PHYSICIAN ALLIANCE OF THE ROCKIES

THE PARADIGM

Our Journey to Value-based Healthcare

4TH QUARTER 2018 ISSUE OF THE PARADIGM!

New Incentive Performance Results are in for 3rd Quarter!

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 clinical health maintenance/physical visit charted notes, where the high-risk conditions have been appropriately documented and coded, an incentive payment of $100 will be paid to the PCP. All of the attestation forms and clinical notes will be reviewed to determine the clinical note support for designated diagnoses. The attestations with either no or insufficient documentation and coding for the high-risk conditions checked on the attestation form will not be eligible for the incentive payment. 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. However, the official incentive calculation began on July 1st, which has been shared with you to show where you stand as a percentage and your potential payout for the quarter. The overall percentage use of the PAR Preferred Specialist Network during the 3rd quarter was 66%. Seventeen percent of the PAR PCP providers achieved the highest tier of performance (>= 85%) for Preferred Network referrals and thus will receive the highest incentive payment.

As a reminder, 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?

UCHealth recently announced providers affiliated with UCHealth, University of Colorado Hospital, and University of Colorado School of Medicine are no longer seeing patients with UnitedHealthcare Medicare Advantage plans.

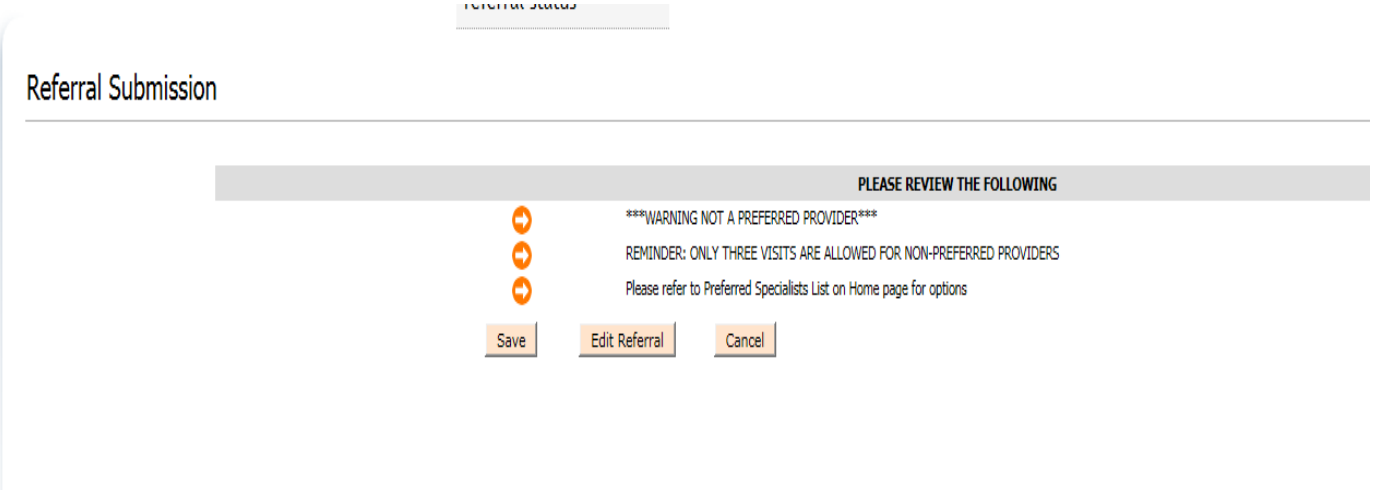
About 600 patients received letters in June informing them that they will no longer be seen by providers at University of Colorado Hospital.

The providers are already out-of-network for those covered by UnitedHealthcare Medicare Advantage plans, meaning most individuals did not see providers with University of Colorado Hospital or the School of Medicine regularly.

In other network news, Western Nephrology has been reinstated as an in-network provider for United AARP Medicare Advantage effective August 1, 2018.

