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WNYHealtheNet Now More User-Friendly

If you are a regular user of WNYHealtheNet, it is likely that recently you have noticed a fresh look and more user-friendly format.

The following is a summary of enhancements to the website that we hope you will find helpful as you go about your daily business:

- **Log-in**—screen has been updated and includes new menu links along the left side for easier navigation
- **Greetings**—this new screen identifies the user date and time of log-in. The page also will serve has a bulletin board for important messages related to WNYHealtheNet
- **Benefit and Eligibility**—screen has been updated to have a more compact viewing area. Elimination of the scrolling feature provides more room to enter information. The user can choose which benefits to display
- **Eligibility**—screen has a neater look with a boldface text for easier reading
- **Benefits**—screen displays in a collapsible format, which enables the user to access easily all copayments and deductibles assigned to a particular benefit
- **Claim Status**—screen has sharper text and includes an error-message display if incorrect data is entered
- **Referrals**—screens have been updated to include a search field and navigation buttons



Reimbursement Policy Update Effective October 28, 2011

Please be advised of updates to our reimbursement policies effective October 28, 2011. These updates are designed to support correct coding and are in addition to our clinical editing software.

Split Surgical Care Modifiers

Inappropriately billed procedures with modifiers 54, 55, and 56 will be denied when billed with a non-surgical service.

Fracture Care

A fracture care procedure code that has a 10-day global period will be denied when it is billed in the office within 10 days of the same fracture care code by any provider (providers do not have to be in the same group practice or specialty).

Scope of Practice - Podiatry

Procedures billed by podiatrists that are not considered within the provider's scope of practice will be denied.

Bundled Services – Injection Services

Codes with a Centers for Medicare and Medicaid Services (CMS) professional status indicator T will be denied when billed with other payable services on the same day.

Services Not Valid for Medicare on the Medicare Physician Fee Schedule

Items, services and procedures designated as Not Valid for Medicare (professional status indicator I) will be denied.

NOTE: Procedure codes with a professional status indicator I that are currently in Behavioral Health provider contracts will not be included in this edit.

Services Not Covered on the Medicare Physician Fee Schedule

Items, services and procedures designated by Medicare as non-covered services (professional status indicator N) will be denied.

Please refer to the following CMS website for status indicators for professional providers (column heading – Status Code):

<http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&intNumPerPage=10>

A Message from the Chief Medical Officer



A patient arrives in your office after a recent hospital stay and thrusts a brown paper bag onto the examining room table that contains various medications prescribed upon discharge from the facility. One medication is duplicative of another that you prescribed previously. A second medication could cause an adverse side effect if combined with another medication that the patient had been taking prior to the hospital stay. The patient does not have a clear understanding as to the purpose of the new drugs prescribed in the hospital.

As practitioners, it is likely that we have experienced a similar scenario more than once in our careers. I cannot stress enough that medication reconciliation is an important responsibility of all parties involved in a patient's care, including the hospitalist, primary care physician, any specialty physicians, caregivers, and the patient.

At the time of discharge, the patient must be advised about any new medications and whether medications prescribed previously should be discontinued. The patient also should be alerted to his or her responsibility to relay any medication changes to the primary care physician. Please do not assume that all medication information will reach the patient's primary care physician via the hospital discharge summary. More often than not, by the time the summary is transcribed and makes its way to the PCP, it is too late to be helpful at the follow-up visit. Or, if the patient was given a copy of the summary, he or she may forget to bring it to the PCP follow-up visit.

The PCP also must take responsibility for gathering as much information as possible by questioning the patient about any changes to medications as a result of an inpatient stay.

Widespread implementation of IT solutions, such as electronic medical records, will be a monumental leap toward resolving this issue. Meanwhile, whether or not you have an EMR system, you can take steps to improve medication reconciliation. Not only will it enhance the patient/physician relationship, but likely will result in lower drug costs, fewer adverse side effects and greater patient safety. Consider integrating the following suggestions into your practice:

- Access to pharmacy prescription fill data
- Documentation of complete or partial non-adherence
- Development or use of an existing universal online medication list
- Wallet-size medication lists printed from an EMR that your patients can carry

I'm sure that you and your staff will devise a solution that works best for you and your patients. As always, thank you for the care that you provide to our members.

-- Richard Vienne, D.O.

Elmwood Health Center Achieves Level 3 Medical Home Recognition

Congratulations to Elmwood Health Center for achieving level-3 recognition under the National Committee for Quality Assurance (NCQA) Physician Practice Connections® – Patient Centered Medical Home program™. Level-3 is the highest level that a practice can achieve under the program.

Physician Practice Connections recognizes practices that use systematic processes and information technology to enhance the quality of patient care. The Patient Centered Medical Home program's standards emphasize the use of systematic, patient-centered, coordinated

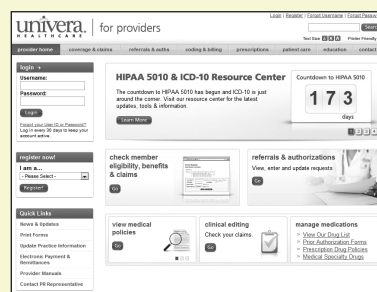
care that supports access, communication and patient involvement.

In order to achieve NCQA recognition as a Patient-Centered Medical Home, practices must meet a set of nine standards, including 10 must-pass elements, and complete a web-based data collection tool while providing information that validates their responses.

