MDX Hawai'i PROVIDER BULLETIN
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Commercial

Network Alert (Cigna)

Reimbursement policy update – Healthcare Common Procedure Coding System code G0463 billed without appropriate revenue codes effective August 12, 2023

Cigna routinely reviews its coverage, reimbursement, and administrative policies for potential updates. During that review, one or more of the following is taken into consideration: Evidence-based medicine, professional society recommendations, Centers for Medicare & Medicaid Services guidance, industry standards, and Cigna's existing policies.

As a result of a recent review, Cigna will administratively deny Healthcare Common Procedure Coding System (HCPCS) code G0463 for a hospital outpatient clinic visit for the assessment and management of a patient when billed without the appropriate revenue codes 510-529. Denials will include administrative appeal rights.

This update is effective for dates of service on or after August 12, 2023. Cigna will update the Revenue Code Billing Requirements (R41) reimbursement policy to reflect this change.

Reimbursement policy update – Procedure and place of service effective August 12, 2023

Cigna routinely reviews its coverage, reimbursement, and administrative policies for potential updates. During that review, one or more of the following is taken into consideration: Evidence-based medicine (EBM), professional society recommendations, Centers for Medicare & Medicaid Services (CMS) guidance, industry standards, and Cigna's existing policies.

As a result of a recent review, Cigna will implement a new reimbursement policy, Procedure and Place of Service (R43), to administratively deny Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes when billed with an inappropriate place of service (POS) based on the code's description or coding guidelines.

This update is effective for dates of service on or after August 12, 2023. Denials will include administrative appeal rights.

Reimbursement update – Frequency limits to allergy laboratory, testing, and immunotherapy effective August 12, 2023

Cigna routinely reviews its coverage, reimbursement, and administrative policies for potential updates. During that review, one or more of the following is taken into consideration: Evidence-based medicine (EBM), professional society recommendations, Centers for Medicare & Medicaid Services (CMS) guidance, industry standards, and Cigna's existing policies.

As a result of a recent review, Cigna will apply daily medically unlikely edits (MUE), or frequency limits, to allergy laboratory, testing, and immunotherapy services. Cigna will

administratively deny reimbursement for services above the MUE limit set by CMS. Denials will include administrative appeal rights.

This update is effective for dates of service on or after August 12, 2023. Cigna will update the Code Editing Policy and Guidelines to reflect this change.

Medical coverage policy update – Frequency limitation for multiple intra-articular corticosteroid injections effective September 17

Cigna Healthcare will deny intra-articular corticosteroid injections for the treatment of chronic osteoarthritic joint pain as not medically necessary when administered at a frequency greater than either four in a 12-month rolling time frame or two per day. This update is effective for dates of service on or after September 17. Denials will include medical necessity appeal rights. The Miscellaneous Musculoskeletal Procedures - (0515) medical coverage policy will be updated to reflect this change.

Additional information

Letters will be sent by June 16 to notify affected providers. Information about the update will also be included in the third quarter 2023 issue of *Network News* and posted on the Cigna for Health Care Professionals website (CignaforHCP.com).

Reimbursement policy update – Revenue codes 249–259 and 637 billed without a procedure code effective September 17

Cigna Healthcare will administratively deny revenue codes 249–259 and 637 when billed without a procedure code. This update is effective for dates of service on or after September 17. The Revenue Code Billing Requirements (R41) reimbursement policy will be updated to reflect this change. Denials will include administrative appeal rights. However, rather than appealing, providers may re-bill the previously denied revenue code with the corresponding Current Procedural Terminology or Healthcare Common Procedure Coding System code for payment.

Additional information

Letters will be sent by June 16 to notify affected providers. Information about the update will also be included in the third quarter 2023 issue of *Network News* and posted on the Cigna for Health Care Professionals website (CignaforHCP.com).

Specialty Medical Injectables with Reimbursement Restriction list expansion

Effective June 1, Cigna Healthcare expanded its Specialty Medical Injectables with Reimbursement Restriction list to include Qalsody™ (tofersen).* Our Specialty Medical Injectables with Reimbursement Restriction guidelines state that certain injectables must be dispensed and their claims must be submitted by a Cigna Healthcare–contracted specialty pharmacy, unless otherwise authorized by Cigna Healthcare.

The reimbursement restriction list:

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• Applies when the specialty medical injectable is administered in an outpatient hospital setting.
• Applies to specialty medical injectables covered under the customer's medical benefit. Coverage is determined by the customer's benefit plan.
• Does not apply when the specialty medical injectable is administered in a provider's office, nonhospital-affiliated ambulatory infusion suite, or home setting.

*Cigna Healthcare may grant approval for coverage of an initial dose to a facility when medical necessity is met to allow arrangements to obtain the drug from a Cigna Healthcare–contracted specialty pharmacy.

Complex Claim Review program expansion

The Complex Claim Review program focuses on billing and coding accuracy of large-dollar claims submitted by participating and nonparticipating facilities. Effective for dates of service on or after June 15, Cigna Healthcare will expand its noncontracted edit to identify and review all applicable nonparticipating and indemnity claims. Providers will have administrative and medical necessity appeal rights.

