Farm Bureau HEALTH PLANS
Tennessee

Quick Reference Guide

Medicare Advantage

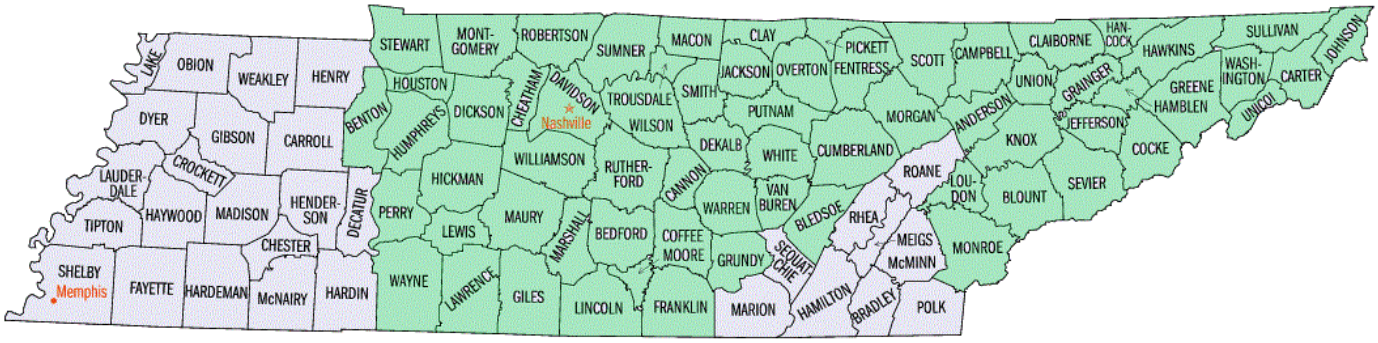
2024

QUICK REFERENCE GUIDE

2024 Service Area

The plan will be offered in accordance with Centers for Medicare and Medicaid Services (CMS) guidelines for Plan Year 2024 for Medicare Eligible individuals in:

Anderson	Bedford	Benton	Bledsoe	Blount
Campbell	Cannon	Carter	Cheatham	Claiborne
Clay	Cocke	Coffee	Cumberland	Davidson
DeKalb	Dickson	Fentress	Franklin	Giles
Grainger	Greene	Grundy	Hamblen	Hancock
Hawkins	Hickman	Houston	Humphreys	Jackson
Jefferson	Johnson	Knox	Lawrence	Lewis
Lincoln	Loudon	Macon	Marshall	Maury
Monroe	Montgomery	Moore	Morgan	Overton
Perry	Pickett	Putnam	Robertson	Rutherford
Scott	Sevier	Smith	Stewart	Sullivan
Sumner	Trousdale	Unicoi	Union	Van Buren
Warren	Washington	Wayne	White	Williamson
		Wilson		



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Contact Numbers

Below are commonly requested departments within Farm Bureau Health Plans and numbers to reach those areas.

Eligibility Verification: (833) 999-0135
Appeals and Grievances: 800-608-2667
Care Management: 800-608-2667
Prior Authorizations: 800-608-2667
Case Management: (800) 608-2667
Customer Service: (833) 999-0103
Provider Service: (833) 999-0135
Utilization Management: 800-608-2667

