



# Commercial Payer Report

A publication of the Indiana State Medical Association

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August 27, 2007

## SEMINARS

### Intermediate ICD-9-CM Coding

Sept. 13, New Albany

### Proposed Stark Changes

Sept. 11, Indianapolis

### Train-the-Trainer Workshop for Residency Programs: A Focus on Family and Domestic Violence

Sept. 28, Friday

### Pay for Performance: A Business and Operations Perspective

Sept. 28, Indianapolis

### Indiana Alliance for Medical Education Symposium

Sept. 28, Indianapolis

### Legalities of Controlled Substance Prescribing

Oct. 10, Indianapolis

Call Meg Patton at the ISMA for registration information, (317) 261-2060 or (800) 257-4762



### Commercial Payer Report

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## Commercial Payer Forum

August 27, 2007

### AETNA

Presenter: Shannon Montgomery

#### Eligibility

Eligibility is available online, but you must be registered to do so. You can check eligibility by name and date of birth, if an I.D. number is not available (if patient did not bring card or has not received it).

Pre-certification for MRI/MRA is not applicable in Indiana.

#### Claims status report

For a claim status check you must enter a date span. Do not enter a span for more than 1,000 claims. Up to 12 hours may be needed to get a report if it is lengthy. If your office runs reports at night, go to "Responses" and click on "CSR" to obtain a report.

#### Clinical policy code lookup

Medical practice staff can look up clinical or payment policy per CPT code or by category. For example, you can learn if a service is designated experimental/investigational.

A patient could be held financially responsible for a service. The patient's explanation of benefits (EOB) will denote whether or not the patient is responsible for payment.

Physician's staff can enter a letter of the alphabet and obtain information regarding various policies. For example, if you enter an "M," you will receive all information related to modifiers.

#### Evolving health care system

Patients can get information to make an informed decision using "Navigator." The link will offer physician information regarding clinical performance, quality and efficiency. The system also provides member feedback regarding physician satisfaction.

#### Filing limit

The filing limit is as designated in the physician contract; the normal timeframe is 90 to 120 days.

For Medicare private fee-for-service (PFFS) claims, Aetna will follow the Medicare claim filing guidelines as a timeframe.

#### Aetna Medicare PFFS

Private fee-for-service (PFFS) can be identified by the notation on the top right corner of a patient's I.D. card. Medical offices do not have to enroll; if they are par with Aetna, they will be par with PFFS.

Aetna pays Medicare's allowed amount and follows Local Coverage Determinations and the Correct Coding Initiative for bundling purposes.

### ADVANTAGE HEALTH SOLUTIONS, INC.

Presenters: Sandy Thorne, director of Provider Relations, Danielle Jaber, director of the Medicare Program

Advantage is local-provider owned by St. Vincent, Sisters of St. Francis, St. Joseph Regional Health System and Ancilla. Currently, the company has 65,000 commercial insureds.

Advantage is NCQA accredited with both full-insured and self-funded plans. The company has point-of-service and out-of-network options but only in limited areas.

For electronic claims, 95 percent are processed in less than 45 days; for paper claims, 95 percent are processed in less than 30 days.

The Web site address is www.advantage.com and the telephone number is (317) 573-6644. Advantage will come to the office to demonstrate how to navigate its Web site.

#### Advantage Preferred Plus

The Advantage Preferred Plus plan, a contracted network, is available only in Allen, Boone, Hamilton, Hendricks, Johnson, Marion, Morgan, Shelby and St. Joe counties. The plan has a \$10 co-pay for in-network primary care and a \$25 specialty co-pay for in-network providers. Plan participants can access any physician that is a provider of Medicare services, but with higher liability if out of network.

Advantage Preferred Plus pays Medicare's allowed amount and follows Medicare's timeframe for filing claims.

### UNITED HEALTHCARE

Presenters: Cheri Gianakos, Natasha Weems, Trina Knox, Kristin Rudd, Ali Sajadi

#### United Healthcare laboratory program

Effective Jan. 1, 2007, Laboratory Corporation of America (LabCorp) is the single source national laboratory vendor for United Healthcare. Quest Laboratory is an out-of-network vendor.