Medical coverage policy update – Implementation delay for frequency limitation for COVID-19 antigen and molecular testing

Cigna Healthcare is delaying implementation of the update to its COVID-19: In Vitro Diagnostic Testing (0557) medical coverage policy, originally scheduled for October 14. The update would deny COVID-19 antigen and molecular testing as not medically necessary when administered at a frequency greater than two per day or 12 in a 12-month rolling time frame.

As a result of conversations with internal partners, this medical coverage policy change is being reevaluated and implementation will be delayed. Letters were not mailed to affected providers on July 14 as originally intended. Cigna Healthcare plans to implement the policy update at a future date and will notify affected providers in advance.

Medical coverage policy update – Transthoracic echocardiography codes effective October 25

Cigna Healthcare will update the Transthoracic Echocardiography in Adults (0510) medical coverage policy to remove 151 International Classification of Diseases, Tenth Revision (ICD-10), codes and add eight ICD-10 codes.

Denials will include medical necessity appeal rights. This update is effective for dates of service on or after October 25.

Additional information

A letter will be sent by July 25 to notify affected providers. Information about this policy update will be included in the fourth quarter 2023 issue of Network News and posted on the Cigna for Health Care Professionals website (CignaforHCP.com)

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Medical coverage policy update – Frequency limitation for COVID-19 antigen and molecular testing effective October 14:

Cigna Healthcare will deny COVID-19 antigen and molecular testing as not medically necessary when administered at a frequency greater than two per day or 12 in a 12-month rolling time frame.

This update is effective for dates of service on or after October 14. Denials will include medical necessity appeal rights. The COVID-19: In Vitro Diagnostic Testing (0557) medical coverage policy will be updated to reflect this change.

Medical coverage policy update – Vascular embolization or occlusion for benign prostatic hyperplasia considered experimental, investigational, or unproven effective October 14:

Cigna Healthcare will deny claims for vascular embolization or occlusion billed with Current Procedural Terminology codes 37242 and 37243 as experimental, investigational, or unproven for the treatment of benign prostatic hyperplasia.

This update is effective for dates of service on or after October 14. Denials will include medical necessity appeal rights. The Benign Prostatic Hyperplasia (BPH) Treatments (0159) medical coverage policy will be updated to reflect this change.

Reimbursement policy updates – Anesthesia claims submitted with unbundled codes or modifier AD effective October 14:

Cigna Healthcare will make the following updates effective for dates of service on or after October 14:

Anesthesia claims submitted with unbundled codes The unbundled Current Procedural Terminology (CPT®) code will be administratively denied when billed with one or more anesthesia codes by the same provider on the same day. Denials will include administrative appeal rights.

Reimbursement for anesthesia claims submitted with modifier AD Reimbursement for anesthesia claims submitted with modifier AD and CPT codes 00100–01999 will be reduced to four units – a combination of three base units and one time unit. Denials will include administrative appeal rights.

Additional information will be sent to affected providers by July 14. Information about the update will also be included in the fourth quarter 2023 issue of Network News and on the Cigna for Health Care Professionals website (CignaforHCP.com).

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Commercial Network Alert (Aetna)

The latest OLU newsletter is here

Thank you for being a part of the Aetna® network. Here is the latest edition of the OfficeLink Updates™ (OLU) newsletter, which keeps you updated on important policy changes and other essential news.

If you missed the latest Provider Education Week emails (PDF), you can read them now. Send topic suggestions to New Provider Training anytime.

Your questions answered

Your survey feedback helps us help you.

Last year, Aetna® conducted two surveys. One was specific to your experience of the OfficeLink Updates newsletters and related communications. The other was our yearly provider experience survey.

Thank you to all who took the time to respond. Here are a few answers to get you started.

Q: I need more information about your telemedicine policies, coverage and reimbursement rates.

Telehealth coverage will remain in effect after the Public Health Emergency (PHE) expiration date of May 11. **View the updated COVID-19 FAQs (PDF)** to get the latest telemedicine updates.

Q: I know that you want me to update my provider profile on Availity®, but I'm having trouble doing that.*

We created a **new quick reference guide (PDF)** to make updating your provider profile easier. First, log in to our **Availity provider portal**. Next, navigate to My Provider and then to Provider Data Management (PDM). Follow the steps in the guide to update your:

- Email address
- Service location
- Appointment phone number
- Telehealth status
- NPI number and more

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Q: I'm confused about when to use Availity® versus Aetna.com.*

Attend our **Doing business with Aetna® — new provider onboarding** webinar, which will cover this topic. The webinar is available to our existing providers and staff members on the **second Tuesday** and **third Wednesday** of each month from 1:00 PM to 2:15 PM ET.

Read the full Q&A

End of the Public Health Emergency (PHE) phase

The U.S. Department of Health and Human Services announced in February 2023 that the COVID-19 PHE "emergency phase" would expire on May 11, 2023.
View the most current **COVID-19 information**.

How to give feedback
Have a question about an OLU article? Have a topic you'd like us to address? **Send us your questions and comments**.
If you have a question unrelated to OLU, you can go to our **Contact Aetna** page or use the "Contact Us" form on **Availity**.*

*Availity® is available only to providers in the U.S. and its territories.

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Help/contact us: If you have any questions, please **contact us**.

aetna®

August 2023

This month's 90-day notices and related reminders

We regularly review and adjust our clinical, payment and coding policies. Review our policies and claim edits on our Availity® provider portal.* Just go to **Payer Space > Resources > Expanded Claim Edits.**

Or you may visit **Aetna.com** to see them.

