HEALTH | CHOICE
UTAH

PROVIDER NEWSLETTER

Q1 – 2024

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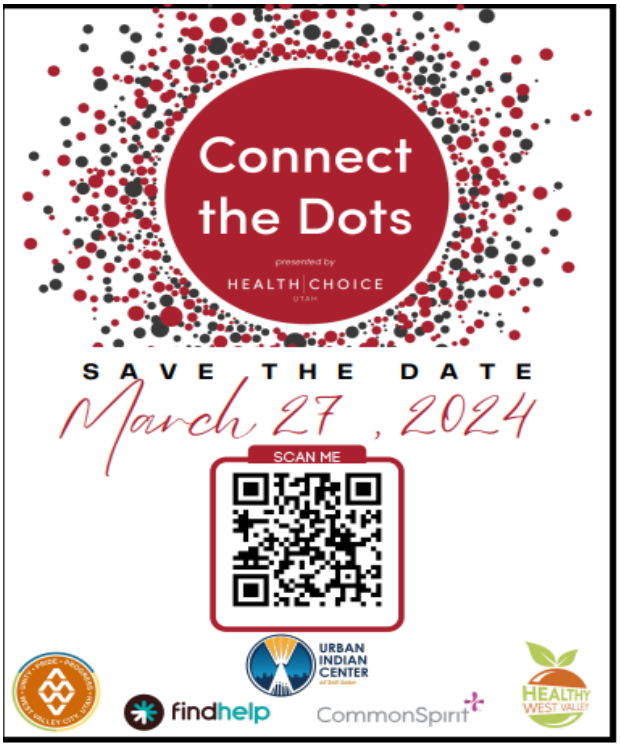
Table of Contents

Network Services



Health Choice Utah is excited to announce the 2024 Connect the Dots Summit!
To receive the registration information, please complete the form via the QR code.
The registration information will be sent out at the beginning of February.
The Connect the Dots Summit is an all-day educational network engagement event.
Below are some of the topics:

- Medicaid 2024 changes, Medicaid Community Waivers; Social Security, Medicare, Disability, Housing, Medical Debt Relief, Immigration, Prenatal & Postpartum, Mental Health, Substance Use Disorder, Trauma Informed Care, Health Equity, Cultural Humility, Suicide Prevention, Caregiver's support.
- All presenters are subject experts. Health Choice Utah is the hosting organization. There is no cost to attend. Breakfast and Lunch are provided. All attendees are encouraged to connect with new people to build their resource network.

For questions regarding the Connect the Dots Summit:
outreach@healthchoiceutah.com
Seating is limited due to the venue. Registration is required to attend.

Health Choice Generations Plan Changes

This is a courtesy notice to let our providers know that, beginning January 1, 2024, Health Choice Utah will no longer offer the Health Choice Generations Medicare Advantage D-SNP plan. Our Health Choice Utah Medicaid product and network is not impacted by this change. We are also sending courtesy notices to our Generations members, advising them of this change. Generations members existing plan of coverage will remain in effect, without any change, through the remainder of 2023. Additional details, along with an official Notice of Nonrenewal as required by the Centers for Medicare & Medicaid Services (CMS), will be mailed to our members and Providers on or around October 1, 2023.

We are alerting our providers to this change early, in case questions arise from our Generation members, and to provide ample time to consider steps to support continuity of care for these members. Again, additional, and official details and notice will be sent on or around October 1, 2023. Please advise your Generations patients who may have questions, to call 844-457-8943. We sincerely appreciate the care our providers give our Generations members and look forward to continuing our relationship in support of our other products and networks. Operations for the Health Choice Generations MA D-SNP plan will continue through December 31, 2024, to allow for claims run-out and provider assistance.

QUESTIONS?

- Claims and benefits – Generations Customer Service –844-457-8943
- Contracting and general questions – Provider Relations providers@healthchoiceutah.com or your Provider Network Representative
- Part D Prescription Medications (contracted with CVS Caremark®)–888-970-0851.

Controlling Blood Pressure

Controlling Blood Pressure (CBP)

Best Practices for Improving HEDIS scores.

