Provider Check Up

Health Partners Plans HPP | SPRING 2023

Welcome to 2023!

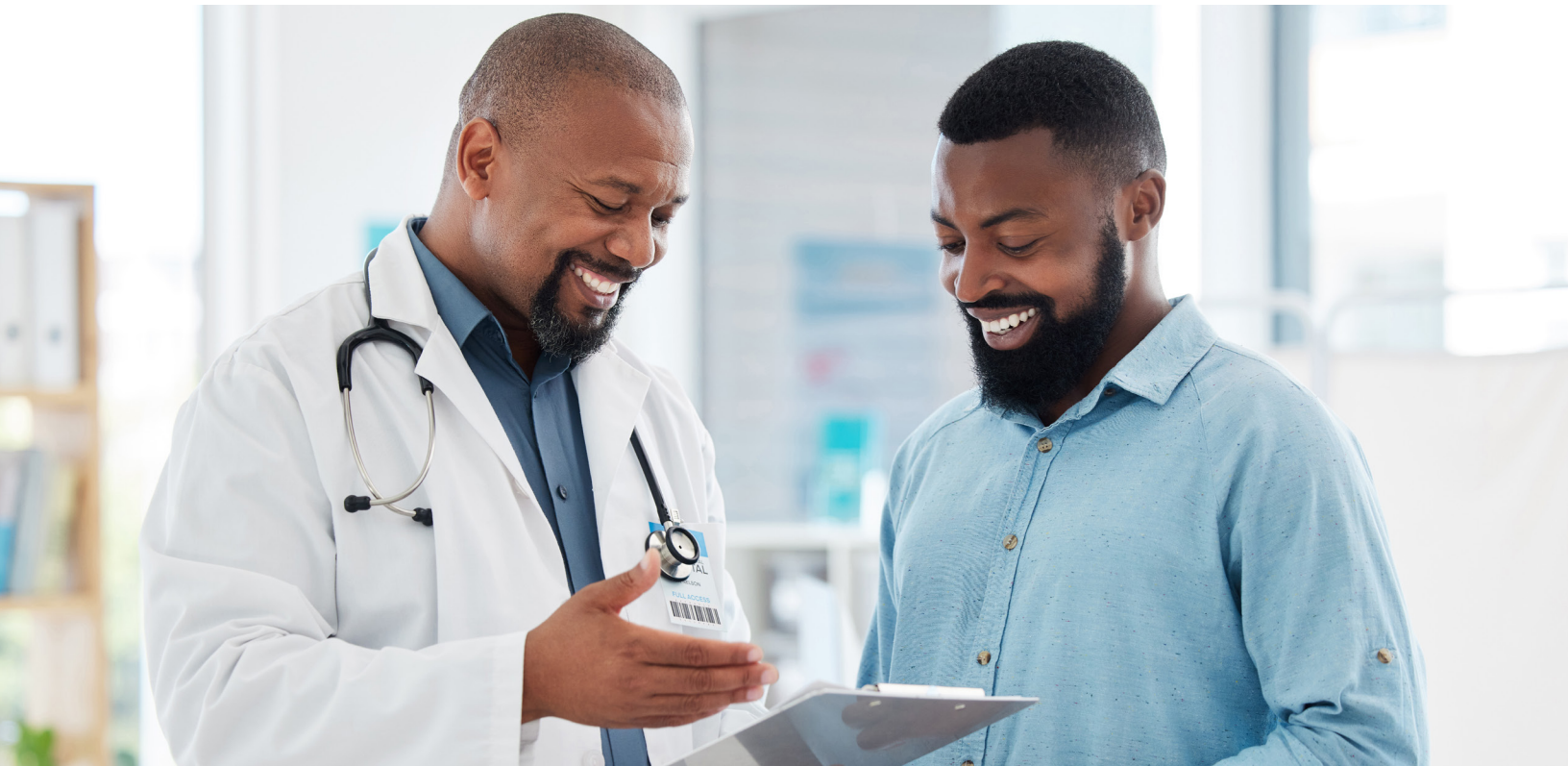
As always, Health Partners Plans thanks you for your continued commitment to improving the health outcomes of our members. We hope you are refreshed and ready to take on this new year! The beginning of the year allows us to set goals and expectations for your patients and our members.

