



Regence MedAdvantage

A workshop to provide you with an overview of this product and administrative guidelines.

Revised April 2010

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Objectives

This provider workshop is designed to provide you with an overview of the Regence MedAdvantage product and will help you:

- Understand member benefits
- Use the member card to determine eligibility and benefit information
- Understand regulations for Medicare Advantage plans such as Regence MedAdvantage

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Overview

Regence MedAdvantage is a Medicare Advantage Preferred Provider Organization (PPO) plan that:

- Is offered as an alternative to Medicare Parts A and B and Medicare supplement plans
- Includes the same benefits that are available from Medicare, plus some additional benefits

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Overview

A plan that provides incentives for members to seek services from physicians, other health care professionals and facilities contracted with our Regence MedAdvantage provider network.

- Services provided by in-network providers are reimbursed at the in-network benefit level with low copayment and coinsurance amounts.
- Services provided by out-of-network providers are subject to higher copayment and coinsurance amounts.

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Overview

When members contact a Regence MedAdvantage participating provider:

- No referrals are required.
- If specialty care is needed, please direct members to participating Regence MedAdvantage specialists and facilities.
- Use the *Regence MedAdvantage PPO* directory to identify participating providers.

Pre-authorization is required for some services.

- Providers are responsible for pre-authorizing all services and supplies listed on the *Medicare Pre-authorization List*.

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Service area

The Regence MedAdvantage service area includes these counties

- Box Elder
- Cache
- Davis
- Iron
- Morgan
- Rich
- Salt Lake
- Summit
- Tooele
- Utah
- Wasatch
- Washington
- Weber

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Regence MedAdvantage benefits

- A [summary of benefits \(PDF\)](#) is included in the Medicare Advantage Plans section of the *Administrative Manual*. All services and supplies are subject to medical necessity and member eligibility.
- For current member benefit information:
 - Access the [Provider Center](#)
 - Contact Customer Service at 1 (877) 508-7362

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Member cards

Include:

- Member name, member number, group name and group number
- Issue date (not coverage effective date)
- Claim submission addresses and important phone numbers

				www.myRegence.com
01 JOHN PUBLIC ID NO 999999999999	M V RX YYY Card Issue Date 02/18/09	BC/BS Plan 360 / 851 OV IN/OUT \$10/\$25 	Providers not contracted with Regence, send claims to your local Blue Cross and / or Blue Shield Plan. *MEDICARE LIMITING CHARGES MAY APPLY* This card is for information only and does not certify eligibility or guarantee benefits. Regence BlueCross BlueShield of Utah is an independent Licensee of the Blue Cross and Blue Shield Association.	Customer Service 1 (800) 541-8981 TTY/TDD Line 711 Med Phrase 1 (800) 824-8563 Nurseline 1 (800) 267-6729 Submit Medical claims to: Regence PO Box 30272 Salt Lake City UT 84130 Submit RX Claims to: Pharmacy Services PO Box 12625 MS S4P Salem OR 97309-0625

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Reimbursement and coding guidelines

Regence MedAdvantage reimbursement and coding guidelines follow Medicare rules whenever possible. Please note the following:

- Coding rules are applied as they are for other Regence products
 - Regence [Correct Code Editor](#) (CCE)
 - Centers for Medicare & Medicaid Services' (CMS) [National Correct Coding Initiative](#) (NCCI)
- Diagnosis codes must reflect all digits to the full extent of the code indicated in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding manual.
- Multiple endoscopic procedures are reimbursed using Regence standard multiple procedure fee reductions rather than Medicare's endoscopic family of codes payment methodology. In most cases, this results in a higher level of reimbursement.

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Payment Vouchers

[Sample payment vouchers \(PDF\)](#) are included in the Medicare Advantage Plans section of our *Administrative Manual*. Claims are processed on our Regence MedAdvantage claims system. These vouchers look different than other Regence payment vouchers. Vouchers include the following information:

- Patient name and member number
- Member's group number
- Claim number
- CPT, CDT, or HCPCS codes billed and written description of the service
- Dates of service
- Total charge for the service
- Fee adjustment or the amount not covered by the member's plan. The member may not be held responsible for this amount
- Amount paid by another carrier
- Amount of patient responsibility. This amount includes copayment, coinsurance, deductible or any non-covered services
- The reason code and description explaining how this particular claim was processed
- Amount paid by Regence
- Claim voucher totals

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Medicare Advantage Requirements

