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CB&C NEWS—

SIMPLIFING INSURANCE ISSUES

Volume 6, Issue 1

Aetna & TRIAD—What the heck is happening???

It's been a hard summer with all the Aetna / TRIAD confusion. Providers have been complaining about the administrative nightmares for months, not to mention being financially stressed by the delays in receiving payment. The changes made to the Aetna / TRIAD relationship included a new authorization process and new fee schedule, as well as the inclusion of Aetna PPO policies into those managed by TRIAD. There has been mass confusion as to how these changes affect providers and it is further complicated because Aetna and TRIAD did not seem equipped to administer these changes when they occurred on 6/1/12. Although it is still a very fluid situation, CB&C can tell you what we know at this point.

Participation Status: Prior to May 2012, there were providers that were out of network with BOTH Aetna and TRIAD, and then there were providers that were participating with Aetna, but NOT with TRIAD. And then there were providers that were already participating with BOTH Aetna and TRIAD. It is important to know which category you were in PRIOR to May and it is even more important to know where you fall AFTER June 2012. If you don't know, you must contact BOTH Aetna and TRIAD and obtain this information. I would suggest you have them verify all the 'numbers' that are relative to your practice. Provide them with your personal NPI and also your facility NPI (if applicable). Give them your tax ID# or SS# as well. You need to know this information to effectively know where to submit claims and understand the authorization requirements.

Claim Submission. If you are non participating with Aetna and TRIAD, you really should just send all your claims to Aetna right now (if there are claims that are to be paid by TRIAD, Aetna will forward your claims for you). It is the same for those of you that are participating with Aetna but NOT TRIAD—send claims to Aetna and they will forward to TRIAD if necessary. For providers that are participating with TRIAD, your verification really needs to be done properly to find out where claims are to be sent. You should call TRIAD and give them the patient's ID#. They can look up the patient and direct you as to whether they are responsible to handle claims processing or not. If TRIAD doesn't have the answer immediately, they have been diligent in researching the problem and calling the provider back within 24 hours. (*continued on page 3)*

Your chiropractic & physical therapy office experts!

Points of interest:

- *Aetna / TRIAD*
- *Medicare & Therapy Svs*
- *Self /Fully funded*
- *Q & A's*
- *UHC Multiple Therapies*

Medicare's New Policy on Therapy Services

As you probably know by now, CMS is changing their policy on therapy services. This should come as no surprise since they also made extensive changes to their chiropractic policy in April of 2012. As a brief summary, under the new guidelines, after the $1880 cap is met, the KX modifier will allow additional payment up to $3700 at which time the provider will need to pre-certify any additional treatment. This will begin in phases. We have outlined some information below and on page 4 of this newsletter. In addition, you can go to our website at CBCbilling.com for a copy of the provider bulletin from Novitas, as well as copies of the pre-certification forms. We also encourage you to visit your Medicare carrier's website for more info.

Which "Phase" your ***personal*** NPI # is listed under will decide when you are required to start with pre-cert.

Phase 1 – October 1st – December 31st

Phase 2 – November 1st – December 31st

Phase 3 – December 1st – December 31st

You can find this information out by going to https://data.cms.gov/**dataset/Therapy**-Provider-Phase.../ucun-6i4t and entering the personal NPI. If the personal NPI is not listed, Novitas has indicated you are automatically assigned to Phase 3. All offices should have received a letter by now advising as to which phase the provider is in. (*continued on page 4)*

Self Funded vs. Fully Funded – What is All the Hype?

By now you ***MUST*** be hearing the terms 'self funded' and 'fully funded' a lot! So…..what's the big deal? What ***IS*** the difference and why is it so important? This is a subject matter that you NEED to get a handle on….sooner rather than later!

Fully Funded Policies:

Small employers are typically fully funded or fully insured. An employer group or individual contacts a broker or an insurance carrier and is provided with plan options (usually a spreadsheet with the monthly premium and the various plan specifications such as in and out of network benefits, hospitalization coverage, chiropractic coverage, etc.). What you see is what you get. You cannot combine or make changes to create your own plan. Once the policy is purchased, the insured receives a Certificate of Coverage (COC). From then on, a monthly premium will be paid to keep the policy active. These polices are under the 'jurisdiction' of the Dept. of Banking & Insurance (DOBI). (www.state.nj.us/dobi)

Checks can still be sent to the patients for self funded plans!

