Reid Health Alliance Medicare
In Partnership with Health Alliance™


# Reid October Informed Newsletter

October 20, 2020

## Think Pink – Raising Awareness about Breast Cancer

October is Breast Cancer Awareness Month. We're always heartened by the pink ribbons we see everywhere this month raising awareness of the disease. But what else should we – as healthcare providers – be doing to aid the cause?

First and foremost, we should remind our patients to get regular mammograms. These breast screenings detect issues early, when they're easiest to treat. Guidance from the Centers for Disease Control and Prevention notes that mammograms are able to detect cancer up to three years before it can be felt.

According to the American Cancer Society, women age 45 to 54 should get mammograms every year, while those 55 and older can switch to every 2 years or continue yearly screenings. Women at higher risk of breast cancer should start getting mammograms before age 45. Many health plans cover these screenings at no cost to the patient. Please advise your patients to call the Member Services number on the back of their ID cards for questions about coverage.

It's also a good time to remind your patients about the importance of breast self-exams. A monthly self-examination is easy to do and only takes a few minutes.

Finally, encourage your patients to make healthy lifestyle changes to help decrease their risk of breast cancer. These include exercising, maintaining a healthy weight and limiting their consumption of alcohol.

Want to learn more? Listen to the latest episode of our *Hally™ Healthcast* to hear Dr. Maria Grosse Perdekamp of the Mills Breast Cancer Institute at Carle discuss the five things every woman should know about breast cancer.

## Understanding the Different Types of Medicare

It's time once again for the Medicare Annual Enrollment Period, which takes place October 15 through December 7. As your patients look at their options and try to decide what's best for them, they might come to you with questions. Here's a quick review of some of the different types of Medicare coverage they can choose:

- **Original Medicare** is offered through the federal government and includes Part A (hospital coverage) and Part B (medical coverage). Like the other types of Medicare, it's available for those who are 65 or older or have certain disabilities. Beneficiaries can see any provider who accepts Medicare, but they won't have extra perks or pharmacy coverage.

- **Medicare Advantage (Part C)** plans are private health plans that replace Original Medicare. They often include pharmacy coverage and extra perks, like dental, hearing and vision benefits. These plans typically have a provider network and can offer more care coordination than Original Medicare.

- **Medicare Supplement** (also known as **Medigap**) plans are sold through private insurance companies. They don't replace Original Medicare but work as an add-on alongside it to help pay for what Original Medicare doesn't. Beneficiaries can generally see any provider who accepts Medicare.

We encourage you to visit our Providers Resources page to find the presentations we've developed specifically for you during this year's Annual Enrollment. Under "Medicare Information" you'll find Medicare Provider Education links based on region and product, and you'll also find this short video describing Medicare Advantage. You can also visit the Understanding Medicare page on our website for additional information, and as always, feel free to reach out to your provider relations specialist with any questions.

## Closing Gaps in Care: End-of-Year Screening Reminders

It's hard to believe, but summer has given way to autumn, and 2021 will be here before we know it. As this year comes to a close, it's important you make sure that your patients are getting the appropriate preventive services needed to identify any issues and close any gaps in their care. As appropriate, please remind your patients about the following end-of-year screenings:

**All Patients:**

- Colorectal cancer screening
- Blood pressure reading
- Medication review

**Women:**

- Breast cancer screening
- Osteoporosis screening for women who've had a fracture

**Patients with Diabetes:**

- A1C test
- Nephropathy screening
- Diabetic retinal eye exams

**Patients with Rheumatoid Arthritis:**

- Treatment with a disease-modifying antirheumatic drug (DMARD)

Also, please remember we have health coaching and care coordination services that can help our members manage their conditions at no extra cost to them. We know you worry about your patients' health between visits, and these services can help improve their health outcomes throughout the entire year.

## The "Big Six"

Coding and documentation may seem boring, but it's incredibly important to your patients' health. When we get accurate claims data and detailed chart documentation, we can identify which members qualify for our Care Coordination program, helping them get the support they need to reduce health risks related to their chronic

conditions. Proper documentation also helps us collaborate with providers and gather data to assess the disease burden of our population.

