Medex® Choice Medicare Supplement Plan Overview

Legal Notes

These training materials have been provided to you in order to assist you in your administrative interactions with Blue Cross Blue Shield of Massachusetts (BCBSMA).

The information and representations herein do not replace or supersede the terms of your BCBSMA provider Agreement, your *Blue Book* manual or *Indemnity Handbook*, or other BCBSMA policies and procedures.

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

MASSACHUSETTS

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

What is Medex®' Choice?

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- Medicare SELECT "Medigap" or Medicare Supplement plan
- Based on a subset of the HMO Blue® provider network
- Requires that member select a "Choice" PCP from select HMO Blue® 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®´ 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
Medicare	Coverage for 60 days, after the $1,216 deductible[1]	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
Medex Choice (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
Medex Choice (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® Choice works for members, *continued*

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	Physician and Other Provider Services Care in the Hospital	**Physician and Other Provider Services** Outpatient Department Visits, Office Visits, and Patient Home Visits	**Other Part B Services** Ambulance Trips, Durable Medical Equipment, Etc.
Medicare	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
Medex Choice (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
Medex Choice (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

	Biologically Based Mental Conditions[1]	
	Inpatient Admissions in a General Hospital or Mental Hospital	Outpatient Visits
Medicare	• Coverage for days 1–60 per benefit period, after the $1,216 inpatient deductible[2] • Coverage for days 61–90, after $304 daily co-insurance • Coverage for an additional 60 lifetime reserve days, after $608 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	Full benefits, less the Part B deductible and co-insurance
Medex Choice (with Medex Choice PCP)	• Full coverage of the Medicare deductible and co-insurance • Full coverage of lifetime reserve days co-insurance • Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end[3]	• Full coverage of the Medicare deductible and co-insurance • When visits are not covered by Medicare, full Medex benefits with no visit maximum
Medex Choice (with other PCP)	• Coverage for Medicare daily co-insurance after you pay the $1,216 Part A deductible • Full coverage of lifetime reserve days co-insurance • Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end[3]	• Coverage of 20% co-insurance, after you pay the $147 annual Part B deductible • When visits are not covered by Medicare, full Medex benefits with no visit maximum

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*

MASSACHUSETTS

	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	• Coverage for days 1–60 per benefit period, after the $1,216 inpatient deductible[1] • Coverage for days 61–90, after $304 daily co-insurance • Coverage for an additional 60 lifetime reserve days, after $608 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	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)	• Full coverage of the Medicare deductible and co-insurance • Full coverage of lifetime reserve days co-insurance • Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end[2]	• Full coverage of the Medicare deductible and co-insurance • Full coverage of lifetime reserve days co-insurance • 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	• Full coverage of the Medicare deductible and co-insurance • When not covered by Medicare, full coverage of up to 24 visits per calendar year
Medex Choice (with other PCP)	• Coverage for Medicare daily co-insurance after you pay the $1,216 Part A deductible • Full coverage of lifetime reserve days co-insurance • Full coverage of up to 365 additional hospital days in your lifetime when Medicare benefits end[2]	• Coverage for Medicare daily co-insurance after you pay the $1,216 Part A deductible • Full coverage of lifetime reserve days co-insurance • 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	• Coverage of 20% co-insurance, after you pay the $147 annual Part B deductible • When not covered by Medicare, full coverage up to 24 visits per calendar year

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.

