Participating Provider Manual

For

Blue Care Network of Michigan Program

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Effective April 1, 2009

(Important Revisions Highlighted in Grey)

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INTRODUCTION

Northwood, Inc. (Northwood) is the exclusive contracted Third Party Administrator and Network Manager for Blue Care Network of Michigan (BCN) for Durable Medical Equipment (DME), Prosthetic and Orthotic (P&O) devices and Medical Supplies.

This updated information replaces all previous Northwood Provider Bulletins and Manuals pertaining to Blue Care Network of Michigan. The information contained in this Provider Manual will assist you when providing DMEPOS services to Blue Care Network of Michigan Members.

Northwood's Participating Supplier Agreement requires network providers to adhere to Northwood's Policies and Procedures. Policies and Procedures include, but are not limited to:

- **Northwood's Fee Schedule**
- **Assignment for All Services Provided By Your Company**
- **Authorization**
- **Member Billing**
- **Claims Processing**
- **Member Appeals**
- **Quality of Service/Member Satisfaction**
- **24-Hour Emergency Service**

SECTION I - BENEFIT/COVERAGE CRITERIA

Northwood administers BCN's Commercial and Advantage (Medicare) Programs in accordance with plan benefits and medical policy guidelines detailed below:

- **Covered DMEPOS benefits for BCN Commercial and BCN Advantage Members must be obtained and provided by a Northwood contracted provider.**
- **Providers may not subcontract covered services to other providers without the consent of Northwood, with the exception of traveling Members.**
- **Benefit criteria may vary by employer group, policy and applicable riders.**
- **The Member's primary care physician must approve all equipment and supplies.**
- **Equipment and supplies provided under the program are based upon the most medically appropriate and cost-effective, standard item(s). This includes prefabricated v. custom fabricated orthotics.**
- **Shipping, handling, and sales tax are not eligible for separate reimbursement.**
- **Services must be prior-authorized unless detailed on the Authorization Exclusions List (see Section II Authorization).**

PROVIDER RESPONSIBILITIES PRIOR TO RENDERING EQUIPMENT OR SUPPLIES

Prior to providing equipment or supplies, the provider is responsible for obtaining and verifying all necessary information, including the following:

- **Review for appropriateness and cost effectiveness.**
- **Documentation to support the medical need for custom v. prefabricated orthotic devices.**
- **Confirming that equipment is to be provided in the Member's home.** ***This program does not cover equipment provided in a hospital or skilled nursing facility.***
- **Other COB information (auto liability, workers compensation, etc.)**

DELIVERY TIMELINES

Northwood requires providers to:

- **Provide covered equipment (excluding custom fitting or design services) on the same day services are requested, unless the request is received after 12:00 Noon.**

- **Provide orders received after noon within 24 hours.**

- **Have on-call servicing available 7 days a week and 24 hours a day for respiratory and other necessary services.**

- **Deliver covered emergency services to Member's place of residence (or hospital pending discharge) within 4 hours of receipt.**

- **Provide emergency services requested outside of Northwood regular business hours and obtain authorization (when required) on the next regularly scheduled business day. (See Section II Authorization).**

ASSIGNMENT – NONDISCRIMINATION

Northwood providers are required to:

- **Provide covered equipment and supplies to Blue Care Network Members in the same manner, quality and promptness as services that are provided to other customers, including after-hours emergency servicing.**

- **Accept assignment on covered equipment or supplies normally provided by the company to Blue Care Network Members.**

- **Render equipment and supplies in a manner consistent with professionally recognized standards of health care.**

EQUIPMENT AND SUPPLIES NOT NORMALLY CONSIDERED A COVERED BENEFIT, INCLUDING DELUXE PRODUCTS/UPGRADES

- **Member health care benefits are determined by the structure of their benefit package.**

- **Although benefit exceptions are rarely made by the plan, circumstances may warrant approval. Therefore, *all equipment and supply items*, including those that are normally considered "not a covered benefit" must be reviewed in accordance with BCN policy.**

- **Blue Care Network has established a process with Northwood to ensure consistency in the review and approval/denial of equipment and supplies that are excluded benefits due to;**

    - **Diagnosis.**
    - **Higher grade equipment.**
    - **Replacement frequency.**
    - **Not being considered medical in nature.**

- **If a requested service normally considered "not a covered benefit" is accompanied by a physician's order, it must be forwarded to Northwood for case review.**

- **All requests for services and medical review must be processed through Northwood. Do not forward requests directly to Blue Care Network or deny service to the Member prior to case review.**

- **The Member may choose to upgrade from a standard product.**

- **It is the responsibility of the provider to inform the Member that there are standard products available that meet plan policy.**

- **When a Member requests equipment or supply upgrades and qualifies for basic services covered by the plan, the Member is responsible for the difference between Northwood's allowed payment and the provider's charge, less 15%.**

- **Under the Blue Care Network program, a 15% discount from retail price must be extended to the Member for non-covered items.**

- **A Member must be advised of his/her estimated payment responsibility and the provider must obtain the Member's signed consent indicating they have been informed of their responsibility for any outstanding balance.**

    - **This must take place prior to ordering the product or before the product is delivered (refer to Northwood Waiver Form – Section XI).**
    - **Medicare supplemental and BCN Advantage Members must sign a CMS Advance Beneficiary Notice (ABN) Form.**

There will be no payment to the provider by Northwood or the Health Plan when the provider fails to follow the Case Review or Product Upgrade waiver process detailed above. Additionally, Members may not be charged for services when providers fail to follow the above process according to "Hold Harmless" Section (5.5) of the Participating Supplier Agreement and Section (6) of the Blue Care Network Third Party Beneficiary Acknowledgement to Northwood Provider Agreement.

