

PracticeMatters

Important information for physicians and other health care professionals and facilities serving Unison Health Plan Medicaid members

Fall 2010



Reimbursement Policy Changes/Updates

Note Regarding Reimbursement Policies

Unless otherwise noted below, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. Unison reimbursement policies do not address all issues related to reimbursement for services rendered to Unison members, such as the member's benefit plan, Unison medical policies and the Provider Administrative Guide.

Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment.

Other applicable reimbursement policies, medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed, in their entirety, on www.Unisonhealthplan.com > Select your state> Select Unison Alliance > For Providers > Reimbursement Policies (under Links/Information).

In the event of an inconsistency or conflict between the information provided in the Provider Newsletter and the posted policy, the provisions of the posted reimbursement policy will prevail.

New Policies

Clinical Lab Edits

Based on the CMS National Coverage Determination (NCD) coding policy manual, services that are excluded from coverage include routine physical examinations and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. CMS interprets these provisions to prohibit coverage of screening services, including laboratory tests furnished in the absence of signs, symptoms, or personal history of disease or injury. A national coverage policy for diagnostic

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laboratory test(s) is a document stating CMS's policy with respect to the circumstances under which the test(s) will be considered reasonable and necessary, and not screening, for Medicare purposes.

Because many of the Unison markets follow CMS guidelines for reimbursement, Unison has made the decision to create a suite of edits for Clinical Diagnostic Lab Services. These edits will ultimately contain many of the services outlined in the CMS National Coverage Determination (NCD) coding policy manual.

Unison will be implementing two edits effective November 15 beginning with the two outlined here.

1. CPT code 82378 Carcinoembryonic antigen (CEA) will be allowed when billed with a diagnosis on the allowed "diagnosis codes for CPT 82378" diagnosis list. If the CPT code 82378 is submitted with a diagnosis that is not on the allowed "diagnosis codes for CPT 82378" diagnosis list, the claim will deny with ACA/FCA remark codes (TBD).
2. Claims submitted with CPT code 82105 Alpha-fetoprotein; serum will be allowed when billed with a diagnosis on the allowed "diagnosis codes for CPT 82105" diagnosis list. If the CPT code 82105 is submitted with a diagnosis that is not on the allowed "diagnosis codes for CPT 82105" diagnosis list, the claim will deny with ACA/FCA remark codes (TBD).

Additional edits will be added in the future and will be announced prior to the implementation.

Payment for L3000 Orthotic Inserts

Unison will allow a maximum frequency of 2 inserts billed as L3000 per foot per year. Unison will also require a prescription (Rx) for DME providers and other documentation for podiatrists/orthopedists.

Unison will no longer reimburse for inserts in states where the codes are not covered. For Medicare members, in alignment with CMS, the inserts will no longer be reimbursed.

This policy will take effect for dates of service of November 1, 2010 or later.

Observation Care Evaluation and Management Services

Unison will publish a new reimbursement policy that will address appropriate coding and documentation for Observation Care Evaluation and Management services billed on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form.

This policy does not apply to claims billed on a UB-04 form. Observation care CPT® codes 99217-99220 as quoted from the CPT manual are used to report evaluation and management services provided to new or established patients designated or admitted as "observation status" in a hospital. The policy will reinforce the correct coding guidelines as published by the American Medical Association Current Procedural Terminology manual in addition to CMS guidelines as outlined below. CMS guidelines for reporting Observation Care states:

- The medical record must contain;
 - dated and timed

- physician's admitting orders regarding patient care in observation status
- nursing notes
- physician progress and discharge notes
- Be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter
- Identify the physician was present, personally performed the services and the admission to and discharge from notes were written by the billing physician
- Satisfy E/M documentation guidelines for admission to and discharge from observation care
- 99218-99220 involve less than eight hours on the same calendar date
- 99234-99236, Observation or Inpatient Care Services for patients admitted and discharged on same date of service, involves a minimum of eight hours, but less than 24 hours on the same calendar date
- An outpatient code, 99211-99215, shall be reported for a visit in those rare instances when a patient is held in observation care status for more than two calendar dates
- Other physicians must bill codes 99201-99215 when providing services to a patient in observation status

Pursuant to the Unison "Global Days" policy, the global surgical fee includes payment for hospital observation services (99217-99220, 99234-99236) unless the criteria for modifiers 24, 25, 57 are met. Refer to the Unison "Global

Days" policy for guidelines on reporting services during a global period.

