



# Medex<sup>®</sup> Choice Medicare Supplement Plan Overview

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To the extent the foregoing terms and policies conflict with or are otherwise inconsistent with anything in these training materials, your BCBSMA provider Agreement, your *Blue Book* manual or *Indemnity Handbook*, and other BCBSMA policies and procedures will govern.

# Agenda



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- What is Medex<sup>®</sup> Choice?
- How Medex Choice<sup>®</sup> works
  - For members
  - For providers
- Who's in the network?
- Working with Medex<sup>®</sup> Choice members

## What is Medex<sup>®</sup> Choice?



- Medicare SELECT “Medigap” or Medicare Supplement plan
- Based on a subset of the HMO Blue<sup>®</sup> provider network
- Requires that member select a “Choice” PCP from select HMO Blue<sup>®</sup> network to be eligible for enhanced benefits over Original Medicare
- Follows standard HMO guidelines (e.g., referrals and prior authorizations) in exchange for reduced member cost-share
- No Medicare supplement benefit if member does not comply with standard HMO guidelines
  - Member always eligible for underlying Original Medicare benefits
- Effective December 1, 2014

Medex<sup>®</sup> Choice is a unique, new Medicare supplement plan from Blue Cross Blue Shield of Massachusetts HMO Blue, a wholly controlled subsidiary of Blue Cross and Blue Shield of Massachusetts.



# How Medex® Choice works for members



- A Medex® Choice member with a Choice PCP who follows standard HMO guidelines will receive the highest level of benefits and lowest out-of-pocket costs, for example:
  - 100% coverage of Medicare Part A and Part B deductibles
  - 100% coverage for Coinsurance days 21-100 in a skilled nursing facility
- No out-of-pocket costs for Medicare Part A and Part B covered services with a Choice PCP
  - Using a “non-Choice PCP” incurs higher out-of-pocket member costs & more limited coverage

	Hospital Services			Skilled Nursing Facility		
	1–60 Days	61–90 Days	Lifetime Reserve	1–20 Days	21–100 Days	101+ Days
<b>Medicare</b>	Coverage for 60 days, after the \$1,216 deductible <sup>1</sup>	Coverage for 61–90 days, after \$304 daily co-insurance	Coverage for an additional 60 lifetime reserve days, after \$608 daily co-insurance	Full coverage for 20 days in a Medicare-participating facility	Coverage for days 21–100, after \$152 daily co-insurance	No coverage after 100 days
<b>Medex Choice</b> (with Medex Choice PCP)	Full coverage of the Medicare deductible and co-insurance		Full coverage for lifetime reserve co-insurance, then an additional 365 days per lifetime when Medicare benefits end	Covered by Medicare	Full coverage for Medicare daily co-insurance for days 21–100	No coverage
<b>Medex Choice</b> (with other PCP)	Coverage for Medicare daily co-insurance after you pay the \$1,216 Part A deductible		Full coverage for lifetime reserve co-insurance, then an additional 365 days per lifetime when Medicare benefits end	Covered by Medicare	No coverage	No coverage

# How Medex<sup>®</sup> Choice works for members, *continued*



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	<b>Physician and Other Provider Services</b> Care in the Hospital	<b>Physician and Other Provider Services</b> Outpatient Department Visits, Office Visits, and Patient Home Visits	<b>Other Part B Services</b> Ambulance Trips, Durable Medical Equipment, Etc.
<b>Medicare</b>	80% coverage of approved services, after the \$147 annual Part B deductible	80% coverage of approved services, after the \$147 annual Part B deductible	80% coverage of approved services, after the \$147 annual Part B deductible
<b>Medex Choice</b> (with Medex Choice PCP)	Full coverage of the Medicare deductible and co-insurance	Full coverage of the Medicare deductible and co-insurance	Full coverage of the the Medicare deductible and co-insurance
<b>Medex Choice</b> (with other PCP)	Coverage of 20% co-insurance after you pay the \$147 annual Part B deductible	Coverage of 20% co-insurance after you pay the \$147 annual Part B deductible	Coverage of 20% co-insurance, after you pay the \$147 annual Part B deductible

