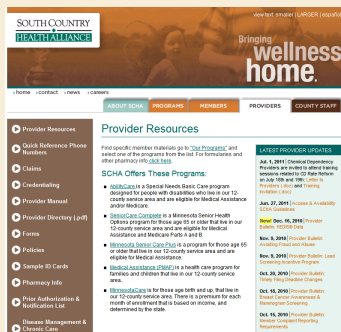


## At A Glance

DM/CCIP .....	2
Flu Shot Performance .....	2
5010 HIPPA Update .....	2
Restricted Recipients .....	3
Part D Star Ratings .....	3
PCA Relative Changes .....	4
ICD-10 Code System .....	5

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## Spotlight

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## Director's Corner

by Mark Ward, Director  
Provider Network Management

### 2011 HHS Omnibus Bill

South Country Health Alliance has been busy since the ending of the State of Minnesota government shutdown researching and planning for the key changes/provisions that will impact payers and Providers as a result of the 2011 HHS Omnibus Bill. Significant changes were made to the Bill during the closed-door sessions that took place during the shutdown, so here is a summary of some of the important changes that will affect the SCHA Provider Network.

#### Enrollment Changes

◆ SNBC eligibility – persons with disabilities will be enrolled in a managed care program unless the member chooses to opt out. This change will be implemented gradually during 2012.

#### Benefit Changes

◆ Chiropractic Services – increased the maximum number of visits from 12 to 24 visits per year without prior authorization. Effective January 1, 2012.

◆ Acupuncture Services – added this benefit to include chiropractors when services are provided by a licensed acupuncturist or by another Minnesota licensed practitioner when provided within the scope of their practice. Chiropractors' benefit is effective January 1, 2012.

◆ Maintenance Therapy – reduced the benefit for maintenance physical, occupational and speech-language therapy and related services to only those recipients who are 20 years old and younger.

◆ Certain dental services may be provided by dental therapists and

advanced dental therapists.

#### Cost Sharing

- ◆ Non-emergency visit to hospital-based ER – the member co-payment will increase to \$20 upon federal approval from the current \$3.50 co-pay.
- ◆ Prescription drug co-payment – increased to \$12 per month maximum from \$7.50 maximum. Effective for managed care on January 1, 2012.
- ◆ Addition of a \$3 co-pay for non-preventative visits (does not apply to mental health services [MA and MnCare]).
- ◆ Addition of a \$3 co-pay for eyeglasses (MA and MnCare).
- ◆ Addition of a family deductible – the family deductible will be equal to the maximum amount allowed under the Code of Federal Regulations and is to be effective January 1, 2012. DHS is working with the Plans on how this will be administered. More detail will follow.

#### Managed Care

- ◆ Payments to Plans will be reduced on average by 5.2% between the Medical Assistance (MA) Elderly Basic Care, MA Families and Children, MA Adults Without Children and MN Care Families and Children programs.
- ◆ Managed Care Plans will also have a number of new “withhold provisions” where they need to work with providers to reduce ER utilization, hospital admissions and hospital re-admissions. SCHA will be working more closely with providers in

Continued on page 5

## The Disease Management/Chronic Care Improvement Program

The Disease Management/Chronic Care Improvement Program (DM/CCIP) is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. The DM/CCIP supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbations and complications using cost-effective, evidence-based guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health.

South Country Health Alliance currently has four DM/CCIPs:

[\*heart failure\*](#) (ages 18-75); [\*diabetes\*](#) (18 and older); and [\*asthma\*](#) (children ages 5-17 and adults 18-50). Referrals are also accepted for children under the age of 18 for the diabetes program, for children under the age of 5 for the asthma program, and for adults with asthma over the age of 50.

Participants are identified through referrals from self/family, county staff, SCHA staff, data warehouse, third party administrators, medical or other providers, and claims are reviewed based on diagnosis, pharmacy, hospitalizations, and ER visits. If a South Country Health Alliance member is identified for one of the programs, they are automatically enrolled. Participation is voluntary, with the member receiving written participation information, including that they can opt out at any time. The provider is notified, by letter, when their patient is actively participating in the DM/CCIP.

