Blue Cross complete of Michigan

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CONNECTIONS

January/February 2026

Contents

HIV pharmaceutical prevention tools available for patients

The Centers for Disease Control and Prevention has published new clinical guidance* recommendations endorsing the use of the twice-a-year injectable lenacapavir as an additional option for HIV prevention in the United States. This update expands the portfolio of available HIV prevention tools and provides another option for individuals who may benefit from long-acting treatment alternatives.

The U.S. Food and Drug Administration approved lenacapavir in June 2025. Lenacapavir may be particularly useful for individuals who have difficulty adhering to daily oral regimens or who prefer less frequent treatment.

The clinical recommendations for lenacapavir are an addition to the CDC's current clinical guidance for PrEP, which includes daily oral pills, and injectable cabotegravir, which is administered every two months.

Health care providers are encouraged to inform all sexually active adults and adolescents about proven options for PrEP, and prescribe PrEP to anyone who requests it. Prior to initiating HIV prevention drugs, providers must confirm a negative HIV test and follow standard clinical assessment protocols.

Important coverage information for providers

Effective November 1, 2025, no pharmacy copayment will be charged to members for prescription drugs used to help prevent HIV infections. This update applies to HIV prevention drugs PrEP and HIV post-exposure prophylaxis, or PEP. The MDHHS issued Bulletin MMP 25-44* on September 30, 2025, designed to remove financial barriers to these type of drugs, increase access to care and support Michigan's Equitable Plan,* aimed at reducing HIV infections. This plan is an effort to reduce new HIV infections by 90% by 2030 through increased diagnosis, treatment, prevention and coordinated response.

Drugs that are exempt from pharmacy copayment requirements will be identified on the Michigan Pharmaceutical Products List as "no" under the copay column. The MPPL can be found at mi.primetherapeutics.com.

CAHPS survey going out to members

As a part of our NCQA accreditation, Blue Cross Complete sends the Consumer Assessment of Healthcare Providers and Systems survey each year to randomly selected members.* It asks them a series of questions about their experiences with their health plan and health care for the previous year. The survey will be distributed in February 2026.

See examples below. Here are some of the questions in the CAHPS survey:

- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often did your personal doctor listen carefully to you?
- In the last six months, how often did your personal doctor show respect for what you had to say?
- In the last six months, how often did your personal doctor spend enough time with you?
- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

Encourage your patients to complete the survey as it gives us a better understanding about where we perform satisfactorily and what areas need improvement. If you have any questions about the CAHPS survey, contact your Blue Cross Complete provider account executive.

*Our website is mibluecrosscomplete.com. While website addresses for other organizations are provided for reference, Blue Cross Complete does not control these sites and is not responsible for their content.

Health care providers can strengthen patient-doctor relationships

Effective communications and mutual trust between patients and doctors are fundamental to delivering quality health care.

Yet, challenges, such as time constraints, health disparities and the increasing reliance on technology can strain these relationships. Experts are emphasizing strategies to enhance patient-doctor relationships, with a goal of fostering better health outcome and improving patient satisfaction.

According to the Center for Advancing Health, patients who have good working relationships with their physicians tend to be more active in their own health care.* These patients are more likely to maintain regular doctor visits, monitor their health, exercise more, make positive dietary changes and stick to medication regimens.

Here are some ways health care providers can help improve doctor-patient relationships:

1. Prioritize clear and compassionate communication: Patients often report feeling unheard or rushed during medical visits.[1] Doctors are encouraged to adopt active listening techniques, allowing patients to share their concerns completely. Summarizing key points and asking clarifying questions can help ensure mutual understanding between doctors and their patients.[2]

2. Embracing shared decision-making: Including patients in their own care decisions has been shown to improve patient satisfaction and adherence to treatment plans.[3] Shared decision-making involves discussing all options, addressing risks and benefits and respecting patients' preferences.

3. Leverage technology thoughtfully: The rise in telemedicine and digital health records offers many benefits to the health care industry, while also introducing some challenges. These challenges include a lack of face-to-face doctor-patient interaction. To avoid this, physicians must look for ways to balance screen time with patient interaction during visits and use technology to enhance, rather than replace personal connections.

4. Address cultural and language barriers: It's key for providers to recognize the importance of cultural competences by offering translation services, understanding cultural sensitivities, and showing interest and respect for diverse beliefs, which can strengthen doctor-patient relationships. Blue Cross Complete provides free language services to members who don't speak or understand English or who are deaf or have difficulty hearing.

5. Continuity of care: Establishing long-term relationships between patients and their doctors fosters familiarity and trust. Medical practices can improve continuity of care by developing ways to ensure patients can see the same doctor or team of doctors consistently. A study published in the Journal of Family Practice found that continuity of care increases patient satisfaction, improves quality of care and reduces hospitalizations and emergency room visits, especially for those with chronic health conditions.*

Health care professionals can implement these strategies to build a better patient-centered approach. Patients can also play a role in improving doctor-patient relationships by preparing for appointments, being honest about health concerns and providing feedback. For more information on establishing good patient-doctor relationships, review standards and guidelines outlined by the American Medical Association.*

Citations:

1. Tongue J. R., Epps H. R., Forese L. L. Communication skills for patient-centered care: research-based, easily learned techniques for medical interviews that benefit orthopedic surgeons and their patients. J Bone Joint Surg Am. 2005;87:652–658.

2. Stewart M. A. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995;152((9)):1423–1433.

3. DiMatteo M. R. The role of the physician in the emerging health care environment. West J Med. 1998;168((5)):328–333.

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Winter months can cause increase in prior authorization requests

During the colder months, medical practices often see an increase in the number of prior authorization requests for antibiotics, cold, flu and RSV medications. This rise in authorizations is typically due to changes in prescription coverage, updates to drug lists and renewal criteria.

You can help ensure your patients receive the medicine they need in a timely manner by taking advantage of the NaviNet platform, which is cost-free for health care providers and staff. Through NaviNet, health care providers can access and electronically submit:

- Prior authorizations
- Real-time clinical Healthcare Effectiveness Data and Information Set alerts
- Claims information and updates
- Member eligibility information
- Benefit information
- Drug authorizations

Health care providers can register for a NaviNet account at **register.navinet.net**.* If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete's Provider Inquiry at **1-888-312-5713**.

Protecting and treating patients with RSV

As respiratory syncytial virus, or RSV, continues to impact populations nationwide, health care providers play a critical role in protecting and treating patients. Groups, such as infants, children, older adults and those with underlying health conditions are particularly vulnerable.

