

ATLANTIS

PROVIDER *Newsletter*

Spring 2006



Sury Anand, MD, Gastroenterologist
CEO of Atlantis Health Plan

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Atlantis Health Plan Advocates for Patients

Atlantis Health Plan views our role as patient advocate as our central mission. **We are constant advocates for the patient and the “good” physician. In this context, I write to you as a fellow physician.**

Recently, we and our patients have been hearing some “noise” from a few of our network physicians regarding authorizations and denials. This is unacceptable.

I would like to extend an open invitation for you to call any member of our senior management team (see contact information at the end of this article) to discuss a denial or payment issue. In my opinion, this will be much more effective for all parties.

Now, a word about our approach to being an advocate for our patients: True to our mission, we at Atlantis are constantly working to make sure that appropriate care is being delivered. In this environment of almost unaffordable health insurance, Atlantis is about delivering a quality, affordable health insurance product to New Yorkers. To do so, we need to address tough issues like inappropriate care.

Physicians, we need to police what our colleagues are doing and what kind of medicine they are practicing. Patients are most vulnerable when they are sick, and we have a high calling to do what is right.

Let me give you some recent examples.

- A 50-year-old man with idiopathic primary thrombocythemia was prescribed interferon and anagrelide. Our consultants suggested that hydroxyurea was cost effective and therapeutically equivalent with fewer side effects. The

original provider was angry at us, but in the end the patient went on hydroxyurea and now has a normal platelet count without appreciable side effects and at a fraction of the cost.

- A 45-year-old woman was diagnosed with breast cancer. The initial oncologist suggested a multidrug chemotherapy regimen that was determined by our consultant to be highly toxic and inappropriate given the patient’s stage and condition. We recommended a second opinion at a cancer center and that we would abide by the second opinion. The second opinion agreed with our consultant, and the patient called to thank our team for steering her in the right direction.
- A 55-year-old woman was diagnosed with a benign thyroid nodule. The surgeon recommended a sub total thyroidectomy and a parathyroid transplant to the forearm. Three of our consultants believed that the appropriate treatment for her condition was a partial thyroidectomy. In this case, the patient went with the recommendation of her original surgeon. We believe that the facts of this case are evident for you to judge.
- A 55-year-old man was scheduled for a surveillance colonoscopy because of history of a colonic polyp. The issue was that the prior colonoscopy was a year ago and the polyp was non-neoplastic. Atlantis sent guidelines published by national societies and recommended that the next colonoscopy be delayed by two years. The patient and the endoscopist agreed and did not appeal the case.

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Atlantis Health Plan Updates Medical Policies

These policies are new or revised and reflect how Atlantis will process claims related to the policies. For claims to be considered for payment, the member must be eligible with Atlantis at the time the services were rendered.



New Policies

Allergy and Immunotherapy Treatment

Allergists providing both components of the service (allergy testing and immunotherapy) must bill with complete service codes. Instead of using a code in the series 95120–95134, you must use one of the injection codes (95115 or 95117) and one of the antigen preparation codes (95145–49, 95165, or 95170). Office visits are not separately payable on the same date of service as immunotherapy. A total of 49 immunotherapy sessions (administrations) is the maximum allowable per 12-month period.

Botulinum Toxin Injections for Cervical Dystonia

This treatment is payable only if all of the following criteria are met.

- Clonic-tonic involuntary contractions of multiple neck muscles
- Sustained head torsion or tilt
- Duration of condition for longer than six months
- Alternate causes of condition like chronic narcoleptic therapy, contractures, or neuromuscular disorder have been ruled out

Cardiac Tests and Procedures

An **echocardiogram** may be performed by a licensed **cardiologist** once per member, per a 12-month period, without preauthorization by the Plan. Atlantis Health Plan's payment policy for echocardiograms is as follows: CPT codes 93320, 93000, and 93307 are paid at 100% of the contracted rate, while 93325 and the office consultation on the same day are considered as included.

