# Federal Employees Program

Federal Government Contracting with Health Plans to Provide Health Care Benefits Coverage for its Employees and Retirees.

Kansas City

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

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# Federal Employee Program

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# Service Benefit Plan (FEP)

Through the Federal Employees Health Benefits (FEHB) Program, the federal government contracts with health plans to provide healthcare benefits coverage for its employees and retirees. Membership records for federal employees are maintained in Washington, D.C.

The Blue KC plan that is part of the FEHB program is termed Service Benefit plan. More federal employees and annuitants subscribe to the Service Benefit plan than any other FEHB plan. The Service Benefit plan is also referred to as the Federal Employee Program (FEP).

## Membership Options

FEP members are enrolled in **Preferred-Care Blue PPO** and can choose a Standard, Basic or FEP Blue Focus option that covers the same services and supplies, it is just the network choices that differ.

### Standard Option

Members can use both in-network and out-of-network Providers or facilities.

### Basic Option and FEP Blue Focus

Members can only use an in-network Provider or facilities.

## Identifying Members

**The type of coverage is identified on the member's ID card as an enrollment code, as defined below:**

| Code | Option | Coverage |
|---|---|---|
| 104 | Standard | Self Only |
| 105 | Standard | Self and Family |
| 106 | Standard | Self Plus One |
| 111 | Basic | Self Only |
| 112 | Basic | Self and Family |
| 113 | Basic | Self Plus One |
| 131 | FEP Blue Focus | Self Only |
| 132 | FEP Blue Focus | Self and Family |
| 133 | Basic | FEP Blue Focus |

**ID Card Details**

The Federal Employee Program (FEP) member ID cards will have an ID number that begins with "R" followed by 8-digits.

## Member Rights & Responsibilities

Blue KC provides services for the Federal Employee Health Benefits (FEHB) members. Blue KC shall pay Provider for covered services deemed medically necessary by Blue KC. These members have specific rights and responsibilities which are posted on FEPBlue.org.

1. We ask that members give us and their healthcare providers' accurate information regarding their health and wellness (including any allergies, medications or over-the-counter (OTC) products), so that collectively we can better work with members to reach their health goals. Together, members' healthcare team should develop a mutually agreed upon care plan. Members should work with their team to better understand these agreed upon goals and follow the plan to the best of their ability. If a member has any information that could affect his/her care – such as a living will or power of attorney – members should provide this information to providers.

2. Healthcare providers must allow members and/or someone they choose, to actively participate in healthcare decisions. Members should ask Provider representatives any information related to a diagnosis, evaluation, treatment or prognosis. Members should discuss any medical treatment options related to their health with providers, regardless of the treatment cost or whether or not we cover it. If members choose to receive treatment that is not a covered benefit, they agree to accept any of the charges as outlined in the Blue Cross and Blue Shield Service Benefit plan brochure.

3. Like the providers who participate in our network, we respect members' right to privacy. Members can approve or refuse the release of any personal information. We hold all our member records confidential and will only release them to the appropriate entities if required to do so by law. The Agreement shall not restrict any disclosure required by law. If responding to a formal disclosure request by law, party must give advance notice to other party involved and take all action to not disclose unnecessary confidential information.

4. Above all, we will always treat members with dignity and respect. The same treatment members expect from us, we ask members to also provide to us, and anyone else involved in their healthcare. If members have any comments, concerns or complaints, we want them to voice those to us by calling the number on the back of their member ID card or on the Contact Us page. Also, if members ever feel the need to change providers for any reason, they can do so easily by searching our Provider Directory.

5. Providers can always ask us for more information about what to expect from members and what members should expect from their healthcare team. Members also have the right to ask for more information about our organization, the providers who participate in our network and their rights and responsibilities. If members have any recommendations on this rights and responsibilities statement, please let us know or have them contact us.

# Summary of Benefits

All benefits are subject to the definitions, limitations and exclusions stated in the member's policy. The summary of benefits, for the Standard and Basic options for the current year, can be found on our website on the *brochures and forms* page (see Contact Resource Directory). There is a separate brochure for the **FEP Blue Focus** product that can be found on the FEP Blue website on the brochures and forms page.

