Dec / Jan 2019

Provider Connection

In this issue...

Hometown Health
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Save Time with HealthConnect!

Don't sit on hold! Use HealthConnect – let us connect you!

Use HealthConnect to quickly and efficiently:

- Check Eligibility and Benefits
- Submit and view status of Prior Authorizations
- Submit and view status of Reconsiderations
- Review status of claims

Need to set up an account or want training? Email our Provider Services Team – they will come to you!

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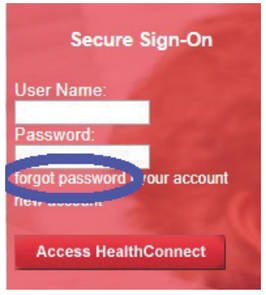
Just need to reset your Password? It's easy! Look for the Forgot Password Link on the Health Connect Login Page. Your HealthConnect Power User can also unlock accounts and reset passwords.



Important Updates

NEW! For Renown HMO no referral for Office Visits to Specialist is needed. Make sure to refer to the specific authorization requirements for each plan in Health Connect to verify what services require authorization. You can find all authorization requirements for each plan under the Forms tab.

As of January 1, 2019 we want to welcome the Atlantis, a new self-funded plan. Their benefits and authorization requirements will be available in HealthConnect.

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Dec / Jan 2019 Hometown Health from Senior Care Plus

What You Need to Know about Part D Opioid Program for 2019

New Centers for Medicare and Medicaid Services (CMS) Drug Management Programs for 2019

CMS is very concerned about the opioid epidemic and its effect on our communities, and is committed to a complete strategy to combat this public health emergency. For 2019, several new drug management programs are being put in place to prevent and combat opioid overuse.

- Opioid prescriptions will be monitored for safe dosage levels. If one or more opioid prescription is above a safe dosage limit, the prescription will be stopped at the pharmacy for review by the prescriber to make sure that the prescription is medically necessary and appropriate. A prior authorization is required for a prescription that exceeds a Morphine Milligram Equivalent (MME) of 200. A 90 MME prescription will also deny but can be over ridden by a pharmacist.
- Opioid prescriptions that are taken together with benzodiazepine prescriptions will be stopped at the pharmacy for review by the prescriber to make sure that the prescriptions are medically necessary and appropriate. This can be overridden by the pharmacist.
- Members who have not had a recent prescription (in the last 60 days) for opioids will be iimited to no more than a seven-day supply for their first opioid prescription for the treatment of acute pain.
- Prescriptions for long-acting opioids that are taken at the same time will be stopped at the pharmacy for review by the prescriber to make sure that the prescriptions are medically necessary and appropriate. This can be overridden by the pharmacist.
- Prior authorizations that are required for the above items will be expedited (24-hour turnaround time), so please send in supporting documentation to include the patient medical record with each prior authorization.
- For prior authorizations, please call MedImpact at (800) 788-2949.
- Prescriptions with ICD 10 codes may be processed by the pharmacy more efficiently

Patients may be exempt from these drug management programs if they have cancer and/or they are in a hospice or long-term care facility.

Get to the M.E.A.T of the Matter

Documentation Improvement and Risk Adjustment; How do they relate?

"Document to the highest specificity", does that sound familiar? Have you been given this direction by your office manager or coding professional?

The implementation of ICD-10 in October of 2015 was a turning point for documentation requirements. The code set was expanded exponentially, and with it, the need for accurate and specific documentation increased.

The terminology "highest specificity" is something we have learned to use as an explanation for the need of more accurate documentation. In order for a diagnosis to be captured for coding, there are strict guidelines regarding the exact verbiage that

Continued on page 3

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Partnering With Providers to Ensure Quality!

What you should know about CAHPS and HOS Quality Measures

What are CAHPS and HOS?

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is an initiative to support and promote the assessment of consumers' experiences with health care. The Health Outcomes Survey (HOS) assesses the ability of a Medicare Advantage organization to maintain or improve the physical and mental health of its members over time.

