billing and payment guidelines for ambulatory surgery facilities are provided at the time a facility is contracted, as part of the provider affiliation agreement.

Providers can access these guidelines by clicking on the following hyperlink:

BCN ambulatory surgery facility billing and payment guidelines

Guidelines for DME claims from VA providers

For DME items, BCN requires U.S. Department of Veterans Affairs providers to bill monthly lease/rental claims using the following modifiers:

- RR - rental
- KH - first rental month
- KI - second and third rental months
- KJ - fourth to thirteenth rental months

These modifiers are used to calculate the appropriate 20% cost-sharing. VA providers should not submit claims for new equipment using modifier NU.

This applies to BCN65 and MyBlue Medigap members.

Note: VA providers, as government entities, cannot bill another government entity, so they do not submit claims to Medicare for primary claim processing. VA claims are received by BCN for processing of the secondary claim payment. Also, Medicare allows only lease/rental billing for DME items such as wheelchairs. As the secondary carrier, BCN relies on Medicare pricing to calculate the 20% cost share that is reimbursable to the VA.

Billing ground ambulance mileage amount

The process of billing ground ambulance claims differs based on whether the trip is less or more than 100 miles.

- For trips under 100 miles: Include actual mileage down to the tenth of a mile. Do not round miles up or down. To receive accurate payment, make sure your claims include actual mileage in the ambulance section (the CR 106 element of the CR1 segment on the 837P electronic standard transaction).

  Note: For trips of less than one mile, enter a “0” before the decimal point. For example, enter 0.9.

- For trips of 100 miles or more: The mileage should be rounded up to the nearest whole-number mile in the ambulance section. Do not use tenths of a mile.

Here are some examples:

- If the trip mileage is 28.7 miles, use 28.7 miles on the claim. Because this is below 100 miles, do not round the units to 29.
- If the trip mileage is 101.3 miles, round up to 102 miles on the claim.

This information applies to both BCN HMO (commercial) and BCN Advantage members.

Other billing and payment guidelines

Billing air ambulance services

The following are general guidelines for billing air ambulance services for all dates of service. These guidelines apply to BCN HMO (commercial), BCN Advantage and Blue Cross PPO (commercial) claims.

Claims for air ambulance services must be filed with the Blue plan located in the ZIP code in which the patient was placed on board the ambulance. This applies regardless of where the air ambulance is located. For example:

- If a BCN member is picked up in a Michigan ZIP code, the provider must file the claim with BCN.
- If a non-BCN member is picked up in a Michigan ZIP code, the provider must file the claim with Blue Cross Blue Shield of Michigan.
- For a patient picked up in an Ohio ZIP code, the provider must file with the local Blue plan in Ohio.
- If a Michigan air ambulance provider picks up a patient in a Florida ZIP code, the Michigan air ambulance provider must submit the claim to the local Blue plan in Florida.

Air ambulance claims submitted to the wrong plan will be rejected.

Providers can follow the guidelines outlined here when submitting claims:

- On CMS-1500 claims:
  - Include medical documentation supporting the need for air ambulance transport. Include the same documentation in the ambulance record.
  - Include the five-digit point of pickup ZIP code in Field 23, Prior Authorization Number.
- On UB-04 claims:
  - If the air ambulance service is not included with the local hospital charges, include Value Code A0 in Fields 39-41.
  - Include the five-digit point of pickup ZIP code in the Value Amount field (related to the Value Code A0 in Fields 39-41).
- For claims filed using the 837 electronic standard transaction:
  - Professional claims: Report all information in the entire Loop 2310E, including the five-digit point-of-pickup ZIP code.
  - Facility claims: Report Value Code A0 in Loop 2300, HI Segment with a BE qualifier and the five-digit point-of-pickup ZIP code as the value amount.

For additional guidelines related to billing for dates of service on or after Jan. 1, 2017, refer to **Billing instructions: Air ambulance services**. These guidelines apply to BCN HMO (commercial) and Blue Cross PPO (commercial) claims. They do not apply to BCN Advantage claims.

Other billing and payment guidelines

Guidelines for billing sleep studies

Reimbursement for sleep studies is available only to providers who have specifically contracted with BCN to perform these services. Facilities must have a separate provider agreement to be paid for home sleep studies.

Claims for sleep studies must be billed either electronically or using a CMS-1500 form. Claims submitted on a UB-04 claim form are not payable.

The following guidelines are provided for billing sleep studies.

Service	Procedure codes	Other guidelines
Home sleep study	• G0398, G0399, G0400[a] • *95800, *95806	• Bill only in the home setting (POS 12). • Bill as a global rate. • Separate billing using modifier 26 or TC is incorrect.
Outpatient / clinic sleep study	• *95782, *95783 • *95801[a], *95805, *95807, *95808, *95810, *95811	• Bill only in the office setting (POS 11), off-campus outpatient setting (POS 19) or on-campus outpatient setting (POS 22).

[a]Procedures associated with G0400 and *95801 are not covered for BCN HMO (commercial) and BCN Advantage members.They may be covered for BCN Advantage members if they are medically necessary and are authorized by the plan.

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Guidelines for billing visits when a physician moves from one group practice to another

Physicians who move from one group practice to another may report only established patient visits for the patients who follow them into the new practice setting.This applies when the patient had a face-to-face visit or service in the prior three years at either practice location. If there has not been such an encounter, or if the patient is seen by a different physician at the new practice, a new patient visit may be reported.

The reasons for this requirement are as follows:

- The physician's provider identification number is the same even if the tax ID is different
- The patients that the physician sees in the new setting are familiar to him or her, even if the records transfer with the patient from the previous practice

Once the patient is seen at the new practice, whether by the patient's current physician or by another physician, the patient would be considered established at that practice when seen by physicians of the same group and specialty.

Other billing and payment guidelines

Reporting of medical device credits by hospitals and ambulatory surgery centers

Manufacturers give credits to hospitals and ambulatory surgery centers for medical devices that must be replaced because of a recall or malfunction.

Note: To ensure equitable payment, in line with CMS policy, the payment for specified device-dependent ambulatory payment classifications is reduced by the estimated portion of the APC payment attributable to device costs (that is, the device offset) (**71 FR 68071 through 68077**).*

In regard to device credits, providers must follow these guidelines:

- Hospitals and ambulatory surgery centers must have an established policy and procedure for identifying and reporting device credits.
- When hospitals or ambulatory surgery centers receive full or partial device credits, they may not bill BCN or BCN Advantage for an item for which there is no cost.
- The Hospital Outpatient Prospective Payment System payment is reduced on the implantation procedure by 100% of the device offset for no cost/full credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC.

In addition, hospitals and ambulatory surgery centers should follow the guidelines in the following table when reporting device credits:

Claim type	Guidelines
Outpatient facility claims with dates of service on or before Dec. 31, 2013	**No cost / full credit: Use modifier FB (includes upgrades).** Append the FB modifier to the procedure code that reports the service provided to furnish the device when the hospital receives full credit for the cost of a new device. **Partial credit: Use modifier FC.** Append the FC modifier to the procedure code that reports the service provided to furnish the device when the hospital or ambulatory surgery center receives a partial credit of 50% or more of the cost of the new device.
Outpatient facility claims with dates of service on or after Jan. 1, 2014	Report the amount of the credit in the Amount field for value code FD (Credit Received from the Manufacturer for a Replaced Medical Device) when the hospital receives a credit for a replaced device listed that is 50% or greater than the cost of the device. Under this rule, hospitals and ambulatory surgery centers are no longer required to append the FB or FC modifier when receiving a device at no cost or with a full or partial credit.
Inpatient facility claims	Populate one of the following, as appropriate: • Condition Code 49: Product replacement within product life cycle — replacement of a product earlier than the anticipated life cycle due to an indication that the product is not functioning properly • Condition Code 50: Product replacement for known recall of a product — manufacturer or FDA has identified the product for recall and therefore replacement In addition, populate Value Code FD and the correlating Amount field with the amount of the credit, or cost reduction, received by the facility for the replaced device.

