Updates for Member Benefits and Co-payments

As a reminder, each year benefits change for our members. Be sure to check the member’s card for copayments due at the time of service. Some of the changes include specialty copays and therapy services. For a detailed listing you can review the Evidence of Coverage posted on our website.

Our members in Maricopa have the option of a premium plan with lower copays. Be sure to check which plan the member has chosen.

New for 2018

Hearing Services
BCBSAZ Advantage members will be able to receive routine hearing services from TruHearing including 1 routine hearing exam and 2 hearing aids. Only services provided by TruHearing will be covered. Members can call 1-855 205-5011 to schedule an appointment.

Vision Services
Member are covered for 1 (one) Glaucoma and 1 (one) Diabetic Retinopathy screening exam a year when rendered by a contracted Optometrist or Ophthalmologist.

In order to be covered, the provider must bill with the following code combination:

Member Out of Pocket Maximums
BCBSAZ Advantage has out of pocket limits set for each member. The maximum for Part B Medical Services for 2017 was $ 3,200. Due to a system issue, some members may have been charged a copay in error. Our Claims Team has been working hard to correct the records of those members affected. You may see an adjusted claim on your EOB which will provide an INCREASE to your payment. Please refund any copayments charged to the member when you receive your EOB.

Duplicate payments
Duplicate payments should be returned to the health plan within 45 days of discovery. Please be sure to include a copy of your EOB with your check in order to ensure the refund is posted to the correct claim. Three overpayment notices are sent to alert a provider of the payment error. If no refund is received within 90 days, an automatic recoupment may occur from future payments.

Overpayments/Refunds
As a reminder, when you identify any overpayment, you should notify our Customer Service Department or issue a refund to the plan.
Glaucoma G0117 or G0118 with ICD10 Z00.00 or Z01.01

Diabetic Retinopathy screenings 92002, 92012 or 92014. ICD10 code E08-E13.9 and Z00.00 or Z01.01.

Note:
Use of any other code combination will result in a copay charged to the member.
Routine Vision services continue to be a non-covered service.

Corrected Claims
When submitting a corrected claim to the health plan be sure to use the appropriate indicator on your EDI submission. This will help to eliminate claims denying as a duplicate in error. When submitting your correction on paper, mark your request with “Corrected Claim” in the top corner of the document along with the original claim number as a reference in the appropriate box. This will identify the claim was originally submitted timely.

When issuing a refund identified by your staff, please include a cover letter and a short explanation of why you are refunding. Include a copy of the EOB and if necessary, a corrected claim for reprocessing.

If the plan has identified an overpayment, an adjustment will be made to the claim in question and a request to issue a refund will be mailed to your practice. In order for the plan to properly apply your refund, please include a copy of the letter with your check.
If additional funds are due, the remaining balance will be released once the check has been posted. Always include the claim number in question in order for our team to properly identify which claim you are refunding.

2018 Prior Authorization Guidelines

Primary Care Providers must obtain Prior Authorization in accordance to BCBSAZ Advantage Guidelines, as necessary. Reimbursement for such services will be paid in accordance to the Provider’s Participation Agreement. The 2018 Prior Authorization List can be found on our website. Please click here.

CMS Guidance on Billing Medicare Advantage Enrollees

The Centers for Medicare & Medicaid Services (CMS) issued guidance regarding the Medicare Advantage program and billing members. CMS’s guidance addresses what a provider must do in order to charge a member on a Medicare Advantage health plan for services that are not covered by the member’s benefits coverage policy.

Prior to this clarification, Medicare Advantage members were often billed for non-covered services when a provider of non-covered services obtained a detailed waiver or an Advance Beneficiary Notice-like document from the member before the non-covered services were provided. However, CMS has stated that providers may not use this waiver process with members of Medicare Advantage plans; instead, they must ensure that the beneficiary has received a pre-service organization determination regarding coverage before the provider can bill the beneficiary for non-covered services.

As a result, providers must refrain from charging any member on a Medicare Advantage plan for any non-covered services unless that member has received a pre-service organization determination.
services are supplied before the Medicare Advantage Plan issues an organization determination, a provider can only charge a member for any applicable cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles).

**Notice of Denial of Medical Coverage**

As clarified by CMS, a provider cannot charge a member on a Medicare Advantage Plan for non-covered services (beyond normal cost-sharing amounts as noted above), unless (1) the member has received a Notice of Denial of Medical Coverage BEFORE the services are provided, AND (2) the member elects to receive the non-covered services after receiving the Notice of Denial of Medical Coverage.

If a provider believes that an item or service may not be covered, and the member has not received a Notice of Denial of Medical Coverage, the provider must advise the member to request a pre-service organization determination or must request the organization determination on the enrollee’s behalf.

**Failure to Obtain a Pre-Service Organization Determination**

If a provider supplies non-covered services to a member who has not received a Notice of Denial of Medical Coverage, the provider must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing amounts. If a provider fails to follow the CMS-mandated process before supplying non-covered services, the provider will not be entitled to reimbursement from Plan or the member for those services.

In compliance with CMS guidance, BCBSAZ Advantage will not accept Advance Beneficiary Notices or similar waivers from providers seeking to charge for non-covered services. Providers participating in Medicare Advantage networks are asked for their cooperation with this federal mandate and to immediately discontinue use of Advance Beneficiary Notices or similar waivers with members of Medicare Advantage plans. Instead, providers should follow the CMS-mandated process and request a pre-service organization determination from BCBSAZ Advantage prior to providing any potentially non-covered service for a Medicare Advantage member if that member is choosing to self-pay for the service if it’s determined to be non-covered.