Updates

Anesthesia Policy

Preoperative and Postoperative Visits

Unison Anesthesia Policy currently follows the American Society of Anesthesiologists (ASA) guidelines which indicate the usual preoperative and postoperative visits are not separately reimbursable with anesthesia management services (CPT® codes 00100-01999 excluding 01996 and 01953).

To more closely align with the Centers for Medicaid & Medicare Services (CMS) guidelines, the following revisions will be made:

- Evaluation and Management (E/M) codes will be considered as usual preoperative and postoperative visits only when reported on the same date of service as the anesthesia management services.
- Critical care CPT codes (99291-99292) will be removed from the list of E/M CPT codes (99201-99499, 92002 92004, 92012-92014 G0396-G0397, S0273 –S0274 99201-99499) that are considered as preoperative and postoperative visits, and will be separately reimbursed when reported with anesthesia management services.
- Since the critical care CPT codes will now be separately reimbursed when reported with anesthesia management services, the requirement to report a modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) is no longer necessary and will be removed from the policy.

Anesthesia Teaching Guidelines

Based on CMS guidelines, the following revisions will be made to the anesthesia teaching guidelines for reporting anesthesia services:

- A teaching anesthesiologist (M.D.) training one Student Registered Nurse Anesthetist (SRNA) would report the modifier AA (Anesthesia services performed personally by anesthesiologist) to be reimbursed at 100% of the fee allowance. The case is not concurrent to any other anesthesia cases.
- When a teaching anesthesiologist (M.D.) and a Certified Registered Nurse Anesthetist (CRNA) are jointly training two SRNAs in concurrent cases, then the CRNA should report medical direction by use of the modifier QX (CRNA service with medical direction by a physician) for each case. However, the time reported for the CRNA is limited to actual time spent with each case.

Modifier 47

The 2010 CPT Manual states: "Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '47' to the basic service (this does not include local anesthesia).

Note: modifier 47 should not be used as a modifier for anesthesia procedures.

Effective November 15, 2010, Unison will revise the Anesthesia Policy to not reimburse for anesthesia management services (CPT® codes 00100-01999 excluding 01996) when a modifier 47 is appended.

Moderate Sedation Policy

According to the American Medical Association (AMA), anesthesia services (CPT

codes 00100-01999) should not be reported by the same physician reporting diagnostic or therapeutic procedures cited in Appendix G of the 2010 CPT® Manual.

Effective November 15, 2010 Unison will not separately reimburse for anesthesia management services (CPT codes 00100-01999 excluding 01996) when reported on the same date of service by the same individual physician or health care professional also reporting a diagnostic or therapeutic procedure cited in Appendix G of the 2010 CPT® Book and not addressed in the Anesthesia Reimbursement Policy.

Therapeutic and Diagnostic Injection Policy – Revisions and Name Change

Revisions to deny Health Care Common Procedure Coding System (HCPCS) Supply Codes when billed with CPT codes 96360-96549

Currently, the Therapeutic and Diagnostic Injection Policy only addresses reimbursement when E/M services are reported in combination with CPT codes 96372-96379. According to CPT® instructions, physician work related to hydration, injection and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff. If a significant, separately identifiable E/M is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549. CPT codes 96372-96379, which are addressed in the Therapeutic and Diagnostic Injection policy, are part of a larger section of CPT® entitled "Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration," which spans codes 96360-96549. The instructions in this section of

Current Procedural Terminology®, 2010 American Medical Association state: “If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- a. Use of local anesthesia
- b. IV start
- c. Access to indwelling IV, subcutaneous catheter or port
- d. Flush at conclusion of infusion
- e. Standard tubing, syringes, and supplies.”

CMS also follows the CPT guidelines for inclusive services.

Unison will update the Therapeutic and Diagnostic Injection Policy to deny HCPCS medical and surgical supply codes (reproduced in the appendix) identified by description as standard tubing, syringes and supplies, when reported with CPT codes 96360-96549 on the same date of service, by the same physician or health care professional.

