HEALTH | CHOICE
UTAH

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GENERATIONS

PROVIDER NEWSLETTER

February 2022

INSIDE THIS ISSUE

20%

Nearly 20 percent of Medicare beneficairies experience a readmission to the hospital within 30 days, costing more than $26 billion each year.

ANNOUCEMENTS

The Utah Office of Inspector General (UOIG) offers a quarterly Medicaid Fraud, Waste, and Abuse (FWA) Prevention training to help providers meet their FWA training requirements and prevention efforts. The next session will be offered virtually on Thursday, April 7, from 10:30 AM-12:00 PM. In addition to the quarterly FWA Prevention training, the UOIG is also available to provide training directly to professional organizations. If you belong to a professional organization and would like to arrange training, please email enapper@utah.gov to discuss your organization's training needs.

Health Choice Utah has seen an increase in provider balance billing of Medicaid enrollees. Please remember balance billing of Medicaid enrollees is not allowed under your registration with Utah State Medicaid or by your Provider Agreement with Health Choice Utah. Follow best practices by checking member eligibility upon each visit via the Health Choice Provider Portal (healthchoiceproviders.com) or the Utah State Medicaid Eligibility Lookup Tool (elt.medicaid.utah.gov) to verify Medicaid enrollment status.

Behavioral Health (BH) and Substance Use Disorder (SUD) services for Health Choice Utah Medicaid enrollees can be tricky to navigate. Using the eligibility lookup methods noted above, you can check to see if a patient is enrolled under the Health Choice Utah Integrated Care plan. If so, BH/SUD claims should be sent to Health Choice Utah. If not, claims for these services need to be sent to the Prepaid Mental Health Plan (PMHP) designated for your county. For additional information or clarification on these claims, please reach out to your Provider Services Representative.

CONTACT INFORMATION

GENERAL INFORMATION

Health Choice Utah – Medicaid
Member Services: (877) 358-8797
Prior Authorizations Fax: (877) 358-8793
www.healthchoiceutah.com/
PAYER ID: 45399

Health Choice Generations D-SNP – Medicare
Member Services: (844) 457-8943
Prior Authorizations Fax: (844) 457-8942
www.healthchoicegenerations.com/utah/
PAYER ID: 45399

Case Management has an email address now!
CaseManagement@healthchoiceutah.com

CLAIMS ADDRESS

Health Choice Utah (or)
Health Choice Generations
PO Box 45900
Salt Lake City, UT 84145

HEALTH CHOICE UTAH - PBM

RealRx Pharmacy Help Desk:
(855) 864-4046
RXBIN: 610830
RXPCN: RRXHCU
RXGRP: N/A

PROVIDER PORTAL HELP

Provider.Portal@healthchoiceutah.com

PROVIDER SERVICES

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Providers@healthchoiceutah.com

QUALITY / RISK ADJUSTMENT

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Jessica Hocker - Risk Coding Auditor: (801) 646-7283
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Polly Davidson - QI Specialist: (801) 646-7281
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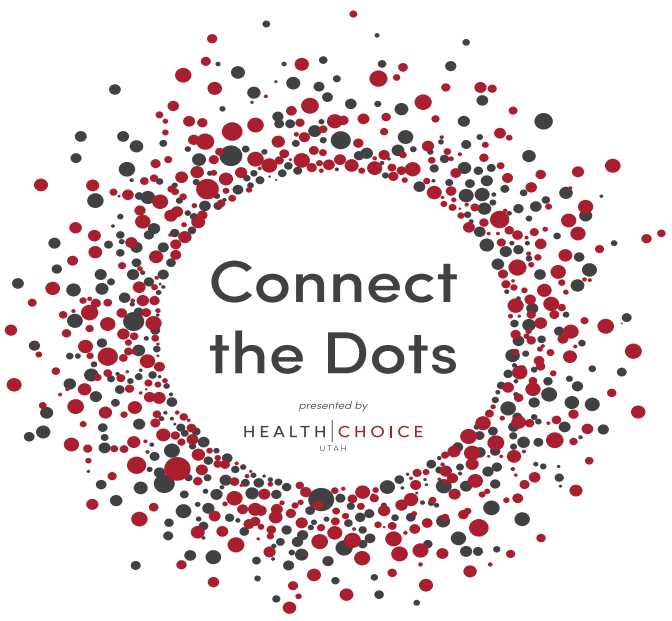
Vickie Jenkins - QI Specialist: (801) 646-7284

CONNECT THE DOTS

Health Choice Utah's Outreach team holds community network meetings called Connect the Dots. These meetings are held throughout the year, virtually and in-person. Education on a variety of topics impacting community wellness are presented. The goal of Connect the Dots is to promote organizations within the community to build a strong network of partnerships & resources.