TTY/TDD: call 711

- Supplemental Vendor Numbers

  Delta Dental: (866) 327-0274 TruHearing: (888) 939-9557

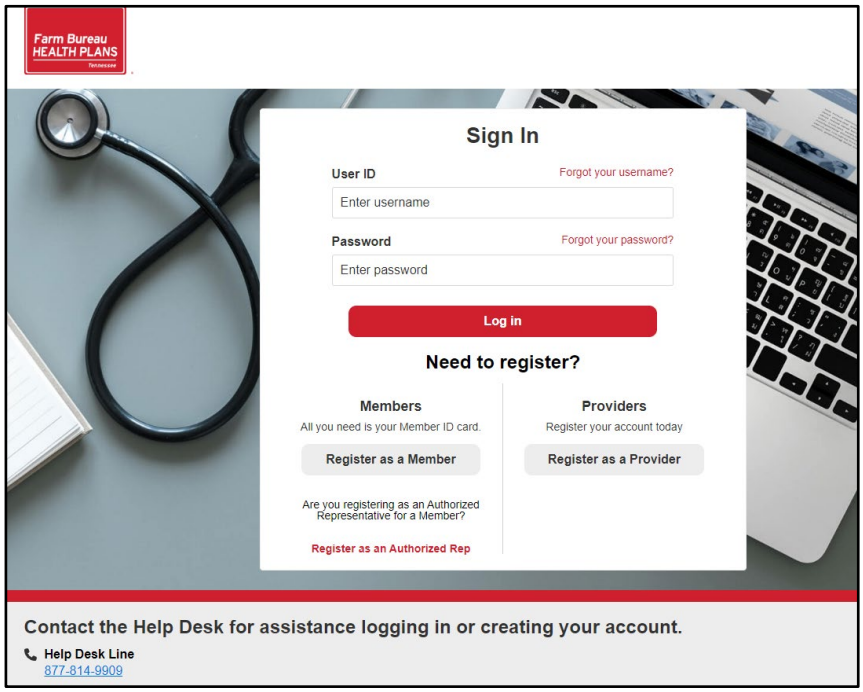
  Vision (VSP): (844) 290-8924 Pharmacy: pharmacyprovidercommunications@optum.com

Medicare Advantage Provider Resources and Provider Portals

Providers are asked to register for the portals. The first of two portals to register for will be the FBHP portal. This portal allows providers to submit Prior authorizations and check Prior Authorization status.

https://fbhealthplans.com/mapd-provider/

Providers should go to: **https://fbhpbeta.healthtrioconnect.com/app/index.page?** to get to the registration page for this portal.



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Providers will need their basic demographics and their tax identification number and appropriate NPI numbers. If multiple people from the Provider's practice will have access to this portal, the Provider must determine a point person to be the Provider's administrator for access to this portal.

The second portal that providers should register or connect with is for the Plan's clearinghouse which is Change Healthcare, (https://www.changehealthcare.com). This portal allows the providers to submit claims, check claim status, receive remittance advices, get electronic funds transfer (EFT).

Providers will need to register for Farm Bureau Health Plans Medicare Advantage HMO with the **payer number 62045** and the electronic data interchange **(EDI) number RP061** (R, P, zero, 61). If there are questions Change Healthcare can be reached at:

Claim Status Inquiry - (866) 506-2830

EFT Access - (866) 506-2830

Providers have access to training and resource documents including the most current Prior Authorization Grid. This information for providers is available at https://fbhealthplans.com/mapd-provider/ or scan this QR code.

Information available at this site includes, Provider Manual, Quick Reference Guide, Prior Authorization code list and other resources which will assist you in navigating information to help with your needs as you provide services to Farm Bureau Advantage members.

Farm Bureau Advantage is a Medicare Part C HMO plan and as such requires certain services and treatments be prior authorized. The Prior Authorization list is available on the **FBHP Medicare Advantage Provider Resources** page (https://fbhealthplans.com/mapd-provider) .