BCN ADVANTAGE PROGRAM

The BCN Advantage Program combines Medicare Parts A and B into Part C. The program provides all Medicare-covered benefits to eligible Members and adds additional benefits not covered by Medicare. These include preventive services, prescription coverage (Part D), vision and dental coverage. The program has three option packages; however, DMEPOS services are consistent throughout the packages and are administered as followed:

- **BCN Advantage Members have varying levels of co-payment for DMEPOS services.**

- **BCN Advantage services not listed on the Authorization Exclusion List must be prior authorized by Northwood.**

- **Northwood providers are required to accept assignment for BCN Advantage covered services.**

- **Medicare documentation requirements must be followed for BCN Advantage members.**

- **Providers must follow the same process as commercial Members regarding the denial of services for BCN Advantage Members. Refer to Equipment and Supplies Not Normally Considered a Covered Benefit.**

DME CO-PAYMENT RIDER FOR SELECT GENERAL MOTORS EMPLOYEES WITH BCN-1 BENEFITS

Select General Motors employees with BCN-1 coverage have a co-payment rider included in their Benefit Certificate. This includes a co-payment of $30.00 or 50% of the reimbursement amount, whichever is less, for durable medical equipment.

Providers checking eligibility through Northwood or utilizing DENIS should review BCN-1 status to determine if the Member has a DME-30 Rider and if so, should collect the appropriate co-payment described above. The co-payment is assessed per line item.

OXYGEN EQUIPMENT

The following oxygen requirements apply for all BCN and BCN Advantage Members, effective January 1, 2009:

- **The minimum manufacturer oxygen output concentration level at any flow rate must be 87%.**

- **The concentrator must have a built-in continuous flow analyzer feature with automatic sensor alarm.**

- **The concentrator must have, at a minimum, a five year manufacturer warranty.**

- **The concentrator must be from one of the following manufacturers (or equivalent):**
    - **Invacare**
    - **AirSep**
    - **Respironics**
    - **DeVilbiss**
    - **SeQual**

- **BCN Advantage and Medicare supplemental business lines follow Medicare guidelines for oxygen rental caps (36 months), reimbursement of oxygen contents for liquid or gas and routine maintenance and service fees (every six (6) months) through 2009.**

- **When an oxygen system rental caps, a supplier may choose to deliver a maximum of a 3 month supply of portable oxygen contents to a Member. The supplier will call Northwood Customer Service to indicate the amount of tanks per month and submit a monthly claim reporting quantity of tanks for (E0441 & E0443).**

- **E0442 & E0444 can be authorized monthly for capped oxygen equipment.**

- **Northwood expects a typical Commercial oxygen patient to use no more than five (5) portable fills per month. If a Commercial Member requires more than five (5) fills in a given month, the provider will call Northwood Customer Service staff to request an individual consideration review for additional reimbursement for (E0443).**

ARRANGING OXYGEN FOR TRAVELING MEMBERS

When a BCN Commercial Member uses oxygen and travels outside the local area for a period of less than 30 days, the Northwood provider should assist the Member by making arrangements with another supplier to provide temporary oxygen services consistent with the type of services currently provided by the Northwood provider.

- **The Member may not be held financially responsible for oxygen equipment or contents under this travel policy (applicable co-payments apply).**

- **For travel exceeding 30 days, the Northwood supplier is expected to assist the Member with making arrangements with another supplier for oxygen equipment, stop billing and pick-up oxygen equipment from the Member until they return to the local area.**

- **Northwood providers are required to pick-up and re-deliver oxygen equipment to reasonably accommodate the Member's travel itinerary and to meet the Member's oxygen needs.**

- **Northwood/BCN will only reimburse one supplier for oxygen during any month.**

3-MONTH SUPPLY ORDERS

For Members receiving the standard quantity (or pre-authorized over-quantity) of supplies, providers may dispense up to a 3-month order for the following;

- **Ostomy supplies.**

- **Urological supplies.**

- **Disposable nebulizer supplies.**

- **CPAP supplies.**

If a three month quantity is dispensed, neither Northwood nor Blue Care Network is responsible for payment of services provided to Members whose coverage has changed or terminated.

Please Note: Member's may choose to receive supplies monthly, due to co-payment, space limitations, etc.

NEBULIZERS

Based upon the diagnosis, a nebulizer may be reimbursed for rental or purchase.

CPAP/BIPAP SUPPLIES

The following CPAP requirements apply for all BCN Members, effective January 1, 2009:

- **The CPAP device must include, as standard equipment, integrated heat and humidification.**

- **Claims for BIPAP humidifiers should be submitted as a rental. BIPAP humidifier rentals cap at 12 months.**

- **The CPAP device must have, at a minimum, a 2 year manufacturer warranty.**

- **The CPAP device must be from one of the following manufacturers (or equivalent):**

    - **Respironics**
    - **Invacare**
    - **DeVilbiss**
    - **ResMed**
    - **Fisher & Paykel**

- **A Northwood authorization is required for CPAP/BIPAP Equipment.**

- **An authorization is also required for supplies dispensed with an initial CPAP/BIPAP set-up.**

- **Northwood recognizes there are numerous CPAP/BIPAP masks and nasal applications available on the market. As of the date this manual has been published, the following are examples of standard/basic CPAP/BIPAP masks and nasal applications:**

- **Respironics Comfort Gel Mask, Respironics Comfort Classic Mask, Respironics Simplicity Nasal Mask, Respironics Comfort Full Mask, Resmed Mirage Activa Mask, Resmed Mirage Vista Mask, Resmed Mirage Swift LT Nasal Mask, Respironics Comfort Select Nasal Mask, Resmed Mirage Swift Nasal Mask, Invacare Twilight Nasal Mask and similar models.**

- **Should a physician order a CPAP/BIPAP mask or nasal application other than one listed above (or an equivalent), a request for individual consideration must be accompanied by the physician's written order stating the specific mask or nasal application requested.**

- **Medicare documentation requirements must be followed for BCN Advantage members.**

- **Providers have 2 business days following delivery/set-up of CPAP/BIPAP equipment to request a supply change to an initial set-up authorization. Such requests should include the specific code relative to the type of mask/nasal application supplied, if it was unknown prior to set-up.**

- **Subsequent supply orders for the following services do not require authorization but are subject to quantity/frequency limitations:**

  - **A7031 Interface replacement for a full mask — 1 per month**
  - **A7032 Cushion for nasal mask, replacement — 2 per month**
  - **A7033 Pillow for nasal cannula type, replacement, pr. — 2 per month**
  - **A7035 Headgear — 1 per 6 months**
  - **A7030 Full Face Mask — 1 per 3 months**
  - **A7034 Mask — 1 per 3 months**
  - **A7027 Combination Oral/nasal mask — 1 per 3 months**
  - **A7028 Oral cushion for combo mask, replacement — 2 per month**
  - **A7029 Nasal pillows for combo mask, replacement, pr — 2 per month**
  - **A7037 Tubing — 1 per 3 months**
  - **A7046 Water Chamber — 1 per 6 months**
  - **A4604 Heated Tubing (Only the Fisher & Paykel Series HC600) — 1 per 3 months**
  - **A7038 Disposable Filters — 1 pkg. per 2 months**
  - **A7039 Permanent Filters — 1 per 6 months**
  - **A7036 Chin Strap — 1 per 6 months**

SECTION II – AUTHORIZATION / AUTHORIZATION EXCLUSIONS

Northwood must review all equipment and supply requests which require prior authorization to determine coverage, based upon the Member's benefit structure.