**No Balance Billing**

As a network provider you are contractually prohibited from billing members for services that you provide that are the legal obligation of the Plan.

Members are to be held harmless. This includes but is not limited to denials for prior authorization or if your claim is denied due to the member not being assigned to you. In both cases, you may not bill the member.

**CMS Announces 2018 Star Ratings!**
CMS has just announced the Star Rating for all Medicare Advantage Health Plans. Our overall Star Rating is 3.5 out of 5 stars.

There are improvement opportunities and we appreciate your continued support in providing high quality of care and services to our members.

Below are a few gentle reminders on how your daily practices can help our rating improve significantly.

- Take body weight & height, Calculate BMI
- Order colorectal cancer screening – FOBT, Cologuard, especially for those who refused colonoscopy
- Refer for mammogram
- Every 3 – 6 months Diabetes care follow-up
  1. A1C test and maintain <9
  2. Urine test for protein
  3. Refer for retinal eye exam
  4. Prescribe at least low dose Statins
- Every 3 – 6 months Cardiovascular care follow-up
  1. Check BP <140/90
  2. Prescribe moderate to high dose of Statins
- Refer to DEXA scan for any members with fall or fracture
- Refer to Rheumatologist or Prescribe DMARD for patients with Rheumatoid Arthritis
- Reconcile the post-discharge hospital and current medications within 30 days

Lastly, documentation and proper coding is the key!

If you need any assistance on documentation or coding, please feel free to contact your Provider Representative.

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**Use of Healthcare Providers National Provider Identifier - NPI's**

Federal regulations 45 C.F.R. § 162.410 (2) indicates that health care providers must use their unique NPI # for every service they deliver, refer or prescribe. This means that other individuals may not use your unique NPI # except under the “incident to” rules. More information about procurement and use of health care providers NPI # is located at the link below.

https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=390be248ffe77d5c78b800c5fc9b810d&mc=true&n=pt45.1.162&r=PART&ty=HTML

Use of a provider’s NPI # for incident to services is described by the Medicare Learning Network (MLN) Matters “incident to” services located at the link below.


BCBSAZ Advantage will monitor this activity through medical record reviews and take appropriate action.
Please Keep Us Posted

Moving? Changing TINs? Have a new phone number? The sooner you let us know, the sooner we can update our system and avoid any delay in the processing of your claims and ensure that our members always know where to find you.

If a provider leaves your practice, please let us know that as well. If you have any updates, notify your provider relations representative. You can call them at: 602-567-1239 or email at Providerrelations@azbluemedicare.com

Provider Claims Call Center

Our Provider Claims Call Center is staffed with friendly and knowledgeable representatives, Monday – Friday from 8:00 am – 5:00 pm. This call center is dedicated to serving our providers with requests including but not limited to:
• Claim status
• Reconsideration status
• Check tracers
• Explanation of Payment

You may contact us by calling 1-800-446-8331, option 2, option 2 or by email to Contact.Claims@azbluemedicare.com. We are unable to accept claim or document submissions via email or fax.

Care Management Update

Care Management Referral Form

We have updated our Care Management Referral form. Please begin using the form immediately for any new referrals to our Care Management Program. Providers can access the updated Care Management Referral form on our website. Click Here

Patients that may benefit from a referral to the Care Management Program are members who have the following:
• Multiple related hospital admissions
• Diagnosis of a catastrophic or chronic illness that results in major changes in lifestyle, living arrangements or caregiver roles
• Suspected emotional, social or financial problems complicating health status
• Suspected knowledge deficit about disease process
• Non-adherence with medication, diet, medical treatment or appointments
• Cognitive/behavioral issues that contribute to poor self-care or impaired decision making

Members can be referred into a Care Management program by completing the Care Management Referral form and preferably faxing or emailing it to the Care Management Department. If you make a referral, please inform your patient that a referral has been made. This will facilitate the Member’s cooperation during the initial call made by the Care Manager and conform to confidentiality standards and release of information rules.
The Care Manager will contact your patient by telephone and arrange an appointment. Referring offices receive notice when their patient has been contacted with the Member’s decision to accept or decline the care management program.

Care Management fax:
ICP & Pima County: (480) 655-2544
Banner network: (480) 655-2500

Care Management Email:
ICP & Pima County: AZBlueAdvantageCM@azbluemedicare.com
Banner network: BHNPopHealthSpec@BannerHealth.com

Care Management phone:
ICP & Pima County: (800)446-8331, option 3
Banner network: (602) 747-7990

Contact Us

Member Eligibility: 800-446-8331
Website Eligibility Link: https://www.azbluemedicare.info/member_elig_check.html

Claims Service Center: 800-446-8331
Claims Service Center Email: Contact.Claims@azbluemedicare.com

Prior Authorization (PA): 855-839-4844
Pharmacy PA – Med Impact: 800-788-2949
For services listed the provider must obtain prior authorization from BCBSAZ Advantage.
Click here for the updated Prior Authorization list. Prior Authorization Form found here

Provider Relations: 602-567-1239
Provider Relations Email: Provider.Relations@azbluemedicare.com

Visit our website