PROVIDER NEWSLETTER

Health CHOICE Utah

FALL/WINTER 2017

UPDATES TO YOUR PRIOR AUTHORIZATION GUIDELINES

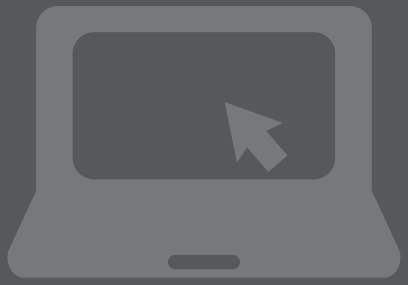
On August 1, 2017, Health Choice Utah published and updated its prior authorization guidelines. Our intent is to provide upfront guidance on the services, tests, and equipment that require medical review prior to authorization. While our effort is to improve the efficient use of Medicaid tax dollars, our intent is to streamline this process as much as possible in order to ensure that patients receive timely, quality, evidence-based, covered care under the Utah Medicaid benefit.

Changes are made from time to time based on changing evidence, provider feedback, and overall utilization trends and medical society guidelines. Updates can be viewed on our website at HealthChoiceUtah.com/Providers/pa-guidelines.

If you have any feedback regarding the prior authorization grid, please reach out to Dr. Christopher B. Valentine or to your local HCU provider representatives. ■

ELECTRONIC DATA INTERCHANGE

Heath Choice Utah staff are very focused on converting your practice or location from paper to electronic. All paper claims we receive are submitted to an outside vendor and then reformatted to appear as an electronic claim. Errors during the reformatting are quite common. Payments made by paper check and with a related paper Explanation of Benefit (EOB) form also go through an outside vendor to be processed. As a result, paper transactions take longer to process and are considerably more expensive than electronic transactions. We encourage providers to (a) submit 100% of your Health Choice Utah claims electronically using Payor ID 45399, (b) receive 100% of your claim payments via Electronic Funds Transfer (EFT), and (c) receive 100% of your EOB forms electronically via an Electronic Remittance Advice (ERA). Please contact your Health Choice Utah Provider Performance Representative with any issue that is either preventing electronic submission of claims or preventing enrollment in the EFT program. Your clearinghouse will be able to assist you to receive EOBs electronically via an ERA. They will need to request the ERA setup directly with the designated Health Choice Utah clearinghouse, Change Healthcare/Emdeon. ■



SERVICE AREA EXPANSION

Existing and new medicaid enrollees throughout Beaver, Juab, Millard, Sanpete, and Sevier counties may choose Health Choice Utah as their Medicaid plan. The online provider directory has been updated to include all of the participating providers and hospitals in these area. To access our online provider directory, please visit us online at www.HealthChoiceUtah.com. ■

PROVIDER DATA

Please contact your Provider Performance Representative with any demographic changes, including new providers, retiring providers, and service and billing address changes, so we can timely update our systems before claims are submitted. These updates enable us to pay your claims without delay and to communicate with your office when necessary. ■

URGENT CARE

Health Choice Utah highly encourages our members to first access their primary care physician for both routine and urgent care. When the primary care physician is not available in a timely manner or if urgent care is needed after the primary care physician business hours, we encourage physicians to refer patients to the after hour or urgent care alternative.

Members should be directed to the closest urgent care location capable of rendering the necessary care regardless of whether they are contracted with Health Choice Utah. Similar to emergency services, we process all place of service 20 urgent care claims at the in-network benefit level regardless of whether the urgent care location is contracted with Health Choice Utah. ■

HELP US KEEP YOUR RECORDS UPDATED

Has any of your information changed? We work hard to keep our records up to date. Please contact your network representative with any changes. Alternatively, you may fax changes to 801-758-3120, or email them to hcucomments@iasishealthcare.com. These updates include any changes to your roster, address, or phone number. ■

DR. VALENTINE'S MEDICAL DIRECTOR'S CORNER

Electronic prescribing has seen widespread adoption with improved incentives over the last decade. It has now been over a decade since electronic prescribing has been available, and currently a majority of physicians are prescribing electronically. More recently electronic prescribing of controlled substances has accelerated along with the benefits that it affords.