Medex® Choice services not requiring a referral*

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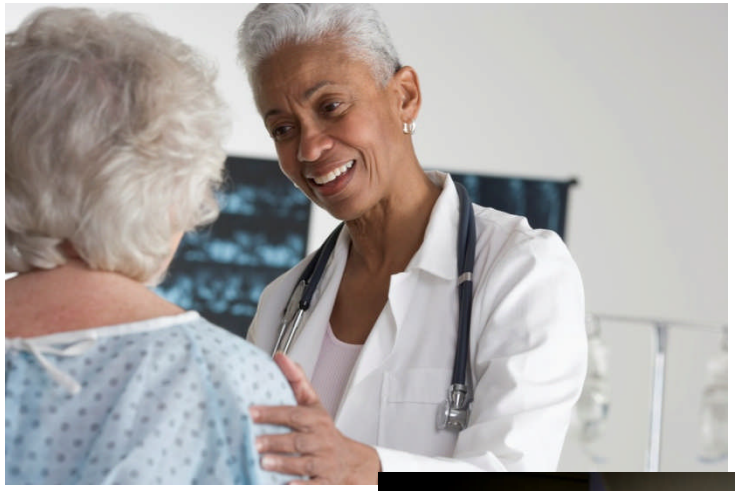
- Emergency medical care
- Urgent care outside the service area
- Lab tests, X-rays, and other covered tests
- Medicare-covered services by a limited services clinic
- Medicare-covered services by a chiropractor
- Mental health and substance abuse treatment
- Women's routine health care (i.e., annual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

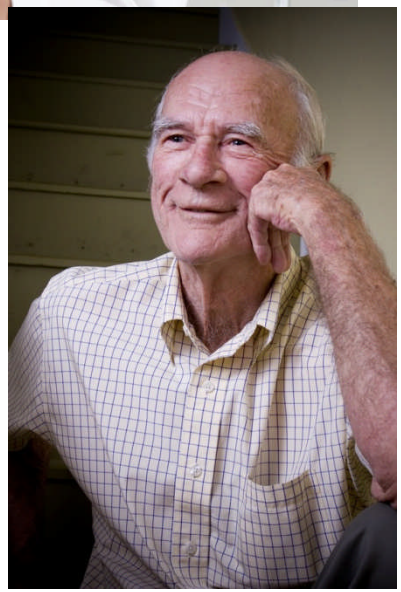
* Member must use HMO Blue providers to get medical care and other covered services. Exceptions include emergency medical care and urgent care when out of the service area, and times when Blue Cross Blue Shield HMO Blue authorizes use of out-of-network providers.

