MediGold

PROVIDER UPDATE

March 2023

National Doctors' Day – March 30

On March 30, 1842, anesthesia was administered during surgery for the first time. This date was chosen for National Doctors' Day to commemorate the anniversary of this historic medical milestone. Although the holiday was widely celebrated in intervening years, it wasn't until 1990 that President George H.W. Bush signed National Doctors' Day into law. You'll often see doctors wearing red carnations, which has become the symbolic flower to celebrate this day.

It is a holiday that honors physicians for the work they do for their patients, the communities they work in, and for society as a whole. It is their hard work and devotion that keeps all of us healthy and this day thanks them for doing that for us and our loved ones.

As we celebrate National Doctors' Day, it's important to acknowledge the important work that's behind the physicians practicing in your exam rooms and operating rooms today.

Many doctors attribute their relationships with patients to be the most rewarding part of their job. This is something that you don't find in many other professions. Physicians are by their patients' side during some of the hardest times of their lives. Physicians are entrusted to hold other human beings' lives in their hands, which is daunting, but the payoff can be gratifying. The demonstrations of gratitude from patients and their loved ones leave an immense impact on doctors.

Focusing our approach to our members encouraging preventive care, managing social determinants of health, and personalizing experiences is part of what we do. We must remember every decision we make is affecting a member. Our members rely on us to make the right decisions, in order to benefit all who have chosen us as their healthcare provider.

-- From the Desk of Dr. Greg Wise, CMO
MediGold

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Upcoming Inflation Reduction Act (IRA) provisions

The Inflation Reduction Act (IRA) of 2022 (https://www.congress.gov/bill/117th-congress/house-bill/5376), has a number of provisions affecting Medicare Part D that have already taken effect, and more that will take effect over the next several years. The IRA provisions regarding adult vaccines and cost-sharing for covered insulin products were effective January 1, 2023, and communicated to members last fall. These provisions include:

- Limiting member cost share up to $35 for a one-month supply for all covered insulins in Part D,
- $0 member cost share for any covered Part D vaccine recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) for adults 19 years of age and older.

Various other IRA provisions to be enacted in the coming years, include:

- Capping Medicare beneficiaries' out-of-pocket spending under the Medicare Part D benefit, first by eliminating coinsurance above the catastrophic threshold in 2024 and then by adding a $2,000 cap on spending in 2025.
- Expanding eligibility for full Part D Low-Income Subsidies (LIS) in 2024 to low-income beneficiaries with incomes up to 150% of poverty and modest assets and repeals the partial LIS benefit currently in place for individuals with incomes between 135% and 150% of poverty.

IRA also requires the federal government to negotiate prices for some high-cost drugs covered under Medicare and requires drug manufacturers to pay rebates to Medicare if they increase prices faster than inflation for drugs used by Medicare beneficiaries.

New provisions

New IRA provisions that will take effect within the next few months include:

1) Part B Rebatable Drug Coinsurance Adjustment – effective April 1, 2023

This provision applies to Part B drugs with prices increasing faster than inflation. "Chemotherapy administration services to include chemotherapy/radiation drugs" or "Other drugs covered under Part B of original Medicare" are among those affected drugs, as listed in § 422.100(j)(1)(i). This provision does not apply to insulin, which will be addressed in a provision taking effect on July 1, 2023 (see below).

CMS will publish the adjusted beneficiary coinsurance for each Part B rebatable drug in the quarterly pricing files posted on the CMS website, as a 0-20% effective coinsurance of the Medicare-approved payment amount.

In order to be in compliance, plans must download the Average Sales Price (ASP) quarterly files located here: https://www.cms.gov/medicare/medicare-fee-for-service-part-b-drugs/mcrpartbdrugavgsalesprice.

Plans must ensure cost share is at or below that Medicare-approved payment amount. This must be reviewed quarterly for changes. If the plan is at or below that amount nothing further is required.
Additionally, enrollees must have the cost adjusted at the point-of-sale (POS) or be given a refund if they paid

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Upcoming Inflation Reduction Act (IRA) provisions - continued

more than the allowed amount. The refund process is for 2023 only, as CMS realizes there is limited time to implement POS fully. Providers who collect coinsurance at the time of service should be aware of and adjust to the quarterly updated adjustable coinsurance for impacted Part B Drugs using the ASP files from CMS. Plans must also update enrollee communications.

2) Part B Insulin Cost Sharing Cap – effective July 1, 2023

Insulin furnished under Part B, through an item of durable medical equipment (DME) covered under section 1861(n) (i.e., a medically necessary traditional insulin pump), is subject to a beneficiary coinsurance cap for a month's supply not exceeding $35, and the Medicare Part B deductible does not apply.

Plans will follow their process for Part B vs. Part D coverage to identify affected insulins. Those covered under part B must be assigned no more than $35 cost share for a month's supply of insulin.

Plans must ensure cost sharing does not exceed $35 for a month's supply of insulin, regardless of the DME used to administer the drug or if purchased at point-of-sale (POS). Plans must also ensure their claims system is configured to not apply a service category or deductible when an insulin pump is billed.

Carotid Artery Disease vs. Carotid Artery Occlusion and Stenosis

There has been additional guidance and clarification provided by the American Hospital Association (AHA) on how to code Carotid Artery Disease in its 2021 Q1 Coding Clinic.

With this update, as long as bilateral carotid artery disease is documented with occlusion and stenosis, code I65.23 (Occlusion and stenosis of bilateral carotid arteries) should be used. If stenosis and occlusion is not documented with carotid artery disease, code I77.9 (Disorder of arteries and arterioles, unspecified) should be the assigned.

