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INSIDER

Educational and program information for providers

For Optum in-office assessment program announcements, see page 2.

February 2022

FOCUS ON: Conditions of the heart

Program / HCC	Prevalent conditions
Medicare Advantage HCC 85: Congestive heart failure Affordable Care Act HCC 130: Congestive heart failure	Prevalent conditions that fall into this category are: heart failure, hypertensive disease with heart failure, hypertensive heart and Chronic Kidney Disease (with specified stage of CKD), pulmonary hypertension,myocarditis, right heart failure
Medicare Advantage HCC 88: Angina pectoris	Prevalent conditions that fall into this category are: angina pectoris, atherosclerotic heart disease of native coronary artery with unspecified angina pectoris, angina pectoris with documented spasm
Medicare Advantage HCC 87: Unstable angina and other acute ischemic heart disease Affordable Care Act HCC 132: Unstable angina and other acute ischemic heart disease	Prevalent conditions that fall into this category are: unstable angina, postinfarction angina, acute ischemic heart disease, atherosclerosis of other coronary bypass graft with unstable angina pectoris
Medicare Advantage HCC 84, 96: Specified heart arrhythmias Affordable Care Act HCC 142: Specified heart arrhythmias	Prevalent conditions that fall into this category are: atrial fibrillation, ventricular fibrillation, sick sinus syndrome, atrial flutter, ventricular flutter, chronic atrial fibrillation, ventricular tachycardia

The conditions listed in the table above do not represent an inclusive list. Please check the CMS mappings for a complete list of conditions. HCC information is provided for educational purposes on the differences between the CMS and HHS models and is not intended to affect provider care.

CMS requires submission of risk adjusting diagnosis codes within the reporting period each calendar year based on what is documented in the medical record.

Documentation should be clear, concise and legible. All conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment and/or management, should be documented.

When documenting conditions of the **heart**, specify:

- Type(s) if known: For example, "left ventricular failure", "diastolic heart failure", "right heart failure", "congestive heart failure", "hypertension with chronic heart failure", etc.
- Severity: For example, "acute", "chronic", "acute-on-chronic", "cardiac arrest"
- Comorbidities/Complicating factors: For example, "renal insufficiency", "diabetes", "atrial fibrillation", "COPD", etc.
- Laterality: For example, "right heart failure", "left ventricular failure", etc.
- Cause: For example, "status post heart transplant"

HEDIS measures

Measure	Documentation
Controlling High Blood Pressure (CBP)	• Documentation should include a BP reading that occurs on or after the date of the second diagnosis of hypertension. • Documentation should include hypertension diagnosis, if applicable, and the BP reading with specified date and result.
Statin Therapy for Patients with Cardiovascular Disease (CVD)	• Documentation should include prescriptions the patient is taking. Please note that medications received at the VA hospital or through cash discount programs where insurance is not billed are excluded from capturing this pharmacy data.
Medication Adherence for Cholesterol and Hypertension	• Documentation should include prescriptions the patient is taking. Please note that medications received at the VA hospital or through cash discount programs where insurance is not billed are excluded from capturing this pharmacy data.

Documentation considerations may be specific to Optum programs such as the Comprehensive Gap Assessment Program (CGAP). Refer to the National Committee for Quality Assurance (NCQA) for a complete listing of documentation requirements.

For information on CGAP documentation verification requirements, please click here.

For additional HEDIS documentation requirement information, please refer to our *Closing gaps in quality measures toolbook*.

For additional information, as well as publications and products available for HEDIS®, please visit the National Committee for Quality Assurance (NCQA) website at ncqa.org.

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

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Optum in-office assessment program updates and reminders

Thank you for your participation in the Optum in-office assessment program. This program is designed to assist you in conducting a comprehensive annual exam and potentially help you detect chronic conditions, at times before your patients have symptoms. We encourage you to schedule a comprehensive annual exam for your patients' next office visit. Please allow enough time to assess all gaps in care and screenings identified on your assessments.

Documentation should be clear, concise and legible. All conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment and/or management should be documented.

