Thank you for participating in our network.

ATLANTIS PROVIDER Newsletter

Winter 05

Sury Anand, MD, Gastroenterologist
CEO of Atlantis Health Plan

The "whooshing sound" from your pockets to the pockets of tricksters and charlatans.

Atlantis Health Plan is accountable for the quality and cost of medical care delivered to its members. The amount of health care dollars sucked out of the premium dollar that is not based on sound clinical and outcome-based criteria is staggering. This is the "whooshing" sound I hear daily, and it goes directly from your pockets into the pockets of the tricksters and charlatans. What would you say if I told you that we received a bill for $28,000 for surgery that lasted 13 minutes! Our close review showed that minor surgery had been performed, and the operating room report and the bill were generated for a complex procedure. This provider claimed it was all an honest mistake. This is an egregious case, but gaming of the system occurs in overt and subtle ways daily. There are also many areas where there are people feeding off the system at its edges and providing services that are marginal in their efficacy at best.

We believe that doctors practicing sound medicine should receive a bigger piece of the pie. Since the pie is fixed, the only way to accomplish this is to ferret out the outliers. It has been our experience that the vast majority of doctors are honest and upstanding. There are some bad apples that cost the health care system enormously.

The mission at Atlantis is to neither over-treat nor under-treat the member. We accomplish this by close monitoring and thorough utilization review by our doctors and our consultants. We are seeing that this heightened level of scrutiny is resulting in lower medical expenses. We intend to turn this into higher levels of reimbursement for the doctors who follow the rules. We already are paying one of the highest rates in the New York area for our participating providers.

I request that you work with us and put up with some tough review questions. I am sure that in the end the "good" doctors will be the beneficiaries.

AHP Adapts "Common Agenda for Health"

This year, the American Cancer Society, American Heart Association, and American Diabetes Association came together to provide unified screening recommendations for cancer, diabetes, heart disease, and stroke. According to the American Diabetes Association's President, Eugene Barrett, MD, PhD, "Health care costs are climbing steadily, but the national investment in prevention was recently estimated at less than 5% of the total annual health care expenditures."

An Ounce of Prevention . . .

Atlantis believes that an ounce of prevention is better than a pound of cure. We support these screening guidelines and have adapted them into our Wellness and Prevention Program. The guidelines are:

Men and Women:

Blood pressure measurement starting at age 20, at each regular health care visit, and at least every two years.

Body mass index measurement starting at age 20, at each regular visit.

Blood lipids test, starting at age 20 and at least every five years.

Blood glucose test, starting at age 45, every three years.

Bone density test for men/women who are at significant risk for osteoporosis or being treated for it.

Colorectal screening starting at age 50, every five to ten years.

Women:

Clinical breast exam starting at age 20, every three years; yearly after age 40.

Mammography starting at age 40, yearly. (AHP recommends a baseline at age 35-39.)

Pap test at age 20, yearly, and after the age of 30 every one to three years depending on the test used and past results. (AHP recommends starting at age 18.)

Men:

Prostate-Specific Antigen test and digital rectal examination starting at age 50 or at any age for men having a prior history of cancer. AHP recommends starting at age 40 for African-American men because of the higher incidence for this group. Members are advised to ask their doctor about the pros and cons of testing.

To learn more about AHP's Wellness and Prevention Program, call 1-866-323-3400.

What ARE Pre-Existing Conditions?

Denials based on pre-existing conditions are independent of medical necessity determinations.

The issue of pre-existing condition vs. a medical necessity determination poses a big question among providers and members. One is independent of the other. In other words, it is possible that a service/procedure that you request for a member has been deemed medically necessary but has been administratively denied because of a contract exclusion called "pre-existing condition."

A pre-existing condition *is any injury or illness, with the exception of a congenital anomaly, for which a member has received any medical care, diagnosis, consultation, advice, and/or taken any prescribed medications within a six-month period preceding the enrollment date of the member to the plan.*

Lapse of previous coverage: If the member's previous insurance lapsed 63 days or less before AHP enrollment began, we consider this as *continuous coverage*. If the prior coverage lapsed *more than 63 days before AHP coverage began, we consider this as no previous coverage. Hence, the pre-existing exclusion would apply.*

Exceptions: The pre-existing condition exclusion does not apply to a group that has more than 50 policyholders.

When you request a service that needs an authorization or have performed one which has not been paid because of a possible pre-existing condition, you will be asked to fill out an attestation to the true nature of the patient's condition. A medical director can also request for medical records during the look back period of six months to confirm the patient's condition.

Quick Reference *AUTHORIZATION* Guide

This is an abbreviated list and is intended to serve only as a quick reference tool for providers and staff. This list is regularly updated by the Plan.

Please remember that services for HMO and HNY members by non-participating providers require prior authorization.

