



MARYLAND physicians care

MANAGED CARE ORGANIZATION

Spring/Summer 2011 Provider Newsletter

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Helpful Information on Prior Authorization

Maryland Physicians Care (MPC) has upgraded our current online Prior Authorization (PA) Requirement Search Tool to a new version that includes several enhancements. The PA Requirement Search tool is available on MPC's secure provider web portal.

We anticipate that these enhancements will better serve our provider groups and make the system more user-friendly. The enhancements include:

Added a new "Site Feedback" page as a link off of the provider webpage to allow providers the opportunity to submit feedback and comments regarding the tool.

Removed the CPT Effective Date and CPT Term Date from the main webpage.

Added a new field "Svc Partner Detail," to the main webpage. 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 offered for adults, but not children, such as PT/OT and ST for members under 21, is covered by the state.

We hope you will find these changes to be helpful in your day-to-day interactions with the PA Requirement Search Tool. If you have any questions, please contact your Provider Relations representative for assistance by calling **1-800-953-8854**, option 2, option 3.

Prevention & Wellness

Blood Lead Testing - Childhood

Lead poisoning is a preventable, silent epidemic affecting close to one million children. The greatest concern for lead toxicity, however, lies in its neurotoxic potential. Several studies have documented a 2 to 3 decrease in children's intelligence quotient (IQ) scores for each rise above 10 mcg/dL of BLL.

According to the Academy of Pediatrics, two lead screens should be obtained regardless of the result of a lead risk assessment. All children should be screened at 12 months and 24 months. A baseline blood level test should be obtained during the initial visit for all children up to 6 years old. If there are any risk factors regardless of age a blood test should be done. Children who have siblings with elevated BLLs above 10 mcg/dL (0.48 mmol/L), recent immigrants and any child whose parents are concerned, should be considered for screening.

Primary care physicians are at the forefront of lead poisoning prevention and should endeavor to obtain blood lead testing during any visit between 12 and 24 months, including sick visits.



Immunization Reminder

Timely administering of vaccines is critical to disease prevention in children. Did you know that only about 80 percent of children in Maryland have received all of the required immunizations by age two? Pediatricians and Family Physicians are key to improving these rates. The American Academy of Pediatrics (AAP) and The American Academy of Family Physicians (AAFP), Centers for Disease Control (CDC) and the Advisory Committee on Disease Prevention (ACIP) collaborate to set immunization guidelines and recommendations.

Completion of the following vaccines is deemed the "Gold Standard" and strongly recommended for all children before the age of 2.

Recommended Immunization List:

- Diphtheria, Tetanus and Acellular (DTaP): four by 2 years old
- Polio (IPV) : three by 2 years old
- Hemophilus Influenza Type B (HIB) : four by 2 years old
- Hepatitis B: three by 2 years old
- Pneumococcal Vaccine: four by 2 years old
- MMR: one by 2 years old
- Varicella: one by 1 year old

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

Please be sure that all immunizations are administered on time!

Attention OBs:

Important Information About High-Risk Pregnant Members!

The Small Miracles Program wants to help you get the best birth outcomes for **MOM** and **BABY**. Our OB nurse case managers are here to HELP!

Please give us a call at 410-401-9052 or 1-800-953-8854, ext. 4019052.

Program covers, but is not limited to members with:

1. Pre-term labor or problems with cervix current or history of HTN/PIH, diabetes, HIV, multi-fetal pregnancy
2. Anemia, taking two or more iron pills or getting iron injections
3. Seizure, blood clotting, thyroid disorders
4. Nausea and vomiting with weight loss, placenta problems
5. Fetal abnormalities and previous stillbirth
6. Fetal death or more than two miscarriages
7. Drug or alcohol use in the past year
8. Smoking one-half pack or more cigarettes
9. Physical abuse in the past year
10. Mental health condition
11. Ages 15 or younger, ages 35 and older

Interested in your patient receiving health education materials?

