Chapter 3

Products, Networks, and Payment

Unit 6: Medicare Advantage HMO, PPO and PFFS Products

In This Unit

3.6 Medicare Advantage Overview

Introduction

In an effort to make broader and more cost-effective coverage options available to people eligible for Medicare, the Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA), created "Medicare Part C."

This term includes a wide variety of delivery models – including Preferred Provider Organizations (PPOs) –, which serve as replacements for Traditional Medicare. All of these models are funded through a combination of payments from the Medicare program and the member's premium. Such plans were originally known as "Medicare+Choice" plans but now are called "Medicare Advantage" programs.

The cornerstone of the program is the network:

- When members receive covered services from **network** providers, those services are paid at the higher level defined in the benefit contract. (Some services require a copayment or coinsurance even when rendered by a network provider.)

- PPO members can still receive most covered services from non-network providers, but if they choose to do so, they are responsible for a greater share of the financial responsibility for the services. Coverage is generally at the lower level of coverage as defined in the benefit contract after the member has met his or her annual non-network deductible. The HMO product requires use of in-network providers – except for urgent/emergent care out of network.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself.

Medicare Advantage Benefits

At a minimum, Medicare Advantage programs such as FreedomBlue PPO are required to provide coverage for the services covered by Traditional Medicare. They may also provide additional services and benefits.

Highmark offers three Medicare Advantage products.
For more information on Medicare Advantage Products, please visit Members section of www.highmark.com.

1. Western Region Medicare Advantage HMO
   Central and Northeastern Medicare Advantage PPO

2. Western Region Medicare Advantage HMO Product Description

3. Western Region FreedomBlue Private Fee-for-Service (PFFS)
   Central and Northeastern FreedomBlue Private Fee-for-Service (PFFS)

Continued on next page

3.6 Medicare Advantage Overview, Continued

FreedomBlue PPO

FreedomBlue PPO offers its members additional benefits and services beyond those covered by the Medicare program. These include preventive services, routine dental and vision care and prescription drugs.

To enroll in FreedomBlue PPO, a member must have both Medicare Part A and B and must reside in the 40-county service area. Effective January 1, 2008 however, Highmark FreedomBlue PPO will be expanded to 62 counties including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia. Additionally, the member cannot have end stage renal disease at the time of enrollment, unless he or she is a current member of a Highmark commercial product.

What Region Am I?

Out-Of-Service Area Benefit

An out-of-area benefit applies to the FreedomBlue PPO product. Members have access to covered services out-of-network, both in area and out-of-area. Members are responsible for paying any applicable cost sharing for covered services. Renal dialysis services are covered at 100%, on a temporary basis, while outside the 40-county service area. Effective January 1, 2008 this service area will be expanded to a 62-county service area, including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Western Region Medicare Advantage PPO *(Western Region Only)*

Western Region Only:
Western Region Medicare Advantage HMO coverage replaces Medicare coverage; however, Western Region Medicare Advantage HMO members may retain their Medicare card while they are covered under the Western Region Medicare Advantage HMO. To enroll in Highmark's Western Region Medicare Advantage HMO, a member must have both Medicare Part A and B and must reside in the 17-county Western Region service area.

A Western Region Medicare Advantage HMO member must show his or her identification card to receive services. Services cannot be paid by traditional Medicare while the person is a member of a Western Region Medicare Advantage HMO, except for services incurred during a hospice election period and routine costs associated with clinical trails paid by Medicare.

Continued on next page

3.6 Medicare Advantage Overview, Continued

FreedomBlue Private Fee-For-Service

Effective January 1, 2008, Highmark Blue Shield began offering another Medicare Advantage plan option – Private Fee-for-Service. FreedomBlue PFFS provides Medicare Parts A and B benefits, as well as routine vision/hearing and SilverSneakers®. As a non-network plan, FreedomBlue PFFS does not require a contract making it different than Highmark's FreedomBlue PPO product.

Members can:

- see any licensed professional provider that has or is eligible for a Medicare billing number, has not opted out of the original Medicare program, and accepts FreedomBlue's PFFS terms and conditions of participation.

