PPP HEALTHCARE
redefining / healthcare

Call our Specialist Fees Team
☎ 01892 772160
Mon-Fri 9am-1pm
specialistfees@axa-ppp.co.uk
We may record and monitor calls for quality assurance, training and as a record of our conversation..

Notification of changes to AXA PPP Schedule of Procedures & Fees – May 2018

1. New Codes

Code	Narrative	Notes	Effective date
XR361	PROSTATE ARTERY EMBOLISATION		21/05/2018
B2999	RECONSTRUCTION OF BREAST USING STACKED DEEP INFERIOR EPIGASTRIC PERFORATOR FLAP(DIEP) (INCL DELAYED RECONSTRUCTION) (UNILATERAL FLAPS)	See 4. Unbundling	21/05/2018

2. Narrative Changes

Code	Previous Narrative	New Narrative	Notes	Effective date
W7470	REVISION OF ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION	REVISION OF ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION INCLUDING AUTOGRAFT/ALLOGRAFT		18/05/2018
P2420	SACROCOLPOPEXY (INCLUDING LAPAROSCOPIC)	SACROCOLPOPEXY (INCLUDING LAPAROSCOPIC) +/- URETEROLYSIS		18/05/2018

3. Deleted Codes

Code	Narrative	Notes	Effective date

4. Unbundling

Code	Narrative	Unbundled	Effective date
T2620	REPAIR OF RECURRENT INCISIONAL OR VENTRAL HERNIA REQUIRING MESH	Added; T4300	01/05/2018
T4300	LAPAROSCOPY INCLUDING BIOPSY AND ADHESIOLYSIS	Added; T2620	01/05/2018
Q0751	LAPAROSCOPIC SUBTOTAL HYSTERECTOMY (+/- OOPHORECTOMY) +/- URETEROLYSIS	Added; Q2230	01/05/2018
Q2230	LAPAROSCOPIC OOPHORECTOMY AND SALPINGECTOMY, +/- BIOPSY EG.	Added; Q0751	01/05/2018

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	OMENTUM, PERITONEUM, LYMPH NODE (AS SOLE PROCEDURE) - BILATERAL		
W6913	TOTAL SYNOVECTOMY OF LARGE JOINT	Added; W1380	15/05/2018
20140	24 HOUR ECG HOLTER (INCLUDING REPORTING)	Added; 20110 ; 20141	
W1380	ARTHROSCOPIC FEMORO-ACETABULAR SURGERY FOR HIP IMPINGEMENT SYNDROME	Added; W6913	15/05/2018
B2996	RECONSTRUCTION OF BREAST USING DEEP INFERIOR EPIGASTRIC PERFORATOR FLAP (DIEP) (INCLUDING DELAYED RECONSTRUCTION) - BILATERAL (SINGLE FLAP PER BREAST)	Added; S1700 ; S1740 ; S1750 S1900 ; S2000 S2002 ; S2502 S2503 ; S3500 S3530 ; S3532 S3622 ; S3623 T7620 ; W3180	21/05/2018
B2986	RECONSTRUCTION OF BREAST USING DEEP INFERIOR EPIGASTRIC PERFORATOR FLAP (DIEP) (INCLUDING DELAYED RECONSTRUCTION) - UNILATERAL (SINGLE FLAP)	Added; B2996	21/05/2018
S1700	DISTANT FLAP - DELAY/DIVISION/INSET	Added; B2996	21/05/2018
S1740	LARGE MYOCUTANEOUS (MUSCULAR/CUTANEOUS) FLAP (9CM2 OR MORE) (INCLUDING CLOSURE OF SECONDARY DEFECT)	Added; B2996	21/05/2018
S1750	LARGE MUSCLE FLAP (9CM2 OR MORE) (INCLUDING SKIN GRAFT AND CLOSURE OF SECONDARY DEFECT)	Added; B2996	21/05/2018
S1900	DISTANT PEDICLE FLAP - ELEVATION INCLUDING TRANSFER (INCLUDING CLOSURE/GRAFTING TO SECONDARY DEFECT)	Added; B2996	21/05/2018
S2000	LARGE ISLAND SKIN FLAP (9CM2 OR MORE) (EG RADICAL FOREARM) (INCLUDING CLOSURE OF SECONDARY DEFECT)	Added; B2996	21/05/2018
S2002	SMALL ISLAND FLAP (LESS THAN 9CM2)	Added; B2996	21/05/2018
S2220	NEUROVASCULAR ISLAND FLAP	Added; B2996	21/05/2018
S2500	LOCAL FLAP - LESS THAN 9CM2	Added; B2996	21/05/2018
S2502	LOCAL FLAP - 9CM2 OR MORE (EXCLUDING GRAFT/FLAP TO	Added; B2996	21/05/2018