Services	*** Prior Authorization	No Authorization
Ambulance	**X** Non-emergency transfers	
Ambulette	**X** Non-emergency transfers	
Ambulatory/Outpatient Surgery and Procedures including dialysis, radiation treatment	**X**	
Anesthesia for Office-Based Procedures including endoscopies	**X**	
Assistant Surgeon	**X**	
Cardiac/Pulmonary Rehabilitation	**X**	
Chiropractic Care	**X** By provider of service after 8 visits	
Diagnostic/Imaging – CT, MRI, MRA, Nuclear Medicine, PET scans, OB Ultrasounds (in excess of 2) during a pregnancy	**X**	
Diagnostic Procedures – EEG, EMG, urodynamic flow studies, nerve conduction studies	**X**	
DME (Selected) – See Provider Manual for list	**X** **By vendor if > $500**	**X** **If < $500**
Laboratory – Participating Free-Standing Lab (**CBC and Rapid Strep test** may be done by PCP in office)		**X**
Home Infusion Therapy	**X**	
Home Health Services (RN, PT/OT, HHA)	**X**	
Hospice	**X**	
Inpatient Care (Hospital, Rehabilitation, Subacute, SNF)	**X**	
Medications – including Chemotherapy/Biotherapy, Injectables	**See separate list**	
Mental Health and Substance Abuse	**Call Value Options @ 1-866-477-9740**	
Optometry – Routine Annual Exam		**X** **Call Block Vision @ 1-800-428-8789**
Pain Management (outpatient)	**X**	
Physical/Occupational/ Speech Therapy	**X** (If a covered benefit) By provider of service after initial evaluation	
Sleep Studies	**X**	
Specialist Providers – Non-Participating (Physicians, Facilities, Ancillary Services)	**X** **(For HMO and HNY members)**	

Health Services @ 1-800-270-9072 will take care of all pre-authorization requests and will complete a review within 24 hours of receipt of necessary clinical information.

If you wish to discuss the case with a clinical person, please ask to speak to one of our nurse reviewers. A peer to peer discussion with one of the Medical Directors is also available.

***Clinical information including doctor's notes and relevant lab/diagnostic reports must accompany request for services to expedite medical necessity determination. Clinical information can be faxed 24/7 to 212-747-8375.

Providers cannot bill for any of the above services if payment is denied because procedure was not pre-authorized.

Providers must call the Health Services department seven days in advance of any elective procedure or admission before rendering services needing pre-authorization. Our intake coordinators are available from 9-5 pm, Monday - Friday. Calls left on a secured line will be answered on the next business day.

Drugs Needing Pre-Authorization

Pharmaceutical expenditures and prices are today's greatest threats to the affordability of health care. In the United States, annual pharmaceutical spending increased by 18.8% in 1999, 14.7% in 2000, and 16.9% in 2001 — more than ten times the overall rate of inflation[1]. People want to be healthy and have access to a menu of medications that will treat their medical condition with increasing effectiveness, convenience, and fewer side effects. AHP believes in working closely with doctors and pharmacists to help members get the best quality pharmaceutical products for their health care needs. Certain categories of drugs undergo medical necessity review before they can be dispensed. These reviews are done for quality control and safety to ensure that members who are taking these medications receive adequate supervision. To facilitate the process, a list of medications requiring prior authorization has been made accessible to AHP providers via the AHP website as well as the Provider Handbook. This list is regularly updated by the Plan.

List of medications requiring authorization:

- Accutane®
- Accolate®
- Allegra®
- Allegra-D®
- Amnesteem™
- Avonex®
- Bextra®
- Botox®
- Celebrex®
- Cerezyme®
- Claravis®
- Copaxone®
- Depo-Provera®
- Enbrel®
- Epogen®
- Figrastim®
- Fragmin®
- G-CSF (Neupogen)
- Genotropin®
- Humatrope®
- Imitrex
- Infertility Drugs (member needs a rider)
- Intron A, Referon-A
- Ketorolac
- Lamisil®
- Levitra®
- Lovenox®
- Nasarel™
- Neulasta™
- Nexium® (members must try 4 weeks of Prilosec OTC first)
- Norditropin®
- Nutropin®
- Pegfilgrastim®
- Prevacid (members must try 4 weeks of Prilosec OTC first)
- Procrit®
- Provera®
- Prozac®
- Raptiva™
- Rebetol®
- Rebetron™
- Remicade®
- RespiGam™
- Rowasa®
- Saizen®
- Sandostatin®
- Serostim®
- Singulair®
- Sotret®
- Sporonax
- Synagis™
- Toradol®
- Tretinoin (> age 25)
- Wellbutrin®
- Viagra®
- Xyrem®
- Zoladex®
- Zyflo®
- Zyrtec®
- Zyvox™

Any prescription costing more than $200 is routinely reviewed by the Plan when the member brings it to the pharmacy; however, only medication on this list must be pre-authorized by the Plan.