- be treated at any Medicare-certified facility that accepts FreedomBlue PFFS terms and conditions of participation

Providers are not required to see FreedomBlue PFFS and elect to do so on a per service basis. If you do provide services, you do so under the terms and conditions of that member's plan.

Becoming A Deemed Provider Under FreedomBlue FFS

Providers, both Medicare participating and nonparticipating, are considered deemed when they meet the following conditions:

1. Are aware in advance that the patient is a FreedomBlue PFFS member. All FreedomBlue PFFS members receive an identification card that includes the FreedomBlue PFFS logo to help identify them as PFFS members.

2. Have a copy of or reasonable access to FreedomBlue PFFS's terms and conditions of participation.

3. Provide services covered by FreedomBlue to a FreedomBlue PFFS member.

Continued on next page

3.6 Medicare Advantage Overview, Continued

Highmark's Compliance Commitment To CMS Regulations

Highmark complies with all state and federal laws related to Medicare and our Medicare Advantage Products. Medical policies related exclusively to Medicare Advantage are available under the Medical Policy heading on the Provider Resource Center. In cases where Highmark policy, Highmark medical policy, settlement provisions and/or CMS policy vary, the CMS regulation prevails.

According to CMS' Medicare Managed Care Manual, Highmark's contracts must contain accountability provisions specifying:

- That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years;
- That the MA organization oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations (422.504(i)(4)(iii)); and
- The person or entity must agree to comply with all State and Federal confidentiality requirements, including the requirements established by the MA organization and the MA program

For more information on specific CMS regulations, please visit www.cms.hhs.gov.

3.6 Medicare Advantage Medical Policy

Medical Policy Overview

CMS requires that Medicare Advantage plans utilize Medicare medical policy or local Highmark policy when Medicare national or local policy does not exist.

Therefore, Highmark developed Medicare Advantage medical policies which are used to process Medicare Advantage claims. Processing guidelines may be added to the Medicare Advantage medical policy.

When appropriate, Highmark's medical policy guidelines are used for the Medicare Advantage products and are referred to as gap-fill policies. Gap-fill policies are generally used in the following instances:

- Where CMS or Highmark Medicare Services do not have a medical policy for a particular service, or,
- The existing CMS or Highmark Medicare Services policy is not appropriate for the Medicare Advantage products

Both Medicare Advantage and Highmark's medical policy guidelines have been integrated into the claims processing system, allowing for cost effective claims processing and ensuring consistent, accurate administration of our customers' health care benefits.

Medicare Advantage medical policies are located on the Provider Resource Center.

Required Terms For Medicare Advantage Plans

The Appendix of the Highmark Blue Shield Office Manual contains a complete listing of the required Medicare Advantage compliance terms that may be included in Highmark's policies and procedures. Highmark's providers are required to comply with all such provisions, including, but not limited to, taking all necessary actions as may be specifically noted or such actions as may be required and requested by Highmark Inc. or Highmark's networks as applicable.

Please select Medicare Advantage Compliance Language from the Office Manual's Table Of Contents, and then select the appropriate region for your line of business.

3.6 Identifying Medicare Advantage Members with End Stage Renal Disease (ESRD)

Definition

End stage renal disease (ESRD) is permanent kidney failure that requires kidney dialysis or a transplant to maintain life. Medicare beneficiaries generally cannot join FreedomBlue PPO if they have this condition. However, if they develop this condition while they are FreedomBlue PPO members, they will continue to be enrolled. It is important to identify all members with ESRD as soon as possible to ensure adequate treatment. Your role in identifying members with ESRD is crucial.

Policy

When a FreedomBlue PPO or Western Region Medicare Advantage HMO patient is determined to have chronic kidney failure and receives treatment in a Medicare-approved dialysis center or receives a kidney transplant, the attending physician should help the dialysis center complete an *ESRD Medical Evidence Report*, CMS-2728-U3. It takes approximately four months for the CMS-2728-U3 forms to be processed through all systems in order to set up the initial record and pay appropriate reimbursement rates for members with ESRD. **However, it is the responsibility of the patient's dialysis center to send completed CMS-2728-U3 forms to the ESRD Networks in a timely manner.**

Procedure

Step	Action
1	The physician ordering dialysis contacts the dialysis center.
2	The dialysis center is responsible for submitting the original copy of the completed CMS-2728-US to the servicing Social Security office. The dialysis center also submits copies of and is responsible for verifying the information on the form and resolving any questionable items before sending the information to the ESRD networks who transmit the information to CMS.
3	The information that CMS receives from the ESRD Networks is documented in CMS's Group Health Plan system (GHP), which is responsible for assigning ESRD status.

