Reid June Newsletter

June 20, 2017

Transplant Service Changes

Important message from Robert Good, DO, Chief Medical Officer and April Vogelsang, RN, MS, VP of Medical Management:

In order to streamline transplant services for our members and providers, we are changing the way transplant services are managed.

Once we approve a member for a transplant, services will be managed through Your Health Alliance for providers and office personnel. Any services that occur before our approval of the transplant should follow current preauthorization processes.

If you have questions about this information, contact your provider relations specialist.

2017 Medicare Provider Manual Available

You can find the Medicare provider manual for all of our plans in the Forms & Resources section of Your Health Alliance for providers. In it, you'll find more information about:

- Our Quality Improvement program, including its purpose, goals, objectives, scope, structure, key personnel, and technical resources and systems
- Our complex case management program and how to refer a member
- How to access and request our utilization management and pharmaceutical management criteria
- Affirmative statement about incentives related to UM decision making
- When decision timeframes begin for non-urgent pre-service requests received after business hours
- How to use our pharmacy management procedures and processes, including our formulary, pharmaceutical classes, tier information, preauthorizations, managed dose limitations, step-therapy, generic substitution, pharmacy savings programs, and how to request a medical exception
- Our disease management programs, including what we do and how you and your patients can access program services

- A comprehensive list of clinical guidelines, including non-preventive, preventive, and behavioral health
- Preventive care guidelines for all age groups
- Members' rights and responsibilities

Meet with a Coding Specialist

The risk adjustment coding consultants are continuing to request meetings with participating, high-volume provider offices. These meetings are designed to share member-specific examples of coding and quality measure needs and to update providers on the latest efforts to educate on risk adjustment. Along with member specific examples, there is information on yearly risk adjustment data validation (RADV) audits and how provider practice participation is essential in this process.

A member of the coding consultant team is willing to meet with you to discuss any coding or quality questions you may have, or to provide member-specific examples from your panel of members. If interested, contact us at CodingCounts@healthalliance.org.

Preauthorization Update

Currently, our Medical Management department is preparing for Wave 2 of eviCore, which will start for dates of service on August 1 or after. You'll be able to access eviCore for these Wave 2 updates starting on July 14.

Our Medical Management team also manages the Clear Coverage requests that come in through Your Health Alliance for providers, and we are following the established CMS and NCQA regulations regarding standard and urgent timeframes for organization determinations.

In order to meet these timeframes, you should be sure to follow the evidenced based guidelines for that particular service or procedure and to provide all necessary supporting medical documentation. Attaching the necessary medical records while completing the online request will help expedite the decision and response time.

Clinical Documentation Through eviCore

When submitting a preauthorization request to eviCore, it is very important that you include any requested clinical documentation with the original submission. This will help avoid unnecessary delays with processing your requests and denials and appeals that are later overturned once relevant clinical information has been received.

For commercial members, there is also a reconsideration period, but you must request the reconsideration within the 14-day window.

Metabolic Panel Coverage

Starting August 1, all metabolic panel codes (80047, 80048, 80050, and 80053) will be paid under the medical benefit for most plans. Some of these codes may still be considered wellness for certain self-funded plans.

If you have any questions, contact your provider relations specialist.

Modifier 50 – Bilateral Procedures Type 3

If you have questions about the reimbursement of the 50 modifier for radiology services, these details about bilateral indicator 3 can help.

Modifier 50 is used as a payment modifier, rather than an informational modifier. Adding this modifier could affect payment, depending on the procedure code and the bilateral surgery indicator. The bilateral surgery indicator for each procedure code can be found on the Medicare Physician Fee Schedule, which we follow.*

Many radiology services have a bilateral indicator 3, which means the usual payment adjustment for bilateral procedures does not apply. If the procedure is reported to us with modifier -50, it will affect your allowed since it's configured as a pricing modifier in our system.

Report services with a bilateral indicator 3 on 2 lines of service, using RT on one line and LT on the other, with one unit of service each, for the expected reimbursement.

Please review your claims for surgical procedures codes appended with modifier 50. If reimbursement is different than expected, contact your PRS to ensure you have been configured correctly.

