Oakland Physician Network Services

News & Highlights

Quarter 2
2020

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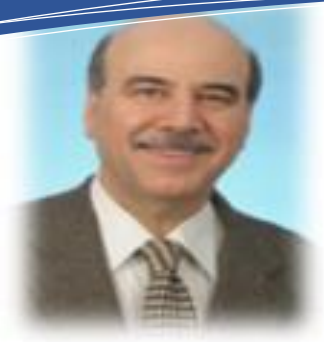

Oakland Physician Network Services

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What's up Doc?

From Dr. Imad Mansoor, OPNS CMO

In recent months, the year began with the rise of COVID-19 throughtout the world.

Reduction of commerce, movement and provision of services has resulted from the immense impact on the population from this illness. Because of this, efforts have been made to control the spread of this illness and its natural progression with some success. Now, as summer approaches, the world seems to be opening back up. With this, the opportunity to commune, congregate and return to normal functioning. This also present a risk and an opportunity for the general public.

During the past few months, concerns have risen regarding the lack of immunizations among children and adolescents; routine responsibilities including maintaining up-to-date schedules for immunizations and well visits has been reduced due to COVID-19. However, without maintained immunization status among children and adolescents, there is a greater risk of contracting vaccine-preventable diseases, illnesses and complications.

Historically providers have taken pride in high vaccination rates and maintained of herd immunity, there is a possibility of resurgence of illnesses previously controlled or eliminated within this population.

As practices begin to open again, it is important to maintain the message of immunization, vulnerability and prevention to parents for their children. Assessing patients for all vaccines due at each visit, both telehealth and face-to-face conversations provide an opportunity to address concerns and keep vaccinations within the forefront for both parents and providers; telehealth visits can begin the conversation and can lead to scheduling of a face-to-face appointment focused on providing vaccinations. As practices begin to open schedules during these next few months of summer, take this opportunity to identify, track and address the critical needs for children and adolescents, following guidelines to provide catch-up immunizations for children.

Opening up can also provide opportunity to address gaps in care; practices inundated with COVID-19 related burdens have been, until most recently, unable to complete these routine responsibilities. With all the time lost during this pandemic, it is important now to ensure that all patients and their needs are being addressed. Leveraging EHR, registries and gap lists from the health plans with telehealth technologies and scheduling face-to-face visits into the summer would be an effort, but a great head start into the rest of the year to ensure patients get the care they need.

From the desk of Rodger Prong

Patient Volumes After COVID-19

They're predicting higher rates of no-shows, cancelled appointments and schedule gaps? Have you looked at your scheduling process lately. Patients like the easy button, so anything that you can do to make scheduling easier can only help. If you don't already, you should send recall SMS appointments or postcard reminders to reduce no-shows and help fill schedules. From a patient perspective their experience is ultimately the key to keeping their loyalty so everyone needs to be engaging. A few key tasks can also help reduce no-shows and schedule gaps and if you employ them correctly, you'll see volumes increase.

As things begin to take off again, I hope that you were able to look under the hood to analyze Revenue Cycle performance. You'll find improvement opportunities by reviewing 5 main areas for reducing denials, improving clean claims, increasing reimbursement and accelerating collections.

1. Discharged Not Final Billed (DFNB) and Charge Lag: Is DNFB greater than 2-3 days? If so, find the bottleneck. It could be coding, failed claims, documentation, registration, auditing, charge capture or billing. If it's limited to one area, review staffing to ensure its appropriate. You may need to consider engaging a vendor to help supplement your efforts or as a learning experience

2. Coding Accuracy: You deserve to be paid commensurate to the work you perform. Look for discrepancies. Independent coding audits can uncover missed opportunities. For physician practices, mis prioritization of diagnoses, missing modifiers or improper pairing can be the problem.

3*. A/R Aging:* If total A/R Aging > 90 days is more than 15%, is it concentrated to 1 or 2 payers? Time to look under the hood.

