BCN Advantage

This chapter is subject to change. To ensure that you review the most current version, we strongly discourage you from relying on printed versions.

Chapter contents

Important! Click a link below to go to that page in the chapter.

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BCN Advantage operates like Blue Care Network

This chapter is updated with information about the 2025 BCN Advantage products.

What are BCN's Medicare products?

Blue Care Network's Medicare Advantage products are:

- BCN Advantage℠ HMO-POS:
  - Group products
  - Individual products: Elements, Classic, Prestige, Community Value and Prime Value

    Note: The BCN Advantage℠ HMO-POS Community Value product is available to residents of Macomb, Oakland, Wayne, Washtenaw, Genesee, Livingston and St. Clair counties.
- 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℠ Local HMO, for Medicare beneficiaries who reside in Macomb, Oakland, 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 and B) coverage
- Provide Part B drugs, including chemotherapy, durable medical equipment, and prosthetics and orthotics, subject to a 20% 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.

Note: BCN Advantage HMO-POS is required to file with CMS as an HMO-POS plan 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 provider. The BCN Advantage HMO ConnectedCare product and the BCN Advantage Local HMO product offers 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 commercial plans. 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, benefits, requirements, 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 commercial provider network but do include primary care providers, specialists, hospitals and other 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 commercial providers are included in the BCN Advantage network.
- Members with a BCN Advantage HMO-POS product must select a primary care provider from within the BCN Advantage HMO-POS provider network.

  Exception: BCN Advantage HMO-POS Community Value has its own designated primary care provider network. Members must select a primary care provider from within the Community Value primary care provider network. However, they can receive care from specialists within the wider BCN Advantage HMO-POS provider network without any special authorization requirements outside of those typically required for any BCN Advantage HMO-POS member.

- BCN Advantage HMO ConnectedCare has its own designated provider network. Members must select a primary care provider 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.
- BCN Advantage Local HMO has its own designated primary care provider network. Members must select a primary care provider from within the BCN Advantage Local HMO provider network — physicians affiliated with Trinity Health and Ascension — who will refer them for appropriate specialty and hospital care. Care outside this provider network requires authorization by BCN.

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 use disorders)

Blue Cross Behavioral Health℠ is responsible for managing behavioral health services, including autism treatment, for BCN Advantage members.

For additional information, providers should refer to the Behavioral Health chapter of this manual and the document Blue Cross Behavioral Health: Frequently asked questions for providers.

Dental services

Blue Cross Blue Shield of Michigan provides preventive and comprehensive dental coverage for dental care to BCN Advantage members. Network dentists can be identified via the following website: Find Care - Blue Dental Resources**. Click *Start Your Search* and follow the prompts.

For additional information:

- For inquiries about dental services that are covered under a member's medical benefit, providers can contact Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections.
- To check member benefits and eligibility, submit claims, review claim and payment status, and access recent communications, providers should register here** for a Blue Dental account. Once registered, providers should visit the dental provider portal at provideraccess.dentaquest.com**.
- For dental provider servicing and automated information, providers can call 1-844-876-7917 Monday through Friday, from 8 a.m. to 5 p.m. Eastern time. Automated information is available 24/7.

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., Eastern time, Monday through Friday (TTY users should call 711.)
- Visit silversneakers.com**

Hearing services

Audiology providers can be identified through the BCN online provider directory. To find audiology providers:

1. Go to bcbsm.com.
2. Click *Find Care*.
3. Click *Search without logging in* and then click *Choose a location*.
4. Follow the prompts for entering a location and then click *Doctors by specialty*.
5. Type in “Audiology” and click the search icon.
6. Review the results.

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 can also help coordinate out-of-state services, as needed.

This also applies to outpatient diabetes and nondiabetes medical items, including diabetic shoes and inserts.

Outpatient home DME and P&O services and diabetes supplies must be authorized by Northwood to be covered by BCN. Example: For plans that cover safety items such as shower/bathtub grab bars, bench/commode rails and elevated toilet seats, Northwood is the provider.

Important: For information about continuous glucose monitor, or CGM, products, refer to the subsection titled “Part B point-of-sale program” on page 65 in this chapter.

For items obtained through 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.

Northwood’s customer service department is available from 8:30 a.m. to 5 p.m. Monday through Friday.

For additional information, refer to:

- The document Durable medical equipment, prosthetics, orthotics and medical supplies management program: Frequently asked questions for providers
- The BCN DME / P&O page on **ereferrals.bcbsm.com**
- The BCN Diabetes Supplies page on **ereferrals.bcbsm.com**

Laboratory services (outpatient)

JVHL provides the statewide network and third-party administration of claims for outpatient laboratory services covered by BCN Advantage.

JVHL — 1-800-445-4979
8 a.m. to 4:30 p.m. Monday through Friday

Medicare Part B drugs and chemotherapy

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

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 Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections. Provider Inquiry features an automated response system that is available 24/7. Follow the prompts for assistance.

Physical, occupational and speech therapy (outpatient)

For information on 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 document Outpatient rehabilitation services: Frequently asked questions for rehab providers on the BCN PT, OT, ST and Physical Medicine page at **ereferrals.bcbsm.com**.
- For information on reporting the nonpayable functional limitation G codes and their applicable modifiers, refer to the document Outpatient rehabilitation services: Frequently asked questions for rehab providers on the BCN PT, OT, ST and Physical Medicine page at **ereferrals.bcbsm.com**. Look for the question “Do providers need to submit functional limitation G codes for BCN Advantage members like they do for Original Medicare members?”
- For claims questions, providers can contact Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections. Provider Inquiry features an automated response system that is available 24/7. Follow the prompts for assistance.

Pharmacy services (for members who have a pharmacy benefit)

BCN Pharmacy Services:

- Manages the pharmacy benefit
- Manages the Pharmacy Clinical Help Desk
- Manages requests for coverage determination and prior authorization of pharmaceuticals

Optum Rx®:

- Processes prescription claims
- Provides the pharmacy network (for pharmacies located both inside and outside the state of Michigan)
- Provides the mail service pharmacy program for BCN commercial and BCN Advantage members

Walgreens Mail Service:

- Provides the mail service pharmacy program for BCN Advantage members only

Walgreens Specialty Pharmacy:

- Provides some drugs covered under the medical benefit, to be administered incident to an office visit

Transportation services

Transportation services are available to BCN Advantage individual members as follows:

- All BCN Advantage individual members receive one round trip to their enhanced annual wellness per calendar year within the State of Michigan. This is available with no referral required and at no copay.
- BCN Advantage provides non-emergency transportation services as a benefit for members who reside in Wayne, Oakland, Macomb and Washtenaw counties, are engaged in the Blue Cross / BCN Coordinated Care Management program and are within 28 days of discharge from an acute inpatient setting. Members must be referred to the transportation provider by their Blue Cross / BCN nurse care manager.
- BCN Advantage also covers ambulance services and worldwide emergency transportation services. BCN Advantage covers ambulance services even if the member is not transported to a facility, if member is stabilized at home or another location. This service is not covered outside of the U.S. or its territories. Cost shares vary.

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 (Eastern time):
  - 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
- Visit vsp.com**

Standards and ratings

Standards for access to care

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.

CAHPS® survey

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.

CMS star rating system

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 plan rating uses quality measurements that are widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services BCN Advantage offers.

CMS compiles its overall score for quality of services based on measures such as:

- How BCN Advantage helps members stay healthy through preventive screenings, tests and vaccines
- How often members receive preventive services to help them stay healthy
- How BCN Advantage helps members manage chronic conditions

- Member satisfaction with BCN Advantage and their experience with their provider
- How often members filed complaints against BCN Advantage
- How well BCN Advantage handles calls from members

In addition, because BCN Advantage offers prescription drug coverage, CMS also evaluates BCN Advantage prescription drug plans for the quality of services covered, such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

For additional information on the CMS star ratings, providers can contact their Blue Cross/BCN provider consultant.

Obligations and compliance

Obligations of recipients of federal funds

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) or in the CMS Preclusion 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% 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 (5% 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 U. S. 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 U. S. General Services Administration System for Award Management can be found at sam.gov**.

Compliance training

CMS requires BCN Advantage, which receives payment from Medicare, to implement an effective general compliance program for their workforce members and downstream entities. To satisfy CMS guidelines, this program must meet some minimum requirements established by federal statutes that pertain to Medicare Parts C and 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.

For additional information, see the How Do I Complete Medicare Fraud, Waste and Abuse Training? webpage at **bcbsm.com/providers**.

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:
    - Combating Medicare Parts C and D Fraud, Waste & Abuse
    - Medicare Fraud & Abuse: Prevent, Detect, Report
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 Combating Medicare Parts C and D Fraud, Waste & Abuse** and the Medicare Fraud & Abuse: Prevent, Detect, Report** modules.

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 that employees can easily access.

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.

Medical records

Signatures on medical records

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.

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.

Documentation supporting diagnosis codes

Providers must include documentation in the medical record that supports all diagnosis codes reported on claims submitted to BCN Advantage for payment.

Maintaining medical records

Providers must maintain accurate and timely medical records for the BCN Advantage members they treat. The records must be maintained as follows:

- In accordance with all federal and state laws and regulations regarding confidentiality and the disclosure of member health information
- In a manner that safeguards the privacy of any information that may identify a particular member

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.

Electronic health records

BCN Advantage encourages the adoption and use of electronic health records. For additional information, refer to the BCN System of Managed Care chapter of this manual. Look in the section titled "Electronic health 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 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. (The validation of risk adjustment data includes audit and non-audit activities by BCN, its affiliates or subsidiaries and governmental entities.) 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. General Accounting Office, the Centers for Medicare & Medicaid 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 or other similar activities conducted by BCN, its affiliates and governmental entities.

The records that are requested for an audit must be submitted according to the requirements set forth in the audit notification.

This chapter is updated to show that the validation of risk adjustment includes audit and non-audit activities by BCN, its affiliates or subsidiaries and governmental entities.

BCN Advantage service area

BCN Advantage geographic service areas

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 BCN Advantage covered 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 Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections. Provider Inquiry features an automated response system that is available 24/7. Follow the prompts for assistance.

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.
- 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
- 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
- Mailing marketing materials on behalf of plans or Part D sponsors
- Offering anything of value to induce plan enrollees to select them as their provider
- Offering incentives to persuade beneficiaries to enroll in a particular plan or organization
- Conducting health screenings as a marketing activity
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities
- Distributing materials or applications within an exam room setting

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. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections.

