



# MARYLAND physicians care

MANAGED CARE ORGANIZATION

Provider Newsletter FALL 2009

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## Healthcare Effectiveness Data and 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 all health plans must follow for identifying relevant populations/samples, collecting data and reporting outcomes. Because all 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 health plan and doctors.

## Blood Lead Level (BLL) Testing and Laboratory Information

Regardless of the results of the lead risk assessments, all children who are Medicaid recipients must have a BLL 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**.



# Making the Most of Adolescents' Office Visits

Almost two-thirds of adolescents in the United States do not get the minimum recommended level of preventive health care services, according to a University of California, San Francisco, study published in Pediatrics. Preventive care is particularly important during adolescence, experts say, because many life-long habits that can affect health – smoking, eating, exercising – are developed during those years. There are several specific health-related issues that should be addressed, including: dental care, eating habits, exercise, wearing seatbelts and bicycle helmets, use of tobacco products, substance abuse and sexuality.

After talking with many of our providers, we have learned that preventive services

are provided much more frequently than they are documented. However, without the appropriate documentation and coding, they do not count towards the HEDIS measure on adolescent health.

It is indeed a challenge to juggle a busy schedule of patients, have meaningful interactions, provide appropriate medical care and fulfill all of the documentation requirements. It is therefore essential to design systems and process that support your practice.

Encourage your office staff to assist you in the completion of billing forms so you and your practice will be appropriately recognized for your work. To count as a complete adolescent visit, HEDIS requires a physical exam, a health and develop-

mental history and health and education/ anticipatory guidance. The appropriate Current Procedural Terminology (CPT) codes for the adolescent visit are 99383-99385, 99393-99395.

Because adolescents tend to shy away from the doctor unless they are ill, it is important to take an interval history, including developmental issues, perform a physical exam and assess and counsel them in the areas noted above. Experts recommend children have time alone with doctors beginning at age 12 to provide an opportunity to discuss potentially sensitive issues. If you accomplish an adolescent visit during a scheduled sick visit, your encounter form should include the CPT code for both.

## Small Miracles OB Case Management and Rewards Program

All Maryland Physicians Care (MPC) pregnant and postpartum members are eligible for the Small Miracles Case Management and rewards program.

After we receive a copy of the ever important Maryland Pre-Natal Risk Assessment Form (MD PRA), outreach begins. The MDPRA is our primary mode to identify our pregnant members. MPC asks all obstetric (OB) providers to send in a MDPRA when requesting authorization for care. Once members are successfully contacted and assessed, they are placed into one of two tracts, high risk or low risk.

OB nurse case managers follow our high-risk members with monthly calls and OB care coordinators follow our low-risk members with calls every three months. During the calls we reassess to determine if risk status has changed and provide medical information, plan

benefits and community resources. This continues through eight weeks postpartum.

Our goal, like yours, is to have a healthy mom and baby with good birth outcomes. In order to achieve that goal we want to help ensure members keep all their prenatal and postpartum appointments.

In July 2008, we implemented the Small Miracles Rewards Program. MPC pregnant and postpartum members receive a gift card when they call in to complete our initial prenatal assessment, our follow-up assessments and also on completion of their six week postpartum visit. When the gift card is offered we remind members to keep up with all their OB appointments and to keep in touch with us to let us know how they are doing. We also provide assistance with scheduling appointments.

Since we started the program we have seen a .5 percent decrease in our very low birthweight rates and are looking to see an increase in our HEDIS rates as well.

Our HEDIS goal is to obtain a substantial increase in the postpartum visit rate (PPV) to 72 percent compliance. The PPV must occur 21-56 days after delivery to meet the HEDIS PPV measure. Some providers have adopted best practices scheduling the PPV during their last antepartum appointment or before discharge from the hospital. Just a note, MPC will pay for a 10-14 day incision check, and the routine six week PPV for all Cesarean section deliveries. Provider incentives are on the horizon as early as next year for improved OB provider performance with OB HEDIS measures.

## Introducing ITA Partners

Beginning this fall, MPC will collaborate with ITA Partners on the review of prior authorization requests for some oncology services. ITA Partners is a company that specializes in cancer care management.