Self Funded Policies:

Most mid to large employer groups are self funded or self insured. Based on the number of employees an employer group has it can become less & less cost effective to pay monthly premiums for a fully funded policy. Instead, an employer group may choose to become self insured. Once the plan is established, the employer group hires an administrator for the plan. They may choose an insurance carrier (such as BC/BS or Cigna) or they can hire an MCO (managed care organization such as Qualcare or First Health). Basically, the employer group hires a carrier or MCO to function as a TPA (Third Party Administrator) for use of a provider network, claims processing, fee schedule, etc., etc. In this self funded model, the employer group provides the TPA with a Summary Plan Document (SPD). This tells the TPA exactly how to administer the benefits for the covered members. In the SPD, the employer dictates ALL the benefit information. In addition, the employer group actually funds the TPA with the money to pay the claims. These policies are NOT under the 'jurisdiction' of DOBI. Instead the administration of the plan & benefits need to follow ERISA guidelines. ERISA is the Employee Retirement Income Security Act. This is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. (www.dol.gov)

Ok – so now you have clarification on self funded vs. fully funded. But how does that affect your practice? Well, truth be told, whether the policy is self funded or fully funded affects so many areas of a provider's office. Just to name a few:

**Who's getting paid – the provider or the patient?	**Appeals	**Copay Maximums
**Complaints regarding a particular carrier	**EOB follow-up	**Interest due on claims not paid timely

For example, many providers are confused as to why some BC/BS checks continue to be sent to patients. Well, the assignment law that was passed a few years back was a DOBI decision. Remember that DOBI only has authority over fully funded policies, so if BC/BS is administering a self funded plan (such as those with NJX prefixes), the assignment law does NOT apply and the payments can still go to the patients. It is the same with the copay maximums. Again, that decision to put a cap on the maximum amount a copay can be is a DOBI decision; so therefore, self funded accounts do not have to abide by such limitations under ERISA guidelines. Also, appeals have different processes for self funded policies and fully funded policies. Also note that EOB follow-up and time frames are slightly different from a fully funded plan to a self funded plan.

There are so many reasons why making sure you obtain this information at the time of verification is imperative. If you have not already done so, add it to your insurance verification immediately. If you obtain this information at the beginning of the patient's treatment, you will be prepared for the checks to go to the patient and act accordingly BEFORE it becomes a problem. You can anticipate that the copay maximum will not apply. You can prepare your staff to watch for runout periods that go along with changes of TPAs, and you can be educated as to what appeal process you may have to follow if there is a medical necessity dispute, etc. My point is - knowing this information is another very important way to set yourself up for success.

Unfortunately, gone are the days that you could just love the patients and get paid for it unconditionally. We find ourselves in an industry now where it is imperative that you always stay one step ahead of the payer to ensure a proper payment for your services. I strongly encourage providers to continue to educate themselves. It is true when they say "knowledge is power and power is money!"

Frequently Asked Insurance Q&A

Q— What is the difference between a provider appeal and a member appeal for a medical necessity denial regarding fully funded policies?

A—Under the NJ DOBI external appeal guidelines, only *member appeals* are eligible for the external appeals process for medical necessity denials.

Q—I have recently noticed Aetna is denying 97140 when billed with a 98940-98943? What's up?

A— Aetna has recently begun enforcing a policy that they claim has been in effect for a long time. They are applying the following logic as per their policy posted on Navinet under Aetna's policy guidelines page:

Procedures 98940 - 98943 are used to report chiropractic manipulative treatment (CMT) performed on one to two spinal regions. This procedure is considered a form of manual treatment to influence joint and neurophysiological function done by a variety of chiropractic techniques. These procedures include the usual pre-manipulation and post manipulation patient assessments.

Procedure 97140 is used to report manual therapy techniques that may be applied to one or more regions for 15-minute intervals. These techniques include, but are not limited to, mobilization/manipulation, manual lymphatic drainage, and manual traction of a specified area. **An assumption of same anatomic site is made during the auditing process.**

The performance of manipulation includes manual traction and mobilization. **There are very few indications for the application of manual therapy techniques, as described in procedure 97140, in addition to manipulation.** An example of such an indication is the presence of lymphedema that cannot be treated by conventional means. This clinical situation is extremely rare. Clinical code auditing logic is based on the most likely clinical situation and therefore assumes that both therapy techniques were applied to the same anatomic location. Thus, the performance of procedure 97140 with CMT represents an overlap of services and a duplication of effort that does not warrant separate reimbursement. Modifiers 25 and 59 will not override this edit. Therefore, procedure 97140 is not recommended for separate reimbursement when submitted with procedure 98940-98943 .

CB&C'S NEW BOOK:
THE MEDICAL NECESSITY FIELD MANUAL

- Develop a **battle plan** that will help you win the war on Medical Necessity Denials
- Understand the **rules of engagement**
- Follow the **MAP** (Massive Action Plan) – to success!

