Northeast
Physician Hospital Organization
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NEWS

INFORMATION LINE
978-236-1732
CALL FOR UPDATED
MEETING CANCELLATIONS
AND OFFICE CLOSURES

OPTUM Newsletter:
November Focus—Diabetes Awareness Month *(see page 6 of this newsletter)*

Nov 2017

PHYSICIAN AND PRACTICE CHANGES/UPDATES

New Physicians

- **Dr. James Liebmann** has joined **Northeast Oncology** at 75 Herrick Street, Beverly, MA 01915 (P) 978-927-6850 and (F) 978-524-7917.
- **Dr. George Lantz** has joined **Pain Modulation Associates** at 480 Maple Street, Suite 203, Danvers, MA 01923 (P) 978-304-8601 and (F) 978-304-8621.
- **Dr. Elizabeth Scannell** has joined **Essex OB/GYN Associates** at 83 Herrick Street, Suite 2004, Beverly, MA 01915 (P) 978-927-4800 and (F) 978-232-5561.
- **Dr. Nirav Shah** has joined **North Shore Pain Management** at 900 Cummings Center, Suite 221, Beverly, MA 01915 (P) 978-927-7246 and (F) 978-927-7249.

Practice Changes

- **Dr. Raymond Liggio** with **Northeast Eye Care** announced his retirement effective 1/1/18.
- **Dr. Sharma Mudgal**, Occupational Medicine physician formerly with **Sports Medicine North,** is now Medical Director of Employee Health at **Northeast Hospital Corporation**.
- **Dr. Ronald Newman**, Hospitalist, terminated his affiliation with NEPHO.
- **Dr. William Wilson,** Hospitalist, terminated his affiliation with NEPHO.
- **Dr. Debra Zucker**, a PCP at **Lahey Health Primary Care, Danvers**, terminated her affiliation with NEPHO.

SAVE THE DATE

MD Orientation

Date: December 14, 2017 @7:30 A.M.
Place: 500 Cummings Center, Suite 6500
Good Harbor Conference Room
Beverly, MA 01915
RSVP: Alycia Messelaar (P) 978-236-1784 or
via e-mail at Alycia.Messelaar@Lahey.org

Office Manager Meeting

Date: December 13, 2017 @12:00 P.M.
Place: 500 Cummings Center, Suite 6500
Good Harbor Conference Room
Beverly, MA 01915 *(lunch provided)*
RSVP: Judy O'Leary (P) 978-236-1739 or
via e-mail at Judith.O'Leary@Lahey.org

NEPHO POD MEETING SUMMARY—NOVEMBER 2017

Quality—High Impact Patients

- Liz Isaac reviewed the rationale and action steps related to "high impact" patients that were identified for each provider.
- As of November, 18 providers have gate scores below the internal threshold of 2.8.
- Members of the Quality team will have one-on-one meetings with providers who are currently performing below the internal threshold of 2.8 gate score to identify action steps to improve scores before year end.

Budget Performance

- Dr. Di Lillo reviewed the contract performance from past years with a focus on the shift to performing on budget.
- While quality measures remain in the payer contracts, more emphasis needs to be given to performing on budget/decreasing utilization for the upcoming years, both in the commercial and Medicare contracts.

Identifying High Risk Patients

- Ken King reviewed the mechanism for identifying high risk patients, with emphasis on partnering with providers to identify which patients should be followed closely to prevent admissions/readmissions.

Lahey Programs

- Information relating to the Stress Management Program for patients of Lahey providers was shared, as was information relating to the new Lahey Opioid Treatment centers in Danvers and Gloucester.

CLINOVATIONS

Update on Clinovations

Last year Lahey and many NEPHO physicians partnered with Clinovations, a division of the Advisory Board Company, to implement the HCC SmartForm. The SmartForm helps us improve clinical quality, enhance documentation and increase risk capture by accurately coding for Hierarchical Condition Categories (HCCs).

We thought it would be useful to share some information from Lahey and Clinovations about the necessity and importance of this work.

- HCC are a risk stratification methodology developed by CMS and used by payers and provider organizations to measure the complexity of patient populations and the corresponding cost of delivering care to those populations.
- Calculation of the HCC score involves the calculation of the Risk Adjustment Factor (RAF), a score comprised of demographic factors, chronic medical conditions, and interaction factors. A patient of average medical complexity would have an HCC score of 1.0. Patients with multiple chronic medical problems, such as congestive heart failure, renal insufficiency, COPD, asthma, morbid obesity, cancer, and heart disease are typically more complex and by extension are more expensive to care for in comparison to average patients and they should have a higher HCC score.

cont.

CLINOVATIONS, cont.

- Accurately capturing appropriate HCC scores for patients is all about appropriate chart documentation and management of the patient's problem list.

Through September 2017, we were at 85% chronic Risk Adjustment Factor (RAF) capture which is much better than last year (84% chronic RAF capture by December 2016). As we approach the end of 2017, we understand that identifying, activating, and closing the gaps of your outstanding patients only gets more difficult for a number of reasons and we want to thank you for your efforts.

