America's 1st Choice of South Carolina, Inc.

AFC HMO Provider Newsletter

AFC CONNECT

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AORTIC ATHEROSCLEROSIS

Is it the Vessel or Valve?

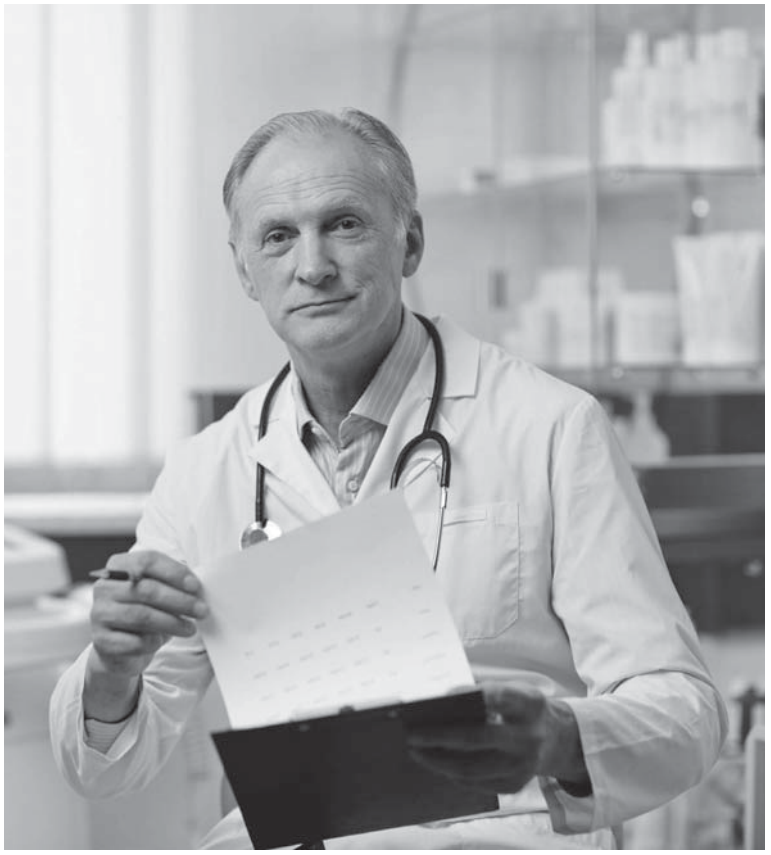
Atherosclerosis of the Aorta is a common disease in the elderly but often an overlooked diagnosis in progress note documentation. This diagnosis is often found noted on diagnostic tests such as chest x-rays, however, diagnostic tests and lab reports are unacceptable medical record data sources for Risk Adjustment. Therefore, it is imperative to assess and document pertinent diagnoses resulting from diagnostic tests and lab reports within a face-to-face visit progress note.

A diagnosis of "Aortic Atherosclerosis" does not support assignment of an ICD-10 code. Documentation must specify if you are referring to the vessel (aorta) or the valve for accurate code assignment.

Atherosclerosis (arteriosclerosis or stenosis) of the Aortic Valve is coded to ICD-10 Category I35 for Non-Rheumatic Aortic Valve Disorders and does not risk adjust. Conversely, Atherosclerosis of the Aorta falls under CMS HCC 108 and is weighted for risk adjustment purposes.

Important Points to Remember:

1. Ensure your documentation clearly identifies Atherosclerosis of the Aorta or of the Valve.
2. Provide objective evidence of the atherosclerosis (imaging) that distinguishes between valve and vessel disease.
3. Assign the correct ICD-10 diagnosis code of I70.0 for Atherosclerosis of the Aorta and category I35.x for Sclerosis and stenosis of the Aortic Valve with the appropriate 4th character selected based upon documented specificity.



ADVANCE DIRECTIVES
A Patient's Right to Decide

According to state and federal laws, patients have the right to decide how they are medically treated, even if they are not able to speak or make their wishes known. The Plan does not condition treatment based on whether or not a patient has executed an advance directive. We expect our contracted providers to uphold this standard of non-discrimination as well.

In order to prepare for these situations in advance, we encourage our members to express their wishes by filing advance directives. It is a patient's individual choice whether or not to file an advance directive. Common types of advance directives include Living Wills, Health Care Surrogates and Anatomical Donations.

Remember, a patient's medical record must contain documentation of whether or not the individual has executed an advance directive; documentation is to be displayed in a prominent location in the record. The Plan and its providers are not required to provide care that conflicts with a member's advance directives.

