

Medi-Pak[®] Advantage: Frequently Asked Questions

General Information:

What Medicare Advantage product is Arkansas Blue Cross Blue Shield offering?

Arkansas Blue Cross and Blue Shield has been approved by the Centers for Medicare and Medicaid Services (CMS) to offer a Medicare Advantage Private Fee-For-Service product: Medi-Pak[®] Advantage.

A Private Fee-For-Service (PFFS) Medicare Advantage product offers enrollees full benefits for covered services from any physician or provider eligible to participate in Medicare and willing to accept the plan's Terms and Conditions of payment (see pages 19-30).

A plan may offer a Network or a Non-Network PFFS product. Arkansas Blue Cross began marketing Medi-Pak[®] Advantage to Medicare beneficiaries on October 1, 2006 with an effective date of January 1, 2007.

Which PFFS network option has Arkansas Blue Cross selected? Arkansas Blue Cross has chosen to offer a **Non-Network** PFFS product. Payment for covered services will generally be the Medicare allowable, less any member cost-sharing amounts.

In accordance with CMS guidelines, if a provider is aware the member is covered by a Medicare Advantage PFFS product, has reasonable access to the Terms and Conditions of payment, and chooses to render services to the Medicare Advantage PFFS enrollee, then the provider is bound by the plan's Terms and Conditions of payment.

A provider is not required to render services to a Medicare Advantage PFFS enrollee. A provider's decision can be made on a patient-by-patient basis.

What is Medi-Pak[®] Advantage? Medi-Pak[®] Advantage combines the benefits of Medicare Part A and B and includes additional services not covered by traditional Medicare.

A Medi-Pak[®] Advantage member is free to choose any doctor, specialist or facility that accepts the Medi-Pak[®] Advantage Terms and Conditions of plan payment. The Benefit Summary is available on the Arkansas Blue Cross and Blue Shield web site and AHIN. Also, providers may call 1-866-390-3369 for benefit and eligibility information.

How do providers identify a patient with Medi-Pak[®] Advantage? Providers can obtain eligibility information by contacting 1-866-390-3369 and providing the member ID number. Eligibility information will also be available on AHIN for Arkansas providers. Note that responses to eligibility inquiries are not a guarantee of eligibility or payment and are subject to limitations (See “Effect of Eligibility Inquiry Responses” in “Terms and Conditions” for Medi-Pak[®] Advantage, outlined at pages 19-30 of this newsletter).

How can an Arkansas Provider participate in the Medi-Pak[®] Advantage Program?

Arkansas Blue Cross has chosen to offer a **Non-Network** PFFS product for 2009. Since this is a non-network product, providers do not need to enter into a PFFS contract with Arkansas Blue Cross. To be eligible to furnish care to a PFFS member, physicians, or other healthcare providers must be state licensed and have a Medicare billing number or be eligible to obtain one.

Institutional providers treating PFFS members, such as hospitals and skilled nursing facilities, must be certified to treat Medicare beneficiaries. The provider must also agree to the plan’s Terms and Conditions of payment.

Where do providers find the Terms and Conditions of Payment? For a copy of the Medi-Pak[®] Advantage Terms and Conditions of payment, go to the Arkansas Blue Cross web site at www.ArkansasBlueCross.com, select the “Provider” page and click on the “Medicare” link or call Medi-Pak[®] Advantage Provider Service at 1-866-390-3369.

What networks are attached to Medi-Pak[®] Advantage? For 2009, Arkansas Blue Cross has decided to offer a Non-Network PFFS Medicare Advantage product so there is no network. A member has full benefits for covered services by any qualified* provider that agrees to accept the Medi-Pak[®] Advantage Terms and Conditions of Plan Payment.

*(Please refer to the Deeming Process and the Terms and Conditions outlined on pages 19-30 of this newsletter for more explanation of the applicable program Terms and Conditions.)

Are there contracted laboratories? Medi-Pak[®] Advantage is a Non-Network PFFS plan. Members have full benefits for covered lab work performed at any Medicare-approved lab that is willing to accept the Medi-Pak[®] Advantage Terms and Conditions.

