

FDR Compliance Newsletter

Mercy Care Advantage, 4350 E. Cotton Center Blvd., Bldg. D, Phoenix, Arizona 85040

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Enhanced MCA Benefits for 2018

Effective with dates of service on or after **January 1, 2018**, the following benefits changes will be available to individuals enrolled in Mercy Care Advantage.

Vision Benefit: MCA will cover up to \$275 for contact lenses and eyeglasses (frames and lenses).

Meals (New Benefit): 7 frozen meals delivered to members residence post discharge from an inpatient hospital stay.

Transportation: Increased to 24 one-way routine transportation trips every year (or 12 round trips) to access covered MCA supplemental benefits.

Chiropractor: Increased routine chiropractic visits (up to 20 per year) to manipulate the spine and correct subluxation.

MD Live: (New Benefit) MD Live allows MCA members to consult with board certified doctors about non-emergency conditions by using secure online video via a smartphone, tablet or computer. This service can be used when members are traveling within the state of Arizona and need non-emergency medical care.

The following benefits did not have any changes for 2018.

Dental- Includes coverage for preventative services at \$0 copay and comprehensive dental coverage up to \$3000.00 annually.

Over-the-counter (OTC) benefit - \$50 to place one- order each month.

Hearing- Up to \$1700 hearing aid allowance every 3 years

Podiatry- One routine visit every 3 months

MCA 2018 formulary updates

Effective **01/01/2018**, Mercy Care Advantage (MCA) moved to a CVS template formulary (drug list), that resulted in some negative changes for members. Transition fills will be provided (exception Part B drugs & items). Impacted members will have to change drug(s) or request a coverage determination/exception request. Advanced communication included prescriber outreach calls and pharmacy fax blasts. The 2018 MCA formulary can be located on the MCA website.

One Touch brand will be the preferred diabetes testing supply mfg. for MCA members effective **01/01/2018**. One Touch brand is already in place for Mercy Care Plan members. Claims for One Touch supplies will adjudicate at the Point of Sale (POS). Claims for other brands of diabetic supplies will reject at POS with a message indicating prior authorization is required. Exceptions for other brands will apply in some member situations.



What is "Deemed"?

For FDR requirements, it means that FDRs (and/or their applicable employees) don't need to complete the CMS Combating Medicare Parts C & D Fraud Waste and Abuse (FWA) training. This doesn't exempt the FDR from completing the CMS Medicare Parts C and D General Compliance training.

An FDR may be deemed. But their downstream entities might not be deemed. It's still necessary to monitor and oversee compliance for downstream entities.

How do I know if I'm deemed?

FDRs (and/or their applicable employees) are deemed if they are enrolled in Medicare Parts A or B of the Medicare program or through accreditation as a supplier of Durable Medical, Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).

What documentation do I need to keep if our organization or if our employees are deemed?

You don't need any more documents. To establish that an employee or FDR is deemed, you just need the documentation necessary for proper credentialing.

Member ID Card Update

Between April 2018 and April 2019, CMS will remove Social Security numbers from Medicare cards. They'll mail each beneficiary a new red, white, and blue Medicare card. The new card will include a unique 11 digit identification number but it won't change a Medicare beneficiary's coverage or benefits. When Medicare beneficiaries get their new card; they should destroy their old card. They can start using the new card right away.

They don't need to do anything to get a new card. But their mailing address needs to be up to date with Social Security. To correct their mailing address, they can visit www.ssa.gov/myaccount or call **1-800-772-1213 (TTY: 1-800-325-0778)**.

You can find more information on the [CMS website](#).

MCA members will be advised to continue to use their current MCA issued ID card when they need to obtain covered services and also advised not to give their new info to anyone who contacts them about their new Medicare card.

Medicare will never ask for personal or private information *in order* to get a new Medicare number and card. MCA members should beware of anyone who contact's them asking for information about their existing card or their new Medicare card OR offers to get them a new card before Medicare provides them one.



Balance Billing of Qualified Medicare Beneficiaries Is Prohibited

The Qualified Medicare Beneficiary (QMB) program is a Medicaid program for Medicare beneficiaries. It exempts them from being charged for Medicare cost sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. But, federal law allows states to limit provider reimbursement for Medicare cost sharing under certain circumstances. Dually eligible individuals may qualify for Medicaid programs that pay Medicare Part A and B premiums, deductibles, coinsurance and copays to the extent provided by the state Medicaid plan.

Medicare providers **must** accept the Medicare payment and Medicaid payment (if any) as payment in full for services to a QMB individual. Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions.

Clarifications about balance billing
Be aware of these policy clarifications to help ensure compliance with QMB balance billing requirements: All Original Medicare and Medicare

Advantage providers — not just those that accept Medicaid — must abide by the balance billing prohibitions.

QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers can't charge QMB individuals even if the patient's QMB benefit is provided by a state that's different from the one where care is rendered.

More information

Visit the CMS' [Medicare-Medicaid General Information](#) website. You'll learn more about dual eligible categories and benefits. You'll also get information on the QMB program and on other individuals dually eligible for Medicare and Medicaid benefits.

Did you receive a grievance or complaint?

Have you had a grievance or complaint from a Mercy Care Advantage member? Not sure what to do with it? You must immediately forward all grievances and complaints to us. CMS defines a grievance as any complaint or dispute, other than an organization determination, expressing dissatisfaction with how a Medicare

health plan or delegated entity provides health care services. The definition applies even if remedial action can be taken. CMS defines complaints as any dissatisfaction expressed to a Medicare health plan, provider, facility or quality improvement organization (QIO) by an enrollee. Complaints can be either verbal or in writing. This can include concerns about provider operations or health plans such as:

- Waiting times
- Attitudes of health care personnel Adequacy of facilities
- Respect for members
- The rights of members to get services or receive payment for services paid for upfront

Members may also submit complaints about a plan's refusal to provide services to which they feel they're entitled. If you get a written grievance or complaint from a Mercy Care Advantage member, simply fax it to us at **602-351-2313** and **include the date it was received**. If a member calls in a complaint, please transfer the member to our Member Service department at **602-263-3000**.