PHYSICIAN ALLIANCE OF THE ROCKIES

THE PARADIGM

Our Journey to Value-based Healthcare

3RD QUARTER 2018 ISSUE OF THE PARADIGM!

Two New Incentives Begin July 1st

As presented at the dinner meetings in March and outlined in *The PARadigm* Newsletter's 2nd Quarter Edition, we are excited to roll-out **two new individual PAR PCP physician incentives for 2018!**

The first incentive is regarding the accurate completion of the attestation form for UHC Medicare Advantage member condition documentation on an annual basis.

IMPORTANT NOTE:
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, an incentive payment of $100 will be paid to the PCP.

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

The second incentive is regarding the use of the PAR Preferred Specialist Network. The Preferred Specialist Network went into effect on April 1, 2018. For April and May, we have tracked your preferred specialist usage percentage and shared those reports with you to provide a snapshot. This percentage shows where you stand prior to the official incentive calculation that begins July 1st. EXPRESS REFERRALS INITIATED AFTER 4/1 WILL NO LONGER BE ACCEPTED.

To assist with Preferred Specialist Network usage, a flag will appear on the Physician Portal when you have **not** selected a Preferred Specialist **(see snapshot of Referral Submission screen below)**.

IMPORTANT NOTE:
Prior to proceeding with a non-preferred specialist, you have the option to edit your specialist referral to a preferred specialist, which will significantly impact your incentive payout.

All you need to do is click the **"Edit Referral"** button rather than **"Save"** button. Please visit our website at www.paotr.com, click on Forms and Documents for the latest updated Preferred Specialist Network list.

DID YOU KNOW?

As a reminder, PAR offers educational and training resources.

While the webinar sessions began in June, the July and August schedule are as follows:

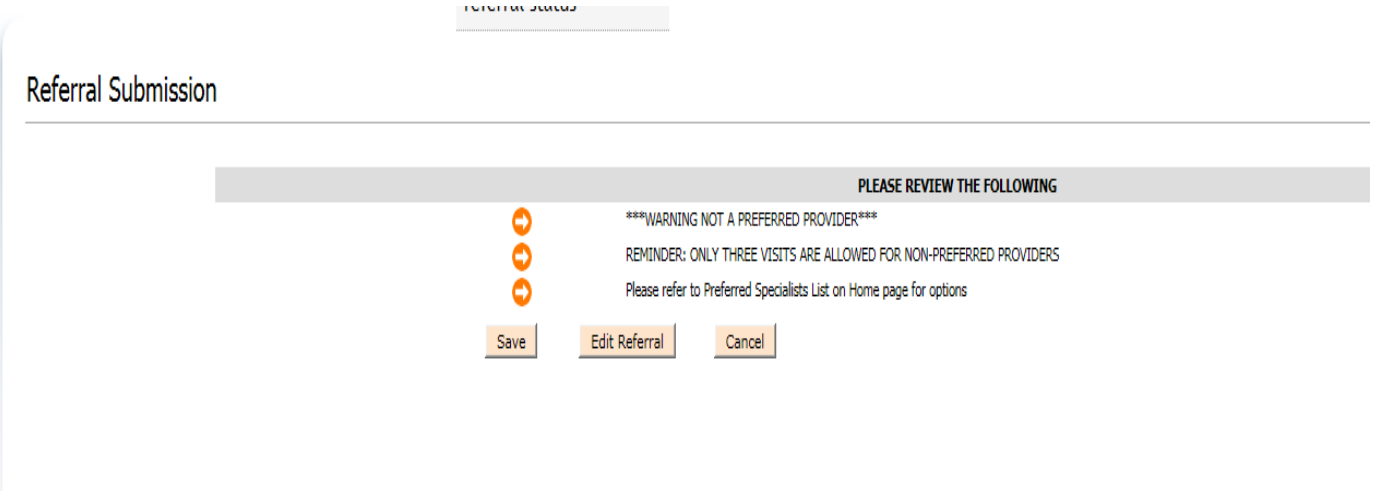
Diabetes Mellitus with Chronic Complications - July 11th or 19th at 12:15pm

Obesity and Protein Calorie Malnutrition – August 8th or 16th at 12:15pm

The call-in information for the sessions will be provided through your webinar invitation. You only need to attend ONE session for each of the topics.