4. Cash Collections: The adage, "Cash is King" still rings true, but how is it measured? At hospitals cash collections should be more than 98% of 12 month rolling Net Patient Revenue. In physician practices, Net Collection Rates should be over 95%.

5. Bad Debt: Patient A/R is one of the most commonly-overlooked areas in the Revenue Cycle. Bad Debt Write-Offs exceeding 3% of Gross Charges warrant a look. Do patient statements go out regularly? Is someone calling on aged balances or are you enlisting the help of an Early Out vendor to call for you? There is usually opportunity here.

Let's face it, it's easy to get distracted by the monotony of what we do when our jobs are often routine. Our work is critical to sustaining our organizations. The tasks we do have an ROI attached directly to them. What are a few things that can be done to increase productivity?

Computer Assisted Coding: It's not just a buzzword. Granted computers can't be relied upon to do it all, however the guidelines put forth in a Computer Assisted Coding (CAC) program can help streamline the coding process.

Workforce Allocations: When it comes to coding, billing and follow-up, one of the most common issues with productivity is that the allocation of work amongst the team members is unbalanced. How do your work allocations look? Is everyone pulling their load and doing their share?

Competency-Based Workflows: Are your more experienced front-line team members assigned higher-complexity accounts while newer employees work the easier claims? A simple tweak can make a big difference.

Outsourcing Menial Tasks: Do you outsource the more menial tasks such as payment posting to a BPO that is both less expensive and more productive? With the right vendor partner, these tasks can be accomplished more consistently.

Incentive Plans: Does everyone on your team know their productivity and accuracy goals that produce for the practice? In the Revenue Cycle, you sometimes have to spend money to make money. Productivity, accuracy and efficiency combine to collect more quickly. Are team members incentivized for productivity, accuracy and results? In the Revenue Cycle, up to a certain point of diminishing returns, there is ***an*** ROI for every dollar you spend. So I hope these few ideas help stay productive and effective. Stay healthy!

Vitals via Telehealth

Per the CMS Newsletter: ACO Spotlight June 10th, issue 12

Updated COVID-19 FAQs Related to Annual Wellness Visits Conducted via Telehealth

CMS recently updated the COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing document. Refer to question 23 under the Medicare Telehealth section addressing annual wellness visits conducted via telehealth. The following question and answer was added:

Question: Are beneficiary-provided vital signs sufficient to satisfy that portion of the annual wellness visits (AWV) when conducted via telehealth?

Answer: If the beneficiary is at home and has access to the types of equipment they would need to self-report vital signs (e.g., weight, blood pressure), and if the visit meets all other requirements of the code, this scenario would satisfy the requirements for purposes of billing the AWV code. CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth during the PHE.

Telehealth Platform

The Coronavirus has had quite an impact on all aspects of medical care. Most physicians were compelled into having to adapt to some form of telehealth to continue their patient care process. There has been a lot learned about telehealth and the hope is that it will continue. In the accelerated need to utilize telehealth, there were quite a few platforms available. Some were non-HIPPA like Facetime, Facebook, Google Duo, Zoom and many more. These were easy for the patients to use and not many steps involved. Moving forward, the relaxation of the HIPPA requirements is “until further notice” to allow practices to have time to try to adapt to a HIPPA compliant platform. The HIPPA compliant platform can be through the Physicians EMR, or an outside entity such as Doximity, Amwell, etc. CMS, BCBSM as well as OPNS.org have many resources on Telehealth

Use of Telehealth

Telehealth that includes visual, audio, review of full burden of illness and during same calendar year can also be utilized for closing gaps in care. This can include:

- Medication reconciliation Post Discharge
- Medication Adherence (Diabetes, HTN, Cholesterol)
- Statin use in persons with Diabetes and Cardiovascular Disease
- Medication Therapy Management

When utilizing telehealth, always be sure to address the full requirements for each measure; tip sheets are also available for full measure descriptions and coding tips. Other telehealth information by health plan is also available on OPNS.org under the PCMH section.

