PROVIDER UPDATE

MERCYONE Health Plan

MediGold

OCTOBER 2024

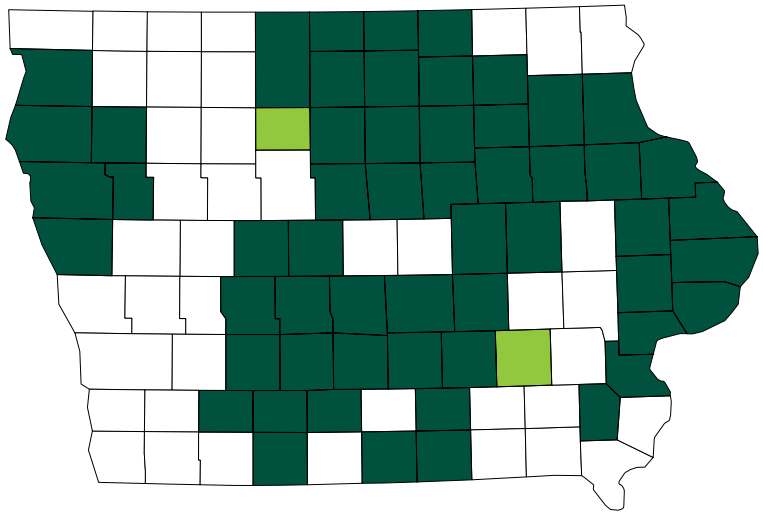
Ready for the Annual Enrollment Period!

It's October and that means the Annual Enrollment Period (AEP) is here! We anticipate 2025 will be another successful year for MercyOne Health Plan and our providers. We are ready to do everything we can to prepare for an excellent AEP and want to ensure that it's a great time for you as well.

That's why we're pleased to provide online information to you and your staff to aid you during AEP and year-round. Just go to our website and select "For Providers" in the title bar across the very top of the page. This will take you to a page with links to our Provider Portal, Provider Administration Manual, our Provider Communication page with links to the Provider Update archive, and much more.

Check out all these resources today!

2025 MercyOne Iowa Service area



- **2024 Counties** – Adair, Adams, Appanoose, Benton, Black Hawk, Boone, Bremer, Buchanan, Butler, Cedar, Cerro Gordo, Cherokee, Chickasaw, Clarke, Clayton, Clinton, Dallas, Delaware, Fayette, Floyd, Franklin, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Henry, Ida, Jackson, Jasper, Jones Kossuth, Louisa, Lucas, Madison, Mahaska, Marion, Mitchell, Monona, Monroe, Muscatine, Plymouth, Polk, Poweshiek, Ringgold, Scott, Sioux, Tama, Union, Warren, Wayne, Winnebago, Woodbury, Worth, Wright
- **2025 Counties** – Humboldt, Keokuk

We're Here To Serve You.

MercyOne Health Plan is a Medicare Advantage plan, fully owned by Trinity Health. It's designed to provide our members with a more seamless health care experience, while also making it easier for health care teams to coordinate and deliver the best possible care. **LEARN MORE**

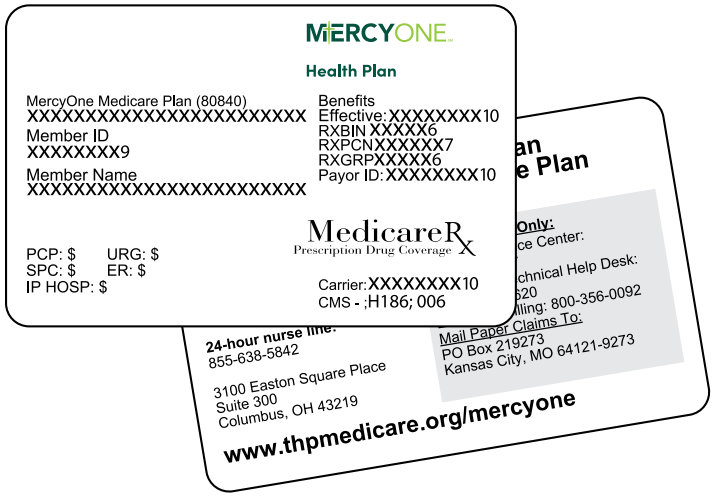
Provider Service Center 1-800-991-9907 (TTY 711)

1 MercyOne Health Plan is a Medicare Advantage organization with a Medicare contract. Enrollment in MercyOne Health Plan depends on contract renewal. Benefits vary by county.

