

Monthly Provider Newsletter

January 2019

In this Edition

[Billing Changes for PCA and HCN Services for Members Under Age 65](#)

[New Product Names for 2019](#)

[2019 Opioid Edits – All UCare Lines of Business](#)

[Enhanced Prior Authorization DME/Supply Form](#)

[Documentation Improvement: Myocardial Infarction](#)

UCare Provider Website
www.ucare.org/providers

Provider Assistance Center
612-676-3300

1-888-531-1493 toll free

Billing Changes for PCA and HCN Providers Servicing Members Under Age 65

Beginning Jan. 1, 2019, all personal care assistance (PCA) and home care nursing (HCN) services for Minnesota Health Care Programs (MHCP) recipients under age 65 will be paid by the Department of Human Services (DHS). What does this mean?

- Contracts with DHS for MHCP members under age 65 no longer include PCA and HCN services.
- Providers will still be able to bill UCare for PCA and HCN services rendered prior to Jan. 1, 2019.
- Annual assessments for existing service authorizations with an end date on or before Dec. 31, 2018, remain the responsibility of UCare.

For service authorizations that end on or before Dec. 31, 2018, follow the usual procedures for annual assessment requests. If UCare approved a service agreement based on its last assessment with an end date that is on or after Jan. 1, 2019, it will be valid for the length of the authorization.

Annual assessments, ending on or after Dec. 31, 2018, are the responsibility of counties or tribes. Provider agencies should submit a [Referral for Reassessment for PCA Services \(DHS-3244P\)](#) to the member's tribe or county of residence 60 days before the end date of a service authorization.

PCA Service Agreements

If a PCA provider does not receive a service agreement to continue services before Dec. 31, 2018, fax the [PCA Technical Change Request \(DHS-4074A\)](#) and a copy of the UCare service agreement to the Disability Services Division (DSD) Resource Center at 651-431-7447. State in the "Additional Information" section "for MCO transition."

Home Care Nursing Service Agreements

Home care nursing (HCN) service authorizations will transition to the Fee-For-Service (FFS) process through the medical review agent, KEPRO, as described in the [Authorization](#) section of the MHCP Provider Manual. HCN providers will continue to assess for HCN services.

If an HCN provider does not receive a service agreement to continue services by Dec. 31, 2018, submit the [Home Care Technical Change Request \(DHS-4074\)](#) and a copy of the UCare service agreement through MN-ITS or the KEPRO portal. State in the “Additional Information/Treatment Plan” section “for MCO transition.”

Changes Do Not Affect Other Health Care Services

Under this contract change, members will continue to be enrolled in UCare plans and UCare will continue to pay for their other health care services.

This contract change does **not** apply to Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+). UCare will continue to authorize and pay for PCA and HCN services for members enrolled in these plans.

Do you have questions?

Staff at UCare and DHS are ready to answer your questions. If you have questions, please call:

- **UCare Provider Assistance Center** at 612-676-3300, 1-888-531-1493 (toll free) or 612-676-6810 (TTY), 8 am – 5 pm Monday through Friday.
- **or**
- **Minnesota Health Care Programs (MHCP) Member Helpdesk** at 651- 431-2670 or 1-800-657-3739. TTY: Use your preferred relay service.

UCare Renames Three Products for 2019

UCare will change the name of three of its product lines beginning Jan. 1, 2019:

2018	2019
<i>UCare For Seniors</i> , a Medicare Advantage plan	UCare Medicare Plans
<i>UCare Choices</i> , through MNsure	UCare Individual & Family Plans
<i>Fairview UCare Choices</i> , through MNsure	UCare Individual & Family Plans with Fairview

Members received their new Member ID Cards with their 2019 health plan information, beginning November 2018. See samples of the [new ID Card design](#) on the provider website.

2019 Opioid Edits – All UCare Lines of Business

On Jan. 1, 2019, UCare executed several opioid edits in response to CMS’ requirement for enhanced management of the opioid misuse epidemic. These edits will be applied across all of UCare’s Medicare, Medicaid and Health Exchange plans except where specifically stated otherwise. Incorporation of these safety edits reflects our compliance and participation in the national effort to encourage appropriate opioid prescribing practices and to promote increased safety for our members. Below is a summary of the 2019 opioid overutilization edits:

- **Opioid-Naïve Patients:** Implementation of a day supply limit to reduce the potential for chronic opioid use or misuse. This hard safety edit (prior authorization required) at the pharmacy limits initial opioid prescription fills for the treatment of acute pain to no more than a 7-day supply. Subsequent fills will not be subject to this safety edit limit. Patients with cancer and those in palliative care, hospice or a Long Term Care setting are excluded from this edit.

- **Long Acting Opioids:** Implementation of a hard safety edit (prior authorization required) will be required for all long-acting opioid medications to ensure appropriate utilization and safe prescribing.
- **Medicaid and Health Exchange Opioid Quantity Limits:** Quantity limits will be in place for all opioids on all formularies to reduce the potential for opioid overutilization and misuse. For Medicaid and Health Exchange, quantity limits will restrict opioid prescriptions to an average daily morphine milligram equivalent (MME) of 90 mg. When the MME is exceeded, a hard safety edit will trigger at the pharmacy and require prior authorization.
- **Medicare Quantity Opioid Limits:** Implementation of a soft and hard formulary-level safety edit for opioids based on the member’s cumulative Morphine Milligram Equivalent (MME) at the point-of-sale to prevent potentially unsafe opioid dosing. The soft safety edit (i.e., can be overridden by the pharmacist) will trigger for an average daily MME of ≥ 90 mg. In addition, there will be a hard safety edit (i.e., requires prior authorization) that is triggered by reaching an average daily MME of ≥ 200 mg.