Changes to our National Precertification List (NPL)

This update applies to both our commercial and Medicare members.

New-to-market drugs that require precertification

- Elfabrio® (pegunigalsidase alfa-iwxj) — precertification is required for the drug and site of care effective August 1, 2023. This drug is part of the enzyme replacement drugs category.

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- Vyjuvek™ (beremagene geperpavec) — precertification is required effective August 11, 2023.

Submitting precertification requests

Be sure to submit precertification requests at least two weeks in advance. To save time, request precertification online. Doing so is fast, secure and simple.

You can submit most requests online through our **Availity provider portal**.* Or you can use your practice's Electronic Medical Record (EMR) system if it's set up for electronic precertification requests. Use our "Search by CPT® code" search function on our **precertification lists** page to find out if the code requires precertification.**

Learn more about **precertification**.

Are you asking for precertification on a specialty drug for a commercial or Medicare member? Then submit your request through Novologix®, also available on Availity®. Not registered for Availity? Go to **Availity** to register and learn more.

Our annual transition to the new edition of the Milliman Care Guidelines® (MCG)

We use evidence-based clinical guidelines from nationally recognized authorities, such as MCG Health, to make utilization management (UM) decisions.

Every year, we coordinate with MCG Health to update to the latest MCG edition. Starting April 29, 2023, we started using the 27th edition of the MCG and will continue to use it for designated reviews.

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You can always find this information on our Availity provider portal.*

Access Availity

You can also use our Code Edit Lookup tools on Availity. Just go to **Payer Space > Applications > Code Edit Lookup Tools.**
And keep your Aetna® provider ID number handy to access them.

*Availity is available only to providers in the U.S. and its territories.

Help/contact us: If you have any questions, please **contact us**.

Want to stop receiving messages like these through email? **Unsubscribe** at any time.

We are located at 151 Farmington Avenue, Hartford, CT 06156.

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2483997-01-01

Burden of Illness (BOI) Program

Summary of MIP Changes with the Blended Model

On March 31, 2023, CMS released the 2024 Final Rate Announcement, and it includes changes to the Risk Model that will now be phased in over three years.

For CY 2024, risk scores will be calculated as a blend of 67% of the risk scores calculated with the current model (v24) and 33% of the risk scores calculated with the updated model (v28). For CY 2025, risk scores will be calculated as a blend of 33% of the risk scores calculated with v24 and 67% of the risk scores calculated with v28, and for CY 2026, 100% of the risk scores will be calculated with v28.

With this change, providers can see open and already assessed chronic conditions, and suspect conditions in both the v24 and v28 CMS risk models on the MIP. If a diagnosis code maps to an HCC that is risk adjusting in the v24 or the v28 risk models, it will appear on the MIP. ***This may mean that there will be more conditions on the MIP until the model is fully phased in. The actions that a provider needs to take are unchanged. They should continue to assess, suppress, and acknowledge as they have in the past.***

These changes will impact paper MIPs and integrated EMR MIPs. iMIP will be updated soon.

Here are examples of how these changes will be displayed:

Example #1: v28 codes now appear on the MIP if a v28 risk adjusting condition is in a patient's known condition history.

H34.8310 is a v28 only condition that was reported in a member's known condition history. It maps to HCC 298 in v28.

BEFORE - MIP shows conditions in only the v24 risk model:

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Member Information Profile

	Female	Member Ph#: (	PCP (per HP): Kohli, MD, Anumeha
Last Annual Visit: 08/17/2022	Member ID: 146049	Ins: UHC PPO	SCP (per EMR): Kohli, MD, Anumeha
Next Sched. Visit:		RBEL: Premier - Medical Village	Clinical Chart Review: 2/5/2021

No Open Conditions to Assess - No Action Required at the time of the MIP Print

Conditions Already Assessed This year:

· To suppress a condition that has already been assessed, please draw a line through the code and indicate reason for suppression (e.g. resolved)

Code	Description	Assessed By	Specialty	Assessed Date (Curr Yr DOS)
I48.91	Unspecified atrial fibrillation	Anumeha Kohli	Internal Medicine	01/11/2023
I73.9	Peripheral vascular disease, unspecified	Anumeha Kohli	Internal Medicine	01/11/2023

Non-PCP Visits

Provider	Specialty	Last DOS
Rita Schultz	Family Medicine	06/05/2021
Robina Poonawala	Family Medicine	04/26/2018

AFTER - MIP shows conditions in both the v24 and v28 risk models:

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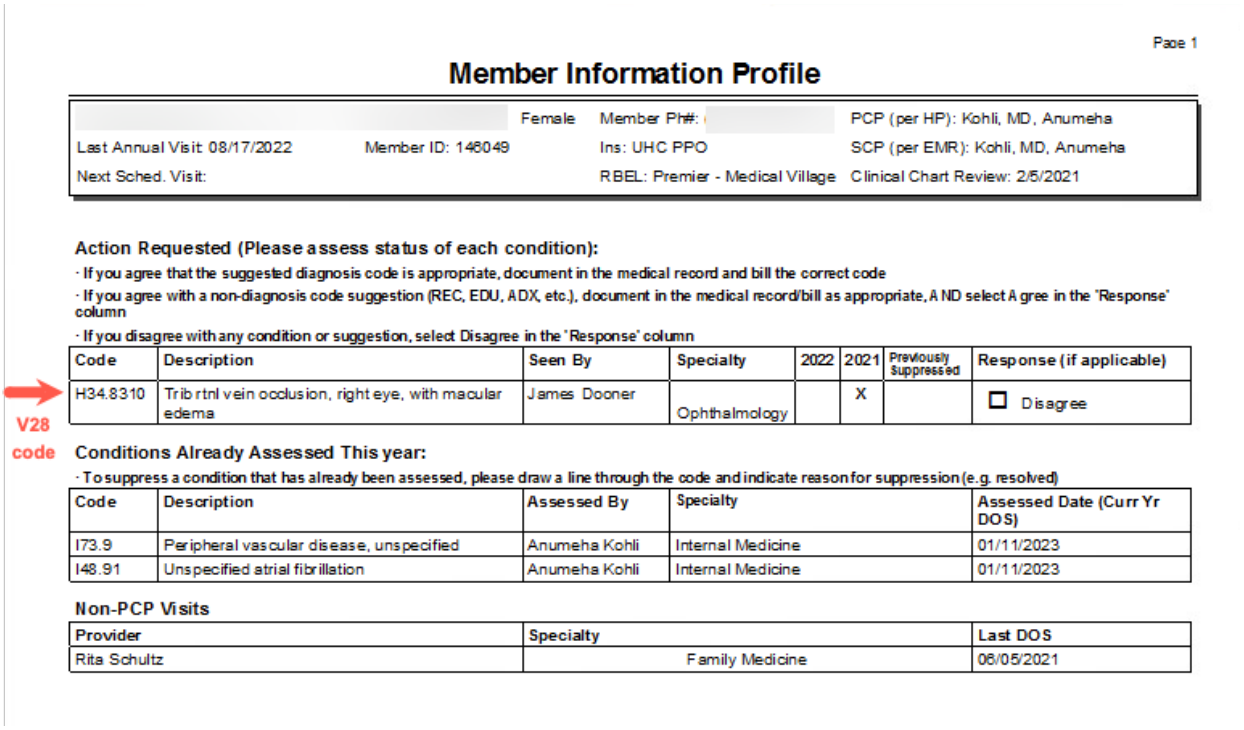

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Member Information Profile

	Female	Member Ph#:	PCP (per HP): Kohli, MD, Anumeha
Last Annual Visit 08/17/2022	Member ID: 146049	Ins: UHC PPO	SCP (per EMR): Kohli, MD, Anumeha
Next Sched. Visit:		RBEL: Premier - Medical Village	Clinical Chart Review: 2/5/2021

Action Requested (Please assess status of each condition):

· If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code

· If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the "Response" column

· If you disagree with any condition or suggestion, select Disagree in the "Response" column

Code	Description	Seen By	Specialty	2022	2021	Previously suppressed	Response (if applicable)
H34.8310	Trib rtnl vein occlusion, right eye, with macular edema	James Dooner	Ophthalmology		X		☐ Disagree

V28 code

Conditions Already Assessed This year:

· To suppress a condition that has already been assessed, please draw a line through the code and indicate reason for suppression (e.g. resolved)

Code	Description	Assessed By	Specialty	Assessed Date (Curr Yr DOS)
I73.9	Peripheral vascular disease, unspecified	Anumeha Kohli	Internal Medicine	01/11/2023
I48.91	Unspecified atrial fibrillation	Anumeha Kohli	Internal Medicine	01/11/2023

Non-PCP Visits

Provider	Specialty	Last DOS
Rita Schultz	Family Medicine	08/05/2021

Example #2: v28 suspect condition codes now appear on the MIP when suggested by a chart reviewer during PMRR.

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PMRR reviewer suggested D86.86, a v28 only condition:

BEFORE - MIP shows conditions in only the v24 risk model:

Member Information Profile

	Male	Member Ph#:	PCP (per HP): Halmari, PA, Irene
Last Annual Visit: 09/15/2021	Member ID:	Ins: Blue Cross Blue Shield	SCP (per EMR):
Next Sched. Visit:		RBEL: CMC	Clinical Chart Review:

Action Requested (Please assess status of each condition):

- If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code
- If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the 'Response' column
- If you disagree with any condition or suggestion, select Disagree in the 'Response' column

Code	Description	Seen By	Specialty	2022	2021	Previously Suppressed	Response (if applicable)
G91.2	(Idiopathic) normal pressure hydrocephalus	Kim Nunez	Nurse Practitioner - Adult Health	X	X		☐ Disagree
F32.0	Major depressive disorder, single episode, mild	David Vo	Internal Medicine		X		☐ Disagree
G21.9	Secondary parkinsonism, unspecified	Kim Nunez	Nurse Practitioner - Adult Health	X	X		☐ Disagree
I70.203	Unsp athscl native arteries of extremities, bilateral legs	BRYAN REVELLE	Podiatrist		X		☐ Disagree

Non-PCP Visits

Provider	Specialty	Last DOS
Gregg Vagner	Orthopaedic Surgery	04/12/2019

AFTER - MIP shows conditions in both the v24 and v28 risk models:

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Member Information Profile

	Male	Member Ph#:	PCP (per HP): Halmari, PA, Irene
Last Annual Visit: 09/15/2021	Member ID:	Ins: Blue Cross Blue Shield	SCP (per EMR):
Next Sched. Visit:		RBEL: CMC	Clinical Chart Review: 4/27/2023