Examples:

- A4206 - Syringe with needle, sterile, 1 cc or less, each
- A4216 - Sterile water, saline and/or dextrose, diluent/flush, 10 ml

With the adoption of the aforementioned revisions, the policy name will also be changed to the **Injections and Infusion Services Policy**.

The revised policy will be effective for dates of claims processing on or after November 15, 2010.

Unlisted Codes-clarification of protocol

Unison is increasing the requirements around claims submitted with unlisted codes. Unison continues to encourage providers to provide bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, Unison is clarifying the following requirements:

Documentation is required for all unlisted codes submitted for reimbursement. Documentation is to include, but is not limited to:

- Complete description of what the unlisted code is being used for
- Procedure report for unlisted surgical/procedure codes
- Invoice for unlisted DME/supply codes
- NDC #, dose and route of administration for unlisted drug codes

Documentation will be reviewed for appropriate coding, existence of a more appropriate code, coverage and reimbursement allowance.

Claims submitted with unlisted codes that do not have documentation with them will be denied

Quality Improvement Program

The Unison Quality Improvement Program strives to continuously improve the care and services provided to members.

Each year Unison Health Plans utilize HEDIS reporting to measure our health care performance. Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures that are related to many significant public health issues. Some of these include well-child visits, immunization rates, lead screening rates, prenatal care visits, cancer screenings and diabetes care.

In 2009, 100% of Unison Plans saw an improvement in the number of children who were completely immunized by age 2 as well as the number of babies who received the recommended number of well-baby visits by age 15 months. In 2010, two of Unison's goals are a continued increase in the number of babies who receive their recommended well visits and an increase in the number of women who receive a post-partum visit 21-56 days after delivery.

If you would like further information about our Quality Improvement Program, our annual goals or our progress towards meeting our goals, please call (412)858-4000.

Topical Fluoride Treatments in the PCP Setting

Starting immediately, physicians and certified registered nurse practitioners in the Unison MedPLUS and Unison Medicaid networks may provide topical fluoride treatments for children within the PCP setting. All providers offering these services must be appropriately

certified for topical fluoride treatments and complete a one-time online training module ("Oral Health Risk Assessment: Training for Pediatricians and Other Child Health Professionals").

When billing these services, please use procedure code D1206. Please call Provider Services at 1.800.600.9007 for online training module instructions or more information.

Electronic Claim Submission Tips

Listed below are some tips to help with Electronic Claim Submission

- Include your tax identification number (TIN) along with your NPI number to help promote timely and accurate payments
- Member ID Numbers are required
- The Payer ID number indicates where clearinghouses should direct their claims.
 - Unison Health Plan of Pennsylvania
Payer ID is: 86049
- For additional assistance with electronic claim submission please contact AmeriChoice EDI Support services at: 1-800-210-8315 or email us at ac_edi_ops@uhc.com

Carrier Tables and Payer ID Set-Up

- Set your computer system payer tables to generate electronic claims instead of paper claims
- Make sure that Payer spelling and setup are consistent. Set them as electronic vs. paper
- Confirm that new patient records and additional payer listings created by front desk staff are set to be sent electronically

- Contact your software vendor or clearinghouse with any questions you may have concerning the placement of information on your computer/practice management system

Managing Your Clearinghouse Reports

- Be sure you are working your reports! Reports show if a claim has been received by the clearinghouse and sent to the payer's system
- You should receive two sets of reports for every claim batch transmitted:
 - Clearinghouse acknowledgement - claims accepted and/or rejected by the clearinghouse
 - Payer acknowledgement- claims accepted and/or rejected by the payer
- Rejected claims must be corrected and re-transmitted electronically. Do not resubmit these claims via paper. Claims will only be rejected if there is something incorrect on the claim. Resubmitting a claim via paper will not correct the issue and may delay processing time.