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

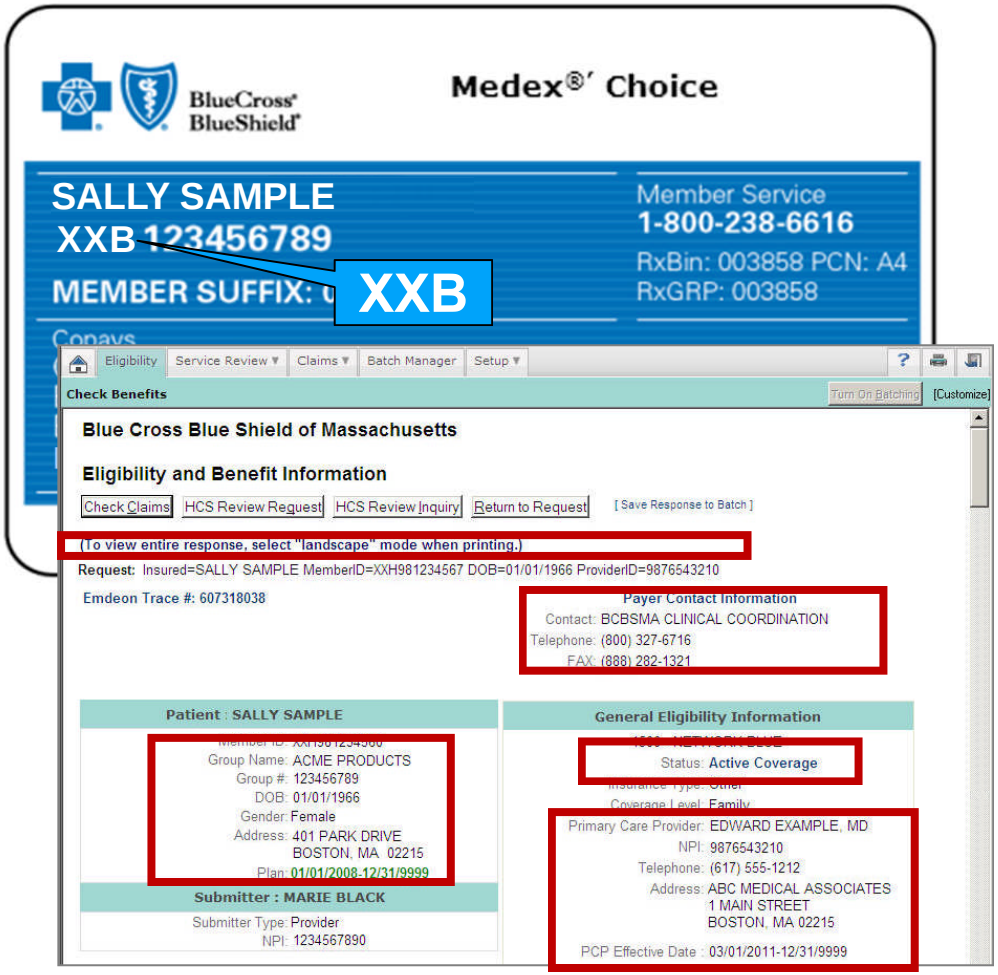


- Member incentives aligned with provider/ACO incentives
  - Lower member costs when care is coordinated through Choice PCP
  - Increased member affinity for their PCP and referral network