Other freestanding labs are participating in the network, such as:

MACL, Arnett Laboratories, PA Labs (formerly Follas & Pathologists Assoc.), Terre Haute Medical Lab, First Source Lab Solutions, Fort Wayne Medical Lab, South Bend Medical Foundation, Cytology Pathology Services, Dermatopathology Services, Diagnostic Cytology Lab, Ameripath

UHC also has participating hospital laboratories in its network. Medical practices may perform any lab test in their offices that is within their level of CLIA certification. There is no specific list of tests that may be performed only in an office.

#### Radiology notification

Effective April 16, 2007, UHC requires prior notification for outpatient CT/CTA scans, MRI/MRAs, PET scans and nuclear medicine, including nuclear cardiology. The ordering physician/provider is responsible for obtaining notification. Once obtained, prior notification number must be sent with the order. Notification is valid for 45 calendar days.

Physicians who have received the UHC Premium quality and efficiency of care designation are exempt from the radiology notification program. Status of an ordering physician may be obtained by logging on to www.unitedhealthcareonline.com and selecting Physician Directory. If two stars appear behind a physician's name, that physician has the UHC Premium designation and is exempt.

If an ordering physician/provider is a UHC Premium quality and efficiency of care designated physician, the rendering provider has two options:

- Put the ordering physician's TIN or NPI on the claim.

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- Obtain an online notification on behalf of the UHC Premium quality and efficiency of care designated physician

## e-Solutions

To log on to [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com), you must register and have a user I.D.

Electronic Payments and Statements (EPS) allows you to receive your claim payments and EOBs electronically. Payments are consolidated and deposited directly into your bank account. You will receive an e-mail notification from EPS ([Notify@Exantebank.com](mailto:Notify@Exantebank.com)) one day prior to deposit. Payments typically are made once per week, directly deposited to the bank of your choice.

As of May 2007, EPS deposits can be processed by NPI number(s).

The consolidated EOB file appears the same day the deposit is made. You can view, search, sort, print or save it. EOBs are housed within the UHConline portal for 13 months.

## Claims reconsideration

Three methods are available for first-level claims reconsideration. You can use:

1. [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com).
2. Voice Enabled Telephone Self Service (VETSS) at (877) 842-3210
3. Request Reconsideration Form

Use UHConline or VETSS when a claim is paid or denied incorrectly and no supporting documentation is required, or when a claim did not pay according to contracted allowable.

You cannot speak with a live person on VETSS. When using VETSS, provide a detailed description of your request for reconsideration and document the tracking number provided for future reference.

Use the reconsideration form when reconsideration requires supporting documentation (primary payer EOB, corrected claim, proof of timely filing) or when there is an existing record for the reconsideration and you are not able to submit online. Complete the entire form. Be careful to check the correct box because commercial, Medicare and Medicaid are handled by different centers.

## 2nd level claims reconsideration

Allow 30 days before checking status via online or VETSS. If no payment resolution is achieved or there is dis-

agreement with the result, contact the Provider Central Service Unit (PCSU) at (800) 521-2603, using prompt 2. Be sure to provide the tracking number.

## Ovations – Medicare Advantage Plan

Ovations – Medicare Advantage Plan is a PPO health plan with network physicians, hospital and other health care providers that is offered in the Fort Wayne, St. Joseph County and central Indiana areas.

United Healthcare has abided by the UHC normal timeframe for filing Ovation claims.

United Healthcare has real-time adjudication online. It allows you to know immediately how much the physician will be reimbursed and how much the patient owes.

By submitting a claim through [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) at the point of care, you will be provided details on the amount of reimbursement within 10 seconds.

### HUMANA

**Presenter: Scott Hyder, Jennifer Kennedy, Patrick Szydowski**

Humana offers PPO plans, high deductible health plans, health savings accounts (HSAs), PCA (HRA) and FSA. Radiology pre-certification is required for MRI/MRA, CT/CTA and PET scans.

