



# MARYLAND physicians care

MANAGED CARE ORGANIZATION

## Winter 2011-2012 Provider Newsletter

### In This Edition:

Summary Report of Provider Satisfaction Survey	1
Screening for Cervical Cancer	3
The Case of the Missing Asthma Medication	4
To Mammogram or Not to Mammogram	5
Diabetes Care	5
Sickle Cell Disease Care	7

### Summary Report of Provider Satisfaction Survey Maryland Physicians Care CY 2011

#### Scope

Primary Care Providers participating in the HealthChoice Managed Care program. The survey was administered between March and June 2011. Office managers responded in 56% of all surveys.

Valid Surveys: 197 of 493  
Response Rate: 40%  
Mailed: 93  
Telephone: 104

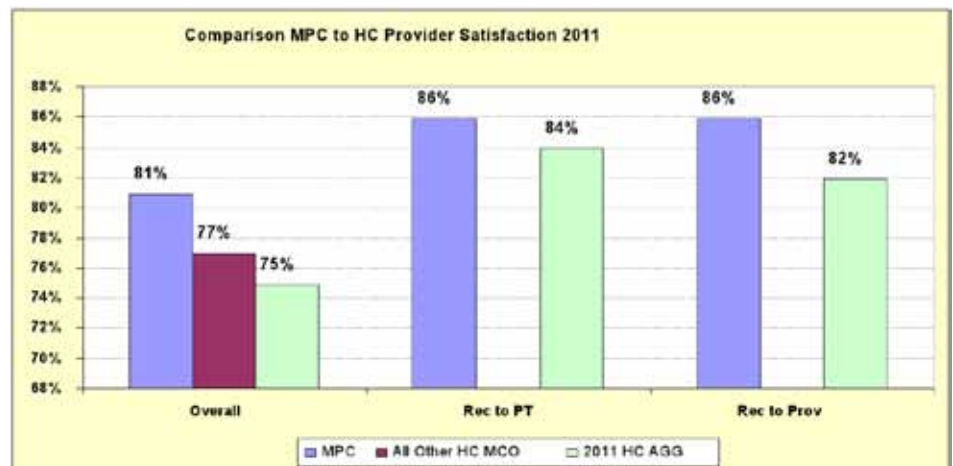
#### Profile of Providers Who Were Surveyed

##### HealthChoice Patient Volumes in Practice:

46% reported 21-50% HC  
20% reported >50 %

Solo Practice: 46%  
2-5 Providers: 37%  
>5 Providers: 17%

Mid-Level Providers in Practice:  
52% reported none.



Composite Measure	What is Measured	Attributes
FINANCE ISSUES	PCP EXPERIENCE WITH THE ACCURACY AND TIMELINESS OF CLAIMS PROCESSING AND ANY ADJUSTMENTS OR APPEALS	ACCURACY OF CLAIMS PROCESSING TIMELINESS OF INITIAL CLAIMS PROCESSING TIMELINESS OF ADJUSTMENT / APPEALS CLAIMS PROCESSING
CUSTOMER SERVICE/PROVIDER RELATIONS	PCP EXPERIENCES WITH PROCESS OF OBTAINING MEMBER ELIGIBILITY, INTERACTIONS WITH THE PROVIDER RELATIONS CUSTOMER SERVICE REPRESENTATIVES, QUALITY OF WRITTEN COMMUNICATIONS AND ADEQUACY OF THE SPECIALIST NETWORK.	PROCESS FOR OBTAINING MEMBER ELIGIBILITY RESPONSIVENESS AND COURTESY OF PR CUSTOMER SERVICE TIMELINESS TO ANSWER QUESTIONS QUALITY OF WRITTEN COMMUNICATION, POLICY, BULLETINS, MANUAL ACCURACY AND ACCESSIBILITY OF DRUG FORMULARY AND FORMULARY UPDATES OVERALL PR CUSTOMER SERVICE TELEPHONE SYSTEM OVERALL SPECIALIST NETWORK HAS ADEQUATE NUMBER TO SUPPORT PCP REFERRALS
COORDINATION OF CARE/CASE MANAGEMENT	PCP EXPERIENCE WITH COORDINATION OF CARE/CM	NO SPECIFIC ATTRIBUTES
NO SHOW APPOINTMENTS	ASKS PCP TO GIVE THE PERCENTAGE OF NO SHOW APPOINTMENTS EACH WEEK	NO SPECIFIC ATTRIBUTES
UTILIZATION MANAGEMENT	PCP EXPERIENCES WITH TIMELINESS OF THE AUTHORIZATION PROCESS	TIMELINESS OF OBTAINING AUTHORIZATION FOR: – OUTPATIENT SERVICES – INPATIENT SERVICES – MEDICATIONS OVERALL EXPERIENCE IN OBTAINING PRIOR AUTHORIZATION FOR MEDICATIONS
OVERALL SATISFACTION	OVERALL SATISFACTION, WILLINGNESS TO RECOMMEND THE PLAN TO PATIENTS AND/OR OTHER PROVIDERS	OVERALL SATISFACTION WITH MPC WOULD RECOMMEND MPC TO PATIENTS WOULD RECOMMEND MPC TO OTHER PHYSICIANS

