The Inside Story

Scott & White Health Plan
The one Texans trust.

Volume 20 Issue 1 SPRING 2014

It may have been the coldest winter on record in Central Texas, but at Scott & White Health Plan (SWHP), it was also one of the busiest! January 1st marked the launch of our new Medicare Advantage Plan, Vital Traditions, and many of you have been able to take advantage of the orientations we have offered either in a group setting or electronically. SWHP also began participating as a Qualified Health Plan (QHP) in the Federally Facilitated Exchange (FFE) on January 1st, ushering in a new and exciting time here at the health plan. As we continue into the year, there will be more exciting opportunities ahead, so stay tuned!

In This Issue

INTERIM CEO ANNOUNCED

March 21, 2014

We are pleased to announce that Marinan Williams has been selected as interim president and chief executive officer for the Scott & White Health Plan and Insurance Company (SWHP). She will begin as president and CEO on March 31, as current SWHP CEO Allan Einboden recently announced his retirement plans. Williams has served as the COO of SWHP since 2007. During that time, she has provided strategic direction for governmental programs, pharmacy/PBM programs, and the establishment of best-in-c1ass operations, as validated by SWHP's top ranking among Texas commercial and Medicare health plans.

"Marinan is the right person to lead the Health Plan at this critical juncture in health care," said Robert Pryor, MD, president and chief operating officer of Baylor Scott & White Health. "She has a wealth of knowledge and insight into our complex industry, and when we combine that knowledge with her previous experience as president of another large Texas insurer, we know the SWHP is in very good hands."

In February, Allan Einboden announced his retirement would be effective April 1, 2014. Einboden joined Scott & White Health Plan in 2000, serving as the chief executive for the last 10 years. In his retirement announcement to Health Plan staff, Einboden said his immediate plans are centered on spending time with his family.

"Allan and his exceptional leadership team have grown the Scott & White Health Plan into one of the most successful of its kind in the country," said Dr. Pryor. "Now Marinan, who has been part of that leadership team for nearly a decade, will continue the good work growing membership, growing provider relationships, and creating key business lines. Also, as she begins to implement her own team, we expect a seamless transition."

I hope you will join me in welcoming Marinan in her new role. We look forward to continuing to partner with you to offer the high-quality care our members have come to expect from the Scott & White Health Plan Provider Network. Please feel free to contact me if you have any questions.

Sincerely,

Maria C. Lima-Leite MPA/HA
Vice President of Medical Delivery Development

Vital Traditions

Dual Eligible Special Needs (D-SNP) Plan

2014 Model of Care Training

As a participating provider for Scott & White Health Plan's (SWHP) Medicare Advantage Dual Eligible Special Needs (D-SNP) Plan, we have created an online training for you to take on our Model of Care (MOC). The training is a Centers for Medicare and Medicaid Services (CMS) requirement. Therefore, it is mandatory that all providers and their staff (as applicable) complete the MOC training. The training plus the short quiz takes approximately 25 minutes to complete. You can access the training any time of day at the following web address: https://swhp.org/providers/training-education.

Helpful Tips:

- To maximize the screen, please click the button located in the bottom right hand corner of the screen.

Maximize screen button =	

- When taking the quiz, please utilize the "Submit" and "Continue" buttons located within the same screen as the questions.

- Once you have successfully viewed all of the slides and answered at least 9 out of the 10 questions correctly, a completion certificate will be emailed to you.

Please contact the Provider Relations Department at (254) 298-3064 or (800) 321-7947, ext. 203064 if you have any questions.

Your Provider Transition to ICD-10

Although CMS has delayed implementing the transition from ICD-9 to ICD-10 to October 1, 2015, there's no reason to delay preparing for it! When you consider the magnitude of work that needs to be completed, advance planning and education are crucial for success. NOW is the time to prepare, though it may be challenging and even overwhelming. Scott and White Health Plan is here to support you with your ICD-10 preparation. We will have a series of presentations available on our Provider Portal that include links and resources that you can use to answer questions and assist you in the transition.