* Priority Health requires billing with usual place of services, but with modifier 95

Returning to the office!

Is your office prepared for patients that are not appropriate for Telehealth and need to have a face to face visit?

Does your staff have the right tools to keep the office safe from COVID19?

The CDC has resources that can help with these questions. They have handouts, office signs, scripting for staff, donning and doffing of PPE Etc.

Please follow the link for these resources.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-resources.html

Specialist Team Based Care Initiative

We would like to take this opportunity to share information about the BCBSM 2020 Specialist Team Based Care Initiative that we have been accepted for participation. The goals of the program include:

- Encourage more specialists to adopt a team-based care approach focused on care management
- Leverage existing and developing Health Information Exchange (HIE) capabilities to facilitate team-based care
- Work with engaged POs to develop a model to expand to additional specialists in 2021

Participating specialists will:

- Identify their high-risk population
- Have a mechanism for receiving real-time admission/discharge/transfer (ADT) alerts via a mobile device
- Secure a licensed care manager by November 2020

One of the goals are to target the efforts of the care management team to those high-risk patients that are likely to go to the ED and to provide a method for potentially avoiding an expensive hospitalization via active care management and collaboration with the emergency department.

Primary care physicians and participating specialists will work together to:

- Map out the ADT coordination process between PCP and SCP for patients shared between physicians
    - Coordinate the care team to determine effective outreach
    - Align ADT encounter follow up with the associated specialty
    - Ensure that each associated physician is aware of the follow up taking place

Participating specialists include:

- **Michigan Kidney Consultants PC**
- **MHP Cardiology & Vascular Associates PC**
- **MHP Hematology/Oncology Consultants**
- **Heart Care PC**

PCMH-New Time Frame for 2020

BCBSM/BCN provides tip sheets for most quality measures, including those needed for BCBSM and BCN populations for HEDIS. If you have not been to the Blue Cross Blue Shield of Michigan website lately, there are updated star Measures sheets available to you. Log in to the BCBSM website, click on BCN Provider Publications and Resources on the right side of the screen and click on Clinical Quality Corner on the left side of the screen to view.

You can also click below: you will be prompted to log in before viewing.

https://provider.bcbsm.com/therecord/quality-corner.html

Also feel free to reach out to Lauren Maier at lmaier@opns.org to get a copy of any/all of these tip sheets as well.

PCMH Corner - Reminders

- ***Core and New Capabilities*** for 2020 need to be completed by September 30th, 2020. This means that the updated Domain policies and examples must be competed and into the PCMH Team by August 30th, so the team has time to review and make suggestions of changes if needed.
- ***Self-Management Training*** needs to be completed yearly. If your training certificate has expired or is going to expire and your office does not have a self-management trained Care Manager than a staff member, that can train the rest of the staff, will need to attend a training session.
- ***Gaps in Care*** need special attention this year due to the COVID19 pandemic. Items like well child exams, adult physicals, blood pressure, hemoglobin A1C, etc. Please let our informatics team know if you do not have a PD Focus sign on or your access is locked out.
- ***Vaccines*** – remember to catch patients up on their vaccines, there is a catch-up schedule (available on MICR.org) for children and adults. Vaccines took a downward turn while COVID19 was present and people were staying in their homes (see Appendix A).

2nd Quarter Low Quality Scores

Recent data from the health plans has provided an opportunity to address a few of the lowest performing quality measures within the OPNS network. This includes HbA1C, Use of Statins, Low Back Pain and Adolescent Well Visits. This information includes some of the quick highlights for these measures from the health plan provided tip sheets that may assist practices in completing these measures.

HbA1c Adequate Control <8 - HbA1c should be completed two to four times each year with documented date and distinct numeric result. The last HbA1c result of the year must be less than or equal to nine to show evidence of control.

