PROVIDER UPDATE

MOUNT CARMEL Health Plan

MediGold

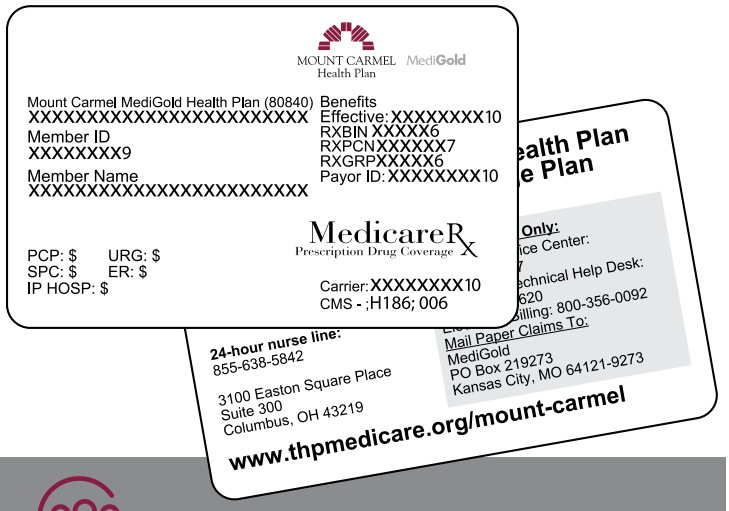
JANUARY 2025

Reminder: Mount Carmel MediGold Health Plan members are your patients!

With the plan/brand name change from MediGold to Mount Carmel MediGold to better align with the Trinity Health system, there has been some confusion as to which health plan your patients are members of. Please rest assured that all Mount Carmel MediGold members are a part of our agreement with you.

The health plan product name of MediGold changing to Mount Carmel MediGold does not alter coverage or the ability to treat them. Some of our members have been refused care because providers did not realize that Mount Carmel MediGold, previously known as MediGold, is still covered under your agreement with us. We apologize for any confusion and want to reiterate that Mount Carmel MediGold members are a part of our agreement.

If you have any questions about our affiliation, please contact the Provider Service Center at 800-991-9907 (TTY:711). Thank you for being a valued Mount Carmel MediGold participating provider!



We're Here To Serve You.

Mount Carmel MediGold 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 Mount Carmel MediGold is a Medicare Advantage organization with a Medicare contract. Enrollment in Mount Carmel MediGold depends on contract renewal. Benefits vary by county.

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Managing Statin Intolerance

For patients who are unable to tolerate daily statin therapy, once-weekly dosing of rosuvastatin offers a potential solution to improve lipid management and promote medication adherence. Once-weekly rosuvastatin is an effective and well-tolerated lipid-lowering therapy option for patients not at LDL goal and previously unable to tolerate statins because of a history of myalgias.* Please keep in mind, if the patient is directed to take their medication less frequently than originally prescribed, it is important that the prescription on file at the pharmacy be updated as well for accurate refill reminders, automatic refills, and adherence insight.

If your patient cannot tolerate a statin for any reason, the proper exclusion codes should be included in the patient's medical record:

- G72.0 (drug induced myopathy)
- G72.9 (myopathy, Unspecified)
- M62.82 (rhabdomyolysis)
- K74.60 (cirrhosis of the liver)
- N18.6 (ESRD)
- R73.03 (pre-diabetes)
- E28.2 (PCOS)

*Reference: Kennedy SP, Barnas GP, Schmidt MJ, et al. Efficacy and tolerability of once-weekly rosuvastatin in patients with previous statin intolerance. Journal of Clinical Lipidology. 2011; 5(4): 308-315

Reminder: Please keep HMO care in-network

Happy New Year! We hope that 2025 is starting out to be a great year for you!

And, just as a reminder, for our HMO plan members, please keep care in-network, if at all possible. If services are not available in our network, then a Prior Authorization is necessary for members to seek treatment out-of-network.

If you need to obtain Prior Authorization for a member seeking treatment out-of-network, please complete the Prior Authorization Request Form found on our website. The completed Prior Authorization Request Form can be faxed to 1-833-263-4869 or emailed to PriorAuth@medigold.com. If you have questions, please contact our Utilization Management team at 1-800-240-3870.