- Let's remind our members/your patients of the importance of annual and preventive screenings, adherence to medications and overall health and wellness.
- Let's work together to break down barriers and provide resources to help them achieve their goals.
- Let's continue to be great partners to one another, to the populations we serve and to our communities.

We look forward to a productive 2023. Thank you again for your hard work and dedication.

Latest HPP News

Learn more about important Medicaid renewal information and our $0 copay update!



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Pharmacy Corner

Pharmacy Formulary Changes

Please click the links below to view the most recent formulary, prior authorization, quantity limit and age edit updates for **Health Partners Medicare**:

- Prime and Complete 2023
- Special 2023
- Silver and Platinum 2023

See below for the most recent formulary, prior authorization and quantity limit updates for **Health Partners Medicaid**:

- Health Partners 2023

For the most up-to-date information regarding all HPP formularies, please visit our online formulary.

Required Training Reminders and Recent Webinars

2023 Model of Care D-SNP (Special Needs Plan) Provider Training

If you are a provider who has at least one Health Partners Medicare Special (D-SNP) member assigned to your practice, at least one person on your staff who is involved in the care of our dual-eligible special needs plan (D-SNP) members must complete our annual D-SNP Model of Care training module. This training is required by the Centers for Medicare & Medicaid Services (CMS).

Start the Model of Care training now. Simply review the information, complete the attestation and click "submit" to complete the requirement.

It will take approximately 10 minutes to complete the course.

Register now for an upcoming quarterly provider orientation and training for new and existing providers.

Coming Soon!

Provider Online Courses and Provider Education Self-Management Tools

HPP online classes were created to keep you informed on a variety of important topics. Coming soon are updated courses on the following topics:

- Timely Filing Protocols and the Reconsideration Process/Claims
- Cultural Competency and Linguistic Requirements and Services
- Provider Annual Orientation and Training

We welcome your feedback and suggestions on topics of interest.

Recent Webinars

If you couldn't make it to one of our live webinars, you can now watch on-demand! Explore these additional interactive presentations designed specifically for you, our providers, and encourage your colleagues and practice staff to take advantage of these online learning opportunities.

Visit www.HPPlans.com/webinars to review recent webinars and register for upcoming trainings.

Billing and Coding Well-Child Visits

One of HPP's primary goals is to make sure our youngest members receive the preventive care they need. Well-child visits are an important way to stay connected with your patients and their caregivers throughout the year, not only when they are sick.

Many times, families only call their PCP when their child is sick. That's why we stress that **you can often complete a well-child visit when a child has come in for a sick visit**. This opportunity exists when a provider has determined that the condition, illness or injury that led to the sick visit does not impede the ability to complete a well-child visit and that the child is eligible for the well-child visit, per their care gap report.

The National Committee for Quality Assurance's (NCQA) HEDIS measures for well-child visits are administrative measures, meaning that the information is reported from claims that are submitted.

- Measure description:
  - Well-Child Visits in the First 30 Months of Life (W30)
    - Well-Child Visits in the first 15 Months: Expectation six (6) or more well-child visits on or before the child's 15-month birthday.
    - Well-Child Visits for age 15 Months to 30 Months: Expectation two (2) or more well-child visits after the child's 15-month birthday but before the child's 30-month birthday.
  - Child and Adolescent Well-Care Visits (WCV)
    - 3–21 years old who have had at least one well-child visit during measurement year.

Based on our claims data, many provider offices miss this opportunity. Well-child visits often do not occur or the submitted claims do not accurately capture the rendered services. When services are documented and billed properly, offices can significantly increase revenue. We want to ensure that our providers are reimbursed properly for the care provided.

Submitting Proper Claims

Your office can submit claims for both a sick visit and a preventive well-child visit for services provided on the same day, provided that the Modifier 25 is added to the claim.