### Survey Structure:

#### Overall Ratings:

Providers are asked to rate their Overall Satisfaction with MPC, and whether they would recommend MPC to patients and/or other providers using a scale of 0-10 with zero being the worst possible and ten being the best possible rating, a summary rate is calculated which represents the percentage of members who rated the category as an 8, 9 or 10.

#### Loyalty Analysis:

Provider loyalty is calculated from a combination of the three overall ratings. Loyalty is defined as a provider who is both satisfied with MPC and willing to recommend the plan to other patients and providers.

#### Composite Measures:

Five composite measures are used to focus on primary issues of concern to primary care providers. They are calculated from a rollup of grouped individual survey questions (attributes). The table below is a summary of the current composite measures, their focus and related attribute measures.

#### Overall Satisfaction

MPC satisfaction rates show more than eight in ten PCPs are satisfied, exceeding both the All Other MCO rate and the Healthchoice aggregate rate. Similarly, providers would recommend MPC to both patients and other providers of care.

The 2011 rate of 81% in overall satisfaction is a significant improvement when compared the HealthChoice Aggregate rate.



## Regular Pap Smear Testing Can Save Lives! You can save a life!

It is no secret that many women frown at the thought of having Cervical Cancer screening done. Data shows that providers can make a difference in increasing the number of women who are screened. Providers who talk to their patients about the importance of cervical cancer screening as well as enlist the help of their staff to talk to patients have a higher percentage of patients who complete this life saving exam.

Below please find the summary of the most recent guidelines on Cervical Cancer Screening from the U.S. Preventive Services Task Force (USPSTF) issued this past August.

# Screening for Cervical Cancer

**The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.**

**Rating:** A recommendation.

**Rationale:** The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years (The USPSTF concludes that the benefits of screening substantially outweigh potential harms).

**The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer**

**Rating:** D recommendation.

**Rationale:** The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to

the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

**The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.**

**Rating:** D recommendation.

**Rationale:** The USPSTF found fair evidence that the yield of cytological screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

**The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer.**

**Rating:** D recommendation.

**Rationale:** The USPSTF found poor evidence to determine whether new technologies, such as liquid-based

cytology, computerized rescreening, and algorithm based screening, are more effective than conventional Pap smear screening in reducing incidence of or mortality from invasive cervical cancer. Evidence to determine both sensitivity and specificity of new screening technologies is limited. As a result, the USPSTF concludes that it cannot determine whether the potential benefits of new screening devices relative to conventional Pap tests are sufficient to justify a possible increase in potential harms or costs.

Encourage total wellness. When you refer or during visits for cervical cancer screening, talk to your patients about mammography. If you need assistance in scheduling a mammogram, call Mary Smith in our HEDIS Department at 1-866-651-7838.



# The Case of The Missing Asthma Medication

**The National Heart Blood and Lung Institute affirms that inhaled corticosteroids continue to be the most effective long-term control medicine for patients with asthma:**

“Angela” has Asthma. She says, “It doesn’t bother me too much.” She carries a short acting beta agonist in her purse for “just in case” and gives herself a spritz two to three times a week. Every so often she uses it two days in a row and every other year winds up in the Emergency Room in need of treatment. “Angela” describes what she has as, “just a little asthma” but the National Heart Blood and Lung Institute (NHBLI) would classify her as having poorly controlled Asthma.

Do you recognize this patient? You should because she is probably a member of your panel. Because “Angela” considers her symptoms mild, she does not bother to report them on her visits. As a result, her asthma regimen is missing a crucial agent.

We want to help you identify Angela and similar patients to help ensure that she and others are put on the appropriate asthma drug regimen. Because asthma is primarily an inflammatory condition, patients who are only on a beta agonist are only treating part of the problem. Patients in this group benefit from the addition of a controller medication which helps prevent the inflammatory build up that blocks their airways.