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Coordination of benefits

Resolving questions about a member's COB issues

Providers with questions about a member's COB issues are encouraged to work with their Blue Cross/BCN provider consultant to get those resolved.

Providers may call the BCN COB department at 1-800-808-6321 and follow the prompts for:

- Option 1: Other party liability (OPL), that is, auto and workers' compensation
- Option 2: Other carrier liability (OCL), that is, other health carriers and Medicare unrelated to BCN Advantage, BCN 65 or MyBlue Medigap

Or write to:

Blue Care Network (or BCN Advantage, as applicable)
COB Department — Mail Code G901
611 Cascade West Parkway S.E.
Grand Rapids, MI 49546-9903

When to bill COB

Coordination of benefits is a process that defines which health carrier or insurance company pays as primary when a member has more than one source of coverage for health care benefits.

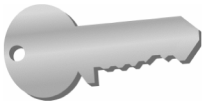
Providers should bill for COB only when both of the following circumstances apply:

- The member is covered by more than one health plan and BCN is secondary.
- The primary carrier has been billed and a Remittance Advice statement has been received showing a balance remaining.

If…	Then…
A claim is sent to BCN and requires COB investigation	Payment may be delayed until the primary coverage is determined.
It is determined that BCN is the primary carrier	The claim is processed as usual.
It is determined that BCN is the secondary carrier	The claim will be rejected unless it is submitted with payment information from the primary carrier

Coordination of benefits

Check member's insurance coverage



BCN may not pay a claim when it is unclear whether BCN is the primary or secondary carrier or plan. Therefore, members should always be asked for the following information when they check in:

- Whether they have coverage from more than one insurance carrier
- Whether their injury is the result of an accident

For any claim for which another carrier may be primary, providers should direct the member to log into his or her acccount and submit an **online Coordination of Benefits form** to BCN. Members can access and submit the form online.

Note: It is the member, not the provider, who must complete the online Coordination of Benefits form and submit it to BCN.

This form is used by BCN to gather the information necessary to determine whether more than one insurance carrier may be involved in adjudicating a claim.

Providers who have questions about a member's COB issues should contact their Blue Cross/BCN provider consultant.

COB and a health reimbursement arrangement

As with any plan, COB applies to members with a health reimbursement arrangement. For members whose primary coverage is through BCN, the BCN medical plan pays first and the BCN health reimbursement arrangement allowance pays second, simultaneously, for services reimbursable through a health reimbursement arrangement. Once BCN has processed the claim, the provider may forward the claim to the secondary carrier for processing.

Coordination of benefits

Situations that involve COB

The following situations may require coordination of benefits:

Worker's compensation

If a BCN member was injured on the job or as a result of his or her employment, the injury may be paid under the Worker's Compensation Act. Providers should bill the worker's compensation carrier and notify BCN's COB department.

Auto-related injuries

For approximately 10 to 15% auto policies, the auto insurer pays as primary. Providers should notify BCN's COB department of any vehicle-related injury so BCN can initiate an investigation.

Note: BCN has several policies that exclude coverage of auto-related injuries.

Working spouse

When both spouses work and both have group health insurance through the employer, the employee's own group health insurance or plan is considered primary and the spouse's plan is considered secondary.

Members covered by two different BCN contracts

Members may be covered by two different BCN contracts. An example of this is when a husband's primary coverage is provided by his employer's BCN plan and his secondary coverage is provided by a BCN plan through his wife's employer.

For members covered by two different BCN contracts, the provider should bill the claim under the primary BCN contract first. Once payment is received, if a balance remains, the provider should bill the secondary contract for the remaining balance. The claim sent to the secondary BCN contract should include the Remittance Advice statement from the primary BCN contract.

Information on which contract is primary is available on web-DENIS. BCN also notifies members who are covered under two different BCN contracts as to which contract is primary and which is secondary.

Dependent children of a married couple

When a dependent is covered by BCN and another health plan (or two different BCN contracts), the birthday rule determines primary coverage. According to this rule, the coverage held by the parent whose birthday occurs first in the year, by month and day, is the primary coverage for the dependent child.

Coordination of benefits

Situations that involve COB (continued)

Divorce

A divorce or paternity decree may assign financial responsibility for medical and hospitalization coverage. A court order, such as a divorce decree or an order from the Friend of the Court, **always supersedes** the birthday rule in determining which health carrier is primary. Providers should call the BCN COB department with questions on individual cases.

Disability/ESRD/working aged

The rules in this area are very complex. Providers should contact the BCN COB department with any questions.

Subrogation/other party liability

If a service is the result of an accident or injury that is covered by another insurance plan such as auto or motorcycle insurance, workers' compensation, homeowner's insurance or business liability coverage, the appropriate other insurer should be billed first, before BCN is billed. If the other plan denies coverage or if there is a balance remaining — due to a deductible, for example — the provider can bill BCN. The explanation of payment from the other party liability carrier must be included along with the claim so BCN can determine whether additional payment is appropriate.

If there is a dispute over who is responsible (for example, the other party liability plan denies the claim, indicating the service is not a covered benefit), the provider may bill BCN. BCN will generally pay these claims as if BCN were primary if all conditions of coverage have been met but will pursue reimbursement from the other party liability carrier if appropriate.

Submitting COB claims

COB claims may be submitted on paper or electronically.

- For claims submitted on paper, when BCN is the secondary carrier, a copy of the primary carrier's Remittance Advice statement should be submitted along with the claim. If the primary carrier denied the claim, an explanation of the denial should be included.
- For electronic claims, providers should refer to the COB billing guidelines in the appropriate EDI Companion Guide. This information can be accessed at **bcbsm.com/providers** > Quick Links > Electronic Connectivity (EDI) > **How to use EDI to exchange information with us electronically**. Under the "Reference Library" heading, select the appropriate provider type. Then click the hyperlink for the pertinent ANSI ASC X 12N 837 & 835 document. Inside the document, locate the COB information.

Coordination of benefits

Treatment of secondary-balance claims

When BCN receives a claim and is providing coverage secondary to another health plan, BCN requires that the primary plan has already processed the claim and issued the appropriate payment or denial. If the required information from the primary plan is not provided with the paper or electronic claim, BCN will deny the claim. If information from the primary plan is present, BCN will process the claim as the secondary plan, according to the standards set by the Michigan Coordination of Benefits Act and the National Association of Insurance Commissioners, as follows:

- **For non-Medicare-related claims:**

  BCN pays the lesser of the following:

  - The member's liability under the primary plan
  - BCN's liability, if BCN is the primary plan

  BCN may grant exceptions to this and pay the entire member liability that remains after the member's primary plan's payment, even if that is more than what BCN would be required to pay, if the amount is nominal. For example, for a claim submitted to BCN in which the original charges were $120, the allowance for the primary plan is $100, the primary plan paid $80 and $20 is indicated as the remaining member liability: If BCN's allowance for this service was $80 or less, no payment is technically owed. However, to eliminate member and provider confusion, to make sure the member is getting a benefit from having BCN as a secondary plan and to allow for automated processing of low-dollar claims, BCN may pay the $20 member liability. BCN currently defines nominal for this situation as under $100.