For more information, or to RSVP, please email: outreach@healthchoiceutah.com.

Meeting Dates (10AM - 11AM)	Meeting Agenda
April 14	Self-Care
May 12	Medicaid Applicatin Process (DWS) & Enrollment, Benefits (UDOH) Open Enrollment: mid-May through mid-June effect date of July 1
August 18	Community Clinics: Affordable Health/Dental Services
September 15	Diabetic Care and Resources
October 13	Annual in-person (in-person TBD based on public safety)
November 3	Medicaid Training: Age & Disability and Dual Special Needs Plan (D-SNP)
December 8	Mental Health: Holiday (A Difficult Season), Substance Use Disorder (SUD), Supporting Community (Neighbor Check-in)



PARTNERING WITH THE UTAH FOOD BANK

Health Choice Utah has partnered with the Utah Food Bank for the better part of a year to provide Food Boxes to underserved and food-insecure populations in Salt Lake County. Each month, Health Choice Utah employees give of their time to build boxes filled with fresh and non-perishable foods and hygiene supplies. After building these boxes, these employees deliver them directly to the homes of UFB clients who depend on these Food Boxes each month for themselves and their families.

KNOWING THE DIFFERENCE BETWEEN A ROUTINE PHYSICAL EXAM, IPPE, AND AWV

Routine Physical Exam

A Routine Physical Exam is an exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. Medicare does not cover the routine physical, but does cover some elements of a routine physical under the IPPE, AWV, or other Medicare benefits.

Initial Preventive Physical Exam (IPPE)

The Initial Preventive Physical Exam (IPPE), also known as the "Welcome to Medicare" preventive visit promotes good health through the review of medical and social health history, disease prevention and detection and preventive services education. Medicare will pay for 1 IPPE per lifetime within the first 12 months of enrollment.

IPPE Components include:

1. Review of the patient's medical and social history
2. PHQ-9 screening with a review of the patients potential depression risk factors, including current or past experiences with depression or other mood disorders
3. Functional ability and safety level status
4. Exam including height, weight, Body Mass Index (BMI), blood pressure, visual acuity screen, and other factors deemed appropriate based on medical and social history and current clinical standards
5. End of life planning including advanced care directive, health care proxy, etc.
6. Current opioid prescription review (if applicable)
7. Screen for potential Substance Use Disorders (SUDs)
8. Educate, counsel, and refer based on previous components
9. Educate, counsel, and refer for other preventive health services

IPPE HCPCS Codes & Descriptors

G0402
Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0403
Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

G0404
Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405
Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

G0468*
Federally Qualified Health Center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

* Get more information on how to bill HCPCS code G0468 in the Medicare Claims Processing Manual, Chapter 9, Section 60.2.

Diagnosis

You must report a diagnosis code when submitting an IPPE claim. Medicare doesn't require you to document a specific IPPE diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.

Billing

Medicare Part B covers an IPPE when performed by a:

- Physician
- Qualified Non-Physician Practitioner (NPP) (a Physician Assistant [PA], Nurse Practitioner [NP], or Certified Clinical Nurse Specialist [CCNS])

When you provide an IPPE and a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service, Medicare may pay the additional service. Report the additional CPT code (99201–99215) with modifier –25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury, or to improve the functioning of a malformed body part.

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CONTINUED - KNOWING THE DIFFERENCE BETWEEN A ROUTINE PHYSICAL EXAM, IPPE, AND AWV

Annual Wellness Visit (AWV)

The Annual Wellness Visit (AWV) includes a Health Risk Assessment (HRA) completed by the provider or the patient before or during the AWV.

