CIPA

Consortium of Independent Physician Associations

CIPA NEWSLETTER

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Medical Advantage Group will be closed on the following dates:

- Monday, December 25, 2017
- Tuesday, December 26, 2017
- Monday, January 1, 2018

Provider-Delivered Care Management Update

Provider-delivered care management (PDCM) is an integral part of Blue Cross Blue Shield of Michigan's (BCBSM) Patient-centered Medical Home (PCMH) program. It involves the delivery of care management services by a care manager and/or qualified health professional working with a physician and care team in an eligible primary care or specialist office. Physicians who participate in PDCM receive reimbursement for care management services rendered through 12 procedure codes. In addition, PCMH designated primary care practices meeting BCBSM claims criteria, training criteria, and attestation process criteria will be eligible for five percent PDCM value-based reimbursement beginning July 1 of each year. Eligibility for PDCM value-based reimbursement is re-evaluated annually, concurrent with PCMH designation.

When attesting for value-based reimbursement in the January 2018 self-assessment database tool, physician organizations (POs) will need to answer questions about completing staff training requirements at the practice level. This will serve as verification that the PDCM training requirements were completed. The questions include:

- Does the practice have a physician champion who is a proponent of care management, understands PDCM and will refer patients for care management?
- Is there a practice panel manager, such as a medical assistant or PO clinical lead, who will actively work to close gaps in care across the patient population, manage the active care relationship file, and support and organize care manager activity?
- Are care plans developed that can be shared with the field team or other Physician Group Incentive Program (PGIP) staff?
- Do patients have access to a care manager employed or contracted by the PO or practice?

To qualify for PDCM, lead care managers in primary care offices must complete:

- In-person Michigan Care Management Resource Center (MiCMRC) complex care management course, MiCMRC-approved self-management support course,
- Online PDCM billing course, and
- Complete 12 hours of longitudinal clinical education per year.

Longitudinal education refers to training completed throughout the year and may consist of live or recorded webinars, in-person educational offerings, and web-based interactive e-learning modules.

Qualified health professionals must complete the three-hour MiCMRC PDCM online care management training course, the PDCM billing online training course, and eight hours of longitudinal clinical education per year.

Any practice team member billing any of the 12 PDCM codes must complete the BCBSM PDCM billing course. It is approximately one-and-a-half hours long.

For practices already billing PDCM codes, the training must be completed by December 31, 2017. For practices that have not yet started billing PDCM codes, the training must be completed within six months of starting to bill. BCBSM reserves the right at any time to request documentation from the PO (e.g., training completion certificates) demonstrating the training requirements were met**.**

For more information about PDCM, contact your practice consultant and/or visit MiCMRC at www.micmrc.org.

PCMH Domain 14 – Specialist Referral Process

As an integral component of the Blue Cross Blue Shield of Michigan (BCBSM) Patient-centered Medical Home (PCMH) and PCMH-Neighbor (PCMH-N) framework, the intent of the specialist pre-consultation and referral process is to encourage specialty/subspecialty physicians to collaborate as partners with primary care physicians. It is also to develop patient-centered and efficient care processes allowing for appropriate and timely consultations and referrals that complement and advance the aims of the PCMH practice. By achieving the goals of Domain 14: specialist pre-consultation and referral process as outlined by the BCBSM PCMH/PCMH-N program, providers will realize the benefit of improved specialist and primary care physician interactions, including appropriate flow of necessary patient care information, shared responsibility for relevant types of clinical interactions and support for patient-centered, high quality, safe care, and enhanced provider access.

In addition to allowing for timely consultations and referrals, the optimal referral processes developed through the implementation of capabilities outlined in Domain 14 of the BCBSM PCMH/PCMH-N program establish clear definitions for clinical interactions between specialist and primary care providers. These types of clinical interactions include the following:

- **Pre-consultation exchange** – PCMH practice will expedite/prioritize care, clarify need for referral, answer clinical questions, and facilitate appropriate diagnostic services for the patient prior to referral for specialty assessment.

- **Formal consultation** – Specialty/subspecialty physicians will address distinct questions regarding a patient's diagnosis, diagnostic results, procedures, treatment, or prognosis with the understanding that the patient will be transferred back to the PCMH primary care physician (PCP).

- **Co-management methods**:
  - *Co-management with shared management for the disease* – specialist shares long-term management with the PCP for a patient's referred condition.
  - *Co-management with principal care for the disease* – specialist assumes responsibility for long-term, comprehensive management of a patient's referred medical/surgical condition. PCP receives follow-up reports, provides input on secondary referrals and quality of life/treatment decisions, and continues to care for all other aspects of patient care and remains first contact for patient.
  - *Co-management with principal care of the patient for a consuming illness for a limited period* – specialist becomes, for a limited time due to the nature and impact of the disease, the first contact for care until the crisis or treatment has stabilized or been resolved. The PCP remains active in bi-directional communication and provides input on secondary referrals.

As PCPs and specialty/subspecialty physicians commit to collaborate as partners by refining their processes to allow for better communication and integration, their patient populations experience the benefits of an improved patient experience of care across the care continuum. This is accomplished through defined workflow processes from the initial referral request to ensuring the patient completes the visit and the consult paperwork is received. This can be managed through a paper tracking log or online referral process.

