MOUNTAIN HEALTH CO-OP

2023

Provider Newsletter
Winter

As we close the door on yet another year of successful partnership, and our shared goal of improving healthcare outcomes and ensuring that every individual receives the care they deserve, I wanted to thank you for working with Mountain Health CO-OP. It's true, we are smaller than most, but our roots run deep, and our heart is always where it needs to be, with our members.

I encourage you to take a look at the content our team has specially curated for this newsletter, share your insights, and let us know how we can better support you as the front line to these efforts. Your feedback is invaluable.

I wish you health and happiness in the coming year.

Warm regards,

Blair Fjeseth
COO, Mountain Health CO-OP

Website Navigation Update

The CO-OP website has gone through a lot of changes in the last year, so we had to update the way online visitors navigate the site.

All the pages, documents, and information you need from the CO-OP are still available. If there are pages you use often, please feel free to bookmark them.

Click below to read more about the update to the navigation or to visit the Provider page.

View Updates

Provider Networks

The CO-OP's provider networks are broken out by state and listed below.

Montana
- Connected Care
- Access Care
- Plus
- Rocky Mountain

Idaho
- Engage
- Access Care
- LINK

Wyoming
- High Plains

Please review each networks full description by clicking the button below.

Read More

Reimbursement Update

Effective February 1, 2024, our standard professional reimbursement rate will be updated in Montana and Wyoming for those who have a direct provider contract with Mountain Health CO-OP. Please note that not all contracts will be modified. We have promised to update our standard professional rates for some time. The changes will include a 3% increase to our conversion factor, and we will also change to the Current CMS Year Fee Schedule.

If you would like more details, please call us 855-447-2900, Option 6 or email us at provider@mhc.coop.

Great Falls Clinic Joins the Montana Connected Care Network

We are pleased to announce, effective January 1, 2024, Great Falls Clinic Hospital and providers will be an in-network option for our Connected Care members! Previously, Great Falls Clinic Hospital was in-network only under our Access Care Network for members covered through a group employer-sponsored plan. This is a significant benefit to our MT membership to have Great Falls Clinic Hospital available in-network for both individual and group members enrolled on either a Connected Care or Access Care plan.

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.

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

Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization. If you are age 60 or older, a vaccine is available to protect you from severe RSV. **Click here** to read more about the CO-OP's RSV Preventative Benefit.

Attention: Prior Authorization is required when a member requires more than 20 combined therapies per year *

For members with an Idaho Mountain Health Co-Op Plan, members are eligible for a combined maximum visit allowance of 20 visits per year for outpatient therapy which includes physical, occupational and speech therapies. For members with a Mountain Health Co-Op Plan in Montana and Wyoming* members may be eligible for additional outpatient therapy visits over the 20 combined therapies per year based on medical necessity. If you suspect a Montana or Wyoming member may be nearing 20 visits (physical, speech and/or occupational therapies combined) within a Calendar Year and will require additional services to complete the care plan, submit a prior authorization. To determine medical necessity for a therapy case, the required documentation includes but is not limited to, the treatment plan including the initial assessment, follow-up assessment visit progress notes, frequency and number of additional visits requested.

How to submit a prior authorization?
- Provider Portal, upload medical records
- Prior Authorization E-App, upload medical records
- Prior Authorization Form PDF Version by fax with medical records

If a prior authorization is not completed when the Montana or Wyoming member exceeds 20 combined visits in a calendar year, any claim submitted after 20 visits will deny for lack of medical records. The provider will have an opportunity to resubmit medical records on post review for medical necessity review. It is recommended all medical records for all dates of service be submitted at one time to expedite claims processing and medical necessity review.

Please call if you have questions, 855-447-2900.

Billing Respective Code Sets Reminder

Since April 1st, 2022 MHC started denying claims in accordance with the International Classification of Diseases, 10th Revision (ICD-10) and Current Procedural Terminology (CPT) Guidelines for Coding and Reporting. Claims will deny for the following two claims edit scenarios.

1. When CPT and ICD do not cross code in the respective code set being billed.
2. When the Primary Diagnosis Code is submitted as Unspecified/NOS.

Risk Adjustment Corner

2024 Unlisted Changes

In 2024, revisions will be made to various sections of the CPT code set that contain unlisted service codes to reflect their appropriate use when reporting with other services. An unlisted code workgroup was established by the CPT Editorial Panel to evaluate the use of unlisted service codes. The workgroup addressed how unlisted codes are used in conjunction with existing Category I and III codes during the same intervention and whether there is a need for guidance on their appropriate

use.

Mountain Health Co-Op has a vested interest in ensuring our members connect with their providers. Through this connection, not only do our members receive the care they need, but our Providers can proactively manage our members' overall health and well-being and lower the cost of care. Studies have shown that engaged members are less costly and experience better outcomes than non-engaged members. As a partner and provider, helping us ensure care is delivered appropriately enables the documentation that is critical for risk adjustment programs.

- **High-quality member/provider connections:** As patients and providers connect in meaningful ways, the promotion of health care delivery, and wellness drive engaged patients in their healthcare.
- **Accurate medical charting and coding:** Capturing the whole disease burden of the patient through annual exams by detailing in the documentation the patient's chronic diseases and ongoing management.
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If you have questions about the Mountain Health Co-Ops Risk Adjustment Program, ways to get involved, or coding? Reach out to **riskadjustment@mhc.coop.** Please allow up to 48 business hours for a response.

Utilization Management Decision Guidelines

We're committed to ensuring that services provided to our members meet nationally recognized guidelines, are provided in 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.

You can view our Medical, Administrative, and Reimbursement Policies or Pharmacy Medication Policies online. For those not yet available, we would be happy to provide you with a copy of the criteria we used to make utilization management decisions. To request UM criteria, call the UM team at **833-981-0213**, option 2, or email your request to UUHP_UM@hsc .utah .edu.

Click here to review pharmacy updates.

Administrative, Medical, and Reimbursement Policy Updates

Mountain Health CO-OP uses coverage policies as guidelines for coverage determinations in accordance with the member's benefits. All new and updated policies, including policies for services requiring prior authorization, are posted on our Coverage Policies website for 60 days prior to their effective date.

Quarterly notice of recently approved and revised coverage and reimbursement policies is provided in Provider Connection for your convenience. The information listed are summaries of the policies. Click on the hyperlinked policy number to view the coverage or reimbursement policy in its entirety.

The Administrative, Medical, and Reimbursement Policy Updates section of this newsletter does not guarantee coverage is provided for the procedures listed. Coverage policies are used to inform coverage determinations but do not guarantee the service is a covered service. For more information on our coverage policies, visit our Coverage Policies website or contact your Provider Relations consultant.

We also encourage you to visit our Prior Authorization site frequently to view all medical services that require prior authorization, links to our coverage policies, and information on submitting an authorization request. Services that do not yet have a policy are reviewed using Interqual® criteria.

Click here to review all Medical Policy Updates.

Do you have topics/concerns that you would like to see addressed in future newsletters? Please send all suggestions to provider@mhc.coop.