Additional information is available on the website at [www.mnscha.org](http://www.mnscha.org) or by calling the Disease Management/Chronic Care Improvement Program Coordinators at 866-722-7770, Susan Branstad RN 507-431-6065 or Dee Ann Frodl RN 507-431-6063. ■

## Special Needs Basic Care (AbilityCare) Flu Shot Performance Improvement Project

With the start of the 2011 flu season, South Country initiated a Performance Improvement Project (PIP) to increase the number of Special Needs Basic Care (*AbilityCare*) members who receive a flu shot.

Outreach efforts are based on the Community Guide for Preventive Services, a model designed to provide population-based interventions to improve targeted vaccination rates among high-risk adults. Over the course of the flu season (September through March), members will receive up to two educational mailings about the importance of getting a flu shot, along with information about benefit coverage and how to obtain a flu shot. Members who fail to get a flu shot after the two mailings will receive a follow-up phone call as a reminder, along with assistance for locating a flu shot clinic, scheduling an appointment, or arranging transportation.

All AbilityCare members will receive a survey that identifies specific factors that influenced their decision to get the shot or not be immunized. Information gathered through this survey will be used to modify intervention strategies and refresh key messages. Results of the survey will be shared in a future edition of the *Provider Network News*.

The flu shot is a covered benefit for South Country members. Flu shot clinics, including those hosted by public health departments, will be promoted to AbilityCare members when possible and as appropriate. For a quick look at what's available in your area, [click here](#) to visit a special page on the MDH website. South Country is interested in partnering with clinics and pharmacies to promote flu shot services and help get AbilityCare members immunized. Contact Anne Grimmus ([agrimmius@mnscha.org](mailto:agrimmius@mnscha.org)) to discuss the ways we can collaborate! ■

## 5010 HIPAA Update from MMSI

The MMSI 5010 Project Team is in the process of implementing the 5010 HIPAA Administrative Simplification Rule, with a mandated go-live date of January 1, 2012. The team completed the internal programming and testing phase in March. We are now undergoing testing with external trading partners to ensure a smooth transition from the 4010 to 5010 transaction platform.

The HIPAA 5010 Administrative Simplification Rule is a set of federal regulations that control health care electronic data interchange (EDI) transactions. MMSI and its trading partners need to exchange data files that are compliant with the new 5010 file formats. The following is a list of the transactions

impacted by the HIPAA 5010 regulations:

- ◆ Eligibility Request (270)/ Eligibility Response (271)
- ◆ Claim Status Request (276)/ Claim Status Response (277)
- ◆ Claim (837)
- ◆ Remit (835)
- ◆ Enrollment (834)

Please contact your EDI clearinghouse if you have questions regarding 5010 transactions. ■

# Provider Alerts

## Restricted Recipient Program (Payment for Emergency Department Services)

South Country Health Alliance (SCHA) members who are in the Restricted Recipient Program must receive services from their assigned health care provider; hospital, pharmacy, and primary care provider. Verification of Restricted Recipient Program status is listed on the eligibility record in MN-ITS.

SCHA currently denies medical claims when a member accesses care from a non-authorized provider, clinic or pharmacy. Effective September 1, 2011, SCHA will deny all medical claims for Emergency Room or Urgent care visits when at a hospital or clinic other than their designated provider.

SCHA will cover triage and stabilization services (codes 99201 and 99211) provided to a restricted recipient by a non-designated hospital. If the triage results in a determination that the restricted recipient does not require emergency department services or admission for inpatient services, refer the restricted recipient to his/her designated medical facility for services.

If the member was experiencing a life threatening medical emergency and needed to utilize the closest emergency room, the denial of payment may be appealed and reviewed for payment.

SCHA defines a medical emergency as : Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the physical or mental health of the individual (or, with respect to a Pregnant Woman, the health of the woman or her unborn child) in serious jeopardy; continuation of severe pain; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death. Labor and delivery is a Medical Emergency if it meets this definition. The condition of needing a preventive health service is **NOT** a Medical Emergency.

