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CalOptima Community Network (CCN)

Lunch and Learn Meeting

August 16, 2016

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Welcome

Michael German, Manager

Provider Relations

Agenda

- Provider Relations Updates
- Medical Management Update
- Initial Health Assessment Process
- Orange County Adult Day Services Coalition
- HCC Coding
- Q&A and Closing Remarks

CCN Meeting Materials

- Meeting Agenda
- Notes page
- CCN Question Sheet
  - Complete if you would like CalOptima staff to follow up with you after this meeting.
- Today's Meeting Evaluation
  - Please complete at the end of each presentation.
- Meeting materials are available on the provider webpage at www.caloptima.org.

Please place your cell phones on silent

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Provider Relations Updates

CCN Lunch and Learn

August 16, 2016

Elisa Ramos

Program/Policy Analyst, Provider Relations

Overview

- Community Network (CCN) Membership Update
- University of California Irvine (UCI) Specialists Prior Authorization Changes
- 3rd Quarter Provider Directory Validation

CCN Membership Update

- Total Medi-Cal Members: 64,169
  - Children: 16,325
  - Adults: 45,814
  - 65 years of age and older: 2,030
- Total OneCare Connect Members: 2,106
- Total Primary Care Providers: 612
- Total Specialists: 2,492

Data as of August 1, 2016

UCI Prior Authorization Changes

- Effective August 1st, CalOptima will no longer require prior authorization for routine specialty follow up visits at UCI Medical Center for CalOptima Community Network members
  - 99215

- Please reference our website for most current Prior Authorization list

3rd Qtr. Provider Directory Validation

- Provider Relations will be visiting your offices to verify demographic information of all CCN providers
  - This outreach process will run from July to September

- Please verify your provider's information on CalOptima's website, www.caloptima.org

- *Remember:* You can report changes to your assigned representative or contact the Provider Relations Department at (714) 246-8600 to report changes

Questions

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Benefits of Early Dialysis Access

CalOptima Care Network Lunch & Learn
August 16, 2016

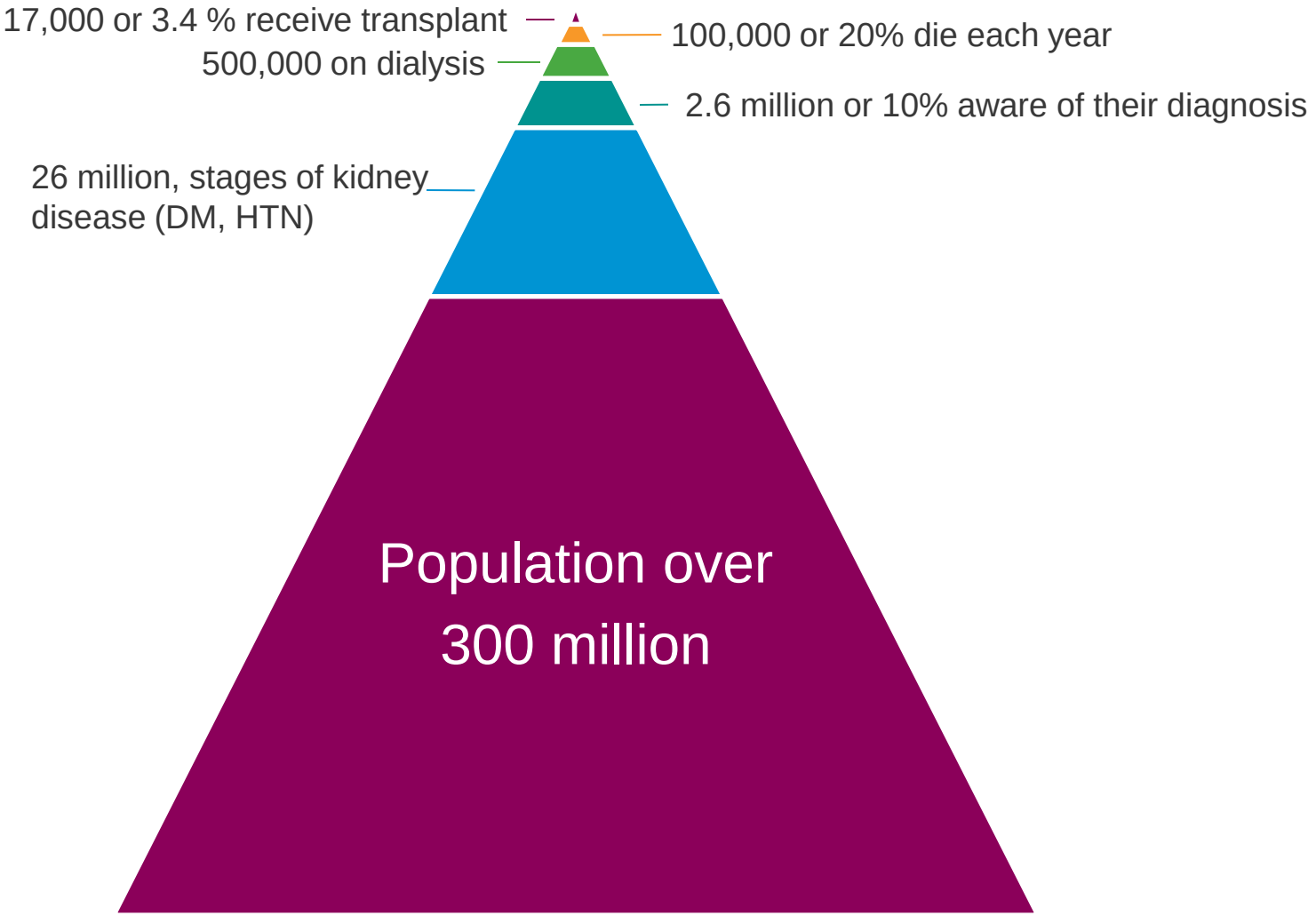
Himmet Dajee, M.D.
Medical Director

Benefits of Early Dialysis Access

The traditional approach has been to initiate dialysis only when conservative therapy fails to control uremic symptoms. However, delayed initiation of dialysis is associated with excess mortality, morbidity and cost.