Prior authorization is required for most BCN Commercial and BCN Advantage services with the exception of equipment or supplies requested and provided after regularly scheduled Northwood business hours (see After-Hours Retrospective Authorizations) and services included on the Authorization Exclusions List.

AUTHORIZATION EXCLUSIONS LIST

The following services do not require prior authorization:

Description	Diagnosis Exempt
Ostomy and Urological supplies (with the exception of NOC codes)	**788.30,V442,V44.3**
Nebulizer w/compressor (E0570) and disposable supplies (A7003, A7015)	**493.9, 162.9, 277.00, 491.0, 492.88, 496, 796**
Commode (E0163)	**335.20, 340, 343.0-343.9,359.0-359.1, 806.00-806.39**
CPAP supplies (subsequent to initial set-up) • **Interface replacement for a full mask (A7031)** • **Cushion for nasal mask, replacement (A7032)** • **Pillow for nasal cannula type, replacement, pr. (A7033)** • **Headgear (A7035)** • **Full Face Mask (A7030)** • **Mask (A7034)** • **Combination Oral/nasal mask (A7027)** • **Oral cushion for combo mask, replacement (A7028)** • **Nasal pillows for combo mask, replacement, pr (A7029)** • **Tubing (A7037)** • **Water Chamber (A7046)** • **Heated Tubing** Only the Fisher & Paykel Series HC600 **(A4604)** • **Disposable Filters (A7038)** • **Permanent Filters (A7039)** • **Chin Strap (A7036)**	**327.20, 327.21, 327.23, 327.26, 327.29**
Lumbar Sacral Orthosis (L0637)	**721.9, 805.1, 224.50, 722.1, 805.4**
Knee Orthosis, with stays/joints (L1810)	**844.20, 755.69, 726.64, 836.60, 717.70, 719.46, 715.9, 727.5, 924.11, 844.10, 716.9**
Knee Orthosis, with condylar pads and joints	**717.9, 755.69, 844.2, 718.86, 844.10**

(L1820)	
Knee Immobilizer (L1830)	**844.2, 824.11, 822.1, 836.2**
Sweedo Ankle Brace (L1902)	**845.00, 824.8, 726.71, 718.87**
Cock-up Wrist Splint (L3908)	**354.0, 842.00**
Ankle Air Cast (L4350)	**718.87, 727.82, 824.8, 845.09**
Walking Boot, Pneumatic (L4360)	**727.81, 824.8, 845.00, 825.20, 823.80, 823.82**
Walking Boot, Non-Pneumatic (L4386)	**824.8, 845.00, 825.25, 825.20, 823.80, 823.82**

Although items listed on the Authorization Exclusions List do not require prior authorization, Northwood strongly recommends that providers continue to do so. Prior authorization provides information on applicable riders, Member co-payments, benefit coverage and limitations, and prevents claim rejections for services received by another provider (i.e.; if no authorization is on file, payment will be made to the 1st claimant).

ELASTIC GARMENTS – NON-COVERED

As of April 1, 2009 the following codes are not a benefit. These codes were previously listed on the January 1, 2009 "Authorization Exclusion List" (page 13).

L0210 – Rib Belt
L0621 – Sacroiliac Orthosis
L0625 – Lumbar Orthosis
L1815 – Knee Orthosis, with Condylar pads

ELASTIC SPINAL GARMENTS AND NON-ELASTIC SPINAL ORTHOSES

As of April 1, 2009, L0459, L0454, L0621, L0625 and L0628 are Spinal Orthosis codes that can be categorized as both rigid and non-rigid.

If you are dispensing a product that falls under one of these codes and it is primarily of non-elastic material and has a rigid posterior panel, the CG modifier must be on the claim when billing. Please notify Northwood staff when authorizing to ensure that a CG modifier is added to the authorization.

AUTHORIZATIONS - GENERAL

To obtain an authorization from Northwood, call the dedicated Provider Inquiry line (800-393-6432) during normal business hours (8:30 a.m. to 5:00 p.m., Monday through Friday), or on the following business day if emergency services are provided.

The following information is required when requesting an authorization:

- **Provider ID Number.**
- **Member Name/Address/Telephone.**
- **Contact/Telephone.**

- **Referral Source/Telephone.**
- **Contract Number.**
- **Other Insurance Information (if any).**
- **Diagnosis - ICD-9-CM Code and Description.**
- **Date of Service.**
- **Referring Physician.**
- **Primary Care Physician.**
- **Level II HCPCS Code.**
- **Description of Product/Service.**
- **Service Type (Purchase or Rental).**
- **Quantity.**
- **Duration of Need.**

Authorizations for services will be provided:

- **For equipment and supplies deemed to be benefits under the program.**

- **When use of the equipment or supply does not exceed the quantity limitation and medical necessity guidelines (i.e.; monthly, yearly, replacement period).**

- **For medically supported over-quantity requests approved through case review.**

- **For the most appropriate, cost-effective, standard and basic equipment or supply.**

Reimbursement will be limited to the authorized equipment or supply based upon the allowable fee for the procedure code(s) approved.

Payment consideration for equipment and supplies includes;

- **Member eligibility at the date of delivery.**

- **Appropriateness of medical necessity coverage criteria determined by BCN is met and documented on the physician's written order.**

- **Benefit structure is met including the most cost-effective standard and basic equipment or supply.**

Northwood does not require authorization for Medicare supplemental services (BCN-65) or other secondary claims.