	<b>Biologically Based Mental Conditions<sup>1</sup></b>	
	<b>Inpatient Admissions in a General Hospital or Mental Hospital</b>	<b>Outpatient Visits</b>
<b>Medicare</b>	<ul style="list-style-type: none"> <li>• Coverage for days 1–60 per benefit period, after the \$1,216 inpatient deductible<sup>2</sup></li> <li>• Coverage for days 61–90, after \$304 daily co-insurance</li> <li>• Coverage for an additional 60 lifetime reserve days, after \$608 daily co-insurance</li> <li>• Coverage for mental hospital admissions is limited to 190 days per lifetime</li> </ul>	Full benefits, less the Part B deductible and co-insurance
<b>Medex Choice</b> (with Medex Choice PCP)	<ul style="list-style-type: none"> <li>• Full coverage of the Medicare deductible and co-insurance</li> <li>• Full coverage of lifetime reserve days co-insurance</li> <li>• Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Full coverage of the Medicare deductible and co-insurance</li> <li>• When visits are not covered by Medicare, full Medex benefits with no visit maximum</li> </ul>
<b>Medex Choice</b> (with other PCP)	<ul style="list-style-type: none"> <li>• Coverage for Medicare daily co-insurance after you pay the \$1,216 Part A deductible</li> <li>• Full coverage of lifetime reserve days co-insurance</li> <li>• Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Coverage of 20% co-insurance, after you pay the \$147 annual Part B deductible</li> <li>• When visits are not covered by Medicare, full Medex benefits with no visit maximum</li> </ul>

1. Biologically based mental conditions are defined as any biologically based mental disorders that are scientifically recognized and approved by the Massachusetts Department of Mental Health. Treatment for rape-related mental or emotional disorders is covered to the same extent as biologically based conditions.
2. A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
3. The 365 additional days per lifetime are a combination of days in a general hospital or a mental hospital.

# How Medex® Choice works for members, *continued*



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Non-Biologically Based Mental Conditions (includes drug addiction and alcoholism)			
	Inpatient Admissions in a General Hospital	Inpatient Admissions in a Mental Hospital	Outpatient Visits
Medicare	<ul style="list-style-type: none"> <li>Coverage for days 1–60 per benefit period, after the \$1,216 inpatient deductible<sup>1</sup></li> <li>Coverage for days 61–90, after \$304 daily co-insurance</li> <li>Coverage for an additional 60 lifetime reserve days, after \$608 daily co-insurance</li> <li>Coverage for mental hospital admissions is limited to 190 days per lifetime</li> </ul>	Same coverage as general hospital, but coverage limited to 190 days per lifetime	Full benefits, less the Part B deductible and co-insurance
Medex Choice (with Medex Choice PCP)	<ul style="list-style-type: none"> <li>Full coverage of the Medicare deductible and co-insurance</li> <li>Full coverage of lifetime reserve days co-insurance</li> <li>Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>Full coverage of the Medicare deductible and co-insurance</li> <li>Full coverage of lifetime reserve days co-insurance</li> <li>When Medicare days are used up, 60 days per calendar year, less any days in a mental hospital already covered by Medicare or Medex in that calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Full coverage of the Medicare deductible and co-insurance</li> <li>When not covered by Medicare, full coverage of up to 24 visits per calendar year</li> </ul>
Medex Choice (with other PCP)	<ul style="list-style-type: none"> <li>Coverage for Medicare daily co-insurance after you pay the \$1,216 Part A deductible</li> <li>Full coverage of lifetime reserve days co-insurance</li> <li>Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>Coverage for Medicare daily co-insurance after you pay the \$1,216 Part A deductible</li> <li>Full coverage of lifetime reserve days co-insurance</li> <li>When Medicare days are used up, 60 days per calendar year, less any days in a mental hospital already covered by Medicare or Medex in that calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Coverage of 20% co-insurance, after you pay the \$147 annual Part B deductible</li> <li>When not covered by Medicare, full coverage up to 24 visits per calendar year</li> </ul>

1. A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
2. The 365 additional days per lifetime are a combination of days in a general hospital or a mental hospital.

