Blue Medicare HMO<sup>SM</sup>
and Blue Medicare PPO<sup>SM</sup>

An independent license of Blue Cross and Blue Shield of North Carolina
Agenda

- The basics
- Member eligibility
- Blue Medicare HMO\textsuperscript{SM} and Blue Medicare PPO\textsuperscript{SM} plans
- Additional services
- Utilization management programs
- Drug utilization
- Claims and administrative activities
The basics – getting started
Before getting started

- Blue Medicare HMO℠ and Blue Medicare PPO℠ products are offered by PARTNERS National Health Plans of North Carolina, Inc. (PARTNERS).

- A health care business or provider must be contracted with PARTNERS in order to be considered as in-network for providing Blue Medicare HMO℠ and Blue Medicare PPO℠ member services.

- Having a BCBSNC contract alone, without a PARTNERS contract, leaves the provider as out-of-network for Blue Medicare HMO℠ and Blue Medicare PPO℠.
Blue Medicare product offerings

**Blue Medicare Rx™**

**Blue Medicare Supplement™**

Products offered by BCBSNC

Products offered by PARTNERS as a BCBSNC company

**Blue Medicare HMO™**

Offered by PARTNERS National Health Plans of North Carolina, Inc.

**Blue Medicare PPO™**

Offered by PARTNERS National Health Plans of North Carolina, Inc.

Your plan for better health™ | bcbsnc.com
Blue Medicare HMO℠ and Blue Medicare PPO℠ plans

- Unique alpha prefixes identify a Blue Medicare HMO℠ and Blue Medicare PPO℠ plan type, even when you do not have the member’s identification card in hand.

YPWJ  = Blue Medicare HMO℠
YPFJ  = Blue Medicare PPO℠
Blue Medicare HMO℠ and Blue Medicare PPO℠ plans

Blue Medicare HMO℠ and Blue Medicare PPO℠ ID cards are readily recognizable but remember that the cards include both BCBSNC and PARTNERS information. Therefore it’s important to review the cards carefully and take note of the Blue Medicare HMO℠ and Blue Medicare PPO℠ alpha prefixes and PARTNERS health plan information.

Blue Medicare HMO℠ and Blue Medicare PPO℠ designation

PARTNERS

Blue Medicare HMO and Blue Medicare PPO SM

BCBS Association symbols and BCBSNC text

Blue Medicare HMO and PPO alpha prefix:
- YPWJ
- YPFJ

BlueCross BlueShield of North Carolina

Your plan for better health℠ | bcbshc.com

BlueCross BlueShield of North Carolina
Blue Medicare HMO℠ and Blue Medicare PPO℠ plans

The cards display PARTNERS claims mailing address and telephone service lines.

Reminder: For fastest claims processing, always file electronically!
Blue Medicare HMO℠ and Blue Medicare PPO℠ plans

Important reminder

Don’t be confused when submitting claims.
Even though the members ID includes an alpha prefix, ,and the cross and shield symbols are on the members ID card, claims are always to be filed to PARTNERS!
Blue Medicare HMO<sup>SM</sup> and Blue Medicare PPO<sup>SM</sup> plans

- As part of the benefit design for Blue Medicare HMO<sup>SM</sup> and Blue Medicare PPO<sup>SM</sup> plans, members are not required to obtain a referral from a primary care physician in advance of receiving care from a participating specialist or when obtaining home durable medical equipment.

Prior plan approval guidelines and pre-certification/authorization requirements still do apply
Member eligibility
Member eligibility

• To be eligible to enroll in either Blue Medicare HMO℠ or Blue Medicare PPO℠, a prospective member must meet all of the following criteria:
  – Be entitled to Medicare Part A and enrolled in Medicare Part B.
  – Individual enrollees must reside in our CMS approved service area for the selected plan type
  – Must not have end stage renal disease (ESRD), unless exception qualifications are met.
Member eligibility

• There is no age limitation for Blue Medicare HMO\textsuperscript{SM} and Blue Medicare PPO\textsuperscript{SM} plans.

