PROVIDER UPDATE

MERCYONE Health Plan

MediGold

MARCH 2025

National Doctors' Day – March 30

The theme of this year's National Doctors' Day is "Behind the Mask: Who Heals the Healers?" It invites us to look beyond providers' dedication and resilience to recognize their need for support and care. "Every day, doctors selflessly put their patients first, often at the expense of their own well-being," according to the National Doctors Day website.* March 30 is a day to express gratitude and to uplift the healers who tirelessly care for us.

We honor physicians for the work they do for their patients, the communities they work in, and for society as a whole. It is their hard work and devotion that keeps all of us healthy and this day thanks them for doing that for us and our loved ones.

Happy National Doctors' Day to all our dedicated providers!

*Source: https://nationaldoctorsday.org/celebrate/

Medicare Experience Surveys coming this month

Each March, the Centers for Medicare & Medicaid Services (CMS) sends the Medicare Experience Survey to select Medicare beneficiaries. This survey measures how well our health plan and providers are serving our members and are the basis of our Star Ratings system.

Survey topics include:

- How easy it is to make appointments with providers and get the care members need
- How well the member felt treated by their health plan's customer service reps
- How well their health plan's medical and drug benefits met their needs

Survey results help us serve our members – and providers – to the best of our ability. Please encourage your patients to participate in the survey, if they're selected.

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.

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Medical Records Requests for HEDIS® and Risk Adjustment

Every year MercyOne Health Plan and/or its vendors will request records for HEDIS® and Risk Adjustment. It is important that providers read the record request to determine which program the records are being requested for and what information is needed. HEDIS record requests look for one specific service while Risk Adjustment requests will look for a date range of records on a specific member.

- Data collection for HEDIS:
  - HEDIS reporting is a significant component of Medicare Star Ratings, required for NCQA accreditation and used for Consumer Report Health Plan Rankings. Our plan uses information from submitted claims to obtain the majority of our HEDIS data and to determine where we need to focus our improvement efforts.
  - HEDIS measures include:
    - Colorectal Cancer Screening
    - Controlling Blood Pressure
    - Diabetes Screenings: A1c, Eye Exam
    - Transitions of Care
- Data collection for Risk Adjustment:
  - CMS requires health plans to submit complete and accurate diagnosis codes on our members annually. Most diagnosis codes are submitted through our claims process. To ensure that we are submitting complete and accurate data, the Risk Adjustment team will complete an annual medical record review on previous years dates of service.
  - Annual medical record reviews are completed to identify additional conditions not captured through claims or encounter data.
  - Diagnosis codes submitted are also audited by CMS through the Improper Payment Measurement or RADV audit. Health plans that are included in these audits will request records from providers to submit to CMS. CMS-certified coders will review the documentation in the records to ensure proper supporting documentation for ICD-10 codes that were submitted to CMS.

It is extremely important that requested records are provided to the proper entity within the timeframe specified in the requests.

Does a policy exist that requires us to provide medical records to the health plan?

Yes. Network participants are contractually required to provide medical records so we may fulfill our state and federal regulatory obligations. We appreciate your timely response to our request for records.

How do I submit medical records to the health plan?

Instructions for submitting medical records will be outlined in the letter to providers. There are several methods for submission that meet HIPAA guidelines:

- Fax
- Hard copy, flash drive or CD delivered through the mail.
- Email encrypted to HIPAA standards. (SSL or TLS encryption is not sufficient).
- Remote electronic medical record (EMR) system. EMR submissions are highly recommended as this will result in fewer visits and emails from the health plan.
- You can request to have a HEDIS coordinator to come into your office to collect a copy of the records.
- Online submission of medical records via the Provider Portal.

When will MercyOne Health Plan request medical records for HEDIS?

Generally, medical records are requested from all health plans during HEDIS Season that runs from February through the end of April. At MercyOne Health Plan, we would like to reduce the number of records that are requested during these few months and our HEDIS Coordinators will be working with your office throughout the year to obtain the records.

When will the health plan request medical records for Risk Adjustment?

Typically, medical records are requested from health plans starting in April. This ensures time for certified coders to review the records for supporting documentation around all ICD-10 codes submitted to CMS. All ICD-10 codes that are added or deleted due to the review, are required to be submitted to CMS by the January 31 deadline.

Under HIPAA laws, can the health plan review patient medical records without a signed member release?

HIPAA allows providers to disclose PHI to another covered entity without a signed release in reference to health care operations. These operations include activities such as quality assessment and improvement and health plan performance evaluations.

What should I do if a medical record request is for a member who is no longer with the health plan or who is deceased?

The requested records need to be submitted to the health plan regardless of the status of the member. Medical record reviews may require data collection on the services obtained over multiple years when the member was receiving benefits from the health plan.

What should I do if a medical record is requested for a member who was seen by a provider who has retired, died or moved?

The requested records need to be submitted to the health plan regardless of the status of the provider. Data collection includes reviewing medical records as far back as 10 years (including before your patient was a health plan member) and archived records and data may be required to complete this process.

CONTACT INFORMATION

Risk Adjustment:
Toll Free Fax: 1-833-978-1756
Local Fax: 614-234-8728
Email: RiskAdjustment@mchs.com

Stars and HEDIS:
Toll Free Fax: 1-833-263-4823
Local Fax: 614-234-8838
Email: StarsAndHEDIS@mchs.com

Chronic Kidney Disease

Chronic kidney disease (CKD), also known as chronic kidney failure and chronic renal failure, involves a gradual loss of kidney function over time.

Hypertension and Diabetes are often caused and linked to chronic kidney disease. If either of these conditions are present and uncontrolled, it can lead to further progression in CKD.

Important Coding Information

When documenting the diagnosis or progression of CKD, there are two tests that are typically used:

- Albumin-to-Creatinine Ratio (ACR)
- Estimated Glomerular Filtration Rate (eGFR)

Provider documentation must specifically state the stage of CKD. The ACR and GFR test results are not sufficient documentation alone.

Since CKD is often caused by Hypertension and/or Diabetes, it is important to code these conditions if they are linked:

- Diabetic CKD (E08.22, E09.22, E10.22, E11.22, E13.22)
- Hypertensive CKD (I12-)

CODE SELECTION

STAGE	GFR	ICD-10-CM CODE
1	>90	N18.1
2	60-89	N18.2
3 (unspecified)	30-59	N18.30
3a	44-59	N18.31
3b	30-44	N18.32
4	15-29	N18.4
5	<15 (without dialysis)	N18.5
End Stage Renal	<15 (on dialysis)	N18.6

Do you have access to our Provider Portal?

Through the Provider Portal you can:

- Verify eligibility of members
- Verify member claims history
- View member payment status, and more!

GET ACCESS TODAY

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