Medicaid Managed Care Program (STAR) and Children’s Health Insurance Program (CHIP)

Facility Provider Orientation

2012 Provider Training
Welcome to Blue Cross and Blue Shield Texas Medicaid Facility Provider Orientation

Program Introduction

2012 Changes

Customer Service

Member Enrollment and Eligibility

Member Benefits and Services

Claims and Billing

Medical Management

Complaints and Appeals
Blue Cross and Blue Shield of Texas (BCBSTX) knows health care coverage in Texas; we invented it. We’re Texas born and bred, and this is the only place we do business. Our mission since our founding more than 80 years ago has been to provide financially sound health care coverage to as many Texans as possible.

Effective March 1, 2012, Blue Cross and Blue Shield Texas will participate in the State of Texas Access Reform (STAR) and Children’s Health Insurance Program (CHIP) programs.

Blue Cross and Blue Shield Texas will strive to make the right connections between members, providers, and the community for our STAR and CHIP members’ better health.

- Develop strong collaborative relationships with our provider/partners
- Promote better health for our members through Case Management and Disease Management programs
- Team with the community to provide outreach to members
Texas Managed Care Programs

- STAR (State of Texas Access Reform) is the Medicaid managed care program for Texas
- CHIP (Children’s Health Insurance Program) is the children’s health insurance option
- Blue Cross and Blue Shield of Texas was selected as one of the plans to administer the STAR and CHIP programs for the Texas Health and Human Services Commission (HHSC) in the Travis Service Area

Other health plans serving in the area include:
- Sendero Health Plans
- Seton
- Superior (Centene) HealthPlan Network
- Amerigroup-STAR Plus ONLY
- United Healthcare-STAR Plus ONLY
Eight Counties:
- Travis
- Bastrop
- Burnet
- Caldwell
- Fayette
- Hays
- Lee
- Williamson
Blue Cross Blue Shield Texas and it’s Material Subcontractors

- Leverage our proven health insurance experience - over 80 years - to deliver exemplary quality services to Medicaid and CHIP members and providers

- Selected WellPoint to provide a variety of administrative services to support BCBSTX Travis Service area programs including Pharmacy Benefits Administration via Express Scripts, Inc.

- WellPoint brings proven call center capacity, processing technology, full process operations and health, disease and care management programs

- BCBSTX and WellPoint have a long history of working together on a national basis and they are partners in Availity
2012 Changes for STAR and CHIP

- Largest re-procurement and expansion Texas Health and Human Services Commission (HHSC) in Texas history; last procurement in 2005

- Almost one million members transitioning from Primary Care Case Management Fee-For-Service to managed care in South Texas and rural Texas
  - From 50% in managed care to over 70%

- Implementing Dental Management Organizations (DMO)

- Transitioning from the HHSC Vendor Drug program to pharmacy benefit administration by the managed care companies statewide
2012 Changes for STAR and CHIP
Continued

- A special waiver (1115) was negotiated to permit the preservation of funding for hospitals and physicians formerly called Upper Payment Limit (UPL)

- Delivery System Reform Incentive Payment Pools will be developed regionally to administer payments based on quality measures

- Health and Human Services Commission (HHSC) is required to implement numerous changes from the Affordable Care Act
  - New provider enrollment and screening requirements to participate in Medicaid
  - Required billing elements such as Present on Admission (POA) to track preventable adverse events
  - Prohibition of using off shore companies
Customer Service
Customer Care Center

Committed to providing excellent service to members and providers

Telephone support
- **Provider**: 888-292-4487
- **Member**: 888-292-4480
- **TTY**: 888-292-4485
- Monday to Friday
- 7 a.m. to 6 p.m. CT

Web Support at

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* Website functionality coming soon
24/7 Nurse Line

- Information line staffed by registered nurses
  - 877-351-8392
  - Available 7 days a week
  - 24-hours a day

- Answer provider questions
  - After-hours member eligibility and Primary Care Physician verification

- Answer member questions
  - General health
  - Community health service referrals

- Over 300 audio health topics available to members
Eligibility Verification for STAR and CHIP

