

# The Provider NEWSLETTER

**PARTNERS**<sup>®</sup>  
Medicare Choice

www.partnershealth.com

## Medicare Advantage: New Name for the Medicare+Choice Program

On December 8, 2003, President George Bush signed the Medicare Modernization Act (MMA), which included several provisions designed to strengthen and enhance the Medicare program. The legislation also changed the name of the Medicare+Choice organizations to Medicare Advantage.

While the name change went into effect with the passing of the legislation in December, the law allows time for companies to update their materials to reflect the new name. Beginning with its 2005 materials, the Centers for Medicare and Medicaid Services (CMS) will begin to replace the Medicare+Choice term with Medicare Advantage. However, the CMS materials related to the new 2004 prescription drug discount card program (more about the card on page 2) already incorporate the Medicare Advantage term. All materials will reflect the Medicare Advantage name by January 1, 2006.

Similarly, PARTNERS has begun to update its communication materials. As a result of these updates, you may see both the Medicare Advantage and/or Medicare+Choice terms used to describe our program with CMS between now and 2006. It is important to note the distinction between our product name—PARTNERS Medicare Choice—and the Medicare+Choice term. We will continue to use PARTNERS Medicare Choice, which is our product/plan name under the Medicare Advantage (formerly Medicare+Choice) government program. ■



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# PARTNERS Is Awarded Medicare Discount Drug Card Sponsorship

PARTNERS recently received CMS approval to offer a Medicare-approved discount prescription drug card to its PARTNERS Medicare Choice enrollees. This card is designed to help beneficiaries pay for prescription drugs and is provided to them at no additional charge.

While this Medicare-approved drug discount program is similar to the drug discount program that is currently offered by PARTNERS as a value-added service, it is different in that the Medicare-approved card provides a \$600 per year transitional credit for qualified members with low incomes.

PARTNERS members may use the card to help pay for noncovered drug expenses. Members who qualify for the \$600 transitional assistance credit can also use the card to help pay copayments related to covered drugs.

The new Medicare-approved drug card program, which takes effect for beneficiaries on June 1, 2004, was included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as a means to provide Medicare beneficiaries immediate assistance for prescription drug costs before the comprehensive Medicare drug benefit starts in 2006. ■

## Real-Time Support From *RadConsult*

HealthHelp works in partnership with PARTNERS Medicare Choice and participating physicians with a variety of imaging-management services. HealthHelp programs are clinically oriented, which means they are focused on ordering the most appropriate test for each patient's clinical indications.

*RadConsult* is a radiology call center program offered by HealthHelp that provides real-time decision support, including physician consultation for physicians ordering complex imaging outpatient procedures such as MRI, MRA, CT and CTA studies. Physicians are encouraged to use this consultation service prior to ordering MRI and CT studies.

If you have questions regarding HealthHelp or *RadConsult*, please contact Sara French, HealthHelp, at 1-888-488-4464, ext. 2410.

HealthHelp also operates the Radiology Scheduling Line (RSL) through which providers who contract with PARTNERS Medicare Choice previously scheduled specific non-emergent outpatient radiology procedures. Effective March 1, 2004, you are no longer required to schedule tests through RSL for your PARTNERS Medicare Choice members. However, the *RadConsult* program mentioned above will continue to be available to PARTNERS Medicare Choice providers. ■

## Be Sure You're in the Know When Collecting Extra Contractual Charges

It's important for you to be aware that when you collect extra contractual charges beyond the approved Medicare deductible and coinsurance that it could be a potential assignment violation. There are potential liabilities that can result if you bill Medicare patients for services that are already covered by Medicare.

Medicare participating providers may charge beneficiaries for any approved Medicare deductibles, copayments, coinsurance or noncovered services without violating the terms of their provider assignment agreements. But when a participating provider requests any other payment for covered services from Medicare patients, they are subject to civil money penalties and possible exclusion from Medicare and other federal health care programs. ■

### Editorial

This newsletter, unless otherwise stated, applies to Medicare Choice members.

PARTNERS is committed to offering its health plans on a nondiscriminatory basis.

