Medicare Advantage

Provider Education 2018
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- About our plans
- How to identify our Medicare Advantage members
- Primary care provider selection
- Referrals, prior authorizations, medical management, and appeals
- Annual wellness visits
- Part D pharmacy
- Online provider tools
- Resources
About our plans
New Medicare Advantage partner: Visiant

- Premera is partnering with Visiant to provide operational support to our Medicare Advantage business
- Visiant is a subsidiary of Blue Cross Blue Shield of Michigan
- Visiant was chosen for their industry leading experience, which includes 400K+ Medicare members in 44 states
2018 five-county service area

Snohomish
Thurston
King
Pierce
Spokane
# 2018 Premera Medicare Advantage plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>King</th>
<th>Snohomish</th>
<th>Pierce</th>
<th>Thurston</th>
<th>Spokane</th>
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</thead>
<tbody>
<tr>
<td>HMO ($0)</td>
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<td>●</td>
<td>●</td>
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<td>Classic HMO ($75)</td>
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<td>Classic Plus HMO ($166)</td>
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*New!*
HMO plans

HMO, Classic HMO, Classic Plus HMO, and Spokane County Total Health HMO

- Member may only access in-network providers
- Referrals to specialists are required
- A prior authorization is required for some non-emergent care services
- Members who don’t receive a prior authorization for some non-emergent services may be required to pay 100% of the costs
Identifying members
Sample ID card

- All Medicare Advantage cards have the ID prefix, ZNP. No change from 2017.
- If the member also has dental, vision, or hearing benefits, it will be listed on the bottom of the card.
- All contact phone numbers are on the back of the card.
- Member PCP and designated clinic are on the back of the card.
- For 2018, the information needed for filling prescriptions has changed; this is on the right-hand side of the front of the card.
Primary care provider (PCP) selection during enrollment

Members can specify their PCP choice on the enrollment application. If they don’t:
• A letter is mailed to the member requesting they call customer service with PCP selection.
• The ID card will reflect “PCP not chosen”.
• If the member doesn’t call Premera with their PCP selection, one will be assigned.
• The member’s assigned PCP is determined by proximity to home address.
Medicare Advantage PCP

- Members are required to select a PCP.
- Only in-network providers can be assigned as PCPs.
- PCP changes are effective on the first of the following month.
- Referrals are required for non-PCP services.

<table>
<thead>
<tr>
<th>Services that do not require a referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine women’s health</td>
</tr>
<tr>
<td>Urgent/emergent care</td>
</tr>
</tbody>
</table>
Identifying a member’s PCP

- Look for the PCP name and designated clinic on the back of the member’s card.
- Use the [eligibility and benefits tool](#) on the Medicare Advantage provider website.
- Use electronic 270/271 inquiry transactions.
- If you have questions, call the customer service phone number on the back of the card.
Referrals, prior authorizations, medical management, and appeals
Referrals
Medicare Advantage referrals

- The primary care provider (PCP) is responsible for making sure the referral is on file with Premera Blue Cross Medicare Advantage.
- The PCP must fill out and submit the referral request forms online or by fax for all services performed by a specialist.
- Check all the appropriate boxes on the referral request form. Otherwise, a new referral form will need to be completed and submitted.
- As a courtesy, providers have the ability to submit referrals with a retroactive date no greater than 60 days.
Types of services that require referrals

- Office visits with a specialty provider
- Procedures performed by the specialty provider
- Labs and diagnostics ordered by the specialty provider
- Durable medical equipment (DME) orders by the provider
- Chiropractic care
- Nutritional counseling
Types of services that don’t require referrals

- Physical therapy, occupational therapy, speech therapy—only a written order is needed from the PCP or specialist
- Routine women’s healthcare: breast exams, mammograms, pap tests, and pelvic exams, provided by an in-network provider
- Flu and pneumonia vaccinations
- Routine vision exams for plans with vision benefits
- Routine hearing exams for plans that include that benefit
- Emergency services
Medicare Advantage referral submission