A more proactive approach is to consider early initiation of dialysis to avoid the onset of uremic symptoms and their consequences. No controlled studies have been published demonstrating the benefits of early dialysis, but a number of observational studies support the concept of early-start dialysis.

End-Stage Renal Disease (ESRD) Pyramid



End-Stage Renal Disease (ESRD) Pyramid

Population	**+300 Million**
Stages of kidney disease	**26 Million (DM, HTN)**
Aware of this disease/diagnosis	**2.6 Million (10 percent)**
On dialysis	**500,000**
Death each year	**100,000 (20 percent)**
Receive transplant	**17,000 (3.4 percent)**

Causes of Kidney Failure

- **Acute kidney failure** most common reasons:
  - Acute tubular necrosis (ATN)
  - Severe or sudden dehydration
  - Toxic kidney injury from poisons or certain medications
  - Autoimmune kidney diseases, such as acute nephritic syndrome and interstitial nephritis
  - Urinary tract obstruction
- **Chronic kidney failure** most common reasons:
  - Diabetes
  - High blood pressure
  - Glomerular kidney diseases
  - Polycystic kidney disease (and other genetic diseases)

(continued on next slide)

Causes of Kidney Failure (cont.)

- **End Stage Renal Disease**
  - Renal meaning how the kidneys filter blood
  - Total or nearly total and permanent kidney failure Glomerular Filtration Rate (GFR) 10–15.
  - Must undergo dialysis or transplantation to stay alive.

Access for Dialysis

- Peritoneal dialysis
- Arteriovenous (AV) fistula
- Tunneled catheter
- Arteriovenous (AV) graft

Peritoneal Dialysis

- 40 percent — initial dialysis modality
- Survival advantage over hemodialysis (HD)
- Preserved residual renal function
- Better renal and transplant outcome
- Improved quality of life
- Cost < $20,000 year over HD

Peritoneal Dialysis (cont.)

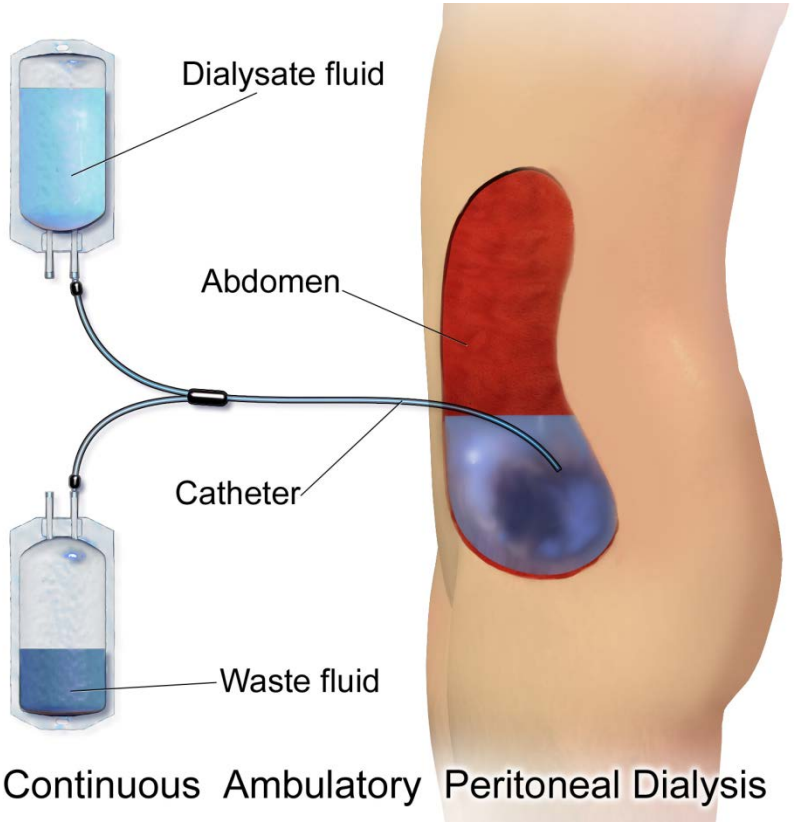


Image by Blausen.com staff. "Blausen gallery 2014". *Wikiversity Journal of Medicine*. DOI:10.15347/wjm/2014.010. ISSN 20018762. — Own work

Peritoneal Dialysis (cont.)

Pros	Cons
Fit your treatment around your lifestyle	You need to be well trained
Independence — mostly you perform the treatment yourself	Permanent catheter access required
Fewer visits to the dialysis unit (usually once a month)	Some risk of infection
Works during sleep time for some people	May show a slightly larger waistline (due to carrying fluid)
Continuous therapy is gentler and more like your natural kidney function	Storage space required in your home
Portable and flexible — easy to take your treatment with you when you travel	Possible changes in your appearance due to medication side effects
Less fluid and diet restrictions	
No needles	
Better blood pressure control	

AV Fistula

- Preferred by 17 percent
- High failure rate (50 percent) low blood flow
- Patency rate 45 percent at one year
- Average maturation rate 4–9 months

AV Fistula for Dialysis (cont.)