- Providers should verify eligibility before each service

Ways to verify STAR and CHIP member eligibility

- Will be able to log on to www.bcbstx.com/provider/network/medicaid.html*
- Use the State’s Automated Inquiry System (AIS) - for STAR (not CHIP)
  - **800-925-9126**
- Call the BCBSTX Customer Care Center:
  - **Provider: 888-292-4487**
    - Live person
    - Interactive Voice Response automated telephone response system
- Call the 24/7 Nurse Line after-hours
  - **877-351-8392**

* Website functionality coming soon
STAR members receive two identification cards upon enrollment:
- State issued Medicaid identification card (Your Texas Medicaid Benefit Card); this is a permanent card and may be replaced if lost
- Blue Cross and Blue Shield of Texas member identification card

CHIP members only receive a Blue Cross and Blue Shield of Texas member identification card, they do not receive a State issued Medicaid identification card

Identification cards will be re-issued to the member
- If the member changes their address
- If the member changes their Primary Care Physician (PCP)
  - The member may change their PCP at any time and the change is effective the day of request
- Upon member request
- At membership renewal
Member Benefits and Services
Some of the benefits include:

- Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
- Physician office visits, inpatient and outpatient services
- Durable Medical Equipment and Supplies
- Chiropractic Services
- Emergency Services
- Family Planning Services (any Medicaid provider in or out of network)
- Transplants
- Vision Plan by Davis Vision
- Behavioral Health by Magellan Health Services
- Pharmacy benefits administered by Express Scripts, Inc.
Some of the benefits include:

- Well-child exams and preventive health services, and screening for behavioral health problems and mental health disorders
- Physician office visits, inpatient and outpatient services
- Family Planning Services and Supplies
- Durable Medical Equipment
- Transplants
- Chiropractic Services (not covered for CHIP Perinate)
- Vision Plan by Davis Vision
- Behavioral Health by Magellan
- Pharmacy benefits administered by Express Scripts, Inc.
**CHIP Perinate Covered Benefits**

- For Mothers that do not qualify for Medicaid, their unborn baby may qualify for perinatal care as a CHIP Perinate member.

- Some of the benefits include:
  - Prenatal care through delivery
  - Medically necessary physician office visits
  - Some inpatient and outpatient services
  - Prenatal vitamins
  - Laboratory, x-rays and ultrasounds
Pharmacy Services

Pharmacy benefits are administered by Express Scripts, Inc. (ESI)

- Provider Customer Service:
  - **STAR** 866-294-1562
  - **CHIP** 866-323-2088
  - Call for 72 hour emergency supplies while waiting for prior authorization approval

- Prior authorization:
  - **STAR** 866-533-7008
  - **CHIP** 866-472-2095

- Prior authorization fax:
  - **Both programs** 800-357-9577
  - Prior authorization requests will be addressed within 24 business hours

The Benefit Identification Number (BIN), or plan identification number, is 003858
Pharmacy Services Continued

The Formulary and clinical edits will mirror Texas Vendor Drug Program
- Providers will be able to view the Formulary at www.txvendordrug.com
- For STAR only, Over The Counter (OTC) items are included if on the Formulary and require a prescription to be processed for reimbursement. Not covered for CHIP/CHIP Perinate
  - Infertility, erectile dysfunction, cosmetic and hair growth products are excluded from this benefit (OTC and contraceptives for contraception are also excluded for CHIP)
  - Diabetic monitors/devices, office based injectables, and nutritional/enteral formulas are available and should be billed to the medical benefit

Pharmacy geographical access
- Within 2 miles of the members home for a retail pharmacy in urban counties
- Within 15 miles of the members home for a retail pharmacy in non-urban counties
- Within 75 miles of the members home for a 24 hour pharmacy
STAR members have no copay; CHIP members’ copay depends on the family’s Federal Poverty Level
- CHIP Perinate unborn children will have prescription coverage with no copay
- CHIP Perinate newborns will have prescription coverage with no copay

BlueCross BlueShield of Texas offers e-prescribing abilities through Surescripts for providers to:
- Verify client eligibility
- Review medication history
- Review Formulary information

For additional information visit the website www.txvendordrug.com

The Formulary is also available for Smart Phones on www.epocrates.com
The Medical Transportation Program (MTP) is provided by Texas Health and Human Services Commission (HHSC).