When a child presents for a sick visit, consider performing the services of the preventive well-child visit, if appropriate, in addition to rendering care for the presenting problem. The components of a well-child visit, as indicated by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Bright Futures criteria, are as follows:

- Physical Exam: VS and at least three systems examined
- Health History: birth history; personal history; age-appropriate lab testing/screening; allergies, medications and immunizations would count if all three were documented
- Physical Developmental History: assessment of physical milestones and progress towards physical milestones
- Mental Developmental History: assessment of mental milestones and progress towards development of mental milestones
- Health education and/or anticipatory guidance that is age appropriate

Please note the following coding reminders/ clarifications:

- Modifier 25 *must* be billed in the **first modifier position with the applicable E&M code** for the allowed sick visit. When modifier 25 is not billed in the first position, the sick visit will be denied.
- Providers can bill the age-appropriate preventive CPT codes (**99381-99385, 99391, 99392-99395**), and **99461**) and a separate identifiable **E&M** code with the modifier 25.
- Well-child visits should be reported with the following diagnosis codes: **Z00.00**, **Z00.01**, **Z00.5**, **Z00.8**, **Z00.110**, **Z00.111**, **Z00.121**, **Z00.129**, **Z02.0-Z02.6**, **Z02.71**, **Z02.82**, **Z76.1**, and **Z76.2**.
- Appropriate diagnosis codes must be billed for the respective well-child visit and sick visit.

Examples of Proper Coding

Example	E&M Description	Well-Child Visit Diagnosis Code (in the Primary Position)	Well-Child Visit E/M Code	Allowable Sick Visits with Modifier 25 (when billing with a Well-Child Visit)
#1	New Patient E&M visit	Z00.121	99382	99202-25
#2	Established Patient E&M visit	Z00.121	99392	99212-25
#3	Established Patient E&M visit	Z00.129	99394	99213-25

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Note: Providers must have **proper medical record documentation** to support the CPT codes and the E/M codes billed. This documentation should be able to be separated into two distinct notes that will support both E/M services billed for the visit.

Two points to remember when performing the components of a well visit during a sick visit are:

- Services cannot be specific to an acute illness or chronic condition
  - Such as counselling on a BRAT diet for a child with diarrhea
- Telehealth visits using video do count towards this measure.
  - In addition to the traditional codes the following modifiers must be used:
    - Telehealth modifier: 95, GT, or GQ
    - Place of service: 02

Best practices:

- Check your provider portal to review updated care gaps to identify opportunities.
- Target family members that are in the same household.
- Partner with HPP to hold block scheduling events.
- Refer to American Academy of Pediatrics' Bright Futures website for their periodicity schedule

If you have questions or concerns, call the Provider Services Helpline at **1-888-991-9023**.

ONAF Reimbursement Program

There is a new reimbursement program for the submission of Obstetrical Needs Assessment Forms (ONAF). The incentive, which went into effect on January 1, 2023, is available to all OB providers in HPP's network.

As you know, obstetrical care is extremely important for pregnant members. Receiving the appropriate prenatal, delivery and postpartum care in a timely manner is critical for both the mom and newborn.

Effective for the 2023 calendar year, the ONAF measure will be removed from the Maternity Quality Care Plus (MQCP) program. In the new ONAF program, providers will be eligible for a maximum of $200 total incentive for submission of one complete prenatal and one complete postpartum ONAF form. All ONAFs must be submitted and accepted electronically via Optum. Providers will receive payments quarterly.

HPP relies on your prompt submission of the Obstetrical Needs Assessment Form (ONAF) to enroll Medicaid members into our Baby Partners program and collect important clinical and quality data. Please note that rejected ONAFs will not be paid unless corrected and re-submitted within the appropriate timeframe. We are excited about this new incentive and will work with you to help implement it for your practice.

Form	Reimbursement
Prenatal/Initial ONAF*	$125
Postpartum/Final ONAF	$75

*** Must be submitted within 7 days of initial prenatal visit.**

If you have additional questions, please reach out to your Provider Relations Representative or contact our Provider Services Helpline at **1-888-991-9023**, Monday – Friday, 9 a.m. – 5:30 p.m. Thank you for your participation and the care that you provide to our pregnant members.

Don’t Let Your Patients Risk a Loss in their Medicaid Coverage

Your Action is Needed!

On April 1, 2023, Medicaid continuous enrollment will end. ALL Pennsylvania Medicaid recipients will be required to renew their Medicaid eligibility status based on their Medicaid eligibility date.

Health Partners Plans wants to ensure you are aware of the potential impact to your practices and your patients if your patients do not submit timely their Medicaid renewal application.

