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BCN Advantage operates like Blue Care Network

What are BCN’s Medicare products?

Blue Care Network’s Medicare Advantage products are:

- BCN Advantage℠ HMO-POS (group products and Basic, Elements, Classic and Prestige individual products)
- BCN Advantage℠ HMO ConnectedCare, for Medicare beneficiaries who reside in Arenac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw and Wayne counties
- BCN Advantage℠ HMO MyChoice Wellness, for Medicare beneficiaries who reside in Kent, Muskegon, Oceana and Ottawa counties
- BCN Advantage℠ HMO HealthySaver and BCN Advantage℠ HMO HealthyValue, for Medicare beneficiaries who reside in Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne counties

Note: In this chapter, “BCN Advantage℠” refers to all BCN Advantage HMO-POS and BCN Advantage HMO products unless otherwise noted.

BCN Advantage is an HMO and HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

BCN has contracted with the Centers for Medicare & Medicaid Services to provide health care coverage to Medicare beneficiaries. The BCN Advantage products:

- Provide members with all Medicare-covered services
- Offer preventive and wellness care (for example, an annual physical exam) and encourage the Medicare population to use medical services for preventive care
- Limit member cost to a predetermined copayment for Medicare Advantage (Medicare Parts A + B) coverage
- Provide Part B drugs, including chemotherapy durable medical equipment, and prosthetics and orthotics, subject to a 20 percent coinsurance

BCN, not Medicare, is the payer for covered health services provided to a BCN Advantage member, with the exception of hospice care, which is discussed later in this chapter.
BCN Advantage operates like Blue Care Network

What are BCN’s Medicare products?

Note: BCN Advantage HMO-POS is required to file with CMS as an HMO-POS plan in order to provide a benefit that covers Medicare services for members who are traveling outside of Michigan for up to six months. When traveling, members need to coordinate and authorize their care through their primary care physician. The BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue products offer coverage for urgent and emergency conditions when members are traveling but do not offer coverage for follow-up care for existing conditions outside the service area.

BCN Advantage products operate like BCN

The BCN Advantage administrative processes for physicians and other health care professionals are for the most part the same as in the BCN HMO℠ (commercial) plan. BCN adjudicates claims, responds to physician inquiries, educates health professionals about the product and administers utilization and quality management programs. Physicians and other health care professionals use many of the processes they are already familiar with to manage their BCN Advantage patients.

Areas that differ

While most of BCN Advantage resembles standard BCN coverage, there are some differences in forms, guidelines and processes. The areas that differ are described in this chapter.

Separate provider networks

The BCN Advantage provider networks are separate from the BCN provider network but do include primary care physicians, specialists, hospitals and providers who are licensed or certified by Medicare and by the state to provide health care services. In addition, the following apply:

- Not all BCN providers are included in the BCN Advantage network.
- BCN Advantage HMO ConnectedCare has its own designated provider network, which is a subset of the BCN Advantage network involving providers affiliated with Trinity Health and Ascension. Members must select a primary care physician from within the BCN Advantage HMO ConnectedCare network. Services provided by a BCN Advantage provider outside the BCN Advantage HMO ConnectedCare network require authorization from the plan.

(continued on next page)
BCN Advantage operates like Blue Care Network

### Separate provider networks

In addition, the following apply (continued):

- **BCN Advantage HMO MyChoice Wellness** has its own designated provider network, which is a subset of the BCN Advantage network involving providers affiliated with Mercy Health in West Michigan. Members select a primary care physician from within the MyChoice Wellness network. Care provided by a BCN Advantage provider outside the MyChoice Wellness network requires authorization from the plan.

- **BCN Advantage HMO HealthySaver** and **BCN Advantage HMO HealthyValue** have their own designated provider network, which is a combination of the ConnectedCare and MyChoice Wellness networks.

Providers who have questions about participation with BCN Advantage or coordinating care for a patient within the network associated with a specific member’s plan should contact Provider Inquiry.

### Behavioral health services (mental health and substance abuse)

The BCN Behavioral Health department is responsible for managing the behavioral health benefit for BCN Advantage members.

For additional information, providers should refer to the Behavioral Health chapter of this manual.

### Dental services

Blue Cross Blue Shield of Michigan provides coverage for routine dental care to BCN Advantage members with a dental benefit. Network dentists can be identified via the following website: [miBlueDentist.com](http://miBlueDentist.com).

For inquiries about dental services that are covered under a member’s medical benefit, providers should contact Provider Inquiry at the appropriate number as shown on the [Provider Inquiry Contact Information](#) list. Select the prompt for BCN Advantage.

Dental providers may also request eligibility and benefit information electronically, using the HIPAA 270/271 transaction standard. For information on this transaction, dental providers should email EDICustMgmt@bcbsm.com or contact their electronic clearinghouse.

A statement is added that dental providers may request eligibility and benefit information electronically, using the HIPAA 270/271 transaction standard.

### Diabetic supplies (outpatient)

J&B Medical Supply provides the statewide network for outpatient diabetic supplies. J&B also coordinates out-of-state services.

**Exception:** Diabetic shoes and inserts are handled through Northwood, Inc.

J&B Medical Supply — 1-888-896-6233

8 a.m. to 5 p.m. Monday through Friday
BCN Advantage operates like Blue Care Network

Fitness services
SilverSneakers® Fitness by Tivity Health™ is the provider of fitness services for those members with a fitness benefit. To identify a participating location, members or providers may do one of the following:

- Call 1-866-584-7352 between 8 a.m. and 8 p.m. Monday through Friday (TTY users should call 711.)
- Visit silversneakers.com

Hearing services
Audiology providers can be identified through the BCN online provider directory available at bcbsm.com/providersmedicare. Then do the following:

1. Click Find a Doctor.
2. Click Search without logging in.
3. In the “All categories” field, select Doctors by specialty.
4. Type in “Audiology.”
5. Click the search icon.
6. Review the results.

The instructions for searching for an audiologist are updated.

Durable medical equipment, prosthetics and orthotics (outpatient)
Northwood, Inc., provides the statewide network and third-party administration for Medicare-covered outpatient home DME and P&O. BCN contracts with Northwood to administer claims for all DME and P&O covered services. Northwood also coordinates out-of-state services.

Note: As a rule, Northwood provides nondiabetic outpatient medical items. Exception: Northwood provides diabetic shoes and inserts.

Outpatient home DME and P&O services must be authorized by Northwood in order to be covered by BCN.

Northwood — Contact Northwood’s customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.
8:30 a.m. to 5 p.m. Monday through Friday

Note: For plans that cover safety items such as shower/bathtub grab bars, bench/commode rails and elevated toilet seats, Northwood is the provider.

Laboratory services (outpatient)
JVHL provides the statewide network and third-party administration for outpatient laboratory services covered by BCN Advantage.

JVHL — 1-800-445-4979
8 a.m. to 4:30 p.m. Monday through Friday
## BCN Advantage operates like Blue Care Network

### Medicare Part B drugs and chemotherapy

For some BCN Advantage products, there is a 20 percent coinsurance applied to Part B drugs provided in the physician office or hospital outpatient setting. Part B drugs administered in the home setting under home infusion therapy have no cost-share applied.

Providers should refer to the online provider directory to locate home infusion therapy providers affiliated with BCN Advantage.

For claims questions, providers can call Provider Automated Response System (PARS) or Provider Inquiry at the appropriate number, as shown on the [Provider Inquiry Contact Information](#) document. Select the prompt for BCN Advantage.

---

### Physical, occupational and speech therapy (outpatient)

**Physical, occupational and speech therapy services in office and outpatient settings, including outpatient hospital settings**

- For guidelines on how to request authorization for these services, providers should refer to the Care Management chapter of this manual, in the section titled “Managing PT, OT and ST / Managing physical medicine services by chiropractors.”

- For information on reporting the nonpayable functional limitation G codes and their applicable modifiers, refer to the document [Outpatient rehabilitation services: Frequently asked questions](#) on BCN’s Outpatient Physical, Occupational and Speech Therapy Management Program page at [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). Look for the section titled “Functional limitation data collection reporting for Medicare and Medicare Advantage members.”

- For claims questions, providers can contact PARS or Provider Inquiry at the appropriate number, as shown on the [Provider Inquiry Contact Information](#) document. Select the prompt for BCN Advantage.
BCN Advantage operates like Blue Care Network

<table>
<thead>
<tr>
<th>Pharmacy services (for members who have a pharmacy benefit)</th>
<th>BCN Pharmacy Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Manages the pharmacy benefit</td>
</tr>
<tr>
<td></td>
<td>• Manages the BCN Clinical Pharmacy Help Desk</td>
</tr>
<tr>
<td></td>
<td>• Manages requests for coverage determination and prior authorization of pharmaceuticals</td>
</tr>
</tbody>
</table>

Express Scripts®:
• Processes prescription claims
• Provides pharmacy network (for pharmacies located both inside and outside the state of Michigan)
• Provides mail service pharmacy program for BCN HMO (commercial) and BCN Advantage members

Walgreens Mail Service
• Provides mail service pharmacy program for BCN Advantage members only

AllianceRx Walgreens Prime
• Provides some drugs covered under the medical benefit, to be administered incident to an office visit

This chapter is updated to show that Walgreens Specialty Pharmacy, LLC, is now called AllianceRx Walgreens Prime.

Transportation services
BCN Advantage does not provide non-emergency transportation services as a benefit, except for covered ambulance services.

Vision care
VSP® is the vision care provider for those members whose plans include routine vision coverage. To locate a VSP provider, members or providers may do one of the following:
• Call 1-800-877-7195 during the following hours:
  8 a.m. to 11 p.m. Monday through Friday
  10 a.m. to 11 p.m. on Saturday
  10 a.m. to 10 p.m. on Sunday
(TTY users should call 1-800-428-4833.)
• Visit vsp.com
# Standards and ratings

<table>
<thead>
<tr>
<th>Standards for access to care</th>
<th>Access standards related to appointments, waiting room times and after-hours care are outlined in the Access to Care chapter of this manual. BCN Advantage providers are responsible for complying with the standards for access to care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS® survey</td>
<td>CMS monitors health care providers through the Consumer Assessment of Healthcare Providers and Systems, which is a survey given to a random selection of members on an annual basis.</td>
</tr>
<tr>
<td>CMS star rating system</td>
<td>CMS has developed a quality and performance rating system commonly referred to as the star ratings. CMS encourages plans and providers to work together to offer quality health care and preventive care. BCN Advantage has also developed provider incentives related to these metrics and measures. The CMS star rating for a plan affects the payments it receives from Medicare. High-performing plans (rated at 4 or 5 stars) receive bonus payments and low-performing plans (rated at 2.5 stars or lower for any combination of their Part C or D summary ratings for three consecutive years) may be put on notice with possible negative impacts. Providers and plans are seen as one entity by CMS and must work together to achieve good ratings. BCN Advantage partners with its providers in order to maintain and improve its good rating. For additional information on the CMS star ratings, providers can contact their Blue Cross/BCN Provider Outreach consultant.</td>
</tr>
</tbody>
</table>
Chapter 15: BCN Advantage

Obligations and compliance

<table>
<thead>
<tr>
<th>Obligations of recipients of federal funds</th>
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Providers participating in BCN Advantage are paid for their services in whole or in part with federal funds and must comply with all laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-Kickback Statute (section 1128B (b) of the Social Security Act) (as amended).

BCN Advantage is prohibited from issuing payment to a provider or entity that appears in the List of Excluded Individuals/Entities as published by the U.S. Department of Health and Human Services Office of the Inspector General (OIG list) or in the General Services Administration’s System for Award Management (GSA list), with the possible exception of payment for emergency services under certain circumstances.

Providers must check their employees, contractors, governing body members, major shareholders (5 percent or more) and downstream entities against the OIG and GSA lists prior to hiring and on a monthly basis to ensure that none of these individuals or entities appears on the lists. Providers must notify BCN immediately if any of these individuals or entities appear on the OIG or GSA lists.

Upon request by BCN, providers must submit an attestation confirming that they are in compliance with these requirements and have performed monthly checks of the OIG and GSA lists.

In addition, BCN’s Medicare Advantage contract with CMS requires BCN to notify CMS if any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any federal program involving the provision of health care or prescription drug services. Providers must notify BCN immediately if any of the provider’s employees, contractors, governing body members, major shareholders (five percent or more) or downstream entities has such a conviction, judgment or sanction. Upon request from BCN, providers must submit an attestation confirming that they are in compliance with this requirement.

Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at oig.hhs.gov > Exclusions > LEIE Downloadable Databases.
- The General Services Administration System for Award Management can be found at sam.gov.
Obligations and compliance

CMS requires BCN Advantage, which receives payment from Medicare, to implement an effective general compliance program for their workforce members and downstream entities. In order to satisfy CMS guidelines, this program must meet some minimum requirements established by federal statutes that pertain to Medicare Parts C & D (Section 1860D-4(c)(1)(D) of the Act, 42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi)).

According to these guidelines, providers are required by CMS to take CMS-specific training about fraud, waste and abuse and compliance. Providers must have their staff complete the training within 90 days of hire or contract and annually thereafter.

To fulfill the requirements for compliance training, providers may either take the training available through CMS (as described in Option 1, below) or design and deliver their own training (as described in Option 2, below).

Regardless of the training option chosen, the certificates or other evidence of training completion must be kept on file for 10 years following the expiration of the contract.

Option 1. To use the training available through CMS, do the following:

1. Click to open the Medicare Learning Network® (MLN) Learning Management System.
2. Log in. (If you are a first-time user, you must create an account.).
3. Complete the following two training modules:
   - Medicare Parts C and D General Compliance Training
   - Combating Medicare Parts C and D Fraud, Waste and Abuse
4. Generate a certificate of completion for each module.

Each employee, contractor, volunteer, governing body member, or downstream entity who provides health or administrative services for Medicare Advantage must have a Congratulations certificate on file from each training section (fraud, waste and abuse training and general compliance training -- two certificates in total).

Note: If the provider is enrolled in Medicare Parts A or B, the provider is “deemed” to have satisfied the fraud, waste and abuse training requirement and is not required to take additional fraud, waste and abuse training. However, the provider must still complete the general compliance training section and maintain a certificate as evidence of training completion.

Option 2. Providers who wish to use their own training program may design their own training or may include the material from both the Medicare Parts C and D Fraud, Waste and Abuse Training and the Medicare Parts C and D General Compliance Training modules.

This chapter is updated to show that effective Jan. 1, 2019, providers may design and deliver their own compliance training.
Obligations and compliance

Code of conduct
A code of conduct, as referred to by CMS guidelines, is a set of values and ethical standards that both BCN Advantage and providers should adhere to in order to prevent, stop or correct noncompliance.

Providers are expected to adhere to the BCBSM Code of Business Conduct and also to create one for their office that best fits the culture in their office. The code of conduct should be a written document, easily accessible by employees.

Effective lines of communication
CMS emphasizes the importance of open and effective lines of communication as an integral part of a compliance program. Having effective lines of communication means that BCN Advantage, providers, and their employees are made aware of the following through training and management:

- What is expected of them regarding ethics and compliance based on the code of conduct
- That compliance is everyone’s responsibility
- How to report instances of suspected fraud, waste, abuse and noncompliance

It is important that employees are comfortable with reporting noncompliant activities within their own organizations. CMS emphasizes that effective communication not only means that employees may report noncompliant activities anonymously, but also that employees understand they are legally protected from retaliation when they report suspected noncompliance in good faith.

To support effective lines of communication, providers must report actual, suspected or potential instances of noncompliance or fraud, waste and abuse to BCN within five business days of becoming aware of the potential issue. These reports may be made by contacting the appropriate contract administrator or by calling the Medicare Hotline at 1-888-650-8136.

Providers must also protect their employees against retaliation for reporting of such compliance and fraud, waste and abuse concerns. Providers should ensure that these reporting requirements and the nonretaliation policy are well publicized.
## BCN Advantage service area

The service areas for BCN Advantage group and individual members are shown as follows:

- For BCN Advantage HMO-POS (Basic, Elements, Classic and Prestige individual products), see the [service area map](#).

- For the BCN Advantage HMO ConnectedCare product, the service area is Arenac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw and Wayne counties. The member must reside in one of those counties. See the [service area map](#).

- For the BCN Advantage HMO MyChoice Wellness product, the service area is Kent, Muskegon, Oceana and Ottawa counties. The member must reside in one of those counties. See the [service area map](#).

- For the BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue products, the service area includes all counties served by both the ConnectedCare and MyChoice Wellness products. See the [service area map](#).

Member enrollment is affected by the service area in the following ways:

- Members enrolled in an individual plan must reside in one of the counties shown on the service area map for a product.

- In general, members enrolled through an employer group can reside in any county in Michigan.
BCN Advantage marketing, Customer Service and Provider Inquiry

Marketing

BCN Advantage is available to Medicare beneficiaries who purchase health care benefits on their own (individual) and who purchase health care benefits through an employer (group).

Individuals can purchase coverage through independent, licensed Blues agents. In addition, BCN Advantage markets itself in ways that include:

- Direct mail, advertisements and social media
- Community-based marketing presentations
- One-on-one sessions with Medicare beneficiaries
- Participation in activities and events (for example, health fairs) targeted to Medicare beneficiaries

Because of the relationship between a Medicare beneficiary and his or her physician, physicians may be asked to answer questions about the plan. The BCN Advantage Provider Services staff is available to assist physicians with these questions. For more information, physicians should call PARS or Provider Inquiry at the appropriate number, as shown on the Provider Inquiry Contact Information document. Select the prompt for BCN Advantage.

They can also contact their Blue Cross/BCN Provider Outreach consultant.

Providers must remain neutral

Providers must remain neutral when assisting with enrollment decisions. CMS provides specific guidance about marketing activities conducted in health care settings and by providers. CMS is concerned about plans/Part D sponsors engaging in provider-based marketing activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary’s provider
- Providers may face conflicting incentives when acting as a plan/Part D sponsor representative

The lists that follow show what providers may and may not do, according to CMS regulations.

Activities allowed by CMS

- Assisting patients with an **objective** assessment of their health needs and discussing options available to meet those needs
- Engaging in discussions with patients seeking advice
  
  Note: In these discussions, providers must remain neutral about Medicare and act on behalf of the patient.

(continued on next page)
BCN Advantage marketing, Customer Service and Provider Inquiry

Providers must remain neutral (continued)

Activities allowed by CMS (continued)

• Providing patients with the names of plans with which they are contracted or with which they participate

• Answering questions or discussing the merits of a plan or plans, including cost-sharing and benefit information
  Note: These discussions may occur in areas where care is delivered.

• Announcing new or continuing affiliations between themselves and specific plans through general advertising
  Note: Providers may announce new affiliations once within the first 30 days of a new agreement via direct mail, email, telephone or advertisement (an affiliation letter). The announcement must clearly state that they do accept other Medicare Advantage plans. All such provider communications must be preapproved by BCN and may also require preapproval by CMS.

• Providing information and giving assistance in applying for the low-income subsidy benefit

• Advertising non-health-related items or services as long as the advertisement is clear that those items or services are not covered by the plan/Part D sponsor

• Making available or distributing marketing materials as long as they do so for all plans with which they participate

• Sharing information from the CMS website, including all documents written by or previously approved by CMS

• Referring patients to the CMS website at medicare.gov, or telling them they can call 1-800-MEDICARE (1-800-633-4227) for more information
  Note: Members can call this number 24 hours a day, seven days a week.

• Referring patients to other sources of information, such as the state’s health insurance assistance program at mmapinc.org, plan marketing representatives, the state’s Medicaid office or the local Social Security office

Activities not allowed by CMS

• Assisting with enrollment decisions or enrollment activities

• Offering “scope of appointment” forms (forms required by insurance agents when meeting with potential enrollees)

• Accepting Medicare enrollment applications
(continued on next page)
## BCN Advantage marketing, Customer Service and Provider Inquiry

### Providers must remain neutral (continued)

<table>
<thead>
<tr>
<th>Activities not allowed by CMS (continued)</th>
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<tbody>
<tr>
<td>• Making phone calls or directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the provider</td>
</tr>
<tr>
<td>• Mailing marketing materials on behalf of plans or Part D sponsors</td>
</tr>
<tr>
<td>• Offering anything of value to induce plan enrollees to select them as their provider</td>
</tr>
<tr>
<td>• Offering incentives to persuade beneficiaries to enroll in a particular plan or organization</td>
</tr>
<tr>
<td>• Conducting health screenings as a marketing activity</td>
</tr>
<tr>
<td>• Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities</td>
</tr>
<tr>
<td>• Distributing materials or applications within an exam room setting</td>
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</tbody>
</table>

### Customer Service

BCN Advantage’s Customer Service team is dedicated to helping members and providers do the following:

| • Answer questions about members’ coverage and benefits |
| • Respond to inquiries about quality of care or service |
| • Process demographic changes (such as a change in address) |
| • Determine member eligibility |
| • Provide claims information |
| • Investigate and respond to member appeals and member grievances |

Members can call BCN Advantage Customer Service toll-free at the number on the back of their member ID card between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call the National Relay Service at 711.)