HbA1c results CPT® II code:

3044F < 7%

3046F > 9%

3051F ≥ 7% and < 8%

3052F ≥ 8% and ≤ 9%

Use of Statins for Diabetics - The goal is to prescribe at least one statin medication during the measurement year to patients diagnosed with diabetes. Educating patients on the importance of taking their medications regularly, tolerance to statins and as prescribed and providing 90-day supplies has been proved effective in completing statin measures.

- Medication samples, when given, could interfere with pharmacy claims and produce false nonadherence results.
- This measure overlaps with the Statin Therapy for Patients with Cardiovascular Disease measure. Patients with ASCVD should be prescribed a moderate-intensity or high-intensity statin.

Low Back Pain - A historically difficult measure for physicians, this measure requires that Treatment should not include x-rays within the first 28 days of a new diagnosis. The sooner the patient is diagnosed, the sooner that first 28 days begins.

- For patients presenting with low back pain without any flags for serious pathology, recommendations would be to treat the patient with NSAIDs, Non-Invasive Physical Therapy, avoidance of bed rest, to name a few.
    - Other suggestions would be to have the patient follow up in 4-6 weeks with the primary care physician (PCP) to be re-evaluated, educating the patient to call the PCP before seeking UC, ED or Chiropractic Medicine.
- Remember to update Low Back Pain diagnoses yearly to keep the diagnoses active and prevent relabeling as a new onset.

Well Visits - Adolescents are expected to have at least one comprehensive well-care visit with a primary care provider or an OB/GYN provider during the measurement year. Documentation of the visit in the medical record must include the date when the well-care visit occurred and evidence of all the following:

- Health history - Notation of allergies, medications or immunization status alone would not count, but must include all three.
- Physical developmental history - Notation of “appropriate for age” without specific mention of development or “well-developed/ nourished/appearing” would not count.
- Mental developmental history - Documentation of “behavior appropriate for age” meets criteria. − Notation of “neurological exam” or **“**well-**developed” alone would not count.**
- Physical exam - Vital signs alone or visits where care is limited to OB/GYN issues (e.g., prenatal or postpartum care) would not count.
- Health education/anticipatory guidance - Handouts given during a visit without evidence of a discussion does not meet criteria. Information given regarding medications or immunizations or their side effects would not count.

Tips for coding Codes to identify Well-Care Visits:

- ICD10CM: 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, Z76.2
- CPT® codes**: 99381-99385, 99391-99395, 99461
- HCPCS: G0438, G0439

Don’t Miss This Incentive Opportunity!

In 2020 OPNS is offering a new incentive metric for **Advance Care Planning (ACP)** as part of the annual shareholder payout program. Primary Care and Specialty Care physicians who can demonstrate their offices have met the following components of the new metric will be eligible for this reward:

- **An established (office) process that promotes Advance Care Planning** (PCMH capability 4.16 reported as “Fully in Place” to BCBSM by 9/30/2020)
- **Evidence of completed Advance Directive forms returned to the practice** (separate rewards will be made for **>1** and **>5 directives** executed between 1/1/2020 and 9/30/2020)

OPNS Patient Centered Medical Home leaders Deborah Spencer 248-682-0088 ext 112 and Lauren Maier 248-682-0088 ext 103 are ready to assist practices in meeting these requirements and will be monitoring the incentive metrics. OPNS has also developed an ***ACP Toolkit*** and a ***GUIDELINES for ACP in the Medical Office.*** To receive either of these helpful resources contact Beverly Walters RN, End of Life Planning lead, at bwalters@opns.org

The COVID-19 pandemic has demonstrated the importance of helping patients develop an end of life plan of care based on their wishes no matter what their age or state of health may be.

