# Practice Roundtable Meeting

**Agenda**

**July 23, 2015 – 8:30 am-10:30 am**

*Oregon Medical Education Foundation Event Center*

For those attending by telephone: Dial 1-888-387-8686, Room Number 226-1554#

## Topics

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Call to Order – Danielle Sobel, OMA</td>
</tr>
<tr>
<td>2.</td>
<td>Oregon RX Card – Sponsor presentation</td>
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<tr>
<td>3.</td>
<td>HEDIS-Quality Reporting Requirement and Medical Record Requests – Penny Warnall, Providence Health Plans</td>
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<tr>
<td>4.</td>
<td>Oregon Health Leadership Council (OHLC) EDI Workgroup – Rohit Thukral (Thuky), Tealeaf Associates</td>
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<tr>
<td>5.</td>
<td>Medical Professional Liability Claim Statistics and Trends – Brian Boe, CNA</td>
</tr>
</tbody>
</table>
| 6. | OMA Updates –  
   - OMA Toolkits- Patient Referrals and Virtual Credit Cards |
| 7. | Whatever else is on your mind |

**ADJOURNMENT**

Brought to you by: [Oregon Rx Card](http://www.oregonrxcard.com)

*Next Practice Roundtable: October 15*
Terminology

- HEDIS – Healthcare Effectiveness Data and Information Set
  - Standard set of performance measurement questions used by >90% of health plans. HEDIS began in 1991.
  - Measures health plans, not medical groups (though health plans may turn around and assess medical groups)
  - Allows benchmarking performance
  - Organizations, such as Consumer Reports, assess health plan ratings on performance
- HP-CAHPS – Consumer Assessment of Health Care Providers and Systems for Health Plans
  - Similar to Clinician Group CAHPS (CG-CAHPS) primary care offices use
  - Separate CAHPS surveys for Medicare, Marketplace, and Commercial
  - Oregon Health Authority administers CAHPS at the CCO level
  - Vendor administered survey to ~800 individuals per LOB
  - Approximately 80 questions, standardized, and benchmarked
Health Plan Key Quality Programs – Why we care…

1. CMS 5 Star Rating Program for Medicare Advantage

2. QRS (quality rating system) for QHP (qualified health plans); a CMS administered program for Marketplace (exchange and off-exchange)

3. NCQA Accreditation for Health Plans

4. Health Share of Oregon CCO Incentive Measures Program

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Oregon 2015 CMS Star Ratings

<table>
<thead>
<tr>
<th></th>
<th>Part C rating</th>
<th>Part D rating</th>
<th>Overall Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser NW</td>
<td>5 Stars</td>
<td>5 Stars</td>
<td>5 Stars</td>
</tr>
<tr>
<td>Providence</td>
<td>4.5 Stars</td>
<td>4.5 Stars</td>
<td>5 Stars</td>
</tr>
<tr>
<td>Moda</td>
<td>4 Stars</td>
<td>4.5 Stars</td>
<td>4 Stars</td>
</tr>
<tr>
<td>Regence</td>
<td>3.5 Stars</td>
<td>3.5 Stars</td>
<td>3.5 Stars</td>
</tr>
<tr>
<td>PacifiSource (HMO)</td>
<td>4 Stars</td>
<td>4 Stars</td>
<td>4 Stars</td>
</tr>
<tr>
<td>Health Net</td>
<td>4.5 Stars</td>
<td>3.5 Stars</td>
<td>4 Stars</td>
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<tr>
<td>CareOregon</td>
<td>3 Stars</td>
<td>3.5 Stars</td>
<td>3.5 Stars</td>
</tr>
<tr>
<td>FamilyCare</td>
<td>3 Stars</td>
<td>3.5 Stars</td>
<td>3 Stars</td>
</tr>
</tbody>
</table>
NCQA Health Plan Accreditation
Commercial and Marketplace (Exchange)

