Provider Satisfaction Survey

Tell Us What You Think

UnitedHealthcare is committed to making sure that our services support the ability of your practice to provide the safest and highest possible quality of health care to your patients who are our members. We value and seek administrative simplicity that takes the hassles out of clinical practice and reduces inefficiency and waste. For this reason, we periodically offer our network physicians the opportunity to comment on our services. In the near future you may be receiving a survey to evaluate the services UnitedHealthcare provides to you and our members Your opinions are important to us and will help us assess the level of satisfaction with our health plan as well as identify opportunities for improvements so that we may better meet the needs of your practice. We appreciate your time and cooperation.

Just Launched:
New UnitedHealthcare Web site for Iowa

UnitedHealthcare is excited to announce the launch of our new Iowa provider Web site, located at www.uhcrivervalley.com/Provider/UHClowa. The web site is streamlined to provide you with Iowa specific information to better serve your UnitedHealthcare hawk-i members. Visit the new Web site to find valuable information, such as the Iowa Administrative Guide and Welcome Kit. Additionally, the eServices tool can be found on the home page for your convenience. The eServices tool provides access to verify patient eligibility and check claim status online.
Immunizations

The UnitedHealthcare hawk-i program covers immunizations. Refer to the UnitedHealthcare hawk-i provider manual at www.uhcrivervalley.com/Provider/UHCIowa to find the link to the Centers for Disease Control child and adolescent immunization schedule. If you have any questions, call Provider Service at 1-888-650-3462.

Immunizations for hawk-i members are not part of the Vaccines for Children (VFC) Program. The VFC program is only available for Medicaid members, uninsured children, and American Indian or Alaskan Native children, as noted on the Iowa Department of Public Health web site at http://www.idph.state.ia.us/adper/vaccines_for_children.asp.

Important Claims Mailing Address Information

Some time ago, we had changed our claims mailing address and are still receiving mail addressed to the old address. Effective immediately, all claims mailed to the old address will continue to be forwarded for one year. After that time, anything received at the old address will be returned to the sender.

The correct claims mailing address for UnitedHealthcare hawk-i is:
United Healthcare of River Valley, Inc.
PO Box 5220
Kingston, NY 12402-5220

Submitting electronic claims can save you time and money. If you are interested in submitting claims electronically or signing up for Electronic Remits or Electronic Funds Transfer, please visit us at https://www.uhcrivervalley.com/Providers/HIPA_A_Information/ERA_EFT/index.html and https://www.uhcrivervalley.com/downloads/provider/ERA_Provider_Profile.pdf or call EDI Support Services at 1-800-210-8315 to get you started.

Quality Improvement Program

The UnitedHealthcare Quality Improvement Program strives to continuously improve the care and services provided to members.

Each year UnitedHealthcare Health Plans utilize HEDIS reporting to measure our health care performance. Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures that are related to many significant public health issues. Some of these include well-child visits, immunization rates, lead screening rates, prenatal care visits, cancer screenings and diabetes care.

In 2009, 100% of UnitedHealthcare Plans saw an improvement in the number of children who were completely immunized by age 2 as well as the number of babies who received the recommended number of well-baby visits by age 15 months. In 2010, two of UnitedHealthcare’s goals are a continued increase in the number of babies who receive their recommended well visits and an increase in the number of women who receive a post-partum visit 21-56 days after delivery.

If you would like further information about our Quality Improvement Program, our annual goals or our progress towards meeting our goals, please call 1-888-650-3462.
When the Patient’s Request Can Lead to Fraud, Waste or Abuse

Healthcare providers familiar with recent news stories should be aware that fraud, waste and abuse against insurance programs are a high priority at both the state and federal level. Most healthcare providers run an honest practice dedicated to the health and wellbeing of their patients. However, the practices of some providers can create an environment that can impact the entire group. This can include patients asking their doctors to take actions that they say are done by other physicians. These actions, such as waiving co-pays, charging a greater amount or billing a higher code, or adding a diagnosis to cover a service are often rationalized as attempts to help the patient. For example, listing a diagnosis of diabetes on a prescription to allow a patient to obtain equipment such as shoes may seem to be helping the patient. However, in addition to insurance fraud, this diagnosis could impact the future eligibility of the patient for other insurance products. Another scenario is a patient asking for a certification or prescription for durable medical equipment the provider does not believe the patient requires.

