UCare

October 2016

In this Edition

Introducing *UCare Connect + Medicare*!

UCare is introducing a new health plan designed to serve individuals with disabilities who are dually eligible for Medicaid and Medicare coverage.

Called *UCare Connect + Medicare*, the new plan will be available Jan. 1, 2017, to qualifying individuals living in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright counties in the metro area and Olmsted County in southeastern Minnesota.

UCare Connect + Medicare helps simplify coverage for Medicare- and Medicaid-eligible individuals ages 18 – 64 with certified physical, developmental, mental health or brain injury-related disabilities. The plan combines Medical Assistance, Medicare and prescription drug coverage benefits into one easy-to-use plan. Since *Connect + Medicare* is an integrated health plan, providers only need to bill UCare for medical services.

UCare's new behavioral health prior authorization fax number

As communicated in the September issue of *health lines*, UCare will no longer use Beacon Health Strategies LLC ("Beacon") to perform utilization review of behavioral health prior authorization requests. Beginning today at 5 p.m., UCare will perform behavioral health utilization management services in-house.

As a result of this transition, **there will be new fax numbers for behavioral health prior authorization requests**. After 5 p.m., Oct. 14, 2016, fax all behavioral health prior authorization requests to 612-884-2033 or 1-855-260-9710 toll free. The fax number for submitting claims adjustments has not changed. Please continue to submit claims adjustment requests to 612-884-2186.

Prior authorization forms have been updated with these new fax numbers and are posted at www.ucare.org/providers/Eligibility-Authorizations/Pages/EligibilityAuth.aspx.

If you have questions about this transition, please contact the Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.

UCare Provider Website
www.ucare.org/providers
Provider Assistance Center
612-676-3300
1-888-531-1493 toll free

Results from 2016 Medical Records Standards Audit

Each year UCare's Quality Management team conducts an annual Medical Records Standards Audit. The purpose of the audit is to assess provider medical record keeping practices. In 2016, 807 UCare members were randomly selected for the Medical Records Standards Audit, and all records selected were from primary care providers (PCPs).

Below are the results for our 2015 and 2016 Medical Record Standards Audit:

No.	Item	2015	2016
1	Medical Record is legible to someone other than the author.	98.2%	100%
2	For every entry, the visit note includes the practitioner's signature and credentials with the date and time documented.	93.7%	98.26%
3	Record contains a current problem list or problems are documented in the progress notes.	87.0%	96.90%
4	The medication list, including OTC drugs, is updated at the last visit and is documented in the progress notes. Prescribed medications should include dosages and dates of initial and refill prescriptions.	76.7%	94.67%
5	The presence/absence of allergies/adverse reactions is documented in a consistent, prominent location. If the member has no known allergies or adverse reactions, this is noted in the record.	91.2%	92.68%
6	If the member has been referred to a specialist, the summary of care and/or operative treatment reports and other reports are present in the medical record.	63.6%	93.31%
7	If the member received care at a hospital or an outpatient care facility, the report for that care is in the medical record.	61.8%	90.71%
8	Immunizations are updated and documented on an immunization record.	37.2%	68.40%
9	Documentation exists related to the inquiry/counseling of smoking habits.	85.2%	90.70%
10	Documentation exists related to the inquiry/counseling of alcohol/other substances habits.	66.3%	80.29%
11	Abnormal lab/diagnostics are noted and there is documented follow-up.	99.2%	96.75%
12	Documentation addresses the availability of preventive screening services.	85.9%	57.49%

Only members who met the criteria for these questions were included in the totals.

Overall, the audit showed a positive result of most measurements being above 80 percent compliant and demonstrating strong improvement from 2015 to 2016. The purpose of a Medical Record Standards Audit is to identify opportunities for better documentation and patient care to support improved patient outcomes and other quality initiatives; whether at the provider or health plan level. The results

highlighted in the chart have been identified as key metrics for monitoring and improvement in future audits.

Ensuring that patients are up to date with their immunizations is a critical public health initiative. In our audit, the majority of charts that lacked updated immunization records were from providers who were seeing these patients for the first time.

As access to health insurance continues to increase, many practices may continue to find their patient panels increasing. Remember to ask new patients to send previous health records prior to their initial visit. Keep in mind that for many people, as a result of health care reform, this may be the first time they have sought out primary care in a very long time, if ever, and they may need to be caught up on their immunizations and preventive screenings.

Part of our quality improvement program is to share quality measurement results with our provider communities as often as possible. Complete and accurate patient record documentation assists with the continuous quality improvement process and ensures continuity of care for members.

The next audit will take place during our 2017 HEDIS collection timeframe beginning in February 2017.

Thank you for your efforts in providing quality and continuity of care to our members. If you have further questions or comments, please call UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.

Antidepressant medication performance improvement project update

In 2016, UCare and four other health plans expanded our Performance Improvement Project on improving antidepressant medication adherence to include Minnesota Senior Health Options (MSHO) and *UCare for Seniors* members in addition to Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members. See below for related resources.

Toolkit update

The health plan collaborative created a provider toolkit with tools to increase antidepressant medication adherence and reduce racial and ethnic disparities in depression management. We have recently updated the toolkit to include resources for seniors. Access the toolkit here.

October 27 Refugee Mental Health Webinar: Compliance and Adherence to Treatment

Please join us on Thursday, Oct. 27, from 12-1 p.m. for the third webinar in a series regarding mental health issues in refugee communities. Georgi Kroupin, Ph.D., LMFT, from HealthPartners Center for International Health, will continue to explore behavioral health challenges and barriers in refugee populations. This webinar will address compliance and adherence to treatment.

The webinar series is free and appropriate for health care providers, nurses (1.2 CE contact hours available), social workers, public health professionals, therapists and Community Health Workers. See flyer for more information. Please register by emailing CJ at Carroll.J.Helm@HealthPartners.com.

Documentation improvement: focus on obesity

Obesity is a prominent topic in today's society. Approximately two-thirds of adult Americans are overweight or obese and spend more than $150 billion on health care every year as a result.

Documenting obesity and the associated chronic conditions should be a common practice due to these alarming numbers. The medical record needs to reflect the complete patient health profile, not just the chronic condition but also any contributing factors, such as obesity.

Clinical documentation of obesity should include:

- Weight gain or loss
- Physical exam signs
- BMI
- Related laboratory values
- Severity
- Notation of any underlying medical conditions
- Conditions associated with
- Treatment plan

The patient's medical record ideally records height and weight with a calculated BMI at every visit, but, at a minimum, this information should be documented once or twice a year. When obesity is being addressed, it should always be documented. A diagnosis of obesity or morbid obesity cannot be assigned based on the BMI value alone and needs to be documented by the provider if valid.

Proper documentation and reporting of all active conditions and relevant historical conditions supports the medical needs of your patients. Obesity affects the majority; does your documentation accurately reflect your patient population's prevalence?

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UCare
P.O. Box 52
Minneapolis, MN
55440-0052

Provider Assistance Center
612-676-3300
1-888-531-1493 toll free
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