RSV is highly contagious and causes respiratory infections ranging from mild cold-like symptoms to severe illnesses, such as bronchiolitis and pneumonia. Most people recover in a week or two, but RSV can be serious. According to the **Centers for Disease Control and Prevention**, it's the leading cause of hospitalization among young children and can exacerbate conditions, such as asthma and chronic obstructive pulmonary disease, or COPD, in adults.*

With seasonal surges typically occurring in the fall and winter, and peaking in January or February, health care systems often face increased patient workloads, making prevention and early intervention vital. Blue Cross Complete provides the following vaccine coverage for RSV to enrolled members:

- Arexvy and Abrysvo vaccines are available to members and have shown promising results in reducing severe cases. Arexvy is limited to members 60 years and older. Abrysvo is available to members under the age of 60, including infants and children.
  - Coverage is also available for pregnant members at 32 through 36 weeks gestational age for the prevention of RSV in infants from birth through six months.
- Nirsevimab, a monoclonal antibody, can be given to infants postnatally for prevention of RSV. In all infants younger than eight months who are born during the RSV season or are entering their first RSV season, the CDC recommends one dose of **nirsevimab*** prophylaxis rather than no prophylaxis unless the birthing parent received the RSV vaccination at least 14 days prior to birth.

The CDC recommends all babies be protected from severe RSV by one of two immunization options: Abrysvo or Nirsevimab. Most babies don't need both.

In addition, health care providers are encouraged to discuss preventive options with patients and caregivers. These options include reinforcing the importance of frequent handwashing, covering coughs and avoiding close contact with sick individuals. Medical professionals are encouraged to identify high-risk patients, including premature infants, individuals with weakened immune systems and older adults with chronic health conditions to provide tailored advice to mitigate exposure risks.

While RSV prevention and treatment requires a coordinated approach, health care providers are at the front-line of RSV management, with opportunities to make a lasting impact through prevention, early treatment and evidence-based treatment strategies. For more information about RSV, go to **michigan.gov/mdhhs***

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Electronic Visit Verification requirements for home health service providers

Effective January 1, 2026, the Michigan Department of Health and Human Services will require all home health care providers to submit claims to Medicaid Health Plans through the Electronic Visit Verification, or EVV, process for home health care services.

EVV is a technology-based validation of personal care services or home health care services provided. It is designed to help ensure that beneficiaries receive their expected care, and helps ensure compliance with federal and state requirements.

Under the MDHHS's Bulletin **MMP 24-11**,* released in February 2024:

- EVV services must be billed through the state's EVV system only, **HHAeXchange**, starting January 1, 2026.
- Home health care providers must electronically verify visits, including details such as date, time, service type and person performing the service.
- Home health care agencies can use their own EVV system, or the state-sponsored EVV solution through **HHAeXchange**.*
- Home health care agencies are responsible for training their employees and caregivers, and managing their agency's provider portal.
- Home health care agencies are urged to comply with reporting standards to avoid potential penalties or service disruptions.

For questions or help, call HHAX at **1-866-576-1179**. To learn more about using your HHAX agency portal and learning EVV at your own pace, sign-up for the **HHAeXchange University**.* To stay up to date on EVV in Michigan, visit **Michigan.gov/EVV**.*

If you have additional questions, contact your Blue Cross Complete provider account executive or call the Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

Blue Cross Complete offers care management and special programs

At Blue Cross Complete, our care management services can help your patients and their families manage medical conditions, avoid duplication of services and reduce the need for costly medical care.

Our care management team can support members and health care providers by:

- Identifying and addressing members' barriers to care
- Identifying and addressing health or social risk factors
- Connecting members to health care services and community resources
- Developing plans for care management

Members, caregivers and doctors can refer members to care management programs. Referrals aren't required for access to care management services.

Special programs

Blue Cross Complete offers special programs that foster improved health and well-being. If a member has a chronic condition, our disease management and complex care programs can offer assistance. Members don't need a referral for these programs. Members, doctors or caregivers can request to be part of these programs. For more information about these programs, go to **mibluecrosscomplete.com**.

Blue Cross Complete's special programs include direct contact with members by phone, online or in person, to offer self-management support, health education or care coordination. Texting is also available to all members who enroll in care management.

Encourage your patients to learn more about how Blue Cross Complete's special programs can support their needs by calling **1-888-288-1722**. TTY users, call **1-888-987-5832**.

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MC3 program expands access to mental health services

Blue Cross Complete is working alongside the Michigan Department of Health and Human Services to address the rising need for mental health support through the Michigan Child Collaborative Care program.

The MC3 program seeks to enhance access to psychiatric support for children, adolescents, young adults through age 26. It also supports pregnancy and postpartum women in Michigan by partnering with primary care providers and obstetricians who provide care to patients with behavioral health concerns.

Many women and children with mental health condition go untreated, making the MC3 program even more vital throughout Michigan, according to a study by the University of Michigan, published in the **JAMA Pediatrics**.

Launched as a response to the growing mental health crisis, MC3 provides real-time access to child and adolescent psychiatrists, behavioral health consultants and perinatal psychiatrists. These experts support PCPs in managing mental health needs by ensuring patients receive timely, evidence-based care within their communities.

How does it work?

The program has a collaborative model. When a primary care provider encounters a patient with mental health needs that exceed their expertise, they can consult with MC3 professionals. This support may include:

- Case consultations: Providers can receive no-cost, same-day guidance from psychiatrists by phone or video calls.
- Training and resources: Providers gain access to resources on best practices for diagnosing and managing mental health conditions. MC3 can connect patients to local resources and services when necessary, ensuring comprehensive care that extends beyond the primary care office.
- Pregnant and postpartum people in Wayne, Oakland, Macomb, Genesee, Ingham and Washtenaw counties can refer themselves to MC3 for services.

The MC3 program is a beacon of hope for many Michigan families, proving that collaborative, accessible mental health care is possible. For more details and to sign up, visit **mc3michigan.org** or call **1-844-828-9304**.*

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The HEDIS Corner

It's HEDIS medical record review time: Guidelines to a successful review

The annual Healthcare Effectiveness Data and Information Set® reporting period is just around the corner, and we need your cooperation with our efforts to collect medical record data.

HEDIS is a performance measurement tool coordinated and administered by the National Committee for Quality Assurance and used by the Centers for Medicare & Medicaid Services for monitoring the performance of managed care organizations. Results measure performance, identify quality initiatives, and provide educational programs for providers and members.

