

Terms of recognition as an approved specialist with AXA PPP healthcare

Updated November 2008



PPP HEALTHCARE

(Please see the **glossary** for definitions of text in **bold**)

Rules & benefits of member policies

Member policies state that benefit for **eligible treatment** must be provided by **specialists, complementary practitioners or clinical practitioners** who are recognised by AXA PPP healthcare for the provision of services to **our** members. Where treatment is provided by a clinician who is not recognised by **us** for benefit purposes, the entire claim will be invalidated, including any associated hospital/facility, specialist or diagnostic charges. For the avoidance of doubt, any offer (and change) of recognition status is made in writing to the individual (to the last correspondence address provided to us) and is effective from the date of the letter.

Nature of care

Our policies are designed to cover the costs of the short term treatment of acute medical conditions. They do not cover continuing supportive, palliative or social care.

Recognition as an approved specialist

We employ robust and consistent procedures to offer, review and withdraw recognition status in an attempt to ensure **our** members receive a high standard of service provision and are safeguarded against aberrant practice. **We** therefore do not consider recognition for benefit purposes to be a right, based purely on qualifications and experience nor on meeting **our** recognition criteria alone.

Types of approved recognition

Recognition of specialists and practitioners may be considered either individually or as a group.

Individual recognition status is considered for those specialists and practitioners who meet **our** recognition criteria, agree to abide by these terms of recognition and who will invoice and be reimbursed directly for the **eligible treatment** they provide to **our** members. Payments to any bank accounts that are not in the name of the approved clinician are not permissible unless **we** have formalised an agreement with the third party e.g. an out-patient clinic. To review the criteria relevant to each specialty and where appropriate, apply for approved status, please refer to **our** [website](#).

If your specialty is not listed within **our** recognition criteria e.g. chiropody, it is likely that your services are not eligible for benefit under the terms of **our** member policies. As such, approved status cannot be considered.

Group recognition status may be considered for a group practice where the group is properly constituted e.g. a limited liability partnership and is prepared to formalise an agreement with **us** based on quality and cost guarantees. In this respect, the group will be responsible for the services provided and will invoice on behalf of the attending clinicians for all **eligible treatment** undertaken. It should be noted however that each individual specialist working within the group practice will still need to retain current recognition with us.

Website listing

Specialists who are offered approved status will automatically have their specialty, contact and consulting details published on **our** website for the benefit of mutual and potential clients. Any **specialist** who does not wish their details to be published on **our** website must advise **us** in writing so that their listing may be removed.

Updating personal details

It is the responsibility of each approved **specialist** to ensure that his or her clinical and business details are kept up-to-date to ensure members have access to current information and that **specialists** receive appropriate and timely communications.

[A change of details form](#) is available on **our** website.

De-recognition

We continually review and maintain **our** database of recognised **specialists** and **clinical** or **complementary practitioners** in an effort to ensure that it is up-to-date. At the same time, **we** have developed close links with the relevant professional regulatory bodies and are kept abreast of registration changes and current and pending investigations. In the event that **we** are advised an individual **specialist** or **clinical** or **complementary practitioner** has had sanctions applied to their registration, **we** will automatically suspend and even withdraw their recognition status, in line with **our** recognition criteria. At that time, **we** will advise the individual concerned and confirm this in writing to the individual

concerned to the last correspondence address **we** have been given. Should the situation change and sanctions be lifted, **we** may consider re-instatement although this is not guaranteed. On receipt of a written request, **we** will review **our** decision based on clinical and commercial grounds and in line with the recognition criteria current at that time.

We also undertake regular audits of claims submitted by **specialists** and **clinical** and **complementary practitioners** and will consider de-recognition should serious or systematic anomalies be identified e.g. charging ineligible fees, up coding, etc.

Effective & appropriate medical treatment

We do not provide benefit for experimental or unproven procedures, including those using new technology or drugs, where safety and effectiveness have not been established. Clinicians must contact **our** medical department before undertaking treatment which might fall into this category. Under no circumstances should codes intended for existing procedures be used for new and as yet un-coded procedures. The narratives and codes are protected by copyright and may not be altered or used in any other way except as published in **our** Schedule of published fees.