Action Requested (Please assess status of each condition):

- If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code
- If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the 'Response' column
- If you disagree with any condition or suggestion, select Disagree in the 'Response' column

Code	Description	Seen By	Specialty	2022	2021	Previously Suppressed	Response (if applicable)
G91.2	(Idiopathic) normal pressure hydrocephalus	Kim Nunez	Nurse Practitioner - Adult Health	X	X		☐ Disagree
F32.0	Major depressive disorder, single episode, mild	David Vo	Internal Medicine		X		☐ Disagree
G21.9	Secondary parkinsonism, unspecified	Kim Nunez	Nurse Practitioner - Adult Health	X	X		☐ Disagree
I70.203	Unsp athscl native arteries of extremities, bilateral legs	BRYAN REVELLE	Podiatrist		X		☐ Disagree
D86.86	Sarcoid arthropathy	v28 suspect condition test					☐ Disagree

Non-PCP Visits

Provider	Specialty	Last DOS
Gregg Vagner	Orthopaedic Surgery	04/12/2019

Example #3: v28 codes now appear on the MIP as already assessed if they were already assessed this year.

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L12.0 is a v28 only code that maps to HCC 387 in v28. This patient has a known history of this condition and already has this condition assessed in the current calendar year (2023).

BEFORE - MIP shows conditions in only the v24 risk model:

Member Information Profile

	Female	Member Ph#:	PCP (per HP): Tannous, MD, Rawah
Last Annual Visit: 05/31/2019	Member ID: M27622	Ins: HUMANA HMO	SCP (per EMR):
Next Sched. Visit:		RBEL: ARC Southwest	Clinical Chart Review: 5/29/2019

Action Requested (Please assess status of each condition):

· If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code

· If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the 'Response' column

· If you disagree with any condition or suggestion, select Disagree in the 'Response' column

Code	Description	Seen By	Specialty	2022	2021	Previously Suppressed	Response (if applicable)
E46	Unspecified protein-calorie malnutrition	DAVID SEKONS	Surgery	X			☐ Disagree
F03.918	Unsp dementia, unsp severity, with other behavioral disturb	CAROLYN TRAN	Registered Nurse	X	X		☐ Disagree
F32.1	Major depressive disorder, single episode, moderate	Anjana Philip	Internal Medicine		X		☐ Disagree
I70.203	Unsp athscl native arteries of extremities, bilateral legs	BRIAN LEYKUM	Podiatry	X	X		☐ Disagree
N18.30	Chronic kidney disease, stage 3 unspecified	Lori Brown-Duncan	Nurse Practitioner - Family	X			☐ Disagree

Conditions Already Assessed This year:

· To suppress a condition that has already been assessed, please draw a line through the code and indicate reason for suppression (e.g. resolved)

Code	Description	Assessed By	Specialty	Assessed Date (Curr Yr DOS)
I50.32	Chronic diastolic (congestive) heart failure	Anjana Philip	Internal Medicine	01/16/2023
I48.91	Unspecified atrial fibrillation	Anjana Philip	Internal Medicine	01/16/2023

Non-PCP Visits

Provider	Specialty	Last DOS
BRIAN LEYKUM	Podiatry	03/07/2022
ANGELA AKIN	Family Medicine	05/05/2020
Meghana Dandekar	Family Medicine	06/08/2018
Swapna Manthena	Family Medicine	05/01/2017
Rodolfo Gutierrez-Macias	Family Medicine	09/30/2016

AFTER - MIP shows conditions in both the v24 and v28 risk models:

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Member Information Profile

	Female	Member Ph#:	PCP (per HP): Tannous, MD, Rawah
Last Annual Visit: 05/31/2019	Member ID: M27622	Ins: HUMANA HMO	SCP (per EMR):
Next Sched. Visit:		RBEL: ARC Southwest	Clinical Chart Review: 5/29/2019

Action Requested (Please assess status of each condition):

- If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code
- If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the 'Response' column
- If you disagree with any condition or suggestion, select Disagree in the 'Response' column

Code	Description	Seen By	Specialty	2022	2021	Previously Suppressed	Response (if applicable)
E46	Unspecified protein-calorie malnutrition	DAVID SEKONS	Surgery	X			☐ Disagree
F03.918	Unsp dementia, unsp severity, with other behavioral disturb	CAROLYN TRAN	Registered Nurse	X	X		☐ Disagree
I70.203	Unsp athscl native arteries of extremities, bilateral legs	BRIAN LEYKUM	Podiatry	X	X		☐ Disagree
F32.1	Major depressive disorder, single episode, moderate	Anjana Philip	Internal Medicine		X		☐ Disagree
N18.30	Chronic kidney disease, stage 3 unspecified	Lori Brown-Duncan	Nurse Practitioner - Family	X			☐ Disagree

Conditions Already Assessed This year:

- To suppress a condition that has already been assessed, please draw a line through the code and indicate reason for suppression (e.g. resolved)

Code	Description	Assessed By	Specialty	Assessed Date (Curr Yr DOS)
F03.90	Unsp dementia, unsp severity, without beh/psych/mood/anx	Anjana Philip	Internal Medicine	01/16/2023
I50.32	Chronic diastolic (congestive) heart failure	Anjana Philip	Internal Medicine	01/16/2023
I48.91	Unspecified atrial fibrillation	Anjana Philip	Internal Medicine	01/16/2023
L12.0	Bullous pemphigoid	Anjana Philip	Internal Medicine	01/16/2023