STAR members can receive transportation assistance to get to and from a provider, dentist, hospital or drug store. HHSC will do one of the following:
- Pay for a bus ride or ride sharing service
- Pay a friend or relative by the mile for the round trip
- Provide gas money directly to the member/parent/guardian

If a member has to travel out of town for services, HHSC may pay for lodging and meals for the member and the member’s parent/guardian.
Claims and Billing Overview
Claims Coding

- Coding will mirror TMHP (Texas Medicaid and Healthcare Partnership) guidelines found in the most current Texas Medicaid Provider Procedures Manual.

- Access the current procedures manual at www.TMHP.com, click on “providers” and then click on “Reference Material”.

- National Drug Code (NDC) for physician-administered prescription drugs.

  - Provides a list of NDCs assigned to HCPCS procedure codes
  - May not contain a complete listing of all NDCs for any given procedure code.
Type of Billed Services

CMS-1450 (UB-04) Institutional Services
- Hospitals
- Home Health (and Home Based Therapies)
- Hospital Based ASCs
Submitting Claims

Timely filing limit is **95 calendar days** from the date of service or as stated in your provider contract:

- Electronic Submission
  - The BCBSTX required payer identification number is 84980
- Web Submission
  - This is in development and not yet functional through Availity
- TMHP Claim Portal [www.TMHP.com](http://www.TMHP.com)

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

- The EFT option allows claims payments to be deposited directly into a previously selected bank account
- Providers can choose to receive ERAs and will receive these advises through their clearinghouse. Enrollment is required
- Contact EDI Services at **1-800-746-4614** with questions or to enroll
Bill with the Medicaid Patient Control Number (PCN), or Medicaid/CHIP identification number, (field 1a). The BCBSTX alpha administrative code (X) and the BlueCard alpha prefixes are not required but will allow for more efficient processing, especially in retrieving member eligibility information (270/271 transactions) and claims status information (276/277 transactions). If you are utilizing the State portal only use the Medicaid/CHIP identification Number

- STAR: ZGTX Medicaid ID number
- CHIP: ZGCX CHIP ID number
- CHIP Perinate: ZGEX CHIP Perinate ID number

Submit paper claims to:

**Blue Cross and Blue Shield of Texas**
ATTN: Claims
PO Box 684787
Austin, TX 78768-4787
Submitting Claims Continued

- Providers are prohibited from balance-billing CHIP or STAR Medicaid members for covered services

- Claim Filing With Wrong Plan - if you file with the wrong plan and can provide documentation, you have 95 days from the date of the other carrier’s denial letter or Remittance Advice to resubmit for adjudication

- Claim Payment - your claim will be adjudicated within 30 days from date of receipt. If not, interest will be paid at 1.5% per month (18% per annum)
Complaints and Appeals
Provider Complaints

- Providers may submit complaints relating to the operations of the plan
  - Providers may file written complaints involving dissatisfaction or concerns about another physician or provider, the operation of the health plan, or a member, that are not related to a claim determination or Adverse Determination

- Complaints are required to include
  - Provider’s name
  - Date of the incident
  - Description of the incident

- Requests for additional information
  - Blue Cross and Blue Shield of Texas may request additional information or medical records related to the complaint, and providers are expected to comply with the request within 10 calendar days

- Timeframes
  - An acknowledgement letter is sent within five business days of receipt of the complaint
  - A resolution letter is sent within 30 calendar days of receipt of the complaint
Submit a complaint to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
Provider Appeals

Providers can appeal Blue Cross and Blue Shield of Texas’s denial of a service or denial of payment

Submit an appeal in writing using the Provider Dispute Resolution Form
- Submit within **120 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
- The Provider Dispute Resolution Form is in development and will be located at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html)

Requests for additional information
- Blue Cross and Blue Shield of Texas may request additional information or medical records related to the appeal, and providers are expected to comply with the request within **21 calendar days**

When will the appeal be resolved?
- Within **30 calendar days** *(standard appeals)* unless there is a need for more time
- Within **3 business days** *(expedited appeals)* for STAR
- Within **1 working day** *(expedited appeals)* for CHIP
Submitting An Appeal

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
External Review

- If a provider is still dissatisfied with Blue Cross and Blue Shield of Texas’s decision to not pay a claim after the initial appeal process, the provider may request an external review from a non-network provider of the same or related specialty.