ICD-10-CM – What's Changing?

1. **ICD-10 codes are more specific:** This will require more specificity in your documentation as well as your clinic practices. Even a straightforward condition such as acute otitis media has expanded from one code to 16! Be aware of the fact that diagnosis codes have expanded from **13,600** codes in ICD-9 to over **69,000** in ICD-10 when creating new superbills, documentation templates and training processes.
2. **ICD-10 codes consist of 3-7 characters:** ICD-9 codes have 3-5 characters.
3. **The code book in 10 has 21 chapters:** There are 17 chapters in ICD-9.
4. **ICD-10 diagnosis codes always begin with a letter:** Most ICD-9 codes begin with a number, except for V and E codes. ICD-10 utilizes all alpha characters except "U"
5. In contrast to **ICD-9**, which **classifies injuries by type, ICD-10 groups injuries first by specific site** (e.g., head, arm, leg) **and then by type of injury** (e.g., fracture, open wound)
6. **Certain diseases have been reclassified/reassigned** to a more appropriate chapter in I-10. For example, gout has been reclassified from the endocrine chapter in I-9 to the musculoskeletal chapter in I-10.

ICD-10-CM - What Stays the Same?

Take heart! Not everything is different about ICD-10-CM. Finding codes in ICD-10 mirrors the processes in ICD-9. So, finding those codes will feel a lot like it does now, but there will be a lot more choices.

ICD-10-CM continues to have the same structure as ICD-9, wherein the first three characters are the category of the code and all codes within the category have similar traits

There is still an Alphabetic and a Tabular index:

- The alphabetic index is still divided into two parts: the Index to Diseases and Injury and the Index to External Causes, similar to ICD-9-CM
- Within the Index to Diseases and Injury there is a 'Neoplasm Table' and a 'Table of Drugs and Chemicals'
- The Alphabetic Index has the same formatting as ICD-9-CM

Transition Takeaways:

- All physician encounters **MUST** be submitted with **ICD-10-CM** diagnoses on **October 1, 2015**
- Claims for dates of service **prior to October 1, 2015** will be submitted with **ICD-9-CM codes**
- Inpatient physician encounters will be submitted using the guidelines for the date of DISCHARGE
- **Physicians will continue to use CPT for any procedures or surgeries, even after October 1, 2015**

Please feel free to contact us with your ICD-10 questions and concerns. The Scott & White Health Plan ICD-10 Transition Team is always happy to help!

Susan Waterman, CCS, CPC, AHIMA ICD-10-CM/PCS Trainer
slwaterman@sw.org

Checklist for Patients for the Office

"The palest ink is better than the best memory."

Chinese Proverb

We all want our patients to achieve the best healthcare outcomes possible, and work to partner with our patients in the management of their healthcare needs. Each and every office encounter is an opportunity to make a difference with our patients. The more prepared our patients are for this encounter, the better we can work together to meet their needs.

Please review the checklist below. Scott & White Health Plan will be communicating this to our members – your patients – and encourage you to use a checklist with your members to help them prepare for their visit.

Checklist for Patient in Preparation When Seeing Health Care Provider

As you get ready for seeing your doctor or other health care provider, reviewing the following checklist will help you prepare:

1. **What is the main reason for your visit?**
   What is it you want the Health Care Provider to do - such as an annual checkup, or what is the main problem you want the Health Care Provider to be sure to look at? Write this down and bring with you any documents you may need, such as copies of previous tests or procedures, and prior medical history related to this condition.
2. **Forms and/or Papers to sign**
   Do you have forms you need the Health Care Provider to sign or complete? Please let the Health Care Provider's staff know about this at the beginning of your visit.
3. **Questions regarding a condition**
   To make the most of your appointment, be sure to express to your Health Care Provider any questions or concerns you have. Do you have any questions or concerns regarding a condition you have, such as diabetes or high blood pressure? Please write down what you may need, such as refills, questions about immunizations or lab results and give to the staff person escorting you to the exam room. And let the office staff know in advance when you schedule, if you can, so they can arrange for the time you need.
4. **Medications**
   Please bring a complete list of the medications you are currently taking. If you are having concerns or problems, including financial, please discuss with the Health Care Provider.
5. **What do you need to do when you leave the office?**
   Has the Health Care Provider instructed you to do anything new, given you any new medications, or changed any of you medications – *be clear before you leave the office*.