V28 code

Non-PCP Visits

Provider	Specialty	Last DOS
BRIAN LEYKUM	Podiatry	03/07/2022

Example #4: Similar codes appear on the MIP more than once, whereas previously they would not, because of the addition of the V28 risk model

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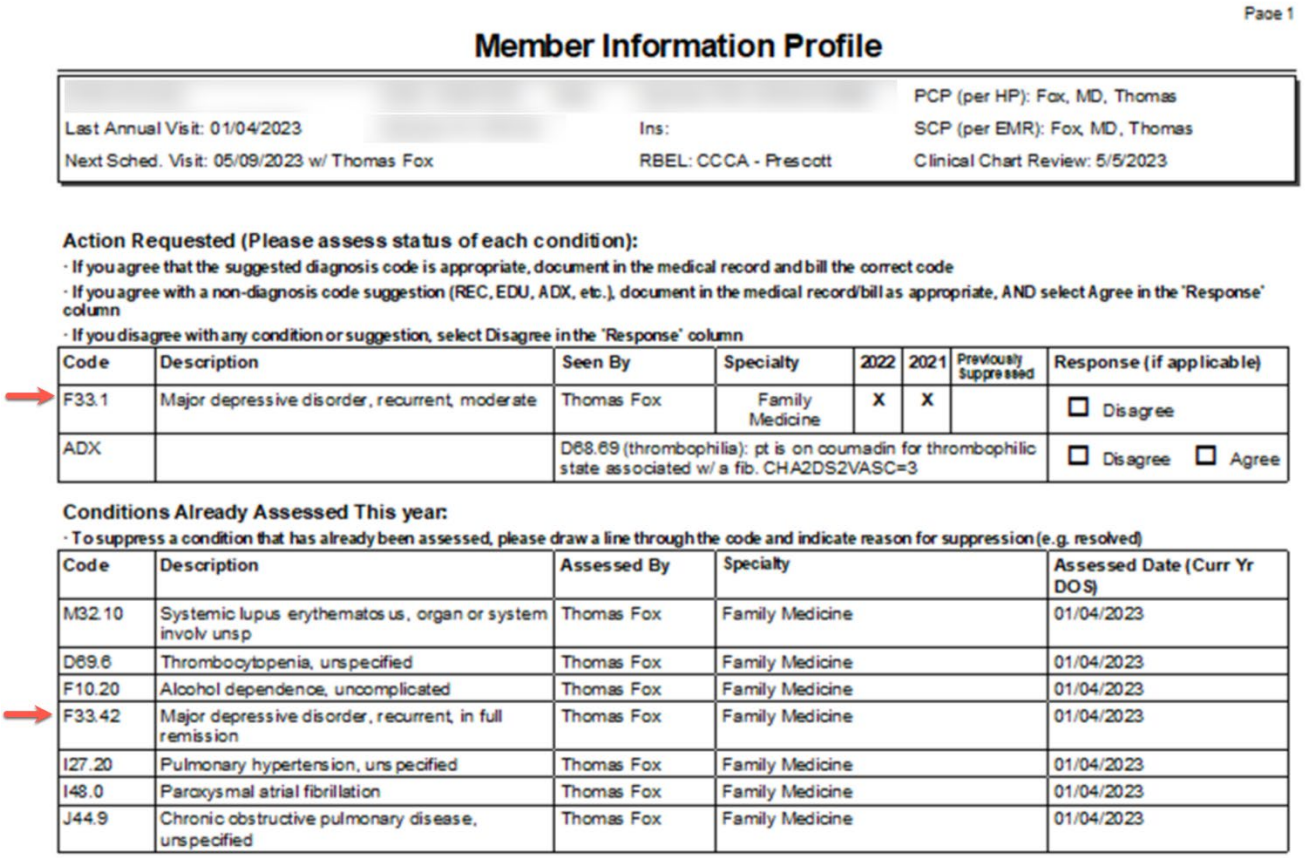
This patient has a known history of F33.1 and F33.41. F33.42 is captured in the current year. All three Dx codes belong to HCC 59 in V24. However, with a MIP that has been modified to show conditions across both risk models, F33.1 appears as needing reassessment and F33.42 appears as "already assessed this year".



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Member Information Profile

		PCP (per HP): Fox, MD, Thomas
Last Annual Visit: 01/04/2023	Ins:	SCP (per EMR): Fox, MD, Thomas
Next Sched. Visit: 05/09/2023 w/ Thomas Fox	RBEL: CCCA - Prescott	Clinical Chart Review: 5/5/2023

Action Requested (Please assess status of each condition):

- If you agree that the suggested diagnosis code is appropriate, document in the medical record and bill the correct code
- If you agree with a non-diagnosis code suggestion (REC, EDU, ADX, etc.), document in the medical record/bill as appropriate, AND select Agree in the 'Response' column
- If you disagree with any condition or suggestion, select Disagree in the 'Response' column

