Montana | Mountain Health CO-OP

Provider Newsletter

MARCH 30, 2019
QUARTER 1


member photo

Gratitude.

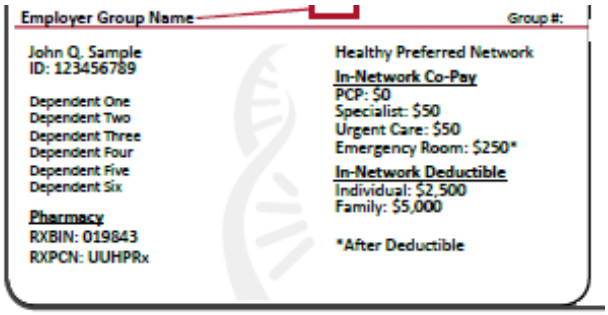
from Richard Miltenberger, CEO

MHC thanks you for your partnership. We are dependent on our provider network and strive to provide exceptional service. This year we are working on important initiatives that we believe will benefit the provider community and our members. For example, we work daily with our partners at the University of Utah streamlining processes from provider set-up and credentialing to processing claims. We are also reviewing the fee-for-service models, and by working together on this initiative we will find a balance that works for providers, members and Montana Health Co-Op. Again, thank you for working with us and we look forward to working with you in the future.

IN THIS ISSUE

New Look For 2019 MHC ID Cards

MHC ID cards are now family-style, with each dependent and their ID number listed on the card.



HEALTH CO-OP

Corrected Claims Billing Change

When submitting a corrected claim, it must be identified by one of the following:
It is preferred to receive corrected claims via Electronic Data Interchange (EDI) transaction. To request a claim be corrected, submit the following information in Loop 2300 of an X-837 electronic claim form:

1. In segment **CLM05-3**, insert the appropriate "Claim Frequency Type" code (may be displayed by your software as a dropdown field):
   - **6** – Adjustment of prior claim
   - **7** – Replacement of prior claim
   - **8** – Void/cancel prior claim

2. Enter the Original Claim Number in the REF*F8 "Payer Claim Control Number" field

Notes:

Effective April 1, 2019, we will no longer accept Modifier CC on the service line of claims.

You must report every line associated with this claim to ensure the full claim is reprocessed.

If you must submit a corrected claim on a paper claim form:

UB-04 Facility Claim Form –

- Enter the "Claim Frequency Type" code (6, 7, or 8) as the 3rd digit of box 4 "Type of Bill" (e.g., 137 indicates a correction to a Hospital Outpatient claim)

- Enter the payer's original claim number in box 64 "Document Control Number"

CMS-1500 Health Insurance Claim Form – Enter the correct "Resubmission Code" and the "Original Ref (claim) Number" in box **22** of the form

Corrected claims or adjustments will be adjudicated within the timeframes set forth as described in the **Timely Filing** section of the Provider Manual.

New MHC Prior Authorization On-line form

We have created a better way to submit prior authorizations. When you use our NEW electronic PA form, you will now get a notice saying your request has been received and will be responded to by a specific time frame. You can also upload medical records. Please click on the link below to access our NEW on-line PA form.

https://app.healthcare.utah.edu/umHealthPlans/main?mhc

If you need to submit Prior Authorizations requests via FAX, we have also updated our Fax numbers:
FAX 801-262-0103 for inpatient notifications
FAX 801-213-1358 for any other prior authorization request.

Sign up for EFT & ERA for MHC

Why wait for snail mail when Electronic Remittance Advice and Electronic Funds Transfer deliver claim information to you and payments to your bank account the same day as they are posted?

With Electronic Remittance Advice (ERA), you can review claims as soon as processing is complete, with no lag time waiting for the mail. Additionally, most Electronic Data Interchange (EDI) software can be configured to automatically post claim information directly to the patient's account without having to manually reenter the data. Using ERA decreases time spent reconciling accounts and reduces data entry errors. With Electronic Funds Transfer (EFT), payments are deposited directly to your bank account as soon as the payment is processed.

