



Commercial Payer Report

A publication of the Indiana State Medical Association

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July 10, 2006

SEMINARS

Basic ICD-9-CM Training

July 12, Indianapolis

Anatomy and Physiology

July 20, Indianapolis

Pay for Performance: It's Got To Be About Safety

Sept. 8, Indianapolis

Certification Commission for Healthcare Information Technology

Sept. 8, Indianapolis

Medical Review Panel

Sept. 8, Indianapolis

Ethics Forum

Sept. 8, Indianapolis

Tools for Exceptional Patient Relations

Sept. 29, Middlebury

Oct. 6, Nashville, IN

Intermediate ICD-9-CM Coding

Oct. 4, Merrillville

Oct. 11, Evansville



Commercial Payer Report

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Commercial Payer Forum

June 9, 2006

M-PLAN

Presenter: Mike Brown

Contact information: (317) 571-5307

Note that M-Plan contracts with health networks, not providers. Find a Provider Reference Guide online at www.mplan.com.

Use MMDDYY (month, day, year) in box 24A on the CMS 1500. Do NOT use four-digit year as only the first two digits of the year can be read. A question was asked about Y2K and four-digit year, and the response was that it only applied to electronic claims.

Bill bilateral procedures on one line with the 50 modifier and one unit of service.

N13 is one of the most frequent claim rejection reasons. Brown advised M-Plan did not get all new codes in the system in a timely manner at the first of the year and claims with the new codes were denied.

Explanation code AFN means please forward medical records to the network. M-Plan uses "AFN" when a procedure or visit does not meet specific parameters set up by a network to auto-adjudicate a claim. The network's Medical Management would like to review the records for medical necessity to obtain a clearer understanding of what was performed.

Therefore, please forward medical records to the network and not to M-Plan. Mailing to M-plan could cause an unnecessary delay in reviewing the records and getting the claim adjudicated since the insurer would need to mail the record to the network.

For corrected claims, the best practice is to use a Corrected Claim stamp. Place the stamp in box 24. Failure to pick up a Corrected Claim stamp on claims is a big issue. Also, do NOT fax claims. All faxed claims will be returned.

For clinical edit (PACE) denials, use the PACE appeal form only. This form may be found on www.mplan.com. Look for an "N" or "Q" remark code on the Explanation of Payment (EOP) signifying a clinical edit. Direct fee schedule appeals to the network, not to M-Plan.

Finally, do NOT use PACE appeal forms for fee schedule appeals.

For Modifier 80, surgical assist pays 20 percent (80 percent discount). Appeal to the network (not M-Plan) for over filing-limit rejections with proof of timely filing. Filing limits are different for each network. The first column of the Provider Reference Guide shows the general filing limit for each network, but this could vary depending on the specific provider contract.

Claim Dispute phone numbers are: (317) 571-2247 or (800) 675-2605. You may fax by using the Dispute Form at www.mplan.com. The fax number is (317) 580-4706.

Aetna

Presenter: Shannon Montgomery

Contact information:

HMO – (800) 624-0756

PPO – (800) 632-3862

Phone calls are routed according to the area code of the caller. If you need to talk to a LIVE person, say "operator." You will not be asked or prompted, but if you say operator, you will get a live person.

HMO numbers are alpha numeric. PPO numbers start with "W." Aetna has removed Social Security numbers from cards. If a claim is submitted with a Social Security number, the Explanation of Benefits (EOB) will come back with the new number.

Aetna has family ID cards with up to five family members on a card. If a card states "Referral required," Aetna will not pay if a referral is not obtained. If a card states "Referral encouraged," Aetna will pay but will pay less.

If an office signs up at www.aetna.com, there will be a 10-day waiting period for "real-time" information (eligibility, claims info, etc.). All other information is available immediately upon signing up.

Clinical Policy Bulletins are available on the Web site. You can obtain an EOB in the "Claims Status" area; claim reports also are available. Click on "Contact Us" to send Aetna an e-mail. A drop-down box will appear asking

what kind of issue you need addressed.

Regarding pre-certifications, the following applies:

- A = approved
- M = approved but modified
- P = pended (*need more clinical information*)

Aetna has ONE claims address, regardless of what a card indicates. That address is:

P. O. Box 981107
El Paso, Texas 77998-1107

Questions and Answers

Question:

If a claim is denied as experimental, can we get a waiver and bill the patient?

