Health Alliance™

Midwest December Informed Newsletter

December 17, 2019

As It Relates to You

Planned Elective Inpatient (IP) Admissions

As a reminder, elective Inpatient (IP) procedures or surgeries need to be preauthorized by admitting physicians. Also, hospitals still need to notify Health Alliance of a planned elective IP admission within 24 hours.

Happy Holidays!

From your Health Alliance Provider Relations staff, we wish you all happy holidays! Each day, you give your patients one of the most important gifts of all – the best health and livelihood possible. Thank you for everything you do!

Changes to Preauthorization List

Please be advised that some changes are happening to the prior authorization (PA) list for 2020:

- Changes to elective inpatient services, please see the Health Alliance website for specific CPT/HCPC changes

- Preauthorization removed for observation stays
- Preauthorization removed for transmyocardial laser revascularization
- Preauthorization is not required for Private Duty Nursing. Please check the members benefit to see if this is a covered service.
- Preauthorization removed for TheraBite
- Preauthorization removed for vacuum assisted wound closure

If you have questions, contact your provider relations specialist.

Preauthorization Moving to Guiding Care

For dates of service on or after January 1, 2020, Clear Coverage and the Health Alliance portal will be replaced with a new preauthorization system called Guiding Care. As previously communicated, anyone responsible for submitting preauthorization requests for our members should register for one of our online training sessions. If you haven't attended one of these sessions yet, there are still two sessions being held:

Wednesday, December 18th at 10 a.m. CST

Wednesday, December 18th at 2 p.m. CST

How to Register:

After you've clicked on a session above, you'll be taken to CenturyLink Guiding Care Pre-Authorization Training to register. Once registered, you will receive an email that includes:

- Toll-free phone number and access code you'll need for the session's audio
- A link to the online session
- A link to test your computer for compatibility prior to the meeting

Save this registration email to access your session and/or add to your calendar by clicking the Outlook calendar link in the email message.

The presentation materials are available by using the Provider Resources link in the Forms & Resources section of Your Health Alliance for providers. Or you can get a copy of the presentation slides by emailing Provider.Relations@healthalliance.org

Techniques to Make Preauthorization Easier

The Prior Authorization process can actually work FOR you. It is a program developed to follow best practice practices and improve outcomes. It has been shown to reduce duplication of services, avoid overutilization of services, as well as avoid unproven surgical procedures than can lead to patient disabilities. So how can you make this easier? When the following techniques are used it enhances the electronic approval rate which makes the request nearly immediate.

1) Use the electronic portal when submitting the request. Any time a fax or telephone is used to make a request, it slows the process tremendously.
2) If your system uses Natural Decision-Making software for advanced images, follow the advice of the system. This electronic system uses the American College of Radiology guidelines. A high score of 7-9 is automatically approved. Low scores of 1-3 require a physician to make the review, which decreases the speed of approval.
3) Know the best practice guidelines. These are available online at Evicore.com and recommendations in UpToDate are usually current. You can set up the criteria within order sets that can be electronically submitted to ensure that the correct information is present.
4) Complete the medical record before submitting. When staff submit an incomplete request, it will be paused or denied until completed. The most common reason for denials and appeal overturns is the lack of adequate information for decision making.
5) If your initial request is denied and you feel you have made the right decision, submit an appeal. The appeal process is done by medical directors at Health Alliance.
6) Create a positive impression for your patients. The approval of your request highly suggests that your recommendations are the correct best practice based on medical evidence. Once the submission is created, keep your patients informed to the process.

I hope this will be helpful. Any questions concerning Health Alliance Prior Authorization process can be directed to me.

Robert G Good, DO, MACOI
Chief Medical Officer

End-of-Year Screening Reminders

As 2019 comes to a close, please ensure your patients are getting appropriate preventative services to identify any issues and close gaps in care.

All patients:

- Colorectal cancer screening
- Blood pressure reading
- Medication review

Women:

- Breast cancer screening
- Osteoporosis screening in women who've had a fracture

Patients with diabetes:

- A1C test
- Nephropathy screening
- Diabetic retinal eye exam

As a reminder, we have health coaching and care coordination services that can help our members better manage their conditions at no extra cost to them. These services can help improve their health outcomes between visits to your office.

Mental Health ABCs and HCCs

CMS recognizes that mental health impacts care for our members. For 2019, the definition of conditions that qualify as Hierarchical Condition Categories (HCCs) has expanded to include 67 new codes, including the addition of personality disorders.

Members with mental health conditions require additional support. When reporting mental health conditions, it's imperative that conditions are well documented and include severity, status and behavior to support the specified ICD-10 code. Lack of specificity in documentation can lower or eliminate an HCC condition. It's also important to note that many mental health disorders map to an RX HCC such as bulimia or autism spectrum disorders. Please address, document and code all mental health conditions.

<u>Documentation Guidance:</u>

- State the severity: mild, moderate or severe.
- State the episode: manic, depressed, mixed, single or recurrent.

- State the status: full or partial remission.
- State the encounter: initial, subsequent or sequela.
- Document and code all psychotic symptoms as well as any known physiological causes.
- Document all forms of treatment: medication, counseling, non-compliance.

