HealthyU Hot Wire: New consumer-directed health plan coming January 2012

This is the first of a 4-part series.

Consumer-directed health care can be good medicine if it is properly designed, implemented, communicated, and embraced by physicians and health systems, as well as by patients. To ensure the best possible outcomes, physicians need to understand and partner with the consumer-directed health care movement.

This new movement in health care financing creates short- and long-term incentives for preventive care, behavior change, and risk-factor reduction. It can also motivate better patient understanding and ownership of acute and chronic care decisions made in partnership with physicians.

A partnership between a member and health care provider means working together to understand and optimize healthy member behaviors, such as yearly preventive exams and immunizations. It means developing a plan to lose weight, reduce stress, increase healthy eating, or quit tobacco. It means having conversations about treatment options and alternatives and creating a shared plan that respects the member’s wishes and values. It enables health care providers to utilize electronic medical records to confidentially share information about a member’s condition with other health care providers about a course of treatment.

UPMC HealthyU is at the forefront of the consumer-directed health care movement because it is a unique combination of a:

- High-deductible, lower premium plan;
- Health Incentives Account with the opportunity for members to earn money for completing healthy activities; and
- Robust online resource center with tools and information.

You may begin to see patients enrolled in UPMC HealthyU as soon as January 2012. To help you learn what you need to know about this new and exciting plan, we will be publishing additional “HealthyU Hot Wire” articles about coding, billing, and answering patient questions in upcoming issues of Physician Partner Update.

As part of our new UPMC HealthyU product offering, UPMC Health Plan has developed a three-pronged process that can help members improve their health and earn financial rewards: Understand, Improve, and Partner.

Understand health status: To begin, members will fill out a confidential health risk assessment. This assessment will provide an overview of their potential health risks and suggest corrective action. Armed with this knowledge, members can start making healthier choices and provide you with information to develop a plan of action.

Improve health to earn more incentives: Members will be able to complete activities that have been specially designed by UPMC’s team of doctors, nurses, nutritionists, physiologists, and behavioral health experts for more rewards. The activities, such as getting a flu shot, annual wellness visits, or talking with a lifestyle or disease management health coach, will help members achieve healthier outcomes. Of course, they’ll also be encouraged with the promise of more money in their Health Incentive Account, funded by UPMC Health Plan.

Partner with a doctor: Even if your patients are committed to making healthy lifestyle changes and improving their care, they can’t do it alone. A comprehensive health improvement program comes full circle with a doctor’s involvement. You can help your patients develop the best strategies for reaching their health goals.
QUALITY CORNER

Glaucoma Screening

Primary open angle glaucoma (POAG) silently, gradually, and progressively drops the curtain on vision and threatens to darken the lives of your patients. Of the estimated 2.5 million Americans with the disease, half are unaware and blindness will result in about 130,000.2

Most patients with POAG have elevated intraocular pressure (IOP), although the IOP of at least one-sixth will be in the normal range.3 Decreased outflow of aqueous fluid from the eye is believed to cause elevated IOP, resulting in mechanical pressure and/or vascular compromise to ganglion cell axons with eventual apoptosis and death of neurons in the optic nerve.4 Measurement of IOP is the hallmark of glaucoma screening; however, fundoscopic and visual field exams by an eye care professional are essential to exclude both elevated and normal tension glaucoma.5

Age is a key risk factor for developing POAG. Prevalence in older age groups is 4-10 times higher than for patients in their 40s.1,3 For this reason, glaucoma testing is a key CMS STARS metric, defined as:

HEDIS Glaucoma Screening in Older Adults

The percentage of Medicare enrollees ages 65 or older without a prior diagnosis of glaucoma (denominator) who had at least one glaucoma exam by an eye doctor during the measurement year (numerator).6

Additional major risk factors for POAG include race, family history of POAG, diabetes, and hypertension.