BCN Advantage primary care provider services

Appropriate managed care

Primary care providers manage their BCN Advantage members' medical care. Responsibilities include the following:

- Encouraging members to receive needed preventive care
- Monitoring specialty use and coordinating required medical care
- Referring members to case management, as appropriate
- Coordinating inpatient admissions
- 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 providers can communicate effectively with members by doing any of the following:

- Sending introduction letters asking new members to come in for a visit
- Discussing current and ongoing health care needs
- Discussing the care members are receiving from other providers
- Encouraging members to discuss care needs
- Discussing their expectations of members (coordinating care, ER use, affiliated specialists, affiliated hospitals, etc.)
- Showing sensitivity to members' needs (literacy concerns, cultural needs, social support, etc.)

BCN provides primary care providers with necessary support

BCN will make available to network providers the needed support materials and systems to serve BCN Advantage members. This support includes:

- Utilization management and chronic condition management
- Medication therapy management
- Medication adherence
- Medication reconciliation
- Reports
- Our provider portal (availity.com**)
- Health e-Blue℠
- Newsletter articles
- Seminars

Information on each of these can be found later in this chapter.

Assistance in closing diagnosis gaps

BCN Advantage provides primary care providers 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:

- Has not been documented and coded in the current year
- Is not confirmed as not applying to the member in the current year

The goal is that each primary care provider close 100% of the diagnosis gaps for his or her BCN Advantage members. A diagnosis gap is closed when one of the following has occurred:

- The condition is documented and coded in the current year
- The condition is confirmed as not applying to the member in the current year

Primary care providers can access information on each member's diagnosis gaps:

- 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 diagnoses. The information in BCN's Health e-Blue system is refreshed monthly.

The Health e-Blue is accessed through our provider portal (availity.com**). Refer to the Register for web tools page for additional information.

BCN Advantage also offers the Diagnosis Closure Incentive program, in which primary care providers are rewarded for closing identified diagnosis gaps.

Medicare wellness visits

There are two types of Medicare wellness visits that a provider can schedule with BCN Advantage members. For general information on these visits, see the information outlined below and the Medicare Network Learning educational tool about Medicare wellness visits (MLN6775421)**.

Welcome to Medicare visit

Medicare pays for one Welcome to Medicare visit per member, per lifetime. This visit, also known as the initial preventive physical examination, or IPPE, is a one-time appointment for new BCN Advantage members, which is to be scheduled within their first 12 months of enrollment.

This visit affords providers the opportunity to get up-to-date information on new members' health screenings, immunization records, family medical history and other preventive care services.

Annual wellness visit

BCN covers an annual wellness visit once per calendar year for BCN Advantage individual members. An annual wellness visit can be scheduled anytime during the calendar year. This means the member doesn't have to wait 365 days from their previous visit. Members become eligible for an annual wellness visit on Jan. 1 of every year.

The annual wellness visit gives providers a chance to develop or update a member's prevention plan based on his or her current health situation and risk factors. Members are asked to complete a health risk assessment before or during the visit. BCN Advantage provides a health assessment form that can be used for this component of the visit. Refer to the "Member health assessment form" information below for additional details.

Member health assessment form

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. Existing BCN Advantage members receive this form annually at the beginning of the year; new members who enroll during the year are sent the form following enrollment.

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 form has been completed, the member needs to send it back to Scantron in the return envelope provided.

Additional information

For additional information, including details about procedure codes, refer to these documents:

- *Medicare wellness visits: Frequently asked questions for providers*
- *Medicare Wellness Visit checklist*
- *Network Performance Improvement Presentation – Medicare Wellness Visits*

Providers can find these documents on the Clinical Quality Overview page in the Member Care section of our secure Provider Resources area, which is accessed through our provider portal (availity.com**).

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 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 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 *Generate Member Letters*.
3. Select the provider or the practice group in the drop-down menu.
4. Select the letter type (Diagnosis Evaluation, 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 of their 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.

Telemedicine visits

For BCN Advantage members, the following types of telemedicine visits are available:

- Visits with BCN-contracted providers
- Virtual Care through Teladoc Health® – Through Virtual Care visits, members can access virtual urgent care, virtual therapy and virtual psychiatry. This service is separate from any virtual care a member's personal provider might offer. For more information, see the document Virtual Care by Teladoc Health: Frequently asked questions for providers.

For additional information about medical (non-behavioral health) and behavioral health telehealth services, including what they consist of, what the requirements are and how to bill for them, refer to the following documents:

- Telehealth for medical providers
- Telehealth for behavioral health providers

In this chapter, the information about telemedicine visits is updated to show the types of telemedicine visits available to BCN Advantage members.

Care navigation services through Homeward Health

Blue Cross and BCN are working with Homeward Health to expand access to care for Medicare Plus Blue and BCN Advantage members in Michigan's Upper Peninsula and in the northern Lower Peninsula.

Homeward's services supplement the services provided by primary care providers to improve patients' health, while focusing on health care provider collaboration and communication.

For additional information about the Homeward program, see the document titled Home-based services: For chronic condition monitoring, in-home medical services, prior authorization determinations and more.

This chapter is updated to include information about Homeward Health. For more information, providers should refer to the document *Home-based services: For chronic condition monitoring, in-home medical services, prior authorization determinations and more.*

Primary care provider assignment for dual-eligible members

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

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.

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 and enrollment confirmation 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.

Member eligibility data files

BCN Advantage members identified in eligibility data files

Through their medical care group or practice administrators, primary care providers 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:

Code	Explanation
MAGP	BCN Advantage HMO-POS group
MA15	BCN Advantage HMO-POS Elements individual - medical only
MB15	BCN Advantage HMO-POS Classic individual - medical with enhanced Part D Rx
MC07	BCN Advantage HMO-POS Prestige individual - medical with enhanced Part D Rx
MAPV	BCN Advantage HMO-POS Prime Value individual - medical with enhanced Part D Rx

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

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

Code	Explanation
MACC	BCN Advantage HMO ConnectedCare individual - medical with Part D Rx (Aranac, Genesee, Iosco, Kalamazoo, Livingston, Macomb, Oakland, Saginaw, St. Clair, Washtenaw and Wayne counties)
MACV	BCN Advantage HMO-POS Community Value individual with Part D Rx (Medicare Advantage non-group in the following counties: Macomb, Oakland, Wayne, Washtenaw, Genesee, Livingston and St. Clair).
MAIB	BCN Advantage Local HMO individual with Part D Rx (Medicare Advantage non-group in the following counties: Macomb, Oakland and Wayne).

Membership ID cards

Member 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 and enrollment confirmation 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 and enrollment confirmation letter as proof of coverage only until they receive their ID card.

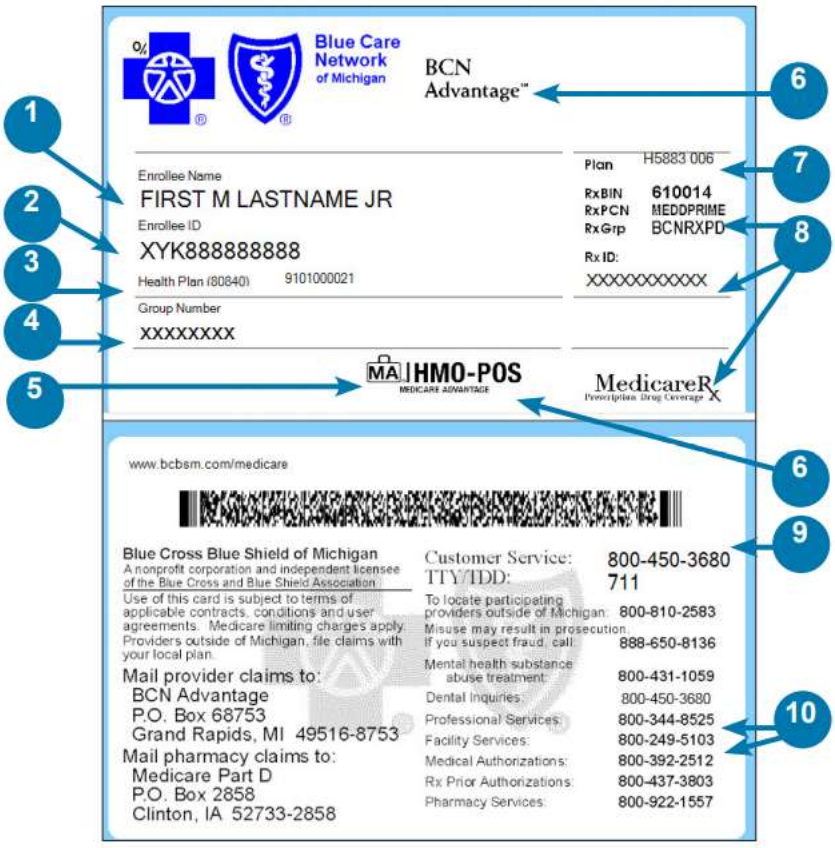
If a member presents a letter more than a month after the date on the letter, providers should verify the member’s eligibility by calling Provider Inquiry. To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections. Provider Inquiry features an automated response system that is available 24/7. Follow the prompts for assistance.

Member ID card brochure

Providers can see images of BCN Advantage HMO-POS and BCN Advantage HMO member ID cards and find additional information about them in the Blue Care Network: Understanding member ID cards brochure.

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

BCN Advantage HMO-POS member ID card



Number	Explanation
1	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.
2	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.
3	Issuer: This number identifies which Blue plan issued the card.
4	Group Number: The BCN Advantage HMO-POS group number
5	BCN Advantage HMO-POS coverage includes a travel benefit for emergency and urgent care and for follow-up care for existing conditions (with prior approval).

Number	Explanation
6	On this ID card, the product name shown is BCN Advantage HMO-POS.
7	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, 007, 012, 014 and 015, it is an individual HMO-POS plan.
8	Pharmacy information: Prescription drug coverage under BCN Advantage HMO-POS
9	On the back of the HMO-POS ID card, various phone numbers are listed. These include numbers for various types of authorizations and for Provider Inquiry. Medical and pharmacy claims addresses are also shown.
10	Different Provider Inquiry phone numbers are shown, including separate numbers for professional and facility providers.

BCN Advantage benefits

Individual plans

For the BCN Advantage HMO-POS product, there are five different options available to individuals, including one option with medical coverage only (Elements) and four with medical and prescription drug coverage (Classic, Prestige, Community Value and Prime Value). All include a worldwide travel benefit that covers urgent and emergency care and follow-up care for existing conditions (with prior authorization). Emergency transport is also covered on a worldwide basis.