  For BCN plans with deductible amounts, BCN applies (that is, subtracts from payment) any applicable BCN deductible amount prior to making payments as the secondary plan.

- **When Medicare is primary:**

  BCN follows CMS guidelines when paying the secondary balance. This applies to claims for BCN 65, Medigap or commercial products.

Coordination of benefits

Payment of secondary balance claims when services are capitated

BCN generally covers a member's copayments for medical services when BCN coverage is secondary.

Note: For pharmacy services, see "Authorization and referral requirements when BCN is the secondary payer," later in this section.

When the copayment applies to a medical service reimbursed through capitation, BCN cannot pay the copayment directly to the primary care physician. In those instances, if a copayment is still due after the primary plan has paid, the primary care physician should collect the copayment from the BCN member. The provider should advise the member to request reimbursement from BCN.

This applies whether the member's primary coverage is through another BCN plan or through a non-BCN plan.

Authorization and referral requirements when BCN is the secondary payer

For medical claims, when BCN is the secondary health plan, no referral or authorization is required as long as all of the following are true:

- The member is eligible for BCN coverage
- The service is a covered benefit
- Information about the primary plan's payment is provided
- The member has followed the rules of the primary carrier
- The primary carrier has made payment on the claim

If the primary plan denied the claim because its rules were not followed, one of the following will apply:

- If BCN requires a referral or prior authorization for the service and it was not obtained, BCN will deny the claim.
- If BCN does not require a referral or authorization, BCN will pay the claim, but only after validating that all other BCN requirements were met.

Coordination of benefits

Billing secondary-balance facility claims when Medicare reserve days are exhausted

When Medicare Part A inpatient hospital limit and lifetime reserve days are exhausted, providers should bill Medicare for all Part B charges first. Once Medicare has paid the Part B charges, the claim will automatically be forwarded to BCN for processing by the Medicare crossover carrier. BCN will process this claim as secondary.

Guidelines for billing Medicare Part A include the following:

- **When Medicare days are exhausted prior to an admission:**

  Providers should submit to BCN an inpatient claim with all charges, using Occurrence Code A3 and the date the Medicare benefits were exhausted. This claim should list Medicare as the primary insurer with no prior payments indicated from Medicare. BCN processes this claim as primary.

- **When Medicare days are exhausted during an admission:**

  Providers should bill Medicare for the total charges of all services. Once Medicare has paid, the provider should submit to BCN an inpatient claim that indicates that Medicare is the primary insurer, shows the Medicare paid amount and includes a copy of the Medicare Remittance Advice statement. BCN will process this claim as secondary.

  The provider should then submit a second inpatient claim to BCN using Occurrence Code A3 and the date the Medicare benefits were exhausted. This claim should show the room and board days and charges that occurred after Medicare Part A benefits were exhausted. BCN processes this claim as primary.

Note: Providers should refer to the Care Management chapter of this manual for information on authorization requirements that apply in these situations.

The Remittance Advice

General information

After BCN processes a claim, a Remittance Advice (also called a claim voucher) is issued that tells the provider about the claim's payment status.

The Remittance Advice is a detailed summary disposition of the claims.

Types of Remittance Advice statements

There are two types of Remittance Advice statements:

- The professional Remittance Advice is sorted by the individual provider within the group. For BCN claims, it is also sorted by Comm/Other, BCN 65 and BCN Advantage for each provider. The claims for individual providers are subtotaled separately. A grand total of the transactions for all providers within the group is shown on the final page.
- The Facility Remittance Advice is sorted by inpatient and outpatient services. For BCN claims, it is also sorted by Comm/Other, BCN 65 and BCN Advantage. The claims for inpatient and outpatient services are subtotaled separately. A grand total of the transactions for all services is shown on the final page.

Two Remittance Advice statements issued for each health reimbursement arrangement claim

For each health reimbursement arrangement claim, providers receive two Remittance Advice statements with the same claim number. The message on each Remittance Advice refers to the health reimbursement arrangement payment as follows:

- The BCN commercial Remittance Advice includes the following message when the health reimbursement arrangement payment is zero or greater and the line of business (LOB) is 2000: "Member has an HRA acct—see the HRA RA for add'l payment."
- The Remittance Advice from the member's health reimbursement arrangement includes the following message when the health reimbursement arrangement payment is zero or greater and the LOB is 3000: "HRA payment." The amount shown in the Allowed Amount field equals the health reimbursement arrangement payment on the total claim.

Additional information about the health reimbursement arrangement Remittance Advice is found in the Member Eligibility chapter of this manual.

The Remittance Advice

Remittance Advice explanation codes

The claim's payment status is indicated by a three-character explanation code called the Explanation of Payment (EX) code, which is used as follows:

- If the payment is less than the amount charged, an EX code is shown. A HIPAA reason and remark code may also be also shown.
- If the payment is the same as the amount charged, no EX code is shown.

The key to these codes appears at the bottom of the last page of each Remittance Advice.

Note: For clinical editing purposes, providers can find a list of explanation codes that may result from BCN's clinical editing activities, along with the code descriptions and a recommendation for each code that indicates either a payment, reduction, denial or adjustment. To access this list, visit **bcbsm.com/providers**, log in to Provider Secured Services and click BCN Provider Publications and Resources > Billing / Claims > **EX Codes: Recommendations Regarding Appeal or Resubmission**.

Locating a Remittance Advice statement online

Providers can search for facility and professional Remittance Advice statements (vouchers) online using web-DENIS.

Note: Paper Remittance Advice statements are not mailed to in-state BCN providers. Providers must access Remittance Advice statements online.

Providers can access instructions for locating Remittance Advice statements (vouchers) online by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Locating a Remittance Advice online**.

Note: Web-DENIS searches can uncover facility Remittance Advice statements (vouchers) going back three years, but not those dated before July 15, 2012, which is the date when vouchers began to be stored in the system.

Receiving an electronic Remittance Advice via the HIPAA 835 standard transaction

Providers must take appropriate steps in order to begin receiving production 005010X221A1 835 transactions, including the completion of an EDI Trading Partner Agreement, a *Provider Authorization Form* and an *835 ERA Enrollment Form*.

To begin this process, receive more information or ask questions, providers should contact the EDI Help Desk at 1-800-542-0945 or visit **bcbsm.com/providers** > Quick Links > **Electronic Connectivity (EDI)** and select the appropriate provider type under the "Reference Library" heading. Then select the ANSI ASC X12N 835 Companion Document.

The Remittance Advice

Special contracted discount arrangements

Reimttance Advice statements can show that a specific discount has been applied to a claim because the provider belongs to to a local network that has a contracted discount arrangement. This information is displayed as follows:

- Electronic 835 remittances display the CAS code 131 when a provider-network-related discount has been applied.
- Paper remittances show:
  - The EX code BQT (BCN contract discount, along with the name of the medical care group) indicates the discount was applied to the claim line.
  - The product ID indicates either “MDCO,” for Metro Detroit HMO, or “TWES,” for Blue Cross Partnered.