You play a central role in promoting the health of your patients, and you and your staff can help facilitate the HEDIS review process by:

- Providing appropriate care within the designated HEDIS time frames
- Documenting all care in the patient's medical record. Examples of medical record documentation to ensure HEDIS compliancy:
  - Documentation of a BMI for members 3-17 years of age must be documented as a distinct percentile (for example, 85th percentile) or on an age growth chart.
  - Documentation of a patient's A1c should include the date of service and the result.
- Accurately coding all claims. **Note:** CPTII codes need to be billed based on resulted date of test
- Responding to our request for medical records in a timely manner

We have contracted with Reveleer to assist with the annual medical record review process. Reveleer — trained in medical record retrieval for HEDIS, CMS and state quality reporting programs of managed care organizations — is required to comply with Health Insurance Portability and Accountability Act privacy requirements throughout the retrieval process. This data collection is permitted under HIPAA legislation.

Covered entities, including health plans and providers, are permitted to use and disclose protected health information to conduct treatment, payment or health care operations in accordance with HIPAA Privacy Rule (45 C.F.R. §164.502 (a)(1)(ii)).

We appreciate your cooperation with this important quality initiative. If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete's Provider Inquiry at **1-888-312-5713**.

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Drug list resources available for Blue Cross Complete

Drug list details

A comprehensive drug list for Blue Cross Complete is available on our website at mibluecrosscomplete.com under the Providers tab.

1. Click **Resources**
2. Click on the **Pharmacy Resources** tab
3. The drug list can be accessed and reviewed in two ways:
   - A printable PDF version is available by clicking on the Preferred Drug List (PDF) link.
   - You can also search by clicking the online drug list link.

The searchable version provides additional details about quantity limits, prior authorization and other coverage details not available on the printable version. This includes guidance on specialty medications.

The Blue Cross Complete drug list is generic-friendly. There are instances for which the Michigan Department of Health and Human Services mandates that a brand is preferred and must be used. This information can be found at mi.primetherapeutics.com.*

1. Click **Documents**
2. Click **Other Drug Information**
3. Click **Brand Preferred Over Generic Products List**

Otherwise, if a generic equivalent is available for a brand-name medication, claims processing will require that the generic equivalent be dispensed for the medication to be covered.

When a nonformulary drug or a formulary drug that has a nonpreferred status is inadvertently prescribed, prescribers and pharmacists are encouraged to work together to convert to a preferred drug, when appropriate.

HCPCS codes list

Prior authorization for health care common procedure coding system medications is required before they are covered by Blue Cross Complete. A list of HCPCS codes is available on our website at mibluecrosscomplete.com under the Providers tab.

1. Click **Prior Authorization Resources**
2. Scroll down to **Prior Authorization Lookup**
3. A printable PDF version is available by clicking on HCPCS PA List (PDF).

Clinical edits

Various clinical edits, including prior authorization, step therapy, quantity limits and age limits are included on the drug list for specific medications. Prior authorization and step therapy criteria are available on the state of Michigan's website at michigan.gov/mcopharmacy.*

It's important to remember that plans may be less stringent than the posted criteria for certain medications or non-PDL classes.

Quantity limits and age limits are established for some medications on the drug list. Quantity limits, or dose optimization edits, are typically established in line with approved dosing schedules. If an elevated dose is required above the approved quantity, the prior authorization process should be followed.

Age limits can be established for multiple reasons. Typically, age limits are implemented to reinforce safety protocol or to help refer a member to a more cost-effective dosage form, such as the use of a tablet for an adult rather than a liquid. In the event that a preferred dosage form isn't medically appropriate, the prior authorization process should be used.

As part of the prior authorization process, providers should complete the Blue Cross Complete Medication Prior Authorization Request or submit their request online. The online version helps to increase efficiency and, depending on the information provided, the system is able to provide an immediate decision for select medications.

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To complete the online form or download the fax form:

1. Visit mibluecrosscomplete.com.
2. Click the **Providers** tab.
3. Scroll to **Prior Authorization Lookup**.
4. For the online form, select Medication prior authorization online form.
5. For the printable fax form, select the Medication prior authorization request form (PDF).

The online medication prior authorization form allows for paperless and secure data and document submission. If you prefer to use the PDF version, complete and fax it to **1-855-811-9326**. You can also call the PerformRx℠ Provider Services help desk at **1-888-989-0057**.

A prior authorization form must be fully completed and submitted with all appropriate documentation that may help us process the request. For example, you must include medical history, previous therapies tried and additional rationale. Incomplete forms or missing documentation may delay or prevent a request from being processed.

Electronic prescribing

Since January 1, 2023, Michigan prescribers have been required to electronically transmit all prescriptions for controlled and noncontrolled substance medications to pharmacies. Originally set for October 1, 2021, the Michigan Department of Licensing and Regulatory Affairs moved the deadline to align the state's e-prescribing requirement with the Centers for Medicare & Medicaid Services' similar requirement, pursuant to authority provided in MCL 333.17754a(10)* and per Public Acts 134*, 135* and 136* of 2020.

Although October 1, 2021, marked the implementation date for the federal requirement, CMS won't begin enforcing compliance with the rule until January 1, 2023. As of this date, prescribers who aren't compliant will be penalized. For more specific information about the Michigan EPCS ruling, see Section 17754a of the Public Health Code,* as well as Senate Bill 248* and Senate Bill 254* from the Michigan legislature, which detail the electronic prescribing requirements and exemptions.

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Drug list changes

Drug list changes approved by the Common Formulary Workgroup, the MDHHS Fee-For-Service Pharmacy & Therapeutics Committee or the AmeriHealth Caritas Pharmacy & Therapeutics Committee are available by doing the following:

1. Visit mibluecrosscomplete.com.
2. Go to the **Provider** tab, and then click the Resource tab.
3. Scroll to the bottom of the page to the **Pharmacy Resource** tab to view **Preferred Drug List** and **online drug list**.

Depending on the type of drug list change, various forms of communication may be used.

Communication strategies may include letters, fax blasts, web documents and provider portal posts. Any necessary communication will be completed as early as possible prior to the implementation of a change. Most direct communications will be the result of a negative drug list change, such as the removal of a medication from the drug list or the addition of a clinical edit. You can anticipate that changes will occur at least quarterly. Additional changes may occur throughout the year to address population need changes or to accommodate new FDA-approved medications or indications.

Medical exception process

In the event that a nonpreferred or nonformulary drug is most appropriate for the member, the prior authorization process allows for a potential coverage consideration. As required, all formulary drugs listed on the Blue Cross Complete drug list are represented on the *Michigan Pharmaceutical Product List* for fee-for-service Medicaid. Although not all medications from the list are included on the plan's formulary, all medications on the MPPL must be considered for coverage under the pharmacy benefit. As with some nonpreferred formulary drugs, nonformulary drugs covered on the MPPL may be available through the prior authorization process.

Typically, if drug list criteria have been met and the preferred formulary drugs have failed or aren't medically appropriate, then a nonpreferred or nonformulary drug may be considered for coverage.

Again, all supporting documentation must be submitted for us to consider covering a nonpreferred or nonformulary drug.

