

## CHAPTER 2: PRODUCT INFORMATION

### UNIT 2: MEDICARE ADVANTAGE PRODUCTS AND PROGRAMS

IN THIS UNIT



TOPIC	SEE PAGE
Introduction	2
Highmark Medicare Advantage Products	6
Prescription Drug Coverage Under Medicare Advantage	9
Dual Eligibility Under Medicare and Medicaid	11
TruHearing Hearing Aid Benefit Program	14
House Call Program for Medicare Advantage	17
Annual Wellness Visit (AWV)	18
Select DME Network (PA Only)	20
Medicare Advantage PPO Network Sharing	21

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

OBSOLETE

## 2.2 INTRODUCTION

What Is My Service Area?

### Background



Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant, sometimes referred to as ESRD). Medicare has:

- **Part A Hospital Insurance** that helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care), hospice care, and some home health care.
- **Part B Medical Insurance** that helps cover certain doctors' services, outpatient care, medical supplies, and preventive services.
- **Part D Prescription Drug Coverage** is an optional benefit for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare.

In an effort to make broader and more cost-effective coverage options available to people eligible for Medicare, the Centers for Medicare & Medicaid Services (CMS) created "**Medicare Part C.**" This term includes a wide variety of delivery models, 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.

These plans, known as "**Medicare Advantage**" programs, are offered by private companies that contract with Medicare to provide members with Part A and Part B benefits. Most Medicare Advantage plans also offer prescription drug coverage. Medicare Advantage Plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service Plans (PFFS), Special Needs Plans, and Medicare Medical Savings Account Plans (MSAs).

### Enrollment and benefits



To enroll in a Medicare Advantage plan, members must have both Medicare Part A and Part B and continue to pay their Medicare Part B premium, as well as their Part A premium if they have one (most people receive premium-free Part A because they paid Medicare taxes while working). 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.

Medicare Advantage plans may also have a premium, although Highmark does provide premium-free options. Deductibles, coinsurance, and copayments all vary based on the plan the member has chosen.

While a person is a member of Medicare Advantage, services are not paid by Traditional Medicare *except* for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.

*Continued on next page*

## 2.2 INTRODUCTION, Continued

### Enrollment and benefits (continued)



At a minimum, Medicare Advantage programs are required to provide coverage for the services covered by Traditional Medicare's Part A and Part B coverage. They may also provide additional services and benefits such as routine dental and vision.

[What Is My Service Area?](#)

### 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 Centers for Medicare & Medicaid (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 ten (10) years;
- That the Medicare Advantage organization oversees and is accountable to CMS for any functions and responsibilities described in the Medicare Advantage 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 Medicare Advantage organization and the Medicare Advantage program.

For more information on specific CMS regulations, please visit [cms.gov](https://www.cms.gov).

**Note:** From time to time, CMS will issue coverage of payment directives that are subject to the terms of the Medicare Advantage plans' agreements in place with their participating providers. In those cases, Highmark will review our Medicare Advantage Provider Agreements and will determine whether the terms of the Medicare Advantage Provider Agreements will take precedence over the CMS directive. If Highmark, upon review of the Medicare Advantage Provider Agreement, makes the determination to reimburse pursuant to the CMS payment directive, such reimbursement will be subject to the terms of the Medicare Advantage Provider Agreement, any applicable administrative requirements, and any outcome-related goals as established by CMS and Highmark, collectively or individually.

*Continued on next page*

## 2.2 INTRODUCTION, Continued

### Compliance language and EOC booklets



Medicare Advantage Compliance Language and Member Evidence of Coverage (EOC) Booklets are available in the Appendix of the *Highmark Provider Manual*.

To access the Appendix, scroll down to the bottom of the manual's home page, click on the down arrow in the **ADDITIONAL RESOURCES** box, and then click on the **Appendix** link.

[What Is My Service Area?](#)

### Medicare Advantage HMO Network Sharing for Transplant Services—effective January 1, 2018



Blue Cross Blue Shield Association (BCBSA) policy, **effective January 1, 2018**, requires Blue Plans that offer Medicare Advantage HMO products to participate in network sharing for transplant services. Under the policy, Blue Plans with Centers for Medicare & Medicaid Services (CMS) approved transplant facilities included in their Medicare Advantage HMO networks are required to share contracted rates for transplant services with out-of-area Blue Plan Medicare Advantage HMO members.