Providers may call PARS after a Remittance Advice has been received

If a Remittance Advice has been received but more discussion is needed, the Provider Automated Response System offers options to speak to a customer service representative. This applies only to issues not related to clinical edits. See the section titled “Clinical editing” later in this chapter for information on calling about clinical edits.

Note: Providers can call PARS 24 hours a day, seven days a week, but your call can be transferred to a Customer Service call center only during the hours the call center is open. Voice messages are not accepted. If the call center is not open, the provider will get a message indicating that.

Complete the following steps:

1. Call PARS using the appropriate number, as shown on the **Provider Inquiry Contact Information** document.
2. Select the Claims Information option.
3. Say “no” when PARS asks if you’re calling about the status of a claim.
4. Say “yes” when PARS asks if you have received a Remittance Advice.
5. Select from among the following additional options:
   - Payment other than anticipated (for all members)
   - Clarify a rejection or denied claim (for all members)
   - Discuss accounts receivable or accounts payable (for all members)
   - Obtain status on a previously submitted medical-surgical preauthorization request (for Blue Cross professional providers only)
   - Initiate a recovery (for Blue Cross commercial and Blue Cross Medicare Plus Blue claims only)
   - Check status (for BCN Advantage and Blue Cross Medicare Plus Blue claims only)
   - Appeals (for BCN HMO and BCN Advantage claims only)

BCN claims troubleshooting

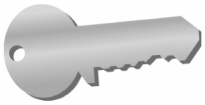
Following up on claims

Providers should take the steps outlined in the **Claims Troubleshooting** document when following up on BCN claims that were initially submitted to BCN.

For claims processed by Blue Cross or by a BCN vendor, providers should refer to the *BCN Provider Resource Guide* for the appropriate telephone number. Both the *BCN Provider Resource Guide* and the *BCN Provider Resource Guide At-a Glance* (a one-page summary of key BCN contact information) can be accessed at on BCN's **Quick Guides** page at **ereferrals.bcbsm.com**. They can also be accessed on the Quick Guides page located in the BCN Provider Publications and Resources website within Provider Secured Services.

Checking the status of a claim

All providers can check the status of a claim



Providers can check on the status of a claim in one of the following ways:

- Use web-DENIS

  Note: The status of a claim can be checked at any time via web-DENIS.

OR

- Call PARS using the appropriate number, as shown on the **Provider Inquiry Contact Information** document.

  Note: PARS provides information on both pending and finalized claims with the exception of pharmacy claims. This information is available 24 hours a day, seven days a week.

Providers who have not received information on a claim they have submitted should allow 45 days from the submission date before sending a new claim. Providers should not submit the same claim again until after 45 days.

All providers can call to check the status of a claim

When calling to check the status of a claim, providers should have the following information available:

For web-DENIS	For PARS
• NPI • Tax Identification Number • Member's enrollee ID number (nine digits) • Member's name • Member's date of birth • Date of service • Place of service (office, inpatient or outpatient) • Procedure code • Amount billed for procedure • Service authorization number or a copy of the referral request form	• Facility code, professional provider ID or NPI • Member's ZIP code • Member's name • Member's birth date • Member's enrollee ID number (nine digits) • Date of service • Procedure code or revenue code (required only if additional claim detail is requested) • Total amount charged on the claim

Through web-DENIS, PARS or the Blue Cross/BCN provider consultant, the provider will be able to determine whether the claim:

- Is in BCN's system waiting for further action
- Was approved for payment
- Was denied
- Is not in the system

Checking the status of a claim

Professional providers can use web-DENIS to status claims

Professional providers can use web-DENIS to check the status of their claims online. Providers can visit **bcbsm.com/providers**, log in to Provider Secured Services and select *web-DENIS*. Click Professional Claims > Professional Claims Tracking, then complete the following steps:

1. Enter the nine-digit enrollee ID number in the Enter Contract Number field.
2. Click *BCN*.
3. Select the servicing provider's NPI from the Provider Code drop-down menu, enter the date of service and click Enter.
4. Click on the member's name to generate a list of BCN services. This will display a listing of all claims processed for the selected member. This list will include the:
   - Approved amount
   - Copays and deductibles
   - Amount paid or denied with an explanation code
5. If the claim was rejected, click on the nonpayment code for a detailed explanation as to why the claim was denied.

Facility providers can use web-DENIS to status claims

Facility providers can use web-DENIS to check the status of their claims online. Providers can visit **bcbsm.com/providers**, log in to Provider Secured Services and select *web-DENIS*. Click Facility Claims > BCN Facility Claims Tracking, then complete the following steps:

1. Enter the enrollee ID number and date of service and choose NPI from the drop-down menu.
2. Click Enter.
3. Click on the Claim Number for the Claim Detail information.
4. If the claim was rejected, click on the nonpayment code for a detailed explanation as to why the claim was denied.

Checking the status of a claim

Primary care physicians can use web-DENIS to access claims summary records

BCN primary care physicians can use web-DENIS to access claims history for BCN online. To access claims history, providers can visit **bcbsm.com/providers**, log in to Provider Secured Services and select *web-DENIS*. Click Professional Claims > BCN PCP Claims Summary and complete the following steps:

1. Enter the nine-digit enrollee ID number, select the NPI for the member's primary care physician from the drop-down menu and click Enter. The database will bring back a 180-day record of all BCN claims.

   Note: The NPI selected must be the primary care physician for the member in order for this information to be viewed.
2. Click on the member's name to generate a listing of BCN services.

   Note: Provider must be the member's primary care physician to view this information.
3. Click on the date of service to access detailed claims summary records.
4. To check another member, click *Input Form* and repeat the process.

Following up on EDI claims using web-DENIS

Providers can use web-DENIS to view the status of EDI claims.

Providers can all PARS to check the status of a claim

Providers may call PARS to check the status of a pending or finalized claim after it has been submitted. Complete the following steps:

1. Call PARS using the appropriate number, as shown on the **Provider Inquiry Contact Information** document.
2. Select the Claims Information option.
3. Select the Claims Status option.

Providers who have not received information on a claim they have submitted should allow 45 days from the submission date before sending a new claim.

The information available through PARS on pending claims

For pending claims, the following information is available through PARS:

- Internal claim number
- Date the claim was received
- Message indicating the claim is pending, as follows:
  - If the claim has been pending less than 30 days, the provider is asked to allow additional time for the claim to finalize.
  - If the claim has been pending for more than 30 days, the provider is offered the option to transfer to a call center.

Checking the status of a claim

The information available through PARS on finalized claims

For finalized claims, the following information is available through PARS:

- For paid claims:
  - Internal claim number
  - EFT trace number (for providers paid electronically) or check number
  - EFT payment date (for providers paid electronically) or the date of the check and the date the check was posted
  - Total amount paid on the claim
  - Member cost-share applied (deductible, coinsurance or copayment, as applicable)
  - Information that the claim was processed to the subscriber, as applicable. If a payment was made, the payment date is also provided.
- For rejected claims:
  - Internal claim number
  - Denial reason
  - Date the claim was finalized

Specific, detailied information is also available for each claim line. To obtain that, the provider must provide the procedure code or revenue code. PARS then provides the following information for each claim line:

- Charged, allowed and payment amounts
- Rejection or denial reason
- Member liability, as applicable (deductible, coinsurance or copayment)

Following up on EDI claims via the HIPAA 276/277 standard electronic transaction

Providers who submit professional or facility claims electronically to BCN can register to receive a weekly 835 HIPAA-compliant transaction set. This file contains claims finalized during the weekly processing cycle. The instructions for registering are found in the “The Remittance Advice” section of the chapter.