The most recent Expert Panel Report 3- Guidelines for the Diagnosis and Management of Asthma Full Report 2007 include the following: Patients with persistent asthma (symptoms more than twice a week during the day or more than twice a month at night) need both long-term and quick-relief medications. It re-affirmed that inhaled corticosteroids continue to be the most effective long-term control medicine for patient with asthma.

Data on patients who have multiple dispensing events for short acting asthma medication and/or has experienced other Asthma related instances is being identified and sent to your office. According to the National Committee for Quality Assurance (NCQA), members are considered to have poorly controlled Asthma when they exhibit any combination of the following Asthma Related incidents over two consecutive years:

- At least one ED visit with asthma as the principal diagnosis
- At least one acute inpatient claim/encounter with asthma as the principal diagnosis
- At least four outpatient asthma visits with asthma as one of the listed diagnoses and at least two asthma medication dispensing events (Table ASM-C)
- At least four short acting asthma medication dispensing events

Maryland Physicians Care is reaching out to you in order to identify your patients who may benefit from a change in their asthma regimen. If you have a patient who fits one of these criteria you will receive a letter with this information. Our goal is for you to schedule these patients for an appointment to discuss their symptoms and to evaluate them for placement on a controller agent.

In the case at the beginning, at the urging of a friend and staff from Maryland Physicians Care, “Angela” shared with her provider how often she takes a quick spritz of her breathing spray. Her provider adeptly identified that she has persistent asthma and placed “Angela” on an inhaled steroid. “Angela” filled her prescription that day and marveled at how well she felt. She had become so used to being a short of breath that she didn’t realize how far from her baseline she had become. Thanks to her provider, “Angela” is no longer missing out on anything. The case of the missing asthma medication was solved!

## Asthma controller medications include:

Description	Prescriptions		
ANTIASTHMATIC COMBINATIONS	DIPHYLLINE-GUAFENESIN	LUTICASONE	THEOPHYLLINE
ANTIBODY INHIBITOR	OMALIZUMAB		
INHALED STEROID COMBINATIONS	BUDESONIDE-FOMOTEROL	FLUTICASONE-SALMETEROL	
INHALED CORTICOSTEROIDS	BECLMETHASONE BUDESONIDE	FLUNISOLIDE FLUTICASONE CFC FREE	MOMETASONE TRIAMCINOLONE
LEUKOTRIENE MODIFIERS	MONTELUKAST	ZAFRILUKAST	ZLEUTON
MAST CELL STABILIZERS	CROMOLYN	NEDOCROMIL	
MATHYLXANTHINES	AMINOPHYLLINE DYPHYLLINE	OXTRIPHYLLINE THEOPHYLLINE	

# To Mammogram or not to Mammogram? That is the question.

In 2009, the U.S. Preventative Service Task Force revised the guidelines for mammogram in women

The recommendation was that screening mammograms should be done every two years beginning at age fifty for women at average risk for breast cancer. In this revision, they went further and stated that screening mammograms before age 50 should not be done routinely and should be based on a woman's values regarding the risks and benefits of mammography. These guidelines differ from those of the American Cancer Society. The ACS mammogram guidelines call for yearly mammogram screening beginning at age 40 for women at average risk of breast cancer screening. With the difference in recommendations, what is a provider to do? Consider the following statistics

- About 1 in 8 U.S. women (just under 12%) will develop invasive breast cancer over the course of her lifetime.
- In 2011, an estimated 230,480 new cases of invasive breast cancer were expected to be diagnosed in women in the U.S., along with 57,650 new cases of non-invasive (in situ) breast cancer.
- About 39,520 women in the U.S. were expected to die in 2011 from breast cancer, though death rates have been decreasing since 1990 — especially in women under 50. These decreases are thought to be the result of treatment advances, earlier detection through screening, and increased awareness.

- For women in the U.S., breast cancer death rates are higher than those for any other cancer, besides lung cancer.
- Besides skin cancer, breast cancer is the most commonly diagnosed cancer among American women. Just fewer than 30% of cancers in women are breast cancers.
- White women are slightly more likely to develop breast cancer than African-American women. However, in women under 45, breast cancer is more common in African-American women than white women.
- Overall, African-American women are more likely to die of breast cancer. Asian, Hispanic, and Native-American women have a lower risk of developing and dying from breast cancer.
- In 2011, there were more than 2.6 million breast cancer survivors in the US.
- About 85% of breast cancers occur in women who have no family history of breast cancer. These occur due to genetic mutations that happen as a result of the aging process. There have been several studies published since the USPSTF guidelines that continue to show benefit with screening women age 40-49. In fact, the health care reform law includes a requirement that insurers cover mammogram for women aged 40-49. Most breast cancer researchers, radiologists and primary care providers agree that the benefits of mammograph outweigh the risks.