What do you do when the patient tells you that another doctor is prescribing this item for patients they know? The best practice is to stick with the facts. Is writing this order within the scope of your practice or specialty? Are you treating the patient for a condition that requires the item or prescription? If no, deny the request, and explain your decision to the patient. Always keep in mind that as the prescribing physician, you would be held responsible for the validity of the orders. Combating fraud, waste and abuse is the responsibility of members, healthcare providers and insurers alike. It is your responsibility to report members or other providers you suspect are committing fraud and abuse. If you notice a trend of patients requesting a particular product or service you do not feel is necessary, you should reach out to your provider representative to notify them of the issue. You can also call the Special Investigations Unit Fraud Hotline at 877-401-9430.

Electronic Claim Submission Tips

Listed below are some tips to help with Electronic Claim Submission

- Include your tax identification number (TIN) along with your NPI number to help promote timely and accurate payments

- Member ID Numbers are required

- The Payer ID number indicates where clearinghouses should direct their claims.
  - UnitedHealthcare Plan of the River Valley
    Payer ID is: 95378

- For additional assistance with electronic claim submission please contact EDI Support services at: 1-800-210-8315 or email us at ac_edi_ops@uhc.com

Carrier Tables and Payer ID Set-Up

- Set your computer system payer tables to generate electronic claims instead of paper claims

- Make sure that Payer spelling and setup are consistent. Set them as electronic vs. paper
- Confirm that new patient records and additional payer listings created by front desk staff are set to be sent electronically.

- Contact your software vendor or clearinghouse with any questions you may have concerning the placement of information on your computer/practice management system.

**Managing Your Clearinghouse Reports**

- Be sure you are working your reports! Reports show if a claim has been received by the clearinghouse and sent to the payer’s system.

- You should receive two sets of reports for every claim batch transmitted:
  - Clearinghouse acknowledgement - claims accepted and/or rejected by the clearinghouse
  - Payer acknowledgement - claims accepted and/or rejected by the payer

- Rejected claims must be corrected and re-transmitted electronically. Do not resubmit these claims via paper. Claims will only be rejected if there is something incorrect on the claim. Resubmitting a claim via paper will not correct the issue and may delay processing time.

**How to Avoid Rejections**

- The majority of rejected claims are the result of an eligibility issue such as:
  - Subscriber/Subscriber ID not found
  - Coverage has been cancelled
  - Conducting an eligibility check on the patient helps avoid most rejections.

- Some Claims might be rejected due to a provider mismatch. To ensure correct matching of the provider, ensure that you are submitting with the Tax ID number as well as the NPI number. If you are submitting the claim with the Provider ID number (not required) you must ensure that the number is exact including the locator code. Should you submit the claim with the Provider ID number, the system will by pass the NPI and match based upon the Provider ID submitted.

- Rejected claims must be corrected and re-transmitted electronically. Do not resubmit these claims via paper. Claims will only be rejected if there is something incorrect on the claim. Resubmitting a claim via paper will not correct the issue and may delay processing time.

**Effectively Manage Re-Bills**

- Make sure you set your re-submissions/re-bills to be sent electronically. Most systems have automatic claim re-bill capabilities that resend claims every 30-60 days if payment has not been posted.

- Do not send paper claim backup for claims that have already been sent electronically.

**Electronic Funds Transfer (EFT)**

**Receive Payment for claims electronically (EFT)**

EFT (Electronic Funds transfer) is the method of transferring money from one bank account directly to another without any paper money or checks actually changing hands. One of the most common EFT programs used is Direct Deposit for payroll. EFT is safe, secure, efficient, and more cost effective than paper claim payments.
Claims that may require supporting information for initial claim review:

A Note about Claim Attachments - Insurance Payers prefer to receive your claims electronically. In fact, many insurance companies have eliminated or significantly reduced the need for paper attachments for referrals/notifications, progress notes, ER visits, and more. Payers will request additional information when it is needed. Denial letters from primary carriers are not sufficient as proof of Coordination of Benefits.