- Referrals can be submitted online through the Medicare Advantage referral and prior authorization website tool or faxed.
- Referral submission forms are available online on our secure and non-secure Medicare Advantage website under forms: premera.com/wa/provider/medicare-advantage
- New fax number for 2018: Completed referral forms can be faxed to 866-809-1370.
Prior authorizations
These services require clinical review for prior authorizations

- Acute hospital admissions
- 30-day bundling for readmissions
- Skilled nursing facility admissions
- Long-term acute care hospital admissions
- Inpatient rehabilitation
- Part B medication prior authorization
- Outpatient prior authorization
Prior authorization reviews for Medicare Advantage

- Medicare Advantage plans have a separate list of services requiring prior authorization than our commercial plans. Check the Medicare Advantage website for the most current list for both medical and pharmacy.
- You can submit your request online by using the referral and prior authorization tool.
- Or fill out and fax the prior authorization form located on the Medicare Advantage provider website in the forms section. Be sure to include pertinent medical records.

Medical Management
Prior authorizations
Fax: 866-809-1370
Phone: 855-339-8127

CVS Caremark for Pharmacy Prescriptions (Part D)
Prior authorizations
Fax: 855-633-7673
Phone: 844-4499-4723
Care management
Care management programs overview

Complex case management

**Complex case management:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services needed to meet members’ health needs and to promote quality and cost-effective interventions and outcomes across the continuum of care.

- An integrated team works with members, their families, their doctors, and other health professionals to facilitate appropriate use of healthcare services, and to help members reach their best level of wellness through education, support and coordination of care.
- Conditions managed include:
  - Complex conditions (e.g., Parkinson’s, ALS, advanced liver disease)
  - Co-morbid conditions (diabetes, congestive heart failure, kidney disease, ischemic heart disease, etc.)
  - Catastrophic conditions such as MVA, loss of limb, multiple burns
  - Oncology
  - Transplant
Disease management overview

Disease management
The disease management program helps members learn how to manage their conditions by encouraging regular provider follow-ups, and proper use of medications. Clinical nursing staff will assist with coordination of the patient’s care to help improve communication with their providers.

Some types of diseases that will be managed and/or coordinated by the clinical nursing staff are:

- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes
- Chronic kidney disease (CKD)
- Congestive heart failure (CHF)
Care management programs
Additional program information

• 24/7 nurse advice line - Provides recommendations over the phone for appropriate level of care. Also provides member education for specific conditions

• Health risk assessment – Questionnaire used to provide individuals, providers, and the health plan with an evaluation of their health risks and quality of life. With a simple look at the member’s medical history and personal health habits, we can get the information needed to engage participants in the proper care and treatment of their health

• Coordination with Optum to ensure members medical and behavioral health needs are well managed

• Coordination with Landmark to prevent duplication of outreach services
Appeals and reconsiderations
Appeals and reconsiderations

New process for 2018:
We’ll send you a letter when a claim for medical services is fully or partially denied for a clinical edit or medical denial. The letter will contain instructions and contact information to submit an appeal.
Annual wellness visits
Annual Wellness Visits (AWV) and related visit types

- AWVs (G0438/G0439) incur no cost share for the member and are an opportunity to:
  - Document the patient’s current chronic conditions and ongoing treatment plans
  - Conduct screenings for conditions such as incontinence, fall risk, high blood pressure, and depression
  - Review medications
  - Schedule preventative tests: colonoscopy, mammography, diabetic eye exam, etc.
  - Complete non-preventive lab work as necessary

- AWVs may not be billed with an annual preventive exam (99387/97)
- AWVs are allowed only after the member has had Part B for a full 12 months
  - During the first 12 months of Medicare enrollment, new beneficiaries are eligible for the Welcome to Medicare Visit (G0402)
Billing for Annual Wellness Visits and related visit types