Providers who submit claims electronically can use the HIPAA 276/277 standard electronic transaction (Claim Status Inquiry and Response) to check the status of a claim. For additional information about the HIPAA 276/277 standard electronic transaction, providers should email Electronic Data Interchange at EDICustMgmt@bcbsm.com.

Submitting a replacement or void claim

Guidelines for filing a replacement or void claim

- **Filing a replacement (corrected, TOB XXX7 or Frequency 7) claim.** A corrected claim is a replacement of a previously submitted claim that contains changes or corrections to previously submitted charges, clinical or procedure codes, dates of service, etc. A corrected claim should be submitted with **all** line items that were billed on the original claim. It should never be filed with **only** the line items that are being corrected. In addition:
  - If services previously billed are being deleted (that is, if the corrected claim has fewer lines than the original claim), the provider may include a note to confirm that the deleted codes were originally billed in error.
  - If it's the member information that's being updated, do not submit a replacement (corrected) claim. Instead, submit a void claim and then bill the services on a new claim that includes the correct member information.
- **Filing a void (TOB XXX8 or Frequency 8) claim.** When filing a void claim, the provider must rebill all services that were billed on the original claim that is being voided. These include both paid and denied services that were on the original claim.

  Submit a TOB 8 (void) claim **only** when voiding the entire claim.

Different from clinical editing appeal process

Providers should not file a replacement or void claim as a clinical editing appeal. The clinical editing appeal process is different from the replacement or void claim process.

Additional information on the clinical editing appeal process can be found in the "Clinical editing appeal process" section of the Claims chapter. For clinical editing appeals, billers should use the *Clinical Editing Appeal Form*, which is available on BCN's **Billing / Claims** page in Provider Secured Services.

Time frame for submitting a replacement or void claim

Information about timely filing limits is found in the "Submitting claims to BCN — the basics" section of this chapter.

If the response to the replacement or void claim is still not what the biller was expecting, the biller should contact his or her Blue Cross/BCN provider consultant.

Submitting a replacement or void claim

Facility and professional providers can file a replacement or void claim electronically

For both professional and facility providers, the easiest way to file a replacement or void claim is electronically, using EDI.

The benefits of filing a claim using EDI include the following:

- Lower costs
- Improved tracking and processing
- Improved turnaround times

For an electronic replacement or void claim to be properly adjudicated, the information listed below must be included in the electronic claim. This is in addition to all regularly required fields.

On the 837, Loop 2300, Field CLM05-3 must have one of the following frequency code values:

- Value of 7, to indicate replacement of a previously processed claim (either paid or denied)
- Value of 8, to indicate a void

When a biller submits a frequency code value of 7 or 8, he or she must include the 12-digit BCN claim number located on the original or previous Remittance Advice for the service in question. The information must be reported in Loop 2300 with a REF segment and must include the qualifier F8.

For more information about claims by EDI, providers can refer to the in the reference documents at **bcbsm.com/providers** > Quick Links > **Electronic Connectivity (EDI)**. Providers can also call the Blue Cross EDI department at 1-800-542-0945.

Submitting a replacement or void claim

Facility providers can file a paper replacement or void claim using a UB-04 with a frequency code 7

Facility providers can submit a paper replacement or void claim using a UB-04 claim form with a frequency code 7.

When completing the UB-04 with a frequency code 7, the provider is replacing a prior claim. Frequency code 7 is used when corrections are needed for previously submitted charges, clinical or procedure codes, dates of service, etc.

The claim should be submitted by completing the following steps:

Print and complete the UB-04 claim form available by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **UB-04 form**.

Note: Providers should complete the form according to instructions available in the *National UB-04 Manual*.

This includes the following:

- Enter the appropriate type of bill code, ending in frequency code 7.
- Enter the claim number from the original or previous Remittance Advice for the service in question.

4. Attach any relevant documentation.
5. Mail the request to the appropriate address:

Blue Care Network
P.O. Box 68710
Grand Rapids MI 49516-8710

BCN Advantage
P.O. Box 68753
Grand Rapids MI 49516-8753

For additional information on how to file a replacement or void claim, facility providers should review the claim example *Replacement claim: outpatient, frequency code 7*, which is available by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Replacement claim: OP frequency code 7**.

Note: Information about Blue Cross Complete claims is found in the *Blue Cross Complete Provider Manual*, which is available at **MiBlueCrossComplete.com/providers**.*

*Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're required to let you know we're not responsible for its content.

Submitting a replacement or void claim

Professional providers can file a paper replacement or void claim using the CMS 1500

Professional providers who want to submit a paper replacement or void claim must submit using the CMS 1500 claim form.

They should insert either a 7 (to replace the original claim) or an 8 (to void the original claim) in Field 22 and enter the original claim number.

Additional billing instructions are available on BCN's **Billing / Claims** page in Provider Secured Services.

All providers: requesting reconsideration

Providers can submit a written request for reconsideration after having submitted a claim with a frequency code 7 and having received a second denial.

When submitting the written request, providers should include the following information:

- Cover letter describing the request
- Replacement or void claim
- Supporting documentation, such as a copy of the referral or office records

Providers should mail the request to the appropriate address:

Blue Care Network
P.O. Box 68710
Grand Rapids MI 49516-8710

BCN Advantage
P.O. Box 68753
Grand Rapids MI 49516-8753

Incorrect payments and negative balances

Negative balances

Occasionally, the Remittance Advice will reference a negative balance. A negative balance is created when BCN pays a provider for services and later discovers this payment was incorrect. In most cases, the provider has already processed the BCN payment before the error is caught. When payment is made in error, BCN will take steps to recover the incorrect payment in accordance with terms contained in the provider agreement.

Among the more common reasons for incorrect payments are the following:

- Provider was overpaid for the service rendered due to billing or processing errors.
- Provider was paid in error because of member ineligibility, or the service provided was not authorized.
- It is determined that the member had other primary insurance.

Negative Balance Report

A Negative Balance Report is system generated when the provider has a negative balance on the Remittance Advice.

Additional information about negative balances is available at the following locations:

- By visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Locating a negative balance report online**
- By visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Understanding negative balances**

Assistance with negative balances

Providers who have questions about negative balances should contact their Blue Cross/BCN provider consultant.

Overpayments and incorrect payments

Overpayments and incorrect payments

For overpayment, payment for services not provided or duplicate payment for BCN members, providers should follow the instructions in the table below.

Note: Information about Blue Cross Complete claims is found in the *Blue Cross Complete Provider Manual*, which is available at **MiBlueCrossComplete.com/providers**.