The 5 W's of HEDIS

What

The National Committee for Quality Assurance (NCQA) continues to be the gold standard for health plan accreditation, and we've worked with the NCQA since 1995. The NCQA accredits and certifies a wide range of health care organizations and manages the evolution of HEDIS® (Healthcare Effectiveness Data and Information Set), the performance measurement tool used by more than 90% of the nation's health plans.

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare health care quality. The annual HEDIS audit includes distribution and reporting of the CAHPS® (Consumer Assessment of Health Plan Survey). Results of the annual HEDIS

audit are combined with the NCQA survey scores to provide the overall NCQA score for health plans. The overall score consists of 50 possible points for the NCQA standards, 37 possible points for the annual HEDIS audit, and 13 possible points for the annual CAHPS results.

Why

For our members, your patients, healthcare quality is imperative. By working together, we can improve care and service, as measured through HEDIS scores from the health plan perspective, which also drives improvement efforts through:

- Medicare Stars
- Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMS)

Who

The HEDIS team consists of 2 key leaders, a HEDIS technician, a dedicated reporting analyst, and 6 coordinators that ensure timely and accurate completion of HEDIS data collection and reporting. Key leaders with a diversity of knowledge and skills help to integrate the data through our quality improvement programs.

Our Quality Improvement Committee (QIC)'s primary responsibility is to provide direction, oversight, and appropriate resources for quality. Data from the annual HEDIS audit is reported to the QIC to evaluate and refine quality improvement programs, including disease management, wellness, and other interventions and initiatives that continuously improve the care and service provided to our members, your patients.

When

The HEDIS timeline to ensure continuous quality improvement includes:

- January through May
  - CAHPS survey populations identified and survey tool distributed.
  - External HEDIS auditors are onsite at Health Alliance to perform a complete assessment of our systems and processes.
  - Random samples are pulled to start the data abstraction process begins. (**Note:** In 2017, our medical record review team reviewed approximately 16,486 medical records as part of the annual HEDIS submission process.
- May through June
  - HEDIS medical record data is finalized and submitted to the external HEDIS auditors. Once the audit is final, data is submitted to NCQA.
- June through July
  - Current HEDIS results are evaluated to assess the impact of interventions.

- - Mid-year adjustments to programs are made as needed.
    - Provider-specific HEDIS is gathered for reporting on key measures.
  - August through December
    - CAHPS results are reviewed and interventions developed.
    - Prospective HEDIS is conducted to identify care gaps and provide the catalyst for change to ensure programs continue to evolve.

HEDIS data is gathered 2 ways, depending on the HEDIS technical specifications for each measure:

- Administrative data, which is based on claims submitted to the health plan.
- Hybrid data, where each hybrid measure is sample-driven, and data is obtained from medical record review (via either remote EMR access or at provider offices). HEDIS staff is trained on abstraction of hybrid measures and undergo inter-rater reliability testing on each measure to ensure accuracy of the data.

Watch for additional information on specific HEDIS measures in future InforMED newsletters. For more information on how we can help support your quality efforts, contact the Quality Management Department at 217-337-8112.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Pharmacy Updates

All Plans

Formulary Additions

- Adlyxin (lixisenatide) – Indicated for the treatment of Type 2 Diabetes Mellitus to improve glycemic control in adult patients as an adjunct to diet and exercise.
  - Medicare – Non-formulary
- Soliqua 100/33 (insulin glargine and lixisenatide) – Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (< 60 units daily) or lixisenatide.
  - Medicare – Non-formulary

- Xultophy 100/3.6 (insulin degludec and liraglutide) – Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus inadequately controlled on basal insulin (less than 50 units daily) or liraglutide (less than or equal to 1.8mg daily).
    - Medicare – Tier 4 with step-therapy (ST), either a formulary GLP-1 or basal insulin
- Rayaldee (calcifediol) – Indicated for the treatment of secondary hyperparathyroidism in adults with stage 3 or 4 chronic kidney disease and serum total 25-hydroxyvitamin D levels less than 30 ng/mL.
    - Medicare – Non-formulary
- Trulance (plecanatide) – Indicated for treatment of Chronic Idiopathic Constipation in adults.
    - Medicare – Non-formulary

Contact Us

1-800-851-3379, option 3

Legal and Privacy

Privacy Practices

Code of Conduct

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