How to Avoid Rejections

- The majority of rejected claims are the result of an eligibility issue such as:
 - Subscriber/Subscriber ID not found
 - Coverage has been cancelled
- Conducting an eligibility check on the patient helps avoid most rejections.
- Some Claims might be rejected due to a provider mismatch. To ensure correct matching of the provider, ensure that you are submitting with the Tax ID number as

well as the NPI number. If you are submitting the claim with the AmeriChoice Provider ID number (not required) you must ensure that the number is exact including the locator code. Should you submit the claim with the AmeriChoice Provider ID number, the system will pass the NPI and match based upon the AmeriChoice Provider ID submitted.

- Rejected claims must be corrected and re-transmitted electronically. Do not resubmit these claims via paper. Claims will only be rejected if there is something incorrect on the claim. Resubmitting a claim via paper will not correct the issue and may delay processing time.

Effectively Manage Re-Bills

- Make sure you set your re-submissions/re-bills to be sent electronically. Most systems have automatic claim re-bill capabilities that resend claims every 30-60 days if payment has not been posted.
- Do not send paper claim backup for claims that have already been sent electronically

Electronic Funds Transfer (EFT)

Receive Payment for claims electronically (EFT)

EFT (Electronic Funds transfer) is the method of transferring money from one bank account directly to another without any paper money or checks actually changing hands. One of the most common EFT programs used is Direct Deposit for payroll. EFT is safe, secure, efficient, and more cost effective than paper claim payments

Claims that may require supporting information for initial claim review:

A Note about Claim Attachments - Insurance Payers prefer to receive your claims electronically. In fact, many insurance companies have eliminated or significantly reduced the need for paper attachments for referrals/notifications, progress notes, ER visits, and more. Payers will request additional information when it is needed. Denial letters from primary carriers are not sufficient as proof of Coordination of Benefits.

You can find the EFT enrollment form and FAQ online at www.unisonhealthplan.com, or contact our EDI Support Services Team directly; we can assist you with the enrollment process. EDI Support Services: 1-800-210-8315 or email us at ac_edi_ops@uhc.com

Provider Satisfaction Survey

Tell Us What You Think

Unison is committed to making sure that our services support the ability of your practice to provide the safest and highest possible quality of health care to your patients who are our members. We value and seek administrative simplicity that takes the hassles out of clinical practice and reduces inefficiency and waste. For this reason, we periodically offer our network physicians the opportunity to comment on our services. In the near future you may be receiving a survey to evaluate the services Unison provides to you and our members. Your opinions are important to us and will help us assess the level of satisfaction with our health plan as well as identify opportunities for improvements so that we may better meet the needs of your practice.

We appreciate your time and cooperation.

The Medical Technology Assessment Committee

The Committee meets at least 10 times per year. Reports from the MTAC are reviewed by the NCMC (National Medical Care Management Committee). Recommendations are forwarded to NQMOC (National Quality Management Oversight Committee) and then disseminated to the health plans.

MTAC is responsible for the development and management of:

- Evidence-based position statements on selected medical technologies
- Assessments of the evidence supporting new and emerging technologies
- Evaluation of new usage of existing technologies
- Maintenance of externally licensed guidelines.
- The consideration and incorporation of nationally accepted consensus statements, clinical guidelines and expert opinions into the establishment of national standards for UnitedHealth Group.
- Ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses.

Provider Billing Alert-Coordination of Benefits Claims

Reminder: United Healthcare does not accept denial letters from primary carriers in place of an Explanation of Benefits. Coordination of Benefit claims that are received without information regarding the primary payers reimbursement cannot be processed.

Should you have any questions, please feel free to contact Provider Services at 1-800-345-3627.

Important Claims Mailing Address Information

Submitted by Deb Convertito and Michelle Petree per Paul Balthazor

Some time ago, we had changed our claims mailing address and are still receiving mail addressed to the old address. **Effective immediately**, all claims mailed to the old address will continue to be forwarded for one year. After that time, anything received at the old address will be returned to the sender.

Submitting electronic claims can save you time and money. If you are interested in submitting claims electronically or signing up for Electronic Remits or Electronic Funds Transfer, please visit us at www.americhoice.com or call EDI Support Services at 1-800-210-8315 to get started.

**The correct claims mailing address is:
Unison Health Plan of Pennsylvania, Inc.
PO Box 1018
Monroeville, PA 15146-5018**

Thank you and we value the services you provide to our members.