Patient impact:

1. Medicaid auto-enrollment will cease, and all recipients will be required to renew their Medicaid eligibility status. This includes Medicare beneficiaries who are also eligible for Medicaid.

2. Loss of coverage will impact your patient’s ability to access care, medications, and testing.

Practice impact:

1. Patient’s inability to pay for care.

2. Reimbursement for services you provide to Medicaid recipients who have lost their coverage will end.

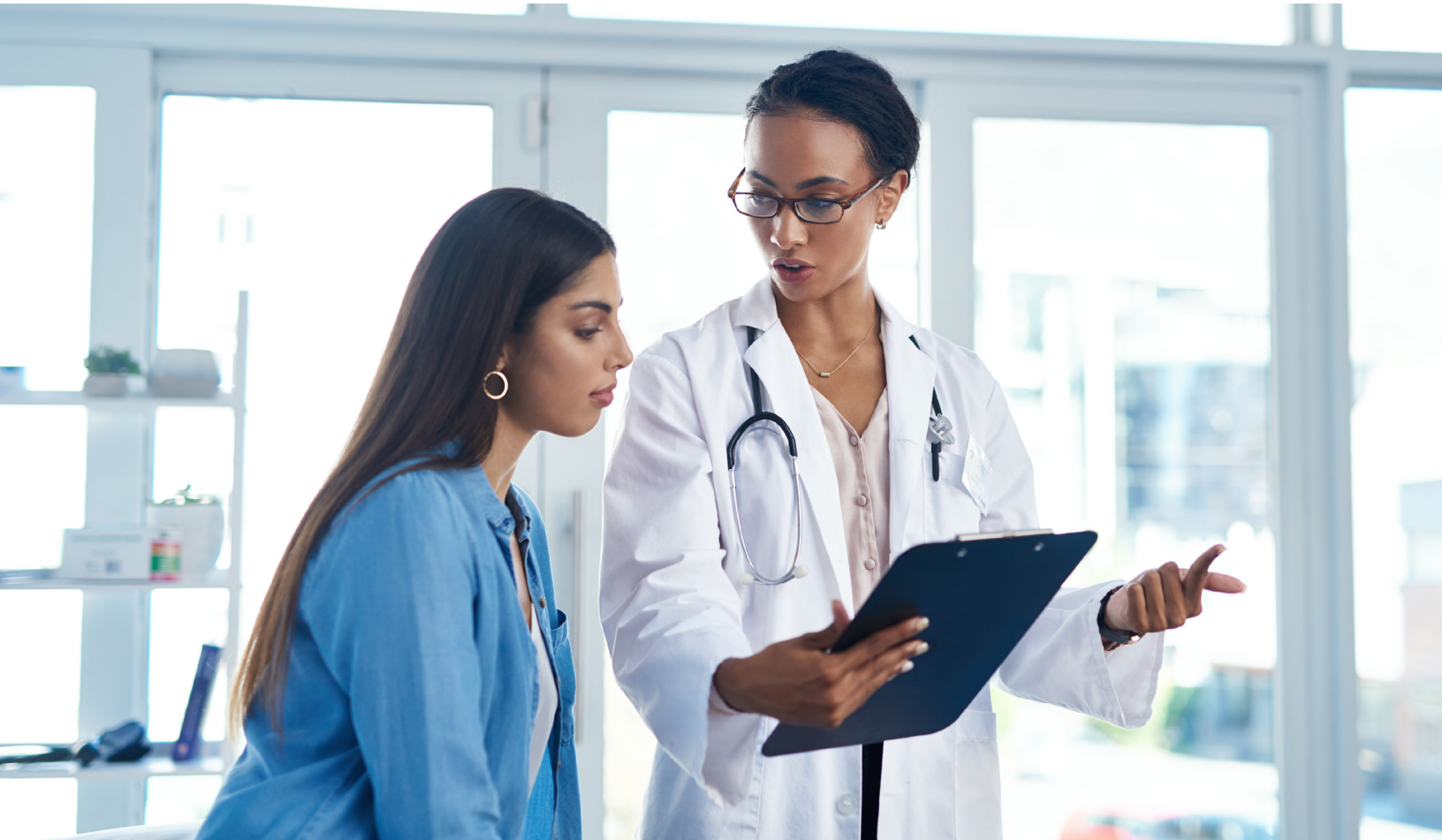
What your office can do to prevent your patients from losing Medicaid coverage:

1. Remind all your patients with Medicaid coverage that they **must renew** their Medicaid coverage starting in 2023 once auto enrollment ceases.