Documentation Example:
Obsessive-Compulsive Personality Disorder

Supported:

- Continue Paxil and counseling appointments for obsessive-compulsive personality disorder.
- The code supported in this scenario is F60.5 Obsessive-Compulsive Personality Disorder (HCC: 60)

Unsupported:

- Continue Paxil and counseling appointments for OCD.
- The code supported in this scenario is F42.9 Obsessive-Compulsive Disorder, Unspecified (RX HCC: 133)

You'll notice that the code supported in this scenario is an RX HCC rather than an HCC. In order to receive the HCC value, there must be documentation that states obsessive-compulsive personality disorder. OCD does not include the words personality disorder. This is why it's important to document as specific as possible.

What's the difference between obsessive compulsive disorder and obsessive compulsive personality disorder? The personality disorder is a pattern of thinking and behaving. Many individuals with OCD know their thoughts and behaviors are illogical. Often individuals with OCD will pursue treatment whereas those with OCPD rarely seek treatment, as they don't see a problem. A common OCPD characteristic is being a workaholic.

References: ICD-10-CM Official Guidelines for Coding and Reporting FY 2019
https://provider.healthalliance.org/coding-counts/page/5/
Optum 360 EncoderPro for Payers Professional
Skodol, A 2018, 'Obsessive-Compulsive Personality Disorder', Merck Sharp & Dohme Corporation

Use Cologuard, FIT for Your Average-Risk Patients

If it isn't already, Cologuard every three years or FIT (Fecal Immunochemical Testing) every year needs to be your go-to method for people at average risk for colon cancer. Colonoscopy is for people with higher risk (family history of colon cancer, personal history of colon cancer or pre-cancerous polyps, inflammatory bowel disease, etc.).

In addition to freeing up endoscopy resources for those at risk, these alternatives offer equal efficacy to colonoscopies in average-risk patients. The less-invasive options make compliance easier for patients, as well. Help your patients understand these at-home stool-screening tests can identify abnormalities before they become cancerous.

In 2014, the National Colorectal Cancer Roundtable called for providers to increase screening rates to 80 percent by 2018. The 80 percent by 2018 campaign helped fuel Carle's focus on increasing screening rates and the right screenings for the right patients.

Genetic Testing In-Network Laboratories

Genetic testing has really increased because the technique of determining genetic sequences has improved and become less expensive. The indication for specific genetic tests has increased because of the number of genetic variations that have been identified. In 2018, Health Alliance processed nearly $9 million in genetic test requests, with only $1.7 million being provided with adequate preauthorization (PA) in network.

It's important to recognize that Health Alliance does have a network of genetic testing and that genetic/molecular testing orders need to have PA to be paid. It's the responsibility of the genetic laboratory to submit the authorization request to Health Alliance prior to the completion of the test.

Like most aspects of medicine, there are national best practice standards of care for genetic testing. Health Alliance and our partners at eviCore utilize these standards. These tests are extremely expensive and should generally be associated with genetic counseling, especially if large, multi-gene profiles are ordered. The results may be poorly understood and lead to additional testing that may have negative consequences for the patient. The overall "positive" rate

for genetic testing is very low, with the current testing techniques rarely changing medical therapy.

The current laboratories are within the Health Alliance network:

- LabCorp (subsidiaries of Monogram Biosciences, Dianon, Accupath, Esterix, MedTox and Sequenom)
- Amby Genetics
- Genomic
- Myriad Diagnostics (subsidiary of Crescendo, Assurex and Counsyl)
- Quest Diagnostics
- GeneDx
- BioReference Lab
- Natera
- MDxHealth
- Vercyte
- Exact Sciences
- Neogenomics
- Foundation Medicine
- Invitae Corp (CombiMatric Molecular Diagnostics)

Pharmacy Updates

Opioid MED Limit Effective 1/1/20 (Affected Members Have Been Notified)

Health Alliance has decided to limit the amount of opioid pain-relief medication that will be covered on a daily basis. Effective 1/1/20, prescription claims for opioid-containing drugs that exceed the maximum safe daily amount of 100 MED will not automatically process in the pharmacy. Health Alliance's claim system will look at the total amount of a patient's opioid prescriptions in assessing safety.

Hospice patients and those who are receiving high doses of opioids as part of treatment for cancer or sickle cell anemia are exempt from this limit. If a provider believes a patient requires a daily amount that is higher than the limit, he or she will need to submit a preauthorization request to the Pharmacy Department for review. Health Alliance will cover opioid prescriptions for patients who are over the threshold if their providers are adhering to best practices in prescribing opioids.

Avoid Delays in the Pharmacy: Update Prescriptions When Increasing Doses or Frequency

The Health Alliance Pharmacy Department sometimes gets calls from members who are told in the pharmacy that it's too soon to refill their prescription, even though they are taking the drug as instructed by the prescriber. This is almost always due to the prescriber failing to write a new prescription when they tell a patient to begin taking more medication per dose or with increased frequency. For example, a member who is told to go from taking one antidepressant tablet daily to one twice daily will run out of their medication twice as quickly. But when they request a refill at the pharmacy, if the prescriber has not submitted a new prescription reflecting the change in frequency, the processing system will reject the claim as "refill too soon." This could lead to a gap in care if the issue isn't resolved and the member can't pick up their prescription.

To avoid treatment delays, remember that new oral instructions also require a new prescription at the pharmacy. Thank you for helping Health Alliance ensure the best care for our members!

Contact Us

1-800-851-3379, option 3