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Health Plan Effectiveness Data & Information Set (HEDIS) Measures

What is HEDIS?: HEDIS is a tool created by the National Committee for Quality Assurance (NCQA) to collect data about the quality of care and services provided by health plans. NCQA prescribes rigorous methodologies that participating health plans must follow for identifying relevant populations/samples, collecting data and reporting outcomes. Because all participating health plans use the same methodologies and reporting mechanisms, purchasers are able to use fair comparisons when making decisions about their health plans and health care.

Specifically, HEDIS consists of a set of performance measures that demonstrate how well a health plan is performing in key areas: quality of care, access to care and member satisfaction with the health plan and doctors.

2011 HEDIS Medical Record Review Process

The 2011 HEDIS (Healthcare Effectiveness Data and Information Set) audit process will begin in February 2011. The purpose of the audit is to measure practice compliance with certain HEDIS measures, such as well child 3-6 years, adolescence well child 12-21 years, infants 0-15 months, immunizations before the age of 2, adolescent immunizations, diabetic eyes, and pap smears.

HEDIS was selected by the Department of Health and Mental Hygiene to measure the quality of Maryland's Medicaid managed care organizations. The results are reported annually in a consumer report card. HEDIS data allows Maryland Physicians Care (MPC) to demonstrate to consumers the quality of care provided to our members. Although we make every effort to collect HEDIS data from claims and encounters, the most reliable source is the Medical Record.

MPC will begin its review the last week of February 2011 and continue through May 2011. The charts reviewed are selected at random. An MPC nurse will contact your medical record department representative and make arrangements to review your charts. The MPC nurse will photocopy the relevant parts of the chart as proof for the state of Maryland of compliance. Our members' personal health information is kept confidential. Patient information will not be presented in any identifiable way. Your contract with Maryland Physicians Care provides for the release of medical record information for quality improvement efforts.

Please update your staff regarding the 2011 HEDIS audit process and encourage them to cooperate. If you have questions or concerns about this process, please contact Brenda Code, HEDIS Project Manager, at **410-401-9474**.

National Correct Coding Initiative (CCI)

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.

Ensure staff work from the most up-to-date information on PA requirements.

The Prior Authorization Requirement Search Tool can be accessed only through our secure web portal. To register, download an application on the Providers section of our website.

Prior to these changes, Provider Relations will offer training and updated user guides and we'll share details with you shortly. With questions, please contact Provider Relations.

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:

CCI 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:

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

New Requirement to Bill for Physician-Administered Drugs

As you may know, providers are being required to submit the National Drug Code (NDC) for physician-administered drugs effective January 1, 2011 for all claims submitted to Maryland Physicians Care MCO. This requirement is due to the implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) (Health Care Reform Law), which requires all state Medicaid agencies to collect rebates from drug manufacturers for physician-administered or dispensed drugs provided through Medicaid health plans. A physician-administered drug includes any covered outpatient drug provided or administered to a recipient, which is billed by a provider other than a pharmacy. Such providers would include, but not be limited to, physician offices, clinics, home health agencies, skilled nursing homes and hospitals.

MPC Billing Requirements – Providers need to include the following data on claims forms/ EDI claims submission to MPC:

■ CMS 1500 forms – Box 24

- > The top area of the six service lines is shaded and is the location for reporting supplemental informa-

tion, such as NDCs for drugs. The shaded areas of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

- > When entering supplemental information for NDC, add in the following order: NDC qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.
- > The Qualifier N4 11-digit valid NDC code, HCPCS (J) Code, quantity and amount billed. More than one NDC can be reported in the shaded lines of Box 24.

■ UB04 – Box 43, Line 1

- > 11-digit valid NDC code, HCPCS Code, quantity and amount billed

■ Electronic Claim Form 837 Professional or Institutional – Loop 2410, LIN03=NDC code, 11-digit valid NDC, HCPCS codes, CTP04 =Quantity and CPT05=Unit of Measure, amount billed.