<table>
<thead>
<tr>
<th>NCQA Excellent</th>
<th>NCQA Commendable</th>
<th>NCQA Accredited</th>
<th>NCQA Interim*</th>
<th>NCQA In Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Lifewize</td>
<td>PacificSource</td>
<td>OR Health Co-Op Health Republic</td>
<td>Providence Regence</td>
</tr>
<tr>
<td>United*</td>
<td>Moda</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cigna</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser</td>
<td></td>
<td></td>
<td></td>
<td>Providence Regence</td>
</tr>
<tr>
<td>Lifewize</td>
<td>Moda</td>
<td>Kaiser</td>
<td>Health Republic</td>
<td>Health Republic</td>
</tr>
<tr>
<td>Moda</td>
<td>PacificSource</td>
<td></td>
<td>OR Health Co-op Trillium</td>
<td>Regence</td>
</tr>
<tr>
<td>Cigna</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PacificSource</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NCQA Interim is Standards only – Performance outcomes measures are not scored

NCQA Scoring

- 50 points from standards
  - Quality (14.65)
  - Utilization Management (13.35)
  - Credentialing (7.7)
  - Rights & Responsibilities (8.2)
  - Member Connections (6.1)

- 13 points from HP-CAHPS
  - Getting Needed Care
  - Getting Care Quickly
  - Rating of Health Care
  - Rating of Personal Doctor
  - Rating of Specialist
  - Customer Service
  - Claims Processing
  - Rating of Health Plan

We need your help for these survey questions!!

- 37 points from HEDIS
Oregon Health Authority CCO
17 Performance Incentive Measures

- Screening for Depression
- Controlling HBP
- HbA1c Poor Control
- Effective Contraception (claims)
- Developmental Screening (claims)
- ED Utilization (claims)
- PCPCH enrollment (OHA data)
- EHR adoption (meaningful use)
- Early Elective Delivery (hospitals)
- SBIRT (claims)
- Colorectal Cancer Screening
- Prenatal Care
- CAHPS - Access to Care
- CAHPS – Satisfaction with Care

CCOs measure these through
Electronic Health Records

Medicaid plans will field these two
measures in your office or EHR

Adult Primary Care Commercial
(and marketplace) Measures

- Adult BMI assessment
- Chlamydia screening
- Breast, Cervical, Colorectal cancer screening
- COPD treatment steroid and bronchodilator; spirometry
- Antidepressant med mgt (acute / continuation)
- Asthma med management
- Persistence of beta blocker
- Prenatal care; Postpartum care
- Controlling HBP
- Diabetes: HbA1c, retina, BP control, nephropathy
- Avoidance of Abx in adults with bronchitis;
- Initiation and Engagement of alcohol or other drug dependence treatment
- Use of imaging studies for Low Back Pain
**Pediatric Commercial (and marketplace) Measures**

- Immunizations (adolescents, childhood)
- Well Child visits 0-15 months
- Chlamydia screening
- Appropriate testing for children w/ pharyngitis
- Weight assessment, counseling for nutrition and physical activity (children)
- Appropriate tx for children with URI
- Pediatric BMI assessment
- Follow up care for ADHD (initiation and continuation)

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**Fielding Measures**

- Once a year, for all health plans, fielding occurs between Feb-May
- We are allowed to review charts for inclusions (numerator hits) or exclusions for some measures (when HEDIS tells us we can)
- These include:
  - BMI
  - Colorectal and Cervical Cancer screening
  - Pediatric weight, nutrition counseling, physical activity counseling
  - Diabetes Care Measures
  - Prenatal and Postpartum Care
  - Controlling High BP

- Health Plans may use Vendors to do the chart review (PHP does not)
- We require copies of records for auditing purposes
- HEDIS is externally audited for all health plans
How you can help….