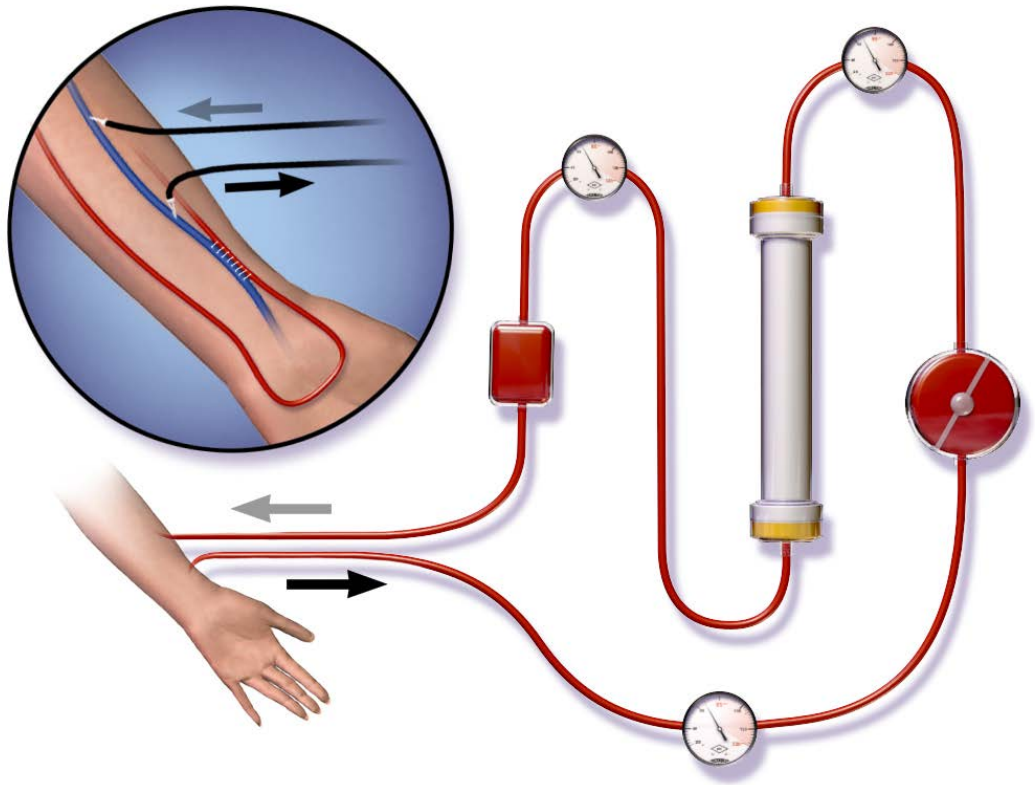


Image by Blausen.com staff. "Blausen gallery 2014". *Wikiversity Journal of Medicine*. DOI:10.15347/wjm/2014.010. ISSN 20018762. — Own work

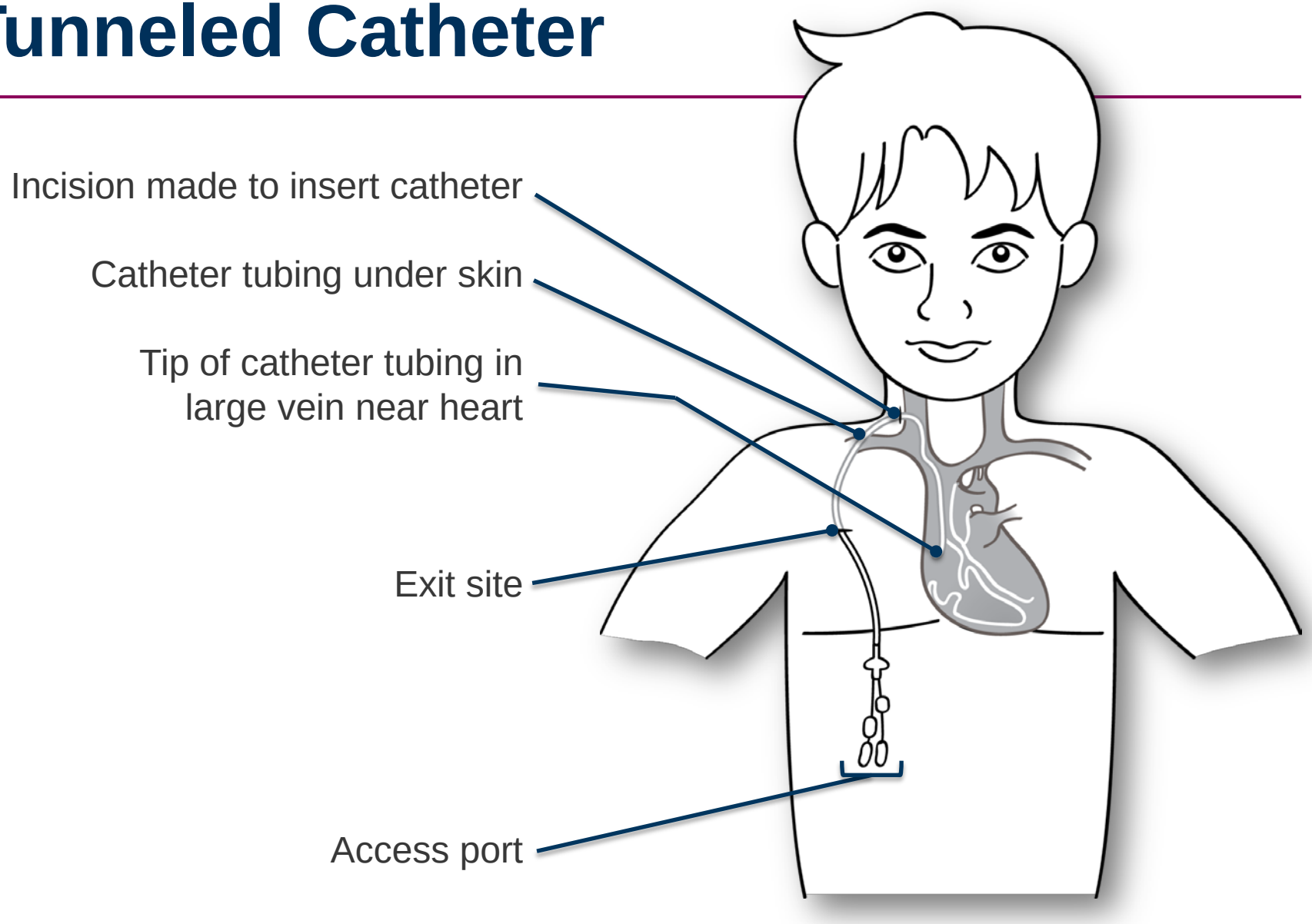
AV Fistula (cont.)