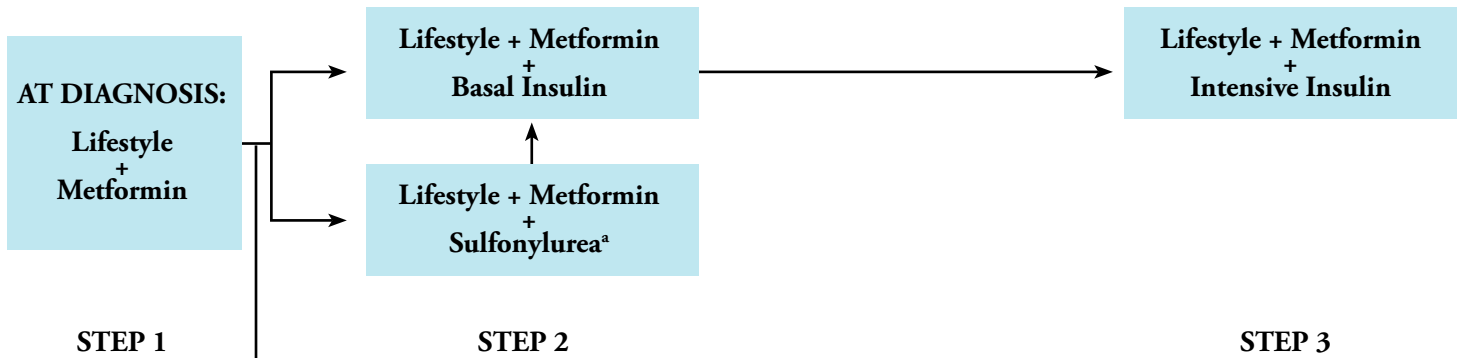
**Maryland Physicians Care encourages providers to review the literature, talk to their patients and refer for mammography when appropriate. If you need assistance in scheduling a mammogram, call Mary Smith in our HEDIS Department at 1-866-651-7838.**

## Diabetes Care

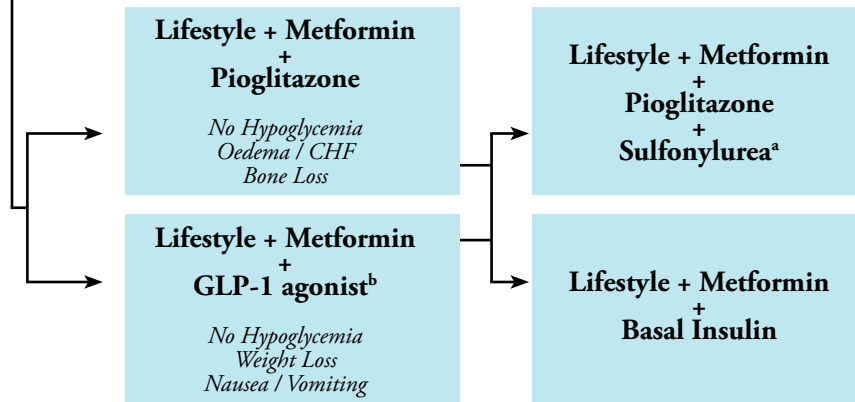
There are many new agents available for the treatment of members with Diabetes. These agents give providers new tools in their arsenal for the management of patients with type II Diabetes. Maryland Physicians Care uses The American Diabetes Association guidelines to develop our formulary.

The American Diabetes Association and the European Association for the Study of Diabetes (EAS) published a consensus statement on the approach to management of hyperglycemia in individuals with type 2 diabetes and a subsequent update. Highlights of this approach include: intervention at the time of diagnosis with metformin in combination with lifestyle changes (MNT and exercise) and continuing timely augmentation of therapy with additional agents (including early initiation of insulin therapy) as a means of achieving and maintaining recommended levels of glycemic control (i.e., A1C < 7% for most patients). The overall objective is to achieve and maintain glycemic control and to change interventions when therapeutic goals are not being met.

## Tier 1: Well-Validated Core Therapies



## Tier 2: Less Well-Validated Therapies



The above algorithm is included which took into account the evidence for A1C lowering of the individual interventions, their additive effects, and their expense. The precise drugs used and their exact sequence may not be as important as achieving and maintaining glycemic targets safely. Medications not included in the consensus algorithm, owing to less glucose-lowering effectiveness, limited clinical data, and/or relative expense,

still may be appropriate choices for individual patients to achieve glycemic goals. Initiation of insulin at the time of diagnosis is recommended for individuals presenting with weight loss or other severe hyperglycemic symptoms or signs.