What is a deemed provider? Any provider furnishing health services to an Arkansas Blue Cross Medi-Pak[®] Advantage member, except for emergency services furnished in a hospital, is deemed to have a contract with Arkansas Blue Cross for purposes of services to Medi-Pak[®] Advantage members if:

1. Services are covered by the plan;
2. The member is an enrollee of Medi-Pak[®] Advantage;

3. The provider is aware the member is a Medi-Pak[®] Advantage enrollee prior to rendering services to the Member; and
4. Providers know the Medi-Pak[®] Advantage Terms and Conditions of payment or have reasonable access to the terms and conditions of payment.

If a facility is considered deemed, then Arkansas Blue Cross will consider any facility-based provider as deemed.

Does the provider have a responsibility to somehow notify the plan that he or she is deemed? No. The provider simply needs to see the member's ID card to identify the individual as a Medi-Pak[®] Advantage member and file a claim for services. The provider should review the Terms and Conditions of payment referenced on pages 19-30 of this newsletter and available on the Arkansas Blue Cross and Blue Shield web site at www.ArkansasBlueCross.com

If the provider renders care to the member and files a claim, that provider is deemed. A provider may choose to provide care to Medi-Pak[®] Advantage enrollees on a patient-by-patient basis and may stop scheduling appointments with enrollees at their discretion.

What if a provider does not want to accept Medi-Pak[®] Advantage? Providers who do not accept Medi-Pak Advantage's Terms and Conditions should not provide services to a Medi-Pak Advantage enrollee, except for urgent or emergency care.

If the provider chooses to provide services, then they by default have agreed to our terms and conditions of payment and must bill Medi-Pak Advantage for covered health care services. The provider should collect the appropriate Medi-Pak Advantage copays or coinsurance from the enrollee at the time of service. The provider may at any time, on a patient-by-patient and visit-by-visit basis, decide that they do not want to treat a Medi-Pak Advantage enrollee.

What if a provider does not want to accept Medi-Pak[®] Advantage but the condition is urgent or emergency? In such cases, claims should be filed to Arkansas Blue Cross (Arkansas providers) or the providers' local Blue plan (out of state providers).

How will providers know when Terms and Conditions change? Any changes to the Terms and Conditions are posted on the Arkansas Blue Cross web site. Providers will be notified of changes through the **Providers' News**. Providers can also receive information on the Terms and Conditions by calling Medi-Pak[®] Advantage Provider Service at 1-866-390-3369. Arkansas Blue Cross and Blue Shield can provide information by phone, by mail, or by fax.

Is it the responsibility of the physician/health care provider to check the Terms and Conditions? While Arkansas Blue Cross does not anticipate frequent changes to the Terms and Conditions, it is the provider's responsibility to understand the Terms and

Conditions. Providers should check the Terms and Conditions as frequently as necessary.

Under the traditional Medicare, hospital patients must fill out a MSP (Medicare Secondary Payer) questionnaire. Should hospitals implement this process for Medi-Pak® Advantage members? Yes, hospitals should have their patients fill out the MSP. Arkansas Blue Cross reimburses physicians or other health care providers and attempts to recover the money from any third party that might be liable after the fact.

Benefits:

What are the benefits of the Medi-Pak® Advantage products? Medi-Pak® Advantage benefits include convenient copayments and no deductibles.

In the Benefit Summary section, under Diagnostic tests, x-rays and lab services, it mentions the member being responsible for a copayment ranging from \$0 to \$250 for diagnostic radiology services. What determines what the copayment will be? For all lab services and x-rays, the copayment is \$0. For most diagnostic radiology services the copayment is \$0. However, there is a copayment for advanced imaging (CT, PET, MRI and MRA). There will be a copayment for each advanced image performed.

Please explain the pharmacy formulary and tiers? Medi-Pak® Advantage has a 4-tier drug formulary: generic, preferred brand, non-preferred brand, and specialty. Information on these drugs is available on the Arkansas Blue Cross website.

Is there a grace period for the beneficiary to move from non-formulary drugs to formulary? New members will have a 60-day grace period to switch to a drug on the formulary.

Does the Arkansas Blue Cross website allow Medicare beneficiaries to check to see if their current medications are covered on the formulary and at what tier (copay)? The full formulary is available on the Arkansas Blue Cross web site or call the Caremark customer service number 1-866-494-6699.