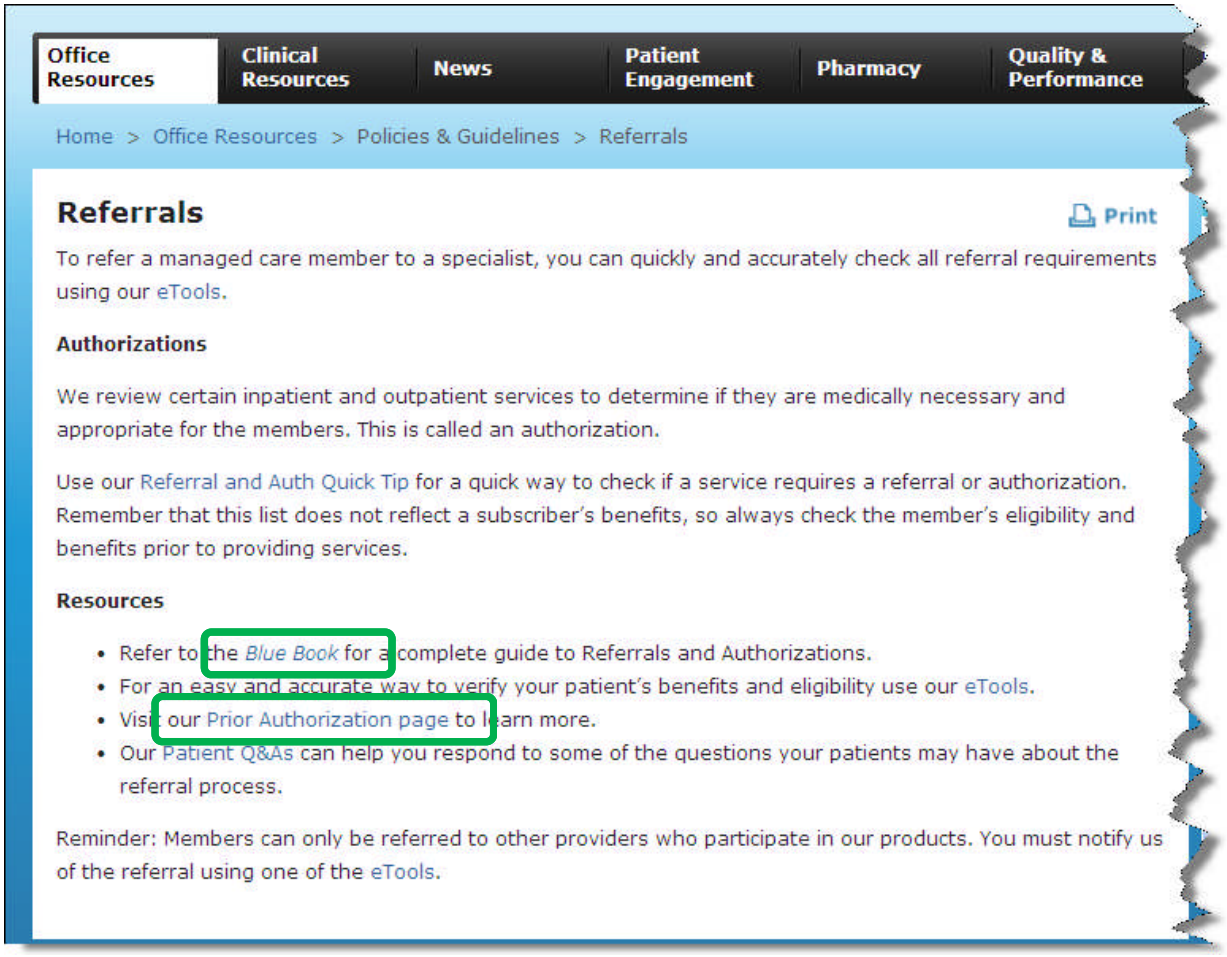


Identifying a Medex® Choice Member

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



Referral and Authorization Requirements

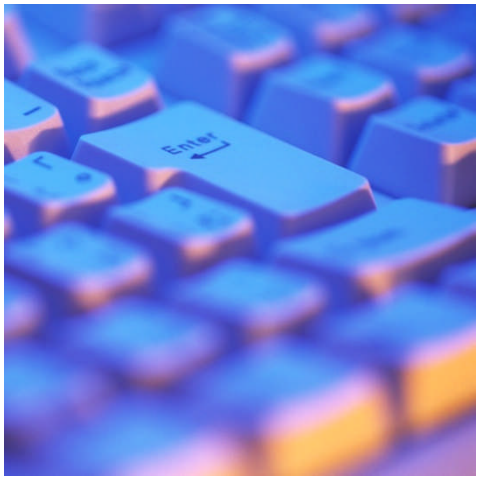


- Information resources
  - Online Services via Emdeon®
  - NEHEN*Net*
- Provider Central
  - *Blue Book*
  - Prior Authorization Overview page

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

Submitting Referrals and Authorizations

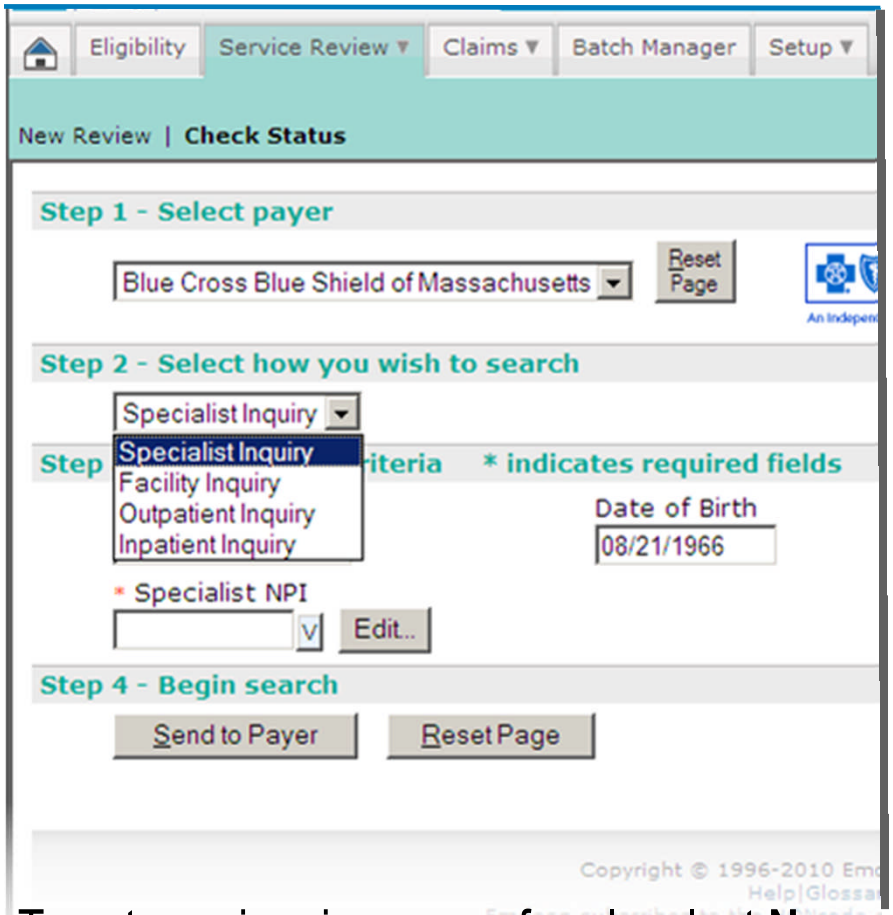
- Enter referrals or seek authorizations **prior to the member's receipt of care** using one of our provider technologies
  - Referrals for specialty care* are at the PCP's discretion
  - Services requiring authorization are approved based on the Plan's determination of medical necessity
- If needed, 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.

