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Director's Corner

by Mark Ward, Director
Provider Network Management

Important Changes for 2012

Happy New Year and welcome to the first edition of the 2012 Provider Network News!

Special Needs Basic Care (SNBC) Expansion

Effective January 1, 2012 recipients that are 18 years and older with disabilities will be assigned to a SNBC health plan unless they have notified the Department of Human Services (DHS) of their choice to "opt-out." The SNBC enrollment with health plans will be phased-in by DHS:

Phase 1 - January 1, 2012

- ◆ Single Plan Counties
- ◆ Members with no waiver services: Includes South Country Health Alliance (SCHA) Counties of Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, and Waseca.

Phase 2 - March 1, 2012

- ◆ All Counties
- ◆ Members who receive waiver services: Includes all SCHA Counties.

Phase 3 - April 1, 2012

- ◆ Multiple Plan Counties
- ◆ Members with no waiver services: Includes SCHA Counties of Morrison, Todd, and Wadena.

The benefit sets that SCHA is responsible for managing are different based on whether the member is eligible for only Medical Assistance (MA) benefits, is eligible for both MA and Medicare (dual eligible) and on whether SCHA is responsible for the Medicare benefit. See grid on Page 7.

Other Key Highlights include:

- ◆ All members will continue to receive Personal Care Assistance, Private Duty Nursing and the Home and Community-based Service waivers of CADI, CAC, DD and TBI from the State plan. These services are not part of the SCHA benefit set.
- ◆ Effective January 1, 2012, SCHA has added just over 900 new SNBC members.
- ◆ DHS plans to add children to the SNBC expansion later in 2012.
- ◆ For more detailed information, go to the DHS website or click on the following link: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139491.

Freeborn County Change in Participation

Effective January 1, 2012, Freeborn County will not be participating with SCHA for the PMAP and MNCARE programs. Former SCHA members now have other health plan options available to them for these Medicaid programs.

Freeborn County continues to participate with SCHA for the Seniors Programs of Senior Care Complete/MSHO and MSC+, as well as for the SNBC Program. ■

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Provider Resources Tab



Spotlight

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5010 Provider Frequently Asked Questions

The HIPAA 5010 Administrative Simplification Rule is a set of federal regulations that control healthcare's electronic data interchange (EDI) transactions. In the HIPAA 5010 transition, the National Provider Identifier (NPI) unique identification number for health care providers is becoming part of uniform reporting requirements. Providers will be required to use the same billing NPI across all insurance payers, so this change has critical impact on claim transactions and billing practices.

MMSI 5010 Implementation Frequently Asked Questions

What transactions will MMSI be supporting with the upgrade to the 5010 version?

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

Will MMSI be providing a file-level acknowledgment for claim files?

Yes, MMSI will be using the 999 transaction as a file-level acknowledgement.

Will MMSI require a file-level acknowledgement for the 835 (remit) files?

No, MMSI will not require an acknowledgement for 835 files.

When will MMSI complete testing?

MMSI anticipates completion of testing by 12/16/2011. MMSI is scheduling implementation of 5010 file formats with each entity as readiness is confirmed. MMSI will be switching to 5010 with all entities by 1/1/2012.

Are providers able to test directly with MMSI?

No. Providers will need to test with their contracted clearing houses. MMSI is testing with each of our contracted clearing houses.

Will providers need to submit revised address formats with 5010?

Yes. Per Centers for Medicare & Medicaid Services (CMS) requirements, with 5010-compliant transactions, the billing provider and service facility address must be complete street

addresses and can no longer be a post office (PO) or lock box. Complete is defined as including the full 9-digit zip code (traditional five digits plus the extra four digits for localized mail delivery).

Will MMSI deny claims that are missing 5010 required data?

Yes. MMSI will deny claims that do not meet minimum 5010 data requirements.

Will MMSI accept both 4010A1 and 5010 transactions? If so, for how long?

MMSI will accept both 4010A1 and 5010 transactions through fourth quarter, 2011. MMSI will not accept 4010A1 transactions after 12/31/2011.

Do I need to do anything if I am not currently submitting the same billing NPI number(s) to all insurance payers?

Yes. In 5010, you must bill all payers using your most detailed level of Type 2 NPI number for the Billing Provider. Please review your billing system to identify which NPI you currently submit to each payer. If your organization has subparts that require enumeration, you will need to report the NPI of the subpart as the Billing Provider.

How should I submit the changes to my billing NPI to MMSI?

If changes need to be made, you must notify MMSI **immediately** by completing the "**Facility Change/Update Form**" to avoid your claims from being rejected and/or delayed when processing. This form can be found on our web site, www.mmsiservices.com.