CAHPS and HOS ratings account for more than a quarter of overall CMS Star Ratings and will be a large focus for Senior Care Plus. We would like to partner with you to ensure that our members are receiving the highest quality of care.

What is being measured and how can you contribute?

Getting Needed Care: Members rate how often it was easy to get appointments with providers and how often it was easy to get the care, tests, or treatment they needed.

- Make scheduling as easy as possible. Ask staff to schedule specialist appointments and write down the details for your patients.

Getting appointments and care quickly: Members also rate how often they saw their provider within 15 minutes of their appointment time.

- Break up wait times by moving patients from the waiting room into an exam room to take vitals. If the provider is delayed, make sure the patient is attended to by staff during the wait (measuring vitals, discussing health status issues such as fall risk and physical activity).
- Contact your patients when delays are expected using telephone, text, or email.

Overall rating of health care quality: On a 0-to-10 scale, members rate their health care in the previous six months.

- Ask open-ended questions to give your patients a chance to disclose health issues and concerns.
- A quick explanation for lengthy wait times has been shown to markedly improve patient satisfaction.

Coordination of care composite measure: Members rate their providers' familiarity with their medical history and prescriptions and how well "personal doctors" are managing care with specialists or other providers.

- Set the expectation on the time it takes to follow up on blood tests, X-rays, and other tests.
- Assure your patient that you have the relevant information about his or her medical history. If you are aware specialty care has occurred, mention it and discuss as needed.

Improving or maintaining physical health: Members report whether their physical health is the same or better than expected in the past two years.

- Educate patients regarding abnormal decline in physical health versus the natural aging process.
- Applaud your patients' physical health when possible, and encourage them to stay positive.

Improving or maintaining mental health: Members report whether their mental health is the same or better than expected in the past two years.

- Ask about your patients' mental health. Simple recommendations have a big impact on a patient's sense of emotional well-being.
- When completing routine depression screenings, be specific in scripting and let the member know the goal of the screening is to ensure that they are improving their mental health.

Monitoring physical activity: Members report whether they have discussed exercise with their provider and if they were advised to start, increase, or maintain their physical activity level during the year.

- Be specific. For example, suggest walking at a particular local park or shopping mall so patients have a specific, actionable idea.

Improving bladder control: Members who report having a urine leakage problem are asked whether they have discussed it with their doctor.

- Ask patients about urinary incontinence because patients are often too embarrassed to bring it up themselves.
- When you recommend Kegel exercises or other less conventional remedies, emphasize that you are, in fact, providing treatment. Also, recommend treatment options no matter the frequency or severity of the bladder control problem.

Reducing the risk of falling: Members who had a fall or problems with balance and discussed it with their health care provider are asked whether they received a fall-risk intervention in the last year.

- Talk to your patients about their risks for falling, including risk factors such as medications, alcohol use, lack of physical activity, or sensory impairments. Remind patients that installing handrails or using a cane can prevent falls.

M.E.A.T. of the Matter Continued from page 1
is needed in addition to at least one qualifying M.E.A.T. statement.

Risk Adjustment reviews are performed retrospectively, after receipt of the claim. Which means, queries or clarifications are not appropriate due to the length of time between a record being completed by a provider and the record being reviewed for Risk Adjustment. During these retrospective reviews, Risk Adjustment's role is to validate that all chronic conditions a patient has been diagnosed with in the past have been captured for the current calendar year. These chronic conditions determine the reimbursement given to Medicare Advantage plans, which is used to fund the anticipated care that a patient will need for the following year.

What can you do to ensure that your documentation is appropriate for code capture? Just follow M.E.A.T.! Remember, a minimum of one M.E.A.T. statement is needed to validate that a condition exists:

Monitor: Follow-up plans / ongoing surveillance of the condition.

Evaluate: Who is managing the condition / what is the plan of care.

Assess/Address: The condition and its status (improving, stable, worsening).

Treatment: The treatment & treatment adherence / tolerance.

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