2019 Medicare Opioid Drug Management Programs

The Comprehensive Addiction and Recovery Act of 2016 (CARA), which amended the Social Security Act and was enacted into law on July 22, 2016, includes authority for Medicare Part D plans to establish drug management programs for “at-risk beneficiaries” effective on or after Jan. 1, 2019.

Specifically, under drug management programs, Part D plans will engage in case management of potential at-risk beneficiaries, through contact with their prescribers.

- Notable behavior includes a beneficiary taking a specific dosage of opioids and/or obtaining them from multiple prescribers and multiple pharmacies who may not know about each other.
- Case management with the prescribers occurs for the safety of the enrollee. Sponsors may then limit at-risk beneficiaries’ access to coverage of “frequently abused drugs” to a selected prescriber(s) and/or network pharmacy(ies).

Criteria for At-Risk Beneficiaries Identification

- Minimum Criteria (Required review potentially at-risk beneficiaries)
 - ≥ 90 morphine milligram equivalent (MME) AND either
 - 3+ opioid prescribers AND 3+ opioid dispensing pharmacies OR
 - 5+ opioid prescribers AND 1+ opioid dispensing pharmacies.
- Supplemental Criteria (Additional review as many at-risk beneficiaries as manageable)
 - Any Level MME AND
 - 7+ opioid prescribers OR 7+ opioid dispensing pharmacies.
- An exempted beneficiary
 - Has elected to receive hospice care or is receiving palliative or end-of-life care, or
 - Is a resident of a long-term care facility, of a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs (FADs) are dispensed for residents through a contract with a single pharmacy, or
 - Is being treated for active cancer-related pain.

Additional Information

The Medicare Claim Edits notices and instructions, as well as the policy and technical guidance for Drug Management Programs are posted on the CMS Part D Overutilization web page at:

<https://www.cms.gov/Medicare/Prescription-Drug-coverage/PrescriptionDrugCovContra/RxUtilization.html>.

Feb. 1, 2019: Enhanced Prior Authorization DME/Supply Form

UCare will launch enhanced prior authorization for Durable Medical Equipment (DME)/Supply Prior Authorization and Pre-Determination requests. The form enhancements will ensure that all of UCare's prior authorization forms have a similar look and feel, provide clear instructions for what is needed to efficiently process requests and reduce the amount of administrative time for the provider community.

The DME/Supply form has been reorganized and updated based on provider and UCare staff feedback. As we transition to the new form, UCare's Clinical Services team will reach out to providers who submit requests on the old forms and will inform and remind providers regarding the use of the new forms.

www.UCare.com/providers will have links to the updated forms effective Feb. 1, 2019. If you submit prior authorization requests to UCare, please ensure staff members are using the latest versions of the forms to avoid confusion.

Documentation Improvement: Myocardial Infarction (MI)

A myocardial infarction (MI) commonly known as a heart attack occurs when the flow of blood to the heart is blocked, causing damage to the heart muscles. Often, the blockage is caused by fat buildup, cholesterol and other substances. Risk factors include high blood pressure, obesity, diabetes, high blood cholesterol or triglyceride level, tobacco use, drug use, lack of physical activities, poor diet, among others. An MI can be fatal and is an emergent condition that is treated in an inpatient setting. Patients are usually seen in a physician's office for follow-up and ongoing care.

- If a patient is receiving ongoing care within four weeks of having an MI, assign current MI codes. In order to support these codes, document the date the MI occurred to help indicate that ongoing care is within four weeks of occurrence.
- For a patient receiving care beyond four weeks of having an MI, note the date of the MI and whether it's a follow up for an old MI or if it's for ongoing care. This will help to determine the correct code assignment.

The presence of any MI more than four weeks or healed MI is classified as an old myocardial infarction and should be assigned the old MI code. An old or healed MI not requiring further care should still be documented into the medical record. If after the four weeks the patient is still receiving care related to the MI, the appropriate aftercare code should be assigned.

Documenting Myocardial Infarction - when an MI occurs, document:

- If it's an ST-elevation MI (STEMI) or non-ST-elevation MI (NSTEMI)
- It's underlying mechanism (e.g., type 1, 2, 3, 4, or 5)
- It's location (e.g., anterior, inferior, lateral)
- Note the date of the MI in the medical record

Complete and accurate documentation will result in the appropriate diagnosis and ICD-10-CM code assignment. Documentation that clearly represents the specificity of the patient's diagnosis will support the patient's true health status, medical necessity and quality care management.

References:

Risk Adjustment Documentation & Coding; Bernard, Sheri Poe, CCS-P, CDEO, CPC, CRC; American Medical Association, 2018.
ICD-10-CM Expert for Provider and Facilities, Coding Guidelines; AAPC, 2019.

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