- The AWV, Welcome to Medicare Visit, and the annual preventive exam should be billed with one of the following appropriate ICD-10 diagnosis codes as the primary diagnosis:
  - Z00.00 – Encounter for general adult medical examination without abnormal findings
  - Z00.01 – Encounter for general adult medical examination with abnormal findings
- When active but stable conditions are addressed and documented during any of these visits, add the diagnosis codes for these conditions subsequent to Z00.00/Z00.01 on the claim
Billing for services added to the AWV and related visits

• If a condition addressed during the AWV, Welcome to Medicare Visit, or an annual preventive exam is significant enough to require additional work:
  – Consider adding an E/M code with a modifier 25 (following CPT guidelines) to indicate a “significant, separately identifiable service”
  – Don’t include elements of the primary visit type in the determination of the level of E&M service
  – Add all managed and documented diagnoses subsequent to Z00.00/Z00.01 on the claim
  – Be sure to discuss member cost share with the member prior to delivering care
• Beginning March 1, 2018, Premera will no longer pay for the code S0250 previously used with the AWV to indicate management of 2 or more conditions
• Premera follows Medicare’s payment policies, which can be viewed at CMS.gov.
Part D Pharmacy
New MA pharmacy partner

- We’ve selected CVS Caremark to manage our part D pharmacy benefits
- Providence Health Plan previously managed this work for us
- We selected CVS Caremark because they best meet the needs for our Medicare Advantage Part D plans
- We’ll continue to use Express Scripts for our other lines of business
What’s changing?

• The Part D pharmacy network will change
• Credena Specialty pharmacy is no longer in our 2018 pharmacy network
• CVS Caremark is the 2018 mail order pharmacy
• Members are being notified of these changes by letter and (for specialty) by phone
• The Part D formulary will change
• Almost 100 commonly used medications were moved or added to Tier 1 (lowest cost sharing tier)
• Some drugs will become non-formulary; requiring members change to a different medication
• Members are being notified of these changes by letter
• Providers will have different phone and fax numbers for Premera Part D prior authorizations and appeal requests
• Providers will start to see communications from CVS Caremark sent on our behalf
Member ID card

- Members will receive new ID cards for 2018
- These cards will include information pharmacies need to fill 2018 prescriptions
- Providers should remind patients to bring their new ID card to the pharmacy the first time they fill their 2018 prescriptions
MA 2018 benefit updates
Diabetic supplies

Today, we cover two brands of blood glucose meters and strips (Accucheck® and OneTouch®)

• For 2018, One Touch® will be the exclusive preferred brand for diabetic supplies
• DME suppliers need to be aware of this change so they can be sure to provide our members with blood glucose meters and test strips from LifeScan to avoid added out-of-pocket costs
• Providers should check Provider News for more information
• Members using non-preferred diabetic supplies received a letter notifying them of this change the week of November 27
MA formulary (drug list)

- **The list of covered drugs** can be found online at premera.com/medicare-advantage/
- The list has been updated for 2018
- Drugs have been added or moved to lower tiers, some drugs are no longer preferred and have been removed from the MA formulary
- The formulary is also available on Epocrates ([www.epocrates.com](http://www.epocrates.com))
- Some drugs covered by Premera commercial plans aren’t on the list for the Medicare Advantage plans
- If you have questions about the MA drug list, call customer service at 888-850-8526
Formulary changes for drugs commonly used by our membership today

