

MedCost Awarded URAC Re-accreditation in Provider Credentialing and Utilization Management

MedCost recently received full re-accreditation status by URAC for its provider credentialing procedures and utilization management programs. URAC is a national, non-profit organization founded in 1990 to establish standards for the managed care industry and is a leader in promoting continuous improvement in the quality and efficiency of health care delivery through its accreditation and certification programs. The MedCost Utilization Management Program has been accredited by URAC since 1994 and our Provider Credentialing Program since 2000.



The re-accreditation process included a formal onsite review during which URAC representatives reviewed files; information technology; credentialing and utilization management policies and procedures; and interviewed key staff members. Following the onsite review, URAC awarded full three-year re-accreditation to the Provider Credentialing and Utilization Management programs.

Continued re-accreditation by URAC is an outstanding example of MedCost's continued commitment to provide excellent services to our customers and clients.

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How Claims Adjustment Policies Can Impact Allowables

The following claims adjustment policies are part of our claims re-pricing process and may impact the amount allowed by MedCost. These adjustments policies are based on CPT and CMS guidelines:

- MedCost determines the primary procedure on a multiple surgical claim by the highest billed amount.
- MedCost uses the CMS guidelines to determine the global day period for a surgical procedure.
- MedCost uses CPT guidelines to determine codes that are 51-modifier exempt.

The modifiers listed below (along with the adjustment policy for each) are recognized by MedCost:

Modifier 24 – Indicates that an Evaluation and Management code was performed in a postoperative period unrelated to the original procedure. MedCost would allow the Evaluation and Management code when this modifier is filed. If the modifier is not filed, this code would be reduced to zero.

Modifier 25 – Indicates patient required a significant, separately identifiable Evaluation and Management service above and beyond the usual preoperative and postoperative care associated with the procedure performed the same day. MedCost would allow the Evaluation and Management code when this modifier is filed. If the modifier is not filed, this code would be reduced to zero.

This process also applies when two Evaluation and Management codes are filed on the same day. If one Evaluation and Management code contains the modifier 25, both codes would be allowed. If no modifier is present, MedCost would reduce the lowest billed amount to zero.

How Claims Adjustment Policies Can Impact Allowables

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Modifier 50 – Indicates that the provider performed a bilateral surgery at the same operative session. MedCost allows 150% of the global allowable on any code filed with a 50 modifier.

Modifier 51 - Indicates provider performed multiple procedures, other than Evaluation and Management services, on the same date of service by the same provider. MedCost allows 50% of the global allowable on any code filed with a 51 modifier.

Modifier 57 - Indicates an Evaluation and Management service that resulted in the initial decision to perform surgery. MedCost would allow the Evaluation and Management code when this modifier is filed. If this modifier is not filed, this code would be reduced to zero.

Modifier 62 – Indicates two surgeons worked together as primary surgeons performing distinct part(s) of a procedure. MedCost reviews Co-Surgeon claims for medical necessity based on CMS guidelines.

Modifier 76 - Indicates repeat procedure by same physician. MedCost would allow the repeat procedure when this modifier is filed. If the modifier is not filed, MedCost would see this claim as a duplicate claim to the original.

Modifier 80 - Indicates Surgical Assistant services performed by an MD. MedCost allows 20% of the global allowable. MedCost reviews Surgical Assistant claims for medical necessity based on CMS guidelines.

Modifier 81, 82, & AS – Indicates Surgical Assistant Charges performed by a non-MD. MedCost allows 14% of the global allowable. MedCost reviews Surgical Assistant claims for medical necessity based on CMS guidelines.

Adding Providers to Your Practice

It is critical that you notify MedCost of any provider joining your practice before submitting claims. MedCost will advise if the provider is in network or not. If the provider is not in network, you will need to submit a provider credentialing application. Upon completion of the MedCost credentialing process, written notification will be sent to your office regarding your provider's approved effective date. Please do not submit any claims from the new provider until you have received written notification from MedCost containing the provider's effective date. This will ensure that claims are correctly processed as in network.

You can access provider credentialing applications at www.medcost.com. Choose the Physicians and Providers portal, then click Credentialing Information and forms on the left sidebar menu. You can access a NC or SC application. Once the application is completed, you may fax it to 336-970-2139, Attn: Credentialing Department.



INCLUSIVE HEALTH

Join the Inclusive Health Network and Help the Citizens of NC and Your Patients

Inclusive Health Update – State and Federal Options

Beginning in July 2010, uninsured North Carolina residents with pre-existing conditions were eligible to apply for the new Temporary Federal High Risk Pool, one of the first initiatives established under the Patient Protection and Affordable Care Act. In North Carolina, this federal pool is administered by Inclusive Health, a North Carolina non-profit established by the State Legislature that also administers the Inclusive Health – State Option.

