Reid Health Alliance Medicare
In Partnership with Health Alliance

Reid June Informed Newsletter

June 12, 2018

As It Relates to You

Coming Soon: New Online Resources and Training Opportunities

To better partner with you, we're in the process of creating new education materials that will be available soon. These will include video presentations you can watch on demand and live education opportunities. We'll cover topics like Medicare, preauthorization, initial provider education, and more.

We'll update you as those resources become available. In the meantime, check out the current resources posted in the Forms & Resources section of Your Health Alliance for providers.

New Fax Numbers

With our recent move to a new office, our fax numbers have changed. Please use the new fax numbers below.

Department or Purpose	New Fax Number
Claims Department*	217-902-9777
Provider Network Management Department	217-902-9701
Provider Service Coordinators (inquiries and appeals)	217-902-9702
Pharmacy Department**	217-902-9798
Medical Management Department (preauthorizations)**	217-902-9771
Acute inpatient notification/reviews	217-902-9750
Preauthorization requests for skilled nursing facilities	217-902-9712

*Please note there is now only one fax number for claims (we previously had two).

**You can also submit preauthorization requests through Your Health Alliance for providers.

New physical and mailing address:
3310 Fields South Drive
Champaign, IL 61822

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

Reminder About In-Network Referrals

Remember to use contracted in-network providers before referring a patient outside our network. You can search a member's network on Your Health Alliance for providers and office personnel by attaching to that member.

When our members need services that aren't available from an in-network provider, they might also be able to get those services from a provider in their secondary or tertiary network. You can also access this while attached to a member.

Note: All providers in secondary or tertiary networks require preauthorization.

Claims Inquiries and Appeals Submission Reminder

Please remember to submit claim inquiries online in one of these ways.

- Use the New Inquiry form under the Claims tab of Your Health Alliance for providers.
- Search for a specific claim and submit a Claim Reprocessing Inquiry.

If you are submitting an actual appeal, please fax it to 217-902-9702 or mail it to:
Health Alliance
Attn: Provider Network Management
3310 Fields South Drive
Champaign, IL 61822

eviCore Updates

Code Changes

The following codes were removed on May 1, 2018: J7330, J3590, J9035

Credentials Check for Ultrasound Procedure

We are continuing our efforts to maintain a high quality of care for our members and your patients. One area in which quality issues have been identified is with OB ultrasound CPT code 76811, which requires documentation of detailed fetal anatomic examination.

The 76811 Task Force Consensus Report on Ultrasound states that:

- Detailed scans are optimally performed in facilities that are accredited in ultrasound by organizations such as ACR or AUIM.
- These scans should only be performed by Maternal-Fetal Medicine (MFM) specialists or by those with fellowships with at least one year of ultrasound training or by those who have scanned and interpreted at least 100 fetal anatomic scans under the formal supervision of a qualified physician.
- Ongoing education and competence in interpretation is required.

If you or your organization have an MFM specialty that will allow you to perform this procedure (76811), please send credentials or documentation of your qualifications to meet the criteria to your provider relations specialist. As you can appreciate, we need to follow best practice standards to prevent further quality episodes.

Access Remittance Advice through Change Healthcare

On Change Healthcare's website you can:

- Access your paper remittance or ERAs
- Access the remittance advice that corresponds with the 835 to see additional messages and information related to claim denials and/or payment
- Search, view and print your payment and remittance advice for participating payers

To learn more, take a quick tour of Change Healthcare's payment manager.

Encourage 90-Day Prescription Fills

It's well known that low medication adherence leads to poor health outcomes and increased healthcare costs. Studies have shown that patients who fill 90-day supplies of medication are more likely to adhere to their treatment plan.

Many pharmacies have other ways to help patients fill medications on time, including refill reminders and synchronizing refills of chronic medications so people can pick up multiple refills at the same time. Enrolling in mail delivery is another option for patients who can't drive or find transportation to the pharmacy.

If you have patients who aren't taking medications as prescribed, make sure they understand:

- Why they are taking the medication and the importance of taking it consistently
- How to take the medication (how often and what time of day)
- How to possibly avoid certain side effects by taking the medication with food or at a certain time of day
- What to do if they miss a dose

Help Us Strive for 5

The Medical Management team is on a mission to "Strive for 5" by working toward earning a 5-star rating from the Centers for Medicare & Medicaid Services (CMS).