In African Americans compared to Caucasians, the age-adjusted prevalence of POAG is 4.3 times greater,7 occurs about a decade earlier, responds less well to treatment, more often requires surgery, and is associated with a higher prevalence of blindness.1,7 A more recent study suggested that older patients of Hispanic, especially Mexican, ancestry had glaucoma rates similar to those of African Americans.8

Of patients with glaucoma, 13%-25% have a family history of the disease.9 Compared to the general public, close relatives of patients with POAG have a 3-6 times higher prevalence10 and a 10 times higher lifetime risk of developing glaucoma.11

Screening is important because glaucoma is most commonly discovered in routine eye exams, and early detection and treatment can prevent disabling visual loss and blindness.1,2 Consider developing office processes to identify patients at risk for glaucoma, refer them to an eye care professional for screening, and follow up and document in the medical record that the exam was completed.

Did You Know: Under UPMC for Life’s plans, a glaucoma screening exam is covered annually when performed by an eye care professional. It is classified as a Medicare preventive service and is covered at 100% if the visit is purely for a glaucoma screening exam. If other services are rendered during the visit, a copayment may apply. Providers are encouraged to access the provider portal for specific member benefits.

References:

Medical Record Retention Tips

This is Part 4 in a 4-Part series.

Follow-up Documentation

This is the final in a series of tips on medical record documentation. This month the focus is on Follow-up Documentation. The information reviewed may be found in the Provider Manual located online at www.upmchealthplan.com. If you have any questions, contact your provider network manager.

- Include a notation regarding follow-up care, calls, or visits on encounter forms or notes.
- Providers should note the specific time of the recommended return visit in weeks, months, or as needed.
- Document any missed appointments or no-shows.
- Physicians should initial consultation, lab, imaging, and other reports to signify review. Review by and signature of another professional, such as a nurse practitioner or physician assistant, does not meet this requirement.
- Regarding consultations, abnormal lab and imaging study results must have an explicit notation of follow-up plans in the record.

www.upmchealthplan.com 2 August 2011
EPSDT Program Updates and Reminders

UPMC for You (UPMC Health Plan’s Medical Assistance Program) and the Department of Public Welfare (DPW) recognize the importance of comprehensive childhood screenings and providing appropriate and timely follow-up diagnostic treatment services. To encourage and support physicians in performing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, UPMC for You offers EPSDT Clinical and Operational Guidelines to explain our requirements for payments and to provide sample billing instructions.

Here are a few very important items to point out regarding the UPMC for You EPSDT requirements:

- For the UPMC for You periodicity schedule and guidelines, please visit the UPMC Health Plan provider portal at www.upmchealthplan.com.
- Per the PA EPSDT periodicity schedule, all children under the age of 5 must have at least 2 blood lead screenings. UPMC for You requires them at the 9-11-month and 24-month checkups. Providers may perform these screenings via Kirby or other methods for blood draws. In addition, UPMC for You will follow up with the provider for any child whose lead level remains above 10.
- Dental referrals must occur per the EPSDT periodicity schedule. The modifier “YD” must be present on the claim, and the referral to a dental home must be documented in the patient’s chart.
- DPW has asked providers to notify the MCO that the child is due for a dental referral. You can contact the UPMC for You EPSDT Department at 1-866-463-1462 or use the Dental Referral Fax Form, which can be found on our provider portal.
- Per the CDC guidelines, the human papillomavirus vaccine (3 doses) is to be administered to females prior to their 13th birthday.
- Autism screenings are required for the 18-month and 24-month visits. Information regarding validated screening tools for developmental delays and autism spectrum disorders is available on our provider portal.
- Providers are allowed to perform EPSDT services during a sick visit; however, providers cannot bill a sick visit and an EPSDT visit with the same date of service.
- The EP modifier must be utilized in conjunction with the correct CPT codes, modifiers, and ICD diagnosis codes per the periodicity schedule in order to receive the enhanced EPSDT payment.
- The “-52” modifier can be used if an EPSDT screening service or component of a service was not completed. However, the provider must complete the service at the next screening opportunity.

Thank you for your cooperation and continued participation with UPMC for You. If you would like more information, or if you have questions or concerns, contact UPMC Health Plan’s Provider Services at 1-866-918-1595 or your UPMC Health Plan network manager.

