Michigan Multipayer CPC+ Monthly Briefing

February 2018

This monthly news briefing provides key multipayer CPC+ Michigan information for Physician Organizations (PO), practices, providers, and other partners. It is intended to supplement, but not replace, CMS' CPC+ Connect site or other information from CMS and its contractors. To be added to the email distribution list for monthly briefings, please send an email to MichiganMultipayerCPCPlus@med.umich.edu *with "Add Me to the Michigan CPC+ Monthly Briefing distribution" in the subject line. This briefing is published monthly from February to December.*

Michigan Multipayer CPC+ Steering Committee January Meeting Key Outcomes

At their January session, the multistakeholder Michigan CPC+ Steering Committee discussed the drafting of a multipayer vision for CPC+ in Michigan. In addition, the group continued discussion on guiding principles for the multipayer CPC+ work in Michigan and on optimizing the helpfulness of the payer/practice leader breakouts at the in-person semiannual meetings.

Soon To Come! Our Multipayer Michigan CPC+ Website

To make multipayer CPC+ Michigan information even easier to access for the CPC+ community in Michigan, we are developing a Michigan mulipayer CPC+ website. The site will be live within a month and we will send an email to all on this distribution list with the link. If you would like to volunteer to test the prototype site for user experience, please contact dbechel@umich.edu. The website will house multipayer tools developed to ease implementation and operations, and multipayer updates, as well as links to our partner sites such as the Michigan Data Collaborative and the Care Management Resource Center. The current and past Monthly Briefing newsletters will also be posted on the site, though we will also continue to distribute this monthly briefing via email as well.

Commercial Payer Financial Reporting

Previous editions of this briefing contained multipayer guidance for reporting of commercial revenue from the Michigan payers. In January of this year, as an additional resource, BCBSM distributed practice-specific CPC+ BCBSM financial revenue reports via the BCBSM PO portal. In future years, we are working toward practices receiving payer-specific revenue reporting from all commercial payers to ease the burden of commercial financial reporting on CPC+ practices.

In addition, the payers have relayed the suggestion that for future years, CMS adjust the timeline for revenue reporting on practices so that it does not coincide with year-end financial closeouts or other reporting deadlines.

HealthScope Benefits, Our New 2018 Payer Partner

As of January 1, 2018, HealthSCOPE Benefits, became our newest commercial CPC+ payer partner in Michigan. HealthSCOPE also participates in CPC+ in the Ohio, Arkansas, and Oklahoma regions and will be sending introductory letters to Michigan CPC+ practices soon that further explains their involvement. Attached as an example is a sample introduction letter that HealthSCOPE distributed to their Arkansas practices. HealthSCOPE is also contributing data to the multipayer data warehouse that is under development for CPC+ in Michigan and performance results for HealthSCOPE members will be available there in the future. (Look for updates in future editions of this briefing on the Michigan Data Collaborative's progress on the Multipayer CPC+ Michigan dashboard).

As a third party administrator, HealthSCOPE members are employees and dependents in self-insured employer groups across the state of Michigan. As HealthSCOPE recruits their self-insured clients to join CPC+, practices may see their HealthSCOPE member attribution increase.

BCBSM Expands Billing to Non-PCMH Practices

BCBSM has expanded care management G and CPT code billing (i.e., PDCM billing) to all CPC+ practices, regardless of PCMH status, as CMS did not require all CPC+ practices to have PCMH designation. Questions can be directed to valuepartnerships@bcbsm.com. For further information on billing training and support, please see Care Management Billing Resources

Priority Health and Care Management Claims

Patient copays or other financial liability for care management services can be an impediment to patient engagement. *To prevent patients from incurring such expenses, Priority Health batches and pays on G codes, telephonic CPT, and collaborative care management CPT codes every 60 days to allow for the claim to be processed and for any member liability to be removed.* If you have questions about any of this information, please contact your Provider Performance Specialist.

Optimizing Risk-Adjusted Reimbursement: Documentation and Coding Best Practices

(one in a series of resource articles for CPC+ practices from Priority Health)

Excelling at risk adjustment requires that you and your team leverage patient data and tools to improve clinical documentation, coding best practices and overall care planning.

The diagnosis codes reported on your claims determine your patient's disease burden and risk score. Risk scores are higher for patients with a greater disease burden, and lower for a healthier patient.

To be captured for risk adjustment, every diagnosis reported as an active, chronic condition must be properly documented with an assessment and plan of care that meet a set of guidelines that can be summarized by remembering "M.E.A.T", an acronym to indicate you are:

- **M**onitoring signs, symptoms, disease progression, or disease regression
- **E**valuating test results, medication effectiveness, or response to treatment
- **A**ssessing/**A**ddressing by ordering tests, reviewing records, or counseling your patient
- **T**reating with medications, therapies, or other modalities

To be coded as a diagnosis, the official ICD-10-CM Official Guidelines for Coding and Reporting state that a condition must exist at the time of the encounter, affect patient care or management, and is documented.

To properly submit diagnosis codes on your claims:

- Use the ICD code that describes the patient's diagnosis, symptom, complaint, condition or problem.
- Do not code suspected diagnosis, or working diagnoses, when coding outpatient or in-office claims.
- List the ICD codes in order of importance, with the primary code appearing first, followed by the codes that most strongly support the medical necessity for the service provided.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions that coexist at the time of the face-to-face encounter/visit and require or affect patient care, treatment or management.
- Always code to the highest level of specificity; unspecified diagnoses do not count toward risk adjustment.
- Clearly support all reported diagnosis codes in the medical record.
- Document all acute, chronic and status conditions every year for risk adjustment purposes.

Accurate diagnosis coding provides a snapshot of medical conditions affecting a patient and ensures you and your patients get the full benefit of the great care you're providing.

Contact Us! How Can We Help? Supporting CPC+ POs and Practices in Michigan

The joint commercial CPC+ payers in Michigan are working together to support multipayer alignment with the University of Michigan. We advocate with CMS to emphasize the important role that POs play in supporting CPC+ and work with them as partners in the Michigan CPC+ community, work with all participating payers in Michigan to create consistency in payer policy and approach wherever possible, and work to remove roadblocks that practices and POs face in CPC+ implementation and operations. We are interested in your experience of what is going well and what your find challenging. **Please contact the CPC+ Michigan Regional Convener, Diane Marriot (dbechel@umich.edu or 734 998 0390) at any time to share your ideas and experiences.**