

# Connection



Important information for Fallon Community Health Plan physicians and providers

## ■ Every day affairs

### FCHP Commonwealth Care changes

Massachusetts provides the majority of the funding for all Commonwealth Care plans. Unfortunately, the level of funding from the state is not keeping up with the rising cost of care.

After careful consideration, we determined at Fallon Community Health Plan that we cannot continue to offer this product in the northern or southern regions. We received approval to withdraw as a health plan of choice for Commonwealth Care enrollees in the northern and Brockton service areas of Massachusetts, effective July 1, 2010. At this time, we'll continue to be available in the central region, as well as the Somerville service area in the Greater Boston region.

All affected members received information from FCHP and from the Health Connector during the open enrollment period, which began on June 3. For questions or more information, contact Chris Nugent, Product Manager, at 1-508-368-9117. ■

### Federal mental health parity rules effective July 1

Interim regulations for the federal Mental Health Parity and Addiction Equity Act of 2008 generally apply to any group insurance plan with 50 or more members, regardless of financial arrangement, at anniversary dates beginning on or after July 1, 2010. All FCHP plans are in compliance.

Broadly, the regulations provide that any health insurance plan that offers mental health or substance abuse benefits must provide them at a comparable level to the medical/surgical benefits provided by the plan. Financial requirements (e.g., copayments, deductibles) and treatment limitations (e.g., visit limits) for mental health/substance abuse must be equal to the predominant (i.e., the most common or frequent) requirements or limitations applied to substantially all medical/surgical benefits. ■

### Dependent coverage extended prior to federal mandate

National health care reform extends coverage to dependents up to age 26, effective September 23, 2010. Similar, but more limited, coverage exists under Massachusetts law for dependents who meet eligibility guidelines as students or under IRS rules.

FCHP has decided on an earlier implementation of the federal mandate. We have extended dependent care coverage for insured accounts as of June 1, 2010. This move will ensure that covered dependents have uninterrupted coverage on their parents' family plan.

This early June 1 extension applies only to individuals who currently have coverage and would lose it prior to the September 23 effective date. Dependents who meet the federal criteria but currently are not covered may apply for coverage during their plan's open enrollment following September 23. ■

## ■ Let's connect

### Change to same-day surgery claims review

Effective September 1, 2010, FCHP will change from a prospective review to a retrospective review of same-day surgery claims. Upon request, providers will have 60 days to send in the appropriate surgical operative notes. Failure to comply with this request will result in claims retraction. This new process will eliminate claims pending during this review and will allow providers ample time to send in the records. Please call Provider Relations at 1-866-ASK-FCHP, prompt 4, with questions. ■



## EDI billing issue

During our system conversion several billing issues have been identified regarding submission of electronic claims. Listed below are a few tips for submitting electronic claims.

1. Per the Implementation Guide, if Loop 2010AB (NM1\*87, Pay-to Provider) is being sent and this value is the same as the 2010AA loop (NM1\*85, Billing Provider), then the 2010AB loop should not be sent. This loop is only required if the Pay-to Provider is a different entity than the Billing Provider.
2. Per the implementation guide, if subscriber is the patient, only Loop 2010BA (NM\*1IL segment) should be sent. If patient is not the subscriber, then Loop 2010CA should be sent with the member (not the subscriber) ID in NM1\*QC segment, field NM109. ■

## Register for online Provider Tools

Our Web-based tools give you the ability to view claims status via the Claims Metric Tool and to verify eligibility. Register today for one or more of these tools. Visit [fchp.org/Providers](http://fchp.org/Providers) to download the registration form. Or, for more information, please contact our EDI coordinators at 1-866-ASK-FCHP, ext. 69968, or via e-mail at [edi.coordinator@fchp.org](mailto:edi.coordinator@fchp.org). ■

## Slight change in negative balance Remittance Advice notification

When there is an overpayment on a provider claim, and the claim is adjusted, it can result in a negative balance if there is not enough positive claims activity to balance out the overpaid amount.

In the past, when a provider had a negative balance, Fallon Community Health Plan would send a negative balance Remittance Advice Sheet (RAS) for informational purposes. Once the negative balance cleared, all of the claims that were caught up in the negative balance would be listed on the FCHP check/RAS to assist the provider with posting the accounts. In some cases, providers would post the payments from the negative balance RAS and the check, which caused duplicate postings to patient's accounts.