### Provider Inquiry

Providers can get answers to BCN Advantage questions by calling the appropriate phone number as shown on the Provider Inquiry Contact Information list and following the prompts.
## BCN Advantage primary care physician services

| Appropriate managed care | Primary care physicians manage their BCN Advantage members’ medical care. Responsibilities include the following:  
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<tbody>
<tr>
<td>• Encouraging members to receive needed preventive care</td>
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<tr>
<td>• Monitoring specialty use and coordinating required medical care</td>
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</tr>
<tr>
<td>• Referring members to case management, as appropriate</td>
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</tr>
<tr>
<td>• Coordinating inpatient admissions</td>
<td></td>
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</tbody>
</table>
| • Directing members to BCN Advantage network physicians for all care, to achieve lower out-of-pocket costs | Note: Referring to out-of-network providers may increase the out-of-pocket costs to members.  
| • Prescribing appropriate medications using the appropriate BCN Advantage formulary and monitoring for potential harmful interactions; discussing the member’s list of medications with the member |  
| • Using BCN resources to provide members with necessary support services |  
| • Regularly accessing and reviewing available reports for important information related to members’ care |  
| • Monitoring the frequency of ER visits and educating members on appropriate ER use |  
| • Helping members complete BCN Advantage documentation, if requested |  
| Communication with members | Primary care physicians can communicate effectively with members by doing any of the following:  
<table>
<thead>
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<tbody>
<tr>
<td>• Sending introduction letters asking new members to come in for a visit</td>
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<tr>
<td>• Discussing current and ongoing health care needs</td>
<td></td>
</tr>
<tr>
<td>• Discussing the care members are receiving from other providers</td>
<td></td>
</tr>
<tr>
<td>• Encouraging members to discuss care needs</td>
<td></td>
</tr>
<tr>
<td>• Discussing their expectations of members (coordinating care, ER use, affiliated specialists, affiliated hospitals, etc.)</td>
<td></td>
</tr>
<tr>
<td>• Showing sensitivity to members’ needs (literacy concerns, cultural needs, social support, etc.)</td>
<td></td>
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</tbody>
</table>
### BCN Advantage primary care physician services

<table>
<thead>
<tr>
<th>BCN provides primary care physicians with necessary support</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN will make available to network providers the needed support materials and systems to serve BCN Advantage members. This support includes:</td>
</tr>
<tr>
<td>• Utilization management and chronic condition management</td>
</tr>
<tr>
<td>• Medication therapy management</td>
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<tr>
<td>• Medication adherence program</td>
</tr>
<tr>
<td>• Medication reconciliation program</td>
</tr>
<tr>
<td>• Reports</td>
</tr>
<tr>
<td>• web-DENIS</td>
</tr>
<tr>
<td>• Health e-Blue℠</td>
</tr>
<tr>
<td>• Newsletter articles</td>
</tr>
<tr>
<td>• Seminars</td>
</tr>
<tr>
<td>Information on each of these can be found later in this chapter.</td>
</tr>
<tr>
<td>BCN also offers the Best Practices Library page, which can be accessed here: <a href="#">Visit the Library</a>.</td>
</tr>
<tr>
<td>The Best Practices Library page can also be accessed on BCN's Best Practices page within Provider Secured Services.</td>
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<thead>
<tr>
<th>Assistance in closing diagnosis gaps</th>
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</thead>
<tbody>
<tr>
<td>BCN Advantage provides primary care physicians with assistance in closing diagnosis gaps. A diagnosis gap is a condition that was present in the member’s medical history but that meets one of the following criteria:</td>
</tr>
<tr>
<td>• Has not been documented and coded in the current year</td>
</tr>
<tr>
<td>• Is not confirmed as not applying to the member in the current year</td>
</tr>
<tr>
<td>The goal is that each primary care physician close 100 percent of the diagnosis gaps for his or her BCN Advantage members. A diagnosis gap is closed when one of the following has occurred:</td>
</tr>
<tr>
<td>• The condition is documented and coded in the current year</td>
</tr>
<tr>
<td>• The condition is confirmed as not applying to the member in the current year</td>
</tr>
<tr>
<td>(continued on next page)</td>
</tr>
</tbody>
</table>
Primary care physicians can access information on each member’s diagnosis gaps as follows:

- In BCN’s Health e-Blue system. The Panel–Diagnosis Evaluation includes historical and suspected diagnosis gaps for each member. Physicians can confirm or close a diagnosis gap or add additional diagnoses. The information in BCN’s Health e-Blue system is refreshed monthly.

- In web-DENIS. The Eligibility/Coverage screen displays member care alerts with printable lists of diagnosis gaps and treatment opportunities organized by member. Member care alerts are color coded, as follows:
  - Red means the member has an open diagnosis gap or treatment opportunity that requires action.
  - Green means the member has a pending or closed diagnosis gap or treatment opportunity for which no action is required.
  - Gray means the member does not have a diagnosis gap or treatment opportunity at this time for which action is required.

When the physician clicks on a diagnosis gap or treatment opportunity in web-DENIS, the Health e-Blue system opens. In the Health e-Blue system, the physician can click either Panel–Diagnosis Evaluation or Panel–Treatment Opportunities by Condition/Measure to close members’ diagnosis gaps.

The Health e-Blue and web-DENIS systems are applications accessed through Provider Secured Services. Contracted primary care physicians can register for access to both the Health e-Blue and web-DENIS provider portals here: How do I get access to Provider Secured Services.

BCN Advantage also offers the Diagnosis Closure Incentive program, in which primary care physicians are rewarded for closing identified diagnosis gaps. Additional information on this program is available at (Provider Secured Services) > BCN Provider Publications and Resources > Patient Care Reporting for Risk Adjustment.
A member health assessment form is available for practitioners to use for BCN Advantage members during their annual wellness visits.

Note: A health assessment completed by the member is encouraged as part of an annual wellness visit for Medicare Advantage members, according to the Patient Protection and Affordable Care Act and CMS.

BCN Advantage mails the form to the member and asks that the member complete it and return it to Scantron®, the BCN Advantage vendor, for processing.

Note: The member may also complete the health assessment online. The member can locate the online form using the access code provided in the letter from BCN Advantage.

The member receives a response letter based on how he or she answered the questions. The letter identifies topics the member should discuss with his or her physician. Each member’s responses are loaded to the Health e-Blue website. Practitioners can log in to Health e-Blue and access the information under Panel – Health Assessment.

Practitioners should remind patients to bring a copy of their member health assessment or the response letter to their annual wellness visit. The results of the member’s health assessment need to be available during the wellness visit so they can be considered when a care plan is created.

Practitioners may complete the form for the member. Practitioners who choose to do this may not charge the member for completing the form, since it is included as part of the annual wellness visit and since providers should be billing only BCN Advantage – and not members – for all Part B services. Once the health assessment form has been completed, the member needs to send it back to Scantron in the return envelope provided.
BCN Advantage primary care physician services

**Patient Assessment Form**

BCN Advantage has developed a *Patient Assessment Form* that can help providers identify the treatment needs of their BCN Advantage patients. The form is intended to be filled out by the member at each visit and used by the practitioner to enhance communication about the member’s needs during the examination.

The form can be accessed here: [Patient Assessment Form](#).

The office staff gives the *Patient Assessment Form* to the member when he or she arrives for an appointment. The member completes the form while waiting to be seen. The provider reviews the member’s answers during the visit and asks the member about anything of concern.

The form does not need to be submitted to BCN Advantage; it is intended only to encourage discussion between the member and the practitioner during an office visit. The questions the member answers on the form are those that CMS considers essential for practitioners to cover at each visit. When providers use this form with their patients, those patients will be in a position to respond in CMS surveys that their provider has discussed these key topics with them during their visits.

The form is not intended as a replacement for the more comprehensive Medicare Advantage member health assessment form that is mailed to every new BCN Advantage member and annually to all BCN Advantage members.

**Reminder letters available through Health e-Blue**

Providers can arrange to print letters to send to their BCN Advantage members reminding them of the recommended tests they need and asking them to call the office for an appointment.

Note: These letters can also be generated for BCN HMO (commercial) members.

To print these letters for specific members, providers should complete the following steps:

1. Log in to BCN’s Health e-Blue system.
2. Click on *Panel – Generate Member Letters*.
3. Select the provider or the practice group in the drop-down menu.
4. Select the letter type (Emergency Room or Treatment Opportunities).
5. Click *Search Records*.
6. Select the other options, as appropriate, for each letter type.

As an alternative, providers can click *View all members* after selecting the Treatment Opportunities letter type. This allows the provider to view all the treatment opportunities for all the provider’s BCN Advantage members.

Providers cannot edit these letters and are encouraged to print the letters on office letterhead paper that includes the office phone number.
BCN Advantage primary care physician services

When their primary care physician is not available, BCN Advantage members can obtain medical and behavioral health services for low-complexity conditions through Blue Cross Online Visits. This service offers members the option to connect with a practitioner by online video 24 hours a day, seven days a week.

Members may also have an online visit with their own provider if the provider offers this service.

Through Blue Cross Online Visits, members can see and talk to:

- A doctor for minor illnesses such as a cold, the flu or a sore throat
- A psychiatrist or another behavioral health clinician for issues like anxiety, depression and grief

Online visits through Blue Cross Online Visits 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 Blue Cross Online Visits.

Blue Cross Online Visits is powered by American Well®, an independent company that provides online visits for Blue Cross Blue Shield of Michigan and Blue Care Network members.

Information is added to show that BCN Advantage members can obtain medical and behavioral health services for low-complexity conditions through Blue Cross Online Visits. This is effective Jan. 1, 2019.

For information on the primary care physician assignment for dual-eligible members — those who have BCN Advantage as their primary coverage and Blue Cross Complete as their secondary coverage — providers should refer to the Blue Cross Complete Provider Manual, which is available at MiBlueCrossComplete.com/providers.
Eligibility, enrollment and effective date

**Membership requirements**
To be eligible for BCN Advantage, potential members must meet the following requirements:

- Those enrolling through an individual plan must be entitled to Medicare Part A, must be enrolled in Medicare Part B and must live in the BCN Advantage service area associated with their individual plan.

- Those enrolling through an employer group must be entitled to Medicare Part A, must be enrolled in Medicare Part B and must reside in the BCN Advantage HMO-POS service area.

- At the time of enrollment, members must not be diagnosed with end-stage renal disease. Unless members with ESRD qualify for an exception, they are not eligible for enrollment in BCN Advantage.

Note: For information on exceptions, providers may call PARS or Provider Inquiry at the appropriate number, as shown on the Provider Inquiry Contact Information document. Select the prompt for BCN Advantage.

**Enrollment**
The BCN Advantage Membership department enrolls all BCN Advantage members by:

- Processing enrollment applications
- Calling members to verify application information
- Ensuring the BCN Advantage enrollment process is consistent with CMS guidelines

To obtain information regarding enrollment status, members can call BCN Advantage Customer Service toll free at the number on the back of their member ID card between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call 711.)

**Effective date**
The effective date of BCN Advantage enrollment is the date in the acknowledgement letter that BCN sends to the member.

Note: The effective date in the acknowledgement letter is subject to CMS approval. CMS decides whether the enrollment request is ultimately approved or denied and determines the effective date of the enrollment, if approved. After CMS approves the enrollment, the member receives a second letter from BCN confirming the CMS approval. The confirmation letter states the CMS confirmed effective date of the enrollment.
Chapter 15: BCN Advantage

Member eligibility data files

Through their medical care group or practice administrators, primary care physicians can access monthly electronic member eligibility data files that identify BCN Advantage members, as well as those enrolled in other BCN programs.

BCN has established the following codes to describe variations of the BCN Advantage product in the member eligibility data files:

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAGP</td>
<td>BCN Advantage HMO-POS group</td>
</tr>
<tr>
<td>MA15</td>
<td>BCN Advantage HMO-POS Elements individual - medical only</td>
</tr>
<tr>
<td>MB15</td>
<td>BCN Advantage HMO-POS Classic individual - medical with enhanced Part D Rx</td>
</tr>
<tr>
<td>MC07</td>
<td>BCN Advantage HMO-POS Prestige individual - medical with enhanced Part D Rx</td>
</tr>
<tr>
<td>MDBA</td>
<td>BCN Advantage HMO-POS Basic individual - medical with standard Part D Rx</td>
</tr>
</tbody>
</table>

Members covered by these products use the BCN Advantage provider network.

In addition, BCN has established the following codes for products with designated provider sub-networks within the larger BCN Advantage provider network:

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACC</td>
<td>BCN Advantage HMO ConnectedCare individual - medical with Part D Rx (Aranac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw and Wayne counties)</td>
</tr>
<tr>
<td>MEHS</td>
<td>BCN Advantage HMO HealthySaver or BCN Advantage HMO HealthyValue individual - medical with Part D Rx (Aranac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne counties)</td>
</tr>
<tr>
<td>MTMA</td>
<td>BCN Advantage HMO MyChoice Wellness individual - medical with Part D Rx (Kent, Muskegon, Oceana and Ottawa counties)</td>
</tr>
</tbody>
</table>
Membership ID cards

Each BCN Advantage member receives an ID card. The front of the card contains information similar to the BCN ID card.

Members who have opted for Part D pharmacy coverage have a Medicare Rx logo on the front of their card.

**AVOID BILLING ERRORS:** BCN Advantage members use only their BCN Advantage ID card and not their red, white and blue Medicare cards. Providers should ask members whether they have insurance other than Medicare Advantage.

In the first month of their enrollment, members may present their acknowledgement letter as proof of their BCN Advantage coverage in lieu of an ID card. The letter states “This letter is proof of insurance that you should show during your doctor appointments.” Members should use the acknowledgement letter as proof of coverage only until they receive their ID card.

If a member presents a letter more than a month after the date on the letter, providers should verify the member’s eligibility by calling PARS or Provider Inquiry at the appropriate number, as shown on the Provider Inquiry Contact Information document. Select the prompt for BCN Advantage.

Providers can find information about BCN Advantage HMO-POS and HMO member ID cards in the Blue Care Network Member ID Cards brochure available here: Blue Care Network Member ID Cards.

Additional information on the BCN Advantage HMO-POS member ID card is found in this chapter.

The ID card brochure is also available on BCN’s Quick Guides page within Provider Secured Services.
Membership ID cards

<table>
<thead>
<tr>
<th>Number</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enrollee Name: All cards are in the name of the BCN Advantage HMO-POS member, whether or not he or she is the contract holder.</td>
</tr>
<tr>
<td>2</td>
<td>Enrollee ID: Providers should use this number, the member’s de-identified BCN Advantage HMO-POS contract number, to check eligibility. The BCN Advantage HMO-POS contract number begins with the XYK code.</td>
</tr>
<tr>
<td>3</td>
<td>Issuer: This number identifies which Blues plan issued the card.</td>
</tr>
<tr>
<td>4</td>
<td>Group Number: The BCN Advantage HMO-POS group number</td>
</tr>
<tr>
<td>5</td>
<td>The coverage for BCN Advantage HMO-POS includes a BlueCard travel benefit for emergency and urgent care and for follow-up care for existing conditions (with prior approval).</td>
</tr>
<tr>
<td>6</td>
<td>On this ID card, the product name shown is BCN Advantage HMO-POS.</td>
</tr>
<tr>
<td>7</td>
<td>Plan code: Indicates whether the member is an individual or group member. If the last three digits begin with an 8, it is a group HMO-POS plan. If the last three digits are 001, 002, 003, 004 or 010 it is an individual HMO-POS plan.</td>
</tr>
<tr>
<td>8</td>
<td>Pharmacy information: Prescription drug coverage under BCN Advantage HMO-POS</td>
</tr>
<tr>
<td>9</td>
<td>On the back of the HMO-POS ID card, various phone numbers are listed, including for various types of authorizations and for Provider Inquiry. Medical and pharmacy claims addresses are also shown.</td>
</tr>
<tr>
<td>10</td>
<td>Different PARS (Provider Automated Response System) phone numbers are shown, including separate ones for professional and facility providers.</td>
</tr>
</tbody>
</table>
BCN Advantage benefits

**Individual plans**

For the BCN Advantage HMO-POS product, there are four different options available to individuals, including one option with medical coverage only (Elements) and three with medical and prescription drug coverage (Basic, Classic and Prestige). All include a travel benefit that covers urgent and emergency care and follow-up care for existing conditions (with prior authorization).

For the BCN Advantage HMO products, there are four options, none of which offers a travel benefit. Urgent and emergency care are always covered, but follow-up care for existing conditions must be completed by providers affiliated with the product’s designated provider network. The four options are:

- BCN Advantage HMO ConnectedCare
- BCN Advantage HMO MyChoice Wellness
- BCN Advantage HMO HealthySaver
- BCN Advantage HMO HealthyValue
Chapter 15: BCN Advantage

BCN Advantage benefits

For individual plans, dental, vision and hearing benefits are covered as described in the summary of benefits.

To locate the description of a particular type of coverage, click to open the pertinent summary and search for “dental,” “vision” or “hearing.”

- BCN Advantage HMO-POS Elements, Basic, Classic and Prestige
- BCN Advantage HMO ConnectedCare
- BCN Advantage HMO MyChoice Wellness
- BCN Advantage HMO HealthySaver
- BCN Advantage HMO HealthyValue

For enhanced benefits, members may purchase one of the optional supplemental dental, vision and hearing benefits (together) packages, known as Package 1 and Package 2. There are two packages being offered for both BCN Advantage HMO-POS and HMO plans.

To access a description of the services associated with each option, open the pertinent summary of benefits and search for “optional.”

Dental, vision and hearing services can be obtained through the following arrangements:

- Blue Cross is contracted to provide coverage for routine dental care to BCN Advantage members with a dental benefit. A network of dental providers is available through a contract with DenteMax and through contracts with Blue Cross Medicare PPO dentists.
  
  Note: BCN Advantage HMO-POS members who purchase one of the optional supplemental dental care packages may go to an out-of-network dental care provider. These members need to seek reimbursement for covered services up to predetermined amounts.

- BCN Advantage members in need of routine vision services should be referred to the VSP network for care.
  
  Note: BCN Advantage HMO-POS members who purchase one of the optional supplemental vision care packages may go to an out-of-network dental care provider. These members need to seek reimbursement for covered services up to the allowed fee schedule.

- BCN Advantage members in need of hearing exams should be referred to qualified providers affiliated with BCN Advantage.

Information on how to locate dental, vision and hearing (audiology) providers is found in the “BCN Advantage operates like Blue Care Network” section of this chapter.

The information about dental, hearing and vision coverage — including the optional supplemental packages members may purchase — is updated.
BCN Advantage benefits

Group plans

There are standard packages available to small groups (groups under 100 contracts). Groups with 100 contracts or more can modify their coverage by adding riders to the BCN Advantage base benefit and designing their own package. Group plans have the option of amending benefits such as office visits, ER and urgent care coverage. Copays vary based on the level of coverage purchased by the employer group. Employer groups also have the option to purchase prescription drug and hearing coverage through BCN, in addition to dental and vision coverage through Blue Cross Blue Shield of Michigan.

Fitness and other benefits

Contact information for vendors associated with fitness and other benefits is found in the “BCN Advantage operates like Blue Care Network” section of this chapter.

Always check benefits

It is essential to check each member’s eligibility and benefits prior to performing services. Use the normal methods, including:

- (Provider Secured Services) web-DENIS
- Provider Inquiry and PARS: Find Provider Inquiry and PARS phone and fax numbers on the Provider Inquiry Contact Information document. Select the prompt for BCN Advantage.

Note: Providers can also use PARS to check certain information about claims. Refer to the Claims chapter of this manual for additional information.

- HIPAA 270/271 electronic transaction standard. For information on this transaction, providers should email EDICustMgmt@bcbsm.com. Additional information is available in the Member Eligibility chapter of this manual.

Note: Eligibility and benefits contact information for dental providers is located in the “BCN Advantage operates like Blue Care Network” section of this chapter.

What are covered services?

This section describes the medical benefits and coverage provided to BCN Advantage members. Covered services include the medical care, services, supplies and equipment that are covered by BCN Advantage.
### BCN Advantage benefits

**General requirements**

Some general requirements apply to all covered services.

Services are covered only when all the requirements listed below are met:

- The medical care services, supplies and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- With few exceptions, covered services must be provided by plan providers, approved in advance by plan providers or authorized by BCN. The exceptions are:
  - Care for a medical emergency
  - Urgently needed care
  - Renal dialysis received by a member when outside the plan’s service area

Note: BCN Advantage members have an out-of-pocket maximum. After that maximum has been reached, BCN Advantage members are not responsible for any cost-sharing (that is, deductible, coinsurance or copayments) for Part A and B services.

**Authorization may be required**

Some services are covered only when the primary care physician or other plan provider has obtained authorization from BCN.

**Benefits at a glance**

For a summary of benefits for BCN Advantage benefit plans for individuals, providers should click on one of the following links:

- **BCN Advantage HMO-POS Elements, Basic, Classic and Prestige**
- **BCN Advantage HMO ConnectedCare**
- **BCN Advantage HMO MyChoice Wellness**
- **BCN Advantage HMO HealthySaver**
- **BCN Advantage HMO HealthyValue**

The benefits under group plans vary from plan to plan. Information on group plans is available at [bcbsm.com/medicare](http://bcbsm.com/medicare) > **Group Plans** (under Medicare plans).
BCN Advantage benefits

**Medicare Diabetes Prevention Program**

Blue Care Network and Blue Cross Blue Shield of Michigan have partnered with Solera Health, Inc., to provide a diabetes prevention program for prediabetic Medicare Advantage members. The program is offered as part of the members’ benefits and is described in their *Evidence of Coverage*.