We understand and acknowledge that it's unlikely every provider will reach 100% capture. Our partners at Clinovations have informed us that last year's top performing organization was able to accomplish 93% chronic RAF capture, which is the organizational goal for this calendar year.

As we look ahead, we've recently received requests for tips and reminders regarding the HCC SmartForm:

Q: If I do not agree with a diagnosis appearing in the HCC SmartForm, what do I do?
A: Most of the conditions appearing in the HCC SmartForm appear because they are on the patient's Problem List. It is not sufficient to document in your note that a condition has resolved. You must go to the Problem List to resolve or delete the problem in order to remove that condition as a care gap.

Q: ***When can I expect to see the HCC Gaps disappear from the patient header?***
A: The HCC header does not update in real time – the header updates when the encounter is closed, the claim is sent, and the registry refreshes. This may take anywhere from 1 day to 2 weeks. If you look at the chart prior to the claim being submitted you will still see gaps in the header, even if you addressed them in the recent encounter.

Q: ***Why do I see radio buttons and get prompted to address status on some conditions but have to enter the diagnosis code on my encounter note and not use the smart form for other conditions?***
A: When the HCC Solution can determine the exact ICD-10 code (e.g. based upon BMI or GFR) it will automatically populate the Diagnosis field for you. For diagnoses that require additional specificity you will be prompted to use the Epic diagnosis calculator to select the correct code. You should always try to leverage the SmartForm when applicable to ensure the appropriate information and documentation is captured and billed for chronic HCC conditions.

Should you require any additional training materials, please reach out to Chris Talley at **TalleyC@advisory.com** or Rob Gilmor at **GilmorR@advisory.com** from Clinovations. If you have any general questions about risk adjustment, please contact Stacey Keough, NEPHO Executive Director at **stacey.keough@lahey.org** or Maureen vonZweck, NEPHO Financial/Accounting Analyst at **Maureen.H.VonZweck@Lahey.org.**

PATIENT EXPERIENCE COMMENT REPORTS—NOVEMBER 2017

BEACON FAMILY MEDICINE

- I feel that Dr. Curtis Ersing is an excellent diagnostician!
- Dr. Erin Heiskell is a very compassionate, kind doctor. I have complete confidence in her and staff as well.

CAPE ANN MEDICAL CENTER

- Dr. Shawn Pawson takes his time to listen to me and clearly answers all of my questions in depth. He's excellent!
- I am very lucky to have Dr. Janet Doran as my doctor.

DANVERS FAMILY DOCTORS

- Dr. Subroto Bhattacharya - not only is he a great provider, but a wonderful person!

FAMILY MEDICINE ASSOCIATES, Hamilton

- Over 10 years at the establishment with Dr. William Medwid, was provided exceptional service flawlessly.

LAHEY PRIMARY CARE, Beverly (100 Cummings Center, Suite 126Q)

- I have been going to Dr. Pierre Ezzi for a long time and I am very confident. His staff are excellent also.

LAHEY PRIMARY CARE, Beverly (30 Tozer Road)

- I don't typically answer surveys but had such a positive experience with Dr. Tina Waugh and wanted to share.

LAHEY PRIMARY CARE, DANVERS (480 Maple Street, Suite 204)

- Dr. Manju Sheth has always been available when I need her, an excellent provider and respects my needs.

LAHEY PRIMARY CARE, DANVERS (140 Commonwealth Avenue, Suite 104)

- Dr. Mauri Cohen is the best primary care physician I have ever had. Great personality.

LAHEY PRIMARY CARE, DANVERS (5 Federal Street)

- Dr. Steven Keenholtz—I was treated on time and with dignity & respect.
- First visit with new primary care physician (Dr. Margaret Legner) - very efficient, good "bedside" manner.

LAHEY HEALTH PRIMARY CARE, GLOUCESTER (298 Washington Street, 4th Floor)

- Dr. Victor Carabba always takes time to explain answers to questions I ask.

LAHEY HEALTH PRIMARY CARE, GLOUCESTER (298 Washington Street, 1st Floor)

- Very pleasant providers & staff.

NORTH SHORE PEDIATRICS

- We love Dr. David Danis!

cont.

PATIENT EXPERIENCE COMMENT REPORTS—NOVEMBER 2017, cont.

NORTH SHORE PREVENTIVE HEALTH CARE

- Very happy with Dr. Roy Ruff—staff very helpful.
- Receptionist very helpful. Dr. Roy Ruff is what every doctor should be—kind, great listener.

PATTON PARK MEDICAL

- Excellent care with Dr. Michael Edwards and the staff is friendly and caring.
- I had the finest care with Dr. Bruce Smith and staff, and I highly recommend this practice!

THOMPSON MEDICAL ASSOCIATES

- Excellent experience with Dr. Candace Thompson. Very caring, knowledgeable, doctor and practice. Wish more doctors were like this.

