

Influenza Vaccination Update for Medicare Choice Members

A new administrative policy for PARTNERS Medicare Choice members extends benefits for the reimbursement of the influenza vaccination at public venues for the upcoming 2004-2005 vaccination season. Public venues include senior centers, churches, pharmacies, grocery stores, or any provider supplying the vaccine at a mass immunization center (location code 60), state or local public health clinic (location code 71), or rural health clinic (location code 72).

Members received a mailing in September with information about where they can get their flu shots this year. They can go online to www.findaflushot.com or they can contact PARTNERS Medicare Choice Customer Service for assistance in finding a location in their area.

No Copayment Required

PARTNERS Medicare Choice will continue to reimburse providers at the contracted fee schedule for the provision of adult influenza vaccine CPT 90658 and HCPCS G0008 for the influenza vaccination when administered in the primary care provider office setting. PARTNERS

reimbursement continues to be full payment per the contracted fee schedule for all services related to the administration of the vaccine. Please note that no copayment should be collected from the member for the administration of a vaccine.

Exception: An Evaluation and Management Service fee should be charged only if a distinct and separate service is performed during the same visit in which the flu shot is administered. If a separate service is rendered and a second charge is made, please help the member recognize and understand that the additional service will result in a copayment.

Pneumococcal Vaccine

This change in policy does not include the reimbursement for the pneumococcal vaccine. Members are directed to their primary care physician for recommendation and administration of this vaccine. Pneumococcal vaccinations should be filed with CPT 90732 for the Pneumovax vaccine and HCPCS G0009 for the administration of Pneumovax.

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Health Services Pre-Certification Reminders

In order to facilitate authorizations for durable medical equipment (DME), please have all required clinical information available at the time the request is made to PARTNERS Health Services. Failure to provide this information at the time of the request results in delays in authorization and callbacks for the information to the requesting provider.

If you are submitting a request for services from a noncontracting provider, please provide us with the name, address and telephone number for the provider in question,

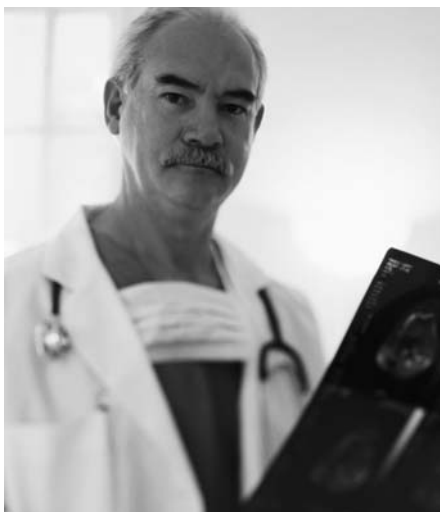
as well as the clinical information necessary to support the medical necessity of the request.

Please review and become familiar with the PARTNERS Prior Approval Guidelines, which we've included in this issue. Providers performing the service and the facilities where the service will be performed are responsible for ensuring that precertification has occurred prior to the date of service. Failure to do so will result in a claims denial due to failure to obtain prior approval.



Protection for Health Care Consumers

Did you know that there are standards in place that protect health care consumers? It's important to remember that any decisions made about coverage for care or service are based on a member's specific health plan, PARTNERS Medicare Choice medical policy, including Medicare coverage guidelines, and information from you, the patient's doctor, about the patient's medical condition.



PARTNERS National Health Plans of North Carolina, Inc., and its associated delegates require that practitioners, providers and staff who make utilization management-related decisions base those decisions solely on the appropriateness of care and service and the existence of the member's coverage.

PARTNERS does not compensate or provide any other incentives to any practitioner or other individual, including our staff, conducting utilization management review to encourage decisions which would result in barriers to care, service or the underutilization of services. We are committed to making appropriate coverage decisions as defined by the terms of our members' health benefit plan while meeting their medical needs.

Editorial

This newsletter, unless otherwise stated, applies to Medicare Choice members.

PARTNERS is committed to offering its health plans on a nondiscriminatory basis.