Maryland Medicaid's Physician Billing Manual (page 9) instructs providers that reporting of the NDC/quantity is required when billing for drugs using A-J-Q-codes and certain CPT codes. The reporting requirement also extends to claims where there is other primary coverage. The NDC number reported must be the actual NDC number on the package or container from which the medication was administered. It may be necessary to pad NDC numbers with left-digit zeros in order to report eleven digits.

Providers may also review sample claim forms on Maryland Physicians Care's website at www.marylandphysicianscare.com

Claims with Date of Service on or after January 1, 2011 that do not meet the NDC reporting requirements to include a valid NDC paired with a valid HCPCS code will result in claims being rejected by Maryland Physicians Care back to the provider for resubmission with the required NDC.

For more information, you may call MPC Provider Services at **1-800-953-8854**.

IMPORTANT Change in MPC's administration of PAC Program and MPC's Value-Added Benefits Effective January 1, 2011

Dental Services will no longer be available to PAC enrollees. Routine Vision Benefits are no longer offered to PAC enrollees who do not have a diabetic diagnosis.

MPC will enforce pharmacy copays to PAC enrollees for all drugs except contraceptive management drugs, over-the-counter drugs or certain specialty drugs per prescription. The copay for brand-name drugs is \$7.50, and \$2.50 for generic drugs per prescription.



Prevention & Wellness



Blood Lead Level (BLL) Testing and Laboratory Information

Childhood lead poisoning is a preventable, silent epidemic affecting close to one million children living in the United States.

Regardless of the results of the lead risk assessments, all children who are Medicaid recipients must have a BLL test at 12 months and 24 months of age. If a child has not been previously tested, or test results are not available, a baseline blood lead level must be obtained during the initial visit for all children up to six years of age. If it is determined that a child may be at risk for lead exposure upon completion of the lead risk assessment, then blood lead level testing should be performed regardless of the child's age. It is the responsibility of the primary care physician to document that blood lead level testing was ordered.

The Division of Healthy Kids Program is available to assist with any lead testing questions or concerns. They may be reached by calling **410-767-1683**.

Health Education Materials

Maryland Physicians Care (MPC) is a values-driven, community-focused managed care organization (MCO) that improves the health status of its members through effective care management systems. One of the ways we improve health status is by providing health education presentations to the community. Each interactive presentation is usually 30-60 minutes, but timeframes are very flexible.

To learn more about Maryland Physicians Care, please visit our website at **www.marylandphysicianscare.com**. To schedule a presentation, please contact me by phone at **410-401-9451** or by e-mail at **apryl.lomax@marylandphysicianscare.com**. In addition, because everyone is planning for a big flu season, attached are some helpful hints that can be placed throughout your church and/or community.

Immunization Reminder

Timely and complete childhood immunizations are crucial to disease prevention. The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Centers for Disease Control and Prevention (CDC), and the Advisory Committee on Disease Prevention developed the immunization guidelines and recommendation that children receive the following immunizations before the child's 2nd birthday.



Immunization List

- (4) Diphtheria, Tetanus, and Acellular Pertussis (DTap)
- (3) Polio (PV)
- (1) Measles, Mumps, and Rubella (MMR)
- (2) H Influenza Type B (Hib)
- (3) Hepatitis B
- (1) Chicken Pox (VZV)
- (4) Pneumococcal Conjugate Vaccines

For more information on vaccines, visit **www.cdc.gov**.

Please be sure that all immunizations are administered on time!

Interested in your patient receiving health education materials?

Contact the Prevention & Wellness Department for more information at **410-401-9451**.

Use of Inhaled Steroids for Patients with Moderate Persistent Asthma

According to the NHLBI, inhaled steroids are first-line agents for patients with moderate persistent asthma who have failed therapy with solitary use of inhaled beta-agonist. If your patients continue to ask for refills on inhaled beta-agonist, take a moment to review the chart for any contraindication to an inhaled steroid. If there are no contraindications, make the appropriate addition to their medication regimen.