Your Health Care Provider wants you to have the time and attention necessary for each of your concerns, and may ask you to schedule a follow up visit to finish addressing your needs based on the time available for the initial appointment.

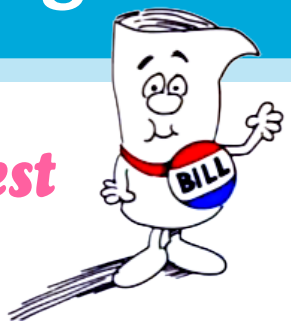
Take an active role in your health. You will be glad you did!

As always, we appreciate your ideas and feedback. Thanks for reading and for the quality work you do.

Michael Hawkins, MD, MSHA
SWHP Medical Director

Medical Management

How a *Request* becomes an *Authorization*



Several steps occur for an authorization. The doctor or referral coordinator sends a request to the Health Plan via a fax or a provider portal (still in creation phase). The Clinical Care Coordinator (CCC) then determines whether it meets contract regulations and medical necessity requirements. In 80% of the cases both are met and an authorization is issued.

If one of the criteria is not met, the CCC asks the UM (utilization management) medical director to review the case with 3 potential outcomes: 1. Authorization, 2. Benefit Denial, or 3. Medical Necessity Denial.

1. Authorization (~60%): Request meets all requirements.

   ***f/u: nothing further needed.**

2. Benefit or contract denial (~25%): Regulations are set up by the contract. Examples:
   A. Patient must use a network, contracted provider.
   B. Patient must use a formulary medication, or the equivalent alternative.
   C. Some services are specifically excluded; ie. acupuncture.

   A benefit denial cannot be overturned on a peer-to-peer call; the decision is based on a legal, binding document. (You may appeal a benefit denial; however, those are rarely overturned.)

   ***f/u: doctor or patient may initiate an appeal via customer service, 254-298-3000.**

3. Medical necessity denial (~15%): National evidence-based medical standards are followed to determine medical necessity, such as InterQual®, Milliman®, Hayes®, ABIM Choosing Wisely®, specialty society guidelines, as well as other sources. The physician's office is notified of a potential denial; and the requesting physician has 24 hours to discuss the case with the reviewing medical director per Texas Department of Insurance (TDI) guidelines for a peer-to-peer call. After 2 days the denial is completed (as required by TDI); then the doctor or the patient would need to proceed to an appeal rather than a peer-to-peer. TDI's regulations must be followed and health plans are audited to ensure rules are met, so there is no leeway in the requirements.

   ***f/u: doctor notified of possible denial.**

   A. Call within 24 hours to discuss with a medical director (peer-to-peer) if more medical information exists.
   B. Denial complete at 2 days. After this stage, denial must go to appeal.

   ***f/u: doctor or patient may initiate an appeal via customer service, 254-298-3000.**

Next we will look at how an appeal progresses through the system.

When is a peel not a banana skin? When it's APPEAL.

What are my options after an authorization request is denied? Either the patient or the physician may initiate an appeal.

1. FAX appeal request to: 254-298-3663 (HIPAA secure line and frequently checked)
   - Cover sheet with physician's contact person and number
   - Include patient name, ID #, DOB
   - Case ID #, if known
   - Reason for appeal and supporting information
   - Write "expedited" on fax if true medical urgency exists

OR

2. Call SWHP customer service at 254-289-3000 to relay the information verbally to a customer service representative on non Medicare LOB.
   - First menu: Press 2 for provider.
   - Second menu: Press 1 for benefit or eligibility choice, as there is not a separate one for appeals.