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



My MPC Source (Our Secure Web Portal)

Did you know you don't have to wait on hold for simple answers? Via Maryland Physicians Care'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 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
- 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

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 we now offer electronic payments through electronic funds transfer (EFT). EFT offers a fast, easy and convenient way to have MPC payments deposited directly to a

provider's bank account on completion of the EFT authorization process. Providers must fully complete an Electronic Fund Transfer Authorization Form (EFTAF) and submit a copy of a voided check for bank verification to complete the EFT authorization process. A copy of the EFTAF may be secured by contacting MPC Provider Relations at **1-800-953-8854**, option 2, option 3 or providers@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
- New providers joining your practice

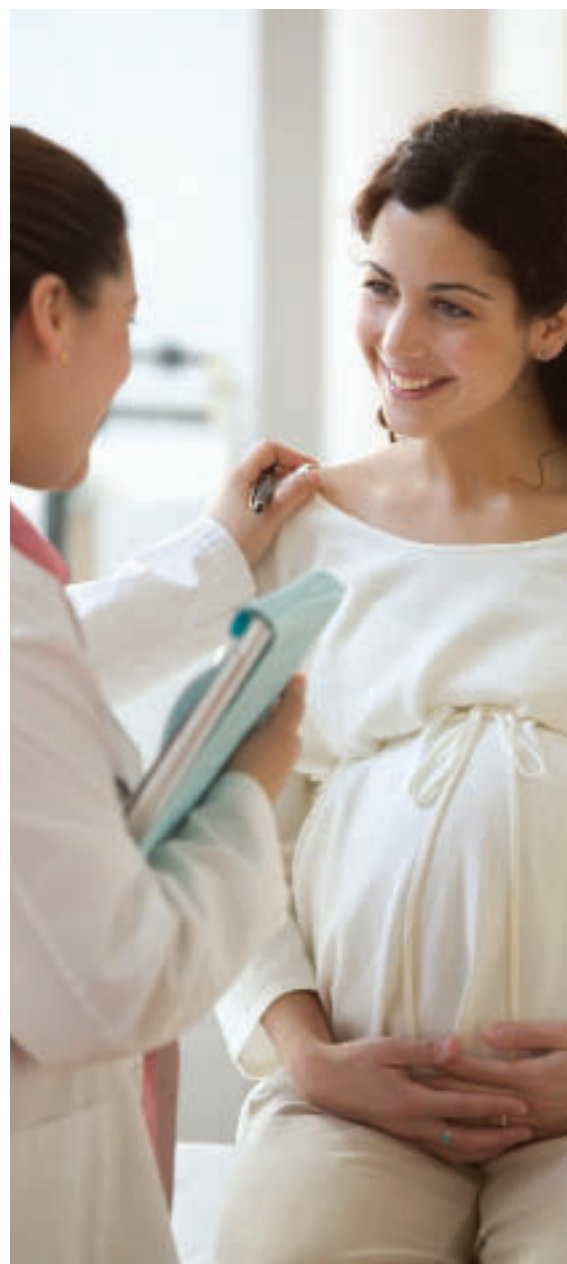
You may contact MPC's Provider Relations department at **1-800-953-8854**, option 2, option 3.

Do we have your e-mail address?

Assuring efficient and timely 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 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 mean of communication in addition to phone, fax and MPC's website, www.marylandphysicianscare.com.



The Claims Corner: Claims Administration

The MPC Managed Care Organization (MCO) member ID number is the member's Maryland Medical Assistance (MA) identification number. For covered medical benefits, the MPC MCO Medicaid/HealthChoice member is not responsible for any deductibles, co-payments 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.
- 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. MPC does not issue a provider number.
- Include National Provider Identifier in the appropriate block on the claim form.

MPC encourages electronic claims transmittal. The electronic claims clearing house that participates with MPC is: 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 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 the retraction was taken due to other primary care insurance. Providers may secure primary insurance information from the member, MPC's secure web portal or by contacting MPC's Enrollment/Eligibility unit at **1-800-953-8854**.



Timeframe for Coordination of Benefits Recoupment and Resubmission of Claims

The time frame for MPC's recoupment of claims dollars due 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.

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 letter 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

If you are seeking review of an action related to a claim dispute, please be aware that 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 remittance advice.
- MPC acknowledges provider written appeals within five business days of 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, then option 2 or through MPC’s secure web portal.