AUTHORIZATION TIMEFRAMES

Rental DME equipment is authorized based upon medical necessity and the appropriate duration of need for the diagnosis provided at the time of rental.

- **Authorizations may be extended for up to 12 months, at which time the equipment rental may cap.**

- **The following items will cap in less than 12 months:**

o	**E0165**	**Drop arm commode**	**6 months**
o	**E0730**	**4 lead tens unit**	**8 months**
o	**E0202**	**Phototherapy light**	**1 month**
o	**E0118**	**Crutch substitute**	**1-2 months**
o	**E0935**	**Lower CPM device**	**21 days**
o	**E0936**	**Upper CPM device**	**21 days**

- **Over-quantity amounts for supplies are based on a review of medical documentation and may be authorized for up to 12 months.**

- **Renewal authorizations for over-quantity amounts will require updated documentation annually.**

- **Twelve month authorizations do not guarantee coverage.**

- **It is the provider's responsibility to verify Member eligibility and co-payment information on a monthly basis.**

- **Neither Northwood nor BCN are responsible for payment of services provided to Members whose coverage has changed or terminated.**

- **Providers may verify Member eligibility through Blue Cross Blue Shield's Denis or CarenPlus Systems.**

- **A Northwood authorization is not a guarantee of payment for service(s) provided.**

IF THE PROVIDER FAILS TO OBTAIN A REQUIRED AUTHORIZATION, THE MEMBER MAY NOT BE BILLED ACCORDING TO "HOLD HARMLESS" SECTION (5.5) OF THE PARTICIPATING SUPPLIER AGREEMENT AND SECTION (6) OF THE BLUE CARE NETWORK THIRD PARTY BENEFICIARY ACKNOWLEDGEMENT TO NORTHWOOD PROVIDER AGREEMENT.

CHANGE TO INITIAL AUTHORIZATION

Claims will be denied if the services provided do not match the authorization.

- **If a change is made to the equipment or supply originally authorized, contact Northwood's Customer Service staff via fax or telephone to request review for a revised authorization. The following information must be included when requesting review:**

  - **Current authorization number.**
  - **Patient name.**
  - **Contract number.**
  - **Documented reason for change of equipment or supply.**

- **Providers are responsible for maintaining the original hard copy authorization. Northwood will not provide duplicate copies of the original faxed authorization for billing purposes or after payment has been made.**

AFTER HOURS - RETROSPECTIVE AUTHORIZATIONS

Authorizations are not provided after regular business hours, weekends and holidays. Providers should not call for authorizations during those hours.

Retrospective authorizations will only be provided for after-hours service and non-routine circumstances as listed below:

- **Services may be requested outside of Northwood regular business hours.**
  - **Under these conditions, the Member should be serviced.**
  - **The provider may obtain authorization on the next regularly scheduled business day.**
  - **Provider staff may verify eligibility through Blue Cross Blue Shield's Denis or CarenPlus systems.**
- **Members should be informed of their potential financial responsibility for co-payments.**
- **Non-routine retrospective authorization requests must be made in writing and faxed to Northwood along with supporting documentation for case review.**

Northwood may issue retrospective authorizations for non-routine circumstances. However, retrospective authorizations will not be issued due to provider's failure to obtain authorization prior to delivery.

SECTION III - MEMBER SERVICES

Covered DMEPOS benefits for Blue Care Network Commercial and BCN Advantage Members must be obtained through Northwood's contracted providers, approved by the Primary Care Physician (PCP), and authorized when required by Northwood.

Members, referral sources, and providers may contact Northwood during regular business hours for questions and inquiries regarding:

- **Provider network locations.**
- **General benefits and/or coverage criteria.**
- **Financial responsibility.**
- **Appeal and grievance procedures.**

Members may contact Northwood's dedicated Blue Care Network line (800) 667-8496.

Providers should utilize Northwood's dedicated Provider Inquiry line (800) 393-6432.

MEMBER BILLING

- **Northwood providers are bound by contract to accept assignment for all covered equipment and supplies rendered to BCN Members.**

- **Members are financially responsible and may be billed for applicable co-payments and retroactive Plan terminations.**

MEMBER HOLD-HARMLESS PROVISION

According to Northwood's Participating Supplier Agreement and Blue Care Network's Third Party Beneficiary Acknowledgement to Northwood's Supplier Agreement, providers agree to abide by Northwood Policies and Procedures and to look solely to Northwood for payment of covered equipment and supplies rendered under the program.

Although Members are financially responsible for any applicable co-payments for equipment and supplies that have been approved by the plan, providers are prohibited from billing the Member for:

- **The difference between the provider's submitted charge and Northwood's fee.**
- **For reduced fee differential amounts on down-coded or adjusted items based upon medical necessity or the least costly alternative.**
- **When medical documentation provided conflicts with the information supplied during the authorization request.**
- **Provider's failure to obtain required authorization for covered equipment and supplies.**
- **Claims submitted past filing limitations.**
- **Provider's failure to follow Northwood policies and procedures.**
- **When the health plan approves equipment upgrades based upon medical review.**

SECTION IV - PRESCRIPTION REQUIREMENTS

It is the Member's responsibility to provide a valid prescription for requested equipment and supplies. Verbal orders are acceptable for initial set-up of equipment and supplies; however, a prescription must be obtained and provided upon request. Providers must have a faxed, photocopied, original signed order or electronic prescription in their records before they can submit a claim for payment to Northwood. Providers must maintain valid prescriptions on file for equipment and supplies.

A valid prescription, paper or electronic, must include:

- **Prescription Date (the original date of service must be within 30 days of the RX date).**
- **Item Ordered.**
- **Duration of Need.**
- **Diagnosis.**
- **Quantity.**
- **Physician Signature (stamped signatures are not valid).**
- **Scripts signed by nurses if accompanied by an NPI number.**

PRESCRIPTION DURATIONS:

- **Most prescriptions are valid for 12 months but may vary according to medical necessity.**

- **Ninety-nine month or lifetime prescriptions are permitted for Oxygen rentals, permanent Ostomy, Urological supplies, Nebulizer kits and CPAP supplies that do not exceed quantity limits approved by Northwood and the health plan.**

SECTION V - CLAIMS

FILING PROCESS

Northwood claims must be:

- **Submitted electronically or on a CMS 1500 Claim Form.**
- **PAPER claims must be completed in entirety and include;**
  - **Northwood's authorization number.**
  - **Physician's written order including NPI number.**
  - **Attached EOB for secondary claims.**
  - **Manufacturer's name, description, and product number documented in Box 19 of the CMS claim form for not otherwise classified (NOC) items.**
- **ELECTRONIC claims must be completed according to HIPAA 837 transaction requirements detailed on Northwood's website www.northwoodinc.com.**
  - **Not otherwise classified (NOC) claims must be submitted hard copy.**
  - **Secondary claims must be submitted hard copy and include the EOB.**

Claims submitted without the required information will be rejected and must be resubmitted within the filing limitation timeframe (see below).