PARTNERS does not discriminate based on color, religion, national origin, age, race, disability, handicap, gender, or health status as defined by CMS.

PARTNERS National Health Plans of North Carolina, Inc.

**Provider Services
336-774-5400 or 1-888-296-9790**

Fast-Track Appeals Training for Skilled Nursing Facilities, Home Health Agencies and Comprehensive Outpatient Rehabilitation Facilities

Recently, PARTNERS and Medical Review of North Carolina, the quality improvement organization in North Carolina (QIO), conducted a lunch and learn session about the Medicare appeals process that affects the termination of services provided by SNF/SNUs, HHAs and CORFs. The session was directed at approximately 100 contracting providers in the Triad. Approximately 50 participants attended. Other sessions will be scheduled for providers in the Triangle and Charlotte areas.

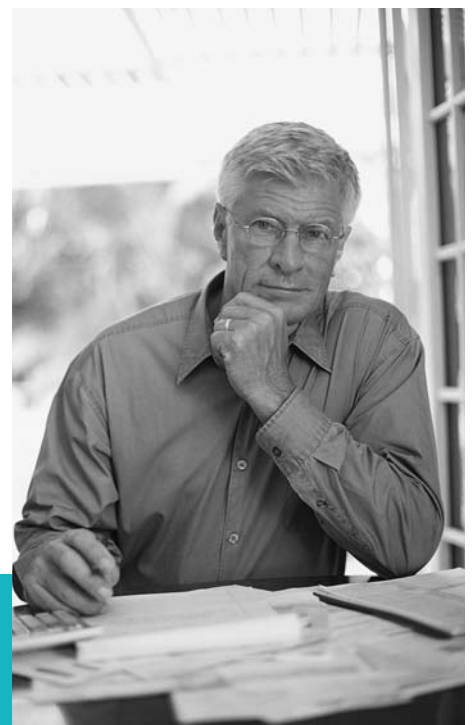
The purpose of the session was to discuss the Fast-Track Appeals requirement and stimulate dialogue regarding compliance challenges that providers, PARTNERS Health Services, clinical staff and staff from the QIO face. The following key components were reviewed:

- SNF, CORF and HH providers must notify Medicare Advantage members before they discontinue services. This includes discontinuation of services due to non-authorizations as well as those where the treatment goals are met.

- The enrollee must receive the notice two days prior to the end of services in the case of residential services or on the second to the last visit in the case of nonresidential services. The notice must be written on a standardized government form, the Notice of Medicare Noncoverage, which is a standardized government form. Forms can be found on the CMS Web site at www.cms.hhs.gov/healthplans/appeals.
- The notice from the provider must contain the date services will end and how the member can contact the QIO to appeal the termination of service.
- An enrollee can appeal to the QIO by noon on the day prior to services ending. Appeals may be initiated on the weekend.
- If the member appeals, the QIO contacts the health plan. The health plan must send a detailed explanation of noncoverage to the member outlining why services are ending. The health plan must also submit any necessary data to the QIO as requested.

- The QIO obtains any needed information from the health plan and then makes a determination on the appeal.
- The process is contingent upon strict conformance to the specified timeframes and the timely submission of information to support compliance with the above requirements.

During the session, providers asked questions about operational challenges and expressed genuine interest in demonstrating compliance with these requirements. For more information on the Fast-Track Appeals process, please go to the CMS Web site.



HEDIS Colorectal Cancer Screening 101 for Providers

Colorectal cancer screening became a HEDIS measure in 2004. PARTNERS 2004 screening rates for this measure were 61.56 percent by hybrid method of data collection. This measure indicates the percentage of adults 50 to 80 years of age who had appropriate screening for colorectal cancer (CRC). Appropriate screenings are defined by any one of the four criteria below:

- Fecal occult blood test (FOBT) during the measurement year
- Flexible sigmoidoscopy in the measurement year or four years prior to the measurement year
- Double-contrast barium enema (DCBE) during the measurement year or four years prior to the measurement year
- Colonoscopy during the measurement year or nine years prior to the measurement year

Documentation in the medical record must include both a note indicating the date the colorectal cancer screening was performed and the result or finding. Any member with a diagnosis of colorectal cancer is excluded from the measurement.