- Correctly measuring BP during every visit
  - *Patients' legs uncrossed, support arm at heart level.*
  - *Don't have a conversation during measurement.*
  - *Empty Bladder, Put cuff on bare arm.*
- Outreach patients for routine follow up appointments.
- Counsel the patient about healthy lifestyle changes.
  - Improved diet and increased exercise
- Consistently document BP readings in medical record for all visit types.
  - Virtual, Telephonic, Home record BP measurements
- Stress importance of medication adherence and benefits of controlled blood pressure

BLOOD PRESSURE CATEGORY	SYSTOLIC MM HG (UPPER NUMBER)	AND / OR	DIASTOLIC MM HG (LOWER NUMBER)
Normal	Less than 120	and	Less Than 80
Elevated	120-129	and	Less Than 80
High Blood Pressure (Hypertension) Stage 1	130-139	or	80-89
High Blood Pressure (Hypertension) Stage 2	140 or Higher	or	90 or Higher
Hypertensive crisis (consult your doctor immediately)	Higher than 180	and / or	Higher than 120

Coding Hypertension

Description	Codes
Hypertensive Diseases- Controlled and Uncontrolled	ICD-10: I10 to I15
Outpatient Visit Codes	CPT: 99202 to 99205, 99211 to 99215, 99241 to 99241, 99347 to 99350, 99381 to 99387, 99391 to 99397, 99401 to 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341 to 99345
CPT II Codes Most recent systolic BP less than 130 mm Hg Most recent systolic BP less than 130-139 mmg Hg Most recent systolic BP greater than or equal to 140 mg Hg Most recent diastolic BP less than 80 mm Hg	 3074F 3075F 3077F 3078F 3079F

Most recent diastolic BP 80-89 mm Hg Most recent diastolic BP greater than or equal to 90 mm Hg	3080F

Did you know? Medicaid will cover a home blood pressure monitor.

- ✓ **Order Type: DME miscellaneous, home BP cuff HCPC A4663**
- ✓ **Patient can take order to any in network Durable Medical Equipment vendor (Alpine Home Medical, Red Rock Medical)**
- ✓ **Some Local libraries offer Blood Pressure Monitors to be "checked out" with a library card.**

Antipsychotic Medications and Increased Risk of Developing Type 2 Diabetes

Individuals taking an atypical antipsychotic drug, particularly younger patients under 40 years of age represent an under recognized group at high risk of developing Type 2 Diabetes. It is recommended members with schizophrenia; schizoaffective or bipolar disorder be screened annually for metabolic syndrome and cardiovascular disease. The prevalence of diabetes is 2–3-fold higher in people with severe mental illness than the general population. Managing diabetes in this population can be further complicated by the potential lack of insight with diet and activity, difficulty with medication adherence, and attending regular appointments. These factors contribute to a higher risk of cardiovascular complications and warrants additional screening measures.

Annual Screenings Recommended: A1C and LDL-C
HEDIS Measure Connection:
SMD: Diabetes monitoring for people with diabetes and schizophrenia
Measure evaluates the percentage of members 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test.
SSD: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.

Measure evaluates percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test.

DESCRIPTION	CODES
HbA1C Lab Tests	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F, 3051F, 3052F
Glucose Lab Tests	**CPT:**80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
LDL- C Lab Tests	**CPT:** 80061, 83700, 83701, 83704, 83721 **CPT-CAT II:** 3048F, 3049F, 3051F, 3052F

Medicaid Update: Twelve- Month Extended Postpartum Coverage

Effective January 1, 2024, Utah Medicaid, and the Children's Health Insurance Program (CHIP) will extend postpartum coverage from **60 days to 12 months**. This coverage aims to provide comprehensive care for new mothers during the critical postpartum period. Twelve-Month Extended Postpartum Coverage goals:

- ✓ Promote continuity of care for the management of chronic conditions such as depression, diabetes, and hypertension.
- ✓ Align pregnancy postpartum Medicaid coverage with the newborn child Medicaid coverage.
- ✓ Reduce maternal mortality. Ensure mothers have access to preventative care and time to seek care for postpartum-related health issues.
- ✓ Decrease the incidence of short interval pregnancies, a known risk factor for poor maternal and infant health outcomes.

(PPC) PRENATAL AND POSTPARTUM CARE

Measure evaluates percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

Timeliness of Prenatal Care: percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

Postpartum Care: percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

DESCRIPTION	CODES
Prenatal Visits	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99483 **CPT-CAT-II:** G0463, T1015
Stand Alone Prenatal Visits	**CPT:** 99500 **CPT-CAT-II:** 0500F, 0501F, 0502F HCPCS**:** H1000, H1001, H1002, H1003, H1004
Postpartum Visits	**CPT: 57170, 58300, 59430, 99501** **CPT-CAT-II: 0503F** **HCPCS: G0101** **ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2**

Diabetes Screening Tests and HEDIS Documentation

EED EYE EXAM FOR PATIENT'S WITH DIABETES

This measure looks at the percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam during the year. It is important to note if the member's eye exam is positive for retinopathy that diabetic retinal exams are to be completed yearly to check for changes.

