The Pulse of
The Physician Alliance
Dedicated to Improving Michigan's Health
Spring 2020

SPECIAL President's MESSAGE

Dear members,

The Physician Alliance has been actively working to support your practices during this turbulent time through the distribution of resources and finances.

In March, Dr. Ken Berkovitz, Ascension Michigan market leader, and I, in our roles as Co-CEOs of Partners in Care, authorized the pre-payment of **$1.9 million** to TPA primary care and specialty physicians to support them in this time of financial need. Thanks to the combined efforts of TPA, Ascension Michigan and PIC, the funds were distributed within five days.

Dr. Dennis Ramus, TPA board chair, and I urged Blue Cross Blue Shield of Michigan senior leadership to accelerate the distribution of Blue Care Network (BCN), PGIP at-risk organized system of care (OSC) enablement opportunity monies and other performance payments scheduled for distribution later in the year. As a result, BCBSM has accelerated payments in several areas.

PIC will be distributing **$2.0 million** in BCN performance monies to TPA PCPs and specialists. In addition to PIC's distribution, TPA distributed **$1.2 million** in BCBSM OSC enablement opportunity monies to PCPs and specialists in late April. BCBSM is also scheduled to distribute **$2.1 million** in PGIP Diagnosis Gap Closure Incentive monies directly to TPA practices in late April.

In total, we successfully stimulated early distribution of **$7.2 million** to TPA physicians in a very short period of time.

Our team also is supporting our practices in a number of other areas including: providing education on telehealth, financial resources and key coronavirus resources; acquiring personal protection equipment for distribution to practices; creating helpful tip sheets and more. Our staff is continuously weeding through the myriad of COVID -19 information to synthesize it down into information you can use. We have increased the frequency of our e-blasts and have enhanced our website with a coronavirus resources webpage.

We are seeing a significant increase in the number of our physicians and practice staff viewing our electronic communications. Please continue to check these information sources and also respond to our practice needs survey emails so we can keep our finger on the pulse of our physicians and their needs.

We are in regular communications with TPA physicians on the frontlines who are helping us understand their needs in real time. Our board members are regularly communicating with me to keep my team and me apprised of the needs of their physician organizations and independent physician associations.

The staff and I thank all of you and your practice staff for your ongoing dedication to patients. We continue to support our practices and we will not stop.

In good health,

Michael R. Madden
President & CEO

SUCCEEDING in a NARROW NETWORK

From technology to patient care to billing codes, change is a common thread in healthcare. Physician reimbursement is also evolving.

Over the past few years, the fee-for-service payment model has transitioned to a pay for performance model. That model now is expanding to a population health model focused on the performance of a network of healthcare providers.

One such program is the Blue Cross Blue Shield of Michigan Organized System of Care (OSC), an expanded network of healthcare professionals focused on population health. An extension of the patient-centered medical home program, an OSC is a community of caregivers who share commitment to quality and cost-effective health care delivery for a defined population. In an OSC, physicians are rewarded for achieving low cost, high quality outcomes for their shared patient population, regardless of where or by whom the services are delivered.

The OSC is responsible for coordinated care and treatment provided to a patient population attributed to the network's primary care physicians. The network expands beyond PCPs to also include hospitals, specialists and other providers to coordinate services across the care continuum for a defined patient population.

"All participants in an OSC are rated, rewarded and influenced by all network physicians," explained Carolyn Rada, MSN, RN, executive vice president of population health at TPA.

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Getting the latest news and tips?

Are you receiving TPA's bi-weekly e-newsletter packed with important updates, coding tips, patient education resources and more? If not, contact **heather.hall@thephysicianalliance.org** to add you or a staff member to the list.

Don't forget to check out TPA's Learning Institute at **www.thephysicianalliance.org.** You'll find patient education materials, tip sheets, upcoming education events, videos and more!

COVID-19 Key Information Sources

Centers for Disease Control & Prevention (CDC): www.cdc.gov/coronavirus
Coronavirus-related posters, flyers and more, including tips for practice preparedness and patient materials, are available on their website.

World Health Organization (WHO): www.who.int

Michigan Department of Health & Human Services (MDHHS): www.michigan.gov/coronavirus

Website provides updated list of testing criteria and updates, and additional resources, including:

- Updated CDC N95 mask guidance
- 24-hour testing referral telephone line (888-277-9894) - exclusive for Michigan clinicians
  - Clinicians should call this number to have patient's symptoms and risk factors assessed against prioritization criteria. If the patient meets criteria, MDHHS will provide instructions for obtaining laboratory testing. ■

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"This makes it critically important for providers to be aware of their quality performance, care processes and population management, as it affects the entire network."

