Provider UPDATE

MOUNT CARMEL Health Plan MediGold

February is American Heart Month

It's a fact. One person dies about every 33 seconds in the U.S. from cardiovascular disease, making heart disease the leading cause of death for men, women and people of most racial and ethnic groups in the U.S.[1] Hypertension (high blood pressure), high blood cholesterol and smoking are key risk factors for heart disease. But there is much that can be done to help prevent and reduce the chances of heart disease by mitigating these risk factors in your patients.[2] American Heart Month in February is an excellent time to share this information with them.

Medication adherence is critical to successful hypertension control for many patients. But it is estimated that over half the medications prescribed for people with chronic diseases, like heart disease, are not taken as directed.[3] And, only 51% of Americans treated for hypertension follow their health care professional's advice when it comes to their long-term medication therapy, according to the Centers for Disease and Control (CDC), Division for Heart Disease and Stroke Prevention.

As a health care professional, you can empower patients to take their medications as prescribed. Effective two-way communication is critical; in fact, it doubles the odds of your patients taking their medications properly. Try to understand your patients' barriers and address them honestly to build trust.

For more information, please go to the Million Hearts® 2027 website, which details steps health professionals and others can take to reduce the number of lives taken and protecting more of the lives impacted by heart disease and stroke in the U.S. Go to https://millionhearts.hhs.gov/about-million-hearts/index.html.

[1] National Center for Health Statistics. Multiple Cause of Death 2018–2021 on CDC WONDER Database. Accessed February 2, 2023.

[2] https://www.cdc.gov/heartdisease/facts.htm

[3] https://www.heart.org/en/health-topics/consumer-healthcare/medication-information/medication-adherence-taking-your-meds-as-directed

WE'RE HERE TO SERVE YOU.

MediGold.com/For-Providers

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

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.

Please Submit New Diabetic Testing Refill

Our members must now obtain their diabetic testing supplies and continuous glucose monitors at any of our in-network retail pharmacies nationwide or our mail order pharmacy, CVS Caremark. Only the following brands will be covered by the plan: Lifescan (OneTouch) and Roche (Accu-Chek) for test strips and glucose monitors and DexCom and Freestyle Libre for CGM 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 call 1-800-991-9907 (TTY:711).

Best Practices for Coding/Documentation

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:

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 as 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.

Important 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

Monthly Coding Tips can be found on the website under Provider Tools and Resources https://www.medigold.com/for-providers/tools-and-resources/stars-and-hedis/risk-adjustment

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 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 CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on 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.

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

- 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:

- Review of medical history and current conditions
- Risk factors
- 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.

CMS Medicare Advantage Reimbursement Model V28 Changes: Liver Disease

In 2024, CMS is shifting from 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 Liver Disease Group had the following changes:

- Two new HCCs were added:
  - HCC 62 (liver transplant status/complications)
  - HCC 68 (cholangitis and obstruction of bile duct without gallstones)
- V24 HCC 27(end-stage liver disease) had all its codes moved to V28 HCC 63 (chronic liver failure/end-stage liver disorders) except for two codes being removed from the model, K71.11 (toxic liver disease with hepatic necrosis, with coma) and K72.01 (acute and subacute hepatic failure with coma)
- V24 HCC 28 (cirrhosis of liver) had most of its codes moved to V28 HCC 64 (cirrhosis of liver) resulting in a RAF increase of 0.027 with a few exceptions:
  - (K70.40, alcoholic hepatic failure without coma) was moved to HCC 63 with a RAF increase of 0.675
  - (K74.3 and K74.5 for primary and unspecified biliary cirrhosis) were moved to V28 HCC 68 (cholangitis and obstruction of bile duct without gallstones) with a RAF decrease of 0.058
  - (K70.9 alcoholic liver disease unspecified and K70.41 alcoholic hepatic failure with coma) were removed from the model
- V24 HCC 29 (chronic hepatitis) had all its codes moved to V28 HCC 65 (chronic hepatitis) with a RAF decrease of 0.019

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

Do You Have Access to Our Provider Portal?

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

Update to Prior Authorization List

With the 2024 new rules from the Centers for Medicare & Medicaid Services (CMS) regarding the Inpatient Only codes, the plan has continued to keep these procedures on our Prior Authorization List. At the time of admission, the plan must be notified.

These reviews will be done in two steps; the first being the prior authorization for the code to be performed and the second step being the validation of the code performed and bed type determination. Please use contact information for Utilization Management below, as needed:

- Utilization Management: 1-800-240-3870
- Prior Authorization Fax and Email: 1-833-263-4869, PriorAuth@MediGold.com
- Hospital Admission Fax and Email: 1-833-263-4866, Inpatient@MediGold.com

As a reminder, Mount Carmel MediGold requires prior authorization on select services through our utilization management team.

Please review the Prior Authorization List for codes/services requiring prior authorization.

Medicare Advantage 30-Day Readmission Claim Submission Guidance

In concurrence with our readmissions policy effective 1/1/24, as outlined in the January 2024 Provider Update, approved 30-day readmissions must be combined with the initial admission and reported on the same UB-04 claim form. Claim reimbursement will be administered as one claim and one reimbursement methodology in accordance with the Hospital's *Reimbursement Schedule* of their contract.*

Always submit claims per the direction of the authorization and level of care made by the Plan. An encounter identified by the Plan as a readmission within 30 days of the initial admission must be combined and submitted with the following data elements**:

- Occurrence span code 74: Report dates leave of absence (LOA) began and ended.

Following ***optional*** data element may be used to further define claim as having non-covered LOA days:

- Revenue Code 018X: Leave of absence days may be shown under revenue code 018x. (Claims will NOT be denied if revenue code 018X is omitted.)

Mount Carmel MediGold adheres to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.6.

**Please note that previously paid inpatient encounters deemed to include days related to the approved 30-day readmission will be recouped with final payment administered on final claim. Correct billing guidelines must be adhered to for the Plan to facilitate timely and accurate claims payment.*

***Also, claims that are not submitted correctly as a readmission will be denied with explanation Code D9 (claim not billed as resubmission-resubmit for consideration) and CARC Code 249 (This claim has been identified as a readmission.) If you have any questions about this new process, please contact our Provider Service Center at 1-800-991-9907 (TTY:711)*