You can find the EFT enrollment form and FAQ online at [https://www.uhcrivervalley.com/Providers/HIPAA_Information/ERA_EFT/index.html](https://www.uhcrivervalley.com/Providers/HIPAA_Information/ERA_EFT/index.html) and [https://www.uhcrivervalley.com/downloads/provider/ERA_Provider_Profile.pdf](https://www.uhcrivervalley.com/downloads/provider/ERA_Provider_Profile.pdf), or contact our EDI Support Services Team directly; we can assist you with the enrollment process. EDI Support Services: 1-800-210-8315 or email us at ac_edi_ops@uhc.com.

Provider Billing Alert - Coordination of Benefits Claims

Reminder: United Healthcare does not accept denial letters from primary carriers in place of an Explanation of Benefits. Coordination of Benefit claims that are received without information regarding the primary payers reimbursement cannot be processed.

Should you have any questions, please feel free to contact Provider Services at 1-800-345-3627.

The Medical Technology Assessment Committee (MTAC)

The Committee meets at least 10 times per year. Reports from the MTAC are reviewed by the NMCMC (National Medical Care Management Committee). Recommendations are forwarded to NQMOC (National Quality Management Oversight Committee) and then disseminated to the health plans.

MTAC is responsible for the development and management of:

- Evidence-based position statements on selected medical technologies
- Assessments of the evidence supporting new and emerging technologies
- Evaluation of new usage of existing technologies
- Maintenance of externally licensed guidelines
- The consideration and incorporation of nationally accepted consensus statements, clinical guidelines and expert opinions into the establishment of national standards for UnitedHealth Group
- Ensuring that clinical decisions about the safety and efficacy of medical care are consistent across all products and businesses
Important Changes to our Preterm Labor Medical Policy — Effective November 15, 2010

UnitedHealthcare hawk-i regularly evaluates its medical policies, clinical programs and health benefits based upon the latest scientific evidence and specialty society guidance. Based upon this review for pre-term labor interventions, we have made some important changes that will be effective November 15, 2010.

Tocolytic Therapy
The use of tocolytic therapy beyond seven days is unproven for preventing spontaneous preterm birth by prolonging pregnancy. Available studies fail to demonstrate any benefit of maintenance tocolysis in terms of gestational age at birth, pregnancy prolongation or birth weight.

Subcutaneous terbutaline pump maintenance therapy is unproven for preventing spontaneous preterm birth by prolonging pregnancy. Terbutaline pump maintenance therapy has not been shown to decrease the risk of preterm birth by prolonging pregnancy.

Home Uterine Activity Monitoring
Home uterine activity monitoring (HUAM) is unproven for preventing spontaneous preterm birth. There is insufficient clinical evidence that HUAM, as an independent variable, reduces the frequency of preterm births. Available studies fail to demonstrate that the use of HUAM reduces the rate of preterm delivery and neonatal complications or improves pregnancy outcomes.

Most benefit plan documents exclude from benefit coverage health services identified as investigational, unproven, and not medically necessary.

You may view the entire policy at https://www.uhcrivervalley.com/Provider/UHClowa/hawki/Claims_Payments.asp

UnitedHealthcare Plan of the River Valley, Inc. a company owned by UnitedHealth Group, is adopting and aligning its medical policies with those of the UnitedHealthcare commercial business. Our Medical Coverage Policies define whether a service (e.g., test, device or procedure) is proven to be effective and/or to have a proven benefit on health outcomes based on the published clinical evidence. Services determined to be experimental, investigational or unproven by the clinical evidence are typically not covered. Medical Policies are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support clinical decision making. The information presented in these policies is believed to be accurate and current as of the date of publication.

Reimbursement Policy Changes/Updates

Note Regarding Reimbursement Policies
Unless otherwise noted below, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all issues related to reimbursement for services rendered to UnitedHealthcare hawk-i members, such as
the member’s benefit plan, UnitedHealthcare medical policies and the Provider Administrative Guide.

Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment.

Other applicable reimbursement policies, medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed, in their entirety, on https://www.uhcrivervalley.com/Provider/UHCowa/hawki/Claims_Payments.asp.

In the event of an inconsistency or conflict between the information provided in the Provider Newsletter and the posted policy, the provisions of the posted reimbursement policy will prevail.

**New Policies**

**Clinical Lab Edits**

Based on the CMS National Coverage Determination (NCD) coding policy manual, services that are excluded from coverage include routine physical examinations and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. CMS interprets these provisions to prohibit coverage of screening services, including laboratory tests furnished in the absence of signs, symptoms, or personal history of disease or injury. A national coverage policy for diagnostic laboratory test(s) is a document stating CMS’s policy with respect to the circumstances under which the test(s) will be considered reasonable and necessary, and not screening, for Medicare purposes.