If your patients are interested in learning more about advance directives, you can refer them to the following resources:

South Carolina Lieutenant Governor's Office on Aging
Website: ***http://aging.sc.gov/***
Phone: **(800) 868-9095**
This website helps educate people about some common legal issues relevant to the aging population, such as living wills and power of attorney. It also provides legal forms in English and Spanish as well as informational brochures about Advance Directives.

Donate Life South Carolina
Website: ***http://www.donatelifesc.org/***
This site offers information on organ and tissue donation as well as the option to register as a donor. You can also register to become a donor at any SC Department of Motor Vehicles office or at ***http://www.scdmvonline.com/DMVNew/***

Aging with Dignity
Website: ***http://www.agingwithdignity.org***
Phone: **(888) 594-7437**
This organization has a document called Five Wishes. This document allows you to express how you want to be treated if you are seriously ill and unable to speak for yourself. This document meets the legal requirements of an Advance Directive in most states.

Caring Connections
Website: ***http://www.caringinfo.org***
Phone: **(800) 658-8898**
Caring Connections is a program of the National Hospice and Palliative Care Organization (NHPCO). This organization works to improve care at the end of life. Their website provides many resources for planning ahead. You can also download your state-specific Advance Directives.

Compliance Training/ Fraud Waste and Abuse

Tips on Helping You Stay Compliant

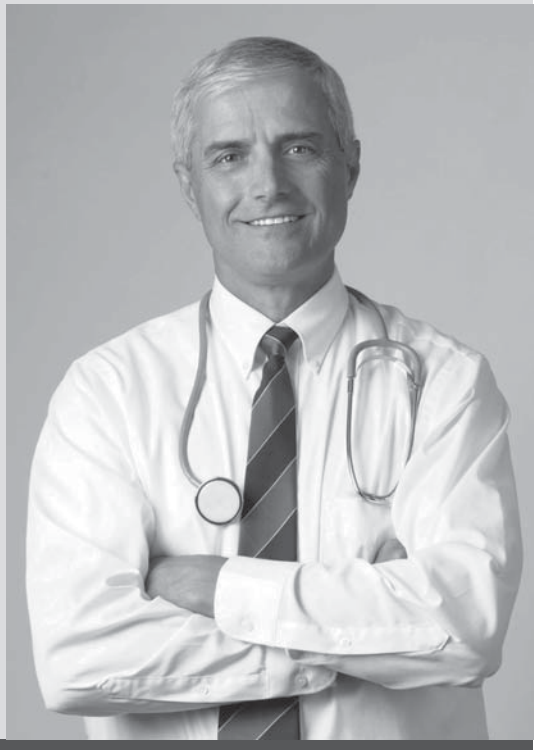
General Compliance Training and FWA Training must be completed within 90 days and annually thereafter. Training must be completed by employees, including temporary workers and volunteers, governing body members, as well as FDR's (first tier downstream related entities) who have involvement in the administration or delivery of Part C and D benefits.

Examples of FWA Topics that should be addressed in Training are:

- Laws and regulations related to MA and Part D FWA (i.e., False Claims Act, Anti-Kickback statue, HIPPA/HITECH, etc.);
- Obligations of FDRs to have appropriate policies and procedures to address FWA; Processes for sponsors and FDR employees to report suspected FWA to the sponsor (or, as to FDR employees, either the sponsor directly or to their employers who then must report it to the sponsor);
- Protections for sponsor and FDR employees who report suspected FWA; and
- Types of FWA that can occur in the setting in which sponsor and FDR employees work.

Examples of General Compliance Topics that should be addressed in Training are:

- An overview of the monitoring and auditing process
- A review of the laws that govern employee conduct in the Medicare program
- An overview of HIPPA/ HITECH, the CMS Data Use Agreement(if applicable), and the importance of maintaining the confidentiality of personal health information
- Examples of reportable noncompliance that an employee might observe
- General Compliance FWA Training modules are available through the CMS Medicare Learning Network (MLN) at http://www.cms.gov/MLNProducts. *Reminder training records must be retained for a period of ten years*
- Compliance Policies and Procedures/ Standards of Conduct
- Sponsor's commitment to business ethics and compliance with all Medicare program requirements
- Emphasize confidentiality, anonymity, and non-retaliation for compliance related questions or reports of suspected or detected non-compliance or potential FWA
- How to report non-compliance concerns



The module is available through the CMS Medicare Learning Network (MLN) at:
http://www.cms.gov/MLNProducts

DISTRIBUTION
Distribution of Standards of Conduct and Compliance Policies and Procedures to employees and entities you may partner/contract within 90 days and annually thereafter. Distribution may be accomplished through Provider Guides, Business Associate Agreements or Participation Manuals, etc.