If a provider would like to choose a medication not included in the consensus algorithm, Maryland Physicians Care requires completion

of a Prior Authorization form. This form is available on line at <http://www.marylandphysicianscare.com/PDF/MPCPAForm.pdf>. The form should be accompanied by clinical notes which document failure of or contraindication to formulary agents. Supporting clinical notes are essential and allows for an appropriate clinical review.

### References

1. American Diabetes Association. Standards of medical care in diabetes--2010. *Diabetes Care*. 2010 Jan;33 Suppl 1:S11-61.
2. Nathan DM, Buse JB, Davidson MB, Ferrannini E, Holman RR, Sherwin R, Zinman B; American Diabetes Association; European Association for Study of Diabetes. Medical management of hyperglycemia in type 2 diabetes: a consensus algorithm for the initiation and adjustment of therapy: a consensus statement of the American Diabetes Association and the European Association for the Study of Diabetes. *Diabetes Care*. 2009 Jan;32(1):193-203.

# Please consider this resource for you and your patient with Sickle Cell Disease

## Maryland iHomes Network

The Improving Health Outcomes and Medical Education for Sickle Cell Disease (iHOMES) Network is dedicated to providing high-quality primary care to people with sickle cell disease (SCD) who live in Maryland.

Supported through a 4-year grant from the Health Resources and Services Administration, we have 3 main goals for iHOMES:

- Connect adult patients who have SCD with primary care providers and support the relationship.
- Help older adolescents and young adults with SCD to transition effectively from pediatric to adult primary care doctors.
- Train primary care providers to care for people with SCD of all ages and provide the necessary tools to deliver high quality care.

To do this effectively, we are creating a network of PCPs who care for or would like to care for patients with sickle cell disease. All members and patients in our iHOMES network receive the following benefits.

### Provider benefits:

- Free webinar series on the basics of primary care for patients with SCD. Free CME may be available
- On-line interactive web based modules that summarize primary care evidence-based recommendations
- Enhanced communication with and access to pediatric and adults hematologists with

a clinical focus on SCD if you have questions about your patients

- The latest evidence-based care guidelines

### SCD Patient benefits:

- Community Health Workers who can provide in-home outreach and education to your patients
- Free transportation to help your patients attend PCP clinic appointments
- Free dental care for your patients who lack dental access
- Links to Community Based Organizations that provide information and services for people with SCD and sickle cell trait

### Contact Information:

- Call our SCD hotline at 443-717-2198 to activate any of these benefits
- Email us at [iHomes@jhmi.edu](mailto:iHomes@jhmi.edu)
- [www.hopkinsmedicine.org/Medicine/sickle](http://www.hopkinsmedicine.org/Medicine/sickle)

### Clarification on Chemotherapy / Radiation Oncology – Prior Authorization Process

Maryland Physicians Care (MPC) is now utilizing eviti as part of our prior authorization process for chemotherapy and radiation oncology services. The use of eviti will ensure that our members are receiving treatment that is evidence-based.

eviti provides a code that designates the treatment plan is evidence based.

Please note as the provider you will still need to receive an authorization number from MPC for the actual treatment, in addition to the eviti code.

### The clarification of the process is as follows:

The provider submits the treatment plan and requested information through the eviti website.

Once the provider receives an eviti code, they will still need an authorization number from MPC.

**MPC will only need to receive the following: the eviti code, the site of service, the dates of service, and if the request is for inpatient, outpatient, or home therapy in order to complete the authorization process.**

This information can be submitted by fax to 800-953-8856 or by accessing our secure web portal “My MPC Source”. If you need access to the My MPC Source website, please contact your Provider Relations Representative at 800-953-8854.

The requesting provider will be notified when the authorization process is completed via a fax.

MPC values your network participation and we hope that you find this information to be helpful. If you have any questions you may contact your MPC Provider Relations Representative.