CLAIMS FILING LIMITATIONS

- **BCN Commercial and BCN Advantage claims must be submitted to Northwood within 6 months from the date of service.**
- **Medicare Supplemental and other secondary claims must be submitted with an attached EOB, within 180 days from the date the claim is paid by other carrier or plan.**
- **Stockings for Medicare Primary/BCN secondary Members do not require submission to Medicare for denial; however, providers must obtain prior authorization and bill Northwood within the 6 month filing limitation.**
- **Filing limitations apply to all claims, including claims previously submitted and returned for missing or incomplete documentation.**
- **Claims statusing must be submitted within 90 days from claim payment date.**
- **Submit paper claims with the required medical and other carrier payment documentation to the following address:**

NORTHWOOD, INC.
P.O. BOX 510
WARREN, MICHIGAN 48090-0510

CLAIMS PAYMENT CYCLE

- **Northwood will process Blue Care Network claims and remit payment for clean claims within 30 days of receipt.**

- **A clean claim consists of the following information:**

    - **Provider Name/Address/ID Number.**
    - **Member Name/Address/Telephone.**
    - **Contract Number.**
    - **Date of Birth.**
    - **Other Insurance Information (if any).**
    - **Diagnosis (ICD-9-CM Code and Description).**
    - **Date of Service.**
    - **Referring Physician and NPI.**
    - **Level II HCPCS Code.**
    - **Manufacturer name, description and product number for NOC items.**
    - **Service Type (Purchase or Rental).**
    - **Quantity**
    - **Duration of Need.**
    - **Modifier.**
    - **Provider Charge.**
    - **Other Payment.**

- **Claims payment shall be limited to Northwood's allowable fee less any co-payment or primary payment amount.**

- **Northwood maintains the right to request proof of delivery or hard copy prescription upon request. Payment will be suspended pending requested documentation.**

- **Payment is contingent upon provider's compliance with all applicable documentation requirements.**

MEDICARE SUPPLEMENTAL CLAIMS

- **Medicare Supplemental claims will be processed through Northwood. Claims must be submitted to Medicare as the primary payer. Following Medicare claims adjudication, supplemental claims may be submitted hard copy to Northwood with the EOB attached.** ***Northwood also accepts electronic supplemental claims submissions.***

- **Medicare supplemental claims will be paid up to Medicare's allowable.**

- **Payment is contingent upon provider's compliance with all applicable documentation requirements, which includes the appropriate EOB form(s) for each claim submitted.**

- **Claims submission must be in accordance with Northwood's filing deadline for supplemental claims.**

SUPPLEMENTAL CLAIMS (other than Medicare Primary)

- **Claims must first be submitted to the primary carrier and a hard copy of the EOB must be submitted with your hard copy claim to Northwood. If a secondary claim is submitted electronically to Northwood, primary payment information must be included pursuant to Northwood electronic claims submission procedures (available at www.northwoodinc.com).**

- **Northwood will reimburse providers for co-payments and deductibles up to the primary insurance allowable as long as it does not exceed Northwood's fee schedule.**

- **Northwood does not reimburse for the difference between the billed and primary insurance allowable.**

PROVIDER REMITTANCE ADDRESS

- **Northwood maintains a primary address on file for all providers that will be used when processing claims for payment.**

- **All checks will be payable to the primary address supplied to Northwood during the credentialing period for network participation.**

- **It is important that each provider have one and only one primary remittance address.**

- **Providers need to notify Northwood in writing on company letterhead of any address changes to primary billing address.**

- **Providers must supply Northwood with an updated W-9 form for address changes.**

- **Providers are responsible for maintaining the original Northwood payment vouchers and providing copies to branch locations. Northwood is not responsible for re-issuing duplicate vouchers.**

COORDINATION OF BENEFITS (C.O.B.)

- **Providers are required to obtain all insurance information from the Member.**

- **Northwood follows Coordination of Benefits guidelines from the National Association of Insurance Commissioners (NAIC).**

- **A claim may be rejected if a provider does not complete the section of the claim form regarding other insurance coverage.**

HIPAA EDI CLAIMS INQUIRY

Beginning January 1, 2009, electronic claim submitters may submit a HIPAA 276 transaction, Health Care Claim Status Request, for claims inquiry.

- **Submitters will only be able to inquire on electronic claims submitted on or after January 1, 2009.**
- **Requests will be accepted in batch and can be uploaded using the same secure connection as with electronic claims.**
- **Northwood will respond with a HIPAA 277 transaction, Health Care Claim Status Response, that can be retrieved using the same secure connection that is used for electronic claim acknowledgements.**
- **Submitters will be notified by email when a new transaction batch is ready for download.**

HIPAA EDI CLAIMS PAYMENT/ADVICE

Beginning January 1, 2009 electronic claim submitters will receive HIPAA 835 transactions, Health Care Claim Payment/Advice, using the same secure connection that is used for electronic claim acknowledgements.

- **Electronic payment /advice transactions will only apply to electronic claims submitted on or after January 1, 2009.**
- **A payment/advice batch of transactions will be available on the day that Northwood prepares cash disbursements.**
- **Submitters will be notified by email when a new transaction batch is ready for download.**

Please see the Northwood web site www.northwoodinc.com for the latest details related to HIPAA EDI transactions.

