



Mississippi | Winter 2018

# practice**matters**



## For More Information

Call our Provider Services Center at **800-557-9933**

Visit **[UHCommunityPlan.com](http://UHCommunityPlan.com)**

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We hope you enjoy the Winter edition of Practice Matters. In this issue, you can read about Dual Special Needs Plan expansion, managing members with diabetes, helping members avoid the emergency room for dental issues, and much more.



## Important information for health care professionals and facilities

### Dual Special Needs Plan Expands

On Jan. 1, 2019, UnitedHealthcare Community Plan began serving even more eligible members in Mississippi with its Dual Special Needs Plan (DSNP) — UnitedHealthcare Dual Complete, a Medicare Advantage plan. The plan has expanded to the following Mississippi counties for 2019:

- George
- Holmes
- Lawrence
- Marion
- Quitman
- Scott
- Simpson
- Smith
- Stone
- Yazoo

In addition to these new counties for 2019, the plan continues to serve members in Benton, Copiah, DeSoto, Hancock, Harrison, Hinds, Jackson, Lafayette, Madison, Marshall, Panola, Rankin and Tate counties.

This is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid. DSNPs are a specialized type of Medicare Advantage Prescription Drug Plan (MAPD) and must follow existing Centers for Medicare & Medicaid Services (CMS) rules. The UnitedHealthcare Dual Complete Program will reimburse claims according to your UnitedHealthcare contractual Medicare Advantage payment appendix.



Visit [UHCprovider.com/MSDSNP](https://UHCprovider.com/MSDSNP) for additional information on the plan or check out the 2019 Dual Complete educational series available on the Mississippi channel of UHC On Air in the Link application.

### Facility-to-Facility Transfers

We require prior authorization for transfer to another facility. This requirement continues case management activities, and helps ensure medical necessity and quality of care. This process should not stop or hinder any emergency transfers, but the receiving facility is required to notify us of the transfer.

For ambulance providers, facility-to-facility ground transports don't require authorization, but transportation providers should make certain the correct modifiers are used when submitting the claim.

### Encourage Members to Get Annual Flu Shot

It's not too late to encourage members ages six months and older who do not have a contraindication to get their annual flu shot. Your office can also follow these practices:

- Establish standing orders for the vaccine. For more information on implementing standing orders, go to [Immunize.org](https://Immunize.org) > For Health Professionals > Handouts for Patients & Staff > Standing Orders. Vaccine information statements are available online at [Immunize.org](https://Immunize.org) > For Health Professionals > Vaccine Information Statements.
- Tell members about the importance of receiving the vaccine and address any barriers.
- Remind your staff about the importance of vaccination and encourage them to get vaccinated.
- Establish a walk-in policy for flu vaccination or flu vaccine clinic hours.

We support your efforts by reminding members about the flu vaccine through recorded voice messages, postcards and online. If you have any questions, contact your local provider advocate.

## New Provider Website for Mississippi

We invite you to begin exploring Mississippi's new care provider website: [UHCprovider.com/mscommunityplan](https://UHCprovider.com/mscommunityplan). This website is your home for the latest UnitedHealthcare Community Plan news, policy information, state updates and access to Link self-service tools.

Care providers told us they wanted all the online content they need in one place, so we're working to make UHCprovider.com the only website you need to access information about UnitedHealthcare plans and members. We transitioned most of our UnitedHealthcareOnline.com and UHCCommunityPlan.com content to UHCprovider.com. If you attempt to access information that has migrated, you'll be automatically redirected.

We hope this new site better serves you and your colleagues.

## A Team Approach to Managing Members with Diabetes

*A Message from Scott A. Edmonds, OD,  
Chief Medical Officer — Vision Benefits*

Caring for people with diabetes is a team effort for everyone involved with their care. The eye is a critical organ in the overall management. It can easily be examined in a non-invasive way on a regular basis. It's often the first place in the body to detect end-organ damage and is a subtle indicator of a progression of the disease.

Although the presence of diabetic retinopathy has been the gold standard to indicate inadequate glucose management, new high level optical coherence tomography can detect vascular changes before they are visible with traditional ophthalmoscopic techniques. This and other subtle ocular changes are revising the standards of eye care for the diabetic population.



Diabetics suffer from a host of other eye and vision problems that affect their quality of life. These problems, revealed in a comprehensive annual eye examination, are often subtle, but affect the patient's ability to perform everyday tasks. Some of these include dry eyes, refractive shifts, convergence problems, early cataracts and low-tension glaucoma.

Any of these diabetic eye changes can be a signal of inadequate blood sugar control but do not tell the whole story. Only in conjunction with fasting blood sugars, HA1c results and other clinical findings can diabetes be appropriately managed using the host of new treatment options now available.

