



**Arkansas Medical Society
10th Annual Insurance
Conference 2013**



Agenda



- ARBenefits: **Silver Plan**
- Helpful Tips and Reminders
- Appeals
- Timely Filing Appeals
- Provider Newsletters
Action Alerts
- Medical Policies
- Out-of-Network Referrals
- In-Network Lab
Reminder
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Transfers
- Self Service Tools
- Top Ten Claim Denials
- Initiatives
- Provider Relations
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ARBenefits: Silver Plan
Arkansas State and Public School Employees



QualChoice administers the
Silver plan option available to:



Arkansas State Employees
Arkansas Public School Employees
(Active and Non-Medicare Retirees)

ARBenefits: Silver Plan Updates



Effective **October 1, 2013**

- **ARBenefits will require pre-certification for all inpatient hospital admissions.**
- Determinations for these admissions will be made for medical necessity, appropriate length of stay and level of care based on nationally accepted industry standards and following ARBenefits Medical Policies.
- Failure to obtain appropriate pre-certification will result in the facility writing off the charges for covered services.

ARBenefits: Silver Plan Updates



To obtain ARBenefits pre-certification call:

1.877.815.1017

Follow the prompts:

Option 2, Option 1, Option 2 and Option 1

*This will lead you to the
American Health Holding intake staff.*

Helpful Tips and Reminders



- **Hospital Admission Requirement Reminder**

All network facilities are required to notify QualChoice of all hospital admissions.

- **Claim Submission Reminders**

EDI claims submission is the best way to submit your claims electronically to QualChoice.

Electronic claims are tracked from the moment of submission through receipt by QualChoice.

- **QualChoice accepts paper claims for:**

Secondary claims: Submit claim and attach copy of primary EOB.

Corrected claims: Send corrected claims via paper only, do not send electronically. Please include claim # of initial claim.

PLEASE DO NOT FAX CLAIMS

Faxed Claim forms are not readable in claims system

Please send “Original Claim”

Helpful Tips and Reminders



Request for Reconsideration Form

1. QualChoice has one form for all reconsideration request types.
2. Without the form, review, reprocessing and payment of claim may be delayed.
3. Form at **qualchoice.com**
 - select 'Providers' tab
 - select 'Forms/Information'

Appeals



- ***Request for Reconsideration Form*** must be submitted with appeals!
- Please refer to your provider agreement for allowable timeframe to submit appeals.
- QualChoice has **30 days** to respond to an appeal following date received in Appeals Department, unless circumstances (such as obtaining medical records) require additional time for review.

Timely Filing Appeals



Timely Filing Requirement

For timely filing reconsideration requests, we must have a copy of your **clearinghouse acceptance report**, showing the claim was received and accepted by QualChoice.

**SCREEN SHOTS FROM YOUR BILLING SOFTWARE
WILL NOT BE ACCEPTED**

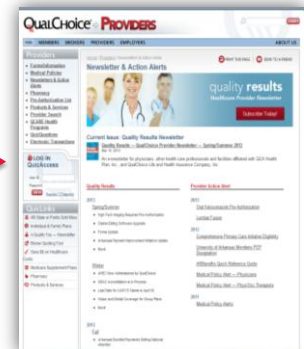
Provider Newsletters and Action Alerts



- **Provider Quarterly e-Newsletter: *Quality Results***
- **Provider Action e-Alerts**
- **Medical Policies**

Newsletter and Action Alerts offer:

- ✓ Medical Policies - new and amended
- ✓ New program announcements
- ✓ Network activities
- ✓ Healthcare Reform updates



Medical Policies: New and Amended




- **New and amended** medical policies electronically accessible in **Quality Results**
- Procedure descriptions, what's changed, and effective dates outlined in detail.

Quality Results QualChoice Provider Newsletter Summer 2012

Amended Medical Policies			
Procedure	Policy Description	What's Changed	Effective Date
B001 Refractive Services	Describes coverage for refraction: an examination conducted by an optometrist or ophthalmologist to determine the need for and proper prescription of corrective lenses/glasses.	Clarification of code 92015. Codes 92012 & 92016 added for ophthalmologic services.	03/01/2012
B005 Neuropsychological Testing	Describes coverage for neuropsychological testing and treatment for evaluation and treatment of brain injury.	Codes updated.	03/01/2012
B043 Cardiac Rehabilitation	Describes coverage for cardiac rehabilitation programs used to allow patients to regain strength and capacity after certain cardiac events.	Criteria added: AHA Class II or IV after cardiomyopathy requires preauthorization.	
B054 Diabetic Educational Sessions	Describes coverage for diabetic counseling sessions.	Dietary Counseling clarified.	04/1/2012
B062 Preventive Health Benefit	Describes coverage of preventive health for early detection and/or treatment of diseases.	Removed contraceptives from policy. For pregnancy, under preventive services: One (1) diabetic screening, and lactose counseling are covered. Any additional will be covered under medical benefit.	08/01/2012
B099 Interferon	Describes coverage for Interferons used for a variety of medical problems. Approved for benefits for some diagnoses.	Added code 50148, which requires preauthorization.	04/01/2012
B132 Bisphosphonates	Describes coverage for bisphosphonates, a class of medications used to increase the strength of bones.	Added codes for Reclast and Zometa, both require preauthorization.	04/01/2012
B143 Enbrel	Describes coverage for Enbrel (etanercept), an injectable medication that is covered when determined by QualChoice to be medically necessary, and when pre-authorized by the prescribing physician.	Removed fencicade as "preference".	04/04/2012
B153 Humira	Describes coverage for Humira	Removed fencicade as "preference".	04/04/2012
B157 Immune Globulin	Describes coverage for IVG (immune globulin), used to treat various immune deficiency states.	Added code J1459; requires preauthorization.	02/01/2012