Family Planning and Reproductive Health

MPC wants to ensure that its practitioners and other family planning service providers realize the important components of a family planning examination listed below:

- Assessment of member's risk for unintended pregnancy, poor pregnancy outcome, or need for family support services
- Age-appropriateness of information provided to members and the need for confidentiality of information
- Pregnancy diagnosis and counseling, including:
 - > Referral to a participating obstetrical practitioner for early entry into prenatal care for members diagnosed as pregnant who wish to continue the pregnancy
 - > Information of all legal options available for members diagnosed with unintended pregnancies and, if they desire, referral for appropriate obstetrical and gynecological service
 - > Information about the availability of contraceptive methods for non-pregnant members
- Early notification to the health plan of high-risk pregnancies education, including:
 - > Reasons why family planning is important to maintain individual and family health
 - > Basic information regarding reproductive anatomy
 - > Risk factors and complications of various contraceptive methods
 - > Information on the transmission, diagnosis and treatment of sexually transmitted diseases
 - > Education about acquired immunodeficiency syndromes (AIDS)/ Humanimmunodeficiency virus (HIV)
 - > Procedures of self-breast examination

MPC encourages practitioners to notify the health plan of any newly diagnosed pregnancies within seven days.

Attention OBs:

Keep Those Maryland Prenatal Risk Assessments Coming!

Please continue to submit the completed **Maryland Prenatal Risk Assessment (MDPRA)** to Maryland Physicians Care's (MPC) Prior Authorization department via **fax at 1-800-953-8856 for each of your pregnant members. Once the MDPRA is completed and submitted to MPC, you can bill code H1000 for a \$40 payment for each pregnant member.**

This **essential** process helps to:

1. **Identify** MPC pregnant members early
2. **Risk stratify** them
3. **Perform more effective and efficient outreach**

4. **Provide wraparound case management services for high-risk pregnant members timely**
5. **Support OB offices** by providing additional monitoring and education to members **in between OB visits**
6. **Troubleshoot member barriers to care to increase OB visit attendance**
7. **Contact and reassess low-risk members** during their pregnancy for status changes

We look forward to continuing our integral partnership with each of you during every member's pregnancy journey to meet the same positive birth outcome—a healthy mom and a healthy baby.

Diabetes Care for Your Patients Living Well with Maryland Physicians Care

MPC has a special program for our members living with diabetes. It's called Living Well with Maryland Physicians Care. MPC partnered with CCS Medical in this program, which is designed to help your patients (and our members) manage their diabetes more effectively. This program consists of periodic health surveys to allow us to encourage the members to schedule and keep regular physicians appointments and adhere to their program of self care.

If you have patients who could benefit from this program, please encourage them to enroll today and help us help your patients live better with diabetes.

From the Desk of: Maryland Physicians Care Substance Abuse Team

According to Governor O'Malley's office, nearly 800 people in Maryland died in 2007 as a result of drug overdose. In 2005, an estimated 290,000 Maryland adults needed alcohol or drug treatment, but only 26% were admitted into treatment.

In order to address these alarming statistics, MPC has built a strong, solid and accessible team of clinicians to help you and your patients access substance abuse treatment.

Our team is here to educate and support you and your patients regarding substance abuse screening, recommendations for appropriate ASAM-driven levels of care, and access to treatment.

As a primary care physician, you are in a unique position to identify patients' drug/alcohol use early on and prevent it from escalating into abuse or addiction. Early intervention reduces the adverse effects on a patient's medical, social and psychological functioning.

The National Institute on Drug Abuse has developed an initiative to provide the medical community with a web-based tool to help you screen patients efficiently and assist in proactively identifying substance abuse issues. Please take the opportunity to learn more about these tools and how they can be utilized in your practice by visiting www.drugabuse.gov/NIDAMED/screening/.

The MPC Substance Abuse team is your partner in helping to navigate members through the spectrum of substance abuse treatment services. We are also available to provide education and resources on-site for office staff, patients, and/or your surrounding community. Our services are available 24 hours a day, 7 days a week.

**You may contact us at
1-800-953-8854**, option 7.

Provider Pearls

Respiratory syncytial virus (RSV) is a common respiratory illness that can be life threatening to premature babies. Because of the special dangers associated with RSV in preemies and babies with certain heart defects, Synagis (Palivizumab) was licensed by the FDA in 1998 to help prevent RSV infections in high-risk babies. Synagis is an antibody used in high-risk children to prevent RSV infection.