Improving Member Awareness

PARTNERS Medicare Choice Preventive Care Guidelines and payment guidelines are in line with Medicare's recommendations for colorectal cancer screening. This will be a focus of future member and provider initiatives. These initiatives will be aimed at improving member awareness of the importance of having regular colon cancer screenings and creating tools that will help physicians in recommending colon cancer screening for their patients.

Updates to the PARTNERS Formulary

Additions to the PARTNERS Formulary

Elestat, Myfortic and Spiriva – effective June 2004

Apokyn, Estrasorb, Estrogel and Vytorin – effective October 2004

Additions to the PARTNERS Formulary That Require Prior Authorization Effective July 2004

Zavesca

MAC'd Drugs

Cipro, Diflucan, Maxidone and Synthroid

(Only the generic version of these drugs is covered. If member receives the brand-name drug, they will be responsible for a higher copayment or additional charges.)

MAC'd Generic Drugs Added to the Medicare Individual Member Formulary

ciprofloxacin, fluconazole, hydrocodone/acetaminophen and levothyracine sodium

Market Withdrawal of Vioxx by Merck

As a result of Merck withdrawing Vioxx from the market on September 30, 2004, PARTNERS has removed Vioxx from its formulary. PARTNERS has added Celebrex (which requires prior approval) to the formulary effective October 1, 2004.

Medical Coverage Policy Updates

The following medical coverage policies have been reviewed and approved by the Quality Improvement Committee and the PARTNERS Physician Advisory Group. Please contact your Network Services representative for additional information, if needed.

Policy	Major Changes	Additional Notes
Oxygen and Oxygen Supplements	<ul style="list-style-type: none"> ✓ Adopted Medicare’s criteria for groups of coverage: <ul style="list-style-type: none"> --Group I- PaO2 at or below 55mmHg --Group II- PaO2 56-59mmHg --Group III- PaO2 at or above 60mmHg 	<ul style="list-style-type: none"> ✓ Requires Prior Approval ✓ Reference to nocturnal use of oxygen w/ CPAP deleted (criteria in “Treatments for Obstructive Sleep Apnea” policy) ✓ Complies with current Medicare coverage guidelines
Skilled Care Services	<ul style="list-style-type: none"> ✓ Deleted commercial language ✓ Language consistent with <i>Medicare Benefit Policy Manual: Chapters 7 & 8</i> ✓ Definitions added for “Place of Residence” & “Part-Time or Intermittent Home Health Care” to be consistent with CMS coverage decisions 	<ul style="list-style-type: none"> ✓ Requires Prior Approval ✓ Complies with current Medicare coverage guidelines
Hyperbaric Oxygen Therapy	<ul style="list-style-type: none"> ✓ Policy Archived 	<ul style="list-style-type: none"> ✓ No longer requires prior approval
Cardiac/Telemetry ISD Criteria for Low-Risk Patients	<ul style="list-style-type: none"> ✓ Policy Archived 	<ul style="list-style-type: none"> ✓ Milliman Care Guidelines utilized for criteria

Did You Know?

Over 36,000 Medicare beneficiaries are enrolled in PARTNERS Medicare Choice¹?

That PARTNERS Medicare Choice processes approximately 30,800 claims per month²?

That since June 2004 99.3 percent of claims received by PARTNERS Medicare Choice have been processed within 30 days of receipt?

¹ As of September 2004 per CMS data
² 2004 year-to-date average



Prior Authorization Guidelines Updates

Effective December 1, 2004, PARTNERS will no longer require prior approval for reconstructive eyelid surgery associated with repairs of symptomatic entropion or ectropion (CPT codes 67916, 67917, 67923, 67924). A revised copy of the PARTNERS Prior Authorization

Guidelines is included below for your reference. Please replace the copy of the Prior Authorization Guidelines that is in your *PARTNERS Provider Manual* with this revised version, which will become effective December 1, 2004.

