



# ProviderNews

Timely News & Information Of Interest To Healthcare Providers

## Fee Schedule Changes

PEIA adopted a number of changes to its medical fee schedules since the beginning of 2011. The following changes became effective on Jan. 1, 2011.

**Resource Based Relative Value Scale (RBRVS)** – PEIA uses Medicare’s Relative Value units (RVUs), adjusted by the West Virginia geographical factors. We continue to multiply the malpractice factor by 2.7 in order to increase the allowances for the more difficult and costly procedures. The new conversion factor is \$33.89.

**Anesthesia** – The new conversion factor for anesthesia services is \$37.00.

**Clinical Lab** – The clinical lab fee schedule was updated to 100 percent of Medicare’s January 2011 rates.

**Durable Medical Equipment (DME)** – The DME fee schedule was updated, making the allowances 84 percent of Medicare’s January 2011 rates.

**Outpatient Prospective Payment System (OPPS)** – PEIA updated its OPPS rates. The statewide conversion factor for all hospitals paid through OPPS is \$76.45, which is 111 percent of Medicare’s rates. The calendar year fixed-dollar threshold is \$2,025. The outlier threshold is the maximum of 1.75 X APC pay and APC pay + \$2,175.

**Drugs and Biologicals** - The agency updated the Drugs and Biologicals fee schedule to Medicare’s January 2011 rates. Therefore, most of the drugs are covered at the average sale price plus 6 percent. Vaccines are included in this fee schedule, but their rates

are set at 95 percent of the average wholesale price (AWP).

The RBRVS, Clinical Lab, DME, and Drugs and Biologicals fee schedules are on PEIA’s web site at [www.wvpeia.com](http://www.wvpeia.com). Under “Our Customers,” select “Providers” and then select “Fee Schedules.”

## Weight Management Program Expands

Effective July 1, 2011, eligibility for the PEIA Weight Management Program is changing to accommodate more members who can benefit from the services of exercise professionals and dietitians at PEIA-approved fitness centers across WV. Current eligibility requires a Body Mass Index of 30 or greater, or a BMI of 25 or greater with a related condition such as hypertension, diabetes, sleep apnea, heart disease or metabolic syndrome.

The new criteria will require either a BMI of 25 or greater, or a waist circumference of 35 inches or greater for a woman, or 40 inches or greater for a man. Additionally, the schedule of services will be changing with greater emphasis on personal training. Our research has shown improved health outcomes for individuals who have changed from a sedentary to active lifestyle. Please refer interested patients wanting to enroll to the toll free number, 1-866-688-7493, or the PEIA Web site section on weight management.

## PEIA Links Premiums to Health Screenings

PEIA is offering Preferred Provider Benefit (PPB) plan policyholders a premium reduction of \$10 per month if they participate in a worksite health screening which measures cholesterol, glucose, waist circumference and blood pressure. Participants and their physicians of record receive a color-coded report using the stop light system to indicate a healthy range, moderate risk

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June 2011

## PEIA Changes, Reminders

With Plan Year 2012 starting on July 1, keep the following in mind when providing services to PEIA Preferred Provider Benefit Plan members.

### *Out-of-State Network Exclusions*

PEIA excludes some providers from its out-of-state network, even though they may be listed with the Aetna out-of-state network as providers.

Exceptions may be approved when medically necessary. To request approval, you or the member must complete a prior authorization form and send it to ActiveHealth. Here are the providers excluded from the out-of-state network:

- The UPMC Health System will remain out-of-network.
- All providers in Boyd County, Ky., including Kings Daughters Medical Center. and Our Lady of Bellefonte Hospital will be out-of-network.
- River Valley Health Alliance in Washington County, Ohio.
- ASA providers in Gallia County and Washington County, Ohio, will remain out-of-network.

### *Active Health Disease Management Programs Discontinued*

Effective July 1, 2011, PEIA will no longer offer ActiveHealth's Disease Management Programs. Discontinued programs include those for heart and blood vessel conditions, blood clots, diseases of leg arteries/PAD, heart attack and angina, heart failure, high blood pressure, high cholesterol, stroke, lung conditions (asthma and chronic obstructive pulmonary disease), diabetes (does not include the Face-to-Face program), low back pain and depression.

PEIA will continue to offer the PEIA Face to Face Diabetes Program, PEIA Weight Management Program, and Dr. Dean Ornish Program for Reversing Heart Disease, tobacco cessation services, and the PEIA Pathways to Wellness Program.