Practices will need to define their main referral networks, educate patients about the need for the referrals, and assist patients with understanding the internal processes – who they will see, contact information, why they need to be seen, and for how long. Key staff involved in the referral process need to be included in the design process, and educating all staff on any changes on an annual basis must be included. For information on reviewing your current referral process and implementing any changes, please contact your practice transformation consultant.

New BCBSM Interpretive Guidelines in Carespective™

Blue Cross Blue Shield of Michigan (BCBSM) has issued updated interpretive guidelines for the 2017-18 program year. It can be found in the Carespective™ Learning Center. In addition to the six capabilities required for Patient- Centered Medical Home (PCMH) designation, six other capabilities will be discontinued in 2018:

   1.9 - Health care information is shared among care partners as necessary

   2.5 - Registry identifies individual practitioners

   6.3 - Process is in place for ensuring patient contact details are kept up-to-date

   12.1 - Available vendor options for purchasing and implementing a patient web portal system have been evaluated

   12.2 - Physician organization or practice has assessed liability and safety issues with portal

   14.5 - Practice or designee ensures patients are scheduled for specialist appointments in a timely manner

Your practice consultant will be reviewing these changes and other updates in the coming weeks.

CODING CORNER

Reporting Proper Antibiotic Use for Acute Bronchitis, Upper Respiratory Infections and Pharyngitis

Prescribing antibiotics for acute adult bronchitis, pharyngitis and upper respiratory infections are not always consistent with evidence-based care. HEDIS data for these measures are captured via **claims only**, making it important to document appropriate diagnosis codes and the reason for dispensing an antibiotic.

What causes an "open gap" on the quality reports?

Acute adult bronchitis: a missed quality opportunity or "open gap" occurs when a patient between the ages of 18-64 is given an antibiotic within three days of a stand-alone diagnosis of acute bronchitis on the claim.

Upper respiratory infection (URI) in children: a missed quality opportunity or an "open gap" occurs when a patient between the ages of 2-18 is given an antibiotic within three days of a stand–alone diagnosis of URI.

Appropriate testing for children with pharyngitis: an "open gap" occurs when children ages 3-18 are given an antibiotic within three days of an encounter of a stand-alone diagnosis of pharyngitis and without having had a rapid strep test. A negative rapid strep should be verified by culture. Document the diagnoses, testing, and include all findings.

Perform a clinical evaluation, use additional diagnoses such as an elevated white blood count (WBC), positive strep test or other diagnoses, and document the need for an antibiotic. Submitting claims with the diagnosis that required antibiotic treatment will ensure it meets the HEDIS requirements. An additional diagnosis is referred to as a competing diagnosis and co-morbid conditions. Always code to the highest specificity. A list of appropriate and accepted codes/conditions are detailed in Blue Cross Blue Shield of Michigan's (BCBSM) clinical quality corners, which can be found in the Carespective™ Learning Center/Patient-centered Medical Home (PCMH) toolkit.

It is important to educate your patients on when an antibiotic is needed and when it is not. Contact the urgent care clinics, after-hour centers, emergency departments and specialists co-managing your patients' care to discuss their protocols, as missed opportunities in these three quality measures could also result in an open gap.

Michigan Antibiotic Resistance Reduction Coalition, or MARR – www.mi-marr.org Centers for Disease Control – www.cdc.gov/antibiotic-use/community
Choosing Wisely – www.choosingwisely.org

Provider Directory October Audit

Blue Cross Blue Shield of Michigan (BCBSM) conducted a physician data confidence value **random audit** to measure the provider data accuracy/quality in the Find a Doctor tool. They called the physician phone numbers between October 2nd and October 20th and three questions were asked during the call:

1. Is this a working phone number?
2. Is this the phone number where a patient can make an appointment to see the doctor?
3. Does the doctor see patients at this location at least once per month?

The Consortium of Independent Physician Associations (CIPA) physicians had a passing rate of 32 percent. Please ensure the health plans have accurate phone numbers and locations of your practice. Do not attest to every location listed unless you are currently working in the facility. There will be 2018 incentives and disincentives based on the accuracy of 2018 quarterly audits.

Practitioner Alignment (PA) and Self-Assessment Data Tool Reporting Deadlines

Physician changes – CIPA reports all Physician Group Incentive Program (PGIP) physician changes to Blue Cross Blue Shield of Michigan (BCBSM) on a quarterly basis through its practitioner alignment online tool. Any physician leaving or joining a practice needs to be reported to CIPA by close of business December 14. Contact your practice transformation consultant today to report any changes so the necessary paperwork can be completed.

BCBSM Self-Assessment Data (SAD) Tool Reporting – You have probably heard practice consultants talk about the SAD tool. It is not to be confused with the SAD syndrome (seasonal affective disorder). The SAD tool is how CIPA reports a practice's Patient-centered Medical Home (PCMH) & PCMH-Neighbor (PCMH-N) capabilities and guides the BCBSM PCMH designation and site visit process. It is completed online twice a year. CIPA consultants will be meeting with practices this month to confirm capabilities and attest to provider delivered care management services with a goal to have all data entered by December 20, 2017.