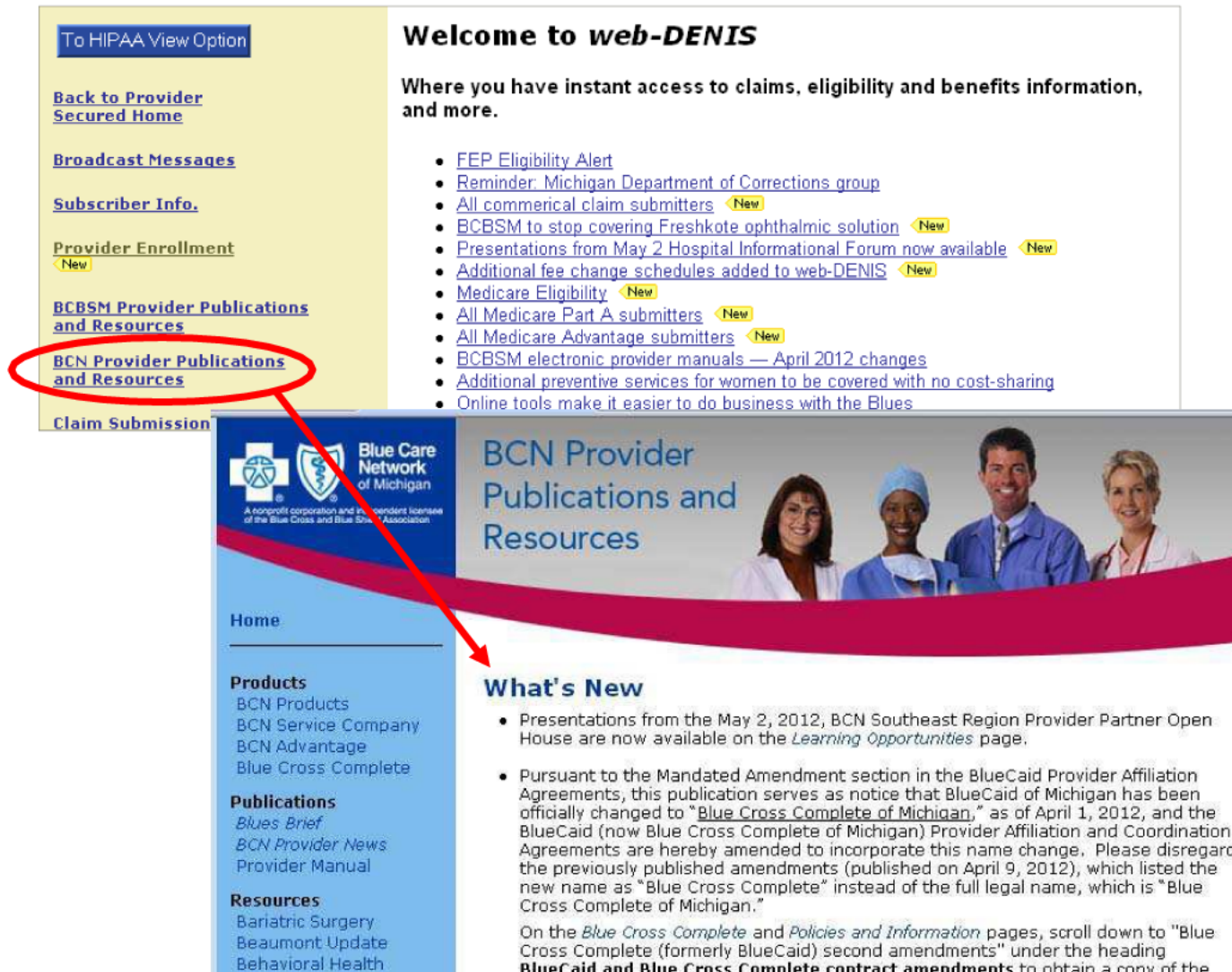


Getting to web-DENIS resources

- Log in to web-DENIS. You'll need your password.
- Click *BCN Provider Publications and Resources*.



[To HIPAA View Option](#)

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Welcome to web-DENIS

Where you have instant access to claims, eligibility and benefits information, and more.