If…	Then…
BCN overpaid a claim and the provider chooses to write BCN a check for the difference between the amount that should have been paid and the amount received	The provider should mail the check to the following address, with a note that must include: • Member name • Enrollee ID number • Date of service • Reason for refund • Copy of BCN Remittance Advice Recovery Team Technicians Blue Care Network (or BCN Advantage, as applicable) 611 Cascade West Parkway, S.E. Grand Rapids, MI 49546-2143
BCN makes a payment other than anticipated, sends a misdirected check addressed to another provider or sends a check for a service not performed	The provider should return the check to BCN at the following address, including a copy of the Remittance Advice with the error underlined or with an accompanying note of explanation. Status Inquiry Unit Blue Care Network (or BCN Advantage, as applicable) 611 Cascade West Parkway, S.E. Grand Rapids, MI 49546-2143 Note: The provider should return the check only if every claim is paid incorrectly.
The provider is from a hospital that is reimbursed through the Blue Cross Interim Payment system and wishes to notify BCN of an overpayment	The provider should send a note to the following address with the information listed here: • Member name • Enrollee ID number • Date of service • Reason for request • Copy of Remittance Advice Corporate Recovery Liaisons Blue Care Network (or BCN Advantage, as applicable) 611 Cascade West Parkway, S.E. Grand Rapids, MI 49546-2143

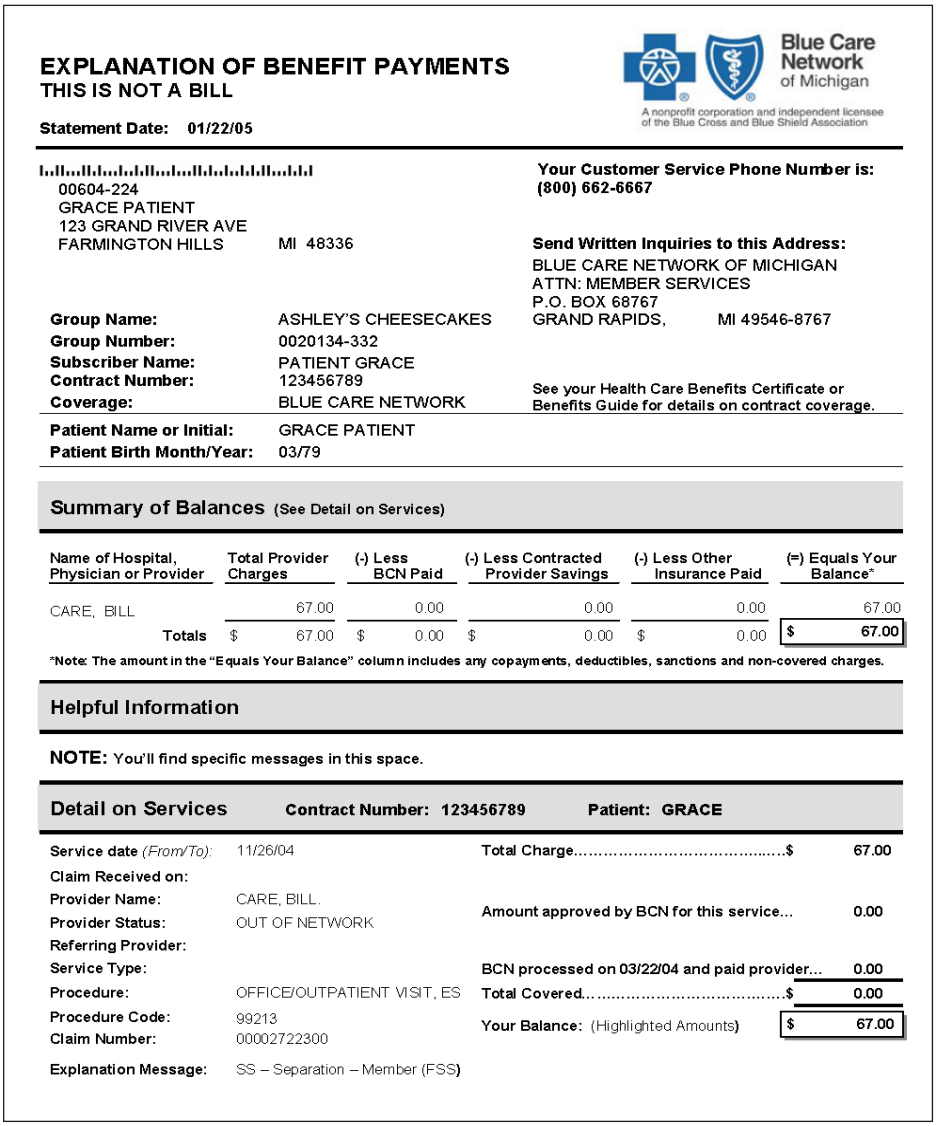
Members' Explanation of Benefits statement

Explanation of Benefits statement

Members may refer to an Explanation of Benefits statement when calling about claims denied by BCN. BCN sends these statements to inform members when they are financially liable for a service that is denied, reduced or paid directly to the member.

The EOB for all BCN claims carries the BCN logo, except for the EOB for BCN Advantage claims, which carries the BCN Advantage logo.

A copy of the EOB members may receive appears here.



EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Blue Care Network of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Statement Date: 01/22/05

00604-224
GRACE PATIENT
123 GRAND RIVER AVE
FARMINGTON HILLS MI 48336

Your Customer Service Phone Number is:
(800) 662-6667

Send Written Inquiries to this Address:
BLUE CARE NETWORK OF MICHIGAN
ATTN: MEMBER SERVICES
P.O. BOX 68767
GRAND RAPIDS, MI 49546-8767

Group Name: ASHLEY'S CHEESECAKES
Group Number: 0020134-332
Subscriber Name: PATIENT GRACE
Contract Number: 123456789
Coverage: BLUE CARE NETWORK

See your Health Care Benefits Certificate or Benefits Guide for details on contract coverage.

Patient Name or Initial: GRACE PATIENT
Patient Birth Month/Year: 03/79

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCN Paid	(-) Less Contracted Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
CARE, BILL	67.00	0.00	0.00	0.00	67.00
Totals	$ 67.00	$ 0.00	$ 0.00	$ 0.00	$ 67.00

*Note: The amount in the "Equals Your Balance" column includes any copayments, deductibles, sanctions and non-covered charges.

Helpful Information

NOTE: You'll find specific messages in this space.

Detail on Services **Contract Number: 123456789** **Patient: GRACE**

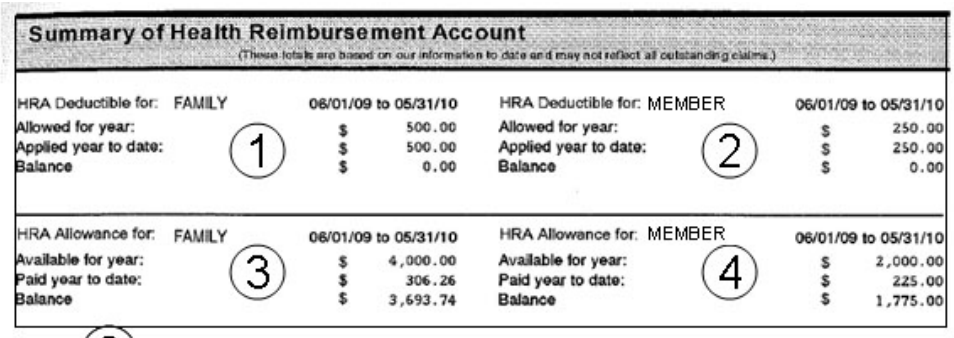
Service date *(From/To)*:	11/26/04	**Total Charge**.....$	67.00
Claim Received on:			
Provider Name:	CARE, BILL	**Amount approved by BCN for this service**...	0.00
Provider Status:	OUT OF NETWORK		
Referring Provider:			
Service Type:		**BCN processed on 03/22/04 and paid provider**...	0.00
Procedure:	OFFICE/OUTPATIENT VISIT, ES	**Total Covered**.....$	0.00
Procedure Code:	99213	**Your Balance:** (Highlighted Amounts)	$ 67.00
Claim Number:	00002722300		
Explanation Message:	SS – Separation – Member (FSS)		

Members' Explanation of Benefits statement

EOB statement for health reimbursement arrangement claims

For health reimbursement arrangement claims, members receive a single EOB statement that tracks their deductible and copayment amounts as well as their health reimbursement arrangement balances.