Advantages of faxing (vs. phone) -

- ***no hold times***
- ***information may be more accurate as less scribing required***
- ***Physician not required to come to phone to request "expedited"***
- ***all lines of business (LOB) accepted by fax (CMS does not allow any Medicare LOB to use verbal appeals)***

The information is sent up to dispute resolution for review by a different medical director with the additional information, the contract requirements and other EBM reviews.

TDI allows 30 days to complete a standard appeal, but only 24 hours for an expedited appeal. Only a physician (not staff) may request an expedited appeal and it must be for medical urgency, not for convenience.

If the doctor or patient still feels that the request should be covered by the insurance company, the next step is an IRO, Independent Review Organization. The IRO, which is independent of all involved parties, reviews the information to determine whether a health care service is medically necessary and appropriate or experimental/investigational. Government health products, such as Medicare, use MAXIMUS. This is the final appeal level.

Some people see things that are and ask, Why? Some people dream of things that never were and ask, Why not? Some people have to go to work and don't have time for all that.

...George Carlin

Outpatient and Ambulatory Surgical Center (ASC) Policies

We updated our claim payment system effective February 1, 2014 with the most recent versions of national and industry standards to provide greater consistency in claim processing. These standards include the Centers for Medicare and Medicaid Services (CMS) Outpatient Code Editor (OCE) policies, Outpatient Prospective Payment System (OPPS) guidelines, national coding policies and guidelines, and revenue code policies.
These standards include the following examples:

1. CMS Outpatient Code Editor (OCE) and Outpatient Prospective Payment System (OPPS) policies and guidelines are applied to facility outpatient claims (bill types 12X, 13X, or 14X) for accurate billing (units of service, correct modifiers, etc.) and to review HCPCS and ICD-9-CM codes for validity and coverage.

2. Evaluation and Management (E&M) services on the same day as a medical or surgical service are included in the payment for the medical or surgical service, unless the claim indicates that the E&M service is separate and distinct from the medical service or surgery.

3. AMA, HCPCS, and ICD-9-CM code descriptions and guidelines support correct coding based on the definition or nature of a procedure code or combination of procedure codes.

4. Revenue code policies ensure that the revenue code billed is appropriate for use with outpatient hospital claims. Revenue codes are 4-digit codes used to classify types of service. They are required for accurate hospital outpatient claims processing. Revenue codes will be required for processing of all outpatient facility claims. If revenue codes are not present on a claim line, the claim may not be considered for reimbursement. Certain revenue codes are not appropriate for use with outpatient hospital claims billed by facilities.

5. Ambulatory Surgery Center (ASC) claims will be reviewed with applicable CMS ASC guidelines.

6. The National Correct Coding Initiative (NCCI) is a collection of policies created and sponsored by CMS that are separated into two major categories. The first category contains the column I and column II procedure code combinations. The second category contains the mutually exclusive procedure code combinations.

7. Services and supplies will be considered for reimbursement when submitted with appropriate codes, modifiers, diagnoses, gender, age, place of service, revenue code, bill type, condition code, related or qualifying service, and number of units.

8. Revenue codes should be reported in conjunction with the related procedure or HCPCS code.

9. Professional, technical, and global services should be reported in the appropriate circumstances, consistent with the nature of the component or global service. Supplies and equipment are not reimbursable as professional services in a facility setting. Professional services are not reimbursable to facilities unless the facility is submitting a claim for professional services with the appropriate revenue code.

New Quality Claim Review Program

In an effort to maintain the quality and integrity level of medical practitioners providing services to Scott & White members, a new Quality Claim Review Program is now being initiated at SWHP. Provider practices are randomly selected for review and approximately 20 patient records are then requested from the practice for review. In addition to the documentation of care provided, the ICD-9 coding for the provided services is also being reviewed. If you are one of the provider offices chosen for review you will be notified by mail.

If your practice is selected to participate, please know that this review is not meant to be intrusive, but rather so we continue to provide the excellent service that you have become accustomed. SWHP asks that you comply with the Quality Claim Review request and return the requested records and associated documentation promptly. Thank you for your continued support in providing quality service to our members!