PARTNERS does not discriminate based on color, religion, national origin, age, race, disability, handicap, gender or health status as defined by CMS.

PARTNERS National Health Plans  
of North Carolina, Inc.

Provider Services  
336-774-5400 or 1-888-296-9790

# Your Help Is Needed: 2004 HEDIS Information

As part of its quality assurance and compliance program, The Centers for Medicare & Medicaid Services (CMS) requires Medicare+Choice organizations, such as PARTNERS, to report HEDIS (Health Plan Employer Data and Information Set) data on an annual basis. Collecting and reporting information for HEDIS is required for CMS certification and licensing.

Over the next several months, PARTNERS staff will be collecting information for the 2004 HEDIS report. A random sample of members that meet the eligibility requirements will be chosen in order to calculate the required measures. Many of you will receive a call and/or visit from PARTNERS staff requesting

access to medical records that pertain to cholesterol management, post-acute cardiovascular events, comprehensive diabetes care, beta blocker treatments, care following a heart attack, colorectal screenings, and controlling high blood pressure.

PARTNERS has reviewed the HIPAA (Health Insurance Portability and Accountability Act) privacy regulation carefully in regard to these activities. HIPAA allows the disclosure—without an authorization—of protected health information (PHI) for the purposes of treatment, payment and health care operations. In section 164.501 and 164.506 of the Privacy Rule, the Department of Health and Human Services makes clear that

activities including evaluating health plan performance, certification and accreditation are defined as “Health Care Operations” activities. Accordingly, a covered entity may use or disclose PHI without an authorization for its own health care operation activities or certain health care operation activities of another covered entity. PARTNERS is a covered entity and requires this information to meet CMS requirements, and under the Privacy Rule you are allowed to disclose this information to us to perform these health care operations activities.

We appreciate your cooperation. ■

## Magellan Behavioral Health Takes Over PARTNERS Mental Health and Substance Abuse Services

As of April 1, all PARTNERS Medicare Choice (PMC) members—with the exception of those enrolled through RJR—began receiving services related to mental health and substance abuse (MH/SA) benefits through Magellan Behavioral Health, Inc. A nationwide company, with an office in Morrisville, North Carolina, Magellan replaced Behavioral Health Resources, Inc. (BHR), which had served as PMC’s benefits manager for MH/SA services for the past seven years.

Magellan, like BHR before it, offers all phases of administration associated with MH/SA services, including utilization management, quality management, provider network management, claims processing, and

customer service. At the same time, PARTNERS Medicare Choice recognizes that with any change there is the potential for some isolated impact on a PMC member and to those dependent upon its administrative services. To minimize any service disruption that may occur during the transition, PMC will continue to work with BHR, Inc. and Magellan to ensure that any problems are resolved quickly, accurately and to the satisfaction of those involved.

“By and large,” according to Deborah Washington-McNeill, director, PARTNERS Medicare Choice, “the change has been transparent to members. While the provider network has recorded some changes, Magellan continues to enroll BHR providers not

currently in their network. If the goal of having the same providers is not achieved, a transition of care plan is in place to ensure that member needs are met within the parameters for managing care through network-affiliated providers.”

Washington-McNeill also pointed out that the main contact number has not changed despite the change in benefits management. The toll-free number of 1-800-266-6167 remains the same despite the change in MH/SA administrators. ■

# Network Management Hosts 2004 Health Care Provider Workshops

We invite you to attend one of our health care provider workshops to be held at various locations across the state this spring. In addition to the Physician's Office Workshops, we have expanded the educational sessions to include a separate workshop for the hospital community in selected locations.

Our workshops will provide you with updates and information about our product lines and procedures for claims submission. We've made our products easier to use, with improved electronic processes and simplified policies. Additionally, we will distribute the new 2004

*PARTNERS Provider Manual* at the workshops.

Our partnership with you is important. We want to assist you in providing our members with quality health care services, by providing updates to you on the work that we do. Please plan to come to one of our annual workshops and get the latest information.