Pros	Cons
Best overall performance	Visible on the forearm
Considered the best vascular access	May take a while to develop
Less chance of infection than other types of access	May require temporary access while fistula matures
Tends to last many years	Not feasible for all patients due to other medical conditions
Predictable performance	Bleeding after the needles are removed
Increased blood flow	Fistulas may fail to mature

Tunneled Catheter

- Tunneled Catheter
  - A tunneled catheter in your neck — temporary
  - 80 percent of hemodialysis (HD) initiated with central venous catheter (CVC)
  - Complications:
    - Pneumothorax
    - Vascular injury
    - Infection and mortality
    - Central vein obstruction
    - Limits showering and swimming

Tunneled Catheter



Tunneled Catheter (cont.)

Pros	Cons
Dialysis can be performed immediately	Not ideal as a permanent access
Readily inserted with an outpatient procedure	High infection rates
Easy removal and replacement	Difficult to obtain sufficient blood flow to allow for adequate toxin removal
Avoids needle sticks	May cause narrowed veins
	Swimming and bathing is not recommended

AV Graft

- 3 percent initiated HD
- Patency rate 23 percent at one year
- Can be calculated immediately
- Heparin coated

AV Graft (cont.)

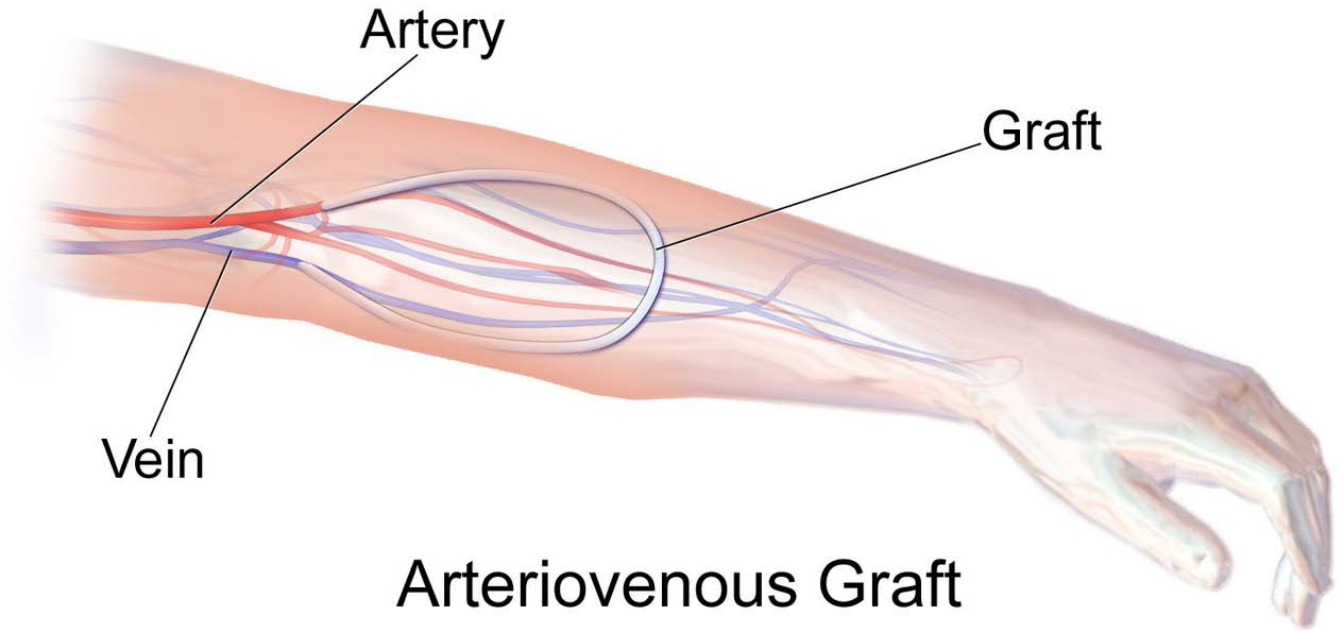


Image by Blausen.com staff. "Blausen gallery 2014". *Wikiversity Journal of Medicine*. DOI:10.15347/wjm/2014.010. ISSN 20018762. — Own work

