MOUNTAIN HEALTH CO-OP

2022

Provider Newsletter
Summer

Get a Jump on the No Surprises Act

We urge providers to keep their office's demographic information updated in our provider directory. Now directory accuracy is even more critical.

The Federal No Surprises Act went into effect January 1, 2022, bringing new requirements for health plans and providers. Inaccuracies in provider directories can create barriers in the care of your patients, making directory accuracy an important aspect of the Act.

To read more about the No Surprises Act and its requirements, please click the button below.

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New Post-Service Claims Process for Medical Documentation

Effective July 1, 2022, there will be some changes to requirements for post-service claims that require medical documentation and utilization management. Please click the button below for the updated process and to view the new form.

Updated Process **Updated Form**

Electronic Funds Transfer

Are you still receiving paper checks from the CO-OP? If so, please consider submitting claims and receiving payments through our Electronic Data Interchange (EDI).

Electronic claims can help improve efficiency and provide faster turnaround for payments. Currently, the average turnaround time for EDI claims (received date to check being received in the provider office) is 15 days. We must have a W-9 on file before we can make any payments to you. You can fax your W-9 form to 801-281-6121.

For information on electronic claims submission and EFT set-up instructions, **please click here** or visit our website by clicking the link below.

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Reinstating Pre-COVID Prior Authorization Criteria

To decrease administrative burden for our providers and facilities during the COVID-19 emergency, the CO-OP—while still requiring prior authorizations—relaxed selected prior authorization requirements. With COVID rates now declining, we returned to our pre-COVID medical necessity review processes, effective April 1, 2022. This includes, but is not limited to, a return to more thorough reviews of inpatient, skilled nursing facility, and behavioral health admissions; and home care, MRI, PET scan, solid organ transplant, and DME requests.

General Services Requiring Prior Authorization provides categories and specific codes of services that require prior authorization.

Coverage is determined by the member-specific benefit plan document and any applicable laws regarding coverage of specific services. Always consult with a Customer Service representative for the member's benefit plan to determine coverage and requirements for any service mentioned on the Prior Authorization list by calling 855-447-2900.

Updated Access Standards

We are committed to ensuring our members have timely access to the services they need. Providers participating in one or more of our networks are expected to also ensure members have access to timely care by complying with the Access Standards below. These standards are established by the Centers for Medicare & Medicaid Services (CMS) and per the Federal Register Qualified Health Plan requirements.

We have updated our Provider Manual with the following Access Standards. Please review these standards by clicking the button below, share with the appropriate staff and incorporate any changes to your business practice as may be warranted.

View Updates

When Members need Urgent Care

Does your practice offer urgent care? When non-emergent illness or injury strikes unexpectedly, members need care quickly. Emergency departments frequently see patients who do not need the level of care offered in an ED, because they didn't know where to find urgent care. The cost of this care is much greater—to the hospital, payer, and member—when provided in an ED than it would be if provided in an urgent care setting.

In addition to cost savings, urgent care services within a provider practice create an

opportunity to enhance a trusted relationship between your practice and your patients, or to create a new relationship.

If your practice offers urgent care services and hours, check your listing in our **Provider Directory** to be certain you are listed as an Urgent Care Facility. If needed, email **provider@mhc.coop** to inquire about adding Urgent Care to your clinic's specialties.

Documenting Blood Pressure Readings to Support HEDIS Performance

The Healthcare Effectiveness Data and Information Set (HEDIS) tool is used to measure many aspects of performance, with the end goal of ensuring members receive quality care and obtain their best quality of life. This article details some of the key documentation features for the HEDIS measure, Controlling High Blood Pressure (CBP).

Click the button below for tips on documenting blood pressure readings.

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Correct Method to Amend Clinical Documentation

Most providers are so busy with clinical practice that documentation is secondary to their care of patients. Busy days of patient care can sometimes result in documentation of the patient's visit that lacks details necessary for subsequent authorizations for reimbursement of procedures, treatments, or
other care.

In these circumstances, providers may wish to modify documentation to reflect more accurately what occurred in the care of the patient. Correctly modifying clinical documents can result in more rapid adjudication of claims and approval of pre- and post-service coverage requests. It can also avoid the appearance of fraud and associated consequences.