In all instances **specialists** or **clinical** and **complementary practitioners** must work within their scope of practice and in line with their professional codes of conduct. Any new procedures that are not routinely undertaken within their routine practice must be considered and agreed by **us** in advance and in conjunction with the clinical governance committees at the treating facility.

Specialist fees

Specialists offered approved status subsequent to 01 July 2008 must invoice in accordance with **our** Schedule of published fees and must apply the tariff in accordance with the principles outlined below under Billing Principles. A copy of **our** fees is available on **our** website and **we** will update these on a regular basis.

Specialists must not ask **our** members to pay any additional amount themselves. The only exception to this is where members have a policy excess or co-payment policy – in these circumstances the benefit statement which will accompany the remittance advice will indicate that an excess or

co-payment has been applied. Members will therefore be responsible for payment of the excess or co-payment but only to the maximum of the applicable charges set out within **our** Schedule of published fees.

Charges will be subject to periodic audit and any charges made in breach of these principles are re-payable to **us** immediately to include written assurances that future billing will be in accordance with **our** published fees. Any breach of these terms will be taken seriously and may result in withdrawal of recognition.

Billing principles

We require all recognised providers of healthcare services to abide by principles of fair trading. The main principles which all providers must adhere to as a condition of recognition are as follows:

AXA PPP healthcare may make occasional additional discretionary payments at the prior agreement of the Medical Director for unusual or exceptionally complex cases. This should not be a regular occurrence and this concession may be withdrawn from any **specialist** who in the opinion of the Medical Director misuses this concession.

Procedure fees

The operator fee for a procedure includes all component parts of that procedure including preoperative assessment, the procedure itself and all routine aftercare including out-patient consultations for at least the first ten days.

Coding

Invoices must be coded using the industry standard CCSD codes.

The only items which must appear on an invoice are the (usually single) CCSD code for the procedure being performed, the standard procedure description and the charge being made. The code should only be used in conjunction with the standard description. If any procedure is undertaken which is not coded, **specialists** should contact the specialist fees team.

Unbundling

The component parts of single procedures or services must not be itemised out and billed as if they were separate or additional services. As a guide, there is no clinical intervention which should routinely need more than one code.

We will not reimburse additional charges for component parts of single procedures and will withdraw recognition from providers who persistently un-bundle charges. Unbundling includes:

- (a) Charging for two procedures where one is part and parcel of the other or is so frequently performed that it is in effect part and parcel.
- (b) Charging for in-patient care or ITU care where this is simply routine post-operative care.
- (c) Charging for pre-operative assessment or post-operative analgesia including nerve blocks.
- (d) Using procedure combinations whose primary purpose is to increase reimbursement. An example of this would be charging for wound infiltration with local anaesthesia.

We will publish guidance on unbundling and this will be available on **our** website in the near future. This list will contain the common unbundled combinations but as billing practices change over time, cannot be considered to be exhaustive.

Multiple Procedures

Different insurance companies have different rules about fees for multiple procedures. Where two procedures are performed at the same time **we** will pay the full benefit for the highest rated procedure and 50% of the fee for the second highest rated procedure. Only in the most exceptional circumstances and on a case-by-case basis discussed prior to any treatment taking place will third procedures be considered for additional reimbursement.

Multiple Specialists

Where two **specialists** operate on a member as a matter of preference, only a single fee is claimable.

Where two **specialists** operate on a member as a matter of best practice guidelines for example with acoustic neuromas, then an amount in total of 150% of the published fee can be claimed by the two surgeons to be split between them.

Where two **specialists** perform different procedures and where the second procedure cannot be performed by a single specialist, then the two **specialists** will be treated separately for the purposes of this fee schedule. An example would be a mastectomy followed by a DIEP flap.

Consultation Charges

An out-patient consultation means a face-to-face consultation only. Only a single consultation may be claimed on any one day.

Inpatient care charges are claimable only by the physician in charge of the case. Other **specialists** may claim benefit for specific consultations for specific problems only.