THOMAS PEARCE, MD

- Any time I have had a concern about something, Dr. Thomas Pearce has always been proactive and had me go to a specialist for specific testing.

OPTUM®

November is Diabetes Awareness Month
November 2017

Insider

Educational and coding information for providers

Focus on: Diabetes

The prevalence rate of diabetes mellitus (DM) in American seniors is 25.9% or 11.8 million seniors (diagnosed & undiagnosed). Diabetes contributes to heart disease and stroke and is the leading cause of kidney failure, blindness and non-traumatic lower limb amputations. Diabetes is the seventh leading cause of death in the U.S.[1] Early detection and treatment of diabetic complications can prevent progression, so monitoring with dilated eye exams, urine tests and foot exams is essential. Because the risk of cardiovascular disease is increased in those with diabetes and prediabetes, blood pressure and lipid management, along with smoking cessation, are especially important.

Screening diabetes

Because diabetic nephropathy can occur in up to 40% of diabetics, annual screening for micro-albuminuria and calculation of the glomerular filtration rate (GFR) should be performed.[2] Diabetic retinopathy is the leading cause of preventable blindness in people 25-74 years of age. Up to 80% of all diabetics will eventually develop some evidence of retinopathy, most without vision loss. A dilated and comprehensive eye examination by an ophthalmologist or optometrists should be performed annually.[2]

According to the American Diabetes Association (ADA), "diabetic adults have heart disease-related death rates of two to four times the rate of non-diabetics." If an adult also has Peripheral Arterial Disease (PAD), they have an increased risk for heart attack and stroke. *An estimated 1 out of every 3 people with diabetes over the age of 50 have PAD*. Screening for PAD is best achieved by obtaining a history of claudication and performing an ankle brachial index (ABI) on DM patients.[2]

70%-100% of diabetics may develop at least mild neuropathy over the course of their lifetime. Of these, 48% of type 2 diabetics present with neuropathy at time of their DM diagnosis, but up to 50% are asymptomatic. DM can cause three types of nerve damage: mononeuropathy, peripheral and autonomic neuropathy. Annual screening for neuropathies should include a comprehensive foot exam, including testing for loss of protective sensation.

Always remember ...

- When documenting diabetes, it is important to document the type of diabetes, the control status, and the complications/manifestations associated with diabetes mellitus (e.g., "with", "due to," "secondary to" or "diabetic")
- If the type of diabetes is not documented, it defaults to type 2 according to the guidelines
- For inadequately controlled, out of control, or poorly controlled, code to Diabetes, by type, with hyperglycemia

Documentation and coding tips

ICD-10-CM diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected and complications affecting that body system.

Coding type 2 diabetes mellitus (*to code type 1 diabetes, change the 3rd character to a zero*):

E11.21-E11.29	Type 2 diabetes mellitus with kidney complications
E11.311-E11.39	Type 2 diabetes mellitus with ophthalmic complications
E11.40-E11.49	Type 2 diabetes mellitus with neurological complications
E11.51-E11.59	Type 2 diabetes mellitus with circulatory complications
E11.610-E11.69	Type 2 diabetes mellitus with other specified complications

What's new in the Oct. 1, 2017-Sept 30, 2018 ICD-10-CM code set?

New codes for Type 2 diabetes with ketoacidosis with or without coma:

- E11.10✦ Type 2 diabetes mellitus with ketoacidosis without coma
- E11.11✦ Type 2 diabetes mellitus with ketoacidosis with coma

For patients with diabetes mellitus who routinely use insulin or oral hypoglycemic drugs, an additional code from category Z79 should be assigned to identify the long-term (current)use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term(current) use of insulin should be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2018: "A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required." The bolding of ICD-10-CM codes represents categories, subcategories or codes that map to the 2017 CMS-HCC risk adjustment model for Payment Year 2018.

Codes marked with a ✦ directly after them represent new additions to the FY 2018 ICD-10-CM code classification; however, these are not bolded and will not follow bolding conventions as explained until official notice is available.

This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 3, 2017, the Centers for Medicare & Medicaid Services (CMS) announced that 2017 dates of service for the 2018 payment year model is based on 100% of the 2017 CMS-HCC model mappings released April 4, 2016, which include additional code updates in the 2017 Midyear Final ICD-10 Mappings released December 30, 2016. See: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html and https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2017.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

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For additional information about the Medicare Advantage Five-Star Quality Rating System, please refer to: http://go.cms.gov/partcanddstarratings

Optum360 ICD-10-CM: Professional for Physicians 2018. Salt Lake City: 2017.

1. "Statistics About Diabetes." American Diabetes Association. N.p., 10 Sept. 2014. Web. 1 Oct. 2014. <http://www.diabetes.org/diabetes-basics/statistics/>.
2. Kalyani RR, Margolis S. 2015 Diabetes: Your annual guide to prevention, diagnosis and treatment. The Johns Hopkins White Papers.:64-79.