There is no coinsurance, copayment or deductible for this benefit.

Members can self-enroll in the program and providers may also recommend that a member enroll in the program. Solera will send providers a toolkit with the information about the program.

Additional information is available in the article **Your patients may qualify for the Medicare Diabetes Prevention Program that goes into effect April 1**, in the January-February 2018 *BCN Provider News*, on page 7.
Exclusions and limitations

| Services not covered | Lists of the items and services that are not covered benefits for BCN Advantage members are available within the pertinent *Evidence of Coverage* documents. |

- To locate the exclusions for a specific BCN Advantage HMO-POS or HMO individual product, click to open the pertinent *Evidence of Coverage* document and search for “exclusions:"
  - *Evidence of Coverage for BCN Advantage HMO-POS Basic, Classic and Prestige members*
  - *Evidence of Coverage for BCN Advantage HMO-POS Elements members*
  - *Evidence of Coverage for BCN Advantage HMO ConnectedCare, MyChoice Wellness, HealthySaver and HealthyValue members*

- To locate the exclusions for BCN Advantage group products, click *Evidence of Coverage*. Under the heading “Do you get your insurance through an employer, union or group?,” and under 2019, click *BCN Advantage Group HMO-POS*. Then click to open the specific *Evidence of Coverage* document you’re looking for and search for “exclusions.”

The information about exclusions is updated to include links to the *Evidence of Coverage* documents in which the exclusions are listed.
### Exclusions and limitations

<table>
<thead>
<tr>
<th>Steps to take before providing services that are not or may not be covered</th>
<th>When a service is not or may not be covered by BCN Advantage but the member is still interested in getting the service, providers should request an authorization for the service. The request should be submitted through the normal channels, either through the e-referral system or by calling BCN’s Utilization Management department. Providers who have the capability may also submit an electronic request for authorization via the HIPAA 278 Health Care Services Request and Response transaction standard. At this time, 278 requests accepted for processing will result in a 278 response indicating the request has been received and additional information will be provided outside of the 278 transaction. The accepted electronic request will be manually processed and the requestor will be contacted regarding the decision outcome. BCN’s Utilization Management department will review the authorization request and make a decision. If the request is approved, the provider may provide the service and bill BCN Advantage. If the request is denied, BCN’s Utilization Management department will send written notification of the denial to both the provider and the member. If the request was submitted through the e-referral system, the denial will show in the e-referral system. Once the denial is available, providers should take the following steps:</th>
</tr>
</thead>
</table>
| | 1. Let the member know the service is not authorized.  
2. Ask whether the member wants to appeal the denial or is willing to pay for the service out of pocket. Ultimate, if the member agrees to pay and the provider provides the service, the provider must keep the following denial notices in the member’s file:  
• The denial notice sent by BCN’s Utilization Management department to the provider  
• The copy the provider receives of the denial letter BCN sent to the member |
| | These documents confirm that the authorization request was denied before the service was provided and that the denial was communicated to the member. With these steps completed and assuming the member’s agreement to pay, the provider may bill the member for the service. |
## Home health review program

**Home health review program provides supportive health evaluations**

To support physician care, BCN Advantage actively conducts outreach efforts with the assistance of a vendor to encourage members to maintain a regular care schedule. This is accomplished by ensuring that the condition of every member’s health is reviewed and documented on a yearly basis. The reviews are completed as part of the home health review program.

Through the home health review program, BCN Advantage members who are identified as having multiple or severe chronic conditions and who have barriers that may prevent them from getting to their physician’s office on a regular basis are offered a free home health review. The review, available once each year, consists of checking basic vital signs, listening to the member’s heart, asking the member some health-related questions and answering questions the member may have.

The review is designed as a supportive health evaluation that helps these members prepare for their annual visit with their physician. The goal of the home health review is to obtain up-to-date information about each participating member’s clinical status.

Members who are eligible for a home health review are sent a letter that describes the program and that lets them know they will receive a call to schedule an appointment. Members may invite a friend or family member to be present during the appointment.

BCN contracts with a vendor to carry out the home health review.

BCN Advantage members who reside in long-term or skilled nursing facilities are among those eligible for the home health review program.

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**Scope of home health review**

BCN Advantage members who elect to participate in the program will receive a free home health review performed by an accredited health care professional who is a physician, physician’s assistant or nurse practitioner associated with the vendor.

The home health review visit will include a medical history and a brief physical exam. It does not replace the member’s annual wellness visit or any other visits the member has with his or her primary care physician.

The visiting health care professionals will not be able to do such things as write prescriptions or make referrals. Their role is to complete the clinical evaluations and reviews; they will not treat any medical conditions.

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**Results reported to the primary care physician**

The information gathered during the visit will be provided to the member’s primary care physician to assist in the continued management of the member’s health. The physician receives a copy of the results of the review along with recommendations for follow-up care.

The information may also help BCN Advantage obtain accurate risk-adjusted reimbursement from CMS.
BCN Advantage utilization management program

The BCN Advantage utilization management program combines the elements of BCN’s commercial utilization management program with the special services that BCN Advantage members require.

The program promotes cost-effective and medically appropriate care and services. Components include clinical review of selected services, inpatient review and discharge planning. BCN also offers case management for certain diseases and conditions.

BCN uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that BCN members receive the medical services required for health promotion and diagnosis, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of HEDIS data
- Results of member satisfaction surveys
- Rate of inpatient admissions and acute care days
- Primary care physician and specialty utilization patterns
- Use of generic pharmaceuticals
- Behavioral health utilization data

Contacting BCN Utilization Management

Providers can contact BCN’s Utilization Management department at the toll-free numbers below, unless directed to use another number in this chapter.

- Normal business hours: 1-800-392-2512
- After hours: 1-800-851-3904

Staff members in BCN’s Utilization Management department are available to answer provider inquiries eight hours a day during normal business hours. Normal business hours are 8:30 a.m. to noon and 1 p.m. to 5 p.m. Monday through Thursday and 9:30 a.m. to noon and 1 p.m. to 5 p.m. on Friday.

Utilization Management care managers are available after normal business hours, Monday through Friday from 5 p.m. to 7 a.m., and on weekends and holidays with 24-hour service, to assist physicians and other providers.

When initiating or returning calls related to utilization management, staff members identify themselves by name, title and organization.

Information is added to clarify how BCN’s Utilization Management staff answer providers’ utilization management inquiries.
BCN Advantage utilization management program

Referral management

The primary care physician is responsible for coordinating all necessary health care services for his or her BCN Advantage members.

In order to make coordinating patient care as simple as possible, services for BCN Advantage members do not require the primary care physician to submit a referral to BCN when using in-network providers. The primary care physician can coordinate services in a manner that is convenient for the office staff, member and specialist. The only requirements are that the member and specialty physician know they have approval for the services and that proof of this can be produced if requested by BCN. Here are some examples of how the primary care physician can coordinate care:

- Handwritten prescription signed by the primary care physician (can be carried to the specialist by the member)
- Faxed note on primary care physician office letterhead or emailed from the primary care physician to the specialist (a copy can be given to the member)
- Telephone call from primary care physician to specialist. Note: Both offices should note the date, time and specifics of the call in the patient record and make sure the member is given the specialist’s contact information in writing

The e-referral system and the 278 electronic standard transaction have been programmed to remind providers that referrals are not accepted for BCN Advantage members. Specifically:

- When a provider submits a referral for a BCN Advantage member through the e-referral system, the following message will be displayed:
  “Referrals are not accepted or needed for BCN Advantage members seeing providers in their health plan’s network, but authorizations and plan notifications are still required for certain services. For more information, go to ereferrals.bcbsm.com.”

When a provider submits a referral request for a BCN Advantage member through a 278 electronic standard transaction, the referral response will state “NA,” which means that no action is needed.

Information is added about the messages providers will see when trying to submit a referral for a BCN Advantage member through the e-referral system or through a 278 electronic standard transaction. For the 278, the message is “NA,” which means that no action is needed.
BCN Advantage utilization management program

Providers can access the BCN Advantage authorization requirements on the BCN Referral and Authorization Requirements document. This document contains, among other things, a list of procedure codes that require authorization and can be accessed by clicking on the following link: BCN Referral and Authorization Requirements.

How to submit plan notifications and requests for authorization

There are various options providers can use to submit plan notifications and authorization requests:

- Providers are encouraged to use the web-based e-referral system, for submitting plan notifications and authorization requests and for viewing the status of a request for BCN Advantage members.

    **Important note:** Providers who are contracted with BCN Advantage are shown as “In” in the network section of the provider search grid. Those who are not are shown as “Out.”

- Providers may also submit plan notifications and authorization requests by phone if the e-referral system is not available.

    Note: To ensure the timely identification and processing of urgent requests, BCN encourages providers to submit all urgent requests by phone, by calling BCN’s Utilization Management department at 1-800-392-2512.

- Medical care groups may submit plan notifications and authorization requests using the HIPAA 278 electronic transaction standard. For information on the 278 transaction, providers should email Electronic Data Interchange at EDICustMgmt@bcbsm.com.

    The information is updated to show that medical care groups may submit plan notifications and authorization requests using the HIPAA 278 electronic transaction standard.
# BCN Advantage utilization management program

**Other information about plan notification and authorization**

For services for BCN Advantage members that require plan notification or authorization:

- Requests for services requiring plan notification must be submitted prior to obtaining the service.
- Requests for services that require authorization, including the necessary clinical information, must be submitted at least 14 days prior to obtaining the service.

The clinical information can be submitted in one of the following ways:

- By entering it directly into the Provider Communication section on the e-referral system
  
  Note: Providers are encouraged to submit the required clinical information via e-referral, with the initial authorization request.
  
- By attaching it to the case. Instructions for attaching a document from the member’s medical record are outlined in the article **“How to attach clinical information to your authorization request in the e-referral system,”** on page 44 of the November-December 2016 *BCN Provider News*. These instructions are also in the e-referral User Guide, in the subsection titled “Create New (communication).”

- By faxing it to BCN’s Utilization Management department at 1-800-675-7278
  
  Note: If the information is being faxed, providers should indicate that in the e-referral Provider Communication section.

BCN is required by regulatory agencies and by Medicare to notify members and providers in writing when clinical information is needed to process a request for authorization. When providers submit the clinical information with the initial request, it decreases the number of letters that BCN is required to send to members and to providers.

**Member requests for BCN authorization**

Requests for medical care or services may also be submitted to BCN by the BCN Advantage member in writing or by telephone. If the member makes the request, BCN will contact the primary care physician to obtain his or her support for the requested treatment and to request any clinical information needed to make the decision.
BCN Advantage utilization management program

Inpatient review and discharge planning

**BCN must be notified of an urgent or emergency inpatient admission within one business day.** Most requests for acute inpatient admissions must be submitted to BCN using the e-referral system. There are some exceptions, however, which must be submitted by fax. Refer to the document [Submitting acute inpatient admission requests to BCN](#) for the details.

The clinical information must be included in the request.

BCN’s Utilization Management department nurses use InterQual® criteria and apply BCN Local Rules for select conditions.

Note: BCN may request that clinical documentation be submitted on weekends or holidays so that the 72-hour time frame for determinations can be met. For BCN Advantage members, CMS encourages plans to make up to three attempts to obtain clinical documentation from providers to make a decision. If the provider doesn’t respond to BCN’s requests by the third day, the nurse will send the request to a BCN medical director for a decision, to ensure that the request is reviewed within the appropriate time frame.

BCN’s Utilization Management department staff are also available to assist physicians and other providers for urgent needs after normal business hours, Monday through Friday from 5 p.m. to 7 a.m. They are also available 24 hours per day on weekends and holidays. To reach a care manager after normal business hours, providers should call 1-800-851-3904.
As a Medicare Advantage organization, BCN Advantage is required by CMS to provide coverage to enrollees for all Part A and Part B Original Medicare covered services. However, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While BCN Advantage does apply medical necessity criteria to determine coverage, the criteria do not have to be applied in the same manner as is required under Original Medicare. Specifically:

- **Benefits**: Medicare Advantage plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.
- **Access**: Medicare Advantage enrollees must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare. (See the accessibility rules for Medicare Advantage plans in the CMS Managed Care Manual, “Chapter 4: Benefits and Beneficiary Protections,” Section 110.)
- **Billing and payment**: Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures as long as providers, whether contracted or not, are paid accurately, in a timely manner and with an audit trail.

Providers can refer to “Chapter 4: Benefits and Beneficiary Protections” in the Medicare Managed Care Manual for additional details about Medicare Advantage organizations.

When determining medical necessity, both BCN and Original Medicare coverage and payment are contingent upon a determination that all three of the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member or is a covered preventive service.
BCN Advantage utilization management program

Medical necessity considerations: inpatient vs. observation stays

When BCN Advantage members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses.

Here are some guidelines that clarify how BCN Advantage determines medical necessity:

- BCN Advantage uses InterQual criteria and BCN-developed Local Rules to make determinations of medical necessity for all BCN Advantage members.
- BCN Advantage does not require physician certification of inpatient status to ensure that a member’s inpatient admission is reasonable and necessary. For Original Medicare patients, however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B and 42 CFR 412.3.

Note: Additional information about InterQual criteria is available in the Care Management chapter of this manual.

- When the application of InterQual criteria or BCN-developed Local Rules results in a BCN Advantage member’s inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- The BCN Advantage authorization request process, as outlined in the Care Management chapter of this manual and also elsewhere in this chapter, takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures and the “two midnight” rule.
BCN Advantage utilization management program

Requirement to notify members of observation stay

Hospitals must use the Medicare Outpatient Observation Notice form to notify BCN Advantage members in the circumstances listed below that they are an outpatient receiving observation services and not an inpatient of the hospital:

- When a member is in the emergency department and is being considered for inpatient admission but has not yet been approved for admission by BCN
  
  Note: When BCN has approved an admission, there’s no need to notify the member using the form. When the member is not being considered for inpatient care, there’s no need to notify either the member or the plan.

- When a member is being moved to observation status within the hospital from any other status or source

- When a member is in an observation setting for 24 hours or more, if the member has not already received the form before being admitted for observation

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

When presenting the member with the notice, the hospital representative is required to explain its content, document that an oral explanation was provided and answer all the member’s questions to the best of his or her ability. The notice must include the reasons the member is receiving observation services and the implications of receiving those services, such as required cost-sharing and post-hospitalization eligibility for coverage of skilled nursing facility services.

The hospital representative should ask the member to sign the notice to indicate that he or she has received and understood it.

Hospitals must deliver the notice to the member no later than 36 hours after observation services are initiated, or sooner if the member is transferred, discharged or admitted.

Providers can access a copy of the notice and the instructions for using it by visiting ereferrals.bcbsm.com > BCN > Forms. To access specific documents, providers should:

- Click Medicare Outpatient Observation Notice, to access the form
- Click MOON form instructions, to access the instructions for the form

The Medicare Outpatient Observation Notice and the instructions are also available on BCN’s Forms page within Provider Secured Services.

Additional information about this requirement is available on the Beneficiary Notices Initiative page of the CMS website.
BCN Advantage utilization management program

**Requesting an expedited decision**

Either the physician or the BCN Advantage member may request an expedited decision if they believe that waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member
- Seriously compromise the ability of the member to regain maximum function
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested

BCN always relies on the physician to determine conditions that warrant expedited decisions.

- If the physician requests an expedited decision, the decision is made according to preservice urgent time frames. (Providers should refer to the table found later in this chapter under the subheading “Standard time frames for BCN Advantage members”).
- If the member requests an expedited decision, BCN calls the physician to determine whether the member’s medical condition requires a fast decision.
  - If the physician agrees, BCN makes a decision to approve or deny the request according to preservice urgent time frames (see table found later in this chapter under the subheading “Standard time frames for BCN Advantage members”).
  - If the physician disagrees, BCN makes a decision according to standard time frames (see table found later in this chapter) and notifies the member of a decision not to make an expedited decision.

BCN will not make an expedited decision about payment for care the member has already received.

**How the physician may request an expedited decision**

Physicians may request an expedited decision by calling BCN’s Utilization Management department at 1-800-392-2512.
**BCN Advantage utilization management program**

BCN’s Utilization Management department staff conduct timely reviews of all requests according to the type of service requested. Decisions are made according to the following standard time frames:

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Decision</th>
<th>Initial notification</th>
<th>Written notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preservice urgent/concurrent</td>
<td>Within 72 hours from receipt of request</td>
<td>Within 72 hours from receipt of request</td>
<td>Within 3 days of initial notification</td>
</tr>
<tr>
<td>Preservice nonurgent</td>
<td>Within 14 days of receipt of request</td>
<td>Within 14 days of receipt of request</td>
<td>Within 14 days of receipt of request</td>
</tr>
<tr>
<td>Postservice</td>
<td>Within 14 days of receipt of request</td>
<td>N/A</td>
<td>Within 14 days of receipt of request</td>
</tr>
</tbody>
</table>

**Requests for information**

Preservice nonurgent requests: An extension of up to 14 calendar days is allowed if the member asks for the extension or if BCN needs more information to make a decision about the request. The member can request an extension by phone or in writing, using the information on the previous page to contact BCN.

Postservice requests: An extension of up to 14 calendar days is allowed if BCN needs more information to make a decision.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
</table>
| The service is approved         | • For all service requests, the members receive written notification.  
|                                 | • For inpatient admissions, providers receive written notification.  
|                                 | • For service requests that do not involve inpatient admissions, providers should check e-referral for the status of the request. |
| The service is denied           | BCN sends the member, practitioner and facility a letter within the time frames stated above. The letter includes the reason(s) for the denial, informs the member and practitioner of their right to appeal and explains the process. |

Additional information available in Care Management chapter

Information about BCN’s utilization management program in addition to that offered in this chapter is available in the Care Management chapter of this manual. This information includes the following:

- Affirmation statement
- Follow-up care
- Review of readmissions that occur within 30 days of discharge
Transitional care services – those services that follow discharge from an inpatient care setting when placement in a transitional setting is necessary or to prevent inpatient hospitalization through the provision of skilled care in the home – are typically coordinated by BCN’s transitional care nurses, with some exceptions.

For BCN Advantage members admitted to post-acute care (to a skilled nursing or rehabilitation facility or to a long-term acute care hospital) on or after June 1, 2019, navihealth manages the authorizations. Refer to the document *Post-acute care services: Frequently asked questions by providers*.

For additional information on the guidelines for transitional care services, refer to the Care Management chapter of this manual. Look in the section titled “Guidelines for transitional care.”

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.

For information on the key components of transitional care management services, on the documentation required and on how to bill, refer to the Claims chapter of this manual. Look in the section titled “Billing guidelines for transitional care management services.”
### Medical records

<table>
<thead>
<tr>
<th><strong>Signatures on medical records</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers should use only handwritten or electronic signatures, or facsimiles (faxes) of handwritten or electronic signatures, on the medical records of BCN Advantage members. CMS prohibits the use of stamped signatures on any medical record.</td>
</tr>
<tr>
<td>Providers must also include their specialty credentials when providing their signature. In addition, CMS requires that signatures be legible. CMS does not accept a signature that cannot be readily identified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Documentation supporting diagnosis codes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers must include documentation in the medical record that supports all diagnosis codes reported on claims submitted to BCN Advantage for payment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maintaining medical records</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers must maintain accurate and timely medical records for the BCN Advantage members treated by them. The records must be maintained as follows:</td>
</tr>
<tr>
<td>• In accordance with all federal and state laws and regulations regarding confidentiality and the disclosure of member health information</td>
</tr>
<tr>
<td>• In a manner that safeguards the privacy of any information that may identify a particular member</td>
</tr>
<tr>
<td>Medical records for BCN Advantage members must be maintained for at least ten years after the final date of the provider’s participation agreement or the completion of a regulatory audit, whichever is later.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Electronic health records</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN Advantage encourages the adoption and use of electronic health records. For additional information, providers may refer to the “Electronic health records” section of the BCN System of Managed Care chapter of this manual.</td>
</tr>
</tbody>
</table>
Chapter 15: BCN Advantage

Medical records

Access to medical records

Providers must allow access to medical records as follows:

- **Administrative access to records:** In accordance with applicable law and with applicable access standards for records outlined in the Health Insurance Portability and Accountability Act, in particular, providers must allow access by BCN or its delegate, including Blue Cross Internal Audit, to member medical records upon reasonable request in order to facilitate its role in adjudicating claims; conducting quality and utilization management processes; and handling members' issues. Providers are also required to submit medical records for the validation of risk adjustment data. Upon reasonable request by BCN, providers must provide copies of members' medical records for such purposes without additional charge. In addition, providers must cooperate with BCN in obtaining attestations to correct signature deficiencies in the medical record.

- **Other access to records:** Providers must permit the U.S. Department of Health and Human Services, the U.S. Comptroller General or their designees to audit, evaluate, collect directly from or inspect any books, contracts, medical records, patient care documentation and other records that pertain to any aspect of services performed, the reconciliation of benefit liabilities and the determination of amounts payable for BCN Advantage members. Providers must provide such information to BCN as is necessary to comply with the reporting requirements established by CMS. Such access must be permitted for up to ten years after the final date of the provider's participation agreement or the completion of a regulatory audit, whichever is later.