In order to perform a comprehensive oncology plan review, the following information is needed by ITA Partners. Providers and their staff should ensure that the following is submitted along with the prior authorization referral:

Supporting documentation for diagnosis: Diagnosis, date of diagnosis, pathology, stage, molecular markers and PET/CT scan results if obtained.

Treatment plan information: Regimen name; drugs to be used, including dosages, schedule, number of cycles,

frequency of administration and treatment goals (curative/palliative/best disease control).

Prior treatment history: Any prior treatments received and response to treatment.

Clinical trial information: If the patient is to be enrolled in a clinical trial, ITA Partners will need the trial information, including phase of trial, outcomes to be measured, patient consent, clinical trial sponsors as well as any insurance plan language pertaining to the use of experimental or investigational drugs/treatments.

ITA Partners may provide a wide array of services depending on the case. It does not provide clinical care to patients. In some cases, it may

simply review the treatment plan. In other cases, it will work directly with members to “listen and explain.” This will help patients comprehend complex information, make visits more productive, follow through on next steps and use good self care.

The goal of ITA Partners is to facilitate quality care that meets evidence-based guidelines. Staff from ITA Partners may call your office to gather information to assist you in providing the best care for your patients. MPC looks forward to this collaboration with ITA Partners and our providers to enhance the care our members receive during what is frequently a difficult time. We welcome your feedback about this initiative.

## Case Management for HIV and AIDS

Did you know MPC provides case management to all of our members who are HIV-infected or have AIDS?

We can help make it easier for you to make sure your patients get the comprehensive care they need to lead healthier lives. Our case managers will outreach to each of these patients and see what needs they may have. Case managers can do a variety of things for your patients, which may include scheduling appointments for HIV/AIDS care or specialty appointments such as ophthalmology or helping your patients gain access to ancillary services such as nutritional counseling.

Call MPC Case Management at **1-800-953-8854** with the name of all newly diagnosed members and fax a copy of either their Western Blot or HIV-1 RNA Viral load and we will take it from there. If you have a member previously diagnosed with HIV/AIDS who is not currently being case managed, let us know.



# Pharmacy News

## Prior Authorization for Agents to Treat Hepatitis C

The diagnosis and treatment of members with Hepatitis C is important. Many of the prior authorization requests for agents that treat Hepatitis C are delayed because the information submitted is not complete. Use of immune modulators for the treatment of Hepatitis C requires you to fax the following documentation and the prior authorization form:

- Progress notes that document therapy is being prescribed by, or in consultation with, an infectious disease physician, gastroenterologist, hepatologist or transplant physician
- Other causes of liver disease have been ruled-out
- Member has been abstinent of both alcohol and illicit drugs for at least six months
- Patient weight
- Laboratory results including HCV genotype, HCV-RNA quantitation, LFTs, and a CBC (all within the last three months)

This information is required at the initial request as well as with requests to continue therapy. Requests without the above clinical information cannot be authorized.

## Prior Authorization for the Use of Singulair in Members with Asthma

In an effort to facilitate care for members with Asthma, MPC removed step therapy requirements for the use of Singulair. Claims will process automatically if a member has a fill for an asthma drug within the last 60 days. The MPC formulary still contains several agents for the treatment of allergic rhinitis. Therefore, the use of

Singulair for this diagnosis requires step therapy. The use of Singulair for rhinitis requires documentation that the member has tried and failed a two-month compliant regimen of Fluticasone Nasal Spray, loratidine OTC, cetirizine OTC, and/or clemastine. Nasal steroids are more effective than non-sedating antihistamines and leukotriene inhibitors in the treatment of allergic rhinitis according to The Medical Letter. Please consider use of a nasal steroid with or without loratidine OTC or cetirizine OTC prior to requesting prior authorization for Singulair.

## Provider Tips

- Each pharmacy prior authorization should be accompanied by progress notes that support your request. If there are no clinical notes, we will be unable to authorize your request.
- The MPC website ([www.marylandphysicianscare.com](http://www.marylandphysicianscare.com)) contains a link that outlines the step-therapy guidelines of the most commonly requested agents. Please refer to this so that you will include the necessary clinical documentation when submitting the prior authorization request. Epocrates is another tool that will help.
- Did you know that Department of Health and Mental Hygiene (DHMH) has paid for all clinicians to have free access to an Epocrates subscription? This program is downloadable to your PDA. You may select a managed care organization (MCO) and have access to its list of plan preferred agents. Many of the drug entries include an abbreviated version of step-therapy guidelines. This information is available at your fingertips and should make it easier to prescribe for your patients.