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge

Update To Policy

Effective July 2, 2007, the policy for notifying Medicare Advantage inpatients of their rights at discharge has changed. Under the new notification process, acute care facilities are required to give all Medicare and Medicare Advantage inpatients a revised "Important Message From Medicare" no later than two days after admission to the inpatient level of care. The member will need to sign and date the Important Message to indicate that he or she received and understood it. The hospital must then provide the member with the signed Important Message and retain a copy of the signed document in the member's medical record.

Definition

Medicare Advantage plans must notify their members of their Medicare appeal rights at or near the time of a hospital or facility discharge

Procedure

Step	Action
1	Give all Medicare Advantage inpatients the 'Important Message From Medicare at or near the time of admission, but no later than two days after admission to the inpatient level of care.
2	Provide a follow-up signed copy of the Important Message From Medicare to all Medicare Advantage patients (or, if necessary, to their representative) prior to discharge, but no more than 2 days before discharge and retain a copy of the signed document in the member's medical record or in some other location/format, in order to be able to demonstrate that the requirement was met.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Additional Steps For Patients Requesting an Expedited Review

This component of the procedure applies only to patients who wish to initiate an expedited review of the discharge decision.

Step	Action
1	Member must call Quality Improvement Organization (QIO) as directed on the 'Important Message From Medicare.'
2	QIO will notify the facility to forward relevant records and complete and deliver the Detailed Notice. The QIO will also notify Highmark that the request was received.
3	The facility will deliver the Detailed Notice to the member no later than noon of the day after the facility is notified of the review request. This notice provides the member with the clinical and coverage reasons why the member's physician has determined that the level of care is no longer reasonable or medically necessary. The member is not required to sign this document.

If the member decides to accept the discharge, he or she leaves the facility and goes home or to an alternative level of care.

If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge (while he or she is still an inpatient) to decide to pursue an appeal (reconsideration). If the member decides to pursue the appeal additional steps would take place.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Definition Of Medically Necessary

Services or supplies that are: proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience of that of your doctor.

If The Member Disagrees With The Appeal Decision

This component of the procedure applies only to patients who disagree with the discharge decision.

Step	Action
1	If the patient disagrees with the discharge decision, no later than midnight on the day of discharge the patient or authorized representative contacts the QIO.
2	The QIO notifies the facility and Highmark of the request to review.
3	No later than noon of the day after the QIO notification, the facility forwards all the information the QIO needs for the review. The facility also prepares and delivers to the patient or representative and the QIO a completed 'Detailed Notice of Discharge'.
4	No later than 1 day after receiving all the necessary information the QIO completed its review and communicates its decision to the member, facility and the health plan.

If The Member Disagrees With The Appeal Decision

The member must be able to understand the purpose and contents of the notice in order to be able to sign indicating receipt. The member may also appeal this discharge decision.

For More Information

Please contact Pennsylvania QIO at www.qipa.org or call Provider Service at:

Western Region Medicare Advantage HMO: 1-800-517-8585
FreedomBlue: 1-866-588-6967

Where Can I Get Forms?

A current copy of the Important Message From Medicare is available on CMS' website at:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

3.6 Advance Directives

Definition

An advance directive is a written document prepared by a patient that indicates how they would want future health care decisions to be made if they are unable to make decisions. An advance directive can tell physicians and family members what life-sustaining treatments one does or does not want at some future time if one becomes incapable of making or communicating treatment decisions.

An essential component of the advance directive is the selection of a person to make health and personal care decisions for one who lacks sufficient capacity to make or communicate choices.

Policy

PCPs must ask Medicare Advantage program members whether they have executed an advance directive and selected a surrogate. PCPs must then review the advance directive and determine their role as described in the procedure below. Advance directive discussions must be documented in a prominent place in the medical record. A copy of the executed advance directive must be placed in a prominent part of the medical record.