Member Expectations Rega Mental Health Issues

More than 55% of older persons treated for mental health services receive care from primary care physicians. Less than 3% aged 65 and older receive treatment from mental health professionals. The numbers are striking. The Plan's annual Health Assessment Tool (HAT) form a series of questions related to stress indicators such as sadness/depression, anxiety, and sleeplessness. Members who return their Health Assessment and indicate that they would like to speak with someone about their stress indicators/ feelings will be contacted telephonically by the Plan social worker. The social worker incorporates the nine questions of the Patient Health Questionnaire (PHQ-9) depression scale into an assessment when following up and speaking with members. Depending on the conversation, members may be provided:

- Resources related to depression
- A referral to behavioral health services, and/ or
- Assistance in coordinating appointments or follow-ups directly with the behavioral provider, Beacon Health Options, when indicated.

Once depression is indicated, members are provided with education and options to seeking

treatment with a goal of improving their overall health.

If a member indicates depression but declines a referral to the Plan's behavioral health vendor, social workers collect anecdotal data regarding reason for the refusal. To date, the greatest reason for declining behavioral health services is that the members prefer their PCP to address depression with them. Per the National Institute of Mental Health:

- Approximately 68% of those ≥ 65 old know little or almost nothing about depression.
- Only 38% of adults ≥ 65 old believe depression is a "health" problem.
- If suffering from depression, older adults are more likely than any other group to "handle it themselves." Only 42% would seek help from a health professional.
- About 58% of people aged 65 and older believe that it is "normal" for people to get depressed as they grow older.

It is good practice to evaluate your patients for depression and take action for follow-up. Talk to them about how behavioral health services can help and remind them that they do have behavioral health benefits through the Plan. Each time a member declines a referral to behavioral health services from a Plan social worker, regardless of the reason, a letter is faxed to the doctor indicating further depression follow-up may be needed. Consider taking action on this important issue which can lead to decreased function and wellbeing.

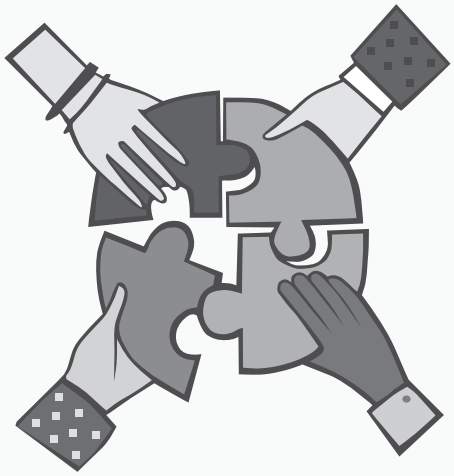
Fortunately, clinical depression is a very treatable illness. More than 80% of all people with depression can be successfully treated with medication, psychotherapy or a combination of both.

Case and Disease Management staff are available to support members who need additional coaching and support related to their conditions. Social services staff are available as well. Referrals can be sent to the department via fax at 1-888-314-0794 or by calling 1-888-211-9913.

The Plan strives to provide the best quality of care to its members and expects all providers who service our members to adhere to stringent Federal and State standards regarding documentation, confidentiality, maintenance and release of medical records, as well as personal health information (PHI).

The Plan's Provider Manual describes the medical record standards required for contracted providers. All providers must follow these standards and cooperate with the Plan in activities related to quality assurance monitoring of medical records. Meeting these requirements applies to both electronic and paper medical records.

CREDENTIALING CORNER



The Plan Accepts CAQH Proview Credentialing applications.

Please continue to keep your credentialing application information and attached documentation current in the CAQH Proview data base. The following items should be current:

- State Medical License(s) expiration date(s)
- DEA Certificate
- Valid insurance information
- Questionnaire responses and explanations as required.
- Hospital Admitting privileges OR if you are a PCP and you do not have hospital admitting privileges please ensure the Hospital Admitting Arrangements Supplemental Form is fully completed.

For Providers Not Part of the CAQH Proview:

The plan sends notification and re-credentialing applications by mail four months in advance of a providers credentialing expiration date. The notification cover letter specifies the steps and documents needed for re-credentialing, as well as the deadline for the submission of all current information. Active provider status is dependent upon completion of the re-credentialing process prior to the three-year expiration date.

Thank you for your timely submission!

