

Provider Update

2015 New Mexico Medicare Advantage Plan Changes

Dear Healthcare Provider,

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2015. 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 members enrolled in the Amerivantage Classic + Rx HMO plan. You can help members manage their health care costs by being aware of these changes. In addition, remember to check the Member identification card at the beginning of each calendar year, as the member may have changed plans.

Notable 2015 benefits changes and highlights by plan type.

Amerivantage Classic + Rx (HMO) Highlighted Plan Changes

- 2015 Plans may include changes to Medical and Part D benefits, copayments and/or coinsurance, deductibles, formulary coverage, pharmacy network, premium and out-of-pocket maximums. Please check the member's benefits for the new Plan year changes, by visiting our website at <http://www.myamerigroup.com/Medicare2015/Pages/New%20Mexico/NewMexico.aspx> or calling Provider Services at 1-866-805-4589.
- Our plan will no longer cover unlimited inpatient days for acute care illness, injury or psychiatric care.
- This plan will offer a new benefit called LiveHealth Online. LiveHealth Online provides convenient access for members to interact with a doctor via live, two-way video on a computer or mobile device.
- Preventive dental consisting of 2 exams, 2 cleanings, and 1 x-ray at a \$0 copay will be a new benefit offering in 2015.
- This plan will offer one routine physical exam in addition to the Medicare-covered "Welcome to Medicare" exam or Annual Wellness Exam. The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient's age, gender, and identified risk factors; face-to-face visit. The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors. It also includes clinical laboratory tests. Providers should bill 99381-99397 (Preventive Medicine Services) for the routine physical exam. When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member's plan.



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- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

Service Area Changes:

- The Amerivantage Classic + Rx (HMO) service area is expanding to Sierra County for 2015.
- The Amerivantage Specialty + Rx (HMO-SNP) will be non-renewing for 2015. The Amerivantage Classic + Rx (HMO) will continue to be offered.

Diabetic Supplies:

Effective January 1, 2015, all of our individual Medicare Advantage plans will only cover certain diabetic supplies if they are purchased at one of our network pharmacies or through our mail-order service. Durable Medical Equipment (DME) providers as well as physicians will no longer be able to bill for these supplies.

HCPC codes that will no longer be covered when purchased through a DME provider or other physicians:

- A4253 blood glucose test strips
- E0607 home blood glucose monitor
- E2100 blood glucose monitor with integrated voice synthesizer
- E2101 blood glucose monitor with integrated lancing/blood sample

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

Covered blood glucometers and blood glucose test strips in 2015:

- ✓ LifeScan, Inc., OneTouch®
- ✓ Roche Diagnostics, ACCU-CHEK®
- ✓ A limit of 100 blood glucose test strips per month

Other blood glucometer or blood glucose test strip brands or quantities of more than 100 test strips per month are not covered unless you as the doctor or provider tell us another brand or a larger quantity is medically necessary for the member's treatment, no other brand or larger quantity limit will be covered.

- If our member is currently using LifeScan, Inc., OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products and using



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an in-network retail or mail-order pharmacy supplier, you don't need to do anything!

- If our member is not using LifeScan, Inc, OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products or using an in-network retail or mail-order pharmacy supplier, then our member will need to get new prescriptions for the supplies by January 1st for these claims to be covered by us.
- You should discuss these coverage changes and possible new prescriptions with our member/your patient. If it is medically necessary for them to continue using a different brand of blood test strips or glucometer and/or more than 100 blood test strips per month, you will need to communicate this to us by requesting an exception. If your patient purchases their supplies through the pharmacy or the ESI mail-order service exceptions may be requested by calling 1-800-338-6180.

New Year! New Formulary!

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 2015 formulary information within their Annual Notice of Change (ANOC) mailing, 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.

Pharmacy Network Changes:

For 2015 plans will be moving from the Caremark pharmacy network to ExpressScripts. The Express Scripts pharmacy network includes preferred and other network retail pharmacies. Members save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include CVS/Pharmacy (participating pharmacies include CVS and Longs Drugs), Giant Eagle Pharmacy, Hannaford Brothers (participating pharmacies include Hannaford and Food Lion), Harris Teeter Supermarkets, Kroger (Kroger Co. participating preferred pharmacies include Kroger, Fred Meyer, King Soopers, City Market, Fry's, Smith's, Dillons, Ralph's, QFC, Baker's, Scott's, Owen's, Pay Less, Gerbes and JayC), Target and Wal-Mart (Walmart participating preferred pharmacies include Walmart, Neighborhood Market and Sam's Club. Members can fill a



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prescription at a network retail pharmacy, but their cost-sharing amount may be higher.)

*Note regarding members on a SNP plan: Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. Members in a SNP plan may go to either type of network pharmacy to receive their covered prescription drugs. Their costs will be the same if they use a pharmacy that offers standard cost sharing or a pharmacy that offers preferred cost sharing.

The 2015 Rx Benefit changes include:

- Tier 6 has select care drugs at a \$0 for the following conditions: high blood pressure, high cholesterol and diabetes and will have the following drugs on it: GLIPIZIDE, LISINOPRIL, LOSARTAN POTASSIUM, METFORMIN HCL, and SIMVASTATIN.
- All plans must contact ESI for prior authorizations on Part D drugs. Exceptions may be requested by calling 1-800-338-6180.

Insulin Exclusivity:

As a reminder for 2015 Individual MAPD plans have an insulin exclusivity contract with Eli Lilly, the manufacturer of Humulin and Humalog human insulins. Other insulins are considered non-formulary and are not eligible for coverage.

Balance Billing Reminder:

The Centers for Medicare and Medicaid Services and our plan does not allow you to “balance bill” Medicare Advantage HMO 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. This also includes charges that are in dispute.

Here is how this protection works for Amerivantage Classic + Rx HMO:

If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.



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If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see.

If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan). If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

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.

What Does the Annual Wellness Visit Cover?

All of our Medicare Advantage plans cover the AWW. 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 AWW which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWW and Personalized Prevention Plan Service, subsequent visit.

What if Additional Services Are Provided at the Same Time As the AWW?

If other evaluation and management services are provided in conjunction with the AWW, 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;



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<https://providers.amerigroup.com/Pages/PLUTO.aspx>

Referral Process Updates for Individual Medicare Advantage Plans:

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/nm-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 an HMO plan with a contract with the New Mexico Medicare program. Enrollment in Amerivantage depends on contract renewal.