EFT eliminates concerns of your check being delivered to the wrong address, stolen from the mail, or signed and cashed by an unauthorized person. EFT also eliminates the need for a staff member to spend time carrying the check to the bank. And, as with ERA, most EDI software can be configured to automatically post payments directly to the patient's account.
EDI transactions are standardized throughout the industry. This means your office can enjoy the efficiencies gained through EDI when doing business with most payers.

Visit uhealthplan.utah.edu/for-providers/edi.php for more information about:

- Accepted transactions
- Enrolling for EDI
- Submitting claims
- Receiving assistance

Don't wait – make your office more efficient by signing up for ERA and EFT today.

Leaving or Terminating with a MHC Network

If you leave or terminate your participation in a Network such as Monida, Rocky Mountain Health Network, or BrightPath your MHC contract may terminate as well. This would cause you to become non-participating. If you leave or terminate with a Network, please contact MHC to contract directly. The sooner you make this call, the less impact to you and your patients. In Montana, please call (406)447-5777. In Idaho, please call (208)917-1602. Or email provider@mhc.coop, for either.

New License

If you receive a new license, email it to provider.credentialing@hsc.utah.edu. Please note that this it is a new license for a new specialty. If you have a board certification (such as FNP) include that as well.

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Professional Providers Dispensing DME

If you are a professional provider who dispenses Durable Medical Equipment to patients, you may have noticed such items denied. Montana/Mountain Health CO-OP (MHC) is creating a policy and a list of approved codes. Please contact us at (406)447-5777 for Montana and (208)917-1602 for Idaho and/or watch for next quarters provider newsletter for further details.

DID YOU RECEIVE YOUR 1099 FROM MHC?

The most wonderful time of the year – if you look forward to receiving tax forms, that is. We mailed Form 1099 to impacted providers the latter part of January. For the 2018 calendar year, we generated 1099s for all vendors that received payment of $600 or more during the year. Please verify that the business name and Tax ID number on the 1099 matches what you file with the IRS. Send us any needed changes with an updated Form W-9, Request for Taxpayer Identification Number and Certification. Remember to always send an updated W-9 to payers anytime your Tax ID or business name changes. Email mhcproviderrelations@hsc.utah.edu or call 801-587-2863 with any questions about your 1099 or W-9.

When and How-to Bill Modifier 59

With the Centers for Medicare & Medicaid Services (CMS) rules becoming increasingly prescriptive, many insurance payers will no longer provide separate reimbursement for CPT or HCPCS codes submitted with Modifier 59 Distinct Procedural Service. According to coding guidelines, Modifier 59 is valid only in certain circumstances when no more descriptive modifier is available. It should never be reported to bypass NCCI or PTP edits, nor should it be appended to an Evaluation and Management (E/M) code.or W-9.

Before reporting Modifier 59, consider whether one of the following alternatives may be more descriptive:

Modifier 25 *Significant, Separately Identifiable Evaluation and Management Service* by the Same Physician (or other qualified healthcare professional) on the Same Day (of the procedure or other service)

Example*
An orthopedist sees a new patient for knee pain evaluation. The orthopedist diagnoses the patient with osteoarthritis of the knee and discusses options for management, then injects a steroid to provide patient relief.
You may report the aspiration and the same-day E/M, as appropriate to the documented E/M service level, with modifier 25 appended. You may also report the drug supply. The orthopedist would make a decision to perform an additional procedure (the injection) only after completing an E/M service.

Modifier XE *Separate encounter* – A service that is distinct because it occurred during a separate encounter

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Example*
The physician performs a diagnostic nasal endoscopy (CPT 31231) at 10 a.m. The patient goes to the ER at 8 p.m. that evening with severe epistaxis, so the doctor uses complex techniques to control the anterior epistaxis (CPT 30903). Had they been performed during the same encounter, the diagnostic endoscopy would have been bundled with the control of epistaxis. Since they were done at different encounters, the modifier XE would be used with the 30903 because it is the Column 2 code.