Anaesthetic Fees

The benefit for anaesthesia includes an amount for pre-operative assessment (whether on the ward or at a clinic), the anaesthetic itself including any lines or monitoring and post-operative care including analgesia, care in ITU or HDU, nerve blockage or neuroaxial blockade. None of these should be listed as extra.

Anaesthesia by the operator

There are many procedures which are commonly performed under local/topical anaesthesia or sedation by the operator such as removal of skin lesions, invasive cardiology procedures or flexible cystoscopy. The published surgical benefit includes an amount for anaesthesia by the operator and no additional charges should be made for this service. **We** may on a case by case basis allow an additional charge to be made for exceptional cases – these would be procedures where general or regional anaesthesia are normal – for example a hernia repair under local anaesthetic. Any such charges must be agreed with **our specialist fee team** in advance.

Intensive Care

For patients in intensive care which is medically necessary and not for routine care post surgery, a daily fee is payable as indicated in **our Schedule of published fees**. This covers consultation, monitoring and procedures such as CVP lines, arterial lines and dialysis, pulmonary artery catheters etc. This fee is applicable per patient and may be claimed by the individual **specialist** who provided the care on any one day or by one **specialist** on behalf of a group of **specialists**. In either event, only one daily fee is applicable. Additional fees may be claimed for procedures with a CCSD code and can be claimed by the **specialist** in primary charge of the case. Other **specialists** may claim for necessary consultations for specific problems but not a daily fee.

Chemotherapy & Radiotherapy

Charges for the administration and supervision of chemotherapy and radiotherapy should be made in accordance with the principles set out in the oncology section of the Schedule of published fees.

All Inclusive Fee Arrangements

Our contracts with hospitals listed in **our Directory of Hospitals** include some services where **specialists'** fees are included within the prices **we** have agreed with the hospitals, notably diagnostic radiology, pathology and in-patient therapies. In these circumstances **specialists** should negotiate appropriate remuneration for their services with the hospital. This arrangement provides clarity and reassurance for patients that all charges associated with such services are covered under **our** contract with the hospital.

Radiology

All diagnostic radiology must be billed through the hospital in accordance with contracted rates.

Therapeutic interventional radiology can be billed in accordance with **our Schedule of published fees**.

Pathology

All pathology charges must be billed through the hospital or clinic where the procedure took place.

Where the specimen is taken in a consulting room owned and managed by a consultant specialist, **we** will accept invoices from any recognised pathology facility with whom **we** have a fee agreement.

Facility Charges

Charges may be made for facilities provided there is a formal agreement in place between the facility and AXA PPP healthcare.

Payment

Payment will be made by monthly interval payment. This will be accompanied by a remittance advice which provides a breakdown of the total amount paid, the members it relates to and any shortfalls in payment made e.g. due to an **excess** on the member policy.

A corresponding benefit statement is also sent to the member advising them of any liability including an invoice to show the amount of any shortfall and to whom this should be paid. To support this payment, the member will

also be provided with the details of the **specialist's** invoice address that was either submitted on the application form or more recently on a change of address form. **Specialists** are advised to consider this if they have provided a home rather than a business address for this purpose.

Fraud and misrepresentation

The Fraud Act 2006 sets out the legal definition of fraud and creates offences of fraud by false misrepresentation, fraud by omission and fraud by abuse of position. A person who makes a false statement, omits material facts or misuses a position of trust with the intention of causing loss to a third party is guilty of fraud even if he or she does not personally gain and even if the deception fails. The law includes false statement made to any device capable of receiving information. Home Office guidance on the application of the Act states that it is intended to cover false statements made to insurance companies at underwriting.

Our business is conducted on the basis of good faith. **We** monitor claims using data mining software and routinely audit claims by reference to medical records. **We** will not tolerate fraud and misrepresentation and will cease doing business with any provider who provides false, misleading or selective information.

We will also refer cases of fraud to the General Medical Council and to the police as appropriate.