For the BCN Advantage HMO products, there are two options, BCN Advantage HMO ConnectedCare and BCN Advantage Local HMO. 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. Worldwide emergency and urgent care, as well as worldwide emergency transport, are also covered.

Dental, vision and hearing benefits for individual plans

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, visit the Medicare Summary of Benefits and Ratings webpage, locate the *Summary of Benefits* document for a specific plan, click to open the document and search for "dental," "vision" or "hearing."

Optional benefit packages

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

Obtaining services

For BCN Advantage HMO plans, dental, vision and hearing services can be obtained as follows:

- Blue Cross is contracted to provide coverage for routine dental care to BCN Advantage HMO 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.
- BCN Advantage HMO members in need of routine vision services should be referred to the VSP network for care.
- BCN Advantage HMO 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 on page 1 of this chapter.

Group plans

Standard packages are available; however, groups can modify their coverage by adding riders to the BCN Advantage base benefit to customize and design their own benefit 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 on page 1 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:

- Our provider portal (availity.com**)
- Provider Inquiry: To identify the phone number, visit the For Providers: Contact Us webpage and make the pertinent selections. Provider Inquiry features an automated response system that is available 24/7. Follow the prompts for assistance.

  Note: Providers can also use these numbers 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 can visit the How do I sign up for Electronic Data Interchange? webpage on **bcbsm.com**. Look under "Blue Cross Blue Shield and Blue Care Network Companion Documents", then click the link to open the document titled HIPAA Transaction Standard Companion Guide - Real Time Transactions (270/271 Eligibility and Benefits, 276/277 Claim Status).

  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 on page 1 of this chapter.

This chapter is updated to show that for information on the HIPPA 270/271 transaction, providers should see the document titled HIPAA Transaction Standard Companion Guide - Real Time Transactions (270/271 Eligibility and Benefits, 276/277 Claim Status).

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.

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 provider 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 visit the Medicare Summary of Benefits and Ratings webpage, locate the *Summary of Benefits* document for a specific plan and click to open it.

The benefits under group plans vary from plan to plan. Information on group plans is available on the Medicare Options from your Michigan Employer webpage.

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 identify the exclusions for a specific BCN Advantage individual or group product:

1. Visit the Medicare Evidence of Coverage Booklets webpage at **bcbsm.com**.
2. Locate the *Evidence of Coverage* document for a specific BCN Advantage plan and click to open it.
3. In the document, search for “exclusions.”

Steps to take before providing services that are not or may not be covered

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, through a vendor portal or by calling BCN’s Utilization Management department or the appropriate vendor.

BCN’s Utilization Management department (or a vendor, as applicable) 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 (or a vendor, as applicable) will send written notification of the denial to both the provider and the member. If the request was submitted through the e-referral system or a vendor portal, the denial will show in the e-referral system or the vendor portal.

Once the denial is available, providers should take the following steps:

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.

Ultimately, 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 to the provider
- The copy the provider receives of the denial letter 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 has agreed 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.

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 provider.

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.

Results reported to the primary care provider

The information gathered during the visit will be provided to the member's primary care provider to assist in the continued management of the member's health. The provider 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

Utilization management program overview

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.

Note: This section does not include information about services managed by vendors.

Monitoring utilization

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 provider 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 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
- 9:30 a.m. to noon and 1 p.m. to 5 p.m. on Friday

Utilization Management staff 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.

Language assistance and TDD/TTY services are available for anyone who needs them, when calling to discuss utilization management issues.

Referral management

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

To make coordinating patient care as simple as possible, **services for BCN Advantage members do not require the primary care provider to submit a referral to BCN when using in-network providers**. The primary care provider 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 provider can coordinate care:

- Handwritten prescription signed by the primary care provider (can be carried to the specialist by the member)

- Faxed note on primary care provider office letterhead or emailed from the primary care provider to the specialist (a copy can be given to the member)
- Telephone call from primary care provider 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

***Michigan providers: BCN global referral, plan notification and prior authorization requirements* document**

Providers can access the BCN Advantage authorization requirements on the Michigan providers: BCN global referral, plan notification and prior authorization requirements document. This document contains, among other things, a list of services that require authorization.

How to submit prior authorization requests

There are various options providers can use to submit prior authorization requests for services managed by BCN's Utilization Management department:

- Providers are encouraged to use the web-based e-referral system for submitting prior authorization requests and for viewing the status of requests for BCN Advantage members.
- When submitting an outpatient prior authorization request, providers must select a provider who participates with the member's plan.

  Important note: Not all providers or provider addresses are considered in network. In the e-referral system, providers who participate with the member's plan are designated "In" or "Pref". Those who do not participate are shown as "Out".

  If an out-of-network provider is selected ("Out" in the Network column), the request will have to go through an out-of-network review.

  For more information about selecting an in-network provider in the e-referral system, refer to these resources:

  - e-referral User Guide: Look for the information titled "A provider may be listed multiple times – make sure to choose the correct one".
  - e-referral Quick Guide: Look for the information titled "(How Do I…) Select the appropriate practitioner or facility to assign to a case?"

- Providers may also submit prior 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.

Other information about prior authorization

For BCN Advantage members, requests for services that require prior authorization, including the necessary clinical information, should be submitted 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 within the e-referral system

  Note: Providers are encouraged to submit the required clinical information via e-referral, with the initial prior authorization request.

- By attaching it to the case. Instructions for attaching a document from the member's medical record are 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 Provider Communication section within the e-referral system.

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 prior 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

Prior authorization requests for medical care or services may also be submitted to BCN by the BCN Advantage member in writing or by phone. If the member makes the request, BCN will contact the primary care provider to obtain his or her support for the requested treatment and to request any clinical information needed to make the decision.

Overview of inpatient review and discharge planning

Important: BCN Advantage must be notified of acute non-behavioral health (medical / surgical) inpatient admissions once the member is admitted to inpatient status and meets applicable Medicare coverage guidelines, InterQual® criteria and BCN Advantage clinical criteria.

Refer to the document Submitting acute inpatient authorization requests: Frequently asked questions for providers for information about the topics listed below and other related issues:

- How to submit inpatient admission authorization requests and the criteria used to make determinations on those requests
- Which requests must be submitted through the e-referral system and which must be submitted by fax
- Facility transfers, including urgent transfers

  Note: BCN Advantage members in an inpatient acute care medical / surgical (non-behavioral health) facility may request a non-emergency transfer to another such facility of their choice at any time.

The BCN Advantage Utilization Management department nurses use InterQual criteria and our internal coverage criteria, along with applicable Medicare coverage guidelines, when making medical necessity determinations on authorization requests.

The BCN Advantage Utilization Management department staff are available to assist physicians and providers for urgent needs after normal business hours, which are 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 BCN Advantage utilization management staff member after normal business hours, providers should call 1-800-851-3904.

For additional information on how to submit prior authorization requests for inpatient admissions on holidays, when the Blue Cross and BCN corporate offices are closed, refer to the document Holiday closures: How to submit authorization requests for inpatient admissions.

Note: For information on inpatient behavioral health admissions, refer to the Behavioral Health chapter of this manual.

The information in this chapter is clarified to show that BCN Advantage members in an inpatient acute care medical / surgical (non-behavioral health) facility may request a non-emergency transfer to another such facility of their choice at any time.

Submitting clinical information for inpatient admission

For inpatient acute medical / surgical admissions of BCN Advantage members, we require admitting physicians and facilities to submit documentation that supports the medical necessity of a hospital admission, in line with the member's severity of illness and the intensity of the services required.

authorization requests

Providers should refer to the document Submitting acute inpatient authorization requests: Frequently asked questions for providers for more information about submitting inpatient admission requests and the criteria used to make determinations on those requests, including the CMS Two-Midnight Rule.

If a request is pended for clinical review, BCN Advantage Utilization Management clinicians will use the clinical information that was submitted to support a medical necessity determination.

Note: BCN Advantage may request that clinical documentation be submitted on weekends or holidays so that the 72-hour time frame for determinations can be met. 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.

In this chapter, providers are referred to the document *Submitting acute inpatient authorization requests: Frequently asked questions for providers* for information about submitting inpatient admission requests and the criteria used to make determinations on those requests, including the CMS Two-Midnight Rule.

How to expedite review of an inpatient admission prior authorization request

To expedite review of an inpatient admission prior authorization request and possibly avoid the need to request a peer-to-peer review, or to appeal a nonapproval decision, providers can:

- Attach all pertinent clinical information from the medical record to the authorization request to validate that an inpatient setting is appropriate.
- Submit only requests that have a complete set of clinical information.
- Include the following clinical documentation with the request:
    - The InterQual criteria subset that was used to support the decision for inpatient admission
    - The pertinent clinical information that validates the InterQual criteria points that are met
    - The procedure code from the CMS inpatient surgical list that was used to support the decision for an inpatient admission

Providers should refer to the document Submitting acute inpatient authorization requests: Frequently asked questions for providers for more information about submitting inpatient admission requests and the criteria used to make determinations on those requests, including the CMS Two-Midnight Rule.

Medical necessity considerations: general

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 Medicare 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.

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 follows CMS coverage guidelines and uses InterQual criteria (for all admissions).
- 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**.
- When the application of InterQual criteria (for all admissions) 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).

  Note: Additional information about InterQual criteria is available in the Utilization Management chapter of this manual.
- The BCN Advantage prior authorization request process, as outlined in the Utilization Management chapter of this manual and 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, and inpatient-only procedures.

Providers should refer to the document Submitting acute inpatient authorization requests: Frequently asked questions for providers for more information about submitting inpatient admission requests and the criteria used to make determinations on those requests, including the CMS Two-Midnight Rule.

This chapter is updated to show that BCN Advantage follows CMS coverage guidelines when determining medical necessity for acute inpatient medical and surgical admissions.

Requirement to notify members of observation stay

Hospitals must use the *Medicare Outpatient Observation Notice*, or MOON, form to notify BCN Advantage members in the circumstances listed below that they are an outpatient receiving observation services and not an inpatient of a hospital or a Critical Access 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 and Critical Access Hospitals must present the member with a completed *Medicare Outpatient Observation Notice*. This is a CMS requirement under the Notice of Observation Treatment and Implication for Care Eligibility Act.

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 and Critical Access 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.