Please note that it may take up to 30 days to process your request. The sooner you determine if there are changes to your NPI Billing Provider and communicate it to us, the sooner we are able to update our system.

Evidence-based Childbirth Program

The Minnesota Department of Human Services (DHS) recently posted an update on the Evidence-Based Childbirth Program. This update provides additional details for hospitals that are required to submit their policies to DHS for approval and information about the process required by physicians submitting claims for deliveries performed in a hospital that does not have approved policies on file at DHS.

The Evidence Based Childbirth Program is a result of a new Minnesota law ([MN Stat. sec. 256B.0625, subd.3g](#)) that goes into effect January 1, 2012. This law requires hospitals to implement policies and processes to reduce the number of elective inductions of labor prior to 39 weeks' gestation for recipients of Minnesota Health Care Programs (MHCP), including Medical Assistance (MA) and MinnesotaCare members. South Country Health Alliance is required to ensure our contracted hospitals follow this law.

Via [MN-ITS](#), DHS is posting the list of hospitals that have submitted their policies for approval. South Country Health Alliance encourages providers that perform delivery services to review this list. Providers performing deliveries at hospitals not on the list must complete the **Non-Participating Facility Births Evidence-Based Childbirth Programs** form and include the form as an attachment with each delivery claim.

Providers will be expected to follow the MHCP guidelines as outlined below in the following provider update:

December 20, 2011 – MHCP Provider Update MHP-11-12 http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=127632

Effective January 1, 2012, Minnesota law:

- ◆ Asks hospitals to implement policies and processes designed to minimize non-medically necessary inductions before 39 weeks gestation
- ◆ Requires hospitals to report induction of labor data for all births covered by MHCP
- ◆ Requires delivering providers to include a form with each delivery claim when the delivery is in a hospital that does not have policies and processes in place for non-medically necessary inductions before 39 weeks gestation

Hospital Policy

MHCP encourages hospitals to have facility and quality improvement (QI) criteria in place and to submit them to MHCP for approval. The facility policy and QI criteria must include the following:

- ◆ A hard stop policy restricting elective* inductions before 39 weeks gestation. A hard stop policy includes the following elements:
- ◆ Defined medical indications for induction in policy with any deviation from this policy reviewed by the QI process
- ◆ Authorization for hospital staff to not schedule an elective induction before 39 weeks gestation
- ◆ Requirements for providers to get permission from physician leadership (e.g., the head of the OB department) before performing an elective induction before 39 weeks gestation

Continued on page 5

South Country Health Alliance along with local County staff will be working with members and Providers to create solutions to alleviate and reduce the inappropriate Emergency Department utilization, hospitalizations and re-hospitalizations.

Some of the interventions that will be implemented include:

- ◆ identifying and educating members about available local resources;
- ◆ promote the use of the afterhours Ask Mayo Clinic nurse advice line;
- ◆ boost case management services to work with members with chronic illnesses and better connect members with their Primary Care Provider; and
- ◆ working with Providers to assist with connecting members with local resources to meet their needs.

South Country Health Alliance will be reaching out to Providers to discuss and implement methods to work towards increasing member communication and awareness in order to decrease utilization of emergency department and hospitalizations.

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. ■



Community Care Connector Jackie Voight talking about her experiences as a Connector

County-based Plans Reach Out to Legislators

On November 14, 2011, the Minnesota Association of County Health Plans (MACHP) held a health care forum entitled, “A Harvest of Health Care Reforms from Rural Minnesota” in St. Cloud, Minnesota. MACHP is a recently formed association between South Country Health Alliance, PrimeWest Health, and Itasca Medical Care, and is meant to help represent the interests of county-based purchasing health plans (CBPs) at the legislative level as health care policy is discussed and made.

The forum was a presentation to over 130 county commissioners, legislators, and other rural health care stakeholders interested in county-based purchasing and health care reform in rural Minnesota. CBPs are different from other private health plans that have contracts for public programs. CBPs have a close association with their county public health and human services departments, with local and regional health care providers including clinics, hospitals and specialists, and with their local communities. CBPs are consistently ranked as providing the highest quality customer service and health care coverage in comparison to other private health plans that service public programs.

At the forum each of the three MACHP health plans demonstrated innovative rural solutions for health care delivery and financing (reflective of the reform concepts from the national or state health care debate). Attendees had an opportunity for in-depth discussions of rural health care reforms and practices employed by CBPs.