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Updated Provider Manual Now on Web



The *Univera Healthcare Participating Provider Manual* has been updated for 2011. The updated version is available on our website, univerahealthcare.com/provider. To access the manual, click on Provider Manuals under the Quick Links tab on the left.

If you would like a printed copy of the manual, contact Provider Service or your Provider Relations representative.

examiner univera HEALTHCARE

News for the WNY Provider Network

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Go Green
With Us!

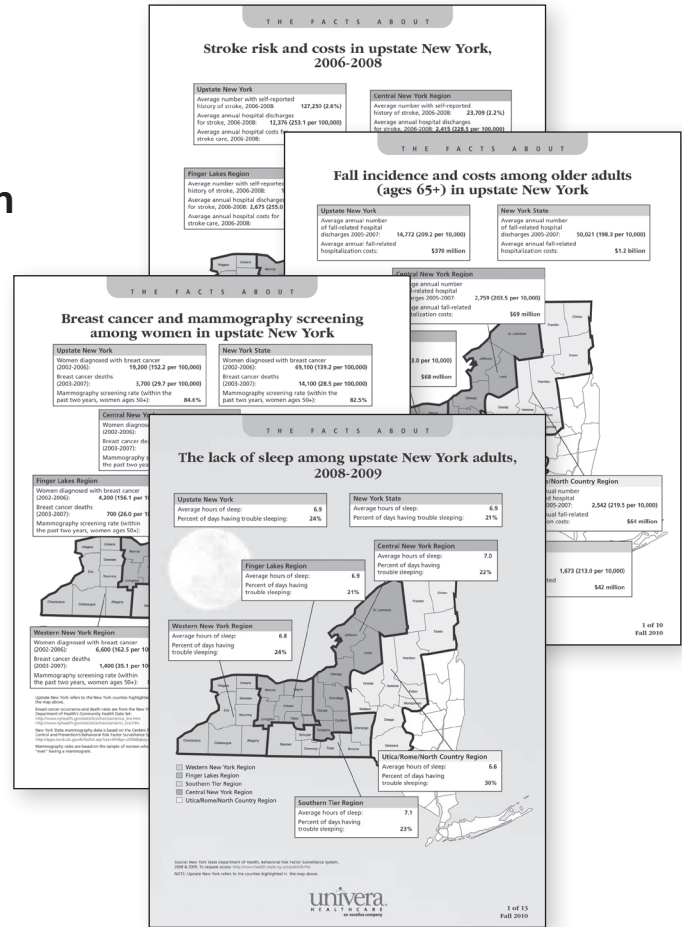
Sign up to receive electronic communications. Go to univerahealthcare.com/provider for details.



Did you know

Our health plan develops and issues fact sheets that convey unbiased information and data about health care issues that affect upstate New York, including regional variations. In 2010, fact sheets have included the following topics:

- Lack of sleep among upstate New York adults, 2008-2009
- Fall incidence among older adults (ages 65+) in upstate New York
- Stroke risk and costs in upstate New York, 2006 – 2008
- Reported sexually transmitted diseases in upstate New York
- Potentially unnecessary emergency room visits in upstate New York
- Trends and benefits of electronic prescribing in upstate New York
- Opportunities for generic drug savings in 2010 and 2011



Copies of all fact sheets, surveys and reports are available online at www.univerahealthcare.com/factsheets

42 New Generics in 2011-12 Could Bring \$900 Million Annual Savings



Upstate New York could see nearly \$900 million in annualized savings as a result of 42 brand-name prescription drugs becoming available in their generic form during 2011 and 2012, led by Lipitor®, Plavix®, and Singulair®, according to a report issued recently by Univera Healthcare. Lipitor has 154,000 users in upstate New York, Plavix has 80,000 users and Singulair has 102,000 users.

According to the Univera Healthcare analysis of prescription patterns in 39 counties, 18 brand-name drugs were identified as becoming available as generics this year. These drugs have average wholesale prices that produce an estimated annual spend of \$340 million. Once these drugs are available as generics, the health plan's projections show a potential annualized savings of \$272 million.

In 2011, the largest potential long-term savings will come from Lipitor. In 2012, the largest potential long-term savings will come from Plavix and Singulair. Once their generics become widely available, potential annual savings could total \$376 million from these three drugs alone.

Other drugs with patents scheduled to expire in 2011 and 2012 include Xalatan®, Nasacort AQ®, Levaquin®, Lexapro®, Actos®, Avalide®, Avapro®, Diovan®, and Diovan HCT®.

The complete report, The Facts about Opportunities for Generic Savings in 2011 and 2012, is available at univerahealthcare.com/factsheets.

2011 Behavioral Health After Hours Access and Availability

The Behavioral Health (BH) Access and Availability Standard and the provider contract states that telephonic access to behavioral health practitioners for urgent/emergent care should be available on a 24-hour, seven-day per week basis. We monitor compliance with the standard. A spring audit of 446 private mental health practitioners resulted in an aggregate compliance rate of 98.2 percent for all BH specialties. Phone calls and follow-up letters are being sent to practitioners found to need improvement.