Submission of medical records for an audit

Providers are required to submit records in the event of an administrative or regulatory audit, including a Risk Adjustment Data Validation audit.

The records that are requested for an audit must be submitted according to the requirements set forth in the audit notification.
## Chronic care management by providers

### Overview of chronic care management services by providers

For BCN Advantage members who have two or more significant chronic conditions, practitioners can provide both face-to-face and non-face-to-face services to help manage these conditions. Non-face-to-face services are activities that would not typically be provided face to face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers.

For eligible BCN Advantage members who meet specific criteria, providers can bill for non-face-to-face chronic care management services using a specific procedure code finalized by the Centers for Medicare & Medicaid Services. This initiative is aimed at ensuring continuity of care and care management, including care planning and coordination, member education and communication with the variety of providers involved in the member’s care, as appropriate.

### Which members are eligible for chronic care management services by providers

Providers may provide and bill for non-face-to-face chronic care management services for a member who meets the following criteria:

- Has two or more significant chronic conditions expected to last at least 12 months or until the member’s death and
- Is at significant risk of death, acute exacerbation or decompensation, or functional decline due to these conditions
Chronic care management by providers

Written consent is required

The provider must obtain the member’s consent in writing before non-face-to-face chronic care management services are billed. The member must sign a form documenting that he or she was informed of the following:

• That the member is eligible for chronic care management services and is offered the opportunity to participate in them. This must occur prior to providing any chronic care management services. The following must also be documented:
  - The member’s decision to accept or decline the offer to participate
  - The member’s permission to share relevant medical information electronically with other providers, if the member is interested in participating

• That the member has the right to discontinue the chronic care management services at any time by giving either oral or written notification. This would revoke the agreement and services would be discontinued at the end of the service period.

• That only one practitioner can furnish and be paid by BCN Advantage for chronic care management services within a service period

• That while there is no copayment or coinsurance for chronic care management services, a deductible may apply and may result in cost-sharing for the member

The member’s electronic health record must contain evidence of the member’s written consent and the documentation that the items listed above were discussed with the member. If the member gives notification to discontinue services, the notification must be stored in the electronic health record as evidence of ending chronic care management services. The electronic health record must be maintained using technology certified for chronic care management services.

Goals of chronic care management services by providers

As a result of the non-face-to-face chronic care management services, members must be able to do the following:

• Reach health care practitioners at any time, 24 hours a day, seven days a week

• Obtain continuous care through successive routine appointments with a designated individual on the health care team

• Receive a systematic assessment of his or her health needs and the appropriate preventive services in a timely way, including review of medication adherence, identification of potential medication interactions, follow up after emergency department visits, follow up after the member is discharged from a hospital or other health care facility and oversight of the member’s self-management of medications

• Receive a copy of the patient-centered electronic care plan that is developed
Chronic care management by providers

When providing non-face-to-face chronic care management services, providers must do the following:

- Initiate the chronic care management services during a face-to-face visit before billing for them
- Use a certified electronic health care record for specified purposes
- Include the following information in the member’s medical record:
  - Demographic information
  - Problems
  - Medications and medication allergies, consistent with 45 CFR 170.314(a)(3)-(7)
- Provide upon request a copy of the member’s structured clinical summary record, consistent with 45 CFR 170.314(e)(2), including:
  - The member’s written consent to receive chronic care management services
  - The member’s written notice or the documentation of the member’s verbal notice to discontinue chronic care management services, as applicable
- Give the member a copy of his or her care plan
- Coordinate and document communication to and from home- and community-based providers
- Access members’ electronic health records 24 hours a day, seven days a week, to address urgent chronic care needs
- Manage the transitions between and among health care providers and settings and community and social services, including referrals, follow up and providing the member’s electronic health record, as appropriate
- Communicate with members about their care over the phone or through secure messaging
Non-face-to-face chronic care management services should be billed using code *99490. The guidelines for billing with this code are as follows:

- Services may be billed once per calendar month, for a minimum of 20 minutes of qualifying services of the types discussed earlier in this article.
- Services can be billed only by qualifying clinical staff. This includes only physician and nonphysician practitioners directly affiliated with Blue Care Network or billing incident to a supervising physician.
- Only one practitioner can bill per month. The billed services are typically provided by primary care practitioners, although specialists may also bill as long as the requirements are met.
- Time spent on various activities may or may not count toward the 20 minutes of chronic care management time, as shown in this table:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Count toward minimum 20 minutes of billable chronic care management time?</th>
<th>Other information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and management services and procedures</td>
<td>No</td>
<td>E&amp;M services should be billed separately.</td>
</tr>
<tr>
<td>Telephone calls between the practitioner and:</td>
<td>Yes</td>
<td>Telephone calls used to schedule appointments cannot be counted toward the 20 minutes of billable chronic care management time. If the time from a phone call leads to scheduling an office visit, that time would be included in the billed office visit, not the chronic care management time.</td>
</tr>
<tr>
<td>- The member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The member’s other health care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General planning or care coordination time that is initiated because of a contact, or does result in a contact with the patient or a contact related to the patient</td>
<td>Yes</td>
<td>General planning or care coordination time that is not initiated because of a contact, and does not result in a contact with the patient or a contact related to the patient, cannot be counted toward the 20 minutes of billable chronic care management time.</td>
</tr>
</tbody>
</table>

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Chronic care management by providers

Billing for non-face-to-face chronic care management services (continued)

The guidelines for billing with procedure code *99490 are as follows:

- Claims for these services are subject to review and audit. You should ensure that the documentation in the member’s medical record supports the claim.

- Chronic care management services cannot be billed in the same month when claims are submitted through the following programs, which reimburse for similar services:
  - Blue Cross/BCN High Intensity Care Model program
  - Multi-payer Advanced Primary Care Practice Demonstration
  - Comprehensive Primary Care Initiative
  - Transitional Care Management

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.

Additional information

Additional information about chronic care management services is available through the following resources:

- **Chronic Care Management Services fact sheet** published by the CMS Medicare Learning Network. This document includes examples of the chronic conditions for which chronic care management services can be billed, among other things.

- **Frequently Asked Questions about Billing Medicare for Chronic Care Management Services**, published by CMS

- **Chronic Care Management Tool Kit** published by the American College of Physicians

Providers may also contact a care manager at 1-800-775-2583.
Chronic condition management programs

The information about chronic condition management programs is clarified to show that these are a type of care management program available through the plan to BCN Advantage members.

Goals for chronic condition management activities

The chronic condition management programs are one type of care management program available through the plan to BCN Advantage members. They are designed to help members understand their condition and achieve and maintain control of it.

BCN works together with the member, the primary care physician and the purchaser of the health care product to promote activities aimed at managing these chronic conditions.

The chronic condition management programs are available at no additional cost to the members, but they are not benefits under Medicare and may not be subject to the appeal process.

Chronic condition management programs

The chronic condition management programs for BCN Advantage members focus on:

- Chronic obstructive pulmonary disease
- Depression management
- Diabetes management
- Heart failure management
- Ischemic heart disease
- Kidney health management

Information on these programs can be found in the Health Education and Chronic Condition Management chapter of this manual.
Case Management program

Overview of Case Management program

The Case Management program is another type of care management program available through the plan to BCN Advantage members.

Identification of members with complex or serious medical conditions

Members with complex and serious medical conditions who are potential candidates for the Case Management program are identified through a variety of methods. Potential candidates are identified through traditional approaches such as length of stay or request for services. In addition, members can self-refer or may be referred by physicians or other providers or caregivers or by other departments such as Customer Service, Chronic Condition Management or Pharmacy.

The Case Management program also utilizes a predictive model to prospectively identify high-risk members who may qualify for case management. The model allows for risk stratification of the entire population by calculating a relative risk score for each member. Predictive modeling allows for assessment of the entire population and identification of members within the population who are most likely to experience high cost or disease complications in the absence of intervention.

Assessment of members with complex or serious medical conditions

Upon enrollment and annually thereafter, members are encouraged to complete a health assessment to identify the case management services, behavioral health follow up or depression screening they may need.

Care managers contact members by phone to perform an initial assessment of the member’s health status. The member is provided personalized support and education about their condition, nutrition and medication through regular phone calls and mailings.

Case management interventions are planned and implemented based on the member’s risk, prioritized case management goals and specific needs. Interventions take into account cultural and ethnic considerations, behavioral and psychosocial issues and the family support available to the member.
Case Management program

Collaboration with the physicians

BCN Advantage care managers may contact the physician:

- When there are significant changes in the member’s health status
- When an intervention on the part of the treating practitioner is thought to be necessary
- When the member uses emergency room services or is admitted for inpatient care
- To review the member’s progress at various intervals in the case management process
- To notify the treating practitioner of a member who was in a case management program but refuses further intervention prior to goals being met
- To notify the treating practitioner that the member hasn’t been compliant with the recommended plan of care
- To obtain the health information necessary to ensure the highest quality of care
Care Transitions program

The information about the Care Transitions program is clarified to show that this program is one type of care management program available through the plan to BCN Advantage members. Other information about the program is updated to reflect current practices.

Care Transitions program overview

The Care Transitions program is another type of care management program available through the plan to BCN Advantage members. This program helps BCN Advantage members transition from hospital to home. It provides education and support to help members get well and stay healthy.

The goals of the program are to help prevent avoidable readmissions within 30 days of discharge and to promote members’ timely follow up with their primary care physician or specialist within seven days of discharge.

The care managers are registered nurses who assist members and their caregivers to coordinate care after discharge from an inpatient facility. The care team includes a medical social worker, pharmacist, behavioral health professional and registered dietitian available to help members address specific issues, as needed.

Proactive interventions begin when a care manager contacts the member either by telephone or at the bedside (at select facilities) during the acute care hospitalization.

Telephone outreach takes place within three days of hospital discharge. Follow-up calls occur as needed based on the acuity of the member’s condition.

Through these follow-up calls, the care manager can:

- Arrange timely follow-up with the doctor and assist with transportation, if needed
- Provide medication review and reconciliation after the hospital discharge and offer tips to improve medication adherence and management
- Explain hospital discharge instructions and how to manage any conditions
- Discuss signs and symptoms of possible complications and what to do next
- Offer other health services and related programs to support the member in the home
- Provide connections to available community resources
- Recommend preventive health screenings, lab tests and other services the patient may need

(continued on the next page)
Care Transitions program

For those members identified as high risk, telephone interaction may occur more frequently. Members are determined to be at high risk based on the assessment of a care manager. High-risk members often have complex needs that require longer engagement with the program and may be monitored for up to 90 days.

For qualified BCN Advantage members involved in the Care Transitions program who reside in Wayne, Oakland, Macomb and Washtenaw counties, non-emergency transportation is available for up to 28 days after discharge to ensure that members have access to timely follow-up with their physician. BCN has partnered with Ford Go-Ride to provide this non-emergency transportation service.

How to contact the Care Transitions program

Providers who wish to speak to a care manager for the Care Transitions program should call 1-800-775-2583, Monday through Friday between 8 a.m. and 5 p.m.
Blue Care Connect

Information is added about Blue Care Connect℠, a care management program available through the plan to BCN Advantage members.

Blue Care Connect is a care management program available through the plan to BCN Advantage members.

Note: Blue Care Connect is not available to BCN HMO (commercial) members.

The purpose of the program is to improve the continuity and quality of care and reduce benefit costs for high-risk members.

The program uses a high-touch approach focused on the behavioral, social and environmental aspects of care management to reduce the burden of disease and overall benefit cost.

To improve continuity of care, members who are identified as eligible to participate in the program are managed by one care manager and the case remains open indefinitely. If a member needs to be referred to external programs, the assigned care manager remains the member’s primary point of contact for follow up.

General services available through Blue Care Connect

The member’s care manager will encourage the member to complete a health assessment, address gaps in care, and identify and address intervention pathways appropriate to the member’s needs.

The care manager first addresses high-priority goals. Other goals are addressed during the program.

Even after acute episodes and immediate goals have been addressed, the care manager continues to support the member and monitor the case due to the complexity of the conditions the members are dealing with.

Currently, high-risk members diagnosed with heart failure may be eligible for remote monitoring.

These members receive a monitor appropriate for their symptoms and condition and are provided with the support needed to operate it. The monitor, which is placed in the member’s home, transmits biometric and other symptom data daily.

When these biometric data fall outside of the usual parameters, a nurse care manager calls the member to validate the information and confirm the symptoms, and contacts the member’s primary care physician as needed.
## Blue Care Connect

| Other services available through Blue Care Connect | Members engaged in Blue Care Connect who reside in southeast Michigan may also have access to assistance with non-emergency transportation to medical appointments for up to 28 days after discharge from an acute care facility. Members engaged in Blue Care Connect who reside in a specific geographic area in west Michigan may also have access to assistance with non-emergency transportation to medical appointments and will be provided with a personal emergency response system. These services (non-emergency transportation and a personal emergency response system) are available only to members engaged in the Blue Care Connect program. |
| Primary care physician opt-out option | The member’s primary care physician receives notification of a member’s engagement in the Blue Care Connect and may choose to have the member not participate in the program. |
BCN Advantage pharmacy services

Prescription drug program overview for individuals

Individuals with BCN Advantage coverage have seven options to choose from for Part D drug benefits. Beneficiaries can select BCN Advantage Basic, Classic or Prestige (options under the BCN Advantage HMO-POS product), or BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver or BCN Advantage HMO HealthyValue (options under the BCN Advantage HMO product), which offer different copayment levels.

Note: The Elements option under the BCN Advantage HMO-POS product does not offer a drug benefit.

Note: The BCN Advantage HMO ConnectedCare product is available only to residents of Arenac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw and Wayne counties. The BCN Advantage HMO MyChoice Wellness product is available only to residents of Kent, Oceana and Ottawa counties. The BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue products are available only to residents of Arenac, Genesee, Iosco, Kalamazoo, Kent, Livingston, Macomb, Muskegon, Oakland, Oceana, Ottawa, Saginaw, St. Clair, Washtenaw and Wayne counties.

Details about the BCN Advantage HMO-POS Basic, Classic and Prestige products, and the BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue products for individuals are found in this section.

Prescription drug program overview for groups

Groups with BCN Advantage coverage may include a BCN Advantage Part D plan for pharmacy services.

Details about the BCN Advantage Part D coverage for groups are available at bcbsm.com/medicare > Group Plans (under Medicare Plans).

Note: Groups may offer pharmacy benefits through BCN HMO (commercial) or through a non-BCN carrier instead of through a BCN Advantage Part D plan.

Drugs covered under the medical benefit

Drugs covered under the medical benefit are handled differently from drugs covered under the pharmacy benefit. Information about drugs covered under the medical benefit is available at these locations:

- In the Pharmacy chapter of the BCN Provider Manual. Look in the section titled “Drugs covered under the medical benefit.”
- On the Medical Benefit Drugs – Pharmacy page at ereferrals.bcbsm.com > BCN > Medical Benefit Drugs – Pharmacy
BCN Advantage pharmacy services

Provider access to the BCN Advantage formularies

BCN Advantage formularies list medications that are covered for individuals and for groups who have selected a BCN Advantage plan option that includes Part D drug coverage.

Note: For group members, Part D coverage through an employer group may vary.

The BCN Advantage formularies represent the clinical judgment of Michigan physicians, pharmacists and other health care experts. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. BCN Advantage will generally cover the drugs listed on a formulary as long as the drug is medically necessary, the prescription is filled at a BCN Advantage network pharmacy and other plan rules are followed.

BCN encourages physicians to refer to the appropriate BCN Advantage formulary when considering drug therapy for BCN Advantage members with a drug benefit. Generic drugs are available at the lowest copayment, a significant savings over brand-name therapeutic alternatives.

Accessing the BCN Advantage formulary for individual members

The BCN Advantage formulary for individual members includes all drugs covered by Part D. The formulary is updated monthly to reflect any additions of drugs to the list and any changes to the cost-sharing status of a covered Part D drug. If a medication is removed from the formulary, BCN provides notice to affected members 30 days in advance of the change through a letter mailed to the members.

The formulary for individual members can be accessed here: BCN Advantage Formulary.

The information about the formulary is updated to show that if a medication is removed from the formulary, BCN provides notice to affected members 30 days in advance of the change.

Accessing the BCN Advantage formulary for group members

The BCN Advantage formulary for group members includes everything offered in the individual formulary, some additional Part D drugs and the non-Part D drugs that are included in the enhanced drug benefit.

The formulary and related drug information for group members can be accessed here: BCN Advantage Formulary for Groups.

OTC coverage

BCN Advantage does not cover over-the-counter drugs, for either individual or group members.
BCN Advantage pharmacy services

Five of the BCN Advantage coverage options offer individual Part D drug benefits, as follows:

- BCN Advantage HMO-POS Basic, which has a $405 deductible for Tiers 2 through 5
- BCN Advantage HMO-POS Classic, which has no deductible
- BCN Advantage HMO-POS Prestige, which has no deductible
- BCN Advantage HMO ConnectedCare, which has no deductible
- BCN Advantage HMO MyChoice Wellness, which has no deductible
- BCN Advantage HMO HealthySaver, which has a $100 deductible for Tiers 3 through 5
- BCN Advantage HMO HealthyValue, which has a $250 deductible for Tiers 3 through 5

BCN Advantage HMO-POS also offers Elements, which does not include drug coverage except for drugs covered under Medicare Part B.

Note: For group members, Part D benefits through an employer may vary.

The responsibilities for members with individual plans can be found in the Evidence of Coverage documents for the plans. Providers can also access that information by clicking on the links provided here:

- Evidence of Coverage for BCN Advantage HMO-POS Basic, Classic and Prestige
- Evidence of Coverage for BCN Advantage HMO ConnectedCare
- Evidence of Coverage for BCN Advantage HMO MyChoice Wellness
- Evidence of Coverage for BCN Advantage HMO HealthySaver
- Evidence of Coverage for BCN Advantage HMO HealthyValue

Note: In these Evidence of Coverage documents, look in the section titled “You have some responsibilities as a member of the plan.”
BCN Advantage pharmacy services

**Coverage limits and member copayment responsibilities**

For the BCN Advantage HMO-POS Basic, Classic and Prestige products, and BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue, the limit for the initial coverage level is reached when $3,820 has been expended on medications. This includes both expenditures made by the plan and out-of-pocket costs paid by the member for Part D drugs.

Once the initial coverage limit has been reached, the individual member enters the gap stage (donut hole). During this stage, the member pays no more than 25 percent of the cost of brand drugs and 37 percent of the cost of generic drugs.

For prescriptions written for less than a 31-day supply, the member’s copayment is prorated based on the days’ supply submitted by the pharmacy provider. Proration of copayment allows prescribers to provide a trial period of a new medication while minimizing the financial impact to the member. BCN Advantage members will not exceed their monthly copay when receiving a reduced day supply of their medication. The following are excluded from proration: nonsolid oral dosages, prepackaged medications such as inhalers, and medications classified as antibiotics.

Note: The amounts mentioned apply to the benefit year. The member’s coverage limits / responsibility for copayments do not carry over beyond a coverage year. At the beginning of each new coverage year, the member’s coverage limits / copayment responsibilities begin anew.

Summaries of BCN Advantage Part D member copayments, coinsurance and discounts after the initial coverage limit has been reached (“gap” coverage) can be found in the *Evidence of Coverage* documents for the plans. Providers can also access that information by clicking on the links provided here:

- Evidence of Coverage for BCN Advantage HMO-POS Basic, Classic and Prestige
- Evidence of Coverage for BCN Advantage HMO ConnectedCare
- Evidence of Coverage for BCN Advantage HMO MyChoice Wellness
- Evidence of Coverage for BCN Advantage HMO HealthySaver
- Evidence of Coverage for BCN Advantage HMO HealthyValue

Note: In these *Evidence of Coverage* documents, look in the section titled “What you pay for your Part D prescription drugs.”
Chapter 15: BCN Advantage

BCN Advantage pharmacy services

<table>
<thead>
<tr>
<th>Part D Explanation of Benefits statement</th>
<th>All BCN Advantage members who receive pharmacy benefits are sent an Explanation of Benefits statement on a monthly basis that reflects their true out-of-pocket costs and the total cost of their Part D covered drugs. The Part D EOB is sent separately from the comprehensive EOB that contains information for all the other services the member has received. The Part D EOB is generated by Express Scripts. It provides information about the member’s pharmacy claims history and amounts paid. This information includes prescription costs paid by the member and by BCN Advantage. The Part D EOB is also available electronically to members who choose to enroll in the Part D e-EOB. BCN Advantage members who have questions regarding their EOB statement can call BCN Advantage Customer Service at 1-800-450-3680, between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call 711.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step therapy and prior authorization</td>
<td>The goal of the BCN Pharmacy department is to ensure that all members receive high-quality, cost-effective pharmaceutical care. To meet this objective, BCN requires prior authorization for certain medications, and clinical criteria must be met before coverage is approved. Clinical criteria are based on current medical information and recommendations of Blue Cross/BCN’s Pharmacy and Therapeutics Committee. In addition, as required by CMS, some drugs that can be processed under either Part B or Part D require prior authorization in order to determine how to process the claim. Drugs that are covered under Part B, based on the member’s circumstance, cannot be processed as a Part D claim. BCN’s step therapy and prior authorization criteria for Part D drugs are the same for individual and group plans and are available here: Prior Authorization / Step Therapy Criteria.</td>
</tr>
</tbody>
</table>
BCN Advantage pharmacy services

Requests for exceptions

BCN Advantage considers exception requests based on medical necessity. To request prior authorization or an override of one of BCN’s drug utilization management tools, the provider should contact the BCN Clinical Pharmacy Help Desk at 1-800-437-3803. This number is available to providers 24 hours a day, seven days a week, including holidays.