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<tr>
<th>Non-formulary as of January 1, 2018</th>
<th>2018 Preferred alternatives</th>
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<tbody>
<tr>
<td>Proair HFA®, Proventil HFA®</td>
<td>Ventolin HFA® (on formulary today)</td>
</tr>
<tr>
<td>Spiriva®</td>
<td>Incruse Ellipta® (on formulary today)</td>
</tr>
<tr>
<td>QVAR®</td>
<td>Flovent HFA® (on formulary today)</td>
</tr>
<tr>
<td>Dulera®</td>
<td>Advair® HFA, Breo Ellipta®, or Symbicort® (on formulary today)</td>
</tr>
<tr>
<td>Lialda®</td>
<td>balsalazide or mesalamine tablet DR (on formulary today)</td>
</tr>
<tr>
<td>Premarin® Tablets</td>
<td>estradiol tablets (on formulary today)</td>
</tr>
<tr>
<td>olopatadine 0.1% opth</td>
<td>azelastine 0.05% opth (on formulary today)</td>
</tr>
<tr>
<td>methocarbamol</td>
<td>cyclobenzaprine, tizanidine (on formulary today)</td>
</tr>
<tr>
<td>lansoprazole, rabeprazole</td>
<td>omeprazole, pantoprazole (on formulary today)</td>
</tr>
<tr>
<td>colchicine</td>
<td>Mitigare®, Colcrys® On formulary today: Colcrys®</td>
</tr>
<tr>
<td>candesartan, telmisartan</td>
<td>Irbesartan, losartan, olmesartan, valsartan (on formulary today)</td>
</tr>
<tr>
<td>clobetasol cream, ointment, solution</td>
<td>halobetasol cream/ointment (on formulary today)</td>
</tr>
<tr>
<td>Fluocinonide ointment</td>
<td>Betamethasone dip ointment (on formulary today)</td>
</tr>
<tr>
<td>Oxycontin®, oxycodone ER tablets</td>
<td>Morphine sulfate ER tablets, Nucyncta® ER</td>
</tr>
<tr>
<td>ibandronate 150mg</td>
<td>On formulary today: Morphine sulfate ER tablets</td>
</tr>
<tr>
<td>modafanil</td>
<td>amlodipine 70mg (on formulary today)</td>
</tr>
<tr>
<td>eszopiclone</td>
<td>Armodafanil, Coverage for this drug starts 1/1/2018</td>
</tr>
<tr>
<td>Humulin N®, Humulin R®, Humulin 70/30®, Humalog®</td>
<td>Novolin N®, Novolin R®, Novolin 70/30®, Novolog® Coverage for these drugs starts 1/1/2018</td>
</tr>
<tr>
<td>Lantus®, Toujeo® Solostar</td>
<td>Levemir®, Levemir® Flextouch, Basaglar® Kwipken, Tresiba® Flextouch</td>
</tr>
<tr>
<td></td>
<td>On formulary today: Levemir®, Levemir® Flextouch and Tresiba® Flextouch</td>
</tr>
</tbody>
</table>
Pharmacy network*

- We have a new 2018 Find a Pharmacy online tool to help customers locate pharmacies. They can also call customer service at 888-850-8526 for help finding a pharmacy in their area.
- Generally, members will pay less for medications at preferred pharmacies.

**Preferred Pharmacies**

- CVS Pharmacy
- Albertson’s Pharmacy
- Bartell Drug
- Costco Pharmacy
- Fred Meyer Pharmacy
- QFC Pharmacy
- Safeway Pharmacy
- Wal-Mart Pharmacy
- Yokes Pharmacy

**Standard Pharmacies**

- Rite-Aid Pharmacy
- Walgreens Pharmacy

* The above list is not a complete list of participating and/or preferred pharmacies.
Premera MA Mail Order Pharmacy

- CVS Caremark is the new network mail order pharmacy for Premera Medicare Advantage Plans starting 1/1/2018
- Mail order forms are available online on the www.premera.com/MA website
- More information on Mail Order services can be obtained by calling Customer Service at 888-850-8526
- Members may manage their mail order prescriptions, obtain benefit and formulary information and access forms by creating an account at www.premera.com/ma and choosing the Pharmacy tab
Premera MA Specialty Pharmacy

- CVS Specialty is the new preferred network Specialty Pharmacy for Premera Medicare Advantage Plans starting 1/1/2018
- [Specialty Pharmacy enrollment forms](#) are available online on the CVS Specialty website
- More information on Specialty Pharmacy services can be obtained by calling Customer Service at 888-850-8526
Requesting pharmacy prior authorizations