Members Rights and Responsibilities

Rights:

1. You have the right to be provided with information regarding member's rights and responsibilities.
2. You have the right to be provided with information about Scott & White Health Care, its services, and practitioners providing member's care.
3. You have the right to be treated with respect; member's providers and others caring for member will recognize his/her dignity and respect the need to privacy as much as possible.
4. You have the right to participate in decision-making regarding member's health care.
5. You have the right to have candid discussions of appropriate or medically necessary treatment options for member's conditions, regardless of cost or benefit coverage.
6. You have the right to voice complaints or appeals about the coverage through Scott & White Health Plan or care provided by SWHP providers in accordance with member's Health Care Agreement.
7. You have the right to make recommendations regarding Scott & White Health Plan's member rights and responsibilities policies.
8. You have the right to have an Advance Directive such as Living Will or Durable Power of Attorney for Health Care Directive, which expresses member's choice about future care with the ability to make decisions if member cannot speak for himself/herself.
9. You have the right to expect that medical information is kept confidential in accordance with member's Health Care Agreement.
10. You have the right to select a Primary Care Physician (PCP) to coordinate your health care. PCP selection is not a requirement.

Responsibilities:

1. The responsibility to notify SWHP regarding any out-of-plan care.
2. The responsibility to follow SWHP instructions and rules and abide by the terms of your healthcare agreement.
3. The responsibility to provide information (to the extent possible) the organization and its practitioners and providers need in order to provide care.
4. The responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
5. The responsibility to follow plans and instructions, to the best of you ability, for care you have agreed on with your practitioner(s) and provider(s).
6. The responsibility to give SWHP providers a copy of an Advance Directive, if one exists.
7. The responsibility to advise SWHP or SWHP providers of any dissatisfaction you may have in regard to your care while a patient, and to allow the opportunity for intervention to alter the outcome whenever possible.

Automated Voice Response Unit for Eyewear Providers

Do you want to save time? Did you know that Eyewear providers can verify a member's eligibility and obtain benefit information through our voice response unit?

Eyewear providers, please call our toll free number (1-800-655-7947) and follow the prompts.

Compliance Corner

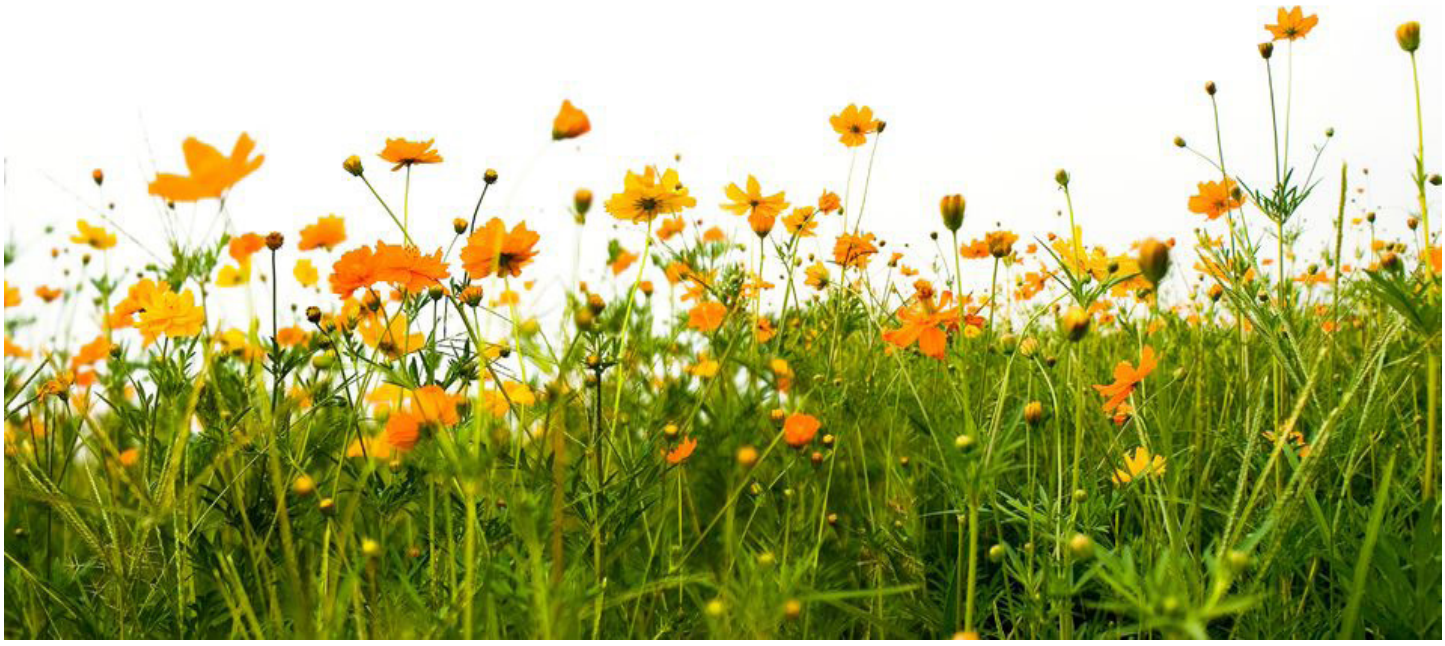
REMEMBER YOUR FWA TRAINING!