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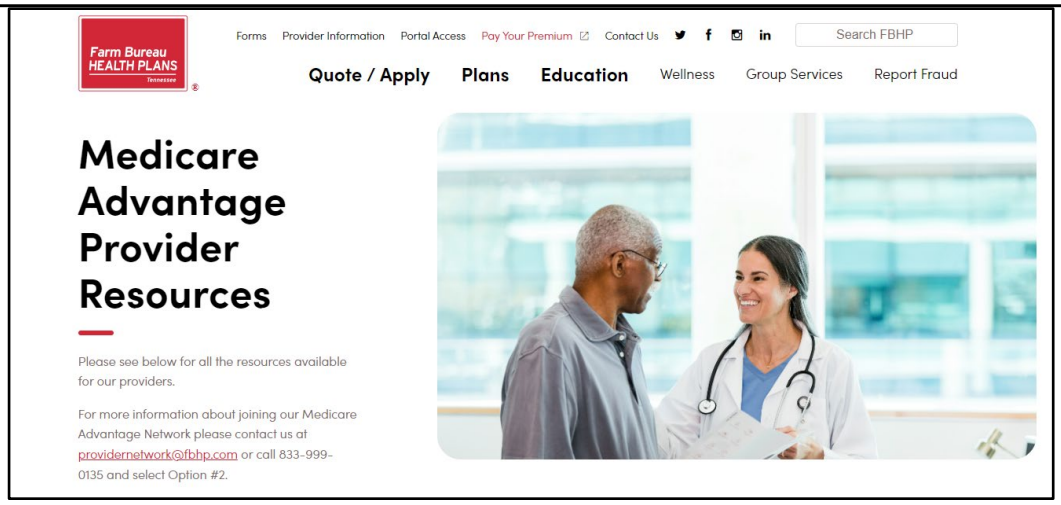
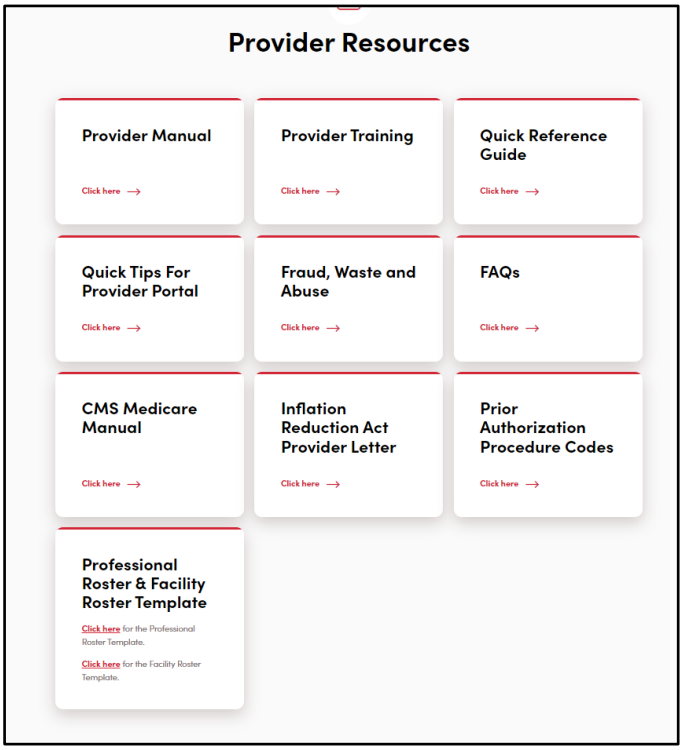


Prior Authorization information can also be found on the Provider Portal at:

http://fbhp.com/portal-access

http://fbhp.healthtrioconnect.com

Or by calling: 800-608-2667



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Prior Authorization Requirements

Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary.

FBHP Advantage uses InterQual as the evidence-based guidance for coverage determinations. Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary.

Prior Authorization instruction for the Provider Portal

Submit Prior Authorization request via the portal at www.fbhp.healthtrioconnect.com or **fax your request to (844) 263-1928**. You may also call with Prior Authorization request at (800) 608-2667.

The Prior Authorization request form can be located at https://fnhealthplans.com/mapd-provider.

Submit Prior Authorization request via the portal at www.fbhp.healthtrioconnect.com or fax your request to (844) 263-1928. You may also call with Prior Authorization request at (800) 608-2667.

The Prior Authorization request form can be located at https://fbhealthplans.com/mapd-provider .

