SelectHealth works hard to limit our impact on the environment. Our campus in Murray received the LEED® Silver award from the U.S. Green Building Council for its energy-efficient design, landscaping, and other environmentally conscious features. We also have an extensive recycling program, and we strive to practice wise use of resources. In addition to these efforts, beginning in February 2015, Provider Insight will be redesigned and available online only.

You’ll continue receiving information important to your practice, including updates to programs and medical policies, helpful tips, announcements, and more, but the newsletter will be designed in a bulletin format rather than as a tabloid. The new design will enable us to deliver information in a more timely manner. Additionally, rather than receiving Medicare or Medicaid information semi-annually, this information will be included in every edition. Each program will have its own clearly marked section to help you quickly find the information that applies to you.

For the first year, we will mail you notifications in the form of a postcard whenever a new Provider Insight is available. The postcard will provide a link to the online location. In addition to being the environmentally responsible solution, having the newsletter online enables us to produce information more quickly and makes it easier to share with everyone in your office. If you would like a paper copy of the newsletter, call your Provider Relations representative, and we’ll be happy to e-mail a copy for you to print.

Here’s a sneak peek at our new banner design!
Adolescent Well Care

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed healthcare plans. Adolescent well-care visits are one measurement tracked by HEDIS. You can find more about this HEDIS measure online at qualitymeasures.ahrq.gov.

Adolescent well-care visits provide an opportunity for the prevention or early intervention of many developmental and behavioral problems that can affect adolescents and young adults. According to the Official Journal of the American Academy of Pediatrics, child healthcare differs from the usual outcomes of medical care. Vulnerable periods during childhood may result in large differences in development and adult function. New research suggests that two different directions (mitigation and optimization) are important for the changes in a child’s development trajectory into adult functioning.

This measure tracks the percentage of members ages 12 to 21 who received at least one comprehensive well-care visit with a Primary Care Physician (PCP) or an Obstetrics and Gynecology (OB/GYN) practitioner during the measurement year. As shown in the following graph, SelectHealth has improved the rate of well-adolescent visits during the past few years, but our rates are still considerably lower than national benchmark rates.

We are performing the following measures to ensure our adolescent and young adult members are receiving appropriate well-care exams:

- Published preventive care guidelines that indicate how often well-child exams should occur
- Interactive voice response telephone call and letters to parents reminding them to take their adolescent in for a yearly exam
- Monthly reports mailed to providers that detail the names of their SelectHealth patients who have not had exams in the last year; this can also be accessed securely online
- Adolescent well-care visits are also part of the Primary Care Incentive Program for Pediatricians

If you would like more information on adolescent well-care visit results or would like to learn more about other SelectHealth Quality Improvement programs, contact the Quality Improvement department at 800-374-4949 or qualityimprovement@selecthealth.org.

Reference:

Care Process Model Reminder

The Intermountain Healthcare Care Process Models (CPMs) summarize current medical literature and, where clear evidence is lacking, provide expert advice on diagnosing and treating chronic conditions. Current CPMs include diabetes, asthma, depression, ADHD, and others.

The CPMs can be accessed by visiting intermountainphysician.org, selecting “Clinical Programs,” and clicking on the specific condition in the “Select a Topic” menu on the right-hand side of the page. You may also request a hard copy of a CPM by calling Intermountain Patient and Provider Publications at 801-442-2963.
We recently launched an initiative called Every Patient, Every Year to encourage members to see their PCP. The reasons for this initiative include the following:

1. Improve the health and wellness of the SelectHealth population
2. Improve quality indicators for HEDIS and Medicare Star ratings
3. Accurately document and code all chronic medical conditions

Commercially insured SelectHealth members may be seen for a Preventive Exam (CPT codes 99381-99387 and 99391-99397) with no out-of-pocket cost for most members or for an E&M visit (CPT codes 99201-99205 and 99211-99215), which will require a copay or coinsurance. If the member’s deductible has not been met, there may be additional costs. A Preventive Exam and an “established patient” E&M code (CPT codes 99211-99213) may be billed on the same date of service if a Modifier -25 is attached to the E&M code and the documentation supports coverage of both services.

For SelectHealth Advantage (Medicare) members, we cover a preventive exam (CPT codes 99385-99387 and 99395-99397) with no out-of-pocket cost for the patient. A Preventive Exam can be combined with an Annual Wellness Visit (AWV) (HCPCS codes G0438 and G0439) or an E&M visit (CPT codes 99211-99213) on the same date of service, and we will pay the provider for both codes on the same date of service when Modifier -25 is attached to the AWV and documentation supports coverage of both codes. A copay will apply if an E&M code is billed.