Myocardial perfusion imaging will be reimbursed according to the follow-

ing schedule: CPT 78465 at 100% of the contracted rate, CPT 78478 at 50% of the contracted rate, and CPT 78480 at 50% of the contracted rate (Note: CPT 78478 and 78480 are add on codes and are not separately reimbursable). CPT 78481 is considered unnecessary when performed on the same day because results would duplicate information obtained from the previous three codes. Radiopharmaceutical material will be reimbursed at cost upon receipt of the invoice. *An office visit is considered as included when procedures are done on the same day. Regular cardiovascular stress test is paid if done on a separate day, but considered as included if done on the same day as the nuclear stress test.*

Ear, Nose, and Throat Policies

- Special ear, nose, and throat (ENT) services **CPT 92502-92700** (with the exception of 92504, which is considered as included in the evaluation and management) are separately reimbursable in addition to an evaluation and management service. A maximum of three procedures for these codes will be paid according to the following schedule: highest level code reimbursed at 100% of the contracted rate; second level code reimbursed at 50% of the contracted rate; third level code reimbursed at 50% of contracted rate. A maximum of three codes are payable per date of service. *Additional codes will be denied as exceeding the daily service limit.*
- **The following codes require preauthorization** (vestibular function tests, with recording and medical diagnostic evaluation) **92541–92548** and (evaluative and therapeutic services) **92601–92700**.
- Diagnostic nasal endoscopy procedures (CPT codes 31231–31238) may be performed without preauthorization once per six-month period. Additional nasal endoscopies in the six-month period require preauthorization. The nasal

endoscopy codes 31239–31294 always require preauthorization.

- When any of these diagnostic nasal endoscopy codes are billed with an evaluation and management service, Atlantis Health Plan will pay for the higher paying of the two, while the less expensive code will be considered as inclusive.
- When a nasal endoscopy is billed with a related ENT surgery, a maximum of three codes will be payable according to this schedule: first procedure will be paid at 100%, second at 50%, and third at 25%.

Experimental or Investigational

The list of procedures considered by Atlantis Health Plan as experimental or investigational is available on request. Please call the Utilization Management Department at 800-270-8072 to obtain this list.

Hemorrhoid Therapy

Band ligation/laser hemorrhoidectomy/infrared ablation/coagulation is considered medically necessary once per year. Repeat procedures are not payable for one year after the first procedure. A maximum lifetime limit of three procedures exists. These procedures require preauthorization.

Modifiers -54, -55, -56

This modifier is used when the preoperative evaluation component of a surgery is performed by a physician other than the surgeon. The provider will be paid at 10% of the contracted surgical fee. The breakdown for payment is as follows: 10% of the contracted rate (modifier -56) paid for the preoperative evaluation component of a surgery if performed by a physician other than the surgeon, 70% of the contracted rate (modifier -54) for the surgical care component, and 20% of the contracted rate (modifier -55) for the postoperative management if performed by a physician other than the surgeon.

Non-Precertified Procedures Billed With Precertified Procedures

When preauthorized services are billed along with services that have not

(Continued on next page)

Update (Continued from page 2)

been preauthorized, the unauthorized services will be denied. If requesting reconsideration, please provide medical documentation justifying the need for the additional procedure(s) and the reason for not obtaining the appropriate precertification.

Ophthalmology Services

- Evaluation and management services will be reimbursed using the specific ophthalmology codes 92002/92004 and 92012/92014. Regular office consultation codes 99241–99245, when used, will be reimbursed at the level of the corresponding ophthalmology code.
- Office ophthalmology procedures and tests 92015–92140 and 92235–92287 are separately payable as 100% of contracted rate for the primary code, 50% of contracted rate for the second, and 50% of

contracted rate for the third. A maximum of three codes are payable per date of service. Additional codes will be denied as exceeding the daily service limit.

- Codes 92225–92230 are not separately payable and are included in the ophthalmology examination codes.

Preventive Medicine Codes

If prolonged service codes 99354–99355 and counseling codes 99401–99412 are billed with preventive service codes 99381–99397, the prolonged service and counseling codes will be bundled into the preventive medicine code.

