

Provider UPDATE

MERCYONESM

Health Plan

MediGold

Proper documentation of Rheumatoid Arthritis

Rheumatoid arthritis (RA) is a chronic autoimmune disorder that results in swollen, painful joints. Please note the following:

- A specialist often diagnoses and treats this condition, but it is important to capture all chronic conditions on an annual basis.
- Best practice is to spell out and fully describe the type of RA; try not to use the

unspecified code

- M05.- and M06.- codes contain detail that indicate the anatomical site, along with any organ involvement.
- Documenting the type, location, and/or associated complications of the RA is important in making sure the highest specified code is selected.

Reminder: Please keep HMO care in-network

Happy New Year! We hope that 2024 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 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:

www.medigold.com/for-provider/tools-and-resources/forms. 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.

Please note: We are currently in the process of adding many of our Provider-related materials, such as the Provider Administrative Manual, to our website. We will inform you when all of this information is available. Please continue to access the above website on www.medigold.com for resources in the meantime.

WE'RE HERE TO SERVE YOU.

MediGold.com/For-Providers

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

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.

Encourage your patients to schedule an Annual Wellness Visit (AWV)

One of the best ways to start off the new year is with an Annual Wellness Visit (AWV) with your patients. One of our health plan's many free preventive services,* an AWV helps you partner with your patients to maintain or improve their health.

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

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. The following are four key best practices for coding/documenting the medical record:

1. **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.
2. **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.
3. **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.

4. **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 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

For more information, please go to our website: <https://www.medigold.com/for-providers/tools-and-resources/stars-and-hedis/risk-adjustment>

CMS Medicare Advantage Reimbursement Model V28 changes: Musculoskeletal

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 Musculoskeletal Disease Group had the following changes:

- The most significant change in this grouping is the addition of V28 HCC 94 (Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders)
 - Codes related to Reiter’s disease, Postrheumatic arthropathy, Giant cell arteritis, and Systemic Lupus Erythematosus were moved to V28 HCC 94 with a RAF decrease of 0.114
 - V24 HCC 39 (Bone/Joint/Muscle Infections/Necrosis) had most of its codes moved to V28 HCC 92 (Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis) with a RAF increase of 0.061

- V24 HCC 40 (Rheumatoid Arthritis and Inflammatory Connective Tissue Disease) had most of its codes moved to V28 HCC 93 (Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders) with a RAF increase of 0.084, with a few exceptions
- Codes used for Sjogren’s disease, polymyalgia rheumatica, and various forms of spondylopathies were removed from the model and are no longer HCCs.

Acceptable documentation

65-year-old female in for annual wellness exam. Patient has history of Rheumatoid Arthritis in her right elbow. Currently taking Methotrexate and is seeing Rheumatologist next month.

- **Code: M05.721** - Rheumatoid arthritis with rheumatoid factor of right elbow without organ or systems involvement

Diabetic testing supplies – changes for 2024

Effective January 1, 2024, MeryOne Health Plan members must obtain their diabetic testing supplies, as well continuous glucose monitors, at any of our 66,000 in-network retail pharmacies nationwide or through our mail order pharmacy, CVS Caremark.

Beginning January 1, 2024, the following preferred blood glucose monitors and test strips will be covered:

- LifeScan: OneTouch Ultra Blue or OneTouch Verio
- Roche: Accu-Chek Plus, Accu-Chek Aviva, Accu-Chek Smart View or Accu-Chek Guide

For Continuous Glucose Monitoring system (CGM), the following preferred CGM

supplies will be covered:

- DexCom
- FreeStyle Libre

Only these brands of preferred monitors, test strips or continuous glucose monitoring system and supplies will be covered by the plan effective January 1, 2024. For your patients to obtain new blood glucose monitors and test strips or CGM and supplies, please submit a new prescription with refills for a full year to their pharmacy on file with your office.

If you need more information regarding this change, please contact Provider Services at 1-800-991-9907 (TTY:711).

Do you have access to our Provider Portal?

Through the Provider Portal you can:

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

Get access today through this link: <https://www.medigold.com/for-providers/provider-portal>

Delivering soon – CAHPS surveys!

To monitor the experiences and quality of care in health plans and providers, each year the Centers for Medicare & Medicaid Services (CMS) distribute surveys to randomly selected Medicare beneficiaries – your patients may be among those receiving the survey. If they discuss with you, please encourage them to complete the surveys. You may find this information helpful during conversations with your patients.

What is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey?

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a program designed to understand a patient's health care experience. Part of the program is the CAHPS survey, which asks questions covering topics focused on several aspects of quality from health plans and providers from the previous year. Below are highlights of questions your patients may be asked about their provider health care experience.

In the last six months, how often did your doctor:

- Have your medical records or other information about your care?

- When a test was ordered, how often did someone from your doctor's office follow-up with you with the results?
- Listen carefully to you?
- Show respect for what you had to say?
- Spend enough time with you?
- Discuss ways to prevent illness?
- Talk about all prescription medicines you were taking?
- Give you the help you needed to manage your care among any different providers and services?

In the last six months, how often:

- Did you get an appointment for a check-up or routine care as soon as you needed?
- Did you get an appointment to see a specialist as soon as you needed?
- When you needed care right away, did you get care as soon as you needed?

Important update to the CAHPS measures

In addition to the traditional survey channels of mail and phone, CMS will distribute surveys through email for beneficiaries who have provided their Health Plan with a valid email address.

MercyOne Health Plan (HMO/PPO) is a Medicare Advantage organization with a Medicare contract. Enrollment in MercyOne Health Plan depends on contract renewal. Benefits vary by county.