# Cost-Containment Measures

Like all FEHB plans, the Service Benefit plan (FEP) has a fee-for-service, cost containment measure. All plans include two specific provisions in the benefit package, pre-certification of inpatient admissions and a flexible benefits option.

## Pre-certification

The member is responsible for ensuring that pre-certification is obtained for all inpatient admissions except routine maternity. Either the member or the member's Provider must contact the local plan prior to the admission to obtain the certification and length of stay assignment.

A $500 per admission benefit reduction occurs if pre-certification is not obtained.

Pre-certification is not required for hospital admissions when Medicare Part A or another group health insurance is primary, or when confined in a hospital outside the United States or Puerto Rico.

## Flexible Benefits Option

Under this Flexible Benefits option, Blue KC has the authority to determine the most effective way to provide services. Blue KC may identify medically appropriate alternatives to traditional care and coordinate plan benefits as a less costly alternative benefit. These are subject to ongoing review and Blue KC may elect to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of future benefits. The decision to offer an alternative benefit is solely Blue KC's, may be withdrawn at any time and is not subject to Office of Personnel Management (OPM) review under the disputed claims process.

# Deductibles

Deductible information for the current year, can be found at fepblue.org.

## Carryover After Enrollment

When the effective date of an Open Season enrollment change for an enrollee is after January 1, any covered expenses incurred from January 1 to the effective date of the change count toward the prior year deductible of the prior plan or option.

If the prior year deductible has been met, the prior plan or option will pay for the covered services rendered from January 1 to the effective date of the change at the new year's level of payment. If the deductible has been partially met, the prior plan or option will first apply the covered expenses to meet the rest of the deductible and then provide reimbursement for covered expenses at the new level of payment.

# Prior Authorization

Prior authorization is a prior review of all services including inpatient stays that are medically necessary as well as services and supplies covered under the Provider Agreement of the member's Benefit Plan. The services listed in the table on page 7 require prior authorization before they may be rendered. Additional information can be found in the Service Benefit plan brochure under "How You Receive Benefits."

| Services Requiring Prior Authorization | |
|---|---|
| Outpatient Sleep Studies | Required for sleep studies performed in a Provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not your home. |
| Applied Behavior Analysis (ABA) | Required for ABA and all related services, including assessments, evaluations and treatments. |
| Gender Affirming Surgery | Prior to surgical treatment of gender dysphoria, your Provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior authorization must be obtained if the treatment plan is approved and your Provider later modifies the plan. |
| BRCA Testing | Required for BRCA testing and testing for large genomic rearrangements in the BRCA 1 and BRCA 2 genes whether performed for preventative or diagnostic reasons. The medical information necessary to make a coverage decision will be requested by Blue KC for these services. |
| Hospice Care | Required for home hospice, continuous home hospice or inpatient hospice care services. We will advise which home hospice care agencies we have approved. The medical information necessary to make a coverage decision should be requested by Blue KC for these services. |
| Organ and Tissue Transplant | Blue KC should request the necessary medical information to make the appropriate medical decision. Both the facility and the procedure require prior authorization. Blue KC will also make sure the member meets the criteria of transplant established by the facility. Members also have enhanced benefits if they receive the transplant services from a Blue Quality Center for Transplant (BQCT). |
| Clinical Trials for Certain Organ and Tissue Transplants | Contact us at the customer service number listed on the back of the member's ID card for information or to request prior authorization before obtaining services. We will request the medical evidence we need to make our coverage determination. |
| Prescription Drugs and Supplies | Certain prescription drugs and supplies require prior authorization. Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior authorization or to obtain a list of drugs and supplies that require prior authorization. The Retail Pharmacy Program will request the medical evidence necessary to make a coverage determination. |
| Outpatient | **Intensity-modulated Radiation Therapy (IMRT)**<br><br>Required for all outpatient IMRT services except IMRT related to treatment of head, neck, breast or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior authorization is required. The medical information necessary to make a coverage decision will be requested by Blue KC for these services. |
| Outpatient Surgery | **Morbid obesity, outpatient surgical correction of congenital anomalies and outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.**<br><br>These surgical services require prior authorization for care performed by Preferred, Participating/Member and Non-participating/Non-member professional and facility providers. The medical information necessary to make a coverage decision should be requested by Blue KC for these services. |
| | Proton beam therapy, stereotactic radiosurgery, and stereotactic body radiation therapy. |
| Sperm/egg Storage | Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility. |