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	SECONDARY DEFECT)		
S2503	LOCAL FLAP - 9CM2 OR MORE (INCLUDING GRAFT/FLAP TO SECONDARY DEFECT)	Added; B2996	21/05/2018
S3500	SPLIT AUTOGRAFT OF SKIN, TRUNK AND LIMBS - UP TO 25CM2 IN AREA	Added; B2996	21/05/2018
S3530	SPLIT AUTOGRAFT OF SKIN, TRUNK AND LIMBS - OVER 25CM2 AND UP TO 5% OF BODY SURFACE AREA	Added; B2996	21/05/2018
S3532	SPLIT AUTOGRAFT OF SKIN, TRUNK AND LIMBS - EACH ADDITIONAL 5% OF BODY SURFACE AREA	Added; B2996	21/05/2018
S3622	FULL THICKNESS GRAFT, TRUNK AND LIMBS - UP TO 9CM2 IN AREA	Added; B2996	21/05/2018
S3623	FULL THICKNESS GRAFT, TRUNK AND LIMBS - EACH ADDITIONAL 25CM2 IN AREA	Added; B2996	21/05/2018
T7620	FREE FUNCTIONING MUSCLE TRANSFER (AS SOLE PROCEDURE) (INCLUDING CLOSURE OF SECONDARY DEFECT)	Added; B2996	21/05/2018
W3180	FREE COMPOSITE (IE INCLUDING BONE) VASCULARISED GRAFTS	Added; B2996	21/05/2018
20110	ECG (INCLUDING REPORTING)	Added; 20140	21/05/2018
B2999	RECONSTRUCTION OF BREAST USING STACKED DEEP INFERIOR EPIGASTRIC PERFORATOR FLAP(DIEP) (INCL DELAYED RECONSTRUCTION) (UNILATERAL FLAPS)	Added; S1700; S1740; S1750; S1900; S2000; S2002; S2220; S2500; S2502; S2503; S3500; S3530; S3532; S3622; S3623; T7602; T7603; T7620; W3180	21/05/2018
W3180	FREE COMPOSITE (IE INCLUDING BONE) VASCULARISED GRAFTS	Added; B2999	21/05/2018

