* 2011 MEDICARE ADVANTAGE PRODUCT UPDATE *

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NOVEMBER 23, 2010 HHIC-PROV-2010-001

TO: (1) CHIEF FINANCIAL OFFICER
(2) DIRECTOR/MANAGER OF PATIENT ACCOUNTS
(3) BILLING OFFICE STAFF

FROM: MOUNTAIN STATE BLUE CROSS BLUE SHIELD PROVIDER RELATIONS

SUBJECT: 2011 MEDICARE ADVANTAGE PRODUCT UPDATE

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PURPOSE

This bulletin notifies facility providers about the changes Highmark Health Insurance Company (HHIC) will be making in its Medicare Advantage products, effective for discharges or dates of service on or after January 1, 2011.

BACKGROUND/OVERVIEW

HHIC Medicare Advantage Product Offerings for 2011

Despite significant decreases in federal funding for Medicare Advantage Plans, HHIC will continue to demonstrate its commitment to seniors and other eligible residents of West Virginia in 2011 by offering a comprehensive selection of **FreedomBlue PPO** benefit plan options to meet their health insurance needs.

As part of its commitment to West Virginia Medicare beneficiaries, HHIC will be launching a new FreedomBlue PPO option – **FreedomBlue PPO HD**. This high-deductible plan has a $0 premium. Under FreedomBlue PPO HD, members must meet a $1,000 deductible for most in-network and out-of-network services (except for physician office visits, prescription drugs, emergency room visits and ambulance services). After meeting the in-network deductible, members continue to pay 5 percent coinsurance until the $3400 in-network out-of-pocket maximum is reached.

HHIC will no longer offer **FreedomBlue PFFS** in any of its markets in the new benefit year beginning January 1, 2011. Members who currently have coverage under that product may choose to enroll in FreedomBlue PPO. (Please see the IMPACT/ACTION section of this bulletin for more information about the implications of this change.)

New Advanced Illness Services Program Available to All FreedomBlue PPO Members
Beginning in 2011, HHIC will offer an **Advanced Illness Services Program** as part of all FreedomBlue PPO plans. The program provides 100 percent coverage for 10 comprehensive, interdisciplinary visits by appropriately accredited network hospice providers to promote quality of care for members with progressive life-limiting illness. The program's key elements focus on enhancing palliative care services, including controlling pain and symptoms, providing psychosocial and spiritual support, facilitating communication and complex decision-making related to goals of care, and coordinating health services across various sites of care. More information about the Advanced Illness Services Program will be announced in a separate bulletin later this year.

2011 Benefit Changes

Wheelchair Van Transportation Benefit
Effective January 1, 2011, FreedomBlue PPO members will have access to a newly defined "Part B" **transportation** benefit.* Unlike the **ambulanc**e benefit, which requires that the patient's clinical condition is such that the use of any other method of transportation, such as taxi, private car or other type of vehicle would be contraindicated, the transportation benefit covers trips to medical appointments, if provided by wheelchair van, when Medicare's medical necessity criteria are not met. As a result, a Physician Medical Necessity Certification (PMNC) is not required when the transportation benefit is being used. (The transport benefit cannot be used for trips to the mall, grocery store, hair salon or other personal errands. In order to be reimbursable under FreedomBlue PPO, the service must be billed by the wheelchair van provider using specific HCPCS modifiers to indicate a medically acceptable origin and destination.)

The transportation benefit provides coverage for **wheelchair van transport only**, while **stretcher van transport** continues to be covered through the ambulance benefit and continues to require Medicare medical necessity, as documented via a PMNC.

***Important: Wheelchair Van Transport Not Separately Reimbursable When the Member is in a Covered Part A Inpatient Stay in an Acute-Care Hospital, LTAC or SNF**
While a FreedomBlue PPO member is receiving covered inpatient ("Part A") services in an acute-care hospital, long-term acute-care (LTAC) facility or skilled nursing facility (SNF), any wheelchair van services the member may use are considered the responsibility of the facility and will not be separately reimbursed. Reimbursement for such services is made via the reimbursement for the covered inpatient stay. The wheelchair van transport provider must bill the acute-care hospital, LTAC facility or SNF for the service, and the facility is responsible to pay the provider for it. Neither the member nor HHIC can be billed for the wheelchair van transport under this circumstance.