The Centers for Medicare and Medicaid Services (CMS) requires Providers who perform services for Medicare members to complete Fraud, Waste and Abuse training on an annual basis. CMS states that Managed Care plans must provide this training to its First Tier Downstream and Related Entities. SWHP offers a FWA training on our website at www.swhp.org or you may choose to take the training through another venue who offers an equivalent training. If you choose to complete the training through another venue, SWHP requires that you attest that you and your staff have completed the mandatory Fraud, Waste and Abuse training. Attestation is available through our website.

Pamela O'Bannon
Compliance Officer

Also, please be aware that the OIG has begun a Provider Education series and the first topic is "Understanding Fraud, Waste and Abuse". You may check out the series at the following website http://oig.hhsc.state.tx.us/oigportal/ProviderEducation.aspx.

If you suspect fraud, please contact the Compliance Officer, Pamela O'Bannon, or report it anonymously through the Hotline (1-888-484-6977).



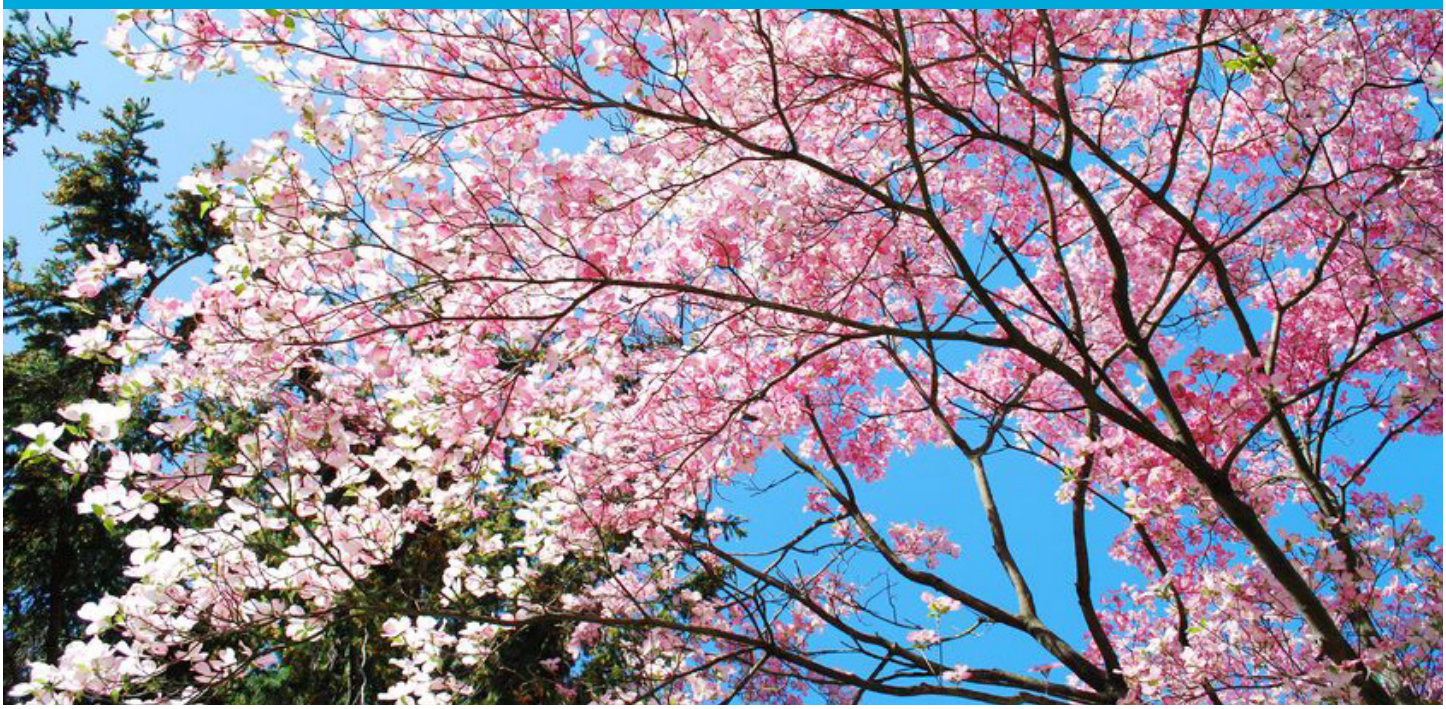
The SWHP Pharmacy and Therapeutics (P&T) Committee meets monthly to review drugs and policies.

You can find formulary updates, formularies/preferred drugs lists (PDLs), prior authorization criteria and prior authorization forms at https://swhp.org/providers/pharmacy-services

SWHP P&T Formulary Changes (January & February 2014)

Medication	Copay	Comments	Indication(s)	SWHP Formulary Alternatives	Effective Date