A HRA includes, at minimum:

- Demographic data
- Health status self-assessment
- Psychosocial risks including, but not limited to depression/ life satisfaction, stress, anger, loneliness/social isolation, pain and fatigue
- Behavioral risks including, but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (for example, seat belt use), and home safety
- Activities of Daily Living (ADLs) including dressing, feeding, toileting, grooming, physical ambulation including balance/risk of falls and bathing
- Instrumental ADLs (IADLs) including using the phone, housekeeping, laundry, mode of transportation, shopping, managing medications, and handling finances

Additional AWV components include:

1. Patient's medical and family history
2. PHQ-9 screening with a review of the patients potential depression risk factors, including current or past experiences with depression or other mood disorders
3. Functional ability and safety level status
4. Measurements for height, weight, BMI, blood pressure, and other routine measurements deemed appropriate based on medical and family history
5. Provide Advance Care Planning (ACP) services at patient's discretion
6. Review current opioid prescriptions
7. Screen for potential Substance Use Disorders (SUDs)
8. List of current providers and suppliers
9. Cognitive function assessment
10. Establish an appropriate written screening schedule
11. Establish a list of patient risk factors and conditions
12. Provide personalized health advice and appropriate referrals to health education or preventive counseling services/programs

An AWV can be performed each year as long as it is 365 +1 day from the last AWV.

AWV HCPCS Codes and Descriptors

G0438
Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit

G0439
Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit

G0468*
See information for G0468 listed on the previous page under IPPE Codes & Descriptors.

Diagnosis

Report a diagnosis code when submitting an AWV claim. Since Medicare doesn't require you to document a specific AWV diagnosis code, capture all diagnoses consistent with the patient's exam.

Billing

Medicare Part B covers an AWV if performed by a:

- Physician
- Qualified Non-Physician Practitioner (NPP) (a Physician Assistant [PA], Nurse Practitioner [NP], or Certified Clinical Nurse Specialist [CCNS])
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician

When you provide an AWV and a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service, Medicare may pay the additional service. Report the additional CPT code with modifier –25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury, or to improve the functioning of a malformed body part.

You can only bill G0438 or G0439 once in a 12-month period. G0438 is for the first AWV and G0439 is for subsequent AWVs. Remember, you must not bill G0438 or G0439 within 12 months of a previous G0402 (IPPE) billing for the same patient. Medicare denies these claims with messages of "Benefit maximum for this time period or occurrence has been reached" and "Consult plan benefit documents/guidelines for information about restrictions for this service."

Medicare telehealth uses HCPCS codes G0438 and G0439. Get more information on the List of Telehealth Services webpage.

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CODING GUIDANCE

- **G0402** - Initial preventive physical examination (IPPE); Face-to-Face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
- **G0447** - Face-to-Face behavioral counseling for obesity, 15 minutes, can only be billed with the G0402-IPPE
- **G0438** - Annual wellness visit; includes a personalized prevention plan of service, initial visit
- **G0439** - Annual wellness visit; includes a personalized prevention plan of service, subsequent visit
- **G0444** - Annual depression screening, 15 minutes (can only be billed with G0439 subsequent AWV)
- **G0513** - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for the preventive service)
- **G0514** - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)
- **99497** - Advanced Care Planning (requires modifier-33 when billed with same-day G0439)
- **99406** - Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407** - Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
- **1170F** - Functional Status Assessment or ADLs (COA)
- **1125F** - Pain present (COA)
- **1126F** - No pain present (COA)
- **1157F** - Advance care plan or similar legal document present in the medical record (ACP)
- **1158F** - Advance care planning discussion documented in the medical record (ACP)
- **1111F** - Medication Reconciliation 30 days post hospitalization (TRC)
- **1159F & 1160F** - Medication Review: Need both codes billed on same claim same DOS (COA)

*Codes are subject to change; please refer to current coding manuals.

TRANSITIONS OF CARE

It is important to have Primary Care Providers (PCPs) participating in their patients care. By building a transitional care management (TCM) team within the office you can bridge the gap between everyday health management and inpatient admission. By ensuring primary care providers follow up with their patients in a structured, reimbursable manner after discharge from a hospital, skilled nursing facility, inpatient rehab facility or other setting can improve the patients overall care, and reduce readmission.

Even though PCPs are central to the overall patient experience, they certainly don't work alone when it comes to managing a chronic patients overall health care needs. Specialists, behavioral health organizations, community and social service groups, home health agencies, long-term care facilities and even inpatient hospitals are all partners in care for vulnerable individuals.

Typically, practices conduct an in-person visit after discharge to discuss the patients current diagnoses, medications and hospital based interventions that can affect their overall wellbeing and offer insight into any ongoing clinical needs. If the patient is unable to be seen in-person, a telehealth follow-up, or phone call appointment with the provider can capture the specific needs of the patient.