Here are some tips to ensure your documentation is accurate and completely reflects the member’s health:

Document Every Condition, Every Year:

> Schedule and see every patient annually

Include This Information with Every Record:

> Patient Name
> Provider Signature and Credentials (MD, DO, NP, etc)
> Date of Service

- **MEAT** for each Diagnosis (Parenthesis notes where to put this in a SOAP note)
  - Monitored – Include that you asked about current status of the condition (Subjective HPI)
  - Evaluated – Exam or lab/imaging findings (Objective PE)
  - Assessed – Note the current medical status of their condition (Assessment)
  - Treated – Record the treatment plan (Plan) – (“Continue current plan” if current plan is noted as well)
Every Patient, Every Year

Document All Relevant Conditions Yearly:

> Chronic conditions (diabetes, heart failure, COPD)
> Active status conditions (amputations, ostomy)
> Pertinent past conditions (previous cancers, previous stroke)
> All conditions being treated with medication

Be Specific:

> Major depression (vs. depression)
> Chronic bronchitis (vs. bronchitis)
> Atrial fibrillation (vs. dysrhythmia)
> Chronic kidney disease should be staged I-IV
> Skin ulcer (vs. open wound)
> Morbid obesity with BMI >40 (vs. obesity)
> Chest pain (vs. angina)
> Malnutrition (vs. weight loss)

Code Multiple Conditions When Applicable:

> Diabetes with retinopathy/nephropathy/neuropathy
> Coronary artery disease with previous MI/hypertension/hyperlipidemia/Afib/angina
> CVA with hemiplegia/dysarthria/dysphagia
> CKD with staging (I-IV)/dialysis status
> Cirrhosis due to alcohol dependence
> Infection with organism (if known)

Include Psych Diagnoses:

> Major depression
> Lifetime illnesses (schizophrenia, bipolar)
> Alcohol/drug dependence

Avoid “Rule Out” As The Diagnosis:

> This must be included as part of the documentation plan

Specific information that defines the conditions listed at the code level may be obtained from your SelectHealth Provider Relations representative. Incorporating correct documentation and coding practices for every visit helps ensure the chart is complete if a medical record review is ever required.

WHAT’S NEW?

Have you had providers leave your practice? New providers coming in? Changes of address, phone numbers, operating hours? We’d like to know! It’s important that our members have access to correct information when they’re viewing our online Provider Directory. CMS and NCQA require us to have correct information available to our members. Please take a moment to review your practice information on selecthealthphysician.org, then click on “Provider & Facility Search.” To update your information, contact your Provider Relations representative at 800-538-5054.
Identifying SelectHealth Advantage (HMO-POS) Members

Members must present their SelectHealth Advantage ID Card at the time of service.

If a patient doesn’t have their member ID Card, verify eligibility in one of the following ways:

• **Online** – Log in to “Secure Content Log in” at selecthealthphysician.org and click on “Provider Benefit Tool,” then “Find a Patient or Member.”
• **EDI** – Select electronic transaction code 270/271.
• **Member Services** – Call 855-442-9900 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 3:00 p.m. TTY users should call 800-346-4128 (Utah), 800-377-3529 (Idaho), or 711.

Prior Authorization

We follow the SelectHealth Advantage list of services requiring prior authorization. Visit selecthealthphysician.org and select “Government Programs.”

If prior authorization is not obtained for services that require it, coverage for these services will be denied. Please refer to the Provider Reference Manual for additional information.

Member Eligibility, Benefits, or Claims Status

Contact Member Services at the number listed above.

Submitting Claims

• **Paper Claims**
  SelectHealth
  P.O. Box 30196
  Salt Lake City, UT 84130

• **Electronic Claims**
  Contact Electronic Data Interchange (EDI) at 801-442-5442 or edi@selecthealth.org for information about electronic filing.

Member Billing

Covered Services

• Contracted providers may not balance bill members. Members are only required to pay the applicable plan cost sharing (copay or coinsurance) for covered services. They cannot be billed for the difference between the billed charges and our allowed amount.

Noncovered Services

• Contracted providers may only bill members the cost of noncovered services if they have followed the preservice denial process defined by SelectHealth. A copy of this process titled “Balance Billing Flyer” may be found by visiting https://physician.intermountain.net/selecthealth/Documents/2802_Balance_billing_flyer.pdf.

Care Management Services

Care managers are nurses who offer ongoing support for enrollees with acute and chronic health conditions. Care managers perform the following functions:

• Evaluate members’ utilization patterns
• Provide hospital discharge assessments for the following care and evaluation:
  > Appropriate post-acute care placement in skilled nursing facilities, inpatient rehabilitation, or home care
  > Evaluation of resources to meet outpatient needs
• Screen enrollees for risk of readmission at the time of discharge from an acute care facility
• Ensure compliance with CMS guidelines
• Advocate for enrollees and caregivers

Questions, Concerns, and Comments

For more information, visit selecthealthphysician.org. To post a question, concern, or comment, log in to the “Secure Content” section and click on “Government Programs.” Type your comment in the “What’s Up Doc” section.
SelectHealth Advantage Expanding Into New Counties

With the success of SelectHealth Advantage in Davis, Iron, Morgan, Salt Lake, Utah, Washington, and Weber counties, we’re expanding our network into Box Elder, Cache, Rich, Sanpete, Sevier, Summit, and Wasatch counties. Medicare beneficiaries may enroll in SelectHealth Advantage plans during Open Enrollment, which runs from October 15 through December 7, and will be eligible for coverage beginning January 1, 2015. If you are new to the SelectHealth Advantage network, visit selecthealthphysician.org and click on “Government Programs” to review the requirements for participation.