[1] Bureau of Labor Statistics

CPT Codes Not Requiring Pre-Authorization

Not all procedures require utilization review. Here is a list of CPT codes that are performed during an office visit. **Please note that AHP will reimburse you for the office procedure if it is done on the same day as the office visit, whichever carries a higher rate of reimbursement.** These codes are:

CPT_From	CPT_To	CPT_From	CPT_To	CPT_From	CPT_To	CPT_From	CPT_To	CPT_From	CPT_To	CPT_From	CPT_To	CPT_From	CPT_To
10040	11044	25622	25624	27220	27222	27760	27762	28570	28570	69200	69200	73590	73610
12001	13160	25630	25635	27230	27232	27780	27781	28600	28605	69210	69210	73620	73660
16000	16036	25650	25650	27238	27240	27786	27788	28630	28635	70100	70130	74000	74020
17250	17250	25660	25660	27246	27246	27808	27810	28660	28665	70140	70160	74022	74022
20000	20005	25675	25675	27250	27252	27816	27818	29049	29280	70200	70330	74210	74220
24500	24505	25680	25680	27256	27257	27824	27825	29305	29515	71010	71030	80048	89399
24530	24535	25690	25690	27265	27265	27830	27830	30200	30200	71100	71130	90471	90474
24560	24565	26600	26607	27500	27503	27840	27840	30300	30300	72010	72120	90645	90748
24576	24577	26641	26645	27508	27508	28190	28190	30801	30906	72170	72190	90700	90701
24600	24605	26670	26675	27510	27510	28400	28405	31231	31231	72200	72220	90707	90707
24620	24620	26700	26705	27516	27517	28430	28435	31500	31513	73000	73030	90710	90710
24640	24655	26720	26725	27520	27520	28450	28455	31575	31579	73060	73080	90716	90716
25500	25505	26740	26742	27530	27532	28470	28475	31603	31603	73090	73110	90718	90718
25520	25520	26750	26755	27538	27538	28490	28495	45300	45340	73120	73140	90721	90723
25530	25535	26770	26775	27550	27552	28510	28515	57452	57460	73500	73520	90744	90744
25560	25565	27193	27193	27560	27562	28530	28530	60100	60100	73540	73540	90748	90748
25600	25605	27200	27200	27750	27752	28540	28545	69000	69000	73550	73565	98940	98943

Clinical Policies and Payment Updates

To keep you abreast of Atlantis Health Plan's clinical guidelines and reimbursement policies, we have highlighted the most frequently requested procedures. Our payment policies are closely aligned to nationally established standards. Please take time to review these with your staff so that claims submission and/or pre-authorization issues are clear and accurate. Please be aware that payments are subject to contractual obligations and eligibility of the members. Members must be active during the dates of service(s) for claims to be processed.