Policy Revisions

Assistant Surgeon

The assistant surgeon's allowance (if performed by a physician) will be 16% of

the surgeon's fee. The rest of the criteria that qualifies an assistant surgeon for payment will remain unchanged. **The services of an assistant surgeon require preauthorization.**

Botulinum Toxin in the Treatment of Acute or Chronic Headaches

The available evidence does not permit the conclusion that any type of Botulinum toxin therapy is beneficial for acute or chronic headaches either for prophylaxis or to abort an attack. **These treatments are considered experimental and will be denied with appeal rights.**

Dermatology

These codes no longer require preauthorization when performed once per 90-day period: CPT 17000, 17003, 19001, 11100, and 11101. **Preauthorization will be required if these procedures are repeated within 90 days.** CPT 17004 will continue to require preauthorization.

Single or Same Surgery Through Multiple Incisions

Multiple codes that cover the same surgery through multiple incisions or surgery in the same anatomical area through multiple incisions will be paid only at the highest level code. All other codes will be considered as inclusive.

Claims Reconsideration Process

Atlantis Health Plan has adopted a claims reconsideration process for all contracted providers, facilities, and ancillary providers to ensure better response to claims issues and questions. The process also will enable Atlantis to more accurately track common issues and questions that arise so that consideration can be made regarding the revision of claim payment policy and procedures to align with fair industry standards.

Following are some examples of claim issues or inquiries that may be sent for reconsideration. You will need to complete the Atlantis Claim Reconsideration Form and send supporting information (**bolded**) before your claim can be reviewed.

- **Late filing:** Claims must be submitted by par providers within 60 days of the date of service, although bills often are accepted as many as 90 days from the date of service performed. **Submit proof of timely filing.**
- **Fee schedule issues:** When requesting review of a claim where codes were bundled or unbundled, keep in mind that Atlantis applies Centers for Medicare and Medicaid Services coding guidelines

in addition to the Plan's own internal guidelines (approved by the Atlantis Board of Directors). **Submit correct coding initiative edit and payment references or office and operative notes to justify your claim. Please note: Per American Medical Association guidelines, documentation must be submitted for review when using modifier 25. Use of the modifier alone does not support separate payment.**

- **Lack of medical necessity determinations:** In cases where no authorization was obtained or clinical information is pending and has not been received. *Upon receipt of the reconsideration, these claims will be forwarded to the Appeals Department for a utilization management determination. Submit clinical information to justify medical necessity.*
- **Fee schedule and payment issues:** Please express your concerns in writing and make sure you have submitted your most current payment information to Atlantis. **Submit current W-9 if you are changing or adding a practice location or have obtained a new tax ID number.**

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Have You Moved? Help Us Deliver Your Mail Faster

It is important that we have your current information on file. Please make sure we have your correct mailing address (city, state, and zip code), office telephone number, office fax number, and e-mail address. You may update this information three ways: on our website www.atlantishp.com; via fax to 212-747-8373, Attention: Provider Relations Department; or by mailing the information to 39 Broadway, Ste. 1240, New York, NY 10006, Attention: Provider Relations Department.

Advocate (Continued from page 1)

The practice of medicine is fractured and fragmented, and patients are sitting ducks for unscrupulous physicians. "I want it because my doctor ordered it" sounds liberating, but the most charming rogue is sometimes the most unscrupulous.

At Atlantis, we try to use our position to work aggressively as patient advocates. In most cases, we offer a silent second opinion—but we become vocal when we believe that a treatment or procedure is an outlier and not in the best interest of a patient's health. These challenges are not mounted easily, and a lot of time,

research, and effort are spent to arrive at the appropriate medical decision.

At Atlantis, we believe our physician panel is of the highest quality, but we also believe in the dictum "trust but verify."

In the end, it is the patient who matters the most because one day we will all be patients.