Monitoring

During an office site visit, a nurse from the Quality Management department will review medical records to determine whether:

- Discussion of the advance directive with the member is documented in a prominent part of the medical record.
- A copy of the advance directive, signed by the member and physician, is on file, if applicable.

Clinical studies may also be conducted to evaluate ongoing use and discussion of advance directives.

Procedure

Step	Action
1	Ask the member whether he or she has executed an advance directive. Document the response in the member's chart. If the member *has completed* an advance directive, go to step 2. If the member *has not completed* an advance directive, initiate a discussion about completing an advance directive and selecting a surrogate decision-maker. Document the discussion in the member's chart. Process complete.

Continued on next page

3.6 Advising Medicare Advantage Members Of Their Rights As Inpatients At Discharge, Continued

Step	Action
2	Review the advance directive. If you *are willing* to honor the request as it is written, document the discussion and place a copy of the advance directive in a prominent part of the member's medical record. Process complete. If you *are not willing* to honor the request as it is written, document the discussion in a prominent part of the member's chart and go to step 3.
3	If possible, notify the member of the decision not to honor the advance directive. Member Services will make every effort possible to place the member with another provider who is able to honor the member's wishes.

3.6 Expedited Review of Initial Determination and Appeals Policy

Policy

Physicians should be knowledgeable about the expedited review of initial determination and appeals processes for FreedomBlue and Highmark's Western Region Medicare Advantage HMO products. Although these processes are largely member-driven, the physician may represent the member and initiate the expedited review. Also, the physician is responsible for the crucial role of providing requested medical records on a timely basis.

When asking for an expedited review, the enrollee or the physician must submit either an oral or written request directly to the organization responsible for making the determination. The physician may also provide oral or written support for an enrollee's own request for an expedited determination.

Background

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determination and appeal processes. As a Medicare Advantage program, FreedomBlue and Highmark's Western Region Medicare Advantage HMO have implemented expedited review of initial determination and appeal processes for members.

Highmark must automatically provide an expedited determination to any request made or supported by a physician. The physician must indicate either orally, or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.

Expedited Review Rights

Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life or ability to regain maximum function may be jeopardized by waiting for the standard review process.

In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

What These Processes Do Not Apply To...

The expedited review of initial determination and appeal process does not apply to claim denials if services have already been received. Members or providers may appeal claims denials through their respective standard appeal processes.

Continued on next page

3.6 Expedited Review of Initial Determination and Appeals Policy, Continued

Your Role	You may be contacted by an HMS care manager or physician advisor to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately. Additionally, if you are contacted for information by a physician advisor about an expedited appeal, you must return his or her call by 8 a.m. the following day. Failure to do so could result in corrective action and/or sanctioning.
Appealing On Behalf Of A Member	You or a treating physician may wish to initiate an appeal on behalf of a Medicare Advantage member if you believe services are medically necessary and covered under the member's benefit plan. If you choose to initiate the appeal on behalf of the member, then the appeal is automatically considered an expedited appeal.
If A Denial Decision Is Upheld	If a denial decision is upheld, the network is required to forward the case to the CMS appeals contractor within 24 hours of the decision. The appeals contractor may request additional information. In such cases, a Medicare Advantage appeals administrator may contact your office for additional information. If you are contacted, please respond to the request immediately.

3.6 Expedited Review of Initial Determinations and Appeals Procedure

Introduction

The information below is intended to help you understand the expedited review process for Medicare Advantage members.

Note: Appeal administrators will automatically forward member appeals that do not meet expedited review criteria through the standard appeal process.