Carve-out medications

The state of Michigan has carved out a portion of the Blue Cross Complete pharmacy benefit. The medications listed below are covered under the fee-for-service portion of the benefit.

- Anti-anxiety
- Antidepressants
- Anti-epileptics
- Anti-hemophilic factors
- Anti-retrovirals for the treatment of HIV
- Antivirals for hepatitis C treatment
- Barbiturates
- Cystic fibrosis transmembrane conductance regulator agents

Note: Instead of billing Blue Cross Complete for the medications, the pharmacy must bill fee-for-service Medicaid, also known as the Prime Therapeutics. Pharmacies will be alerted in a reject message if they submit a claim to Blue Cross Complete for a carve-out medication. For claims questions associated with these medications, contact the Prime Therapeutics clinical call center at 1-888-277-551.

You can also find additional information on the state of Michigan's fee-for-service drug coverage at mi.primetherapeutics.com.*

Out-of-pocket cost — pharmacy benefit

To prevent a potential barrier with medication affordability, Blue Cross Complete members don't have copayments at the pharmacy. Healthy Michigan Plan members are the only group with an out-of-pocket cost requirement. The copay tier is established by MDHHS and cost is reconciled through the member's MI Health account. More information can be found by visiting mi.primetherapeutics.com.*

If you have any questions, contact your Blue Cross Complete provider account executive, Blue Cross Complete's Provider Inquiry department at **1-888-312-5713** or the Blue Cross Complete Pharmacy help desk at **1-888-288-3231**.

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Sickle cell disease can present oral health challenges

Sickle cell disease has long been associated with a range of health challenges, from severe pain to organ damage. However, a lesser-known aspect of sickle cell disease is its effect on oral health.

Those living with sickle cell disease, especially children, are often unaware of the unique oral health challenges they may face. There are several ways in which the disease can affect oral health. These include oral infections, delayed dental development and acute pain crises, which can manifest in the jaw and oral cavity. Poor oral care can lead to gingivitis or periodontal disease, which may result in loss of teeth, infection and other complications.

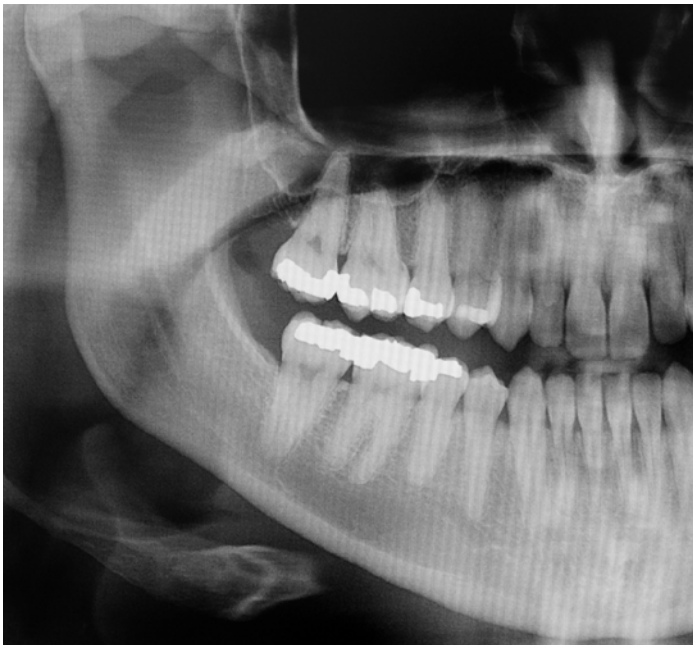
For individuals with sickle cell disease, oral health is even more important to make sure it doesn't further complicate an already challenging disease state. Treatments such as hydroxyurea can increase the risk of oral sores, which can worsen symptoms and make it difficult to brush and floss. Therefore, it's important to encourage patients to make oral health a vital part of their daily routine.

The Sickle Cell Disease Association of America estimates that 100,000 Americans have sickle cell disease and that cases in the U.S. are highest among Black Americans, affecting one in every 365 births. Every baby born in the U.S. is tested for sickle cell disease.* The Centers for Disease Control and Prevention provides additional information about sickle cell disease.*

By educating patients about the connection between sickle cell disease and oral health, health care providers can empower patients to take proactive measures to decrease and mitigate complications resulting from the genetic disorder.

As a reminder, Blue Cross Complete coverage includes dental benefits, including exams, cleanings and extractions for members. Additional dental benefits include:

- Four bitewing X-rays every year
- Full-mouth X-rays once every five years
- One filling per tooth every two years
- Emergency exams, no more than twice a month
- Sealants, once every three years



- Topical fluoride up to age 21, twice per year
- Fluoride varnish up to age 21, twice per year
- Crowns, once every five years on the same tooth
- Root canal therapy
- Retreatment of previous root canal, once per tooth per lifetime
- Periodontal evaluation, once every 12 months**
- Periodontal maintenance, once every six months*
- Complete and partial dentures, once every five years per arch

Eligible members can locate a dentist by visiting mibluecrosscomplete.com and selecting **Find a doctor**, then **Find a dentist**. Members may also call Blue Cross Complete's Dental Customer Service at **1-844-320-8465**.

While sickle cell disease poses various health challenges, its impact on oral health shouldn't be overlooked. Together, we can continue to educate our members, while promoting better health.

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

**Periodontal services, including scaling and root planning requires prior authorization.

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Prior Authorization Lookup tool available on Blue Cross Complete website

Confirming authorization requirements is as simple as entering a current procedural terminology code or a health care common procedure coding system code and clicking submit using Blue Cross Complete's Prior Authorization Lookup tool. This user-friendly resource allows users to enter a CPT or a HCPCS code to verify authorization requirements in real time before delivery of service.

The Prior Authorization Lookup tool was designed to help reduce the administrative burden of calling Provider Services to determine whether prior authorization is required. The tool is easy to use and offers general information for outpatient services performed by a participating provider.

To try the Prior Authorization Lookup tool, visit mibluecrosscomplete.com and go to the Providers tab.

1. Click on **Self-Service Tools**.
2. Scroll down to **Prior Authorization Lookup**.
3. Enter a CPT or HCPCS code in the space provided.
4. Click **Submit**.
5. The tool will tell you if that service needs prior authorization.

Prior authorization requests can't be submitted through the tool and should continue to be requested through your current process. You can submit your requests electronically through NaviNet. Through your single login to NaviNet, you can request prior authorization and view authorization history. If you aren't already a NaviNet user, visit Navinet.net to register.*

If you have questions, please contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

NaviNet is a contracted vendor that provides a payer-provider web portal on behalf of Blue Cross Complete through which member information can be accessed including but not limited to tracking claims status.