Coordination among all care providers who care for patients with diabetes allows improved control of this complex disorder. MARCH<sup>®</sup> Vision Care supports this team approach by faxing a letter to the Primary Care Provider (PCP) when any patient has an exam and the PCP is identified in the eligibility file MARCH<sup>®</sup> receives. In addition to the procedure codes and some diagnosis codes, this letter includes the name and telephone number of the vision provider so complete medical record from the eye exam may be obtained from the vision provider.

Working together, we can improve coordination of care and help our members deal with diabetes and related issues.

## Important information for health care professionals and facilities

### How to Help Members Avoid the Emergency Room for Dental Issues

Research has pointed to an increase in emergency room (ER) use for dental conditions not associated with trauma. The Pew Center on the States landmark 2012 issue brief, *A Costly Dental Destination*, found that ER visits for preventable dental diagnosis increased 16 percent from 2006 to 2009. A study published in 2015 by the American Dental Association (ADA) said a toothache was the fifth most common reason for any ER visit and was the third most common reason for uninsured ER visits by 20- to 29-year-olds. The ADA's Health Policy Institute said dental ER visits in the U.S. cost the health care system \$1.6 billion, or \$749 per visit, and up to 79 percent of dental ER visits would be preferable in community settings.

UnitedHealthcare is noting similar trends. In many states, particularly for our government-sponsored plans, we are considering programs that would divert members from the ER to community dentists. These programs focus on patient education, emphasizing the value of finding a dental home and making use of existing benefits. Members visiting the ER, particularly those with multiple visits, receive outreach encouraging them to visit their dentist or to find one if they don't already have a dental home.

Members can contact UnitedHealthcare for help in finding a plan dentist. Hospitals are also considering ER referral programs making use of in-house dental clinics, urgent care centers and partnerships with practices accepting referrals.

Care providers and their teams play an important role by performing simple oral screenings to identify those who may be at risk, reinforcing what patients should do in case of dental pain or another emergency, providing patients with information on the importance of finding a dentist and encouraging all patients, particularly those who come in primarily for emergencies, to engage in comprehensive care emphasizing prevention and early intervention.

*This article was contributed by Michael D Weitzner, DMD, MS, who serves as Vice President of National Clinical Government Programs, UnitedHealthcare. Dr. Weitzner oversees UnitedHealthcare's dental clinical initiatives, focusing on government programs*

### Dental Plan: Continuity of Care Submission for Orthodontia

MSCAN dental providers may submit Continuity of Care (CoC) requests using three methods of submission:

- Online via the provider web portal at [UHCprovider.com](http://UHCprovider.com).
- Electronic submission via payer ID GP133
- By mail to:  
UnitedHealthcare Community Plan of Mississippi  
P.O. Box 1391  
Milwaukee, WI 53201

Here are the requirements for all methods of submission:

- All CoC requests must contain:
  - Code D8999 and Code D8670
  - Code D8670 must include the number of adjustments requested.
- CoC requests received without the required code will result in incorrect processing.
- D8999 must be submitted for CoC requests only.
- Claims should be submitted with the actual services rendered.
- Select the applicable box when submitting a CoC request. Selecting the incorrect box will result in a claim denial.
- For Continuation of Care requests, select "Request for Pre-Determination/Pre Authorization."
- For claim submissions, select "Actual Services" which indicates that the submission is specifically for a claim.

### Continuity of Care — Submission Options and Instructions

#### Mail Submissions

1. Submit a prior authorization request on a current ADA form.
2. List Codes D8999 and D8670.
3. Include the number of adjustments requested for Code D8670 to successfully complete the orthodontic case.

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## Important information for health care professionals and facilities

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4. Mail to:  
UnitedHealthcare Community Plan of Mississippi  
P.O. Box 1391  
Milwaukee, WI 53201

### Required Documentation

1. A copy of the initial orthodontic case approval if applicable
2. Attestation from the referring or treating primary care dentist that preventive and dental treatment services have been completed
3. A copy of the orthodontic treatment notes if available from provider who started the case
4. Recent diagnostic photographs and/or panoramic radiographs and if available pre-treatment ones (comprehensive and exceptions only)
5. The date when active treatment was started and the expected number of months for active treatment and retention with a maximum of 24 visits to be expected to treat a case; and, (If applicable) a new treatment plan and documentation to support the treatment change if re-banding is planned
6. Payment history for all previous services

### Provider Portal Submissions:

1. Submit a prior authorization request on a current ADA form.
2. List two codes: D8999 and D8670.
3. Include the number of adjustments requested for D8670 to successfully complete the orthodontic case.
4. Submit online via the provider web portal at [UHCprovider.com](http://UHCprovider.com)

The required documentation is the same as for mail submissions.