PAR calculates the number of preferred specialist referrals as a percentage of total specialist referrals on a quarterly basis. There are three performance tiers for this Preferred Specialist Network incentive and they are as follows:

- Tier 1: 50-69% preferred specialist use = $1 PMPM
- Tier 2: 70-84% 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. We must have a W-9 form on file prior to distributing any incentive fund payment. **Please complete and send us a copy of your W-9 (attached) to ensure timely payment of the incentives.**

PAR IPA Advisory Committee Created

PAR has created an IPA Advisory Committee that will have its inaugural meeting in October. The initial structure of the Advisory Committee will consist of six members, including three PAR PCPs and three PAR Management. We plan to have quarterly in-person meetings with this committee to discuss how best we can support each PAR practice to achieve the Quadruple Aim:

- Improved patient care quality
- Improved patient experience
- Lower cost of care through appropriate medical care
- Improved physician practice satisfaction

Some of the initial Roles and Responsibilities of the PAR IPA Advisory Committee include, but are not limited to, the following:

- Advise regarding areas of support that PAR IPA can provide to PCP network
- Advise on most effective means of communication to PCPs and most appropriate and effective information to distribute
- Advise and review PCP performance data including:
    - PCP specialist referral data
    - Risk Adjustment Factor (RAF)
    - Coding and quality data (HCC performance)
- Identify provider education topics based upon review of performance data
- Provide input for the review of the PAR Preferred Specialist network, along with PCP requests and geographic coverage

Medicare FFS Conversion to Medicare Advantage Planning

PAR is beginning to assess the opportunity to support the conversion of Medicare fee for service (FFS) members in PAR PCP practices to Medicare Advantage plans. According to an analysis of both the programs from Avalere Health, a leading healthcare consulting firm, the Medicare Advantage (MA) programs have surpassed Medicare fee-for-service (FFS) in developing positive member healthcare outcomes and reducing care costs.

Medicare Advantage beneficiaries had 23 percent fewer inpatient stays and 33 percent fewer emergency room visits than Medicare fee-for-service beneficiaries during 2015. Inpatient spending was 17 percent lower in Medicare Advantage than Medicare fee-for-service ($2898 in MA versus $3477 in FFS), and outpatient spending was 5 percent lower in MA.

The analysis found that annual spending per beneficiary on preventive care services was 21 percent higher in Medicare Advantage than Medicare FFS. Medicare Advantage is more likely than FFS to spend on preventive services in order to prevent the development of more costly chronic diseases.

Medicare Advantage also outperformed Medicare fee-for-service when it came to improving healthcare outcomes, even though MA had a greater proportion of high-risk beneficiaries.

This focus of preventive care and interventions, along with Medicare Advantage plans' care coordination efforts, may avert preventable complications, hospitalizations, and emergency care services and result in better health outcomes and lower overall cost to Medicare for the growing population of high-need, high-cost beneficiaries.

For these reasons, we think this will be an important initiative to partner with you in the coming weeks.

PAR has created a template letter specifically to assist with this conversion process and we will provide PAR PCPs with tools and patient communication to facilitate this conversation with the overall goal of even greater positive healthcare outcomes for **all** the Medicare patients in your practice.

Evaluation and Management of Chronic Low Back Pain

Low Back Pain (LBP)

LBP is one of the most common conditions in primary care and associated with some of the highest variability in practice patterns. Evidence based medicine has one of its greatest applications in the management of back pain, as most current care patterns are not evidence based. Variability in practice patterns has been associated with poor outcomes and increased cost. This is particularly true when advanced imaging and surgical referrals are made early in the course. That being stated, what would an optimal evidenced base algorithm look like?

- **When is early advanced imaging indicated?**
  Patients presenting with red flag signs need early imaging. These include:
  - **Acute onset of bilateral sciatica**
  - **Acute foot drop**
  - **Sensory level on the trunk/saddle anesthesia**
  - **Bowel/bladder incontinence/retention**
  - **Fever**
  - **Recent diagnosis of malignancy or infection**

Also, early plain films are indicated for suspected osteoporotic or traumatic fracture. In the absence of the above clinical findings, early imaging is not indicated.

- **Are the imaging guidelines different for elderly patients?**
  Several guidelines use advanced age as one of the red flag indicators for imaging, without an evidence base of support. A report in JAMA (3/17/2015) looked at over 5,000 patients who presented with axial lower back pain along with a group of matched controls to see if outcomes one year later were affected by early imaging. Clinical outcomes were identical, and as expected cost and procedures were higher in the early imaging group with an average increased cost of $1500 per patient over the first year. A cited concern in older patients is malignancy. There was only one found in the entire imaging group and it was an abdominal lymphoma found on MRI that had nothing to do with the patients' back pain. Only 2% of patients in the early imaging group had fractures and none had infection. Patients without the above red flag signs do not require early imaging prior to conservative therapy irrespective of their age.

