2012 Insurance Industry Changes

Insurance Plans

With 2012 rapidly approaching and the Health Care Reform Act in full swing, many insurance carriers are offering "designer" plans geared to fit all consumers' needs beginning January 1, 2012. Some have criticized the insurance industry for offering too many different policies, making it very confusing for providers as well as members concerning each plan's coverage, deductibles and co-pays. Plan changes have occurred for commercial as well as Medicare Advantage policies, encompassing changes within their HMO, PPO, POS and other products.

These insurance plan changes were too numerous for us to list in our newsletter. However, most carriers published detailed information about their plan changes in their latest newsletters. This information may be obtained by accessing the carrier's website, going to their ***Provider*** section and then on to ***newsletters/communications, etc***., to find their latest newsletter.

We suggest that you and your staff become aware of the new plan offerings from your most popular insurance carriers, as many plan changes will result in larger co-payments and deductibles.

AETNA

Agreements with out-of-network labs violate your Aetna Contract

If you have a physician agreement with Aetna, you are required to refer your Aetna patients to in-network providers, which includes laboratories. LabCorp has contacted many providers to sign laboratory agreements with them. LabCorp is not a participating laboratory with Aetna and providers using LabCorp for their Aetna patients are in violation of their Aetna agreement.

If you have been requested to sign or have signed a laboratory services agreement with LabCorp, Aetna has requested you contact them at

nationalancillarycontracting@aetna.com

HUMANA

Updating of Pre-Auth and Notification Lists

Effective Date: January 23, 2012

Humana will be updating their preauthorization and notification lists for all commercial fully insured plans and Medicare Advantage Plans. You may view these lists at ***humana.com/providers***. Some of the services now on their preauthorization and notification lists are:

- Cardiac implantable device services for outpatient procedures. These services will be administered by HealthHelp®
- Facility based sleep studies. (administered by Humana.
- Medical management of inpatient post-acute services. (administered by Humana)
- Pain management services for members in Alabama, Georgia, Louisiana, Mississippi, North and South Carolina and Tennessee administered by OrthoNet.
- Drug lists

MA BLUE CROSS & BLUE SHIELD (BCBSMA)

Subscribers May be paid for Blue Choice Plans

Effective Date: January 16, 2012

Effective January 16, 2012, BCBSMA will begin to ***pay subscribers*** who belong to their Blue Choice® Plan 1 and Plan 2 products for services they receive from any provider who does not participate in their product, including both professional and facility providers. BCBSMA states that this change is designed to encourage providers to participate in all of their networks and to ensure their members are treated by contracted, in-network providers in order to better manage their members' health care costs and quality.

Reimbursement for non-participating providers will change

Effective Date: January 1, 2012

Effective January 1, 2011, BCBSMA's Usual and Customary fee schedule, which is used to determine reimbursement for non-participating physicians, clinicians, and facilities, will be based on their indemnity fee schedule rather than the provider's charges. This will affect providers and facilities that do not participate in BCBSMA's PPO network.

Patients will be responsible for the difference between the provider's charges and the indemnity fee schedule, when the provider's charges are greater than the indemnity fee schedule. This is in addition to any applicable cost sharing amount.

This change does not apply to non-participating, hospital-based emergency medicine physicians, anesthetists, pathologists, or radiologists when providing emergency care to their members.

For questions, contact BCBSMA's Network Management Services at 1-800-316-2583.

TUFTS HEALTH PLAN

Tufts Acquires Network Health Plan

In November, Tufts Health Plan announced the completion of its acquisition of Network Health, a managed Medicaid plan with nearly 180,000 subscribers throughout Massachusetts. Tufts is now the only health insurer in Eastern Massachusetts to participate in commercial, Medicare and Medicaid markets, and brings its membership to nearly 925,000.

Previously, Network Health was a subsidiary of Cambridge Health Alliance and has been recognized as one of the top 10 Medicaid health plans in the country.

There are no changes planned for Network Health employees, members or contracted providers and they will continue to offer both its Medicaid (Network Health Together) and Commonwealth Care (Network Health Forward) plans.

NEIGHBORHOOD HEALTH PLAN (NHP)

Modifier Reimbursement Changes

Effective Date: January 1, 2012

Effective January 1, 2012, NHP will change their reimbursement for services submitted with the following modifiers. The percentage is that of NHP's allowed fee schedule.

- 25 – Significant, separately identifiable E& M service by same physician on same day of procedure or service – 50%
- 53 – Discontinued Procedure – 25%
- 59 – Distinct procedural service – 50%
- 74 – Discontinued outpatient/ASC procedure after anesthesia administration – 50%
- 78 – Unplanned return to OR for related procedure during post-op period. – 70%

IN & OH - ANTHEM BLUE CROSS AND BLUE SHIELD

Expanded EFT Reimbursement

If you are signed up to receive your Anthem payments by EFT (electronic transfer funds), some of your reimbursement continues to be paid by check, due to differences in Anthem's claims processing systems. Effective April 2012, Anthem will now be able to offer EFT on their National claims, further reducing check reimbursement.

Providers currently set up for EFT will be automatically added to receive EFT payment for the National claims. Providers who are not set up for EFT, may access the Anthem website at www.anthem.com\edi and select ***EFT Maintenance Form*** and follow the directions for obtaining the EFT payment method.

Medicine Updates

MA BCBS

HPV Vaccine now covered for males

Effective Date: October 25, 2011

BCBSMA is now covering a three-dose series of the quadrivalent HPV (Human Papillomavirus) vaccine for males aged 9-21, with the preferred aged of 11-12 years of age.

MA Medicaid

Drug Screen Code Changes

Effective Date: December 1, 2011

Effective December 1, 2011, MassHealth will no longer pay for the following drug screen CPT Codes:

- 80100 (Drug screen, qualitative; multiple drug classes chromatographic method, each procedure) and
- 80101 (Drug screen, qualitative; single drug class method (e.g., immunoassay, each drug class).

Drug screen services should now be reported using these HCPCs' Codes:

- G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method(e.g., immunoassay, enzyme assay), per patient encounter) or
- G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter).

G0431 and G0434 are bundled codes that pay a single fee for the drug screen services being provided at the patient encounter regardless of the number of drug classes being tested.

Providers should not routinely bill for the quantification of drug classes (e.g., chemistry section 82000-84999 or therapeutic drug assay section 80150-80299) being tested as part of the drug screen service.

Providers should bill only for the quantification of drug classes being tested as part of a drug
screen service or a confirmatory drug test if there is a positive screen for one or more drug
classes being tested.

MA - Tufts

Tufts Will No longer Cover Preventive Service Code 99397

Effective Date: January 1, 2012

Effective January 1, 2012, Tufts Health Plan ***Medicare Preferred*** will not compensate for preventive service code 99397 (Periodic comprehensive preventive medicine reevaluation and management). Instead Tufts should be billed with the appropriate G code for preventive medicine services, same as Medicare.

Emergency Room Co-pays

Effective Date: January 1, 2012

Copayments for ER services will increase by $50 on the following plans:

- HMO Premium, Value, Choice Co-pay, and Basic plans
- Select Network HMO plans
- PPO and POS plans

This change applies to Massachusetts' groups only.

ER Deductibles on Advantage Plans

Effective Date: January 1, 2012

ER services will be subject to the deductible on all Advantage plans. This change applies to both Massachusetts and Rhode Island groups.