- Submit request in writing to:
  
  Blue Cross and Blue Shield of Texas
  
  Attn: Complaints and Appeals Department
  
  PO Box 684249
  
  Austin, TX 78768
Outpatient Services

- Outpatient charges will be reimbursed according to the State of Texas Medicaid outpatient reimbursement methodology or the contracted rate.

- Outpatient surgery charges will be reimbursed according to the Medicaid Ambulatory Surgery Center groupings and locality or the contracted rate.

- Emergency room claims will be paid at the State of Texas Medicaid outpatient reimbursement methodology or the contracted rate.
  - Effective 3/1/2012 must bill with revenue code 450 and CPT codes 99284, 99285 to receive emergency room rate reimbursement.
  - Claims will be reduced if billed with CPT codes 99281-99283.
If a member is initially admitted for outpatient observation and then admitted for inpatient care

- Call BCBSTX’s Utilization Management department at **855-879-7178** for authorization for an inpatient admission;
- Allowed up to 48 hours for observation
- An authorization is required for out-of-network providers

Outpatient services are usually defined by:

- Place of Service 22 (outpatient hospital), or 23 (hospital emergency room)
- Type of Bill 131
Inpatient Services

- Children’s facilities will be reimbursed at a percentage of billed charges for services rendered.

- Other Tax Equity and Fiscal Responsibility Act (TEFRA) facilities are paid the standard dollar amount (SDA) issued by HHSC.

- Non TEFRA facilities will receive the Standard Medicaid Reimbursement-Medicare Diagnostic Related Groupings (DRG) issued by Health and Human Services Commission (HHSC)
  - Submit claims for full length of stay (interim claims are acceptable).
  - Outliers will be paid for members when the following criteria is met:
    - Under the age of 21
    - Day threshold is exceeded
    - Cost threshold is exceeded
    - If both Day and Cost outlier apply, the higher payment is paid to the hospital.
Billing On A CMS-1450 (UB-04) Claim Form

- Box 42 - Appropriate Revenue Code
- Box 43 - Appropriate CPT/HCPC Code
- Box 56 - National Provider Identifier (NPI)
- Box 60 - Member Medicaid or CHIP ID number
- Box 63 - Authorization Information
- Box 65 - Other Coverage Information
- Box 66 - Primary Diagnosis Code
Present on Admission

- Present on Admission (POA) value is required on hospital claims.
- POA is defined as present at the time the order for inpatient admissions occurs.
- Conditions that develop during an outpatient visit including emergency department, observation, or outpatient surgery are considered POA.
- POA is not currently required for all facilities.
- POA value must be submitted for each diagnosis on the claim form.
- Claims submitted without POA will be rejected unless the facility is exempt from POA reporting.
Ancillary Billing
Providers who will use CMS-1500 include:

- Ambulance
- Freestanding Ambulatory Surgical Center (ASC)
- Early Childhood Intervention providers
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Durable Medical Equipment (DME)
- Laboratory
- Physical, Occupational, and Speech Therapists
- Podiatry
- Radiology
Providers who will use CMS-1450 (UB-04) include:

- Hospital Based ASC
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Home Health Agency
- Hospital - both inpatient and outpatient
- Renal Dialysis Center
In general, no additional documentation or attachments are required for services that do not require prior authorization.