Expedited Review Process

The table below explains how the expedited review process for Medicare Advantage members works:

Step	Who does it	What happens
1	Member or treating physician	Decides to pursue an expedited initial determination or expedited appeal.
2	Member	Does member want to pursue the review or the appeal or appoint someone as a representative? If the member is pursuing the review, go to step 4. If the member is appointing a representative, go to step 3.
3a OR 3b	Member Or Physician An appointed representative	3a. For expedited appeals the member or the physician does not require a representative statement to make a request. Members or physicians may request an expedited appeal by phone, fax or by mail. If the request does not meet expedited criteria, it will be processed as a standard appeal and then a representative statement will be requested for a physician or other appointed representative request only. 3b. The appointed representative may submit a Representative Statement Document by following instructions located on the form directly or sending a written equivalent. Both member and representative must sign the document. Fax or mail the signed document to the contact information in step 4.
4	Member or appointed representative	Contacts the Expedited Review department at: 1-800-485-9610 May send a physician's statement supporting the urgent need for services to: Fax: 1-800-894-7947 Mail: Expedited Review Department P.O. Box 535073 Pittsburgh, PA 15253-5073

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3.6 Expedited Review of Initial Determinations and Appeals Procedure Procedure, Continued

Expedited Review Process **(continued)**

Stage	Who does it	What happens
5	HMS care manager and/or physician advisor	Investigates the review. (The 72-hour period begins upon receipt of this request.) Is there enough information to render a decision? If yes, go to step 7. If no, request additional information from provider of care and go to step 6.
6	Care provider	Forwards member's medical records to care manager or physician advisor.
7	HMS care manager and/or physician advisor	Renders decision. Notifies member by telephone and letter. Notifies physician.

Where Can I Get Forms

A current copy of the Representative Statement Form is available under the CMS' forms section of the CMS website at:

http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf

3.6 DME/Respiratory Supplies Management Program

Overview

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all Medicare Advantage program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports Highmark's efforts by administrating utilization management, claims processing and provider support.

DME Not Requiring Authorization

DME that does not require authorization simply requires a prescription written by the ordering physician.

DME Requiring Authorization

Physicians should contact DMEnsion, Inc. (formerly Wright & Filippis) or HMS to request authorization for DME and supplies furnished through a stand-alone, Highmark Ancillary DME, prosthetics and orthotics supplier for the items listed in the Procedures/DME that Require Authorization list. The Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials.

Authorization Requirements Vary By Product

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all HMO and Medicare Advantage HMO and PPO program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports the network's efforts by administrating utilization management, claims processing and provider support. For all other members, these items should be authorized through HMS Care Management.

What Region Am I?

For these products…	Authorization is through…
Western Region HMO Medicare Advantage HMO (Western Region Only) FreedomBlue PPO	**DMEnsion, Inc. (formerly Wright & Filippis)**
DirectBlue (group)	**HMS Care Management**
DirectBlue (individual) PreferredBlue PPOBlue EPOBlue	**No authorization required**

3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products

Applicable Products

This program applies to all HMO and Medicare Advantage HMO and PPO Products.

Process

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory equipment.

Step	Action
1	The ordering physician determines whether the request must be sent to DMEnsion, Inc. (formerly Wright & Filippis).
2	If required, the ordering physician submits the request for authorization to DMEnsion, Inc. (formerly Wright & Filippis) through one of the following methods: • Submit the request through NaviNet℠. • Fax an authorization request form to 1-248-844-8614. • Mail an authorization request form to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460 • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774.
3	DMEnsion, Inc. (formerly Wright & Filippis) will review the request for benefits, eligibility, prior utilization, diagnosis, etc. • If benefits are not available, go to step 4. • If medical appropriateness cannot be determined, go to step 5. • If the request is approved, go to step 8.
4	If benefits are not available for the requested item or service, DMEnsion, Inc. (formerly Wright & Filippis) will deny the authorization request and an explanation letter from Highmark will be sent to the ordering physician and the member. Proceed to Step 9.

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3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products,
Continued

Process, (continued)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>5</td><td>If medical appropriateness cannot be determined from the documentation provided by the ordering physician, DMEnsion, Inc. (formerly Wright & Filippis) will contact the ordering physician for additional information. This information must be returned to DMEnsion, Inc. (formerly Wright & Filippis) within 48 hours or the request may be voided and must be resubmitted. Proceed to step 6.</td></tr>
<tr><td>6</td><td>If the documentation does not substantiate the request, the authorization request is denied and an explanation from Highmark will be sent to the ordering physician and member. If medical necessity cannot be determined, the authorization request is pended and sent to the Highmark Physician Advisor Office for review. Proceed to step 7.