Timely Filing

Please remember:

All encounter 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**

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?*

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 My MPC Source to 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 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.

A NOTE FROM THE MPC COMPLIANCE DEPARTMENT

Help Us Stop Fraud!!!

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

To report fraud or abuse, call the Maryland Physicians Care compliance hotline at **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 ID number
- Name of doctor, hospital or other health care provider
- 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. Click on "Fraud" and you can e-mail us suspected fraud information.

Thanks for your continued support!



Appropriate Usage of Modifier 59

Maryland Physicians Care 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 59.

Modifier 59 - Distinct Procedural Service

The American Medical Association's 2011 CPT Manual includes the following description for the use of this modifier: "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier [HYPERLINK "http://localhost:8812/CPT0186.html"](http://localhost:8812/CPT0186.html) \l "CPT Pro Appendix A, Mod 59" 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier [HYPERLINK "http://localhost:8812/CPT0186.html"](http://localhost:8812/CPT0186.html) \l "CPT Pro Appendix A, Mod 59" 59. Only if no more descriptive modifier is available and the use of modifier [HYPERLINK "http://localhost:8812/CPT0186.html"](http://localhost:8812/CPT0186.html) \l "CPT Pro Appendix A, Mod 59" 59 best explains the circumstances should modifier [HYPERLINK "http://localhost:8812/CPT0186.html"](http://localhost:8812/CPT0186.html) \l "CPT Pro Appendix A, Mod 59" 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier ["http://localhost:8812/CPT0186.html"](http://localhost:8812/CPT0186.html) \l "CPT Pro Appendix A, Mod 25" 25."

Appropriate Modifier 59 Use

Use modifier 59 when billing a combination of codes that would either not normally be billed together (i.e. mutually exclusive procedures) or would ordinarily be bundled together, but there are extenuating circumstances that should allow payment for both codes.

Circumstances in which it would be appropriate to allow both codes separately include:

- Different session or patient encounter
 - > *Example: Patient is seen in the emergency department for an open wound of an extremity requiring simple closure (12002). The patient returns to the emergency department in the afternoon with a closed radial fracture (25600). According NCCI, a simple wound closure is a component of a closed radial fracture; however, because the services were not performed at the same session or the same site, it would be appropriate for the physician to append modifier 59 to the simple closure code.*
- Different procedure or surgery
 - > *Example: Patient is seen for the performance of a cystourethroscopy (52000). During the course of the exam the physician notices some debris in the bladder which cannot be irrigated through the cystoscope. After the cystoscope is withdrawn, the physician irrigates the bladder by hand through a catheter (51700). According to the National Correct Coding Initiative, irrigation is a component of a cystoscopy, however, because the irrigation was not done as a component of the cystoscopy, but rather as a separate service, it would be appropriate for the provider to append modifier 59 to the irrigation code.*
- Different site or organ system
 - > *Example: A skin graft and an allograft in different locations.*

- Separate incision/excision
 - > *Example: A ventral and umbilical hernia repair through two different incisions.*
- Separate lesion
 - > *Example: A biopsy of the skin of the neck is performed at the same session as an excision of a benign lesion of the face.*
- Separate injury
 - > *Example: A fracture of the left femoral condyle and a fracture of the left greater trochanter of the femur.*

Inappropriate Modifier Use

Appending this modifier to Evaluation and Management codes.

Using modifier 59 as a replacement for modifier 24 (Unrelated E/M during postoperative period by the same physician), 25 (Separate and distinct E/M service on same day as procedure), 78 (Return to operating room) or 79 (Unrelated procedure during postoperative period by same physician).

Using modifier 59 in place of modifier 51 (Multiple procedures).

Using modifier 59 when 2 procedures performed at the same time, through the same incision, as part of one global procedure (i.e. an arthroscopic knee chondroplasty in the same compartment as an arthroscopic knee meniscectomy).

Modifier Reimbursement

Codes appended with modifier 59 are subject to multiple procedure guidelines as appropriate.

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/>



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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, Meritus Health, and Western Maryland Health System. Schaller Anderson, an Aetna company, administers the plan.