Responses to requests for coverage determinations are made within 72 hours. The provider should alert the Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the member’s life, health or ability to regain maximum function would be jeopardized or that, in the opinion of the prescriber with knowledge of the member’s condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. The provider should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

The different types of exception requests include:

- Coverage for a nonformulary medication
- Waiver of coverage restrictions or quantity limits, including prior authorization and step therapy requests
- Coverage at a higher level for a drug (lower copayment amount)

Documentation must be provided regarding the reason a formulary alternative is not appropriate for the member. If the request is for a higher quantity of a medication than BCN allows, the physician must provide documentation showing that the allowed quantity is not adequate for the member’s condition.

Copayment exception requests are allowed for formulary medications for the drugs included on Tiers 2, 3, 4 and 6. BCN does not consider requests to lower the copayment amount for drugs included on Tiers 1 and 5. Copayment exception requests are not allowed for drugs approved through the nonformulary drug approval process.

The form to use

Providers should use the Medicare Part D Coverage Determination Request form to request an exception. A copy of this form is available here: Request for Medicare Prescription Drug Coverage Determination

Providers should print the form, complete it and fax it to the BCN Clinical Pharmacy Help Desk at the fax number listed on the form.
BCN Advantage pharmacy services

90-day transition period for new members

New BCN Advantage members who are using Part D drugs that are not on a BCN Advantage formulary or that are subject to prior authorization, quantity limit, step therapy or other requirements are given a transition time of 90 days to work out other medication options with their prescriber.

During the first 90 days of membership, BCN Advantage may cover the member’s drug in certain cases. Specifically, a temporary 31-day supply may be covered for each drug (unless the prescription is written for fewer days), when the member uses a network pharmacy. No additional coverage will be provided for the drug after the temporary 31-day supply, even if the ninetieth day of membership has not yet been reached.

When a transition supply of medication is filled at the pharmacy, both the member and the prescriber receive a letter explaining the process for requesting a Medicare Part D coverage determination.

Members and their prescribers can also submit a medication exception request using the Medicare Part D Coverage Determination Request form.

Note: For members who are residents of a long-term care facility, BCN Advantage will cover the 31-day temporary supply and more than one refill during the first 90 days of membership. Once the ninetieth day of membership has been reached, BCN Advantage will cover a 31-day emergency supply of that drug (unless the prescription was written for fewer days) while the member and prescriber pursue a medication exception. In addition, according to CMS, residents of long-term care facilities who are prescribed brand-name solid oral drugs can receive only a 14-day supply at one time. For these members, copayments and coinsurance are prorated based on their 31-day supply copay.

Pharmacy network

More than 2,400 retail pharmacies participate in the BCN Advantage prescription drug program in the BCN Advantage service area.

Express Scripts is the Medicare Part D Preferred Value Network vendor. The network includes both standard and preferred pharmacies.

Preferred pharmacies are those that offer discounted copayments to members. Members can get a prescription filled at any network pharmacy, but using a preferred pharmacy saves members money.

More information about the BCN Advantage pharmacy network is available on the BCN website at bcbsm.com/medicare > Find a Doctor > Find a pharmacy.
BCN Advantage pharmacy services

90-day supply at retail or by other means

BCN Advantage members can obtain a 90-day maintenance supply of most medications through either their local pharmacy or through one of BCN’s mail-order vendors.

- Through Express Scripts Mail Order and Walgreens Mail Service, mail-order prescription services are available to BCN Advantage members who have prescription drug coverage through their plan.
- When a member will be ordering prescriptions through mail order, these steps should be followed:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
</table>
| 1    | Write two prescriptions for the member:  
One for an initial 14-day supply of the medication to be filled at a local retail pharmacy  
The second for a 90-day supply, with refill options, to be filled by mail order |
| 2    | Give the prescriptions to the member. The member has the 14-day supply filled at a participating BCN Advantage pharmacy and mails the 90-day supply prescription in a preaddressed mail-order envelope.  
OR  
E-prescribe or fax a copy of the member’s prescription to Express Scripts Mail Order or Walgreens Mail Service using the appropriate fax form. |

To request mailing envelopes, members may call BCN Advantage Customer Service at 1-800-450-3680.

The fax forms can be found at (Provider Secured Services) BCN Provider Publications and Resources > Forms. Look under the Pharmacy heading.

Additional information about ordering is available in the “BCN Advantage operates like Blue Care Network” section, which appears earlier in this chapter.

Medication adherence program

The BCN Advantage pharmacy department assists members who have difficulties with medication adherence. Some adherence tools that are available include:

- Refill consolidation  
- Text message reminders  
- Smartphone application setup  
- Free pill boxes  
- Timers

Members interested in a medication adherence assessment can contact the BCN Advantage TakeMiMeds hotline at 1-855-815-9414. TTY users should call 711. Certified pharmacy technicians are available Monday through Friday from 9 a.m. to 5 p.m.
CMS requires a Medication Therapy Management program for Part D plans. The MTM program is a comprehensive program designed to manage BCN Advantage members with chronic diseases at high risk for developing adverse drug events. The goals of the plan are to:

• Ensure safety
• Improve prescribing practices
• Decrease overall medication and medical costs for enrollees

Members are automatically enrolled in the MTM program if they meet all of the following criteria:

• They have at least $4,044 in drug costs per year.
• They have at least three of the following chronic conditions:
  - Chronic obstructive pulmonary disease
  - Congestive heart failure
  - Hypertension
  - Diabetes mellitus
• They are prescribed eight or more concurrent unique Part D drugs or pharmaceutical preparations.

Members are identified for the MTM program through medical and pharmacy claims data and remain enrolled unless they request to be removed from the program.

The BCN Pharmacy department works closely with members, physicians and pharmacies to improve appropriate member medication compliance.

Member assessments are performed by BCN Advantage pharmacists upon the member’s enrollment in the MTM program. Pharmacists may contact physicians to verify medications, alert them to possible safety issues or coordinate therapies when multiple prescribers are involved.

Members enrolled in the MTM program are offered an opportunity to participate in a comprehensive medication review. BCN pharmacists conduct the interview by telephone. They discuss with the member a variety of topics including medication adherence, medication safety, over-the-counter medication use, drug interactions and opportunities to save costs. A detailed report that summarizes the findings is mailed to the member for follow up with the physician.

Case managers may be contacted to assist with the member’s health education and with management of the member’s condition.
BCN Advantage pharmacy services

Providers are encouraged to carry out medication reconciliation efforts for all members discharged from a hospital stay. Medication reconciliation services can be provided by a prescribing practitioner, a clinical pharmacist or a registered nurse and should be documented in the member’s outpatient chart within 30 days of hospital discharge.

The goals of medication reconciliation services are to:

- Address medication errors
- Help patients understand how and when to take medications
- Look for potential adverse interactions

For information on how providers can complete, document and bill for medication reconciliation services, refer to the Pharmacy chapter of this manual, in the section titled “Provider tools for pharmacy management.”

In addition to the medication reconciliation services that providers can offer, BCN Advantage Pharmacy Services assists providers as described below:

- For members discharged from a BCN Advantage partner hospital, BCN Advantage contacts the member within seven days of discharge without the need for the member’s physician to request the service. This applies to members discharged from one of the following hospitals:
  - McLaren Flint
  - McLaren Greater Lansing
  - Genesys Regional Medical Center
  - St. Joseph Mercy Hospital, Ann Arbor
  - Michigan Medicine (formerly called the University of Michigan Health System)
  - Sparrow Hospital

- For members discharged from other hospitals, a BCN Advantage pharmacist contacts the member for medication reconciliation only at the request of the member’s physician.

When providing these services, BCN Advantage does the following:

1. A BCN Advantage pharmacist calls the member at home.
2. The pharmacist completes a medication reconciliation report and faxes it to the primary care physician.
3. The primary care physician should place the report in the member’s chart and can use it to document the member’s medication reconciliation.

Providers may refer a BCN Advantage member for medication reconciliation services by calling 1-855-815-9414 (the Take My Meds phone number).

The information about medication reconciliation services is updated to show that these services should be documented in the member’s outpatient chart within 30 days of hospital discharge.
### BCN Advantage pharmacy services

#### Drug exclusions
Certain medications are excluded from individual coverage and are not payable through the Part D benefit.* These include:

- Nonprescription drugs
- Drugs when used for anorexia, weight loss or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs covered under Part B
- Drugs used to treat sexual dysfunction (examples: Viagra®, Cialis®, Levitra®, Caverject®, and Muse®)
- Drugs deemed less than effective by the FDA, also known as DESI (Drug Efficacy Study Implementation) LTE (less than effective) drugs. These are pre-1962 drugs that never underwent efficacy studies, such as Levsin®, Levsinex®, Anusol-HC® suppositories and Tigan® products.

*Some of these drugs may be covered for BCN employer group members electing BCN Advantage.

#### Part B vs. Part D coverage
Medications that are covered under Medicare Part B are not covered under the Part D benefit. Providers should forward any claims for Part B drugs directly to BCN Advantage for payment.

Some drugs are covered under either Part B or Part D. For example, immunosuppressants that are used for treatment of a member who has had a Medicare-covered transplant are covered under Part B. If the transplant was NOT covered by Medicare, then the drug is covered by Part D. Pharmacists will need to bill Part B (BCN Advantage billed directly) or the individual’s Part D plan (billed via the BCN Advantage pharmacy claims system), based on information received from BCN.

#### Immunizations
Flu, pneumonia and hepatitis B vaccines and vaccines given to treat injury or disease (for example, tetanus) are covered under Part B. All other vaccines are covered under Part D.

#### Medications for dual-eligible members
For information on medications for dual-eligible members — those who have BCN Advantage as their primary coverage and Blue Cross Complete as their secondary coverage — providers should refer to the *Blue Cross Complete Provider Manual*, located at [MiBlueCrossComplete.com/providers](http://MiBlueCrossComplete.com/providers).
BCN Advantage pharmacy services

Prescribers are encouraged to complete prescription verification forms

All providers who administer or deliver Medicare Part D prescription drug benefits are strongly encouraged to respond promptly to prescription verification requests when contacted by the NBI MEDIC (Health Integrity LLC), the CMS program integrity contractor. The prescription verification initiative is part of an ongoing effort to combat fraud, waste and abuse in the Medicare Part D program.

The NBI MEDIC routinely mails prescription verification forms containing the beneficiary’s name, the name of the medication, the date prescribed and the quantity given. The prescriber is asked to respond within two weeks, indicating whether he or she wrote the prescription. If no response is received, the investigator follows up with a second request.

Timely and complete responses to prescription verification requests can help eliminate any question of wrongdoing or prevent payment for fraudulent prescriptions without need for further investigation.

Safety edits for members with opioid prescriptions

BCN Advantage uses the safety edits listed below for members with opioid prescriptions. These edits are intended to encourage both prescribers and members to actively think about and discuss overdose risks and prevention:

• Initial fills for treatment of acute pain are limited to no more than a seven-day supply for opioid-naive members (members who have not filled an opioid prescription in the preceding 108 days). This includes short- and long-acting opioids, except for buprenorphine and other medication-assisted treatment products, which do not trigger an edit.

• Pharmacists must consult the prescriber and document the discussion when a member’s cumulative morphine milligram equivalent reaches or exceeds 90 MME for all opioid prescriptions written for the member by all providers over the previous 180 days. This does not apply to buprenorphine and other medication-assisted treatment products, which do not trigger an edit. If the prescriber confirms the intent, the pharmacist can use an override code that indicates the prescriber has been consulted.

Note: When a member has a cumulative MME per day of 200 or more, BCN Advantage requires that the prescriber attest to the medical necessity of the prescription and obtain authorization prior to the services being provided.

• BCN Advantage may limit at-risk members’ coverage of frequently abused drugs to certain prescribers and pharmacies. Member-specific post-claim edits will be applied after case management, discussion with the prescriber and notice to the member.

(continued on the next page)
BCN Advantage pharmacy services

(continued from previous page)

BCN Advantage uses the safety edits listed below for members with opioid prescriptions:

• BCN Advantage alerts pharmacists about a member’s duplicative long-acting opioid therapy and concurrent use of opioids and benzodiazepines. The pharmacist can use a override code once the safety edits are reviewed. This does not apply to buprenorphine and other medication-assisted treatment products, which do not trigger an edit.

• BCN Advantage wants to make prescribers aware that CMS has requested increased vigilance and monitoring of members taking the combination of opioids and the opioid-potentiator medications gabapentin and pregabalin.

• BCN offers access to medication-assisted treatment. No authorization is needed for buprenorphine and other medication-assisted treatment products.

Information is added about the safety edits BCN Advantage uses for members with opioid prescriptions. These edits are effective starting Jan. 1, 2019. As part of the safety edit, BCN Advantage does not require authorization for drugs used in medication-assisted treatment.

Providers can find out more about Part D coverage at the CMS website at [cms.hhs.gov](http://cms.hhs.gov). This website also includes educational materials about Medicare prescription coverage for physicians and other health care professionals.
## BCN Advantage member appeals

### Members can appeal

BCN Advantage members have the right to appeal problems getting the medical care they believe BCN should provide. This includes:

- Authorizing care or prescription drugs
- Paying for care or prescription drugs
- Arranging for someone to provide care
- Continuing to receive a medical treatment they have been getting

### Possible appeal scenarios

Problems getting the medical care or a Part D prescription drug that the member believes BCN should provide include the following situations:

#### Medical appeals

- The member is not getting the medical care they want and they believe this care is covered by BCN Advantage.
- BCN will not authorize the medical treatment the member’s doctor or other medical provider wants to provide and the member believes that this treatment is covered by BCN Advantage.
- The member is being told that coverage for a treatment or service they have been receiving will be reduced or stopped and they feel that this could harm their health.

#### Part D appeals

- The member has received a Part D prescription drug that the member believes was covered by BCN Advantage but BCN has refused to pay for this care or drug.
- BCN Advantage will not provide or pay for a Part D prescription drug that the member’s doctor has prescribed because it is not on the pertinent BCN Advantage formulary.
- The member disagrees with the amount BCN Advantage requires the member to pay for a Part D prescription drug the member’s doctor has prescribed.
- The member is told that coverage for a Part D prescription drug that the member has been getting will be reduced or stopped.
- The member disagrees either with the requirement that the member try another drug before BCN Advantage will pay for a drug the doctor has prescribed or with a limitation BCN Advantage has placed on the quantity (or dose) of the drug.

For concerns other than those listed, the member is instructed to use the BCN Advantage grievance procedure described later in this chapter.
# BCN Advantage member appeals

<table>
<thead>
<tr>
<th>BCN Advantage appeals procedure</th>
<th>The levels of the appeals process are listed below. If an appeal is not resolved at one level, it proceeds or can proceed to the next.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BCN Advantage standard or fast appeals process</td>
<td>1. BCN Advantage standard or fast appeals process</td>
</tr>
<tr>
<td>2. Review by an independent review organization (MAXIMUS)</td>
<td>2. Review by an independent review organization (MAXIMUS)</td>
</tr>
<tr>
<td>4. Review by a Medicare Appeals Council</td>
<td>4. Review by a Medicare Appeals Council</td>
</tr>
<tr>
<td>5. Review by federal district court</td>
<td>5. Review by federal district court</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who may file a member appeal</th>
<th>Members can appeal a medical, behavioral health or Part D prescription drug decision on their own behalf. They can also designate a representative, including a relative, friend, advocate, doctor or other person, to act for them.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The member and the representative must sign and date a statement giving the representative legal permission to act on the member’s behalf.</td>
</tr>
<tr>
<td></td>
<td>The member can call BCN Advantage at 1-800-450-3680 to learn how to name an authorized representative. (TTY users should call 711.) This statement must be sent to BCN Advantage at the following addresses:</td>
</tr>
</tbody>
</table>

**Medical and behavioral health appeals**

BCN Advantage Appeals and Grievance Unit  
P.O. Box 284  
Southfield, MI 48037-9887  
Fax: 1-866-522-7345

**Part D appeals**

BCN Advantage Clinical Pharmacy Help Desk  
Mail Code 1610  
P.O. Box 32877  
Detroit, MI 48232-1127  
Fax: 1-800-459-8027
BCN Advantage member appeals

Peer-to-peer review

Providers who have received an adverse determination of a medical or behavioral health service and wish to speak to a medical director about the determination can submit a request for a peer-to-peer review. To submit the request, follow the instructions outlined in the document How to request a peer-to-peer review with a BCN medical director.

Additional requirements related to submitting a peer-to-peer request are located in the Care Management chapter of this manual. Look in the section titled “Guidelines for observations and inpatient hospital admissions,” in the subsection titled “Discussing a denial with a BCN medical director.” These requirements apply to both inpatient and outpatient services.

A request for a peer-to-peer review of an outpatient medical or behavioral health service will be initiated as a standard pre-service member appeal.

Using an attorney

Members also have the right to have an attorney initiate an appeal on their behalf. They can contact their own lawyer or get the name of a lawyer from the local bar association or other referral service. There are also groups that will give free legal services if the member qualifies. Members can refer to their Evidence of Coverage booklet or contact the BCN Advantage Customer Service department for additional information.
BCN Advantage member appeals

Supporting the appeal

BCN must gather all the information needed to make a decision about an appeal. If the member’s assistance is needed in gathering this information, BCN will contact him or her. The member has the right to obtain and include additional information as part of the appeal. For example, the member may already have documents related to the issue or may want to obtain the doctor’s records or the doctor’s opinion to help support the request. The member may need to give the doctor a written request to get information.

Members also have the right to ask BCN for a copy of information regarding their appeal. They can call or write using the telephone number and address shown in the table that follows.

<table>
<thead>
<tr>
<th>Activity</th>
<th>For medical appeals</th>
<th>For Part D appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail to</td>
<td>BCN Advantage Appeals and Grievance Unit P.O. Box 284 Southfield, MI 48037-9887</td>
<td>BCN Advantage Clinical Pharmacy Help Desk Mail Code 1610 P.O. Box 32877 Detroit, MI 48232-1127</td>
</tr>
<tr>
<td>Fax to</td>
<td>1-866-522-7345</td>
<td>1-800-459-8027</td>
</tr>
<tr>
<td>Telephone</td>
<td>1-800-450-3680 between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call 711.)</td>
<td></td>
</tr>
</tbody>
</table>
BCN Advantage member appeals

Members or providers can call or write BCN Advantage to request a medical or Part D prescription drug appeal within 60 calendar days of receiving BCN’s letter denying the initial request for services or payment.

<table>
<thead>
<tr>
<th>Activity</th>
<th>For medical appeals</th>
<th>For Part D appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail to</td>
<td>BCN Advantage Appeals and Grievance Unit</td>
<td>BCN Advantage Clinical Pharmacy Help Desk</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 284</td>
<td>Mail Code 1610</td>
</tr>
<tr>
<td></td>
<td>Southfield, MI 48037-9887</td>
<td>P.O. Box 32877</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Detroit, MI 48232-1127</td>
</tr>
<tr>
<td>Fax to</td>
<td>1-866-522-7345</td>
<td>1-800-459-8027</td>
</tr>
<tr>
<td>Telephone</td>
<td>1-800-450-3680, between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call 711.)</td>
<td></td>
</tr>
</tbody>
</table>

Note: Before appealing a medical service, BCN Advantage providers may request a peer-to-peer review for either an inpatient or an outpatient medical service. To submit that request, follow the instructions outlined in the document **How to request a peer-to-peer review with a BCN medical director**. For information on additional requirements, look in the subsection titled “Peer-to-peer review” earlier in this section. A request for a peer-to-peer review of an inpatient medical service will be handled through Utilization Management. A request for a peer-to-peer review of an outpatient medical service will be initiated as a standard pre-service member appeal and the provider will be contacted by the Grievance and Appeals team to schedule the peer-to-peer-review.

The information about member appeals is updated to show that before appealing a medical service, BCN Advantage providers may request a peer-to-peer review. The instructions for submitting the request are updated. The provider will be contacted by the Grievance and Appeals team to schedule the medical appeal.
BCN Advantage member appeals

BCN reviews the appeal and notifies the member or provider of the decision within the following time frames:

<table>
<thead>
<tr>
<th>Type of appeal</th>
<th>BCN's process for handling standard appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN denied payment for medical care already received</td>
<td>BCN has 60 calendar days to make a decision. If BCN does not decide within 60 calendar days, the appeal automatically goes to an independent organization to review the case.</td>
</tr>
<tr>
<td>BCN denied medical care not yet received</td>
<td>BCN has up to 30 calendar days to make a decision but will make it sooner if the member’s health condition requires. However, if the member requests it or if BCN finds that some information is missing which can help the member, BCN can take up to 14 more calendar days to make the decision. If BCN does not tell the member or the provider the decision within 30 calendar days (or by the end of the extended time period), the appeal automatically goes to an independent organization to review the case.</td>
</tr>
<tr>
<td>BCN denied a Part D drug already received</td>
<td>BCN has seven calendar days to make the decision. If BCN approves the appeal, BCN must pay for the drug within 30 calendar days.</td>
</tr>
<tr>
<td>BCN denied a Part D drug not yet received</td>
<td>BCN has seven calendar days to make the decision but will make the decision within 72 hours if the member’s health condition requires it.</td>
</tr>
</tbody>
</table>
BCN Advantage member appeals

If BCN’s denial of a Part D prescription drug appeal is maintained, the member (or his or her health professional, on behalf of the member) may request that the appeal be submitted to the independent review organization MAXIMUS. If BCN’s denial of a medical care appeal is maintained, the appeal proceeds automatically to the independent review.