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qualchoice.com ■ 'Providers' tab


www.qualchoice.com | [Medical Policies](#) | 501.228.7111 or 800.235.7111

Medical Policies



Search for a medical policy by entering a keyword, policy number or code.

The screenshot shows the 'Medical Policies' page on the QualChoice PROVIDERS website. At the top, there is a navigation bar with 'FOR: MEMBERS BROKERS PROVIDERS EMPLOYERS ABOUT US'. Below this is a search bar with a 'SEARCH' button. The main content area is titled 'Medical Policies' and includes a section for 'ARBenefits' with a link for Arkansas State or Public School employees. Below this is a section for 'High Tech Imaging (MRI, CT, PET) and Nuclear Medicine' administered by Care Core National. A search bar is located below the 'High Tech Imaging' section, with a red arrow pointing to it. The search bar contains the text 'INDEX: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z'. Below the search bar is a list of medical policies, including Abdominoplasty, Ablation of Hepatic Lesions, Abortion, Abraxane, Asthma, Acupuncture, Adicetin (brentaninab), Add-on Codes, Admission for Eating Disorders, Adult Attention Deficit/Hyperactivity Disorder (ADHD), Against Medical Advice, Always Clearance Devices, Allergy Immunotherapy, Allergy Testing, Alprostadil, Alpha 1-Antitrypsin Inhibitor Therapy, Alternative or Complementary Healing, and Ambulatory Blood Pressure monitoring.

Out of Network Provider Referrals



1. If sending patient to another provider for care, referral must be to in-network provider.
2. Out-of-network provider payments may transition to pay directly to insured member
3. Common example: referrals made to out of network reference labs. **These claims will be paid OON.**

In Network Lab Reminder




- Referring patients to **out-of-network** laboratory or pathology group violates provider's agreement with QualChoice, and causes patients to pay significantly more for these services.
- List of participating independent labs at **qualchoice.com**.
 - select 'Provider Search'
 - then 'Ancillaries' tab
 - then 'Independent Laboratory'

When services are not available through an **in-network** laboratory, participating providers must contact Care Management to submit

Out-of-Network Authorization Request Form

Lab Claims: Patient Cost Examples



Code	In Network Hospital Lab		In Network Lab		Out of Network Lab	
	Average Allowed	Average Patient Responsibility	Average Allowed	Average Patient Responsibility	Average Allowed*	Average Patient Responsibility*
80053	\$47.00	\$9.40	\$13.00	\$2.60	\$24.00	\$9.60
80061	\$56.00	\$11.20	\$16.00	\$3.20	\$58.00	\$23.20
 82306	\$130.00	\$26.00	\$37.00	\$7.40	\$102.00	\$40.80
84443	\$75.00	\$15.00	\$21.00	\$4.20	\$50.00	\$20.00
85025	\$35.00	\$7.00	\$10.00	\$2.00	\$36.00	\$14.40
87491	\$157.00	\$31.40	\$43.00	\$8.60	\$54.00	\$21.60
88175	\$81.00	\$16.20	\$23.00	\$4.60	\$39.00	\$15.60

*Patient may be responsible for entire allowed amount, instead of percentage of allowed, if out of network deductible has not been met.

OON Reference Laboratories



Reference Labs **not** in the QualChoice Network

- Berkeley HeartLab
- Bostwick laboratories
- Capital Toxicology
- Genoptix
- Genomic Health Inc.
- Genova Diagnostics
- Genzyme Genetics
- Myriad Genetic Laboratories
- Prometheus Labs
- US Labs

Electronic Funds Transfers (EFT)



EFT: Fast, confidential and secure claims payments deposited directly into one or more designated bank accounts.

EFT is required for participating providers and available to non-participating providers.

To enroll:

Call: Alegeus Technologies at 1.877.389.1160
Alegeus-<https://providernet.adminsource.com>

Self Service Tools



- Claims editing software upgraded to **McKesson Clear Claim Connection 10.0**.
 - Incorporates National Correct Coding Initiative (NCCI) edits to prevent improper payment when incorrect code combinations are billed.
 - Allows access to the editing rules, clinical rationale and code review.
- To access Clear Claim Connection:
 - Log in at **qualchoice.com**
 - After log-in select 'Clear Claim Connection' at right

Self Service Tools



Provider Forms and Information

Provider Forms are updated frequently.

