Accurate Member Information Is Key to Smoother Claim Submissions

Providers should ask for a current subscriber insurance card each time a subscriber presents for services and update information in their electronic records system to reduce rejected claim submissions or delayed claims processing.

The subscriber ID listed on the card or returned on the electronic eligibility and benefit transaction should be submitted on the claim exactly as provided. No digits should be added or excluded.

Please note that all UCare members have their own individual unique ID numbers.

Maintaining current insurance information for subscribers is imperative to successful and timely claims processing. Wrong member information can cause suspected fraudulent claims investigations and possible HIPAA violations, so please remember to verify that the information on the claim submission matches the information for the member receiving the service (name, member ID#, birth date, address, etc.).

Provider Reminder: Release of Information to UCare

As an in-network provider, you may be asked to provide information and documentation to UCare, including but not limited to patient medical records. These records are needed in order to support a variety of initiatives such as HEDIS audits, risk adjustment chart and quality reviews, utilization review programs, and/or other UCare investigations or inquiries into covered services. Please refer to your UCare Provider Participation Agreement to review your contractual obligations related to provision of this information.
Medicaid Nursing Home Claims Payments
January 1, 2019, UCare began applying real-time rates for Medicaid Skilled Nursing Facility (SNF) claims reimbursement payments using the Minnesota Department of Health (MDH) Nursing Home Report Card as provided by the Minnesota Department of Human Services (DHS). Learn more about the Nursing Home Report Card at http://nhreportcard.dhs.mn.gov/SearchLS.aspx

UCare will use Nursing Home Report Card rates for claims on Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO), UCare Connect and UCare Connect + Medicare health plans. Two pieces of information make this process possible:
1. Providers are required to be registered on the MDH website.
2. SNF rate information is loaded on the website and accessible to UCare.

Since Nursing Home Report Card does not support historical data, UCare will be applying real-time rates as of the claim processing date. Should a provider not be listed on the MDH website, the claim will be denied with a code of CARC CO163: Attachment/other documentation referenced on the claim was not received.

For payment dispute or claim denial due to not being listed on MDH website:
- Submit an appeal via the Provider Claim Reconsideration Request form. The form is found under “Forms & Links” with several options based on the type of submission.
- Attach the DHS rate letter that would be applicable to claim DOS.

Medicare Annual Wellness Visits
All Medicare beneficiaries are eligible for an Annual Wellness Visit (AWV) at no cost to them. Many times, clinicians are doing this preventive care at the same time as chronic disease management or other office visits. Are you getting your patients into your office at least once a year to dedicate time to the AWV?

Some of the valuable aspects of the AWV include the opportunity to:
- Perform a Health Risk Assessment and identify new areas of concern.
- Update/verify list of current care team providers.
- Assess for cognitive impairment and mood disorders.
- Establish a written health screening schedule and personalized prevention plan.
- Discuss advance care planning.
- Update and “refresh” HCC diagnoses for risk adjustment purposes.

UCare believes that all of our members benefit from having an AWV every single year. Please assist us in reaching that goal whenever you have an opportunity to see your Medicare patient in the office. If there is time to perform the AWV at the same time as another type of visit, please consider doing so – patients appreciate that convenience. If it is better for them to return for the AWV on a different day, please discuss the importance of the visit and schedule their next appointment before they leave your office. UCare will continue to try to engage those members who have not been seen at all in primary care.
**Transition to Patient Driven Payment Model Methodology for SNF Claims**

As previously communicated, UCare is supporting the Centers of Medicare and Medicaid Services (CMS) transition to Patient Driven Payment Model (PDPM) as of Oct. 1, 2019.

Per CMS, in order for providers to receive a Health Insurance Prospective Payment System (HIPPS) code, providers will need to complete an Interim Payment Assessment (IPA) with an Assessment Reference Date (ARD) no later than Oct. 7, 2019. Please follow the usual process outlined by CMS for completing the IPA (this information is handled by CMS, not UCare).