QUICK REFERENCE GUIDE

Farm Bureau Health Plans - Prior Authorization Form
Phone: (800) 608-2667
Fax: (844) 263-1928

PATIENT INFORMATION

Last Name: First Name: DOB:
Insured ID #: Phone:
Address: City: State: Zip:

PLEASE CHECK ONE OF THE FOLLOWING

☐ **Routine**
☐ **Expedited/ Urgent:** (Applying the standard time-frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function)

REQUESTING PROVIDER INFORMATION:

Provider Name:
Group Name:
Specialty:
Tax ID#:
Address:
City: State: Zip:
Contact Name:
Phone: EXT:
Fax:

PLACE OF SERVICE INFORMATION

Provider/ Facility:
Group Name:
Specialty:
Tax ID#:
Address:
City: State: Zip:
Contact Name:
Phone: EXT:
Fax:

SERVICES

DOS:

DME ITEMS (CHECK ONE) ☐RENTAL ☐PURCHASE

TYPE OF SERVICE: ☐OUTPT ☐NPT ☐Office ☐Surgery Center ☐SNF ☐Home ☐Other:

Diagnosis Code(s):

CPT/HCPCS CODE(S):
(INCLUDE NUMBER OF UNITS PER CODE)

PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

Other/ Notes:

- ALL SECTIONS OF THIS FORM MUST BE COMPLETED.
- ON ADVERSE DETERMINATIONS, A RECONSIDERATION/EXPEDITED APPEAL MAY BE REQUESTED.

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

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Identification Cards

Each Farm Bureau Health Plan member will receive a Farm Bureau Health Plans identification card. The card will provide information you need to process the patient through your system. Please see the sample card below.