### Change in ID Number

When an enrollee is assigned a new FEP identification number for any reason, the amount applied to the deductible and the benefit maximums under the old identification number will be transferred to the new identification number. Re-enrollment under the existing option occurs within same year in which the previous FEP coverage was terminated or canceled. The only thing that changes is a new identification number. This provision occurs with or without a break in coverage), includes spouses eligible under the Spouse Equity Act and ID cards are only issued under the policyholder's name.

### Coinsurance

Coinsurance is the percentage of covered charges the member must pay once the applicable deductible is satisfied and Blue KC has paid for the benefits. The plan will base this percentage on either the billed charge or the allowable charge, whichever is less. The member's share of covered charges (after meeting any applicable deductible) is limited to the stated coinsurance amounts based on the allowable charge.

### Using Preferred and Member/Participating Physician

For Provider services, coinsurance will be based on the lesser of the billed charge or the negotiated amount that providers have agreed to accept, including any savings Blue KC realizes through discounts that are known and that can be accurately calculated at the time the claim is processed.

*For example, when Blue KC pays 65 percent of the allowable charge for a covered service, the member is responsible for the coinsurance which is the remaining 35 percent of the allowable charge.*

### Using Non-Participating Physicians

Under the Standard option, members who use a non-participating physician may have significantly more patient responsibility. Under Basic Option and FEP Blue Focus, no benefit is available when a non-participating physician is used.

# Claim Processing

## Claims and Payments

### Secondary Payor

When FEP is the secondary payor, Blue KC determines the allowance. After the primary plan pays, FEP pays what is left of the Blue KC allowance, up to the FEP regular benefit. Blue KC does not pay more than the Blue KC allowance up to the FEP regular benefit. In certain circumstances when FEP is the secondary payor and there is no adverse effect on the member, Blue KC may use Provider discount arrangements coordinated by the primary plan.

## Preferred Providers

### Basic Option and FEP Blue Focus

Members may **only use preferred providers.** No benefit is available when a non-participating Provider is used.

### Standard Option

Members may **use preferred or member/participating providers**. Members who use a non-participating Provider may have significantly more patient responsibility.

## Copayments

A copayment is the stated amount the member must pay for certain covered services before the FEP program makes its payment.

For outpatient facility care, inpatient and outpatient mental conditions and substance abuse care at in-network hospitals, the members are responsible for the lesser of the sum of the applicable per day copayments, the billed charge or the Preferred or Member rate, after they have met any applicable deductibles.

## Prescription Drugs

The pharmacy carrier for retail and mail order is Caremark. See the Service Benefit plan brochure for the current year benefit as well as the cost per tier. Outpatient prescription drugs are not covered under either Medicare Part A or Part B.

## FEP Claims Submission

FEP claims should be submitted on a CMS claim form using the appropriate CPT or HCPCS codes and must be submitted within 180 days from the date of service. Fax claims inquiries to the FEP member number indicated on the Claim Inquiry form. The Claim Inquiry form is available on the Provider website (see Contact Resource Directory).

Claims must be submitted no later than 180 days after date of service. If not submitted within this period, claims will not be honored and the Provider will not bill members for services associated with such claims. Providers submit complete and accurate claims of covered services to members within 180 days after date of service to receive payment from Blue KC. Provider must obtain a signed release of information and assignment of benefit form from all members.

The Provider has an additional 90 days to file claims if payor causes delay, including if the Provider is unaware to member's insurance time availability to file claim, or the Provider experiences problems with Coordination of Benefits. Providers need to give Blue KC written notice of a request for review within 90 days of the disallowance, payment or other notice of adjudication.