- [FEP Eligibility Alert](#)
- [Reminder: Michigan Department of Corrections group](#)
- [All commercial claim submitters](#) New
- [BCBSM to stop covering Freshkote ophthalmic solution](#) New
- [Presentations from May 2 Hospital Informational Forum now available](#) New
- [Additional fee change schedules added to web-DENIS](#) New
- [Medicare Eligibility](#) New
- [All Medicare Part A submitters](#) New
- [All Medicare Advantage submitters](#) New
- [BCBSM electronic provider manuals — April 2012 changes](#)
- [Additional preventive services for women to be covered with no cost-sharing](#)
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- Blue Cross Complete

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- BCN Provider News*
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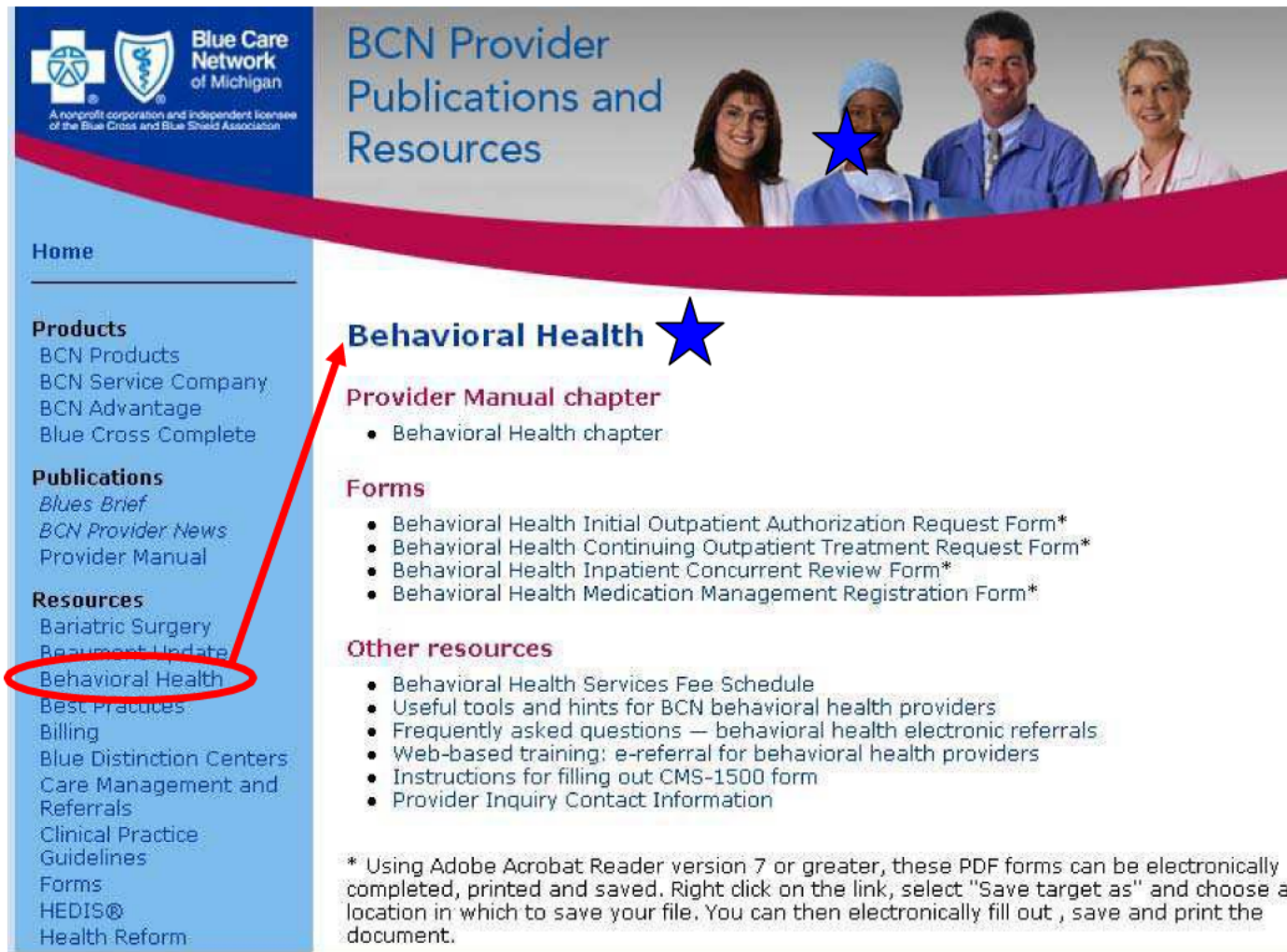
- Bariatric Surgery
- Beaumont Update
- Behavioral Health

