PHYSICIAN ALLIANCE OF THE ROCKIES

THE PARADIGM

Our Journey to Value-based Healthcare

2ND QUARTER 2018 ISSUE OF THE PARADIGM!

Physician Alliance of the Rockies (PAR) thanks all of you who attended the dinner meetings in March to review the new initiatives and incentive programs. These new initiatives align with our goals that focus on improved patient care quality outcomes, improved patient experience, lower cost of care, and improved physician practice satisfaction.

Two New Incentives Begin July 1, 2018

In addition to the ACO group incentive outlined in *The PARadigm* Newsletter's 1st Quarter Edition, we are excited to announce **two new individual PAR physician incentives for 2018!**

The first incentive is regarding the use of the Preferred Specialist Network. While the incentive starts July 1, 2018, the new Preferred Specialist Network went into effect on April 1, 2018. Please visit our website at www.paotr.com, click on Forms and Documents for the updated Preferred Specialist Network list.

We will calculate the number of preferred specialist referrals as a percentage of total specialist referrals on a quarterly basis. There will be three tiers of performance targets when the Preferred Specialist Panel is used:

- Tier 1: 50-70% preferred specialist use = $1 PMPM
- Tier 2: 70-85% preferred specialist use = $3 PMPM
- Tier 3: 85-100% preferred specialist use = $5 PMPM

The second incentive is regarding the accurate completion of the attestation form for UHC Medicare Advantage member condition documentation on an annual basis. **For each accurately completed attestation form submitted with the patient's health maintenance/physical note, where the high-risk conditions have been appropriately documented and coded, a fee for service incentive payment of $100 will be paid to the PCP.** Similar to the Preferred Specialist Network incentive program, this attestation incentive will be paid quarterly and will begin on July 1, 2018.

The attestation form we will be using for this incentive program is attached to this newsletter. Additionally, the details regarding this submission process of the completed attestation form to earn this incentive are on our website at www.paotr.com.

Physician Alliance of the Rockies is here to assist you with achieving these incentive payments. Please let us know if you have any questions.

DID YOU KNOW?

In 2018, the industry will increasingly turn to primary care physicians for ground-level leadership on efforts to improve quality, outcomes, and cost-efficiency. The move to value-based care is putting PCPs in the spotlight.

PCPs are often in the best position to ensure quality and control costs, principally through referral decisions.

As the payment model continues to evolve, payers, hospital systems, and providers increasingly bear more risk. As a result, efforts to continue to strengthen care coordination are a high priority.

Preferred Specialist Panel Referral Procedure Effective April 1, 2018

An auto-approval procedure for any referral to one of the PAR preferred specialists has been established, which allows for a more streamlined process for the patient and the practice.

The following is the process we are utilizing for required specialist referrals:

- Auto-approval for a referral to a PAR preferred specialist that is submitted using the Portal will be instant, while fax submissions could take 2-3 days. Up to six visits in six months will be approved.
- For referrals to a UnitedHealthcare contracted specialist, not designated as a PAR preferred specialist, the new process will require a pre-approved referral before the patient can be seen by the UHC contracted specialist. Up to three visits in three months will be approved.
- The current process for UnitedHealthcare non-contracted specialist referrals that require a pre-approval referral, will remain the same

Prior Authorization Changes Effective April 1, 2018

PAR has enhanced its prior authorization list now requiring approval for procedures such as colonoscopies, sleep studies, and epidural steroid injections (ESI) to name a few. We utilize evidence-based medicine guidelines and criteria to advise providers regarding the appropriate setting and level of service for procedures. To determine what currently requires prior authorization, the entire updated prior authorization list is on our website at www.paotr.com under Forms and Documents.

Focus on Colonoscopy Surveillance Guidelines

Determining the optimal timing of follow up colonoscopy after a polyp resection should be easy, right? The GI consultant either has it documented in the original report or bases it on the pathology findings. Unfortunately, our GI colleagues are not consistent in making guideline-based recommendations and are frequently inaccurate regarding a family member's history of high risk polyps (or no information was sought). It has been estimated that approximately 30% of colonoscopy testing in the United States is either done too early or inappropriately all together. This is unfortunate considering the relative invasiveness and discomfort that most patients feel in undergoing colonoscopy exams.

While there are some slightly differing recommendations for interval follow up across professional societies, we have compiled a best practice aggregate to apply for our patients. This guideline has been reviewed and endorsed by all the major GI groups in the Denver area. Despite their agreement with these guidelines, it is still necessary for the PCP to obtain pathology reports and make sure that the patient is on an optimal screening path. A few common areas of "misuse" of the guidelines:

- Recommending 5 year follow up after 1-2 small (<10mm) tubular adenomas or any hyperplastic polyp
- Categorizing a patient as high risk based on a personal history (of any polyp) or due to family history—this should be based on a history of colon cancer or documented high risk adenoma (>10mm) in a first degree relative under age 60 or two first degree relatives at any age
- Screening beyond age 75—this should not be done unless the previous colonoscopy had a high-risk adenoma. In selected very healthy patients this can be considered at the 7-10 year interval after the previous scope had 1-2 small adenomas

Our medical management team has started reviewing colonoscopy prior authorization requests effective 4/1/18. Now is the perfect time for you to become familiar with the surveillance guidelines that we are using. To reduce the frustration of making one recommendation in the exam room, only to have to update the patient to the appropriate intervals after utilization review, please keep a copy of these guidelines in all your patient exam rooms.

Also, do not forget about stool fecal immunohistochemistry (FIT) testing. This very cost-effective and accurate test can be used on a yearly basis instead of more invasive screening. For older patients where the risk/benefit of a last colonoscopy is being considered we might also recommend a few years of FIT testing instead.

OptumCare Documentation and Coding Education

At our dinner meeting for PAR physicians, it was rather clear that there was a thirst for education about improving and optimizing RAF coding. In addition to a general medical management topic, I would like to present either overlooked or poorly documented RAF diagnoses. I sincerely hope that this improves the quality of your documentation as well as risk adjusted scores to increase premium dollars to care for your patients.

Secondary Hypercoagulable State in Atrial Fibrillation

As we all know, patients with atrial fibrillation are at a notable increased risk for stroke. We don't question that patients with an increased CHADS2 or CHADS2VASC score are candidates for anti-coagulation to prevent such strokes. It is appropriate to add the diagnosis of secondary hypercoagulable state (or other thrombophilia) to any patient with a CHADS2VASC score of 1 or greater, regardless of use of anti-coagulant medications.

Patients with atrial fibrillation meet all criteria of virchow's triad and clearly have a hypercoagulable condition. Appropriate documentation should include a CHADS2/VASC score along with the patient's general risk of stroke and plan for modifying this risk. Atrial fibrillation and secondary hypercoagulable state should be coded at the same visit. See attached focus on diagnosis for details.

Diabetic Dyslipidemia

Chronic complications of diabetes increase RAF scores due to the likelihood of extra care needed to manage these patients. An often-overlooked chronic complication is dyslipidemia. Since nearly all diabetic adults have elevated LDL, triglycerides, or low HDL cholesterol levels AND should be treated with statin medications per guidelines, this is a thoughtful diagnosis to add for any patient that does not have another chronic diabetes complication (retinopathy, nephropathy, neuropathy, PAD, etc.).

These RAF codes are not additive so, if the patient already has a documented chronic condition, then diabetic dyslipidemia does not add to the RAF score. See attached focus on diagnosis for details.

Thank you for your time and let us know if you have any questions or comments about the information provided.

Warm regards,

Scott Clemens, M.D.
Internal Medicine
Medical Director

Glenn Kjosen, MBA
Vice President and Executive Director