5. Fee Changes

Code	Narrative	Notes	Effective date

6. Other

Code	Narrative	Notes	Effective date

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7. Billing Principles

Previous Narrative	New Narrative	Effective date
Introduction This is the Schedule of procedures and fees for providers recognised by AXA PPP healthcare. It includes codes for procedures for which our policies provide benefit and is based on work undertaken by the Clinical Coding and Schedule Development group (CCSD). It also details billing principles which apply to invoices for private medical services provided to our members. **Reimbursement status** 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 AXA PPP healthcare in advance and in conjunction with the clinical governance committees at the treating facility. This document sets out what AXA PPP healthcare would expect specialist and practitioners to charge for the services they provide to patients. We will pay eligible fees in full when a specialist or practitioner charges up to the level shown within this document for treatment that they have provided; no payments will be made for supervision of services provided by others. All services claimed for must be listed in the Schedule of Procedures and Fees. We have identified certain specialists and practitioners whose fees exceed this limit and these specialists' and practitioners' charges will always be limited to the level shown in the Schedule of Procedures and Fees for Fee Limited Specialists and any excess charge over this amount will not be	**Introduction** This is the Schedule of procedures and fees for providers recognised by AXA PPP healthcare. It includes codes for procedures for which our policies provide benefit and is based on work undertaken by the Clinical Coding and Schedule Development group (CCSD). It also details billing principles which apply to invoices for private medical services provided to our members. **Reimbursement status** 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 AXA PPP healthcare in advance and in conjunction with the clinical governance committees at the treating facility. This document sets out what AXA PPP healthcare would expect specialist and practitioners to charge for the services they provide to patients. We will pay eligible fees in full when a specialist or practitioner charges up to the level shown within this document for treatment that they have provided; no payments will be made for supervision of services provided by others. All services claimed for must be listed in the Schedule of Procedures and Fees. We have identified certain specialists and practitioners whose fees exceed this limit and these specialists' and practitioners' charges will always be limited to the level shown in the Schedule of Procedures and Fees for Fee Limited Specialists and any excess charge over this amount will not be	01/05/2018

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reimbursed. **Billing principles** The main principles which all providers must adhere to as a condition of recognition are as follows: **Procedure Code Query** If the operator is uncertain how to code for a specific procedure then they can ask us to advise what code they should use. To determine what the appropriate representative code is we will require the following information, a copy of the clinic letter and/or a justification letter detailing what is planned to take place during the treatment, this can be sent to us by using the following link https://survey.axappphealthcare.co.uk/pss-recognition-fees **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 consultation for at least the first ten days. **Injections** We do not accept separate charges for giving sub-cutaneous, intramuscular or intravenous injections (or vaccinations where eligible) as on their own these are not deemed to be separate surgical procedures and any charge for giving injections is covered by the standard consultation charge. **Coding** Invoices must be coded using the industry standard CCSD codes as listed in this Schedule. The only item which should appear on an invoice is the (usually single) CCSD code for the procedure being performed. This code should only be used for the use set out in the standard	reimbursed. **Billing principles** The main principles which all providers must adhere to as a condition of recognition are as follows: **Procedure Code Query** If the operator is uncertain how to code for a specific procedure then they can ask us to advise what code they should use. To determine what the appropriate representative code is we will require the following information, a copy of the clinic letter and/or a justification letter detailing what is planned to take place during the treatment so that we can identify the most appropriate code for the planned treatment, this can be sent to us by using the following link https://survey.axappphealthcare.co.uk/fee-query **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 consultation for at least the first ten days. **Injections** We do not accept separate charges for giving sub-cutaneous, intramuscular or intravenous injections (or vaccinations where eligible) as on their own these are not deemed to be separate surgical procedures and any charge for giving injections is covered by the standard consultation charge. **Coding** Invoices must be coded using the industry standard CCSD codes as listed in this Schedule. The only item which should	

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description. If a code states 'as sole procedure' in its narrative it should not be performed in addition to another procedure. If any procedure is undertaken which is not coded, specialists should contact the specialist fees team with a detailed letter outlining what is being done and a breakdown of the proposed costs via the following link https://survey.axappphealthcare.co.uk/pss-recognition-fees **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 unbundle charges. Unbundling includes: • 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. • Charging for in-patient care or ITU care where this is simply routine post-operative care. • Charging for pre-operative assessment or post-operative analgesia including nerve blocks. • Using procedure combinations whose primary purpose is to increase reimbursement. An example of this would be charging for wound infiltration with local anaesthesia. • Charging for anaesthetic when anaesthetic services have also been provided by an anaesthetist. **Multiple procedures** Different insurance companies have	appear on an invoice is the (usually single) CCSD code for the procedure being performed. This code should only be used for the use set out in the standard description. If a code states 'as sole procedure' in its narrative it should not be performed in addition to another procedure. If any procedure is undertaken which is not coded, specialists should contact the specialist fees team with a detailed letter outlining what is being done and a breakdown of the proposed cost so that we can identify the most appropriate code to be used or the most appropriate level of reimbursement for the planned treatment, this can be sent to us by using the following link https://survey.axappphealthcare.co.uk/fee-query **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 unbundle charges. Unbundling includes: • 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. • Charging for in-patient care or ITU care where this is simply routine post-operative care. • Charging for pre-operative assessment or post-operative analgesia including nerve blocks. • Using procedure combinations whose primary purpose is to increase reimbursement. An example of this would be charging	