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## Medex® Choice services not requiring a referral\*

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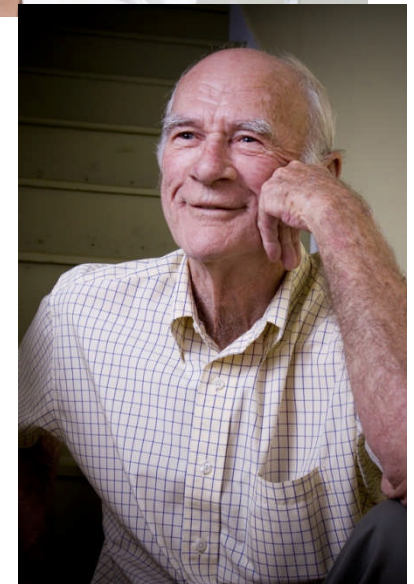
- Emergency medical care
- Urgent care outside the service area
- Lab tests, X-rays, and other covered tests
- Medicare-covered services by a limited services clinic
- Medicare-covered services by a chiropractor
- Mental health and substance abuse treatment
- Women's routine health care (i.e., annual GYN exam and resulting services) or services as a result of an acute or emergency gynecological condition

\* Member must use HMO Blue providers to get medical care and other covered services. Exceptions include emergency medical care and urgent care when out of the service area, and times when Blue Cross Blue Shield HMO Blue authorizes use of out-of-network providers.



# How Medex® Choice works for participating HMO Blue providers

- Supports existing care management model
  - Better manage member care through traditional HMO Blue requirements (referrals/prior authorizations)
  - Greater ability to control quality and cost with referrals to desired specialists
- Member incentives aligned with provider/ACO incentives
  - Lower member costs when care is coordinated through Choice PCP
  - Increased member affinity for their PCP and referral network