The answering options that were considered acceptable are:

- Reaching the practitioner or a person with the ability to forward the call to the practitioner (i.e.; answering service); or
- Reaching an answering machine or voice mail with instructions for contacting the private practitioner or his/her backup in the event of an urgent/emergent clinical situation (i.e.; message with home phone number, cell phone, or beeper with direction for the patient or family member calling on the patient's behalf. Call forwarding also can be used, but the practitioner must state the call is being forwarded so the patient or that patient's family is aware). It is recommended strongly that phone and voice mail messages advise patients to call 911 or go to the emergency room in the event of a life-threatening situation.

Access Measure	Health Plan Standard	Behavioral Health Measurement Tools
Timeliness of BH emergency care	<p>Access to the BH specialist for life-threatening emergencies should be available immediately by telephone on a 24 –hour, seven-day per week basis</p> <p>Access to the BH specialist for non-life-threatening emergencies should be available within six hours</p>	<p>Random After Hours Call Program</p> <p>Complaint analysis</p>

Additional BH Access Standards can be seen on the Health Plan's web site by clicking on *Providers > Patient Care > Behavioral Health > Quality Management*.

For more information about the BH Quality Management Program, please contact Brian Moser, RN at 1 (800) 240-6956 or brian.moser@univerahealthcare.com.

Help for Patients with Eating Disorders

If you are treating a patient who has an eating disorder, be aware of an important support service available to patients who have Univera Healthcare coverage.

The Buffalo Centre for the Treatment of Eating Disorders, a New York state Office of Mental Health-approved program, provides treatment for adolescents, adults, and their families with an emphasis on maintaining long-term recovery through proven methodologies and individualized treatment planning. Buffalo Centre staff provides weekly progress reports to the patient's physician and other providers, if requested to do so by the patient.

Treatment sessions run Monday through Friday with length of treatment averages 4 to 12 weeks. The therapeutic

day program for individuals 14 years and older includes:

- Physician consultation for each admission
- Complete individual assessment for eating disorders
- Group sessions that meet twice daily
- Psychiatric consultation as indicated
- Consultations with a registered dietitian
- Interactive group activities
- Educational programs for individuals and families
- Coordination with community resources and education systems

For further information and patient application forms, please visit buffalocentre.com. If you have questions, please contact the Buffalo Centre at (716) 276-6939.

Depression Case Management Program is Collaborative Effort

Our Behavioral Health Depression Case Management program provides for collaboration with members, providers and practitioners to maximize effective, person-centered treatment, and to assure quality, and evidenced-based patient care. The goal is to achieve member and provider satisfaction while maintaining cost efficiency and effectiveness. We strive to enhance the member's quality of life while supporting wellness through preventative intervention including providing resources, education, and assistance with managing his or her health care.

This program identifies commercial and Medicare members who are at risk for, or have been diagnosed with a mood disorder. The depression case manager collaborates with the member and providers to develop a person-centered plan of care aimed at achieving member wellness and autonomy through advocacy, communication, education, coordination of service resources and solutions. The case manager will assist the member to identify and plan for potential barriers to treatment including transportation, financial issues, child care, work or other scheduling conflicts.

External referral sources include, but are not exclusive to the following:

- Primary care physicians
- Mental health and chemical dependency providers
- Specialty providers, such as cardiology; cardiac rehabilitation; endocrinology; diabetes educators; cancer centers; OB/GYN; bariatric surgeons
- Members
- Employer groups
- Other health-care programs

For more information, please contact Mary Warchocki, RN at 1 (877) 830-0414.



- Child Health Plus
- PlusMed
- Family Health Plus

Let us Support your Efforts to help your Patients

Univera Community Health offers telephonic support services to members. Registered nurses, social workers, and drug and alcohol abuse counselors educate members about preventative care and ways to manage their chronic conditions. Our case and disease managers will follow up with your patients regarding your treatment plan and assist their needs with housing, transportation, and social issues, etc. **This is at no cost to our providers or members.**

Here is just a overview of the programs that we offer:

Case managers/disease managers: Support members with chronic illnesses including diabetes, coronary artery disease, asthma and ADHD/behavioral health. We will identify community resources and assist members in accessing and coordinating their health care services

Pregnancy program: Provides support during a member's pregnancy and after delivery. We will assist her with appoint-

ment planning, information about the baby's development, nutritional advice and will provide answers to questions

Health Promotion programs: Including preventative health education and reminders. Health risk assessments encourage members to engage in activities that increase healthy behaviors

Outreach coordinators: Work with provider offices to educate staff regarding our programs; accept member referrals; and provide outcome reports. Coordinators establish relationships with community resources

24/7 nursing line: Our specially trained health professionals, such as nurses, respiratory therapists and dietitians are available 24 hours a day and 7 days a week. The Health Coaching Program supports patients as they work with their physicians to improve their self-management skills and ability to make shared decisions

Please contact us at 1-800-509-5290 if you would like more information on our programs.

Access Key to Quality Care

Univera Community Health's mission includes ensuring that our members always have access to quality medical care. Our plan adheres to New York state Access and Availability standards.

The New York State Department of Health conducts annual "mystery shopper" surveys to determine compliance with these standards. In the past few years, survey results indicate there is much opportunity for improvement regarding timeliness of preventive and routine care for PlusMed members. Additionally, our own health plan surveys indicate opportunities for improvement related to members with commercial as well as safety net coverage.