What's New

- Presentations from the May 2, 2012, BCN Southeast Region Provider Partner Open House are now available on the *Learning Opportunities* page.
- Pursuant to the Mandated Amendment section in the BlueCaid Provider Affiliation Agreements, this publication serves as notice that BlueCaid of Michigan has been officially changed to "Blue Cross Complete of Michigan," as of April 1, 2012, and the BlueCaid (now Blue Cross Complete of Michigan) Provider Affiliation and Coordination Agreements are hereby amended to incorporate this name change. Please disregard the previously published amendments (published on April 9, 2012), which listed the new name as "Blue Cross Complete" instead of the full legal name, which is "Blue Cross Complete of Michigan."

On the *Blue Cross Complete* and *Policies and Information* pages, scroll down to "Blue Cross Complete (formerly BlueCaid) second amendments" under the heading **BlueCaid and Blue Cross Complete contract amendments** to obtain a copy of the

web-DENIS Behavioral Health page



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Billing
Blue Distinction Centers
Care Management and Referrals
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Health Reform

Behavioral Health ★

Provider Manual chapter

- Behavioral Health chapter

Forms

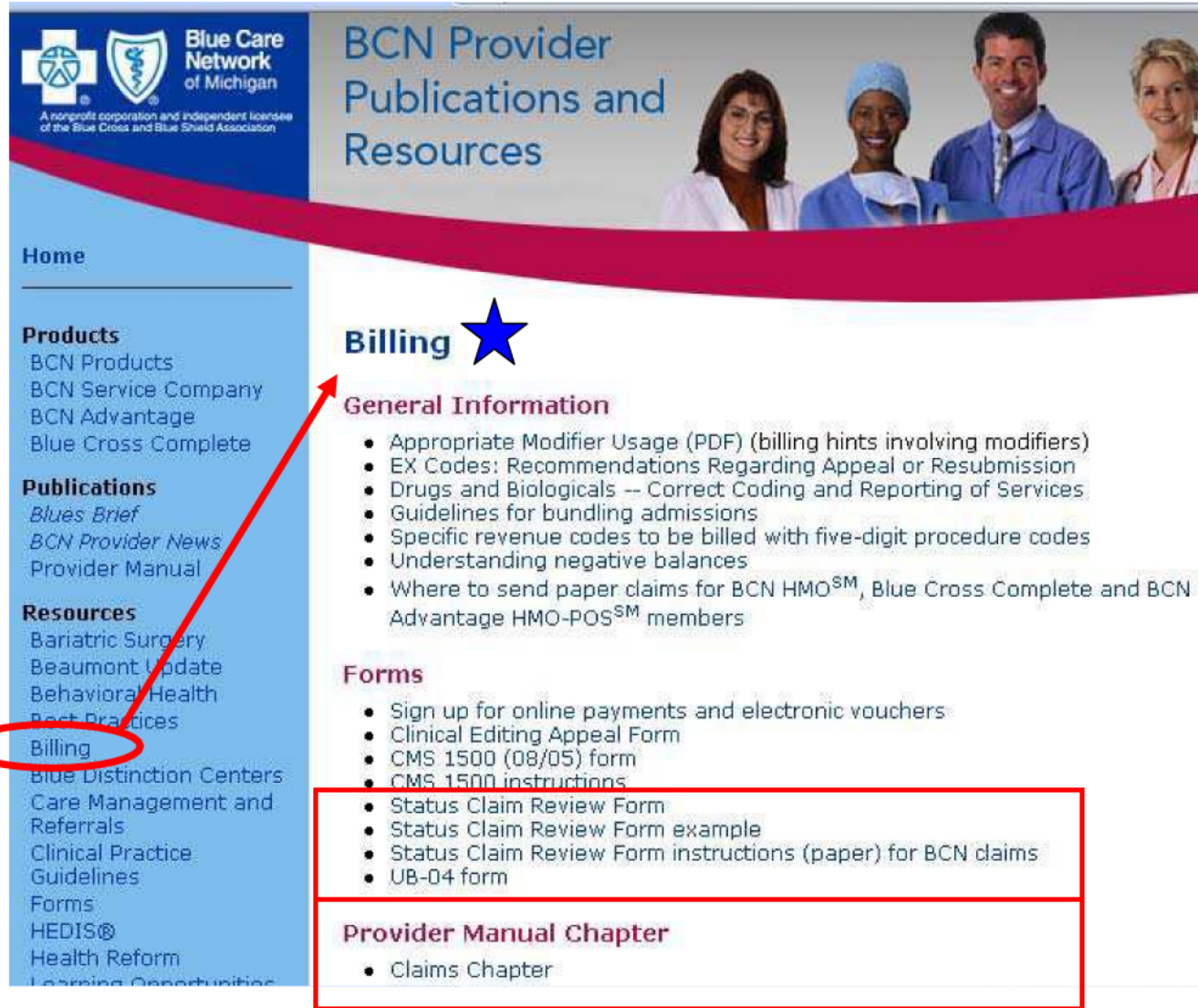
- Behavioral Health Initial Outpatient Authorization Request Form*
- Behavioral Health Continuing Outpatient Treatment Request Form*
- Behavioral Health Inpatient Concurrent Review Form*
- Behavioral Health Medication Management Registration Form*