Evidence-based Clinical Practice Guidelines

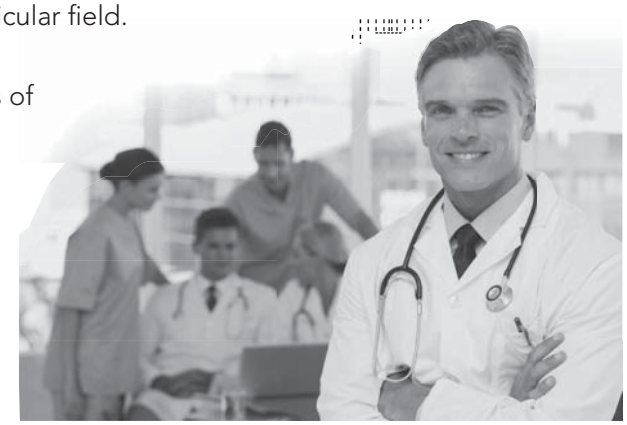
The plan reviews and adopts Evidence-based Clinical Practice guidelines in consultation with the Plan's medical director, a panel of physicians, an interdisciplinary care team of board certified specialists and the Quality Management Steering Committee.

The Plan utilizes evidence-based clinical practice guidelines on which it bases its management of member's healthcare needs, including the development of all disease-based assessments, education of members on suggested self-care, condition monitoring and care plans.

The plan updates its practice guidelines periodically and reviews them at least annually. National agencies and medical specialty societies also adopt evidence-based clinical practice guidelines. They are based on reasonable medical evidence or the consensus of physicians in a particular field.

Adapted to the needs of the Plan's members, the guidelines are included in the Care Plan Manual sent to primary care providers. They are available to members when appropriate and upon request. A copy of the evidence-based clinical practice guidelines and the links to their sources are available on the Plan's websites at:

https://sc.americas1stchoice.com/ -> Providers -> Tools & Resources -> Clinical Practice Guidelines



PARTNER WITH CASE & DISEASE MANAGEMENT NURSES

THE PLAN CAN COLLABORATE WITH you to help provide each member the services they need to better manage their health or plan of care. Physicians and providers can refer a patient to one of our programs with just a phone call or written referral. Our overall goal is to support the member's success in implementing his or her plan of care. The referral form can be found on the Plan's website or in your Provider Manual.

DISEASE CASE MANAGERS CAN OFFER education and coaching programs for Members based on chronic conditions such as Diabetes and Cardiovascular Disease. These programs are built around national evidence-based guidelines. The focus is on preventing complications and/or exacerbations, enhance self-management and reduce acute episodes.

COMPLEX CASE MANAGERS CAN ASSIST members with urgent or acute events and coordination of services. The goal is to enhance coping and problem solving capabilities, assist in appropriate self-direction, support proper and timely needed services and reduce readmissions.

SOCIAL WORKERS SUPPORT IS INTEGRATED into the Disease and Case Management programs and their physicians received ongoing support from nurses on staff. Members may choose not to participate in the program at any time and it does not affect their benefits.

MANY TIMES, NURSES OR SOCIAL WORKERS will need to engage the PCP to resolve members concerns or identified issues. We appreciate providers supporting Member participation in these programs as a collaborative effort to maximize health and wellbeing. Provider communication efforts are also enforced via a care plan developed by the nurse and/ or social worker, along with the member, highlighting mutually agreeable goals and interventions. Updates to the care plan are provided as well as when initiatives change.

CONTACT

Call us toll-free at

1-888-211-9913

from 8:00 a.m. to 4:30 p.m. Monday through Friday.

To access the referral form on the internet visit the Plan website and follow this path:

Providers -> Tools and Resources -> Case Disease Management Referral Form

Follow-Up After Hospitalization for Mental Illness

Measure Description:

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Who is in the population?

Members 6 years of age or older who were discharged after hospitalization for treatment of selected mental illness diagnoses.

Who is excluded from the measure?

1. Exclude discharges followed by readmission or direct transfer to a non-acute impatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
2. Excludes discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health.

What would make a member compliant for this measure?

30-Day Follow-Up- A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day-Follow-Up- A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.

HEDIS® General Guidelines Update - CPT Code Modifiers

CPT Code Modifiers are two-digit extensions that when added to CPT codes, provide additional information about a service or procedure.

Based on HEDIS® criteria CPT Category II code submitted along with any of the following 4 modifiers indicate the service did not occur.