Answer:

Yes

Question:

Do you have a form for this?

Answer:

No

Advantage

Presenter: Amy Brown
Contact information:
(317) 816-6723

Advantage is owned by four Catholic health care systems:

- Ascension Health
- Sisters of St. Francis Health Services
- St. Joseph's Regional Medical Center
- Ancilla Systems

The insurer sells both commercial employer group and individual Medicare Advantage

products. Advantage commercial products are predominantly an HMO model and the Medicare product is a PPO.

The Medicare product, called Advantage Preferred Plus, works like a Medicare replacement program. Enrollees must have Medicare Part A and Part B.

Advantage Preferred Plus is currently being offered to beneficiaries who reside in Allen, Boone, Hamilton, Hendricks, Johnson, Marion, Morgan, Shelby and St. Joseph counties.

Patients have access to any physician providing Medicare services, but will incur increased costs if an out-of-network provider is used.

Advantage Preferred Plus (PPO) was a demonstration project from 2003 to 2005. It transitioned to a Medicare Advantage Plan on Jan. 1. Benefits may change and, therefore, should be reviewed annually.

An Advantage handout indicated:

- Eyewear (post cataract surgery) – \$0 co-payment.
- Eye exam (post cataract surgery) – \$0 co-payment

Questions and Answers

Question:

Is the zero co-payment for standard frames, such as Medicare allows, or is it for any frame?

Answer:

Advantage covers the standard Medicare frames at \$0 co-pay for in-network services.

Question:

Is zero co-pay for eye exams only in the post-operative period of the cataract surgery or forever thereafter?

Answer:

The zero co-pay is for eye exams only in the post-op period of the cataract surgery.

Question:

We've been getting paid less than Medicare from some other Medicare Advantage plans. Can they do that?

Answer:

Because the Centers for Medicare & Medicaid Services (CMS) chose to contract with private health plans to provide Medicare coverage, those plans have the ability to negotiate reimbursement structures and fee schedules. In some cases, their negotiated rates may be less than 100 percent of Medicare allowable.

Anthem

Presenter: Cheryl Cossell
Contact information:
Phone: (317) 287-6274
Fax: (317) 287-8906

Cossell advised anyone not signed up for the Anthem listserv to do so. All "Rapid Updates," etc. are placed on the Web site. If you wait to receive information via newsletter, the information may be two or three months old when you receive it.

Effective Feb. 15, 2006, if multiple modifiers are needed for a claim line, the

99 modifier should be listed first, followed by the necessary modifiers. Anthem's computer recognizes only one modifier.

If the 99 modifier is the first modifier, the system will look at the others on the line. If the 99 is not there, only the first modifier listed will be seen and utilized for processing purposes. This applies to each line that needs more than one modifier.

If modifier 99 is used and there are no other modifiers, the claim will be returned to the provider. If modifier 99 is used and only one other modifier is used, the claim will be processed.

Effective Sept. 1, 2006, Anthem will recognize the anesthesia servicing modifiers for all products including AA, QY, QK, AD, QZ and QX.

Also effective Sept. 1, routine assistance from an anesthesiologist or CRNA for average risk patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures will be considered not medically necessary. Please refer to the Rapid Update of May 30 for details.

Note that effective Nov. 1, Anthem will round time units to the next tenth.

Beginning June 1, Anthem's new member prefixes are: OLN, HQP, AOE and KAC. For radiology pre-certification see Rapid Update of May 24.

For Medicare Crossover claims, the Anthem PIN must be tied to the provider's Medicare number. If not, information will not be noted during processing. In order for claims to crossover from Medicare,

providers must make sure Anthem has a current Medicare number on file.

Many times, when providers apply to Anthem, they have not yet received a Medicare number. Once the number is obtained, providers must notify Anthem to update their provider files.

eBusiness with Anthem

Eventually all communication, including letters to providers, will occur on the Internet. The company Web site, www.anthem.com, now provides:

- Online provider maintenance form
- Online fee schedule requests
- Provider directories
- Rapid Updates and Network Newsletters
- 2006 Network Reference Guide
- MyAnthem
- Claims
- Eligibility
- Pre-certification

A contract amendment of Nov. 1, 2005, allows providers to collect up front the individual's co-payment, co-insurance and deductible. If an overpayment is collected from the patient, the office must refund to Anthem or the patient, as applicable.