There has been significant debate about which babies should receive Synagis. New guidelines were issued for the 2009-2010 RSV season. The most significant change will impact preemies born between 32 and 35 weeks gestation. The present guidelines have more stringent criteria.

The new guidelines recommend:

- A. Babies born between 32 and 35 weeks, who were born within 3 months before the start of RSV season or at any time throughout the RSV season, qualify for prophylaxis if they have at least 1 of the following 2 risk factors:
 1. Attendance at child care, or having at least 1 sibling or
 2. Other child younger than 5 years who permanently resides in the infant's household. (Previous recommendations considered a list of 5 risk factors, and required babies to have at least 2 of them.) Unless they have chronic lung disease or certain heart defects, babies in this group will now receive no more than three doses of Synagis.
- B. Babies born before 32 weeks gestation, or those with chronic lung disease or hemodynamically significant heart disease should receive no more than 5 doses of Synagis. Previously, these babies received Synagis

monthly for the entire RSV season, which varies by geographic location. In our region, immunoprophylaxis begins in November.

- C. Synagis prophylaxis may be considered for infants and children younger than 24 months with chronic lung disease who receive medical therapy (supplemental oxygen, bronchodilator, diuretic or chronic corticosteroid therapy) for CLD within 6 months before the start of the RSV season. These infants and young children should receive a maximum of 5 doses. Patients with the most severe CLD who continue to require medical therapy may benefit from prophylaxis during a second RSV season.

References:

www.aap.org

www.kristiemcnealy.com/

[new-synagis-guidelines-for-rsv-prevention-medical-monday/](http://www.kristiemcnealy.com/new-synagis-guidelines-for-rsv-prevention-medical-monday/)

Automated Eligibility Verification System (AEVS)

MPC's Automated Eligibility Verification System (AEVS) offers telephonic verification of member eligibility and confirmation of the assigned primary care provider (PCP) if the contacting provider (caller) is the assigned PCP for the member in question. It is important to note that the AEVS does not identify the name of the PCP of record, but rather identifies if the tax identification number that is entered into the AEVS is attached to the PCP on the member's record. To access the AEVS, call **1-800-953-8854**, option 1, option 5 and follow the prompts to perform the necessary data entry using the keypad on your phone.

MPC's Secure Web Portal

MPC's secure web portal is a great way to save time. When you register, you can accomplish all of the following online:

- Verify member eligibility
- Identify an MPC member's primary care provider
- 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
- Verify claims status
- Print remittance advice notifications
- Verify issued checks

MPC's secure web portal is a free service for MPC providers. Learn more at www.marylandphysicianscare.com or call MPC's Provider Relations Department at **1-800-953-8854**, option 2.

Begin using MPC's secure web portal today!

Electronic Funds Transfer (EFT)

Maryland Physicians Care (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 **1-800-953-8854**, option 2, option 3 or using e-mail address: providers@marylandphysicianscare.com.

Maryland Physicians Care Website

MPC program administration guidelines and documentation, e.g., provider manuals, directories, forms, drug formulary, Block Vision directory via Block Vision online, DentaQuest directory via DentaQuest online. www.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 e-mail address, please send it to the attention of michael.brown@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.

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.

- 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

You may contact MPC's Provider Relations Department at **1-800-953-8854**, option 2, option 3.

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 provider 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.

You may contact MPC's Provider Relations Department at **1-800-953-8854**, option 2, option 3.

Important Changes to Prior Authorization Process

Maryland Physicians Care has made important changes to its prior authorization (PA) process that are intended to reduce the number of outpatient services that require PA and:

- Specify PA requirements by current procedural terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes.
- Activate the Prior Authorization Requirement Search Tool, available via our secure web portal. With this tool, providers can:
 - > Search PA requirements by individual or multiple codes simultaneously
 - > Review PA requirements by specific procedures or service groups
 - > Receive immediate, detailed Yes/No information regarding PA requirements
 - > Ensure staff work from the most up-to-date information on PA requirements

The Prior Authorization Requirement Search Tool can only be accessed through Maryland Physicians Care’s secure web portal. If you are not already

registered, download an application on the Providers section of www.MarylandPhysiciansCare.com.