Hospital emergency rooms and urgent care centers should be used only for emergencies and not for routine care that members can get from their primary care provider during regular office hours.

To receive reimbursement for triage, bill using:

- ◆ Claim format 837I
- ◆ Revenue code 045X
- ◆ CPT codes 99201 or 99211 with modifier UD (If the enrollee/patient is triaged more than once on one date, modify the subsequent triage submissions with the CPT modifier for repeat procedure.)

One facility claim for triage will not conflict with another facility's claim for triage.

## Medicare Part D Star Ratings—

### Improving Member Outcomes through Medication Adherence

2012 Medicare Part D has new requirements around medication adherence related to Star Ratings for Plan Sponsors. SCHA has kicked off an adherence program via analysis of pharmacy claims to determine members who appear to be less adherent than CMS standards. Prescribers of targeted SCHA members will receive a letter and a copy of the member(s) medication profile. We hope this information will be helpful in opening a conversation with your patients to encourage member medication adherence in support of CMS standards to help improve member outcomes.

## REMINDER!

South Country provides primary care clinic managers with monthly reports containing the names of children ages 0–19 years who are due for their next C&TC or who have never had one. For information or to request the reports electronically, contact Jim Barkhaus at [jbarkhaus@mnscha.org](mailto:jbarkhaus@mnscha.org). ■

# Provider Alerts

## Personal Care Assistant Relative Care Giver Changes

New Legislation changes impact PCA services provided to South Country Health Alliance enrollees. Effective October 1, 2011.

2011 Legislation Chapter 9, Article 7, Section 10 requires that “when the personal care assistant is a relative of the recipient, the commissioner shall pay 80% of the provider rate.” In order to comply with this legislation, DHS will be requiring FFS and Managed Care Personal Care Provider Agencies (PCPAs) to identify and report on all PCA claims, (including extended PCA services) the relationship of the individual PCA provider to the recipient they are providing services to. PCPAs will be required to use the following modifiers with the T1019 procedure code to identify the type of relationship when submitting the claim for payment:

- ◆ U1 – Related as Parent, Adult Child, Sibling, Grandparent and Grandchild
- ◆ UD – Not related as any of the relationships in the U1

These modifiers will be required for dates of service October 1, 2011 and going forward. The requirement will not apply to qualified professional services (RN PCA Supervision T1019 – UA).

Claims will be denied when you:

- ◆ Do not include at least one of the relationship modifiers on the claim line
- ◆ Enter more than one of the relationship modifiers on the same claim line
- ◆ Include a relationship modifier to bill RN PCA Supervision
- ◆ Do not meet other PCA billing requirements

### Agency Responsibilities

For each individual PCA provider and the recipient(s) for whom they provide services, SCHA requires all PCA agencies to identify, document and report individual PCA and recipient relationships.

### Identify & Document Relationships

Identify and document the relationship of each individual PCA provider with each recipient for whom they provide services:

- ◆ Complete the [Individual PCA Relationship Acknowledgment](#) form and keep in your agency files and the recipient health service record
- ◆ Identify the relationship on the agency’s [PCA Time and Activity Documentation](#) each pay period and keep in your agency files

Failure to maintain required documentation may result in a \$500 fine to the PCA provider agency.

Additional information can be found in the following DHS Provider Updates:

- ◆ September 2, 2011 – MHCP Provider Update PCA-11-02

### Limitation on Residential Treatment Placement

On August 1, 2011, DHS has issued Bulletin #11-51-01 in response to the Health and Human Service Omnibus bill, Fist Special Session, Chapter 9, Article 8, Section 4 language that specifies eligibility for treatment in residential settings. The bulletin clarifies the legislative intent on placement criteria for residential Chemical Dependency Treatment. The bulletin states:

Eligibility for treatment in residential settings: Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor’s discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, and recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

This provision was adopted to implement a budget reduction that limited services with a room and board component to individuals who score severity 4 in either Dimension 5 (Relapse and Continued Use) or Dimension 6 (Recovery Environment). A score of severity 4 is not required in both Dimension 5 and Dimension 6.