• There are no pre-existing condition limitations for Blue Medicare HMO\textsuperscript{SM} and Blue Medicare PPO\textsuperscript{SM} plans.
  – If a prospective member meets all of the previous requirements, they are eligible regardless of age or pre-existing conditions. This includes individuals who receive their Medicare benefits through disability.
Blue Medicare Medicare HMO<sup>SM</sup> and Blue Medicare Medicare PPO<sup>SM</sup> plans
Members are offered 3 HMO plans & 2 PPO plans

Benefits comparison for in-network benefits

<table>
<thead>
<tr>
<th></th>
<th>Blue Medicare HMO™</th>
<th>Blue Medicare PPO™</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP office visits</td>
<td>$5 / $15</td>
<td>$10 / $15</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>$10 / $30</td>
<td>$20 / $30</td>
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<tr>
<td>Inpatient care</td>
<td>$350 / $700</td>
<td>$350</td>
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<tr>
<td>Total out-of-pocket maximum</td>
<td>$3,350 / $4,000</td>
<td>$3,250</td>
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<tr>
<td>Outpatient surgery</td>
<td>$0 - $100, 20%</td>
<td>$0 - $100</td>
</tr>
<tr>
<td>Diagnostic tests, x-rays and labs</td>
<td>$0 or 0-20%</td>
<td>$0 or 0-10%</td>
</tr>
</tbody>
</table>

✓ Please note that employer plans may vary from the individual plan
✓ Medical & Rx benefits may vary by plan
✓ Please verify benefits prior to service by calling 1-888-296-9790
✓ Out of pocket maximums do not apply to out of network services
✓ Out of network PPO coinsurance applies
Physical exams

• Members having enhanced benefits are eligible for periodic (or well) examinations according to the following schedule when provided by a member’s PCP:
  – 40 + Years (1 exam every 12 months)
  – $0 For routine physical exams.

Physical exams must be coded as physicals, not problem focused visits
Blue Medicare HMO℠

• Blue Medicare HMO℠ is our original Medicare Advantage plan and was the first Medicare Advantage plan in North Carolina.

• HMO plan members are required to stay within a large network of doctors and specialists in order to receive covered benefits. Prior approval must be obtained for any out-of-network services.

• Members are required to designate a primary care physician upon enrollment, who will assist in care coordination.
Blue Medicare HMO℠

• Blue Medicare HMO℠ Medical Only has the richest medical benefits, but no prescription drug coverage.

• Blue Medicare HMO℠ Enhanced has the most robust combination of medical and prescription drug coverage.

• Blue Medicare HMO℠ Standard has a competitive level of medical coverage with Medicare prescription drug coverage comparable to the Medicare Standard plan.
Blue Medicare HMO℠

• Blue Medicare HMO℠ primary care physicians (PCP’s) are responsible for providing or arranging for all appropriate medical services for Blue Medicare HMO℠ members, including:
  – Preventive care
  – Coordinating care management for the patient

• Family practice, general practice, internists (internal medicine), pediatricians, and geriatric providers are all eligible to serve as a PCP.

• Nurse Practitioners and Physician Assistants who meet required criteria are also eligible to serve as a PCP.
Blue Medicare PPO℠

• Provides members with the freedom to choose in- or out-of-network providers.
  – Members share a greater portion of the cost when electing out-of-network services

• Benefits are similar to Blue Medicare HMO℠ but the PPO plans require higher co-pays and coinsurance for some benefits.

• Both PPO plans have the Enhanced Medicare prescription drug benefit.
Compliance training
Compliance training

• On December 5, 2007, CMS issued a Final Rule clarifying requirements for Medicare subcontractors, including Medicare Advantage providers. This rule requires that all such providers participate in a compliance program. In general, you will need to do the following:
  – All of your employees working under our contract agreement with you must complete annual Medicare compliance training.
  – All personnel working under our contract agreement with you must be informed about our Special Investigation Unit’s (SIU) hotline number for reporting suspected fraud, waste or abuse of noncompliance with Medicare rules.
  – Any of your subcontractors working under our contract agreement with you must be made aware of these requirements, take the compliance training, and be informed of our fraud hotline number.
Compliance training

• We partnered with the nationally-recognized, National Health Care Anti-Fraud Association (NHCAA) and the Blue Cross Blue Shield Association to develop a computer-based training program entitled, “Medicare Advantage and Part D Compliance Training – Recognizing and Reporting Fraud Waste and Abuse.”