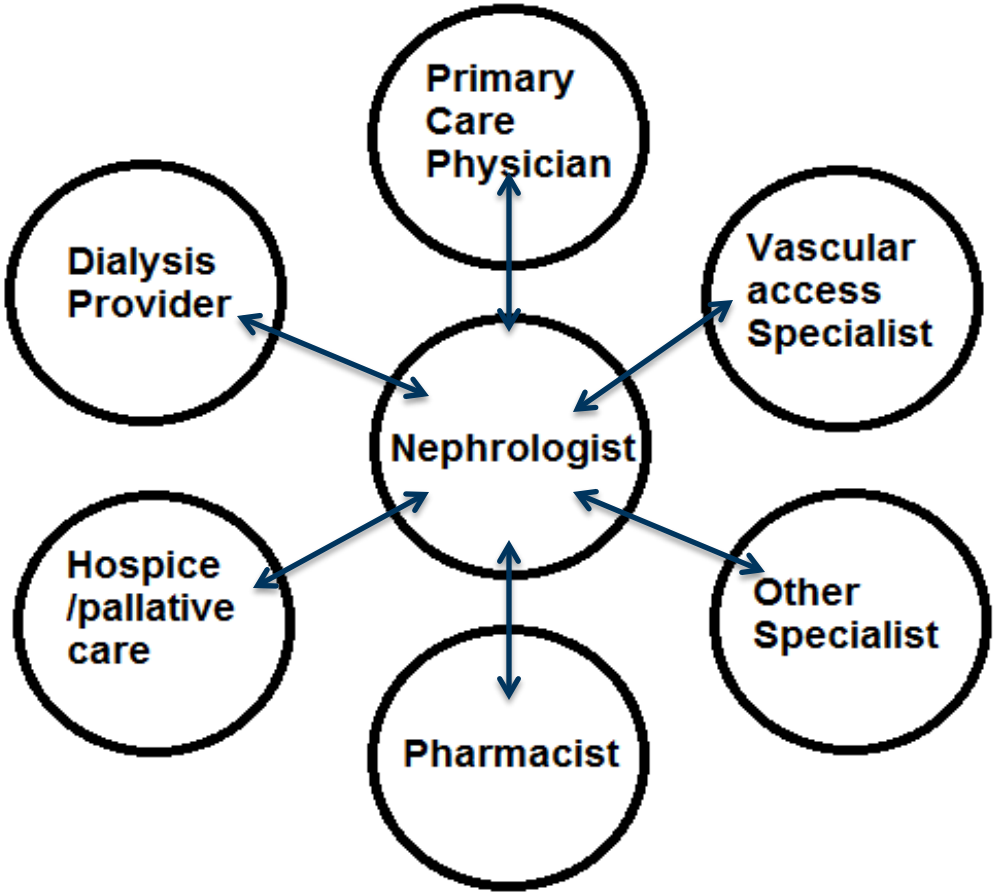
AV Graft (cont.)

Pros	Cons
Can be readily implanted	Increased potential for clotting
Predictable performance	Increased potential for infection
Can be used faster than an AV fistula	Does not usually last as long as AV fistula

Hemodynamics

- Blood flow –
  - Radiocephalic fistula 600–700 ml/minute
  - Brachiocephalic fistula 1,300–1,500 ml/minute
  - AV Graft 800–1,200 ml/minute
- Heart rate
- Blood pressure
- Ejection fraction
- Cardiac rhythm
- Volume status
- BP medications
- Intrinsic atherosclerosis

New ESRD Seamless Care Organizations (ESCOs) Model



Gold Standard for Vascular Access

- PCP to recognize chronic kidney disease (CKD)
- Referral to nephrology
- Timely preparation for renal replacement therapy (RRT)
- Timely access to vascular surgeon for AVF
- Prefer referral six months prior to HD

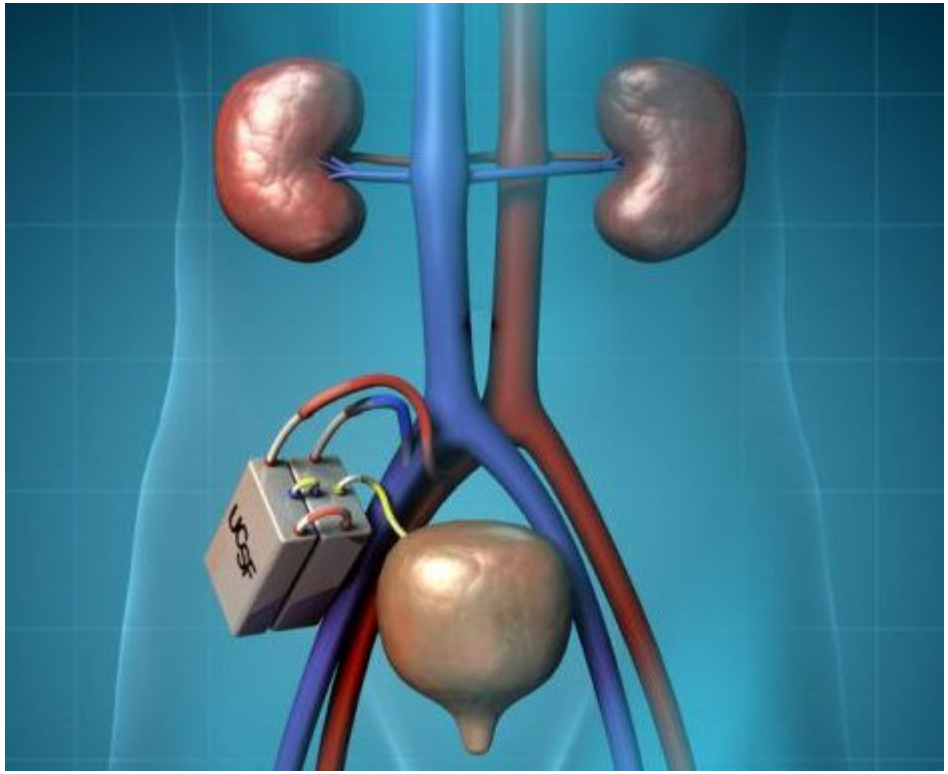
(continued on next slide)

Gold Standard for Vascular Access (cont.)

- A fistula is the "**gold standard**" because:
  - It has a lower risk of infection than grafts or catheters.
  - It has a lower tendency to clot than grafts or catheters.
  - It allows for greater blood flow, increasing the effectiveness of hemodialysis as well as reducing treatment time.
  - It stays functional longer than other access types; in some cases a well-formed fistula can last for decades.
  - Fistulas are usually less expensive to maintain than synthetic accesses

Artificial Kidney

- How the artificial kidney will work:
  - After entering the device, the patient's blood will pass through two components:
    - **Filter side:** First, silicon membranes will filter the blood, removing toxins
    - **Cellular side:** Then a bed of transplanted kidney cells will regulate the chemical balance of the blood
  - Toxins will be removed to the bladder as waste.



Graphic used with permission of The Kidney Project at the University of California, San Francisco

Artificial Kidney (cont.)