Medicare Advantage HMO Network Sharing for Transplant Services will provide in-network access to all Blue Plans' Medicare Advantage HMO provider networks for Blue Plan Medicare Advantage HMO members who may require a transplant service outside of their home Plan's licensed service area.

**Beginning January 1, 2018**, transplant facilities participating in Highmark's Medicare Advantage HMO networks in Pennsylvania will be reimbursed according to their contracted Medicare Advantage HMO rate for approved transplant services for out-of-area Blue Plan Medicare Advantage HMO members. If you are a contracted Highmark Medicare Advantage HMO provider, you must provide the same access to transplant services for members of other Blue Plan Medicare Advantage HMO plans as you do for Highmark's Medicare Advantage HMO members. These members will receive in-network benefits for approved transplant services in accordance with their plan's in-network benefits, with any applicable member cost sharing applied.

### Geriatric Resource Binder



The Geriatric Resource Binder, developed by Highmark's Geriatric Advisory Board Committee, is a comprehensive resource designed to help health care professionals assess problematic areas in the older adult population.

To access the **Geriatric Resource Binder** on the Provider Resource Center, select **EDUCATION/MANUALS** from the main menu.

*Continued on next page*

## 2.2 INTRODUCTION, Continued

---

### Highmark Passport



The Highmark Passport is a custom-designed three-ring binder with valuable information provided to Medicare Advantage members to help plan and track their health care needs and services. Members are mailed information specific to their individual needs throughout the year and encouraged to add these materials to their Passport binder.

The Highmark Passport stresses the critical role providers play in helping our members stay well and manage their health conditions. Members are encouraged to take the Highmark Passport to their provider visits to assist them in keeping their health records up to date, including taking notes of your instructions and recommendations.

In addition, the Passport Rewards program rewards our Medicare Advantage members for taking the right steps toward better health and well-being.

You can access a sample online version of the Highmark Passport, as well as additional Medicare Advantage information, on the Provider Resource Center in NaviNet®. Log in to NaviNet, and then select **Resource Center** from the Highmark Plan Central menu. Select **VALUE-BASED REIMBURSEMENT PROGRAMS** from the Provider Resource Center main menu, and then **Medicare Advantage Stars/ Medicare Advantage Member and Provider Programs**.

---

[What Is My Service Area?](#)

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS

### Overview



Highmark offers the following Medicare Advantage products:

- Freedom Blue PPO – offered by Highmark Senior Health Company in the Western, Central, and Northeastern Regions of Pennsylvania, and by Highmark Senior Solutions Company in West Virginia.
- Community Blue Medicare HMO – a select network product administered by Highmark Choice Company is offered in select counties in Pennsylvania’s Western, Central, and Northeastern Regions.
- Community Blue Medicare PPO -- these plans are administered by Highmark Senior Health Company and are available in select counties in Pennsylvania’s Western, Central, and Northeastern Regions.
- Community Blue Medicare Plus PPO – this plan, also administered by Highmark Senior Health Company, offers exclusive access to Geisinger Danville facilities and doctors and is offered only to members living in Clinton, Lycoming, Sullivan, and Tioga counties in Pennsylvania.
- Security Blue HMO – offered in 28 counties of Pennsylvania’s Western Region by Highmark Choice Company.

[What Is My Service Area?](#)

### Freedom Blue PPO



Freedom Blue PPO is a Medicare Advantage Preferred Provider Organization plan. To enroll in Freedom Blue PPO, a member must have both Medicare Part A and Part B and must reside in the service area.

- In Pennsylvania, Freedom Blue PPO is administered by Highmark Senior Health Company and is available in a 62-county service area (all Pennsylvania counties except Bucks, Chester, Delaware, Montgomery, and Philadelphia).
- In West Virginia, Freedom Blue PPO is offered by Highmark Senior Solutions Company in a 33-county service area.

Freedom Blue PPO offers members a choice of where they receive in-network care throughout the Freedom Blue PPO network and from providers who participate in other Blue Plan Medicare Advantage PPO networks in 35 states and Puerto Rico. Members also have access to covered services out-of-network, both in area and out-of-area. Freedom Blue PPO members are not required to select a PCP; however, they are encouraged to select a Physician of Record, such as a primary care practice that will provide routine care and coordinate specialist care.