The easiest way to register is to go online to [www.cvent.com/cvent\\_rsvp.asp](http://www.cvent.com/cvent_rsvp.asp) and enter the event code for the location that you want to attend. It's that simple. You will receive an immediate confirmation. ■



## WORKSHOP LOCATIONS

Workshops will be held from 9:00 a.m. to 11:00 a.m.; 11:30 a.m. to 1:00 p.m.; and 1:30 p.m. to 3:30 p.m. Please select the session and location most convenient for you.

<p><b><u>May 18, 2004</u></b>            Durham Hilton            (919) 383-8033            3800 Hillsborough Road            Durham, NC 27705  <b>event code: HJ6H442DBU</b></p>	<p><b><u>May 26, 2004</u></b>            Greenville Hilton            (252) 355-5000            207 SW Greenville Boulevard            Greenville, NC 27834  <b>event code: HL6H242DBU</b></p>	<p><b><u>June 15, 2004</u></b>            Adam's Mark Hotel            (704) 372-4100            555 South McDowell Street            Charlotte, NC 28204  <b>event code: AL5SRD0NEQ</b></p>
<p><b><u>May 19, 2004</u></b>            Holiday Inn Bordeaux            (910) 323-0111            1707 Owen Drive            Fayetteville, NC 28304  <b>event code: UR70AH7NM8</b></p>	<p><b><u>June 8, 2004</u></b>            Holiday Inn Select            (336) 767-9595            5790 University Parkway            Winston-Salem, NC 27105  <b>event code: H5BJUA3B3F</b></p>	<p><b><u>*June 16, 2004</u></b>            Park Inn Gateway Conference Ctr.            (828) 328-5101            909 Highway 70, SW            Hickory, NC 28602  <b>event code: HL6HC42DBU</b></p>
<p><b><u>*May 20, 2004</u></b>            Hampton Inn            (252) 333-1800            402 Halstead Boulevard            Elizabeth City, NC 27909  <b>event code: UL061H852Q</b></p>	<p><b><u>June 9, 2004</u></b>            Clarion Greensboro            (336) 299-7650            415 Swing Road            Greensboro, NC 27409  <b>event code: U180AH7NM8</b></p>	<p><b><u>June 17, 2004</u></b>            Renaissance Asheville Hotel            (828) 252-8211            One Thomas Wolfe Plaza            Asheville, NC 28801  <b>event code: H5BJUA3L3F</b></p>
<p><b><u>May 25, 2004</u></b>            UNCW Executive Development            Center            (910) 962-3193            Military Cutoff Road, Suite A            Wilmington, NC 28405  <b>event code: KUCP6613YH 1241</b></p>	<p><b><u>*June 10, 2004</u></b>            Holiday Inn            (704) 637-3100            530 Jake Alexander Blvd., S.            Salisbury, NC 28147  <b>event code: ULO6BH852Q</b></p>	<p><i>*There are no afternoon or hospital workshops offered on May 20, June 10 and June 16.</i></p>

**For more information,** call your local Network Management representative. Here's a list of local Network Management field offices and contact numbers:

Office	Phone	Fax	Address
Charlotte	(704) 561-2740	(704) 676-0501	P.O. Box 35209 Charlotte, NC 28235
Greensboro	(336) 316-5374	(336) 316-0259	2303 W. Meadowview Rd., Ste. 200 Greensboro, NC 227407
Hickory	(877) 889-0002	(828) 431-3155	P.O. Box 1588 Hickory, NC 28601
Raleigh	(919) 469-6935	(919) 469-6909	2501 Aerial Center Drive, Suite 225 Morrisville, NC 27560
Greenville/Wilmington	(877) 889-0001	(910) 509-3822	2005 Eastwood Road, Suite 201 Wilmington, NC 28403

## New CMS Expedited Appeal Process

As of January 1, 2004, enrollees of Medicare Advantage (formerly Medicare+Choice) plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their Medicare Advantage plan's decision that Medicare coverage of their services from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) should end.

The Centers for Medicare & Medicaid Services (CMS) issued a final ruling in April 2003, which stated that skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must provide an advance Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage enrollees no later than two days before coverage of their services will end. If the patient does not agree that covered services

should end, they may request an expedited review of the case by the Quality Improvement Organization in that state. The enrollee's Medicare Advantage plan must furnish a detailed notice explaining why services are no longer necessary or covered.