If the documentation substantiates the request, proceed to step 8.</td></tr>
<tr><td>7</td><td>If the Highmark Physician Advisor Office determines that the authorization
<table>
<tr><th>Is medically appropriate</th><th>Is not medically appropriate</th></tr>
<tr><td>DMEnsion, Inc. (formerly Wright & Filippis) will approve the pended authorization
Proceed to step 8</td><td>Highmark will send a denial letter to the PCP and the member and instruct DMEnsion, Inc. (formerly Wright & Filippis) to deny the pended authorization.
Proceed to step 9</td></tr>
</table></td></tr>
<tr><td>8</td><td>DMEnsion, Inc. (formerly Wright & Filippis) gives the ordering physician the appropriate HCPCS codes and the authorization number.</td></tr>
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3.6 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process (continued)

Step	Action
9	The ordering physician receives the completed authorization (approved or denied) and communicates the information to the DME, respiratory, prosthetic, or orthotic network participating supplier.
10	If the supplier believes that the equipment or supplies authorized by the ordering physician are inadequate, the supplier must contact the PCP to correct the previous authorization. The supplier may contact DMEnsion, Inc. (formerly Wright & Filippis) to make adjustments to the original request or provide additional information as long as the authorized benefits do not change. This can be done through one of the following methods: • Fax an authorization request form to 1-248-844-8614. • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774 (1-877-FILIPPI). The supplier must provide patient information and the reason the original order is inappropriate.

3.6 Submitting Claims for DME, Prosthetics, Orthotics, and Respiratory Equipment Authorized through DMEnsion, Inc.

Submitting Claims

The steps listed below describe the process for submitting claims.

Step	Action
1	The DME supplier submits the claim to DMEnsion, Inc. (formerly Wright & Filippis) on a CMS-1500 form by mailing it to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460
2	DMEnsion, Inc. (formerly Wright & Filippis) verifies benefits eligibility and authorization and processes the claim.
3	The check and remittance are sent to the supplier (or member, if appropriate).
4	Claim information is sent to Highmark for administrative purposes and historical record.

3.6 Pre-Service Denials for Medicare Advantage Products

Definition

A pre-service denial occurs when a physician tells a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the physician's decision, this is not a pre-service denial. However, if the member continues to request the service, a pre-service denial has occurred.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all contracting Medicare Advantage programs and their physicians to advise members of their right to appeal any denial of a service to which they believe they are entitled.

Policy

All Medicare Advantage HMO and Medicare Advantage PPO members have the right to appeal a pre-service denial and to be informed in a timely manner of their right to appeal an adverse decision. CMS requires that all Medicare Advantage programs must comply with pre-service denial regulations.

Pre-Service Denials After The Member Leaves The Office

If the member agrees with the physician's decision not to supply the service at the time of the visit, **but later reconsiders** and decides that he or she wants to have the service, this is a pre-service denial.

If the member calls the physician's office to communicate this disagreement, the physician's office must send a pre-service denial notice generated from the practice and a statement of member appeal rights to the member within one business day. However, if the member calls Member Services instead, a Highmark representative will issue a statement of member appeal rights to the member.

New Members Who Have Never Been Seen At The Office

If a Medicare Advantage HMO or PPO member, who has never been examined by the physician, telephones and requests a service, the physician has the right to ask the member to come for an office visit. If the member refuses, this does not constitute a pre-service denial because the member is not following the plan's rule that members must coordinate all non-urgent, non-emergent care. If the member is not in agreement, the physician should advise the member to contact their Member Service Department.

3.6 Medicare Advantage Home Oxygen Therapy

Introduction

Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

Equipment Included

The equipment necessary for delivery of home oxygen therapy includes the following:

- Oxygen furnishing system
- Oxygen storage vessels
- Tubing
- Administration sets

Supplies	Codes
Stationary oxygen delivery system only ***(One code per patient per month)***	E0424 E0439 E1390
Portable oxygen delivery system only ***(One code per patient per month)***	E0431 E0434 E0443 contents payable only when stationary liquid is used with portable gaseous (E0431)
Patient owned equipment	E0425 E0430 E0435 E0440 E0441 E0442 A4615 (cannula) A4616 (tubing) E0550 (humidifier) E0555 (humidifier) E0560 (humidifier)

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3.6 Medicare Advantage Home Oxygen Therapy, Continued

Conditions For Which Coverage Is Available

Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

Conditions For Which Coverage Is Unavailable

Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable Oxygen Systems

Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, check both boxes, "portable" and "stationary."

