Enrollee Health Assessment Program
2016 Updates

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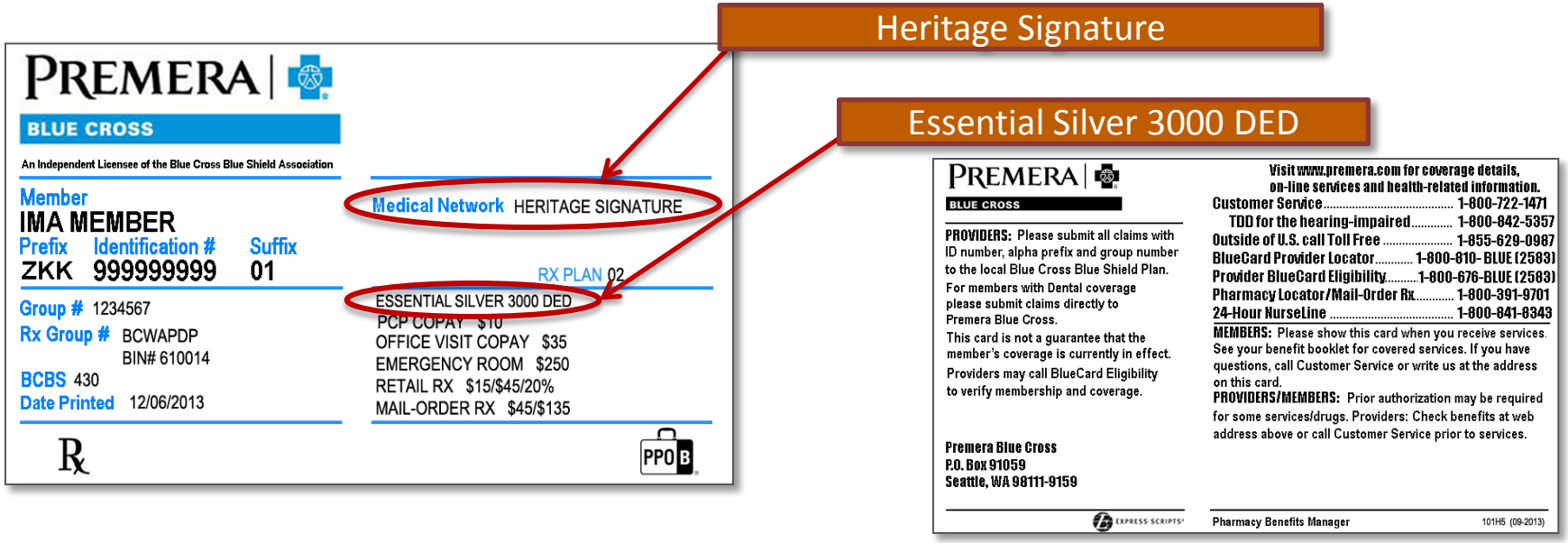
What We Will Cover Today

- How to identify qualified members
- The EHA process and updates for 2016
- The clinician's role in the EHA Program
- The importance of coding and documentation of chronic and complex conditions
- How to bill the Annual Health Review (AHR)

Identifying Washington Qualified Members

To be eligible for the EHA Program, a member must:

1. Have an individual or small group metallic plan (bronze, silver, or gold)



2. Meet the clinical criteria of **<u>two</u>** or more chronic or complex conditions

Identifying Alaska Qualified Members

To be eligible for the EHA Program, a member must:

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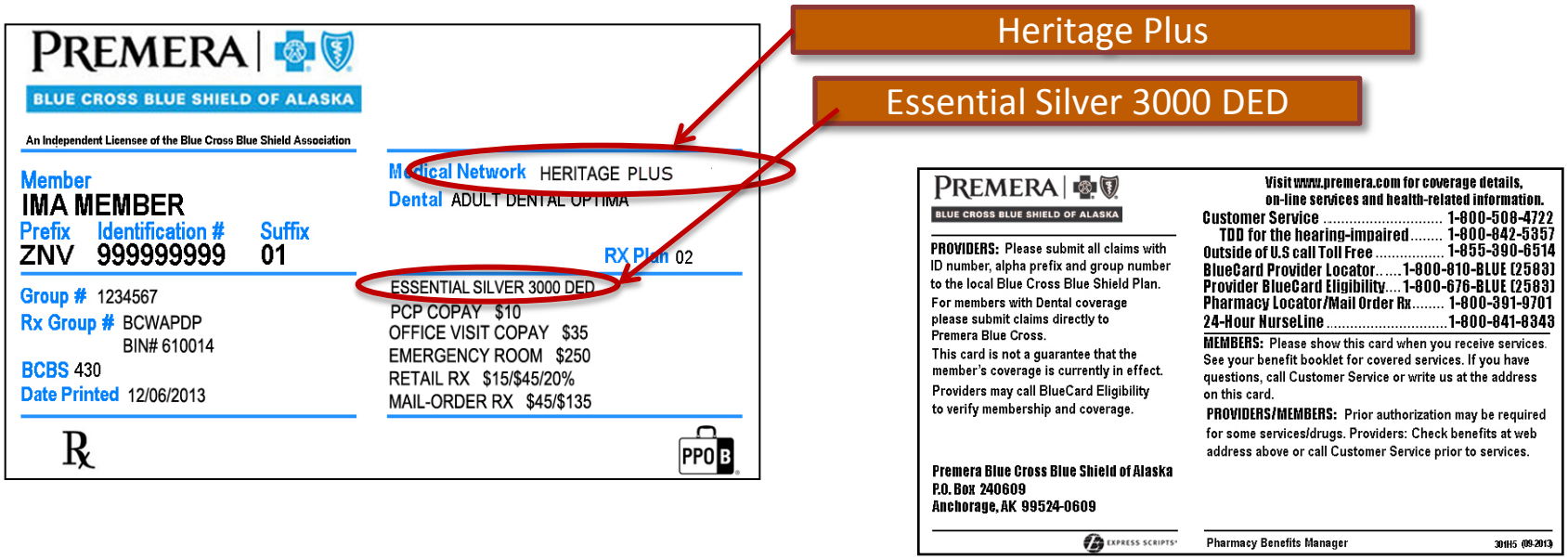
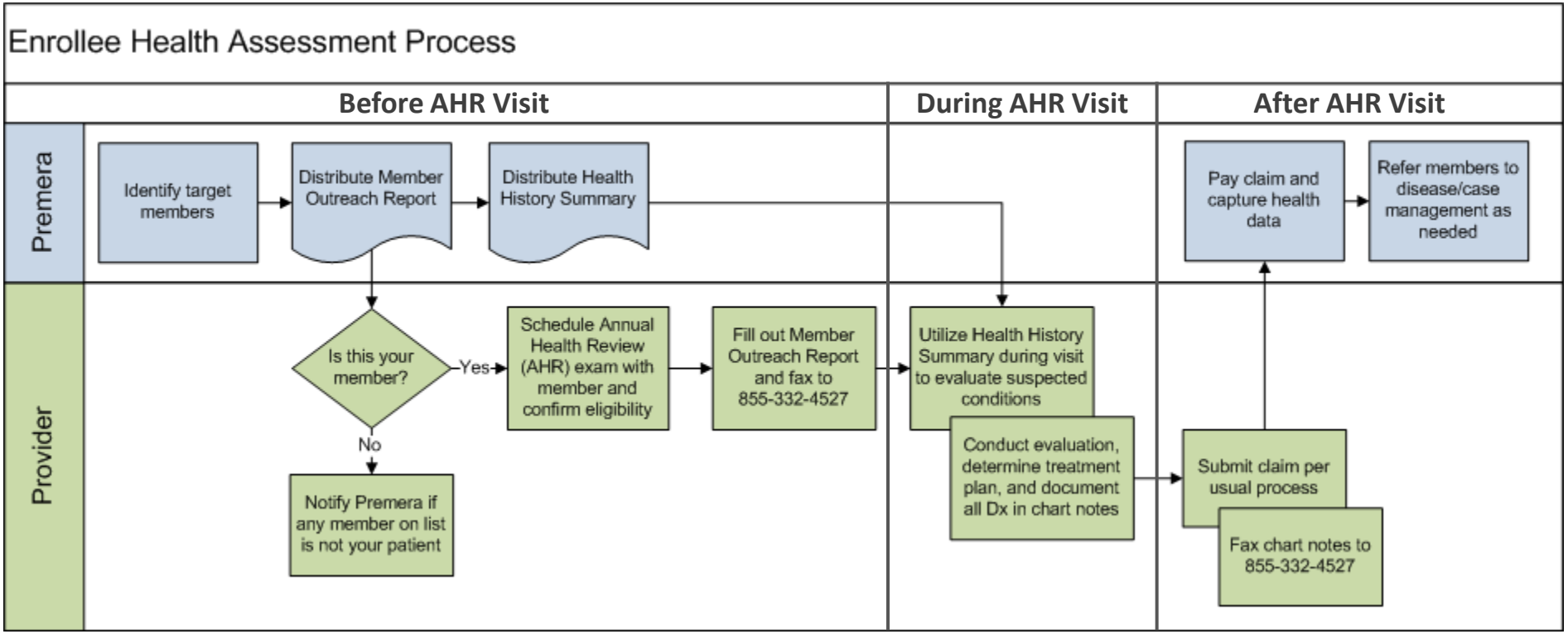