Final claim adjudication's shall include itemized information deemed necessary by payor. Provider must enter diagnosis and procedure codes consistent with member's medical records when reporting claims to payor.

### Appeals of Medical Necessity/Appropriateness

Under the Federal Employee Program (FEP), review and appeal rights are available to the member as outlined in the Service Benefit plan brochure, under the Disputed Claims Process. Providers need to give Blue KC written notice of a request for review within 90 days of the disallowance, payment or other notice of adjudication. For claims for services rendered to a member under the Federal Employee Health Benefits Program (FEP), some adjustments are possible even after the 90 day period.

## Tips to Avoid Claim Processing Delays

- Lab charges need to be filed with a medical diagnosis. A diagnosis of laboratory exam will be denied for a more specific diagnosis.
- Physical therapy, occupational therapy and speech therapy claims need to be itemized and filed by individual dates of service. One copayment applies per day when two types of therapies are billed by one Provider. Two separate copayments apply per day when two types of therapies are billed by two different providers.
- When a treatment plan is being submitted for behavioral health or substance abuse services, the number of days of authorization being requested must be indicated for each visit the member will have.
- If a patient is Medicare age 65 or older, please verify Medicare eligibility prior to submitting the claim to Blue KC.
- Home nursing claims must be billed on a HCFA 1500 claim form using a professional Provider number.
- Facility and/or Provider numbers on prior authorizations must match the facility and/or Provider number on the claims being submitted for the services. If the facility and/or Provider numbers do not match, the claim will deny for no prior authorization.
- Providers who accept Medicare's assignment of benefits agree to accept the amount approved by Medicare for covered service as payment in full. FEP benefits are provided for the applicable Medicare deductible and coinsurance amounts. Members are not responsible for any difference between the Provider's charge and the combined Medicare and FEP payment. Under the Basic option, only services rendered by in-network providers are payable.
- When billing for late charges or corrected/replacement charges, please use the appropriate bill type.
- Providers cannot update other insurance information for a member. Providers can retrieve a Coordination of Benefits survey via the web. The member must update this information by responding to a Coordination of Benefits survey or by calling the Federal Customer Service Department (see Contact Resource Directory). To update Medicare eligibility, the member must provide a copy of his/her Medicare card.
- CRNA and Anesthesiologists must submit a claim using valid anesthesia procedure codes and modifiers.
- Claims must be submitted with valid charge amounts. Zero charge claims will not be accepted or processed.

# Coordinating Benefits with Medicare

The FEP program covers many of the same kinds of expenses as Medicare. But, FEP will never pay primary benefits for qualified skilled nursing facility care.

Any member who is eligible for Medicare may enroll in a Medicare+Choice (should this be Medicare Advantage) plan and also remain enrolled with FEP. An annuitant or former spouse can suspend their FEHB coverage and enroll in a Medicare+Choice plan if one is available in their area.

## Primary Payor

**FEP is the primary payor in these situations:**

1. If the member is employed by the federal government, age 65 or older and has Medicare Part A or Medicare Parts A and B.
2. If the spouse covered under the FEP contract is 65 years of age or older, has Medicare Part A or Parts A and B and the contract holder or the spouse is employed by the federal government.
3. When the member is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) (when Medicare was not already primary for the member due to age or disability).
4. If the member is employed by the federal government and the member is under age 65 and eligible for Medicare benefits solely on the basis of disability.

**Medicare is the primary payor if:**

1. The member is an annuitant age 65 or over, covered by Medicare Part A or Parts A and B and is not employed by the federal government.
2. The covered spouse is age 65 or over, has Medicare Part A or Parts A and B and neither the member nor the spouse is employed by the federal government.
3. The member is age 65 or over and is: (A) a Federal judge who retired under Title 28 of U.S. Code or (B) a Tax Court judge who retired under Section 7447 of Title 26 of U.S. Code. Medicare is also primary for the covered spouse of a retired judge described in (A) and (B).
4. The member is an annuitant, not employed by the federal government and either the contract holder or a covered family member (who may or may not be employed by the federal government) is under the age of 65 and eligible for Medicare on the basis of disability.
5. The member is enrolled in Medicare Part B only, regardless of his/her employment status.
6. The member is age 65 or over, employed by the federal government in an appointment that excludes similarly appointed non-retired employees from FEHB coverage and has Medicare Part A or Parts A and B.
7. The member is a former Federal employee receiving workers compensation and the Office of Workers' Compensation has determined that the member is unable to return to work.
   - The member has completed the 30-month End Stage Renal Disease (ESRD) coordination period and is still eligible for Medicare due to ESRD.
   - The member becomes eligible for Medicare due to ESRD after Medicare has assumed primary payor status for the member under rules 1) through 7) above.

