2018 Blue Dot Changes to the *Blue Cross Complete Provider Manual* and related documents

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Change Description

The following updates have been made to the *Blue Cross Complete Provider Manual* **(January 2018)**:

- **Section 2 - Systems of Managed Care** (p. 6): Added language that informs providers that CHAMPS enrollment is required
- **Section 2 - Systems of Managed Care** (p. 8): Added language that informs providers that same day transportation is available
- **Section 5 - Standards and Ratings** (p. 26): Added non-urgent symptomatic care, speciality care, acute speciality care and dental health access standards

The following updates have been made to the *Blue Cross Complete Provider Manual* **(February 2018)**:

- **Section 4 - Managing the Quality of Care** (p. 20): Changed “chief medical director” to “medical director”
- **Section 4 - Managing the Quality of Care** (p. 21): Steps 1,2,4,6, 7 and 8 in the peer review process were revised for clarity.
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 2 “in writing within 30 calendar days of the date of the letter”
- **Section 4 - Managing the Quality of Care** (p. 22): Removed from step 3 “For cases reviewed by committees, the committee makes a decision and forwards it to the designated Blue Cross Complete chief medical officer within 30 calendar days.”
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 3 “If the case is forwarded to a committee, the committee reviews the case and request that a...”
- **Section 4 - Managing the Quality of Care** (p. 22): Added to step 4 “The letter also notifies the practitioner that he or she has the right to ...”
- **Section 4 - Managing the Quality of Care** (p. 22): Removed from step 5 “Blue Cross Complete monitors compliance with the performance improvement plan. Noncompliance or unsatisfactory compliance may result in termination”
- **Section 4 - Managing the Quality of Care** (p. 23): Added “If deemed appropriate, the disciplinary steps may be completed on an expedited basis...”
- **Section 4 - Managing the Quality of Care** (p. 23): *Medical boards and data bank must be notified* revised for clarity. Note: Action resulting in restriction or regulation of clinical practice for a period greater than 30 days has been changed to 15 days.
- **Section 4 - Managing the Quality of Care** (p. 23): *Additional information about termination* revised for clarity.
- **Section 4 - Managing the Quality of Care** (p. 23): Added “An effective and consistent practitioner appeal process is available for when ...”

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Change Description

- The following updates have been made to the *Blue Cross Complete Provider Manual* **(February 2018) continued**:

- **Section 4 Managing the Quality of Care** (p. 23): Added a definition of *administrative issues*
- **Section 4 Managing the Quality of Care** (p. 23): Added a definition of *quality of care issues*
- **Section 4 Managing the Quality of Care** (p. 24): Removed from section 2 of *Level 1 appeal process* "The committee's decision is communicated to the appealing practitioner by certified letter within 60 days of the decision"
- **Section 4 Managing the Quality of Care** (p. 24): Added additional clarity for administrative and quality of care issues to section 2 of *Level 1 appeal process.*
- **Section 4 Managing the Quality of Care** (p. 25): *Level 2 appeal process* step 3 changed 30 days to 14 calendar days and added "For non-emergent terminations, a written decision is provided within 30 days".
- **Section 10 Managing Utilization** (p. 55): Added "...within three business days. Please follow the peer to peer request process as indicated in section 10B" to *What to do if the stay is denied*
- **Section 10 Managing Utilization** (p. 58): Removed from *Peer-to-Peer Request for Denied Services* section "If a request for inpatient or outpatient authorization is denied, the ordering or treating provider can request a Peer-to-Peer discussion with the Blue Cross Complete chief medical officer who issued the adverse determination. A Peer-to-Peer request will be accepted up to three business days from the date of the original denial.
- **Section 10 Managing Utilization** (p. 58): Added "A Peer to Peer request will be accepted up to three business days from the date of the original denial.
- **Section 10 Managing Utilization** (p. 58): Changed timeframes from 60 to 30 and added "calendar days" to standard appeal timeframe.
- **Section 10 Managing Utilization** (p. 58): Changed timeframes from 60 to 10 and added "calendar days" to expedited appeal timeframe.
- **Section 10 Managing Utilization** (p. 59): Removed "Claims appeal" information from this section
- **Section 13 Managing Utilization** (p. 55): Removed *Guidelines for appealing a denied claim* from this section
- **Section 14 Provider appeals** (p. 89): Added Provider appeals section to the provider manual

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Change Description

The following updates have been made to the *Blue Cross Complete Provider Manual* **(May 2018)**:

- **Section 7 Member eligibility** (p. 38): Removed bullet "A phone number the member can call for mental health care".
- **Section 7 Member eligibility** (p. 39): Updated member ID card for traditional Medicaid plan members
- **Section 7 Member eligibility** (p. 40): Updated member ID card for Health Michigan plan members
- **Section 7 Member eilgibility** (p. 41): Removed "...issed starting May 1, 2015" from line 6 of the table
- **Section 8 Member benefits** (p. 45): Added a note that tells providers that only Healthy Michigan plan members should complete a health risk assessment
- **Section 8 Member benefits** (p. 45): Added Wellness program to list of qualifying programs for member incentives
- **Section 8 Member benefits** (p. 48): Added "Blue Cross Complete pregnant women will have dental coverage up to three (3) months after due date"
- **Section 8 Member benefits** (p. 48): Added "The Health Kids Dental program is available statewide to all members up to age 20 years
- **Section 8 Member benefits** (p. 48) Added "...and are not a pregnant member"