For more information, call 1-888-680-7342 or visit [peia.help@wv.gov](mailto:peia.help@wv.gov).

### *Deductibles and Out Of Pocket Expenses*

Keep in mind the deductibles and out-of-pocket amounts for Plan Year 2012 will start over as of July 1, 2011. For the medical plan, the deductibles are salary-based for active employees and for retirees; they are based on years of service.

### *End-of-Life Benefit*

Effective July 1 2010, PEIA began covering one end-of-life consultation for members. Reimbursement for this benefit is based on the following:

### **S0257 End-of-Life Consultation**

Units	Allowance
1	\$25
2	\$50
3	\$75
4	\$100

PEIA covers a maximum of four units. Providers may bill, as appropriate, a hospital visit and an end-of-life consultation on the same day.

PEIA members covered by Preferred Provider Benefit Plans A, B or C, The Special Medicare Plan or Humana can receive a \$4 monthly premium discount for having an advanced directive/living will. Please record any discussions about a member's living will in his or her chart.

### *Lifetime Maximum Eliminated*

As of July 1, 2011, PEIA members will no longer have a lifetime benefit maximum. In July of 2010, the lifetime maximum was increased from \$1,000,000 to \$1,500,000, and now this limitation is removed altogether.

## Want Timely Payments?

To assure them, it's important to keep your practice information in the Wells Fargo TPA system up-to-date. For your protection, Wells Fargo TPA requires that updates be made in writing on office letterhead with the provider's or office manager's signature and contact information. Please be sure to include all information you want changed or corrected and the effective date of the change or correction. Include the previous and changed information that applies. These may be submitted via mail to:

Wells Fargo TPA  
Attn: Provider Specialty Department  
P O Box 2451  
Charleston WV 25329-2451

Please inform Wells Fargo TPA right away about changes to your practice, such as a new address or suite number, phone, fax, tax identification number, ownership or group name change, provider additions or deletions, or any new practice limitations. Note: A W-9 form is required for any changes to a group name, new ownership, or tax identification number.

### *New Providers*

New providers in West Virginia should complete the Provider Demographic Worksheet available on PEIA's Web site at "Find a Form" on the home page or under "Forms and Downloads" and "Providers" and "Preferred Provider Benefit (PPB) Plans." This form, along with a copy of the W-9 and practitioner's license, should be submitted to the address above.

## Wells Fargo Billing Reminders

The proper use of CPT modifiers can speed up claim processing and decrease payment errors or denials. All providers must bill using the modifiers below when appropriate.

Certain procedures are a combination of a physician component and a technical component. Use the following modifiers for these procedures:

**Modifier - 26** represents the professional (provider) component of a service or procedure.

**Modifier - TC** represents the technical component of a service or procedure. This modifier corresponds to the equipment/facility part of a given service or procedure.

Unmodified procedure codes represent a complete service or procedure that includes both the professional and technical components.

**Place of service codes** should be used to specify the entity where services were rendered. When billing for Rural Health Clinics or Federally Qualified Health Clinics, the following place of service codes are to be used

**71 – Public Health Clinic** – A facility maintained by either state or local health departments that provide ambulatory primary medical care under the general direction of a physician.

**72 – Rural Health Clinic** – A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

### *CMS Form 1500 Box 32 and 33*

**Item 32** - Indicate the correct address, including a valid ZIP code, where the service was rendered to the beneficiary. Any missing, incomplete or invalid information in the service facility location information field could cause the claim to be denied or delayed. This is a required field.

**Item 33** - Enter the provider of service/supplier's billing name, address, ZIP Code and telephone number. This is a required field.

Handwritten bills are discouraged, and could cause delay in your claim being processed.

## AccessWV Expands

AccessWV is the state's high-risk pool that offers comprehensive health insurance coverage to individuals with chronic health conditions who are denied insurance or quoted a higher rate in the commercial market. Many of these individuals are ones you see in your practices and may be unaware of AccessWV or the availability of premium subsidies.

Following legislative action this year, AccessWV premium subsidies have been expanded for eligible members with household incomes up to 400 percent of the Federal Poverty Level (FPL). Household incomes from 0-100 percent FPL are now eligible for a 60 percent subsidy; from 101-200 percent FPL, a 45 percent subsidy; from 201-300 percent FPL, a 30 percent subsidy; and

from 301-400 percent FPL, a 15 percent subsidy. Poverty-level determination is based on number of household members and total household income, and for a single individual, roughly varies from \$11,000 at 100 percent FPL to \$43,000 at 400 percent FPL. Four-member households vary from \$22,000 at 100 percent FPL to \$88,000 at 400 percent FPL.

