# Reid February Newsletter

February 13, 2018

## Utilization Review Determinations

As you all know, in 2017 we entered into a partnership with eviCore for managing certain preauthorization and utilization management requests. Some providers may be communicating to patients that eviCore is making coverage decisions.

We own all utilization review decisions, so any determinations made by us or through our partnership with eviCore should be communicated as coming from Health Alliance.

This helps our members avoid confusion and ensures they contact us directly when they need help. All members should be contacting us at the numbers on the back of their ID cards for any coverage concerns, regardless of how the review was processed.

## Claims Editing Enhancements

Our claims editing program follows nationally accepted sources. We continuously deploy enhancements. These professional claims enhancements will be released in March:

- **Anatomical modifiers**, as outlined in the HCPC manual on procedures that designate an area or part of the body for which the procedure was performed. When an anatomical modifier is **not** appended, then the procedure code will also be disallowed, and you must submit a corrected claim with the anatomical modifier.

  Examples of anatomical modifiers:

  - E1-E4 – Eyelids
  - FA-F9 – Fingers
  - TA-T9 – Toes
  - LC – Left circumflex, coronary artery
  - LD – Left anterior descending coronary artery
  - LM – Left main coronary artery
  - RC – Right coronary artery

    - RI – Ramus intermedius
    - LT – Left side
    - RT – Right side
- **Anesthesia modifiers** that show whether the service was personally performed, medically directed, medically supervised, or represented monitored anesthesia care for members on commercial plans. (In the past, we'd only required this for Medicare members).

  Similarly, CRNAs must report the appropriate anesthesia modifier to indicate whether the service was performed with or without supervision by a physician. When an anesthesia modifier is **not** appended to an anesthesia procedure, then the procedure code will also be disallowed, and you must submit a corrected claim with the anesthesia modifier.

  Appropriate modifiers for anesthesia services are:

    - AA – Anesthesia services performed personally by an anesthesiologist
    - AD – Medical supervision by a physician: more than 4 concurrent anesthesia procedures
    - G8 – Monitored anesthesia care [MAC] for deep complex, complicated, or markedly invasive surgical procedure
    - G9 – Monitored anesthesia care (MAC) for patient who has history of severe cardiopulmonary condition
    - QK – Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
    - QS – Monitored anesthesiology care services
    - QX – Qualified nonphysician anesthetist with medical direction by a physician
    - QY – Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
    - QZ – CRNA without medical direction by a physician

  You also should not bill multiple anesthesia modifiers AA, AD, QK, QX, QY, and QZ on the same claim line since they're considered mutually exclusive.

- **ICD-10 laterality codes.** Some ICD-10 codes specify if the condition occurs on the left or right or bilaterally. If no bilateral code is provided and the condition is bilateral, then you should use codes for both the left and right. If the side is not identified in the medical record, then you should use the unspecified code.

  In addition, we will perform additional comparisons, such as:

    - The Diagnosis-to-Diagnosis comparison, which assesses the lateral diagnoses associated with the same claim line to determine if the combination is inappropriate

- The Diagnosis-to-Modifier comparison, which assesses the lateral diagnosis associated with the claim line to determine if the procedure modifier matches the lateral diagnosis

**We will be editing across same date of service for any Tax ID, any Provider ID, and specialty following Medicare CCI/MUE edits, as well as identification of duplicative services.**

## Diagnosis Codes and Risk Adjustment

Both the Medicare Advantage and commercial Marketplace condition category models are dependent on us receiving diagnosis codes through claims submission. We recommend that all claims submitted to us be coded to the highest level of specificity for the encounter reported. 2 areas of opportunity related to provider business processes that could significantly improve to support this higher level of coding accuracy include:

- Code truncation, or limiting the number of diagnosis codes per claim submission
- Claims not submitted at all (e.g. claims for capitated, custodial care, etc.)

These scenarios lead to inaccurate reporting of the overall risk of our population. Please assess your billing practices at an organizational and provider level to ensure these situations don't apply to you.

If you identify these issues in your provider system, contact us at CodingCounts@healthalliance.org, and we'll reach out to help with a solution.

## New Medicare Numbers & Cards Coming in April 2018

Medicare is taking steps to remove Social Security numbers from Medicare cards to help fight fraud. People with Medicare will begin receiving new Medicare cards in April 2018, until all cards are replaced by April 2019. These cards will have a Medicare Beneficiary Identifier (MBI) number that is randomly generated.

