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

UCare Provider Manual updated

UCare's Provider Manual has been updated to reflect current business practices. You can view the Provider Manual on UCare's website at https://www.ucare.org/providers/Resources-Training/Provider-Manual/Pages/ProviderManual.aspx. Please note the URL to the Provider Manual has changed so update any bookmarks you may have to previous Provider Manual content. We consolidated the information into one, more user-friendly PDF file.

The Provider Manual contains critical information so referencing it regularly for up-to-date content is important. Providers are encouraged to explore all sections of the manual that pertain to their interactions with UCare, especially those pertaining to Authorizations and Notifications; Claims and Payments; and Fraud, Waste and Abuse.

National Coverage Determinations - late updates from CMS for ICD-10-CM diagnosis codes

New ICD-10-CM diagnosis codes for 2016-2017 became effective on Oct. 1, 2016; however, CMS experienced a significant administrative burden due to the volume of diagnosis code changes as well as the "partial code freeze" that officially ended Sept. 30, 2016. As a result, numerous National Coverage Determinations (NCDs) have not been updated to include the new ICD-10-CM codes.

CMS published information detailing their plan to make modifications/updates to the NCDs over two quarterly releases – one in January 2017 and the second in April 2017. This only affects NCDs (not LCDs).

What does this mean for you? Since not all of the ICD-10-CM diagnosis codes have been updated in the NCDs, you may receive a claim denial for "missing or invalid diagnosis code" even if the diagnosis code that you submitted is correct. Claims editing software follows existing NCDs (and LCDs), so if a NCD has not been updated, the editing software may not recognize the diagnosis code as "valid."

If that happens, please send in an appeal. The claim will be reviewed in our Coding Department, and, if appropriate, the denial will be overturned and the claim will be paid.

Message from CMS: "Please note that due to this being the first regular ICD-10 code update since the partial code freeze October 1, 2011, (there were limited new codes introduced in fiscal years 2012, 2013, 2014 and 2015), and the voluminous number of new codes involved, the Medicare shared systems will split

implementation of the new codes over the January 2017 and April 2017 quarterly updates. While the implementation dates will be in January and April, the effective dates of the new codes will still be Oct. 1, 2016. All deleted codes will not be valid for payment after Sept. 30, 2016. Contractors will be instructed to adjust claims brought to their attention."

Medicare Outpatient Observation Notice required by March 8, 2017

All hospitals that contract with UCare are expected to be compliant with the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act. The Act requires all hospitals and critical access hospitals (CAHs) to provide written notification and an oral explanation of the notification to individuals receiving observation services in an outpatient status for more than 24 hours by March 8, 2017.

The Medicare Outpatient Observation Notice (MOON) was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. In accordance with the statute, the notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

Please ensure that your organization is properly notifying patients in observation stays no later than March 8, 2017.

The CMS guidance, instructions and MOON templates are available at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Access the 270/271 transaction and save time verifying member eligibility and benefits

The 270 transaction is used to request eligibility and benefit information for medical lines of business, and the 271 transaction is used to respond with information for the specified member.

Access the **270/271 transaction** via McKesson PCS Support. If your clearinghouse has not already done so, they can enroll with PCS to begin transmitting these transactions to your organization. Have your clearinghouse contact PCSSupport@Mckesson.com or call 1-877-411-7271 to begin the enrollment and provisioning process.

Click here to access UCare's 270/271 Companion Guide, which describes to UCare trading partners the content and format of the Eligibility and Benefit 270/271 transaction set in the electronic data interchange (EDI) environment.

Use of the JW Modifier for Reporting Drug Waste

Effective Jan. 1, 2017, the use of the JW modifier is required by Medicare Administrative Contractors (MACs), the Department of Human Services (DHS), UCare and other health plans. Although it was previously a valid modifier, it was considered "optional."

The JW modifier is a Healthcare Common Procedure Coding System (HCPCS) Level II modifier used on a Part B drug claim to report the amount of drug or biological that is discarded but is eligible for payment

under the discarded drug policy. It should only be used for drugs or biologicals that are contained in single-dose vials or single-use packaging.