Will a provider be able to obtain prior authorization on Medicare Part D drugs online through Arkansas Blue Cross web site, by telephone or paper process? For Prior authorizations, providers can call Caremark at.1-800-294-5979

Claims:

How are emergencies treated? Claims for emergency services furnished in a hospital pursuant to 48 CFR 489.24 will be processed as filed (accepting or not accepting Medicare assignment).

Providers who accept assignment will be paid the Medicare allowable less the member's cost-share amounts. Providers who do not accept assignment will be paid the Medicare limiting charge less the member's cost-share amounts.

Where should Arkansas providers submit their Medi-Pak® Advantage claims?

Medi-Pak® Advantage claims for members covered by **any** BlueCross BlueShield Plan should be submitted to Arkansas Blue Cross. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Where should out-of-state providers submit Medi-Pak® Advantage claims?

Providers outside of Arkansas should file their Medi-Pak® Advantage claims to their local Blue Plan in their normal manner. Do not bill Medicare directly for any services rendered to a Medi-Pak® Advantage member.

What coverage guidelines does Medi-Pak® Advantage use?

Medi-Pak® Advantage uses the same National Coverage Determinations (NCDs) as traditional Medicare along with Arkansas Blue Cross and Blue Shield Coverage Policy. Arkansas Blue Cross may use the Local Coverage Determinations (LCD) in effect for the area where care is rendered.

Providers may call Medi-Pak® Advantage Provider Service area at 1-866-390-3369 with specific questions about LCDs. LCDs can be found by going to the following web sites and select the search function (<http://www.cms.hhs.gov/coverage/default.asp> or www.arkmedicare.com/provider/medpol/default.htm).

What format does Arkansas Blue Cross and Blue Shield require for claims?

Arkansas providers should submit claims for Medi-Pak® Advantage members as follows:

*Use NPI number.

If a Provider currently submits their claims electronically to Arkansas Blue Cross Private Business, they may submit their Medi-Pak® Advantage claims using the same process. Please refer to the Terms and Conditions for further details.

Paper claims may be mailed to:
Arkansas Blue Cross and Blue Shield
Attn: Medi-Pak® Advantage
P. O. Box 2181
Little Rock, AR 72203-2181

Providers do not need to sign Block 31 of the CMS 1500 since the provider's signature is already on file with Arkansas Blue Cross or their provider's local carrier if out of state.

Providers outside of Arkansas should file claims to their local Blue Plan in their normal manner. Claims for Medi-Pak[®] Advantage members should be filed using the same CMS billing guidelines, forms, and codes as traditional Medicare.

Will payment also come back on the regular Blue Cross Remittance Advice or on another Remittance Advice? Payment will be on a separate Blue Cross Remittance Advice and will be available for Arkansas providers on AHIN. Also, 835's will be prepared.

Are claims filed through AHIN? Arkansas provider claims come through AHIN – Medi-Pak[®] Advantage doesn't change how a provider is filing today. Out-of-state providers should file through their local Blue Plan.

For Arkansas providers, AHIN will have the Remittance Advice and 835 online. At this time, Electronic Fund Transfer is not available for Medi-Pak[®] Advantage.

Can providers use vendors other than AHIN for claims? Yes, the payment source code that providers will use for this product is Arkansas Blue Cross Private Business (not Medicare).

What is the claims payment timeliness standard for Medi-Pak[®] Advantage? As a Medicare Advantage Organization (MAO) under contract with the CMS, Arkansas Blue Cross must follow Medicare Advantage regulations. These contain provider protections, including a requirement for prompt payment to health care providers. Under this provision, a MAO must pay 95 percent of clean claims within 30 days of receipt for services rendered as deemed.

What is the timely filing provision for Medi-Pak[®] Advantage? 365 days from the date of service is the timely filing period.

Are Medicare ID numbers required on claims submitted? No, Arkansas provider claims should be submitted using their NPI number.

Do providers have to have a Medicare number to submit a claim for a Medi-Pak[®] Advantage member? To be eligible to furnish care to a PFFS member, physicians or other health care providers must be state licensed and be a Medicare eligible provider.