MAXIMUS is contracted with CMS and has no connection to BCN. The member is informed by BCN when the appeal has been forwarded to MAXIMUS. The member has the right to obtain a copy from BCN of the case file that is sent.

Once MAXIMUS receives the appeal, a decision is made according to the following time frames.

<table>
<thead>
<tr>
<th>Type of appeal</th>
<th>MAXIMUS’ role</th>
<th>BCN’s role if MAXIMUS decides in favor of the member</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN denied payment for medical care already received</td>
<td>MAXIMUS has up to 60 calendar days to make a decision from the date the member’s request for an appeal was received.</td>
<td>BCN must pay within 30 calendar days of receiving the decision.</td>
</tr>
<tr>
<td>BCN denied medical care not yet received</td>
<td>MAXIMUS has up to 30 calendar days to make a decision from the date the member’s request was received. This time period can be extended by up to 14 calendar days if more information is needed and the extension benefits the member.</td>
<td>BCN must authorize the care within 72 hours of receiving notice of the decision from MAXIMUS or provide the care as quickly as the member’s health requires, but no later than 14 days after receiving the decision.</td>
</tr>
<tr>
<td>BCN denied a Part D drug already received</td>
<td>MAXIMUS has up to seven calendar days to make a decision from the date the member’s request was received.</td>
<td>BCN must pay within 30 calendar days of receiving the decision from MAXIMUS.</td>
</tr>
<tr>
<td>BCN denied a Part D drug not yet received</td>
<td>MAXIMUS has up to seven calendar days to make a decision from the date the member’s request was received.</td>
<td>BCN must authorize or provide the member with the Part D drug within 72 hours of receiving the decision from MAXIMUS.</td>
</tr>
</tbody>
</table>

MAXIMUS provides the member with written notification of its decision and the reasons for it. BCN notifies MAXIMUS that it has implemented the decision.
**BCN Advantage member appeals**

**Review by an Administrative Law Judge**

If MAXIMUS maintains BCN’s denial, the member can continue the appeal by asking for a review by an administrative law judge, provided that the dollar value of the medical care or the payment in the appeal is $150 or more. The member must make a request for review by an administrative law judge in writing within 60 calendar days of the date of being notified of the decision made by MAXIMUS. The member can extend this deadline for good cause.

**Review by a Medicare Appeals Council**

The member has the right to appeal the administrative law judge decision by asking for a review by the Medicare Appeals Council. A letter from the administrative law judge will tell the member how to request the review.

The Medicare Appeals Council does not review every case it receives. When it gets a case, it will first decide whether to review the case.

If the Medicare Appeals Council reviews the case, it will make a decision as quickly as possible.

If the Medicare Appeals Council decides in favor of the member, BCN will comply as follows:

<table>
<thead>
<tr>
<th>Type of appeal</th>
<th>BCN’s responsibility if the council decides in favor of the member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care denial</td>
<td>BCN must pay for, authorize or provide the medical service within 60 calendar days from the date BCN receives notice of the decision.</td>
</tr>
<tr>
<td>Part D drug denial</td>
<td>BCN must reimburse the member no later than 60 calendar days or authorize or provide the Part D drug within 72 hours of the date BCN receives notice of the decision.</td>
</tr>
</tbody>
</table>

If the amount involved is $1,500 or more, for cases filed on or after Jan. 1, 2016 ($1,460 or more for cases filed on or before Dec. 31, 2015), the member or BCN has the right to continue the appeal by asking a federal court judge to review the case. If the value is less than $1,500, for cases filed on or after Jan. 1, 2016 ($1,460 for cases filed on or before Dec. 31, 2015), the Council’s decision is final and neither party can take the appeal any further.

If the Medicare Appeals Council decides not to review the case, then either the member or BCN may request a review by a federal court judge. However, the federal court judge will only review cases when the amount involved is $1,500 or more, for cases filed on or after Jan. 1, 2016 ($1,460 or more for cases filed on or before Dec. 31, 2015). If the dollar value is less than $1,500, for cases filed on or after Jan. 1, 2016 ($1,460 for cases filed on or before Dec. 31, 2015), the member cannot appeal any further.
BCN Advantage member appeals

Fast appeals

A decision about whether BCN will cover medical care or Part D prescription drugs that have not yet been received can be an expedited or “fast appeal” that is made within 72 hours.

A member can ask for a fast appeal only if the member or any doctor believes that waiting for a standard appeal could seriously harm the member’s health or ability to function. Fast appeals apply only to requests for medical care or Part D prescription drugs that have not yet been received. A member cannot get a fast appeal on requests for payment for care or prescriptions already received.

If any doctor asks for a fast appeal for a member or supports the member in asking for one and the doctor indicates that waiting for a standard appeal could seriously harm the member’s health or their ability to function, BCN will automatically provide a fast appeal.

If the member asks for a fast appeal without support from a doctor, BCN will decide if the member’s health requires a fast appeal. If it is decided that the member’s medical condition does not meet the requirements for a fast appeal, BCN will send the member a letter indicating that if the member gets a doctor’s support for a fast appeal, BCN will automatically provide them a fast decision. The letter will also tell the member how to file a grievance if the member disagrees with the decision to deny the request for a fast appeal. It will also tell the member how to ask for a fast grievance. If BCN denies the request for a fast appeal, BCN will provide a standard appeal.

Requesting a fast appeal

A member, any doctor or his or her authorized representative can ask BCN for a fast appeal (rather than a standard appeal) as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>For medical appeals</th>
<th>For Part D appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mail to</td>
<td>BCN Advantage Appeals</td>
<td>BCN Advantage Clinical Pharmacy</td>
</tr>
<tr>
<td></td>
<td>and Grievance Unit</td>
<td>Help Desk</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 284</td>
<td>Mail Code 1610</td>
</tr>
<tr>
<td></td>
<td>Southfield, MI 48037-9887</td>
<td>P.O. Box 3287</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Detroit, MI 48232-1127</td>
</tr>
<tr>
<td>Fax to</td>
<td>1-866-522-7345</td>
<td>1-800-459-8027</td>
</tr>
<tr>
<td>Telephone</td>
<td>1-800-450-3680, between 8 a.m. and 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31. (TTY users should call 711.)</td>
<td></td>
</tr>
</tbody>
</table>
## BCN Advantage member appeals

### Fast appeal time frames

If the member receives a fast appeal, BCN will give the member a decision within 72 hours — sooner if the member’s health requires.

**Fast appeals for medical care only** — BCN is allowed to take up to 14 more calendar days to make this decision if it is found that some information is missing that may benefit the member or if the member needs more time to prepare for this review. If the member feels that BCN should not take any additional days, they can make a specific type of complaint called a fast grievance. See the section on BCN Advantage member grievances later in this chapter.

**Fast appeals for Part D drugs only** — If BCN decides the member is eligible for a fast appeal and the member has not received an answer within 72 hours of receiving the appeal, the member’s appeal will automatically be sent to MAXIMUS to review the case.

BCN will tell the member the decision by phone as soon as the decision is made. If the appeal is denied (completely or in part), BCN will send the member a letter explaining the decision within three calendar days of notifying the member by phone or in person of the decision.

If BCN does not tell the member about the decision within 72 hours (or by the end of any extended time period), this is the same as denying the appeal.

### BCN’s response to fast appeals

BCN must authorize or provide the member with the care the member has asked for within 72 hours of receiving the appeal — or sooner if the member’s health would be affected by waiting this long. If, in the case of a medical care appeal, BCN extends the time needed to decide the appeal, BCN will authorize or provide the member medical care at the time a decision is made.

<table>
<thead>
<tr>
<th>If BCN denies any part of the fast appeal…</th>
<th>Then…</th>
</tr>
</thead>
<tbody>
<tr>
<td>For a medical care appeal</td>
<td>The appeal automatically goes to an independent organization, MAXIMUS, to review the case. BCN will tell the member in writing that the appeal has been sent to MAXIMUS for review. BCN must send all of the information about the appeal to MAXIMUS within 24 hours of a decision.</td>
</tr>
<tr>
<td>For a Part D prescription drug appeal</td>
<td>The member or the member’s authorized representative has the right to ask MAXIMUS to review the case.</td>
</tr>
</tbody>
</table>
Members can contact Customer Service

Members who have questions or concerns can contact BCN Advantage Customer Service.

<table>
<thead>
<tr>
<th>Contacting BCN Advantage Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call</strong></td>
</tr>
<tr>
<td>• For UAW Retiree Medical Benefits Trust members: 1-800-222-5992</td>
</tr>
<tr>
<td>• For behavioral health services for all BCN Advantage members: 1-800-431-1059</td>
</tr>
<tr>
<td>• For all other calls: 1-800-450-3680. Calls to these numbers are free.</td>
</tr>
<tr>
<td><strong>TTY</strong></td>
</tr>
<tr>
<td>711. This number is for the hearing impaired and requires special telephone equipment. Calls to this number are free.</td>
</tr>
<tr>
<td><strong>Business hours</strong></td>
</tr>
<tr>
<td>8 a.m. to 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31</td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
<tr>
<td>1-866-364-0080</td>
</tr>
<tr>
<td><strong>Write</strong></td>
</tr>
<tr>
<td>BCN Advantage P.O.Box 5184 Southfield, MI 48086-5184</td>
</tr>
</tbody>
</table>

<p>| Walk in to visit a Customer Service representative in person at this location |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Services / times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate headquarters Southfield</strong></td>
<td>20500 Civic Center Drive Southfield, MI 48076</td>
</tr>
<tr>
<td>Walk-in customer servicing – 9 a.m. to 5 p.m.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Call Customer Service using a hotline* telephone at these locations |</p>
<table>
<thead>
<tr>
<th>Location</th>
<th>Services / times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flint</strong> 4520 Linden Creek Parkway Suite A Flint, MI 48507</td>
<td>Call Customer Service using hotline telephone – 9 a.m. to 5 p.m.</td>
</tr>
<tr>
<td><strong>Grand Rapids</strong> 611 Cascade West Parkway, S.E. Grand Rapids, MI 49546</td>
<td>Call Customer Service using hotline telephone – 9 a.m. to 5 p.m.</td>
</tr>
<tr>
<td><strong>Lansing</strong> 232 S. Capitol Ave. Lansing, MI 48933</td>
<td>Call Customer Service using hotline telephone – 9 a.m. to 5 p.m.</td>
</tr>
</tbody>
</table>

*Hotline customer service telephones ring directly into the BCN Advantage Customer Service center, which the member can also reach from home by calling 1-800-450-3680.
BCN Advantage member grievances

What is a member grievance?

A grievance is the type of complaint a member makes if he or she has a problem with BCN Advantage or one of the BCN plan providers. Members can submit grievances about medical care (Part C) and about pharmacy services (Part D).

Here are some examples of problems that are included in these types of grievances:

- Problems with the quality of the medical care the member received, including quality of care during a hospital stay
- The member’s perception that he or she is being encouraged to leave (disenroll from) BCN Advantage
- Problems with the customer service received
- Problems with the length of time the member has to spend waiting on the phone, in the waiting room or in the exam room
- Problems with getting appointments when the member needs them or having to wait a long time for an appointment
-Disrespectful or rude behavior by doctors, nurses, receptionists or other staff
- Cleanliness or condition of doctor’s offices, clinics or hospitals

In addition, members have the right to ask for a fast grievance if they disagree with BCN’s decision not to give them a fast appeal or if BCN takes an extension on the initial decision or appeal.
BCN Advantage member grievances

Grievances must be filed within 60 calendar days of the condition, situation, event or issue which resulted in the dissatisfaction.

Grievances related to the following two decisions must be acknowledged within 24 hours of receipt:

- Refusal to grant a request for an expedited organization determination or reconsideration
- An extension — or refusal to grant a member’s request for extension — of the time frame to make an organization determination or reconsideration

If BCN Advantage denies a request for an expedited organization determination or reconsideration, the request will be automatically transferred to the applicable standard process. If the member is dissatisfied with the decision not to expedite the request for organization determination or reconsideration, the member may request an expedited grievance to be resolved within 24 hours, unless an extension is required.

If BCN Advantage justifies the need for additional information and documents how the delay is in the interest of the member, BCN may extend the time frame for reconsideration by up to 14 calendar days for standard and expedited requests. If the member is dissatisfied with BCN’s decision to extend the time frame, the member may file a grievance to be resolved within 30 days, unless an extension is required.

The member may withdraw the grievance at any time before BCN has made its decision by calling or writing to the BCN Advantage Grievance and Appeals unit. Written confirmation of the withdrawal will be provided within three calendar days of receipt.
BCN Advantage member grievances

How to file a grievance

To file a grievance, the member or the properly appointed authorized representative of the member must take one of the following steps:

- Send a signed statement of the grievance (either a letter or a completed Member Request for Appeal or Grievance form) by mail or by fax. The address and fax number are listed below.
- Call the BCN Advantage Grievances and Appeals unit at the number listed below.
- File a complaint using the Medicare tool at medicare.gov > Claims & Appeals > File a complaint.

The Member Request for Appeal or Grievance form can be accessed at the following locations:

- Providers can access the form at (Provider Secured Services) > BCN Provider Publications and Resources > Forms > Member Request for Appeal or Grievance (under the BCN Advantage heading).
- Members can access the form at bbsm.com/medicare > Frequently Asked Questions (under the Help menu) > How do I appeal a decision you made about my coverage? > BCN Advantage plans > Member Request for Appeal or Grievance

Note: Members can also use the online form to submit the grievance or appeal. Additional information can be accessed using the contact information shown in the table that follows.

<table>
<thead>
<tr>
<th>Filing a grievance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
</tr>
<tr>
<td>Mail to</td>
</tr>
<tr>
<td>Fax to</td>
</tr>
<tr>
<td>Telephone</td>
</tr>
</tbody>
</table>
Quality Improvement Organization — Livanta

What is a QIO?  A Quality Improvement Organization consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like BCN Advantage. The QIO for Michigan is Livanta LLC.

Contacting Michigan’s QIO  Members may request a QIO review from Livanta if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

To appeal, members may contact Livanta at:

Livanta LLC
BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105

Toll-free phone number: 1-888-524-9900 (TTY: 1-888-985-8775)

Hours:
9 a.m. to 5 p.m. (local time) Monday through Friday
11 a.m. to 3 p.m. (local time) weekends
24-hour voicemail service is available.

Website: livantaqio.com

The information in this section is updated to show that the QIO for Michigan is Livanta, effective June 8, 2019.
## QIO immediate review of hospital discharges

<table>
<thead>
<tr>
<th>Member appeal rights for hospital discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.</td>
</tr>
<tr>
<td>Hospitals are required to notify all BCN Advantage members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS form <em>An Important Message from Medicare About Your Rights</em> twice — the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or of his or her representative and provide a copy.</td>
</tr>
<tr>
<td>Providers can access the <em>An Important Message from Medicare About Your Rights</em> form here: Forms. Look under the BCN Advantage heading and the “Hospitals, for inpatients” subheading.</td>
</tr>
<tr>
<td>BCN Advantage members have the right to appeal to the QIO for immediate review when a hospital and BCN Advantage, with physician concurrence, determine that inpatient care is no longer necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital discharge appeal process</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the BCN Advantage member is dissatisfied with the discharge plan:</td>
</tr>
<tr>
<td>1. A member who chooses to exercise his or her right to an immediate review must submit a request to the QIO, following the instructions on the <em>An Important Message from Medicare About Your Rights</em> notice.</td>
</tr>
<tr>
<td>2. The QIO notifies BCN Advantage that the member has requested an immediate review.</td>
</tr>
<tr>
<td>3. BCN Advantage or the facility is responsible for delivering to the member a <em>Detailed Notice of Discharge</em> as soon as possible, but no later than noon of the day after the QIO’s notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable and necessary or are otherwise no longer covered. The <em>Detailed Notice of Discharge</em> must be completed and submitted by the entity that determines that covered services are ending, whether it is BCN Advantage or the facility.</td>
</tr>
<tr>
<td>Note: Providers can access the <em>Detailed Notice of Discharge</em> form here: Forms. Look under the BCN Advantage heading and the “Hospitals, for inpatients” subheading.</td>
</tr>
</tbody>
</table>

(continued on next page)
QIO immediate review of hospital discharges

Hospital discharge appeal process (continued)

If the BCN Advantage member is dissatisfied with the discharge plan (continued):

4. BCN Advantage or the facility must supply any other information that the QIO needs to make its determination as soon as possible but no later than the close of business on the day that BCN Advantage notifies the facility of the request for information. This includes copies of both the *An Important Message from Medicare About Your Rights* notice and the *Detailed Notice of Discharge* and written records of any information provided by phone.

5. The QIO makes a determination and notifies BCN Advantage, the member, the hospital and the physician of its determination within one calendar day after it receives the requested information.

6. BCN Advantage continues to be responsible for paying the costs of the member’s stay until noon of the next calendar day following the day that the QIO notifies the member of their coverage decision.

7. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from BCN Advantage.

The chart below summarizes the effect on member responsibilities of appeal decisions related to hospital discharges.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The QIO agrees with the doctor’s discharge decision</td>
<td>The member is responsible for paying the cost of his or her hospital stay beginning at noon of the calendar day following the day that the QIO notifies the member of the coverage decision.</td>
</tr>
<tr>
<td>The QIO disagrees with the doctor’s discharge decision</td>
<td>The member is not responsible for paying the cost of additional hospital days, except for certain convenience services or items not covered by BCN Advantage.</td>
</tr>
</tbody>
</table>

Member responsibilities related to hospital discharges

Circumstances in which the immediate review process does not apply

The immediate review process does not apply in these circumstances:

- To care provided in a physician clinic
- To observation care
- To inpatient-to-inpatient transfers
- To admissions for services that Medicare never covers
- When the member has exhausted all of his or her Medicare days
QIO immediate review of SNF, CORF and HHA discharges

Special expedited appeal rights for members being discharged from SNF, CORF or HHA services

BCN Advantage members receiving skilled nursing facility care, home health agency services or services at a comprehensive outpatient rehabilitation facility, have special appeal rights that allow an expedited review if they disagree with the decision to end covered services.

- **For members receiving home health agency or CORF services**, the Medicare form *Notice of Medicare Non-Coverage* is delivered to BCN Advantage members by the HHA or CORF provider in one of the following situations:
  - When medical necessity criteria are no longer met and no additional days are authorized by BCN Advantage
  - At least two days prior to a scheduled discharge date

- **For members in these situations who are receiving services in a SNF**, naviHealth will prepare the *Notice of Medicare Non-Coverage* for the provider, who delivers it to the member. For additional information, refer to the document *Post-acute care services: Frequently asked questions for providers*.

The NOMNC contains detailed instructions about how members may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

The information about appeal rights for members being discharged from SNF, CORF or HHA services is updated to show that for members receiving SNF services, naviHealth will prepare the *Notice of Medicare Non-Coverage* for the provider, who delivers it to the member.
QIO immediate review of SNF, CORF and HHA discharges

Medicare regulations require the provider to deliver the standard NOMNC to all members when covered services are ending, whether or not the member agrees with the plan to end services. Here’s how:

1. The provider delivers the NOMNC to members at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the NOMNC at the next-to-last time that services are furnished. The form must be delivered whether or not the member agrees with the plan to end services.

   Special considerations related to delivery of the NOMNC:
   - BCN encourages providers to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
   - If services are expected to be less than two days in duration, the provider may deliver the NOMNC at the start of service. A member who receives the NOMNC and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
   - If the member is not mentally competent to receive the notice, the provider must deliver it to the member’s authorized representative.

2. The provider requests that the member sign and date the NOMNC, acknowledging receipt of his or her appeal rights. If the member refuses to sign the form, the provider must record the date and time it was delivered to the member.

3. The provider must submit the signed NOMNC as follows:
   - For HHAs and CORFs, fax it to BCN’s Utilization Management department at 1-877-372-1635, Attention: Medical Records.
   - For SNFs, send it to naviHealth either electronically through the naviHealth provider portal (access.navihealth.com) or by fax at 1-844-736-2980.

4. The provider is expected to retain a signed copy of the NOMNC form with the member’s medical record. The member is responsible for contacting the QIO by noon of the day before services end if he or she wishes to initiate an expedited review by following the detailed instructions on the form.

(continued on next page)
QIO immediate review of SNF, CORF and HHA discharges

The NOMNC appeal process (continued)

Here’s how (continued):

5. When the member initiates an expedited review, the *Detailed Explanation of Non-Coverage* is delivered to the member by the close of business on the same day that the QIO is notified of the member’s request for appeal. The DENC provides specific and detailed information as to why the member’s SNF, HHA or CORF services are ending.