Medicare will send people their new ID cards directly, and CMS will send us the new numbers to put in our system. This will not affect the ID cards we issue. Members may still get new ID cards from us as they renew, but that's unrelated to the Medicare card changes.


# HEDIS® Chart Reviews Coming Soon

Each spring, Health Alliance collects data to determine how we measure up against national averages for HEDIS® (the Healthcare Effectiveness Data and Information Set). This data collection and analysis indicates where we need to focus our quality efforts and is required for NCQA accreditation.

Successfully generating our HEDIS report depends largely on the cooperation we receive from provider office staff. Our representatives may visit your office this spring and ask to review specific medical records or ask you to copy, fax, or mail records to us as part of the audit. All individually identifiable information concerning patients will be kept strictly confidential in compliance with HIPAA regulations.

Results of the HEDIS audit will be available on our website in the fall of 2018.

If you have any questions about HEDIS, contact the Quality Management Department at 1-800-851-3379, ext. 8656.

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

# Potentially Harmful Drug-Disease Interactions in the Elderly

Potentially Harmful Drug-Disease Interactions in the Elderly is a HEDIS measure that shows the percentage of Medicare members 65 years of age and older who have evidence of underlying diseases, conditions, or health concerns and who have filled prescriptions for potentially harmful medications. We've identified 2 conditions, history of falls and dementia, for review.

These tables show Health Alliance's results from the HEDIS 2017 audit and the national average.

Percentage of members with a **history of falls** and a medication fill for anticonvulsants, non-benzodiazepine hypnotics, SSRIs, antiemetic, antipsychotics, benzodiazepines, or tricyclic antidepressants:

| Service Area | HEDIS 2017 | National Average |
|---|---|---|
| Illinois and Indiana | 48.71% | 47.27% |
| Washington | 52.70% | 47.27% |
| Iowa | 47.50% | 47.27% |

Since a lower rate reflects better performance, our results are worse than the national average.

Percentage of members with diagnosis of **dementia** and a medication fill for antiemetic, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, non-benzodiazepine hypnotics, or anti-cholinergic agents:

| Service Area | HEDIS 2017 | National Average |
|---|---|---|
| Illinois and Indiana | 48.77% | 46.24% |
| Washington | 45.54% | 46.24% |
| Iowa | Not enough data to report | |

The lower rate reflects better performance.

As you can see, our Medicare Advantage results are close to the same or worse than the national average.

Some of the most frequently prescribed medications on the potentially harmful medication lists are Zolpidem, Promethazine, Haloperidol, Alprazolam, Hydroxyzine, and Amitriptyline. If you have older patients on these medications or other medications in these drug classes, consider changing their medication to a safer alternative.

# Pharmacy Update

## All Plans

### Morphine Equivalent Dose (MED) Coding

- Tentatively expected by the end of January 2018

### Formulary Additions

- Shingrix vaccine – Approved for patients 50 years and older per MMWR recommendations.
    - Medicare – Tier 3 with 2 copays (one for each of the 2 injections) for patients over 50

## Medicare

### New Policies

- AAT Deficiency
    - Created new AAT Deficiency policy to merge existing criteria from Aralast, Glassia, Prolastin-C, and Zemaira
- Amitriptyline
    - Removed amitriptyline criteria from Medicare Tricyclic Antidepressant policy and created stand-alone amitriptyline policy
- Doxercalciferol
    - 2018 doxercalciferol Medicare PA criteria approved by CMS
    - Commercial doxercalciferol policy approved at April P&T meeting
- Enbrel
    - PA criteria approved by CMS for 2018
    - Existing Enbrel patients have had PA grandfathered for 2018
- Haegarda
    - 2018 Haegarda Medicare PA criteria approved by CMS
    - Commercial Haegarda policy approved at October P&T meeting
- Humira
    - PA criteria approved by CMS for 2018
    - Existing Enbrel patients have had PA grandfathered for 2018

### Tier Changes – Effective January 1, 2018

- Combigan – Moved from Non-Formulary to Tier 3
- Narcan Nasal Spray – Moved from Non-Formulary to Tier 3

## Contact Us

1-800-851-3379, option 3





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