As of March 1, 2010, FCHP modernized its core business system, known as QNXT, and so there is a slight change to the negative balance RAS process.

**Providers will only receive the detailed patient claim information on the negative balance RAS.**

Once the provider's negative balance is cleared, they will see only the negative balance dollar value and not the patient information, which

was indicated on the prior negative balance RAS notification. Therefore, it is very important to keep the negative balance RAS notification, as this will be needed to post the accounts. ■

## New process for verification of nurse practitioner status

Fallon Community Health Plan recognizes nurse practitioners (NPs) as primary care providers and physician extenders. If NPs select the primary care provider status, they can be listed in the categories of pediatrics, internal medicine, family practice and geriatrics. They'll appear in the *FCHP Provider Directories* for the products they participate in. If they select the physician extender status, they'll be listed in the category of nursing; however, they will not appear in the directories.

FCHP Network Development and Management has created tools and processes whereby nurse practitioners' contracts and relative information will be housed. Additionally, FCHP does plan to credential all NPs who are seeing FCHP members.

Should you have any questions, please call Provider Relations at 1-866-275-3247, prompt 4. ■

## Reporting fraud, waste and abuse

Fraud, waste and abuse affects everyone. Combating fraud, waste and abuse is essential to maintaining strong and affordable health care.

- **Fraud** can be defined as an intentional misrepresentation that causes a victim to part with something of value, and is considered a criminal act.
- **Waste** is generally categorized as an act that causes a company to pay unnecessarily for a service.
- **Abuse** occurs when an individual or entity "works the system," so as to be paid (or paid more) for a service to which he/she would not otherwise be entitled.

Fallon Community Health Plan is committed to detecting, investigating and resolving instances of error, fraud, waste and abuse.

If you suspect fraud, waste or abuse, please be sure to report the activity to Phil Benvenuti, FCHP Senior Director of Internal Audit, at 1-508-368-9412, or Anne Doyle, FCHP Chief Compliance Officer, at 1-508-368-9433. You also may call FCHP's Compliance Hotline anonymously at 1-888-203-5295. ■

## Ongoing audits of provider records

Fallon Community Health Plan is committed to the delivery of quality and cost-effective care options to our members. As part of this mission, it is important to FCHP that its claim payments properly reflect the services provided.

FCHP requests that the provider community actively participate and continually ensure correct billing, coding and documentation of services provided. This is essential for offering reasonable premiums to our members, while still providing fair reimbursement to our providers.

FCHP continues to audit claims payments and medical records with respect to the services provided to our members. As part of this process, we will request to review medical records to ensure that documentation supports the services billed.

We recommend that you review FCHP's *Provider Audit Payment Policy* and other relevant FCHP payment policies to assure that you are following our standards. Payment policies are located in the Physicians and Providers section of our Web site, [fchp.org](http://fchp.org). Should you have any questions, please do not hesitate to contact Provider Relations at 1-866-ASK-FCHP, prompt 4, or e-mail [askfchp@fchp.org](mailto:askfchp@fchp.org). ■

## Updates: Clinical Practice Guidelines

### COPD guideline

FCHP's Clinical Practice Guideline Committee recently endorsed the *Global Initiative for Chronic Obstructive Pulmonary Lung Disease (GOLD) Executive Summary*® that was updated in 2009 by Medical Communications Resources, Inc.

Algorithms designed to assist you in the evaluation and treatment of COPD are posted on [fchp.org](http://fchp.org) with a link to the GOLD Executive Summary. ■

### Dementia guideline

FCHP's Clinical Practice Guideline Committee recently updated the *Clinical Practice Guideline for the Diagnosis and Management of Dementia*. The rivastigmine patch was added to the medication list and requires prior authorization. The updated guideline is posted at [fchp.org/ Providers/healthcare\\_guidelines.htm](http://fchp.org/Providers/healthcare_guidelines.htm).