- **Which early therapies are effective?**
  - **Medication** – NSAID's and opioids are effective for short term use of acute LBP. Gabapentinoids have recently shown to be no better than placebo for acute and chronic sciatica and are associated with significantly more side effects. They are likely vastly over prescribed by primary care and specialists alike. There are only limited data on the use of oral steroids for acute sciatica however they are usually well tolerated and may be effective. There are limited data on the use of duloxetine and topiramate for short- and long-term pain relief. Additionally, muscle relaxants have a high frequency of side effects and very limited data to support any meaningful benefit. Acetaminophen, lidocaine patches and TCA's are no better than placebo.
  - **Manipulative therapies** - There are data to support physical therapy and non-high velocity chiropractic manipulation in acute low back pain. PT is more cost effective than chiropractic. Transition to core strengthening programs is effective for chronic low back pain.

  Early therapy therefore consists of combinations of the above modalities, transitioning to core strengthening, without imaging.

- **What are the next steps when conservative therapy fails?**
  These patients can largely be grouped into those with acute refractory sciatica due to disk herniation and those with chronic axial pain with or without radiculopathy due to degenerative disease including DJD with spinal and foraminal stenosis and spondylolisthesis.

  Failure of initial conservative therapy for sciatica – 75% of patients are healed by 12 weeks. When looked at one year after presentation, conservative therapy and surgery are equally effective for acute sciatica. However, if patients are disabled by pain and/or weakness and not improved by 12 weeks, surgery may be indicated to achieve a more rapid return to function. ESI may have a benefit in temporary pain relief for acute disk herniation, thus allowing conservative therapy to become effective. MRI is therefore indicated at 12 weeks in patients who do not improve, to evaluate whether they are candidates for ESI or referral to spine surgery.

Chronic degenerative lumbar disease, foraminal stenosis, spinal stenosis, and spondylolisthesis – This is by far our most problematic group. This is also where we see the greatest variability in care patterns. Evidenced based interventions include:

- **The core principles of managing chronic LBP include structured physical education programs and cognitive behavioral treatment.**
- **There are not strong data for the use of drugs for chronic LBP. Medications which may be of benefit include NSAID's, topiramate and duloxetine. Opioids have not been shown to improve outcomes in chronic LBP and should not be routinely used.**
- **Well done placebo-based trials have not demonstrated benefit to ESI or facet injections for chronic LBP.**
- **Well done trials have not shown a benefit to TENS for chronic LBP.**

Surgical benefit in chronic LBP is primarily seen in the subset of patients with severe spinal stenosis who have pseudoclaudication or severe radiculopathy that has failed conservative therapy.

In conclusion - Examining the above data, it becomes clear that the **initial referral** for virtually all patients with chronic LBP who have failed initial conservative therapy should be **to one of our chosen physiatrists**. Although some of our patients are already entrenched in the **chronic injection model**, we should be careful not to continue to refer patients to practitioners relying on this model and **try and transition these patients to a noninvasive approach** whenever possible. Many providers continue to refer early to spine surgery. If a patient with chronic LBP clearly meets surgical criteria based on severe symptomatic spinal stenosis, surgical referral is appropriate. However, since these patients do not require surgery on an urgent basis, physiatry referral is a clinically sound initial approach. Our physiatrists can help us choose patients who have the highest probability of surgical benefit. We have carefully chosen and worked with the PAR physiatry panel to assure our patients will receive optimal evidenced based care. An evidenced based algorithm for the evaluation of chronic LBP is attached.

RAF Education/Coding Tip

SECONDARY HYPERPARATHYROIDISM OF RENAL ORIGIN

Patients with chronic kidney disease have multiple metabolic/electrolyte abnormalities that worsen over time. Beginning as early as CKD stage 3 (GFR< 60) abnormalities of calcium, phosphorus, vitamin D, and parathyroid hormone develop. Without checking proper laboratory values, the clinician will miss an opportunity to reduce the development of metabolic bone disease (CKD-MBD) and catch a common risk adjusting (RAF) condition. Secondary hyperparathyroidism is the rise of parathyroid hormone in a response to decreased calcium serum, phosphate retention, and reduced vitamin D levels.

For all patients with CKD (3 and higher) it is recommended to check calcium, phosphate, vitamin D 25(OH), and parathyroid hormone at least yearly. Phosphate elevations should be managed first with dietary changes and appropriate phosphate binders as required. More commonly you will see elevations in PTH and associated vitamin D deficiency (<30 ng/mL) which can be successfully corrected with supplementation of vitamin D2 (ergocalciferol 50,000 units weekly for 8 weeks and then monthly for the next 4). This can be followed by OTC vitamin D3 1000-2000 units daily thereafter. Vitamin D levels should be maintained >30 ng/mL.