## Do we have your e-mail address?

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

- To register, go to: <https://www.epocrates.com/sessionManager.do?type=rxweb&refererurl=/online.do&refernext=https://online.epocrates.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 [MBUProviders@marylandphysicianscare.com](mailto:MBUProviders@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.

## Maintaining Complete and Accurate Immunization Records for Your Patients

Providers have a very important role in ensuring immunization records are well documented. In addition to documenting the vaccinations administered in their offices, providers should also document the Heb-B that is received at birth during hospitalization. Most often this information is communicated to the provider as part of the infant's discharge summary from the hospital.

Two immunization registries available to assist providers in their endeavor to maintain complete and accurate immunization records are Baltimore City Immunization Registry Program (BIRP) and Maryland's Immunization Registry, ImmuNet. (Note: ImmuNet is not a replacement for the BIRP. Baltimore City mandates that all immunizations given within the city limits be reported to BIRP.)

Some of the advantages of using immunization registries include, but are not limited to:

- Maintaining a complete immunization history
- Consolidating multiple immunization records of patients
- Printing immunization certificates for schools, day care, camps, etc.
- Tracking contraindications and adverse reactions
- Avoiding duplicate immunizations

To join ImmuNet, e-mail the state at [mdimmunet@dhmh.state.md.us](mailto:mdimmunet@dhmh.state.md.us).

To join the BIRP, e-mail the program director, John R. Lamoureux, at [john.lamoureux@baltimorecity.gov](mailto:john.lamoureux@baltimorecity.gov).

## The Claims Corner: 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, co-payments or balances due.

To prevent unnecessary processing delays:

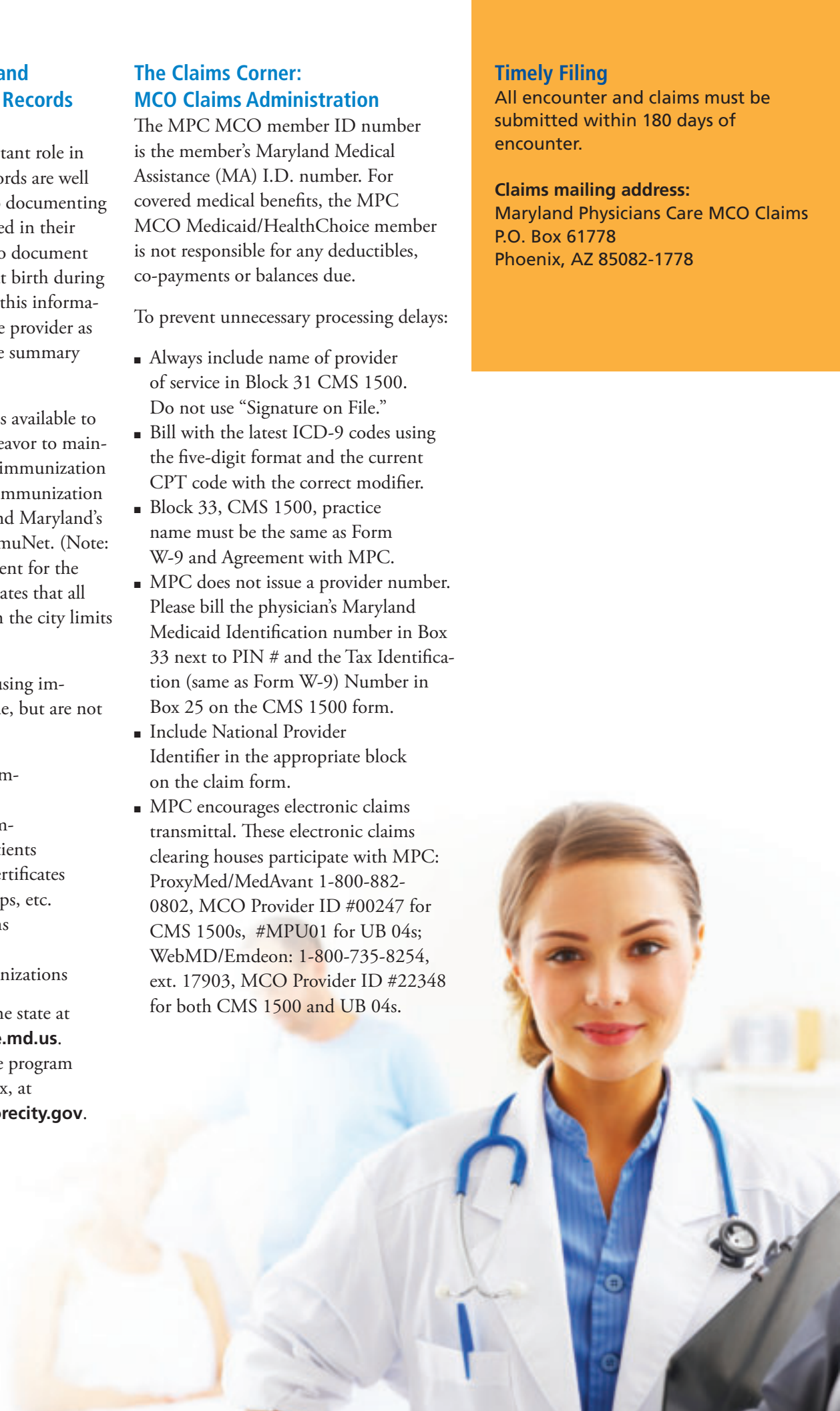
- Always include name of provider of service in Block 31 CMS 1500. Do not use "Signature on File."
- Bill with the latest ICD-9 codes using the five-digit format and the current CPT code with the correct modifier.
- Block 33, CMS 1500, practice name must be the same as Form W-9 and Agreement with MPC.
- 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.