Note: A Critical Access Hospital is a CMS designation. For more information, refer to the Critical Access Hospital** webpage at **cms.gov**.

MOON form and instructions

To access specific documents, providers should go to the FFS & MA MOON page** of the CMS website and do the following:

- Click the *CMS-10611 (MOON)* Form link to access the MOON form and instructions.
- Click the *MOON FAQs* link to access frequently asked question about the form

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. (Refer to the subsection titled “Standard time frames for BCN Advantage decisions” on page 40 of this chapter.)
- 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. (Refer to the subsection titled “Standard time frames for BCN Advantage decisions” on page 40 of this chapter.)
    - If the physician disagrees, BCN makes a decision according to standard time frames and notifies the member of a decision not to make an expedited decision. (Refer to the subsection titled “Standard time frames for BCN Advantage decisions” on page 40 of this chapter”.)

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:

- During normal business hours: 1-800-392-2512
- After normal business hours: 1-800-851-3904

Standard time frames for BCN Advantage decisions

For information about the time frames within which BCN must make determinations on prior authorization requests related to acute medical inpatient admissions, refer to the document Submitting acute inpatient authorization requests: Frequently asked questions for providers.

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 Advantage 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 Advantage.

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

If…	Then…
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 the e-referral system for the status of the request.
The service is denied	For pre-service urgent / concurrent requests, BCN Advantage sends the practitioner and facility a letter within 3 days of initial notification. The letter includes the reason(s) for the denial, informs the practitioner of the right to appeal and explains the process. For pre-service non-urgent requests and for post-service requests, BCN Advantage 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.

Emergency and post-stabilization care services do not require prior authorization

For BCN Advantage members, prior authorization is not required for emergency or post-stabilization care services.

For BCN Advantage, the financial responsibility for post-stabilization care services ends when one of the following conditions occurs:

- A physician with privileges at the treating hospital assumes responsibility for member's care.
- A physician assumes responsibility for the member's care through transfer.
- BCN Advantage and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

Additional information available in Utilization Management chapter

You can find additional information about BCN's utilization management program in the Utilization Management chapter of this manual.

Home health care services

For BCN Advantage members, prior authorization isn't required for home health care services, except for noncontracted and out-of-network providers.

Transitional care services coordinated by BCN

Transitional care services are:

- Services that follow discharge from an inpatient care setting when placement in a transitional setting is necessary
- Services that prevent inpatient hospitalization through the provision of skilled care in the home

These services 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), prior authorization requests are managed by BCN Utilization Management. For more information, refer to:

- The document Post-acute care requirements: Information for providers
- The BCN Post-Acute Care webpage at **ereferrals.bcbsm.com**

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

BCN Advantage continuity of care arrangements

Scope of section

This section applies only to BCN Advantage members.

For continuity of care information for BCN commercial members, refer to the Utilization Management chapter of this manual. Look in the section titled "Continuity of care."

Which members are eligible for continuity of care

Continuity of care arrangements are available for the following members:

- Existing BCN Advantage members whose primary care provider, specialist or behavioral health provider voluntarily or involuntarily disaffiliates from BCN

  Note: BCN Advantage members cannot see their current practitioner if that practitioner was terminated from BCN for quality reasons. In this instance, the member must receive treatment from an in-network practitioner.

- New BCN Advantage members who require an ongoing course of treatment
- Members who move from a Medicare Plus Blue plan to a BCN Advantage plan or vice versa

How continuity of care works for new BCN Advantage members

In line with continuity of care guidelines set by the Centers for Medicare & Medicaid Services, Blue Cross and BCN will allow members to continue with an existing course of treatment from their current provider within the first 90 calendar days after enrollment. However, first:

- Blue Cross and BCN must confirm that the member is in an active course of treatment when they join one of our Medicare Advantage plans a BCN Advantage plan or when they move from a Medicare Plus Blue plan to a BCN Advantage plan or vice versa.
- Providers must document the member's course of treatment or treatment plan in the member's medical record. The documentation must show the services planned for the member.
- Providers may be asked to verify that the member is undergoing an active course of treatment.
- Blue Cross and BCN will ask for the member's treatment plan to use in reviewing the prior authorization request.

What is a course of treatment

According to CMS, a course of treatment is a prescribed order or ordered course of treatment for a specific individual with a specific condition outlined and decided upon ahead of time with the patient and provider.

A course of treatment may be part of a treatment plan but is not required. An active course of treatment means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

Transitional care management services

Transitional care management services through provider practices

BCN provides coverage for transitional care management services for both BCN 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."

Cardiology care management services

Cardiology care management services

BCN contracts with AMC Health to manage BCN Advantage members with select cardiology conditions. For more information, refer to the document Cardiology: For home monitoring and cardiology and echocardiology procedures.

This chapter is updated to show that AMC Health manages BCN Advantage members with select cardiology conditions. A link to the document Cardiology: For home monitoring and cardiology and echocardiology procedures is also added.

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

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

Provider responsibilities

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

Billing for non-face-to-face chronic care management services

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 section.
- 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 providers, 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:

Activity	Count toward minimum 20 minutes of billable chronic care management time?	Other information
Evaluation and management services and procedures	No	E&M services should be billed separately.
Telephone calls between the practitioner and: • The member • The member's other health care providers • The pharmacy • The laboratory	Yes	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.
General planning or care coordination time that is initiated because of a contact, or results in a contact with the patient or a contact related to the patient	Yes	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.

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

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 Practitioner Billing for Chronic Care Management Services** published by CMS
- Chronic Care Management Tool Kit** (American College of Physicians® login required)

Providers may also contact a care manager at 1-800-775-2583.

Blue Cross / BCN Coordinated Care Management

Description of Blue Cross / BCN Coordinated Care Management program

The Blue Cross / BCN Coordinated Care Management program aims to deliver a holistic, member-centric approach to coordinated care delivery for those members who most need it. The program is member-centric because it supports members in making informed decisions and in successfully managing their own health by being active participants in the care planning process.

The program actively manages members through:

- Enhanced analytics that identify and target members who most need care management services
- Multidisciplinary team to support the members' care management needs

The program features include:

- Integrated care teams that are led by a nurse care manager and that include social workers, behaviorists, pharmacists, physician consultants and dietitians. Each team focuses on a specific geographic region to enable more community-centric care.
- Mobile-based digital technology that connects members to relevant care information through the channel of their choice — digital libraries, text or email

Identification of members for coordinated care management

The Blue Cross / BCN Coordinated Care Management program identifies members who could use assistance through the following:

- Robust analytics and enhanced data sets (that is, data related to the social determinants of health), which identify and target members who might benefit most from the services
- Reactive analytics, which identify members who are already at high risk and who have clinically complex conditions, based on observed conditions, health care utilization and risk factors
- Predictive analytics, which identify members whose risk or costs are likely to increase based on early indicators or potential future needs

Care planning process

The member is assessed and care managers use the member's responses to develop comprehensive care plans for the member that include interventions, goals, barriers and measurable outcomes.

The care plan includes medical, behavioral and psychosocial care goals to meet the member's needs.

Care managers ensure that the care goals reflect input from the member, physician, caregiver and nurse. The care goals are prioritized in tandem with the member based on clinical guidelines and motivational interviewing techniques.

When applicable, the care plan is also supplemented by input from the multidisciplinary care team, which includes pharmacists, social workers, behavioral health specialists and dietitians.

Collaboration with the physicians

The Blue Cross / BCN Coordinated Care Management program is designed to support providers in their efforts to provide the best possible care for their patients. To do this, a multidisciplinary, integrated care team provides holistic care management to members for all their health needs.

This team supports provider-delivered care by:

- Assisting members with scheduling medical appointments
- Following up with members after doctors' appointments to reinforce the importance of adhering to treatment plans
- Providing condition-specific education to members with chronic and complex care needs
- Co-managing members participating in provider-delivered care management to support the prescribed treatment plan, when applicable

To support patient care, a member of the integrated care team contacts the primary care provider or specialist to let him or her know that a patient is participating in the Blue Cross / BCN Coordinated Care Management program, when necessary. The Blue Cross / BCN Coordinated Care Management program is not intended to replace the doctor-patient relationship in any way.

Post-discharge care coordination

As part of the Blue Cross / BCN Coordinated Care Management program, identified members at risk of readmission receive outreach from the coordinated care management team.

The coordinated care management team works with these members to ensure a smooth and successful transition. The goals include:

- Educate the member about clinical warning signs
- Discuss and encourage adherence to treatment plan and discharge instructions
- Assist members in scheduling follow-up appointments with their treating physicians
- Educate members about the importance of medication adherence
- Assess each member's social determinants of health
- Assess each member's behavioral health needs
- Connect members with treating providers and services

BCN Advantage pharmacy services

Part D prescription drug program overview for individuals

Individuals with BCN Advantage coverage have six options to choose from for Part D drug benefits. Beneficiaries can select from the following plans, which offer different copayment levels:

- BCN Advantage Classic, Prestige, Prime Value and Community Value (options under the BCN Advantage HMO-POS product)

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

- BCN Advantage HMO ConnectedCare (BCN Advantage HMO product option)
- BCN Advantage Local HMO (BCN Advantage HMO product option)

Part D prescription drug program overview for groups

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

Details about BCN Advantage Part D coverage for groups are available at **bcbsm.com/medicare** > Group Plans.

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

Medicare Prescription Payment Program

Members with a Medicare drug plan or Medicare health plan with drug coverage, such as a BCN Advantage plan with drug coverage, can choose a new payment option to help manage their out-of-pocket Medicare Part D drug costs by spreading them throughout the calendar year. Participation is voluntary and members won't pay any interest or fees on the amount owed, even if a payment is late.

Members receive a *Medicare Prescription Payment Program Participation Request form* with their annual enrollment materials. To participate, members can opt in online, contact BCN Advantage by phone, or send the completed form to BCN Advantage by mail.

Members who have high drug costs are most likely to benefit from this plan. The plan doesn't lower their drug costs but will help them manage their monthly expenses.

Members who select this payment option will get a bill from BCN Advantage to pay for their prescription drugs instead of paying the pharmacy. The member's payments might change every month, so they might not know what their exact bill will be ahead of time. Future payments might increase when a new prescription is filled because, as new out-of-pocket costs get added to the monthly payment, there are fewer months left in the year to spread out the remaining payments.

For additional information, see the What's the Medicare Prescription Payment Plan? webpage.

This chapter is updated to show that BCN Advantage members can participate in the Medicare Prescription Payment Program to help manage their out-of-pocket Medicare Part D drug costs. This program is available starting Jan. 1, 2025.

