SUMMER 2019

AFC CONNECT

HMO Provider Newsletter

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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: (850) 681-2010
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.

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 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 our Case and Disease Management program. Our Managed Care Coordinator staff works in conjunction with our Medical Management Specialists and Nurses in identifying health and community resources in which the member might benefit.

MEMBERS ENROLLED INTO ONE OF OUR Case and Disease Management programs, and their physicians, receive 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 managed care coordinator, along with the member, highlighting mutually agreeable goals and interventions. Updates to the care plan are provided as well 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

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Medical Records Standards

All of Our Members Benefit from the Safeguards Established by Federal and State Guidelines

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.

ACCESSING THE PORTAL

*You can access the MRA HEDIS® Portal by visiting the Health Plan website and selecting **MRA HEDIS® Portal** under the **Providers** dropdown menu on the home screen.*

What's new
on the MRA HEDIS® Provider Portal?

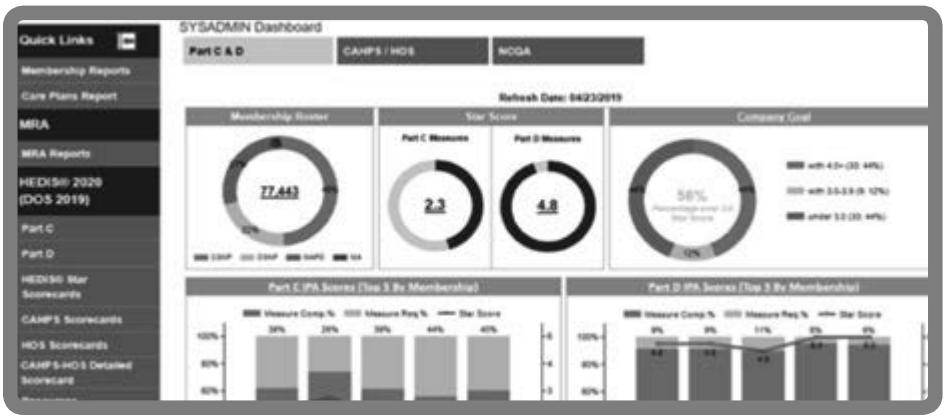
WE'RE PROUD TO ANNOUNCE A NEW FEATURE ON THE MRA HEDIS® PORTAL to help you and your office staff access important information about your patients. You can access the MRA HEDIS® Portal by visiting the Health Plan website and selecting MRA Hedis® Portal under the Providers dropdown menu on the home screen. Here's what's new:

MEMBERSHIP REPORTS

This feature allows you to review and print your current **membership roster** as well as **authorization**, **inpatient** and **discharge** reports. You can access this information by selecting ***Membership Reports*** on the home screen.

CARE PLANS REPORTS

As you know, for each of your patients that is enrolled in a Special Needs Plan (SNP), a Tier 1 Care Plan is developed using Evidence-Based Clinical Practice Guidelines. This Care Plan addresses the specific needs of the population diagnosed with the condition that qualified your patient into the SNP.



In addition to the Tier 1 Care Plan, the Plan also encourages SNP members to complete a Disease Specific Health Assessment Tool. The self-reported responses on this tool will generate a Tier 2 Care Plan using Evidence-Based Clinical Practice Guidelines. A new feature on the MRA HEDIS Portal allows you to access and print these Care Plans by selecting ***Care Plans Report*** on the home screen.

Requests for Additional Information on Organizational Determinations

When the Utilization Management (UM) Department receives a PCP's organizational determination request, complete clinical information from the member's health record is necessary to determine whether clinical guidelines for specific requested services are met.

UM leverages phone and fax communication efforts in their outreach efforts. UM has a process and policy in place that mirrors the CMS guidance, emphasizing that outreach be made as early in the coverage decision process as possible.

In order to assure rapid authorization turn-around times, the PCP should respond on the same day to information requests from UM. This is especially critical if the request is expedited. Quick response times from PCP's contribute significantly to our goal of completing all standard organizational determinations within 5 days.

This same process of PCP outreach occurs when requests for services are received from a provider other than a member's PCP. In these cases, UM will notify the member's PCP about the request, inclusive of the clinical information received with the request, and seek PCP review and input on the request.

If PCP responses to information requests are not received timely, the request and information will be forwarded to the health plan's Medical Director for a final decision. Having all relevant information available leads to

more informed, accurate decisions, so it is important to minimize instances in which information is not provided by the PCP in a timely manner. Being responsive to UM requests assures the plan has the relevant PCP medical records and clinical opinions during UM decision-making.