Anthem will accept the unique physician NPI along with the Anthem professional PIN currently in use. For more information, visit www.cam.hhs.gov/hipaa/ or call the

CMS HIPAA Hotline at (866) 282-0659. Information is also available at www.anthem.com.

The Office of Medicaid Policy and Planning (OMPP) is currently procuring new managed care organization (MCO) contracts for the Hoosier Healthwise program. Anthem has bid for this contract and is fairly confident of getting it. For additional information on this issue, call (800) 618-3141 or contact your contract consultant.

Provider seminar dates and locations are:

- Indianapolis
– Lytle Center, Sept. 27, 28
- Valparaiso
– Strong Bow Inn, Oct. 3
- Evansville
– Marriott, Oct. 10
- Ft Wayne
– Marriott, Oct. 17

United Healthcare

Presenter: Robin Regine
Phone: (401) 732-7133,
E-mail: Robin_L_Regine@uhc.com

If the claim you submit is not an original claim, you MUST include a "Request for Reconsideration" form or the claim will deny as duplicate.

Request for Reconsideration forms can be obtained online at www.uhc.com. Use your provider number and password to login and search for the form under the Help and Forms links.

If you sent in a secondary claim and forgot to include the primary's EOB with the original claim, you will need a form

with the second submission or it will deny as a duplicate.

If calling United Healthcare (UHC), you must say "customer service" to get a LIVE person. You will not be asked, but you need to say it to speak to someone.

The Provider Central Service Unit (PCSU) is a second level of appeal. If an office has not initiated an adjustment request, the appeal cannot go to PCSU. Allow up to 30 business days to receive payment for initial claims and 30 days to receive a response to adjustment requests BEFORE contacting the PCSU.

If you contact PCSU, the representative should give you a master ID number. If necessary, ask for one.

Claim adjustment online is basically for UHC errors in payment, those filed correctly but paid wrong. Medical offices cannot request an adjustment for claims denied due to error on the part of the provider. That claim must be submitted with a "Request for Reconsideration" form. Submit one form for each claim.

When submitting documentation such as corrected claims, primary payer EOB, proof of timely filing or clinical notes, paper submission is your only option.

Medical policies are on the UHC Web site

Offices submitting commercial medical claims only MUST have access to the Internet. In signing UHC contracts, providers agree to conduct busi-

ness electronically. Up to now UHC has not enforced this provision, but all business will be conducted electronically beginning this summer.

All payments will be made by electronic funds transfer (EFT). Currently ONE deposit will be made to ONE account for all providers under ONE tax ID number. UHC is working on the ability to deposit to different accounts but that is not yet possible. EFT will be done once a week on the same day, and you will be notified one day in advance of the transfer.

EOBs will be posted to your computer. You must download and post the payments, or you can agree to auto-posting. Denials will be intermingled with payments. There will be ONE set of EOBs for all providers under ONE tax ID number, and they will be sent to ONE location. EOBs will not be separated by office location.



Lisa Jarrells, M.D.

How's the health of your medical practice?

Is reimbursement declining while expenses are rising?

Can't close your office to attend?

All sessions will be held on Thursday evenings at ISMA Headquarters beginning in mid September. Join the group for one or all of the program series.

No time to drive to Indianapolis?

Join us online from the comfort of your own home for real-time participation.

Thursday not a good day?

You'll be able to access an archived version of each session to view at a time that's best for you.

Join other Indiana physicians and practice managers for a fresh look at revenue sources and issues affecting the health of your medical practice.

Presenters will be Indiana attorneys, accountants and consultants who stay informed about current health care issues in Indiana.

Topics to be discussed:

- Contracting – what you're really agreeing to
- Financial analysis of the contract
- Enhancing revenue through new revenue streams
- Practical finance and accounting analysis for physicians
- Links between correct coding and revenue
- Collections – real ways to reduce AR
- Personnel and physicians
- Malpractice
- Lobbying for change

Watch your mailbox for additional information coming soon!



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State
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Association