Be aware that the NYSDOH and our health plan will conduct mystery shopping surveys in 2011. These surveys check access by having surveyors pose as patients seeking care. This differs from other surveys, which ask patients directly about their recent experiences with care. We understand the challenges that you face in the delivery of medical care in our community and thank you for the valuable service that you provide. We hope that we can work together to find ways to alleviate many of these challenges and to increase access to care for our members.

A tipsheet outlining the Access and Availability standards was mailed to primary care practices in January. Additionally, you can view the standards on our website, univeracommunityhealth.org.

Stay Informed About State HIV Requirements

Many people with HIV do not know their HIV status, and many are still receiving their HIV diagnosis when they have already advanced to AIDS. The New York State Department of Health (NYSDOH) has HIV counseling, testing and reporting requirements, along with guidelines to help increase HIV testing, ensure entry into care and increase laboratory reporting.

The NYSDOH provides resources, including forms for informed consent and release of medical information, and phone numbers for HIV information, referrals, or testing. Information about rapid test technology and reporting requirements also are provided. Details about these requirements and guidelines can be found in the *Univera Community Health Participating Provider Manual* on our website, univeracommunityhealth.org. NYSDOH HIV resources also are available at www.health.state.ny.us/diseases/aids/.

Educate Patients About Smart Use of Antibiotics



Today we see many patients coming into provider offices with an expectation that they will receive an antibiotic for their illness. It can be a challenge explaining to a patient that they do not need an antibiotic.

The Centers for Disease Control (CDC) developed the following communication strategies that can improve patient satisfaction and understanding when it comes to antibiotic use.

1. Provide a specific diagnosis to help patients feel validated. For example, say “viral bronchitis” instead of referring to an illness as “just a virus.”
2. Recommend symptomatic relief. This can make a difference when a patient does not require an antibiotic. Often, patients request

an antibiotic because they think it will help them or their child feel better. They may not realize that effective symptomatic therapies can give them the relief they are seeking. One option is to provide patients with cold-care kits to prevent them from leaving your office empty-handed. You can also write a prescription for over-the-counter products. CDC’s downloadable symptomatic prescription pad is useful for this.

3. Share normal findings as you go through your exam. For example, let patients know that their lungs sound clear, or that you aren’t seeing inflammation in their child’s ear. This reassures the patient or parent that the illness may not be as severe as they thought and may make them more open to the idea that they don’t need an antibiotic.
4. Discuss potential side effects of antibiotic use, including adverse events and resistance. Many patients don’t realize that antibiotics can be harmful.
5. Explain to the patient or parent what to expect over the next few days. This can help them feel reassured and empowered. For example, explain that a cough

may persist for several days, or discuss how long it may take for their child’s earache to subside. Give patients a plan of action in case symptoms do change or become more severe -- including that you will reevaluate their situation and prescribe antibiotics if it becomes medically appropriate.

To learn more about the CDC program Get Smart: Know When Antibiotics Work or to order free patient materials visit www.cdc.gov/getsmart

The Cost of Antibiotic Resistance

Antibiotic resistance is an economic burden on the entire healthcare system. In the U.S., antibiotic-resistant infections are responsible for \$20 billion in excess healthcare costs, \$35 billion in societal costs and \$8 million in additional hospital days. By using antibiotics appropriately and only when they are needed, we can all play a role in lowering the cost of resistance on our communities and the country.

Incentive Offered to PlusMed, FHP Members

Univera Community Health has implemented a member incentive campaign for PlusMed (Managed Medicaid) and Family Health Plus.

Targeted preventive health measures include breast cancer screening and diabetic A1C and LDL testing. Eligible members are identified by HEDIS data as being non-compliant in one or more of these measures.

In late June, a notification was mailed to eligible members. The member must complete the preventive health measure by December 31, 2011, to be eligible to receive a \$25 gift card.

State Using Encounter Data to Establish Risk-Adjusted Payments

It is important that Univera Community Health and its participating providers work together to ensure that members receive appropriate care and that all applicable diagnosis codes are included on the claim and in the chart. The coding practices in your office impact the way your patients’ health care services are represented in the state’s new risk-adjusted methodology.

We would like to encourage providers to use each office visit as an opportunity to evaluate ongoing problems/conditions, assess medication compliance, document in the medical record and submit appropriate diagnosis codes.

Providers should report all diagnoses that impact the patient’s evaluation, care, and treatment including:

- Main reason for visit
- Co-existing acute conditions
- Chronic conditions (such as Atrial fibrillation, CHF, Chronic Renal Failure, Hypertension, Rheumatoid arthritis, Crohn’s disease, Diabetes, COPD/ Asthma, & Cardiomyopathy)
- Pertinent past conditions
- V-codes (factors that influence health, such as amputations, ostomies and quadraplegia)



Coding Tips for Heart Failure



The ICD-9 coding of heart failure is very challenging. “Heart failure occurs when the heart cannot pump enough blood to meet the body’s needs.”* Heart failure can be one, or a combination, of two types: 1) a pump problem, as in systolic failure (428.2X), when the left ventricle is dilated, muscle contraction is impaired, and there is a decreased outflow of blood from the heart;* 2) a filling problem, as in diastolic failure (428.3X), when the left ventricle is normal but the muscle is unable to relax, cannot fully fill with blood, and the outflow to the body is decreased;** or 3) both systolic and diastolic failure (428.4x).*** If the type of heart failure is not specified in the documentation, code 428.9 should be assigned.** The severity of the failure (acute, chronic, acute on chronic, or unspecified) is indicated by the addition of a 5th digit to the appropriate code from category 428.**

