2013 Nevada Medicare Advantage Update

Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2013. The changes apply to members enrolled in Anthem Medicare Preferred Core (LPPO). You can help members manage their health care costs by being aware of these changes. In addition, it is important to check the Medical ID card at the beginning of each calendar year as the member may have changed plans.

Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS). CMS re-evaluates and approves the benefits we’ll offer to our Medicare Advantage members for the upcoming year.

Notable 2013 benefit changes and highlights.

Anthem Medicare Preferred Core (PPO) plan changes
- The Anthem Medicare Preferred Core (PPO) will no longer be offered in 2013.
- Members currently enrolled in Anthem Medicare Preferred Core (PPO) residing in Clark and Washoe counties will no longer have this plan available to them in 2013.
- Members in Washoe county will be able to enroll in the new Anthem Medicare Preferred Standard (PPO).

Anthem Medicare Preferred Standard (PPO)
- In 2013 we will be offering a new PPO plan. Anthem Medicare Preferred Standard (PPO) will be available in the following counties: Washoe.

Anthem Medicare Preferred Standard (PPO) plan highlights
- $10 copay for Primary care physician (PCP) visits and $30 copays for specialist visits.
- Anthem Medicare Preferred Standard (PPO) plan participates in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain network-level benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider. You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the “MA” in the suitcase, which indicates the member is covered under the MA PPO network sharing program. In 2013 the states of New Jersey and Texas have been added to the service area.
- $0 copay for Medicare-covered Preventive Care.

Group/Union Sponsored Plans may not be impacted by most of the changes described above for PPO plans including reductions to the plans service areas. Our members in Group/Union Sponsored Medicare Advantage LPPO Plans will continue to enjoy access to health plan services nationally.
Optional Supplemental Benefits (OSB)
For 2013, many of our Medicare Advantage plans will be offering three Optional Supplemental Benefit (OSB) packages for an additional premium. These packages will allow the Medicare Advantage plan to be tailored to add additional dental, vision, chiropractic and acupuncture coverage by enrolling in an OSB package. Anthem will offer the following Optional Supplemental Benefit (OSB) packages on select plans in which members will have up to 90 days from their plan effective date to enroll. New for 2013 will be the removal of the 10 visit limit on chiropractic and acupuncture benefits, but the yearly dollar cap for these services will still apply.

1.) Preventive Dental Package
2.) Comprehensive Dental and Vision Package
3.) Combination Package (includes dental, vision, chiropractic, and acupuncture).

Medicare Part D Prescription drug coverage changes (applicable to plans with Part D coverage)
- Initial Coverage Limit (ICL) for Medicare Part D will increase from $2,930 to $2,970.
- TROOP amount will increase from $4,700 to $4,750.
- During the Catastrophic Coverage Phase: Members will pay 5% or $2.65 whichever is more for generic drugs, and members will pay 5% or $6.60 for brand drugs.

Group/Union Sponsored Plans are not impacted by the changes described above for Pharmacy plans.

In 2013, when a member reaches the gap for Medicare Preferred Standard (PPO), they will be expected to pay a 79% coinsurance for all generics, or a 47.5% coinsurance (plus a portion of the dispensing fee) for their brand drugs until they reach the catastrophic phase.

Help your patients get the best buy—each year—for their health care needs

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: actual formulary change, tier name changes, the tier that a drug may sit on, drug removals, and new Prior Authorization, Step Therapy and Quantity Limit requirements. Your patients experiencing formulary changes will likely want to discuss their options with you. They will need your help to ensure they get their needed treatments at the most affordable cost.

Encourage your patients to review the 2013 formulary information within their Annual Notice of Change (ANOC) mailing, or to view the information online when it is available, beginning October 1, 2012. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meets their need.

Balance Billing Reminder:
The Centers for Medicare and Medicaid Services and our plan does not allow you to “balance bill” Medicare Advantage HMO and PPO members for Medicare covered services. CMS provides for an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan’s cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an
amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service and includes charges that are in dispute.