Code	Description	Seen By	Specialty	2022	2021	Previously Suppressed	Response (if applicable)
F33.1	Major depressive disorder, recurrent, moderate	Thomas Fox	Family Medicine	X	X		☐ Disagree
ADX		D68.69 (thrombophilia): pt is on coumadin for thrombophilic state associated w/ a fib. CHA2DS2VASC=3					☐ Disagree ☐ Agree

Conditions Already Assessed This year:

- To suppress a condition that has already been assessed, please draw a line through the code and indicate reason for suppression (e.g. resolved)

Code	Description	Assessed By	Specialty	Assessed Date (Curr Yr DOS)
M32.10	Systemic lupus erythematosus, organ or system involv unsp	Thomas Fox	Family Medicine	01/04/2023
D69.6	Thrombocytopenia, unspecified	Thomas Fox	Family Medicine	01/04/2023
F10.20	Alcohol dependence, uncomplicated	Thomas Fox	Family Medicine	01/04/2023
F33.42	Major depressive disorder, recurrent, in full remission	Thomas Fox	Family Medicine	01/04/2023
I27.20	Pulmonary hypertension, unspecified	Thomas Fox	Family Medicine	01/04/2023
I48.0	Paroxysmal atrial fibrillation	Thomas Fox	Family Medicine	01/04/2023
J44.9	Chronic obstructive pulmonary disease, unspecified	Thomas Fox	Family Medicine	01/04/2023

Quality/STARS Program

Aloha Providers,

We are currently in the middle of our **2022 retrospective chart chase** and we have partnered again this year with Advantmed to assist us with retrieving charts for **dates of service 2022 to current**. Thank you to those providers who have already submitted their charts for review. If you are still working on getting charts, the deadline is October 1st, 2023 to ensure that charts are coded and reviewed by the end of this year. There is always an extension until 12/31/23 for Advantmed to code out the rest of the charts but there is no guarantee that these will be submitted to CMS for the 2023 deadline so the earlier they can obtain record and code them out, the better. This also allows the quality team to abstract records for 2023 STAR year.

You can submit your charts to Advantmed:

1. By uploading charts directly to their secure site
    a. http://www.advantmed.com/uploadrecords
2. By secure e-mail or fax (toll free):
    a. E-mail: records@advantmed.com
    b. (800)340-7804 (Main Fax Line)
    c. (949)222-0185 (Alternate Fax Line)
3. Remote EMR:
    a. To begin set up for remote EMR download by Advantmed's trained Medical Record Technicians, email necessary forms to RemoteAccess@advantmed.com. Please provide a point of contact and number for further communication.
4. By Mail:
    a. 17981 Sky Park Circle, Building 39/Suite B & C, Irvine, CA 92614
5. To schedule an onsite appointment:
    a. Please contact Advantmed at (800)698-1690.

Thank you for partnering with us & taking care of our members.

Kidney Health Evaluation for Patients with Diabetes (KED)
***Display Measure in 2023**

The American Diabetes Association and National Kidney Foundation recommend that patients with diabetes have annual kidney health evaluations. The KED measure requires patients have the following test each year:
(1) Estimated Glomerular Filtration rate (eGFR)
(2) Urine albumin to creatinine ratio (uACR)- 2 tests- quantitative urine albumin and urine creatinine with service dates 4 days or fewer apart
The evaluation and monitoring of kidney health is an essential component to address chronic conditions and prevent complications.

Test	CPT II codes*
Estimated Glomerular Filtration rate	82565
Quantitative urine albumin	82043
Urine creatinine	82570

Required Exclusions	Code*	Timeframe
Hospice	99377, 99378	Any time during the measurement year
Palliative Care	Z51.5	
Members who died		

Members with evidence of ESRD or dialysis	N18.5, N 18.6 and Z99.2	Any time during the member's history on or prior to December 31 of the measurement year
Frailty		Frailty diagnosis must be in the measurement year and on 2 separate dates of service
Members enrolled in an institutional special needs plan or members living long term in an institution		Any time during the measurement year
Members with no diagnosis of diabetes and a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes		Any time during the measurement year or the year prior to the measurement year

*Codes can be used to close HEDIS numerator gaps in care

How you can help:

1. Educate patients about the importance of having these labs completed annually. Order and request labs to have members complete prior to their appointment. This will allow the results to be available for discussion on the day of office visit.
2. Educate patients that some complications from diabetes may be asymptomatic and routine testing may help prevent complications or detect early disease thereby early intervention.
3. Create reminders in the electronic medical record to alert when patients are due for screening.

If you perform these tests through DLS or CLH, we will be able to obtain the results directly from them. However, if you perform this test in other labs, please be sure that they are submitting those codes on a claim to show that it was completed.

The quality team has started auto-faxing the Provider Quality Opportunities Report (PQOR) using a robotics program this past August. We would like to say a big "Thank you" for sending in the medical records to close the HEDIS quality care gaps. Please continue to fax/email your patient's medical records, especially the latest hemoglobinA1c test results and the latest blood pressure (both triple-weighted on your STAR scorecard).

Attn: Quality Analysts at Fax # 808-451-2201 or email QualityAnalysts@mdxhawaii.com

Focus on Monitoring Urinary Incontinence (Bladder Control)

MDX Hawaii PROVIDER BULLETIN

October 2023 Volume 4, Issue 5

The 2 questions that your patients are asked during the CMS Health Outcomes Survey (HOS) regarding bladder control:

1. In the past 6 months, have you experienced leakage of urine? How much did leaking of urine make you change your daily activities or interfere with your sleep?
2. Have you discussed treatment options with your doctor or other healthcare provider?

