INSIDER

Educational and program information for providers

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

October 2022

FOCUS ON: Cancer

Medicare Advantage	Prevalent conditions that fall into this category are: primary and secondary malignant neoplasms, primary and secondary carcinoid tumors, Merkel cell carcinoma, neuroendocrine tumors, disseminated malignant neoplasms, leukemias, melanomas, hepatoblastomas, mesotheliomas, plasmacytomas, sarcomas, hemangiomas, benign neoplasms, neoplasms of uncertain behavior, benign neoplasm of meninges, benign neoplasm of brain and other parts of central nervous system, benign neoplasm of pituitary gland, benign neoplasm of craniopharyngeal duct, benign neoplasm of pineal gland, neurofibromatoses and others. *Unique to the ACA model: Waldenstrom macroglobulinemia, benign neoplasm of heart, tumor lysis syndrome.*
HCC 8: Metastatic cancer and acute leukemia HCC 9: Lung and other severe cancers HCC 10: Lymphoma and other cancers HCC 11: Colorectal, bladder and other cancers and tumors HCC 12: Breast, prostate and other cancers and tumors	
Affordable Care Act	
HCC 8: Metastatic cancer HCC 9: Lung, brain and other severe cancers, including pediatric acute lymphoid leukemia HCC 10: Non-Hodgkin's lymphomas and other cancers and tumors HCC 11: Colorectal, breast (age <50), kidney and other cancers HCC 12: Breast (age 50+) and prostate cancer, benign/uncertain brain tumors and other cancers and tumors HCC 13: Thyroid cancer, melanoma, neurofibromatosis and other cancers and tumors	

The conditions listed in the table above do not represent an inclusive list. Please check the CMS and HHS 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 all 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 related to **cancer**, specify (if applicable):

- Behavior: Malignant (primary, secondary, unknown), neuroendocrine, carcinoma in situ, benign, uncertain behavior or unspecified behavior
- Morphology: Histological type, stage and grade
- Anatomic site(s): Location, quadrants, multiple and contiguous sites
- Laterality: Right, left or bilateral for paired organs and the extremities

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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.

HEDIS measures

Measure	Details
Breast cancer screening (BCS)	Recommended for female patients ages 50–74, who have not had a mammogram in the 27 months prior to 12/31 of the current year. Medical record stating date mammogram was completed or diagnostic report. *Documented exclusions: two unilateral mastectomies or bilateral mastectomy.*
Colorectal cancer screening (COL)	Screening is recommended for patients ages 50–75, who have not had any of the following: • FOBT in the current calendar year • FIT-DNA test (Cologuard®) during current year or two prior calendar years • CT colonography during current or four prior calendar years • Flexible sigmoidoscopy during current or four prior calendar years • Colonoscopy during current or nine prior calendar years Medical record stating screening was completed on a specified date with/without result or radiology/lab report. Member refusal will not make them ineligible for this measure. Documented exclusions: colorectal cancer or total colectomy.
Cervical cancer screening (CCS) *This measure is specific to the ACA and Medicaid population*	Screening is recommended for: • Women 21–64 years of age who had cervical cytology performed during the current calendar year or two years prior • Women 30–64 years of age who had cervical cytology/ human papillomavirus (HPV) co-testing during the current calendar year or four years prior Documentation should include a notation indicating the date and type of screening performed. This quality measure or gap can also be closed via claims as permitted by the health plan.

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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 each patient's 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.

2022 program performance update

Now that the 2022 in-office assessment program year is more than halfway through, it is a great time to review available reports to assess your group's performance. The Provider Scorecard is a great tool to help track your group's program performance at an aggregate level. Items presented on the scorecard include:

- Year-over-year membership
- Risk score for your group
- Percentage of HCCs captured
- Diagnosis prevalence percentages

Please contact your Optum representative or the Provider Support Center to review and discuss your group's scorecard in depth.

Training opportunities

Optum offers a variety of documentation and coding 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 your Optum representative is, 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 the Optum 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**

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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 presentation 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 April 4, 2022, the Centers for Medicare & Medicaid Services (CMS) announced that 2022 dates of service for the 2023 payment year model are based on the Centers for Medicare & Medicaid Services Announcement. cms.gov/files/document/2023-announcement.pdf.

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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