Click the button below to read more.

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Annual Reminder: Member Rights and Responsibilities

Please click the button below to review our full list of Member Rights and Member Responsibilities.

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Annual Reminder: Obtaining Utilization Management Criteria

The CO-OP makes every effort to ensure services being provided to our members meet nationally recognized guidelines and are provided at the appropriate setting (inpatient or outpatient) and that the length of stay can be supported for medical indications. We reference InterQual® and Hayes criteria, nationally recognized guidelines, to help determine medical necessity.

We would be happy to provide you with a copy of the criteria we used to make utilization management decisions. Please call the Utilization Management team at 833-981-0213, option 2, for additional information. You may also email your request for criteria to **UUHP_UM@hsc.utah.edu**.

Reporting Behavioral Health Care Coordination

Recognizing mental health is an integral part of a person's overall health, we encourage PCPs and behavioral health professionals to coordinate care of at-risk individuals. To facilitate integrated care coordination, we cover a number of services that can be reviewed by clicking the button below.

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Pharmacy

Cosentyx Update for Commercial and Individual/Family Plans

Effective July 01, 2022, Cosentyx will no longer be covered, and Taltz will be the preferred medication for Commercial and Individual/Family plan members. We will outreach to members currently on Cosentyx for conversion to Taltz. Providers may consider a loading dose when switching members from Cosentyx to Taltz.

Reminders:

- Pharmacy Prior Authorization forms are available online with specific requirements for use and limitations listed in the form. Visit our **Pharmacy Coverage Policies** to ensure you are submitting the correct form for the requested medication. The link for Pharmacy Medication Use Policies is on the left side of the Web page. Bookmark these links in your internet favorites for quick access to submit pharmacy prior authorization requests.
- Formulary updates for retail and specialty pharmacy medications may be viewed on the **Preferred Drug List (PDL)/Formulary**. This list also includes prescribing limits such as quantity limits, step therapy, and/or prior authorization requirements. Multiple formularies are available, depending on the member's benefit plan.

Coding Corner

Billing Respective Code Sets

In accordance with the International Classification of Diseases, 10th Revision (ICD-10) and Current Procedural Terminology (CPT) Guidelines for Coding and Reporting, Mountain Health CO-OP will begin to deny claims on **April 1st, 2022**, for the following two claims edit scenarios.

1. If a claim is billed with a primary diagnosis that is unspecified, the claim will be denied. A corrected claim can be submitted with a more specific diagnosis code within twelve months of the denial. Requirements and details for submitting corrected claims are available on our website, **www.mountainhealth.coop**.
2. If a claim is billed with diagnosis and CPT codes that are not compatible according to Chapter 18 of the ICD-10-CM Coding Guidelines manual, those claims will also be denied, and same as above, can be rebilled with corrected codes on corrected claims. Chapter 18 of ICD-10-CM,
    - Section: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified
    - Subsection: (codes R00.0 - R99), contains many, but not all, codes for

symptoms.
- See Section I.B.18 Use of Signs/Symptom/Unspecified Codes of the 2022 ICD-10 Coding

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Risk Adjustment - Did you know?

When coding, the goal is to capture the highest level of specificity and complexity of the patient's disease. What is the best way to do that? Click below to see a few examples and learn more.

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Reporting Colorectal Cancer Screening - Tips for Accurate Coding

Colorectal Cancer Screening is an important, often lifesaving benefit available to our members, and is considered a "preventive" measure by the United States Preventive Services Task Force (USPSTF) for all adults ages 45-75 years. Qualifying screening procedures are mandated and regulated by the Affordable Care Act of 2010 (ACA); therefore, they are offered as an "essential benefit" for Individual/Family plans with no out-of-pocket cost for the member.

We support you in encouraging applicable members to receive colorectal cancer screening. Due to the different types of screenings available, anesthesia options, and possible adjunct procedures, reporting colonoscopies correctly continues to challenge even the most experienced coding staff. Click below to learn more.

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Coverage and Reimbursement Policy Updates

To review updates for medical and reimbursement policies, please click the button below.

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