Can Arkansas physicians or health care providers go online to review their claims status or obtain information on patient eligibility? Providers can check benefits and eligibility online using AHIN. See "Effect of Eligibility Inquiry Responses" in the "Terms and Conditions" located on pages 19-30 for limitations applicable to eligibility inquiry responses.

For providers who do not presently have AHIN may obtain access by following the directions below:

- Download the [AHIN Setup Document and Agreements](#) (82 KB PDF)

- Complete, sign and mail the documents to:
Advanced Health Information Network
601 S. Gaines Street
P.O. Box 1489
Little Rock, Arkansas 72203-1489

An AHIN Customer Support Representative will notify the contact person listed on the AHIN setup document when all testing is complete and provide the assigned user names and password.

How do I submit a corrected claim? The process is the same as for submitting corrected claims to ABCBS. Please use the Corrected Claim Form on our web site and mark ABCBS.

Ancillary Issues:

What are the criteria for patient eligibility for home health care? Medi-Pak[®] Advantage uses the same home health criteria that are in place for traditional Medicare.

Are payments for home healthcare the same as the Medicare Prospective Payment System (PPS)? Yes, Arkansas Blue Cross uses home health PPS. Claims are submitted for individual services. Four services or less during a 60 day period are paid at the individual service rate with the Low Utilization Payment Adjustment (LUPA).

Is there an initial and final payment for home health care, as with traditional Medicare, or is there one payment per 60-day episode? Arkansas Blue Cross pays the same way as traditional Medicare with an initial and final payment. However, home health agencies may request reimbursement per 60-day episode of care by submitting a Request for Accelerated Payment (RAP).

Disputed Payment Amounts:

What recourse do providers have to dispute payments? Physicians and other providers have the right to dispute payments by notifying Arkansas Blue Cross. If a physician or other provider has information that traditional Medicare would pay more for a service, the provider can submit documentation to Arkansas Blue Cross for review, verification, and payment adjustment, if appropriate.

Reimbursement:

Which fee schedule does Arkansas Blue Cross use to determine the physician payment rate? As with traditional Medicare, the fee schedule for the locality where the service is rendered is used to reimburse physicians and other providers.

What services are subject to the annual deductible? Medi-Pak[®] Advantage does not have an annual deductible. The one exception is for emergency services received outside the U.S.

What happens if a member disenrolls from Medi-Pak[®] Advantage and goes back to traditional Medicare? How are the member's cost-shares calculated? If a member disenrolls from Medi-Pak[®] Advantage and returns to the traditional Medicare, then traditional Medicare cost-sharing provisions apply.

How are payments for outpatient hospital services determined? Similar to traditional Medicare, reimbursement is determined by Ambulatory Payment Classification (APC) codes. However, under traditional Medicare, the APC code payment methodology often includes a high beneficiary cost-share; this is not the case under Medi-Pak[®] Advantage.

Arkansas Blue Cross and Blue Shield pays the Medicare-allowed amount, minus the member's Medi-Pak[®] Advantage copayment. Outpatient copayments are based on the type of facility where care is rendered.

How does inpatient reimbursement work? Inpatient services are reimbursed at the full Diagnostic Related Group (DRG) allowable amount, minus the Medi-Pak[®] Advantage member copayment for inpatient services. Critical Access Hospitals are reimbursed based on their individual Medicare interim per diem.

How should a provider notify Medi-Pak Advantage if they believe they have a claim that qualifies for outlier payment? Medi-Pak Advantage follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Provider Services if the claim has already been paid.

Will Medi-Pak Advantage reimburse facilities for bad debt based on cost settlement reports? No. Bad debt is a component of the DRG/per diem rate.

Are facilities required to file an informational claim to Medicare in addition to billing Medi-Pak Advantage? No. Only Prospective Payment System teaching facilities should file an informational claim to receive operating IME payment.

How are teaching facilities reimbursed for IME? Use condition codes 04 & 69.

Will the reimbursement rates change? Reimbursement rates are tied to Medicare fee schedules and only change if Medicare rates change. Under Arkansas Blue Cross' Terms and Conditions, Arkansas Blue Cross continues to pay at least the Medicare reimbursement rate.

