Medi-Pak® Advantage: Eligibility Inquiries and Claims Submission Guidelines

Eligibility:

1. Before rendering services, providers should request to see the patient's Medi-Pak® Advantage identification card.
2. Providers may obtain available information concerning Medi-Pak® Advantage members' eligibility by calling Medi-Pak® Advantage customer service at 1-866-390-3369, Monday – Friday, 8 a.m. – 8 p.m. CST.
3. Arkansas providers may also obtain available information concerning Medi-Pak® Advantage members' eligibility by accessing AHIN by utilizing the electronic gateway which is operational 24 hours a day, 7 days a week.

Effect of Eligibility Responses:

Please see reference to eligibility inquiries in the "Terms and Conditions" section of these Medi-Pak® Advantage materials for an explanation of the limitations on eligibility responses, which should not be relied upon as a guarantee of eligibility of payment.

Claims Submission:

Claims for Medi-Pak® Advantage members should be sent to Arkansas Blue Cross and Blue Shield and not to any Medicare carrier or fiscal intermediary. The only exception is for hospice services, which continue to be paid by traditional Medicare. Please send all claims for hospice services to your Medicare carrier or fiscal intermediary.

Submission of Claims:

All providers should submit claims as soon as possible after a service is provided using the standard CMS-1500, CMS-1450, UB-92, or UB-04 claim form. All Medicare billing guidelines must be followed when submitting Medi-Pak® Advantage claims. Services billed beyond 365 days from date of service are not eligible for reimbursement.

Electronic claims:

If providers are currently submitting claims through AHIN, providers can submit Medi-Pak® Advantage claims using the following:

- Source of Payment Medi-Pak® Advantage – Arkansas Blue Cross Private Business
  - Facility = MA
  - Professional = MB
- Payer ID:
  - Facility = a
  - Professional = b

Please check your electronic filing support to make sure that you can bill and accept the new source of payment changes. Do not use the Medicare Source of payment code.

Paper Claims:

Paper claims should be submitted to Arkansas Blue Cross at the following address:

Medi-Pak® Advantage
Arkansas Blue Cross Blue Shield
PO Box 2181
Little Rock, AR 72203-2181

Paper Claim Forms:

- Bill facility paper claims on a UB-92 orUB-04 claim form. Form must be in red ink.
- Bill professional claims on a CMS-1500 claim form. Form must be in red ink.

Important claims information:

Be sure to include the following on the Medi-Pak® Advantage claims:

- National Provider Identification Number (NPI), Medicare Provider Number and Federal Tax identification number
- Medi-Pak® Advantage member ID number

Laboratories:

Providers need to send laboratory claims directly to Arkansas Blue Cross and use the CLIA number.

Facilities:

When submitting claims on a CMS-1450, UB-92 or UB-04, include the six-digit Medicare number (NPI) in Field 51 (PROVIDER NO.).

Providers Outside of Arkansas:

All providers outside of Arkansas should submit claims to the local Blue Cross plan, using the alpha prefix **XCX**.

Coordination of Benefits:

If a member has primary coverage with another plan, please submit a claim for payment to the primary plan first. The amount payable by Medi-Pak® Advantage will be governed by the Medicare allowed amount and amount paid by the primary plan and the coordination of benefits policies.

Advanced Beneficiary Notification (ABN):

ABN's are not required for Medi-Pak® Advantage members. Providers must inform a PFFS member in advance of the service that will not be covered. A provider's notification can be verbal or in writing but providers are encouraged to document the discussion.

Notices of Discharge and Non-Coverage:

Arkansas Blue Cross and Blue Shield delegates to providers the responsibility for issuing Notices of Discharge and Medicare Appeal Rights (NODMAR) and Notices of Non-Coverage (NOMNC) in accordance with applicable Medicare regulations.

Claims Payment:

Medi-Pak® Advantage processes claims by following the traditional Medicare billing rules including the prospective payment system requirements. Submit claims by using the same coding rules as traditional Medicare and by using CPT codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Remember to use the CMS-approved HCPCS codes and CMS-approved modifiers.

Prospective Payment System teaching facilities should file an informational claim to Medicare to receive payment for operating IME. No other facilities need to file this type of claim.

Providers should inform Medi-Pak® Advantage if they believe a facility claim qualifies for an outlier payment. Medi-Pak® Advantage follows Medicare's methodology in reimbursing outlier payments according to the appropriate prospective payment methodology. Notification to the plan can be made either on the claim, on an attachment, or by phoning Provider Services if the claim has already been paid.

CMS requires that 95% of all clean claims be processed within 30 days from receipt. In the event that a clean claim is not processed within the 30 day timeframe, Arkansas Blue Cross will comply with Medicare's prompt payment of claims requirements for all clean claims.

Claims Appeals:

Except for pharmacies, if the payment amount a provider receives from Medi-Pak® Advantage (including the member cost sharing collected) is less than the provider would have received under traditional Medicare for the service; the provider can appeal the payment amount. To appeal the payment amount, the provider must provide reasonable documentation to the plan of the traditional Medicare payment amount that applies to the service. For example, a remittance advice from a Medicare carrier would be considered as documentation.

If providers have questions about a claim payment, please call the Medi-Pak® Advantage Customer Service at 1-866-390-3369, Monday-Friday, 8 a.m.— 8 p.m. CST.

When calling, please have the following information available for the representative:

- NPI Member's name;
- Member's date of birth;
- Member's Medi-Pak® Advantage ID number listed on the member’s ID card;
- Claim number in question;
- Date of service;
- Issue wanting reviewed;

- Additional information if necessary; and
- Copy of claim (if available).

Appeals should be sent to:

Medi-Pak Advantage
Arkansas Blue Cross Blue Shield
Grievance and Appeal Management
P. O. Box 2181
Little Rock, AR 72203-2181

If providers demonstrate that they have not received proper payment, Medi-Pak® Advantage will then pay the difference between what was received and what would have been received under traditional Medicare.

Providers may appeal for application of the limiting charge only one time per patient. Once a patient is known as a Medi-Pak® Advantage member, the providers will for that member's future services have access to the Terms and Conditions of Medi-Pak® Advantage.

Record Retention and Audit:

In accordance with federal law, all records will be retained for 10 years.

- Arkansas Blue Cross and Blue Shield and the U.S. Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of a provider involving transactions related to the provider's treatment of any Medi-Pak® Advantage member. This right to inspect, evaluate, and audit remains in effect for the time period established by Medicare regulations and providers must retain relevant documents accordingly.

- Arkansas Blue Cross will conduct retrospective audit review using National Coverage Determinations, Local Coverage Determinations, Arkansas Blue Cross Coverage Policy, and Durable Medical Equipment Regional Carrier guidelines.