### Electronic Claim Submissions:

1. Submit a prior authorization request via electronic ADA via payer ID GP133
2. List two codes: D8999 and D8670
3. Include the number of adjustments requested for D8670 to successfully complete the orthodontic case.
4. Submit via electronic claim submission method via payer ID GP133

The required documentation is the same as for mail submissions.

### CoC Submission Guidelines Specific to Transitioned MSCAN and CHIP members with Open Cases:

For members banded under MS Medicaid fee-for-service, a different MSCAN program or any Medicaid vendor other than UnitedHealthcare and has now transitioned to UnitedHealthcare, the care provider MUST submit the request for CoC before submitting claims for D8670. In addition, if the member is transferring care providers, the entire payment history from the original treating care provider must be submitted. The new care provider will only be paid their case fee minus what was paid to the previous provider. Refer to the example below.

### Required Documentation

- ADA Form with codes D8999 and 8670
- D8670 must include the number of adjustments requested.
- Copy of EOB/remit showing paid banding (D8080)
- Copy of original approval from prior Medicaid Vendor
- Payment history from prior vendor(s)

The plan covers 24 monthly adjustments. Prior authorization is required for cases that may exceed the benefit or visit limitation. Expectation for case completion is 36 months. Cases banded longer than 36 months will require prior authorization.

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Orthodontic case rates consist of one banding payment (D8080) and 24 monthly adjustment payments (D8670). Therefore the calculation is  $D8080 + (D8670 \times 24) =$  case rate. To determine the remaining visits to be approved use the following formula:

Case rate - dollars paid = remaining dollars

Remaining dollars ÷ D8670 contracted rate = remaining number of visits

### References:

For Medicaid policy on orthodontic services, refer to: Title 23 of the Mississippi Administrative Code, Section 204. [medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf](https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf)

Mississippi Provider Reference Guide Section 204. [medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-204.pdf](https://www.medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-204.pdf)

## Easing the Burden of Record Review Requests

Care providers can use CPT® Category II codes to reduce review for HgbA1c results, blood pressure measurement and retinal eye exam results within your primary care diabetic medical records during the busy Healthcare Effectiveness Data and Information Set (HEDIS®) record collection season. These events routinely account for the majority of medical record review requests for the Comprehensive Diabetes Care (CDC) HEDIS® measure. Your submission of corresponding CPT Category II codes on encounter claims, reflecting documentation within your visit medical record, provides informational detail that may be used to document compliance and/or reduce medical record review requests:

- Hemoglobin A1c result CPT Category II  
3044F Most recent result <7.0  
3045F Most recent result 7.0–9.0  
3046F Most recent result >9.0

\*When assigning a CPT Category II code after reviewing HbA1c test results, the date of service for the Category II code submission may not match the date of service for the HbA1c test. The Category II informational code may be submitted as a single line item CPT zero pay claim within seven days of the date of the test.

- Blood Pressure Measurement Systolic Blood Pressure CPT Category II  
3074F Most recent <130  
3075F Most recent 130–139  
3077F Most recent > 140
- Diastolic Blood Pressure CPT Category II  
3078F Most recent <80  
3079F Most recent 80–89  
3080F Most recent > 90
- Retinal Eye Exam Findings CPT Category II
  - 3072F Low risk of retinopathy (no evidence of retinopathy in the prior year)
  - 2022F Dilated retinal exam with interpretation by an ophthalmologist or optometrist documented and reviewed
  - 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
  - 2026F Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

## Access and Availability Standards

As a reminder, primary care providers (PCPs) and obstetricians who accept Mississippi CAN and Mississippi CHIP must be available to members by phone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. Any coverage arrangements that deviate from this requirement must be approved by a UnitedHealthcare medical director or physician reviewer.

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## Important information for health care professionals and facilities

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### Standards for Timely Appointment Scheduling:

#### Emergency Care:

Immediately upon the member's presentation at a service delivery site.

#### Primary Care:

- Urgent, symptomatic office visits must be available from the member's PCP or another care provider within 24 hours. This would involve the presentation of medical symptoms that require immediate attention but are not life-threatening.
- Routine office visits or non-urgent, symptomatic visits must be available from the PCP or another care provider within seven days. A non-urgent, symptomatic office visit would involve medical symptoms that don't require immediate attention.
- Non-symptomatic office visits must be available from the member's PCP or another care provider within 30 days. This type of visit could include wellness and preventive care such as physical examinations, annual gynecological examinations, child and adult immunizations or other services.