Fraud, Waste, and Abuse Training Now Available

CMS requires Medicare Advantage plans to provide Fraud, Waste, and Abuse (FWA) training and compliance information to their contracted partners on an annual basis. Watch your mail (e-mail or postal service) for a letter from SelectHealth providing instructions on how to access the training materials and complete the annual attestation. Visit selecthealthphysician.org and click on Educational Opportunities to complete this requirement early. We appreciate your commitment to compliance, and thank you for helping us do our part to combat fraud, waste, and abuse by completing this important training.

New CMS Authority to Directly Request Information From First-Tier, Downstream, and Related Entities (FDRs)

In a final rule effective July 22, 2014, the Centers for Medicare & Medicaid Services (CMS) was granted regulatory authority to collect information and records directly from a Medicare Advantage (MA) plan’s First-tier, Downstream, and Related entities (FDRs). This right comes from CMS’s authority to regulate the contractual provisions between MA plans and their FDRs. If you receive a request from a federal regulatory agency or contractor related to services rendered under your agreement with SelectHealth, please contact us immediately so we can assist you with it.

Medicare Advantage Plan Marketing in the Healthcare Setting

The Medicare Advantage Annual Enrollment Period (AEP) begins October 15 and continues through December 7. This is the time your patients may inquire about your affiliations with Medicare Advantage plans as they assess their enrollment options for the upcoming plan year. Please keep in mind that CMS has specific guidelines for marketing activities by a provider and those that take place in a healthcare setting, such as a provider office. SelectHealth has prepared a summary of those requirements with quick reference “dos” and “dons’t” to assist you with these requirements. Please visit selecthealthphysician.org and click on Government Programs for more information.

Medicare Part B Versus Part D Benefits

Prescription medications for SelectHealth Advantage members may be covered under their Medicare Part B medical benefit for outpatient service or Medicare Part D pharmaceutical benefit for pharmacy services, depending on the type of medication. Here are some general guidelines:

Medicare Part B prescription drugs*
Claims for these types of medications are paid as part
of the member's medical benefit and include the following types of medications:

- Drugs that usually aren’t self-administered by the patient and are injected or infused in a physician, hospital outpatient, or ambulatory surgical center setting
- Drugs administered by durable medical equipment (such as nebulizers)
- Clotting factors members with hemophilia self inject
- Immunosuppressive drugs, if the member was enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, or Aranesp®)
- Intravenous immune globulin for the home treatment of primary immune deficiency diseases

*Prior authorization is required for certain drugs covered under Medicare Part B. Visit selecthealthphysician.org and click on “Pharmacy” to learn more.

**Medicare Part D prescription drugs**

Most medications that are covered by the Part D benefit are dispensed from a retail or mail-order pharmacy. Benefits for different medications are classified as follows and are paid through the member’s pharmacy benefit:

- Preferred generic drugs
- Nonpreferred generic drugs
- Preferred brand-name drugs
- Nonpreferred brand-name drugs
- Specialty drugs

On occasion, a physician’s office will administer a medication that applies to the member’s pharmacy benefit. For example, Zostavax®, the vaccine to protect against the shingles virus, may be administered by a physician or a pharmacy. Regardless of where it is administered, the vaccine and administration are paid under the pharmacy benefit. If a claim for Zostavax is submitted as a medical claim, the claim will be denied under the medical benefit then forwarded to the Pharmacy department for processing and payment. In this situation, the provider will receive two remittance advices: the first denying the medical benefit, followed by payment under the pharmacy benefit.

For questions about what injectables are applied to the member’s pharmacy benefit, call Medicare Pharmacy Services at 855-442-9988.

SelectHealth identifies many of the drugs in this letter by their respective trademarks, but SelectHealth does not own those trademarks; the manufacturer or supplier of each drug owns the drug’s trademark. By using these trademarks, SelectHealth does not endorse or sponsor any drug, manufacturer, or supplier. And these manufacturers and suppliers do not endorse or sponsor any SelectHealth service or plan and are not affiliated with SelectHealth.
All SelectHealth medical policies and technology assessments can be viewed on selecthealthphysician.org. Click on “Policies and Procedures” on the left side of the page.