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different rules about fees for multiple procedures. Where two procedures are performed at the same time we will pay 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 further procedures be considered for additional reimbursement. Please contact the specialist fees team via the following link & include copies of the Anaesthetist Charts & the Operation Notes for our review: https://survey.axappphealthcare.co.uk/pss-recognition-fees **Multiple specialists** Where two or more specialists operate on a member as a matter of preference, only a single fee is claimable. 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. These requests must be preauthorised and will be considered on a case by case basis, a justification letter will be required that clearly explains the clinical need for additional specialists to be present. Please contact the specialist fees team via the following link https://survey.axappphealthcare.co.uk/pss-recognition-fees In any other circumstances where two specialists are required, this should be agreed in advance with the specialist fees team. **Fees Outside Of Our Billing Principles** Requests for additional fees for services that sit outside of our billing principles must be preauthorised & will be considered	for wound infiltration with local anaesthesia. • Charging for anaesthetic when anaesthetic services have also been provided by an anaesthetist. **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 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 further procedures be considered for additional reimbursement. Please contact the specialist fees team via the following link & include copies of the Anaesthetist Charts & the Operation Notes for our review so that we can understand the additional complexities involved during the surgery that may indicate that a higher fee may be warranted: https://survey.axappphealthcare.co.uk/fee-query **Multiple specialists** Where two or more specialists operate on a member as a matter of preference, only a single fee is claimable. 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. These requests must be preauthorised and will be considered on a case by case basis, a justification letter will be required that clearly explains the medical need for additional specialists to be present, the procedure codes, the estimated time in	

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on a case by case basis. To review a request we will require a copy of the clinic letter sent back to the GP which relates to the specific treatment you are recommending and/or a justification letter detailing why this additional cost is warranted. Please contact the specialist fees team via the following link https://survey.axappphealthcare.co.uk/pss-recognition-fees **Consultation charges** A consultation means a face-to-face consultation only. Only a single consultation may be claimed on any one day, consultation fees are set regardless of time or complexity. We do not provide benefit for consultations using electronic communication for example by email, telephone or across the internet. Consultation fees are inclusive of any room charges or any other additional charges. In-patient care charges are claimable only by the physician in charge of the case and are for face to face visits and are not claimable for being on-call. Other specialists may claim benefit for specific consultations for specific problems only, but this should be pre-authorised. We consider out-patient follow-up within ten days of a surgical procedure to be an integral part of post-operative care and thus to be covered by the charge for the procedure and this would not be reimbursed as an extra service. During the course of a members treatment we may need to request medical information or a Medical Information Form may need to be completed to obtain relevant information about a claim. We try to ensure that only the minimum amount of information is requested in order to service the request. Any medical information or Medical Information Form submitted must be completed and/or signed by the controlling specialist. Please	theatre and requested fees (for each specialist) so that we can determine the appropriate level of reimbursement required . Please contact the specialist fees team via the following link https://survey.axappphealthcare.co.uk/fee-query In any other circumstances where two specialists are required, this should be agreed in advance with the specialist fees team. **Fees Outside Of Our Billing Principles** Requests for additional fees for services that sit outside of our billing principles must be preauthorised & will be considered on a case by case basis. To review a request we will require a copy of the clinic letter sent back to the GP which relates to the specific treatment you are recommending and/or a justification letter detailing why this additional cost is warranted so that we can understand the clinical rationale for the recommended treatment and determine the appropriate level of reimbursement required. Please contact the specialist fees team via the following link https://survey.axappphealthcare.co.uk/fee-query **Consultation charges** A consultation means a face-to-face consultation only. Only a single consultation may be claimed on any one day, consultation fees are set regardless of time or complexity. We do not provide benefit for consultations using electronic communication for example by email, telephone or across the internet. Consultation fees are inclusive of any room charges or any other additional charges. In-patient care charges are claimable only by the physician in charge of the case and are for face to face visits and are not	