2. Meet the clinical criteria of **<u>two</u>** or more chronic or complex conditions

Annual Health Review: An added benefit for patients in the EHA Program

- Added benefit focused on reviewing chronic conditions for patients on metallic plans
- No co-pay, deductible, or co-insurance apply
- If labs or other diagnostic services are ordered during the AHR, the standard benefit structure would apply
- In the future, some patients may receive an incentive

Enrollee Health Assessment Process



2016 Program Updates

Based on your feedback, we continue to make improvements

- Improved quarterly mailings by combining your patient list and health data–removing the need for two separate mailings each quarter
- Improved feedback loop on member outreach report
- Redesigned Health History Summary with clear links between suspected conditions and diagnosis/ prescription claims history

Paradigm Shift

Documenting and coding chronic conditions annually

Status quo: Most providers were trained to address the conditions that were the focus of the visit

Paradigm shift: Document and code annually for ***all conditions and for all patients***, regardless of insurer or program participation

Benefits to documenting and coding chronic conditions annually:

- Enhance patients' access to care management programs by insurers
- Ensure appropriate allocation of resources based on health of patients
- Assure providers get credit for appropriate risk in value-based contracts

Clinician's Role

All documentation must be refreshed ***annually***

- Document and code to the highest specificity
- Use the HHS for HEDIS care gaps
- Close the chart note with appropriate signature
- Confirm or deny suspected conditions
- Review medications

Importance of Documentation and Coding

Required documentation to support each diagnosis

Each diagnosis must be supported by documentation with proof of MEAT in order to be coded:

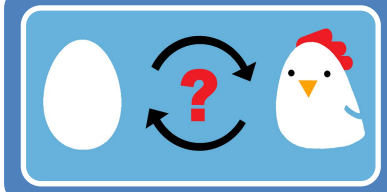
- **M**onitor —Reviewing signs, symptoms, disease progression or regression
- **E**valuate—Examining (as in physical exam)
- **A**ssess—Acknowledging/giving status/level of condition
- **T**reat—Prescribing medication, reviewing past medication history and validating or discontinuing

Importance of Documentation and Coding

EHA program shared learnings

Acceptable Signature

Each entry in the medical record must be signed and dated by the author including the clinician's credentials



Documentation of a cause and effect relationship

Clearly document a causal link between the disease and the complications

The term "history of"

Use "history of" only for a condition that is not active and no longer treated

Code all chronic conditions annually

Per CMS, patients are considered completely healthy until diagnosis codes are reported and submitted on claims, annually

Billing the Annual Health Review Visit

EHA Program shared learnings

- The Annual Health Review is intended for review and management of chronic and complex conditions only
- Only chronic medical diagnoses, not preventive diagnoses, should be billed with G-code on the claim
- For annual preventive visits, continue to use the age-appropriate evaluation and management code

Common Pitfalls	Shared Learning
Billing evaluation and management codes (99201-99397) for the AHR visit	Use G0438—Initial visit G0439—Subsequent annual visits
Billing G-code with preventive ICD-10 diagnoses (e.g.; Z00.00)	Code for any chronic or complex conditions evaluated during the visit
Sending EHA form/chart notes with no claim	Use normal claims submission process (electronic/paper)
Sending claim without sending chart notes	Chart notes should be faxed to 855-332-4527, separate from claim

Summary

- The Annual Health Review for qualified metallic plan members is an added benefit (in addition to the annual preventive visit) and is for review of chronic conditions only
- Premera will send providers a quarterly Member Outreach Report to validate that members are their patients
- Use the Health History Summary to confirm or deny suspected conditions
- Use the AHR Visit Guide to assist in documentation of the visit and code to the highest specificity
- Providers should bill with the appropriate G-code (G0438 or G0439) using the standard claims submission process and fax chart notes to 855-332-4527
- Chronic and complex conditions should be documented and coded annually

