Provider Connection™

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Delaware Physicians Care
An Aetna Medicaid Plan℠

MISSION STATEMENT

Delaware Physicians Care, an Aetna Medicaid Plan, strives for value, integrity and compassion in health care management and consulting.

VISION

The vision of Delaware Physicians Care, an Aetna Medicaid Plan, is to be recognized as the nation's foremost managed care resource by providing the highest value management and consulting services throughout the health care continuum.

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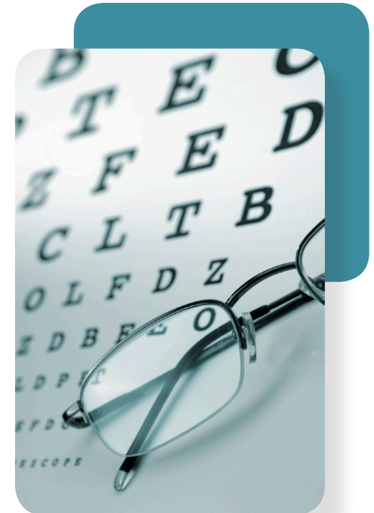
Delaware Physicians Care
252 Chapman Road, Suite 250
Newark, DE 19702 | 1-800-287-9860

Claims Inquiry
Please call 1-866-543-2167.
Select option #2 for provider, then select option #1 for claims department.

Editor - Jeanne Walsh

Vision Benefit Update



As of July 1, 2011, we will no longer provide routine annual eye exams, contact lenses or eyeglasses for adults 21 years of age and older.

Eye exams that are medically necessary for treatment of disease conditions in adults - for example, diabetes - will continue to be covered.

Children will continue to receive routine eye exams and/or glasses and contact lenses as part of the federal mandate for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT).

What's New on Our Website?

We continue to update and add important information to our website. Just go to www.DelawarePhysiciansCare.com and click on the Providers tab.

Important postings new to the website:

Provider Refund Process
Behavioral Health Intensive Outpatient Services Request Form
Behavioral Health Conversion Form
MedSolutions Information
Appeals Timeframes
Provider Office Toolkit
NCQA Quality Improvement Connection link to access CME activities
Practitioner Application Screening Form
Roadmap for Physicians to Combat Fraud and Abuse
Home Page: Covered Benefits Effective July 1, 2011

Visit us often at www.DelawarePhysiciansCare.com for important news, information, resources and links to make your job easier and more efficient.

Healthy Living Rewards Program

Beginning March 1, 2011, Delaware Physicians Care members have the opportunity to take part in our new healthy living rewards program. The goal of this program is two-fold: to encourage our members to have on-time preventive care and to support our providers as they deliver care that meets preventive care standards for their patients.

Qualifying services are based on the following categories and HEDIS® measures:

- **Children** (birth to age 12) – well visits and on-time immunizations
- **Teens and young adults** (age 13 up to 21) – well visits and on-time immunizations
- **Adults** (age 21 and over) – annual wellness exam
- **Women** (age 21 and over) – annual wellness exam, including Pap test and mammogram

Beginning March 1, 2011, with each preventive health visit and on-time immunization billed to Delaware Physicians Care, active members are eligible to win a Healthy Rewards prize package made up of a Wii™ fitness system, a grocery store gift card to buy healthy foods, and "Picture of Health" portrait package.

Prize drawings will take place quarterly in June, September and December of 2011 and March of 2012. Names are automatically entered into the drawing when we receive the provider's claim for the wellness visit and/or immunization.

Online Provider Disclosure Requirement

As noted in the Delaware Medical Assistance Program (DMAP) second quarter 2011 Medicaid Special Bulletin, the 2011online provider disclosure requirement went "live" on 1/3/2011.

According to the Code of Federal Regulations title 42, part 455, sections 100-106, all providers enrolled with the DMAP program must complete a disclosure form. This form must be submitted electronically and is an annual CMS requirement.

If your office has not completed the online disclosure form, please contact the **DMAP Provider Relations Team at 1-800-999-3371, option "0" then option "2".** Additional information about this requirement can be found at the Provider Special Bulletins page at http://www.dmap.state.de.us/downloads/bulletins.html.

As a contracted managed care organization with Delaware Health and Social Services, Delaware Physicians Care is required to ensure its contracted providers comply with this CMS requirement. Failure to abide by the provider disclosure requirement could result in claim denials.

ICD-9-CM Coding Persistency

What is ICD-9-CM (diagnosis) coding persistency?

Persistency in coding refers to the ongoing identification of members with chronic medical or behavioral health conditions on a CMS-1500 form through the use of coding from one year to the next. The "persistence rate" is the percentage of members coded with the chronic condition in year 1, who are also coded for the chronic condition in year 2.

Who does persistency of correct ICD-9-CM coding affect and how?