Prior Authorization and Notification Update and Changes beginning January 2012

Several changes to the services requiring prior authorization and or notification took effect January 1, 2012. The new Prior Authorization/Notification Listing is posted on our website at: http://mnscha.org/providers_priorauth.htm

Summary of changes:

- ◆ The addition of Acupuncture Services, the threshold and forms to use to request an authorization
- ◆ Chemical Dependency Services – see Prior Authorization listing for details
- ◆ Durable Medical Equipment and Related Supplies – Equipment, Orthotics or prosthetics greater or equal to \$750.00 require authorization, Oxygen and supplies require authorization, Custom wheelchairs and power operated vehicle require authorization.
- ◆ Home Care Services – see Prior Authorization listing for details
- ◆ Elderly Waiver Home Care Services – Changes to authorization requirements will be posted in the near future, watch for upcoming updates.
- ◆ Mental Health Services – addition of Eating Disorders and Adult Day Treatment
- ◆ Nursing Home Services – Skilled Care Days and Private Rooms require authorization and clinical documentation
- ◆ Medications administered in a physician office require authorization (Orencia, IVIG, Humira are examples of medications that require an authorization)
- ◆ Added continued stays for more than 4 days under Hospital Care- Inpatient
- ◆ Hearing Aid – new and replacement authorizations
- ◆ Added Swing bed to Nursing Home Services
- ◆ Rehabilitation - outpatient therapies added no maintenance (custodial) therapies for members over 20 years old

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. Username: SCHA, Password: Owatonna

Childbirth Program Continued from page 5

- ◆ Provider documentation of final estimated date of delivery (EDD) by 20 weeks gestation (including data from any ultrasound measurement) and share the information with the recipient
- ◆ Guidelines for recipient education about elective inductions, and documentation of the education recipients receive
- ◆ Ongoing QI review and facility-level reporting of the number of elective, singleton births (including induction and Cesarean) at 37 to less than 39 weeks gestation divided by total number of singleton deliveries at 37 to less than 39 weeks of gestation
- ◆ Ongoing audits if the proportion of births using induction at gestations less than 39 weeks is above 25%
- ◆ Analysis of provider variation regarding use of elective inductions
- ◆ Peer review of all inductions less than 39 weeks for appropriateness of indication

*Elective is defined as not having a medical/obstetric indication, as defined in the hospital's QI criteria list.

MHCP Approval Process

MHCP will verify facility policies and QI efforts meet hospital policy criteria through a review process. Use the Facility Policy Cover Sheet Evidence-based Childbirth Program (DHS-6470) with appropriate documentation to submit hospital/facility policies for the evidence-based childbirth program.

If approved, MHCP will:

- ◆ Notify the facility within five weeks of receipt
- ◆ Add the hospital name and NPI to a provider list available in MN-ITS for delivering provider reference

If denied by the initial review process, MHCP will forward all documents to the Medicaid Medical Director. Facilities may resubmit a request after outstanding items are addressed.

Facilities will be required to re-attest to their policies and QI processes every 5 years.

Annual Reporting Requirements

All hospitals that provide OB delivery care services to MHCP enrollees are required to annually report the following data to MHCP:

- ◆ Rate of overall early and pre-term induction for all births covered by MHCP (the number of singleton inductions less than 39 weeks gestation divided by the total number of singleton deliveries)
- ◆ Rate of elective induction at 37 to less than 39 weeks gestation for all births covered by MHCP (the number of elective, singleton births (induction and/or Cesarean) at 37 to less than 39 weeks gestation divided by the total number of singleton deliveries at 37 to less than 39 weeks gestation)

MHCP will announce the process for annual reporting (under development) in Provider News.

Delivering Provider Services

MHCP encourages delivering providers to review the MN-ITS Evidence-based Hospitals list.

- ◆ Providers delivering at hospitals included on the list are not required to submit an attachment with their delivery claims
- ◆ Providers delivering at hospitals not on the list must complete the Non-participating Facility Births Evidence-based Childbirth Program (DHS-6469) form and include the form as a claim attachment with each delivery claim. ■

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

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

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• Web site: www.mnscha.org

Changes and Clarifications for Nursing Facilities in 2012

South Country Health Alliance would like to outline some changes and clarifications to nursing facility services and processes in 2012 including:

- ◆ Demand Billing
- ◆ Single Room Authorization
- ◆ Prior Authorizations for Skilled (SNF) Care

Demand Bills

Prior to November 1, 2011 demand bills for Medicare payment were typically handled by the DHS Medicare Revenue Enhancement Program (MREP), but as of November 1, 2011, the Minnesota Department of Human Services discontinued the Medicare Revenue Enhancement Program (MREP). If Providers review their denials to determine if a demand bill for Medicare payment is appropriate, please contact South Country's Health Services department at 507-431-6368 or 110 W Fremont Street, Owatonna, MN 55060.

Private Room

South Country Health Alliance (SCHA) allows payment for a single bed room for medical assistance recipients, under limited conditions. Services must be medically necessary and prior approval by SCHA/MMSI.

