UnitedHealthcare®
hawk-i

PracticeMatters

Important information for physicians and other health care professionals and facilities serving UnitedHealthcare ***hawk-i*** members

Spring 2010

UnitedHealthcare Expands Service Area for Iowa *hawk-i*

UnitedHealthcare Plan of the River Valley, Inc. currently has a contract with the State of Iowa's ***hawk-i*** program in 53 counties. Effective March 1, 2010, ***hawk-i*** members can choose UnitedHealthcare as their health plan in all 99 Iowa counties. We are delighted to serve our new ***hawk-i*** members across the State.

Reimbursement Policy Changes

In October 2009, UnitedHealthcare notified the provider community of changes to the manner in which it would implement reimbursement policies with regard to the UnitedHealthcare ***hawk-i*** program utilizing a robust claims editing tool called the Ingenix Claims Editing System or iCES.

In our efforts to increase transparency to all UnitedHealthcare ***hawk-i*** providers, we have created a suite of new documents, each of which focus on particular elements of billing (e.g. Modifiers, Bundling, Bilateral Procedures, Supplies) or on specific services (Anesthesia, DME, etc.).

UnitedHealthcare ***hawk-i*** has posted these policies to the website and will be available to you for all your resource needs. While some of these documents may reflect changes and enhancements to the reimbursement of services, many of these serve to more clearly articulate to you, how your claims are currently being paid.

Additional information about these policies that should be considered:

- Reimbursement Policies are different than medical policies.

Reimbursement Policies are controls to detect and prevent fraud, waste and abuse as required by the State of Iowa ***hawk-i*** program and CMS.

Articles of Importance to Read:

Reimbursement policies reflect appropriateness of billing (correct coding initiatives), assess when multiple billed codes should in fact be paid as one service (bundling edits) or evaluate against appropriate values for the services rendered (maximum frequency per day for different services, age/gender, and bi-lateral/unilateral edits).

Medical policies reflect some level of medical necessity and/or medical appropriateness. These policies are implemented either through back-end review of medical records or through prior authorization or other means. But these policies are based on clinical evidence and input from specialty societies.

- All Reimbursement policies have outside sourcing. These policies go through a rigorous research and approval process to ensure that they are based on CMS, Correct Coding Initiatives (CCI), the National Physician Fee Schedule (NPFS), or other external sources. For some policies such as the Anesthesia policy, these also use the appropriate specialty society as additional references.
- The newly created documentations are located on our provider website. We encourage you to review the policies on the website at https://www.uhcrivervalley.com/10Provider/01AmeriChoice/hawki/. Select "Iowa Reimbursement Policies".
- Claims or claim-lines can be denied, even if a service was approved by a prior-authorization. While the service may be approved, if the claim is not billed appropriately, the reimbursement policy will edit the claim per the correct coding protocols.

Please note that these policies and the changes to current edits were delayed slightly from what was originally communicated in October 2009. These changes went into effect for all claims processed on or after February 1, 2010.

Should have any questions regarding these policies, you may contact Provider Service at 1-888-650-3462.

UnitedHealthcare *hawk-i* Reimbursement Policies

These policies apply to services reported using the 1500 Health Insurance Claim form (a/k/a CMS-1500) or its electronic equivalent or its successor form.