Diabetic retinal exam (DRE) performed during the measurement year (2024)

- OR –

Evidence of a negative Dilated retinal exam performed during the measurement year or the prior year (2023- 2024)

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP, or other health care professional indicating that the diabetic retinal eye exam was completed by an eye care professional (Include name of professional in letter) the date when the procedure was performed and the results.

- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - ✓ Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - ✓ Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- ✓ Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).

It is important to remember documentation in the chart limited to a statement that indicates "diabetes without complications" does not meet criteria for this measure.

(KED) KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

DESCRIPTION	CODES
Estimated Glomerular Filtration Rate (eGFR)	**CPT:** 80047, 80048, 80050, 80053, 80069, 82565
Urine Albumin-Creatinine Ratio (uACR)	**CPT:** 82043, 82570
Palliative Care	**HCPCS:** G9054, M1017 **ICD-10:** Z51.5

HBD HEMOGLOBIN A1C CONTROL FOR PATIENT'S WITH DIABETES

Please note this measure has been renamed to GSD for 2024

https://www.ncqa.org/wp-content/uploads/2023/02/01.-Diabetes-Care.pdf

Measure reports the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

- HemoglobinA1C (HbA1c) testing
- HgbA1c control (<8.0%)
- HgA1c poor control (>9.0%)

DESCRIPTION	CODES
Outpatient Codes	**CPT:** 99201-99205, 99211-99215, 99241-99245, 99347 -99350, 99381-99387, 99391-99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483, 99341-99345 **HCPCS:** G0402, G0438, G0439, G0463, G9054, M1017, ICD-10: Z51.5, T1015
Non-acute Inpatient	**CPT:** 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
HbA1C Lab Test	**CPT:** 83036, 83037 **CPT-CAT-II:** 3044F, 3046F
HbA1c Level Greater than/ equal to 7 and Less than 8	**CPT-CAT-II:** 3051F

(W30) Well-Child Visits in the First 30 Months of Life

The W30 HEDIS measure includes completion of at least 6 well visits within the first 15 months of life and at least two well visits between 15 and 30 months of age.

Well-Child Visits Key Takeaways

- For new patients, obtain well-child medical records from the prior provider and submit them to the health network as supplemental data.
- Follow best practices for scheduling well-child visits, vaccinations, and screenings, including blood lead screening at 12 and 24 months of age.
- Take advantage of sick visits to convert to well-child visits.
- A primary care physician (PCP) provider type must provide well-child services.
- Well visits must occur at least 14 days apart to be counted as distinct visits.
- Code specifically and accurately for all well-child visits, including newborn visits. See table below.

CPT Codes	ICD-10 Codes
Use Both CPT and ICD Codes	
New Patients • 99381 Infant (younger than 1 year) Established Patients • 99391 Infant (younger than 1 year)	• Z00.110 Health supervision for newborn under 8 days old • Z00.111 Health supervision for newborn 8 to 28 days old • Z00.129 Encounter for routine child health examination without abnormal findings (for infants > 28 days old

When to Schedule Well-Child Visits

- Well-child visits should align with the Bright Futures Guidelines and Pocket Guide.
- Coordinate the timing of well-child visits and the timing of vaccines. Schedule the first newborn visit early, by one week of age, followed by a visit at one month of age and so forth outlined by the AAP/ Bright Futures well-child visit schedule.
- For children behind on their well-child visits or vaccinations, consider scheduling catch-up visits and/or converting sick visits to well-child visits.

Optimize Office Processes for Well-Child Visits

- Open schedules six to nine months in advance to allow for appointments to be scheduled ahead of time.
- Make reminder calls or leverage text messaging to confirm upcoming appointments and to recall patients who have missed appointments.
- Offer appointments during evening/ weekend hours for member accessibility.
- Leverage eligibility files and gap reports to identify and outreach to members due for well-child services.

Pre-visit Planning

Save Time, Improve Care and Strengthen Care Team Satisfaction

Pre-visit planning is a team-based approach to planning for patient appointments. This process involves scheduling patients for future appointments, arranging for pre-visit lab testing, gathering necessary information for upcoming visits, and collaborating with other members of the patients care team to ensure the patients care is under consideration. The objective of pre-visit planning is to ensure that the provider and member make the best use of the visit or service delivery time.

The American Medical Association recommends the following steps for implementing pre-visit planning into your office's daily processes.