PROVIDER

- Accurate diagnosis in the chart accomplishes quality and continuity of care goals.
- Improved quality of care standards.
- Improved risk stratification of patients – higher risk scores for members with more comorbidities.
- Avoids office interruptions for clarification of claims information.
- Improves office administrative efficiencies by decreasing unnecessary payer requests for additional information during the prior authorization or clarification of claims information.

PATIENT

- Better and earlier identification of patients with chronic conditions allow us to employ quality targeted interventions and education with the patient.
- Funding from the State and Federal governments is dependent upon documented morbidity of the population. Persistency in risk scores from year to year potentially results in more dollars being available to purchase services for Medicaid patients.

Why is it important to code the care that is documented?

- Specificity in diagnosis documentation results in accurate ICD-9-CM coding.
- Documentation that supports the diagnosis has always been important from a quality of care perspective.
- Accurate ICD-9-CM coding achieves accuracy in the diagnosis portion of the claim.

ICD-9-CM Coding Facts

- Diagnosis codes submitted on claim forms establish the necessity for services performed.
- The codes submitted on the claims are used by outside agencies and organizations to forecast health care trends and needs.
- The provider of services is the only person who has authority to formulate and determine a diagnosis. Non-clinical staff should not choose a diagnosis for a patient, but may accurately convert a narrative description to a diagnosis code, ideally after they've been trained on the proper use of the ICD-9-CM Manual.
- Proper diagnosis coding requires using the ICD-9-CM Volumes I and II to choose appropriate codes.

Where are ICD-9-CM codes entered on the CMS-1500 form?

- Paper Claim – Box 21
- Electronic Claim – Loop 2300, Segment HI01-2; HI02-2;HI03-2; HI04-2

FROM STAN'S CORNER
Dr. Stanley Lynch, CMO

Chaperone Practice Management Guide for Physicians

Use of a chaperone during physical exams is an effective risk avoidance tool for physicians.

Why: There are no laws requiring a physician to use a chaperone. However, there is a heightened awareness of inappropriate and unprofessional conduct throughout the State of Delaware given allegations brought about Dr. Bradley and associated abuses. This has resulted in what are called the 'Bradley laws' in 2010. Potential quality of care issues reported by members continues to rise. The Delaware Board of Medicine, legislature, Delaware Medicaid and Medical Assistance programs as well as Delaware Physicians Care have zero tolerance for inappropriate and unprofessional conduct by network providers. Peer review and ongoing monitoring processes are in place with Delaware Physicians Care.

How can you protect yourself from any allegations of impropriety?

1. Make it an office policy and process to use a chaperone during physical exams. Do not leave yourself in a room alone with a patient during physical exams.

AMA Code of Medical Ethics 2010-2011 edition, 8.2.1 "Use of Chaperones during Physical Exams" – From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended. Physicians aim to respect the patient's dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient; such actions include the provision of appropriate gowns, private facilities for undressing, sensitive use of draping, and clear explanations on various components of the physical examination. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or physician. The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere.

If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature to a minimum during the course of the chaperoned examination (I, IV).
Issued: December 1998 based on the report "Use of Chaperones During Physical Exams", adopted June 1998."

"Garman Guidelines – California Board of Medicine 5 points to help create a circumspect environment during physical examinations:

- Allow patients to disrobe and dress in private and offer cover gowns and appropriate drapes.
- Have one of the office staff in the room whenever possible, especially during breast and pelvic exams.
- Improve your communication with the patient about the reasons for and methods of examinations.
- Avoid any flirtatious behavior towards patients.
- Ask someone else to review your office procedures regarding physical exams with a view toward avoiding any risk procedures or making necessary changes."

2. Be consistent in using chaperones as a risk management tool. Educate your staff.

3. Contact your provider relations representative for questions or assistance in putting this practice in place.

Durable Medical Equipment Authorization Updates

Effective March 10, 2011, our durable medical equipment authorization guidelines have been updated as follows:

All durable medical equipment (DME) requires prior authorization. Prior authorization requests, ***including durable medical equipment up to $250.00,*** should be submitted through the request for prior authorization tool on our secure provider web portal.

As a reminder, DME **rentals** always require prior authorization.

Please contact your Provider Relations representative at 1-800-287-9860 with any questions about Delaware Physicians Care's prior authorization process.

Billing of Delaware Physicians Care Members

Delaware Physicians Care adheres to the requirements included in both the Code of Federal Regulations (CFR) and the Delaware Medical Assistance Program (DMAP) General Provider Policy Manual regarding provider payments and provider billing of Medicaid enrollees.