• This training has been reviewed by CMS and should satisfy your training requirement under your other Medicare Advantage contracts.
Compliance training

• Our vendor, LearnSomething, Inc. will administer the online mandatory training. We have arranged a discount rate of $14.95 per person. You will need to enroll through the Web at bcbsnc.com/providers for the training course.
  – Bulk rates are also available through the vendor.
  – If your organization has completed a CMS-approved training through another organization, you may not have to retake the training. We just need a record of completion or the attestation form. If the course was completed through our vendor, but sponsored by another organization, you do not have to submit the attestation form.

Compliance training is required under the rule by December 31, 2009
Additional services
Community Eye Care (CEC)

- PARTNERS contracts with Community Eye Care (CEC) to provide medical/routine vision care to Blue Medicare HMO™ and Blue Medicare PPO™ members:
  - No referrals needed
  - Direct access to contracting ophthalmologists and optometrists
  - Routine vision
  - Medical surgical
  - Community Eye Care 1-888-254-4290
Magellan Behavioral Health

- Mental health and substance abuse management programs and services are open access.
- PARTNERS contracts with Magellan Behavioral Health for mental health and substance abuse management and administration (including certification, concurrent review, utilization management, discharge planning and case management).
  - Magellan Behavioral Health 1-800-359-2422
Laboratory services

• Reference labs:
  – If a specimen is drawn and the laboratory work is sent to a reference lab, the only service billable to PARTNERS is the administrative/handling charge i.e. 36415. (The reference lab will bill directly to PARTNERS for the services it provides).

• In-office labs:
  – If you are performing the laboratory service in your office, and your lab is CLIA certified, services can be filed directly with PARTNERS for reimbursement.
### 2009 Service area for Blue Medicare HMO℠ and Blue Medicare PPO℠

<table>
<thead>
<tr>
<th>ALAMANCE</th>
<th>CARTERET</th>
<th>FORSYTH</th>
<th>JOHNSTON</th>
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<tr>
<td>ALEXANDER</td>
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<td>STOKES</td>
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<td>GATES</td>
<td>MARTIN</td>
<td>PERSON</td>
<td>SURRY</td>
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<td>CHATHAM</td>
<td>GREENE</td>
<td>MECKLENBURG</td>
<td>PITT</td>
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<td>AVERY</td>
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<td>GUILFORD</td>
<td>NASH</td>
<td>RANDOLPH</td>
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<td>BERTIE</td>
<td>DAVIDSON</td>
<td>HALIFAX</td>
<td>NEW HANOVER</td>
<td>RICHMOND</td>
<td>WAYNE</td>
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<tr>
<td>BRUNSWICK</td>
<td>DAVIE</td>
<td>HERTFORD</td>
<td>NORTHAMPTON</td>
<td>ROCKINGHAM</td>
<td>WILKES</td>
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<tr>
<td>CABARRUS</td>
<td>DURHAM</td>
<td>HOKE</td>
<td>ONSLOW</td>
<td>ROWAN</td>
<td>YADKIN</td>
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<td>CALDWELL</td>
<td>EDGECOMBE</td>
<td>IREDELL</td>
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</table>
Credentialing and re-credentialing

- Blue Cross and Blue Shield of North Carolina (BCBSNC) provides the credentialing services for PARTNERS.

- Initial credentialing requires a completed application. However, if you are currently a participating provider with BCBSNC, additional credentialing may not be necessary for participation in Blue Medicare HMO℠ and Blue Medicare PPO℠ plans.

- Full instructions by medical specialty, along with a copy of the application are housed on our Web site @ bcbsnc.com/providers/blue-medicare-providers

- All documents should be sent to the BCBSNC credentialing department for verification and processing.
Utilization management programs
Case management programs

• In certain health situations, Blue Medicare HMO℠ and Blue Medicare PPO℠ members are eligible to work one-on-one with a case manager. Your patients may be eligible for a case manager if they:
  – Have a qualifying complex, chronic or rare disease
  – Are at risk for developing a complex and serious medical condition
  – Have been involved in an accident or other catastrophic health event
  – Need assistance managing their health care needs

• Case managers are available at no additional cost, but co-payment and coinsurance for covered services may apply.
Case management programs

- Case management programs are available for members with chronic diseases including:
  - Congestive heart failure
  - Diabetes
  - Chronic obstructive pulmonary disease
  - PARTNERS proactively seeks to identify these members to facilitate early education and intervention.
Prior plan authorization (PPA)

• Prior plan authorization (PPA) requires that a provider must receive approval from PARTNERS before the member is eligible to receive coverage for certain health care services.

