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Contents

Hierarchical Condition Categories (HCC) Update

To ensure that an appropriate illness severity and risk score is calculated for each Medicare beneficiary, physicians need to document all relevant diagnoses in the assessment and plan section of the visit progress notes for all Medicare patients each calendar year. Unless each chronic condition is assessed, documented and on a visit claim <u>at least once a year</u>, Medicare does not know that it exists!

The link below leads to a brief webinar on Clinical Documentation Improvement in the primary care setting and an overview of key diagnoses that are important to Medicare.
https://www.cmocares.org/mipa-resources

Members of the HCC Coding team are happy to answer any of your questions. Feel free to call the HCC coding department at 914-378-6629 or send us an email:
CMOHCCCoding@montefiore.org

How Best to Pass a CMS Audit

Pay special attention when coding the following three conditions in the outpatient setting: CVA, MI and cancer. These conditions are frequently documented and assessed with the acute codes rather than the more appropriate historical codes.

CVA
Acute CVA (**I63.50**) should only be used when the CVA is occurring. Personal history of CVA (**Z86.73**) should be documented post discharge, and any late effects resulting from the CVA should be coded from category (**I69** Sequelae of CVA). Provider documentation must state the cause-and-effect relationship of the CVA to the residual condition.

Personal history of CVA is <u>NOT</u> in the Medicare HCC risk adjustment model.

Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction **without residual deficits**

The following list of sequelae risk adjusts in the Medicare HCC model.

I69.131 to I69.159	Monoplegia, Hemiplegia or Hemiparesis upper / lower limb (right dominant, left dominant, right non-dominant, left non-dominant, or unspecified side) following **non traumatic intracerebral hemorrhage**
I69.331 to I69.359	….. **following cerebral infarction**
I69.931 to I69.959	….. **unspecified cerebrovascular disease**

Myocardial Infarction
Acute MI <u>should only be coded</u> when the patient is *less than four weeks* from AMI and is asymptomatic.

Personal history of MI is <u>NOT</u> in the Medicare HCC risk adjustment model.

I25.2	Old myocardial infarction; Healed myocardial infarction; Past myocardial infarction diagnosed by ECG or other investigation, but currently presenting no symptoms

Active Cancer vs. History of Cancer
For cancer patients, only those who have active disease or who are receiving on-going treatment for the condition should be coded as having active cancer. When there is no further treatment and no evidence of disease, please use a code from category Z85--Personal history of malignant neoplasm.

Personal history of Cancer is <u>NOT</u> in the Medicare HCC risk adjustment model.

Z85.118	Personal history of malignant neoplasm of bronchus and lung
Z85.3	Personal history of malignant neoplasm of breast
Z85.46	Personal history of malignant neoplasm of prostate
Z85.51	Personal history of malignant neoplasm of bladder

Clinical Tools Impact Patient Outcomes

Montefiore's commitment to population health management and improving patient outcomes is supported by the use of advanced patient solution tools such as Emmi Solutions and Cureatr.

Emmi Solutions provides interactive call campaigns designed to help patients understand why it's important to actively participate in maintaining and improving their health, and by connecting

them directly with their provider. Each month Montefiore selects a campaign and tailors the message based on population need and strategy. In January, patients will receive calls reminding them to schedule their Annual Wellness Exam, and, if they desire, they can be transferred directly to their provider to schedule the appointment.

Cureatr is a message-delivery application that enables providers to receive real-time notifications when their patients have been admitted to or discharged from a hospital. Montefiore has successfully implemented this tool among a number of community practices, and is making strides to connect the entire provider network by the end of 2019.

Next Generation ACO Regulatory Reporting

Every year CMS requires a medical record audit of selected measures to evaluate and score the ACO network's performance. Montefiore ACO quality staff will conducts the review based on patient lists have been received from CMS.

The goal is to accurately and efficiently capture all documentation of the specified clinical measures, the performance of which is essential to achieve shared savings. Here's what you can expect during this process:
- We will call your office to schedule a time to conduct a chart review in your office.
- A member of our quality staff will come to your office to review the charts. Please designate an area for them to work.

Our success is the result of the excellent care you and your colleagues in our network deliver to the ACO's attributed beneficiaries. We look forward to another successful year!