This is also important to note as payments move toward population health outcomes instead of fees for individual services. *Much of the success in an OSC is ensuring collaboration and communication between providers.*

Narrow network criteria

The Physician Alliance was selected to participate in the BCBSM OSC, providing additional reimbursement opportunities to TPA members. There are currently 1,195 TPA physicians in the OSC. All OSC physicians have access to the BCBSM Personal Choice Preferred Provider Organization insurance product. However, physicians must meet specific requirements to participate in the OSC.

To join TPA's OSC, providers must meet BCBSM criteria, as well as requirements set by TPA. Overall practice expectations include a focus on population health processes, commitment to improving coding accuracy, consistently engaging in care coordination processes and providing care management services. TPA's OSC participation includes primary care physicians designated as patient-centered medical home (PCMH) and specialists receiving BCBSM's value-based reimbursement or receive at least a 3-star rating in TPA's Service Excellence Awards – Care Coordination. Additional requirements for OSC inclusion can be provided by a practice's assigned practice resource team members. Eligibility is reviewed annually.

Some tips for success in an OSC include:

- Reduce inpatient admissions
- Reduce emergency department utilization
- Improve care coordination
- Reduce service duplication
- Improve access to care at most cost effective sites

Transitioning to risk-bearing payments

Last year, BCBSM launched another expansion of the OSC to begin transitioning to risk-bearing. The OSC Enablement Opportunity is a two-year risk-bearing project that focuses on cost reduction along with improved quality performance. The program rewards OSCs for appropriate cost management of their attributed populations. The risk-bearing performance will be based on cost-trend performance relative to overall OSC-attributed average cost-trend.

"Healthcare payments are moving toward risk-bearing, whether physicians are ready or not," said Karen Swanson, MD, TPA's chief medical officer and a primary care physician. "Physicians need to work collaboratively with all healthcare providers to improve care coordination and reduce costs."

The 2019 measurement year monies will be paid in 2020 and 2020 measurement year monies will be paid in 2021. Payment will be based off the TPA 2019 and 2020 OSC scorecards. Key metrics for incentive capture include: improve accurate diagnostic coding to reduce risk adjusted cost of care, panel management of high risk patients, and strong MA STARS performance. ■

For more information on the OSC and OSC Enablement Opportunity, contact Carolyn Rada at Carolyn.rada@thephysicianalliance.org.

New Blueprint for Affordability program focuses on narrow network risk-sharing model

Last December, The Physician Alliance entered into an agreement with Blue Cross Blue Shield of Michigan (BCBSM) as part of Blueprint for Affordability (Blueprint), a new value-based reimbursement model with shared risk among partners.

The Physician Alliance is one of the first partners to join this model. There are now 14 organizations participating in Blueprint. TPA joins Blueprint in partnership with Ascension Southeast Michigan as the contract is held by Partners in Care, the managed care entity co-owned by TPA and Ascension Southeast Michigan.

"Risk contracting is the future of healthcare and Blueprint is the next generation of providing excellent care delivery for patients while reducing cost and improving reimbursement for providers," said Michael Madden, president/CEO of The Physician Alliance. "TPA is pleased to be at the forefront of creating a model that engages multiple parties to work together for shared risk in population health management."

The new payment model between The Physician Alliance and BCBSM enhances the ability to work together to help patients get healthy and stay healthy, maintain high quality of care standards and better manage the overall cost of care. This new payment model provides new incentives for the population management work done in primary care and specialty practices meeting targeted criteria.

BCBSM Commercial PPO and Medicare Advantage PPO lines of business are included in Blueprint for Affordability. PPO provider contracts started in January 2020 with participating organizations. Blueprint includes a narrow network of physicians. Those physicians qualified to participate in TPA's Organized System of Care network will be included in the Blueprint program. ■

Specialists recognized for improved quality of care

More than 900 physicians from The Physician Alliance recently received a value-based reimbursement (VBR) from Blue Cross Blue Shield of Michigan. The Physician Alliance total represents the highest number of specialists in the physician organization to receive a value-based reimbursement since the program began.