In the USA, 51% of women and 14% of men experience urinary incontinence. Adults who experience urinary incontinence report worse physical health, mental health, and quality of life. For older adults, it can potentially reduce the ability to socialize and be independent. Discussing this clinical indicator with your patients can help build trust and improve their overall well-being.

Centers for Medicare and Medicaid (CMS) administers the HOS Survey to Medicare Advantage patients from August to November. Patients are randomly selected and will be surveyed twice over a 2-year period. HOS comprises a total of 13% of the STAR Ratings result in 2022. This is one of the HOS questions where our MDX Hawaii providers rated lower than the national average. For Humana, we show 40.53% and for UHC we show 53% (pdf attached files).
How you can help:
1. Screen regularly and ask your patients to complete a bladder control assessment/ check list in person or prior to the visit. MDX has 1 page questionnaire that you can use while patients are waiting to see you, or you can have your MA ask these questions prior to your telehealth visit.
2. We have buttons you can wear that have the patient ask you about bladder control. These little triggers help patients who are too shy to just bring it out and remind patients that you asked them about this when the survey comes out. MDX Hawaii has buttons and can send them to your office free of charge. Let us know if you want some.
3. Discuss with patients if they are having difficulty with urine leakage.
4. Ask patients to keep a daily diary tracking when they urinate and when they experience urine leakage.
5. Determine if exercise or other treatment options, such as medications or PT or surgery may help.
5. If surgery is needed, refer the patient to a specialist to follow through on the care plan.
6. Consider using screen savers or display posters in waiting or exam rooms. MDX Hawaii has flyers, posters, waiting room slides, and waiting room questionnaires. Please let us know if you want any materials free of charge.
We value your support and partnership with taking care of our members!

If you have questions or would like more support or resources, please contact the Quality Team at QualityAnalysts@mdxhawaii.com or send us a fax at (808)-451-2201.

Clinical Programs

MDX Hawai'i PROVIDER BULLETIN
October 2023 Volume 4, Issue 5

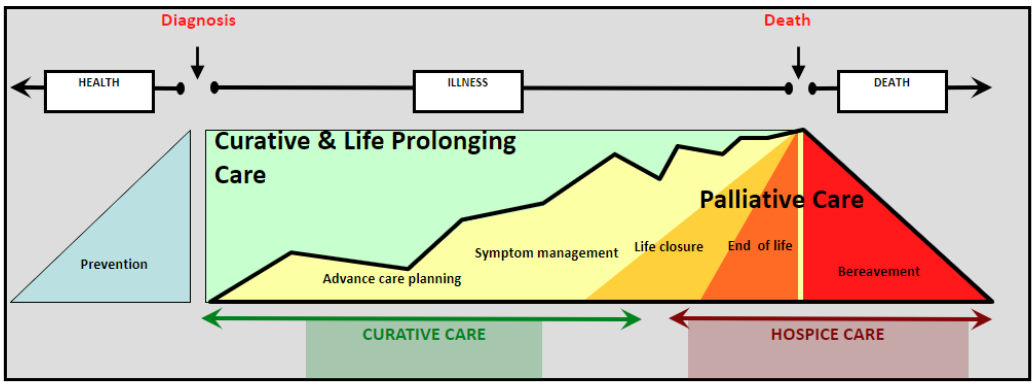
Palliative Care

- This new program was created to ensure critical support for patients with serious illnesses. Patients have in-home support from the palliative team that includes a palliative medicine physician, nurse practitioner, social worker, registered nurse case manager, pharmacist, and chaplain.
- MDX will cover the total cost of the program up to 90 days with the potential for an extension - requires PCP request and medical review. Some patients will stabilize and transition to a lower acuity program. Others will continue and be admitted to hospice. MDX will provide PCP with a list of eligible patients. With agreement from PCP and patient/family, referrals are made to the preferred agency.
- The patients' goals for care guide the team and care plan to reduce harm, increase quality of life, manage pain and symptoms and transition to hospice care when requested.

Bristol Healthcare Services HOSPICE MAUI Kaua'i Hospice a special kind of caring

Palliative Program Overview

Purpose	To **improve quality of life** for patients with a **serious illness**	**Target Population**	In collaboration with PCPs, patients with **serious illness** and a high palliative care score of .9 and above
Interventions	1. **Advance care planning (ACP)** to discuss patient's values, beliefs, and healthcare goals. ACP includes goals of care, health care proxy, and advanced directives 2. **Pain and symptom management** from palliative provider (either in home, office, or virtual) 3. **Care transitions** into hospice at appropriate time		



MDX Hawai'i PROVIDER BULLETIN
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Ala'O Ho'ola, *Pathways to Healing*

- This ***referral-based program*** supports high-risk or rising-risk patients who could benefit from additional help to manage complex health conditions.
- The patient has access to a care management team that includes a registered nurse care manager, nurse practitioner, pharmacist, and care management coordinator.
- Patients are actively engaged for 2-6 months depending on complexity of needs and patient preference.
- Nurse care managers identify patient goals, barriers and provide health education to help patients understand their conditions and how to remain healthy at home.
- ***Pathways to Healing*** helps members and their families develop all aspects of a care plan including end of life care planning including palliative care or transition to hospice.