Here is how this protection works.

- If the member cost sharing is a copayment (a set amount of dollars, for example, $15.00), then the member pays only that amount for any services from a network provider. Copayments may be higher for services performed by an out-of-network provider.

- If the member cost sharing is a coinsurance (a percentage of the total charges), then the member never pays more than that percentage. However, the cost depends on the type of provider:
  - If the member obtains covered services from a network provider, the member pays the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
  - If the member obtained covered services from an out-of-network provider who participates with Medicare, then the member pays the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
  - If a member obtains covered services from a provider who has opted out of Medicare, then the plan will not pay for these services, and depending upon the circumstances, the member may be liable for the entire amount.

**New Hampshire Member ID Card Prefix Will Change**

Effective January 1, 2013, retirees covered by our Medicare Advantage plans based in New Hampshire will receive new ID cards. The new prefix for these retirees will be “YGJ”. Please note the claims address does not change; you should continue to submit claims to your local Anthem Plan for processing. Providers should reference the member’s ID card for changes at every visit to help ensure proper billing. You can also assist your patients by passing on any ID card prefix or benefit change information to any ancillary providers who will be asked to serve your patient.

Employer or Union Sponsored Group Medicare Advantage plans may not be impacted by most of the changes to services areas, plan names and benefits described above. For Employer or Union Sponsored Group members, please refer to the members Evidence of Coverage or call Provider Services at the number on the back of the member ID card for more benefit details. Providers should reference the member’s ID card for changes at every visit to help ensure proper billing. You can also assist your patients by passing on any ID card prefix or benefit change information to any ancillary providers who will be asked to serve your patient.
Medicare Advantage: The Annual Wellness Visit

What Providers Should Know

The Annual Wellness Visit (AWV) was a new benefit effective on all plans January 1, 2011. Beneficiaries new to Medicare will continue to be covered under the once in a lifetime "Welcome to Medicare" exam. However, now all beneficiaries are covered for the AWV every 12 months.

What codes are billed for the AWV?
For the first visit, providers should bill G0438 for the AWV which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWV and Personalized Prevention Plan Service, subsequent visit.

Routine Physical Exams and the Annual Wellness Visit
Medicare Advantage plans may offer extra supplement benefits that could include a routine physical exam. Providers should check with the plan to confirm if this is an extra benefit on the member’s plan before billing. The codes for the routine physical (under preventive services) include: CPT code range 99381 through 99397. These codes are not covered by original Medicare and may not be an extra benefit on the member’s plan.

However, all Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

What if additional services are provided at the same time as the AWV?
If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.

Prior authorization updates for Medicare Advantage Plans.
A list of the 2013 prior authorization requirements will be posted in December to the Medicare Advantage Provider Portals. Please reference the document: Medicare Advantage 2013 Precertification Requirements; for the list of precertification requirements. The most current list of Precertification Requirements can be found at www.anthem.com/medicareprovider or applicable website such as www.empireblue.com/medicare.

Private Fee For Service Claims
Anthem Blue Cross and Blue Shield discontinued sales of Medicare Advantage Private Fee for Service (PFFS) plans as of 12/31/11. We will continue to provide run out services for original timely claims as well as provider submitted adjustments through 12/31/12.
Please review any PFFS members’ you may have seen to determine if claims submissions or adjustment requests and submit them for payment by October 1, 2012 to ensure claims and adjustments are reviewed and processed prior to 12/31/12.

The claims submission, adjustment request, and Grievance and Appeal addresses will remain the same during this run-out period. The dedicated PFFS Provider Service will also be available for questions regarding PFFS claims processing through 12/31/12.

Please visit our website at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) for more detailed product information or contact Provider Services at the number on the back of the member’s ID card. You can find important Medicare Advantage updates in the Plan & Administrative Changes/Update section. Contact your provider representative for participation details for our contracted plans.

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