## SUBOXONE

Maryland Physicians Care does not require prior authorization for the use of Suboxone. In an effort to be consistent with guidelines found on the SAMSHA website ([http://buprenorphine.samhsa.gov/Bup\\_Guidelines.pdf](http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf)) [http://buprenorphine.samhsa.gov/Bup\\_Guidelines.pdf](http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf)) which state the target dose is 16/4mg Maryland Physicians Care will soon begin instituting quantity limits. Beginning January 15th, Prescriptions for doses above 24/6 mg will require prior authorization. The prior authorization form can be found at: <http://www.marylandphysicianscare.com/PDF/MPCPAForm.pdf>. We understand that there may be unique features about your patients. If you are requesting doses above 24/6mg providers are asked to complete the prior authorization form and submit clinical notes and/or a treatment plan that document the medical necessity of that dose. Please be sure to include visit and medication compliance, toxicology results, participation in counseling as well as any plans for tapering if clinically appropriate. We appreciate your assistance with the care of our members. If you have any questions, you may reach a member of our Substance Abuse team by calling 410-401-9528.

# My MPC Source

## Our Secure Web Portal

Did you know that you don't have to wait on hold for simple answers?

Via MPC's secure online web portal, members and providers can check eligibility, claims status, benefits and much more. It all happens in just a matter of minutes.

Visit us on the web at [www.marylandphysicianscare.com](http://www.marylandphysicianscare.com) to register or ask your Provider Relations Representative for details today.

My MPC Source is a great way to save time. When you register, you can also accomplish all of the following online:

Identify a MPC member's primary care provider

Claims status and inquiries

Request up-to-date rosters

Receive "HEDIS Interventions Required" notifications for members in the eligibility screens

Request prior authorization

Check the status of prior authorization requests

Print remittance advice notifications

Verify issued checks

## Interactive Voice Response System (IVR) No Longer Available after December 31, 2011

**Please be advised that effective January 1, 2012, MPC's Interactive Voice Response (IVR) functionality will no longer be available as an option when calling into our call centers. We are strongly encouraging providers to utilize our secured web portal "My MPC Source" as a valuable resource to save time when accessing member eligibility information.**

MPC has upgraded its current online Prior Authorization (PA) Requirements Lookup Tool to a new version that includes several enhancements. We anticipate that these enhancements will better serve our provider groups and make the system more user-friendly. The enhancements are as follows:

Added a new "Site Feedback" page as a link off of the Provider Web Page to allow providers the opportunity to submit feedback and comments regarding the PA Requirement Lookup Tool.

Removed the CPT Effective Date and CPT Term Date from the main web page.

Added a new field, "Svc Partner Detail", to the main web page. This field will be used to populate information/guidance regarding carved out services or benefit related information.

*For example, a statement related to a specific benefit that is offered for adults but not children, such as:*

*PT/OT and ST for members under 21 is covered by the state.*

We hope that you will find these changes to be helpful in your day-to-day interactions with the PA Requirement Lookup Tool and if you have any questions, please contact your Provider Relations Representative for assistance by calling 800-953-8854.



## Electronic Fund Transfer (EFT)

MPC is pleased to announce that it now offers electronic payments through electronic funds transfer (“EFT”), which offers a fast, easy and convenient way to have MPC payments deposited directly into providers’ bank accounts upon completion of the EFT authorization process. A fully-completed Electronic Fund Transfer Authorization Form (“EFTAF”) and a copy of a voided check for bank verification are required to complete the EFT authorization process. A copy of the EFTAF may be secured by contacting MPC’s Provider Relations Department by calling 800-953-8854 or using email address: [providers@marylandphysicianscare.com](mailto:providers@marylandphysicianscare.com)

## Do we have your e-mail address?

Expedient communications with our network providers is a high priority for MPC. We want to be able to get information about our policy changes or updates into your hands as quickly as possible. If your practice or facility has an email address, please send it to the attention of [providers@marylandphysicianscare.com](mailto:providers@marylandphysicianscare.com). Please state in the e-mail that you are establishing the point of contact for the provider, practice or facility. This will allow us to communicate quickly any policy changes or updates and also create an alternative means of communication in addition to phone, fax, and MPC’s website ([www.marylandphysicianscare.com](http://www.marylandphysicianscare.com)).

## Maintain Current Network Information to Support Access to Care

Please keep your participation in the MPC provider network current by furnishing the information and/or documentation listed below to your assigned MPC Provider Representative via e-mail, fax or direct mail. You may also send this information to MPC’s Provider Relations Department at [Providers@marylandphysicianscare.com](mailto:Providers@marylandphysicianscare.com).

- Credentialing and/or re-credentialing information and documentation
- Any status change in provider or facility licensure
- Provider departure and/or relocation
- Office closures, openings or relocation
- Expansion of services offered
- New providers joining your practice

You may contact MPC’s Provider Relations Department at 800-953-8854.

## Provider Credentialing and Recredentialing

MPC employs a Credentialing Verification Organization (CVO), which performs primary source verification on its behalf through the employment of the CAQH (i.e., common repository for provider credentialing information).