Other resources

- Behavioral Health Services Fee Schedule
- Useful tools and hints for BCN behavioral health providers
- Frequently asked questions — behavioral health electronic referrals
- Web-based training: e-referral for behavioral health providers
- Instructions for filling out CMS-1500 form
- Provider Inquiry Contact Information

* Using Adobe Acrobat Reader version 7 or greater, these PDF forms can be electronically completed, printed and saved. Right click on the link, select "Save target as" and choose a location in which to save your file. You can then electronically fill out, save and print the document.

web-DENIS Billing page



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Billing ★

General Information

- Appropriate Modifier Usage (PDF) (billing hints involving modifiers)
- EX Codes: Recommendations Regarding Appeal or Resubmission
- Drugs and Biologicals -- Correct Coding and Reporting of Services
- Guidelines for bundling admissions
- Specific revenue codes to be billed with five-digit procedure codes
- Understanding negative balances
- Where to send paper claims for BCN HMOSM, Blue Cross Complete and BCN Advantage HMO-POSSM members

Forms

- Sign up for online payments and electronic vouchers
- Clinical Editing Appeal Form
- CMS 1500 (08/05) form
- CMS 1500 instructions
- Status Claim Review Form
- Status Claim Review Form example
- Status Claim Review Form instructions (paper) for BCN claims
- UB-04 form

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- Claims Chapter

Professional Claims - Billing Instructions

Maternity and delivery services

- Antepartum care: one - three visits
- Antepartum care: four or more visits
- Single delivery
- Multiple-gestation births: vaginal

Other professional claims

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- Coordination of benefits
- Emergency care
- Healthy Blue LivingSM visits and forms
- Medical care, inpatient
- MiPCT project: Provider-delivered care management
- Modifiers for site-specific procedures
- Modifiers for repeat procedures

- Multiple
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- Nation
- Observ
- Pap sm
- Physical
- therap
- Radiolo
- Sick ba
- Surger
- Urgent
- Well newborn examination

Facility Claims - Billing Instructions

Inpatient services

- Room and board, general stay
- Delivery, normal, mother
- Newborn nursery care, well baby
- Newborn nursery care, sick baby

- Skilled nursing facility
- Status inquiry claim: IP TOB 7
- Void claim: IP TOB 8

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- Behavioral health: intensive outpatient (mental health)
- Behavioral health: partial hospitalization (mental health)
- Chemotherapy
- End-stage renal disease, freestanding facility
- Home health care
- Laboratory and radiology services with repeat modifier
- Well newborn examination

- Multiple-line surgery, ASF
- Multiple-line surgery, hospital-based
- National Drug Code reporting
- Observation stay
- Outpatient surgery with preadmission testing
- Per-diem services
- Physical, occupational and speech therapy
- Status inquiry claim: OP TOB 7

STATUS CLAIM REVIEW FORM

LAST NAME OF INSURED/SUBSCRIBER

FIRST NAME

GROUP NO.