Heart failure may be further manifested as left sided (428.1), right sided (428.0), or congestive (428.0), which is defined as blood backing up into the liver, abdomen, lower extremities, and lungs.* Please note: congestive heart failure includes left heart failure so codes 428.1 and 428.0 should not be coded together.** Cardiomyopathy (425.X) is a disorder of the cardiac muscle, the manifestation of which can be similar to heart failure or contribute to the heart failure.***

Any time a documentation of the type of heart failure (codes 428.2X, 428.3X,

428.4X, or 425.X), regardless of severity, includes documentation of CHF (428.0), all applicable diagnoses should be coded.****

Further, if the heart failure is caused by hypertension, with or without the addition of chronic kidney disease (CKD), multiple diagnoses codes are required: 1) a hypertensive heart disease code (402.XX or 404.XX); 2) the appropriate heart failure code(s) (codes 428 and 425), and, if applicable; 3) the appropriate CKD code (category 585).*****

It is clear that complete provider documentation of a patient’s heart failure is critical to correct diagnosis code assignment. Therefore, the following are suggested to assist in avoiding coder queries:

1. Clearly document the type of heart failure (systolic, diastolic, or both)
2. Clearly document the manifestation of the heart failure (right, left, congestive)
3. Always document the severity of the heart failure (chronic, acute, acute on chronic)
4. Always document any causal relationship between hypertension and heart failure
5. Always document any existing co-morbidities (cardiomyopathy, CKD).

Please remember to utilize the most up-to-date version of the ICD-9-CM manual when choosing diagnoses codes to correctly illustrate the health status of your patients.

*Coding for Heart Failure, For the Record, Volume 20, No. 6, P. 28, March 17, 2008

**Challenges for Coding Heart Failure, Advance for Health Information Professionals, May 22, 2007

***Coding Guidelines, DRG-127 Congestive Heart Failure, Primaris Healthcare Business Solutions, March 2006

****Coding Clinic, 1st quarter 2009, p 8, 3rd quarter 2008, p. 12-13, 4th quarter 2004, p. 140, and 2nd quarter 1990.

*****Coding Clinic, 4th quarter 2002, p. 49-52, 4th quarter 2002, p 52, and 2nd quarter 1993, p 9

ERA 835 Remittance News

Due to HIPAA 5010 implementation, ERA 835 remittances will now display a blank space in the first-name field in rare instances where the claimant has a single legal name.

Please make a note of this change.

New Extenders in Your Practice Must Register with Plan



Each time a physician extender joins your medical practice, he or she must complete a Univera Healthcare Physician Extender Agreement Registration Form and submit it to our organization and include all documentation specified on the form.

Please note that submission of the form and documentation is required even if the nurse practitioner or physician assistant registered with Univera Healthcare previously as an employee of another medical practice.

The form is available on our website, univerahealthcare.com. If you have questions, please contact Provider Service at (716) 857-6269 or 1 (800) 617-1114.



Medicare Risk Adjustment Coding Corner

Combination diagnoses codes exist for certain medical condition scenarios. In most cases, the relationship or causation for the conditions must be established within the provider's encounter documentation. However, with hypertension and chronic kidney disease (and several other renal diagnoses, as listed in the inclusion list in the ICD-9 Manual) a relationship between the two conditions is assumed.*

Hypertension codes are found in category 401-405. Category 401.X identifies primary, or essential, hypertension with the 3rd digit (0-1) used to identify whether the hypertension is malignant (0) or benign (1). These fourth digit specifics, applicable to all of the hypertension categories, must be established by the provider's documentation rather than any particular blood pressure measurements. If hypertension is diagnosed without a specific category, then the 3rd digit assignment would be "9" for unspecified.**

Chronic Kidney Disease is codified in category (585) with the fourth digit (1-6, 9) representing the stage of kidney failure. The stages are defined based on the glomerular filtration rate (GFR). But, the actual assignment of stage (fourth digit) will be dependent on the provider's documentation. Therefore, if no specific stage is documented, the 4th digit assigned will be "9",

regardless of any documented GFR.***

Unlike hypertension with heart disease (discussed last month), ICD-9-CM presumes a cause-and-effect relationship and classifies documentation of renal failure



and hypertension as hypertensive renal disease.**** The inclusion list for hypertension category 403 allows this code set to be used whenever any condition from category 401 (essential hypertension) and 585 (Chronic Kidney Disease) or 587 (renal sclerosis, unspecified) are documented in the record.* In this situation, two codes are required to fully illustrate the patient's condition: 1) category 403, with the fourth digit indicative of type of essential hypertension and fifth digit (0-1) indicative of chronic kidney failure stage; and 2) category 585 to identify the stage of kidney failure, if known.*****

Hypertensive category 404 is used when conditions classifiable to category 402 (hypertensive heart disease) and 403 (hypertensive kidney disease) is documented.*

For this category, the fifth digit (0-3) illustrates the presence or absence of heart failure and the stage of chronic kidney disease. In the absence of heart failure, two codes (one from category 404 and one from category 585) are required. If heart failure is present, three or more codes would be submitted (category 404 and 585 and all codes necessary to fully illustrate the type of heart failure).*

For both categories 403 and 404, if renal sclerosis is the type of chronic kidney disease documented, the fifth digit code to illustrate unspecified kidney failure would be appended and code 587 would be submitted in place of a 585 code.*****

Please remember to utilize the most up-to-date version of the ICD-9-CM manual when choosing diagnoses codes to correctly illustrate the health status of your patients.