Enrollment is increasing in both the federal and state options. As of August 15, 2010, the Inclusive Health state option included 4,241 active members, while the federal option included 121 active members. There are currently 26,130 providers and 122 hospitals participating in the Inclusive Health network. If you would like to be part of this network, please contact Adrienne N. Golding, Provider Network Representative, at (336) 774-4216 or by e-mail at agolding@medcost.com. For detailed benefit information on both the state and federal options, visit Inclusive Health at www.inclusivehealth.org.

Save Time and Money: File Claims to the Correct Payer ID and Know Who to Call for Verification of Benefits

To ensure that you receive payment for services in the most efficient manner, please check the patient ID card and file claims electronically to the correct payer ID. (For the MedCost Preferred PPO, the ID is 56162.) Directing your claim otherwise may create unnecessary delays in processing and payment.

When a claim is received by our system, it is repriced based upon contracted arrangements. The claim is then forwarded to the appropriate claim administrator for payment consideration within two working days.

Over 20% of the calls that MedCost receives into our Customer Service Contact Center are to verify benefits. Remember, MedCost is not a payer and cannot verify benefits or eligibility. To do that, you should call the claim administrator listed on the patient's insurance ID card. MedCost recommends that you verify benefits for all services rendered to MedCost patients. Verifying benefits allows you to collect any co-payment, co-insurance, deductible, etc., at the time of service. Claim administrator names and phone numbers also can be found in the MedCost Reference Guide on our web site.



Legislative Update

Health Care Reform and Preventive Care Services



Now that President Obama has signed the Patient Protection and Affordable Care Act into law, we are faced with making many changes in the U.S. health care delivery system. Sections of the law, such as dependent coverage to age 26, high-risk pools, preexisting condition exclusions, and preventive care services, have been published in the Federal Register with additional releases to come. The health care reform bill extends coverage to 32 million Americans who do not currently have insurance.

Over the next four years, new exchanges will be created through which individuals and small businesses will be able to buy insurance at group rates. There will be subsidies and tax breaks to help, and Americans who can afford it will be required to buy insurance.

A range of preventive care services will soon be available at no extra cost to consumers under new health insurance plans. Under the new rules, insurance companies offering these new plans are required to cover mammograms, immunizations, colonoscopies and other preventive services without charging customers through a deductible or a co-payment. A list of covered services can be found at: www.healthcare.gov/law/about/provisions/services/lists.html.

HIPAA 5010 Electronic Transaction Standards and ICD-10 Code Sets:

Are You Ready?

The deadline for implementing the HIPAA 5010 electronic health care and pharmacy transaction standards is January 1, 2012. This updates the current standards for transactions and sets the stage for ICD-10 diagnosis code expansion, which has an October 1, 2013 compliance deadline.

HIPAA requires covered entities (such as health plans, health care clearinghouses, physician practices, hospitals, rehab facilities, and inpatient/outpatient facilities) to adopt these standards for electronic health care administrative transactions, which include claims, remittance, eligibility, and claims status requests and responses.

MedCost is currently working with our vendors and will be fully compliant by the January 1, 2012 deadline. You are responsible for testing with your vendors; MedCost will not make you compliant. Any transactions submitted to MedCost after the deadline that are not in the 5010 format will not be accepted.

MedCost Welcomes New Groups

The following employer groups began accessing the MedCost Preferred network on May 1, 2010:

Employer	Group #	Employees	Claim Administrator	Eligibility
Appalachian State University	CHH0071031	1660 (students)	Pearce Administration/Maksin Mgt Corp.	888-722-1668
NC State University	CHH0071041	3000 (students)	Pearce Administration/Maksin Mgt Corp.	888-722-1668
University of NC Chapel Hill	CHH0071051	2300 (students)	Pearce Administration/Maksin Mgt Corp.	888-722-1668

The following employer group began accessing the MedCost Preferred network on June 1, 2010:

Employer	Group #	Employees	Claim Administrator	Eligibility
McCreary Modern Inc.	322002	595	Employee Benefit Services (EBS)	800-242-1510

The following employer groups began accessing the MedCost Preferred network on July 1, 2010:

Employer	Group #	Employees	Claim Administrator	Eligibility
Town of Fort Mill	L250	110	MedCost Benefit Services	800-334-0609
Town of Matthews	N019	140	Preferred Health Plan of the Carolinas Inc.	800-636-1239
City of Roanoke Rapids	211200	165	DST Health Solutions/FCC	800-811-3298

The following employer groups began accessing the MedCost Preferred network on August 1, 2010:

Employer	Group #	Employees	Claim Administrator	Eligibility
City of Newton	SF382	189	ACS Benefit Services, Inc.	800-849-5370
Primary Capital Advisors	5165	150	CoreSource Lancaster	877-543-3935
Ideal Fastener Corporation	IFC59	115	Key Benefit Administrators	800-242-1510

MedCost Decisions on Medical Necessity

As a provider, you may regularly receive notifications about certified and noncertified procedures and hospital stays. Certification is not a guarantee of payment; it only confirms the medical necessity of the service. Have you ever wondered how those medical necessity determinations are made? At MedCost, our decisions are based on Milliman Care Guidelines. These guidelines are developed by physicians, nurses and other health care professionals and based on actual practices of clinical care in the US, along with the most current medical literature. Milliman outlines the most efficient treatment for a given condition and the typical progress that patients can expect.