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 BCN Medical Benefit Drugs webpage at **ereferrals.bcbsm.com**

Oncology Value Management program

The Oncology Value Management program is a utilization management program that requires providers to request prior authorization for oncology and supportive care drugs.

Under this program, oncology and supportive care drugs under both the medical benefit and the pharmacy benefit require prior authorization from OncoHealth. This applies to most BCN commercial and all BCN Advantage members.

For more information about the Oncology Value Management program, including how to submit prior authorization requests to OncoHealth, see the document titled Oncology Value Management program through OncoHealth: Frequently asked questions for providers on **ereferrals.bcbsm.com**.

This chapter is updated to include information about the Oncology Value Management program, effective April 1, 2025. For more information, providers should refer to the document *Oncology Value Management program through OncoHealth: Frequently asked questions for providers*.

Blue Cross Personalized Medicine

Blue Cross Personalized Medicine℠, a precision medicine program, helps providers tailor the medication regimen of a member to that member’s specific needs. The program uses pharmacogenomics, or genetic testing, to personalize medication treatments.

Providers can find more information about this program in the Pharmacy chapter of this manual. Look in the section titled “Pharmacogenomics.”

Provider access to the BCN Advantage Part D formularies

BCN Advantage formularies show 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, the drug criteria are met 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 often available at a lower copayment, a significant savings over brand-name therapeutic alternatives.

Accessing the BCN Advantage Part D formulary for individual members

The BCN Advantage formularies for individual members include drugs covered by Part D. The formularies are 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. In the event of any CMS-approved mid-year non-maintenance formulary changes, BCN provides notice to affected members 30 days in advance of the change through a letter mailed to the members.

The BCN Advantage formularies for individual members can be accessed on the Drug Lists for Medicare Members webpage at **bcbsm.com/medicare**.

Accessing the BCN Advantage Part D formulary for group members

The BCN Advantage formulary for group members includes everything offered in the individual formularies, 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 is available on the Drug Lists for Medicare Members webpage at **bcbsm.com/medicare**.

OTC coverage for Part D drugs

BCN Advantage offers the Advantage Dollars program allowance for over-the-counter and healthy food items for BCN Advantage HMO-POS Elements, Classic, Prestige, Community Value and Prime Value plans and BCN Advantage HMO ConnectedCare and BCN Advantage Local HMO. This program comes with an Advantage Dollars card.

To locate the specific Advantage Dollars allowance of a particular plan, visit the Medicare Summary of Benefits and Ratings webpage, at **bcbsm.com**, locate the *Summary of Benefits* document for the plan, click to open the document and search for “OTC.”

This benefit comes with a quarterly allowance that can be used on eligible over-the-counter and healthy food items including but not limited to oral care, skin and sun care, digestive aids, vitamins, first aid supplies, ear drops and eye wash, and allergy and sinus medications. In addition:

- For a complete list of covered items, go to OTCNetwork.com**.

- The Advantage Dollars card can be used in store at participating retailers and online at the Blue Cross Blue Shield and BCN Advantage Over-The-Counter website.

One order can be placed per quarter. Unused amounts roll over to the next quarter but must be used within that calendar year.

Note: In addition to the over-the-counter benefit, members can use their allowance to purchase healthy foods if BCN Advantage has a diagnosis on file for the member for any of the following chronic conditions: arthritis; autoimmune disorders (polyarteritis nodosa, polymyositis rheumatica, polymyositis, systemic lupus erythematosus); cancer (excluding pre-cancer conditions or in-situ status); cardiac arrhythmias; chronic alcohol and/or other drug dependence; chronic cardiovascular disorders (coronary artery disease, peripheral vascular, chronic venous thromboembolic disorder); chronic and disabling mental health conditions; chronic heart failure; chronic lung disorders (chronic obstructive pulmonary disease); dementia; diabetes; end-stage liver disease, end-stage renal disease (ESRD) requiring dialysis; HIV/AIDS; hypertension; neurologic disorders; pre-diabetes; severe hematologic disorders (aplastic anemia, hemophilia, immune thrombocytopenic purpura, myelodysplastic syndrome, sickle cell disease [excluding having the sickle-cell trait]; chronic venous thromboembolic disorder); and/or stroke.

Allowances are provided quarterly on Jan. 1, April 1, July 1 and Oct. 1.

There are four ways members may use their benefit:

- In store. Members can use their allowance card to purchase many common items at local retailers. For a complete list of participating retailers, visit bcbsm.com/medicareotc.
- Online. Members may visit bcbsm.com/medicareotc and follow the prompts to place the order using the online catalog.
- By mail. Members may call 1-855-856-7878 to request a printed catalog (TTY: 711). They can complete and mail the order form that's included with the catalog.
- By phone. Members may select items using the printed or online catalog and call 1-855-856-7878 (TTY: 711) to place an order. Items will be mailed to the member.

Initial level of drug benefits and member responsibility for Part D drugs

The BCN Advantage coverage options offer individual Part D drug benefits. All individual BCN Advantage HMO-POS plans (Classic, Prestige, Prime Value and Community Value) and BCN Advantage HMO plans (ConnectedCare and Local) have no deductible.

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.

Part D coverage limits and member copayment responsibilities

For the BCN Advantage HMO-POS Classic, Prestige, Community Value and Prime Value products, and for BCN Advantage HMO ConnectedCare and BCN Advantage Local HMO products, the limit for the initial coverage level is reached when $2,000 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.

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, insulins 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 plan.

Part D Explanation of Benefits statement

All BCN Advantage members who receive pharmacy benefits are sent an Explanation of Benefits statement for the months that the benefit is utilized 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 medical EOB that contains information for all the other services the member has received.

The Part D EOB is generated by Optum Rx. 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. 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.)

Part D step therapy and prior authorization requirements

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 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 available on the Drug Lists for Medicare Members webpage at **bcbsm.com/medicare**.

About Part D exception requests

BCN Advantage considers requests for exceptions to utilization management requirements based on medical necessity. The different types of exception requests include:

- Coverage for a non-formulary 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, and 4 for all BCN Advantage formularies (BCN Advantage Comprehensive Formulary, BCN Advantage Healthy Value Comprehensive Formulary and BCN Advantage Comprehensive Formulary for Groups). 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 non-formulary drug approval process.

How to submit requests for prior authorization for Part D drugs or exceptions to utilization management requirements

For drugs covered under the pharmacy benefit, there are four ways to request prior authorization or an exception to a utilization management requirement:

- **Electronically**: For most drugs, providers can submit prior authorization requests using their electronic health record or CoverMyMeds® online account. (Other free electronic prior authorization, or ePA, services include Surescripts®.) Submitting through ePA is the preferred method, as certain requests may receive immediate determinations.

  Note: More information about submitting requests electronically is available in the Pharmacy chapter of this manual. Look in the section titled “Medications requiring prior authorization.”

- **By phone**: Providers can contact the Pharmacy Clinical Help Desk at 1-800-437-3803, which is open from 8 a.m. to 9 p.m. (Eastern time) Monday through Friday. Responses to requests for coverage determinations for non-covered drugs and other routine requests are made within 72 hours.

  Note: Alert the Pharmacy Clinical Help Desk if the request is urgent. Staff is available after hours and on weekends and holidays to respond to urgent requests. 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 urgent requests will be provided within 24 hours.

- **Electronically.** Visit the Medicare Pharmacy Forms page. Scroll down and click Prescription Drug Coverage Determination Online Form. Complete the form and click *Submit* at the bottom of the form. This will generate an email request to the coverage review team.

- **By fax**: Visit the Medicare Pharmacy Forms page. Scroll down and click Prescription Drug Coverage Determination Paper Form. Print the form, complete it and fax it to the Pharmacy Clinical Help Desk at the fax number listed on the form.

108-day transition period for new members for Part D drugs

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 108 days to work out other medication options with their prescriber.

During the first 108 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 108th 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 during the first 108 days of membership. Once the 108th 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.

Part D pharmacy network

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

Optum Rx 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 Find a pharmacy webpage.

Part D drugs: 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 the Optum Home Delivery service and Walgreens Specialty Pharmacy, 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:

Step	Action
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:
	• The Optum Home Delivery pharmacy
	• The Walgreens Mail Service pharmacy
	  ○ Fax: 1-866-515-1356
	  ○ E-prescribe: Walgreens Specialty Pharmacy – MICHIGAN

To request mail order information, members may call BCN Advantage Customer Service at 1-800-450-3680.

Part D pharmacy forms

Providers can access forms related to pharmacy requests as follows:

- For BCN Advantage members: Medicare Pharmacy Forms webpage
- For BCN commercial members:
  - FDA online MedWatch form: All dispense-as-written (DAW) requests require that a MedWatch form be submitted to the FDA and to the plan for review.
  - Quantity Limit Request form: Use this form to submit requests for exceptions to the quantity limits of a drug.

Part D Medication Therapy Management program

CMS requires a Medication Therapy Management program for all Medicare 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 $1,623 in drug costs per year.
- They have at least three of the following ten chronic conditions:
    - Respiratory disease, including chronic obstructive pulmonary disease and asthma
    - Congestive heart failure
    - Diabetes mellitus
    - Bone disease, including osteoporosis, osteoarthritis and rheumatoid arthritis
    - Alzheimer's disease
    - Dyslipidemia
    - End-stage renal disease
    - HIV/AIDS
    - Hypertension
    - Behavioral health conditions, including depression, schizophrenia and bipolar disorder
- They are prescribed eight or more chronic / maintenance Part D medications.

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

MTM pharmacists work closely with members and physicians to improve member medication adherence and to address any other medication-related issues.

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. Pharmacists conduct the review by telephone upon the member's enrollment in the MTM program. They discuss a variety of topics with members, 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.

The Medication Therapy Management program information is updated to reflect current practices.

Medication reconciliation services for BCN Advantage members

Providers are encouraged to carry out medication reconciliation efforts for all members discharged from a hospital stay.

For information about medication reconciliation services providers can perform for BCN Advantage members, refer to the Pharmacy chapter of this manual. Look in the section titled “Provider tools for pharmacy management,” in the subsection titled “Medication reconciliation.”

Part D insulin

The Inflation Reduction Act, or IRA, caps insulin out-of-pocket spending at $35 per month’s supply of each insulin product covered under a Medicare Part D plan. This applies during all stages of member coverage.