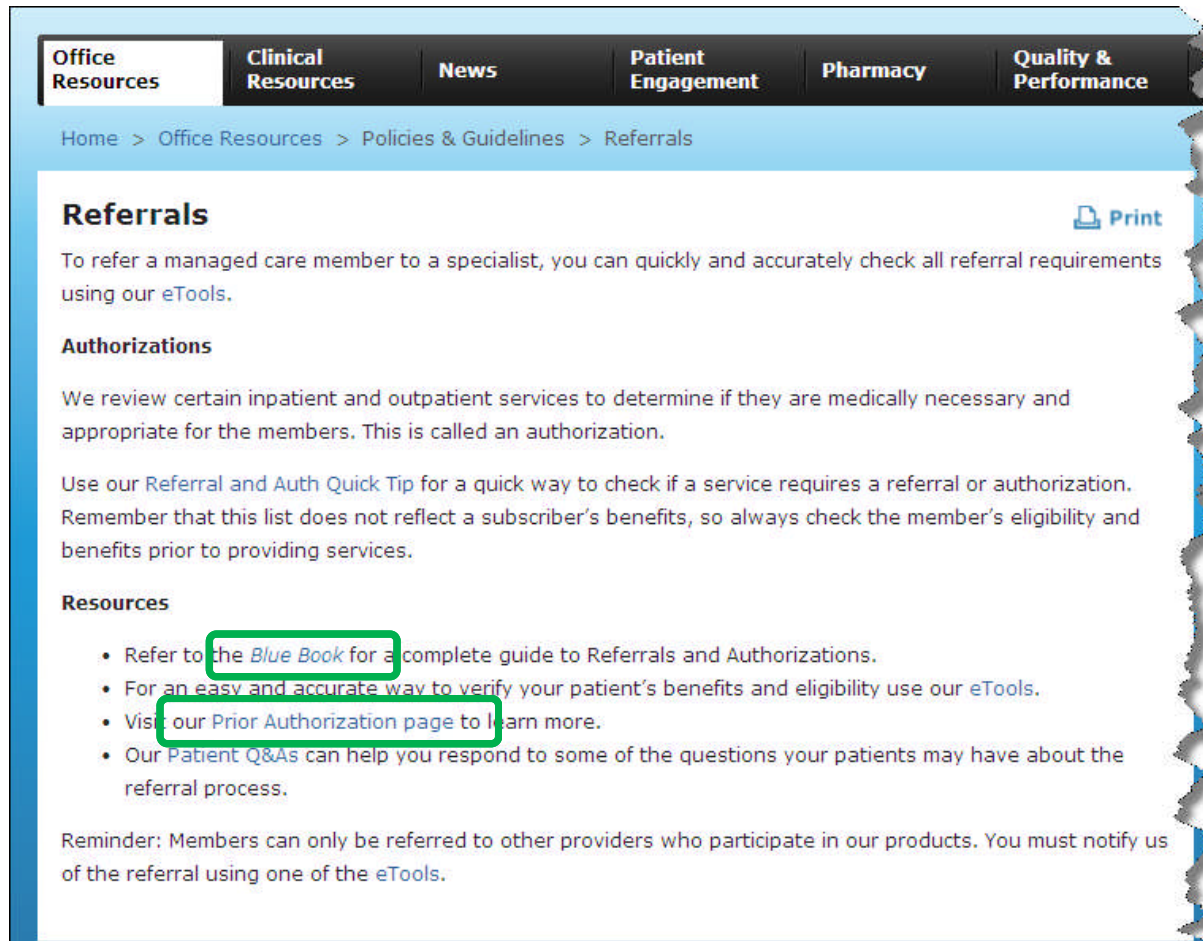
# Identifying a Medex® Choice Member



- Prefix XXB
- ID card “Medex® Choice”
- Check benefits and eligibility using online technologies
  - Online Services
  - NEHENNet

The screenshot displays the Blue Cross Blue Shield of Massachusetts Medex Choice online portal. At the top, the Blue Cross Blue Shield logo and 'Medex® Choice' are visible. Below this, a blue banner contains the member's name 'SALLY SAMPLE', ID 'XXB 123456789', and 'MEMBER SUFFIX: XXB'. To the right, 'Member Service' contact information is provided: '1-800-238-6616', 'RxBin: 003858 PCN: A4', and 'RxGRP: 003858'. A navigation bar includes links for 'Eligibility', 'Service Review', 'Claims', 'Batch Manager', and 'Setup'. The main content area is titled 'Check Benefits' and 'Blue Cross Blue Shield of Massachusetts'. It features a section for 'Eligibility and Benefit Information' with links for 'Check Claims', 'HCS Review Request', 'HCS Review Inquiry', and 'Return to Request'. A red box highlights the instruction: '(To view entire response, select "landscape" mode when printing.)'. Below this, the 'Request' details are shown: 'Insured=SALLY SAMPLE MemberID=XXH961234567 DOB=01/01/1966 ProviderID=9876543210' and 'Emdeon Trace #: 607318038'. The 'Payer Contact Information' section includes 'Contact: BCBSMA CLINICAL COORDINATION', 'Telephone: (800) 327-6716', and 'FAX: (888) 282-1321'. The 'Patient: SALLY SAMPLE' section lists 'Member ID: XXH961234567', 'Group Name: ACME PRODUCTS', 'Group #: 123456789', 'DOB: 01/01/1966', 'Gender: Female', 'Address: 401 PARK DRIVE BOSTON, MA 02215', and 'Plan: 01/01/2008-12/31/9999'. The 'Submitter: MARIE BLACK' section shows 'Submitter Type: Provider' and 'NPI: 1234567890'. The 'General Eligibility Information' section includes 'Status: Active Coverage', 'Insurance Type: Other', 'Coverage Level: Family', 'Primary Care Provider: EDWARD EXAMPLE, MD', 'NPI: 9876543210', 'Telephone: (617) 555-1212', 'Address: ABC MEDICAL ASSOCIATES 1 MAIN STREET BOSTON, MA 02215', and 'PCP Effective Date: 03/01/2011-12/31/9999'.

