Communication from BCBSNS re:

Medicare Advantage Procedures

4/2/15

These are the answers from BCBSNC to the questions posed by the NCCA on behalf of our members:

Q - If a provider sends a fax to Blue Medicare for a pre-service determination, how will the provider and member receive a response?
A - both provider and member will receive a written response via mail for the pre-service determination notice. Also, Blue Medicare will attempt to verbally communicate with the members.

Q – How long will it take to receive the written pre-service determination notice from Blue Medicare?
A – At this time, the timeframe is 1-3 days. With this being said, there could be a high volume of requests during any given day and the timeframe to receive the pre-service notice could take longer. CMS's guidelines state we have up to 14 days to render the notice.

Q – Is there a form that needs to be completed or do providers simply fax a letter to the numbers listed?
A – At this time, there is no form today that providers must use. Providers can either call the numbers outlined in the communication (1-888-310-4110 for Blue Medicare HMO or 1-877-494-7647 for Blue Medicare PPO) or they can send a faxed letter with member name, ID number, and CPT code(s) with description of service(s) to fax number 1-336-794-1556 and a written response will be sent to the member and a copy to the provider. Stay tuned on additional information about a form being created to provide greater efficiency for the providers. Update: Blue Medicare is currently reviewing some templates/examples of forms. Until further notice, please fax a letter with above information noted in the letter.

Q – Will there be any urgent requests allowed?
A – The provider can request the services as urgent/expedited, however, clinical information will be required to support that the request meets the CMS guidance of expedited and that a delay in the service could jeopardize the member's health. In addition, it will be requested that the ordering physician who has ordered the services as urgent provide supporting information on why the services being delayed could jeopardize the member's health. The CMS

timelines and guidance is fourteen (14) days for a standard determination and seventy-two (72) hours for an expedited review although we work to complete the reviews as expeditiously as possible.

Q – If a consistent course of treatment is needed i.e. same CPT codes to be filed for a two week period at the same intervals i.e. 2 x's a week, can an approval be given for the entire 2 week period or will a notice be required for each visit?
A – Yes, we will authorize for extended periods of time for same services that are going to span a designated date range based on the member's healthcare needs. If there is a fluctuation in the services the provider is providing from week to week, providers must obtain another pre-service determination notice that would reflect the other services needed..

Q – What cost sharing amounts are allowed to be collected on the day of the service if a pre-service determination notice has not been issued?
A – pending.

Q – How does the HIPPA law that states if a member requests their provider to not file a claim for the services rendered, either covered or non-covered, impact the pre-service determination notice required by CMS from the Medicare Advantage plan?
A – Providers must have a specific waiver signed by the member which includes details such as the members name in print, date of service, CPT codes, description of service(s), costs, amounts member is agreeing to pay, a member signature and with language that states the member has requested that a claim or claims not be filed to the insurance payer. Providers must be careful to not use generic waivers when members make these type requests.

Q – Will BCBSNC consider sending the notice real-time i.e. provide a notice on the same day?
A – see above response for urgent requests.

Additional questions sent 3/23/15-
Q -How can we pick a specific day for a maintenance patient to come in when we do not know how long it takes for the patient to receive the predetermination letter?
A - The notice will be responded to within 1-3 days. This is the timeframe today to receive a notice from Blue Medicare.

Q - What happens when a patient has to reschedule to a day later or earlier?
A – in order to bill the member, the member will need to return on another day to receive their non-covered services if the provider wishes to bill the member for the non-covered services incurred.

Q - How are we supposed to explain to a acute patient that we have to wait 1-2 weeks to treat them? Because they have to receive a letter stating that x-rays or exam are not covered.
A –. As of today, notices are being issued within 1-3 days from receipt date. Please have members to contact the Blue Medicare Customer Service to have any questions answered.

Q – Did BCBSNC communicate anything to their members? If not, providers are being held responsible to educate members on this process and they will surely be upset when they hear that there has been a change in the process. If members were previously used to obtaining their non-covered service at the time of service, they will now be inconvenienced with making multiple trips to the provider's office.
A – No communication was posted for Blue Medicare members.

Dr. Siragusa, please let me know if I have missed anything or if you have additional questions. I will follow up with you on the last remaining question above as soon as I get confirmation.