CLAIMS INQUIRY

A provider may make a claim inquiry under the following circumstances:

1. PAYMENT OTHER THAN ANTICIPATED

- **If payment received is other than anticipated and not in accordance with the Northwood fee schedule, please submit a completed Claims Status Form in Section XI within 90 days from the date of the Northwood remittance voucher and include the following;**
  - **Copy of the original claim.**
  - **Supporting documentation.**
  - **Northwood's remittance voucher.**

2. NO RESPONSE TO CLAIMS SUBMISSION

- **If you have not received a response to your original claim submission in accordance with Northwood's claim payment turnaround time, please verify that the claim was submitted to the correct address and resubmit.**

- **If a claim was correctly submitted and has not been responded to within 45 days (mailing, provider posting time, etc.) please copy the claim form and required documentation, write SECOND REQUEST at the top of the CMS claim form and resubmit.**

Post payments and WORK REJECTIONS prior to resubmitting claims to Northwood.

REFUND REQUESTS

From time to time, Northwood may be required to request a refund from the provider for reasons such as; retroactive terminations, COB, eligibility changes, etc. Northwood provides a written request form with the refund explanation, amount, check run, check date and amount paid.

Providers have 60 days from request date to remit refunds or Northwood may deduct from future payments.

In addition, Northwood may request Member reimbursement when the provider has failed to abide by Northwood's policies and procedures for covered equipment and supplies or under Blue Care Network's Grievance and Appeal Process determination. Providers must refund Members within 30 days of notification.

ELECTRONIC FUNDS TRANSFER

Electronic funds transfer (EFT) is now available, please visit the Northwood, Inc. website www.northwoodinc.com to sign up today.

SECTION VI - QUALITY

IT IS THE RESPONSIBILITY OF CONTRACTED PROVIDERS TO ENSURE THAT THEIR EMPLOYEES UNDERSTAND NORTHWOOD POLICIES AND PROCEDURES, INCLUDING SERVICING AND QUALITY ISSUES AS THEY MAY PERTAIN TO THIS CONTRACT.

Quality issues include but are not limited to:

- **Substandard care.**
- **Deviations from standards and guidelines from generally accepted industry practices as they pertain to the provision of equipment and supplies in accordance with health plan provisions.**
- **Member discrimination related to plan coverage.**
- **Behavior of staff as perceived by the Member, provider, Northwood or Blue Care Network as inappropriate.**
- **Adverse comments to Members regarding reimbursement and policies established by Northwood and Blue Care Network.**

PROVIDER COMPLAINT AND QUALITY IMPROVEMENT PROCESS

Northwood strives to provide quality service in a professional and timely manner. In the event a provider believes that Northwood has not satisfactorily resolved a problem or concern, providers may utilize Northwood's Complaint and Grievance Process.

- **Providers may contact Northwood in writing regarding quality issues/concerns such as those outlined in the Quality Section of this manual.**
- **Northwood encourages providers to participate in the continuous quality improvement process by submitting quality concerns in writing.**

Northwood monitors the quality and performance of its network providers through its Member Satisfaction Survey and complaint process.

- **Northwood routinely performs Customer Satisfaction Surveys for Blue Care Network Members.**
- **Survey results are summarized and forwarded to providers semi-annually and the health plan on a quarterly basis.**

MEMBER COMPLAINTS

- **Member complaints may be received through the survey process, provider, referral source, health plan, Member or patient advocate.**

- **Members should be directed to contact Northwood (800) 667-8496 or Blue Care Network (800) 662-6667 to register a complaint or concern.**

- **Members are encouraged to discuss their concerns with the provider who often can correct the situation to the Member's satisfaction.**

- **Providers are required to notify Northwood of all Member complaints for initiation of the Member Complaint and Grievance Process.**

- **Complaints are investigated by Northwood personnel, documented on a Northwood Non-Conformity Form and faxed to provider for written resolution.**

- **Providers will be contacted telephonically when complaints require immediate attention. A Non-Conformity Form will be forwarded to provider via fax for written resolution.**

- **Non-Conformity Forms must provide written resolution, be signed by a company manager and returned to Northwood within 48 hours.**

- **Northwood performs a follow-up survey with the Member to determine if the concern is resolved to the Member's satisfaction.**

- **If the resolution is not to the Member's satisfaction, Northwood will notify the Member of the Member Complaint and Grievance Process.**

- **Northwood reports Member complaints to Blue Care Network for quality monitoring and tracking purposes.**

- **As program administrator, all Member and provider requests for equipment reviews, appeals and inquiries must be processed through Northwood. Do not submit requests directly to Blue Care Network.**

SECTION VII - BLUE CARE NETWORK MEMBER GRIEVANCE and APPEAL RIGHTS

The following Grievance and Appeal Rights is solely for use by BCN Members and may be provided upon request.

Step 1: Review and Decision by BCN

To submit a grievance, you or someone authorized by you in writing, must submit a written statement of the problem to BCN's Appeals and Grievance Unit at the following address:

Appeals and Grievance Unit — Mail Code C248
Blue Care Network
P.O. Box 284
Southfield, Michigan 48086

The Appeals and Grievance Unit will review your grievance and give you a decision within 15 calendar days for pre-service claims (claims that must be decided before a Member is afforded access to health care) and within 20 calendar days for post service claims (claims for a benefit involving the payment or reimbursement of the cost for medical care that has already been provided).

The person or persons who review this first-level appeal are not the same individuals who were involved in the initial determination. If an adverse determination is made, BCN will provide you with a written statement in plain English containing the reasons for the adverse determination, the next step of the grievance process and the forms to request the next grievance step. Upon request, we will provide, free of charge, all documents and records used to reach BCN's determination.

If you are not satisfied with the determination, you may appeal to Step Two within 180 calendar days of receiving BCN's determination. You, or a person authorized in writing to act for you, must notify the Appeals and Grievance Unit in writing at the address listed above of your decision to appeal. If you do not file a Step Two Grievance within the 180-calendar day time frame, your grievance is considered abandoned and no further action may be taken.

Step 2: Review and Decision by BCN Grievance Panel

If you appeal from Step One, Blue Care Network's Step Two Member Grievance Panel will review and reconsider the determination made at Step One. You, or someone authorized by you in writing, may present the grievance in person or by telephone conference to the Step Two Member Grievance Panel.