Prior Authorization Guidelines

Cosmetic Procedures (or those potentially cosmetic), such as, but not limited to:

- Abdominoplasty
- Blepharoplasty
- Breast Reduction
- Genioplasty/Sliding Osteotomy
- Rhinoplasty
- Strabismus Surgery

Dental Services for Accidental Injury

Diagnostic Testing

- Neuropsychological Testing
- Psychological Evaluations for Medical Reasons

Durable Medical Equipment and Prosthetics

- All Rental Items
- Items Greater Than \$600 (purchase price)
- Penile Implants

External Counterpulsation

Home Health Agency Services

Hospice

Inpatient Admissions

- Scheduled admissions, including acute hospital, rehabilitation facility, hospice and skilled nursing facility
- **NOTE:** For urgent/emergency admits (including obstetric admits), prior authorization is NOT required. However, notification to PARTNERS of urgent/emergency admits (including obstetric admits) within 24-hours or the first business day after the admission is required.

Investigational Procedures (or those considered potentially investigational)

Nonparticipating Providers and Services

Pharmaceuticals (See also PARTNERS formulary)

- Amevive (Alefcept)
- Cerezyme

Rehabilitation/Therapy

- Biofeedback
- Cardiac Rehabilitation
- Pulmonary Rehabilitation
- Speech Therapy
- Wound Care Clinic

Surgery

- Capsulotomy (laser)
- Extracapsular Cataract Extraction With Intraocular Lens
- Lithotripsy, Extracorporeal for Orthopedic Problems (plantar fasciitis and chronic lateral epicondylitis are the two conditions considered for coverage)
- MOHS Surgery
- Refractive Surgical Procedures
- Retina, Central Photocoagulation (laser)
- Pan-Retinal Photocoagulation (PRP, laser)
- Photodynamic Therapy With Visudyne
- Spinal Neurostimulators
- Surgical Treatment of Morbid Obesity
- Surgical Treatment of Sleep Apnea
- Temporomandibular Joint Surgery
- Transplants, Bone Marrow and Organ
- Varicose Vein Treatment
- Vertebroplasty and Kyphoplasty, Percutaneous

Transportation (non-emergency)

Medicare Advantage: The New Name for the Medicare+Choice Program

In previous communications, we have informed you that the Medicare Modernization Act changed the name of the Medicare+Choice program to the Medicare Advantage program. Effective January 1, 2006, all references to Medicare+Choice must be replaced with Medicare Advantage. The Centers for Medicare and Medicaid Services (CMS) is currently making these changes in its literature, and you have seen this change gradually in communications from PARTNERS. We will continue to make changes in the references we use, and we will continue to send various notices to providers about this change in order to comply with the requirements.

Please note the name of the current PARTNERS Medicare Advantage product is PARTNERS Medicare Choice, and we will continue to market our HMO plan under the PARTNERS Medicare Choice name.



2005 Medicare Advantage Benefit Changes

Individual Medicare Advantage plans renew every January. We are pleased to report that we will extend the existing 2004 copayments and premium into 2005. The 2005 benefits were filed with CMS in September as part of the National Medicare Advantage renewal process. Here are the highlights:

Premium	\$34
Inpatient hospitalization	\$250 per admission subject to the out-of-pocket maximum of \$2710 per year
Office Visits	\$15
Outpatient Surgery	\$0
Skilled Nursing Facility Services	\$75 per day up to 10 days
Unlimited, Formulary Generic Drugs	\$15 per prescription

Please note that employer plans may vary from the individual plan. Please check the member's ID card and contact Medicare Choice Provider Services at **1-888-296-9790** to verify benefits.



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Address Service Requested

Have You Heard about HealthTrio Connect?

HealthTrio™ Connect is an electronic tool that providers can use to verify member benefits' eligibility and check on the status of a submitted claim. PARTNERS makes this connectivity tool available to contracting providers at no charge.

To obtain more information about HealthTrio Connect, please contact Medicare Choice Provider Services at **1-888-296-9790** or visit the PARTNERS Web site today at www.partnershealth.com, and click on "HealthTrio Connect."