This limitation will be implemented on August 1, 2011 and applies to Rule 25 assessments provided on and after that date.

Bulletin 11-51-01: [http://www.dhs.state.mn.us/main/groups/groups/publications/documents/pub/dhs16\\_162954.pdf](http://www.dhs.state.mn.us/main/groups/groups/publications/documents/pub/dhs16_162954.pdf)

## **REPORTING Fraud, Waste and Abuse**

SCHA believes it is the responsibility of everyone to report suspected fraud, waste or abuse. You can report anonymously through our REPORT-IT hot line by calling 1-877-778-5463. You can also make a report at [www.reportit.net](http://www.reportit.net). Username: SCHA, Password: Owatonna

# Provider Alerts

## ICD-10 Code System

It's October 2011! The healthcare industry has entered the 2 year countdown to the implementation of ICD-10. That is 24 months, 104 weeks, or as of the writing of this article: 726 days, 14 hours, 7 minutes and 1 second – who's counting, right? So what's all the hype about, anyway? What are the major changes in ICD-10?

The ICD-10 code system includes both a classification of diseases, ICD-10-CM, and a procedure coding system, ICD-10-PCS. The changes in the two code systems vary. It is basic to understand that the two systems were designed by two different groups of experts with some common objectives, such as greater specificity and code set expandability. However, the revisions are vastly different.

The Clinical Modification (ICD-10-CM) was built upon the ICD-9 framework therefore the structure of the code system remains intact though the enumeration of the codes has changed to meet the expandability objective. A closer examination of the tabular index reveals changes in many of the business rules and definitions. For example, an acute myocardial infarction previously defined as 8 weeks or less has been changed to 4 weeks or less in ICD-10. Another change is the added greater specificity throughout the code

set to identify body parts, laterality and timing of the patient's medical encounter.

The Procedure Code System (ICD-10-PCS) is radically new. Not only was the code enumeration expanded and changed, a new ICD-10 nomenclature has been introduced. To achieve standardization of medical terminology, changes have been made to replace common terms such as 'tonsillectomy' to 'resection of tonsils, external approach' - which is only one of many variable terms used to classify the surgical removal of tonsils. Another change is the elimination of combination codes. After 10/1/2013, each procedure will be assigned a unique ICD-10 code. Whereas a tonsillectomy and adenoidectomy was assigned a single ICD-9 procedure code, two distinct codes must be used to identify each procedure in the ICD-10 procedure code set.

The impact of the changes will vary by business, role and current utilization of the diagnosis and procedure code sets. Regardless of the range of impact, the implementation of the ICD-10 Code Sets will penetrate the healthcare industry bringing greater opportunities to consistently and specifically communicate and report diseases, medical interventions and outcomes. ■

## Director's Corner Continued . . .

2012 to achieve these DHS withhold targets.

### Provider Rate Reductions

- ◆ Ambulance and Transportation Services – a 4.5% reduction in payment effective for managed care plans on January 1, 2012. SCHA will implement this rate reduction except for non-emergency transportation services.
- ◆ Physician and professional services – a 3% reduction for services provided

on or after September 1, 2011.

- ◆ Hospital Outpatient facility services – a 5% reduction for services provided on or after September 1, 2011.
- ◆ Ambulatory Surgery Centers, medical supplies and DME, renal dialysis, PT, OT and ST, anesthesia, and hospice services will be reduced by 3% for service on or after September 1, 2011.

SCHA will be implementing these legislative rate reductions with our Third-Party Administrator, MMSI. ■

## DID YOU KNOW?

DHS' website provides updates to Personal Care Attendant (PCA) providers specifically for training requirements, both for individuals and for agency administration staff.

**CLICK ON ME!**

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_139462](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139462)

Click on the "CLICK ON ME" square to go directly to DHS' website.

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