Patient engagement interventions should consider the needs of vulnerable patient populations that have complex medical needs, limited health literacy, and social vulnerabilities. These at-risk patients may require additional support to prevent ineffective transitions of care and other safety issues.

The time spent assessing and supporting patients should improve efficiency and resolve gaps in care relative to patient engagement and outcomes.

In order to gain visibility into patient activities and conduct TCM in a timely manner, PCPs need to invest in a combination of internal capabilities and external relationships. An effective approach to TCM includes five key steps create a comprehensive transitional care management program that relies heavily on data analytics and community partnerships to ensure high-quality care for attributed beneficiaries.

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Five key aspects to be aware of when implementing a TCM program are:

- Laying the Groundwork
- Working Closely with Other Providers in the Community
- Data Analytics and Workflow Improvement
- Closing the Loop with Community-Based Organizations, Caregivers and Patients
- Assessing Progress and Applying Lessons Learned to Future Initiatives

Implementation start-up may seem time-intensive at the beginning, but should decrease as new and improved processes are integrated in existing workflows.

RISK ADJUSTMENT CORNER

Since ICD-10-CM diagnoses that map to a Hierarchal Condition Category (HCC) must be documented and substantiated at least once per year, Annual Wellness Visits are an excellent time to address chronic conditions. Consider the following lists when conducting AWVs to ensure accurate and complete capture of chronic conditions.

COMMONLY UNDER-DOCUMENTED AND MISSED HCCs:

- Acquired absences of organs or limbs
- Transplant status
- Artificial openings
- Chronic respiratory diseases
- Chronic ulcerations
- Heart failure
- Drug dependence
- Cancers, active or in remission
- Current BMI with obesity or malnutrition
- Rheumatoid arthritis
- Psoriasis or psoriatic arthritis
- Depression with severity and episode
- Old myocardial infarction
- Essential hypertension
- Migraines
- Osteoporosis
- Gastroesophageal reflux disease
- Lipoprotein metabolism disorders, lipidemias
- Thyroid disorders
- Diabetes with complications or manifestations
- Late effects of stroke

COMMONLY OVER-CODED AND MISDOCUMENTED HCCs:

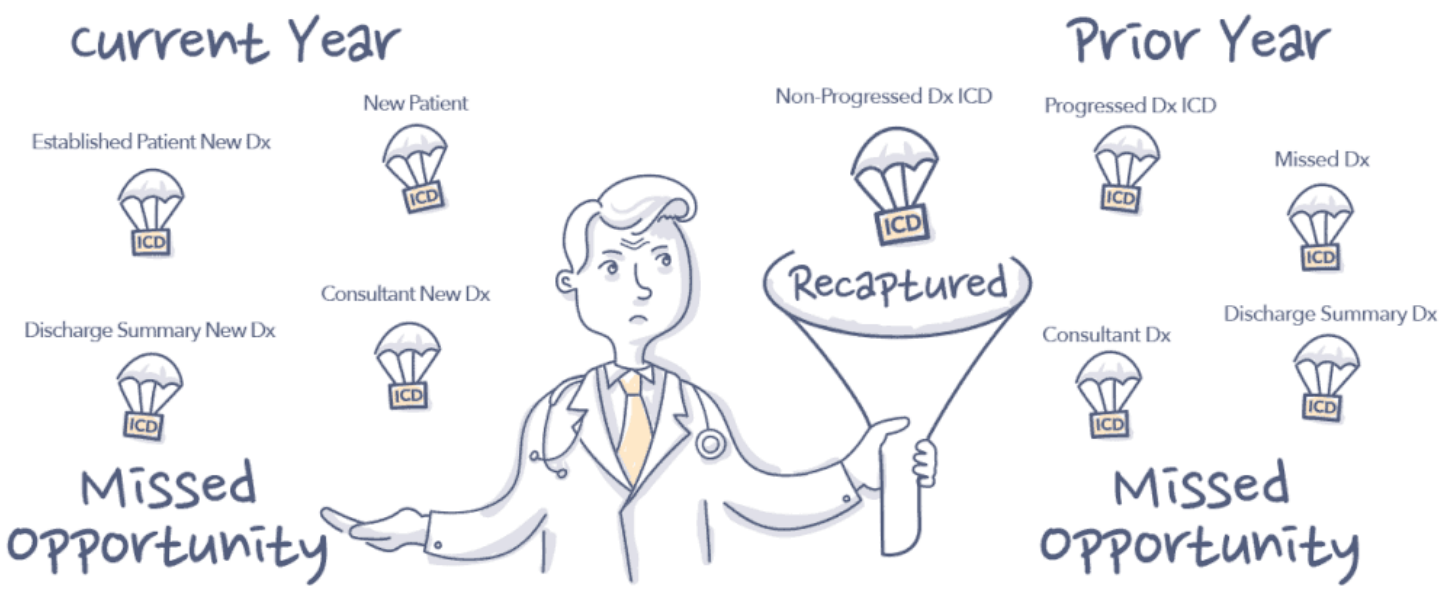
- Surgically corrected conditions (e.g. abdominal aortic aneurysm)
- Old pathological fractures reported as current
- Unspecified pneumonia reported as pneumococcal
- Polyneuropathy reported as current when no treatment, evaluation, or monitoring is documented
- Historical cancers that have been eradicated, removed, excised, or have no further treatment directed to that site
- Acute strokes reported in an office setting
- Vascular diseases reported as current when no treatment, evaluation, or monitoring is documented

