MediGold

PROVIDER UPDATE

January 2023

Member rebrand is official!

Effective January 1, our rebrand and new plan names for members are official, enterprise-wide. Although all affected members have been informed, there may still be questions during the transition.

As a reminder, while we will still be known as MediGold to our providers, our members throughout our operating territory will have different plan names, per below:

Saint Alphonsus Health Plan = Idaho members
MediGold MercyOne Medicare Plan = Iowa members
Trinity Health Plan Of New England = Connecticut members
MediGold = New York & Ohio members*

*MediGold will continue to be the marketing name in Ohio and New York for 2023. However, beneficiaries in the Central Ohio market may see materials and advertising using our legal entity name, Mount Carmel Health Plan, as we align more closely with Mount Carmel — our founding partner and a member of Trinity Health.

Any changes in your office for 2023? Please follow these tips

If you have any new practitioners in your office this year, please contact Provider Services at 1-800-991-9907 to see if they are new to our network.

- If they are new to our network, you will need to complete the "Join the Network" application on our website, at https://www.medigold.com/for-providers/join-our-network.
- If they are just new to your office, then a Provider Information Change Form will need to be submitted with a W-9 form. The Provider Information Change Form can be found at https://www.medigold.com/for-providers/tools-and-resources/forms, under Network Providers – Data Update Forms at the bottom of the page.
- Or, if you have a new address or new billing department that has a new financial address, please submit the Provider Information Change Form with the updated information and a W-9 form.

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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. 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 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

Monthly Provider Coding Tips can be found on our website under Provider Tools and Resources

https://www.medigold.com/for-providers/tools-and-resources/stars-and-hedis/risk-adjustment

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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. You may find this information helpful during conversations with your patients.

What is the 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?
- Did you see the person you came to see within 15 minutes of your appointment?

Important Update to the CAHPS Measures

Member satisfaction with the plan and provider remain a critical influencer for the 2023 Star Ratings, now weighted a 4 factor.

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Encourage your patients to schedule an Annual Wellness Visit

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.

Reminders

2023 Member Part D Formulary

In 2023, our members will remain on the same formulary as in 2022 with minimal year-over-year changes. Member disruption is very low, and impacted members have been notified.

Inflation Reduction Act (IRA)

On August 16, 2022, the 2022 Inflation Reduction Act (IRA) was signed into law. This law includes many changes to Medicare Part D that will take place over several years. However, for the 2023 plan year, two provisions from the IRA are now in place effective **January 1, 2023**.

Coverage of Adult vaccines:
Effective January 1, 2023, our plan covers those Part D vaccines recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices at $0 for individuals 19 years of age and older.

Appropriate Cost-Sharing for Covered Insulin Products:
Effective January 1, 2023, our plan covers a one-month supply for each covered Part D insulin product with a copay of no more than $35, no matter what cost-sharing tier it's on and will not charge a deductible. The IRA cost sharing changes for insulins covered under **Part B** will take effect on July 1, 2023.