# Referral and Authorization Requirements



**Office Resources** | **Clinical Resources** | **News** | **Patient Engagement** | **Pharmacy** | **Quality & Performance**

Home > Office Resources > Policies & Guidelines > Referrals

## Referrals

To refer a managed care member to a specialist, you can quickly and accurately check all referral requirements using our [eTools](#).

### Authorizations

We review certain inpatient and outpatient services to determine if they are medically necessary and appropriate for the members. This is called an authorization.

Use our [Referral and Auth Quick Tip](#) for a quick way to check if a service requires a referral or authorization. Remember that this list does not reflect a subscriber's benefits, so always check the member's eligibility and benefits prior to providing services.

### Resources

- Refer to the [Blue Book](#) for a complete guide to Referrals and Authorizations.
- For an easy and accurate way to verify your patient's benefits and eligibility use our [eTools](#).
- Visit our [Prior Authorization page](#) to learn more.
- Our Patient Q&As can help you respond to some of the questions your patients may have about the referral process.

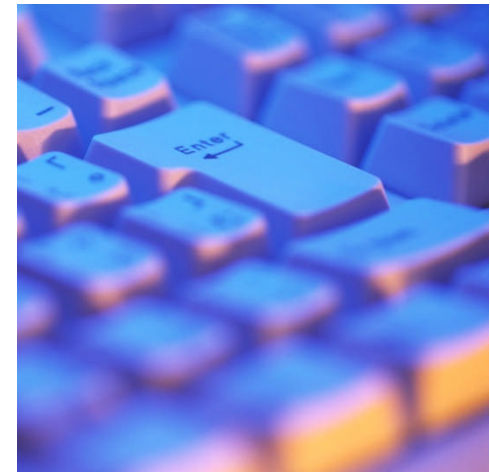
Reminder: Members can only be referred to other providers who participate in our products. You must notify us of the referral using one of the [eTools](#).

- Information resources
  - Online Services via Emdeon®
  - NEHENNet
- Provider Central
  - *Blue Book*
  - Prior Authorization Overview page

\* For details about referrals and authorizations see the Utilization Management section of the *Blue Book Provider manual* at [www.bluecrossma.com/provider](http://www.bluecrossma.com/provider) **Office Resources > Policies & Guidelines > Provider Manuals.**

# Submitting Referrals and Authorizations

- Enter referrals or seek authorizations **prior to the member's receipt of care** using one of our provider technologies
  - Referrals for specialty care\* are at the PCP's discretion
  - Services requiring authorization are approved based on the Plan's determination of medical necessity
- If needed, submit retroactive referrals by the next business day, or **no later than 90 days** from the date of service
  - Referrals are valid for 365 days from the date they're entered
- Use provider technologies to check the status of referrals or authorizations, eliminating follow-up phone calls.



\* Behavioral health care does not require a referral



# Obtain a Referral or Authorization

## Online or Printable Forms



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Eligibility Service Review Claims Batch Manager Setup

New Review | Check Status

**Step 1 - Select payer**

Blue Cross Blue Shield of Massachusetts Reset Page

**Step 2 - Select how you wish to search**

Specialist Inquiry

Specialist Inquiry  
Facility Inquiry  
Outpatient Inquiry  
Inpatient Inquiry

Date of Birth  
08/21/1966

\* Specialist NPI  
[ ] Edit...