HELPFUL HINTS

Diagnosis codes you may receive for your patients can come from several provider sources, including:

- Specialists
- Inpatient/ Outpatient Hospital
- Pharmacy
- Radiology
- Laboratory
- Outpatient Visits

Several diagnosis codes within the same family may be listed, due to the wide variety of provider sources. In those cases, choose the option that best describes the patient's condition in your medical opinion. Systemic diseases, like diabetes, and any complications related to it, may require multiple diagnosis codes to completely and accurately describe the patient's condition.



MEDICATION RECONCILIATION POST DISCHARGE (MRP)

Medication Reconciliation is defined as a review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record within 30 days of discharge from the Hospital.

For several reasons, it can be vital to have your patients bring their medication bottles into the office for reconciliation:

- It helps avoid medical errors that could result from an incomplete understanding of past and present medical treatment
- Less likely to have a medication name or dosage forgotten or overlooked
- Allows the provider to effectively look for dosing errors, avoid unnecessary duplication of medications that treat the same symptoms and discuss proper administration
- Ability to identify and avoid adverse drug interactions

Primary care physicians can help their patients by being aware of, and/or monitoring inpatient stays, to remain up to date on the patients' overall health status. After you receive notification that the patient has discharged or is scheduled to discharge soon, it is important that you obtain the discharge summary from the hospital to be aware of any services ordered post discharge and medications they were discharged home with. It is important to see the patient in your office as soon as possible, preferably within 7 days after an acute inpatient stay, or at minimum within 30 days after discharge. Once you review the discharge summary, document all reconciled medications in the outpatient medical record and submit the appropriate code to the health plan.

HOW TO BE SUCCESSFUL IN YOUR MRP EFFORTS

To do well, practices must ensure all medications are reconciled by a prescribing practitioner, clinical pharmacist, or registered nurse within 30 days of discharge from the hospital. Evidence of the reconciliation and the date it was done must be documented in the outpatient record.

Any of the following examples meet criteria:

- Documentation that the provider reconciled the current and discharge medications
- Documentation of the current medications with a notation that references the discharge medications
- Documentation of the members current medications with a notation that the discharge medications were reviewed
- Documentation of a current medication list, a discharge medication list and notation that both were reviewed on the same date of service
- Notation that no new medications were prescribed or ordered upon discharge

DESCRIPTION	CODES
OUTPATIENT VISITS	**CPT**: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483 **HCPCS**: G0402, G0438, G0439, G0463, T1015
ONLINE ASSESSMENTS	**CPT**: 98969-98972, 99421-99423, 99444, 99457 **HCPCS**: G0071, G2010, G2021, G2061-G2063
TELEPHONE VISITS	**CPT**: 98966, 98967, 98968, 99441, 99442, 99443
TRANSITIONAL CARE MANAGEMENT SERVICES	**CPT**: 99495, 99496
MEDICATION RECONCILIATION	**CTP**: 99483, 99495, 99456 **CPT-CAT-II**: 111F

REFERENCES

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5. Agency for Healthcare Research and Quality. Defining the PCMH. Patient Centered Medical Home Research Center.
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