CB&C issue quote:
Let's talk expertise; leader to leader……

Aetna & TRIAD–What the heck is happening ??? *(continued)*

Authorization Requirements: If non participating with Aetna and TRIAD or if you are still currently participating with Aetna only —you generally do not have to fulfill or complete any type of treatment plan / pre-cert requirements. However, they could (and probably will) ask the provider to support medical necessity and request clinical documentation for review. If you are participating with TRIAD, you will have to complete any authorization requirements for that patient's policy. As of 6/1/12, the paperwork the providers are required to complete has changed. There is now a 'Physical Medicine Authorization' form that needs to be completed. In addition, time frames for when this paperwork has to be completed has also changed. Under the new TRIAD guidelines, the provider may not have to submit the authorization paperwork until after the 10th visit (but before the 11th). This is referred to as the '10 visit waiver'. Just as we suggested that if you were participating with TRIAD you inquire upon verification whether they are responsible to receive and process claims, you should also inquire about authorization requirements. Due to the confusion, we suggest that if the policy is managed by TRIAD, you give them information about the patient (are they a new patient or a returning patient, etc), and ask them SPECIFICALLY when you should submit the authorization paperwork. Get a reference # from them and make sure the information in that reference # is specific to your questions. It is also important to note that there are Aetna insured employer groups who have opted out of TRIAD either managing the claims payment OR managing the authorization or BOTH. Aetna has made this information available by going to: http://www.aetna.com/healthcare-professionals/claims-administration/chiropatic-services.html. This will actually give you the claim submission guidelines by provider class, and if you scroll down the webpage to the Utilization Management section, you will notice additional links to different classifications of excluded employer groups.

Fee schedule: Although there is still a fee schedule per CPT code, TRIAD participating providers will now be reimbursed a ***Maximum Daily Allowed Amount*** per day. There are different daily maximums for PPO policies and HMO policies. In addition, the maximum daily amount changes if an exam was performed. In addition, there is a $3 administration fee that will also be deducted from the providers PPO payments. To view this information, please visit our website at www.CBCbilling.com or contact TRIAD healthcare directly.

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Read and learn the best kept secrets to assisting your Chiropractic office achieve its financial potential.

SIMPLIFING INSURANCE ISSUES

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CB&C, Inc. specializes in providing services for Chiropractic and Physical Therapy Offices.

Depending on your office needs, our services include office training, consulting, insurance verifications, billing & collections, appeals, managed care contracting and keeping offices current with the ever changing insurance industry.

Aside from working with our clients, we are also Chiropractic patients and therefore appreciate and value Chiropractic care. We understand that the less time the Chiropractor and the office staff spend dealing with insurance issues; the more time that is available to focus on what's important—YOUR PATIENTS!

Medicare's New Policy on Therapy Services (continued)

Note the following important points:

- For services up through $1880 (this means the "allowed amount". Not just what is paid. It includes the deductible amounts, coins & payments), submit them with CPT codes & applicable modifiers (eg. 97140 – 59)
- For services from $1881 up through $3700 (this means the "allowed amount". Not just what is paid. It includes the deductible amounts, coins & payments), submit CPT codes, applicable modifiers (eg. 97140 – 59) AND the KX modifier
- For services over $3700 (this means the "allowed amount". Not just what is paid. It includes the deductible amounts, coins & payments), you need pre-certification. Once Medicare receives the pre-cert request, they have 10 business days to get a response to the office by either phone, fax or letter (depends on what you list on the form for NY or the letter you send in for NJ, etc.). They will authorize up to 20 consecutive DOS per authorization…this doesn't mean that you will get 20, it just means that they will allow no more than 20 per request. Per the phone conference 9/27/12, the authorization is NOT a guarantee of payment.
- NJ providers must utilize the designated forms and include the information listed on the "Part B Therapy Cap Cover/Transmittal Sheet", and fax to 717-526-6560. NY providers also have a specific form that must be used, and faxed to 717-565-3783. Please visit your Medicare carrier's website for more information.
- To find out how much of the $3700 has been processed for your patient, you can call 877-235-8073 for NJ providers & for NY providers you can call 877-869-6504. According to Medicare, this information will be available after October 5, 2012. Please visit your Medicare carrier's website for more information.

Reductions on Multiple Procedures

If you have noticed recently that UHC and Aetna seem to be applying a 'multiple therapy reduction' formula to their claims payment, you are not alone.

Both UHC and Aetna seem to be adopting Medicare's policy on using a 'multiple therapy reduction' formula when a provider (chiropractor or physical therapist) bills more than 1 '97' code on any one date of service. Medicare's policy became effective January 1, 2011 whereas Aetna adopted their use of this policy effective November 14, 2011. This "multiple therapy reduction" isn't applied to just one product, it applies to all Aetna products. Unfortunately, UHC is also applying this methodology of payment.

You may find when reviewing your EOBs it's difficult to decipher exactly how the claims are paying as well as trying to decide if the payments are correct. The reduction formula is as follows: the modality with the highest RVU is allowed at 100% of the *allowable* rate. For subsequent units and procedures, performed on the same patient on the same day, the reduction is at 80% of the *allowable* rate—less the patients benefit.

For further information, you may visit: www.navinet.net or www.cms.gov.