Patient Satisfaction Surveys

This is something that is always on the bottom of the priority list and the last thing that a busy office would like to pay attention to. The office is knee-deep in activity and many other priorities. Patient care can take on a lot of different definitions, but if a patient does not feel safe and taken care of, then they will most likely go somewhere else. How do we find out if the patients are happy with their care? We conduct a patient satisfaction survey. Not only is this a PCMH capability but it is also a vital source of information that the office can use to improve their own process. Please contact Deborah at dspencer@opns.org, if your office is interested in a Patient Satisfaction Survey link through Survey Monkey that would be specific to your office.

2020 OSC HIE Diabetic Retinopathy Program

We are pleased to announce that Physician Direct Organized System of Care (OSC) has been accepted to participate in the **BCBSM 2020 OSC Health Information Exchange (HIE) Program for a PCP based Teleretinal Program**. Addressing diabetic retinal eye exams and ensuring that the exam results are shared with the patient's care givers has been a complicated journey. The goals of the program are to:

- Support PCPs who wish to increase the number of patients appropriately receiving diabetic retinal eye exams by providing Teleretinal services in their office
- Using statewide HIE to ensure results are shared with the patients' other caregivers via Physician Direct Focus
- Improve performance on a historically difficult clinical quality measure

Following the communication of this opportunity to PCPs and OPNS Ophthalmologists, we received interest in participation from:

- MHP Kingswood Internal Medicine
- MHP IMPCP
- MHP Rochester Medical Group
- Mindlin-Koh Center of Ophthalmic Medicine and Surgery PC
- Wilkinson Eye Center PC
- Arezo Amirikia MD PC

Program milestones will be measured during the 2020 performance year. OPNS has purchased three RetinaVue cameras and anticipates training to be underway in June and July. OPNS anticipates expanding the program following this initiative.

How does Quality and Utilization effect PCMH Designation

In 2019 there were emails sent out in September for any practice that was in the bottom 1/3 or under 30% in their Quality/Utilization score (Utilization scores are watching ER and Radiology utilization and cost). There were several additional reminders sent out to **all** the practices to be attentive to the Gaps in care following that notification.

We have been informed by BCBSM that two OPNS practices (they have already been notified) may lose their designation status for Quality/Utilization scores in 2019 because they have fallen below the 20% thresh-hold margin. This could mean that the offices had some open Gaps in care or that the utilization costs were high. This loss of the BCBSM PCMH Designation will be for 2020-2022. **We emphasize, it is imperative for any PCMH designated practice to maintain their Quality/Utilization scores in order to maintain designation, VBR and the ability to participate in the PDCM (Care Manager)Program.**

BCBSM is giving the affected practices the opportunity to explain any extenuating circumstances that may have impacted their designation scoring last year and OPNS is working with them to improve future scoring.

Welcome New Affiliates

Last Name	*First Name*	*Degree*	*Group Affiliation*
Auito	Marci	NP	MHP DBA Cardiology & Vascular Associates, PC
Fisher	Katie	PA	Legacy Dermatology
Metwally	Sherif	MD	Michigan Kidney Consultants, PC
Meyes	Jeffrey	MD	MHP DBA MDIV
Evans	Jason	PA	Siegel Dermatology
Kus	Kaitlyn	NP	Fadi Salloum, MD, PC
Al-Hakim	Mazen	MD	MHP DBA Oakland Neurology Center
Ekkah	Maan	MD	Fadi Salloum, MD, PC/Mercy Hopsitalists, PLLC
Pullukat	Roy	MD	Roy J. Pullukat, MD
Vogt	Jennifer	NP	MHP DBA CAVA
Zebari	Samira	MD	Southfield Pediatrics, PLLC

BCBSM PCMH-N Specialist Nominations

Specialist nominations are complete for 2019 engagement. If you are a specialist and are wanting to participate in PCMH-N to potentially earn a Value Based Reimbursement from BCBSM, as well as OPNS incentives.

Please contact one of the PCMH team members, Deborah Spencer at dspencer@opns.org, Kortnie Strain at kstrain@opns.org or Lauren Maier at lmaier@opns.org or you can also call the OPNS office at 248-682-0088.