Certain Exceptions for Medicare Advantage Members in a Covered Part A Inpatient Stay *in a Skilled Nursing Facility*

Like the Medicare Program, HHIC recognizes that there are "certain exceptionally intensive or emergent services" that are outside of the care plan to be expected from a skilled nursing facility. When a member is transported from the skilled nursing facility where he or she is an inpatient to a hospital to receive these particular services on an outpatient basis, the member is considered to have been discharged from the skilled nursing facility, even though he or she will be returned to it when the services are complete. The particular services to which this situation applies are the following:

- Cardiac catheterization
- Computerized axial tomography (CT) scans
- Magnetic resonance imaging (MRI)
- Ambulatory surgery involving the use of an operating room (includes GI suite)
- Emergency room services
- Radiation therapy and/or chemotherapy
- Angiography
- Lymphatic and venous procedures

If the member is in a covered Part A stay in a skilled nursing facility and needs one of these services on an outpatient basis but **does not meet Medicare's medical necessity criteria**, he or she could be transported to the hospital by wheelchair van to receive the service. The provider of the wheelchair van transport should bill HHIC for the transportation in this situation.

Of course, if a member who is in a covered Part A stay in a skilled nursing facility needs one of these services on an outpatient basis, **and he or she meets the Medicare medical necessity criteria**, the member could be transported to the hospital by ambulance to receive the service. The ambulance provider should bill HHIC for the transportation in this situation.

Importance of Using Network Providers

Facilities that will need to arrange for wheelchair van transport for FreedomBlue PPO members *not* in a covered inpatient stay are reminded that it is in the member's best interest to have the service provided by a network transportation provider. Members with coverage through FreedomBlue PPO are responsible for **greater cost-sharing amounts** if an out-of-network transportation provider performs the service.

FreedomBlue PPO Network Sharing Expanded

The FreedomBlue PPO Visitor/Travel Program initiated in benefit year 2010 involves the sharing of the Medicare Advantage PPO network among participating Blue Plans. This year, the Visitor/Travel Program will be extended to 29 states and the Territory of Puerto Rico. (Click here for a list of the states participating in the Visitor/Travel Program in benefit year 2011. Please note that in some of the states listed, Medicare advantage PPO networks are only available in portions of the state.) As announced in the August 2009 *Provider News*, contracted facilities will be reimbursed for services provided to these members at the local Medicare Advantage rate in effect at the time of service.

Members from any of these Plans who receive services from Highmark Medicare Advantage participating providers will pay the same in-network cost-sharing they would pay if receiving covered services from in-network providers in their own service area. To confirm their cost-sharing amounts, providers should always check the out-of-area member's benefits via BlueExchange(R) or the BlueCard® eligibility line (1-800-676-BLUE).

2011 Member Cost-Sharing and Out-of-Pocket Maximums
As always, providers are advised to review the member's benefits via NaviNet or the HIPAA 270/271 Eligibility Benefit Inquiry and Response transactions to identify any applicable limitations and cost-sharing amounts before rendering services.

Cost-Sharing Increases
For the benefit year beginning January 1, 2011, cost-sharing amounts have been increased for certain services. The daily copayment required for skilled nursing facility services will apply to **days 16 to 75**.

Cost-Sharing for Outpatient Rehabilitative Therapy Services
As in the past, member cost-sharing applies on a per therapy type/per day/per provider basis to outpatient physical medicine, occupational therapy and speech therapy services. **In-network cardiac rehabilitation therapy and respiratory therapy services are covered at 100 percent** under all plan options except FreedomBlue PPO HD. Under FreedomBlue PPO HD, outpatient cardiac rehabilitation therapy and respiratory therapy services apply to the plan deductible.

Reminder: Certain Categories of Medicare Part B Drugs Excluded from Cost-Sharing
Providers are reminded that certain categories of Medicare Part B drugs have been excluded from member cost-sharing. They include certain vaccines and toxoids, certain miscellaneous drugs and solutions, certain miscellaneous pathology and laboratory drugs, and certain contrast materials. Prior authorization is necessary for coverage of certain of these medications.