The Humana Access card for HSA accounts is the insured's I.D. card and debit card. Offices should have the patient sign a consent form, available on Humana's Web site, which gives the office permission to debit or credit the patient's Humana Access account.

Humana claims address is:  
P. O. Box 14601  
Lexington, KY 40512-4601

The Customer Service telephone number is: (800) 448-6262

Provider Relations telephone number is: (800) 626-2741 (for demographics, credentialing and enrollment)

## Real-time claims adjudication

Jennifer Kennedy is the contact person for training on electronic remittance advice, electronic funds transfer and real-time claims adjudication setup; contact her at (502) 476-7117.

Humana has real-time claims adju-

dication. Physician offices can obtain financial information at the time of service and collect the amount a patient owes at the time of visit. Availability is Humana's national clearinghouse.

## Drug prior authorization requests

Humana representatives can tell you if an authorization is needed, and also give you the authorization number along with the confirmation number.

## Medicare fee-for-service products

Humana Choice PPO and Humana Gold Choice (PFFS) are fee-for-service projects. If you have questions or concerns, contact Patrick Szydowski at (800) 664-4140, ext. 0982.

Humana pays according to the Medicare allowed amount. If out-of-network, there is a higher liability for the patient. The company follows Medicare's claims filing timeframe.

Humana had bundling edits in place denying some services. The problem has been resolved. An example is EKGs bundled with an E/M code. A mass adjustment is being carried out on the claims.

### ANTHEM

**Presenter: Cheryl Cossell**

Anthem has 60 percent of NPI numbers loaded into its system. By September, all should be loaded. Offices may call (800) 455-6805 to determine if a physician's NPI or an entity's NPI are loaded.

Cossell recommended continuing to use Anthem's number until September. Effective Jan. 28, 2008, Anthem will accept the NPI only.

If you have questions or concerns, you may contact Cossell at (317) 287-6274 or fax her at (317) 287-8906.

## E-Review

An E-review enables you to:

- Send demographic information for verification of benefits and eligibility
- Send clinical information requests for review
- Receive authorization decisions, including the authorization number

Some procedure codes and supply codes are billed per unit of service or per unit of supply. The description of

the codes usually indicates a "unit" (each lesion, each tendon, each additional, per 15 minutes, per mile, etc.).

Modifier 22 is paid at an additional 10 percent if allowed. It should be used only if something unusual happens during a procedure.

For multiple modifiers, place all modifiers in box 24D. Place modifier 99 first, followed by all other applicable modifiers with no spaces, hyphens or commas.

*Please note: Effective Sept. 15, file bilateral procedures with 50 modifier and one (1) unit of service.*

The Provider Inquiry/Refund/Adjustment form is now on the Web site, [www.anthem.com](http://www.anthem.com). You can submit the form online and receive an answer online.

Accounts beginning with "YR" are local accounts. Blue Card accounts are national accounts.

Some time in 2008, Anthem hopes to show a termination date in the system instead of "inactive."

Anthem's recoupment timeframe is 18 months. This means notification will be given within 18 months of the date of service. Actual recoupment may not occur within this timeframe.

Anthem requires non-physician practitioners (NPP) to be credentialed.

Claims should be filed using the NPP's number. According to Cossell, using the NPP's number is not mandatory. However, in an audit situation where the claim was filed under the physician's number but the NPP provided the service, Cossell said the money would be recouped.

Some plans, such as General Motors, do not recognize NPPs. If the service is provided by an NPP under those plans, it is a non-covered service. Here is a listing of some, but not all, of those accounts that do not recognize nurse practitioners:

All GM, Ford, Chrysler, DCC, DXP, DCH, DKM, NCH, DKP, DEH, DMH, DMM, DPR, DTP, SMP, FGP, FHC, FMA, FMM, FMA, FMM, FMP, FMR, FRC, FSP, MCS, GHP, GMH, GMM, GMP, GTP, GME, GSM & NGM

Cossell advised that within the next year Anthem's position will be:

If the NPP is not credentialed and the service is provided by the NPP, the claim will have to be filed identifying the NPP as the provider of service. The claim will be processed as out-of-network and payment will be sent to the patient.