Freedom Blue PPO provides coverage for all of the member’s health care needs, including medical, prescription drugs, routine dental, vision, hearing, and preventive care. Members are responsible for paying any applicable cost sharing for covered services. Renal dialysis services are covered at 100 percent, on a temporary basis, while outside the 62-county service area.

*Continued on next page*

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS, Continued

### Community Blue Medicare HMO



Community Blue Medicare HMO is a select high-value network product that offers high quality at a lower cost for seniors and administered by Highmark Choice Company. Members must seek care from providers participating in the Community Blue Medicare HMO network, with the exception of urgent and emergency care.

To enroll in Highmark's Community Blue Medicare HMO, a member must have both Medicare Part A and Part B and must reside in the service area.

- Community Blue Medicare HMO is offered in most counties in western Pennsylvania and features a select high value network of Allegheny Health Network and other community doctors and hospitals. Individuals who select this option will have a choice between two plans – Signature and Prestige (both include Part D prescription drug coverage).
- Community Blue Medicare HMO is also available in select counties in central and northeastern Pennsylvania. The product features a local network of 23 hospitals and more than 4,800 physicians. A shared network in select western Pennsylvania locations is available to members traveling across the state.

**PLEASE NOTE: The Community Blue Medicare HMO network differs from the network associated with the commercial Community Blue products.**

Community Blue Medicare HMO participating providers can be located by searching the Provider Directory in the applicable service area.

[What Is My Service Area?](#)

### Community Blue Medicare PPO

**New in 2018!**



Effective January 1, 2018, Community Blue Medicare PPO plans, administered by Highmark Senior Health Company, are available in 27 counties of western Pennsylvania as well as 27 counties in the Central and Northeastern Regions of Pennsylvania. As with other Medicare Advantage products, a member must have both Medicare Part A and Part B and must reside in the service area.

Community Blue Medicare PPO has a broader network of providers than Community Blue Medicare HMO and provides flexibility to use out-of-network providers. It also provides more freedom for members who travel by providing in-network cost sharing when members use Medicare Advantage PPO participating providers of other Blue Plans.

The benefit design and cost sharing for the Community Blue Medicare PPO Signature plans are similar to Community Blue Medicare HMO.

*Continued on next page*

## 2.2 HIGHMARK MEDICARE ADVANTAGE PRODUCTS, Continued

### Community Blue Medicare Plus PPO

**New in 2018!**



Community Blue Medicare Plus PPO, effective January 1, 2018, provides the same level of benefits as Community Blue Medicare PPO, with the addition of exclusive access to Geisinger Danville facilities and doctors. It also provides coverage for out-of-network hospitals and physicians at a higher level of cost sharing for the member.

Administered by Highmark Senior Health Company, this plan is available to members who reside in the limited service area, which includes Pennsylvania's Clinton, Lycoming, Sullivan, and Tioga counties.

[What Is My Service Area?](#)

### Security Blue HMO-- PA Western Region ONLY



The Medicare Advantage HMO product, available only in Pennsylvania's Western Region, covers all Medicare-covered Part A and Part B benefits, including preventive care, doctor visits, hospital stays, and more. In addition, members get added benefits like routine dental, vision, and hearing care. Members have the option to choose a plan that includes Part D Prescription Drug coverage, giving them access to all drugs allowed by Medicare.

Security Blue HMO members choose a primary care physician (PCP) who coordinates care with network participating specialists and facilities when necessary.

To enroll in Highmark's Security Blue HMO, a member must reside in the 28-county Western Region service area. Members are required to receive care from the network of participating providers in the 28 counties, *except* in emergencies.



## 2.2 PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE

[What Is My Service Area?](#)

### Overview



Medicare Advantage HMO and PPO products provide Medicare 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).

### Part B prescription drug coverage



Medicare Part B covers certain types of injectable and infusible drugs that are not usually self-administered. These include drugs that are furnished and administered as part of a service performed by a health care professional.