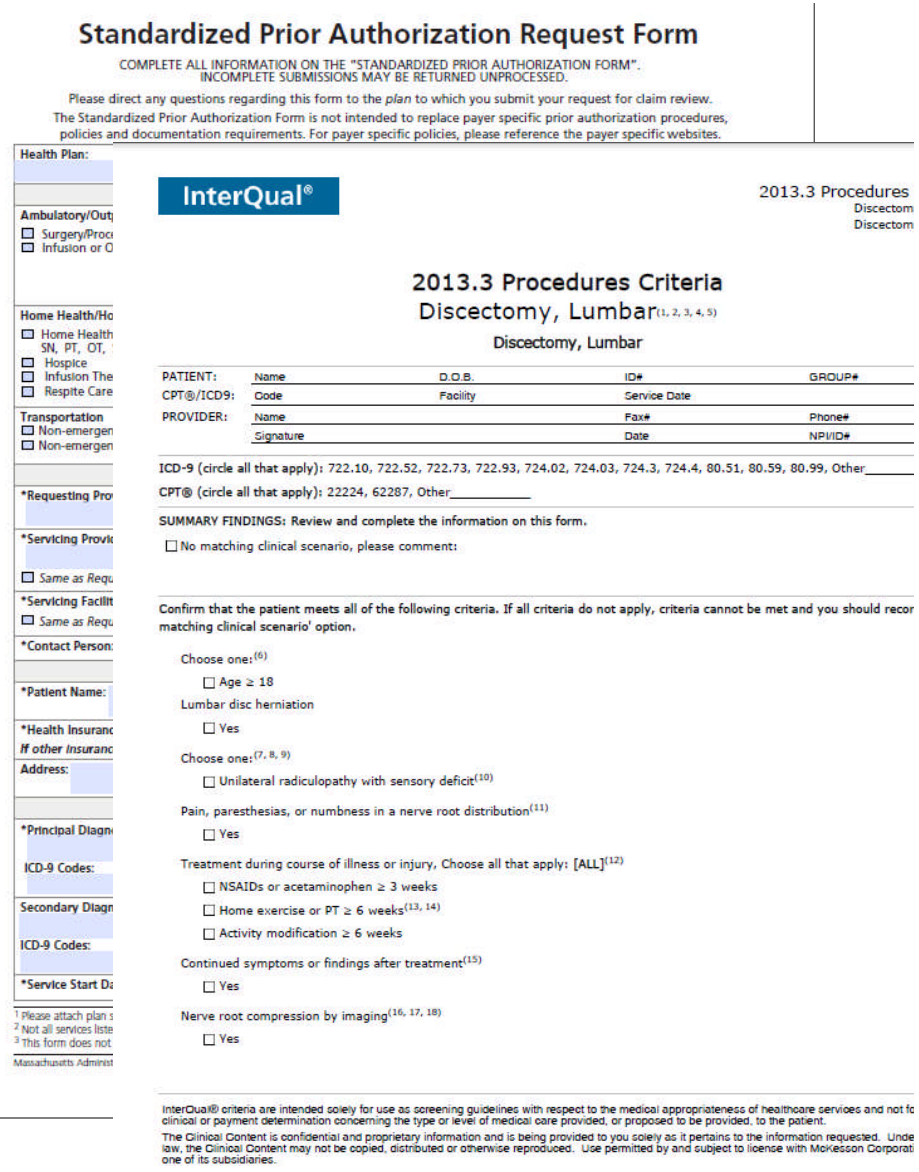


* Behavioral health care does not require a referral

Obtain a Referral or Authorization

Online or Printable Forms





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:

InterQual®

2013.3 Procedures
Discectom
Discectom

2013.3 Procedures Criteria
Discectomy, Lumbar[1, 2, 3, 4, 5]

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 recor
matching clinical scenario' option.

Choose one:[6]

☐ Age ≥ 18

Lumbar disc herniation

☐ Yes

Choose one:[7, 8, 9]

☐ Unilateral radiculopathy with sensory deficit[10]

Pain, paresthesias, or numbness in a nerve root distribution[11]

☐ Yes

Treatment during course of illness or injury, Choose all that apply: [ALL][12]

☐ NSAIDs or acetaminophen ≥ 3 weeks
☐ Home exercise or PT ≥ 6 weeks[13, 14]
☐ Activity modification ≥ 6 weeks

Continued symptoms or findings after treatment[15]

☐ Yes

Nerve root compression by imaging[16, 17, 18]

☐ Yes

InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not fo
clinical or payment determination concerning the type or level of medical care provided, or proposed to be provided, to the patient.

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law, the Clinical Content may not be copied, distributed or otherwise reproduced. Use permitted by and subject to license with McKesson Corporati
one of its subsidiaries.

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

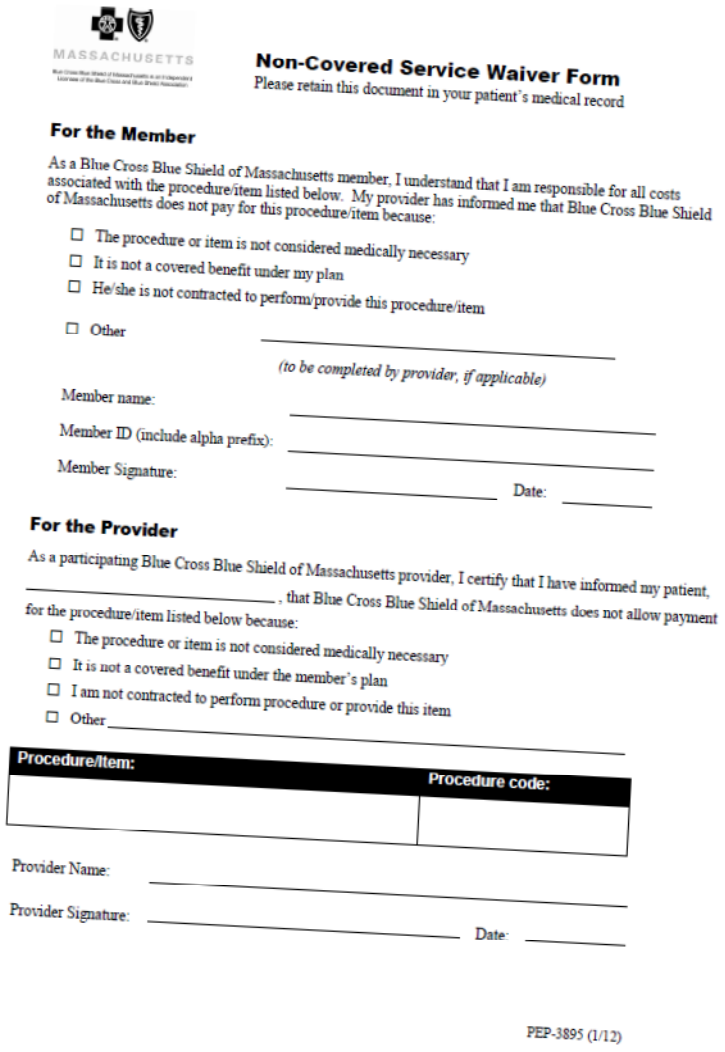
The Specialist's Role in Managing Referrals and Authorizations