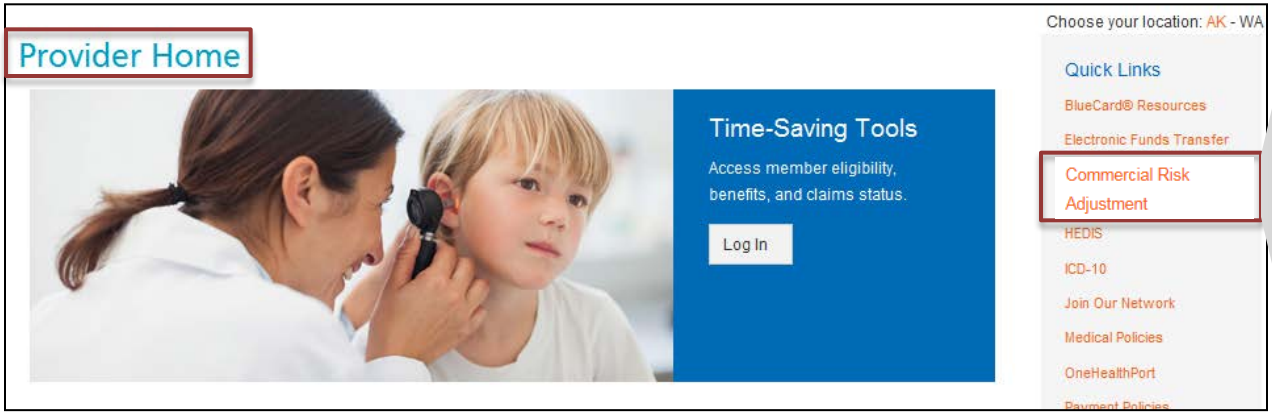
Contact Information

- Call our dedicated provider line at 877-342-5258 (WA) 800-722-4714 (AK), option 4, or email us at providerengagementteam@premera.com for:
  - Assistance with the EHA process
  - Questions regarding member qualification
  - Any questions/concerns related to commercial risk adjustment/EHA Program
  - Additional training on coding and documentation by Premera's Provider Engagement Team
- Fax your chart notes to 855-332-4527

Additional Resources

We have tools and resources to assist you

You can find additional tools, resources, and information regarding the Enrollee Health Assessment Program on ***Premera's website.*** Go to the ***provider home page,*** look for ***Commercial Risk Adjustment***



What's New:

- Medical Records Requests page
- Sample Altegra Health Provider Letter
- ACA Medical Records Audits

Existing Resources:

- EHA Program User Guide
- AHR Visit Guide
- EHA 301
- Patient Scheduling Talking Points
- AHR vs. Other Visit Type Comparison

Questions?

Appendix

Importance of Documentation and Coding

EHA program shared learnings

Common Pitfalls	Examples/Explanation	Shared Learnings
Unacceptable signature	Examples of acceptable signature: • Legible full signature or first initial and last name followed by credentials and date signed • Illegible signature over a typed or printed name followed by credentials and date signed • "Electronically signed by" followed by provider's name, credentials, and date signed	Each entry in medical records must be signed and dated by the author and must include the provider's credentials
Incorrect use of "history of"	Z85.3 = Personal history of malignant neoplasm of breast C50.919 = Malignant neoplasm of unspecified site of unspecified female breast	Use "history of" only for a condition that is not active and no longer treated. Avoid using "history of" for a condition that is chronic but currently stable such as COPD, DM, or A-Fib
Not reviewing/updating active problem list	Active problem list for DOS 04/01/2014 • History of pneumonia. Hospitalized in 02/14 • Asthma—continue Albuterol as needed • History of breast cancer—last chemo 11/1999	Update active problem list at each visit. If a condition is no longer active, either remove from the list or add "history of"
Incorrect documentation of cause/effect relationship between a disease and its complications	Examples of acceptable documentation: • Diabetic neuropathy • Neuropathy due to diabetes Example of unacceptable documentation: • "Patient comes in with diabetes, neuropathy…"	Clearly document a causal link between the disease and the complication

Importance of Documentation and Coding

EHA Program shared learnings

Common Pitfalls	Examples/Explanation	Shared Learnings
Conditions not documented as "chronic"	Examples: • K71.6 = Toxic Liver disease with hepatitis NEC • K75.9 = Inflammatory liver disease UNS • K72.00 = Acute and subacute hepatic failure without coma • K73.9 = Chronic hepatitis, unspecified	Update all acute and chronic conditions with appropriate status
Not coding all chronic conditions annually	Per CMS, patients are considered completely healthy until diagnosis codes are reported on claims and supported by documentation, annually. It is important for the PCP to document conditions that are being managed by a specialist	Conditions should be reported every time they are reviewed even if they are not the primary reason for a visit
Incomplete coding of complications and comorbidities	Example: "Patient comes in with the flu but also has CHF and DM." If both conditions were addressed, they need to be coded in addition to the primary reason of the visit	Per coding guidelines: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management"
Not coding "status of"	These conditions don't need to be supported by evaluation or management documentation. Stating their presence under Active Problem List would be sufficient	Diagnoses that indicate status of amputations, ostomies, and solid organ transplants should be documented and reported on a claim annually
Not documenting/coding to the highest specificity	Example: You documented: F32.9 = Major depressive disorder, single episode, unspecified But you meant: F43.0 = Acute reaction to major stress with depressive symptoms Or you meant: F34.0-F34.9 = Depressive states associated with stressful events	Every condition should be documented and coded to the highest specificity