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



Similar to the Attestation Completion incentive program, this Preferred Specialist Network incentive will be calculated quarterly and will be paid out after each quarter end. Please complete and send us a copy of your W-9 (attached) to ensure timely payment of the incentives.

Preferred Skilled Nursing Facility (SNF) Network Effective July 1st

Over the last several months, PAR met with SNFs in the Denver-metro area with the goal of developing a preferred SNF network who share the Triple Aim values. PAR utilized specific criteria and metrics in the final selection of the preferred SNF facilities.

Starting July 1st, PAR case managers will be reviewing all admissions to non-preferred SNFs, which will require prior authorization from PAR before the patient can be admitted to the non-preferred facility. PAR will **not** require the preferred SNFs to obtain prior authorization for the SNF admission, and will continue to provide medical management services at all facilities with PAR patients.

This new process will help direct your patients to the preferred SNF facilities as well as streamline the hospital discharge planning process. The preferred SNF list is available on the PAR website at www.paotr.com under Forms and Documents

Sleep Apnea – Diagnosis and Management

Most patients with obstructive (and even central) sleep apnea can be evaluated and treated by primary care physicians. Multiple studies in the last few years have demonstrated that home sleep testing followed by auto-titrating CPAP are at least as good, and possibly better, than in-lab studies with CPAP titrated to a set level. Not surprisingly, cost of care is far superior for home sleep testing compared to in-lab studies.

When comparing primary care physician vs. specialist management, the results show similar outcomes in patients with suspected or diagnosed obstructive sleep apnea, according to research published in Annals of Internal Medicine. Unfortunately, in-lab sleep studies continue to be requested inappropriately and at excessively high rates by a large proportion of primary care physicians. Facility studies will still be recommended/approved for patients with high concern for narcolepsy, parasomnias, or periodic leg movement disorder.

For patients (not on baseline nocturnal oxygen) with a moderate to high pretest probability for OSA, home sleep testing should be performed.

Management of AHI (based on CMS guidelines)

AHI Range	Treatment Guidelines
AHI 5-15	Borderline OSA, only treat for significant symptoms
AHI 15-20	Mild OSA, treatment optional based on symptoms
AHI 20-30	Mild-Mod OSA, MAD (SnoreRx vs Custom) or CPAP
AHI >30	CPAP recommended, download effectiveness/compliance report in 1 month

A note about mandibular advancement devices—these can be semi-custom (SnoreRx about $100) or custom (dentist provided, up to multiple thousands of $). For patients with AHI < 30 it is reasonable to try an OTC/semi-custom MAD like SnoreRx (snoreRx.com).

Role of Nocturnal Oximetry in OSA Evaluation and Treatment

Concern over central apnea—check overnight oximetry on CPAP to see if supplemental O2 needed based upon >5% of night at <85% saturation
Presence of potential "hypoxic triggered events" (seizure, PAF, CAD, PAH, etc)—maintain saturation >/= 88% nocturnally

Evidence-based treatment of central sleep apnea continues to be initiation of auto-titrating CPAP, followed by nocturnal oximetry and determination of addition of oxygen if a patient spends >5% of time with saturations < 85%. If AHI and symptoms are not improved with auto-CPAP and oxygen, referral to a sleep specialist should be considered.

RAF Coding Tip

Morbid obesity continues to affect an increasing proportion of American adults with high financial and health related co-morbid costs. Morbid obesity can be coded when a patient with excessive fat stores has a BMI > 40, or > 35 with two or more co-morbid health conditions. These can be HTN, DM, vascular disease, hyperlipidemia, OSA, and even GERD, depression, or arthritis. No rounding is allowed when assessing the patient's BMI. Accurate coding requires listing the co-morbid health conditions if the BMI is 35-40. Attached in the OptumCare Morbid Obesity training document are further details to support coding.

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

Warm regards,

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