*ICD-9-CM Official Guidelines for Coding and Reporting, 2011 ICD-9-CM Coding Manual

**Coding for Hypertension, For the Record, Vol 18, No 2, P 44, January 23, 2006

***Coding for Chronic Kidney Disease, For the Record, Vol 18, No 16, P 57, August 7, 2006.

****Coding for Renal Failure, For the Record, Vol 16, No 23, P 37, November 15, 2004

*****AHA Coding Clinic 4th Quarter 2010, p 139-141

*****AHA Coding Clinic, 4th Quarter 2010, p 137

Keep This Helpful Tip in Mind for Efficient Claims Processing

To avoid claims processing and payment delays, do not use LOOP 2300 Segment PWK of your electronic claim submission to indicate that medical records have been mailed.

LOOP 2300 Segment PWK is used to indicate that medical records have been attached to your electronic submission, but at this time, the electronic claims submission system does not have the capability to attach medical records, so claims will suspend if submitted with an

indicator in LOOP 2300 Segment PWK.

We will check our medical records database when we receive your electronic claim submission and will contact your office if we do not have the records we need to support the claim.

Please share this important information with your billing service and practice management vendor.

If you have any questions regarding this information, please contact Provider Service.

HIPAA 5010 Changes Format

With the implementation of HIPAA 5010 electronic transactions, response reports will be in an ANSI 5010 format. Please contact your practice management software vendor, billing service, clearinghouse, or IT department to confirm that they are programming the response reports into a format that you will be able to read.

HIPAA 5010 Internal Readiness Testing Checklist*

Use this checklist to assist with completing internal readiness testing in preparation for external testing of the new Versions HIPAA 5010 standards with your trading partners.

✓	Dates	Testing Action	Elements
	1/1/2010	Obtain the Technical Report Type-3 (TR3) Documents	To purchase the TR3, go to Washington Publishing Company, publisher of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Accredited Standards Committee (ASC) X12 TR3 Document for Health Care, at www.wpc-edi.com .
	1/1/2010	Set-up Project Team to Develop Initial Plan	<ul style="list-style-type: none"> Obtain executive sponsorship for the team: Estimate the financial impact of technical and business changes to the organization so sufficient financial and personnel support can be acquired. Elect a leader who can lead a multidisciplinary task force. Include representatives from the IT department, all areas using the data, and business end-users. Develop metrics and measurement tools to track the status of the project.
	6/1/2010	Determine Gap Analysis	<p>A gap analysis determines the system and business process changes needed to create a project plan, timeline, and communication strategy. Basic gap analysis tasks include:</p> <ul style="list-style-type: none"> Inventory of software applications and vendors. Identify potential impact by determining whether these applications take in or produce the HIPAA EDI transactions (e.g., claim, remittance, eligibility inquiry, claim status) or Code Sets (e.g., procedure and diagnosis codes). Contact the vendor and determine when they will deliver their software upgrade. Understand the upgrade requirements: hardware, file conversions, and implementation compatibility with the current version. Perform necessary hardware or software procurements. Determine which payers represent the primary source of revenue; contact these payers to learn of their implementation timeline and information distribution channels (e.g., listservs). Contact clearinghouses to learn when they will complete testing with the payers representing the provider's primary source of revenue. If provider is at risk, plan an alternate delivery channel for EDI. Analyze hardware requirements to ensure they support the required upgrades. Identify what's new in Versions 5010 and D.0 and determine what information is applicable to the organization: Medicare has performed a comparison of the current and new formats for the transactions used, available at: www.cms.gov/ElectronicBillingEDITrans/18_5010D0 Identify what content was deleted from Versions 5010 and D.0 and determine the impact to business processes. Identify changed content (e.g., infrastructure changes made to Version 5010 for ICD-10) Identify business processes impacted by the new systems.
	Beginning 6/1/2010 ongoing to implementation on 1/1/2012	Communicate	<ul style="list-style-type: none"> Identify internal and external stakeholders and trading partners and engage them in the planning. Coordinate/manage direct connection with trading partners throughout the transition. Contact application vendors to learn of their delivery schedule for the system upgrade. Contact clearinghouse vendors to learn of their testing schedule for payers of key interest to the provider. Contact key payers to learn of EDI exchange modifications (e.g., Will a new submitter ID be required for the 5010 version versus the current 4010 version; will telecommunication connectivity changes be required).
	Beginning 6/1/2010 ongoing to implementation on 1/1/2012	Provide Education/Training	<ul style="list-style-type: none"> Provide training for business and technical staff on the changes identified through the gap analysis. Training should focus on: <ul style="list-style-type: none"> - Understanding the transaction changes - Learning the practice management system (software) changes - Learning new workflow processes

* This chart was prepared based on information from Centers for Medicare & Medicaid Services (CMS) and is not intended to grant rights or impose obligations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents. To access the CMS "Checklist for Level I Testing Activities," go to: <http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf>

HIPAA 5010 External Readiness Testing Checklist*

Use this checklist to assist with completing external readiness testing in preparation for external testing of the new Versions HIPAA 5010 standards with your trading partners.