### **View the New Rule Online**

You may view this new rule in its entirety by visiting the "Provider" page online at [partnershealth.com](http://partnershealth.com) and click on the education article titled "New Enrollee Rights and Provider Responsibilities in the Medicare Advantage Program." The rule or information can also be located on the CMS Web site. To assure compliance with this new rule, the PARTNERS Medicare Choice policy and procedure will be as follows:

"All contracting and non-contracting providers must ensure delivery of the notice to the enrollee no later than two days/visits prior to the proposed termination of SNF, HHA or

CORF services and obtain the enrollee's or authorized representative's signature on the NOMNC. The provider must place the original NOMNC in the enrollee's case file, give a copy to the enrollee, and fax a copy of the notice to the Health Services Department at PARTNERS Medicare Choice (fax number: (336) 659-2945)."

### **How to Appeal**

The enrollee has the right to an immediate review of the decision to end the coverage while the services continue. The enrollee must submit a timely request for the immediate review directly to the QIO by noon of the day following receipt of the NOMNC. When the enrollee receives the NOMNC more than two days/visits prior the date coverage is expected to end, the enrollee can request an appeal to the QIO by noon of the day before coverage ends (effective date of notice).

*continued on page 8*

# Advance Beneficiary Notice Does Not Apply to PARTNERS Medicare Choice

Advance beneficiary notices (ABNs) are designed for use with patients who have traditional Medicare coverage, including those who are dually eligible for Medicare and Medicaid. ABNs are not for use with patients who have Medicare+Choice plans.

The purpose of the ABN is to inform a Medicare beneficiary before he or she receives specified items or services that

otherwise might be paid for, that Medicare probably will not pay for them in this particular instance. PARTNERS has enhanced our member's benefits so that there are additional services that are covered as compared to traditional Medicare benefits. As a result of these benefit enhancements, the ABN is not appropriate for use with PARTNERS Medicare Choice members.

Recently, PARTNERS has seen an increase in the use of the modifier "GA," which indicates that a waiver of liability statement or a ABN is on file for the member. Use of this modifier on a PARTNERS member's claim will make that claim line automatically deny. Please do not use the modifier "GA" on claims for PARTNERS Medicare Choice members. ■

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## Provider Agreement Terms: "Hold Harmless"

Sometimes components of a contractual agreement can be confusing to understand or apply to real situations. We thought it might be helpful to further clarify what is meant by the term "Hold Harmless." The agreement you signed with PARTNERS contains a Hold Harmless section similar to the text below:

**Hold Harmless:** "Provider agrees that except for applicable deductibles, copayments or coinsurance, in no event,

including but not limited to nonpayment, PARTNERS insolvency, or breach of this agreement, shall provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a PARTNERS Medicare Choice member or a person acting on such Medicare Choice member's behalf for covered services."

So what exactly does this mean for you? Quite simply, it means that no provider may

request or require an additional financial obligation before obtaining services. For example, a skilled nursing facility may not require a monetary deposit from a PARTNERS Medicare Choice member as a condition of accepting them as a patient for covered skilled nursing services. ■

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## Reminder About Chiropractic Services and Referrals

PARTNERS Medicare Choice is no longer using the American Whole Health Network to provide its network of chiropractic providers or to manage the number of referred visits. This means that each primary care physician (PCP) must specify the number of chiropractic visits to be authorized. The referral form is being modified to reflect this change. Until you receive the updated forms, please continue to use the old form and clearly indicate how many referral visits are being authorized.