- Some drugs on the MA drug list require prior authorization; coverage criteria can be found online at [www.premera.com/medicare-advantage/](http://www.premera.com/medicare-advantage/)
- You can request a coverage determination for your patient by telephone, fax, or mail:
  - Phone: 844-449-4723 (NEW for 2018)
  - Fax: 855-633-7673
  - Mail:
    CVS Caremark Part D Appeals and Exceptions
    P.O. Box 52000, MC109
    Phoenix, AZ 85072-2000
- Coverage for medication not on the formulary needs a supporting statement from the provider for the exception review
- Additional information can be found online or by calling customer service at 888-850-8526
Medication therapy management (MTM)

- Members who meet specific criteria are enrolled in the Premera Blue Cross Medicare Advantage MTM program
- The program is designed to ensure members are using drugs that work best to treat their condition(s) and to help identify possible medication errors
- Members who choose to participate receive a comprehensive medication review from one of our pharmacists and are sent a medication list and action plan to discuss with their providers
- Additional information on this program will be included in the February 2018 Provider Newsletter
Part D vaccines

- Medicare coverage for vaccines is complicated
- Premera Medicare Advantage Plan encourages members to work with their provider and customer service to understand coverage for vaccines and avoid unexpected bills for vaccines given in the provider’s office
- Some vaccines, such as Zostavax® (shingles vaccine), are only covered with a member cost share under the member’s Part D prescription drug coverage
- Premera Medicare Advantage members will generally pay less for Part D vaccines when they are administered at an in-network preferred pharmacy
- If your patient needs help finding a pharmacy offering vaccine services, call customer service at 888-850-8526
- If you provide a Part D vaccine in office, the member will need to pay for the vaccine and submit a request to Premera for reimbursement
Quick Medicare Advantage pharmacy resources

- Formulary (Drug List)
- Medication Therapy Management (MTM)
- Prior authorization form for Part D drugs
- Pharmacy network (Find a Pharmacy website tool)
- General information on Pharmacy
Online provider tools
OneHealthPort login page
Select Medicare Advantage from OneHealthPort single sign-on page
New Medicare Advantage single sign-on page

Make your selection based on patient’s date of service
Medicare Advantage landing page
premera.com/wa/provider/medicare-advantage/

Make your selection based on patient’s date of service
Eligibility & Benefits

Please enter either member ID(s), or enter the date of birth and first and last names.

Select provider:
All Providers

First name

Member ID(s)

Date of birth

Last name

Group

Search
Clear
Eligibility & Benefits

To search for a member:

- Enter the Member ID (Multiple Member IDs can be entered. Press the 'enter' key after each Member ID)

or

- Enter the Last name, Date of birth (MM/DD/YYYY) and Group

or

- Enter the First name, Last name, Date of birth and Group

Click on member name to access plan details
Eligibility & Benefits details page
Claims & Payments

To search for a member claim:

- Enter a claim ID

or

- Enter the member ID, date of birth (MM/DD/YYYY), and a begin/end date

You can enter multiple claim ID’s. Be sure to hit the ‘enter’ key after each additional entry.

Select provider:
All Providers

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Search  Clear
Claims & Payment search

Click on claim number to access claim details
### Claims & Payments details page

**Claim #N6361900001**

- **Member name**: [redacted]
- **Dates of service**: 08/29/2017
- **Member ID**: 66666666600
- **Service provider**: [redacted]
- **Total charges**: $39.17

**Payment details**

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**Claim details**

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<th>HIPPA code</th>
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<th>Charges</th>
<th>Member responsibility</th>
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**Reason code descriptions**

- J7149 - PRESCRIPTIONS DISPENSED

**Disclaimer**

- THIS IS NOT A BILL
- Claim for Sam Jones

[View Explanation of Payment (EOP)]