With best regards,

Sury Anand, MD
CEO of Atlantis Health Plan

Senior Management Direct Phone Numbers

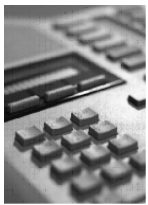
Sury Anand, MD, CEO: 212-747-8230

Tom Dwyer, COO: 212-747-8396

Delia Baquiran, RN, SVP of Health Services: 212-747-8283

Irene Ruiz, RN, Director of Health Services: 212-747-8390

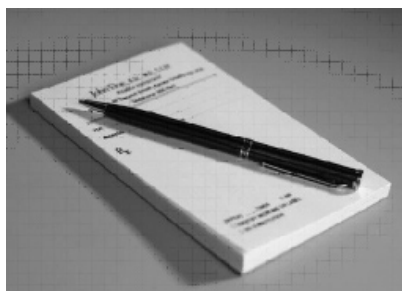
After Hours Availability



Take advantage of an added feature to our call center. You and your staff can leave a voice mail on the Member/Provider Services Line when our offices are closed (before 9 am and after 5 pm on weekdays and all day on weekends and holidays). When you call 866-747-8422 or 212-747-0877, press 3 and leave your name, number, and reason for call. You will get a call back from one of our customer representatives on the next business day.

New York State Has a New Law on Prescriptions

A new public health law requires that all prescriptions written in New York State be issued on an official New York State prescription form. The new law was enacted to combat prescription fraud and went into full



effect on April 19, 2006. It is very important to note that **after April 19, 2006, pharmacies will not be permitted to fill prescriptions written on non-official prescription pads.**

All practitioners must first register with the Department's Official Prescription Program to receive official prescriptions

free of charge. Registered practitioners are urged to now order an ample supply of official prescriptions (the number you would normally use for all prescribing in a three-month period). As the new program gets un-

der way, the Department anticipates an increased influx of such requests from practitioners for the new forms.

If you have not yet registered to receive your official prescriptions, please obtain a registration packet as soon as possible by calling the State's Official Prescription Program toll free at 866-772-4683.

Claims

(Continued from page 3)

All requests for reconsideration should be submitted to Atlantis within 60 days from the date of the original explanation of benefit. Reconsiderations submitted after this time frame will not be considered without a valid explanation. Atlantis will respond within 45 days from receipt of the reconsideration request.

Any claim with a date of service more than a year old will not be eligible for reconsideration.

Claim Reconsideration Forms can be obtained via mail, fax, or e-mail or by calling Atlantis Member Services toll free at 866-747-8422. Forms also can be downloaded from www.atlantishp.com in the provider section.

Mail your completed Claim Reconsideration Forms and supporting documentation to

Claims Reconsideration Unit

Atlantis Health Plan
39 Broadway, Ste. 1240
New York, NY 10006

For new claims:

Atlantis Health Plan
PO Box 4656
Houston, TX 77210-4656

Atlantis Health Plan Score Card on HEDIS Measures

The success of Atlantis Health Plan (AHP) as a managed care organization depends on the quality of care and services that we provide and the public's perception of that quality.

At AHP, quality management is an important mission. This is accomplished through a planned and systematic evaluation and continuous monitoring of all aspects of care and services that are provided to members. When the levels of care or goals established are not met, the Quality Improvement Committee—composed of clinical and nonclinical representatives from Health Services, Member Services, Credentialing and Provider Network, Claims, Grievance and CSB complaints, and Regulatory Compliance—takes action to improve the performance on the measure or performance criteria that is being monitored.

In the past three years, AHP has launched quality initiatives through our Quality Improvement program that address different aspects of services relevant to the members that it serves. Most of these studies are patterned after the Health Plan Employer and Data Information Set (HEDIS), which measures performance and quality of care rendered by different health plans to New York State residents. The New York State Department of Health (DOH) monitors this public reporting system, called Quality Assurance Reporting Requirements, which is based on the HEDIS and National Committee on Quality Assurance measures. Not all plans are required to report to the DOH.

In this issue and subsequent issues, we will share our score card on the measures. We want to thank you for your assistance in the data collection process.

