Survey Results Are In!

UPMC Health Plan has once again maintained an “Excellent” rating by The National Committee for Quality Assurance (NCQA) for Health Plan Accreditation (HPA). NCQA HPA is the gold standard for improving quality care and patient experience. Participation in this rigorous survey process and off-site evaluations conducted by a team of physicians and managed care experts advances our efforts to continue enhancing and improving the quality and value we provide to our members.

Provider and Office Staff Education

UPMC Health Plan offers a variety of classes covering coding and documentation, risk adjustment, electronic health records, and medical records requirements. Most classes are offered in community locations. We publish a list of all the classes we’re offering and email a calendar to your office quarterly. If you’re not on our mailing list, email us at riskadjustment@upmc.edu for a full calendar.

Credits are available from AAPC and AHIMA for most classes. In 2013, in addition to the standard courses, there will be new class offerings including:

- ICD-10-CM Specialty Classes, including cardiology, internal medicine, pediatrics, and others
- CPT Updates for 2013
- Quality Alphabet: HEDIS, STARS, PQRS, MU
- Diabetes Coding
- Coding for Cardiovascular and Renal Conditions

Attention All Tobacco Cessation Providers

If you or someone in your practice provides tobacco cessation counseling, please note that the Pennsylvania Department of Health (DOH) recently revised the Tobacco Cessation Registry application process.

To be included in the registry — and this is one of the main ways your patients will find you — you must submit an application for DOH review and approval. If your practice is interested in Medicare reimbursement for cessation services, you must indicate that on your application.

For application instructions, visit health.state.pa.us/cessationregistry.

Frequently Asked Questions

**How can I gain access to the Radport Decision Support Tool?**

The person in your practice designated as your online account administrator can help you. Your account administrator needs to go to the Provider OnLine homepage and click on the Security Management tab. He or she can then provide you with Radport access by selecting Modify user permissions and checking the box next to RadPort Decision Support Tool. The RadPort Reference Number Inquiry option can be used to check the status of an RRN request.
PHYSICIAN PARTNER

QUALITY CORNER
Rheumatoid Arthritis
Nicholas DeGregorio, MD, FACP, MMM

Rheumatoid arthritis (RA) is an autoimmune inflammatory disease. If left untreated, the natural course of RA begins with joint erosions and structural damage. From there, it advances to joint destruction, deformity, and disability.

Primary care physicians play a pivotal role in the early diagnosis of RA. Without early treatment, the disease can cause irreversible joint damage. Early diagnosis and treatment with Disease-Modifying Antirheumatic Drugs (DMARDs) can induce disease remission, preserve joint integrity, and improve long-term outcomes in RA. Treatment is most effective when started in the first three months after symptoms begin.

Patients presenting with the following symptoms should be considered for prompt referral to a rheumatologist:

- Three or more swollen joints,
- Metacarpophalangeal or metatarso-phalangeal joint involvement, or
- Morning stiffness lasting more than 30 minutes.

Research has found that combination DMARD therapy is more effective than monotherapy for RA. DMARD therapy is also generally well tolerated. However, this strategy is not recommended for everyone. In 2012, the American College of Rheumatology recommended DMARD combination therapy for those with characteristics of poor prognosis. Characteristics include:

- Extra articular disease (e.g., rheumatoid nodules, RA vasculitis, or Felty’s syndrome)
- Positive rheumatoid factor
- Anti-citrullinated peptide antibodies
- Radiographic bony erosions

Monotherapy is recommended for all other patients with active RA.

The Centers for Medicare and Medicaid Services (CMS) tracks and measures DMARD therapy in RA. CMS uses a Healthcare Effectiveness Data and Information Set (HEDIS) guideline. The HEDIS guideline is the percentage of patients 18 years old and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD.

References:

Why You Must Screen Your Employees

If you are a provider submitting claims to the UPMC for You (Medicaid), UPMC for Kids (CHIP), or UPMC for Life (Medicare or Special Needs Programs,) or you provide services to Federal Employee Healthcare Program participants, it’s important to screen your employees and contractors monthly to make sure they have not been excluded from participating in Medicare, Medicaid, CHIP, or any other federal health care program. Medicaid, CHIP, and Medicare providers who employ or enter into contracts with excluded individuals or entities are:

- Subject to termination from the Medicaid, Medicare, and CHIP programs, including all federal health care programs
- Responsible for refunding monies paid for services provided by an excluded individual or entity
- Subject to civil monetary penalties

Exclusion from Medicaid, Medicare, CHIP or a federal health care program applies not only to individuals who provide clinical services, but also to individuals who provide administrative services, such as billing and claims processing. Thus, a provider who employs an excluded individual is not entitled to reimbursement for services provided by the excluded individual, including claims for clinical services provided by the individual, or for claims for which the individual only provided billing services.

If you discover you have utilized the services of an excluded employee or contractor, you will need to self-report any affected payments to the UPMC Health Plan Fraud, Waste & Abuse Department at 1-866-372-8301.

For Medicaid recipients, you may also report this to the Bureau of Program Integrity via:

- Email through the Medical Assistance Self-Audit Protocol at http://www.dpw.state.pa.us/learnaboutdpw
- U.S. mail at the following address:
  Bureau of Program Integrity
  Commonwealth of Pennsylvania
  P.O. Box 2675
  Harrisburg, PA 17105-2675
- Fax: 1-717-772-4655 or 1-717-772-4638

A Reminder: Voluntarily Leaving the Network

If you are a UPMC Health Plan provider and you want to leave the Health Plan network, here is what you need to know:

- You must provide at least 90 days’ written notice before your exit takes effect.
- You must send termination notices by overnight courier or certified mail.
  - Be sure to request a return receipt if you choose certified mail.
- You must supply copies of medical records to the Health Plan or any other entities for whom you have been excluded.