We consider the following examples constitute fraudulent billing:

- (a) Exaggeration of the complexity of the procedure performed – for example coding a diagnostic procedure as if it were therapeutic.
- (b) Misrepresentation of the medical history or the procedure performed.
- (c) Omission of material facts.
- (d) The use of jargon or technical information which, whilst strictly correct is presented in a way that is deliberately used to mislead a non-medically qualified claims assessor (an example would be a claim for laser in situ keratomileusis (LASIK) coded as a keratoplasty).
- (e) Unbundling.

Audit

On occasion, **we** conduct audits of medical notes as part of **our** quality control procedures. **Specialists** and **clinical** and **complementary practitioners** who are recognised by **us** for benefit purposes are required to provide this information on receipt of a signed consent letter from the member authorising this disclosure.

Network policies

The majority of **our** members (over 90%) have chosen to purchase a network policy which requires them to receive **treatment** at one of the facilities listed in their **Directory of Hospitals**. Under the terms of **our** network arrangement, **we** settle hospital charges in full for eligible treatment at any of these listed hospitals, but only a small daily benefit is paid if **in-patient treatment** and **day-patient treatment** is undertaken at a hospital facility which is not in **our** Directory.

This arrangement does not, however, compromise access to care that is medically necessary. Should a patient need facilities or treatments, which are not available at a convenient hospital in **our** Directory of Hospitals, then **we** will cover the costs of **eligible treatment** in full at whichever hospital is best able to provide the necessary care. However, this must be agreed with **us** before treatment takes place or, in an emergency, as soon as is possible after admission

To request an exemption, please complete a [network exemption referral form](#) and fax it to the number below. The nurses in the network team will be happy to review the clinical justification for the out-of-directory admission and confirm whether it will be eligible for full reimbursement.

Network exemption team:

Helpline: 01892 772218

Fax: 01892 772409

E-mail: network.exemption@axa-ppp.co.uk

Failure to pre-authorise out-of-directory admissions may result in the member incurring a significant shortfall in benefit.

Glossary

clinical practitioner

A practicing member of certain professions allied to medicine who, because of their qualification, **we** recognise for benefit purposes and in respect of whose services **we** will therefore pay benefits. However, **we** will only pay **out-patient treatment** benefits for services when a **specialist** refers a member to them. The professions concerned are **qualified nurses**, orthoptists, physiotherapists, psychologists, psychotherapists and speech therapists.

complementary practitioner

a medical practitioner with full registration under the Medical Acts, who specialises in homeopathy or acupuncture or a practitioner in osteopathy or chiropractic who is registered under the relevant Act; and who in all cases, meets **our** criteria for **complementary practitioner** recognition for benefit purposes and whom **we** have told in writing that **we** currently recognise them as a **complementary practitioner** for benefit purposes in that field of practice for the provision of **out-patient treatment** only.

day-patient treatment

Treatment which, for medical reasons, means the member requires a period of supervised recovery but does not need to stay overnight.

diagnostic tests

Investigations, such as x-rays or blood tests, to find or to help to find the cause of symptoms.

Directory of Hospitals

A document **we** publish which lists the **private hospitals, day-patient units** and **scanning centres** in the United Kingdom covered by the **policy**. The facilities listed may change from time to time.

eligible

Those **treatments** and charges which are covered by the member's **policy**.

in-patient treatment

Treatment which, for medical reasons, means the member requires to stay in hospital overnight or for longer.

out-patient treatment

Treatment given at a hospital, consulting room or out-patient clinic where the member does not go in the **in-patient** or **day-patient treatment**.

policy

The insurance contract between the member and **us**.

private hospital

A hospital listed in the current **Directory of Hospitals**.

scanning centre

A centre in which out-patient CT (computerised tomography), MRI (magnetic resonance imaging) and PET (positron emission tomography) is performed. The centres **we** recognise for benefit purposes are listed in the **Directory of Hospitals**.

specialist

A medical practitioner with particular training in an area of medicine (such as consultant surgeons, consultant anaesthetists and consultant physicians) with full registration under the Medical Acts, who meet **our** criteria for **specialist** recognition for benefit purposes and whom **we** have told in writing that **we** currently recognise them as a **specialist** for benefit purposes in their field of practice.

treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

we/us/our

AXA PPP healthcare.



PPP HEALTHCARE

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