SERVICE CODE

INSURED'S/SUBSCRIBER IDENTIFYING NO. (INCLUDE ANY LETTERS)

PHYSICIAN OR PROVIDER NAME, ADDRESS, ZIP CODE

PROVIDER CODE/NPI

TELEPHONE NUMBER

P.O.T.A.

REJ.

CORR.

COMP NPR

ORIGINAL FORM WAS PAY PROVIDER

YES

NO

1. PATIENT'S LAST NAME

2. MID.

3. FIRST NAME

4. PAT'S BIRTH

5. PAT'S SEX

6. PAT'S RELATIONSHIP TO INSURED

7. PATIENT'S MEDICARE HIB NO.

8. PATIENT'S ACCT. NO.

9. INSURED'S TELE. NO.

10. WAS CONDITION REL TO

11. CR IND

12. ATTACH

13. MULT.

14. INSURED'S STREET ADDRESS

15. CITY

16. ST.

17. ZIP CODE

18. PRIOR AUTHORIZATION NO.

19. DATE OF ILLNESS (FIRST SYP.)
INJURY (ACCIDENT)
PREGNANCY (L.M.P.)

20. ADMISSION DATE

21. DISCHARGE DATE

22. SERVICE FACILITY CODE/NPI

23. REFERRING/ORDERING LICENSE # /NPI

24. PPO REFERRING PHYSICIAN CODE/NPI

25. PAY'T. AMT. REC'D

26. CHECK DATE

27. CHECK NO.

28. NON-PAYM'T CODE

29. DOCUMENT NO.

30. DIAGNOSIS OR ADDITIONAL INFORMATION AREA

31. DATE OF SRV	32. DX CODE	33. PLACE	34. PROC. CODE	35. QTY.	36. DURATION	37. CHARGES	38. MISC. DATE	39. I.C.
1	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI	
					A.	B.	NPI	
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					A.	B.	NPI	

DO NOT WRITE IN THIS AREA - DOCUMENT NUMBER

Blue Care Network

Filling Out the Paper *Status Claim Review Form* for BCN Claims

For BCN claims, providers completing the *Status Claim Review Form* must re-bill the entire claim for any services performed on a particular date of service and include any corrections. The chart below provides step-by-step instructions for professional billers completing the paper *Status Claim Review Form* for BCN claims.

Note: For Blue Cross Blue Shield of Michigan claims, providers should follow the instructions on page 2 of the [BCBSM Status Review Claim Form](#).

How to complete the paper <i>Status Review Claim Form</i>		
Field #	Field Name	Information
Upper left corner	SUBSCRIBER INFORMATION	
	Subscriber Name	Enter subscriber's last name and first name.
	Group Number	Not required
	Service Code	Not required
	Insured Subscriber Identifying No.	Enter the subscriber's alphanumeric ID number.
	Type of Coverage	<ul style="list-style-type: none"> • BC/BS: — Leave blank. • F.E.P. — Leave blank. • COMP. — Leave blank. • O/S — Leave blank.
Upper right corner	PROVIDER INFORMATION	
	Provider Name and Address	Enter the provider's name and address.
	Provider Code/NPI	Enter the NPI. Note: Effective Sept. 30, 2009, only the NPI is accepted as the provider identifier.
	Provider's Phone	Enter area code and phone number.