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

ICD-10-CM Code I77.9 Disorders of Arteries and Arterioles

The ICD-10-CM code I77.9 is for Disorder of Arteries and Arterioles, unspecified. It is a non-specific diagnosis of some disorder (not otherwise specified) of arteries and/or arterioles. It is part of the larger group of diseases of the arteries, arterioles and capillaries, code range I70-I79. The key to this diagnosis is that it is **unspecified**. We are encouraged to code to the most specific code, to seek specificity to provide the most appropriate and effective treatment. Equally important, from a quality of care perspective, if a disease is unspecified, it makes it difficult to treat. This code should not be used if the diagnosis can be specified, including all codes in I70-I79 with greater specificity.

It is incorrect to assign code I77.9, Disorder of arteries and arterioles unspecified, for the following diagnoses which is lacking the greater level of specificity described in the diagnosis:

PERIPHERAL VASCULAR DISEASE:
A diagnosis of Peripheral Vascular Disease (PVD), also commonly known as Peripheral Artery Disease (PAD), is assigned to ICD-10 code I73.9.

CAROTID ARTERY DISEASE:
A diagnosis of Carotid Artery Disease is assigned to ICD-10 code category I65.2X.

CORONARY ARTERY DISEASE:
A diagnosis of Coronary Artery Disease, also commonly known as CAD, is assigned to ICD-10 code category I25.X.

I77.9 should not be used as a differential diagnosis for ordering tests, referrals, consultations etc. When requesting these types of services, it is more appropriate to document and report signs and symptoms, such as:

- Claudication
- Arterial bruit
- Decreased pedal pulses
- Leg numbness and weakness
- Coldness of lower leg or foot

I77.9 should also not be used when the condition is an unconfirmed diagnosis prior to cardiovascular testing and physician correlation. Positive results from testing will indicate if an arterial disorder does exist and should be more specific than an unspecified arterial disorder.

IT IS IMPERATIVE TO CODE TO THE GREATEST LEVEL OF SPECIFICITY AS KNOWN AND DOCUMENTED FOR ACCURATE AND COMPLETE ICD-10 CODE ASSIGNMENT.

REDUCING Diabetic Risk:

Chronic Care Improvement Program

Medicare Advantage (MA) organizations are required to conduct a Chronic Care Improvement Program (CCIP) initiative every three years. Our Health Plan's CCIP is focusing on promoting effective management of members that are "at-risk" for developing diabetes. Members are identified for inclusion into our CCIP via their recent Hemoglobin A1c test results. The target population is Medicare members (individuals aged 65 or older or disabled) with an HgbA1c value of 8 to 9. The CCIP will be carried out over a three-year period.

In 2017 the National Center for Chronic Disease Prevention and Health Promotion reported that 9.4% of the U.S. population, 30.3 million people, have diabetes. The report also indicated that 7.2 million of those individuals are undiagnosed. The economic burden in the United States in 2017 was $327 billion total costs, including $237 billion in direct medical costs and $90 billion in indirect costs (disability, work loss, and/or premature mortality). The burden of diabetes in South Carolina corresponds to the nationwide epidemic rate; approximately 577,000 people or 13.9% of the population have diabetes according to the American Diabetes Association (2019).

The Health Plan's goal is to reduce the potential for these at-risk members to develop an HgbA1c level of 9 or above and reduce morbidity and mortality associated with diabetes. As an included benefit, members have access to nurses that can provide Disease Management at no additional cost. As part of the Plan's Disease Management model, nursing staff provide ongoing self-management education and support to the member and help to coordinate medical and social services needs. The goal is to keep members healthy and happy.

CCIP progress will be measured by advancement toward a target goal approved through the Plan's Quality Program up to and including the Board of Directors. The goal is derived from review of the Comprehensive Diabetes Care (CDC) rate out of the Plan's NCQA HEDIS certified software.

If you have a member that you feel could benefit from participation in this program please complete the Case/ Disease Management Referral Form found in your provider manual or on the Plan website under the 'Tools and Resources' page.

summer 2019
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. When logging into your ProView Provider Sign-in, please take note of the informational banners that CAQH uses to announce updates to their system, as well as the monthly emailed CAQH ProView Updates. Also, please ensure the following items are updated and current:

- State Medical License(s) please include expiration date(s)
- DEA Certificate
- Valid Insurance Information
- Practice locations
- 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
- Partners/Covering Colleagues
- Questionnaire responses and explanations as required.

For Providers Not Part of 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!

……and just a quick reminder, please promptly notify us of any change in your location or other credential, or if you are adding a new practitioner to your practice.

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 members' health care 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

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

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HMO Provider Newsletter

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Columbia, SC 29210

LAB REMINDER

Quest Laboratory
www.questdiagnostic.com **866-697-8378**

Laboratory Services of America (LabCorp)
www.labcorp.com **800-432-6078**

TIP: Lab and pathology tests for America's 1st Choice members performed at a participating facility can improve HEDIS® scores.

Provider Relations Directory

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Fax: (803) 509-5035 or (803) 748-4907

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