- Electronic Health Record access with access to a printer
- Remote access
  - Reduces inconvenience of needing space in your office
  - Reduces costs of being out of the office, need for taking copies which contributes to lowering premium costs
- Clear documentation
  - Follow through with calculating BMI
  - Clear documentation indicating counseling for nutrition and physical activity in children
  - Allow time and recheck BP if high; then document the new BP
  - Indicate to whom you referred the patient for their diabetic eye exam or better yet, assure you receive the record, and it is in your EHR
- Automate CPT2 codes
  - These are non-billable codes that come across claims for BMI, BP, diabetes, OB
  - If you bill these codes, and they result in a positive numerator hit, we will not be required to review those records in your office!

Questions?

Penny Warnell, RN
CPT CATEGORY II CODES

This is not a complete list of CPT Category II codes - refer to the AMA CPT Standard Edition® for a full list. Refer to the NCQA Volume 2 HEDIS Technical Specifications 2015® for a complete list of codes in the administrative specifications for each measure.

<table>
<thead>
<tr>
<th>HEDIS/Other Measure</th>
<th>Indicator Description</th>
<th>CPT Category II Codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment</td>
<td>BMI assessed/documeted</td>
<td>3008F</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Blood pressure readings</td>
<td>3074F, 3075F, 3077F, 3078F, 3079F, 3080F</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care</td>
<td>A1c test &amp; A1c level</td>
<td>3044F, 3045F, 3046F</td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>2022F, 2024F, 2026F, 3072F</td>
</tr>
<tr>
<td></td>
<td>Nephropathy screening</td>
<td>3060F, 3061F, 3062F, 3066F, 4010F</td>
</tr>
<tr>
<td></td>
<td>Blood pressure readings</td>
<td>3074F, 3075F, 3077F, 3078F, 3079F, 3080F</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care</td>
<td>Patient care</td>
<td>0503F, 0500F, 0501F, 0502F</td>
</tr>
</tbody>
</table>

* Codes listed in bold typeface qualify as administrative numerator positive according to specifications in Volume 2 HEDIS Technical Specifications 2015®. The gray-shaded cells indicate codes where the only other source for the data is extraction from an EMR or manual chart review, rendering the CPT Category II code the sole electronic data source.

<table>
<thead>
<tr>
<th>Category II Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0503F</td>
<td>Postpartum care visit</td>
</tr>
<tr>
<td>0500F</td>
<td>Initial prenatal care visit</td>
</tr>
<tr>
<td>0501F</td>
<td>Prenatal flow sheet documented in medical record by first prenatal visit</td>
</tr>
<tr>
<td>0502F</td>
<td>Subsequent prenatal care visit</td>
</tr>
<tr>
<td>2022F</td>
<td>Dilated retinal eye exam interpreted by ophthalmologist/optometrist</td>
</tr>
<tr>
<td>2024F</td>
<td>7 standard filed stereoscopic photos w/interpretation by eye professional</td>
</tr>
<tr>
<td>2026F</td>
<td>Eye imaging validated to match dx from 7 std stereoscopic photos results</td>
</tr>
<tr>
<td>3044F</td>
<td>Most recent HbA1c level less than 7.0%</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent HbA1c level between 7.0 – 9.0%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent HbA1c level greater than 9.0%</td>
</tr>
<tr>
<td>3008F</td>
<td>BMI documented</td>
</tr>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3061F</td>
<td>Negative microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3062F</td>
<td>Positive microalbuminuria test result documented &amp; reviewed (confirm + with lab results)</td>
</tr>
<tr>
<td>3066F</td>
<td>Documentation of tx for nephropathy (dialysis, ESRD, CRF, ARF, renal</td>
</tr>
<tr>
<td></td>
<td>insufficiency, nephrologist visit)</td>
</tr>
<tr>
<td>3072F</td>
<td>Low risk for retinopathy (no evidence of retinopathy in prior year)</td>
</tr>
<tr>
<td>3074F</td>
<td>Most recent systolic blood pressure &lt;130 mm Hg</td>
</tr>
<tr>
<td>3075F</td>
<td>Most recent systolic blood pressure 130-139 mm Hg</td>
</tr>
<tr>
<td>3077F</td>
<td>Most recent systolic blood pressure &gt;=140 mm Hg</td>
</tr>
<tr>
<td>3078F</td>
<td>Most recent diastolic blood pressure &lt;80 mm Hg</td>
</tr>
<tr>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80-89 mm Hg</td>
</tr>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure &gt;=90 mm Hg</td>
</tr>
<tr>
<td>4010F</td>
<td>ACEI or ARB therapy prescribed or currently being taken</td>
</tr>
</tbody>
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Improving EDI Services – via Intermediaries.