For additional information, refer to the BCN Advantage formularies on the Drug Lists for Medicare Members webpage at **bcbsm.com/medicare**.

Part D 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 who elect BCN Advantage.

Prescribers are encouraged to complete Part D 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 Part D 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 120 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 120 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

point-of-sale edits will be applied after case management, discussion with the prescriber and notice to the member.

- The Centers for Medicare & Medicaid Services uses updated daily morphine milligram equivalent, or MME, conversion factors to align with the Centers for Disease Control and Prevention *Clinical Practice Guideline for Prescribing Opioids for Pain*. These updates will apply to all hydromorphone, methadone and tramadol prescriptions. As a result, patients who are filling hydromorphone, methadone or tramadol prescriptions may experience a claim rejection if the member's total daily MME exceeds the plan threshold level, even if the patient has not actually changed doses.

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 an 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 these members:
    - Members taking the combination of opioids and the opioid-potentiator medications gabapentin and pregabalin
    - Members with a history of opioid overdose who are receiving an opioid prescription
- BCN offers access to medication-assisted treatment. No prior authorization is needed for buprenorphine and other medication-assisted treatment products.

Polypharmacy safety edit

BCN Advantage will stop claims at the point of sale for members 65 years of age or older who are on two or more anticholinergic medications at the same time. This safety edit is intended to encourage providers to prescribe safer alternatives to anticholinergic medications for our BCN Advantage members.

The common side effects of anticholinergic drugs include:

- Dry eyes
- Xerostomia
- Constipation

- Urinary retention

These adverse effects can be especially harmful in members 65 years of age or older, for whom the use of multiple anticholinergics has also been associated with a greater risk of cognitive decline and dementia.

This chapter is updated to include information about the polypharmacy safety edit for members 65 years of age or older who are on two or more anticholinergic medications at the same time.

Additional information about Part D drugs

Providers can find out more about Part D coverage at cms.hhs.gov**. This website also includes educational materials about Medicare prescription coverage for physicians and other health care professionals.

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 or the individual's Part D plan, based on information received from BCN.

Immunizations

Flu, pneumonia, COVID-19 and hepatitis B vaccines and vaccines given to treat injury or disease (for example, tetanus) are covered under Part B. Most other vaccines are covered under Part D.

Under the Inflation Reduction Act, all Part D vaccines recommended by the Advisory Committee on Immunization Practices, or ACIP, will be provided to all members at no copay. This will apply during all stages of member coverage.

Part B point-of-sale program

Pharmacies can bill BCN Advantage plans directly for certain drugs and equipment approved for coverage under the medical benefit. This includes but is not limited to nebulizer solutions, immunosuppressants and select oral cancer medications.

The point-of-sale program is only for members with medical coverage through a BCN Advantage plan. The member must pay the out-of-pocket expenses that are dictated by the member's plan.

The table below lists the types of drugs and equipment that can be procured through the point-of-sale program and the benefit under which each item is adjudicated.

Note: This information applies to BCN Advantage plans with or without prescription coverage if the member's BCN Advantage ID card for medical coverage is used.

Type of drug or equipment	Process
Antiemetics	These items are adjudicated under the correct benefit once a Part B versus Part D coverage review is complete. **Note:** For long-term care or skilled nursing facility residents without a BCN Advantage prescription drug plan, pharmacies should bill using the member's Part D plan ID card.
Continuous glucose monitor products	Requirements and options for obtaining CGM products vary depending on the member's plan. For example, most Medicare Advantage members must obtain CGM products through a participating network pharmacy while some commercial members can obtain them from a DME supplier or from a participating network pharmacy. For more information, see the document titled Continuous glucose monitor products: Frequently asked questions for prescribing providers.
Immunosuppressants	These items are adjudicated under the correct benefit once a Part B versus Part D coverage review is complete.
Nebulizer solutions	These items are automatically adjudicated as follows: • Under Part B if the member lives at home • Under Part D if the member resides in a long-term care or skilled nursing facility **Note:** For long-term care or skilled nursing facility residents without a BCN Advantage prescription drug plan, pharmacies should bill using the member's Part D plan ID card.
Oral cancer medications, select	These items are adjudicated under Part B. Prior authorization isn't required.

This chapter is updated to refer providers to the document *Continuous glucose monitor products: Frequently asked questions for prescribing providers*.

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* at MiBlueCrossComplete.com/providers.

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.

For concerns involving the discharge plan of an acute inpatient facility or a skilled nursing facility, BCN Advantage members should contact the Quality Improvement Organization, Livanta. See "Quality Improvement Organization — Livanta" for more information.

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.

All other concerns

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

BCN Advantage appeals process

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.

1. BCN Advantage standard or fast appeals process
2. Review by an independent review organization:
    - Maximus (for appeals related to medical care)
    - C2C Innovative Solutions, Inc. (for appeals related to Part D prescription drugs)
3. Review by an Administrative Law Judge
4. Review by a Medicare Appeals Council
5. Review by federal district court

Who may file a member appeal

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.

The member and the representative must sign and date a statement giving the representative legal permission to act on the member's behalf.

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:

Medical and behavioral health appeals

BCN Advantage Appeals and Grievance Unit
P.O. Box 44200
Detroit, MI 48244-0191

Fax: 1-866-522-7345

Part D appeals

BCN Advantage
Pharmacy Clinical Help Desk
Mail Code 512J

P.O. Box 441877
Detroit, MI 48244

Fax: 1-800-459-8027

Website: bcbsm.com/complaintsmedicare

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 Blue Cross or BCN medical director.

Additional requirements related to submitting a peer-to-peer request are located in the Utilization 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.

Supporting the appeal

BCN must gather all of 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:

Supporting the appeal		
Activity	**For medical appeals**	**For Part D appeals**
Mail to	BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191	BCN Advantage Pharmacy Clinical Help Desk Mail Code 512J P.O. Box 441877 Detroit, MI 48244
Fax to	1-866-522-7345	1-800-459-8027

Supporting the appeal		
Activity	**For medical appeals**	**For Part D appeals**
Telephone	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.)	

Where to file an appeal

Members and noncontracted providers can call or write BCN Advantage to request a medical or Part D prescription drug appeal within 65 calendar days of the date on the letter sent by the plan denying the initial request for services or payment.

Note: Contracted providers must submit appeals within the time frame stated in their contract.

Where to file an appeal		
Activity	**For medical appeals**	**For Part D appeals**
Mail to	BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191	BCN Advantage Pharmacy Clinical Help Desk Mail Code 512J P.O. Box 441877 Detroit, MI 48244
Fax to	1-866-522-7345	1-800-459-8027
Telephone	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.)	

This chapter is updated to clarify the time frames within which members and noncontracted providers can submit a medical or Part D prescription drug appeal.

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 Blue Cross or BCN medical director. For information on additional requirements, look in the subsection titled “Peer-to-peer review” on page 69 of this chapter. 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 Appeals and Grievance team to schedule the peer-to-peer-review.

BCN's response to standard appeals

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

Time frames for responses to standard member appeals	
Type of Appeal	**BCN's process for handling standard appeals**
BCN denied payment for medical care already received	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.
BCN denied medical care not yet received	BCN has up to 30 calendar days to make a decision but will make it sooner if the member's health condition requires it. 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.
BCN denied a Part D drug already received	BCN has seven calendar days to make the decision. If BCN approves the appeal, BCN must pay for the drug within 30 calendar days.
BCN denied a Part D drug not yet received	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.

Review by an independent review organization

If BCN's denial of an appeal is maintained:

- For appeals related to medical care: The appeal proceeds automatically to the independent review organization Maximus.
- For appeals related to Part D prescription drugs: 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 C2C Innovative Solutions, Inc.

Maximus and C2C are contracted with CMS and have no connection to BCN. The member is informed by BCN when the appeal has been forwarded to Maximus or C2C. The member has the right to obtain a copy from BCN of the case file that is sent.

Once Maximus or C2C receive the appeal, a decision is made according to the following time frames.

Maximus or C2C standard member appeals		
Type of Appeal	**Role of Maximus or C2C**	**BCN's role if Maximus or C2C decides in favor of the member**
BCN denied payment for medical care already received	Maximus has up to 60 calendar days to make a decision from the date the member's request for an appeal was received.	BCN must pay within 30 calendar days of receiving the decision.
BCN denied medical care not yet received	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.	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.
BCN denied a Part D drug already received	C2C has up to seven calendar days to make a decision from the date the member's request was received.	BCN must pay within 30 calendar days of receiving the decision from C2C.
BCN denied a Part D drug not yet received	C2C has up to seven calendar days to make a decision from the date the member's request was received.	BCN must authorize or provide the member with the Part D drug within 72 hours of receiving the decision from C2C.

Maximus and C2C provide the member with written notification of their decisions and the reasons for those decisions. BCN notifies Maximus or C2C, as appropriate, that it has implemented the decision.

Review by an administrative law judge

If Maximus (for appeals related to medical care) or C2C (for appeals related to Part D prescription drugs) 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 $190 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 or C2C. 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.

Note: If the administrative law judge rules in favor of the member, BCN Advantage can appeal the decision by asking for a review by the Medicare Appeals Council.

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:

Medicare Appeals Council member appeals	
Type of appeal	**BCN's responsibility if the council decides in favor of the member**
Medical care denial	BCN must pay for, authorize or provide the medical service within 60 calendar days from the date BCN receives notice of the decision.
Part D drug denial	BCN must reimburse the member no later than 30 calendar days or authorize or provide the Part D drug within 72 hours of the date BCN receives notice of the decision.

If the Medicare Appeals Council decides not to review the case or if they decide in favor of the denial and if the amount in controversy is $1,900 or more, the member or the member's appointed representative has the right to continue the appeal by asking a federal court judge to review the case.

This chapter is updated to reflect current practices when a member appeal is reviewed by an administrative law judge or the Medicare Appeals Council.

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:

Requesting a fast appeal		
Activity	**For medical appeals**	**For Part D appeals**
Mail to	BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191	BCN Advantage Pharmacy Clinical Help Desk Mail Code 512J P.O. Box 441877 Detroit, MI 48244
Fax to	1-866-522-7345	1-800-459-8027
Telephone	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.)	

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 ”BCN Advantage member grievances” on page 76 of 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 C2C 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.

If BCN denies any part of the fast appeal…	Then…
For a medical care appeal	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.
For a Part D prescription drug appeal	The member or the member’s authorized representative has the right to ask C2C to review the case.