## Timely Filing

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



## Coordination of Benefits

As a Maryland-based 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 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.

## 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.

## Claims 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."

## Claims Inquiries

- For telephone inquiries for claims status only, call 1-800-953-8854, select option 2, then option 2 or through MPC's secure web portal.

## 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](http://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
- Services not under the member's plan, 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 error 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.maryland-physicianscare.com](http://www.maryland-physicianscare.com)

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

## MCO Provider Appeals

MPC 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. MPC requires all provider appeals to be submitted in writing to the attention of The Appeals Department at Maryland Physicians Care 509 Progress Drive, Suite 117, Linthicum, Maryland 21090.

## 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.

## 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.



# Program Administration Electronic Support

## 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**, select option 1, then 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 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
- 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](http://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!

## Maryland Physicians Care Website

MPC program administration guidelines and documentation (examples: provider manuals, directories, forms, drug formulary) are available on MPC's website at [www.marylandphysicianscare.com](http://www.marylandphysicianscare.com).

# Correct Coding Initiative

## Multiple Evaluation and Management Services on the Same Day

In its Medicare Claims Processing Manual, Centers for Medicare and Medicaid Services (CMS) clarifies when it is correct to bill multiple evaluation and management services for the same patient on the same day in an office or outpatient setting. The following are general policy guidelines to follow when more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same tax group:

- Only select the level of service representative of the combined visits and submit the appropriate code for that level when evaluation and management (E/M) services are for

the same or related problems.

**Example:** A cardiologist provides a low-complexity hospital follow-up visit to a patient in the hospital for chest pain. Another cardiologist from the same group practice sees the patient later that day for another low-complexity hospital follow-up visit also for chest pain. Only one bill should be submitted with a hospital follow-up visit that represents the combined services. If both providers submit claims for hospital follow up visits, only one claim will be allowed.

- Only one E/M service may be reported unless the E/M services are for unrelated problems.

**Example:** Office visit for hypertension and medication change, followed four hours later by a visit for the evaluation of elbow pain following an accident. List the E/M code and

the specific diagnosis code for the second unrelated E/M service for the same date. In this situation, modifier 25 should be appended to signify a separate and distinct service.

- Only one E/M service may be reported for the same patient when the patient is seen in the office and then admitted to the hospital.