1P-Performance measure exclusion due to medical reasons

Includes:

- Non indicated (absence of organ/limb, already received / performed, other)
- Contraindicated (patient allergic history, potential adverse drug interaction, other)
- Other medical reasons

2P-Performance measure exclusion modifier due

Includes:

- Patient declined
- Economic, social or religious reasons
- Other patient reasons

3P-Performance measure exclusion modifier due to system reasons

Includes:

- Resources to perform the services not available (e.g. equipment, supplies)
- Insurance coverage or payer-related limitations
- Other reasons attributed to health care delivery system

8P-Performance measure reporting modifier-action not preformed, reason not otherwise specified

A PATIENT-CENTERED APPROACH

As a health plan that is always striving to improve our strategies in order to affect the health outcome of your patients, we would like to share with you an approach that has been proven to work. The Patient-Centered Medical Home model (PCMH) and other similar models have been recognized for their various benefits to the patient, providers, health plans and the overall health care system. Two major advantages are ***maximizing health outcomes and cutting down unnecessary*** cost by putting the patient first.

America's 1st Choice supports and ascribes to a Medical Home Model. With the ongoing research and support from accrediting agencies, many practitioners have pursued the Accountable Care Organization (ACO) or PCMH accreditation in an effort to focus on positive patient outcomes. You can review the list of almost 400 practices in South Carolina on the National Committee for Quality Assurance (NCQA) site (*https://reportcards.ncqa.org*) who are dedicated to improving their patients' health.

For more information on why these accrediting programs are so widely adopted in the Country, please visit

http://www.ncqa.org/Programs/Recognition.aspx

PRESCRIBE FITNESS to Help Prevent or Control Type 2 Diabetes

More than 25 percent of Americans age 65 and older have type 2 diabetes—that's 12 million people. An additional 23.1 million have prediabetes, increasing their risk for type 2 diabetes, heart disease, stroke, and other health problems. Chances are, many of your older patients fall into those statistics. Now you can "prescribe" an award-winning fitness program to help them feel better, have more energy, stay independent, and reduce their risk for type 2 diabetes and many other health conditions.

SilverSneakers is the nation's leading fitness program for seniors and it's free for **America's 1st Choice of SC members**. SilverSneakers includes:

- trained instructors who specialize in senior fitness
- group classes designed for all levels and abilities
- fitness articles, recipes and meal plans
- an active and supportive online community
- access to thousands of fitness locations nationwide
- weights, pools, cardio-equipment access (varies by location)

SilverSneakers works. In fact, **93 percent of SilverSneakers participants report good, very good, or excellent health**. Exercise can have a positive impact on many health conditions, including diabetes. Only 18 percent of SilverSneakers participants responding to the 2017 survey said they have diabetes, compared to 28 percent of seniors nationwide. Of those surveyed, **68 percent reported an improvement** in their condition after participating in SilverSneakers.
Research shows that people who are physically active on a regular basis can lower their A1C and help prevent or manage type 2 diabetes. Encourage your senior patients to start using their free **SilverSneakers** benefit to gain the benefits of an active lifestyle.

YOUR VOICE MATTERS

Prescribe SilverSneakers to help your patients stay active and reduce risk for diabetes.

SilverSneakers.com
1-888-423-4632 (TTY: 711), Monday through Friday, 8 am to 8 pm ET.

1. http://www.diabetes.org/diabetes-basics/statistics/
2. https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics
3. https://www.niddk.nih.gov/search?s=all&q=prediabetes. Prediabetes Fact Sheet, April 2017.
4. 2017 SilverSneakers Annual Member Survey

Providers Participating With Telemedicine

If the Plan has given approval for a provider to deliver telemedicine services to America's 1st Choice of South Carolina members, the provider is required to have protocols in place to prevent fraud waste and abuse. The provider must implement telemedicine fraud, waste and abuse protocols that address the following:

- Authentication and authorization of users.
- Authentication of the origin of the information.
- The prevention of unauthorized access to the system or information.
- System security, including the integrity of information that is collected, program integrity and system integrity.
- Maintenance of documentation about system and information usage.
- Maintenance of documentation about system and information usage.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Measure Description:
Members with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Who is in the population?
Adult members 42 years and older as of December 31st of the measurement year and had their first COPD diagnosis in a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

What would make a member compliant for this measure?
At least one claim/encounter for spirometry during the 730 days (2 years) prior to the new diagnosis of COPD or newly active COPD through 180 days (6 months) after the new diagnosis of COPD or newly active COPD.

What codes trigger compliance for this measure?

Spirometry Value Set	
Code System	Code
CPT	94010
CPT	94014
CPT	94015
CPT	94016
CPT	94060
CPT	94070
CPT	94375

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