Practitioner rights

Providers contracted with Blue Cross Complete have rights. Understanding these rights helps clarify roles and responsibilities. In accordance with legal requirements and upon written request, Blue Cross Complete practitioners or prospective practitioners are given the opportunity to:

- Review credentialing application forms from the practitioner requesting participation to Blue Cross Complete.
- Review Blue Cross Complete's credentialing policies and procedures
- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This doesn't include information collected from references, recommendations and other peer-review protected information. Either attest to the accuracy of that information or correct the information, if erroneous.
- Be notified if any credential information is received that varies substantially from application information submitted by the practitioner: Actions on license; malpractice claim history; suspension or termination of hospital privileges; or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. The practitioner will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on the application.

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- Upon request, be informed of the status of the application — if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the credentialing committee for approval.

Practitioners or prospective practitioners must submit a written request to review information submitted in support of their credentialing or recredentialing application to:

Email: bccproviderdata@mibluecrosscomplete.com

Fax: **1-855-306-9762**

Mail: Blue Cross Complete of Michigan
Attn: Provider Network Operations
4000 Town Center,
Suite 1300
Southfield, MI 48075

- A two-week notice is required for scheduling a review date and time.
- The practitioner is informed in writing of the dates and times available for the review.
- Upon receipt of the practitioner's response, the date and time of the scheduled review are confirmed in writing.

If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

Learn more about Blue Cross Complete member rights and responsibilities

Members of Blue Cross Complete have rights and responsibilities. Understanding these rights and responsibilities helps members get the most out of their health care benefits.

Member rights

Member rights will be honored by all Blue Cross Complete staff and affiliated providers. Members have the right to:

- Understand information about their health care
- Get required care as described in the **member handbook**
- Be treated with dignity and respect
- Receive culturally and linguistically appropriate services, or CLAS
- Privacy of their health care information, as outlined in the **member handbook**
- Treatment choices, regardless of cost or benefit coverage
- Full participation in making decisions about their health care
- Refuse treatment
- Voice complaints, grievances or appeals about Blue Cross Complete and its services, benefits, providers and care
- Get clear and easy-to-understand written information about Blue Cross Complete's services, practitioners, providers and rights and responsibilities
- Review their medical records and ask that they be corrected or amended
- Make suggestions about Blue Cross Complete's rights and responsibilities policies
- Be free from any form of abuse, being restrained or secluded, as a means of coercion, discipline, convenience or retaliation when receiving services
- Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand
- Request and receive:
  - The **Blue Cross Complete provider directory**
  - The professional education of their providers, including those who are board-certified in the specialty of pain medicine for evaluation and treatment

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- The names of hospitals where their physicians are able to treat them
- The contact information for the state agency that oversees complaints or corrective actions against a provider
- Any authorization, requirements, restrictions or exclusions by service, benefit or a specific drug
- The information about the financial agreements between Blue Cross Complete and a participating provider

Member responsibilities

Members have the responsibility to:

- Know their *Certificate of Coverage* from Blue Cross Complete
- Know the contents of the **member handbook** and all other provided materials
- Call Customer Service with any questions at **1-800-228-8554**
- Seek services for all non-emergency care through their primary care provider
- Use the Blue Cross Complete provider network
- Make and keep appointments with their primary care provider
- Contact their doctor's office if they need to cancel an appointment
- Be involved in decisions about their health
- Behave in a proper and considerate manner toward providers, their staff, other patients and Blue Cross Complete staff
- Tell Blue Cross Complete of address changes, and any other changes for their dependent coverage
- Protect their ID card against misuse
- Call Customer Service right away if their card is lost or stolen
- Follow their doctor's instructions regarding care
- Make treatment goals with their physician
- Contact the Blue Cross Complete anti-fraud unit if they suspect fraud

Additional rights and responsibilities

In addition to these rights and responsibilities, members also have the right to:

- Ask for and get information about how our company is structured and operated
- Have their health information stay confidential
- Use their rights without changing the way they're treated by us, health care providers or the state of Michigan
- Ask for the professional credentials of their provider
- Ask for any prior authorization requirements, limits, restrictions or exclusions
- Ask about the financial responsibility between Blue Cross Complete and any network provider
- Know if there are any provider incentives, such as pay for performance
- Ask about stop-loss coverage

Members also have the responsibility to tell their doctor and Blue Cross Complete about their health and health history.

If you have any questions, contact your Blue Cross Complete provider account executive or Blue Cross Complete's Provider Inquiry department at **1-888-312-5713**.

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Blue Cross Complete offers language assistance

Blue Cross Complete serves a diverse population. As a result, providers may see patients who don't speak English or have limited English proficiency. Almost 7% of our members speak a different language, such as Spanish, Arabic, Chinese, Bengali or other less-common languages. To help ensure information is accurately reported and understood, Blue Cross Complete offers certified translation and interpretive services in more than 200 languages.

These services include:

- Interpreting conversations with providers or health care staff
- Translating health care plan documents
- Getting plan documents in different formats

For language assistance, providers and members can call Customer Service at **1-800-228-8554**.

To learn more about the culture and demographics in Michigan, visit Data USA, then click **Cities & Places**.*

- In the search bar, type in "Michigan."
- In the results, select **Michigan (state)**.

Categories include:

- Diversity
- COVID-19
- Economy
- Civics
- Education
- Housing and living
- Health

Continuous cultural competency training and education is a critical component in helping providers reduce health disparities. Blue Cross Complete understands the importance of enhancing awareness of social and cultural factors that influence the delivery of care. For more resources, visit mibluecrosscomplete.com:

- Click the **Providers** tab.
- Click **Training**.
- Scroll down to **Cultural diversity training**.
  - Cultural awareness and responsiveness training opportunities

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete's Provider Inquiry at **1-888-312-5713**.

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Refer patients to our Integrated Health Care Management program

Blue Cross Complete offers an Integrated Health Care Management program that provides a population health strategy for comprehensive disease management and complex case management. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

Blue Cross Complete members are eligible for the program if they have specific health risks due to complex health conditions, require a high level of care coordination and typically access medical services from multiple providers' sites. Members with the following identified issues or diagnoses may be referred to the program:

- Asthma
- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Depression management
- Diabetes
- Ischemic heart disease
- Kidney management
- Pregnancy – high risk
- Sickle cell anemia
- Transplants – bone marrow and human organ

Note: This list isn't all-inclusive.

Both adult and pediatric members are eligible for IHCM and are automatically enrolled unless they choose to opt out. The program helps members understand their condition and achieve and maintain control of their disease. Collaboration is an essential component of the process, as success increases when everyone involved agrees. Our care managers will seek input from you for the care plan, potential interventions and goals. We'll also contact other members of the treatment team, including behavioral health providers, if applicable.