**Example:** The patient is seen in the office for severe hypertension. The patient is then admitted on the same date by the same physician to the hospital for Uncontrolled Hypertension. The office service is then combined into the admission E/M code for billing of the service.

Only the admission E/M is reported.

Reference: Centers for Medicare and Medicaid Services (CMS) IOM Manual, Pub 100-04, Chapter 12, Sections 30.6.5 and 30.6.7.

## Correct Coding-Manifestation Codes

The ICD-9-CM manual states, “Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology.” As such, they are appropriately reported with two codes, one for the underlying condition and another for the manifestation of that condition. The latter are termed “manifestation codes.” Additionally, correct coding requires that the code for the underlying condition be reported as the primary diagnosis on the claim and the manifestation code be reported as the secondary diagnosis.

Where these code combinations exist, the ICD-9 manual contains instructional notes both to identify each code and indicate the proper sequencing of such codes. Many manifestation codes will have in their code descriptor, the following phrase, “in diseases classified elsewhere.” Other manifestation codes that do not have this phrase in the code descriptor will invariably contain a note below the descriptor stating, “code first...” referring to the fact that an underlying condition code should be coded as the primary diagnosis on the claim. Underlying condition codes may have the instruction “use additional code” below their descriptor. **In all instances, manifestation codes should never be reported as the first listed or principal diagnosis on the claim.** Depending on the edition of the ICD-9 manual, manifestation codes may also be identified by color coded highlighting.

### Example 1

#### 250.5 Diabetes with ophthalmic manifestations

Use additional code to identify manifestation, as diabetic:

#### 366.4 Cataract associated with other disorders

##### 366.41 Diabetic cataract

Code first diabetes (249.5, 250.5)

In this example, ICD-9 code 250.5 is the underlying condition and should be reported as the primary diagnosis on the claim while ICD-9 code 366.41 is the manifestation code. Instructions clearly indicate that an additional code is needed to qualify the diabetic condition with a manifestation and that the diabetes code should be reported as the primary diagnosis.

### Example 2

#### 331 Other cerebral degenerations

Use additional code, where applicable, to identify dementia

#### 294.1 Dementia in conditions classified elsewhere

Code first any underlying physical condition as dementia in:  
Alzheimer's disease (331.0)

In this example, ICD-9 code 331 (or 331.0) is the underlying condition while ICD-9 code 294.1 is the manifestation code. This latter code should not be reported as the principal diagnosis as indicated in the instruction accompanying the listing. As well, note the term “conditions classified elsewhere” in the code descriptor of the manifestation code.

## In summary:

- Manifestation codes are reported to identify a process due to an underlying condition.
- Both the manifestation code and the underlying condition code must be reported together on the claim.
- Manifestation codes should not be reported as the primary diagnosis on the claim.
- Manifestation codes can be identified in the ICD-9 manual by their code descriptors and instructions.

## 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 (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](http://www.marylandphysicianscare.com)! Launch on “Fraud” and you can email us suspected fraud information.

Thanks for your continued support!

Sincerely,

MPC Compliance Department

The targeted population, services required, codes used to identify services rendered for HEDIS and Value are listed below.