Quillivant XR® (methylphenidate)	**SWHP Tier 3**	Age Limit (max of 8 years old)	Indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD)	Daytrana® methylphenidate solution	3/1/2014
Imbruvica® (ibrutinib)	**SWHP Specialty Formulary- Tier 1** **SWHP Exchange Formulary-Tier 4** **MCD-Tier 5 (specialty)**	Prior authorization required	Indicated for the treatment of patients with mantle cell lymphoma (MCL) who have received at least one prior therapy	Velcade® Revlimid®	3/1/2014
Xiaflex® (collagenase clostridium histolyticum)		Revision of prior authorization criteria			3/1/2014
Eylea® (aflibercept)		Revision of prior authorization criteria			3/1/2014
Crestor® (rosuvastatin) 5mg, 10mg, 20mg	**SWHP Non-formulary**	**Tier change:** move from Tier 2 to non-formulary status		atorvastatin simvastatin lovastatin pravastatin	5/1/14 for new starts; plan year for current users
Vytorin® (ezetimibe/simvastatin)	**SWHP Non-formulary**	**Tier change:** move from Tier 2 to non-formulary status		atorvastatin simvastatin lovastatin pravastatin	5/1/14 for new starts; plan year for current users
Benicar® (olmesartan) **Benicar HCT® (olmesartan/hydrochlorothiazide)**	**SWHP Non-formulary**	**Tier change:** move from Tier 2 to non-formulary status		irbesartan irbesartan/hctz losartan losartan/hctz candesartan candesartan/hctz valsartan/hctz	5/1/14 for new starts; plan year for current users
Actemra® Sub-Q (tocilizumab) **Orencia® Sub-Q (abatacept)**		Revision of prior authorization criteria			4/1/2014

Our Friday FOCUS editions may be found at https://swhp.org/about-us/news/newsletters/providers-friday-focus



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The one Texans trust.

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