The following specific objectives direct our activities:

- Ensure members have access to the appropriate health care services, health plan benefits and community resources
- Improve the health outcome measures of our members (as reflected by the HEDIS®* scores)
- Decrease the burden of disease complication through early identification and intervention
- Improve member self-management by providing education and self-management tools
- Increase member compliance with treatment plans through education about the disease process through self-monitoring interventions
- Improve the member's functional status and quality of life
- Coordinate and facilitate health care services
- Assist in communication with the member's primary care provider
- Promote evidence-based treatment guidelines
- Encourage participation in our Tobacco Quit Program, as applicable, at no cost to the member

Some of the interventions provided by our nurse case managers include:

- **Coordination of care:** We help make sure the member is seeing theirr primary care provider. We also assist with referrals to specialists and make sure the primary care provider is aware of other care the member is receiving (for example, specialists or emergency room).
- **Patient education:** We make sure the member understands the disease and treatment regimen.
- **Self-management:** We provide guidance that motivates the member toward compliance and self-management.

How to refer members to the Integrated Health Care Management program

Providers can directly refer members that agree to ICHM for disease, case and complex case management services by calling **1-888-288-1722**.

When calling to make a referral, providers should have the following information available:

- Member's name, date of birth and enrollee ID number

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- Member's address and current phone number
- Reason for member referral
- Name of contact person at the provider's office
- Provider phone and fax numbers
- Specify if provider's office prefers to be contacted by phone or fax with follow-up on member outreach activities

Disease management programs

Blue Cross Complete also offers several disease-specific management programs with interventions ranging from one-on-one nurse interaction for high-risk members to periodic educational mailings for low-risk members. The goal of our disease-specific management programs is to improve the quality of life for members by providing risk-appropriate case management and education services with a special emphasis on promoting self-management.

- **Asthma:** The asthma management program is for members of all ages. We especially promote member compliance with controller medications. Our program is based on current asthma practice guidelines from the National Heart Lung and Blood Institute.*
- **Diabetes:** The diabetes management program is for members of all ages. The goal is to prevent or reduce long-term complications. Our program is based on current diabetes practice guidelines from the American Diabetes Association.*
- **Cardiovascular disease:** The heart failure management program emphasizes self-management interventions, such as daily weight measurements and medication compliance.

Note: This list isn't all-inclusive.

Complex care management

This program targets members with complex medical conditions that could include multiple comorbidities or a single serious diagnosis, such as HIV or cancer. Our nurses work one on one with these patients to meet their care needs.

Maternity management (Bright Start®)

This program targets pregnant members who have high-risk medical or social determinants of health needs. We welcome your referrals of members with Blue Cross Complete that you feel would benefit from our programs. Call us at **1-888-288-1722**, and we'll reach out to the member to design a specific care plan.

Provider rights and responsibilities when members receive complex case management services

Providers treating members who are participating in Blue Cross Complete's Integrated Health Care Management program have the right to:

- Obtain information about Blue Cross Complete, including its programs and services, its staff and its staff qualifications
- Be informed about how Blue Cross Complete coordinates the interventions and plan of care for individual members
- Know how to contact the care manager responsible for managing the case and for communicating with the provider's patients
- Be supported by Blue Cross Complete and work collaboratively in decision-making with members regarding their plan of care
- Receive courteous and respectful treatment from Blue Cross Complete staff and know how to communicate complaints to Blue Cross Complete

Providers are responsible for participating in a member's integrated care management program by:

- Providing relevant clinical information as requested
- Taking action to follow up on reported information
- Participating in the member's plan of care

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Transition of care

Members receiving services from a provider prior to enrollment with Blue Cross Complete are able to continue receiving services for 90 days. This may also include certain prescriptions without prior authorizations. Members must have a relationship with a specialist, primary care provider or other covered provider prior to enrolling with Blue Cross Complete to establish continuity of care. For more information, view Blue Cross Complete's Transition of Care Requirements at mibluecrosscomplete.com.

Clinical practice and preventive care guidelines

Blue Cross Complete promotes the development, approval, implementation, monitoring and revision of uniform evidence-based clinical practice and preventive care guidelines for practitioners. Such guidelines promote the delivery of quality care and reduce variability in physician practice.

Evidence-based guidelines are nationally known to be effective in improving health care outcomes. Blue Cross Complete endorses the clinical proactive and preventive care guidelines developed by the Michigan Quality Improvement Consortium and uses Change Healthcare's InterQual® criteria to make utilization management determinations about bariatric surgery.

Our quality improvement program encourages Blue Cross Complete's adherence to clinical practice and preventive care guidelines. Ongoing monitoring of compliance is conducted through medical record reviews and quality studies. Approved clinical practice guidelines are available to all Blue Cross Complete primary care providers, primary care groups and specialists.

Guidelines and updates are accessible to all providers at mibluecrosscomplete.com in the provider section under Resources. Blue Cross Complete also distributes clinical practice guidelines to members and prospective members upon request. Blue Cross Complete will mail clinical practice guidelines to those who don't have fax, email or internet access. The MQIC guidelines can be accessed by visiting mqic.org* and clicking on **Current guidelines**.

In addition to the MQIC and InterQual guidelines, Blue Cross Complete maintains internal guidelines about the diagnosis and management of the following:

- Abdominoplasty
- Anesthesia services for gastrointestinal endoscopy
- Chronic obstructive pulmonary disease or COPD
- Orthognathic surgery

These guidelines can be accessed at mibluecrosscomplete.com; go to **Providers**, click **Resources** and scroll down and click **Clinical resources**.

More information about the guidelines can be found in Section 3 of Blue Cross Complete's Provider Manual at mibluecrosscomplete.com, click **Providers** and then **Provider Programs**.

If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

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Addressing low birth weight in Michigan

Low birth weight remains a significant and growing public health concern in Michigan. Defined as a birth weight of less than five pounds, eight ounces at birth – low birth weight is closely associated with preterm delivery, maternal health challenges and disparities in access to care, according to the Michigan Department of Health and Human Services

As trusted partners in maternal and infant health, Blue Cross Complete health care providers play a critical role in early identification, prevention and coordination of care for pregnant members and newborns. Michigan continues to experience low birth weight rates that exceed national benchmarks. According to the MDHHS, statewide maternal infant health data show:

- Approximately 8.9% of live births in Michigan were low birth weight
- Racial disparities persist, with Black infants experiencing low birth weight rates more than twice of White infants.
- Low birth weight is strongly correlated with preterm birth, chronic maternal health conditions, and limited access to early prenatal care
- Infants born with a low birth weight face higher risk of neonatal complications, developmental delays and long-term health challenges.