The "Big Six" are six important diagnosis categories that are most commonly *not* coded from one year to the next:

- Congestive Heart Failure (HCC 85)
- Diabetes without Complications (HCC 19)
- Diabetes with Chronic Complications (HCC 18)
- Specified Heart Arrhythmias (HCC 96)
- Chronic Obstructive Pulmonary Disease (HCC 111)
- Vascular Disease (HCC 108)

Carle ACO and Health Alliance™ have joined efforts in a Big Six initiative to help providers remember to properly document and code these conditions. With these diagnoses and all others, we remind providers to follow best documentation practices using the acronym **M.E.A.T.**

- **M**onitor: disease progression/regression, symptoms and give a status
- **E**valuate: review test results, medication and/or treatment effectiveness
- **A**ssess: counsel, order tests, review records
- **T**reat: medications, therapies, referrals

More information about coding can be found in the next article. We ask that as you go about your busy days seeing patients, remember the importance of proper documentation – and don't forget the "Big Six."

## Code for What You See

Robert G Good, DO, MACOI
Associate Chief Medical Officer for Carle Population Health

Accurate diagnostic coding is a vital part of completing any patient visit. While providers have traditionally focused on the procedure, or CPT, code that describes the level of service, we haven't been well trained on the importance of the diagnostic, or ICD-10, code. A subset of ICD-10 diagnostic codes, called HCC codes, further define the healthcare risk score for the patient.

The health risk scores (HCC) are bundled together for each patient to describe the patient's degree of illness (risk adjustment factor [RAF] score) or the overall risk you have to take to care for the patient. Diagnostic codes are used to determine the

patient's expected outcomes, including mortality rates or readmission rates. When care and services produce patient outcomes better than what was expected, this indicates high quality care. This is a predominate way healthcare systems and physician groups are evaluated for quality.

Additionally, CMS uses the HCC codes to compensate care for sicker patients. Money is transferred from care of people who are less sick to systems that care for sicker patients, using these codes.

Providers can maximize benefit by utilizing specific diagnoses with staging. For instance, listing a diagnosis of obesity does not indicate an HCC code. But a BMI>39 indicates morbid obesity and is an HCC code. A diagnosis of renal failure is not an HCC code, but a GFR<30 is stage IV renal disease and does have an HCC code. These codes must be used at least annually with documentation that includes the status of the condition and the plan of action. Often a person with an ostomy who is otherwise doing well is not coded annually, missing an opportunity to improve accurate documentation.

Following proper coding procedures applies to *all* providers, especially specialists. Throughout the medical decision-making process, you should include any condition that's considered in the overall care of the patient. As an example, a cardiologist who is treating heart failure with atrial fibrillation should also include consideration of renal failure, since the treatment program is directly related to the consideration of kidney function.

All the above can be summed up quite easily: we're simply asking you to *code for what you see* when evaluating a patient, and *code for what you need to know* in order to treat them.

## Updates to Blood Pressure Reporting

With more patients using telehealth services due to the ongoing pandemic, NCQA has made changes that allow for increased inclusion criteria for blood pressure monitoring. For the Controlling Blood Pressure HEDIS® measure, NCQA will now include member-reported blood pressure readings taken on any remote digital device. The patient-reported blood pressure must be recorded and dated in the patient's chart. Please note that patient-reported blood pressures taken with a manual cuff are not acceptable.

# Reminder: Notification of Provider Changes

Please remember to notify Health Alliance if your office has any provider-related changes, including the addition of a National Provider Identification (NPI) number, a mid-level provider, address change, fax number change, tax I.D. number change, practice name change or the opening or closing of primary care panels. Timely notification of any changes to your practice is a contractual requirement – and it also allows us to update the information in our claims payment system for proper and speedy reimbursement. Furthermore, we need this information for updating our Provider Directory.

Also remember to notify Health Alliance of the termination of any provider from your practice, and include both the reason for termination and the effective date.

Please use this Provider Information Change Form for the above types of changes.

**Continuity of Care:** If a healthcare provider terminates a provider agreement with Health Alliance, they must continue to provide care at the member's request if he or she has a condition that requires ongoing treatment or is in the second or third trimester of pregnancy. The provider will be required to honor the contracted reimbursement rates to qualify for this continued care provision.

**Notice of Termination:** The Illinois Managed Care Reform and Patient Right Act requires providers to give 90 days' notification, in writing, for termination of a provider agreement without cause. Health Alliance must give at least 60 days' notice to members who are receiving service from a terminating provider. Therefore, it's vital that providers follow the termination guidelines.