continued on next page

Blue Care Network

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper <i>Status Review Claim Form</i>		
Field #	Field Name	Information
Located under provider code (upper right corner)	Reason For Submission Enter an X in all boxes that apply.	<ul style="list-style-type: none"> P.O.T.A. — A payment was received other than what was anticipated. REJ. — A rejection is being questioned. CORR. — A correction to the original claim is being submitted. COMP NPR — Leave blank. Original Form Was Pay Provider — Enter an X in the appropriate box.
1	Patient's Last Name	Enter patient's last name.
2	Mid	If known, enter patient's middle initial.
3	First Name	Enter the patient's complete first name. Do not use a nickname unless the patient is listed that way on the contract.
4	Patient's Birth	Enter the patient's birth date in a six-digit format with no spaces (MMDDYY).
5	Patient's Sex	Enter an X in the appropriate box.
6	Pat's. Relationship to Insured	Enter an X in the appropriate box.
7	Patient's Medicare HIB No.	Leave blank.
8	Patient's Account No.	Not required. If an office has assigned a case number to the patient, enter it here. A maximum of 20 characters may be used. BCN will include this number on the payment voucher to assist providers in the patient's accounting.
9	Insured's Tele No.	Enter the subscriber's area code and phone number.
10	Was condition Rel. to	<ul style="list-style-type: none"> EMP — Enter an X if the accident took place in the patient's place of employment. AUTO — Enter X if the patient's condition is related to an auto accident. OTH — Enter X if the accident is not related to employment or auto accident.
11	CR Ind	Leave blank.
12	Attach	Enter the number of pages attached to the claim form. This includes explanatory letters or copies of other carrier's payment vouchers. If the number of attachments is not indicated, the claim may not be processed correctly.
13	Mult.	Enter an X in this box if there are multiple diagnoses or to indicate that additional information is entered in field 30. This field applies only for claims with multiple diagnoses or additional information.
14	Insured's Street Address	Enter the subscriber's address.
15	City	Enter the subscriber's city.
16	ST	Enter the subscriber's two-letter state abbreviation as used by the U.S. Postal Service.
17	Zip Code	Enter the subscriber's ZIP code.
18	Prior Authorization No.	If billing a service that was authorized by BCN, enter the authorization number received. The number of digits may vary.

continued on next page

Blue Care Network

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper <i>Status Review Claim Form</i>		
Field #	Field Name	Information
19	Date of	<ul style="list-style-type: none"> Enter the date the patient first experienced symptoms of the illness or condition for which services were performed, with the following exceptions: <ul style="list-style-type: none"> If the service is related to end stage renal disease, enter the date of the first maintenance dialysis or the date of the kidney transplant. If the service is related to an injury — whether it is the initial treatment or a follow-up service — enter the date of the injury. If the service is related to pregnancy, enter the date of the last menstrual period. If unable to determine the LMP, use the estimated date of conception. Enter the date in a six-digit format: for example, enter Jan. 1, 2007, as 010107.
20	Admission Date	If the service was performed on an inpatient basis, enter the admission date. Otherwise, leave the field blank. <i>For inpatient services only</i>
21	Discharge Date	<p>If the service was performed on an inpatient basis, enter the discharge date. (Only the discharge doctor is responsible for this information.) Otherwise, leave the field blank.</p> <p>Use this field only for inpatient services performed by the physician who discharged the patient.</p>
22	Facility Code	Not required
23	Referring/ Ordering Physician Information	Not required
24	PPO Referring Physician Code/NPI	Leave blank
25	Payment Amt. Rec'd.	Enter the total payment received for the services in question.
26	Check Date	Enter the date of the Remittance Advice for the service in question.
27	Check No.	Enter the check number from the Remittance Advice.
28	Nonpayment Code	Enter the nonpayment code from the Remittance Advice for the service in question.
29	Document No.	Enter the BCN claim number from the Remittance Advice for the service in question.
30	Diagnosis or Additional Information Area	<ul style="list-style-type: none"> Diagnosis — Enter diagnosis codes. Additional Information — Provide an explanation of why BCN should reconsider action on this claim. Enter additional information or any information that was omitted on the original claim. Describe any attachments. Attach a second sheet of paper if needed. If original claim was denied for no authorization on file and a copy of the authorization has been retained from the primary care physician, attach it to the <i>Status Claim Review Form</i>.