These trends highlight the need for continued care coordination, screening and strong provider-member engagement throughout pregnancy.

Strategies for prevention and improvement

Blue Cross Complete is reminding OB-GYNs, doulas and MIHP providers who serve Michigan women they can help improve low birth weight outcomes and eliminate health disparities in maternal and infant health by encouraging members who are or may be pregnant to schedule a prenatal visit during their first three months of pregnancy, or within 42 days of enrolling with Blue Cross Complete.

Once the baby arrives, members should schedule their postpartum visit within seven to 84 days after delivery. If members need a ride to appointments, they can make arrangements with Blue Cross Complete's transportation provider at **1-888-803-4947**. TTY users should call **711**.

Smoking

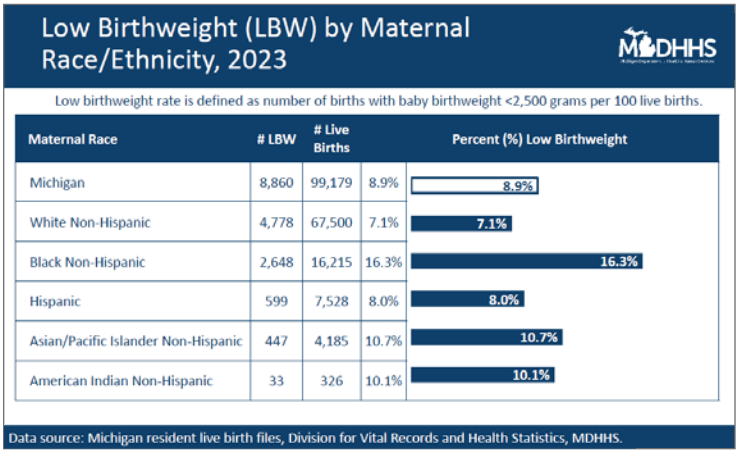
Smoking during pregnancy significantly increases the risk of having a preterm birth or a low-birth-weight baby. According to the Centers for Disease Control and Prevention, one out of every five babies born to mothers who smoke — including e-cigarettes and marijuana — is born too small or too early.* A woman who smokes while pregnant is also more likely to have a pregnancy outside the womb, which usually results in a miscarriage. What's more, smoking after the baby is born increases the baby's risk for asthma and sudden infant death syndrome.

If you have a patient who smokes, quitting will help no matter what stage of family planning a member is in. Blue Cross Complete has a confidential, no-cost Tobacco Quit program with special resources for pregnant women. This includes nine counseling calls, a dedicated female quit coach and rewards for sticking with smoking cessation appointments. Encourage eligible members to enroll by calling the Tobacco Quitline at **1-800-QUIT-NOW (784-8669)**, 24 hours day, seven days a week.

For more information, call Blue Cross Complete's Provider Inquiry department at **1-888-312-5713**.

Community Resource Hub

Blue Cross Complete can connect pregnant members to food, housing, utilities, clothing, behavioral health services, ride services, resources for alcohol misuse and more. If your patient needs immediate assistance, call our Rapid Response and Outreach Team at **1-888-288-1722**. TTY users should call **1-888-987-5832**. RROT is available from 8 a.m. to 5:30 p.m. Monday through Friday. More resources are available through our Community Resource Hub at mibluecrosscomplete.com/resources. Users can enter a ZIP code and select the category that fits their needs.



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Utilization management

Blue Cross Complete utilization management contact information

Providers and members can contact Blue Cross Complete about utilization management issues, such as plan notification or authorization requests, using one of the following methods.

- Call Utilization Management at **1-888-312-5713 (press 1, then 4)** from 8 a.m. to 5 p.m. Monday through Friday.
- For urgent or emergency requests outside of the above listed normal business hours and on weekends and holidays, call **1-888-312-5713 (press 1, then 4)** but request an urgent review with the reviewer on call.
- Telecommunications devices for the hard of hearing-text telephone services are available for the hearing impaired by calling **1-888-765-9586**.

Certified translation services are available to all Blue Cross Complete providers and eligible members whose primary language isn't English or who have limited English proficiency or low literacy proficiency.

Translation and interpretive services are available in more than 200 languages. Call **1-800-228-8554** to:

- Obtain immediate services over the phone.
- Schedule an appointment for services to be delivered. Let our staff know if you need the services over the phone or in person.
- For TTY services, call **1-888-987-5832**.

For more information, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

Availability of criteria for Blue Cross Complete utilization management determinations

Criteria used for utilization management determinations are available upon request to all Blue Cross Complete practitioners, providers and members free of charge.

Members, practitioners and providers are made aware of the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the Provider Manual and member handbook, and written utilization management determination letters. Upon request, Blue Cross Complete personnel will fax a copy of the criteria used in the review. Blue Cross Complete will mail criteria to those who don't have fax, email or internet access.

To request criteria, contact Blue Cross Complete at **1-888-312-5713**. TTY users should call **1-888-765-9586**.

Providers can request criteria for utilization management decisions

Blue Cross Complete's utilization management department responds to authorization requests in accordance with the following guidelines:

- Decision-making related to authorization requests is based only on the existence of coverage and appropriateness of the care and service.
- Practitioners and other individuals aren't rewarded for issuing denials of coverage.
- Decision-makers for authorization requests don't receive financial incentives for decisions that result in underutilization.

Providers have the right to request the information used to make a decision. This includes benefit guidelines and other criteria. Blue Cross Complete will mail guidelines and criteria to those who don't have fax, email or internet access. To request this information, providers should call utilization management or write the appeals coordinator at the following address:

Appeals coordinator
Blue Cross Complete of Michigan
P.O. Box 41789
Charleston, SC 29423

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete's Provider Inquiry department at **1-888-312-5713**.

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Promoting health equity and cultural competency

We're committed to promoting effective, equitable, understandable and respectful quality services that are responsive to our members' and participants' diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs. Our plans use the National CLAS Standards and the National Committee for Quality Assurance health equity standards as a blueprint to advance health equity, improve quality and help eliminate health care disparities.

We foster cultural awareness both in our staff and provider communities by encouraging everyone to report race, ethnicity and language data to help ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. The race and ethnicity of our providers are confidential. However, the languages reported by providers are published in our plan's *Provider Directory* so that members and participants can easily find doctors who speak their preferred language.

Our website offers resources and educational tools that can assist you and your practice with questions about delivering effective health services to diverse populations. For additional information, visit mibluecrosscomplete.com:

1. On the blue bar, click **Providers**.
2. In the drop-down menu, click **Training**.
3. Scroll down to **Cultural Diversity Training** and then click **Cultural awareness and responsiveness training opportunities**.