Value-based reimbursement is the primary method for rewarding specialists who actively collaborate with primary care physicians and their physician organization leadership to create improved systems and care processes, implement and promote effective evidence-based care, and ensure the efficient and appropriate flow of information in co-management situations. The measures used to select which specialists receive a VBR are population-based and reward specialists who serve patient populations with higher overall performance.

TPA nominates physicians each year for a value-based reimbursement. BCBSM determines who receives a VBR after reviewing performance measures. Possible VBR range from 5–10 percent. Participation in different initiatives may increase the percentage.

2020 TPA specialist value-based reimbursement:

- **943** specialists, representing **265** specialty practices, received a VBR– 96% of total TPA specialists received a VBR
- TPA nominated **974** specialists – 97% of nominated specialists received a VBR
- **713** TPA specialists received a 10% VBR

Items to note for selected practices:

- Additional detailed documentation regarding the specialist value-based reimbursement, including your practice's final results report and a report data dictionary, are available on The Physician Alliance's secure physician portal at tpareporting.org. For information on the eligibility and nomination process for the VBR, please contact your practice resource team member.
- **IMPORTANT:** Please be aware that your 5–10 percent additional reimbursement may cause payments to exceed your current charges in some practices. Please review your current fee structure and make the appropriate adjustments in your charges, if necessary. If you have any billing questions regarding this, please contact your biller and your BCBSM representative. ■

Why should doctors care about coding?

A Physician's Perspective
Dr. Kathleen Rheaume
- *Family medicine physician*
- *The Physician Alliance senior physician advisor*

It's good patient care!

Coding has much more importance beyond payment. It translates the reasons that services were performed. Medical coding is a little bit like translation. Coders take medical record documentation from doctors, such as a patient's condition, diagnosis, prescription, and any procedures performed on the patient by the doctor or healthcare provider and turn that into a set of codes. These make up a crucial part of the medical claim.

Documentation serves many purposes. The most obvious is a historical record of the patient's condition and treatment plan. Insurance reimbursement depends on medical coding accuracy as it alerts the payor to a patient's illness or injury and method of treatment. Since the advent of ICD-10, new HEDIS and quality measures, and a move to pay for performance, coding has become more important.

Codes also have the potential to provide better and updated data for improving overall patient and health care.

Consider this: congestive heart failure previously was a reimbursable diagnosis. Doctors were paid and patients were covered by insurance. Now, ICD-10 requires documentation to include left- or right-sided, systolic or diastolic congestive heart failure. Without this specific coding, doctors can lose money and earn lower quality ratings as it appears patients have a lower severity of illness and complication rates may be high.

Payment

Billing is a means to an end. You need to file your claims to payors for payment. Codes help insurance companies know what specifically was rendered and why it should be covered (medical necessity). Coding to the highest specificity as possible is critical. Doctors must accurately document conditions treated and ensure the correct ICD-10 codes are assigned. Correct coding and billing can increase payments to a practice. Incorrect coding can cause a practice to lose income.

Data and statistics

Codes also have the potential to provide better and updated data for improving overall patient and health care. Data obtained from codes provides clearer understanding of complex disease conditions and allows designing of clinical algorithms to track patient care outcomes.

Registries, governmental agencies and hospitals track events and conditions such as traumas, causes of death, cancer types/morphologies, implanted devices, and hospital-caused injuries for many reasons. Researchers can obtain de-identified health information based on codes. These abstractions can answer research questions, giving preliminary results for additional research project funding. Coding properly can also help improve data for better overall patient care.

So, what can a doctor do?

1. Code to the highest level of specificity each encounter. This provides credit for your time in caring for higher risk patients and ensuring appropriate care. The most recent coding guidelines are necessary for accurate coding.
2. Make sure coding software, books and references are current. Deletions, revisions and additions to ICD-10 PCS, CPT, and/or HCPCS "books" occur each year.
3. Ensure coding or billing staff are familiar with new materials. Make a list of your practice's needed changes.
4. Don't throw out your old coding books. You may need them to refile a claim from the previous year using former codes. ■

Patient Centered Medical Home designation extends to two years

More than a decade ago the patient-centered medical home (PCMH) was created to help improve America's healthcare by transforming how primary care is delivered. Over time this innovative care model helped diverse groups of care professionals provide comprehensive care to patients, improve shared decision making with patients and families and implement quality improvement activities. Blue Cross Blue Shield of Michigan recently announced the next phase of their patient-centered medical home designation program includes moving to a two-year cycle starting Sept. 1, 2020.