1. Re-appoint the patient after the visit.
2. Use a visit planner checklist to arrange the next appointment(s).
3. Arrange for laboratory tests to be completed before the next visit.
4. Perform visit preparations.
5. Use a visit prep checklist to identify gaps in care.
6. Send patients appointment reminders.
7. Consider a pre-visit phone call or email.
8. Hold a pre-clinical team huddle.
9. Use a pre-appointment questionnaire.
10. Handoff the patient to the physician.

To learn more about the 10 step pre-visit planning process, how to save time, improve care and strengthen care team satisfaction, check out The 10 Steps of Pre-visit Planning — Business of Primary Care (thebusinessofprimarycare.com)

Pre-visit Template Ideas

CHART PREP CHECKLIST

PROVIDER:_____Date:_____

Patient Name	Age	Diagnostic Referrals	Pediatrics Last WCC (V20.2)	Last Fit Test Date	Last Pap Date	Last Mammo Date	Last PHQ Date
1				□Nl □Abnl	□Nl □Abnl	□Nl □Abnl	
2				□Nl □Abnl	□Nl □Abnl	□Nl □Abnl	
3				□Nl □Abnl	□Nl □Abnl	□Nl □Abnl	
4				□Nl □Abnl	□Nl □Abnl	□Nl □Abnl	

Date: _____ **Name:** _____ **F M** **DOB:** _____

Pharmacy: _____

Allergies: _____

Procedures: _____

Chief Complaint: _____

Accident: Yes No

Recent Hospitalization: Yes No

Vision Test: None Glasses Contacts Surg Correct

Left: _____ Right: _____ Both: _____

Hearing: Impaired R____ L____ Aides R____ L____

Last Wellness visit/6x15: _____

GC/CHL 16-24 + Sexual hx or OCP _____

Diabetic: Last A1C_____**DM Eye 18+**_____

Microalbumin 18+: _____

Histories: Tobacco_____ Alcohol _____
Flu shot_____ Prevnar_____ Menst Hx _____

Contraception: OCP Other

Medications:

VITALS:

BP: __________ HR: _____
HT: _____ WT: _____
O2 Sat: _____ Temp: _____
BMI: _____ BMI %: _____
Pain: 1 2 3 4 5 6 7 8 9 10

PHQ2 age 12+ (if positive proceed to PHQ-9)

Feeling down, depressed, hopeless?
No Several Most Nearly every
Little Interest/Pleasure in Activities?
No Several Most Nearly every

ORDERS:

LABS

BMP	FREE T4	Hgb A1C
CBC	HCT	LIPID PANEL
Chlamydia	LFTs	TSH
CMP	Hgb	

Other: _____

VACCINES

DTaP	INFLUENZA	PREVNAR 13
HEP B	IPV	HEP A
IPV	MMR	HIB
CHICKEN POX	PNEUMOCOCCAL	

OTHER

Check every chart

- ✓ Wellness visit 1 X year
- ✓ BMI documented & coded
- ✓ Immunizations up to date
- ✓ Medications verified
- ✓ BP under 140/90

Women' Health

- ✓ Age 21-64: PAP every 3 years
- ✓ Age 16-24 : Chlamydia screening 1 X year
- ✓ Age 52-74: Mammogram every 2 years

Colorectal Cancer Screening (Age 50-75)

- ✓ Colonoscopy every 10 years
- ✓ FOBT yearly
- ✓ Cologuard every 3 years

Diabetics

- ✓ A1c testing 2 X year
- ✓ A1c below 8.0
- ✓ Diabetic eye exam every 2 years (yearly if positive)
- ✓ Nephropathy screening
  -Urine microalbumin
  -ACE or ARB medication
- ✓ Taking statin

References

- Antipsychotics and Metabolic Syndrome Risks
- https://diabetesjournals.org/care/article/26/5/1597/24475/Patients-on-Atypical-Antipsychotic-DrugsAnother
- The 10 Steps of Pre-visit Planning — Business of Primary Care (thebusinessofprimarycare.com)
- https://www.ncqa.org/
- https://www.aapc.com/tools/riskadjustment/

Submitting Corrected Claims

Health Choice Utah Plans prefers to receive corrected claims via EDI transaction. To request a claim be corrected, submit the following information in **Loop 2300** of an **837I** (*Institutional*) or **837P** (*Professional*) electronic claim form.

1. In segment **CLM05-3**, insert the appropriate "**Claim Frequency Type**" code (these may be displayed by your software as a drop-down field):
   - » **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.
   - » If you are submitting a **primary payer's EOB** with this corrected claim, you **must include the primary payment date**, also in **REF*F8**.
3. **You must report every line associated with this claim** to ensure the full claim is reprocessed.
4. Refer to your *5010 Implementation Guide* for additional information.