**Step 4 - Begin search**

Send to Payer Reset Page

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Help | Glossary

To enter or inquire on a referral, select **New Review** or **Check Status**, then **Specialist Inquiry** and enter the physician specialist's NPI.

### Standardized Prior Authorization Request Form

COMPLETE ALL INFORMATION ON THE "STANDARDIZED PRIOR AUTHORIZATION FORM".  
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the plan to which you submit your request for claim review.  
The Standardized Prior Authorization Form is not intended to replace payer specific prior authorization procedures, policies and documentation requirements. For payer specific policies, please reference the payer specific websites.

Health Plan:

Ambulatory/Outpatient  
☐ Surgery/Procedure  
☐ Infusion or O

Home Health/Hospice  
☐ Home Health SN, PT, OT,  
☐ Hospice  
☐ Infusion Therapy  
☐ Respite Care

Transportation  
☐ Non-emergent  
☐ Non-emergent

\*Requesting Provider  
Name: [ ]  
Title: [ ]

\*Serving Provider  
☐ Same as Requesting Provider  
☐ Different

\*Serving Facility  
☐ Same as Requesting Provider  
☐ Different

\*Contact Person:  
Name: [ ]  
Title: [ ]  
Phone: [ ]  
Email: [ ]

\*Patient Name:  
Name: [ ]  
DOB: [ ]

\*Health Insurance  
If other Insurance Address: [ ]

\*Principal Diagnosis  
ICD-9 Codes: [ ]

Secondary Diagnosis  
ICD-9 Codes: [ ]

\*Service Start Date: [ ]

InterQual®

2013.3 Procedures  
Discectomy  
Discectomy

2013.3 Procedures Criteria  
Discectomy, Lumbar<sup>(1, 2, 3, 4, 5)</sup>  
Discectomy, Lumbar

PATIENT:	Name	D.O.B.	ID#	GROUP#
CPT@/ICD9:	Code	Facility	Service Date	

PROVIDER:	Name	Fax#	Phone#
	Signature	Date	NPI/ID#

ICD-9 (circle all that apply): 722.10, 722.52, 722.73, 722.93, 724.02, 724.03, 724.3, 724.4, 80.51, 80.59, 80.99, Other: [ ]

CPT@ (circle all that apply): 22224, 62287, Other: [ ]

SUMMARY FINDINGS: Review and complete the information on this form.

☐ No matching clinical scenario, please comment:

Confirm that the patient meets all of the following criteria. If all criteria do not apply, criteria cannot be met and you should record matching clinical scenario option.

Choose one:<sup>(6)</sup>  
☐ Age ≥ 18  
Lumbar disc herniation  
☐ Yes

Choose one:<sup>(7, 8, 9)</sup>  
☐ Unilateral radiculopathy with sensory deficit<sup>(10)</sup>  
Pain, paresthesias, or numbness in a nerve root distribution<sup>(11)</sup>  
☐ Yes

Treatment during course of illness or injury, Choose all that apply: [ALL]<sup>(12)</sup>  
☐ NSAIDs or acetaminophen ≥ 3 weeks  
☐ Home exercise or PT ≥ 6 weeks<sup>(13, 14)</sup>  
☐ Activity modification ≥ 6 weeks

Continued symptoms or findings after treatment<sup>(15)</sup>  
☐ Yes

Nerve root compression by imaging<sup>(16, 17, 18)</sup>  
☐ Yes

<sup>1</sup> Please attach plan  
<sup>2</sup> Not all services listed  
<sup>3</sup> This form does not  
Massachusetts Administ

# The Specialist's Role in Managing Referrals and Authorizations

- **Verify** that referrals and authorizations are in place using BCBSMA provider technologies **prior to providing care**.
  - If not on file, contact the Member's PCP to ensure that the office has entered it.
  - A specialist may not make a subsequent referral to another provider.
- If the service to be provided at the visit **may not be covered** by the Member's plan, have the Member sign a ***Non-Covered Service Waiver Form***\* acknowledging that they're aware of their potential responsibility to pay out-of-pocket for the service.