2025 Health Plan Highlights

NEW: Enhanced Cash Back benefit:

We have enhanced the monthly Cash Back benefit for 2025 on select plans.* In our qualifying plans, members can receive up to approximately $1,343 per year (or approximately $112 per month) toward their Medicare Part B Premium beginning in January 2025. This will continue to be offered as extra money in their monthly Social Security checks, or as a reduction to the amount paid directly to Medicare.**



NEW: One Pass® Fitness Vendor:

The One Pass® mission is to make fitness engaging for everyone, and to that end they provide partnerships with more fitness locations than ever before – including most local YMCAs, LA Fitness, Lifetime Fitness, boutique studios (specialized fitness centers, such as Club Pilates, Pure Barre, Orangetheory, and more), and many other gym locations.

CogniFit, the new mental fitness benefit for 2025 (included with One Pass®) offers a baseline assessment that captures members' cognitive profile. It also has a collection of brain games to keep them interested, challenged, and engaged.

These new features, along with the many benefits our members currently enjoy including 24/7 Nurse Advice Line, Visitor/Travel benefit, Over-The-Counter (OTC) allowance, Flex Card, Dental, Vision, and Hearing benefits, all included to assist our members on their healthcare journey.

** Premiums and benefits vary by plan.*

*** Other eligibility restrictions apply. Medicare Part B Premium Cash Back is applicable to only certain plans.*

Peer to Peer Conversation Requests

The Utilization Management and Physician Services departments would like to introduce a new route to submit requests for Peer to Peer conversations for acute care hospital admissions. For any requests where a Peer to Peer is warranted, please utilize this NEW email, which is the preferred method. You are still able to utilize the phone option, at **1-800-240-3870**.

Please send your request to **P2Prequest@trinity-health.org** and the team will review the request and respond.

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Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults.

Polypharmacy, particularly the use of multiple anticholinergic (ACH) medications, is a significant concern for older adults on Medicare. ACH medications are often used to treat conditions like allergies, depression, and urinary incontinence, however, their use in older adults should be carefully monitored due to the potential for adverse effects. The use of multiple ACH medications is linked to significant health risks, including increased fall risk, cognitive impairment, exacerbation of neurogenerative diseases, adverse drug reactions, and increased hospital admissions. Monitoring and managing the use of multiple ACH medications can help mitigate these risks and improve the overall well-being of older adults. CMS has implemented measures to track and reduce the use of multiple ACH medications among Medicare Advantage beneficiaries.

The Polypharmacy: Use of multiple anticholinergic medications in older adults (POLY-ACH) measure, developed by the Pharmacy Quality Alliance (PQA), monitors performance on the percentage of patients with concurrent use of two or more unique ACH medications. The goal of this measure is to reduce multiple ACH medication use in older adults, ultimately intending to improve patient safety and outcomes. A lower rate indicates better performance in managing polypharmacy. CMS aims to incentivize healthcare providers to monitor and manage the concurrent use of these medications more effectively by incorporating the measure into its Star Ratings system.

DEFINITION: This measure identifies the percentage of individuals aged 65 and older who are concurrently using two or more unique anticholinergic medications. Concurrent use is the number of days with overlapping days' supply for ≥ 2 ACH medications.

DENOMINATOR: Members are included in the eligible population for the measure based on the following criteria:

- Aged 65 years or older, and
- Two or more claims for the same ACH medication on different dates of service

NUMERATOR: The number of eligible members with concurrent use for ≥ 30 days of ≥ 2 unique anticholinergic medications.

WHAT YOU CAN DO

Healthcare providers can enlist several strategies to reduce the risks associated with POLY-ACH and improve the overall health outcomes for older adults:

- Use non-pharmacological alternatives whenever possible to manage conditions.
- Conduct frequent medication list reviews.
- Talk to patients about their medications and encourage self-monitoring for side effects.
- Collaborate with pharmacists, nurses, and other healthcare professionals to optimize medication management.
- Discontinue medications where potential harms outweigh benefits.

https://www.pqaalliance.org/assets/Measures/PQA_Measures_Overview.pdf

https://www.pharmacyquality.com/wp-content/uploads/2021/05/PQA29Polypharmacy2021.pdf

https://www.pqaalliance.org/index.php?option=com_content&view=article&id=304:measures-overview&catid=20:site-content#poly-ach

https://www.cms.gov/files/document/2024-patient-safety-memo-20240424.pdf

Medicare Part B Coverage of Pre-exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention

HIV PrEP drugs were previously covered under Medicare Part D and were typically subject to a deductible and coinsurance or co-pay. Effective September 30, 2024, the Centers for Medicare & Medicaid Services (CMS) transitioned coverage of PrEP drugs to Medicare Part B, and beneficiaries have no Part B cost-sharing obligations (i.e., deductibles or co-pays). Antiretroviral drugs used for the treatment of HIV continue to be covered under Medicare Part D.