Because many of the UnitedHealthcare markets follow CMS guidelines for reimbursement, UnitedHealthcare has made the decision to create a suite of edits for Clinical Diagnostic Lab Services. These edits will ultimately contain many of the services outlined in the CMS National Coverage Determination (NCD) coding policy manual.

UnitedHealthcare will be implementing two edits effective November 15 beginning with the two outlined here.

1. CPT code 82378 Carcinoembryonic antigen (CEA) will be allowed when billed with a diagnosis on the allowed “diagnosis codes for CPT 82378” diagnosis list. If the CPT code 82378 is submitted with a diagnosis that is not on the allowed “diagnosis codes for CPT 82378” diagnosis list, the claim will deny with ACA/FCA remark codes.

2. Claims submitted with CPT code 82105 Alpha-fetoprotein; serum will be allowed when billed with a diagnosis on the allowed “diagnosis codes for CPT 82105” diagnosis list. If the CPT code 82105 is submitted with a diagnosis that is not on the allowed “diagnosis codes for CPT 82105” diagnosis list, the claim will deny with ACA/FCA remark codes.

Additional edits will be added in the future and will be announced prior to the implementation.
Payment for L3000 Orthotic Inserts

UnitedHealthcare will allow a maximum frequency of 2 inserts billed as L3000 per foot per year. UnitedHealthcare will also require a prescription (Rx) for DME providers and other documentation for podiatrists/orthopedists.

This policy will take effect for dates of service of November 1, 2010 or later.

Observation Care Evaluation and Management Services

UnitedHealthcare will publish a new reimbursement policy that will address appropriate coding and documentation for Observation Care Evaluation and Management services billed on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form.

This policy does not apply to claims billed on a UB-04 form. Observation care CPT® codes 99217-99220 as quoted from the CPT manual are used to report evaluation and management services provided to new or established patients designated or admitted as “observation status” in a hospital. The policy will reinforce the correct coding guidelines as published by the American Medical Association Current Procedural Terminology manual in addition to CMS guidelines as outlined below. CMS guidelines for reporting Observation Care states:

• The medical record must contain;
  – dated and timed
  • physician’s admitting orders regarding patient care in observation status
  • nursing notes
  – physician progress and discharge notes
  – Be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter
  – Identify the physician was present, personally performed the services and the admission to and discharge from notes were written by the billing physician
  – Satisfy E/M documentation guidelines for admission to and discharge from observation care

• 99218-99220 involve less than eight hours on the same calendar date

• 99234-99236, Observation or Inpatient Care Services for patients admitted and discharged on same date of service, involves a minimum of eight hours, but less than 24 hours on the same calendar date

• An outpatient code, 99211-99215, shall be reported for a visit in those rare instances when a patient is held in observation care status for more than two calendar dates

• Other physicians must bill codes 99201-99215 when providing services to a patient in observation status

Pursuant to the UnitedHealthcare “Global Days” policy, the global surgical fee includes payment for hospital observation services (99217-99220, 99234-99236) unless the criteria for modifiers 24, 25, 57 are met. Refer to the UnitedHealthcare “Global Days” policy for guidelines on reporting services during a global period.
Updates

Anesthesia Policy

Preoperative and Postoperative Visits
UnitedHealthcare Anesthesia Policy currently follows the American Society of Anesthesiologists (ASA) guidelines which indicate the usual preoperative and postoperative visits are not separately reimbursable with anesthesia management services (CPT® codes 00100-01999 excluding 01996 and 01953).

To more closely align with the Centers for Medicaid & Medicare Services (CMS) guidelines, the following revisions will be made:

• Evaluation and Management (E/M) codes will be considered as usual preoperative and postoperative visits only when reported on the same date of service as the anesthesia management services.

• Critical care CPT codes (99291-99292) will be removed from the list of E/M CPT codes (99201-99499, 92002 92004, 92012-92014 G0396-G0397, S0273 –S0274 99201-99499) that are considered as preoperative and postoperative visits, and will be separately reimbursed when reported with anesthesia management services.