Part 1: Childhood Health

Immunizations are one of the safest and most effective means of protecting children from many communicable diseases, and they are one of the most cost-effective preventive healthcare strategy. Although

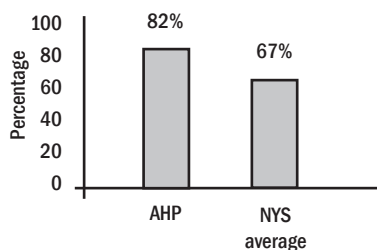
the immunization rate of children in the United States remains high, these high levels must be maintained to avoid the incidence of diseases that are preventable by vaccine.

At AHP, all medically necessary immunizations and boosters are covered in full during well-child visits to an in-network provider. Please waive the copayment for visits per the following schedule, as recommended by the American Academy of Pediatrics.

- Newborn: ages 2–4 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months
- Ages 2–19: one visit per year

Childhood Immunization Status

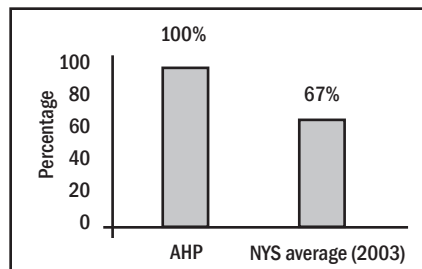
Performance measure: The percentage of children who turned two years old during the reporting year who were fully immunized. The HEDIS specifications for fully immunized consisted of the following vaccinations: 4 diphtheria/tetanus/pertussis, 3 polio, 1 measles/mumps/rubella, 3 H. influenza type B, 3 hepatitis B, and 1 varicella.



Lead Testing

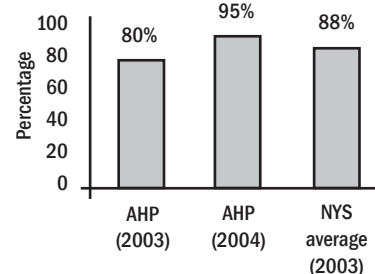
Children are exposed to lead from lead-based paint and lead-contaminated dust and soil. According to a recent report from the Attorney General's office, about 10,000 children suffer from lead poisoning in New York State alone.

Performance measure: The percentage of two-year-olds who were tested for lead poisoning at least once



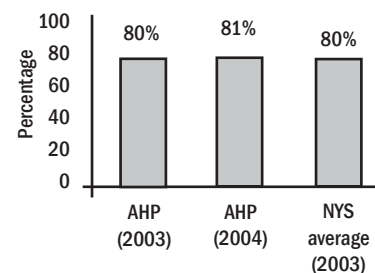
Well-Child and Preventive Care Visits in the First Five months of Life (Five or More Visits)

Performance measure: The percentage of children who had five or more well-child and preventive health visits in their first 15 months of life



Well-Child and Preventive Care Visits at Ages 3, 4, 5, or 6

Performance measure: The percentage of children three to six years old who had a well-child visit and preventive health visit in the past year



In the next issue, data on Women's Health such as screening for breast cancer, cervical cancer, and prenatal and postpartum care follow-up will be shared.

Important Phone Numbers

<u>Administrative/ General Phone Number</u>	<u>212-747-0877</u>
<u>Administrative/ General Phone Number (toll free)</u>	<u>888-258-1498</u>
<u>Administrative Fax Machine</u>	<u>212-747-0843</u>
<u>Behavioral Health Preauthorization</u>	<u>866-477-9740</u>
<u>Member Services</u>	<u>866-747-8422</u>
<u>Provider Services</u>	<u>866-747-8422</u>
<u>24/7 MD Hotline</u>	<u>347-537-8789</u>
<u>Prescription Drug Plan</u>	<u>888-645-9303</u>
<u>Utilization Management Preauthorization</u>	<u>800-270-9072</u>
<u>Vision Care Services</u>	<u>866-747-8422</u>



Website www.atlantishp.com

* Please note: Although we try to be timely and accurate in the information presented in this newsletter, some information may have changed. Please contact Atlantis Member Services for the most up-to-date information.

Sensible health care at a sensible price



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