Review criteria used for Blue Cross Complete utilization management determinations

Criteria used for utilization management determinations are available upon request to all Blue Cross Complete practitioners, providers and members free of charge. Members, practitioners and providers are made aware of the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the Provider Manual and member handbooks and written utilization management determination letters.

Upon request, Blue Cross Complete personnel will fax a copy of the criteria used in the review. Blue Cross Complete will mail guidelines and criteria to those who don't have fax, email or internet access. To request criteria, contact Blue Cross Complete at **1-800-228-8554**. TTY users, call **1-888-987-5832**.

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The importance of collecting race, ethnicity and language data

In an increasingly diverse society, the ability to deliver equitable and personalized health care has never been more crucial. Blue Cross Complete emphasizes the importance of health care providers collecting and reporting race, ethnicity and language (also known as REL) data to ensure every member receives culturally competent care, and to meet requirements outlined by Culturally Linguistically Appropriate Services, or CLAS.

CLAS are national standards and guidelines established in 2000 (and enhanced in 2013) by the U.S. Department of Health and Human Services, Office of Minority Health, to advance health equity, improve quality and help eliminate health disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate care.

Why is collecting REL data important?

- **Addresses health disparities:** Health outcomes often vary significantly across different racial, ethnic and linguistic groups. Collecting REL data allows Blue Cross Complete and its providers to identify and address disparities in care. Having consistent and reliable data is important when identifying and tracking health disparities.
- **Promotes equitable care:** REL data is an equitable service for patients. By promoting diversity among health care providers, we can better accommodate a diverse patient population and thus improve health outcomes for disenfranchised groups.
- **Empowers patients:** Sharing REL data gives patients the tools and autonomy to choose a provider who meets their preferences.
- **Promotes values of cultural and linguistic competency:** For some patients, racial and ethnic concordance with their physician allows for greater physician understanding of the social, cultural and economic factors that influence their patients. This enhances the patient-physician relationship through promoting trust and communication.

How do we collect REL information?

- Blue Cross Complete requests that its contracted provider network voluntarily share REL data, as well as their office support staff's languages.
- Blue Cross Complete requests and collects network provider REL data using the same Office of Management and Budget categories it uses to collect members' REL.

How do we store and share this information?

REL data is housed in a database that is made available to members:

- Gender data is available through Blue Cross Complete *Provider Directory*.
- Provider's language, staff's language and additional language services are also available through the *Provider Directory*.
- Information on race and ethnicity is only made available to enrollees upon request.
- Research by the National Institutes of Health shows that race, culture or ethnicity concordance within the patient-provider relationship aren't strong indicators of overall quality care. However, cultural competence and awareness are critical to building rapport, comfort and trust with diverse patients. REL data is one essential tool that health plans use to establish, enhance and promote cultural competence.
- When the health plan is able to share other languages spoken by the provider network, members have the autonomy to select a provider that matches their cultural and linguistic preferences.

Blue Cross Complete provides CLAS training and evaluates providers' compliance with these standards. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

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Help us keep Blue Cross Complete Provider Directory up to date

Accurate Provider Directory information is crucial to ensuring members can easily access their health care services. Confirm the accuracy of your information in our online Provider Directory so our members have the most up-to-date resources. Some of the key items in the directory are:

- Provider name
- Phone number
- Office hours
- Hospital affiliations
- Address
- Fax number
- Open status
- Multiple locations

To view your provider's information, visit mibluecrosscomplete.com, then click the **Find a doctor** tab and search your provider's name. If any changes are necessary, you must submit them in writing using Blue Cross Complete's *Provider Change Form* also at mibluecrosscomplete.com. Go to the **Providers** tab, click **Forms** and then click **Provider Change Form**.

Send completed forms by:

- Email: bccproviderdata@mibluecrosscomplete.com
- Fax: **1-855-306-9762**
- Mail: Blue Cross Complete of Michigan
  Provider Network Operations
  Suite 1300
  4000 Town Center
  Southfield, MI 48075

If you have any questions, contact your Blue Cross Complete provider account executive.

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Keep medical records up to date for your patients

According to the National Committee for Quality Assurance, health care providers are required to maintain accurate and timely medical records for Blue Cross Complete members for at least 10 years in accordance with all federal and state laws. Providers must also ensure the confidentiality of those records and allow access to medical records by authorized Blue Cross Complete representatives, peer reviewers and government representatives within 30 business days of the request at no charge.

As a reminder, medical records must include, at a minimum:

A. A record of outpatient and emergency care

B. Specialist referrals

C. Ancillary care

D. Diagnostic test findings, including all laboratory and radiology

E. Therapeutic services

F. Prescriptions for medications

G. Inpatient discharge summaries

H. Histories and physicals

I. Allergies and adverse reactions

J. Problem list

K. Immunization records

L. Documentation of clinical findings and evaluations for each visit

M. Preventive services risk screening

N. Other documentation sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided

Medical records must be signed, dated and maintained in a detailed, comprehensive manner that conforms to professional medical practice, permits effective medical review and medical audit processes and facilitates an organized system for coordinated care and follow-up treatment. Providers must store medical records securely and maintain written policies and procedures to:

- Allow access to authorized personnel only.
- Maintain the confidentiality of all medical records.
- Maintain medical records so that records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information.
- Train staff periodically on proper maintenance of member information confidentiality.

Blue Cross Complete provides training and evaluates providers' compliance with these standards. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.

Source: Healthcare Effectiveness Data and Information Set, or HEDIS®

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Report suspected fraud to Blue Cross Complete

Health care fraud affects everyone. It significantly affects the Medicaid program by squandering valuable public funds needed to help vulnerable children and adults access health care.

If you or any entity with which you contract to provide health care services suspect another Blue Cross Complete provider, employee or member is committing fraud, notify Blue Cross Complete's Special Investigations Unit:

- Phone: **1-855-232-7640** (TTY **711**)
- Fax: **1-215-937-5303**
- Email: fraudtip@mibluecrosscomplete.com
- Mail: Blue Cross Complete
  Special Investigations Unit
  P.O. Box 018
  Essington, PA 19029

Blue Cross Complete's Special Investigations Unit supports local and state authorities in investigating and prosecuting fraud. You can also report suspected fraud related to Blue Cross Complete to the Michigan Department of Health and Human Services Office of Inspector General in one of the following ways:

- Website: michigan.gov/fraud*
- Phone: **1-855-643-7283**
- Mail: Office of Inspector General
  P.O. Box 30062
  Lansing, MI 48909
- Reports can be made anonymously.

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Blue Cross Complete of Michigan LLC is an independent licensee of the Blue Cross and Blue Shield Association.

*The content presented is for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients and should not use the information presented to substitute independent clinical judgment.

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