Maryland Physicians Care Provider Relations offers trainings and updated user guides. We will notify providers of more specific information as it becomes available. If you have questions, please contact Maryland Physicians Care Provider Relations at **1-800-953-8854**, option 2, option 3.

Child in State-Supervised Care-Initial Medical Exam Type of Provision: Self-Referral

A child in state-supervised care is a child in the care and custody of a state agency pursuant to a court order or voluntary placement agreement, including, but not limited to HealthChoice-eligible children who are:

- Under the supervision of the Department of Juvenile Services,
- In kinship or foster care under the Department of Human Resources, and

- In residential treatment centers or psychiatric hospitals for the first 30 days after admission.

Prior to rendering care to a child in state-supervised care, a provider must receive EPSDT certification from the Department of Health and Mental Hygiene.

The MCO is required to permit the self-referral of a child in state-supervised care for an initial examination and is obligated to pay for all portions of the examination except for the mental health screen. Eligible providers should bill the child’s MCO utilizing the age-appropriate preventive CPT code (see code list below) in conjunction with the modifier -32 (Mandated Services). Eligible providers will be reimbursed by MCOs at the current Medicaid Fee for Service rate.

FOR CURRENT FEE SCHEDULE, SEE THE MEDICAID PROVIDER FEE MANUAL ON LINE AT: www.dhmf.state.md.us/mma/providerinfo/

CPT Code	Description	Modifier
Initial Comprehensive Preventive Medicine (New Patient)		
99381	Infant (age under 1 year)	32
99382	Early Childhood (age 1 through 4 years)	32
99383	Late Childhood (age 5 through 11 years)	32
99384	Adolescent 9 (age 12 through 17 years)	32
— or —		
Periodic Comprehensive Preventive Services (Established Patient)		
99391	Infant (age under 1 year)	32
99392	Early Childhood (age 1 through 4 years)	32
99393	Late Childhood (age 5 through 11 years)	32
99394	Adolescent 9 (age 12 through 17 years)	32

Please contact the staff specialist for Children’s Services for additional information at **1-410-767-1903** or to report MCO reimbursement difficulties.

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. These electronic claims clearing houses participate with MPC: ProxyMed/MedAvant 1-800-882-0802, MCO Provider ID #00247 for CMS 1500s, #MPU01 for UB 04s; WebMD/Emdeon: **1-800-735-8254**, ext. 17903, MCO Provider ID #22348 for both CMS 1500 and UB 04s.

Coordination of Benefits

As a Maryland-based HealthChoice MCO, MPC serves as the payer 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 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 claim 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**.



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

Claim Appeals, 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 MPC MCO Claims, P.O. Box 61778, Phoenix, AZ 85082-1778, ATTN: “Resubmission.” Not clearly indicating “Resubmission” may result in further delays.
- To appeal a claim denial, submit a letter of explanation, copy of remittance advice, MPC denial letter and other documentation relevant to the reason for the denial to the 509 Progress Drive address below, ATTN: “Grievance and Appeals Coordinator” within 90 working days of the receipt of a pre-authorization or claim denial.
- If you receive an overpayment, send a refund check and copy of the MPC remittance advice noting the reason for overpayment to Maryland Physicians Care 509 Progress Drive, Suite 117, Linthicum, Maryland 21090, ATTN: “Finance.”

MCO Provider Appeals

Maryland Physicians Care has a process regarding provider appeals as a request for a review of an action related to claims denials. Appeals for service denials, reductions or terminations are considered member appeals and follow the MCO member appeal process.

Maryland Physicians Care requires all

provider appeals to be submitted in writing to:

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

Timeframes related to the appeals process

- Providers have 90 business days to file an appeal from the date of claim denial.
- MPC acknowledges provider written appeals within five business days of its receipt.
- Providers are allowed 30 days from the date of MPC’s appeal determination to file one subsequent level of appeal for consideration. Second appeals must include additional information or documentation for consideration.
- MPC resolves appeals within 90 business days of receipt of the initial appeal by MPC.
- Previously denied claims are paid within 30 days of the appeal decision date when a claim denial is overturned.