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note that we do not expect any charge to be made for the provision of this information or the completion of the report. **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, neuroaxial blockade or epidural. None of these should be listed as extra. Operations should be coded using the single CCSD code which describes the operation performed plus all its component parts. Additional codes should only be used for genuine separate and additional procedures. There is no code for CVP lines as part of anaesthesia or ITU care and specifically the code L9110 should not be used. **Anaesthesia by the operator** There are many procedures which are commonly performed under local/topical anaesthesia by the operator such as investigations and simple procedures, including but not limited to those procedures listed in Chapter 1. E.g. removal of skin lesions. In these instances the published surgical benefit includes an amount for anaesthesia by the operator and no additional charges should be made for this service. For some procedures normally performed under general or regional anaesthesia an additional fee of up to £100 may be made for IV sedation by the main operator as long as no separate anaesthetic is billed. An example of this is a colonoscopy under IV sedation. This should be billed as code X3510 and an asterisk will show which codes this is allowed with. If you require any further advice please contact the Specialist Fees team via the following link https://survey.axappphealthcare.co.uk/pss-	claimable for being on-call. Other specialists may claim benefit for specific consultations for specific problems only, but this should be pre-authorised. We consider out-patient follow-up within ten days of a surgical procedure to be an integral part of post-operative care and thus to be covered by the charge for the procedure and this would not be reimbursed as an extra service. During the course of a members treatment we may need to request medical information or a Medical Information Form may need to be completed to obtain relevant information about a claim. We try to ensure that only the minimum amount of information is requested in order to service the request. Any medical information or Medical Information Form submitted must be completed and/or signed by the controlling specialist. Please note that we do not expect any charge to be made for the provision of this information or the completion of the report. **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, neuroaxial blockade or epidural. None of these should be listed as extra. Operations should be coded using the single CCSD code which describes the operation performed plus all its component parts. Additional codes should only be used for genuine separate and additional procedures. There is no code for CVP lines as part of anaesthesia or ITU care and specifically the code L9110 should not be used. **Anaesthesia by the operator** There are many procedures which are *continued on next page*	

recognition-fees **Intensive care** For patients in intensive care which is medically necessary and not for routine care post-surgery, a fee is payable as indicated in this Schedule. This covers consultation, monitoring and procedures such as CVP lines, arterial lines and dialysis, pulmonary artery catheters etc. 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 and radiotherapy** Charges for the administration and supervision of chemotherapy and radiotherapy should be made in accordance with the principles set out section 18 of this Schedule. **All inclusive fee arrangements** Our contracts with hospitals listed in our Network of Hospitals www.axappphealthcare.co.uk/specialists 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 fees contained in this Schedule.	commonly performed under local/topical anaesthesia by the operator such as investigations and simple procedures, including but not limited to those procedures listed in Chapter 1. E.g. removal of skin lesions. In these instances the published surgical benefit includes an amount for anaesthesia by the operator and no additional charges should be made for this service. For some procedures normally performed under general or regional anaesthesia an additional fee of up to £100 may be made for IV sedation by the main operator as long as no separate anaesthetic is billed. An example of this is a colonoscopy under IV sedation. This should be billed as code X3510 and an asterisk will show which codes this is allowed with. If you require any further advice please contact the Specialist Fees team via the following link https://survey.axappphealthcare.co.uk/fee-query **Intensive care** For patients in intensive care which is medically necessary and not for routine care post-surgery, a fee is payable as indicated in this Schedule. This covers consultation, monitoring and procedures such as CVP lines, arterial lines and dialysis, pulmonary artery catheters etc. 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 and radiotherapy** Charges for the administration and supervision of chemotherapy and radiotherapy should be made in accordance with the principles set out section 18 of this Schedule. **All inclusive fee arrangements** Our contracts with hospitals listed in our *continued on next page*	