- Current limitations
  - Is not available for personal use (as of now)
  - Because it is not available for humans, transplants and dialysis are the only ways to effectively treat kidney failure.
  - Will be costly when first coming out (from $25,000–$75,000)

Future of the Artificial Kidney

- Will go through clinical trials and be on the market.
- Will be more affordable.
- Remove need for constant dialysis.
- Will be able to function without rejection or malfunction.

Questions

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Initial Comprehensive Health Assessment

CCN Lunch & Learn

August 16, 2016

Pshyra Jones

Director, Health Education & Disease Management

DHCS Requirement

- What is the IHA?
  - The IHA is a comprehensive assessment that is completed during the member's initial encounter(s) with a primary care physician (PCP) or other qualified health professional

- IHA Components
  - The IHA consists of the following:
    - Comprehensive History
    - Preventive Services
    - Comprehensive Physical and Mental Status Exam
    - Diagnoses and Plan of Care
    - Individual Health Education Behavioral Assessment

DHCS Requirement

- Timelines for the Provision of the IHA
  - All new plan members must have a completed IHA within 120 calendar days of enrollment
  - IHA must be completed by the newly assigned PCP within the first 120 days of enrollment when the member or plan initiates a change in PCP and IHA has not yet been completed.
- Effective Date of Enrollment
  - The effective date of enrollment is defined as follows:
    - The first of the month following notification from DHCS that
      - The member is eligible to receive services from the plan, and capitation will be paid; and
      - The member is not on “hold’ status

DHCS Requirement

- Exceptions from IHA Requirements (must be documented in the medical record)
  - Completed 12 Months Prior to Enrollment
  - New Plan Members Who Choose Their Current PCP
  - Member Not Continuously Enrolled
  - Disenrolled Members
  - Member Refusing an IHA
  - Missed Scheduled Appointment

CalOptima 2015 Audit Findings

- IHA Completeness for new CalOptima Members **7.8%**

- Additional reporting identified up to 60% of new CalOptima members with any utilization (claims/encounters, RX, or Labs) and no evidence of an IHA or SHA.

- At least 66,000 new members assigned to Health Networks do not have evidence of new Member visit or utilization in 2015.

CalOptima Response

- Created an IHA Task Force
  - Includes members from:
    - Audit & Oversight
    - Case Management
    - Clinical Outcomes
    - Customer Service
    - Health Education
    - Provider Relations
    - Information Services
    - Quality Analytics
- Task Force Focus for 2016:
  - Provider Focused Actions
    - Engage Health Networks in assuring completion/compliance in IHAs
    - Gather physician feedback on barriers to completing IHA/SHA

CalOptima Response

- Increased Reporting and Monitoring of IHA completeness
  - New member without evidence of IHA Days Aged report
  - Review monitoring reports created by the Health Networks
  - Regular Monitoring of IHA Completeness by Quality Improvement Committee and Audit & Oversight Committee
- Member Engagement Strategies for CalOptima Membership with no Evidence of an Office Visit
  - Automated reminder calls
  - Welcome calls for Community Network
  - Member incentives

Health Network Support

- Include IHA physician reminders for new members with the monthly enrollment process.
- Document missed appointments and refusals in the medical record or appointment log.
- Administer the Individual Health Education Behavioral Assessment (IHEBA), also called the Staying Healthy Assessment

Health Network Support

- Submit the following billable codes when any of the services below are performed.
  - SHA Coding
    - 96150 (Initial)
    - 96151 (subsequent visits)
  - SBIRT
    - H0049
    - H0050
  - Tobacco Cessation Intervention Coding
    - 99406

Questions

Adult Day Services

adult day services coalition

trusted solutions for care


Adult Day Care Services for Patients

Families Often Need Help Caring for a Loved One

- Caregiving can be:
  - Isolating
  - Overwhelming
  - Physically and Mentally Draining
  - Financially Burdensome

Easter Seals Senior Day Center

Commonwealth Adult Day Health Care

When Do Families Ask for Help?

- Change in Health
- Falls and Accidents
- Memory Loss
- A Loved One Gets Lost

Anaheim VIP Adult Day Health Care

Commonwealth Adult Day Health Care

Day Services: The Best Solution for Long-Term Care in the Community

- Health Models
  - CBAS – Medi-Cal Only
  - ADHC – Private Pay, LTC Insurance, Veteran's Benefits
- Social Model
  - Private Pay, LTC Insurance

Rehabilitation Institute of Sothern California (RIO)

Why Day Services?

- We Keep Families Together
- Relief from 24 Hour Care Responsibility
- Social Interaction and Mental Stimulation
- Assistance with ADLs, Done with Dignity
- Daily Medical Care (Health Model) and Protective Supervision
- Cost Effective Care

Irvine Adult Day Health Services

Day Services & Population Health

- Address the goals of population health
  - Joint partnership in improving the health outcomes of the population
- Multidisciplinary nature of care addresses the various factors that affect health
  - Social determinants of health
- Chronic disease management and improved health outcomes
- Close monitoring of health status

Person-Centered Care

- World Health Organization (WHO) definition of health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”

- ***Person-centered care:*** looking at the whole person and affirming personhood, autonomy, and self-worth as an individual

Diversity In Day Services

- Program Diversity Options in OC
  - Dual Licensed ADHC/CBAS and Social Model
  - Stand Alone ADHC/CBAS or Social Model
  - Faith Based
  - Culturally Specific
  - Age Specific
  - Diagnosis Specialties i.e. Alzheimer's Disease or TBI
- Each Program Has It's Own Unique Style, Feel & Look
- Many Programs Serve Culturally Diverse Populations
- Programs are staffed with caring professionals and volunteers needed to meet the social, clinical, language and cultural needs of program participants and their families

Meet Our Participants

Anaheim VIP Adult Day Health Care

- Average age 73
- 58% women
- 94% have fall risk
- 71% use cane, walker, or wheelchair
- 48% do not speak English
- 45% suffer from dementia
- 61% have sensory deficits

Health Models: CBAS and ADHC

- Person Centered Care
- Multidisciplinary Team Coordination
- Daily Health Monitoring
- Medication Review and Administration
- Home Safety and Community Service Coordination
- Well Balanced Meals
- Individualized Health and Therapeutic Services
  - Occupational, physical and speech therapies
  - Psychological services
- Recreation Programs & Socialization
- Accessible Transportation

Anaheim VIP Adult Day Health Care

Health Models: CBAS Eligibility

Acacia Adult Day Services

- Participants must meet eligibility criteria for at least one of the five CBAS categories;

AND

- Five ADHC eligibility and medical necessity criteria in Welfare and Institutions Code Sections 14525 and 14526.1(d)(1)-(5) (as modified by the settlement).