The HCC/RAF code of secondary hyperparathyroidism of renal origin can be utilized for these patients moving forward even after PTH levels return to normal. PTH goals for CKD3 range from 70-110. Activated vitamin D (calcitriol) can be considered for progressive rise in PTH levels (usually > 150-200) and require close attention to calcium and phosphorus levels at a more regular follow up period. An evidenced based algorithm for the evaluation of secondary hyperparathyroidism of renal origin is attached.

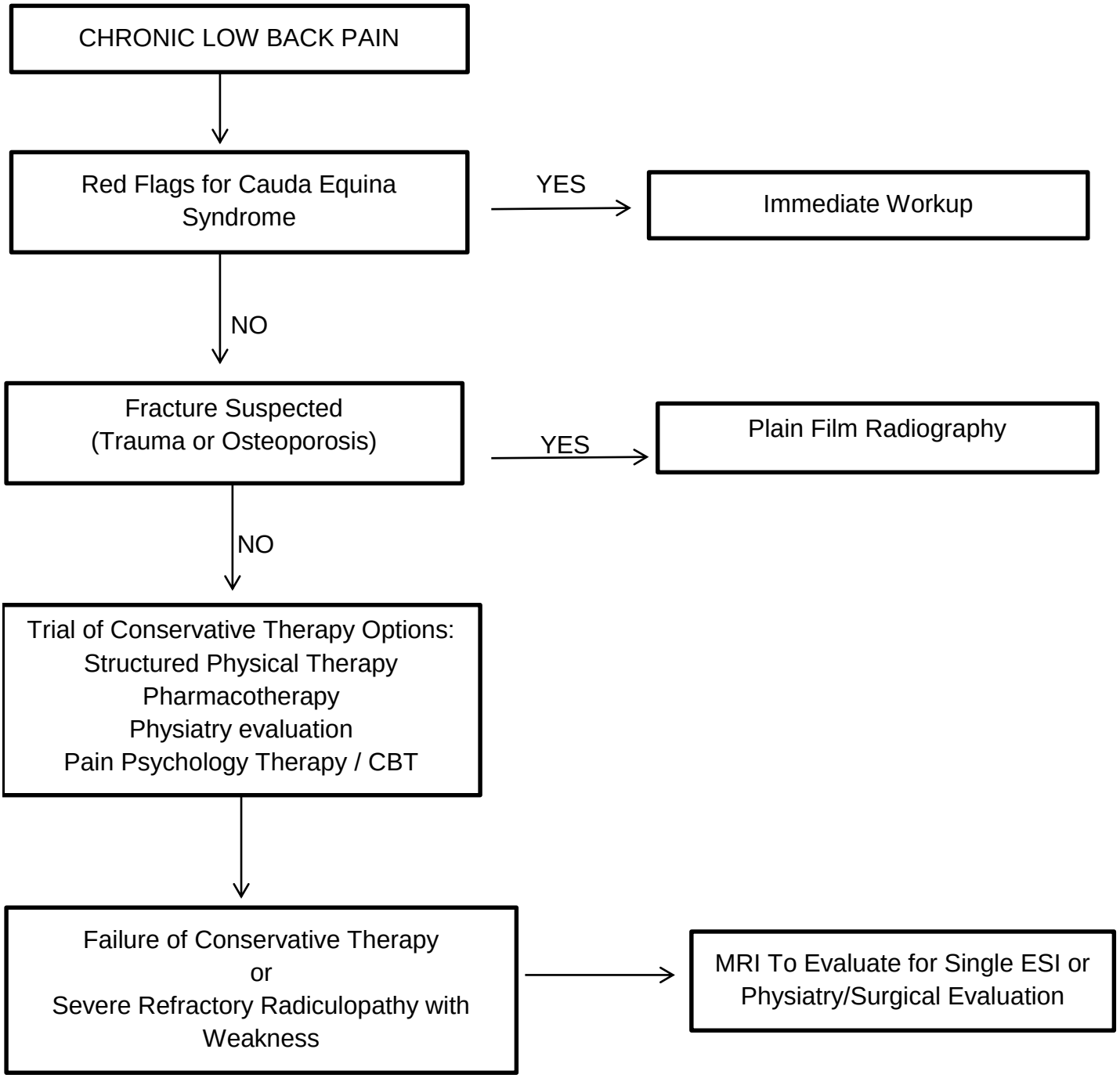
Thank you for your time and let us know if you have any questions or comments about the information provided.

Warm regards,

Scott Clemens, M.D.
Internal Medicine
Medical Director

Glenn Kjosen, MBA
Vice President and Executive Director

CHRONIC LOW BACK PAIN ALGORITHM



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