Use of the JW modifier allows for payment, not only of the amount of drug that has been administered to a member, but for the amount of drug that has been discarded, up to the amount that is indicated on the vial or package label. The discarded drug amount is the amount of a single-use vial or other single-use package that remains after administering a dose/quantity of the drug to an individual.

The JW modifier should not be used to report overfill wastage (the amount of a drug that may exceed the actual amount of drug indicated on labeling), and it is not appropriate to use the modifier for drugs that are from multiple-dose vials or packages.

When billing for drug waste, the amount of the drug or biological administered should be reported on one claim line, and the amount of the drug discarded should be billed on a separate line with the JW modifier. The unit field should reflect the amount of drug discarded.

Use of the JW modifier would typically be expected to be billed from a physician office, clinic or a hospital outpatient setting. The JW modifier does not apply to drugs or biologicals administered in a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC). It is not intended for use on claims for hospital inpatient admissions.

If the actual dose of the drug administered is less than the HCPCS billing unit, the JW modifier should not be used.

Remember to maintain accurate medical records that indicate the amount of drug administered and the amount of waste. Medicare Learning Network (MLN) Matters article SE 1316 provides good information about documentation requirements.

Additional information:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf

MLN Matters MM9603 **-** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf

Chapter 17 of the CMS Medicare Claims Processing Manual (Section 40) - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf

Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey

As a health care provider, you play a critical role in helping our members and your patients maintain or enhance their health. The Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey gives UCare members the opportunity to share how UCare, including our provider network, is doing at meeting their health care needs.

February through May, the Centers for Medicare and Medicaid Services (CMS) will collect information about our Minnesota Senior Health Options (MSHO) and *UCare for Seniors* (UFS) members' experiences via the annual CAHPS survey. DHS sends a similar survey to our state program members between November and February each year.

The survey is distributed through the mail and includes telephonic follow-up. Questions ask about:

- The ease of getting needed care and seeing specialists
- Getting appointments and care quickly

- Doctors who communicate well
- Coordination of health care services
- Customer service
- How well the health and/or drug plan provides information when members need it
- How they would rate health care quality, their personal doctor and specialists

The results of the CAHPS survey are used for many purposes, including: several measures are included in the Medicare Star Ratings program, consumers may reference results when selecting a health plan, and UCare uses results to identify areas for quality improvement. Most importantly, the information gathered from our members through the CAHPS survey helps us better understand how to serve them.

Your interactions with our members, including timely availability of appointments, do affect their experience and their opinions. We look forward to continuing to work with you to improve the impressions our customers have of their health care experiences. Thank you for all that you do for your patients and our members!

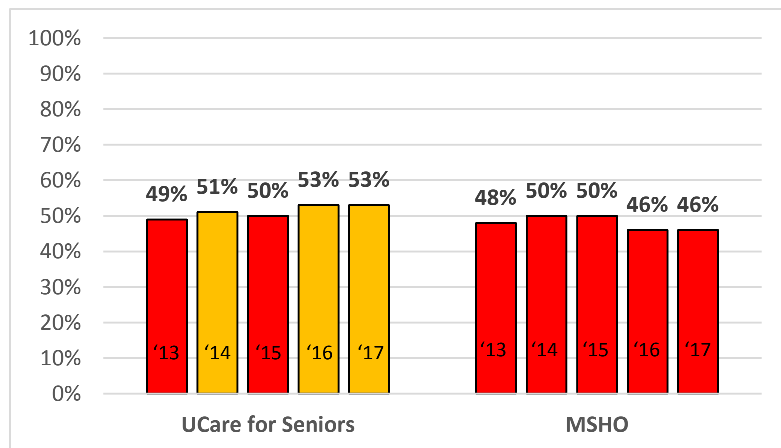
Health Outcomes Survey (HOS) highlight: monitoring physical activity

In the next few months, many *UCare for Seniors* (UFS) and Minnesota Senior Health Options (MSHO) members will receive the Health Outcomes Survey (HOS) required by the Centers for Medicare and Medicaid Services (CMS) for all Medicare Advantage plans. The HOS measures UCare on how often the providers we partner with discuss certain preventive health subjects with patients. We will highlight some of these topics in *health lines* from time to time.