Social Model of Care

Easter Seals Senior Day Center

- For Seniors and Persons with Disabilities
  - Can serve 18 or older
  - Some Providers specialize in serving seniors or persons with developmental disabilities
  - Can vary, check with individual Providers for level of care and assistance options offered

Social Model of Care

Acacia Adult Day Services

- Services Offered
  - Socialization and Recreational Activities
  - Meals
  - Physical and Cognitive Exercise
  - Individualized Assessment
  - Relief from 24/7 Caregiving Responsibilities

Improving Quality of Life

- For Caregivers
  - *"I never feel alone on this journey with my husband." Caregiver*
- For Day Services Participants
  - *"I love coming here and being with others like me." Participant*

Easter Seals Senior Adult Day Center

Coalition Members

- Acacia Adult Day Services
- Commonwealth Adult Day Health Care Center
- SeniorServ:
  - Adult Day Health Care Center, Anaheim
  - Adult Day Center, Buena Park
  - Adult Day Health Care Center, Santa Ana/Tustin
- Easter Seals Senior Adult Day Services

Coalition Members

- Irvine Adult Day Health Services
- Rehabilitation Institute of Southern California (RIO)
  - Adult Day Health Care Center, Orange
  - Adult Day Health Care Center, Fullerton
  - Leo Fessenden Adult Day Health Care Center, San Clemente
- Sarang ADHC
- Shepherd of the Hills Church, Adult Day
- Program
- South County Adult Day Services
  Sultan Adult Day Health Care

adult day services coalition

trusted solutions for care

www.ocadultdayservices.org

Best Practices to Support HCC Coding Medicare Risk Adjustment Model

CCN Lunch and Learn

August 16, 2016

Marty Reza, RHIT, CCS

Senior HCC Coding Specialist

Agenda

- CMS-Hierarchical Condition Category (HCC) Risk Adjustment model
- Chart Documentation Tips
- CMS RADV Audit
- Available Coding Tips and Tools

Hierarchical Condition Category (HCC)

- Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) Medicare Risk Adjustment Model
- The current CMS-HCC risk adjustment model is V22
  - Contains more than 3,800 ICD-10CM diagnosis codes
    - Maps to 79 categories (costly/chronic diseases)
  - CMS assigns a Model Relative Factor (demographic score)
    - Based on the enrollee's age, gender and other socio-economic factors

What's a Risk Adjustment Factor (RAF)?

- RAF = the numeric value assigned by CMS to identify the health status of a beneficiary
- Average RAF score from Medicare **= 1.00**
  - Determines coefficients for current year payment
  - RAF score **above** 1.00 = a sicker population
  - RAF score **below** 1.00 = a healthier population

Chart Documentation

- Why is it so important?
  - To ensure **all** patient's health conditions are accurately addressed, evaluated, treated and monitored
  - Improves communications between physicians
  - Better identification of members for care management
  - Accurate documentation supports data integrity/chart audits

Chart Documentation Tips

- It is key to document all conditions so they accurately reflect the patient's true severity of illness that impacts patient care:
  - Clinical evaluation (test results, medication's effectiveness, response to treatment)
  - Document the diagnosis, its status and any causal relationships
  - Therapeutic treatment (any response or changes in treatment)
  - Plan for care (diet, medications, referral, lab/diagnostic orders, patient education, return visits)

Coding Tips for Chronic Conditions

- How often?
  - At each visit re-assess the patient's chronic condition(s), code and report based on treatment and care for the conditions.
  - Fully identify the patient's diabetic conditions when more than one body system is being impacted.
  - This demonstrates a good standard of practice and quality of care.

Documentation/Diagnosis Coding Errors

- Common diagnosis coding errors can affect a member's actual health status.
- Documentation must support coding to the highest level of specificity.
- Could lead to an inaccurate RAF value
  - Not documenting the complications or co-morbidities.
  - Omitting the acuity or type of disease
  - Stage of disease not documented (CKD)

RADV (Risk Adjustment Data Validation)

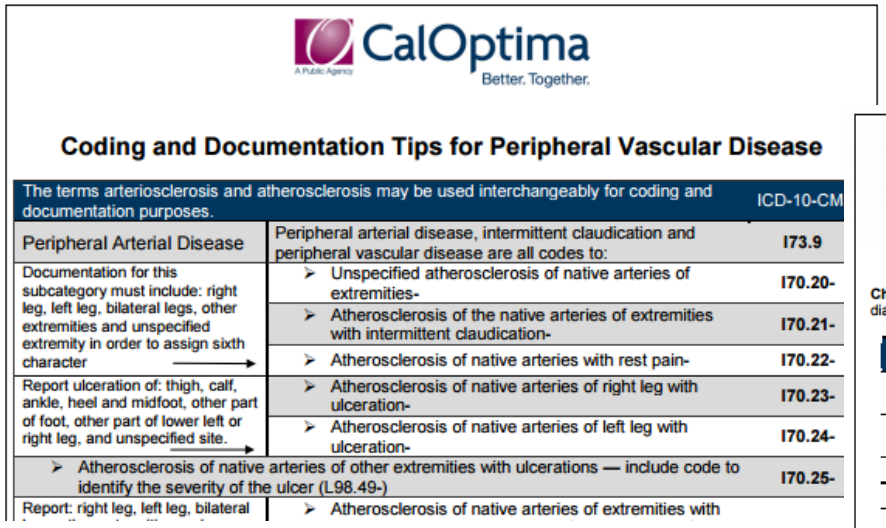
- Purpose of CMS RADV audit:
  - Confirms documentation substantiates diagnosis codes reported to ensure risk adjustment payment integrity and accuracy
  - CMS clinical auditors validate diagnoses codes reported to ensure the medical record documentation is accurate.
  - CMS **can and will** recoup payment from the plan if chart documentation does not support diagnosis codes reported.