**View EOP here**
Example of Explanation of Payment—page 1
# EXPLANATION OF PAYMENTS

Premera Blue Cross Medicare Advantage Plans  
P.O. Box 361396  
Plano, TX 75026

**Provider Name**  
Address Line 1  
Address Line 2  
City, State Zip

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<tr>
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<table>
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| Provider/Prof No: | 1234567  
| Employer name: | name  
| Employer Id: | 9999999999 |

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**EOC Codes: 123,456**  
**Denial Reason:** Text

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<tbody>
<tr>
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<td>$110.00</td>
<td>$3.62</td>
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**EOC Codes: 123,456**  
**Denial Reason:** Text

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$220.00 | $7.24  
$0.00 | $0.00  
$0.00 | $0.00  
$0.00 | $0.00  
$0.00 | $0.00  
$0.00 | $0.00  
$7.24

Interest Paid this claim:  
$0.00

Adjustment Amount this claim:  
$0.00

Total Paid this claim:  
$7.24

Paid by Primary Payer:  
$0.00

EOC Explanation  
123  explanation text  
456  explanation text
## Example of Explanation of Payment-page 3

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<tbody>
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**EOP Explanation**
- 123  explanation text
- 456  explanation text

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### This is an offset of a previously processed claim

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### Explanation of Check Adjustments

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<th>Refund</th>
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**Adjustment Reason:** 12345678900 38  Miscellaneous
Referral & Prior Authorization

Please check the prior authorization code list prior to submission to ensure your service requires prior auth.

Please check the applicable prior authorization code list, prior to submission to ensure your service requires prior auth. You’ll also need a login for AIM and Optum.
Prior Authorization Tool: Jiva

- Jiva website is accessed via Single Sign On (SSO) from the provider website.
- Jiva is the comprehensive Care Management tool used by Case Managers, Utilization Review RNs, and Customer Service Reps. It also includes websites for members and providers.
- Member-centric tool allows for a comprehensive view of a member’s recent procedures, hospitalizations, and clinical data.
- Use Jiva for:
  - Entering referrals
  - Inpatient (IP) and outpatient (OP) requests
  - Case Management (CM) requests
Provider website dashboard

Select “Menu” to initiate a new request:
Menu>New Request
Menu>Search Request

Information on specific requests, including status and type of request are available by clicking the indicative bar.
Dashboard functions

• Once a request has been created in Jiva, it’s defined as an episode
• Widgets are actionable boxes that help providers access alerts and requests
• From the dashboard, a provider views statistics of the episodes, including:
  – approval
  – denial
  – needs more information status
  – documented member contact
• Episodes are viewed by type, including:
  – Inpatient
  – Outpatient (OP)
  – Case Management (CM).
• Use the indicative bars on the dashboard for complete request or status details
Adding new requests for inpatient, outpatient, and care management

New requests are made by navigating to:

• Menu> Provider> New Request
• Member Overview> Add Request
• Menu> Search Request> Add New Request

Please Note: For requests including high-cost radiology, behavioral health, and services provided by delegated entities, providers will receive a hard-stop alert and be instructed to contact the vendor or delegated entity with any further questions.
Hard-stop alert: Behavioral Health

Message from webpage

This code should be reviewed by Optum. Please contact Optum at 855-339-8125 for further direction.
Hard-stop alert: High-tech radiology and cardiac procedures

Message from webpage

This code should be reviewed by AIM. Please contact AIM at www.aimspecialtyhealth.com for further direction.
Submitting an Inpatient (IP) Request

• An inpatient episode can include many service requests, but only one initial stay request
• IP episodes need to have admitting and treating provider and servicing facility attached
• If an IP request includes auto-approvable ICD-10 codes and/or CPT codes, and includes in-network providers with an appropriate length of service, it may auto-approve
• Otherwise, the episode pends for clinical review
Submitting an Outpatient (OP) Request