2. To prevent a loss in coverage, HPP recommends that offices inform patients to:

- ✔ Make sure their address is up to date with the Pennsylvania Department of Human Services. If their address has changed, Medicaid recipients must contact their local County Welfare Office or update their information on the state’s website here.
- ✔ Look for their application to come in the mail
- ✔ Return their application timely
- ✔ **Remind them that failure to complete this renewal application process may result in a loss of their Medicaid coverage**

3. Access resources to post in your office and share with your patients here.



Telemedicine Tips

HPP encourages providers to utilize telehealth when appropriate to improve and expand patient access to care. Professional telehealth services are covered and is a reimbursable service when the following requirements are met:

- The service is medically necessary and is delivered using:
  - Interactive, synchronous (real-time) two-way audio and video
  - A telephone (audio telecommunication only/ telephone call)
  - Online digital communication
- Interaction must occur between provider and member.
- Service must be rendered by an HPP Physician (PCP or Specialist), CRNP, Nutritionist, Registered Nurse or Physician Assistant working under the direct supervision of the physician contracted to perform professional telehealth services.

Why should you consider using telehealth?

- Telehealth is a covered reimbursable service
- Reduces patient barrier to accessing timely care for non-emergent or routine care
- Increases patient ability to access primary care, specialists and behavioral health visits for chronic conditions and medication management
- Improves your ability to monitor clinical signs for certain chronic medical conditions (e.g. blood pressure, blood glucose, weight gain)
- Increases patient compliance with needed post-hospitalization follow up visits
- Improves your no-show rates

Medicare Annual Wellness Visit

Your Medicare patients are encouraged to have an Annual Wellness Visit (AWV), which is a preventive care visit covered by Medicare. According to the American Medical Association (AMA), less than 20% of Medicare beneficiaries are getting this primary care exam that focuses on preventive care. This annual visit is free to the patient and is a great way for you to foster a better relationship with your patient.

The AMA suggests the following steps for the Medicare AWV:

- Engage your patients to make an appointment. Remind them that this annual appointment is a benefit they receive from Medicare and is free of charge to them. You can check your patient care gap reports on the HPP portal to determine which patients are due for their AWV.
- Remind your patients to complete their Health Assessment (HA) before they meet with the provider and that they are eligible to earn $30 in rewards through HPP's Medicare Rewards Program for doing so.
- Send your patients for pre-visit labs. This allows you to review labs prior to the visit and then discuss the results with your patients during the visit.

Important information to collect during the AWV includes the following:

- Health Assessment
- Personal and family health history
- Current health care providers, suppliers and pharmacy
- Medication review
- Screenings, including cognitive function, depression, functional status, etc.

HPP identified a disparity in the number of males that completed their AWV in 2022 compared to females. We also found that a large number of males did in fact see their PCP in 2022, but the appropriate codes for the Medicare AWV were not billed.

Please see below for guidance on the appropriate codes to bill for the AWV:

- **G0402**: Welcome to Medicare visit for new patients (must be completed in the first 12 months of Part B coverage)
- **G0438**: Initial Medicare annual wellness visit (applies the first time a patient receives an AWV after 12 months of Part B coverage)
- **G0439**: Subsequent Medicare annual wellness visit (applies to all AWVs after the initial AWV)

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For additional guidance, please see the AMA's educational module on AWVs: Medicare Annual Wellness Visit (AWV): Streamline Workflow to Perform a Thorough AWV | Health Care Economics, Insurance, Payment | AMA STEPS Forward | AMA Ed Hub (ama-assn.org).

HPP looks forward to working with you so you can provide optimum care for your patients.

Resources:

American Medical Association: Medicare Annual Wellness Visit (AWV)

CMS Medicare Learning Network (MLN): MLN6775421 August 2022

HPP Telemedicine Well Visit Guide

Thanks to improved technology, telemedicine has allowed providers to safely increase medical access and availability during the COVID-19 pandemic and beyond. HPP continues to strongly support access to health care for children and adolescents utilizing both in person and remote telemedicine services.