Blue Care Network

Filling Out the Paper *Status Claim Review Form* for BCN Claims

How to complete the paper <i>Status Review Claim Form</i>		
Field #	Field Name	Information
Service information In fields 31 through 45, enter service information. If entering information that was omitted or reported incorrectly on the original claim, enter an X in the small shaded box to the right of that item.		
31	Date of Srvc.	Enter the date each service was provided. Enter the date in a six-digit format (MMDDYY).
32	Dx Code	Enter the full five-digit, four-digit or three-digit ICD-9-CM code that represents the primary diagnosis.
33	Place	Enter the appropriate HIPAA-compliant location of service code to describe where care was provided. Refer to the CMS-1500 (08/05) claim information earlier in the <i>Professional Claim Examples</i> chapter of the <i>BCN Provider Manual</i> .
34	Proc. Code	Enter the five-character procedure code for the procedure performed.
35	Qty.	Enter the number of treatments, visits or anesthesia minutes.
36	Duration	Leave blank.
37	Charges	Enter the original charge billed for the service. If billing multiple services as one line item, enter the total amount for all services on the same service line. Do not include dollar signs, decimals, negative signs or any other nonnumeric characters. Also, do not indicate if the patient has already paid all or some portion of the charges; payments from the patient should not be shown anywhere on the form.
38	Misc. Date	<ul style="list-style-type: none"> If reporting multiple services on one line, enter the last date of service in this field. If the service date is related to pregnancy, enter the first date of prenatal care. In all other cases, leave this field blank.
39	I.C.	Enter modifier 22 if reporting unusual circumstances and have used an unlisted procedure code*. Use for unusual circumstances and unlisted procedure codes only.
40	Modifiers	Enter up to four two-character modifiers to further define the procedure code entered in Field 34. Report up to four modifiers for each procedure code.
41	Med. Reasonable	Leave blank.
42	Med. Deduct.	If requesting additional BCN 65 payment, enter the total amount applied to the Medicare deductible as shown on the Medicare payment voucher. Use only for BCN 65 inquiries when an amount was applied to the patient's deductible.
43	Other Carrier Amount	Not required.
44	Qual. Rendering License #	A. Not required. B. Enter the rendering physician's BCBSM license number, for example, AS123456. This is crucial when billing with a Group Bill PIN.
45	Rendering NPI	Enter the rendering provider's NPI.
Lower right corner	Provider Signature	Enter the provider's authorized signature or stamped reproduction and date. If completing claims form on computer, "signature on file" is acceptable.

STATUS CLAIM REVIEW FORM

LAST NAME OF INSURED/SUBSCRIBER

FIRST NAME

GROUP NO.

SERVICE CODE

INSURED'S/SUBSCRIBER IDENTIFYING NO. (INCLUDE ANY LETTERS)

PHYSICIAN OR PROVIDER NAME, ADDRESS, ZIP CODE

PROVIDER CODE/NPI

TELEPHONE NUMBER

A.

B. NPI

P.O.T.A.

REJ.

CORR.

COMP NPR

ORIGINAL FORM WAS PAY PROVIDER

YES

NO

1. PATIENT'S LAST NAME

2. MID.

3. FIRST NAME

4. PAT'S BIRTH

5. PAT'S SEX

6. PAT'S RELATIONSHIP TO INSURED

7. PATIENT'S MEDICARE HIB NO.

8. PATIENT'S ACCT. NO.

9. INSURED'S TELE. NO.

10. WAS CONDITION REL TO

11. CR IND

12. ATTACH

13. MULT.

14. INSURED'S STREET ADDRESS

15. CITY

16. ST.

17. ZIP CODE

18. PRIOR AUTHORIZATION NO.

19. DATE OF ILLNESS (FIRST SYP.)
INJURY (ACCIDENT)
PREGNANCY (L.M.P.)

20. ADMISSION DATE

21. DISCHARGE DATE

22. SERVICE FACILITY CODE/NPI

23. REFERRING/ORDERING LICENSE # /NPI

24. PPO REFERRING PHYSICIAN CODE/NPI

25. PAY'T. AMT. REC'D

26. CHECK DATE

27. CHECK NO.

28. NON-PAYM'T CODE

29. DOCUMENT NO.

30. DIAGNOSIS OR ADDITIONAL INFORMATION AREA

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1	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI	
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4	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI	
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5	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI	
					A.	B.	NPI	
31. DATE OF SRV	32. DX CODE	33. PLACE	34. PROC. CODE	35. QTY.	36. DURATION	37. CHARGES	38. MISC. DATE	39. I.C.
6	40. M-1 M-2 M-3 M-4	41. MED.REASONABLE	42. MED DEDUCT.	43. OTR CARRIER AMOUNT	44. QUAL.	RENDERING LICENSE #	45. RENDERING NPI	
					A.	B.	NPI	

DO NOT WRITE IN THIS AREA - DOCUMENT NUMBER

Resubmitting a claim for inquiry

Facility providers can file a paper inquiry using a UB-04 with a TOB 7



Facility providers can submit a paper status inquiry claim using a UB-04 claim form with a TOB 7.

When completing the UB-04 with a TOB 7, the provider must rebill all services that were performed on a particular date of service and include any corrections. The claim should be submitted by completing the following steps:

1. Print and complete the UB-04 claim form available at web-DENIS > BCN Provider Publications and Resources > Billing > [UB-04 form](#).