In order to move forward with the credentialing process, MPC will need your CAQH identification number. In the event that you currently do not share your credentialing information with CAQH, you may do so at no cost by accessing the CAQH website at: <http://caqh.org/credapp/>.

It is important to keep in mind that network practitioners must maintain a free and clear licensure, and report any changes in status of licensure to Maryland Physicians Care’s Provider Relations Department immediately upon receipt of notification of change of license status.

Please keep your participation in the Maryland Physicians Care provide network current and provide a timely response to credentialing and/or recredentialing requests. Also, any additional provider activity, e.g., any status change in provider or facility licensure, provider departure and/or relocation, office closures, openings or relocation, expansion of services offered, should be reported to MPC’s

Provider Relations Department during the normal course of business and not just at the point of provider recredentialing.

This information and/or documentation should be furnished to MPC’s Provider Relations Department direct mail, fax or e-mail: [providers@marylandphysicianscare.com](mailto:providers@marylandphysicianscare.com).

You may contact MPC’s Provider Relations Department at 800-953-8854.

## A Notice from Maryland Department of Health and Mental Hygiene (DHMH)

### *DHMH Compliance with National Correct Coding Initiative (NCCI) Edits*

Under section 6507 of the Patient Protection and Affordable Care Act (ACA) of 2010, the Department of Health and Mental Hygiene (the Department) is mandated to comply with National Correct Coding Initiative (NCCI) edits for the Physician’s Program. NCCI was developed by the Centers for Medicare and Medicaid Services (CMS). The NCCI edits are used to ensure correct and accurate reporting of procedure codes by all of the providers listed\*below which would prevent improper reimbursement for duplicate services:

\*Physicians, Osteopaths, Physical Therapists, Occupational Therapists, Speech Therapists, Nurse Practitioners, Nurse Anesthetists, Certified Nurse Midwives, Podiatrists, Optometrists, Nutritionists, Audiologists, and Therapeutic Behavioral Aides

Providers are encouraged to visit the CMS “NCCI Edits Overview” website to learn more about this federally mandated program. The implementation of the NCCI edits by the Department may result in reduced provider payments including, but not limited to:

- Procedure codes that are mutually exclusive (mutually exclusive codes are clinically unlikely to be performed on the same patient on the same day, such as two diagnostic studies aimed at achieving the same result)
- Procedure codes that are inappropriately bundled (an inappropriately bundled code is when a component procedure is billed with a comprehensive procedure).

Providers are responsible for ensuring their claims are in compliance with all current NCCI edits. Claims that are submitted to the Department with a date of service on or after October 1, 2010, as stated under section 6507 of the ACA, will be reviewed. Reimbursements on services found to be in conflict with the NCCI edits will be retracted by the Department or a designee of the Department. The retraction will occur on claims that have dates of service from October 1, 2010. In accordance with CMS, NCCI edits are not subject to official appeal or review by the Department.

# Filing, Benefits Coordination, Resubmissions and Overpayments

## Coordination of Benefits

As a Maryland Medicaid HealthChoice MCO, MPC serves as the payor of last resort and is required to demonstrate its due diligence with regard to coordination of benefits. MPC routinely reviews its member eligibility data to ensure accuracy. Opportunities for coordination of benefits are an integral part of MPC's enrollment review.

“If the member has another health insurance program and MPC HealthChoice or Primary Adult Care Program (PAC) coverage, then the primary insurance carrier should be billed first. Upon receipt of the primary carrier's remittance advice, the fully-completed claim form with a

copy of the primary insurance carrier's remittance advice notification should be sent to MPC's Claims Department for processing.

If a primary insurance carrier is identified for MPC members and MPC has paid claims for services rendered to these members prior to the primary care insurance carrier, then it is MPC's fiduciary responsibility to recoup the claims dollars paid as primary through its retraction process. Providers are notified of this recoupment through MPC's remittance advice notification, which clearly states that the retraction was taken due to other primary care insurance.

Providers may secure primary insurance information from the member, MPC's secure web portal website or by contacting MPC's enrollment/eligibility unit at 1-(800)-953-8854.

The timeframe for MPC's recoupment of claims is eighteen (18) months from the date on which the claim was paid.

## Resubmissions and Overpayments

To submit a corrected claim or missing attachment, within 90 working days of the denial return the claim stamped “Resubmission” with requested change(s), corrected error(s) and requested attachments to the claims address;

## The Claims Corner: MCO Claims Administration

### MCO Claims Administration

The MPC MCO member ID number is the member's Maryland Medical Assistance (MA) I.D. number. For covered medical benefits, the MPC MCO Medicaid/HealthChoice member is not responsible for any deductibles, copayments or balances due.