For more information on telemedicine best practices, please refer to our Well-Child Visits: Telemedicine Documentation and Billing Guide.

Medicaid Fraud Prevention Tips

Medicaid fraud is a felony offense. What can you do to avoid allegations and findings of fraud, waste or abuse in your practice?

Accurate and Thorough Documentation is Essential:

Ensure that your documentation includes all necessary elements to confirm what you did during an appointment.

- What was the reason for the appointment?
- Did you provide a thorough exam? How long did you spend examining the patient? Were any tests or medications ordered? Why were they ordered? Is a return visit required?
- Are levels of care and treatments ordered medically necessary and is there documentation to support them? Documentation is a main item requested and reviewed and will be used by payors and prosecutors as evidence.

Documentation becomes part of a patient's medical record and will be the basis for future treatment for that patient. In order to minimize harm, it is vital that all documentation is accurate for each specific patient.

Accurate Billing:

- Do your chart notes support the claims being submitted?
- Are procedures which are combined under one code being billed under that one code, or are they being submitted as two separate codes?
- Do chart notes reflect the requirements of codes being submitted as claims?

Telemedicine:

Since the onset of COVID-19, many appointments are taking place remotely. However, patients are recruited for tests and services which they don't need and are often coerced. Given this, telemedicine is now a focus area of law enforcement agencies. Be sure to let your patients know not to fall for schemes where someone calls them with an offer of Durable Medical Equipment (DME) or prescriptions. Inform that if they are having an issue, they should bring it to your attention for evaluation and treatment.

Contact your Network Account Manager if you have any questions about documentation requirements.

Caries Risk Assessment

The most common chronic childhood disease is dental decay. Not only can poor oral health affect a child's physical health, but it can also negatively impact lifestyle and emotional state of mind.

Because children are more likely to see their primary care provider in the early stages of life, primary care providers are well positioned to identify the early risk factors contributing to dental caries.

Common caries risk factors to look out for include:

1. **Fluoride exposure** – Fluoridated drinking water has protective effects on teeth. Even if the child lives in an area with community water fluoridation, many people consume bottled water, which might mean the child does not get the necessary fluoride supplementation to prevent decay. Evaluate the child for a fluoride supplement and/or more frequent topical fluoride applications.
2. **High exposure to sugary foods or drinks** – Frequent or prolonged exposures to a high-sugar diet will cause decay. Advise parents to limit sugary food and drinks to mealtimes.
3. **Caregiver with active decay** – Children with primary caregivers who have active decay are at high risk for developing cavities. High levels of cariogenic bacteria can be transmitted from caregiver to the child. Encourage both the caregiver and the child to see the dentist.
4. **Visible plaque or decay** – A visual oral screening should be completed to look for obvious signs of decay, white decalcified spots on the teeth or visible plaque. The presence of decay or heavy plaque is a sign that dental intervention is needed. Dental providers will be able to address issues and provide more thorough oral hygiene instruction.
5. **Special health care needs** – Developmental, physical, medical or mental disabilities can be challenging to perform proper home care raising caries risk. A referral to a dental office equipped to see special needs patients can help to establish a dental home early will help to alert the caregiver of potential problems early on.

Screening for caries risk factors and engaging caregivers in conversation during well visits can help to motivate them to take their child for regular dental visits.

Have You Discussed the Importance of Advance Care Planning with Your Patients?

Advance Care Planning (ACP) is one of the most important conversations you can have during a wellness visit to help support patient autonomy and facilitate decision making and better care at the end of life.

Voluntary ACP is a face-to-face service between the physician (or other qualified health care professional) and a patient discussing advance directives with or without completing relevant legal forms.

Examples of advance directives include:

- Living wills
- Instruction directives
- Health care proxy
- Health care power of attorney

Medicare pays for ACP, so you may be reimbursed for ACP services. Please discuss CPT codes with your HPP Provider Representative.

Keep Your Patients Safe by Encouraging Colorectal Cancer Screening

Colorectal Cancer (CRC) is the third most diagnosed cancer in men and women. However, the death rate has dropped over the past several decades, largely because of higher rates of screening. Therefore, CRC screening is critical to achieve positive patient outcomes and promote quality care.