Note: Providers should complete the form according to instructions available in the *National UB-04 Manual*.

This includes the following:

- Enter the appropriate type of bill code ending in 7.
- Enter the claim number from the original or previous Remittance Advice for the service in question.

2. Attach any relevant documentation.

3. Mail the request to the appropriate address:

Blue Care Network

P.O. Box 68710

Grand Rapids MI 49516-8710

BCN Advantage

- OR -

Blue Cross Complete

P.O. Box 68753

Grand Rapids MI 49516-8753

For additional information on how to file a status inquiry claim, facility providers should review the claim example *Status inquiry claim: outpatient, TOB 7*, which is available at web-DENIS > BCN Provider Publications and Resources > Billing > [Status inquiry claim: outpatient, TOB 7](#).

Resubmitting a claim for inquiry

Professional providers can file a paper inquiry using the *Status Claim Review Form*



Professional providers can submit a paper status inquiry using the *Status Claim Review Form*.

When completing the *Status Claim Review Form*, providers must rebill all services that were performed on a particular date of service and include any corrections. The claim should be submitted by completing the following steps:

1. Print and complete the front page of the *Status Claim Review Form*, which is available at web-DENIS > BCN Provider Publications and Resources > Billing > [Status Claim Review Form](#).

Note: Providers should complete the form according to the instructions available at web-DENIS > BCN Provider Publications and Resources > Billing > [Status Claim Review Form instructions \(paper\) for BCN claims](#).

This includes entering the claim number from the original or previous Remittance Advice for the service in question.

2. Attach any relevant documentation.
3. Mail the request to the appropriate address:

Blue Care Network
P.O. Box 68710
Grand Rapids MI 49516-8710

BCN Advantage
- OR -
Blue Cross Complete
P.O. Box 68753
Grand Rapids MI 49516-8753

For additional information on how to complete the form, professional providers should review the *Status Claim Review Form example* available at web-DENIS > BCN Provider Publications and Resources > Billing > [Status Claim Review Form example](#).

Professional providers only: obtaining the paper form



A copy of the front page of the *Status Claim Review Form* (without the BCBSM back-page instructions) is available at web-DENIS BCN Provider Publications and Resources > Billing > [Status Claim Review Form](#).

Note: To order large quantities of the *Status Claim Review Form*, providers should complete and fax or mail the *BCBSM Professional and Facility Supply Requisition Form*. This can be found at [MiBCN.com](#) > I am a provider > Provider Supply Forms > BCN Providers > [Use the Facility and Professional Provider Supply Requisition Form](#).

Status inquiry claim: outpatient, TOB 7

This claim example illustrates a status inquiry claim sent by a facility provider to request that BCN reconsider a denial on the original claim.

When completing the UB-04 with a TOB 7, providers must rebill all services that were performed on a specific date of service and communicate any corrections.

For additional information, providers should refer to the “Resubmitting a claim for inquiry” section of the *Claims* chapter of the *Blue Care Network Provider Manual*.

Form locator	Description	What to enter
4	TYPE OF BILL	Enter the appropriate outpatient type of bill code ending in 7, to indicate replacement of a prior claim.
54	PRIOR PAYMENTS	Enter the payment amount the provider has received toward payment of this bill prior to this billing date by the payer indicated.
64	DOCUMENT CONTROL NUMBER	Enter the 12-digit BCN claim number located on the original or previous Remittance Advice for the service in question.
80	REMARKS	Indicate the reason for resubmission.

Note: If any of the information presented here conflicts with the BCN provider contract, the contract language should be followed.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2011 American Medical Association. All rights reserved.

Guidelines for reviewing the claim examples: The entire claim must be completed before it is sent to BCN for processing. It is not possible to show examples of all types of claims, so providers may need to reference multiple examples to obtain the information needed to properly complete a claim.

Where appropriate, providers should substitute their own billing information. For example, a claim submitted for a different type of facility or classification will have a different type of bill (form locator 4) than that shown in the example. In all cases, providers should refer to the *National UB-04 Manual* for a detailed description of each form locator.

continued on next page

January 2012

In Box 4
(Type of Bill),
enter "7."

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In Box 64,
enter original
claim number.