We will not take any punitive action against a provider for utilizing our provider complaint process.

Claims Inquiries

For telephone inquiries for claim status only, call **1-800-953-8854**, option 2, option 2 or through MPC’s secure web portal.

Timeframe for Coordination of Benefits Recoupment and Resubmission of Claims

The timeframe for MPC’s recoupment of claim dollars is 18 months from the date on which the claim was paid.

Upon receipt of notification of retraction, the provider should bill the primary insurance carrier using the appropriate claim form with a copy of MPC’s remittance advice notification attached. The claim with attachment should be submitted to the primary insurance carrier within six months of the date of MPC’s retraction notification.

Upon receipt of the primary insurance carrier’s remittance advice notification, a fully completed claim form with the primary insurance carrier’s remittance advice notification should be submitted to MPC’s Claims Department within six months of the date of receipt of the primary carrier’s remittance notification.

It is important to note that providers may need to employ the claims appeals process for certain insurance carriers.

Common Claim Denial Reasons and How to Avoid Them

Help us pay your claims as quickly as possible! MPC wants to eliminate claim denials as much as possible. Our claims department performs ongoing analysis of top claim denial reasons, with a goal of providing feedback and education to the provider community of what to look for when researching a denied claim. The chart below reflects the most common types of denials and points out ways to research them.

MPC will soon roll out individualized provider reports on a quarterly basis, with a full breakdown of denial details. Please contact your provider relations representative at any time for a report of the top denial reasons specific to your office or facility.

Benefits that Require Authorization

Determine if authorization was obtained. The fastest and easiest way to check this is through MPC's secure provider web portal, via www.marylandphysicianscare.com.

- Check the status - Was it approved, pending, denied?
- MPC does not issue retroactive authorizations. Claims denied for no authorization may be reviewed via MPC's appeals process, with documentation of why authorization was not obtained.
- If approved authorization is on file, review what was authorized against what was billed to MPC. Look for:
 - > The range of approved services vs. billed services.
 - > Does the billed procedure code match the code authorized? Authorization of one CPT code and billing of another CPT code will lead to a denied claim.
 - > Was the correct level of care billed? (examples: inpatient, outpatient, observation)
 - > Was the provider authorized to perform the services the same provider that billed MPC?

Benefit Exclusions

For services not under the member's plan, the member or provider may contact member solutions with questions about benefits.

Member Eligibility

This patient does not have coverage with MPC on the date of service billed.

- Verify the member information on the claim for inaccuracies, such as:
 - > Correct spelling of member's name
 - > Member ID number
 - > Member address
- Check EVS for confirmation of member eligibility

- If inaccuracies found, please submit a corrected claim

Claims Errors

Review the submitted claim for inaccuracies or invalid billing combinations.

If errors are found, please submit a correct claim for reprocessing.

If you have questions about claim payment, please review the claim on MPC's secure web portal at www.marylandphysicianscare.com.

If further clarification is needed, call MPC Claims and Customer Service at **1-800-953-8854**, option 1, option 1.

Contract and Provider Errors

Provider should review the MPC contract:

Do the codes billed mirror codes that are billable per your contract with MPC?

Verify participation of the billing provider on the date of service billed. Was the billing provider credentialed and contracted on the specific date of service?

If participation is verified, contact your Provider Relations representative for assistance at **1-800-953-8854**, option 2, option 3.

How to Report Suspected Fraud and Abuse

Please remember it is your responsibility as a Medicaid program provider to report suspected fraud and/or abuse, a requirement which can be subject to federal or state sanctions! To report fraud or abuse, call the Maryland Physicians Care (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 following:

- 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 involved
 - Date of service
 - Amount of money that MPC paid for service
 - Description of the acts you suspect involve fraud or abuse
- You can also visit MPC's website at www.marylandphysicianscare.com! Launch on "Fraud" and you can e-mail us suspected fraud information.

Thanks for your continued support!

MPC Compliance Department





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 410-401-9508.

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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.