Note: The DENC must be completed and submitted by the entity that determines that covered services are ending, whether it is BCN Advantage, naviHealth or the SNF, HHA or CORF provider. BCN Advantage or naviHealth may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.

6. A copy of the DENC is also sent to the QIO, the primary care physician and the provider.

7. The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, the member and BCN Advantage are notified of the decision by the QIO.

8. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from BCN Advantage.

The chart below summarizes the effect on member responsibilities of appeal decisions related to discharges from SNF, CORF or HHA services.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>The QIO agrees with the doctor’s decision to end covered services</td>
<td>The member is financially responsible for services on the date indicated on the NOMNC.</td>
</tr>
<tr>
<td>The QIO disagrees with the doctor’s decision to end covered services</td>
<td>BCN Advantage will continue to cover the services.</td>
</tr>
</tbody>
</table>
QIO immediate review of SNF, CORF and HHA discharges

Other considerations in the NOMNC process

Providers should also be aware of the following when notifying a member that his or her services are ending:

• Contracted HHA and CORF providers should be using the appropriate NOMNC forms. Providers should insert their name, address and phone number in the spaces provided at the top of the form.

  Note: For members in SNFs, naviHealth will prepare the appropriate form and give it to the provider, who must give it to the member within the time frame described earlier in this section.

• If there is a change in the member’s condition after the NOMNC is issued, both BCN Advantage (for HHA and CORF care) and naviHealth (for SNF care) should consider the new clinical information. If there is a change in the effective date that coverage ends, the provider should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.
QIO immediate review of SNF, CORF and HHA discharges

Sometimes a BCN Advantage member remains in a SNF for days beyond the service end date on the NOMNC.

If the extended stay is not medically necessary and is due to a provider’s failure either to deliver a completed NOMNC in a timely manner or to comply with guidelines from Livanta, the QIO (in accordance with CMS guidelines), naviHealth will issue an administrative denial for these days on behalf of BCN Advantage.

In an administrative denial, the authorization is approved but the reimbursement for the extra days is denied.

Examples of improper handling and delivery of the NOMNC include:

- Late delivery of the NOMNC. Members must receive the NOMNC 48 hours prior to the planned discharge date.
  
  Note: naviHealth completes as much of the NOMNC as possible and tells the provider when to issue the NOMNC.

- Failure to fill out the NOMNC in its entirety. All fields in the NOMNC must be completed, including all date and signature fields. For more information, see the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123.*

- Not submitting the requested medical information to the QIO in a timely manner, when the member appealed the service end date with the QIO

When SNF providers have repeated difficulties handling the NOMNC according to CMS guidelines, their naviHealth care coordinators will reach out to provide education about CMS guidelines and health plan requirements. If, after receiving education, a SNF provider continues to have difficulties, naviHealth will deliver an administrative denial letter to the provider when members stay beyond the end date stated on the NOMNC.

The administrative denial letter will include details on the specific CMS guideline violations. BCN Advantage will hold the provider responsible for the additional days the member stayed in the SNF. Per CMS guidelines, providers cannot bill members for the additional days.

For additional information, refer to Medicare Claims Processing Manual, Chapter 30*: See section “260.3.6 — Financial Liability for Failure to Deliver a Valid NOMNC.”

*Blue Cross Blue Shield of Michigan and Blue Care Network don’t own or control this website.

Information is added indicating that naviHealth will issue an administrative denial when a BCN Advantage member spends additional, medically unnecessary days in a SNF due to the provider’s failure to issue the NOMNC in accordance with CMS guidelines.
QIO immediate review of SNF, CORF and HHA discharges

**Oversight of the NOMNC process**

BCN Advantage conducts oversight of the NOMNC process by performing compliance audits periodically. NOMNC reports are reviewed on a regular basis.

Providers are asked to keep the signed NOMNC form in the member’s medical record and do the following:

- For HHA and CORF care: Fax a copy to BCN’s Utilization Management department at 1-877-372-1635. BCN Advantage will request completed NOMNC forms that have not been received.

- For SNF care: Submit the signed form to naviHealth either electronically through the naviHealth provider portal (access.navihealth.com) or by fax at 1-844-736-2980.

**Where to find the NOMNC and DENC forms**

A copy of the NOMNC and DENC forms and the instructions related to these forms can be accessed here: Medicare regulations. See sections 90.2 through 90.5.
BCN Advantage provider appeals

Providers and practitioners who provide services for BCN Advantage members have the right to appeal any denial decision made by BCN Advantage. The provider appeals process for BCN Advantage members, however, is governed by Medicare regulations. The steps providers should take are outlined in this section.

Overview of BCN Advantage provider appeal process

BCN is required by Medicare to verify that the member has been notified and approves of the physician’s appeal request. If it is not evident that the member is aware of the appeal request, BCN will reach out to the physician to gather this information. If BCN verifies the member’s knowledge of the physician’s appeal request, it will be processed according to the BCN Advantage five-level member appeal process.

A physician who is providing treatment to a member, upon providing notice to the member, may request a standard first-level appeal on the member’s behalf without submitting an Appointment of Representative form or Waiver of Liability form.

Physicians or other providers who do not participate with BCN Advantage must submit a signed Waiver of Liability form prior to BCN’s consideration of the appeal. When the physician or other provider signs the form, he or she agrees not to bill the member regardless of the outcome of the appeal. Medicare regulations prohibit BCN from considering the appeal until the signed Waiver of Liability form is received.

A copy of the Waiver of Liability form can be accessed here: Waiver of Liability.
# BCN Advantage provider appeals

The table that follows shows how to submit appeals of denial decisions related to BCN Advantage members.

Note: The time frames shown in this table may be extended by 14 calendar days, for any type of appeal.

<table>
<thead>
<tr>
<th>Type of appeal</th>
<th>Steps in appeal process</th>
<th>Time frame for resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals by contracted providers related to inpatient admissions, including bundled admissions</td>
<td>The appeal is conducted according to the two-level provider appeal process described in the “Appealing utilization management decisions” section in the Care Management chapter of this manual.</td>
<td>The times frames for appeal resolution are described in the “Appealing utilization management decisions” section in the Care Management chapter of this manual.</td>
</tr>
<tr>
<td>All other appeals, including by noncontracted providers</td>
<td>Submit the appeal to: Blue Care Network ATTN: BCN Advantage Grievances and Appeals Unit P.O. Box 284 Southfield MI 48076-5043 Fax: 1-866-522-7345 Phone: 1-800-450-3680 (TTY: 711)</td>
<td>Expedited BCN automatically grants an expedited appeal if any physician or other provider, whether participating with BCN Advantage or not, asks for one on the grounds that waiting for a standard appeal could seriously jeopardize the member’s life, health or ability to regain maximum function or, in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment being requested. Note: An expedited appeal will not be granted for a service that has already been provided. All substantiated expedited requests will be resolved within 72 hours of receipt of the request.</td>
</tr>
<tr>
<td>Standard (non-urgent) pre-service</td>
<td>Within 30 calendar days from the date of receipt of the request</td>
<td></td>
</tr>
<tr>
<td>Post-service</td>
<td>Within 60 calendar days from the date of receipt of the request</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 15: BCN Advantage

Reporting end stage renal disease

Introduction to reporting ESRD

BCN Advantage physicians providing renal care are responsible for federal reporting requirements related to end stage renal disease.

At the time of enrollment, members must not be diagnosed with end stage renal disease. Unless members with ESRD qualify for an exception, they are not eligible for enrollment in BCN Advantage.

Note: For information on exceptions, providers may call PARS or Provider Inquiry at the appropriate number, as shown on the Provider Inquiry Contact Information document. Select the prompt for BCN Advantage.

BCN Advantage members cannot be disenrolled from the plan when they develop ESRD.

CMS must be notified of all ESRD diagnoses, because ESRD patients are eligible for Medicare and may be eligible for Social Security payments if they are found to be disabled.

CMS notification

The process for submitting ESRD documentation to CMS involves the following steps:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The diagnosing physician completes the CMS form 2728-U3 (End Stage Renal Disease Medical Evidence Report — Medicare Entitlement and/or Patient Registration). To obtain a copy of this form, visit the CMS website at cms.hhs.gov and search for CMS 2728.</td>
</tr>
<tr>
<td>2</td>
<td>The diagnosing physician mails the completed form to the appropriate ESRD network office. The offices are listed in the ESRD program instruction manual that CMS sends to all renal care physicians.</td>
</tr>
</tbody>
</table>
| 3 | The physician also mails a copy of the completed form to BCN Advantage to indicate a pending change in member status.  
BCN Advantage Clinical Operations  
Mail Code C330  
Blue Care Network  
P.O. Box 5043  
Southfield, MI 48076 |
| 4 | CMS updates its ESRD database if the member is already enrolled in Medicare. If the member is not covered by Medicare, CMS waits for notification from the Social Security office before updating its information. |
## Hospice care

### BCN Advantage does not cover hospice

BCN Advantage members who have been diagnosed with a terminal illness and have a life expectancy of six months or less are eligible for hospice care, but these members do not receive hospice benefits through BCN Advantage.

Hospice benefits are provided through Original Medicare. BCN Advantage members may elect to enroll in a Medicare-certified hospice program. Benefits offered under that program include both hospice and non-hospice care and services.

### Hospice election

The process for electing hospice care involves both the member and the physician. The steps are outlined as follows:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member designates a hospice election effective date.</td>
</tr>
<tr>
<td>2</td>
<td>Member selects a Medicare-certified hospice program.</td>
</tr>
<tr>
<td>3</td>
<td>Member completes a form that acknowledges the waiver of services such as cure-oriented services in a hospital setting for supportive services that include home care and pain control. Note: The hospice election form is available through the hospice facility.</td>
</tr>
<tr>
<td>4</td>
<td>The member’s physician and the medical director or staff physician of the hospice periodically recertify the member’s need for hospice care.</td>
</tr>
</tbody>
</table>

### Status of members who enroll in a hospice program

BCN Advantage members who elect hospice care remain enrolled as BCN Advantage members until they formally disenroll, as long as premiums are paid. If premiums are not paid, the member is disenrolled after 60 days for nonpayment of premium. For a BCN Advantage member who is disenrolled, if the hospice election is revoked after disenrollment, the member may re-enroll with BCN Advantage.

As long as members are enrolled in BCN Advantage, they remain on the eligibility lists of the primary care physicians they have selected.

### Claims for members who enroll in hospice

Information on submitting claims for BCN Advantage members enrolled in hospice is found in the “BCN Advantage claims processing” section of this chapter.
# BCN Advantage claims processing

The BCN Advantage claims processing information is clarified to distinguish between claims submitted electronically and claims submitted using a paper form.

### Claims processing overview

For the most part, providers are required to bill **claim information** the same way claims are submitted to Medicare. Differences are detailed individually within the Claims chapter of this manual. Look for regular updates via *BCN Provider News* for additional billing information or differences.

When billing BCN Advantage claims, the provider should submit BCN Advantage claim **provider information** the same way as for BCN commercial products, using the National Provider Identifier.

Note: Providers who are not eligible to obtain an NPI may bill electronically using a Bill PIN, if approved to do so, or can submit paper claims.

### Timely filing limit for claims

The filing limit for BCN Advantage claims is 12 months from the date of service or the discharge date, for both initial submissions and replacement (corrected/adjusted) claims, unless the claim qualifies as an eligible exception as identified by CMS.

### Electronic claims

Electronic claims for BCN Advantage members follow the same process as submitting commercial product BCN claims. For more information, see the Claims chapter of this manual.

### CMS-1500 claim form

Claim information should be filed with the same information as would be submitted to CMS except for claim types noted. BCN Advantage providers must indicate Yes in FL 27 of the Accept assignment field.

### Mailing address for BCN Advantage claims and written inquiries

In general, BCN Advantage claims and written inquiries should be mailed to:

BCN Advantage  
Blue Care Network  
P.O. Box 68753  
Grand Rapids, MI 49516-8753

Exceptions to this, along with other information related to the processing of BCN Advantage claims, are outlined in the table that follows.

### Checking claim status

Professional providers should refer to the Claims chapter of this manual for instructions on checking claims status.
BCN Advantage claims processing

All BCN Advantage members who had services receive one comprehensive EOB that includes all BCN Advantage medical, hospital, durable medical, dental and vision services, Part B drugs and other ancillary services, whether or not the claim is paid by BCN, Blue Cross or an external vendor.

If the member has the BCN Advantage Optional Supplemental Dental, Hearing and Vision plan, that information also appears on this single EOB. The only information not included is about Part D pharmacy claims. That information is sent on a separate Part D EOB.

On the comprehensive EOB, important information is included to help members keep track of their plan usage, such as:

- Out-of-pocket accumulator to date

  Note: Members also receive a customized tear-out card showing the out-of-pocket costs they can expect to pay for certain covered medical services. The card also has definitions of common health care terms related to costs; a breakdown of copayment and coinsurance amounts during the initial coverage phase for prescription drugs for Tiers 1 through 5; and some pharmacy cost-share information for prescriptions from preferred and standard pharmacies. Members receive this card whether or not they have received services.

- Amount of deductibles met, if applicable

- All claims submitted to BCN Advantage

The EOBs are sent to members on a monthly basis, so members may receive a bill from their provider before they receive the EOB.
## BCN Advantage claims processing

The following table offers information useful in processing certain types of BCN Advantage paper claims:

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>How to submit claims</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME/P&amp;O</td>
<td>DME guidelines in the Care Management chapter of this manual apply, but BCN-billable claims should be sent to the address on the right.</td>
<td>Send paper claims for BCN-billable services to: BCN Advantage Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753</td>
</tr>
<tr>
<td>All claims from Federally Qualified Health Centers</td>
<td>Federally Qualified Health Centers must use a 77x Type of Bill for all claims billed on a UB-04 claim form. Using an incorrect Type of Bill will result in the rejection of claims.</td>
<td>Send paper claims to: BCN Advantage Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753</td>
</tr>
<tr>
<td>Out of state</td>
<td>See the Member Benefits chapter of this manual.</td>
<td>Send paper claims to: BlueCard Program Blue Care Network Claims P.O. Box 68710 Grand Rapids, MI 49516-8710</td>
</tr>
</tbody>
</table>

Information about processing other types of claims is found in the remainder of this subsection.
BCN Advantage claims processing

BCN Advantage follows the CMS prompt payment provisions. If the BCN Advantage screening process determines that a paper claim is not clean, the claim will be returned with a BCN Advantage 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 Advantage claim return letter to BCN Advantage along with the corrected information on an original claim form
- Ensure that BCN Advantage receives it within 48 days of the date on the BCN Advantage claim return letter. (The three additional days allow for mail delivery time from the time BCN Advantage mails the BCN Advantage claim return letter to the providers.)

The 45-day payment period begins on the date that BCN Advantage receives the original claim. It is tolled (suspended) from the date the provider or facility receives the BCN Advantage claim return letter requesting corrections to the claim until the date that BCN Advantage receives a response.

If the response makes the claim clean, BCN Advantage has 30 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 Advantage will send an adverse determination notice within the 30-day payment period, excluding any time that was tolled.

When will BCN Advantage pay interest?

If BCN Advantage fails to pay a clean claim within the 30-day time period, BCN Advantage is required to pay simple interest of 12 percent per claim to the provider or facility. It is important to note that BCN Advantage 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 Advantage 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 Advantage payment policies and may not be paid if they exceed the timely filing limits specified in the BCN Provider Manual.
# BCN Advantage claims processing

<table>
<thead>
<tr>
<th>Ambulatory surgery center claims</th>
<th>Providers should submit BCN Advantage ambulatory surgery center claims electronically using the HIPAA 837I transaction standard or via a paper UB-04 form just as they do for the HMO (commercial) product. BCN Advantage payment for these services, however, will still be based on Medicare ambulatory surgery center rates and methodology. For additional information on billing these claims, providers can log in to Provider Secured Services and click BCN Provider Publications and Resources &gt; Billing / Claims &gt; Multiple-line surgery, ASF.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrical care</td>
<td>Obstetrician-gynecologists and other physicians who bill for maternity care submit claims to BCN Advantage the same way they do for BCN commercial products (electronically or via a paper claim). For more information, providers can refer to the professional claim examples that are available on BCN’s Billing / Claims page within Provider Secured Services.</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Chiropractic manipulation services for BCN Advantage members are billed the same way as for Original Medicare. Claims submitted electronically (via a HIPAA 837P transaction) or via paper (via a CMS-1500 form) for chiropractic manipulative treatment (CPT codes *98940, *98941 and *98942) must contain an AT modifier or the services will be considered not medically necessary. Additional information is available in <a href="#">MLN Matters® Number SE1602</a>. In addition, if the provider is contracted with BCN Advantage, one office visit and one set of X-rays are allowed annually for BCN Advantage members. <em>CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.</em></td>
</tr>
<tr>
<td>Billing ground ambulance mileage amounts</td>
<td>For information on billing ground ambulance mileage amounts, refer to the Claims chapter of this manual. Look in the “Other billing and payment guidelines” section. The information found there applies to both BCN HMO (commercial) and BCN Advantage members.</td>
</tr>
<tr>
<td>Reimbursement for therapy services</td>
<td>Physical, occupational and speech therapy services in all settings that are reimbursed from the BCN Advantage fee schedule are subject to a maximum daily amount.</td>
</tr>
</tbody>
</table>
BCN Advantage claims processing

An advance care planning service provides the opportunity for an open dialogue to occur between the practitioner and patient, family member or surrogate about the type of care the patient wants if he or she becomes incapable of making decisions. Practitioners can bill advance care planning services only for BCN Advantage members.

Practitioners should use CPT codes *99497 and *99498 to report the face-to-face advance care planning service.

The member’s copayment and deductible are waived if the discussion is performed in conjunction with the member’s annual wellness visit or an initial preventive physical examination. For this situation, practitioners must append modifier 33 to codes *99497 and *99498 and report the annual wellness visit or initial preventive physical examination on the same claim. If modifier 33 is not present, both the copayment and deductible apply. In addition, if the advance care planning service is reported with modifier 33 and the annual wellness visit or initial preventive physical examination is not reported, the claim line may be subject to denial.

Advance care planning services are payable once every 12 months, on the first claim, regardless of who submits it. The member gets the most benefit from the service when it is done in conjunction with the annual wellness visit or an initial preventive physical examination.

Additional information is available in CMS Transmittal 216.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.
## BCN Advantage claims processing

### Laboratory services

The table below offers guidelines on how to bill laboratory services.

<table>
<thead>
<tr>
<th>Setting</th>
<th>How to submit claims for laboratory services</th>
<th>BCN Advantage / Blue Care Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician office setting</td>
<td>In-office billable labs should be billed the same way as for the BCN commercial product. The procedures outlined in the “BCN in-office laboratory billable procedures” chart in the Claims chapter of this manual apply for services performed in the physician’s office. The claim, however, should be sent to the BCN address shown at the right. All other labs performed in the provider’s office are NOT payable and are not the responsibility of the member.</td>
<td>BCN Advantage / Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753</td>
</tr>
<tr>
<td>Non-office setting</td>
<td>Submit all claims for labs performed in an ER, inpatient, observation or urgent care location to the BCN address shown at the right. All other laboratory services claims should be sent electronically to JVHL.</td>
<td></td>
</tr>
<tr>
<td>Outpatient hospital setting</td>
<td>Effective Jan. 1, 2014, for laboratory services in an outpatient hospital setting, use the following guidelines from the CMS MLN Matters article MM8572 in determining how to bill:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X [014x Type of Bill] electronic 837I transaction or UB-04 paper claim in the following circumstances:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14X [014x] claim and the other hospital outpatient services would be billed on a 13X [013x] claim.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>It will be the hospital’s responsibility to determine when laboratory tests may be separately billed on the 14X [014x] claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of *81200 through *81383, *81400 through *81408, and *81479 are not packaged in the OPPS and should be billed on a 13X [013x] type of bill.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CMS packages clinical laboratory tests in the hospital setting when they are integral to, ancillary to, supportive of, dependent on or adjunctive to a primary service or procedure. Likewise, hospitals (including provider-based designations) may not carve out and submit bills for laboratory services to JVHL for payment purposes when there is an integral, ancillary, supportive, dependent or adjunctive procedure, as this is considered unbundling. Hospitals using bill type 014x should bill JVHL.</td>
<td></td>
</tr>
</tbody>
</table>

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.*
BCN Advantage claims processing

Claim edit for controlled substances prescriptions

Claims for Drug Enforcement Administration Schedule II-V controlled substance prescriptions are subject to a CMS-mandated claim edit that checks for the prescriber’s authority to prescribe these drugs. This protects patient safety and strengthens oversight of controlled substances by verifying that the prescriber’s DEA schedule registration is current and valid and reflects his or her authority to prescribe these drugs.

BCN’s claims processing system rejects a claim if it does not find a valid, active DEA number on record or if the prescribed scheduled drug and the DEA schedule registration do not match.