PAPER CLAIM FORMS

If you must submit a corrected claim on a CMS 1500 (02/12) paper claim form:

» In box 22, enter the appropriate Resubmission Code:

7 – Correction to prior claim

8 – Void of a professional claim

» **Enter the payer's original claim number in box 22** under the "*Original Ref. No.*" field.

» Remember, if you're correcting to add an EOB, **you must attach the primary EOB** to the corrected claim.

If you must submit a corrected claim on a **UB-04** *Facility* claim form:

» Enter the CLAIM FREQUENCY TYPE code as the **4th digit of Box 4** *"Type of Bill"*

7 – *Correction to prior claim* (e.g., 0137 indicates a correction to a Hospital Outpatient claim)

8 *– Void/correction to prior claim*

» **Enter the payer's original claim number in Box 64** *"Document Control Number."*

» Again, if you're correcting to add an EOB, **you must attach the primary EOB** to the corrected claim.

Rejected vs. Denied Claims

A **rejected claim** is a claim that is sent back due to an **error** in the claim. This could be due to an input error, incorrect data, or data that does not match what the payer has on file.

A **denied claim** has been processed and adjudicated in the payer system but is **denied and deemed unpayable**. The denial could be for several reasons.

When a claim has been rejected (i.e., it has not been adjudicated), you can resubmit the claim. To resubmit the claim, simply create a new claim and resubmit it through the clearinghouse. **If you resubmit a claim that has been denied, the new claim will be denied as a duplicate claim**.

A corrected claim will replace the previously adjudicated claim, so ensure all charges are included on the corrected claim. You can submit a corrected claim if:

» The plan denied the claim for **missing information** (i.e., primary insurance EOB not submitted or complete)

Note: **You need to correct information** on the original claim submission, even if the claim has already paid

Common reasons to submit a corrected claim include:

» Primary insurance EOB missing (you must attach the primary EOB to the corrected claim)

» Primary insurance EOB amount is changing

- Incorrect billed amount
- CPT©/Modifier changes
- Transposed procedure or diagnosis code
- Inaccurate data entry
- Denial of claims as duplicates
- Missing or invalid ordering or referring provider

Reporting CPT II Codes Correctly for Diabetes HBA1C Testing

Diabetes HbA1c testing is one of the key tests to help diagnose and manage diabetes. The National Commission for Quality Assurance (NCQA) requires health plans to review medical records to capture HbA1c results for members with diabetes; therefore, we conduct a randomized sampling of records as part of our annual HEDIS® medical record review.

Diabetes HbA1C HEDIS Measures

The American College of Physicians' guidelines for people with type 2 diabetes recommend HbA1c blood sugar control levels remain between 7 to 8 percent.

The diabetes HbA1C HEDIS measures focus on members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- HbA1C control (<8.0%)
- HbA1c poor control (>9.0%)

Category II CPT Codes to Report Diabetes HbA1C Results

Utah Medicaid recently opened the following Category II CPT codes to report HbA1C results for all Medicaid members:

Category II CPT code	HbA1C Test Result
3044F	<7.0%
3051F	7.0-7.9%
3052F	8.0-9.0%
3046F	>9.0%

CPT II codes were developed by the American Medical Association (AMA) as supplemental tracking codes that can be used for performance measurement. Health Choice Utah strongly encourages providers to report

Category II HbA1C codes because monitoring HbA1C results on a more granular level can lead to better health outcomes for patients. While there is no additional reimbursement available for Category II codes, use of these codes will result in more complete reporting of HbA1C results to the health plan and fewer medical record requests to your office. Provider offices can additionally benefit from using these codes with improved performance in value-based payment arrangements.

Category II codes cannot be used to replace Category I codes on claims. Providers should bill these codes along with **CPT 83036** or **83037** on the same claim.

In order to meet the HEDIS HbA1C measures, you must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and **use the date of service as the date of the test**, not the date of the reporting of the Category II code.

NOTE: Multiple dates of service may be associated with a single lab test (e.g., a collection date, a reported date, and a claim date). For a laboratory test CPT II code to count toward HEDIS, **the Category II date of service and the test result date must be no more than seven days apart**.

References:

Qaseem, Wilt, Kansagara. Hemoglobin A1c Targets for Glycemic Control With Pharmacologic Therapy for Nonpregnant Adults With Type 2 Diabetes Mellitus: A Guidance Statement Update From the American College of Physicians. Annals of Internal Medicine. MAR 05 2018. Web. Accessed DEC 21 2023.