- A significant number of regulations and requirements apply for Medicare Advantage plans and contracted networks of providers, including required training, billing practices, claims payment and more.
- As a Regence MedAdvantage provider, you are required to comply with these regulations and requirements. Please review them in:
 - Your provider agreement
 - The [Medicare Advantage Plans \(PDF\)](#) section of the *Administrative Manual*

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CMS rules for provider activities and materials

The following CMS requirements must be observed:

- Engage in discussions with beneficiaries when patients seek information or advice regarding their Medicare options
- If desired, make available and/or distribute permitted plan marketing materials for all plans with which they participate
 - May also display posters or other materials announcing contractual relationships
- Cannot accept enrollment applications or offer inducements to persuade beneficiaries to join plans. We advise you to refer your patients to other sources of information, such as:
 - Regence marketing representatives at 1 (888) REGENCE
 - State Health Insurance Assistance Program
 - Local Medicaid office
 - Local Social Security Administration office
 - www.medicare.gov
 - 1 (800) MEDICARE

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Medicare Risk Adjustment

- Part of Regence Medicare Program Management
- Based on the Medicare Hierarchical Condition Category (HCC) algorithm
 - The diagnosis codes submitted from physician and hospital inpatient and outpatient claims are assigned to categories defined by CMS.
 - These categories are used to calculate a risk score for each Medicare Advantage beneficiary that reflects his or her overall health status.

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Medicare Risk Adjustment

- Payments from CMS to health plans are based entirely on the risk scores. It's important that the data submitted includes as much detail as possible.
- Regence conducts regular reviews of medical records to validate the risk scores reported to CMS.

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Medicare Risk Adjustment

Documentation and coding tips

The following tips can help ensure accurate medical coding and billing compliance, as well as the detail needed to accurately assess the risk scores of Regence MedAdvantage members.

- Include a legible identifier (name and credentials of provider) for services rendered/ordered
 - **Rubber stamp signatures are not acceptable**
 - Initials are acceptable only if the full name and credentials of the provider appear elsewhere in the record
- Record the patient's name and date of service on each page
- Evaluate the status of each active diagnosis or chronic condition on the patient's problem list, and update the progress notes accordingly
 - The problem list alone is not reportable documentation

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Medicare Risk Adjustment

Documentation and coding tips continued

- Report chronic conditions at least once each calendar year, preferably at the patient's annual physical
 - These may not have been routinely submitted on claim forms as a secondary diagnosis (e.g., history of myocardial infarction, congestive heart failure, chronic obstructive pulmonary disease, complications of diabetes)
 - Include appropriate coding on claims
- Include information in the patient's progress note to reflect all over-the-counter or prescription medications that are being actively managed or assessed on that date of service for each acute and/or chronic condition
 - e.g., "DM well controlled - taking Metformin", "Atrial fib stable – on Coumadin as directed"
- Include an accurate ICD-9-CM diagnosis code selection, including the fourth and fifth digits, when required
- Include the maximum number of codes allowed per submission

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Required Discharge Notices

Hospitals

- The [*An Important Message From Medicare About Your Rights*](#) form, along with additional information can be obtained from CMS.

Skilled Nursing Facilities

- Medicare requires the [Notice of Medicare Non-Coverage \(PDF\)](#) (NOMNC) form to be issued for every discharge. There are specific requirements for skilled nursing facilities. See the [NOMNC Fact Sheet \(PDF\)](#) for details.

Home Health Agencies

- Medicare requires the [NOMNC form \(PDF\)](#) to be issued for every discharge. There are specific requirements for home health agencies. See the [NOMNC Fact Sheet \(PDF\)](#) for details.

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Regence MedAdvantage Resources

Thank you for completing this online workshop. We encourage your feedback or questions on this workshop via [email](#).

Provider Center

This free online tool allows you to:

- Access eligibility, benefits, and claims information
- View and respond to patient feedback and expand your individual profile page

Provider Web Site

- [Coding toolkit](#)
- [Products section](#)
- [Administrative Manual](#) section - [Medicare Advantage Plans \(PDF\)](#)
- [Medicare Pre-authorization List](#) - List of services requiring pre-authorization
- [Forms](#) - NOMNC forms and fact sheets for skilled nursing facilities and home health agencies

Online workshop

[Medicare Compliance: Detecting, Correcting and Preventing Fraud, Waste and Abuse](#)

Completing this course meets the CMS annual compliance training requirement for providers and their staff

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