Immunization: Medicare Part B vaccines

When billing for immunizations under Medicare Part B, providers should keep the following guidelines in mind:

- Bill BCN Advantage for the pneumonia, hepatitis B and flu vaccinations.
- Rural health centers and federally qualified health centers should bill Part B vaccines electronically via a HIPAA 837P transaction or on a paper CMS-1500 form with the appropriate administration code.
- When billing flu vaccines for BCN Advantage members, do not use CPT code *90658. Instead of the *90658 code, use one of the following codes:

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Vaccine product administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2035</td>
<td>Afluria®</td>
</tr>
<tr>
<td>Q2036</td>
<td>FluLaval®</td>
</tr>
<tr>
<td>Q2037</td>
<td>Fluvirin®</td>
</tr>
<tr>
<td>Q2038</td>
<td>Fluzone®</td>
</tr>
<tr>
<td>Q2039</td>
<td>Not otherwise specified vaccine</td>
</tr>
</tbody>
</table>

Note: Claims for BCN Advantage members submitted with the incorrect *90658 code will be denied. Providers may not bill members for charges denied due to use of the *90658 code.

- The hepatitis B vaccine is covered under Part D if the member is not in a high-risk population for hepatitis B.
- The other standard codes for flu vaccines can also be used when billing for BCN Advantage members.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2018 American Medical Association. All rights reserved.
BCN Advantage claims processing

<table>
<thead>
<tr>
<th>Immunization: Medicare Part D vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers should bill for immunizations under Medicare Part D as follows:</td>
</tr>
<tr>
<td>• If the vaccine is administered from the physician’s stock:</td>
</tr>
<tr>
<td>- The physician should bill the member and provide the member with the 11-digit National Drug Code for the vaccine administered and the amount administered (for example, 0.5 ml).</td>
</tr>
<tr>
<td>- The member should remit payment to the physician.</td>
</tr>
<tr>
<td>- The member should then submit proof of payment and a Medicare Part D coordination of benefits/direct claim form to BCN. The member must include both the NDC and the quantity administered (ml) on the reimbursement form.</td>
</tr>
<tr>
<td>• If a member-specific vaccine is supplied to the physician from outside the office and is administered by the physician:</td>
</tr>
<tr>
<td>- The physician should bill the member for the administration fee.</td>
</tr>
<tr>
<td>- The member should remit payment to the physician.</td>
</tr>
<tr>
<td>- The member should then submit proof of payment for the administration and an Express Scripts reimbursement form to BCN.</td>
</tr>
</tbody>
</table>

Note: Member-specific vaccines supplied from outside the office include those that the physician orders from a vendor and those that members purchase from a pharmacy and bring to the physician. **Members have lower out-of-pocket costs when the pharmacy from which they purchase the vaccine also administers it.** Members must bring a prescription from the physician to the pharmacist in order for the pharmacist to dispense the vaccine. In addition, members who purchase the Zostavax® vaccine from a pharmacy should be encouraged to have the pharmacy administer the vaccine due to concerns about the vaccine's stability when removed from proper storage conditions.

Members can contact BCN Advantage at 1-800-450-3680 to obtain a Medicare Part D coordination of benefits/direct claim form.
## BCN Advantage claims processing

### Hospice claims

Hospice care is covered through Original Medicare, not through BCN Advantage. For BCN Advantage members who enroll in a Medicare-certified hospice program and remain enrolled in BCN Advantage, the following guidelines apply:

- Claims for both hospice and non-hospice medical care and services should be submitted to Original Medicare with one of the following appending modifiers:
  - Modifier GV, for services that are related to the diagnosis for which the member was enrolled in hospice
  - Modifier GW, for services that are not related to the diagnosis for which the member was enrolled in hospice

- BCN Advantage provides primary coverage for all supplemental services such as routine vision and hearing services and dental and fitness services.

- BCN Advantage will coordinate benefits for the Medicare deductible and coinsurance amounts (less the plan-specific cost-share) if the member uses a provider who is part of the BCN Advantage network. When services are received from a non-network provider, the member is responsible for the Original Medicare deductible and coinsurance amounts.

- Once Medicare has been billed and a Remittance Advice statement has been received, providers in the BCN Advantage network may submit the Remittance Advice statement and claim to BCN for the balance, so payment can be considered.

Providers may contact the Fiscal Intermediary or Part B carrier/Medicare Administrative Contractor for additional information.

### Home care and home infusion claims

Providers should bill home care and home infusion services for the majority of BCN Advantage members the same way they bill BCN commercial claims. There are a few exceptions for home infusion. Some BCN Advantage products do not cover home infusion under Part B benefits. For members with these products, home infusion drugs need to be billed to the Part D carrier.

Providers should verify each member’s benefits in case split billing for home infusion services is required for Part B and Part D drugs.

Payment for these services is outlined in the BCN Advantage Payment Exhibit in the provider contract.

For home care and home infusion services, BCN Advantage uses the network of providers contracted with BCN Advantage.

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Information is added that split billing (Part B and Part D) may be required for some home infusion drugs. Providers should check each member’s benefits to determine coverage under Part B and Part D.
BCN Advantage claims processing

**Dialysis**

Providers should bill for ESRD and dialysis services for BCN Advantage members the same way they bill BCN commercial claims. Payment for these services is outlined in the BCN Advantage Payment Exhibit in the provider contract.

For ESRD and dialysis services, BCN Advantage uses the network of providers contracted with BCN Advantage.

**SNF claims must include RUG or PDPM levels authorized by naviHealth**

For BCN Advantage members admitted to skilled nursing facilities, naviHealth authorizes resource utilization group levels or patient-driven payment model levels during the patient’s stay (from preservice through discharge) to align with the CMS payment methodology.

Claims submitted for these members must include the following:

- For dates of service prior to Oct. 1, 2019 — RUG levels that match the ones authorized by naviHealth
- For dates of service on or after Oct. 1, 2019 — PDPM levels that match the ones authorized by naviHealth

For members with a SNF stay that includes dates of service both before Oct. 1, 2019, and extending through or beyond Oct. 1, 2019, the claim must include both RUG and PDPM levels.

Prior to discharge, a naviHealth care coordinator will work with the biller to verify that the authorized RUG or PDPM levels are submitted for reimbursement.

BCN Advantage reviews paid SNF claims on a quarterly basis to ensure that RUG or PDPM levels in the claims match the RUG or PDPM levels on the authorizations.

Providers do not need to submit medical records during the quarterly post-payment review process.

Information is added about the responsibility providers have to ensure that RUG or PDPM levels submitted on BCN Advantage SNF claims match the RUG or PDPM levels authorized by naviHealth. These claims are audited on a quarterly basis. The RUG and PDPM levels on the claims are reviewed as part of that audit.
### BCN Advantage claims processing

**Clinical and device trials**

The table that follows shows the guidelines for billing clinical and device trials.

<table>
<thead>
<tr>
<th>Type</th>
<th>Guidelines</th>
</tr>
</thead>
</table>
| **Clinical trials** | Original Medicare and not BCN Advantage will pay for routine costs as well as the cost to diagnose and treat complications arising from a BCN Advantage member’s participation in a Medicare-approved clinical trial. Claims associated with a clinical study should be submitted to Original Medicare. Providers should not bill BCN Advantage for any services associated with a clinical trial until Original Medicare has been billed.  

In order for Medicare to correctly identify and pay for clinical trial services provided to a Medicare Advantage member, these services must be billed by appending modifier Q0 for the investigational service and Q1 for the routine service associated with a clinical trial and must include the clinical trial number, per CMS Manual System Transmittal 2955.  

BCN Advantage will pay the 20 percent coinsurance of the Medicare-allowed amount minus the plan’s service-specific deductible and copayments. The investigational drug or service is usually paid for by the research company. BCN Advantage will not pay any part of the investigational drug or device costs.  

While members do not need to obtain permission from BCN Advantage to participate in a clinical study, it is important that members notify BCN Advantage before participation in such studies to ensure reimbursement for certain expenses not paid by Original Medicare. |
| **Device trials**   | BCN Advantage will pay as primary for a BCN Advantage member’s participation in a Medicare-approved category A or B device trial. These services do require plan approval.  

In order for BCN Advantage to correctly identify and pay for device trial services, these services must be billed by appending modifier Q0 for the investigational service and Q1 for the routine service associated with a device trial. Here are some additional guidelines:  

- When billing for a Category A device trial, the clinical trial number must be billed the same way it is billed under Original Medicare. Category A devices are considered experimental and should not be billed.  

- When billing for a Category B device trial, the IDE number must be billed on the claim. Payment for Category B devices may not exceed the Medicare-approved amount for a comparable device that has been FDA approved. Providers can refer to Medicare IOM 100-04, chapter 32, Section 68. In addition, MLN Matters® Number: SE1344 states the following:  

"NOTE: For clarification, the clinical trial identifier number is required for all items/services provided in relation to participation in a clinical trial, clinical study, or registry that may result from coverage with evidence development (CED), the Medicare Clinical Trial Policy, or a CMS-approved investigational device exemption (IDE) study. For IDE trials, both the IDE and the clinical trial identifier number are required. Specifically, include the clinical trial identifier number if: the beneficiary is enrolled in an approved clinical trial; AND, the claim is for the investigational item or service, AND/OR, the costs are related to the investigational item or service, AND/OR, the costs are related to routine care for the condition in the clinical trial." |
BCN Advantage claims processing

**Billing with NOC codes**
When a specific HCPCS code is not available for a service provided to a BCN Advantage member, providers must bill with a not OTHERWISE-classified code using the following guidelines:

**Billing drugs and biologicals using NOC codes**
When a specific HCPCS code is not available for a particular drug, follow the CMS guidelines for billing the J3490, J3590 or J9999 code, as follows:

- Submit NOC codes in the 2400/SV101-2 data element in the 5010 professional claim transaction (837P). When billing an NOC code, providers are required to provide a description in the 2400/SV101-7 data element. The SV101-7 data element allows for 80 bytes (that is, 80 characters, including spaces).

- Include all of the following information in the SV101-7 data element:
  - Name of the drug
  - National Drug Code
  - Total dosage plus strength of dosage, as appropriate
  - Method of administration

BCN Advantage payments for drugs and biologicals billed with NOC codes follow CMS guidelines. Pricing information for most unlisted drugs may be found on the CMS website. Look under Medicare Part B Drug Average Sales Price.

**Billing medical services using NOC codes**
For medical services for which no CPT or HCPCS code is available other than a HCPCS “S” code, providers must bill using an unlisted NOC code.

BCN Advantage does not recognize the HCPCS “S” codes except in certain circumstances, so providers should not submit the HCPCS “S” codes in place of NOC codes unless otherwise advised by the health plan.

When the health plan has approved the use of an NOC code for the medical services you’re billing, you must include a description of the service on the claim.

**Authorization requirements**
All drugs/biologicals and medical services with NOC codes require authorization by the plan. When the request for authorization is made, the service is reviewed for clinical appropriateness. Services with NOC codes that are not authorized will be denied.

**Reporting of medical device credits by hospitals and ambulatory surgery centers**
When the device is provided free of charge or for partial cost credit, hospitals and ambulatory surgery centers should refer to the “Other billing and payment guidelines” section in the Claims chapter of this manual. The information is found in the “Reporting of medical device credits by hospitals and ambulatory surgery centers” subsection.
BCN Advantage claims processing

Billing for dual-eligible members

Federal law prohibits all Medicare providers from billing qualified Medicare beneficiaries for Medicare deductibles, coinsurance, or copayments.

All Medicare and Medicaid payments a provider receives for furnishing services to a Qualified Medicare Beneficiary (QMB) are considered payment in full.

These billing rules apply to BCN Advantage dual-eligible members (those who have BCN Advantage as their primary coverage and a Medicaid product as their secondary coverage). Per the CMS requisite language in the BCN provider contracts under the “Member Hold Harmless” provision: “Provider is also prohibited from holding Members liable for Medicare Parts A and B cost-sharing that are the legal obligation of Health Plan or the State.”

Providers must accept payment in full or bill the state for applicable BCN Advantage cost-sharing for enrollees eligible for both Medicare and Medicaid. Providers must also abide by these provisions even if they don’t accept Medicaid and regardless of whether the State Medicaid agency is liable to pay the full Medicare (BCN Advantage) cost sharing amounts.

Providers are subject to sanctions if they bill a QMB individual for amounts above the sum total of all BCN Advantage and Medicaid payments (even when Medicaid pays nothing).

BCN Advantage uses the payment explanations on the claim to indicate when a provider cannot bill a member for the balance. Specifically, the Remittance Advice statement will state:

- Explanation Code: Q76 – “When your patient has Medicare and MDCH coverage, the patient isn’t responsible for Medicare cost-sharing amounts.”
- Reason Code: 22 – “This care may be covered by another payer per coordination of benefits.”
- Remark Code: N192 – “Patient is a Medicaid/Qualified Medicare Beneficiary.”

The electronic 835 transaction for these claims will reflect the Remittance Advice Remark Code N192 (Patient is a Medicaid/Qualified Medicare Beneficiary) with every Claim Adjustment Segment.

Additional information about dual-eligible categories and benefits is available:

- In the Medicare Learning Network booklet ICN 006977
- In the MLN Matters document SE1128
### Health care fraud, waste and abuse

<table>
<thead>
<tr>
<th>Detecting and preventing fraud, waste and abuse</th>
<th>BCN Advantage 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.” Providers must 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is fraud?</td>
<td>Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as BCN Advantage) in order to get money or a benefit.</td>
</tr>
<tr>
<td>Examples of fraud</td>
<td>Examples of fraud include:</td>
</tr>
<tr>
<td>• Billing for services not provided or provided to a member at no cost</td>
<td></td>
</tr>
<tr>
<td>• Upcoding services (the billing of a higher-level service when a lower-level service is warranted)</td>
<td></td>
</tr>
<tr>
<td>• Falsifying certificates of medical necessity</td>
<td></td>
</tr>
<tr>
<td>• Knowingly double billing</td>
<td></td>
</tr>
<tr>
<td>• Unbundling services for additional payment</td>
<td></td>
</tr>
<tr>
<td>What is waste?</td>
<td>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.</td>
</tr>
<tr>
<td>Examples of waste</td>
<td>Examples of waste include:</td>
</tr>
<tr>
<td>• Inaccurate claims data submission resulting in unnecessary rebilling or claims</td>
<td></td>
</tr>
<tr>
<td>• Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed</td>
<td></td>
</tr>
<tr>
<td>• Overuse, underuse and ineffective use of services</td>
<td></td>
</tr>
<tr>
<td>What is abuse?</td>
<td>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.</td>
</tr>
</tbody>
</table>
## Health care fraud, waste and abuse

<table>
<thead>
<tr>
<th>Examples of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of abuse include:</td>
</tr>
<tr>
<td>• Providing and billing for excessive or unnecessary services (including billing a higher-level service</td>
</tr>
<tr>
<td>when a lower-level service is warranted)</td>
</tr>
<tr>
<td>• Routinely waiving member coinsurance, copayments or deductibles</td>
</tr>
<tr>
<td>• Billing Medicare patients at a higher rate than non-Medicare patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Repayment rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the Patient Protection and Affordable Care Act, providers are required to report and repay overpayments</td>
</tr>
<tr>
<td>to the appropriate Medicare administrative or other contractor (Fiscal Intermediary or Carrier) within the</td>
</tr>
<tr>
<td>later of (a) 60 days after the overpayment is identified, or (b) the date of the corresponding cost report</td>
</tr>
<tr>
<td>is due, if applicable.</td>
</tr>
<tr>
<td>Any overpayment that is retained by the provider after the deadline to report/return the overpayment is an</td>
</tr>
<tr>
<td>obligation under the federal False Claims Act, meaning that knowingly failing to report and return the</td>
</tr>
<tr>
<td>overpayment as required may subject the provider to liability and penalties under the FCA.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCN Advantage reserves the right to adjust payment when its clinical editing software identifies instances</td>
</tr>
<tr>
<td>of a high-level service being billed when a lower-level service is warranted. In such instances, BCN</td>
</tr>
<tr>
<td>Advantage may adjust payment to an amount consistent with the lower-level service. These payment adjustments</td>
</tr>
<tr>
<td>are part of BCN Advantage’s program to detect, prevent and deter health care fraud, waste and abuse.</td>
</tr>
<tr>
<td>For more information, refer to the Claims chapter of this manual, in the section titled “Clinical editing</td>
</tr>
<tr>
<td>denials.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional information</th>
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</thead>
<tbody>
<tr>
<td>Additional information on Blue Cross/BCN’s policies on fraud, waste and abuse is available on BCN’s Policies</td>
</tr>
<tr>
<td>and Information page, which can be accessed at (Provider Secured Services) &gt; BCN Provider Publications and</td>
</tr>
<tr>
<td>Resources &gt; Policies and Information.</td>
</tr>
</tbody>
</table>
### Care within Michigan outside the service area

**Overview** Coverage within Michigan but outside the BCN Advantage service area is limited to medical emergencies, urgently needed care, renal dialysis and care preapproved by BCN Advantage or the member’s primary care physician. Emergency care and urgent care are covered worldwide for BCN Advantage members.

The travel benefit does not apply for services within the state of Michigan.

- **A statement is added that emergency care and urgent care are covered worldwide for BCN Advantage members.**

**Emergency care** Members do not need referrals to access emergency, life-saving care. In a medical emergency, members should go directly to the closest hospital. The facility should notify the member’s primary care physician within 48 hours of emergency admission.

BCN covers poststabilization care according to Medicare guidelines. BCN Advantage Utilization Management department staff and the primary care physician will arrange for BCN-contracted providers to take over the member’s care as soon as the member’s medical condition and the circumstances allow.

**Urgent care** Members do not need referrals to access urgent care services. BCN covers urgently needed care from nonplan providers when members are outside the BCN Advantage service area.

BCN will also cover follow-up care received from nonplan providers outside the BCN Advantage service area as long as the care still meets the definition of urgently needed care.

**Renal dialysis** BCN covers renal dialysis services when the member is living temporarily outside the plan’s service area for up to six consecutive months.

Whenever possible, the member should contact BCN prior to leaving the service area so that BCN can arrange for maintenance dialysis while outside the service area.
Care outside of Michigan

BlueCard covers care outside of Michigan for BCN Advantage HMO-POS members

BCN Advantage HMO-POS members who spend less than six consecutive months a year outside of Michigan are covered through the BlueCard benefit while traveling out of state.

BCN Advantage HMO-POS members who use the BlueCard benefit can receive covered services from providers who participate with Blues plans. These services must be preapproved by BCN Advantage HMO-POS.

Except for emergency services (including emergency dialysis), urgently needed services or services preapproved by BCN Advantage HMO-POS, unauthorized services may not be covered. Both Medicare and BCN Advantage HMO-POS may decline to pay for services that are not approved.

Services obtained by BCN Advantage HMO-POS members who take advantage of the BlueCard travel benefit are subject to a $200 deductible for out-of-state services.

If a member plans to be out of the service area for more than six months, he or she must be disenrolled from BCN Advantage HMO-POS and re-enrolled under traditional Medicare.

Note: BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver and BCN Advantage HMO HealthyValue members do not have the BlueCard benefit. For these members, all services must be provided by the designated network of identified providers associated with each product, with the exception of medical emergencies (including emergency dialysis) and urgently needed care, which are covered worldwide. Neither BCN Advantage HMO ConnectedCare, BCN Advantage HMO MyChoice Wellness, BCN Advantage HMO HealthySaver nor BCN Advantage HMO HealthyValue offers a travel benefit for follow-up care for existing conditions.

A statement is added that BlueCard services for BCN Advantage HMO-POS members must be preapproved by BCN HMO-POS.
Member notification of provider termination

When a provider terminates

When a physician stops participating with BCN Advantage for any reason, BCN makes a good faith effort to provide written notice of the physician’s termination to all of the physician’s members at least 30 days prior to such termination.

If the terminating provider is a primary care physician, all members assigned to that physician receive written notification.

If the terminating provider is a specialty care provider, members who have seen the provider recently receive written notification.
### BCN Advantage physician reports

| A variety of reports | BCN sends reports to medical care groups to help manage their BCN Advantage members. These include financial, clinical, utilization and pharmacy reports.  
Note: These reports will be enhanced over time to help support the quality and bonus payment ratings, to include more reporting related to gaps in care and outreach to members to obtain their data. |
|----------------------|-------------------------------------------------------------------------------------------------|
| **Financial reports** | BCN makes available the following financial reports:  
• Eligibility (Data are available electronically only and must be retrieved via an electronic mailbox.)  
• Paid medical claims  
• Paid pharmacy claims data file  
• Medical care group financial statement  
• Physician reinsurance for medical claims  
• Physician reinsurance for Rx claims  
• Rx profile report card |
| **Clinical reports** | BCN sends out the following clinical reports:  
• *Quality Summary report*  
• *Members Who Need Services report* |
| **Utilization reports** | BCN sends out the following utilization reports:  
• Inpatient authorization reports  
• Medical care group profiles  
• *PEERiodical Primary Care Group report*  
• “Real-time” inpatient and ER reports |
| **Pharmacy reports** | BCN produces and sends pharmacy safety reports to the primary care physician or prescribing physician, depending on the situation. |
BCN Advantage forms

The BCN Advantage forms discussed in this chapter can be found at (Provider Secured Services) > BCN Provider Publications and Resources > Forms, under the BCN Advantage heading. These full-sized forms can be printed and completed.

Links to some of these forms can also be found on the Forms page in the BCN section of the ereferrals.bcbsm.com website.