- Service requests are required for OP episode creation
- OP episodes need to have treating provider attached
- If an OP request contains CPT codes or HCPC codes which are not included on the prior authorization list, and the attached providers are seamless access providers (Partner Systems), the request may auto-approve (this is a referral)
- All providers can submit these requests
Prior Authorizations

- An authorization pends for “Clinical Review Required” if the stay or service codes exist on the Premera prior auth list
- The request is received by the Utilization Management team and is reviewed using InterQual™ Clinical Criteria (a tool embedded in the Jiva Nurse Portal)
- Providers see a decision based on the designated turnaround time for Expedited (up to 72 hours), Standard (up to 14 days), or Retrospective Requests (30 days)*
  *Generally; although some exceptions may exist.
- For all types of requests, medical records can be attached. Necessary fields are indicated with an asterisk* (no character limit)
Referrals to case management

- Referrals are created using the same steps for creation of inpatient/outpatient authorizations. Select Case Management for a new episode
- Creating a new episode ensures that Case Management RNs will perform outreach to the member and manage them for specific conditions. These episodes help the RNs coordinate and monitor care in order to achieve optimum health outcomes
- Providers access Case Management episodes by performing a member search and navigating to the member-centric view (MCV) screen of the required member
- Clicking the corresponding then click “Open” to see the episode
Resources

Here you’ll find additional resources to help you as a Premera Medicare Advantage Provider.

- View Medical and Pharmacy Policies
- Learn more about partnering with Premera while caring for Medicare Advantage Patients
- View all Medicare Advantage forms
- Reference Manual
- Forms
Medical, Payment, and Pharmacy Policies

Medical, Payment, and Pharmacy Policies:

Premera Blue Cross is using strict policies for its Medicare Advantage plans and has updated its medical, payment, and pharmacy policies.

You can link to the policies here:

- Prior Authorization List
- Pharmacy
- Ambulatory Surgical Services and Mobile General Surgery
- Applicable Services and Reimbursement for Mental Health
- Anti-Inflammatory Drugs
- Bone, Joint, and Muscle
- Cancer Care
- Chronic Kidney Disease
- Dialysis
- (Continued...)

Pharmacy Part B

- Drugs for Medical Benefits
- Drugs for Medical Benefits
- Self-Administration Drugs
- Self-Administration Drugs
- Medicare Part B Covered Drugs
- Medicare Part B Covered Drugs
- Medicare Part B Drugs

Terms and Conditions: Policy Documents/Privacy Agreement

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Primary Care Provider Roster

Use this tool to search members assigned to individual providers as their PCP within your clinic.

- Select an individual provider from the drop-down menu and click search.
- PCP roster is updated daily.
- Annual Wellness Visit information provided individually.
## Reporting website issues

<table>
<thead>
<tr>
<th>Description of Issue</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Medicare Advantage homepage, Find A Doctor, and forms</td>
<td>800-722-9780</td>
</tr>
<tr>
<td><strong>2018</strong> Medicare Advantage secure pages and online tools</td>
<td>888-850-8526</td>
</tr>
<tr>
<td><strong>2017</strong> Medicare Advantage secure pages and online tools</td>
<td>855-339-8141</td>
</tr>
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</table>
Resources
Contact us

Call customer service at 888-850-8526, 8 a.m. to 8 p.m., Monday through Sunday, for help with:

• General information
• Member benefits verification
• Member eligibility confirmation
• Claims payment, payment vouchers, or remittance assistance
• Pharmacy Part B policy questions
• Provider network status confirmation
• Formulary questions
Contact us

Call Physician and Provider Relations, 8 a.m. to 5 p.m., Monday through Friday, at 877-342-5258, option 4, for help with:

- Billing, practice, or remittance address changes
- Practice location additions
- Tax identification number updates
- Adding/deleting a provider at your office
- Application and contract requests
- Contract status verification
- Copies of past communications
Contact us

- Quality Medical Management, call 855-339-8127 (after hours, 866-322-6287)
- Prior authorizations, call 855-339-8127
- Medical and payment polices, call: 855-339-8130