The following updates have been made to the *Blue Cross Complete Provider Manual* **(July 2018):**

- **Section 2 System of Managed Care** (p. 12): Added "...within XXX business days of the request with no charge"
- **Section 10 Managing Utilization** (p. 54): Added additional instructions for contacting Utilzation Management and after hours request.
- **Section 10 Managing Utilization** (p. 54): Relocated "Providers can request criteria for decisions" section to the latter part of section 10.
- **Section 10 Managing Utilization** (p. 54): Removed "Steps to take before rendering services that are not or may not be covered"
- **Section 10 Managing Utilization** (p. 54): Updated notification to the plan or request authorization section with phone, fax, NaviNet contact information. Removed "Plan notifications can be given up to the following business day..."
- **Section 10 Managing Utilization** (p. 56): Added "...for non-contracted hospitals..."
- **Section 10 Managing Utilization** (p. 56): Removed "The following table provides important information for hospitals notifying Blue Cross Complete about an urgent or emergent inpatient admission"
- **Section 10 Managing Utilization** (p. 56): Removed "An extension of the standard time frames is also allowed if the member request it"
- **Section 10 Managing Utilization** (p. 59): Added "member representative" and "...to include a severvice denia, delay or limitation" to *Appeal of utilization management decisions* section

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Change Description

The following updates have been made to the *Blue Cross Complete Provider Manual* **(July 2018):**

- **Section 10 Managing Utilization** (p. 59): Added "note" section to *Appeal of utilization management decisions* section
- **Section 10 Managing Utilization** (p. 59): Revised language under *State fair hearing* sections and revised state fair hearing request including notification requirements to 120 days of Blue Cross Complete's internal appeal determination
- **Section 10 Managing Utilization** (p. 59): Revised External review request to 120 days following the receipt of Blue Cross Complete's determination
- **Section 11 Managing Care** (p. 61): Added "....Integrated Care Management..."
- **Section 11 Managing Care** (p. 61): Added "Members outreach and collaboration" to *Members work with a care management nurse* section
- **Section 11 Managing Care** (p. 62): Added "...that agree to Integrated Health care management..."
- **Section 14 Appeals** (p. 90): Removed "Peer to Peer request for denied services" language
- **Section 14 Appeals** (p. 90): Revised language under *Appeal of utilization management decisions* section "...related to adverse action of a post service request by Blue Cross Complete, including a service denial, delay or limitation."
- **Section 14 Appeals** (p. 90): Added appeals address
- **Section 14 Appeals** (p. 90): Added State fair hearing language to *"Appeal of Utilization Management Decisions"* sections
- **Section 14 Appeals** (p. 91): Added revised sentence to "All claim appeals should be submitted to..."
- **Section 16: Health Care Fraud, Waste and Abuse** (p. 95): Entire section revised with updated Special Investigations Unit and Fraud, Waste, and Abuse language.

The following updates have been made to the *Blue Cross Complete Provider Manual* **(September 2018):**

- **Section 2 Systems of Care** (p12): Added "within 30 business of the request days at no charge"
- **Section 10 Managing Utilization** (p. 56): Changed "urgent concurrent hours timelines to 72 hours
- **Section 12 Pharmacy** (p. 68): Added "...but not limited to..."
- **Section 12 Pharmacy** (p. 69): Changed responses to request for coverage determinations to 24 hours
- **Section 12 Pharmacy** (70): Added "...and other select vaccines..."
- **Section 13 Claims** (p. 72): Added "all providers are required to follow...."
- **Section 13 Claims** (p. 72): Added "All claims must be resolved within one year from the date..."
- **Section 13 Claims** (p.72): Removed "Claims over one year old must have continous active review to be consider..."
- **Section 13 Claims** (p. 73): Added "Medicaid beneficiary eligibility/authorization was established...."

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The following updates have been made to the *Blue Cross Complete Provider Manual* **(September 2018):**

- **Section 13 Claims** (p. 73): Added “Primary insurance taking back payment after timely...”
- **Section 13 Claims** (p. 73): Added “...with Blue Cross Complete”
- **Section 13 Claims** (p. 73): Removed Sumit encounters for prepaid claims sections
- **Section 13 Claims** (p. 74): Updated website address

The following updates have been made to the *Blue Cross Complete Provider Manual* **(November 2018):**

- **Section 15 Electronic funds transfer** (p. 93): Updated the entire chapter with additional EFT information.

The following updates have been made to the *Blue Cross Complete Provider Manual* **(December 2018):**

- **Section 14 Provider Appeals** (p. 92): Revised MDHHS rapid dispute resolution process for hospitals.