Community HEALTH OPTIONS®

In This Issue

Medical Management Update

Our Medical Management department is committed to a strong partnership with our providers. We continuously strive to improve processes in response to Provider feedback. Here is a snapshot of what to expect over the next few months:

Online resources: We heard your questions and suggestions, and we added further clarification to our online *Prior Approval and Notification* reference guides

Despite the efforts of the Maine Medical Association and the Maine Legislature to institute controls on the use of opioid medications, the epidemic of deaths due to narcotic overdose continues. We currently lose one Maine resident to death by overdose every day. Last year 376 people died, the highest total ever recorded in Maine which represented a 40% increase from 2015.

In the last 12 months, our plan had noticed an initial decrease in the average number of days per opioid prescription, but that has started to rise again despite the limits placed by the legislature. Community Health Options spent over $1,000,000 on opioid prescriptions and about $900,000 on medication that is used to treat addiction in the past 12 months. Only 12 prescriptions for antidote medication were filled during that same time.

We continue to monitor the problem and are developing an intervention strategy. In the coming months, we hope to identify members who may be at risk for addiction and make an attempt to reach out to them with education and support. Also, we hope to begin an educational program for patients getting new prescriptions for narcotics to safely use and dispose of their medication when no longer needed.

Dr. John Yindra

Provider Survey

Health Options values the relationship we have with you. We are conducting a brief survey to gather feedback on our service to you and information on how we can improve the care given to our Members. Please take a few minutes to fill out this survey.

Click on https://www.surveymonkey.com/r/PRsurveynews

that are posted on our website at HealthOptions.org > HealthCare Professionals tab > Professional Documents and Forms.

Coming soon: Our new online authorization platform is moving from internal alpha testing to network provider beta testing within the next few weeks.

Stay tuned: We will be transitioning some of our authorization work (e.g., advanced imaging) to EviCore on January 1, 2018. We will provide pertinent updates and post applicable resources on our Health Options website by November 1, 2017.

Quick Links

Our Website
Quick Reference Guide
Online Portal Access
Documents & Forms
Contact Us

Risk Adjustment and Data Collection

Risk Adjustment is designed to spread risk among health plans to prevent market instability and protect consumers with complex medical conditions. Adverse selection happens when a health plan insures a disproportionately higher number of consumers with complex medical conditions. This program spreads the risk across all health plans in a state. Health plans who enroll a disproportionately high number of people with complex medical conditions will receive payments from plans that enroll lower risk populations.

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or success or code is assigned, and
- They are used to validate diagnosis data that was previously provided to HHS by the Exchange participating organizations, like Health Options.

We have partnered with Datafied to retrieve medical records on our behalf. The requests are part of the Risk Adjustment Data Validation (RADV) required by the Centers for Medicaid and Medicare Services (CMS) to validate the accuracy of risk adjustment data submitted by Health Options.

The Provider and Facility play an extremely important role in ensuring that the best documentation practices are established. HHS record documentation requirements include:

1. Patient's name and date of birth should appear on all pages of the record.
2. Patient's condition(s) should be clearly documented in the record.
3. The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
4. The documentation describing the condition and MEAT must be legible
5. The documentation must be clear, concise, complete and specific.
6. When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
7. Physician's signature, credentials, and date must be legible.

Coding

In recent chart audits for validation of coding to justify the Member's risk score, common coding errors have been noted in many of the records. Therefore, we felt it was important to share these finding with you. Coding conditions to the highest level of specificity is important. Common coding errors that have been noted:

"History of" versus "Active Conditions"

"History of" means the patient no longer has the condition. Frequent documentation errors regarding the use of "history of":

- Coding past conditions as active
- Coding "history of" when condition is still active

Active Conditions require that each active diagnosis that is assessed must have a

corresponding plan of care **and** what is being done for that condition (Rx, labs, referrals, monitoring).

Examples of Errors in Documentation:

- **Diabetes:** A patient with uncontrolled Type 2 diabetes that is coded as E11.65 needs to have their Hyperglycemia documented in their medical record.
- **Cancer:** It is important to only code cancer as active if the patient is still receiving treatment.
- **Asthma:** "A History of Asthma" is insufficient documentation to code for asthma. There must be a plan of care and what is being done for asthma.

Documentation Coding Tips:

- When writing medications, connect them to the diagnoses they treat
- Remember always to link causal relationships of diseases and their manifestations
- Remember to document pressure ulcers with the location and stage of the ulcer
- Drug and/or alcohol use instead of dependence is an important differentiation for coding
- If the following words or phrased are used, that diagnosis will not be permitted to be coded: Probable, possible, presumed, likely, suspect, rule-out, questionable

Member Satisfaction Survey Results

Health Options conducted a Member satisfaction survey and learned the following that is relevant to your work. If there is anything that you believe we could do to improve your interactions with Health Options or Member's understanding of the healthcare process, please let us know.

Access to Medical Care		Care Coordination	
Question	**Rating**	**Question**	**Rating**
Getting care quickly Composite	99th	Access to test results	93rd
Received care right away when needed	96th	Received test results as soon as needed	89th
Received appointment for routine care as soon as needed	99th	Dr. was informed about specialty care	85th
Ease of receiving care/tests/treatment	92nd	Dr. discussed prescription medications	79th
Received a specialists appointment as soon as needed	89th	Obtained help from Dr. to manage care	80th

Rating of all health care received	73rd
Rating of personal doctor	56th
Rating of specialist	75th

The percentile ranking is based on a national comparison of the same survey results.

NCQA

Affirmative Statement	Health Options facilitates delivery of appropriate care and monitors the impact of our medical management program. We do not specifically reward Providers or other individuals conducting utilization review for issuing approvals or denials of coverage. To review the Affirmation statement, please refer to the Medical Management Functions, Ensuring Appropriate Utilization section in the Provider Manual.
Member Rights and Responsibilities	Community Health Options provides our Members a Rights and Responsibilities document annually. We believe you should also have a copy of this document. Please refer to the Health Options Provider Manual for a copy of the Member Rights and Responsibility document.
Quality Improvement Annual Summary	Quality Improvement Program. This plan includes initiatives for the health plan to work on during the upcoming year to help improve the quality of the healthcare and services rendered to our Members. At the end of the year, Health Options provide Members and Providers a written report of the plan's activities and accomplishments. To read the report, follow this ***link***