When a certification request is submitted to MedCost, our experienced team of registered nurses collects the medical information and reviews it against Milliman Care Guidelines. If there is any question of medical necessity, the medical information is then reviewed by a physician. MedCost maintains a review panel of over 90 consulting physicians who are in active practice and board certified in various specialties.

If a service is noncertified for medical necessity reasons, an appeals process is available. To initiate this process, call the pre-certification number listed on the patient's insurance card or follow the instructions on the certification notice. You will need to send complete information and medical records related to the noncertified period. Once this information has been received and reviewed, a determination will be made. Written notification of the final decision will be sent to the patient, provider, and claim administrator.

For additional information about medical necessity decisions and the appeals process, please refer to the MedCost Provider Manual, available under the Physicians & Provider portal of our web site.



Credentialing/Re-credentialing Questions & Answers

The MedCost credentialing program has been accredited by URAC since 2000. Before a physician or facility can be added to the MedCost network, the physician or facility must be credentialed and approved. In order for physicians and facilities to remain in the network, they must also follow an approval process for re-credentialing.

MedCost re-credentials participating providers every three years. We will notify you at least four (4) months prior to the expiration of your current credentials. We make every effort to send this notification to the correct address and person responsible for network credentialing issues; however, we ask that you forward any misdirected notifications to the appropriate person within your organization. Prompt attention to these notifications ensures claims continue to be paid as in network.

Our Credentialing Coordinators – Patricia, Sharleen and Linda – work each day to complete all aspects of credentialing and re-credentialing of providers and facilities and to assure compliance with Department of Insurance and URAC guidelines. If you have specific questions concerning credentialing that are not answered below, please call Customer Service at 1-800-824-7406, and they will connect you to a Credentialing Coordinator.

Here are some of the most commonly asked questions concerning MedCost credentialing and re-credentialing:

Q: What is your average turnaround time to process a credentialing or re-credentialing application?

A: MedCost completes the credentialing process for 97% of all applications received within 30 days.

Q: How do I obtain an application?

A: Applications are available on our Web site, www.medcost.com. To access the North Carolina and South Carolina standard applications, the facility application, and the application for providers outside of the Carolinas, choose the Physicians & Providers portal and then click on “Re-credentialing Information and Forms” on the left side. If you do not have access to the Internet, please call our Customer Service Contact Center at 1-800-824-7406 for an application.

Q: Do I have to complete residency prior to submitting an application?

A: Yes. The MedCost credentialing plan requires proof of residency either through a certificate or a letter from the facility.

Q: When credentialing a new provider, will you retro the credentialing date or will you pay claims if the date of service is before the credentialing date?

A: No, we do not “retro” an effective date. You must wait until you receive written notification from MedCost that the provider is effective before you file any claims. Otherwise, the claim will be processed as out of network.

Q: What can I do to help prevent a delay in processing my application?

A: Ensure that your application is complete and includes a current date and signature, as well as all of the following information:

Provider Applications:

- Copy of provider's state license
- Copy of the face sheet of your current professional liability insurance policy, indicating name of the practice, name of the provider covered, coverage amounts, effective date, expiration date, and policy number



Patricia Simpson, Sharleen Payton, and Linda Henley

- Copy of certificate from Specialty Board
- Copy of Curriculum Vitae or work history
- Explanation of all "Yes" responses on the "Professional Information" section of the application
- Residency certificate, if residency was completed within the last 6 months (MDs and DOs must have completed residency.)

Facility Applications:

- Copy of applicable accreditation (JCAHO, URAC, NCQA, ACR, AAAHC, NACC, ACHC, American Lithotripsy Society, CHAP, CARF, AAAASF, American Board for Certification in Orthotics & Prosthetics, ISO9000-(DME companies), AASM, ICAVL, CLIA, Board for Orthotist/Prosthetist Certification - (BOC), HQAA, (DNV) – Det Norske Veritas Healthcare, Inc., The Compliance Team-deemed by CMS, Medicare, AAPSF, Mastectomy Fitter training certificate)
- Copy of state license
- Copy of Medicare certification
- Copy of Medicaid certification
- Copy of current liability insurance
- Copy of secondary or excess liability information

NOTE: Non-participating providers in North and South Carolina that wish to join our network should contact the MedCost Customer Service Contact Center at 800-824-7406 for additional information, or go to How to Join Our PPO Network.