The majority of Ancillary claims submitted are for:
- Laboratory and Diagnostic Imaging
- Durable Medical Equipment (DME)
- Home Health (including therapies)
- Physical, Occupational, and Speech Therapies
Ancillary Services - Lab and Radiology

- Routine Lab and X-ray do not require prior authorization
- When billing for Lab or Radiology, all required information must be included on the claim
- Superbills, or itemized statements are not accepted as claims supplements
- Attested NPI numbers for STAR must be included on the claim
- Any services requiring prior authorization must include the authorization number on the claim form
Ancillary Services - DME

- Durable Medical Equipment (DME) is covered when prescribed to preserve bodily functions or prevent disability.
- All custom-made DME must be pre-authorized.
- When billing for DME services, follow the general billing guidelines:
  - Use HCPCS codes for DME or supplies.
  - Use miscellaneous codes (such as E1399) when a HCPCS code does not exist.
  - Attach manufacturer’s invoice if using a miscellaneous code.
  - Catalog pages are not acceptable as a manufacturer’s invoice.
  - Sales tax must be billed separately from the service code (do not include in the rental or purchase amount charged).
  - L9999 is used to bill sales tax.
Ancillary Services - Home Health

- Home Health Agencies bill on a CMS-1450 (UB-04) with the exception of DME

- DME provided during a Home Health visit must be billed on a CMS-1500

- Home Health services include:
  - Skilled Nursing
  - Home Health Aides
  - Home Health Physical and Occupational Therapy (Modifier GP for Physical Therapy (PT) and GO for Occupational Therapy (OT) must be billed for these services)
Ancillary Services - PT/OT/SP Therapies

- Independent/group therapists providing PT/OT/SP services in an office, clinic setting, or outpatient setting must bill on a CMS-1500 form.

- Prior Authorization will be required for these services, and the authorization number must be included on the claim form.

- Please refer to the Texas Medicaid and Healthcare Partnership for a listing of all applicable coding and limitations.

- Billing information will be found in the Texas Medicaid Provider Procedures Manual on the TMHP website.
  - [www.TMHP.com](http://www.TMHP.com)
Medical Management Overview
Prior Authorization vs. Concurrent Review

Prior Authorization
- Review outpatient requests
- Examples: Home Care, DME, CT/MRI, etc.

Concurrent Review
- Review inpatient requests
- Examples: Acute Hospital, Skilled Nursing Facility, Rehabilitation, etc.
Intake Department

- Assists providers in determining if an authorization is required, create cases, and forwards cases to nurses for review as needed.

- Utilization requests are initiated by the providers by either phone or fax to the Intake Department:
  - Intake phone number: 855-879-7178
  - Intake fax number: 855-879-7180
  - Intake fax number for concurrent review: 855-723-5102
Intake Department Continued

- Prior authorization and/or continued stay review phone calls and fax requests from providers
- Phone calls regarding overall questions and/or case status inquiries
- Notification of delivery processing and tracking via phone calls and fax
- Assembly and indexing of incoming faxes
- Out-of-network letter processing
The three most important questions for Utilization Management (UM) requests are:
- What service is being requested?
- When is the service scheduled?
- What is the clinical justification?

To access a list of services that require a prior authorization, Medical Policies and/or UM Clinical Guidelines used to review for medical necessity go to the BCBSTX website or request a copy from your Provider Representative

* Website functionality is in development
Please have the following information available when calling the Intake Department at 855-879-7178

- Member name and identification number
- Diagnosis code(s)
- Procedure code(s)
- Date of service
- Primary Care Physician, specialist and facility names
- Clinical justification for request
- Treatment and discharge plans (if known)
**Turn Around Times (TAT)**

- **Concurrent Stay requests (when a member is currently in a hospital bed)**
  - Within **24 hours**

- **Prior authorization requests (before outpatient service has been provided)**
  - Routine requests: within **three calendar days**
  - Urgent* requests: within **72 hours**

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* URGENT Prior Authorization is defined as a condition that a delay in service could result in harm to a member.
Nurse Review

Nurses utilize Clinical Guidelines, Medical Policies, Milliman Guidelines, and plan benefits to determine whether or not coverage of a request can be approved

- If the request meets criteria, then the nurse will authorize the request
- Nurses review for medical necessity only, and never initiate denial
- If the request does not appear to meet criteria the nurse refers the request to a Peer Clinical Reviewer (PCR) – a.k.a. Physician Reviewer
The Peer Clinical Reviewer (PCR) reviews the cases that are not able to be approved by the nurse.