1	**Add-On Codes (R0071)** This policy describes reimbursement for physician claims submitted with add-on codes.
2	**Age and Gender to Diagnosis Code Policy (R0086)** This policy addresses edits involving diagnosis (ICD-9) codes with age and gender limitations.
3	**Anesthesia Policy (R0032)** This policy describes reimbursement for anesthesia and pain management services.
4	**Assistant Surgeon Policy (R5000)** This policy describes services provided by assistant surgeons that are reimbursable services and the method for determining reimbursement amounts for assistant surgeon services.
5	**Audiologic Vestibular Function Testing Code List - ICD 9 Filter (R0090)** This policy identifies circumstances in which reimbursement will be made to physicians or other health care professionals for audiologic/ vestibular function testing to identify problems with balance or hearing.
6	**B Bundle Codes Policy (R0100)** This policy describes reimbursement of status "B" codes found on the Physician Fee Schedule.
7	**Bilateral Procedures Policy (R0023)** This policy describes bilateral procedures and the application of multiple procedure reductions.
8	**CCI Editing Policy (R0105)** This policy describes National Correct Coding Initiative (NCCI) edits not otherwise addressed in reimbursement policies to determine whether CPT and/or HCPCS codes reported together are eligible for separate reimbursement.
9	**Care Plan Oversight Policy (R0033)** This policy describes reimbursement for Care Plan Oversight Services.
10	**Co-Surgeon Team-Surgeon Policy (R0052)** This policy identifies the method of reimbursement for co-surgeons (modifier 62) and team surgeons (modifier 66), and describes the circumstances under which assistant surgeon services are reimbursable services in conjunction with services provided by a co-surgeon.
11	**Contrast and Radiopharmaceutical Materials Policy (R0104)** This policy describes reimbursement for high and low osmolar contrast materials (Healthcare Common Procedural Coding System [HCPCS] codes A4641, A4642. A9500-A9700, J1245, Q3001, Q9951, Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, Q9964, Q9965, Q9966 and Q9967).
12	**Discontinued Procedure Policy (R0110)** This policy describes reimbursement for claims submitted with modifier 53 (discontinued procedure). This policy does not apply to anesthesia services other than for Procedure Pain Management Codes (PPMC). To report anesthesia services where a procedure has been discontinued, see Anesthesia policy.

13	**Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy (R0109)** This policy describes the appropriate billing guidelines for reporting HCPCS (Healthcare Common Procedural Coding System) codes with modifiers to indicate the rental, purchase, and maintenance and service of equipment for participating network Durable Medical Equipment (DME), orthotics or prosthetic vendors. The policy also addresses the frequency limitations concerning the rental, rental to purchase, and maintenance and service of this equipment. This policy does not apply to non-network DME, orthotics or prosthetic vendors, or home health services/home health agencies, or to any physician or other health care professionals reporting DME, orthotics or prosthetics services. Refer to the "Maximum Frequency per Day" policy for information pertaining to reimbursement for physician claims submitted with multiple units for the same CPT or HCPCS code on the same date of service.
14	**Facet Joint - ICD 9 Filter (R0091)** This policy describes circumstances in which reimbursement will be provided for facet joint nerve blocks.
15	**Global Days Policy (R0005)** This policy identifies the global period of a procedure and the reimbursement for Evaluation and Management (E/M) or other related services performed by a physician or other health care professional that are included in that global period, as well as the use of modifiers to indicate services that are not included in the global package.
16	**Increased Procedural Services Policy (R0061)** This policy was formerly the Unusual Services Policy. This policy describes reimbursement for claims submitted with modifier 22 (increased procedural services) or modifier 63 (procedure performed on infants less than 4 kg), but does not describe reimbursement for use of modifier 22 in connection with anesthesia delivery services. See Anesthesia Policy.
17	**Injections into the Tendon Sheath and Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel (R0070)** This policy describes circumstances in which reimbursement will be provided for injection(s) to treat problems in the tendon/tendon sheath, ligament, ganglion cyst, carpal tunnel or tarsal tunnel.
18	**Interventional Radiology Policy (R0011)** This policy describes reimbursement for interventional radiology procedures. This policy does not apply to anesthesiologists or CRNAs. Please refer to the Anesthesia policy.
19	**Laboratory Rebundling Policy (R0010)** This policy describes reimbursement of laboratory panels and component codes.
20	**Maximum Frequency Per Day Policy (R0060)** This policy describes reimbursement for physician claims submitted with multiple units for the same Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code on the same date of service. This policy does not apply to: network home health services and supplies/home health agencies; anesthesia services other than for Procedure Pain Management Codes (PPMC) which are subject to the Maximum Frequency per Day Policy; ambulance services; network physicians and other health care professionals contracted at a case rate (in some markets known as a flat rate). For HCPCS codes reported with rental modifiers (KH, KI, KJ, KR, or RR) or the Maintenance and Service modifier (MS) by participating network durable medical equipment (DME), orthotics or prosthetics vendor, please refer to Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency Policy.

