

HRA/HSA Billing Procedure

Reminder to all physicians and office staff: No patient should be charged up front for services if they have Health Reimbursement Account (HRA) or Health Savings Account (HSA) benefit plans for the following reasons:

- UPMC Health Plan's allowed amounts can change or they may be different from what the office staff determines.
- The amount for the visit could be reimbursed with funds from the HRA or HSA.

You should always wait until you receive the UPMC Health Plan Explanation of Payment (EOP) before billing the patient. Please note that if the patient has an HRA and there are available funds, notification is sent at the same time as the provider reimbursement.

If you have any questions or need clarification, contact Provider Services at 1-866-918-1595 or your Network Representative.



CHIP Compliance Update

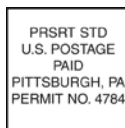
Re: CHIP Transmittal 2009-12, Abortion Services Certification Requirements

The Pennsylvania Insurance Department has issued a policy transmittal outlining Abortion Services Certification Requirements, which will become effective February 1, 2010. This policy transmittal clarifies when abortion services are covered, and is consistent with federal and state laws. This policy also indicates that beginning February 1, 2010, the CHIP *Physician Certification Form for an Abortion* and, if applicable, a copy of the *Member Statement Form* must be completed for the services to be paid through CHIP. You can obtain copies of both forms on the UPMC Health Plan website at www.upmchealthplan.com.

Instructions follow:

- The physician must use Part I of the *Physician Certification Form* in situations where the member's life is considered threatened if the abortion service is not provided. A *Member Statement Form* does not need to be completed in this situation.
- The physician must use Part II of the *Physician Certification Form* when a provider determines that a member who is seeking an abortion became pregnant as a result of rape or incest. A *Member Statement Form* must be completed in this situation.

If you have any questions regarding the policy or obtaining the proper forms, contact your Network Manager.



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UPMC Health Plan's Anesthesia Submission Guidelines

As suggested by the American Society of Anesthesiology (ASA), UPMC Health Plan agrees that it is inappropriate to allow the unlimited reporting of time units from insertion of the epidural through delivery. Therefore, UPMC Health Plan has implemented a "face time" billing method, which includes basic units, plus patient contact time (insertion, management of adverse events, delivery, and removal) for procedure code 01967 when billed alone or with add-on codes 01968 or 01969. The contracted rate of reimbursement for the following procedures will be unaffected:

- Procedure Code 01967 — Neuraxial labor analgesia/anesthesia for planned vaginal delivery. (This includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor.)
- Procedure Code 01968 — Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia. (List separately in addition to code for primary procedure performed.)
- Procedure Code 01969 — Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia. (List separately in addition to code for primary procedure performed.)

Procedure codes 01968 and 01969 must not be billed as stand-alone codes, but should be billed in conjunction with Code 01967. According to CMS (Centers for Medicare and Medicaid Services) administrators, anesthesia time should be submitted with the primary anesthesia code, with the exception of add-on obstetrical codes. Time should be reported with primary code 01967 in addition to add-on codes 01968 and 01969.

Anesthesia minutes must be documented whether submitting paper or electronic claims. Minutes may be identified as total minutes or time span, noting both the beginning and ending times. Units are not required on the claim since the Health Plan's claim system is configured to determine the appropriate number of units in accordance with the ASA code and subsequent modifier.



Certificate of Medical Necessity Form Updated

Our Certificate of Medical Necessity forms are now available online for Nutritional Product requests. The form can be printed from our website and faxed to the number indicated on the form. To find the form, log on to <http://www.upmchealthplan.com/providers/medmgmt.html> under "Physician Forms".

Partners Program Quality Incentive Rewards Program — Changes for 2010

The UPMC Health Plan Partners Program will be celebrating its two-year anniversary on April 1, 2010. The program's measures and goals have remained constant so you, our Partners, had adequate time to understand the whole program, tools, and reports. In late 2009 we introduced some changes to our Physician Advisory Boards and received valuable feedback. We are putting the final touches on the 2010 Partners Program QIRP measurements, which will be effective April 1, 2010. Please watch for updates in February.



PCMH Assessment — Preliminary Results on Their Way

The preliminary results of the UPMC Health Plan Patient Centered Medical Home (PCMH) assessment, which your Physician Account Executive or Network Manager conducted in the last 18 months, were mailed or hand delivered to each practice in January for review. The surveys concentrated on required and scored elements in six domains: Access, Care Coordination, Technology, Satisfaction, Efficiency (administrative and clinical), and Quality of Care, which support the joint principles of PCMH.

Please take time to review the preliminary results, and:

- If you agree with the information provided, sign, date, and return the score sheet; or
- Contact your Physician Account Executive or Network Manager to review the information in more detail.

Thank you for taking the time to review this information.



Technology Assessment Committee

The Technology Assessment Committee meets regularly to review medical technology. The following chart details recent committee decisions. Please refer to the designated policy for complete indications and limitations.

Subject	Reason for Review	UPMC Health Plan Summary
Telephonic Rhythm Strips	Coverage Update	Effective 01/01/2010, UPMC Health Plan removed restrictions for Telephonic Rhythm Strips for all products.
Chiropractic Care	Policy Review	Reminder that UPMC <i>for Life</i> Specialty Needs Plan (SNP) follows the Centers for Medicare & Medicaid Services' (CMS) guidelines for chiropractic care.
Routine Foot Care Services	Updated Pay Policy	Effective 02/01/2010, UPMC Health Plan limits routine foot care to once every sixty (60) days when performed by a physician or podiatrist, unless documentation substantiates the medical necessity for the increased frequency. The documentation should include evidence of the patient's physical status as being of such an acute or severe nature that more frequent services are appropriate. This applies to all Health Plan products.
Extra-Cranial Carotid Angioplasty with Stenting	Policy Review	Effective 03/01/2010, this procedure requires a prior authorization for all products. Requires stents with distal embolic protection. Vertebral artery angioplasty with or without stent is not covered due to the lack of scientific evidence.
Salivary Hormone Testing	Policy Review	Considered experimental and investigational for all products.
Low Back Conductive Wraps — TENS Unit Accessory	Policy Review	Considered experimental and investigational for all products.