AccessWV premiums are based on age, geographic region, gender, tier (individual or family) and which of four plans is chosen. Premium tables, as well as the application and additional information on the high-risk pool, are available at the plan website, [www.accesswv.org](http://www.accesswv.org). We are happy to supply rack-card holders and information cards for your office. For more information, please call our toll-free number, 1-866-445-8491.

## Changes to Wells Fargo Remittance Advice

In an effort to deliver provider remittance advice as quickly as possible and remain eco-friendly, Wells Fargo TPA will soon change the way all health care providers receive remittance advice.

Wells Fargo TPA will eliminate paper remittance advices, making them available on their Web site [wellsfargo.com/TPA](http://wellsfargo.com/TPA) in Adobe Acrobat PDF format. This will eliminate any delay in providers' offices receiving the remittances by mail, making them available immediately online when the weekly check run processes.

In the near future, all providers will begin receiving documents with their weekly remittances explaining this process further, including information on how to create an account and print the remittance advice. Once this is launched, all providers will receive their paper check, along with a link to obtain their remittance advice on the Web site. At that time, there will no longer be a paper version mailed with the check. This will not only reduce paper waste but also provide a more secure way to receive this information.

Providers should make their billing departments aware of these coming changes, as well as have them watch for additional details coming with the current paper remittance advice. This will prevent any delay in account posting once the new system is started.

### **PEIA LINKS PREMIUMS continued from page one**

range or high risk range for each of the measures, as well as an aggregate score. PEIA is recommending that providers use these reports as an avenue to discuss plans of treatment with their patients to reduce their risk factors.

If a patient would like to participate, please complete the provider portion of the form and have the patient mail it to beBetter Health, as indicated on the form. More information on the Improve Your Score initiative may be found at [www.peia.pathways.com](http://www.peia.pathways.com).

## PEIA Provider Audits Coming

A basic question many ask is “Why audit?” It’s simple: We don’t live in a perfect world; human beings make mistakes.

That being said, PEIA is currently starting an audit on evaluation and management (E & M) charges (CPT 99211-99215). A random sample of practices will be selected for the audit. Those offices will be contacted by our external auditors, Tichenor and Associates PC, to provide documentation in support of the E & M charges selected. Our goal is to ensure that we are accurately paying for the services provided.

## PEIA, CAMC Team up to Treat Hemophilia

To provide quality care at a reasonable cost, PEIA and the Charleston Area Medical Center (CAMC) have partnered to provide a Hemophilia Care Program to PEIA, CHIP and AccessWV members.

Members who participate in this program will have their hemophilia drugs covered at 100 percent with no deductible, copay or coinsurance. They will also be eligible for reimbursement of travel and lodging expenses, when appropriate. The patient must complete an annual evaluation at CAMC. However, ongoing medical care may continue through the patient’s medical home provider and/or specialist. The evaluation at CAMC is not intended to interrupt the patient’s medical home relationship.

Individuals who choose not to participate in CAMC’s Hemophilia Care Program will maintain their current benefits. Cov-

ered services will be paid at 80 percent of the allowed amount after the deductible is met. Services rendered out-of-network will be covered at 60 percent of the allowed amount after the out-of-network deductible is met. Office visit copays will apply.

For more information about this program, you may contact CAMC at 304-388-8896 or you may also contact ActiveHealth at 888-440-7342.

## WV Hospitals Named Preferred Providers for Certain Transplants

West Virginia University Hospital and Charleston Area Medical Center (CAMC) are preferred providers for certain transplants for PEIA, CHIP and AccessWV patients. West Virginia University Hospital is a preferred provider for bone marrow transplants and CAMC is a preferred provider for kidney transplants.

With use of in-network providers, such as West Virginia University and CAMC, the patient is eligible for additional benefits. Because these network facilities may be located some distance from the patient’s home, a \$5,000 travel allowance is available to the patient and a family member or friend who is providing support.

If you have a patient who needs a bone marrow or kidney transplant, call ActiveHealth at 888-440-7342. ActiveHealth offers support and assistance to the patient and family in evaluating treatment options and referrals.

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