Obtain the Prior Authorization Form

Annual Wellness Visits (AWV) and In-Home Assessments (IHA)

The **Annual Wellness Visit (AWV)** is one of many Medicare preventive services. You may find these FAQs helpful in preparation for patient AWVs. Mount Carmel MediGold offers our members one AWV per calendar year under the following qualifying situations:

- Beneficiaries with more than 12 months since their effective date of their first Medicare Part B coverage period.
- Beneficiaries who have not received the Initial Preventive Physical Exam (IPPE) or AWV within the past 12 months.
- Beneficiaries with more than 12 months since their Welcome to Medicare preventive visit.

Is there cost-sharing for the AWV?

With Mount Carmel MediGold, there is no coinsurance, copay or deductible for the AWV. If other services are provided during the AWV, cost-sharing may apply.

The initial AWV includes:

- Health Risk Assessment (HRA).
- Establishing a list of current providers and suppliers.
- Medical/family history.
- Review of risk factors for depression or mood disorders.
- Review of functional ability and level of safety.
- Can be face to face or telehealth visit.

Subsequent AWVs can generally be a continuation of the initial AWV. They provide a great opportunity for members to make a personalized prevention plan to keep them healthy.

Which codes would be used?

HCPCS Codes
Initial visit: G0438
Subsequent visits: G0439
Diagnosis Code

When submitting the AWV claim, you may choose any diagnosis code consistent with the beneficiaries' exam.

What other services may be completed with the AWV?

Preventive services such as Advance Care Planning (ACP) can be completed as an optional element of an AWV. Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:

- Provided on the same day as the covered AMW.
- Furnished by the same provider as the covered AWV.
- Billed with modifier -33 (Preventive Service).
- Billed on the same claim as the AWV.

For more information on qualifying preventive services, **visit the Medicare Learning Network website**.

Because cost-sharing will apply if other services are completed during the AWV, our plan recommends you explain applicable cost-sharing information with your patient prior to completing any services. With that prior approval, the AWV is a good opportunity to:

- Close gaps in care, such as BMI, CBP, A1c and discussion about the mammogram, colonoscopy and medication adherence.
- Review all patient conditions and determine the yearly plan of setting up follow-up appointments to address and treat all conditions.

In-home Assessment – Healthy House Call program

The Healthy House Call program provides members with an opportunity for an in-home or virtual (online) visit by a nurse practitioner, free of charge. The nurse practitioner will complete a comprehensive assessment that includes:

o Review of medical history and current conditions

o Risk factors

o Medication review

The nurse practitioner will leave a completed assessment for the member as well as mail the assessment to the member's PCP. Members are informed that an in-home assessment does not take the place of scheduling visits with the PCP, and are encouraged to schedule an appointment to review the assessment with their PCP.

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Best Practices for Coding/Documentation

The Centers for Medicare & Medicaid Services (CMS) requires reporting all applicable diagnosis codes, diagnoses to the highest level of specificity and substantiation in the medical record. Proper coding and documentation can impact the patient's overall quality of care and reimbursement accuracy. Following are four key best practices for coding/documenting the medical record:

- Problem list: Should be kept up-to-date and show the status of each condition, e.g., active, chronic or resolved, and whether the condition is "current" or no longer has the condition "history of." Do not use only default, unspecified codes – they do not accurately show severity.
- Include all problems in the assessment: Don't limit the diagnosis codes to only those that brought the patient into the office. All problems assessed during the visit should be noted in the assessment and coded accordingly.
- All diagnoses should be documented: Any diagnoses that were part of the provider's medical decision making process should be documented. Example: patient being treated with medication that might affect the treatment of the current presenting issue should be documented and coded.
- Annually document all chronic conditions: All chronic conditions should be assessed during a face-to-face encounter, at least once annually, and documented in the medical record. This includes status codes such as amputations, transplant status, ostomies, etc., as well as pertinent past conditions and other underlying medical problems.

Importance of Documentation

- Assure all of the patient's medical conditions are addressed during the visit
- Supports accurate claim payment, reducing denials
- Accurate coding of conditions is needed for appropriate Risk Adjusted payment
- If a condition is not documented, it cannot be coded

Medicare Satisfaction Survey

The Centers for Medicare and Medicaid Services (CMS) is preparing to send this year's Medicare Satisfaction Survey, which collects information on members' experience and satisfaction with the health care they receive. Members are randomly sampled, so some of your patients may receive a survey in the mail in March.

Some of the survey questions include the following topics:

- How easy it was to make appointments with their providers and get the care they needed
- How well they felt treated by their health plan's customer service representatives
- How well their health plan's medical and drug benefits meet their needs

Please encourage them to complete the survey as this information will help us improve our services to you and our members.

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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