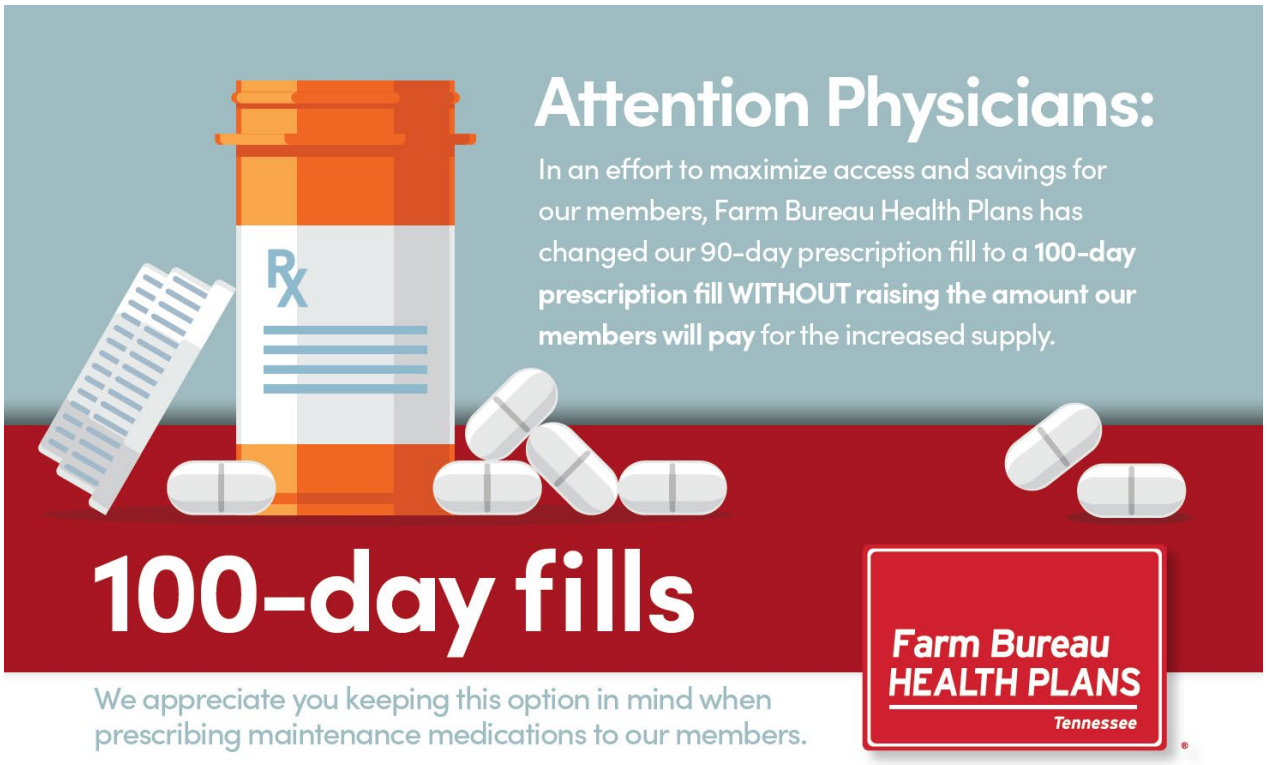
Front of ID Card

Back of ID Card

QUICK REFERENCE GUIDE

Benefits

New for 2024



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Value Added Benefits

Farm Bureau Health Plans offers Value Added Benefits for Members in the Farm Bureau Health Plans Medicare Advantage Plan. Farm Bureau Advantage has waived the 3-day inpatient stay requirement.

The Value Added Benefits include:

The Dental Benefit offers members:

Two (2) oral exams per year, with zero ($0) co-pay,
Two (2) prophylaxis (cleanings), with zero $(0) copay,
Two (2) fluoride treatments, with zero ($0) copay,
One (1) bitewing dental x-ray, with zero ($0) copay,
One (1) panoramic x-ray every five (5) years, with zero ($0) copay.

Comprehensive Dental Benefit offers members:

One (1) filling per year, with twenty percent (20%) copay,
One (1) crown repair per five (5) year period, with fifty (50%) copay,
Diagnostic services are unlimited, with zero (0) copay,
Endodontics one (1) per year, with fifty percent (50%) copay,
Periodontics one (1) per year, with fifty percent (50%) copay,
Perio surgical one (1) per year, with fifty percent (50%) copay,
Perio non-surgical one (1) per year, with fifty percent (50%) copay,
Extractions one (1) simple extraction per year, with twenty percent (20%) copay,
Other oral surgery, with fifty percent (50%) copay,
Prosthodontics / Oral / Maxillofacial Surgery / other services one (1) per year, with twenty (20%) copay,
Bridges one (1) per five-year period, with fifty (50%) copay,
Dentures one (1) per five-year period, with fifty (50%) copay,
Implant services one (1) per year, with fifty percent (50%) copay,
Occlusal guards one (1) per year, with fifty percent (50%) copay.

The Vision Benefit offers members:

Routine eye exams, one (1) per year, with zero ($0) copay,
Eyeglasses / contact lenses, a two hundred dollar ($200) maximum benefit per year.

The Hearing Benefit offers members:

Routine hearing exam one (1) per year, with zero ($0) copay.
Hearing aids two (2) per year which must be **TruHearing** brand and obtained from a **TruHearing** provider. The copay amount $599 - $899 depending on device and optional features.

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The Fitness Benefit offers members:

Home fitness Kit for a ten-dollar $10 copay.

Gym membership annual fee at a Silver and Fit participating fitness center, for a twenty-five-dollar ($25) copay.

Over-the-Counter Card (OTC Card):

Farm Bureau Health Plans Medicare Advantage plans offers an over-the-counter card. This card supplies the Farm Bureau Advantage member with one hundred ($100) per quarter to be used within the quarter. The $100 allotment per quarter does not roll over from quarter to quarter. The card can be used for medical needs and the Medicare FSA eligible items.

Member Appeals and Grievances

Farm Bureau Health Plans will accept and process any Prescription Drug Plan (PDP) or Medicare Advantage appeal from a member or an authorized representative expressing dissatisfaction with Farm Bureau Health Plans' adverse determination. In addition, Farm Bureau Health Plans will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Farm Bureau Health Plans will identify and remove any communication barrier that might impede members or representatives from effectively making appeals. Farm Bureau Health Plans will facilitate the request to file an appeal for a member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- A TTY (711) line for the hearing impaired
- A translation service unable to speak English
- Additional accommodations for any member with special needs who is unable to follow the standard process

Farm Bureau Health Plans will provide a full and fair review of the appeal, including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice, unless the member can demonstrate good cause.