Collection of payments from Medicaid enrollees for service(s) for which a third party is liable, also known as third party liability (TPL), is addressed in CFR TITLE 42--Public Health, Chapter IV, in the following sections:

- § 447.15 - speaks to acceptance of State payment as payment in full
- § 447.20 - speaks to provider restrictions under State plan requirements regarding third party liability
- § 447.21 - speaks to reduction of payments to providers who seek reimbursements from the member

Payment for services furnished out of State, which affects out of network, out of state providers is addressed in § 431.52.

Providers may view and download the most current electronic CFR online at: http://ecfr.gpoaccess.gov. The DMAP General Provider Manual, Section 1.16, Billing DMAP Clientw, may be accessed at http://www.dmap.state.de.us/downloads/manuals/General.Policy.Manual.pdf.

Attention Coders and Billers

The American Medical Association (AMA) has published an **Overview of CPT® 2011 Changes**. You can view and download this document from our website. Log onto www.DelawarePhysiciansCare.com, click on the Providers page, then on Billing Alerts on the left side of the page.

Please refer to the CPT 2011 codebook for a complete listing of new and revised CPT® codes for 2011. Additional helpful information can be found on the AMA website at: http://www.ama-assn.org/ama/pub/physician-resources.shtml.

National Correct Billing Initiative

History

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to enforce appropriate billing and reimbursement of certain combinations of codes, which will edit when billed together without appropriate modifiers. The correct coding policies are based on the American Medical Association's Current Procedural Terminology (CPT) Manual in collaboration with other national and local standards of practice guidelines. Originally, this method of payment was for processing Medicare Physician Provider claims. Subsequently a separate table of edits was developed for Outpatient Facilities many of which are similar to the Physician Provider edits. Recently, CMS created NCCI tables for state Medicaid plans for Physician Provider and Outpatient Facilities which are effective October 1, 2010.

NCCI Tables

The code combinations are separated into two tables: Column I and Column II tables (formerly known as the Comprehensive and Component edits) and Mutually Exclusive table.

- **Column I and Column II Tables:** NCCI has identified Column I (previously "Comprehensive") procedure codes and their associated Column II (previously "Component") procedure codes. Column II codes are considered part of the more global Column I code and are not eligible for reimbursement when billed with the Column I code. A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services

  Example: If a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with a bilateral salpingo-oophorectomy, the physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube/s, and /or ovary(s)). The physician should not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less) or CPT code 58720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) with code 58262 because 58260 and 58720 are components of the comprehensive procedure 58262.

- **CCI Mutually Exclusive Table:** NCCI has identified procedures that are considered mutually exclusive of each other. Mutually exclusive procedures are those procedures that generally cannot be done at the same session by the same provider on the same patient. These codes are considered mutually exclusive of one another based on CPT definition or the medical impossibility or improbability that the procedures could be performed at the same session. When the same provider bills mutually exclusive procedures for the same date of service, CMS allows the Column I code (generally the code with the lesser RVU for Mutually Exclusive pairs) and denies the Column II code.

  Example: A physician bills 97001 (Physical Therapy Evaluation) on the same day as 97002 (Physical Therapy Re-Evaluation). Because these services cannot reasonably be performed in the same session, the procedure with the lowest Medicare RVU is paid to the provider (97002).

NCCI Modifiers and Modifier Indicators

The use of a modifier appended to a HCPCS/CPT code must clinically justify its use, and may bypass the NCCI edit. Separate patient encounters, separate anatomic sites or separate specimens may be appropriate circumstances for the modifier use. A modifier indicator is designated by CMS for each code combinations in both the Column I and Column II and the Mutually Exclusive tables. They include:

- **Modifier Indicators:**

  - **0** (indicates there are no circumstances in which a modifier would be appropriate.
  - **1** (indicates that a modifier is allowed in order to differentiate between the services provided. If used correctly separate payment for the services billed may be considered justifiable.
  - **9** (NCCI edits do not apply to this code pair).

References:

National Correct Coding Initiative Policy Manual for Medicare Services, Intro. Doc, Version 14.3

National Correct Coding Initiative Policy Manual for Medicare Services, General Correct Coding policies National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1 Doc, Version 14.3, I-13

Modifier 25 Guidance

Delaware Physicians Care, an Aetna Medicaid Plan, promotes correct claims coding including the appropriate use of modifiers. To support this effort and our goal of physician education, outlined below are summary guidelines to assist you with the appropriate usage of Modifier 25.

Modifier 25 - Significantly, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or other Service.

The American Medical Association's CPT Manual describes the use of modifier 25 as "the physician may need to indicate that on the day of a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date."

APPROPRIATE MODIFIER 25 USE

- This modifier may be appended to Evaluation and Management codes (99201-99499) or to general ophthalmologic codes (92002-92014).
- This modifier should be used when the Evaluation and Management service is distinct and separately identifiable from the service or procedure being performed.
- This modifier should only be added to Evaluation and Management services in conjunction with the service or procedure (CMS' 0 and 10 day Global Surgery periods) on the same day.