Reaching a 5-star rating is part of our organizational goal of achieving the top decile of member satisfaction and quality in the nation. As our members' partner in health, we want to provide excellent customer service and access to the best possible care.

We Need Your Help!

We all play a part in helping improve our members' healthcare experiences and health outcomes.

Our team will contact provider offices when help is needed to improve HEDIS® scores for measures such as diabetic eye exams, osteoporosis, and A1C control.

How We're Striving for 5

We have a multidisciplinary group within our Medical Management Department dedicated to tracking and improving our Star Ratings throughout the year.

This team:

- Educates and organizes interventions within Health Alliance and with provider partners
- Makes sure we're enhancing our members' experiences in the healthcare system
- Works to improve the quality of treatment and services members receive

What Are CMS Stars?

CMS Star Ratings measure a health plan's impact on the health and wellness of its Medicare Advantage members. This rating system incorporates quality ratings for:

- Outcomes
- Patient experiences
- Access
- Processes

If you have any questions email, Danielle.Daly@healthalliance.org.

Nephropathy Monitoring Reminder

Kidney disease is one of the most frequent complications of diabetes. According to the American Diabetes Association, 20–40 percent of patients with diabetes develop diabetic kidney disease or chronic kidney disease attributed to diabetes. Identifying kidney disease early can prevent or slow the progression of kidney disease. Yearly urine screening to check for elevated albumin is recommended.

Monitoring for nephropathy is one of the measurements included in the HEDIS Comprehensive Diabetes Care set. To meet the requirements of the measure, patients with diabetes need to have documentation of any of the following each calendar year.

- Urine test for albumin or protein
- Documentation of a visit to a nephrologist
- Documentation of a rental transplant
- Documentation of medical attention for any of the following:
    - Diabetic nephropathy
    - End-stage renal disease
    - Chronic renal failure
    - Chronic kidney disease
    - Renal insufficiency
    - Proteinuria
    - Albuminuria
    - Renal dysfunction
    - Acute renal failure
    - Dialysis
- Evidence of ACE inhibitor/ARB therapy

Note: Blood tests, including glomerular filtration rate, do not meet the requirements for this HEDIS measurement.

Diagnosis Code Submissions

The Medicare Advantage and commercial Marketplace adjustment models are both dependent on us receiving diagnosis codes through claims submission. All claims submitted to us must have associated diagnosis codes.

These are claims submission issues that we hope to improve:

- Code truncation, or limiting the number of diagnosis codes per claim submission
- Claims that are 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. 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.

Tips for Back-to-School Visits

Back-to-school prep will start soon, and many kids will be getting school and sports physicals. These appointments are a great time to document weight assessment and counseling for nutrition and physical activity, as recommended by the HEDIS 2018 guidelines.

At these visits, it's also a good idea to discuss:

- Filling out school forms with health and emergency contact information
- Arranging with the school nurse to administer any medication the child needs
- Keeping up to date on vaccinations

E/M Coding Reminder

As part of our claims editing system, we review commonly billed scenarios and wanted to send a reminder regarding billing an Evaluation and Management (E/M) code in a hospital setting along with code 93042.

According to our policy, which is based on the AMA CPT manual, **the physician's interpretation of diagnostic tests or studies should only be reported in a separate, distinctly identifiable, signed written report.**

Physicians should not report the interpretation of a rhythm strip or telemetry output when they are not ordered as a diagnostic study and there is no official interpretation. When a patient is on continuous monitoring in the hospital, emergency room, or any monitored unit, the interpretation of telemetric rhythm strips is considered to be part of the E/M service. If 93042 is a distinct service, then it should be billed using a -59 modifier.

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

Continuity of Care When Providers Leave Network

When a primary care provider or specialist leaves our network, we take steps to make sure our affected members continue to have access to the care they need.

Any member who is in an ongoing course of treatment may be eligible to continue care with the termed provider (if certain criteria are met) during a 90-day transitional period. Any member in the 13th week or more of pregnancy may be eligible to continue care with the termed provider through post-partum care.

Members with prescription coverage can also fill any remaining prescription refills after the prescribing provider leaves the network.

If you have questions, contact your provider relations specialist.

Pharmacy Updates

Medicare

Tier Changes

- Zostavax – Moved to Excluded
    - Will not be in effect until January 2019
- Bydureon, Bydureon BCise, Victoza – Moved from Tier 4 to Tier 3
- Trulicity – Moved from non-formulary to Tier 3