Only a physician can deny service for lack of medical necessity.

If denied by the PCR, the UM staff will notify the provider’s office of the denial. Providers have the right to:

- Request a peer-to-peer discussion with the reviewing physician
  - 877-496-0071
- Appeal the decision
  - Submit an appeal in writing using the Provider Dispute Resolution Form within 120 calendar days from receipt of the Remittance Advice (RA) or notice of action letter
  - The Provider Dispute Resolution Form is in development and will be located at www.bcbstx.com/provider/network/medicaid.html
Submitting an Appeal

Submit an appeal to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals Department
PO Box 684249
Austin, TX 78768
Utilization Management (UM) staff utilize the BCBSTX Network Department to assist with one-time contracts for out-of-network contract negotiations.
Retrospective Requests

- The service has already been performed - medical record documentation needs to be submitted with the claim.
- A UM case will not be started if a retrospective case is called into the Intake Department.
- The Post Service Clinical Claims Review Unit (PSCCR) reviews retrospective cases.
Provider Website

The provider website contains resources such as:
  – Access to list of services requiring Prior Authorization
  – Access to Prior Authorization Toolkit
  – Access to view Clinical Guidelines
  – Access to many other very helpful resources and forms

Log on at www.bcbstx.com/provider/network/medicaid.html

* Website functionality is in development
Prior Authorization Toolkit

- Contains a list of more than 30 procedure specific pre-service forms, including Synagis, bone stimulators, insulin pumps, home oxygen, bariatric surgery, wheelchairs, and more

- The provider completes the form and faxes it to the Intake Department at:
  - 855-879-7180

- If the form is completed fully and criteria is met, the Intake Department can authorize the request without forwarding for a nurse review
Codes Requiring Authorization

- Reviewed on a periodic basis, approximately every two years
- The authorization list will be available on line at [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html)*

* Website functionality coming soon
Notification of Newborn Delivery

To enable the healthiest outcome for both mothers and babies, and to help ensure needed services are obtained in a timely manner, BCBSTX requests, but does not require, that we receive notification of all newborn deliveries within three days of delivery:

- Use the Newborn Enrollment Notification Report found on the BCBSTX website: [www.bcbstx.com/provider/network/medicaid.html](http://www.bcbstx.com/provider/network/medicaid.html)*
- Failure to notify us will not result in denial of newborn claims

Routine vaginal or cesarean deliveries do not require medical necessity review/prior authorization

* Website functionality coming soon
The mission of Case Management (CM) is to empower members to take control of their health care needs by coordinating quality health care services and the optimization of benefits.

The CM team includes credentialed, experienced registered nurses many of whom are Certified Case Managers (CCMs) as well as social workers.

Social workers add valuable skills that allow us to address not only the member’s medical needs, but also any psychological, social and financial issues.
Providers, nurses, social workers and members, or their representative, may refer members to Case Management in one of two ways:

- Call 855-879-7178*
- Fax a completed Case Management Referral Form to 866-333-4827

  - A Case Manager will respond to the requestor within three business days
A 49 year old, 88 pound woman in end-stage Chronic Obstructive Pulmonary Disease (COPD). Member was referred to CM from a post-discharge call screening following an admission for COPD exacerbation. Co-morbidity of throat cancer which had been diagnosed and treated earlier in the year with chemotherapy and radiation therapy.

- Received Social Worker support for getting home air conditioning fixed by landlord and for obtaining nutritional supplements
- Sent member’s physician paperwork for Abbott Patient Assistance program for prescription
- Obtained a home glucometer from Bayer Customer Service
- Helped spouse find in-home assistance through a community program
- Facilitated collaboration between CM, PA, Customer Care, physicians, hospital staff, home health and medical equipment providers
- Member is now enrolled in hospice and will be disenrolled from CM
Questions?
Thank you for your time!
We look forward to working with you!

Please complete and fax the training evaluation form.