This section is intended to notify you of in-office assessment program updates and reminders for our health plans' Medicare Advantage (MA), Medicaid Managed Care Plan (MCAID) and Affordable Care Act (ACA) members and to inform you of trainings that you and your team may leverage to support program success. Disclaimer: The information provided below is not specific to any one group or health plan; the terms below may vary from health plan to health plan. If you would like to understand what terms apply to what health plan, would like a reference to the full program requirements and/or have any further questions, please contact your Optum representative, or contact the Optum Provider Support Center at 1-877-751-9207 between 8 a.m. and 7 p.m. ET, Monday–Friday.

Account Setup Form, W-9 revisions and direct deposit assistance

The last day for ASF/W-9s for 2021 program year is March 31, 2022. Please meet with your Optum representative to review your Account Setup Form (ASF) and W-9 to make any necessary changes before then. Please contact your Optum representative or the Optum Provider Support Center at 1-877-751-9207, option 3 (Optum Pay support) for assistance with the ASF and W-9.

All providers who qualify for reimbursement for the Optum in-office assessment program must receive their reimbursement via direct deposit. For providers enrolling in direct deposit, please visit the Optum Pay website and select "Enroll Now." If you have any questions, please see the Optum in-office assessment program administrative reimbursement guidelines, or contact the Optum Pay support team at 1-877-620-6194 between 8 a.m. and 7 p.m. ET, Monday–Friday.

Training opportunities

Optum offers a variety of coding and documentation courses for Medicare Advantage (MA) and the Affordable Care Act (ACA). Classes are available with continuing education unit (CEU) and/or continuing medical education (CME) credits.

- On-demand sessions for Medicare Advantage.
- Regional trainings: Please speak with your Optum representative for a schedule of virtual trainings within your region pertaining to documentation considerations.

If you are not sure who is your Optum representative, please contact the Optum Provider Support Center at 1-877-751-9207 between 8 a.m. and 7 p.m. ET, Monday–Friday.

Did you know?

Your Optum representative or the Provider Support Center can provide access to several tools to assist you in completing the program as well as tracking your results in the program. If you have questions, please contact your Optum representative or Optum's Provider Support Center at 1-877-751-9207 between 8 a.m. and 7 p.m. ET, Monday through Friday or via email at providersupport@optum.com.

To minimize errors or to correct previously rejected assessments, please refer to the Checklist and FAQ for Providers.

Remember:

Assessments must be submitted via:

- **In-office Assessment delivered as PDF:**
  - **Optum Uploader:** please visit optumupload.com.
  - **Secure fax:** 1-972-729-6103
  - **Traceable carrier:** (any commercial carrier with traceable delivery) to the following address:
    Optum Prospective Programs Processing
    2222 W. Dunlap Ave.
    Phoenix, AZ 85021
- **Optum electronic portal/modality**

The following references were used to create the content of this document:

Optum360 ICD-10-CM: Professional for Physicians 2022. Salt Lake City, UT: 2021.

11000 Optum Circle, Eden Prairie, MN 55344

This guidance is to be used for easy reference; however, the current ICD-10-CM code classification 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. This document supplies general information regarding HEDIS and the Five-Star Quality Rating System, but NCQA administers HEDIS and CMS administers the Five-Star Quality Rating System and you should consult the NCQA and CMS websites for further information. Lastly, on January 15, 2021, the Centers for Medicare & Medicaid Services (CMS) announced that 2021 dates of service for the 2022 payment year model are based on the Centers for Medicare & Medicaid Services Announcement. cms.gov/medicarehealth-plansmedicareadvtgspecratestatsannouncements-and-documents/2022.

For the Affordable Care Act (ACA): The Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) model applies in the health exchange risk adjustment program under the Affordable Care Act. This model differs significantly from the CMS-HCC model, which applies in the Medicare Advantage risk adjustment program. For more information, please visit: cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium%20Stabilization%20Programs. HHS also issues an annual notice of benefit and payment parameters, which may contain additional guidance on risk adjustment coding and other related issues under the Affordable Care Act.

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