✓	Dates	Testing Action	Elements
	Beginning 1/1/2010 and continuing communications to ensure compliance on 1/1/2012	Engage Vendor	<p>Software vendors are not covered entities; therefore, they are not responsible for compliance. However, vendors are critical to provider compliance and any interruption in vendor implementation of compliant products will delay end-to-end testing. Some questions to ask your vendor(s):</p> <ul style="list-style-type: none"> • Will you upgrade your current system to accommodate Versions 5010 and D.0 transactions? • Will the upgrade include acknowledgement of transactions 277CA and 999? • Will the upgrade include a “readable” error report produced from 277CA and 999 transactions? • What is the time frame for when you will be capable of supporting Version 5010 transactions exchange? • Will you be able to support both Version 4010A1 and Version 5010 transactions exchange concurrently (<u>across multiple trading partners both in test and production modes</u>)? • When will the current system accommodate both the data collection and transactions conduction for Versions 5010 and D.0? • When will the upgrades be available? • Will there be a charge for the upgrade? • When will the software installation to the systems be completed? • Will the transition be completed before the Jan. 1, 2012 compliance date? • Will there be sufficient lead time to test the new software before Jan. 1, 2012? • What is my role in testing 5010 and D.O. with trading partners? <p>Based on the vendor’s responses to the questions above, evaluate the impact to routine operations and begin planning for training and transition.</p>
	Begin communicating 6/1/2010 and continue to work with them through beginning of test phase	Communicate with Clearinghouses, Billing Services, and Payers	<p>Contact clearinghouses or billing services and health insurance payers early to learn about their implementation plans. Some questions to ask your clearinghouses, billing services, and payers:</p> <ul style="list-style-type: none"> • Will you be upgrading your systems to accommodate Versions 5010 and D.0 transactions? • When will the upgrades be completed? • Will you change your fees for Versions 5010 and D.0 transactions? • How will we need to register in order to conduct 5010 transactions? • When can we send you our test transactions to ensure the system works correctly prior to Jan. 1, 2012? • <u>If we’re unable to complete testing of 5010 and D.0. in time to go live by Jan. 1, 2012, what are our options for submitting claims and receiving remittances electronically?</u> <p>Based on the responses to the questions above, you will know if your clearinghouses and billing service can continue to support your business. This information will assist you with planning budget needs and help develop a time frame for testing and implementation.</p>
	Begin as soon as your trading partner schedules you for testing Full testing could take up to 60 days	Test with Your Trading Partners	<p>The final step for a provider before going “live” with Versions 5010 and D.0 transactions will be to complete testing with its trading partner(s). Trading partners are the organizations providers use to exchange transactions. Some questions to consider regarding testing:</p> <ul style="list-style-type: none"> • Which transactions should we test? • When should we begin testing? • Which trading partners do we test with? • Do we use test data or live data during testing?

* This chart was prepared based on information from Centers for Medicare & Medicaid Services (CMS) and is not intended to grant rights or impose obligations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents. To access the CMS “Provider Action Checklist,” go to: <http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf>

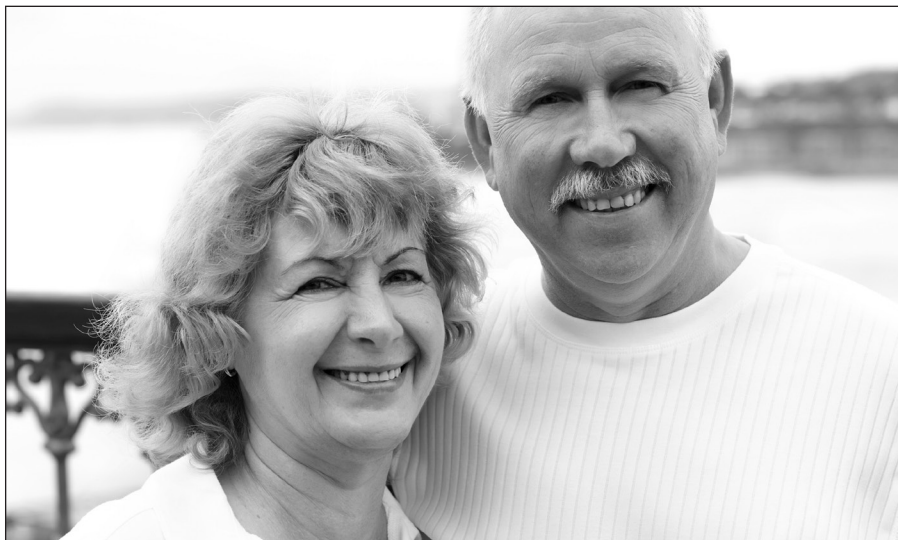
UM Medicare Reopening Reminder for Medicare Advantage Products

The process for requesting reopening of a Medicare determination can be confusing. This process is governed by the Centers for Medicare & Medicaid Services (CMS), which offers the following helpful information:

Reopening is a remedial action taken to change a final determination or decision even though the initial determination or decision was correct based on the evidence of record.