Highmark's Medicare Advantage products also cover such drugs which can be categorized as follows:

- Drugs that include substances naturally present in the body, including blood clotting factors and insulin
- Clotting factors for patients with hemophilia
- Immunosuppressive drugs for patients who have had an organ transplant covered by Medicare
- Injectable osteoporosis drugs, for homebound patients with a bone fracture certified by a physician as related to post-menopausal osteoporosis
- Chemotherapy
- Drugs administered during outpatient dialysis, such as heparin, heparin antidote, topical anesthetics, erythropoietin (EpoGen) or Epoetin Alfa and Darboetin Alfa
- Certain oral anti-cancer drugs and anti-nausea drugs
- Intravenous immune globulin for the home treatment of primary immune deficiency diseases

Highmark provides a link on the Provider Resource Center to the Centers for Medicare & Medicaid (CMS) Medicare Part B Drug website. This website includes the Medicare Part B Drug Regulations, the Medicare Part B Drug Average Sales Price (ASP) tables, which are updated quarterly, and the quarterly ASP NDC-HCPCS Crosswalks. To access this information from the Provider Resource Center, select **PHARMACY PROGRAM/FORMULARIES** from the main menu, and then **Pharmacy Information**. Select the third bullet, Medicare Part B Drug Average Sales Price, on the Pharmacy Information page.

### Authorization may be required



Some Medicare Part B drugs require authorization. Please check the **List of Procedures/DME Requiring Authorization** available on the Provider Resource Center – access the list quickly by selecting **REQUIRING AUTHORIZATION** from the **Quicklinks Bar**

*Continued on next page*

## 2.2 PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE, Continued

### Purchasing Part B prescription drugs



There are several network specialty pharmacies and durable medical equipment (DME) vendors from which members can choose. Participating specialty pharmacies and DME vendors can be located through the provider search function available on the regional member websites accessible via [highmark.com](http://highmark.com) (select the **FOR MEMBERS** tab).

Choose the appropriate region, and then select the link titled **FIND A DOCTOR OR RX**, and then click on **Find a Doctor, Hospital or other Medical Provider**. Once in the *Provider Directory*, select **Medical Supply & Services** as the search option.

Medicare Advantage members are **not** able to purchase any Part B drugs at a retail pharmacy.

[What Is My Service Area?](#)

### IMPORTANT! Verify member cost sharing via NaviNet®

To determine the Medicare Advantage member's Part B prescription drug cost-sharing, verify eligibility and benefits through NaviNet® prior to providing the service.

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

### Medicare Part D prescription drug coverage



Highmark offers Medicare Part D prescription drug coverage under many of its Medicare Advantage HMO and PPO plans as well as through the Medicare-approved stand-alone Blue Rx Prescription Drug Plans.

These plans provide coverage for prescription drugs that are covered under the Medicare Prescription Drug Benefit (Part D) and that are also on the Highmark Medicare-Approved Formulary for Medicare Products.

### FOR MORE INFORMATION



To locate participating retail pharmacies, please visit the Highmark public website for your service area. Select **FIND A DOCTOR OR RX**, and then click on **Find a Pharmacy**. And you can select **Find a Drug** to quickly access drug formularies.

Additional information is also available to providers on the Provider Resource Center – select **PHARMACY PROGRAM/FORMULARIES** from the main menu.

## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID

### Dual eligible beneficiaries



“Dual eligible beneficiaries” is the general term that describes individuals who are enrolled in both Medicare and Medicaid. The term includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost-sharing through one of the Medicare Savings Programs (MSPs):

- **Qualified Medicare Beneficiary (QMB) Program:** Helps pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments;
- **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay for Part B premiums;
- **Qualifying Individual (QI) Program:** Helps pay for Part B premiums; and
- **Qualified Disabled Working Individual (QDWI) Program:** Pays the Part A premium for certain people who have disabilities and are working.

Medicare-covered services also covered by Medicaid are paid first by Medicare; Medicaid is generally the payer of last resort. Medicaid may cover the cost of care that Medicare may not cover or may partially cover (such as personal care and community-based services).

[What Is My Service Area?](#)

### Qualified Medicare Beneficiary (QMB) Program



The goal of the Qualified Medicare Beneficiary (QMB) Program is to assure meaningful access to Medicare benefits for those individuals who are elderly and those with disabilities with limited assets and income under one hundred percent (100%) of the Federal Poverty Level. It does so by requiring State Medicaid Plans to cover Medicare Part A and Part B premiums as well as the cost-sharing per service for which a Medicare beneficiary is normally liable.