If a Medi-Pak[®] Advantage member transfers from an acute inpatient facility to an acute rehabilitation facility, does the member's copayment per day apply at the acute rehabilitation facility in addition to the acute inpatient facility? If a member is discharged and readmitted; or, discharged and admitted to a different type of facility, the copayment for that facility will apply.

What is the copayment for infusion patients in a home health care setting? There is no member copayment for Medicare covered home health visits. There is member coinsurance.

What grouper is used for DRG's? The DRG grouper software used is the same as CMS grouping and pricing.

What grouper is used for APC's? The APC grouper software used is the same as CMS grouping and pricing.

Is reimbursement for home health care from Home Health Resource Group (HHRG) codes and for a 60-day episode of care? Yes, reimbursement is the same as traditional Medicare.

What is the coverage for medical supplies under the home health benefit? Medical supplies are covered the same as traditional Medicare.

What is the limit on Durable Medical Equipment (DME) rentals? As with traditional Medicare, there is a 15-month limit on most DME rentals. Arkansas Blue Cross reimburses equipment rental for up to 15 months as long as it does not exceed the purchase price of that equipment.

What is the reimbursement for a deemed provider, versus a non-deemed provider? All deemed providers will be reimbursed at 100% of the current Medicare allowable whether the provider is participating or non-participating with Medicare and whether the claim is assigned or not assigned. Balance billing is prohibited for deemed providers. If the provider inadvertently collects more from the member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

Non-deemed providers (those that do not accept Medi-Pak[®] Advantage's Terms and Conditions) should not provide services to a Medi-Pak Advantage enrollee, except for urgent or emergency care.

If the provider chooses to provide services, then they by default have agreed to our terms and conditions of payment and are therefore considered deemed. They must bill Medi-Pak Advantage for covered health care services. The provider should collect the appropriate Medi-Pak Advantage copayments or coinsurance from the enrollee at the time of service. The provider may at any time, on a patient-by-patient and visit-by-visit basis, decide that they do not want to treat a Medi-Pak Advantage enrollee.

Will Medi-Pak[®] Advantage pay at the par or non-par Medicare rate for deemed non-participating providers with Medicare? If a deemed provider is non-participating with Medicare, Medi-Pak Advantage will reimburse at the participating Medicare rate

and payment will go to provider. Member cannot be balanced billed. Limiting charge will not apply.

If there is no contract or agreement with the physician, what recourse does Medi-Pak[®] Advantage have if the provider does not follow their guidelines? Will they fall back on the Medicare regulations? How does that apply to the Medicare non-participating provider? This falls under the Deeming Guidelines and Terms and Conditions. Once a provider files a claim they are considered deemed and based on Terms and Conditions are agreeing to accept the Medicare allowable as outlined.

What if a beneficiary won't pay copayments at time of service? Can providers remove beneficiary from their practice, as providers could with commercial products, (i.e., for not paying their copayments at the time of service or not at all)? It's a cost savings for a clinic to not have to bill the beneficiary for the copayment. The provider can choose to be deemed or non-deemed at the time of each service. If a member will not pay copayments up front, providers can choose to be non-deemed and not offer services to the member.

Is a copayment assessed only on E/M codes or for each encounter regardless of the provided service? Only on the E/M code.

Utilization Management:

Are authorizations or referrals required for Medi-Pak[®] Advantage? Authorizations and referrals are not required for Medi-Pak[®] Advantage.

Do additional documentation requirements (ADR) apply to this plan? The same ADR requirements apply as do for traditional Medicare.

Out of State:

Where do providers submit out-of-state Medi-Pak[®] Advantage claims? Arkansas providers should submit claims to Arkansas Blue Cross. Do not bill Medicare directly for any services rendered to a Medi-Pak[®] Advantage member. Payment is made directly by a Blue Plan.

Based upon CMS regulations, if a provider accepts Medicare assignment and renders services to a Medi-Pak[®] Advantage member from another Blue Plan, providers will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than the charge amount.

CMS regulations state that the Medicare allowable amount is considered payment in full. Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. Providers may collect only the applicable cost sharing (i.e. co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Providers can make claim status inquiries through Arkansas Blue Cross.