The new designation cycle means practices designated effective Sept. 1, 2020 will maintain PCMH designation through Aug. 31, 2022. Designation in 2020 will be based on calendar year 2019 claims data. Designation in 2022 will be based on claims data from 2020 and 2021. PCMH designated practices earn 10 percent value-based reimbursement (VBR) on their evaluation and management (E&M) billing and also earn another 10 percent due to TPA being a low-cost benchmark performer by BCBSM.

"Many practices are retaining their PCMH designation and value-based reimbursement for consecutive years and there are fewer first-time designations, leading to the shift in this model," said Ashley Shreve, director of practice transformation at The Physician Alliance. TPA will nominate practices every two years, according to Shreve. However, if a practice does not earn designation, there will be an opportunity to be nominated during a mid-cycle review. Designation will then only be valid until the new cycle nomination process begins.

Primary care physicians joining a currently designated practice at the midcycle review will automatically receive PCMH value-based reimbursement (VBR) for the remainder of the PCMH designation period. No changes will occur to PCMH capability implementation, reporting or practice nominations, and the other primary care VBR programs will maintain current timelines.

Annual site visits will still occur to help ensure practices are clear on PCMH guidelines and BCBSM staff can answer questions as well as get practice input to refine, clarify, and enhance the guidelines.

Practices should contact their practice resource team members for more information on this new designation cycle.

In 2019, The Physician Alliance had 125 primary care practices, representing 354 physicians, selected as patient-centered medical home practices by BCBSM. More than 4,600 primary care physicians in over 1,700 practices in Michigan currently participate in BCBSM's PCMH program. More than 1.3 million Blue Cross members have access to a PCMH-designated practice. According to BCBSM, the Michigan PCMH program saved an estimated $626 million from July 2008–June 2017. ■

CODING FOR CORONAVIRUS

As the world tries to take back control from the coronavirus (COVID-19), healthcare organizations are working to create new and updated guidelines for many aspects, including coding.

Updated codes

For suspected COVID-19, not confirmed or ruled out at the encounter, **report codes for the presenting signs and symptoms.** Do not report a code for coronavirus when this diagnosis is not stated in the medical record.

Signs and symptoms without definitive diagnosis of COVID-19

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

R05 Cough
R06.02 Shortness of breath
R50.9 Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 ***also has an actual or suspected contact with or exposure to someone who has COVID-19, assign*** **Z20.828,** Contact with and (suspected) exposure to other viral communicable diseases, **as an additional code.**

For suspected exposure to COVID-19 ***that is ruled out after evaluation, report*** **Z03.818,** "Encounter for observation for suspected exposure to other biological agents ruled out."

If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, **do not assign code U07.1.** Assign a code(s) explaining the reason for encounter (such as fever) and Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

Using current codes

What you need to know: Current ICD-10-CM codes providers could use to code for the virus (prior to April 1, 2020 claims).

Pneumonia

For a pneumonia case confirmed as due to COVID-19, assign codes:

J12.89 Other viral pneumonia
B97.29 Other coronavirus as the cause of diseases

Acute Bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes:

J20.8 Acute bronchitis due to other specified organisms
B97.29 Other coronavirus as the cause of diseases

Lower Respiratory Infection

If the COVID-19 is documented as being associated with a lower respiratory infection, or an acute respiratory infection, assigned codes:

J22 Unspecified acute lower respiratory infection
B97.29 Other coronavirus as the cause of diseases

SARS-associated

For classifying the SARS-associated coronavirus, providers could use:

J12.81 Pneumonia due to SARS-associated coronavirus
B97.21 Sepsis due to SARS-associated coronavirus

New codes released

Due to the "urgent need to capture the reporting of [COVID-19] in our nation's claims and surveillance data," the CDC made the unprecedented move of changing the effective date of the new diagnosis codes. Note that these new ICD-10 and CPT codes may not yet be in EMR systems. Practices should contact EMR providers for assistance.

- **Effective 4/1/20: The new ICD 10 code is U07.1: COVID-19**
- Effective 3/16/20: The new CPT code is 87635: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
- The new CPT code is under parent code 87471: Infectious agent detection by nucleic acid (DNA or RNA)

More information on these codes and other guidelines can be found at cms.gov (search coronavirus). ■

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20952 12 Mile, Ste. 130
St. Clair Shores, MI 48081

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