# Coverage Options

## When Medicare is the primary payor, the benefit limits and lifetime maximums are not waived.

FEP benefits in coordination with Medicare are not paid like Medicare complementary coverage. If FEP members have Medicare Part A or B, most FEP deductibles and coinsurances are waived, for covered services, if Medicare is the primary payor. This applies to both Standard, Basic and FEP Blue Focus. Any visit limitations that apply to member's care under the FEP are still in effect when Blue KC/FEP is the secondary payor. Outpatient prescription drugs are not covered under either Medicare Part A or Part B.

### Medicare Part A - Hospital Insurance

- Covers inpatient hospital care, inpatient care in a skilled nursing facility, home healthcare and hospice care.
- Under Standard option, when the member has Medicare Part A as his/her primary coverage, he/she does not have to meet the FEP inpatient per admission deductible for care in a member or non-member hospital. All of the covered inpatient care expenses in a Preferred Member or non-member hospital are paid in full when Medicare is primary. The requirement for pre-certification for hospital admissions is waived.
- Under Basic and FEP Blue Focus option, only services in a network facility are paid in full when Medicare is primary.
- Under the FEP Blue Focus option, precertification is required for Part A services.

### Mental Conditions and Substance Abuse

Under Standard option, when a member with Medicare Part A as the primary payor is hospitalized for the treatment of mental conditions or substance abuse in a Preferred Member or non-member hospital, the per day copayment is waived. Under Basic option, only services rendered in an in-network facility are covered.

### Home Hospice Care

Under home hospice care benefits, any per admission deductible on inpatient hospital care in a member and non-member hospital and freestanding inpatient hospice facility is waived for Standard option. Under the Basic option, only services rendered by in-network providers are payable.

### Skilled Nursing Facility Care

When Medicare Part A is primary and FEP secondary, Medicare pays the 1st through the 20th day in full. FEP benefits begin on the 21st day (when Medicare Part A copayment begins) and will continue to the end of the 30th day. The Medicare Part A benefit period starts after the member has been out of the skilled nursing facility or hospital for 60 consecutive days. The Basic option members have no benefits for skilled nursing.

## Medicare Part B - Medical Insurance

- Covers Provider services, outpatient hospital services and equipment and supplies. Part B also provides benefits for home healthcare if the subscriber does not have Part A.
- Under Basic option, members are required to use in-network providers in order to receive covered benefits.

### Deductibles and Coinsurance

When the member has Medicare Part B and Medicare is the primary payor, he/she does not have to meet any applicable FEP calendar year deductible.

- Coinsurance amounts under surgical, maternity, mental conditions and substance abuse and other medical benefits are waived.
- Copayment for each home and office visit, outpatient consultation and outpatient second surgical opinion will be waived.
- Copayments for physical examinations provided by network providers are waived. Under Basic and FEP Blue Focus option only services rendered by in-network providers are payable.

### Participating Providers

All Medicare participating providers must accept the Medicare assignment of benefits. The Provider must accept Medicare as form of payment. Blue KC, or the applicable Provider, will make payment only for Medicare cost sharing amounts. Non-Medicare Participating providers can choose this on a claim-by-claim basis. However, all eligible providers must file the Medicare claim.

Federal law prohibits Non-Medicare Participating providers from charging more than a certain percentage in excess of Medicare's prevailing charge. This limit on non-participating Medicare Provider's charges for covered Medicare services is called the "limiting charge." The limiting charge must be accepted as payment in full by the Provider. The limiting charge only applies to members that are age 65 or older that do not have Medicare.

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