

PROVIDER UPDATE

MediGold

MARCH 2024



National Doctors' Day – March 30

On March 30, 1842, anesthesia was administered during surgery for the first time. This date was chosen for National Doctors' Day to commemorate the anniversary of this historic medical milestone. Although the holiday was widely celebrated in intervening years, it wasn't until 1990 that President George H.W. Bush signed National Doctors' Day into law. You'll often see doctors wearing red carnations, which is the symbolic flower to celebrate this day.

It is a holiday that honors 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!



We're Here To Serve You.

MediGold 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)



Provider Administrative Manual (PAM) Now Located Online

We're pleased to announce that the Provider Administrative Manual (PAM) is now available as online content on your website, rather than as a PDF manual. This new platform will allow for easier viewing of all the information you need as a MediGold provider and will also allow for more efficient and timely updates, as needed.

The easy-to-use online manual is divided into clickable sections, including Eligibility and Enrollment, Provider Policies and Protocols, Claims Processing Procedures, and much more. All information from the previous PDF document is included, but it is much easier to review and update.



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CAHPS Surveys Coming This Month

Every year from March to May, the Centers for Medicare & Medicaid Services (CMS) sends the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to select Medicare beneficiaries. This survey measures how well our health plan and providers are serving members. Responses to the CAHPS survey contribute greatly to our health plan's overall quality Star rating. Survey topics include:

- The quality-of-care patients receive from their providers and health plan
- The ease in receiving needed care, tests or treatment
- How quickly members can make an appointment with their providers

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.



Medical Records Requests for HEDIS® and Risk Adjustment

Every year MediGold 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 documentation of specific care events 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 our Medicare Star rating, 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 and Medication Reconciliation Post Discharge
- 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 year's 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 Risk Adjustment Data Validation (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?

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.

When will MediGold 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 MediGold, 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: 614-234-8838

Email: StarsAndHEDIS@mchs.com

CMS Medicare Advantage Reimbursement Model V28 Changes: Cognitive Disease

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

The Cognitive Disease Group had the following changes:

- This group has changed from classifying dementia as complicated or uncomplicated to placing codes into separate HCCs based on severity:
 - V24 HCC 51 (dementia with complications) has been split between V28 HCC 125 (dementia, severe), 126 (dementia, moderate), or 127 (dementia, mild or unspecified)
 - All three severities have the same RAF value
 - HCC 52 (dementia without complication) has removed a few rare causes of dementia or dementia-like disorders such as Tay-Sachs, Krabbe disease, senile degeneration of brain unspecified, and degeneration of the nervous system due to EtOH
 - Important codes to note are that Alzheimer's disease, hydrocephalus, and Lewy body dementia all now fall into V28 HCC 127 (mild dementia)



New Rules Regarding Medical Necessity Criteria

Please be advised that MediGold is in alignment with the 2024 new rules from CMS regarding the posting of Medical Necessity criteria on our website. This information is posted throughout the website for both providers and members. Please contact us if you have any questions:



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

Utilization Management:
1-800-240-3870

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

Dementia

Dementia is an overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities.

Important Coding Information

Dementia is classified based on etiology:

- Vascular, F01.-
- In other diseases classified elsewhere, F02.-
- Unspecified, F03.-

Importation Documentation

The severity of the dementia is crucial for diagnosing:

Stage	Description	ICD-10
Mild dementia	Functional impact on daily life, requires occasional assistance	F01.A-, F02.A-, F03.A-
Moderate dementia	Impact on daily life, no longer independent and requires assistance with daily activities	F01.B-, F02.B-, F03.B-
Severe dementia	Complete dependency due to severe functional impact	F01.C-, F02.C-, F03.C-

In addition to staging, with or without behaviors documentation is required:

- Dementia without behaviors has a 0 as the final character of the diagnosis code
- Dementia with behaviors is represented with the following as the 5th/6th character:
 - -11, Agitation
 - -18, Other specified behaviors
 - -2, Psychotic disturbance
 - -3, Mood disturbance
 - -4, Anxiety

Dementia in Other Diseases

When coding dementia in other diseases, it is crucial to first code the underlying condition, such as the example below:

- Patient has mild dementia without behavioral disturbance due to underlying Parkinson's disease
 - G20.C – Parkinsonism, unspecified
 - F02.A0 – Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety

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!