For pre-service claims (claims that must be decided before a Member is afforded access to health care) and post service claims (claims for a benefit involving the payment or reimbursement of the cost for medical care that has already been provided), notification of the Step Two grievance resolution will be sent to you within 15 calendar days of receiving your notice to appeal. If the grievance pertains to a clinical issue, the grievance will be forwarded to an independent medical consultant within the same or similar specialty for review. For post service claims only, if BCN needs to request medical information, an additional ten business days will be added to the resolution time.

If an adverse determination is made, a written statement in plain English will be sent within five calendar days of the panel meeting, but not longer than 15 calendar days after receipt of the request for review. Written confirmation will contain the reasons for the adverse determination, the next step of the grievance process and the form to request an external grievance review. Upon request, BCN will provide, free of charge, all documents and records used to reach our determination.

External Grievance Process

If you do not agree with the decision at Step Two, you may appeal in writing to the State of Michigan insurance commissioner no later than 60 days following your receipt of BCN's final determination at:

State of Michigan
Office of Financial and Insurance Services
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
1-877-999-6442

When filing a request for an external review, you will be required to authorize the release of any applicable medical records to the state that was used for review in reaching a decision.

If BCN fails to provide you with its final determination within 30 calendar days for pre-service claims or 35 calendar days for post service claims (plus ten additional business days if BCN requests additional medical information) from the date BCN receives your written grievance, you may request an external review from the insurance commissioner. You must do so within 60 business days of the date you either received BCN's final determination or the date their final determination was due. Mail your request for a standard external review, including the required forms that BCN will provide to you, to the Office of Financial and Insurance Services at the address noted above.

If you are a Member of an ERISA*- qualified group, you may file a lawsuit according to the time limits defined in your General Provisions and Benefits booklet after completing BCN's internal grievance process. You do not need to file an appeal with the insurance commissioner. Non-ERISA groups or non-group subscribers, including their dependents, must exhaust all grievance steps (including an external review by the State of Michigan insurance commissioner) prior to filing a civil action. Subscribers may obtain further information from the local U.S. Department of Labor Office or by contacting the State of Michigan insurance commissioner. If you do not know if your group is an ERISA-qualified group, you should contact your employer.

***Employee Retirement Income Security Act**

Requesting an Expedited Grievance from Blue Care Network

You may request an expedited grievance when:

- **A physician provides verbal or written confirmation that you have a medical condition for which the time frame for completing a standard grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.**
- **You believe that BCN has wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or you believe BCN has failed to respond timely to a request for benefits or payment.**

Submit your request for an expedited grievance to BCN in writing by mail or by fax. Your physician must also confirm that your condition qualifies for an expedited grievance. Your physician's confirmation can be submitted in writing — by mail or by fax — or by telephone.

Mail or fax your request to:

Appeals and Grievance Unit — Mail Code C248
Blue Care Network
P.O. Box 284
Southfield, Michigan 48086
Telephone: 1-800-662-6667
Fax: 1-888-458-0716

BCN must provide a decision within 72 hours of receiving both your grievance and your physician's substantiation. If the decision is communicated to you verbally, BCN must provide a written confirmation within two business days.

If you do not agree with BCN's decision, you may request an expedited external review from the Office of Financial and Insurance Services within ten calendar days of receiving the decision.

From the State

You may request an expedited external review from the State of Michigan when all three of the following conditions are satisfied:

- **A physician provides verbal or written confirmation that you have a medical condition for which the time frame for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.**
- **You have filed a request with Blue Care Network for an expedited internal grievance. You do not have to wait for the final determination before you request an expedited external review.**
- **You believe that BCN has wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service.**

To request an expedited external review from the state, submit your request to the insurance commissioner at the same time you file your request for an expedited internal review with BCN or within ten calendar days of receiving the final determination. Your request can be made over the phone or in writing.

Office of Financial and Insurance Services
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Toll-free telephone: 1-877-999-6442

After receiving your request, the commissioner will decide if it is appropriate for external review. If so, the commissioner will assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the commissioner should uphold or reverse BCN's determination. The commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The commissioner's decision is the final administrative remedy.

SECTION VIII - CONFIDENTIALITY

CONFIDENTIALITY OF MEDICAL RECORDS

In accordance with applicable state and Federal statutes and regulations, Blue Care Network, Northwood and Northwood subcontracted providers shall not:

- **Disclose medical records or information except to an authorized representative of Blue Care Network, Northwood or to a properly identified and authorized government agent and as otherwise specifically provided in the Northwood Participating Supplier Agreement and Blue Care Network Third Party Beneficiary Agreement.**

- **Both Northwood and Northwood contracted subcontractors are required to maintain accurate and timely medical records for Members describing covered equipment and related financial records. These records must be kept for at least six (6) years (children's records must be retained up to age of majority) from the last date of provision of covered equipment. Such records must be kept in a manner that safeguards the privacy of any information that may identify a particular Member.**

- **Northwood and Blue Care Network have the right to inspect and obtain at no additional charge, copies of all medical records of Members.**

CONFIDENTIALITY OF BUSINESS INFORMATION

In accordance with Northwood's Participating Supplier Agreement and Blue Care Network Third Party Beneficiary Agreement to Northwood's Participation Supplier Agreement, Northwood providers are bound to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated in the above named agreements.

SECTION IX - PARTICIPATION REQUIREMENTS AND CREDENTIALING

PROVIDER CRITERIA

Northwood requires its providers to meet the following minimum requirements for participation in its network:

- **Centers for Medicare and Medicaid Services (CMS) approval/supplier number.**
- **Accreditation by an independent accrediting organization adopted by CMS.**
- **Acceptable levels of liability insurance as outlined in Section IX, Liability Insurance Requirements.**
- **Notification to Northwood of changes or termination of such insurance.**
- **Sound financial standing.**
- **A preference for five (5) or more years in the DMEPOS business.**
- **Possession of manufacturer's warranties on equipment.**
- **Ability to service equipment according to warranty specifications.**
- **Available skilled and/or credentialed staff to support services provided.**
- **Appropriately staffed business hours (8 hours per day).**
- **Staff available twenty-four hours per day, seven days per week for emergency services.**
- **After-hours answering service/paging system.**
- **Participation in quality assurance/utilization review programs, including;**
  - **Determination of appropriate equipment,**
  - **Complete and detailed Member treatment records, available to Northwood/Blue Care Network for review,**
  - **Emergency visits to Member's home/place of residence,**
  - **Two-hour provision for emergency equipment/service delivery,**
  - **Member education, including written patient instructions on proper use and maintenance of equipment.**
  - **Physician contact when necessary to review prescriptions and changes in patient's conditions.**
  - **Scheduled follow-up visits to Member's home or by appointment in provider's facility.**
  - **Integrity and ethical business practices.**
  - **Solid community standing.**