Adding a diagnosis code to prescriptions written for PrEP, especially for drugs that could be used for either HIV prevention or HIV treatment, would be helpful in ensuring the appropriate billing. Our network pharmacies have also been notified of this change and encouraged to bill original Medicare for PrEP.

Access the CMS Fact Sheet

OB/GYN Coding Guidance for Women's Exams

Effective with dates of service as of January 1, 2025, MercyOne Health Plan will only accept industry standard coding for women's health exams. Gynecologists should bill G0101 for the exam and Q0091 for the pap smear along with any appropriate E/M code if a separate and identifiable E/M service is provided.

MercyOne Health Plan will not accept claims billed with non-industry standard codes. Claims submitted with anything other than CPT/HCPC codes that are effective on the date of service will be denied or rejected.

Please see our Provider Administration Manual or contact the Provider Service Center at **1-800-991-9907 (TTY:711)** or your Provider Relations Network Manager with any questions.

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CMS Medicare Advantage Reimbursement Model V28 Changes: Injury Disease

In 2024, CMS is shifting from V24 Risk Adjustment model to the new V28 model for Medicare Advantage reimbursement. This will influence Hierarchical Classification of Conditions (HCCs) codes related to patients.

The Injury Disease Group had the following changes:

- V24 HCC 166 (Severe head injury) had all of its codes moved to V28 HCC 397 (Major injury with loss of consciousness > 1 hour) with a decrease in RAF
- V24 HCC 167 (Major head injury) had most codes divided between V28 HCC 398 (Major head injury with loss of consciousness < 1 hour or unspecified) and V28 HCC 399 (Major head injury without loss of consciousness)
- V24 HCC 169 (Vertebral fractures without spinal cord injury) had all of its codes moved to V28 HCC 401 (Vertebral fractures without spinal cord injury) with an increase in RAF
- V24 HCC 170 (Hip fracture/dislocation) had all codes moved to V28 HCC 402 (Hip fracture/dislocation) with an increase in RAF
- V24 HCC 173 (Traumatic amputations and complications) had most of its codes moved to V28 HCC 405 (Traumatic amputations and complications) with an increase in RAF
- Codes removed from the model include amputation of toes, compartment syndrome, and unspecified early complications of trauma

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Morbid Obesity

BMI is defined by the ratio of an individual's height to his or her weight. Normal BMI ranges from 20-25. An individual is considered morbidly obese if he or she is 100 pounds over his/her ideal body weight, has a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes.

IMPORTANT CODING INFORMATION

- To code morbid obesity appropriately, providers must document morbid obesity in the assessment and/or plan to address the morbid obesity (weight loss, diet, exercise, referral to dietitian or bariatric surgeon)
- If morbid obesity is documented in the physical exam section without additional documentation supporting the clinical significance of this condition, it should not be captured. Providers must document the condition in the A/P and address the treatment plan such as weight reduction diet or counseling.
- If morbid obesity is documented and a BMI ≥ 40+ is documented then it is appropriate to capture E66.01 (Morbid Obesity) and Z68.4X (BMI of 40 or greater).
- If BMI of 40 or greater is documented and there is no mention of a related diagnosis, such as overweight, obesity, morbid obesity etc., then it is NOT appropriate to code a BMI status code.

According to the ICD-10-CM Coding Guidelines, the BMI may be recorded by non-physician clinicians, such as nurses or dieticians; but it cannot be reported unless also documented by the physician and associated with a related condition, such as overweight or obesity. Therefore, unless the physician makes a comment on the significance of the BMI, it cannot be coded.

Correct Coding

Vitals: BMI 41

A/P: Morbid Obesity – working on a controlled diet with exercise

Coded: Morbid Obesity (E66.01)

Incorrect Coding

Vitals: BMI 41

A/P: Diabetes Mellitus – encouraged controlled diet and exercise

(No other conditions are listed under the A/P for this visit)

Coded: Body mass index (BMI) 40.0-44.9, adult

(Cannot capture BMI without documenting a secondary diagnosis to support the BMI)

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