The HOS asks members two questions about monitoring physical activity:

1. In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
2. In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity? For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Monitoring Physical Activity Five-Year Trend



HOS survey results directly impact our Star Ratings for UFS and MSHO.

Here you can see a slight improvement in Monitoring Physical Activity in the last few years for UFS members. Unfortunately, MSHO rates are on the decline and have held steady at the 2 Star mark for the last five years. The 2017 national average for this measure was 50%. We know we can do better.

Our members might find it difficult to initiate these conversations.

However, you can help by incorporating conversations on physical activity into members' annual visits. When discussing exercise with members, be sure to share information about UCare's fitness benefits. Learn more at https://www.ucare.org/HealthWellness/FitnessPrograms/Pages/default.aspx.

Documentation improvement: chronic conditions

Chronic conditions need to be managed and treated on a continual basis, yet they are often under documented in the patient's medical record. Each time a patient receives treatment or care for a chronic disease, the documentation should record the management, this includes medication refills.

Documentation is easily accomplished using an evaluative statement. Three basic elements will proficiently document a condition.

- Name of the condition – being as specific as possible.
- Condition status – worsening, improving, unchanged, etc.
- Supporting evidence and/or plan of care – adjusting XYZ medication, referred to PT, etc.

Frequently, the chronic condition is not the main focus of the visit but is taken into consideration when determining the treatment plan for an acute illness. This chronic condition evaluation happens during the acute condition assessment and management and can be easily overlooked when finalizing the visit note. All conditions that affect the care of the patient should be properly captured in the documentation.

Documentation of a coexisting condition considered in the treatment of another condition can follow a similar evaluative statement.

- Name of the condition – being as specific as possible.
- Interaction consideration with the other condition – why the chronic condition affects the current condition management (frequently a drug interaction).
- Plan of care – any changes in current treatment of the chronic condition.

Adding a chronic condition evaluative statement to the medical record is a simple and effective way to provide quality patient care. The patient's complete health status will be accurately noted promoting appropriate care management at future visits.

UCare's MSHO Model of Care (MOC) trainings for providers

Members of UCare's Minnesota Senior Health Options (MSHO) product face a host of unique challenges and barriers to getting the care they need. Challenges can include a high prevalence of acute and chronic medical conditions, advancing age, geographic location and several others.

UCare's MSHO product is designed with a unique set of benefits and services to help members meet these needs and assist them in staying healthy and independent.

A key component of the MSHO product is the assignment of a care coordinator to every MSHO member, who coordinates care for the member and acts as a liaison with the member's care providers.

UCare provides training on our Model of Care (MOC) to our providers. The training promotes understanding of the MSHO care coordination model and how care coordinators can assist providers in coordinating services and supports for MSHO members.

UCare offers provider training on our MSHO MOC in a variety of ways:

- An audio recording and PowerPoint presentation of MOC training posted on UCare's website.

- In-person presentations at select provider offices and available upon request.
- MOC brochure mailed to select provider offices and available upon request.
- MOC information in new provider orientation packets and on our website.

Please contact us at clinicalliaison@ucare.org for more information about our MSHO MOC training.

Mental health webinar: providing mental health services to Latinos

Join us for a webinar to discuss the delivery of mental health services to the Latino population on Tuesday, Feb. 28, from 12-1 p.m. Dr. Carla Maldonado, Marriage and Family Therapist at Un Pueblito Counseling, will present. Dr. Maldonado has extensive experience working with people from diverse backgrounds, particularly those with Latino heritage.

The webinar is intended for health care providers, nurses, public health, health educators, social workers, therapists, Community Health Workers and anyone who interacts with individuals from the Latino population. CMEs are available. **Click here to register**. See the webinar flyer for additional information.

This webinar will be recorded and available for viewing later at www.stratishealth.org/pip/antidepressant.html.

This webinar is presented by a collaboration of Minnesota health plans working to improve antidepressant medication management in Minnesota.

UCare Provider Website
www.ucare.org/providers

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

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612-676-3300
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Contact the newsletter staff: providernews@ucare.org

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