Be sure to visit the Provider forms page often to ensure you are using the most current form.

PROVIDER FORMS & INFORMATION

If you need a form that is not available online, contact Customer Service at 877.238.7111 or 503.338.2288

Form	Effective Date	Form	Effective Date
AAA-B-C-Coverage Form	10/1/12		
Alternative & Day Services Provider/Subscriber Request Form	10/1/12		
Change of Provider/Subscriber Information Form	10/1/12		
Case Management Submittal Form	10/1/12		
Change of Primary Care Provider	10/1/12		
Member Enrollment/Transfer Information	10/1/12		
Member Self-Service Request	10/1/12		
Plan of Care Form	10/1/12		
Pre-Admission Request Form	10/1/12		
Request for Information/Referral	10/1/12		
CDL/CDL-Coverage Form	10/1/12		
Claim Form	10/1/12		
CDL/CDL-Coverage Form	10/1/12		
Provider Open Access/Referral	10/1/12		
Provider Referral/Referral Slip	10/1/12		

NEW! Control & Vision Benefits

NEW! QuikChoice

NEW! Comprehensive Care

Top Ten Claim Denials



Denial Explanation	Tips
These charges are not eligible for payment based on terms of your facility/provider contract. No member liability.	Review contract rate sheet. Generally applies to facility charges.
This procedure is incidental to the primary procedure billed.	Utilize Clear Claim Connection prior to claim submission.
This is a duplicate of a previously processed claim.	Corrected claims must be submitted on paper with Request for Reconsideration Form attached.
Pre-existing condition review in process. No determination has been made at this time.	Wait for letter from QC requesting medical records for specific date range.
Pre-existing condition - request for records. Member's plan has pre-existing limitations. Please submit medical records.	
Submit medical records.	ATTN: Care Management Fax to: (501) 228-0135 Mail to: P.O. Box 25610, Little Rock, AR 72221

Top Ten Claim Denials



Denial Explanation	Tips
This service(s) requires pre-authorization. No pre-authorization on file. Patient is not liable for charges.	Ordering physician responsible for pre-authorizations.
MH/SA (Mental Health/Substance Abuse) Denied no treatment plan, services not covered. Submit plan for reconsideration.	
Submit these charges to the Primary Carrier.	Once primary has processed, resubmit paper claim with Request for Reconsideration Form and primary EOB attached.
Member not effective at time of service.	Use online tools or contact QC customer service for patient eligibility.
Provider is not an eligible provider under the benefit plan.	Verify provider is an accepted provider type.

Arkansas Payment Improvement Initiative Update

- QualChoice first quarter reports for hip, knee, and perinatal episodes have been posted to [AHIN \(Advanced Health Information Network\)](#), where you may log in to download your historical report.
- Future episodes such as lumbar fusion, colonoscopy, and cholecystectomy are in development.

CPCI – Comprehensive Primary Care Initiative



QualChoice is participating in the Comprehensive Primary Care (CPC) Initiative, one of seven four-year multi-payer initiatives aimed at strengthening primary care practices' critical role in promoting health, improving care, and reducing overall health care costs.

QC Participating CPC Providers:

- Reports go out the first week of the month for the previous month. Monthly reports are sent via secure email to the practice contact name.
- Payment is made on a quarterly basis. Payment is made by the 15th of the month for the previous quarter. Payments are mailed with paper check.

AR Health Insurance Exchange



Arkansas Health Insurance Exchange

Enroll: October 1, 2013
Effective Date: January 1, 2014

QualChoice participating in 5 of 7 Exchange regions

URAC Accreditation



**QualChoice is in the
process of seeking
accreditation for**

**URAC Health Plan
and
Health Utilization
Management**

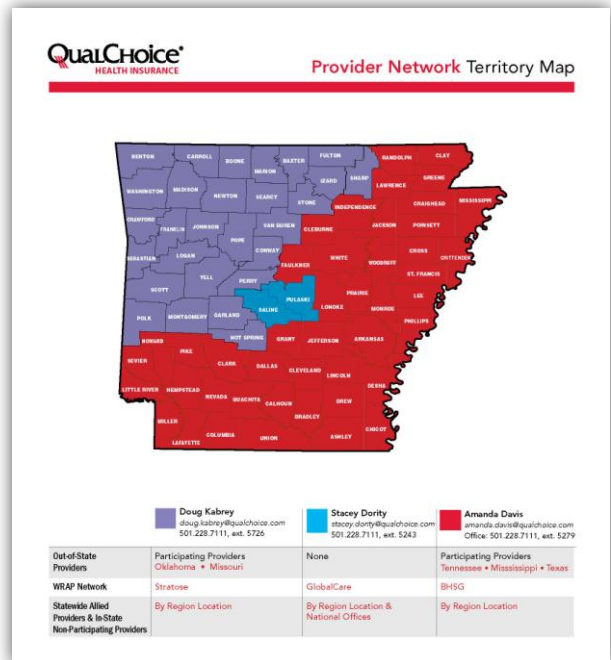
Senior Provider Relations Representatives



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Questions?

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HEALTH INSURANCE