PROVIDER CREDENTIALING

Providers must submit and update the following credentialing information to Northwood during the initial credentialing process:

1. **A copy of NSC document indicating CMS's approval and assignment of your Medicare supplier number(s);**
2. **A copy of your accreditation letter or certificate for Durable Medical Equipment issued by an independent accrediting organization adopted by CMS (e.g., JCAHO);**
3. **A copy of your Prosthetic/Orthotic certification/accreditation (e.g., ABC);**
4. **A copy of your Business License;**
5. **A copy of your Certificate of Liability Insurance with Northwood named as a Certificate Holder**
6. **A complete copy of your current liability insurance certificate or declaration page (face sheet) of your insurance policy. The document should include the name of the company, name of applicant, policy number, dates of coverage and amounts of coverage (with a minimum of coverage outlined in Section X Liability Insurance Requirements);**
7. **A copy of your National Provider Identifier (NPI) notification;**
8. **A copy of your Sales Tax License;**
9. **Copies of any other certifications held.**

Northwood provides an annual summary of the demographics and other information it maintains in the provider database. Providers must review and make any changes to data, provide certificates or other information as requested and return to Northwood by the return date indicated on the form.

RE-CREDENTIALING PROCESS

It is the responsibility of the provider to notify Northwood in writing of any changes to the information initially supplied on the Northwood Participating Provider Application including;

- **Additions or deletions to locations.**
- **Address changes, phone, fax, key personnel.**
- **Changes to remittance address.**
- **Changes to ownership.**
- **Insurance coverage changes.**
- **Federal Tax ID numbers.**

Northwood will make its best efforts to accommodate the addition of newly added locations of the provider. Requests should be directed to the Provider Affairs Manager.

Changes to ownership will require reapplication into the network.
Upon notification from Northwood, providers will be required to submit a completed re-credentialing application and all requested supporting documentation.

Failure to respond to the credentialing notice may result in termination from Northwood as a DMEPOS services provider.

SECTION X - LIABILITY INSURANCE REQUIREMENTS

The following insurance minimums are required for contract participation in accordance with Northwood's agreements with Blue Care Network and other contracted payers:

- **General Liability coverage with minimum limits of $1,000,000 and Products/Completed Operations Liability coverage with minimum limits of $2,000,000.**
    - **Such coverage shall include provider, its employees and agents at all sites and for all activities related to provision of Covered Equipment.**
- **Provider is required to promptly notify Northwood:**
    - **Upon discovery of any loss or impairment of required coverage, or;**
    - **When more than half of any required annual limits have been exhausted or reserved by the applicable insurance carrier;**
    - **And, submit annually a listing of all Products/Completed Operations losses incurred by provider, including those reported to provider's insurers regardless of whether any such losses have been paid.**
- **If liability coverage is secured on a "claims made" policy:**
    - **Provider must purchase a "tail" policy covering a period of not less than five (5) years following termination of the coverage or termination of your agreement with Northwood/Blue Care Network, whichever is later, or;**
    - **Agree to continue to provide the certificate of insurance as outlined in this request for a period of five (5) years after termination of**
    - **Your agreement with Northwood/Blue Care Network.**
- **Providers are required to name Northwood as a certificate holder and immediately notify Northwood in writing of any lapse or change in coverage. Failure to do so may result in termination from network participation.**

SECTION XI - FORMS

1. **NORTHWOOD WAIVER OF LIABILITY**

2. **NORTHWOOD CLAIM STATUS FORM**

3. **FEE SCHEDULE / POLICY UPDATE ACKNOWLEDGMENT FORM**

NORTHWOOD WAIVER OF LIABILITY
For Non-Covered or Higher Grade Equipment or Supplies

Date: _____

Member Name: _____

Contract Number: _____

Equipment/Supply Requested:

_____

_____

Provider Charge: $_____Member Liability: $_____

I, _____, have been informed, prior to receiving services, that the equipment or supplies I have requested from_____ (Provider) has been *reviewed and denied for coverage under the terms of my health plan.* It is my decision to request the service irrespective of its coverage. I understand that the charges for the requested services are my own financial responsibility.

Signature: _____ Date: _____

Print Name: _____Relationship: _____

PA-13
01-01-96

CLAIM STATUS FORM

Date of Status_____Provider Contact/Statuses: _____

Provider Name and Tax ID: _____

Health Plan _____

Patient Name: _____

Contract Number: _____

Procedure Code(s) Status: _____

Usual and Customary Charge(s): $_____

Date of Service: _____

Authorization Number: _____

Date of First Submission: _____

Reason for Claim Status:_____

_____

Additional Documentation Submitted (YES) _____(NO) _____

Additional Comments:

_____

_____

Status forms are to be used for underpayment or rejected claims only.

Mail to: Northwood, Inc.
P.O. Box 510
Warren, MI 48090-0510
1-800-393-6432

CL-19
04-29-09

FEE SCHEDULE/POLICY UPDATE ACKNOWLEDGEMENT FORM

Dear Northwood Provider,

Please review the enclosed Fee Schedule, Manual Revision or Policy Update. One copy of the Fee Schedule, Manual Revision or Policy Update has been mailed to the primary location as specified in your Agreement with Northwood. Please copy and distribute to other branch locations as necessary.

Northwood Provider Affairs requests that you acknowledge your receipt of the revision dated _____. Please sign, date and return a copy of this form via mail (P.O. Box 510, Warren, MI 48090) or fax (586-755-3733). You may also email your acknowledgment to debbiec@northwoodinc.com.

Acknowledgement of Receipt

I, _____ the _____of
Authorized Company Representative (Printed Name) *(Title)*

_____Acknowledge receipt of one or
Company Name

more of the following items:

Northwood, Inc. Fee Schedule effective _____

Northwood DME Manual or Policy Update effective _____

Signature: _____ Date: _____
Authorized Company Representative

PA-9
10-20-08