For a paper copy of these or any FCHP guideline, please contact our Quality and Health Services Department at 1-508-368-9103. ■

## Payment policy updates

### Payment policies this issue

#### Revised policies – effective Sept 1, 2010

The following policies have been updated effective September 1, 2010; details about the changes are indicated on the policies:

- **Inpatient Medical and Payment Policy:** Updated language in the Reimbursement and Billing/coding guidelines sections.
- **Nurse Practitioner Payment Policy:** Updated language about nurse practitioners acting as PCPs vs. physician extenders. ■

## Script alert

### Closed formulary changes

We have made changes to the list of covered drugs for our plans that use a closed formulary (Premier II, Premium Saver II and PS 2000/500 II) and have notified subscribers of these plans. Effective June 30, 2010, the following medications will no longer be available on the closed formulary:

- Anagrelide
- Campral
- Clobetasol Aer 0.05%
- Depo-Testost inj
- Fluoxetine cap 40mg
- Itraconazole
- Leuprolide inj
- Lyrica
- Meloxicam
- Meperidine inj
- Midodrine
- Octreotide Inj
- Oxycodone Con 20mg/ml
- Progesterone inj
- Requip 5 mg tabs
- Testost Cyp inj
- Testost Enan inj
- Tev-Tropin
- Tizanidine

For a complete list of drugs included in the closed formulary, visit our Web site at [fchp.org](http://fchp.org) and click on the Pharmacy and Prescriptions section. ■

# Coding corner

## Billing bilateral procedures

As you all know, the use of modifier -50 has caused headaches for providers and payers alike. Below are the suggested correct billing methods. These are general suggestions; there will be code-by-code exceptions, so use these guidelines with your specific billing needs in mind.

Do not use -50, -LT or -RT modifiers to report services that are already identified as bilateral by CPT definition, e.g., 69210 – Removal impacted cerumen, one or both ears.

Radiology exams	Use -LT and -RT modifiers on two separate lines, 1 unit each line (paying 100% each)
Ophthalmology exams	Use -LT and -RT modifiers on two separate lines, 1 unit each line (paying 100% each) Punctum plugs are generally considered incidental to another code, but if you bill, please submit with two lines, -LT and -RT modifiers on separate lines
Surgical/office procedures	Use modifier -50, on one line, 1 unit will pay 150%, (100% first side and 50% second side)
Splints/orthotics	Use -LT and -RT modifiers on two separate lines, 1 unit each line (paying 100% each)
Drugs	Drugs are not bilateral; do not use -50, -LT or -RT modifiers. Bill the total units of the drug given on one line. ■

## Code updates

**Effective September 1, 2010**, the following codes *require plan prior authorization*.

43201	Esophagoscopy, rigid or flexible, with directed submucosal injection(s), any substance
43236	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance
46505	Chemodenervation of internal anal sphincter
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)
64613	Chemodenervation of muscle(s); neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia)
64614	Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis)
64650	Chemodenervation of eccrine glands; both axillae
64653	Chemodenervation of eccrine glands; other area(s) (e.g., scalp, face, neck), per day
67345	Chemodenervation of extraocular muscle
J9160	Injection, denileukin diftitox, 300 mcg

**Effective September 1, 2010**, the following codes *no longer require plan prior authorization*.

36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified
58356	Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed

**Effective September 1, 2010**, the following codes will be covered for MassHealth members only and they require prior authorization. These codes will deny vendor liable for all other plan types.

E0602	Breast pump, manual, any type
E0604	Breast pump, hospital grade, electric (AC and/or DC), any type

**Effective September 1, 2010**, the following codes are covered for all plan types.

95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report

**Effective September 1, 2010**, the following codes are covered for Fallon Senior Plan™ and MassHealth members only.

93228	Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report
93229	Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports

**Effective September 1, 2010**, the following codes are covered for Fallon Senior Plan members only.

G0425	Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth
G0426	Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth
G0427	Initial inpatient telehealth consultation, typically 70 minutes communicating with the patient via telehealth
G0428	Initial inpatient telehealth consultation, typically 80 minutes communicating with the patient via telehealth
G0429	Initial inpatient telehealth consultation, typically 110 minutes communicating with the patient via telehealth
Q3014	Telehealth originating site facility fee

**Effective September 1, 2010**, the following codes will deny vendor liable for all plan types.

G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration
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**Reminder:** The following codes are not covered and are considered member liable.

V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens ■

# Have you seen your Connection?



Please pass this along to the  
next person on the list.

Date received \_\_\_\_\_

Please route to:

- Office manager
- Physician
- Billing department
- Receptionist
- Referral site
- Other

## Get connected



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There are no supplemental articles for this issue.

*Connection* is a bimonthly publication for all FCHP ancillary and affiliated providers. The next copy deadline is **July 7, 2010**.

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**Questions?**  
Call 1-866-ASK-FCHP