There are only two circumstances that allow a reopening to be conducted when appeal rights have not been exhausted or the timeframe to request an appeal has not expired:

1. If the Medicare Health Plan issues an organization adverse determination because it did not receive requested documentation and the party subsequently submits the requested documentation within the timeframe to request an appeal, it will be treated as a reopening (If a Medicare Health Plan did not request additional documentation in order to make the original organization adverse determination but the party subsequently submits additional documentation after the denial, this should be treated as an appeal, not a reopening).
2. Clerical errors (which are minor errors and omissions) will be treated as reopenings. If the organization receives a request for reopening and disagrees that the issue is a clerical error, the organization must dismiss



the reopening request and advise the party of any appeal rights, provided the time frame to request an appeal on the original denial has not expired. For purposes of this section, clerical error includes human and mechanical errors on the part of the party or the Medicare Health Plan (i.e. transposed procedure or diagnostic code).

There are several guidelines that you need to follow in order to make a request for a reopening. If these guidelines are not followed your request will not be processed as a reopening:

- The request must be made within one year from the date of the organization determination unless there is an extenuating circumstance. In that case, the request must be made

within four years from the date of the organization determination.

- The request for a reopening must be clearly stated/documented. If you simply send in medical records after getting a denial, we cannot automatically assume that you are requesting a reopening.
- The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted)

Re-openings are at the discretion of the Medicare Health Plan and are not a party's right. The Medicare Health Plan's decision not to reopen is not appealable. If you have questions on this process, please call Provider Service, or refer to the CMS website at <http://www.cms.gov>.

Quality Improvement Program Summary Updated

The goals of the Quality Improvement program support the mission of our organization, which is to improve the quality of life in the communities that we serve. As a health plan, we work to engage members and employers to make healthy and well-informed choices, and to influence practitioners and providers to deliver quality, cost-effective care. The success of the program is evidenced by measurable improvements in health and satisfaction.

If you are interested in obtaining a copy of our Quality Improvement program description, which describes progress toward our goals, please visit our website, univerahealthcare.com.

New Preauthorization Forms Required for Benlysta, Yervoy

Select medical specialty drugs require preauthorization under the medical benefit. Claims will deny or suspend for review across all lines of business if preauthorization is not obtained.

Preauthorization forms for Benlysta® and Yervoy™ are available on our website. Please visit univerahealthcare.com/provider. Go to: *Referrals & Auths>Prescriptions, Medical Drugs & Specialty Meds>Access Prior Authorization Request Forms*.

For a complete list of medications that require preauthorization under the medical benefit, go to: *Referrals & Auths>Prescriptions, Medical Drugs & Specialty Meds>View list of Provider Administered Drugs Requiring Preauthorization*.

Let Us Know Your Thoughts

Univera Healthcare is committed to assuring that all participating physicians and providers are satisfied with daily operational plan functions such as network management and provider services relationships, resource management processes, quality improvement activities, and customer service.

To that end, we invite your comments, concerns and questions. Your feedback will help us know how we're doing. Please contact Maria N. Valvo, Provider Communications Manager in writing at 205 Park Club Lane, Williamsville, NY 14221; via fax, (716) 857-4578 or by calling (716) 857-6269 should you wish to share your thoughts.



Univera Healthcare
205 Park Club Lane
Williamsville, NY 14221

Summer 2011

Univera Healthcare Mission: *To improve the health and quality of life of our members and the communities we serve.*

Thank You for Assisting with Our Claim Review



Thank you to those providers who responded to our request for medical records and other documentation related to our ICD-9-CM coding validation retrospective record reviews of Medicare Advantage claims. The diagnosis code review assists in compliance with Centers for Medicare & Medicaid Services regulations. It also helps us to educate you and your staff regarding the Medicare Risk Adjustment Model, which relies on ICD-9-CM diagnosis codes to accurately reflect the health status for Medicare Advantage beneficiaries.

We advised you previously that coding guidelines recognize how many chronic conditions have a significant effect on a member's overall health and the corre-

sponding diagnoses codes should be submitted to clearly reflect a patient's overall health status.* Additionally, "[c]hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)."

Points to remember when identifying whether a chronic condition has received treatment and care during an encounter include:

- referring to the condition as "chronic" rather than "history of," per coding guidelines, "history of" defines the condition as resolved;
- linking the medications that the member is receiving to the condition it is treating;
- clearly indicating if any observed physical findings are related to existing chronic conditions;
- clearly stating any causal association between medical conditions (e.g. diabetes and chronic kidney failure).**

Other documentation guidelines:
Assure that the patient's name is on each page of the record;

Assure that each encounter note is clearly dated and that each page can be clearly identified as relating to the encounter;

Assure that the existence of all submitted diagnoses is clearly documented

within the encounter note;

Assure that the medical record is legible; Sign all encounter notes, including your credentials.***

*History of COPD, Coding Clinic, Second Quarter 1992 pages 16-17

**ICD-9-CM Official Guidelines for Coding and Reporting, 2011 ICD-9-CM Coding Manual

***Guidelines for Medical Record Documentation, NCQA, www.ncqa.org

News Regarding Clinical Practice Guidelines

Univera Healthcare has reviewed and updated the following clinical practice guidelines:

- Asthma - no changes
- Preventive Health Care for Adults
- Preventive Health Care for Children

Clinical Practice Guidelines are posted to our website, univerahealthcare.com/provider. Click on *Patient Care > Clinical Practice Guidelines*. Scroll and click on the guideline you wish to view.