An example of an EOB with a health reimbursement arrangement section is shown below, with some explanation.



Summary of Health Reimbursement Account

(These totals are based on our information to date and may not reflect all outstanding claims.)

HRA Deductible for:	FAMILY	06/01/09 to 05/31/10	HRA Deductible for:	MEMBER	06/01/09 to 05/31/10
Allowed for year:		$ 500.00	Allowed for year:		$ 250.00
Applied year to date:	(1)	$ 500.00	Applied year to date:	(2)	$ 250.00
Balance		$ 0.00	Balance		$ 0.00
HRA Allowance for:	FAMILY	06/01/09 to 05/31/10	HRA Allowance for:	MEMBER	06/01/09 to 05/31/10
Available for year:		$ 4,000.00	Available for year:		$ 2,000.00
Paid year to date:	(3)	$ 306.26	Paid year to date:	(4)	$ 225.00
Balance		$ 3,693.74	Balance		$ 1,775.00

(1) and (2) HRA Deductible section

- If the FAMILY Applied year to date and the MEMBER Applied year to date fields are greater than zero, section 1 and 2 will print
- If the MEMBER Applied year to date field is zero, but FAMILY Applied year to date is greater than zero, only section 1 will print.
- The MEMBER subsection (2) should not print without the Family section (1) printing

(3) and (4) HRA Allowance section

- If the FAMILY Paid year to date and the MEMBER Paid year to date fields are greater than zero, section 3 and 4 will print
- If the MEMBER Paid year to date field is zero, but FAMILY Paid year to date is greater than zero, only section 3 will print.
- The MEMBER subsection (4) should not print without the Family section (3) printing

Clinical editing

Overview of clinical editing

BCN uses nationally recognized clinical editing software that automatically compares procedure codes billed on claims against nationally accepted coding and billing standards to check for clinical appropriateness and data accuracy.

The software identifies appropriate relationships between CPT-4 and HCPCS codes for medical, surgical, radiology, laboratory, pathology and anesthesiology procedures based on the following:

- CPT-4, HCPCS and ICD (diagnosis) coding requirements
- AMA and CMS (formerly HCFA) guidelines
- Industry standards
- Current medical policy and literature

Inappropriate relationships include:

- Unbundled procedures
- Incidental procedures
- Pre- and postoperative care included in a surgical fee
- Mutually exclusive procedures
- Upcoding services (the billing of a higher-level service when a lower-level service is warranted)

The system also flags procedures that are potentially cosmetic, experimental, obsolete or age or gender dependent. The Remittance Advice shows how each service was paid in full, paid in part or denied.

BCN clinical editing software is reviewed and updated regularly for consistency with nationally accepted coding and billing standards.

Modifier usage guidelines

BCN follows CMS and industry-standard billing and reimbursement practices related to the use of procedure code modifiers.

Providers can access guidelines involving modifer usage by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Resources and Publications > Billing / Claims > **Appropriate Modifier Usage**.

Drugs and biologicals guidelines

Providers can access guidelines related to the correct coding and reporting of services for drugs and biological agents that are subject to clinical editing by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Resources and Publications > Billing / Claims > **Drugs and Biologicals — Correct Coding and Reporting of Services**.

This applies to BCN Advantage members only.

Clinical editing denials

Reasons for nonpayment or reduction in payment

Here are some of the most common reasons for a clinical editing denial or payment reduction:

Procedure unbundling/rebundling

All procedures must be grouped, or bundled, under the most comprehensive procedure code. There are two types of unbundling and rebundling edits:

- Two or more procedure codes are used to indicate parts of a service for which there is a single, more comprehensive code that accurately describes the entire service but was not included in the claim(s). (Codes A + B should be billed as Code C.)
- Two or more procedure codes are submitted for the same date of service, but one of the codes is a comprehensive code that more accurately represents the services performed and billed. (Codes A + B are billed, but Code A is included in Code B.)

Incidental procedures

A procedure is determined to be incidental when it is performed at the same time as a more complex procedure and is an integral component of the primary procedure. (Codes A and B are billed but Code A is considered a component of the primary procedure, Code B.)

Mutually exclusive

These edits consist of procedure codes for which the technique varies but the outcome is the same, such as a total abdominal hysterectomy or a vaginal hysterectomy. Additionally, procedures that represent overlapping services or report an initial and subsequent service are considered mutually exclusive. (Codes A and B are reported but the relationship is improper. Clinically, B opposes A.)

Duplicate procedures

Procedures or services that are billed more than once on the same date of service may be considered duplicates. If clinical editing detects a duplicate service or procedure, the claim is denied. Examples include:

- Certain procedures can only be performed once in a person's life. The second billed procedure will be denied.
- Certain procedures should only be done a maximum number of times on a single date of service. When a procedure is performed more times than is clinically indicated on a single date of service and the need is not supported by a modifier (such as site modifiers), the duplicate procedure(s) will be denied.

Unlisted codes

A generic code used when there is not a specific CPT or HCPCS code for the service provided. Unlisted procedure codes require authorization and the submission of clinical documentation.

(continued on next page)

Clinical editing denials

Reasons for nonpayment or reduction in payment

(continued)

Invalid modifier or inappropriate procedure code-modifier relationship

Not all modifiers or procedure code and modifier combinations are valid. An incorrect combination will result in a denial.

Providers can get additional information on appropriate modifer usage by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Resources and Publications > Billing / Claims > **Appropriate Modifier Usage**.

Limit rules

Limit rules determine the appropriateness of units billed.

Cosmetic procedures

The billing of a potentially cosmetic procedure triggers an evaluation of services to determine medical necessity. BCN handles this through the authorization process.

Age or gender conflicts

The clinical appropriateness of the procedure code reported is inconsistent with the member's age or gender.

Obsolete procedures

Edits identify services that are no longer viewed as clinically appropriate to perform; authorization does not override these rejections.

Investigational

Claims for procedures classified as experimental will be denied unless authorized during BCN's authorization process.

Evaluation and management codes inconsistent with the service rendered

E&M services must be medically reasonable and necessary and must meet the requirements of the CPT code used on the claim. Documentation must support the medical necessity, appropriateness and level of the E&M service billed. E&M codes are subject to E&M coding edits.

BCN reserves the right to perform coding edits or to adjust payment when its clinical editing software identifies instances of a higher-level service being billed when a lower-level service is warranted. In such instances, BCN may deny payment or may adjust the payment to an amount consistent with the lower-level service. Inappropriate coding may also subject claims to audit review. These activities are part of BCN's program to detect, prevent and deter health care fraud, waste and abuse.

For more information, refer to the section titled "Health care fraud, waste and abuse" elsewhere in this chapter.

Clinical editing appeal process

Appealing a clinical editing decision

To appeal a clinical editing reimbursement determination, providers should first review the denial code. In some cases, the use of the **Clinical Editing Appeal Form** is necessary for an appeal. In other cases, the claim should be resubmitted.

Before responding to the denial, providers may refer to the list of *EX Codes: Recommendations Regarding Appeal or Resubmission*, which shows the denial codes for the paper remittance advice and BCN's recommendations as to whether an appeal or a resubmission is the most appropriate response.

This list can be accessed by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **EX Codes: Recommendations Regarding Appeal or Resubmission**.