Documentation Example 1

Assessment/Plan:

Carotid Artery Disease due to occlusion and stenosis – continue statin and will continue to monitor

Correct code: I65.23, Occlusion and stenosis of bilateral carotid arteries

Documentation Example 2

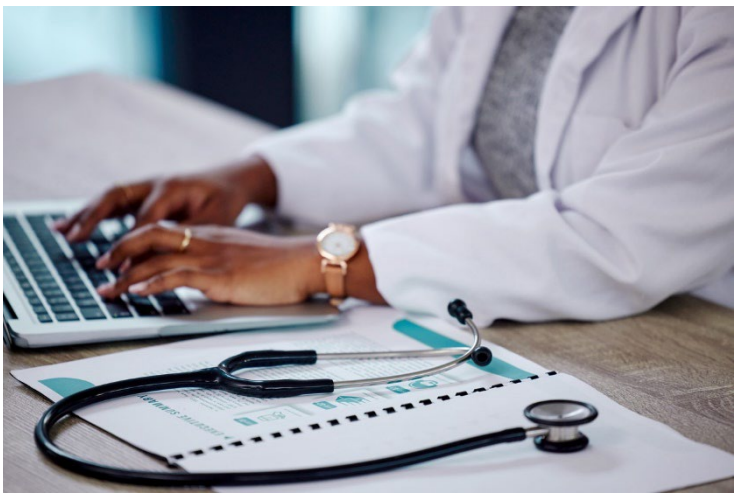
Assessment/Plan:

Carotid Artery Disease – continue statin and will continue to monitor

Correct code: I77.9, Disorder of arteries and arterioles, unspecified

Medical Records Requests for HEDIS® and Risk Adjustment

Why is MediGold asking to provide Medical Records for a patient for HEDIS® and Risk Adjustment?



Every year MediGold and/or its vendors will request records for HEDIS and Risk Adjustment. It is important that providers read the record request to determine which program the records are being requested for and what information is needed. HEDIS record requests look for one specific service while Risk Adjustment request will look for a date range of records on a specific member.

- Data collection for HEDIS.
  - HEDIS reporting is a significant component of Medicare Star Ratings, required for NCQA accreditation and used for Consumer Report Health Plan Rankings. MediGold uses information from submitted claims to obtain the majority of our HEDIS data and to determine where we need to focus our improvement efforts.
  - HEDIS measures include:
    - Colorectal Cancer Screening
    - Controlling Blood Pressure
    - Diabetes Screenings; A1c, Eye Exam
    - Transitions of Care and Medication Reconciliation Post Discharge
- Data collection for Risk Adjustment:
  - CMS requires Health Plans to submit complete and accurate diagnosis codes on our members annually. Most diagnosis codes are submitted through our claims process. To ensure that we are submitting complete and accurate data, the Risk Adjustment team will complete an annual medical record review on previous years dates of service.
  - Annual medical record reviews are completed to identify additional conditions not captured through claims or encounter data, as well to review documentation to ensure codes submitted to CMS are supported within the medical record.
  - Diagnosis codes submitted are also audited by CMS through the Improper Payment Measurement Audit. Health Plans that are included in these audits will request records from providers to submit to CMS. CMS-certified coders will review the documentation in the records to ensure proper supporting documentation for ICD-10 codes that were submitted to CMS.

It is extremely important that requested records are provided to the proper entity within the timeframe specified in the requests.

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Medical Records Requests for HEDIS® and Risk Adjustment - continued

Does a policy exist that requires us to provide medical records to MediGold?
Yes. Network participants are contractually required to provide medical records so we may fulfill our state and federal regulatory obligations. We appreciate your timely response to our request for records.

How do I submit medical records to MediGold?
Instructions for submitting medical records will be outlined in the letter to providers. There are several methods for submission that meet HIPAA guidelines:

- Fax
- Hard copy, flash drive or CD delivered through the mail.
- Email encrypted to HIPAA standards. (SSL or TLS encryption is not sufficient).
- Remote electronic medical record (EMR) system. EMR submissions are highly recommended as this will result in fewer visits and emails from MediGold.
- You can request to have a HEDIS coordinator to come into your office to collect a copy of the records.

When will MediGold request medical records for HEDIS?
Generally, medical records are requested from all Health Plans during HEDIS Season that runs between February and May. At MediGold, we would like to reduce the number of records that are requested during these few months and our HEDIS Coordinators will be working with your office throughout the year to obtain the records.

When will MediGold request medical records for Risk Adjustment?
Typically, medical records are requested from Health Plans starting in May. This ensures time for certified coders to review the records for supporting documentation around all ICD-10 codes submitted to CMS. All ICD-10 codes that are added or deleted due to the review, are required to be submitted to CMS by the January 31 deadline.

Under HIPAA laws, can MediGold review patient medical records without a signed member release?
HIPAA allows providers to disclose PHI to another covered entity without a signed release in reference to health care operations. These operations include activities such as quality assessment and improvement and health plan performance evaluations.

What should I do if a medical record request is for a member who is no longer with MediGold or who is deceased?
The requested records need to be submitted to MediGold regardless of the status of the member. Medical record reviews may require data collection on the services obtained over multiple years when the member was receiving benefits from MediGold.

What should I do if a medical record is requested for a member who was seen by a provider who has retired, died or moved?
The requested records need to be submitted to MediGold regardless of the status of the provider. Data collection includes reviewing medical records as far back as 10 years (including before your patient was a MediGold member) and archived records and data may be required to complete this process.