Spare Tanks Or Emergency Inhalators

Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Oxygen Determinations

Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO_2) in arterial blood. **The study must be performed within 30 days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician
- Ordered and evaluated by the attending physician and performed under his or her supervision
- Performed by a qualified provider or supplier of laboratory services

Note: Medicare does not recognize DME suppliers as qualified to provide or supply blood oxygen determinations.

Conditions Of Blood Gas Studies

The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include the following:

- At rest
- While sleeping
- While exercising
- On room air
- On oxygen

Note: If the study is performed while the patient is receiving oxygen, indicate the following:

- Amount
- Body position during testing
- Additional information required for interpretation

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria

The table below describes three groups of blood gas levels for which coverage is provided.

Group	Blood gas level criteria
Group 1 *Medically necessary*	Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake. OR A greater than normal fall in oxygen level during sleep (arterial PO_2 decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). OR Arterial PO_2 is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria, continued

Group	Blood gas level criteria
Group 2 *Medically necessary*	Arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF) • Erythrocythemia with a hematocrit greater than 56%
Group 3 ***Not*** *medically necessary*	Home use of oxygen is not medically necessary for members with PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional Studies

Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient's initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO_2 was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

Certificate Of Medical Necessity

A *Certificate of Medical Necessity* (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

Continued on next page

3.6 Medicare Advantage Home Oxygen Therapy, Continued

Obtaining Authorization

DMEnsion, Inc. (formerly Wright & Filippis) must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization.

Step	Action
1	The physician enters a request for oxygen into NaviNet[SM]. The physician should also fax a CMN form to DMEnsion, Inc. at 1-248-844-8614 at the same time.
2	The electronically submitted request is automatically sent to DMEnsion, Inc. (formerly Wright & Filippis). Fax paper referral forms to DMEnsion, Inc. at 1-248-844-8614.
3	If the physician has not included a CMN form, DMEnsion, Inc. will send or fax a CMN form to the physician for completion.
4	Physician returns completed CMN form to DMEnsion, Inc.
5	DMEnsion, Inc. sends an authorization approval through ROAR or by fax.
6	The physician sends the approved request to a DME supplier.
7	The DME supplier provides services to the patient.

Recertification

Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO_2 was 56 mm HG or greater at the initial certification
- If the patient's oxygen saturation was 89% or greater at the initial certification
- If the physician initially estimated that oxygen was needed for one to three months

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

3.6 Diabetic Testing Devices for Medicare Advantage HMO and PPO Members

Changes Effective January 1, 2006

Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips and lancets effective January 1, 2006. Insulin pens and insulin pumps are also being covered under DME. Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

Purchasing Diabetic Testing Devices

Members are now able to purchase these items from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage.

Part B Drugs are covered in full after a copayment when they are obtained from an in-network specialty pharmacy, DME vendor, or furnished in a physician's office. Any out of network supplies, are subject to additional copayments and coinsurance.

Although FreedomBlue PPO members have out-of network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions For Multiple, Daily Diabetic Testing

If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written to clearly state the correct frequency of testing (Ex. To be tested three times daily). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail Order Diabetic Testing Supplies

Members are still able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long term supplies.

For More Information

If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact Provider Service.

3.6 Medicare Prescription Drug Coverage under Medicare Advantage

Prescription Drug Coverage

Medicare Advantage HMO and PPO products provide Part B prescription drug coverage (MA-only plans). Some Medicare Advantage plans may also include Medicare Part D Prescription Drug Coverage benefits (MA-PD plans). Effective January 1, 2006, Medicare Advantage members can obtain the following Part B drugs from the following providers/suppliers:

- oral medication for cancer from specialty pharmacies including Medmark and
- nebulizer solution from approved Durable Medical Equipment (DME) vendors.

