MSMS MICHIGAN STATE MEDICAL SOCIETY Reimbursement Advocate Alert

BCBSM has a new fax number for requesting practice profiles

Practice profiles for professional providers in the PPO TRUST and Traditional networks are available by mail, fax and email. BCBSM recently changed the fax number and it's listed below.

To request copies of practice profiles, use one of the following methods to provide your name, signature, address and Blue Cross Blue Shield of Michigan provider ID number:

Mail:

Information Management - Mail code J426
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Fax: 1-866-297-0983

Email: IMPRPProfileRequest@bcbsm.com

As a reminder, practice profiles requested by email can be sent either from the physician's personal or business email address, but they must have the physician's electronic signature.

Profiles are based on 12 months of paid claims data. Updated data is available every six months as follows:

- Full-year profiles (Jan. 1 to Dec. 31) are available in March of the following year.
- Mid-year profiles (July 1 to June 30) are available in September of the current year.

If your request is received just before new data becomes available, the request will be honored once that data is available. Follow-up inquiries may be faxed to the new number provided above.

Reminder: ClaimsXten™ to perform multiple radiology reduction for professional radiology services

Effective first quarter 2016, when a member receives multiple radiology services on the same date, Blue Cross Blue Shield of Michigan will pay for the first one at the highest allowed amount. Subsequent procedures will be paid at 75 percent of the allowed amount.

The appropriate modifier may be appended to indicate the subsequent service(s) are separate and distinct.

BCBSM enhancing claims processing systems to link medical records and claims

Blue Cross Blue Shield of Michigan and Medicare Advantage are enhancing their claims processing systems to better support instances where they require medical records in order to finalize a professional or institutional claim service. BCBSM expects that they will be able to systematically link a medical record to its corresponding claim before the end of 2016. **Note:** Blue Care Network, FEP and BlueCard® claims are

excluded from these changes. However, FEP will participate in the use of the *Medical Record Routing Form*.

Medical records are the supporting clinical documentation (e.g., patient history, lab results and medical reports) that cannot be sent as part of or within the electronic claim (the 837 transaction).

Implementation of this linkage capability will require the following:

- When Blue Cross or Medicare Advantage requires additional documentation (medical records) to finalize a claim service, the electronic claim must indicate that medical records are being sent (the PWK segment of the 837). If the electronic claim doesn't indicate additional documentation is being sent, the service will automatically reject.
- When Blue Cross or Medicare Advantage requires additional documentation (medical records) to finalize a claim -- and you have indicated on the 837 that the information is being sent -- it must be received within seven days of the electronic claim receipt. If the medical records aren't received within seven days, the service requiring documentation will be rejected.
- BCBSM will be expanding the current use of the *Medical Record Routing Form* to allow for the submission of medical records related to an original electronic claim for Blue Cross Blue Shield of Michigan, Medicare Advantage and FEP members. The form will be updated to include the new information required for these types of claims.

BCBSM will include additional information about this new capability in future issues of *The Record*.

New NDC daily quantity maximum messaging begins in January

The daily quantity maximum is the number of units a National Drug Code can be billed on a single claim line for a particular date. Starting Jan. 1, 2016, when an NDC reaches or goes over its daily quantity maximum, you'll receive a new message on your provider voucher:

BCBSM can pay for this service, but their payment policy has limits for this National Drug Code. This drug claim has a daily quantity maximum that's more than BCBSM can pay. BCBSM have based their payment and the member's liability on the eligible limit amount. (P610)

For example, if an NDC's quantity maximum is five per date of service and 15 are coded, the message will also say that there's been an adjustment in the reimbursement. Payment will be made for the first five units only.

A participating provider shouldn't ask the member to pay more than the amount BCBSM allows.

Complete Coding Updates for 2016

December 10, 2015
1:00 - 4:00 p.m.
MSMS Headquarters - East Lansing

The new CPT codes are out for 2016. Which ones affect your practice coding? Which ones affect your practice reimbursement? Are there any Medicare comments on the new codes? What other Medicare updated information is available in these last days before the new year and their implementation? Come and hear the most up to date information on the new CPT codes to be used January 1 and information about the ICD-10 codes you should have been using for the past two months.

Jill Young, CPC, CEDC, CIMC, will provide an overview of all of the 2016 changes to CPT and HCPCS.

Who Should Attend

This course is intended for billers, coders, office managers, billing managers, and physicians.

Fees

MSMS Members/Office Staff: $135
Non-Members: $185

Details & Registration >>

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