Enrollees who meet the QMB program’s qualifying criteria fall into two groups: “QMB Only” and “QMB Plus.” QMB Only beneficiaries are entitled to QMB cost-sharing support for Medicare benefits, but do not qualify for any other Medicaid benefits; QMB Plus enrollees qualify for both QMB cost-sharing support and all services provided by their states’ full Medicaid programs.

Within broad national guidelines established by Federal statutes, regulations, and policies, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own Medicaid program.

The 1997 Balanced Budget Act clarified that a state is not obligated to pay providers up to the full amount of Medicare cost-sharing if the total payment (including both the Medicare portion and the State’s portion) would exceed the state’s Medicaid rate for that service. Instead, states may limit their reimbursement

*Continued on next page*

## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID, Continued

### QMB Program (continued)



to the lesser of two amounts: the full amount of Medicare cost-sharing, or the difference between the Medicaid rate and the amount already paid by Medicare. The vast majority of states limit Medicare cost-sharing payment levels for QMB enrollees and other full-benefit dually eligible beneficiaries at their Medicaid rates.

[What Is My Service Area?](#)

### Balance billing restrictions



An important component of the QMB Program is enrollee protection against “balance billing” (billing for Medicare cost-sharing, including deductibles, coinsurance, and copayments). Federal law prohibits all Medicare and Medicare Advantage providers from balance billing QMB individuals for all Medicare deductibles, coinsurance, or copayments. Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary.

All original Medicare and Medicare Advantage providers – not only those that accept Medicaid – must abide by the balance billing prohibitions. Medicare and Medicare Advantage providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. Balance billing restrictions apply regardless of whether the State Medicaid Agency is liable to pay the full Medicare cost-sharing amounts. Even if payment is not available under the State Medicaid Plan, QMB enrollees are not liable for Medicare deductibles, coinsurance, and copayments.

Individuals in the QMB Program retain their protection from balance billing even when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient’s QMB benefit is provided by a different State than the State in which care is rendered. In addition, **QMB enrollees cannot choose to “waive” their QMB status and pay Medicare cost-sharing** (the federal statute supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect).

### Prohibition on discrimination based on QMB status



Federal and state laws prohibit unlawful discrimination in the treatment of patients on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information or source of payment.

The Centers for Medicare & Medicaid Services (CMS) notes in the applicable anti-discrimination provisions that Medicare Advantage providers are prohibited from discriminating against patients based on their QMB status (see Managed Care Manual, Chapter 4, Section 10.5.2): “Discrimination based on ‘source of payment’ means, for example, that Medicare Advantage providers cannot refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program.”

*Continued on next page*

## 2.2 DUAL ELIGIBILITY UNDER MEDICARE AND MEDICAID, Continued

### Identifying QMB enrollees



You can contact the Medicaid Agency in the State(s) in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for Medicare cost-sharing.

If you have questions concerning QMB status for Highmark Medicare Advantage members, please contact the Provider Service Center.

[What Is My Service Area?](#)

### Tips to avoid inappropriate billing of QMB beneficiaries



The following practices will help Medicare and Medicare Advantage providers to ensure compliance with balance billing restrictions for QMB beneficiaries :

- Contact the Medicaid Agency in the State(s) in which you practice to learn about identifying QMB enrollees and the processes in place to receive reimbursement for Medicare cost-sharing (different processes may apply for original Medicare and Medicare Advantage services).
- Determine whether a patient with original Medicare or Medicare Advantage coverage is a dual eligible beneficiary under the QMB program prior to providing services.
- Establish processes that identify QMB beneficiaries when a patient is first seen at a practice and during routine insurance information updates.
- Educate your administrative staff on the federal balance billing law and the policies regarding QMB individuals.
- Ensure that your billing software will exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

### FOR MORE INFORMATION

For more information on the QMB Program, please refer to the Medicare Learning Network publication titled [Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary \(QMB\) Program](#).

## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM

### Introduction



Highmark provides an enhanced hearing aid benefit to all individual Medicare Advantage members and most Medicare Advantage group plans through a partnership with TruHearing™, a national hearing aid provider. This partnership is designed to ensure quality, exceptional service, and minimize our members' out-of-pocket expense.

As an exclusive hearing aid provider to contracted health plans, TruHearing negotiates exceptional prices with top hearing aid manufacturers. This allows health plans to make hearing aids more affordable for their members. The benefit plan for Highmark Medicare Advantage members provides coverage, with a low copayment, for select TruHearing digital hearing aids.

**IMPORTANT!**  
Contract with  
TruHearing  
required



**Highmark participating providers must also be contracted with TruHearing in order to dispense hearing aids for eligible Medicare Advantage members.**

Providers interested in contracting with TruHearing should contact TruHearing's Provider Outreach:

- Email: [provider.outreach@truhearing.com](mailto:provider.outreach@truhearing.com)
- Phone: **1-855-286-0550**

[What Is My Service Area?](#)

### Benefit coverage



Eligible Highmark Medicare Advantage members are covered for up to two TruHearing hearing aids per calendar year. The benefit is limited to the TruHearing Enhanced and Premium hearing aids, which come in various styles and colors. Copayments range from \$499 to \$999 depending on the member's benefit plan and the type of TruHearing hearing aid. Members should reference their Medicare Advantage Evidence of Coverage (EOC) booklet to determine their applicable copayment. Copayments for hearing aids apply only to TruHearing's Enhanced and Premium products.\*

A routine hearing exam, including fitting and evaluation for up to two hearing aids, is covered once every calendar year (member copay applies as per their benefit plan). The benefit also includes:

- Forty-eight (48) free batteries per hearing aid
- Three year manufacturer's warranty for repair and one-time loss and damage replacement
- Forty-five (45) day trial period during which returns or exchanges are permitted. (No returns or refunds will be issued for purchases beyond 45 days post-fitting.)

*\* All other hearing aid brands are not covered under the hearing aid benefit. However, if members prefer another brand available through TruHearing, they can still utilize TruHearing's services to take advantage of TruHearing's discount program that offers savings off of regular retail prices.*

*Continued on next page*

## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM, Continued

### Provider responsibility



Highmark participating TruHearing providers conduct comprehensive hearing exams for eligible Highmark Medicare Advantage members, reviewing and discussing the results with the member. If the diagnosis requires treatment with hearing aids, the provider would recommend the appropriate hearing aids from the options available in the member's benefit, including specifics on products, styles, technology levels, and costs.

The provider places the orders for hearing aids through TruHearing. TruHearing will ship the hearing aids to the provider's office for fitting and programming for Highmark's members. The member receives up to three visits for programming, fitting, and adjustments that are included in the purchase of the hearing aid.

***TruHearing will handle all claim submissions to Highmark. This includes claims for the following:***

- *Hearing exam (V5010 – assessment for hearing aid);*
- *Hearing aid(s); and*
- *Follow-up visits for programming or fitting*

*To receive payment, providers must collect the applicable copays for both the hearing exams and hearing aids from the member, and then enter the copay amounts into Echo, TruHearing's online provider portal. TruHearing will submit the claims to Highmark on behalf of providers, and then remit the full allowable amount to providers within ten (10) days.*

***Why blue italics?***

### Questions?

*For questions about the billing and payment process, please contact TruHearing's Provider Outreach by email at [provider.outreach@truhearing.com](mailto:provider.outreach@truhearing.com), or by telephone at **1-855-286-0550**.*

### Non-covered services



If it is believed that a service or item is not covered or may not be covered for a Highmark Medicare Advantage member, providers must advise the member that a written coverage decision ("pre-service organization determination") is required from Highmark before the service or item can be provided. Providers can request a pre-service organization determination on the member's behalf or direct members to request a pre-service organization determination by calling the phone number on their identification card.

If a provider supplies a non-covered hearing aid and a pre-service organization determination has not been issued, the member or Highmark will not be responsible for payment.

*Continued on next page*

## 2.2 TRUHEARING HEARING AID BENEFIT PROGRAM, Continued

### Directing members



Highmark Medicare Advantage members can reference their Evidence of Coverage (EOC) booklet for their plan’s hearing aid benefit and call Highmark Member Services with any questions. Member Services can transfer calls, when applicable, to a TruHearing Customer Care Representative.

