EmblemHealth

NEWS&NOTES

The Newsletter for EmblemHealth, GHI and HIP Providers

WINTER 2013

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UPDATE DIRECTORY INFORMATION

Claims Corner

Claims Corner is an online resource for information on claims policy, best practices for claims coding, regulatory-driven payment methodology and other useful claims-related tips. Visit the page regularly to view updates that may have an impact on your practice's management system.

New HIP Outpatient Imaging Self-Referral Payment Policy

Effective July 2013, EmblemHealth will implement a new Outpatient Imaging Self-Referral Payment Policy (SRPP) to replace HIP's Radiology and Cardiology Imaging Privileging programs. SRPP will apply to HIP commercial plans, state-sponsored programs and Medicare benefit plan members.

SRPP designates which imaging procedures (CPT-4 codes) performed by specified provider specialties can be reimbursed in an office setting (POS11). Certain accreditation and certification requirements apply for a provider to receive reimbursement under this program.

SRPP Exclusions

This policy does not apply to HIP members assigned to a Montefiore (CMO) or HealthCare Partners (HCP) primary care physician or members assigned to one of our four physician group practices: Queens-Long Island Medical Group, Staten Island Physician Practice, Manhattan's Physician Group and Preferred Health Partners. These members can be identified by their member ID card or by accessing member eligibility information on our Web site. Requirements for GHI, GHI HMO and Vytra members are not changing at this time.

Prior approval rules will continue to apply where applicable.

Prior to July 2013, participating physicians will be reviewed for active accreditation in national databases from the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL) for echocardiography services, and the Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL) or the American College of Radiology (ACR) for nuclear medicine/nuclear cardiology services.

Inquiries about accreditation status or accreditation certificate submissions should be directed to: provideraccreditations@carecorenational.com or by calling **1-800-918-8924 ext. 27901**.

To obtain information on accreditation requirements and instructions on how to submit an application for accreditation, please refer to the accrediting

organizations below.

- American Board of Internal Medicine (ABIM)
- American Board of Nuclear Medicine (ABNM)
- American College of Radiology (ACR)
- American Osteopathic Board of Internal Medicine (AOBIM)
- Certification Board for Nuclear Cardiology (CBNC)
- Intersocietal Accreditation Commission (IAC)
- National Board of Echocardiography (NBE)

No Cost Sharing for Women's Preventive Services

For benefit plans issued or renewed on and after August 1, 2012, the following preventive health services have been added to the enhanced list of services that do not require member cost-sharing:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- Sexually transmitted infection (STI) counseling
- HIV screening and counseling
- Contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening

The Health Care Reform guidelines are based on recommendations by the Institute of Medicine, which was commissioned by the Health Resources and Services Administration to determine what preventive services are necessary for women's well-being. Visit our Web site for additional information on women's preventive services.

HIP and Vytra Dual Specialty Providers: Include Taxonomy Code on Claims

We strive to provide the most accurate and timely reimbursement to our HIP and Vytra clinicians who are dual specialty providers, practicing both as PCPs and specialists. To ensure an excellent claims-paying experience, we request that you include the taxonomy (specialty) code for the specialty in which you provided services.

By including the taxonomy qualifier and value on the CMS 1500 form in columns 24I and 24J, or in Loop 2000A, segment PRV03; Loop 2310B, segment PRV03; or Loop 2420A, segment PRV03 for electronically submitted claims, we can determine the correct copayment to deduct.

Note: This request applies to professional claims for HIP and Vytra lines of business and only for services rendered in the following locations:

- POS 11 – Office
- POS 12 – Home
- POS 22 – Outpatient department of a hospital

You may view the Health Care Provider Taxonomy Code Set at the Washington

Publishing Company Web site.

Look Back Periods to Reconcile Overpayments

To ensure fair and accurate claims payment, EmblemHealth routinely conducts audits of previously adjudicated claims. The time period for these audits is referred to as the “Look Back Period” and it applies to all plans. Claims may be audited based on the settlement or paid/check date, not the date(s) of service. The date range for each audit is primarily determined by regulatory requirements and varies with the member's plan type. The Look Back Periods are summarized in the table below (and may be modified as needed to reflect statutory and regulatory changes).

Plans	Look Back Period
Commercial Plans and Child Health Plus Plans	2 years
FEHB Plans; Medicare Advantage Plans; Medicaid Reclamation Claims	3 years
Medicaid, Family Health Plus and Veterans Administration (VA) Facilities’ Claims*	6 years

*No unilateral off-set permitted.

If an overpayment is identified, a notice and a request for repayment are sent to the provider. The notice provides a detailed explanation of the payment that was made in error and also includes information about your repayment options and how to dispute the repayment request. The provider may challenge an overpayment recovery by following the Provider Grievance process as described in the applicable Dispute Resolution section of our Provider Manual: Commercial/Child Health Plus; Medicaid/Family Health Plus or Medicare.

If the identified overpayment is not returned within the requested time frame or the dispute of overpayment is not submitted in a timely manner, EmblemHealth will withhold funds from future payment(s) to the provider up to the amount of the identified overpayment.

Please note: The look back period timeframe limitations do not apply to:

- Claims that fall under the False Claims Act
- Duplicate claims
- Fraudulent or abusive billing claims
- Claims of self-funded members
- Claims of members enrolled in one of our Medicare plans: HMO, PPO, ASO, Dual Eligible SNP, MLTC or in Medicaid, Family Health Plus or Child Health Plus
- Claims of members enrolled in coverage provided by the state or a municipality to its employees
- Claims subject to specifically negotiated contract terms between an EmblemHealth company and a provider; contractual time frames will apply