21	**Microsurgery Policy (R0038)** This policy describes the code ranges allowed for separate reimbursement for microsurgical technique
22	**Moderate Sedation Policy (R0035)** This policy was formerly the Intravenous/Conscious Sedation policy. The Moderate Sedation policy describes reimbursement for moderate (conscious) sedation procedures.
23	**Modifier 25 Policy (R0050)** This policy describes reimbursement for claims submitted with modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service).
24	**Modifier 76 and 77 Policy (R0066)** This policy is a reference tool to guide readers to reimbursement policies in which the use of modifier 76 (Repeat Procedure or Service by Same Physician) and/or modifier 77 (Repeat Procedure by Another Physician) is discussed.
25	**Multiple Procedure Policy (R0034)** This policy describes reimbursement related to multiple procedure reduction percentages, which CPT and HCPCS codes are subject to multiple procedure reductions, and the method by which procedures are determined to be primary versus secondary or subsequent.
26	**New Patient Visit Policy (R0004)** This policy describes the appropriate use of new office/outpatient Evaluation and Management (E/M) CPT and HCPCS codes. Home Health Care/ Home Health Agencies are excluded from this policy.
27	**Physical Medicine and Rehabilitation Policy Maximum Combined Frequency Per Day (R0101)** This policy addresses reimbursement for certain timed therapy services provided in an office or outpatient place of service.
28	**Physical Medicine and Rehabilitation Policy PT, OT and Evaluation and Management (R0098)** This policy describes reimbursement for physical and occupational therapy evaluations.
29	**Physical Medicine and Rehabilitation Policy Speech Therapy (R0097)** This policy addresses procedure codes that will and will not be reimbursed for speech therapy.
30	**Professional-Technical Component Policy (R0012)** This policy describes the professional and technical components of a global procedure code and other matters related to professional, technical and global reimbursement.
31	**Prolonged Services (R0003A)** This policy describes reimbursement of prolonged physician services involving direct (face-to-face) patient contact that are beyond the usual service in either the inpatient or outpatient setting.
32	**RAST Testing - ICD 9 Filter (R0092)** This policy describes circumstances in which reimbursement will be provided for radioallergosorbent (RAST) type tests.
33	**Radiology Multiple Imaging Reduction Policy (R0085)** This policy describes reimbursement related to multiple imaging reduction percentages, which CPT and HCPCS codes are subject to multiple imaging reductions, and the method by which procedures are determined to be primary versus secondary or subsequent.

34	**Rebundling Policy (R0056)** This policy provides an overview of coding relationships through rebundling edits.
35	**Reduced Services Policy (R0065)** This policy describes reimbursement for claims submitted with modifier 52 (reduced services
36	**Respiratory Therapy Services Code List - ICD 9 Filter (R0093)** This policy describes circumstances in which reimbursement will be provided for respiratory therapy services.
37	**Same Day-Same Service Policy (R0002)** This policy describes reimbursement for multiple medical services, including Evaluation and Management (E/M) services, provided on the same date of service for the same patient by the same physician or other health care professional.
38	**Split Surgical Package Policy (R0106)** This policy describes reimbursement for services constituting components of the global surgical package.
39	**Stand By Physician Policy (R3003)** This policy describes reimbursement for physician standby services.
40	**Supply Policy (R0006)** This policy describes reimbursement for supplies and surgical trays.
41	**T Status Codes Policy (R0107)** This policy describes reimbursement of codes with a status of "T" found on the Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule.
42	**Telemedicine Policy (R0046)** This policy describes reimbursement for medical services delivered other than in-person (such as over the phone, Internet or other communication devices), but does not include care plan oversight services (see instead the Care Plan Oversight Policy).
43	**Therapeutic and Diagnostic Injection Policy (R0009)** This policy describes reimbursement for therapeutic and diagnostic injection services (Current Procedural Terminology (CPT®) codes 96372, 96373, 96374, 96375, 96376 and 96379) when submitted with medications and/or evaluation and management (E/M) services. This policy does not apply to DME and home health care/home health agencies.
44	**Transforaminal Epidural Injections Policy (R0094)** This policy describes circumstances in which reimbursement will be provided for nerve block transforaminal epidural injections.
45	**Viral Hepatitis Serology Testing - ICD 9 Filter (R0096)** This policy describes circumstances in which reimbursement will be provided for viral hepatitis serology testing.