Members can contact Customer Service

Customer Service can answer questions

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

Contacting BCN Advantage Customer Service	
Call	• For UAW Retiree Medical Benefits Trust members: 1-800-222-5992, 8:00 a.m. to 5:30 p.m., Monday through Friday • For behavioral health services for all BCN Advantage members: 1-800-431-1059 • For all other calls: 1-800-450-3680, 8 a.m. to 8 p.m., Monday through Friday, with weekend hours available Oct. 1 through March 31 Calls to these numbers are free.
TTY	711. This number is for the hearing impaired and requires special telephone equipment. Calls to this number are free.
Fax	1-866-364-0080
Write	BCN Advantage Mail Code A02B P.O. Box 441936 Detroit, MI 48244

In this chapter, the URMBT Customer Service hours and the mailing address for BCN Advantage Customer Service are updated.

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.

The BCN Advantage member grievance process

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 Appeals and Grievance unit. Written confirmation of the withdrawal will be provided within three calendar days of receipt.

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 by mail or by fax. The address and fax number are listed below.

- Complete an electronic callback form for a medical care concern or a prescription drug concern. These online forms can be found on the What If I Have a Complaint About My Medicare Plan? webpage at **bcbsm.com/medicare**.
- Call the BCN Advantage Appeals and Grievance unit at the number listed below.
- File a complaint (grievance) using the Medicare Complaint Form** at **medicare.gov**. Click *File a Complaint* and complete the requested information.

Filing a grievance		
Activity	**For medical grievances**	**For Part D grievances**
Mail to	BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191	BCN Advantage Pharmacy Clinical Help Desk Mail Code 512J P.O. Box 441877 Detroit, MI 48244
Fax to	1-866-522-7345	1-800-459-8027
Telephone	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.)	

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

BCN Advantage members may request an immediate review from Livanta if they disagree with the decision of an acute inpatient facility or a skilled nursing facility 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**

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 acute inpatient facilities

Member appeal rights for an acute hospital discharge

Members who are hospitalized at an acute 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.

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 *An Important Message from Medicare About Your Rights* 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.

Providers can access the *An Important Message from Medicare About Your Rights* form on the FFS & MA IM** webpage at **cms.gov**.

BCN Advantage members have the right to appeal to the QIO for an immediate review when a hospital and BCN Advantage, with physician concurrence, determine that inpatient care is no longer necessary.

Acute hospital discharge appeal process

If the BCN Advantage member is dissatisfied with the discharge plan:

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 *An Important Message from Medicare About Your Rights* notice.

2. The QIO notifies BCN Advantage that the member has requested an immediate review.
3. The facility is responsible for delivering to the member a *Detailed Notice of Discharge* 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 *Detailed Notice of Discharge* must be completed and submitted by the entity that determines that covered services are ending.

   Note: Providers can access the *Detailed Notice of Discharge* form on the FFS & MA IM** webpage at **cms.gov**.

   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.
4. 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.
5. 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.
6. 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.

Member responsibilities related to acute hospital discharges

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

If…	Then…
The QIO agrees with the doctor's discharge decision	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.

If…	Then…
The QIO disagrees with the doctor's discharge decision	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.

QIO immediate review of SNF discharges

The information in this section is updated to reflect current practices related to the QIO's immediate review of SNF discharges.

Special appeal rights for members being discharged from a SNF

BCN Advantage members receiving skilled nursing facility care have special appeal rights that allow an immediate review from the QIO if they disagree with the decision to end covered services. For members receiving services in a SNF, refer to the following resources for more information:

- The document Post-acute care requirements: Information for providers
- The document Post-acute care: NOMNC and DENC forms
- The BCN Post-Acute Care webpage at **ereferrals.bcbsm.com**

Note: For members receiving other services that may be subject to a QIO review, follow CMS guidelines. For more information, see the FFS & MA NOMNC/DENC page on **cms.gov**.*

BCN Advantage provider appeals

The provider appeal process is different for BCN Advantage than for BCN commercial

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 found in this section.

Who made the denial decision on the authorization request	What to do about provider appeals
Any entity other than the BCN Advantage Utilization Management department	Refer to the instructions in the denial letter. Do not follow the instructions outlined below.
The BCN Advantage Utilization Management department	Follow the instructions outlined below.

Overview of BCN Advantage provider appeal process, for decisions made by the BCN Advantage Utilization Management department

BCN Advantage is required by Medicare to verify that the member has been notified and approves of the appeal request submitted by the physician or other provider.

If it is not evident that the member is aware of the appeal request, BCN Advantage will reach out to the physician or other provider to gather this information. If BCN Advantage verifies the member's knowledge of the appeal request submitted by the physician or other provider, the appeal request will be processed according to the BCN Advantage five-level member appeal process.

In addition:

- Physicians and other providers who participate with BCN Advantage and who are 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 and 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.

  For the *Waiver of Liability* form:

  - Providers can access the form at **bcbsm.com/providers** > Resources > Wavier of Liability.
  - Providers must submit the signed form in one of these ways:
    - By fax: 1-866-522-7345
    - By email: bcngrievance@bcbsm.com

- By U.S. mail:

  BCN Advantage Appeals and Grievance Unit
  P.O. Box 44200
  Detroit, MI 48244-0191

Submission process and time frames for appeal resolution for decisions made by the BCN Advantage Utilization Management department

The table that follows shows how to submit appeals of denial decisions related to BCN Advantage members that were made by the BCN Advantage Utilization Management department.

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

Type of appeal	Steps in appeal process	Time frame for resolution	
Appeals by contracted providers related to inpatient admissions, including bundled admissions	The appeal is conducted according to the two-level provider appeal process described in the "Appealing utilization management decisions" section in the Utilization Management chapter of this manual.	The time frames for appeal resolution are described in the "Appealing utilization management decisions" section in the Utilization Management chapter of this manual.	
All other appeals on decisions made by the BCN Advantage Utilization Management department, for both contracted noncontracted providers	Submit the appeal to: BCN Advantage Appeals and Grievance Unit P.O. Box 44200 Detroit, MI 48244-0191 Fax: 1-866-522-7345 Phone: 1-800-450-3680 (TTY: 711)	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.

Type of appeal	Steps in appeal process	Time frame for resolution	
		Standard (non-urgent) pre-service	Within 30 calendar days from the date of receipt of the request
		Post-service	Within 60 calendar days from the date of receipt of the request

Reporting end stage renal disease

Introduction to reporting ESRD

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

BCN Advantage members cannot be denied coverage or disenrolled from the plan when they have or 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:

Step	Action
1	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.gov** and search for CMS 2728**.
2	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.
3	The physician also mails a copy of the completed form to BCN Advantage to indicate a pending change in member status. BCN Advantage Mail Code J208 P.O. Box 441010 Detroit, MI 48244-1010

Step	Action
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:

Step	Action
1	Member designates a hospice election effective date.
2	Member selects a Medicare-certified hospice program.
3	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.
4	The member's physician and the medical director or staff physician of the hospice periodically recertify the member's need for hospice care.

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 during a valid election period. As long as members are enrolled in BCN Advantage, they remain on the eligibility lists of the primary care providers 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 on page 86 of this chapter.

BCN Advantage claims processing

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 and taxonomy.
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 Box 27, the Accept Assignment field.
Medicare provider taxonomy codes	Medicare provider taxonomy codes determine how providers are reimbursed for professional services provided to BCN Advantage members. When submitting professional claims for these services, providers are encouraged to include the appropriate Medicare provider taxonomy codes.

For providers billing with a Type 2 (group) NPI

When billing BCN Advantage professional claims with a Type 2 (group) NPI, providers are encouraged to do the following:

- When billing electronically:
  - Include the Medicare taxonomy code for the billing provider in loop 2000A of the electronic 837P claim transaction.
  - Include the Medicare taxonomy code for the rendering provider, as applicable, in loop 2310B of the electronic 837P claim transaction.
- When billing with the CMS-1500 paper claim form:
  - Report the billing provider's taxonomy code and qualifier ZZ in box 33b.
  - Report the rendering provider's Medicare taxonomy code in the first row of box 24J along with qualifier ZZ in box 24I.
  - Report the rendering provider's NPI in the second row of box 24J.

Including the Medicare taxonomy code for both the rendering provider and the billing provider on professional claims billed with a Type 2 (group) NPI helps ensure that the claims can be processed accurately and in a timely manner. It also meets the requirements of the Affordable Care Act and the Centers for Medicare & Medicaid Services.

For providers billing with a Type 1 (individual) NPI

When billing BCN Advantage professional claims with a Type 1 (individual) NPI, providers are encouraged to do the following:

- Include the Medicare taxonomy code for the billing provider in loop 2000A of the electronic 837P claim transaction.
- Report the billing provider's taxonomy code and qualifier ZZ in box 33b of the 1500 paper claim form.

For additional information

For more information about Medicare provider taxonomy codes, refer to the Find Your Taxonomy Code** webpage at **cms.gov**.

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.

Comprehensive Explanation of Benefits statement

All BCN Advantage members who have services, receive a comprehensive EOB that includes all BCN Advantage medical, hospital, durable medical, dental and vision services, Part B drugs and other ancillary services, whether the claim is paid by BCN, Blue Cross or an external vendor.

If the member has the BCN Advantage Optional Supplemental 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
- Amount of deductibles met, if applicable
- All claims submitted to BCN Advantage

The EOBs are sent to members on a monthly basis if they have services, so members may receive a bill from their provider before they receive the EOB.

BCN Advantage claims payment process for paper claims that are not clean

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% 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.

Claims received more than 365 days from the date of service will not be eligible for late payment interest as defined in 2004 PA 28. 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*.

Behavioral health integration services

For guidelines on billing behavioral health integration services, refer to the Claims chapter of this manual. Look in the section titled “Billing guidelines for behavioral health integration services.” The information found there applies to both BCN commercial and BCN Advantage members.

Ambulatory surgery center claims

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 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 refer to the billing instructions for multiple-line surgery, ASF, in the Secure Provider Resources area of our provider portal (availity.com**). On the Billing and Claims menu, select *BCN and BCN Advantage*; scroll down and look under the Facility Claims – Billing Instructions heading.

Obstetrical care

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 in the Secure Provider Resources area of our provider portal (availity.com**); on the Billing and Claims menu, select *BCN and BCN Advantage.*

Chiropractic services

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 MLN Matters® Number SE1602**.

Billing ground ambulance mileage amounts

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 commercial and BCN Advantage members.

Reimbursement for therapy services

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.