• The most current prior plan approval list is located on the BCBSNC Web site under Blue Medicare HMO℠ and Blue Medicare PPO℠ provider resources @ bcbsnc.com/providers/blue-medicare-providers

• Services on the PARTNERS prior authorization guideline list require the PCP or authorized specialist to contact PARTNERS Healthcare Services to obtain an authorization.

PARTNERS Healthcare Services
1-336-774-5400 or 1-888-296-9790
Pre-admission certification

- All non-emergency hospital admissions require pre-certification by calling PARTNERS Healthcare Services department at 1-336-774-5400 or 1-888-296-9790.
- Plan authorization is required for scheduled admissions, including acute hospital, rehabilitation facility and skilled nursing facility.
- For urgent and emergency admissions, prior authorization is not required. However, notification to PARTNERS of urgent/emergency admissions within (48) hours or the first business day after the admission is required.
Fast track appeals process

- Members receiving care from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) have the right to a fast appeal if they think their Medicare-covered services are ending too soon.

- The review is completed by the quality improvement organization (QIO)

- Information regarding the CMS requirement is located @ www.cms.hhs.gov/MMCAG
Fast track appeals process

- Providers are responsible for delivering the notice of Medicare non-coverage (NOMNC) to the member at least two (2) days prior to the termination of the SNF, HHA or CORF service.

- The member or authorized representative must sign and date the NOMNC.

- A copy of the signed NOMNC is faxed to case management at 1-336-659-2945 (the provider is liable if the notice is not given and the Plan incurs additional days to cover).

- The member or authorized representative must contact the QIO by noon of the day before coverage ends, to request an expedited review, if he or she disagrees with the termination of services.
Fast track appeals process

• PARTNERS is required to issue a detailed explanation of non-coverage (DENC) by the close of business day, upon notification from the QIO of the expedited review

• The SNF, HHA, CORF provider must supply PARTNERS with any information the QIO requires to conduct it’s review

• The QIO is responsible for notifying the member, the provider and PARTNERS, of their determination by 4:30 p.m. of the day of the planned coverage of termination
Drug utilization
Prescription drug utilization management

• Medication therapy management programs are available at no additional cost to select members who:
  – Take many prescription drugs
  – Have multiple medical conditions
  – Have high prescription drug costs

• Members who meet the criteria will be contacted by PARTNERS and invited to join the program – participation is voluntary.
Formularies

• PARTNERS will generally cover a drug listed in our formulary as long as it is medically necessary, the prescription is filled at a PARTNERS network pharmacy, and other plan rules are followed.
Prescription drug utilization management

• Quantity limit drugs (a few drugs are subject to quantity limits including):
  – Migranal nasal spray
  – Butorphanol / Stadol nasal spray
  – Ketorolac tablets
  – Triptans

To request an exception call PARTNERS at 1-888-296-9790
Prescription drug utilization management

• Prior approval drugs (some prescription drugs require prior approval).

• Formulary, criteria and fax form are located on the BCBSNC Web site under Blue Medicare HMO℠ and Blue Medicare PPO℠ provider resources at: bcbsnc.com/services/formulary/prior-medicare.cfm

Formulary, criteria and fax form may also be Obtained by calling PARTNERS at 1-888-296-9790
## Prescription drugs

- Certain types of drugs are excluded by law and are considered non-Part-D drugs. They are excluded from coverage.

<table>
<thead>
<tr>
<th>Non-prescription drugs</th>
<th>Drugs used to promote fertility</th>
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<tbody>
<tr>
<td>Drugs used for symptomatic treatment of colds or cough</td>
<td>Drugs used for cosmetic purposes or hair growth</td>
</tr>
<tr>
<td>Drugs used for anorexia, weight loss or weight gain</td>
<td>Barbiturates and Benzodiazepines</td>
</tr>
<tr>
<td>Prescription vitamins and minerals except prenatal and fluoride</td>
<td>Outpatient drugs for which the manufacturer seeks to insist that monitoring services be purchased directly from the manufacturer</td>
</tr>
<tr>
<td>Drugs when used for the treatment of sexual or erectile dysfunction</td>
<td></td>
</tr>
<tr>
<td>Drugs that are not, or have never been, FDA approved for efficacy and safety</td>
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</tbody>
</table>
Claims and administrative activities
Claims by mail or fax

- **Always** send Blue Medicare HMO℠ and Blue Medicare PPO℠ claims to PARTNERS in Winston Salem.
- **Never** send Blue Medicare HMO℠ and Blue Medicare PPO℠ claims to BCBSNC in Durham.