#### Specialty Care:

- Specialists and specialty clinics should arrange appointments within 45 days.

#### Behavioral Health (Mental Health and Substance Abuse):

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation
- Urgent problems within 24 hours of the member's request
- Post Discharge from an acute psychiatric hospital within seven days
- Routine Non-urgent issues within 21 days of the member's request

UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability. Periodic surveys are conducted to monitor appointment availability times and 24/7 after-hours access. PCPs and obstetricians are required to participate in all activities related to these surveys.

## Options Care Providers May Take Concerning Claim Outcomes

### Reconsiderations

You should submit a claims reconsideration request when you believe a claim was paid incorrectly. This can be done through claimsLink. Situations for reprocessing through reconsideration include, but are not limited to:

- Payment amount is different than what care provider expected\*
- Claim was filed in a timely manner but UnitedHealthcare has no record but the provider has proof
- Claim was denied for no authorization, when provider has an authorization number
- Coordination of Benefits (COB) information needs to be appended to a claim decision

Unable to access the claimsLink tool and need a paper form to mail? Use our Single Paper Claim Reconsideration Request Form.

### Corrected Claims\*:

You should submit a corrected claim when you want to discard the original claim (all lines) and "start over." This process tells us to disregard the original claim in favor of a new submission. If a claim was partially paid, we will discard all paid and unpaid lines, which will result in a recovery/offset for what was paid. However, we will repay for eligible services that are appropriately resubmitted when you submit the corrected claim. This is used to simply correct a claim whereas the Reconsideration process will permit you to include additional supporting documentation.

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## Important information for health care professionals and facilities

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### Disputes & Appeals

You should submit an appeal when you want to challenge a decision or request an exception. This can also be done through claimsLink. Situations for reprocessing through an appeal include, but are not limited to:

- Medical necessity (must be filed as a member appeal and can be submitted by the member or by the provider on their behalf)

If you are not satisfied with the outcome of a claim reconsideration request, you may submit a formal Claim Dispute/Appeal using the process outlined in your provider manual. A formal Claim Dispute/Appeal is a comprehensive review of the disputed claim(s) and may involve a review of additional administrative or medical records by a clinician or other personnel. UnitedHealthcare Community Plan generally completes the review within 30 days. However, depending on the nature of the review, a decision may take up to 60 days from the receipt of the claim dispute documentation. We will contact you if we believe it will take longer than 30 days to render a decision. Send your appeal request to the claim address on the back of the member's ID card.

Allow 10 business days from the submission date to allow us to begin processing the review before requesting a status update. Consult the applicable state Provider Administrative Guide or manual for more details or contact the provider services center at **877-743-8734**.



If your practice is not already active on claimsLink, you can find information at [UHCprovider.com/en/claims-payments-billing/claimslink-self-service-tool.html](https://UHCprovider.com/en/claims-payments-billing/claimslink-self-service-tool.html).

### Online Resources

We offer many online resources to help providers enhance their experience with us. Here are some that have recently been added or enhanced:

**UHCprovider.com:** [UHCprovider.com](https://UHCprovider.com) is your home for care provider information with 24/7 access to Link self-service tools, medical policies, news bulletins and great resources to support administrative tasks, including eligibility, claims and prior authorizations and notifications.

**Link:** Access Link — your gateway to UnitedHealthcare's online tools — through [UHCprovider.com](https://UHCprovider.com). Link contains powerful online tools that give you comprehensive information without the extra step of making a phone call. You can get eligibility and benefit details, submit referrals and prior authorization requests, manage claims, submit claims reconsideration and appeals, and even manage your demographic information that appears in our provider directory. To access the Link tools, sign in to [UHCprovider.com](https://UHCprovider.com) with your Optum ID. The most popular Link tools include:

- **eligibilityLink:** Search for covered members, view detailed benefits information for multiple plans, get copayment, coinsurance and deductible amounts, see therapy accumulators or get an ID card.
- **claimsLink:** View the status of your claim, get payment details, and submit claims reconsideration and online appeals.
- **My Practice Profile:** View, update and attest to the accuracy of the care provider demographic data UnitedHealthcare members see for your practice. Sign in to [UHCprovider.com](https://UHCprovider.com) using your Optum ID, then select the My Practice Profile tool on Link to review your practice information. My Practice Profile is not available for facilities.



To access the Link tools, go to [UHCprovider.com](https://UHCprovider.com) and sign-in with your Optum ID. Get more information on these and other Link tools at [UHCprovider.com/Link](https://UHCprovider.com/Link).



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Practice Matters is a quarterly publication for physicians and other health care professionals and facilities in the UnitedHealthcare network.