If you have questions, call Provider Services at 1-866-918-1595.
Facts About False Claims

The False Claims Act (FCA) has been federal law since 1863. The passage of time and amendments has not changed its purpose, which is to discourage people and companies from defrauding government programs.

The FCA holds people and companies responsible when:
- They submit a claim they know (or should know) is false.
- They submit records they know (or should know) are false to obtain payment from the government.
- They use false statements or records to keep government money to which they may not be entitled.

In addition to penalizing those responsible for false claims, the FCA allows whistleblowers to file actions and receive a portion of any recovered money.


When to Use ABNs

Providers can give an Advance Beneficiary Notice of Non-Coverage (ABN) to a Medicare member when Medicare is likely to deny coverage for a service.

To bill a UPMC for Life (Medicare) member for a non-covered service, you must inform the member before performing the service. The member should know and understand:
- The nature of the service
- That UPMC Health Plan does not cover the service and will not pay for it
- His or her out-of-pocket cost for the service

The member must sign an ABN to record that he or she agrees to pay for the non-covered service. Use an ABN when Medicare covers a service in some cases, but you believe the service will not be covered in a specific case.

Instructions for completing the ABN are available at www.advancebeneficiarynotice.net.

Per the Department of Public Welfare, UPMC for You members (Medical Assistance) do not need to sign an ABN. They can verbally accept financial responsibility for a service. You must document in the medical record that the member was advised and agreed to pay. The member should sign the record. For more information, refer to the UPMC for You provider manual at www.upmchealthplan.com/providers/manual.html.

UPMC Health Plan Never Events Policy

The UPMC Health Plan Never Events policy was effective for claims beginning August 9, 2009.

Never Events are serious, preventable medical errors that cause injury and death. Never Events are costly to both the Health Plan and the member. They are clearly identifiable and measurable, and their risk of occurrence is influenced by a health care organization’s policies and procedures. The following Never Events are covered by the UPMC Health Plan policy:

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign object</td>
<td>Unintended retention of a foreign object in a patient after surgery or other procedure</td>
</tr>
<tr>
<td>Air embolism</td>
<td>Patient death or serious disability caused by an intravascular air embolism that occurs while being cared for in a health care facility</td>
</tr>
<tr>
<td>Blood incompatibility</td>
<td>Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products</td>
</tr>
<tr>
<td>Medication error</td>
<td>Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)</td>
</tr>
<tr>
<td>Wrong body part</td>
<td>Surgery performed on the wrong body part</td>
</tr>
<tr>
<td>Wrong patient</td>
<td>Surgery performed on the wrong patient</td>
</tr>
<tr>
<td>Wrong surgery</td>
<td>Wrong surgery procedure performed on a patient</td>
</tr>
</tbody>
</table>

Network physicians must report Never Events to the Quality Improvement Manager at UPMC Health Plan within 10 days of identifying that the event occurred with a UPMC for You, UPMC for Life, or UPMC for Life Specialty Plan member. Notification should include the following: member name and ID number, date of service, attending physicians, and description of the event. Event information should be sent to:

Manager of Quality Improvement
UPMC Health Plan
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

The UPMC Health Plan Quality Improvement Department will research every potential Never Event that we identify, validate that the event occurred, and determine the responsible provider.

Physicians may not knowingly seek payment from UPMC Health Plan or from a UPMC Health Plan member for a Never Event or for any services required to correct or treat the problem created by a Never Event when it occurred under their control. The Health Plan will deny or recover reimbursement in these situations. If a health care facility or provider discovers that they received payment from the Health Plan or a member in error, they must immediately notify the Health Plan or the member and refund the payment within 30 days of discovery or receipt of the payment, whichever is later.
UPMC Health Plan Pharmacy Updates

Effective on the dates below, UPMC Health Plan will initiate changes to medical coverage policies. Please see chart below. Questions can be directed to Provider Services at 1-866-918-1595.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Lines of Business</th>
<th>Effective Date</th>
<th>Benefit Change</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2315</td>
<td>Vivitrol (naltrexone)</td>
<td>Commercial</td>
<td>1/1/13</td>
<td>This code will now be covered and require a prior authorization before the Health Plan will reimburse for this product.</td>
<td>A prior authorization will be required or the claim will be denied. Please call 1-800-979-UPMC (8762) for questions on the prior authorization process. All prior authorization forms are available on our website at <a href="http://www.upmchealthplan.com/providers/pa_forms.html">http://www.upmchealthplan.com/providers/pa_forms.html</a>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid</td>
<td>2/1/13</td>
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</tbody>
</table>

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>Antigen Leukocyte Cellular Antibody Test (ALCAT)</td>
<td>Clinical Review</td>
<td>Effective date Feb. 1, 2013, this is experimental and investigational for all products.</td>
</tr>
<tr>
<td>Provent Therapy Device (Nasal) for Obstructive Sleep Apnea</td>
<td>Clinical Review</td>
<td>Effective date Feb. 1, 2013, this is experimental and investigational for all products.</td>
</tr>
<tr>
<td>Inspire Therapy Device (implantable) for Obstructive Sleep Apnea</td>
<td>Clinical Review</td>
<td>Effective date Feb. 1, 2013, this is experimental and investigational for all products.</td>
</tr>
</tbody>
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