PARTNERS Claims
PO Box 17509
Winston-Salem, NC 27116

PNHP fax numbers are located in the provider manual, which can be found on-line at [bcbsnc.com/providers/blue-medicare-providers/](http://bcbsnc.com/providers/blue-medicare-providers/). Fax to the dedicated business area for quickest turnaround time.
Timely filing of claims

• All PARTNERS claims must be filed directly to PARTNERS and not to an intermediary carrier.

• Claims must be submitted within one hundred and eighty (180) days of providing services.

• Claims submitted after one hundred and eighty (180) days will be denied unless mitigating circumstances can be documented.
  – To have these claims reviewed, please submit proof of timely filing to the claims department by faxing to 1-336-659-2962.
Claims reimbursement disputes

• In the event an error is suspected on an explanation of payment (EOP), a request for correction may be initiated either by telephone or in writing by using the PARTNERS claim inquiry form.

• To request a review in writing, the following information must be included:
  – Letter of explanation, relative to any error in the processing of the claim
  – Copy of the original claim
  – Copy of the corresponding EOP with the claim in question circled
Hold harmless

• The member will not be held financially responsible for the cost of covered services except for any applicable copayment, coinsurance, or deductible, if all of the following are true:
  – The member has followed PARTNERS guidelines in consulting with and following the direction of his/her PCP or a participating specialist to whom he/she has direct access.
  – The PCP or participating specialist fails to obtain pre-certification with PARTNERS Healthcare Services department for those covered services, which require pre-certification.

• Providers may bill the member for non-covered services, as long as, a specific written waiver has been obtained prior to services being rendered.
HealthTrio Connect is an electronic tool that providers can use to verify member’s benefits, eligibility, check claim status and review the EOP. HealthTrio connectivity is free to PARTNERS contracting providers.

PARTNERS Provider Services 1-888-296-9790 and @ bcbsnc.com/providers/blue-unicare-providers

HealthTrio Connect claims inquiries
healthtrioconnect.com
Electronic billing – batch transmissions

• Electronic Solutions supports applications for the electronic exchange of health care claims, remittance, enrollment inquiries and responses.

• Electronic Solutions provides support for health care providers and clearinghouses that conduct business electronically.
  – Electronic Solutions is available to assist via the Provider Service Line 1-888-296-9790

✓ Reminder:Rejected claims are claims not being processed, negatively effecting your AR. Please remember to work your rejected claims report so that claims are submitted to PARTNERS and accepted for processing.
Medical records

• Providers are not required to obtain consent from the member to send medical records.

• Providers agree to make records freely available to PARTNERS for review.

• Providers agree to discuss records and the connected treatment with PARTNERS, its representatives or committees.
Blue Medicare HMO℠ and Blue Medicare PPO℠ Provider Information Line

• Eligibility verification
• Claims inquiries
• Benefit Inquiries

 Provider Information Line:

Monday through Friday, 8:00 a.m. until 5:00 p.m.
1-888-296-9790 or 1-336-774-5400

✓ Reminder that HealthTrio Connect can deliver information directly to your desktop.
Online Information
www.bcbsnc.com/providers/blue-medicare

• Browse the provider section of our Web site and discover the following information:
  – Online provider manual
  – Provider newsletters
  – Resources for electronic batch processing
  – Information about prior authorization
  – Medical management programs
  – Contact information
  – Much more!
Is your practice moving or opening a new location – We need to know

• If your health care business moves or opens a new location we must be notified in order to properly enter your businesses information into our data systems. Without the correct information:
  – Claims will be denied because the location will show as non-participating.
  – Members may not be able to find you because your new information will not be displayed in our member directories.
  – Credentialing may go uncompleted – preventing members to be seen

• If you think that your information may be in need of updating, please let us know by contacting your regional Network Management representative or complete and return a provider demographic form that can be found on the “providers” page on our Web site at bcbsnc.com/providers/.
Thank you!