Non-Emergent Transportation Guidelines

UPMC Health Plan recognizes the benefits of providing members with routine non-emergent ambulance and wheelchair van transportation when medically necessary per the Centers for Medicare & Medicaid Services (CMS) guidelines. The UPMC Health Plan Non-Emergent Ambulance Transportation Policy and Procedure (CRM.072), effective September 1, 2011, has been posted to the UPMC Health Plan provider portal at http://www.upmchealthplan.com/providers/PandP.html. EMS providers must adhere to policy criteria when providing non-emergent transportation to UPMC Health Plan members. Referring providers for non-emergent transportation (e.g., skilled nursing facilities and hospitals) must follow the UPMC Health Plan Non-Emergent Transportation policy criteria when requesting non-emergent transportation through coordination centers. Per policy, when a UPMC for Life member is in a skilled nursing facility under a Medicare Part A stay, CMS guidelines will be utilized when determining who the primary payer should be under the PPS (Prospective Payment System) for non-emergency transports.

As outlined in the Provider Manual, the referring provider (e.g., skilled nursing facilities and hospitals) is required to coordinate all non-emergent transportation requests through the appropriate coordination center. UPMC Health Plan uses two separate coordination centers, NORCOM and PARC, to coordinate non-emergent transportation. The coordination centers work in conjunction with UPMC Health Plan to facilitate non-emergent transportation between referring providers and participating non-emergent EMS providers to offer cost-effective and efficient services. Coordination centers will continue to coordinate the transport, but will no longer provide authorizations on behalf of UPMC Health Plan for non-emergent transportation. Per policy, UPMC Health Plan will monitor and audit EMS providers for policy compliance and billing accuracy.

The coordination process will not change. Referring providers currently using PARC will continue to use PARC; providers currently using NORCOM will continue to use NORCOM. Referring providers may contact UPMC Medical Transportation/NORCOM at 1-877-521-RIDE (7433) or PARC at 412-647-7180 to coordinate non-emergent transportation.

If you have questions regarding the UPMC Health Plan Non-Emergent Transportation Policy and Procedure, please contact our Provider Services Team at 1-866-918-1595.

New Clinical Guidelines

The following clinical guidelines were recently updated on our website: 1. Depression 2. Substance Abuse and Dependence 3. Adult Diabetes

Technology Assessment Committee

The Technology Assessment Committee meets regularly to review medical technology. The following chart details recent committee decisions. Please refer to the designated policy for complete indications and limitations.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Reason for Review</th>
<th>UPMC Health Plan Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulator Boot (End Diastolic Pneumatic Compression Therapy)</td>
<td>Policy Review</td>
<td>• Effective October 1, 2011, considered Experimental and Investigational for all products except Medicare.</td>
</tr>
<tr>
<td>Joint Active Systems</td>
<td>Clinical Review</td>
<td><strong>Reminder:</strong>• Effective October 1, 2008, static progressive stretch devices and soft interface material were considered Experimental and Investigational for all products except Medicaid.</td>
</tr>
<tr>
<td>Liberation Treatment for chronic cerebrospinal venous insufficiency (CCSVI) in Multiple Sclerosis</td>
<td>Clinical Review</td>
<td>• Considered Experimental and Investigational for all products.</td>
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<tr>
<td>CVProfilor® CardioVascular Profiling System</td>
<td>Clinical Review</td>
<td>• Considered Experimental and Investigational for all products.</td>
</tr>
<tr>
<td>Combination Therapy (Combination Custom-made CPAP and Oral Appliance)</td>
<td>Clinical Review</td>
<td>• Considered Experimental and Investigational for all products.</td>
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Ethical and Religious Directives

UPMC Health Plan insures groups who abide by the Ethical and Religious Directives for Catholic Health Care Services. Some of the benefits that may be excluded for these groups include abortions; contraceptives (except for authorized medical reasons); assisted fertilization techniques, such as, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT); and voluntary sterilization, including vasectomy and tubal ligation. If you are unsure if a patient’s employer group requires that the patient abide by the Ethical and Religious Directive for Catholic Health Care Services, contact UPMC Health Plan Member Services Monday through Friday from 7 a.m.–7 p.m. and Saturday from 8 a.m.–3 p.m. to verify benefit information.