Out-of-Pocket Maximums
For the new benefit year, HHIC has eliminated most of the separate out-of-pocket maximums that applied in the past to particular categories of benefits under FreedomBlue PPO.

- Instead, out-of-pocket amounts for **all in-network Medicare-covered services** will accumulate toward the **$3400** annual program out-of-pocket maximum. Once a member reaches the $3400 amount, he or she will no longer be responsible for cost-sharing on Medicare-covered services received from **in-network providers** through the end of the calendar year.
- Cost-sharing amounts for **both in-network and out-of-network Medicare-covered services** will accumulate toward the "catastrophic out-of-pocket maximum" of **$5100**. From that point until the end of the calendar year, the member will no longer be responsible for cost-sharing on Medicare-covered services, **either in- or out-of-network**.

Services covered by FreedomBlue PPO that are not covered by Traditional Medicare do not count

toward the annual program out-of-pocket maximum. (Examples of services that do not count toward the annual out-of-pocket maximum include preventive routine dental services, health and wellness services and the wheelchair van transportation benefit.)

IMPACT/ACTION

Prepare for these Changes

Providers are asked to be aware of the changes that may affect their Medicare Advantage patients in 2011 and make any necessary preparations to accommodate these updates.

Authorization Requirements When a Member's Coverage Changes from FreedomBlue PFFS to FreedomBlue PPO During an Episode of Care Spanning December 31, 2010 to January 1, 2011

Providers who treat FreedomBlue PFFS members today should be aware that although authorization is not required for inpatient admissions and certain other services under FreedomBlue PFFS, authorization *is* required under FreedomBlue PPO. (Note that this includes authorization through National Imaging Associates[SM] for selected advanced radiological studies.)

As the end of the 2010 benefit year approaches, facilities should review any ongoing treatment plans for FreedomBlue PFFS members and determine whether the services to be provided will require authorization under the member's new benefit plan as of January 1, 2011. If so, the ordering provider should be prompted to request the authorization. If the authorization is not in place at the time of service, the facility should request it before providing the care. As always, if a required authorization is not in place at the time of service, the claim may be rejected or the services may be subject to retrospective review.

Authorization Not Required in These Situations

Authorization will **not** be required in the following circumstances when a member's FreedomBlue PFFS coverage changes to FreedomBlue PPO on January 1, 2011:

- The member is an inpatient in a **hospital** and the stay continues into 2011
- The member is an inpatient in a covered Part A stay in a **skilled nursing facility** and the covered Part A stay continues into 2011

Authorization Required in These Situations

Authorization **will** be required in the following circumstances, when a FreedomBlue PFFS member's coverage changes to FreedomBlue PPO on January 1, 2011:

- The member is an inpatient in a skilled nursing facility **but is no longer receiving a skilled level of care or has exhausted Part A benefits and continues to receive Part B therapy services**

- The member is receiving **rehabilitation therapy services** (physical medicine, occupational therapy, speech therapy, cardiac rehabilitation, pulmonary rehabilitation) under a plan of

treatment that begins in 2010 and continues in 2011.

- The member is receiving **home health services** under a plan of treatment that begins in 2010 and continues in 2011. (A separate bulletin will be issued to address specific requirements for home health services received by members transitioning from FreedomBlue PFFS to FreedomBlue PPO on January 1, 2010.)

Arrange Post-Discharge Services with Network Participating Providers
As always, when a facility arranges for post-discharge services for FreedomBlue PPO members, those services should be arranged with network participating providers.

TIME FRAME

The changes described in this bulletin become effective for dates of service/discharges occurring on and after January 1, 2011.

ASSISTANCE

This Bulletin
For questions regarding this bulletin, please contact your assigned External Provider Relations Representative.

Inquiries about Eligibility, Benefits, Claim Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, HHIC encourages providers to use the electronic resources available to them – NaviNet® and the applicable HIPAA transactions – prior to placing a telephone call to the Customer Service Center.