Spotlight: Modifier 25 Policy (R0050) Change

As shown above, the Modifier 25 policy is one of the reimbursement policy changes for UnitedHealthcare ***hawk-i*** providers. This change means that for claims submitted on or after February 1, 2010, UnitedHealthcare ***hawk-i*** providers will receive reimbursement for both E/M and P/M covered services when significant, separately identifiable Evaluation Management services are performed by the same provider on the same day a procedure or other covered service is provided and billed with the 25 modifier. Please read the policy in full online at https://www.uhcrivervalley.com/10Provider/01AmeriChoice/hawki/.

The Importance of Collaboration between Primary Physicians and Behavioral Health Clinicians

A substantial number of people who have serious illnesses also have behavioral health conditions. For example, 20% of patients who have had a heart attack are likely to develop depression within 12 months of the event. Between 20% and 27% of patients with diabetes also have depression.

It is important to determine if a behavioral health clinician is treating a patient with these and other illnesses. If so, it is helpful to coordinate care with the behavioral health clinician. Coordination of care takes on greater importance for enrollees with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when patients have been hospitalized for a medical or psychiatric condition.

Communication between clinicians can also maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions for patients being prescribed psychotropic medication. It can also help reduce the risk of relapse for patients with substance abuse disorders or psychiatric conditions.

Please discuss with your patients the benefits of sharing essential clinical information. We encourage you to obtain a signed release from each UnitedHealthcare ***hawk-i*** patient that allows you to share appropriate treatment information with the patient's behavioral health clinician.

Information from United Behavioral Health: ADHD

Please keep the following guidelines in mind when treating patients with ADHD:

- All patients with ADHD should keep one follow-up visit within the first month and at least two additional visits for monitoring their progress.
- If taking medication, patients should take medication as prescribed and remain on the medication.

In addition, the National Committee for Quality Assurance (NCQA) has established a set of measures to monitor treatment adequacy for patients with ADHD who are prescribed medication. These Healthcare Effectiveness Data and Information Set (HEDIS) measures are based on established research and reflected in many treatment guidelines.

For children ages 6-12 taking medications for ADHD, HEDIS guidelines are as follows:

- Attend one follow-up visit with prescriber in 30 days (Initiation Phase).
- Stay on medication for at least seven months (Continuation Phase)
- Attend two additional follow-up visits in nine months with any practitioner (Maintenance Phase)

United Behavioral Health has a Preventive Health Program for ADHD available online at http://prevention.liveandworkwell.com, including a screening tool, educational articles, and information on additional resources. You can also request information about ADHD by calling the Behavioral Health Info Request Line at 1-888-697-3815 and selecting prompt #3, or by e-mailing requests to BHInfo@uhc.com. This request line is also available to UBH members.

Online Tools at Your Fingertips

www.uhcrivervalley.com/10provider/01americhoice/hawki offers many tools and resources to UnitedHealthcare ***hawk-i*** network providers. Check out the Provider Welcome Kit, Provider Manual, as well as newsletters like this one. Finally, you can verify patient eligibility and check claim status when you register for Provider e-Services. Go to the web site and select "Iowa/Illinois Providers" under Provider e-Services to get started. If you have any questions, please call provider service at 1-888-650-3462.

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Practice Matters is a periodic publication for physicians and other health care professionals and facilities in the UnitedHealthcare network.

M44278 3/10