Medicare Advantage HMO and PPO members are **not** able to purchase any Part B drugs, including those listed above, at a retail pharmacy.

Medicare Advantage HMO and PPO members can obtain oral medication for cancer from a specialty pharmacy when it is covered under their Part D benefit, but are not required to do so.

Coverage Levels for In And Out Of Network Purchases

Part B drugs are covered in full after a co-payment when they are obtained from an in-network specialty pharmacy or a DME vendor.

If FreedomBlue PPO members purchase these drugs at an out-of-network specialty pharmacy or DME vendor, in addition to a co-payment, they are responsible for 20-30% coinsurance on the lesser of the out-of-network charge or network allowed amount as well as any difference between the out-of-network charge and network amount. Highmark's Western Region Medicare Advantage HMO product does not have an out-of network benefit.

Members Can Buy Supplies From A Listing Of Vendors And Pharmacies

There are several network specialty pharmacies and DME vendors from which members can choose. A listing of specialty pharmacy providers and DME vendors are now available on NaviNet℠ and via www.highmark.com.

For More Information

If you have specific questions about changes to the way Medicare Advantage members can obtain certain Part B drugs, please contact Provider Service.

3.6 DME Supplies Provided in the Physician Office

Simple DME Supplies Can Be Provided In The Office Setting

Minor DME items, prosthetics, orthotics, and supplies *incidental to a physician or facility that do not require authorization* can be furnished to members for their convenience in the physician office setting.

What Region Am I?

Applicable Products

The supplies listed below can be provided in the office setting for Medicare Advantage HMO and PPO members as well as other Highmark managed care members enrolled in many Highmark Blue Shield products.

Submit A Claim For The Appropriate Charge

Under no circumstances should a member be charged for such items or supplies. Include the charge for the item/supply on a claim and submit to Highmark following normal billing protocols.

Eligible Supplies/Items

Following is a list of those items that can be supplied to members in the office setting and billed to Highmark for reimbursement at fee-for-service. *These supply items do not require authorization.*

Item	Code
Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips	E0112
Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	E0114
Cervical, Flexible, non-adjustable (foam collar)	L0120
Knee orthosis, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	L1830
Plastazote sandal-each	L3265
Wrist hand Orthosis, wrist extension control cock-up, non molded, prefabricated, includes fitting and adjustment	L3908
Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel) prefabricated, includes fitting and adjustment	L4350
Pneumatic knee splint, prefabricated, includes fitting and adjustment	L4380
Peak Expiratory Flow Rate Meter, Hand Held (Effective 03/01/06)	A4614
Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (Effective 03/01/06)	A4627

IMPORTANT! All Other DME And Supplies

Requests for all other DME, prosthetic and orthotic supplies must be directed to a network DME, prosthetic and orthotic provider. Search in NaviNet[SM] for eligible providers within each managed care product.

3.6 Record Retention Procedures For Medicare Advantage

Overview

Highmark complies, and requires its contracted providers to comply, with Centers for Medicare and Medicaid Services polices and procedures including inspection of records.

Record retention is required to ensure efficient availability in case of immediate need. Compliance with CMS' requirements is paramount for continuing participation in the Medicare Advantage (M.A.) program and the ability services our M.A. members.

Policy

CMS has revised its regulations with respect to records retention and access to records, increasing the period from six to ten years. Therefore, network providers must maintain records and information in an accurate and timely manner in accordance with 42CFR §422.504(d) and provide access to such records in accordance with 42CFR §422.504(e)(2).

42CFR §422.504(d) states M.A. organizations are to maintain records and allow CMS access to them, for 10 years from the termination date of the contract or the date of the completion of any audit.

42CFR §422.504(e)(2) states,

"HHS, the Comptroller General, or their designees may audit evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the Medicare Advantage (M.A.) organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract."

If you wish to read the entire context of the requirement please visit The Code of Federal Regulations, Title 42, Volume 2, Chapter 1V – Centers for Medicare and Medicaid Services, Department of Health and Human Services, Part 422, Medicare Advantage Program, Subpart K, Contracts with Medicare Advantage Organizations.

Previous Record Retention Regulations

Previous record retention regulations specified that records must be maintained for six years. This period is now ten years.