- **Anesthesia in office settings** – Anesthesiologists will be reimbursed for monitored anesthesia care (MAC) in the office setting when medically appropriate. Atlantis has adopted the latest Medicare guidelines for reimbursement of monitored anesthesia care. A separate approval should be obtained for MAC and the appropriate supporting documentation for medical necessity should be submitted. **Non-par anesthesiologists will be paid at AHP's participating provider fee schedule.** Atlantis will deny MAC for ASA Classification 1 and 11. The denial will be based upon medical necessity. **Conscious sedation** is considered the anesthesia of choice in this setting. Pre-certification is needed for exceptions.
- **Arthroscopic lavage** – Service is not approved/payable as it is considered medically not necessary. *Appeal rights will be given with the denial.*
- **Body photography** – Services will be approved/payable once a year. Any additional photography will be subject to UM review.
- **Cardiac rehabilitation** – Criteria for approval/payment for these services have been established as follows: **A.** Rehab must begin within 24 weeks of any of the following conditions: acute myocardial infarction, coronary artery bypass, heart valve replacement, heart transplantation, or Class 111 or Class 1V congestive heart failure unresponsive to medication. **B.** Rehab must be monitored by continuous EKG. **C.** Rehab is limited to 24 sessions per diagnosis.
- **Complex repair of wounds** – Certain wounds require complex repair. For any claim that is billed for a complex repair, documentation will be requested before payment can be issued. Documentation will include a pathology report, description of the wound with length, depth, and a photograph of the wound or residual scar. If the documentation requested is not received in a timely manner, the payment will be made at the intermediate level for a wound of less than 2.5 cm.
- **Copies of X-rays, CT Scans, MRIs,** and other imaging films – This is not approved/payable by the plan. Payment will be the responsibility of the member.
- **Cord blood and cord stem cell infusions** – Approval/payment is limited to cases of leukemia in a sibling with a 6/6 HLA match.
- **Debridement of wounds** – Wound debridement is considered an integral part of any wound closure unless it is performed separately.
- **Drugs obtained from facilities, physicians, or self paid** – Payment will be made at Average Wholesale Price (AWP) minus 15%. This is the same as the price paid to the Plan's Pharmacy Benefit Management, Eckerd drugs.
- **External cardiac defibrillator** – Criteria for approval/payment for this service have been established as follows:
  - A. Documented cardiac arrest due to ventricular fibrillation.
  - B. Life-threatening tachyarrhythmias.
  - C. Post myocardial infarction ventricular arrhythmias.
  - D. Familial cardiac conditions causing ventricular tachyarrhythmias, e.g., prolonged QT syndrome, hypertrophic cardiomyopathy.
  - E. Failure of medication in controlling life-threatening arrhythmias.
  - F. Implantation of an internal defibrillator is not possible due to technical or medical issues.
- **Intralesional injections** (CPT 11900-1057) will be considered for the following diagnosis: epidermal cyst (706.2), fibroma (709.2), hyperkeratosis (701.1, 701.9), keloid (701.4, 709.2), lipoma (214.0, 214.1, 214.9), papilloma (701.8), and seborrheic keratosis (702.19).
- **Pachymetry** – Services will be approved/payable once a year. Any additional services will be subject to UM review.
- **Preadmission testing (PAT)** – AHP requires that all necessary PAT for ambulatory surgery and/or inpatient admissions be performed in the provider's office instead of the hospital. Members should be referred to participating labs for all laboratory tests ordered.
- **PET scans** – The following guidelines have been established for approval/payment:
  - A. As part of a workup to determine the extent of metastatic disease from a known cancerous primary site, if not established by other modalities like CT Scan or MRI Scan. The information to be obtained has to be critical for a clinical management decision.
  - B. As part of a workup to differentiate between a benign or malignant lesion over 2 cm in size. PET scan is not to be used as a primary modality in place of a biopsy. The information to be obtained has to be critical for a clinical management decision.
  - C. PET scans are not payable if used as a primary tool to diagnose cancers, e.g., pancreas, ovarian, prostate, sarcoma, thyroid.
- **Screening Immunoassay for tumor markers** – Screening Ca 125 and periodic annual monitoring is approved/payable if the patient has a BRCA1 or BRCA2 mutation or if the patient has a first degree relative with ovarian cancer. First degree relative is defined as a parent, sibling, or child.
- **Speech therapy** – Services are not approved/payable for stuttering, stammering (ICD 307.-307.9), developmental speech delay (ICD 315.-315.9), and mental retardation (ICD 317-319). Evaluation and Management (E&M) services will be payable once per month during speech therapy for a specified condition.
- **Tumor localization** is considered not medically necessary if it is performed within 50 days of a PET scan in patients with colorectal cancer, lymphoma, or melanoma.

The following services are considered part of the E&M, surgery, or procedure and are not approved/payable separately:

- A. Corneal topography
- B. Removal of cerumen from the ear
- C. Memory cards for cardiac holter monitors
- D. Spinal allografts

The following services are considered investigational and are not approved/payable by the Plan. The Plan will provide the member/provider appeal rights with the denial:

- A. ACL healing response
- B. Endocinch, Stretta, and photo therapy for GERD and Barrett's metaplasia
- C. Endoscopic laparoscopy
- D. Endovascular repair
- E. Enteryx injections for GERD
- F. Radioimmunoscintigraphy
- G. Radio pharmaceutical tumor localization for breast cancer, lung cancer, and ovarian cancer
- H. Surface EMG
- I. Trivex transilluminated powered phlebotomy
- J. Vestibular rehabilitation therapy

Please Update Your PRACTICE Information

Accurate practice information is key so members can access you when they are looking for a PCP or a Specialist. It is also important to keep us posted so we can direct mailings and reimbursement checks to the correct address. Please notify the Plan in a timely manner when any of these conditions happen: relocation of an office site, closing of any or all office sites, retirement, change in hospital affiliation, or change of practice.

On office letterhead, please include the following:

1. A description of the change, including a signed W-9 form if there is a Tax ID change
2. The effective date of any change
3. Your federal Tax ID number and provider ID number
4. Your old and new practice address, including any changes in telephone numbers, fax numbers, and billing address and number

All changes should be mailed to:

Provider Relations Department
Atlantis Health Plan
39 Broadway, Suite 1240
New York, NY 10006

Doctors make the difference

ATLANTIS HEALTH PLAN℠
39 BROADWAY, SUITE 1240, NEW YORK, NY 10006