Nursing Facilities must complete the SCHA Nursing Home Communication or DHS form [Private Room Request Form](#) and fax to SCHA/MMSI Health services at (888) 889-7822.

To receive payment for covered services for a private room, the following requirements must be met:

- ◆ The recipient's attending physician must determine and certify that a single bed room is necessary because of a medical or behavioral condition that affects the health of the recipient or other residents (the estimated length of time the private room is needed must also be indicated);
- ◆ The single bed room must be located in a nursing facility which has chosen to assign a greater proportion of their costs to single bed rooms
- ◆ The bed in the single bed room must be certified for Medical Assistance by the MDH
- ◆ The Quality Assessment and Assurance Committee (QAAC) must review the attending physician's recommendation for the single bed room, and sign a statement that a single bed room is required
- ◆ The attending physician's statement, the QAAC's statement and any additional relevant documentation from the recipient's medical record, must be submitted to SCHA/MMSI Health Services for review.

Prior Authorization for Skilled Nursing

For 2012, South Country Health Alliance (SCHA) has changed the payment process for skilled (SNF) care in a nursing facility for members enrolled in the special needs plans of SeniorCare Complete (MSHO) and AbilityCare (SNBC, integrated product of Medicare and Medical Assistance).

Nursing facilities are required to contact SCHA/MMSI Health Services (approval authority) for admission for members within one business day of admission, whenever possible.

- ◆ **** CHANGE **** Skilled care (SNF) requires an authorization from SCHA/MMSI Health Services within one business day of admission or determination, and when ongoing services are extended beyond the current authorization.
- ◆ Non-skilled (NF) care requires notification to SCHA/MMSI Health Services within one business day of admission or re-determination.

South Country Health Alliance does NOT require a prior three (3) day hospitalization for skilled (SNF) care coverage for members. This is not a change for 2012, but nursing facilities must assure that members have available Medicare Part A days, meet SNF coverage/eligibility criteria, and must meet one of the following:

- ◆ Present to a clinic, Emergency Department or Urgent Care setting and require ongoing skilled care, observation, monitoring, or rehabilitation therapy that cannot be appropriately provided in the home setting.
- ◆ The member is a long-term care resident, and experiencing an acute illness or exacerbation of a chronic condition that would meet criteria for an inpatient admission, and care can be safely be provided in the nursing facility. Coverage will only be authorized for the period of time that the member requires skilled services that meet coverage criteria.

Nursing facilities must fax the [SCHA Nursing Home Communication Form](#) to MMSI Health Services (the approval authority) to request authorization or notification. This form is used to notify SCHA of Medicare days used and notification of the 100 and 180 days benefit. **The reason for the skilled coverage should be included in the "Notes" section.** MMSI Health Services will review the request and contact the nursing facility with a determination.

This article is a summary of the nursing facilities changes. For a more in depth view of the changes, go to <http://www.mnscha.org/pdfs/providers/bulletins/2012-01-12%20NF%20Communication.pdf>. ■

Important Changes Continued from page 1

SNBC Expansion – January 1, 2012

The SNBC (Special Needs Basic Care) Expansion moves people with disabilities on Medical Assistance into Managed Care. As a result, their Medical Assistance benefit will shift from the State Fee-For-Service Plan to an MCO.

- ◆ Group A (MA17): SCHA's current AbilityCare program. Dual Members with Medical Assistance and Medicare in which SCHA is responsible for both benefit sets. Members will not be automatically enrolled into this product. Current approximate enrollment: 670



Financial Responsibility

Group A	Doctors	Hospitals	Drugs	Dental	Mental Health	Transportation	Home Care	Co-Pays
SCHA	X	X	X	X	X	X	X	X

- ◆ Group B (MA 37): Members eligible for ONLY Medical Assistance benefits. Current approximate enrollment: 70



Financial Responsibility

Group B	Doctors	Hospitals	Drugs	Dental	Mental Health	Transportation	Home Care	Co-Pays
SCHA	X	X	X	X	X	X	X	X

- ◆ Group C (MA 37) New Group: Dual Members with Medical Assistance and Medicare in which SCHA is only responsible for Medical Assistance Benefits. Medicare and the Part D Plan are not the financial responsibility of SCHA.



Financial Responsibility

Group C	Doctors	Hospitals	Drugs	Dental	Mental Health	Transportation	Home Care	Co-Pays
Other Plan	X	X	Part D				Skilled	
SCHA			Non Part D	X	X	X	Maintenance	X

All members will continue to receive Personal Care Assistant (PCA), Private Duty Nursing (PDN), and the Home and Community- Based Service waivers of CADI, CAC, DD and TBI from the State Plan. **These services are NOT part of the SCHA benefit set.**