Modifier XS *Separate organ/structure* – A service that is distinct because it was performed on a separate organ/structure

Example*
Two codes that often get unbundled inappropriately are bone marrow aspiration, CPT 38220 and bone marrow biopsy, CPT 38221. They are not permitted to be coded together unless they are performed at different sites. So, if the physician performs a marrow biopsy on the left hip and has documented medical necessity to perform a bone marrow aspiration on the right hip, both procedures can be coded and billed. Modifier XS is applied to 30220 since it is the Column 2 code.

Modifier XP *Separate practitioner* – A service that is distinct because it was performed by a different practitioner

Example*
Modifier XP is used when one doctor in the group does a service and a different practitioner in the practice does a different service that's bundled with the first. The medical necessity for using the two different practitioners for these two bundled procedures must be documented. Though rarely appropriate in an office setting, you might see this situation in the care of trauma patients in an ER setting when multiple physicians care for the patient at the same time.

Modifier XU *Unusual separate service* – A service that is distinct because it does not overlap usual components of the main service

Example*
If an anesthetized patient is not emerging from anesthesia, the anesthesiologist may have to resuscitate the patient using CPR. This is part of anesthesia services, and the CPR is bundled with the anesthesia services. But if CPR is performed as an emergency procedure because the patient codes, both services may be billed by the anesthesiologist. As of January 1, 2019, instead of using a 59 modifier with CPTs 92950 and 92953, an XU modifier should be reported.
** Examples derived from the AAPC Knowledge Center.*

Perhaps reporting no modifier at all is more appropriate.

The CMS National Correct Coding Initiative Policy Manual indicates: "Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier." (CHAP 1, pg. 21) "Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used." (CHAP 1, pg. 25)

CMS directs that the documentation must clearly support that a "different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual" was provided.

Whether you report Modifier 25, an "X" modifier, or no modifier at all, the safest course is to fully document the services performed and medical decision-making involved for every encounter. We will never—Never—ask you for less documentation.

References:

- "Modifier 59 Article." Centers for Medicare & Medicaid Services. Nov. 2005. Web. 29 Aug. 2018.
- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip

Asthma as a Chronic Condition

IDENTIFYING PATIENT RESPIRATORY SYMPTOMS

Seventy to ninety-percent of school-aged children have an identifiable, specific IgE sensitization. Up to 40% of allergic rhinitis patients have co-existing asthma. Yet, respiratory symptoms are frequently diagnosed on the basis of history and physical findings, though studies have demonstrated this may only be accurate 50% of the time. In turn, this may lead to potentially avoidable health care costs associated with unmanaged symptoms, repeat office visits, and unnecessary referrals

Patient Care Plans Established with Current Asthma Diagnosis and Management Guidelines Aim to Improve Outcomes and Reduced Healthcare Expenditures May Be an Added Benefit. Foundational to current guidelines are four overarching components of asthma management.

1. Assess and monitor findings, form objective tests, physical exam, patient history and patient report to:
   - diagnose and evaluate characteristics and severity of asthma
   - monitor asthma control achievement and maintenance

2. Patient education that promotes a patient-family-clinician partnership

3. Control of environmental factors and comorbid conditions that affect asthma

4. Pharmacologic therapy

In addition to other elements of care, Component 3 from above (Control of environmental factors and comorbid conditions that affect asthma), addresses the role of testing.

- Identification and reduction of relevant allergens and irritants as well as controlling factors that increase symptoms and/or cause exacerbations
- Allergy testing – in vitro or skin – is the only reliable way to accurately ascertain a patient's sensitivity to suspected allergens.
- Positive test results are to be assessed within the context of the patient's history and utilized as a foundation for patient education regarding management strategies including allergen avoidance.

ASTHMA IN THE U.S.

#1

Asthma is the most common chronic illness amount children and the leading cause of hospital visits among children between the ages of 1 to 15 years.

1/3

Emergency department and inpatient treatment account for approximately one-third of healthcare costs related to pediatric asthma.

4K

Hospital admissions data from 2011-2014 demonstrated the median hospital cost per stay was just over $4,000.

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