\* To download the *Non-Covered Service Waiver Form* logon to: [www.bluecrossma.com/provider](http://www.bluecrossma.com/provider) Go to: **Forms > Services Extension Requests** and select the ***Non-Covered Service Waiver Form***.

# Denied or Missing Referrals



- If a referral for services is denied or not on file:
  - You may not bill **BCBSMA** for the services
  - You may not bill the **Member** for the services – **unless you obtain written consent from the Member before you render the service** stating that the Member will be responsible for payment.

  
MASSACHUSETTS  
Blue Cross Blue Shield of Massachusetts is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, sex, age, religion, sexual orientation, gender identity or expression, or national origin.

**Non-Covered Service Waiver Form**  
Please retain this document in your patient's medical record

**For the Member**  
As a Blue Cross Blue Shield of Massachusetts member, I understand that I am responsible for all costs associated with the procedure/item listed below. My provider has informed me that Blue Cross Blue Shield of Massachusetts does not pay for this procedure/item because:

☐ The procedure or item is not considered medically necessary  
☐ It is not a covered benefit under my plan  
☐ He/she is not contracted to perform/provide this procedure/item  
☐ Other \_\_\_\_\_  
*(to be completed by provider, if applicable)*

Member name: \_\_\_\_\_  
Member ID (include alpha prefix): \_\_\_\_\_  
Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For the Provider**  
As a participating Blue Cross Blue Shield of Massachusetts provider, I certify that I have informed my patient, \_\_\_\_\_, that Blue Cross Blue Shield of Massachusetts does not allow payment for the procedure/item listed below because:

☐ The procedure or item is not considered medically necessary  
☐ It is not a covered benefit under the member's plan  
☐ I am not contracted to perform procedure or provide this item  
☐ Other \_\_\_\_\_

Procedure/Item:	Procedure code:

Provider Name: \_\_\_\_\_  
Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PEP-3895 (1/12)

## Participating providers (effective 12/1/14)



- Primary Care Providers (PCPs) in:
  - Accountable Care Associates
  - Atrius Health\*
  - Baycare Health Partners
  - Beth Israel Deaconess Physician Organization
  - Central Massachusetts Independent Physicians Association
  - Cooley Dickinson Physician Hospital Organization
  - Mount Auburn Cambridge Independent Practice Association
  - Partners<sup>®</sup> HealthCare
  - Steward Health Care System<sup>®</sup>
  - All HMO Blue primary care providers in Berkshire County
- All hospitals and specialists with a valid referral/authorization are included in the network

\* Participating Atrius groups include: Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates

# Tools and Resources



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- Patient education materials support patient management practices
  - Customizable “We’re committed to your health” practice welcome letter
  - “How Referrals Work” handout
- “Introducing Medex<sup>®</sup> Choice” brochure

The value of having a primary care provider (PCP) is in managing all aspects of your health. A PCP can provide seamless coordination between specialists. Medex Choice is a Medex Choice plan that allows you to spend less each year on your most comprehensive coverage available.

## Introducing Medex<sup>®</sup> Choice

Highlights:

• Supplement plan

• Comprehensive coverage

• Coordinated care by



Medex Choice is the only plan that covers the gap. It combines low cost coverage with all the services your PCP. Call us today at 1-800-678-2265.

The lowest cost, most comprehensive supplement coverage in the market.<sup>1</sup>

Get it if Medex Choice is right for you. Call us at 1-800-678-2265, 24 hours a week, Monday to 8:00 p.m. ET.



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1. Compared to Most Insurance Plans

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

is part of a smaller list of Blue Cross Blue Shield of Massachusetts primary care providers.



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Thank you!

For additional information, go to [www.bluecrossma.com/provider](http://www.bluecrossma.com/provider),  
or contact **Network Management and  
Credentialing Services** at **1-800-316-BLUE (2583)**.