INAPPROPRIATE MODIFIER USE

- This modifier should not be used on Evaluation and Management codes the same day as the procedure or service, when the patient's purpose for being in the office was strictly for the performance of the procedure or service.
- This modifier should not be appended to an Evaluation and Management service that resulted in the decision to perform major surgery (CMS' 90 day Global Surgery period).
- Appending this modifier to non-Evaluation and Management services is an incorrect coding practice.

For further information on the appropriate use of modifiers, please refer to:
Centers for Medicare & Medicaid Services - http://www.cms.hhs.gov/mcd/
American Medical Association - http://search.ama-assn.org/

Claims Reconsideration Process vs. Provider Appeal Process

Delaware Physicians Care has two separate and distinct processes designed to assist providers with issue resolution.

The chart below illustrates the process to follow when filing a claims reconsideration/resubmission versus an appeal.

	CLAIMS RECONSIDERATION	APPEAL
FORM (available at www.DelawarePhysiciansCare.com)	Claims Reconsideration/Resubmission Form	Appeal Form
ADDRESS	Delaware Physicians Care Attn: Claims Resubmission/Reconsideration PO Box 61145 Phoenix, AZ 85082-1145	Delaware Physicians Care Attn: Appeals Department 252 Chapman Rd, Ste 250 Newark, DE 19702-5406 Fax: 877-473-8125
APPROPRIATE CATEGORIES	• Claim resubmissions • Corrected claims (including missing/incomplete/invalid diagnosis, procedure or modifier denials) • Timely filing • COB (missing/illegible primary explanation of benefits)	• Denied days for inpatient stays • Authorization denials for late notification • Claims denials for no authorization/precertification • Services denied per finding of a review organization
TIMEFRAME FOR SUBMISSION	Claims reconsiderations / resubmissions must be submitted within 12 months of the date of service.	Claim denial appeals must be submitted within 12 months of the date of service. Authorization denial appeals must be submitted within 90 days after the date of the adverse action (denial letter).

Provider Refund Check Process

Do you need to submit a refund to Delaware Physicians Care?
We would like to remind our providers of the correct process for check refunds.

All provider refund checks must be sent directly to the address below, with supporting documentation.

Delaware Physicians Care, Incorporated (DPCI)
P.O. Box 61145
Phoenix AZ 85082-1145

To ensure your refund check is processed quickly and correctly, please include the following information:

- Copy of DPCI original remittance advice (it contains all the information needed to identify the claim in which the refund should be applied to).
- If you do not have the original remittance advice, please provide:
  - Member name
  - Member ID
  - Date of service
  - DPCI claim number
  - Reason for refund
  - Amount of refund
- Attach a copy of the other carrier's Explanation of Benefits (EOB), if applicable

Please contact your Provider Relations representative with any questions about this process at 1-800-287-9860.

Road Map for Physicians to Avoid Medicare and Medicaid Fraud and Abuse

The Office of Inspector General and Department of Health and Human Services have recently published a guide to assist physicians in understanding how to comply with Federal laws that combat fraud and abuse and ensure appropriate medical care.

The information is organized around three types of relationships that physicians frequently encounter in their careers:

I. Relationships with payers,
II. Relationships with fellow physicians and other providers, and
III. Relationships with vendors.

The key issues addressed in this brochure are relevant to all physicians, regardless of specialty or practice setting.

For your convenience, we have added the link to this publication to the provider page on our website www.DelawarePhysiciansCare.com. We encourage all provider offices to download and reference this easy to understand information.

http://oig.hhs.gov/fraud/PhysicianEducation/roadmap_web_version.pdf

DE-11-06-07

Primary Care Provider Panel Size Attestation Process

The Delaware Physician Care provider relations department annually issues a panel size attestation forms to all primary care providers (PCPs). The State of Delaware, Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance, requires us to regularly distribute and collect attestation forms.

The purpose of the PCP panel size verification process is to ascertain that PCPs contracted with Delaware Physicians Care (as a contracted DHSS provider) have a panel size of 2,500 total patients, per full-time equivalent provider, inclusive of all insurance carriers with which the provider participates.

Please look for this form in July 2011. We ask that when your office receives this form, each PCP must complete and fax the form within 30 days of receipt to the fax number on the form.

Note that for purposes of this measurement, the following specialties are permitted to serve as PCPs:

- Licensed physicians in the following specialties:
  - Family and General Practitioners
  - Pediatricians
  - Obstetricians and Gynecologists (OB/GYN)
  - Internists
- Advance Nurse Practitioners
- Nurse Midwives

Should you have any questions about this process, please contact your provider relations representative at 1-800-287-9860.

DE-11-06-07