

Provider Update

2016 New Jersey Medicare Advantage Plan Changes

Annual benefit changes for our Medicare Advantage plan members will be effective January 1, 2016. Each year, we renew our contract with the Centers for Medicare and Medicaid Services (CMS) and CMS re-evaluates and approves the benefits we'll offer to our Medicare Advantage members for the upcoming year.

The below changes apply to our 2016 Medicare Advantage plans. You can help members manage their health care costs by being aware of these changes.

Notable 2016 benefit changes and highlights:

- In 2016 Amerivantage Specialty + RX (HMO SNP) is changing its name to Amerivantage Dual Coordination (HMO SNP). Please note: Although "+ Rx" will be removed from the plan name, this plan will continue to offer Part D Prescription Drug coverage.
- 2016 Plans may have changes to Medical and Part D benefits, formulary coverage, and pharmacy network. Please check the member's benefits for the new Plan year changes by visiting our website at <https://www.myamerigroup.com/Medicare2016/Pages/New%20Jersey/NewJersey.aspx> or calling provider services at 1-866-805-4589.
- Preventive dental services and routine eye services will not be covered under Amerivantage Dual Coordination (HMO SNP)'s Medicare benefit in 2016. Members will continue to receive coverage under their Medicaid benefit through the integrated benefit of this plan.
- Our Medicare Advantage plans provide supplemental transportation services. Covered trips may be used for preventive and routine services.
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

New Plans and Service Area Changes:

- The Amerivantage Dual Coordination (HMO SNP) will be expanding into the following counties: Atlantic, Cumberland, Gloucester, Mercer, and Morris counties.

Diabetic Supplies:

Effective January 1, 2016, all of our Medicare Advantage plans will only cover certain lancets if they are purchased at one of our network pharmacies or through our mail-order service. Lancets will be limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug



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Centers, Dillon Companies, Ralph, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor.

Members will be covered for up to 100 lancets per month.

Members impacted by this change will be notified in October through their Annual Notice of Change and Evidence of Coverage plan benefit materials.

To be covered at a \$0 copay, the members must purchase these supplies at an in-network retail or mail-order pharmacy supplier.

As a reminder, providers that participate in a delegated arrangement with the health plan are responsible for the provision of services as indicated in the Division of Financial Responsibility (DOFR) section of the provider group's contract or services agreement. If your provider group participates in a delegated arrangement, please remember that diabetic test strips and Part B drugs must be supplied at the provider's office and not through a retail pharmacy or mail-order service.

New Year! New Formulary Changes!

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: tier changes, drug removals, and new Prior Authorization and Quantity Limit requirements.

Your patients will have formulary changes and will need your help to ensure they get their needed treatments at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online when it is available, beginning October 1. 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 meet their needs.

Balance Billing Reminder:

The Centers for Medicare and Medicaid Services and our plan do 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



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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. This also includes charges that are in dispute.

Amerivantage Dual Coordination (HMO SNP):

To fulfill state and federal contractual requirements, this plan applies the Medicare statutory amounts to Medicare covered services. The remaining Medicare Advantage deductible, coinsurance or copayment amounts are then applied to the members' Medicaid benefits; those claims are processed subject to Medicaid processing guidelines.

Under Medicaid, additional payment may be available dependent upon the Medicaid rate of reimbursement. If the Medicaid rate of reimbursement is more than the filed Medicare benefit, the difference will be paid to the provider. If the Medicaid rate is less than what the filed Medicare benefit has already paid on that claim, no additional payment will be made. Providers are prohibited from balance billing members for any portion of that Medicare cost share that is deemed not covered under their Medicaid benefit.

What Does the Annual Wellness Visit (AWV) Cover?

All of our 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.

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 for subsequent visits.

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:

Providers are required to periodically review and comply with the latest Medicare Advantage Prior Authorization requirements found at <https://providers.amerigroup.com/Pages/PLUTO.aspx>

Referral Process Updates for our Medicare Advantage Plans:



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In most situations, our members may need to receive a referral from their PCP before they can use specialists in the Plan's network. Examples of specialists include Cardiologists, Dermatologists, Orthopedic surgeons, Oncologists and Urologists. However, referrals from a PCP are not required for emergency care or urgently needed care. There are also other kinds of care members can obtain without having approval in advance from their PCP.

Please visit our website at <https://providers.amerigroup.com/pages/nj-2012.aspx> 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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Amerivantage is a DSNP plan with a Medicare contract and a contract with the State Medicaid program. In New Mexico: Amerivantage is an HMO with a Medicare contract. Enrollment in Amerivantage depends on contract renewal.

*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup, Texas, Inc. In Washington, Amerigroup Washington, Inc.



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