My experience with electronic prescribing has been through 3 systems. I started with a free online system in about 2008 that I used in combination with a paper chart. Once my patient's medications were entered, I found that this improved my workflow and saved time in the long run. Further, it made medication reconciliation much easier. This helped to keep track of medications longitudinally and was much better than the multitude of paper carbon copies retained in the chart.

ELECTRONIC PRESCRIBING

Shortly after, I transitioned to an electronic health record (EHR) with integrated electronic prescribing. In addition to the previous benefits, I was able to concomitantly monitor allergies and drug interactions and integrate the medication list into the patient note automatically. I was able to authorize refills directly from the pharmacy, further improving efficiency and decreasing the chance for errors. This freed up the front desk in the medical assistants from having to manage refill requests and faxes.

When I moved to the next EHR, in addition to more comprehensive decision support, I was able to prescribe controlled substances. Through secure two-factor authentication, I am able to transmit and monitor controlled substances and refills. I am safer prescribing electronically than by providing paper prescriptions, based on my previous experience of being a victim of prescription fraud. The system has not been error free, but the opportunities for exposure, loss or fraud are significantly reduced through the use of the electronic prescribing system versus conventional paper.

Studies seem to show that first-fill medication adherence seems to improve with electronic prescribing. With improving technology, electronic prescribing allows real-time verification of insurance formularies in many cases as well. Electronic prescribing is required under the Medicare incentive payment system, the component that covers what was previously referred to as "meaningful use". However, the practical day-to-day benefits of electronic prescribing make it a worthwhile effort and investment on its own merits. I have never been subpoenaed to testify in court over a fraudulent electronically prescribed prescription. I have never had to deal with a lost e-prescription.

I will be the first to testify that efficiency returns on EHR implementations have been… variable. That said, electronic prescribing has been a component of the digitization of medical practice workflow that has been successful. The prescription pad still serves as a personal touch for writing outpatient instructions and reminders. However, in an increasingly complex medical system with better tools available, written prescriptions are quickly going the way of the head mirror and reusable catheters.

Christopher B. Valentine,
MD, FAAFP ■

MONTHLY TIPS AND TRICKS:
AVOIDING PENALTIES

BEST PRACTICES FOR APPROPRIATE PROVIDER DOCUMENTATION

ALWAYS:

- Maintain accurate and complete medical records and documentation of the services you provide.
- Make certain that the services rendered are appropriate, **medically necessary** and are supported in your documentation.

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported." - CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1

Good documentation practices help other providers, who may rely on your records for an accurate clinical picture of your patient. It is vital to continuity of care.

AVOID:

- **Copying and pasting the documentation in the patient's EMR from a previous encounter to the current one.**

"Cloning" (copying portions of an existing record and adding it to another) is a potential source of inaccurate information entered into the patient's record and could lower the integrity of the documentation. This could result in inappropriate charges being billed to patients and payers, or worse – compromise quality of care.

REMINDER: an unsigned medical record has no legal validity. If a note is not signed, it does not support the service billed.

ACCURATE CODING AND BILLING

When you submit a claim for services performed for a Medicare or Medicaid beneficiary, you are filing a bill with the Federal Government certifying that the payment requested was earned and all billing requirements were met.

To maximize reimbursement and minimize denials:

- Document in full all services rendered
- Make a note of medical necessity when providing medical services
- Make sure that services are provided and documented by a properly supervised, qualified staff member
- Bill only for services performed by staff active and participating with Medicare/Medicaid
- Avoid billing separately for services already included in a global fee
- Make sure you have all documentation and the right CPT code to avoid unnecessary errors

Remember, duplicate billing may cause denial of a claim.

CAUTION • CAUTION • CAUTION • CAUTION

UPCODING: COMMON EXAMPLES

- Providing a follow-up office visit or follow-up inpatient consultation, but billing a higher level E&M code as if a comprehensive new patient office visit or an initial inpatient consultation was provided
- Misuse of Modifier 25. Modifier 25 allows additional payment for a separate E&M service rendered on the same day as a procedure. Upcoding occurs if a provider uses Modifier 25 to claim payment for an E&M service when the patient care rendered **was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.**
- Using an unnecessarily high volume of documentation to justify a higher level of service than is supported by **medical necessity** ■

For more information, visit https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf

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