- **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 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

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)

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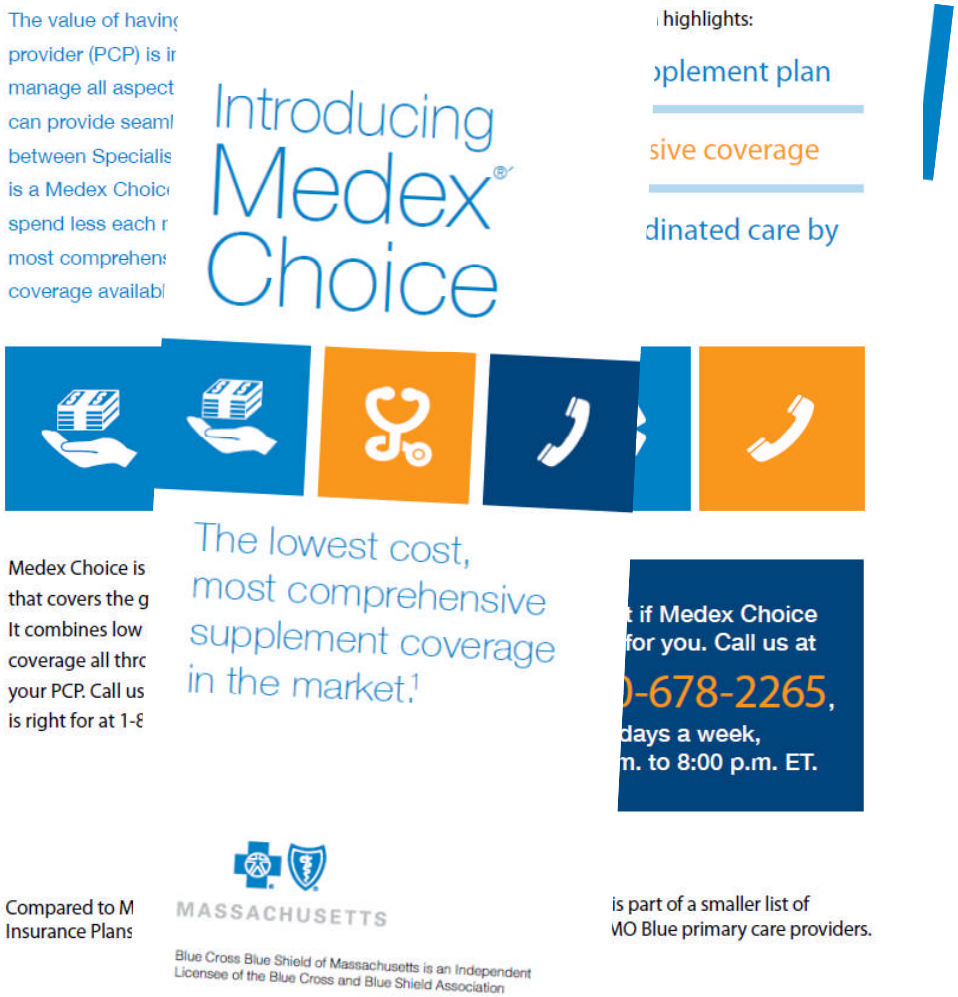
- Primary Care Providers (PCPs) in:
  - Accountable Care Associates
  - Atrius Health*
  - Baycare Health Partners
  - Beth Israel Deaconess Physician Organization
  - Central Massachusetts Independent Physicians Association
  - Cooley Dickinson Physician Hospital Organization
  - Mount Auburn Cambridge Independent Practice Association
  - Partners®˝ HealthCare
  - Steward Health Care System®˝
  - 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

- Patient education materials support patient management practices
  - Customizable "*We're committed to your health*" practice welcome letter
  - *"How Referrals Work"* handout
- *"Introducing Medex®' Choice"* brochure



MASSACHUSETTS

Thank you!

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