We know many people are hesitant to get a colonoscopy because they don't have the time, don't like the prep or are afraid of the procedure.

If you have patients who are not interested in a colonoscopy or flex sigmoidoscopy, you can educate them about colorectal screening and offer alternative tests that are non-invasive, such as a FOBT or FIT-DNA test. These home tests can be obtained by writing a script. The member can pick up the home test kit at a Quest Lab.

Support CRC screening for your patients who are 50-75 years of age by ordering one of the following preventive tests:

- Fecal occult blood test (FOBT)
- FIT-DNA test
- Flexible sigmoidoscopy
- CT Colonography
- Colonoscopy

March is National Kidney Month

More than 1 in 7 U.S. adults may have chronic kidney disease (CKD).

- CKD is more common in non-Hispanic Black adults (16%) than in non-Hispanic white adults (13%) or non-Hispanic Asian adults (13%).
- About 14% of Hispanic adults have CKD.

Additionally, nearly 1 in 2 U.S. adults have high blood pressure—the second leading cause of kidney failure in the U.S. after diabetes.

Healthy kidneys filter about a half cup of blood every minute, removing waste and extra water to make urine. Kidneys that have been impacted by high blood pressure can suffer from constricted blood vessels. When this happens, the kidneys are not able to remove all waste and extra fluid from the body. Extra fluid in the blood vessels can raise blood pressure even more, creating a dangerous cycle, and causing more damage leading to kidney failure.

The best way for patients to slow or prevent kidney disease from high blood pressure is to take steps to lower blood pressure.

These steps include a combination of medicines and lifestyle changes, such as:

- Being physically active
- Maintaining a healthy weight
- Quitting smoking
- Managing stress
- Following a healthy diet, including less sodium intake

No matter the cause of kidney disease, high blood pressure can negatively impact kidney function. This National Kidney Month, speak with your patients about their individual blood pressure goals. If a patient has advanced kidney disease, refer them to a nephrologist to learn about different treatment options, including kidney transplantation.

References:

1. National Institute of Diabetes and Digestive and Kidney Diseases

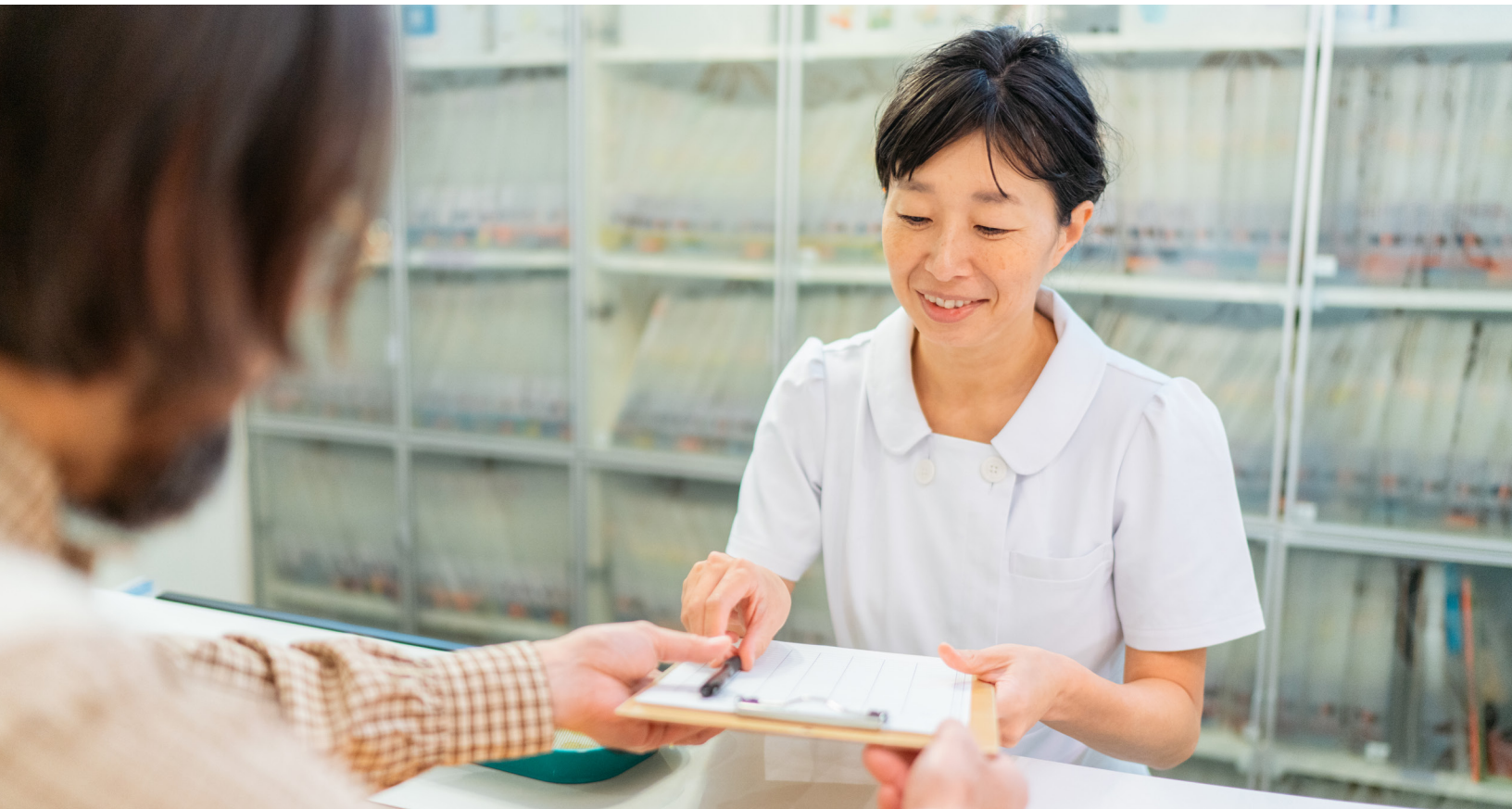
2. CDC

NATIONAL KIDNEY MONTH

2023 Medicaid Copay Update

To reduce barriers to care for our Medicaid population, Heath Partners Plans has adopted a $0 copay for all medical benefits for our Health Partners (Medicaid) health plan, effective January 1, 2023. We believe that greater access and lower out-of-pocket costs for our members will lead to improved health outcomes. Please reference the table below for copay updates.

Benefit/ Service	2022 Copay	2023 Copay
Advanced Diagnostic Radiology (MRI, CT, PET)	$1	$0
Ambulatory Surgery Center/ Short Procedure Unit	$3	$0
Chiropractic Services	$1	$0
Diagnostic Radiology (X-ray)	$1	$0
Elective Inpatient Surgical Care	$3 per day up to $21 per admission	$0 per day
Inpatient Acute Hospital	$3 per day up to $21 per admission	$0 per day
Inpatient Rehab Hospital	$3 per day up to $21 per admission	$0 per day
Medical Diagnostics	$1	$0
Nuclear Medicine	$1	$0
Pharmaceutical	$1 generic and $3 brand	$0 for covered drugs
Sleep Studies	$1	$0
Stress Echocardiography, Echocardiography & Cardiac Nuclear Medicine Imaging	$1	$0
Ultrasound (US)	$1	$0



Transportation Benefit

Do your members cancel appointments due to lack of transportation?

Health Partners Medicare members have a transportation supplemental benefit:

- Health Partners Medicare Special – unlimited one-way trips
- Health Partners Medicare Prime – 50 one-way trips
- Health Partners Medicare Complete – 22 one-way trips

HPP's transportation vendor, Access to Care, can be reached at **1-866-213-1681**.

Health Partners Medicare's transportation benefit covers the following:

- Routine trips to PCP and specialists
- In-network pharmacies and medically necessary appointments
- A family member or caregiver can ride with the member
- Wheelchair accessible vans available (need to call ahead)

Importance of Post Hospital Follow Up

HPP would like to remind you of the importance of scheduling an office visit for a patient within 7 days of a discharge from a hospital. This visit allows you to engage with your patient after a discharge, conduct medication reconciliation and may prevent a follow-up hospitalization. If your practice participates in the HPP Quality Care Plus (QCP) program, this visit is a measurement for the program. Please educate your office staff on the importance of assisting members with making an appointment within 7 days of being discharged from a hospital.