Specialty Pharmacy Injectable Drug Vendors Directory & Process

Medical benefit specialty injectables are defined as medications that are generally administered by a clinician, most often incident to an office visit. CMO is financially responsible for specialty injectable medications administered by providers to members covered by Emblem and Empire health benefits. There are several IPA contracted vendors that will supply your office with the injectables needed to treat your patients. The prior authorization process mirrors the criteria established by Emblem and Empire.

To arrange coverage and authorization of medical benefit injectables:

1. Contact CMO Medical Management to verify eligibility and benefits for injectables requested. Provide all medical necessity information. **Phone: 914-377-4400, Fax: 914-377-4798**

2. A clinical pharmacist in CMO Pharmacy will review the medical necessity information submitted by your office. CMO Pharmacy will contact your office if there are questions about the submitted medical necessity information.

3. If eligibility and the health plan criteria are met, CMO Pharmacy will contact the appropriate vendor from the list below. Thereafter, your office will be notified about the length of coverage and the vendor that was selected.

4. After notification, your office will need to contact the injectable drug vendor to communicate the medication Rx and coordinate delivery of the medication in advance of the patient's appointment. Please allow at least 1-2 business days to complete an order.

Medication Guidelines for **Empire** can be found at this link:
https://www.empireblue.com/wps/portal/ehpculdesac?content_path=medicalpolicies/noapplication/f2/s2/t0/pw_ad088732.htm&na=onlinepolicies&rootLevel=1&label=By%20Category#P71_5213

Medication Guidelines for **Emblem** can be found at this link:
https://www.emblemhealth.com/Providers/Medical-Policies/Medical-Policies

Injectable Drug Vendors:
- **CVS Specialty:** E-prescribe to CVS Specialty. Phone: 800-237-2767; Fax: 800-323-2445 After receiving the Rx, CVS will contact the patient and your office to arrange delivery.
- **Walgreens Specialty:** E-prescribe to Walgreens.   Phone: 718-547-4133; Fax: 718-547-1634
- **SimfaRose:** E-prescribe to SimfaRose, Phone: 888-663-9765; Fax: 718-823-6451
- **Accredo:** Fax to Accredo, https://accredo.com/prescribers/referral_forms The fax number is located on the referral form. Accredo will contact the patient and your office to arrange delivery.

MMC Outpatient Pharmacy E-prescribe to MMC Pharmacy, Phone: 718-920-4934; Fax: 718-652-0733
Note: The MMC Outpatient Pharmacy is available only to Montefiore employed providers. Non-Montefiore providers may access only the vendors listed above.

Questions about this process can be directed to the CMO Pharmacy Team, 914-378-6688 or CMOPharmacyDepartment@Montefiore.org.

Medical Management Utilization Review Criteria

CMO Medical and Behavioral Care Management clinical staff use criteria developed and approved by the CMO Medical and Behavioral Health Committee to assist in the determination of clinical appropriateness. The guidelines include, but are not limited to:

- InterQual ISD A-P
- InterQual Acute Rehabilitation
- InterQual Skilled Nursing Facility
- Guidelines developed by the American Society of Addictive Medicine (ASAM)
- Guidelines developed by the American Psychiatric Association (APA)
- Medicare coverage guidelines
- Managed Care Organization guidelines for benefit interpretation

The guidelines are applied with consideration of the needs of the patient and characteristics of the local delivery system, and with the advice of practicing physicians who are members of the CMO Medical and Behavioral Health Committee. Clinical criteria used in the review of a request for service/benefit will be shared with the provider and with the member/member's designee upon request. Any participating provider may request to review the entire Medical Management

criteria used in the review process. Providers may schedule an appointment to conduct such a review by contacting the Medical Management Medical Director either in writing or by telephone. Instructions on how to obtain the reference criteria, as well as how to reach the Medical Director are included in all determination letters.

Statement Regarding Appropriate Service & Coverage for Members

CMO is dedicated to ensuring the delivery of appropriate care to patients of IPA members. This statement affirms CMO's policy regarding utilization management-UM decision-making when conducted by CMO staff.

1. All UM decisions are based on the member's eligibility, the benefits covered under the member's certificate of coverage and the appropriateness of care and service.
2. CMO does not specifically reward UM decision makers for issuing denials of coverage or service and encourages the use of medically necessary and appropriate care and services to prevent and/or treat medical conditions.
3. CMO does not compensate UM decision makers for non-certification of service or offer incentives to encourage non-certification or underutilization of health care services.