Advance care planning services

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. Advance care planning services for BCN Advantage members are billed the same way as for Original Medicare.

Laboratory services

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

Setting	How to submit claims for laboratory services	
Physician office setting	In office setting 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. If submitting via a CMS-1500 form, the claim 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.	BCN Advantage / Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516- 8753

Setting	How to submit claims for laboratory services	
Non-office setting	Submit all CMS-1500 paper claims for labs performed in an ER, inpatient, observation or urgent care location to the BCN address shown at the right. Send all other laboratory services claims electronically (837P) to JVHL.	
Outpatient hospital setting	For laboratory services in an outpatient hospital setting, use the following guidelines from the CMS *MLN Matters* article MM8572** in determining how to bill: 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: (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; (2) 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** (3) 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. 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. 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.	

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:

HCPCS code	Vaccine product administered
Q2035	Afluria®
Q2036	FluLaval®
Q2037	Fluvirin®
Q2038	Fluzone®
Q2039	Not otherwise specified vaccine

  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.

Immunization: Medicare Part D vaccines

Providers should bill for immunizations under Medicare Part D as follows:

- If the vaccine is administered from the physician's stock:
  - 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).
  - The member should remit payment to the physician.

- The member should then submit proof of payment and a Medicare PART D Claim Form to BCN. The member must include both the NDC and the quantity administered (ml) on the reimbursement form.

- If a member-specific vaccine is supplied to the physician from outside the office and is administered by the physician:
  - The physician should bill the member for the administration fee.
  - The member should remit payment to the physician.
  - The member should then submit proof of payment for the administration and an Optum Rx reimbursement form to BCN.

  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.

Reimbursement for comprehensive opioid treatment programs

BCN commercial, BCN Advantage, Blue Cross commercial and Medicare Plus Blue℠ are using bundled rates to reimburse providers who offer certified opioid treatment programs, or OTPs.

For information on this, refer to the Claims chapter of this manual. Look in the section titled "Reimbursement guidelines for providers who offer comprehensive opioid treatment."

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 infusion therapy claims

For home infusion therapy claims, BCN Advantage follows original Medicare guidelines, which show the following:

- For home infusion medications that require an external infusion pump to administer (along with other ancillary items such as equipment, supplies and nursing services), providers should bill the member's Part B benefits.
- For home infusion medications that are not administered using an external infusion pump, providers should bill the member's Part D benefits.

The *BCN Advantage HIT Fee Schedule* shows what BCN Advantage reimburses for services within the home infusion therapy enhanced benefit. Fees for all other HIT-related covered services are reimbursed at Medicare rates.

Blue Cross and BCN commit to the timely implementation of changes to Medicare rates. However, claims will not be adjusted retroactively for such changes. Covered services that are not priced by CMS or the applicable regional Medicare Administrative Carrier, or are not priced on the *BCN Advantage HIT Fee Schedule*, will be paid at 65% of the billed charges, less any applicable copayments.

Providers can request a copy of a BCN fee schedule by sending an email to feeschedule@bcbsm.com. Refer to the "BCN commercial and BCN Advantage fee schedules" subsection in the Claims chapter for more information.

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

This chapter is updated to show that the *BCN Advantage HIT Fee Schedule* shows what BCN Advantage reimburses for services within the home infusion therapy enhanced benefit. Fees for all other HIT-related covered services are reimbursed at Medicare rates.

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.

Billing inpatient experimental and investigational drugs

For information about billing experimental and investigational drugs in an inpatient setting, refer to the Claims chapter of this manual. Look in the section titled "Other billing and payment guidelines."

Billing inpatient blood gas analysis by point-of-care testing

For information about billing blood gas analysis by point-of-care testing in an inpatient setting, refer to the Claims chapter of this manual. Look in the section titled "Other billing and payment guidelines."

Billing inpatient respiratory services

For information about billing respiratory therapy services in an inpatient setting, refer to the Claims chapter of this manual. Look in the section titled "Other billing and payment guidelines."

SNF and home health claims must include a code generated by CMS

For SNF and home health claims for BCN Advantage members, providers must include a code generated by the Centers for Medicare & Medicaid Services, as follows:

- For BCN Advantage members admitted to skilled nursing facilities, providers must include the patient-driven payment model, or PDPM, code.
- For BCN Advantage members receiving home health care services, providers must include the patient-driven groupings model, or PDGM, code.

BCN Advantage performs post-payment audits for these codes and for other billing requirements.

Clinical and device trials

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

Type	Guidelines
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% 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. BCN Advantage members don't need prior authorization to participate in a clinical study.
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. Inpatient services do require prior authorization. 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

Type	Guidelines
	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."

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 on the Medicare Part B Drug Average Sales Price** webpage.

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 an NOC code for the medical services you’re billing, you must include a description of the service on the claim.

Prior 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.

Carrier-priced codes

BCN Advantage follows CMS guidelines when establishing reimbursement for procedure codes that CMS lists as carrier priced. This applies to services for BCN Advantage members.

Definition of a carrier-priced code

A carrier-priced code is a CPT* or HCPCS code that has a specific description but for which CMS has not identified a fee. Carrier-priced codes are included in the Medicare Advantage Professional Fee Schedule.

When there’s no fee identified by CMS, BCN Advantage establishes the reimbursement for carrier-priced codes using the process outlined below.

Process for establishing the reimbursement for a carrier-priced code

BCN Advantage follows these steps in the order listed below, to establish reimbursement for a carrier-priced code:

1. BCN Advantage looks at the fees published by one of these jurisdictional Medicare Administrative Contractors, or MACs:
    - Wisconsin Physician Services Government Health Administrators is the jurisdictional MAC providing Part A and Part B benefit administration for Indiana and Michigan. They publish the local carrier fees for professional services.
    - CGS Medicare, which publishes local carrier fees for durable medical equipment
2. If BCN Advantage doesn’t find a fee published by one of those jurisdictional MACs, it looks at the BCBSM TRUST fee schedule.
3. If BCN Advantage doesn’t find a fee in the BCBSM TRUST fee schedule, it bases its reimbursement on a percentage of the billed charges, as defined in the provider agreement.

Additional information about carrier-priced codes

The Health Plan Medicare Advantage Professional Fee Schedule reflects locally adjusted reimbursement amounts established by CMS. BCN Advantage commits to timely implementation of any changes to its fee schedules based on changes to the CMS fee schedule, including carrier-priced codes, for reimbursement of services to BCN Advantage members. BCN Advantage doesn't retroactively adjust reimbursements to reflect these changes.

BCN Advantage Fee Schedule for Professional Services

The *BCN Advantage Fee Schedule for Professional Services* shows what BCN Advantage reimburses for professional services. This fee schedule includes rates for enhanced benefits and for carrier-priced codes.

When a service has a fee schedule amount listed on the *BCN Advantage Fee Schedule for Professional Services*, it doesn't guarantee that the member has coverage for that service.

To access the *BCN Advantage Fee Schedule for Professional Services*:

1. Go to bcbsm.com/providers.
2. Click *Resources*.
3. Under the "Key forms and documents" heading, click *View All*.
4. Under the "Medicare Advantage" heading, locate the BCN Advantage Fee Schedule for Professional Services document and click to open it.

BCN Advantage enhanced benefit policies

BCN Advantage provides at least the same level of benefits as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This means that BCN Advantage can offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

There's a policy document available for each enhanced benefit offered with the BCN Advantage individual plans. In addition to other types of information, the policy documents include some or all of these:

- A description of the benefit that Original Medicare offers along with a description of the enhanced benefit offered by BCN Advantage
- Excluded services
- Information about the conditions that must be met for payment
- Information about reimbursement and member cost-sharing
- Billing instructions

To access the BCN Advantage enhanced benefit policies:

1. Go to bcbsm.com/providers.
2. Click *Resources*.
3. Under the "Key forms and documents" heading, click *View All*.
4. Under the "Medicare Advantage" heading, click the BCN Advantage Enhanced Benefit Policies link.

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.

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**
- In the Claims section of the Blue Cross Complete Provider Manual. Look in the subsection titled “How to bill for dual-eligible members”. This applies only to dual-eligible members who have coverage through Blue Cross Complete.

This chapter is updated to show that providers can find additional information about billing dual-eligible members in the Blue Cross Complete Provider Manual.

Health care fraud, waste and abuse

Detecting and preventing fraud, waste and abuse

BCN (for BCN commercial and 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, or CFI, department; the corporate compliance officer; the Medicare compliance officer; or the Fraud Hotline.

Providers can report fraud, waste and/or abuse in one of these ways:

- Email CFI: StopFraud@bcbsm.com

- Call the Fraud Hotline: 1-844-STOP-FWA (844-786-7392)
- Visit the Report Health Care Fraud webpage at **bcbsm.com**

The reports may be made anonymously.

This chapter is updated to include the ways providers can report fraud, waste and/or abuse.

What is fraud?

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

Examples of fraud

Examples of fraud include:

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

What is waste?

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

Examples of waste

Examples of waste include:

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

What is abuse?

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

Examples of abuse

Examples of abuse include:

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

Repayment rule

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

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

Payment adjustments

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

For more information, refer to the Claims chapter of this manual, in the section titled "Clinical editing denials."

This chapter is updated to show that efforts to detect and prevent fraud, waste and abuse are carried out by BCN on behalf of both BCN commercial and BCN Advantage.

This chapter is updated to show that payment adjustments for clinical editing denials occur pre-pay.

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 provider.

Emergency care, urgent care and transportation are covered worldwide for BCN Advantage members.

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

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 provider within 48 hours of emergency admission.

BCN covers post-stabilization care according to Medicare guidelines. BCN Advantage Utilization Management department staff and the primary care provider 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

Care outside of Michigan covered 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 while traveling out of state.

BCN Advantage HMO-POS members can receive covered services from providers who participate with Blue Cross Blue Shield 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 travel benefit are subject to a 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 and BCN Advantage Local HMO members do not have the out-of-network point-of-service coverage benefit. For these members, all services must be provided by the designated network of identified providers associated with the product, with the exception of medical emergencies (including emergency dialysis) and urgently needed care, which are covered worldwide. BCN Advantage HMO ConnectedCare and BCN Advantage Local HMO do not offer a travel benefit for follow-up care for existing conditions.

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 provider, all members assigned to that provider 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.

Financial and Eligibility reports

BCN makes the following financial and eligibility reports available electronically via an electronic mailbox:

- Member eligibility
- 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 provider or prescribing physician, depending on the situation.

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