Targeted Population	Services Required	CPT Codes	ICD-9-CM Diagnosis/LOINC Codes/HCPCS/CDT-3/UB Revenue
Newborns 0-24 months	Well visits that include: <ul style="list-style-type: none"> <li>Physical, growth and developmental growth</li> <li>Health, education or anticipatory guidance</li> <li>Complete physical examination</li> </ul> <b>And</b> Immunizations before the child's 2nd birthday <ul style="list-style-type: none"> <li>3 IPV                      1 MMR</li> <li>4 DtaP/DT              3 Hep B</li> <li>3 HiB                      1 VZV</li> <li>4 Pneumococcal conjugate (PCV-7 or Prevnar)</li> </ul> <b>And</b> Lead screening at: <ul style="list-style-type: none"> <li>12 months      23 months</li> </ul>	<b>Well Visits CPT Codes</b> 99381, 99382, 99391, 99392 and 99432  <b>Lead CPT Codes</b> 83655	<b>ICD-9</b> V20.2, V70.0, V70.3, V70.5, V70.6, V70.8 and V70.9  <b>Lead LOINC Codes</b> 17052-2, 5671-3, 10368-9, 2129-6, 5674-7, 10912-4, 14807-2, 32325-3 and 25459-9
Children age 3-6 years old	Yearly physicals that include: <ul style="list-style-type: none"> <li>Physical and development history</li> <li>Complete physical exam</li> <li>Growth and development</li> <li>Health education or anticipatory guidance</li> </ul>	99382, 99383, 99392 and 99393	<b>ICD-9</b> V20.2, V70.0, V70.3, V70.5, V70.6, V70.8 and V70.9
Adolescents well care visits	Yearly physicals that include: <ul style="list-style-type: none"> <li>Physical and development history</li> <li>Complete physical exam</li> <li>Growth and development</li> <li>Health education or anticipatory guidance</li> </ul>	99383-99385, 99393-99395	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8 and V70.9
Sexually active women 16-24 years old	Annual chlamydia screening	87110, 87270, 87320, 87490, 87491, 87492 and 87810	<b>LOINC</b> 557.9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 16602-5, 20993-2, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 43931-6, 43406-8, 47527-7 and 47528-5
Women 21-64 years old	Pap smear at least one every 3 years	88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167 and 88174-88175  58570-58573	<b>ICD-9-CM Diagnosis</b> V72.32 and V76.2 <b>ICD-9-CM Procedure</b> 91.46 <b>UB Revenue</b> 0923 <b>LOINC</b> 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0 and 47528-5

Targeted Population	Services Required	CPT Codes	ICD-9-CM Diagnosis/LOINC Codes/HCPCS/CDT-3/UB Revenue
Women 42-69 years old	Yearly mammograms	76083, 76090-76092 and 77055-77057	<b>ICD-9-CM Diagnosis</b> V76.11 and V76.12 <b>ICD-9-CM Procedure</b> 87.36 and 87.37 <b>UB Revenue</b> 0401 and 0403 <b>HCPCS</b> G0202, G0204 and G0206
All members diabetes care 18-64 years old	Annual services: <ul style="list-style-type: none"> <li>■ Retinal eye exam</li> <li>■ HbA1c testing</li> <li>■ LDL-C screening</li> <li>■ Diabetic nephropathy screen</li> <li>■ Blood pressure</li> </ul>		
All members 2-21 years old	Annual dental visit	70300, 70310, 70320, 70350 and 70355	<b>HCPCS/CDT-3</b> D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999 <b>ICD-9-CM Procedure</b> 23, 24, 87.11, 89.31, 93.55, 96.54, 97.22, 97.33-97.35 and 99.97
Timely prenatal and postpartum	Prenatal visit(s) in their first trimester or within 42 days of enrollment Postpartum visit(s) between 21-56 days after delivery		
Adult/Children 0-64 years old	Yearly ambulatory visits	99301-99205, 99211-99215, 99241-99245, 99341-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420 and 99429	<b>ICD-9-CM Diagnosis</b> V20.2, V70.0, V70.3, V70.5, V70.6, V70.8 and V70.9
Use of appropriate medications for people with asthma	Identified as having persistent asthma and were appropriately prescribe medication		<b>ICD-9-CM Diagnosis</b> 493 <b>UB Revenue</b> 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 0982, 0983, 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x and 0987 <b>ED Visits UB Revenue</b> 045x and 0981
Appropriate treatment for children with upper respiratory infection	Diagnosis of upper respiratory infection and not dispensed an antibiotic prescription	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429 and 99499 <b>ED Visits</b> 99281-99285	<b>ICD-9-CM Diagnosis</b> 460, 465 <b>UB Revenue</b> 051x, 0520-0523, 077x, 0982 and 0983 <b>ED Visit UB Revenue</b> 045x and 0981
Appropriate testing for children with pharyngitis	Dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429 and 99499 <b>ED Visits</b> 99281-99285	<b>ICD-9-CM Diagnosis</b> 462, 463 and 034.0 <b>UB Revenue</b> 051x, 0520-0523, 0526-0529, 077x, 0982 and 0983 <b>ED Visits</b> 045x and 0981

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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.

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