RADV Chart Review/Audit Finding

- Common coding errors found in chart review:
  - Current cancer vs. history of cancer
  - Acute stroke codes (CVA) vs. history of CVA /late effects
  - Coding (active) sepsis in during PCP visit.

CalOptima Coding Tips

- Available on the CalOptima website
- https://www.caloptima.org/en/Providers/ManualsPolicies AndResources/ProviderTrainings/CodingTips.aspx



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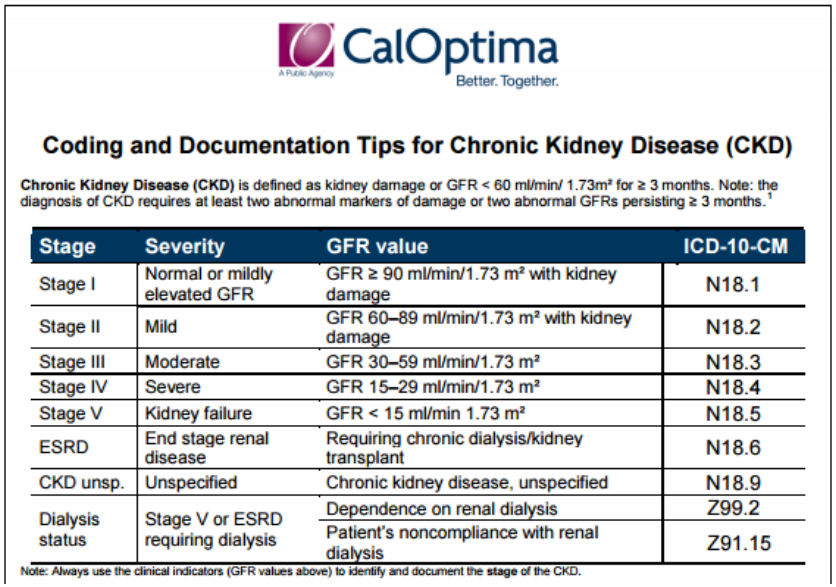
Coding and Documentation Tips for Peripheral Vascular Disease

The terms arteriosclerosis and atherosclerosis may be used interchangeably for coding and documentation purposes.		ICD-10-CM
Peripheral Arterial Disease	Peripheral arterial disease, intermittent claudication and peripheral vascular disease are all codes to:	I73.9
Documentation for this subcategory must include: right leg, left leg, bilateral legs, other extremities and unspecified extremity in order to assign sixth character →	➢ Unspecified atherosclerosis of native arteries of extremities-	I70.20-
	➢ Atherosclerosis of the native arteries of extremities with intermittent claudication-	I70.21-
	➢ Atherosclerosis of native arteries with rest pain-	I70.22-
Report ulceration of: thigh, calf, ankle, heel and midfoot, other part of foot, other part of lower left or right leg, and unspecified site. →	➢ Atherosclerosis of native arteries of right leg with ulceration-	I70.23-
	➢ Atherosclerosis of native arteries of left leg with ulceration-	I70.24-
➢ Atherosclerosis of native arteries of other extremities with ulcerations — include code to identify the severity of the ulcer (L98.49-)		I70.25-
Report: right leg, left leg, bilateral	➢ Atherosclerosis of native arteries of extremities with	



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Coding and Documentation Tips for Chronic Kidney Disease (CKD)

Chronic Kidney Disease (CKD) is defined as kidney damage or GFR < 60 ml/min/ 1.73m² for ≥ 3 months. Note: the diagnosis of CKD requires at least two abnormal markers of damage or two abnormal GFRs persisting ≥ 3 months.[1]

Stage	Severity	GFR value	ICD-10-CM
Stage I	Normal or mildly elevated GFR	GFR ≥ 90 ml/min/1.73 m² with kidney damage	N18.1
Stage II	Mild	GFR 60–89 ml/min/1.73 m² with kidney damage	N18.2
Stage III	Moderate	GFR 30–59 ml/min/1.73 m²	N18.3
Stage IV	Severe	GFR 15–29 ml/min/1.73 m²	N18.4
Stage V	Kidney failure	GFR < 15 ml/min 1.73 m²	N18.5
ESRD	End stage renal disease	Requiring chronic dialysis/kidney transplant	N18.6
CKD unsp.	Unspecified	Chronic kidney disease, unspecified	N18.9
Dialysis status	Stage V or ESRD requiring dialysis	Dependence on renal dialysis	Z99.2
		Patient's noncompliance with renal dialysis	Z91.15

Note: Always use the clinical indicators (GFR values above) to identify and document the **stage** of the CKD.

ICD-10 Websites

- ICD-10 general information at the CMS website: www.cms.gov/ICD10
- CMS: http://www.roadto10.org/
- AHIMA resources: http://www.ahima.org/icd10training
- AAPC: http://www.aapc.com/ICD-10/training.aspx

Questions

CCN Lunch and Learn Q & A

- Evaluation Form — Please complete and leave behind.
- In your packet, there is a form on which you can write any questions about anything that we have not addressed today.
- What questions do you still have?

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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Medi-Cal
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OneCare (HMO SNP)
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PACE
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