Completing the *Clinical Editing Appeal Form*

The required fields on the *Clinical Editing Appeal Form* are marked with a red asterisk. When a form is submitted with required information missing, the appeal will be returned as incomplete.

Mailing or faxing the *Clinical Editing Appeal Form*

For an appeal, the date the *Clinical Editing Appeal Form* is postmarked or faxed must be within 180 days from the date of the **first** Remittance Advice on which the clinical editing denial appears. Providers should include the supporting documentation listed on the form and send the request to:

BY MAIL
Clinical Editing Appeals — Mail Code G820
Blue Care Network (or BCN Advantage, as applicable)
611 Cascade West Parkway, S.E.
Grand Rapids, MI 49546-2143

BY FAX
Fax to the number for BCN shown on the **Clinical Editing Appeal Form**.

Clinical editing appeals are typically reviewed within 30 days of receipt and a determination made. If the decision is upheld, the provider is sent a letter to that effect; if the decision is overturned, the appealed claim is processed for payment.

Note: Information about Blue Cross Complete claims is found in the *Blue Cross Complete Provider Manual*, which is available at **MiBlueCrossComplete.com/providers**.

Clinical editing appeal process

Only one opportunity to appeal a clinical editing denial

BCN has only one level of appeal for clinical editing denials. Providers should make sure they submit all pertinent information on the initial request and that the appeal form is complete and accurate. If the appeal is submitted with incomplete or inaccurate information, no additional opportunity for appeal is available.

Some key items to remember with submitting a clinical editing appeal include:

- Fill out the clinical editing form completely and accurately.
- Submit the appeal within 180 days of the **original** clinical editing denial.

  Note: Appeals submitted after the 180-day time limit are denied with the EX code BHP ("We cannot review the clinical editing claim appeal because it was sent after the filing limit of 180 days").
- Include all pertinent clinical information relevant to the appeal. These may include office notes, surgical reports, radiology reports or duplicate reports. The information that should be included depends on the denial received. If in doubt, include it.
- Include a contact person and phone number so BCN can call you if there are any questions.

For more information

For questions about the clinical editing appeal process, providers should call Provider Inquiry at the appropriate number as shown on the **Provider Inquiry Contact Information** list.

Providers who receive a BCN Remittance Advice containing any other denial code and wish to appeal the decision should refer to the "BCN claims troubleshooting" section earlier in this chapter.

The *Clinical Editing Appeal Form* can be found by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Billing / Claims > **Clinical Editing Appeal Form**.

Note: Providers should always use the most current form, which is available as described here. The online form displays the most updated list of codes that can be appealed.

Electronic funds transfer

Electronic transfer of payments

For medical care groups, provider groups and individual providers, arrangements can be made to deposit the following types of payments directly into a bank account through an electronic transfer of funds:

- Monthly capitation payments (to a medical care group, provider group or individual provider)
- Payments for professional claims (to a provider group or individual provider only)

BCN facility claims can be paid either by check or by EFT.

Benefits of EFT

The benefits of electronic funds transfer include:

- Faster payment and no cost to participate
- Elimination of problems associated with multiple mailings of checks and paper payment vouchers, including the incidental disclosure of protected health information by mail when addresses change and are not updated in BCN's system
- Access to 36 months of voucher history

Arranging for electronic payments

Providers who want to sign up for EFT payments should do the following:

- Medical care groups should contact their Blue Cross/BCN provider consultant.
- Provider groups and individual providers should follow the instructions at **bcbsm.com/providers** > Help Center > How to get access to Provider Secured Services > Sign up for EFT > **Online payments and electronic vouchers**.
- Facilities can sign up for EFT payments online as well. They should contact their Blue Cross/BCN provider consultant with any questions.

Note: BCN's EFT payments for claims and capitation are delivered to the same account to which Blue Cross EFT payments are delivered.

Electronic Remittance Advice statements

All providers, including those paid through EFT, can access Remittance Advice statements online. Providers can learn how to find a Remittance Advice online by visiting **bcbsm.com/vouchers** > **Steps for locating a voucher or remittance advice online**.

Note: BCN does not mail paper Remittance Advice statements to any in-state providers.

Assistance with EFT

Providers who have questions about EFT or who would like assistance in arranging for EFT should contact their Blue Cross/BCN provider consultant.

Health care fraud, waste and abuse

Detecting and preventing fraud, waste and abuse

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

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

What is fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as BCN) in order to get money or a benefit.

Examples of fraud

Examples of fraud include:

- Billing for services not rendered or provided to a member at no cost
- Upcoding services (the billing of a higher-level service when a lower-level service is warranted)
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

What is waste?

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

Examples of waste

Examples of waste include:

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

What is abuse?

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

Health care fraud, waste and abuse

Examples of abuse

Examples of abuse include:

- Providing and billing for excessive or unnecessary services (including billing a higher-level service when a lower-level service is warranted)
- Routinely waiving member coinsurance, copayments or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

Repayment rule

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

Any overpayment that is retained by the provider after the deadline to report/return the overpayment is an obligation under the federal False Claims Act, meaning that knowingly failing to report and return the overpayment as required may subject the provider to liability and penalties under the FCA.

Payment adjustments

BCN reserves the right to adjust payment when its clinical editing software identifies instances of a high-level service being billed when a lower-level service is warranted. In such instances, BCN may adjust the payment to an amount consistent with the lower-level service. These payment adjustments are part of BCN program to detect, prevent and deter health care fraud, waste and abuse.

For more information, refer to the section titled “Clinical editing denials” elsewhere in this chapter.

Additional information

Additional information on Blue Cross/BCN’s policies on fraud, waste and abuse is available on BCN’s Policies and Information page, which can be accessed by visiting **bcbsm.com/providers**, logging in to Provider Secured Services and clicking BCN Provider Publications and Resources > Policies and Information.

Corporate Recovery

Overview of Corporate Recovery

BCN's Corporate Recovery department is responsible for identifying recovery opportunities by analyzing data to identify billing irregularities and trends to pursue claims payment recoveries. Activities addressed by this department include:

- Incorrect payment — duplicate, overpayments or payment to wrong provider
- Negative balance accounts with no recent claim activity
- Inappropriate modifier usage
- Trends and inappropriate use of coding

Time frames

For overpayments due to duplicate payments and payments to the wrong provider, or for billing fraud or similar reasons, BCN may pursue recovery for as long as the law allows. For overpayments due to reasons such as identification of other carrier liability, clinical editing issues or pricing errors, BCN will generally pursue recovery for no more than two years from the date of payment.

Recovery method for incorrect payments

For all incorrect payments, BCN will immediately adjust the claim and process a systematic take-back.

This applies to incorrect payments that involve, for example, overpayments due to duplicate payments, adjustments to fee schedules or contracted fees, claims processing errors, payments to the wrong provider, identification of other primary insurance, audit findings, and services that were determined not to be a benefit, that were paid at the wrong benefit level or that were not properly authorized.

Recovery method for accounts with a negative balance

If the provider has a negative balance — which means that claims previously paid were adjusted, resulting in an overpayment to the provider — then future claims will be reduced to offset those overpayments. If the future payments are not enough to offset the negative balance within 30 days, the provider may receive a cover letter requesting payment for the overpayment and a spreadsheet with the member name, enrollee ID number, date of service, overpayment amount and reason for the overpayment.

The communication will request the refund within 45 days. If no response is received, BCN may forward the account to a collection agency.