When the Patient's Request Can Lead to Fraud, Waste or Abuse

Healthcare providers familiar with recent news stories should be aware that fraud, waste and abuse against insurance programs are a high priority at both the state and federal level. Most healthcare providers run an honest practice dedicated to the health and wellbeing of their patients. However, the practices of some providers can create an environment that can impact the entire group. This can include patients asking their doctors to take actions that they say are done by other physicians. These actions, such as waiving co-pays, charging a greater amount or billing a higher code, or adding a diagnosis to cover a service are often rationalized as attempts to help the patient. For example, listing a diagnosis of diabetes on a prescription to allow a patient to obtain equipment such as shoes may seem to be helping the patient. However, in addition to insurance fraud, this diagnosis could impact the future eligibility of the patient for other insurance products. Another scenario is a patient asking for a certification or prescription for durable medical equipment the provider does not believe the patient requires. What do you do when the patient tells you that another doctor is prescribing this item for patients they know? The best practice is to stick with the facts. Is writing this order within the scope of your practice or specialty? Are you treating the patient for a condition that requires the item or prescription? If no, deny the request, and explain your decision to the patient. Always keep in mind that as the prescribing physician, you would be held responsible for the validity of the orders.

Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud and abuse. If you notice a trend of patients requesting a particular product or service you do not feel is necessary, you should reach out to your provider representative to notify them of the issue. You can also call the Special Investigations Unit Fraud Hotline at 877-401-9430.

Text4baby

Each year in the U.S., more than 500,000 babies are born prematurely and an estimated 28,000 children die before their first birthday, which is a national public health crisis.

Unison would like to inform you about an exciting new mobile information service called text4baby. An educational program of the national Healthy Mothers, Healthy Babies Coalition (HMHB), text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Text4baby is a free mobile information service designed to promote healthy birth outcomes and to reduce infant mortality among underserved populations.

With over one trillion SMS text messages sent in the U.S. last year and texting use disproportionately higher among women of childbearing age and minority populations, text messaging represents an enormous and as yet untapped channel for delivering this vital health information to those who need it most. The goal of text4baby is to address a critical national health priority through the use of mobile health technology and

demonstrate a new model for reaching and engaging underserved populations and promoting healthy behavior.

The text4baby service was initially launched in Virginia in November 2009 and nationally in January 2010. More recently, Center for Medicaid and State Operations (CMSO) Director Cindy Mann released an endorsement bulletin to all the States' Health Department Directors supporting this initiative.

Women can sign up for the service by texting BABY to 511411 (or BEBE for Spanish) to receive free SMS text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health: birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep, among others. Text4baby messages also connect women to early prenatal care as well as a variety of existing resources available to them. Of particular significance, CTIA-The Wireless Foundation has reached out to all the major U.S. mobile operators to ensure their commitment to make text4baby a free service for all subscribers. Because of this generous commitment, text4baby is the first-ever free mobile health information service in the U.S. and has great potential to reach an enormous audience.

As of April 2010, Unison Health Plan of Pennsylvania is text4baby's newest partner.

Unison Health Plan of Pennsylvania is very excited to share that we recently signed an agreement with Voxiva and HMHB Coalition to join in the partnership. Our outreach efforts will be spearheaded by our Healthy First Steps™ (HFS) Program, and we will be

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An important message to health care professionals and facilities

sending all newly identified pregnant women a text4baby flier in both English and Spanish in their welcome packets. After the member signs up, she will be asked for a participant code. Our code is HFS. Participants will also have the opportunity to opt out of the program at any time by simply texting

“STOP” to cancel the messaging. HFS Case Managers will be available to answer any questions members may have about participating in the text4baby program. We are currently in the implementation phase of full execution and are awaiting approval from all states. Once the states have approved the execution of the program, we will be sending out posters to display in your office. We will keep you posted as to the official start date.

We appreciate your help in spreading the word about text4baby and encourage you to explain and promote this program to your patients so that they may participate in this innovative way of health messaging.



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Practice Matters is a periodic publication for physicians and other health care professionals and facilities in the Unison Health Plan network.