**Coding Changes for Adult and Children’s Mental Health Crisis Response Services for UCare State Public Program Products - Updated Oct. 7, 2019**

A new code-set has been legislated for Adult and Children’s Mental Health Crisis Response Services. Effective for claims with 2019 dates of service received on or after Nov. 1, 2019, UCare will require crisis response services to be submitted using HCPCS code H2011. One unit of service should be billed for each 15 minutes of care. Claims submitted with HCPCS code S9484 will be denied. For your convenience a coding crosswalk is provided below.

The legislated change is retroactive to Jan. 1, 2019. Although the units of service have changed, payment is intended to be budget neutral. UCare will not reprocess 2019 claims that have been previously processed.

### Adult Crisis Response Services

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Narrative Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9484</td>
<td>H2011</td>
<td></td>
<td></td>
<td>Adult crisis assessment, intervention and stabilization – individual by a mental health professional</td>
</tr>
<tr>
<td>S9484</td>
<td>HN</td>
<td>H2011</td>
<td>HN</td>
<td>Adult crisis assessment, intervention and stabilization – individual practitioner</td>
</tr>
<tr>
<td>S9484</td>
<td>HM</td>
<td>H2011</td>
<td>HM</td>
<td>Adult crisis stabilization – individual by mental health practitioner</td>
</tr>
<tr>
<td>S9484</td>
<td>HQ</td>
<td>H2011</td>
<td>HQ</td>
<td>Adult crisis stabilization – group</td>
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<tr>
<td>90882</td>
<td>HK</td>
<td>90882</td>
<td>HK</td>
<td>Community Interventions</td>
</tr>
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<td>90882</td>
<td>HK, HM</td>
<td>Community intervention by a mental health rehabilitation worker</td>
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### Children’s Crisis Response Services

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<thead>
<tr>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Narrative Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9484</td>
<td>UA</td>
<td>H2011</td>
<td>UA</td>
<td>Child crisis intervention mental health service (Mental Health Crisis Intervention and Stabilization)</td>
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<tr>
<td>S9484</td>
<td>UA, HN</td>
<td>H2011</td>
<td>UA, HN</td>
<td>Child crisis intervention mental health service (Mental Health Crisis Intervention and Stabilization) furnished by a qualified mental health practitioner or qualified clinical trainee</td>
</tr>
</tbody>
</table>
**Documentation Improvement: Current and Historical Conditions**

Oftentimes, the lack of specificity in documentation can cause confusion when it comes to current and historical medical conditions. When documenting, keep in mind that if a patient is receiving treatment for a condition, it should be documented as a current condition. The condition is considered to be active and the phrase “history of” should not be used in the medical record. If a condition no longer exists and it is no longer being treated, then using the phrase “history of” would be appropriate. History of indicates that the condition has been resolved and no longer requires medical management.

Examples of how to correctly document current and historical conditions:

- “History of COPD, albuterol refilled.” COPD should be documented as a current condition because the patient is using albuterol, which is being refilled.
- “History of breast cancer, continue tamoxifen.” Breast cancer should be documented as an active condition because the patient is still receiving treatment.
- “Stroke, balance improved.” Stroke should be documented as “history of stroke” as the patient is not actively having a stroke during the office visit.

Providers must be clear and concise in their documentation, so that conditions may be reported to the highest level of specificity. Active conditions need to be clearly identified, even those that coexist at the time of an acute illness. Also, be sure to include any treatment plans in the medical record. Accurate documentation will help eliminate any confusion and lead to better documentation and improve patient care.

**Ineligible Provider List Updated Sept. 27, 2019**

Contracted UCare providers must ensure that they, their company, owners, managers, practitioners, employees and contractors are not on the UCare Ineligible Providers List. Providers should search the list of UCare Ineligible Providers on a regular basis, and before hiring or entering into contracts with individuals to provide services or items to UCare members. Please reference Chapter 5 of the UCare Provider Manual for additional information.

Questions regarding the UCare Ineligible Providers List should be directed to compliance@ucare.org.