• Since the critical care CPT codes will now be separately reimbursed when reported with anesthesia management services, the requirement to report a modifier 25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) is no longer necessary and will be removed from the policy.

Anesthesia Teaching Guidelines

Based on CMS guidelines, the following revisions will be made to the anesthesia teaching guidelines for reporting anesthesia services:

• A teaching anesthesiologist (M.D.) training one Student Registered Nurse Anesthetist (SRNA) would report the modifier AA (Anesthesia services performed personally by anesthesiologist) to be reimbursed at 100% of the fee allowance. The case is not concurrent to any other anesthesia cases.

• When a teaching anesthesiologist (M.D.) and a Certified Registered Nurse Anesthetist (CRNA) are jointly training two SRNAs in concurrent cases, then the CRNA should report medical direction by use of the modifier QX (CRNA service with medical direction by a physician) for each case. However, the time reported for the CRNA is limited to actual time spent with each case.

Modifier 47

The 2010 CPT Manual states: “Regional or general anesthesia provided by the surgeon may be reported by adding the modifier ‘47’ to the basic service (this does not include local anesthesia).

Note: modifier 47 should not be used as a modifier for anesthesia procedures.”

Effective November 15, 2010, UnitedHealthcare will revise the Anesthesia Policy to not reimburse for anesthesia management services (CPT® codes 00100-01999 excluding 01996) when a modifier 47 is appended.
Moderate Sedation Policy

According to the American Medical Association (AMA), anesthesia services (CPT codes 00100-01999) should not be reported by the same physician reporting diagnostic or therapeutic procedures cited in Appendix G of the 2010 CPT® Manual.

Effective November 15, 2010 UnitedHealthcare will not separately reimburse for anesthesia management services (CPT codes 00100-01999 excluding 01996) when reported on the same date of service by the same individual physician or health care professional also reporting a diagnostic or therapeutic procedure cited in Appendix G of the 2010 CPT® Book and not addressed in the Anesthesia Reimbursement Policy.

Therapeutic and Diagnostic Injection Policy – Revisions and Name Change

Revisions to deny Health Care Common Procedure Coding System (HCPCS) Supply Codes when billed with CPT codes 96360-96549

Currently, the Therapeutic and Diagnostic Injection Policy only addresses reimbursement when E/M services are reported in combination with CPT codes 96372-96379. According to CPT® instructions, physician work related to hydration, injection and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff. If a significant, separately identifiable E/M is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549. CPT codes 96372-96379, which are addressed in the Therapeutic and Diagnostic Injection policy, are part of a larger section of CPT® entitled “Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration,” which spans codes 96360-96549. The instructions in this section of Current Procedural Terminology®, 2010 American Medical Association state: “If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia
b. IV start
c. Access to indwelling IV, subcutaneous catheter or port
d. Flush at conclusion of infusion
e. Standard tubing, syringes, and supplies.”

CMS also follows the CPT guidelines for inclusive services.

UnitedHealthcare will update the Therapeutic and Diagnostic Injection Policy to deny HCPCS medical and surgical supply codes (reproduced in the appendix) identified by description as standard tubing, syringes and supplies, when reported with CPT codes 96360-96549 on the same date of service, by the same physician or health care professional.

Examples:

• A4206 - Syringe with needle, sterile, 1 cc or less, each
• A4216 - Sterile water, saline and/or dextrose, diluent/flush, 10 ml

With the adoption of the aforementioned revisions, the policy name will also be changed to the Injections and Infusion Services Policy.
The revised policy will be effective for dates of claims processing on or after November 15, 2010.

**Unlisted Codes-clarification of protocol**

UnitedHealthcare is increasing the requirements around claims submitted with unlisted codes. UnitedHealthcare continues to encourage providers to provide bill with the most accurate and specific CPT or HCPCS code. If an unlisted code is used, UnitedHealthcare is clarifying the following requirements.

Documentation is required for all unlisted codes submitted for reimbursement. Documentation is to include, but is not limited to:

- Complete description of what the unlisted code is being used for
- Procedure report for unlisted surgical/procedure codes
- Invoice for unlisted DME/supply codes
- NDC #, dose and route of administration for unlisted drug codes

Documentation will be reviewed for appropriate coding, existence of a more appropriate code, coverage and reimbursement allowance.

Claims submitted with unlisted codes that do not have documentation with them will be denied.