Members can also be directed to call TruHearing Customer Care directly at **1-855-544-3128**. TruHearing’s personal consultants will answer any questions, check a member’s insurance eligibility, including verifying copayment amounts, and set up appointments with Highmark participating TruHearing providers.

### FOR MORE INFORMATION



For additional information about TruHearing, please visit their website at <https://www.truhearing.com/>.

To learn more about the benefits under Highmark’s Medicare Advantage plans, you can access Medicare Advantage Evidence of Coverage (EOC) booklets in the Appendix of the *Highmark Provider Manual* – scroll down to the bottom of the manual’s home page, and then click on the down arrow in the **ADDITIONAL RESOURCES** box. Select **Appendix** from the available options.

[What Is My Service Area?](#)

OBSOLETE



## 2.2 HOUSE CALL PROGRAM FOR MEDICARE ADVANTAGE

### Overview



In June 2015, Highmark launched the House Call Program for all Medicare Advantage members. (The program had been in place for a portion of our Medicare Advantage population since 2011.) This free program is aimed at helping members who have chronic conditions or who are frail and at risk of further health complications to better understand their conditions and how they can access the resources they need.

Highmark identifies members with chronic conditions and those who may be disengaged from their normal care routines through claims data. Once identified, we are able to reach out to them through the House Call program to evaluate the situation and to ensure their complete health needs are being met.

[What Is My Service Area?](#)

### Visit focus



Highmark has contracted with two vendors, Matrix Medical Network and CenseoHealth, to administer the Medicare Advantage House Call Program. Members are contacted and asked if they would invite a licensed health professional into their homes to perform a free health assessment that lasts approximately one hour. The visit focuses on four primary areas:

- Assessing the member's current health status
- Reviewing the member's current medications
- Answering any health-related questions the member may have
- Ensuring the member's medical history is accurate and up to date with complete documentation

Since the assessments are conducted in the members' homes, they may feel comfortable discussing additional health issues or concerns. The in-home setting also can bring light to issues that may be difficult to detect in a clinical setting such as fall risk, home safety, medication adherence, and dietary and nutrition concerns. Recommendations from the visit are provided to the member and a summary of the visit is mailed to the PCP or other provider indicated by the member. At the conclusion of the sessions, members are strongly encouraged to follow up with their PCPs to discuss the findings.

**Note:** The House Call Program does not replace or bypass the member's relationship with his or her PCP. The program is intended to complement the PCP-member relationship by helping to identify any health issues that may arise between office visits and to reinforce the importance of regular preventive care. A House Call is not performed or billed as a routine physical or as an Annual Wellness Visit (AWV).

## 2.2 ANNUAL WELLNESS VISIT (AWV)

[What Is My Service Area?](#)

### What is the Annual Wellness Visit?



The Annual Wellness Visit (AWV) benefit for Medicare beneficiaries, including Medicare Advantage members, is intended to encourage individuals to take an active role in accurately assessing and managing their health, and consequently improve their well-being and quality of life. This service also includes a comprehensive health risk assessment in order to provide a personalized prevention plan of services. Unlike much of medical care, which is primarily directed at treating acute and chronic illnesses, the AWV aims to prevent the onset of disease and disability or to slow the progression and exacerbation of existing illnesses. It is not to be considered a “physical exam.”

The AWV extends but does not replace the Initial Preventive Personal Examination (IPPE), also known as the “Welcome to Medicare Visit,” that is provided to new beneficiaries within 12 months of enrolling in Medicare. The AWV is not covered during the first 12 months of a beneficiary’s enrollment in Medicare.

The Medicare AWV and IPPE visits are both important aspects of Highmark’s overall wellness and prevention initiatives, and we feel that it is important for network physicians to conduct these assessments for our Medicare Advantage members. Highmark is offering incentives to members (through the Passport Rewards Program) as well as to providers for completing the AWV.