To prevent unnecessary processing delays:

- Always include name of provider of service in Block 31 CMS 1500. Do not use “Signature on File.”
- Bill with the latest ICD-9 codes using the five-digit format and the current CPT code with the correct modifier.
- Block 33, CMS 1500, practice name must be the same as Form W-9 and Agreement with MPC.
- MPC does not issue a provider number. Please bill the physician's Maryland Medicaid Identification number in Box 33 next to PIN # and the Tax Identification (same as Form W-9) Number in Box 25 on the CMS 1500 form.
- Include National Provider Identifier in the appropriate block on the claim form.
- MPC encourages electronic claims transmittal. Emdeon: 1-866-506-2830, MCO Provider ID #22348 for both CMS 1500 and UB 04s.

MPC MCO Claims,  
P.O. Box 61778,  
Phoenix, AZ 85082-1778,  
ATTN: "Resubmission."

Not clearly indicating "Resubmission" may result in further delays.

If you receive an overpayment, send a letter denoting reason for overpayment along with a copy of the MPC remittance advice to:

Maryland Physicians Care  
509 Progress Drive, Suite 117  
Linthicum, Maryland 21090  
ATTN: Finance

#### Provider Appeals

MPC requires all provider appeals to be submitted in writing to:

Maryland Physicians Care  
509 Progress Drive, Suite 117  
Linthicum, Maryland 21090  
ATTN: Appeals Department

Providers have 90 business days to file an appeal from the date of remittance advice.

MPC acknowledges provider written appeals within five business days of its receipt.

#### Timely Filing

All encounters and claims must be submitted within 180 days of encounter.

Claims mailing address:

Maryland Physicians Care MCO  
Claims  
P.O. Box 61778  
Phoenix, AZ 85082-1778



# Help Us Stop Fraud!!!

\*\*\* A Note from MPC Compliance Department \*\*\*

Please remember it is your responsibility as a Medicaid program provider (a requirement which can be subject to federal or state sanctions) to report suspected fraud and/or abuse!

To report fraud or abuse, call the MPC compliance hotline at 1-(866)-781-6403. We prefer, but do not require, that you leave your name. Please leave enough information to help us investigate, including the:

- Name of the MPC member or provider you suspect of fraud
- Member's MPC card number
- Name of doctor, hospital or other health care provider
- Date of service
- Amount of money that MPC paid for service if applicable
- Description of the acts you suspect involve fraud or abuse

You can also visit MPC's website at [www.marylandphysicianscare.com](http://www.marylandphysicianscare.com)! Click on "Fraud" and you can email us suspected fraud information.

Thank you for your continued support!



509 Progress Drive • Suite 117 • Linthicum, MD 21090

1-800-953-8854 • Fax 410-401-9013

Provider Update is published by Maryland Physicians Care for physicians and other providers. Please share with your practice manager, billing & referral specialist. If you have questions or comments about this newsletter, please call 1-800-953-8854.

## SENIOR MANAGEMENT

Chief Executive Officer  
Cynthia M. Demarest

Chief Operating Officer  
Jason Rottman

Chief Medical Officer  
David L. Yalowitz, MD, MPH

Compliance Officer  
Linda Dietsch

Medical Directors  
Nina F. Miles Everett, MD  
Dr. Maislyn Christie

## ADVISORY BOARD

Prevention & Wellness Coordinator  
Apryl Lomax, CHES

Manager, Provider Relations  
Michael L. Brown

### Mission

We are a value-driven, community-focused managed care organization that improves the health status of its members through effective care management systems. Our vision and values as a provider-sponsored organization enhance the missions of the owners' health systems.

### Vision

We seek to be a dominant, financially sound and socially responsible managed care organization of choice for members, providers and health care purchasers in the markets we serve.

### Values Quality

Emphasize continuous efforts to improve health status and quality of life for those individuals and communities we serve.

### Respect

Promote dignity and integrity in all aspects of plan governance and management.

### Collaboration

Achieve corporate goals and objectives through effective partnerships with key health care stakeholders.

### Financial Strength

Maintain long term financial viability through sound plan governance and management.

**You'll Love the Way We Treat You!**



Maryland Physicians Care is owned by Maryland General Health Systems, St. Agnes HealthCare, Washington County Health System, and Western Maryland Health System. Schaller Anderson, an Aetna company, administers the plan.