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 which we have a fee agreement. **Facility, Consumable and Equipment Charges** Charges may be made for facilities provided there is a formal agreement in place between the facility and AXA PPP healthcare. Consumable items (including drug costs) and equipment charges should be invoiced to AXA under the agreement of the facility unless there has been a prior arrangement made directly with AXA PPP healthcare. No charges should be made for any item which is not subject to a formal agreement. **Submission of Claims** In line with our members' policies, all eligible claims must be submitted within six months of treatment. Invoices for eligible treatment must be submitted electronically and full treatment details must be provided to avoid processing delays. Electronic billing must be submitted via Healthcode & the following link www.healthcode.co.uk/medical-billing/home When you open this link you should select the option to "register for HC VEDA". **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	Network of Hospitals www.axappphealthcare.co.uk/specialists 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 fees contained in this Schedule. **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 which we have a fee agreement. **Facility, Consumable and Equipment Charges** Charges may be made for facilities provided there is a formal agreement in place between the facility and AXA PPP healthcare. Consumable items (including drug costs) and equipment charges should be invoiced to AXA under the agreement of the facility unless there has been a prior arrangement made directly with AXA PPP healthcare. No charges should be made for any item which is not subject to a formal agreement.	

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members it relates to and any shortfalls in payment made such as shortfalls due to a policy excess. A similar remittance advice 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.

Effective and 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 or generally accepted. Please contact the Medical Department at AXA PPP healthcare 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 uncoded procedures. The narratives and codes are protected by copyright and may not be altered or used in any other way except as published in the Schedule of procedures and fees.

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

Submission of Claims

In line with our members' policies, all eligible claims must be submitted within six months of treatment. Invoices for eligible treatment must be submitted electronically and full treatment details must be provided to avoid processing delays. Electronic billing must be submitted via Healthcode & the following link www.healthcode.co.uk/medical-billing/home

When you open this link you should select the option to "register for HC VEDA".

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 such as shortfalls due to a policy excess. A similar remittance advice 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.

Effective and 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 or generally accepted. Please

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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:

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

Audit

On occasion, we conduct audits of medical notes as part of our quality control procedures. Specialists and practitioners who are recognised by us for benefit purposes are required to provide this information on receipt of a consent form

contact the Medical Department at AXA PPP healthcare 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 uncoded procedures. The narratives and codes are protected by copyright and may not be altered or used in any other way except as published in the Schedule of procedures and fees.

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:

- Exaggeration of the complexity of the procedure performed for example coding a diagnostic

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signed by 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 our 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 treatment is undertaken at a 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 which can be found at www.axapphealthcare.co.uk specialists/contact us/Network Exemption/PDF Hospital Exemption form and fax it to the number below. The Network team will review the clinical justification for an out-of-directory admission and confirm whether it will be eligible for full reimbursement.

Network exemption team:

Helpline: 01892 772218

Fax: 0117 972 6006

procedure as if it were therapeutic.
- Misrepresentation of the medical history or the procedure performed.
- Omission of material facts.
- The use of jargon or technical information which whilst strictly correct is presented in a way likely to mislead a non-medically qualified claims assessor (an example would be a claim for laser insitu keratomileusis (LASIK) coded as keratoplasty).
- Unbundling.

Audit

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

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This letter is available in other formats

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