### Billing For AWV’s



All Medicare Advantage members are eligible for an initial AWV as long as they have been Medicare beneficiaries for at least 12 months. Subsequent AWVs are covered once every calendar year. The Centers for Medicare & Medicaid Services (CMS) has created two HCPCS codes for AWVs:\*

- **G0438:** The initial AWV is to be billed using code G0438, which is defined as “annual wellness visit, includes a personalized prevention plan of service first visit.” **Procedure code G0438 is a once-in-a-lifetime benefit.**
- **G0439:** The subsequent AWVs are to be billed with code G0439, which is defined as an “annual wellness visit, includes a personalized prevention plan of service subsequent visit.”

Providers should submit a claim using a preventive diagnosis code; there are no required diagnosis codes. Deductibles and coinsurance do not apply for AWVs; the member has no financial responsibility. **Note:** If the member is receiving care for any medical condition at the same time, deductibles and coinsurance do apply and the member should be advised if this may occur.

*\*HCPCS code G0402 is used when filing claims for the IPPE.*

*Continued on next page*

## 2.2 ANNUAL WELLNESS VISIT (AWV), Continued

FOR MORE  
INFORMATION



For additional information, please see the **Annual Wellness Visit (AWV) Provider Toolkit** available on the Provider Resource Center. Select **EDUCATION/MANUALS** from the main menu, and then **Geriatric Resource Binder**.

[What Is My Service Area?](#)

OBSOLETE

## 2.2 SELECT DME NETWORK (PA ONLY)

### Overview



To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

[What Is My Service Area?](#)

### Select DME Network effective January 1, 2017



Effective January 1, 2017, the Select DME Network will be the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

Providers should refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

### FOR MORE INFORMATION



For the most current lists of providers in the Select DME Network, select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then **Select DME Network**. You can select a list of [all participating providers](#) or a [list organized by category](#), which includes telephone numbers.

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

## 2.2 MEDICARE ADVANTAGE PPO NETWORK SHARING

### Overview



All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. Under this inter-Plan arrangement, Blue Medicare Advantage PPO members -- including Highmark's Freedom Blue PPO (in PA and WV) and Community Blue Medicare PPO/Plus PPO (in PA only) -- will receive in-network benefits when traveling or living in the service area of any other participating Blue Medicare Advantage PPO Plan. As long as covered services are provided by participating Medicare Advantage PPO providers, the member's in-network benefit level will apply.

[What Is My Service Area?](#)

### Identifying out-of-area members



You can recognize an out-of-area Medicare Advantage PPO member covered under the Blue network sharing program when their ID card has the following logo:



The "MA" in the suitcase indicates a member who is covered under the Blue Medicare Advantage PPO network sharing program. Members have been asked to not show their standard Medicare ID card when receiving services. Instead, members should provide their Blue Cross and/or Blue Shield member ID card.

### Eligibility and benefits verification



To determine whether a Medicare Advantage PPO member from another Blue Plan is covered under the network sharing program, please call the BlueCard Eligibility Line at **1-800-676-BLUE** (2583).

**Note:** Please be sure to have the member's three-character alpha prefix in order to obtain eligibility information.

### Impact to Highmark Medicare Advantage PPO providers



If you are a contracted Highmark Freedom Blue PPO and/or Community Blue Medicare PPO/Plus PPO provider, you should provide the same access to care for members of other participating Blue Medicare Advantage PPO Plans as you do for Highmark's Medicare Advantage PPO members.

You will be reimbursed in accordance with your contracted rate under your Medicare Advantage PPO contract. These members will receive in-network benefits in accordance with their member contract.

*Continued on next page*

## 2.2 MEDICARE ADVANTAGE PPO NETWORK SHARING, Continued

### If you are not contracted with Highmark for Medicare Advantage PPO plans



If you are not a contracted Highmark Medicare Advantage PPO provider, you may see out-of-area Blue Medicare Advantage PPO members but are not required to do so.

Should you provide services to these members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent and emergency care, you will be reimbursed at the in-network benefit level.

### Member cost sharing



A Medicare Advantage PPO member's cost sharing level and copayment is based on their health plan. A Medicare Advantage PPO participating provider may collect the copayment amounts at the time of service or bill for any deductibles, coinsurance, and/or copayments. However, you may not balance bill the member the difference between your charge and the Medicare Advantage PPO allowance for a particular service.

To determine the member's cost sharing, you should call the BlueCard Eligibility Line at **1-800-676-BLUE** (2583).

[What Is My Service Area?](#)

OBSOLETE