Medically necessary chiropractic services and treatment for manual manipulation of the spine for subluxation are covered benefits when the PCP refers the PARTNERS Medicare

Choice member to a participating provider. As of January 2000, services for subluxation do not have to be demonstrated by X-ray. However, if X-rays are needed by a chiropractor, they must be ordered by the member's PCP in order to be covered. If X-rays are ordered by a chiropractor, they will not be covered and the member cannot be billed. Please note that Medicare does not cover maintenance therapy. ■



# Medical Policy Coverage Updates

The following medical coverage policies have been updated and approved as of March 2004 by the PARTNERS Physician Advisory Group:

Policy	Major Changes	Additional Notes
Amevive	New Policy	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> <li>■ Covered for treatment of adults with moderate to severe chronic plaque psoriasis who are candidates for systemic treatment or phototherapy</li> <li>■ Complies with current Medicare coverage guidelines</li> </ul>
Breast Implant Removal	Breast implant removal may be covered even when the implant insertion was not a covered service under certain circumstances	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> <li>■ Complies with current Medicare coverage guidelines</li> </ul>
External Infusion Pumps	Criteria added for coverage of anti-cancer drugs, narcotic analgesics, antifungal drugs, antiviral agents, intropic therapy, and parenteral epoprostenol	<ul style="list-style-type: none"> <li>■ C-peptide levels added as diagnostic criteria for diabetes</li> <li>■ Chronic renal dialysis removed as condition for non-coverage</li> </ul>
Footwear (Diabetic and Custom)	Coverage is limited to diabetics only	<ul style="list-style-type: none"> <li>■ Complies with current Medicare coverage guidelines</li> </ul>
Hyperbaric Oxygen Therapy	Expanded criteria for coverage of diabetic wounds	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> <li>■ Complies with current Medicare coverage guidelines</li> </ul>
Implanted Infusion Pumps	Expanded coverage description for chemotherapy, anti-spasmodic and opioid drugs	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> <li>■ Complies with current Medicare coverage guidelines</li> </ul>
Observation	<ul style="list-style-type: none"> <li>■ New Policy</li> <li>■ Established guidelines for review of observation status during hospitalization</li> </ul>	<ul style="list-style-type: none"> <li>■ Reflects current Medicare coverage guidelines</li> </ul>
Orthognathic Surgery	Covered when medically necessary and the symptoms of skeletal facial deformities present a significant functional impairment for the member	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> </ul>
Speech Language Pathology	Includes criteria for coverage of language and swallowing interventions	<ul style="list-style-type: none"> <li>■ Reflects current Medicare coverage guidelines</li> </ul>
Ophthalmology Guidelines for Esotropia/Exotropia, Vitrectomy, and Corneal Endothelial Microscopy	Renamed Strabismus Surgery Removed references to corneal endothelial microscopy and vitrectomy	<ul style="list-style-type: none"> <li>■ <b>Requires Prior Approval</b></li> </ul>

If you have questions regarding the PARTNERS policies or wish to obtain a copy of a policy, please contact your Network Management representative. ■

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## Expedited Appeal Process (continued from page 5)

The enrollee does not incur financial liability if the QIO reverses the Medicare Advantage Plan's termination decision or if the enrollee stops receiving services no later than the effective date inserted on the NOMNC.

On the date the QIO receives the enrollee's request, the QIO immediately notifies the Medicare Advantage Plan and provider that the enrollee has filed a request for immediate review.

By the end of the business day (4:30 p.m.) of the QIO's notification, the Medicare Advantage Plan must send a detailed notice to the enrollee and QIO titled "Detailed Explanation of Non-Coverage" (DENC) which includes a specific explanation of why services are either no longer reasonable and necessary or are no longer covered. In addition, the Medicare Advantage Plan must provide to the QIO all pertinent medical documentation that the QIO requires to conduct its review.

All providers are required to immediately provide the Medicare Advantage Plan with the medical information needed to support the issuance of the DENC when requested by the Plan representative. Failure to assist with the compliance of this regulation may result in lost revenue on behalf of the provider.

### ***The Role of the QIO***

The QIO must determine whether coverage of provider services should continue, and must notify the enrollee, the provider, and the Medicare Advantage Plan of its determination by 4:30 p.m. of the day of the planned coverage termination, assuming it receives all necessary information from the SNE, HHA, CORF or the Medicare Advantage Plan.

If the QIO does not receive the information it needs to sustain the Medicare Advantage Plan's decision

to terminate services, then the QIO may make a decision based on the information at hand, or it may defer the decision until it receives the necessary information. If the QIO defers its decision, then coverage of the services by the Medicare Advantage Plan continues.

If you have any questions regarding your responsibility as a contracting provider, please contact your local Network Management representative. ■