Medicare Advantage Plans: Notification of the decision will be issued within the following time frames from the date the request is received (with the exception of Medicare Part B drugs):

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Preservice – As expeditiously as required based on the member's health, but no later than 30 calendar days

- Postservice – 60 calendar days from the receipt of the request

The time frames for Medicare Part B drugs are:

- Expedited – No later than 72 hours (no extensions permitted)
- Standard Preservice – No later than seven days (no extensions permitted)

Time frames for decisions might be extended for expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension
- Farm Bureau Health Plans justifies the necessity for additional information and documents, in the best interest of the member

The extension notification to the member must occur prior to the expiration of the decision time frame and must include the right to file an expedited grievance if the member disagrees with the extension.

Medicare Prescription Drug Plans: Notification of the decision will be issued within the following time frames from the date of receipt of the request:

- Expedited – As expeditiously as the member's health condition requires, but no later than 72 hours
- Standard – Seven calendar days If the initial determination is upheld during the appeal process, the resolution letter from Farm Bureau Health Plans will provide additional information on next-level appeals.

Fraud, Waste and Abuse

Fraud, Waste and Abuse costs taxpayers billions of dollars each year and can put your health and welfare at risk. Healthcare fraud can increase the cost of services and expenses, such as premiums and amounts you pay out-of-pocket. Farm Bureau Health Plans is committed to detecting, preventing and reporting healthcare fraud, waste and abuse.

What is Fraud, Waste and Abuse?

Fraud is knowingly and willingly misrepresenting or deceiving a healthcare program for the purpose of receiving money or services not owed.

Waste is the overutilization of services that, directly or indirectly, results in unnecessary costs to the healthcare program.

Abuse is an action that may, directly or indirectly, results in unnecessary costs to the healthcare program.

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Examples of member and/or beneficiary fraud, waste, or abuse:

- Misrepresentation of status: A member or a beneficiary misrepresents identity, eligibility, or medical condition to illegally receive the drug benefit or medical service.
- Identity theft: Perpetrator uses another person's Farm Bureau Health Plan Member Identification card and/or original Medicare card to obtain services of prescriptions.
- Doctor shopping: A member or a patient consults several doctors to try to obtain multiple prescriptions for narcotic painkillers or other drugs.
- Improper Coordination of Benefits: A member or a beneficiary fails to disclose all insurance policies or leverages multiple policies to "game" the system and receive more benefits than allowed.
- Prescriptions forging, altering or diversion: Someone changes a prescription without the prescriber's approval in order to increase quantities or get additional refills of drugs, usually narcotics.
- Resale of drugs on black market: A member or a beneficiary falsely reports loss or theft of drugs or fakes an illness to obtain drugs for resale on the black market.

Reporting your Concerns

Providers, Members and other individuals can submit information to the Compliance Officer in writing or by calling the toll-free Compliance Reporting Hotline:

Contact:
Tom Tutaj
Medicare Compliance Officer
ttutaj@fbhp.com
(844) 223-3451

Farm Bureau Health Plans Compliance Mailing Address:

Compliance Department
Farm Bureau Health Plans Office
147 Bear Creek Pike
Columbia, TN 38401

Online Reporting: http://www.fbhp.ethicspoint.com

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U.S. Office of the Inspector General

Hotline: (800)-447-8477 | TTY: (800) 377-4950 | Website: oig.hhs.gov/report-fraud/index.asp

Mail: U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Medicare

Customer Service Center: (800) 633-4227 | TTY: (877) 486-2048

Website: medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud

Additional Information

To locate Provider forms, resources and other information, please visit the Farm Bureau Health Plan website.

Provider forms and additional resources please go to: **https://fbhealthplans.com/mapd-provider/**

Provider Network Management can be reached at **ProviderNetwork@fbhp.com**

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Attestation

This attestation confirms receipt of training information for Farm Bureau Health Plans Medicare Advantage Plan.

Please click **HERE** to submit the attestation form.

Thank you,

Farm Bureau Health Plans