The Oregon Medical Association (OMA) and the Oregon Health Leadership Council’s EDI Workgroup are collaborating on an initiative aimed at improving EDI transaction related services available to the healthcare Provider community within the State of Oregon.

On July 23, 2015 a team from OHLC’s EDI Workgroup will attend the Provider Roundtable meeting and engage the attendees in a discussion to understand the problems and issues being faced by practice managers and administrators when submitting standard HIPAA electronic transactions to health plans.

Health Plans are required to accept, process, and respond to these HIPAA transactions. Many providers submit these transactions via an intermediary or Clearinghouse such as Relay Health, Availity, SecureEDI, WebMD, Payer Connection etc. The inability to successfully transmit all the EDI transactions could be a result of intermediary services not being able to address a medical practice’s range of needs.

Based on anecdotal information it appears most practices have no trouble submitting claims via an 837 transaction. We understand that practice managers sometime confront issues with the submission of other transactions such as eligibility inquiry and response (270/271), claims inquiry and response (276/277), and receive the Remittance Advice and EFT (835) transactions.

EDI transactions are generally the cheapest and most efficient method to execute business processes between Providers and Health Plans. This initiative aims to maximize the ability of Provider practices to use these EDI transactions.

Key Steps

In order to successfully complete this initiative we intend to complete the following tasks –

- Discuss range of issues and key problems with the Practice roundtable on July 23, 2015.
- Develop and administer a survey to OMA membership to understand the range and priorities associated with open issues. Identify specific EDI support issues and the Clearinghouses concerned.
- Analyze results from survey and develop a preliminary report of issues and corresponding recommendations to address them.
- Discuss preliminary report with Clearinghouses/Intermediaries to get their feedback and response.
- Publish report with action plan for OHLC Administrative Simplification Executive Committee for further action.

Example Survey – Improving EDI Services Initiatives

The following page includes an example survey we may use to collect additional information relating to this initiative. This document is likely to change following the discussion with the Provider Roundtable.
Thinking about the electronic transactions you may use in your practice:

<table>
<thead>
<tr>
<th></th>
<th>Answer</th>
<th>If No - then Reason / Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1b</td>
<td>If Yes, which Clearinghouse(s)?</td>
<td></td>
</tr>
<tr>
<td>1c</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2a</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2b</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>None - we are able to do everything we need to do electronically</td>
<td>none / no problems</td>
</tr>
</tbody>
</table>

When receiving or sending electronic transactions via intermediaries/clearinghouses, please list issues and problems that you face and the associated priority/importance. The priority should be rated 1 (lowest) to 5 (highest).

<table>
<thead>
<tr>
<th></th>
<th>Priority</th>
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<tbody>
<tr>
<td>7a</td>
<td></td>
</tr>
<tr>
<td>7b</td>
<td></td>
</tr>
<tr>
<td>7c</td>
<td></td>
</tr>
<tr>
<td>7d</td>
<td></td>
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</tbody>
</table>

Next Steps

Please think about the improvements that could be made in the processing of EDI transactions to enable your business. Is your Clearinghouse/Intermediary/EDI service provider providing the services you need to successfully process EDI transactions and complete key business transactions?

Please bring your thoughts on this subject to the meeting. We look forward to meeting with you on June 23!

Thank you

The OMA and EDI Workgroup
OMA Toolkit: SB 683 Final Rule- Patient Notification of Referral Rights

What is this alert about?

Notification of patients about their choices when being referred for diagnostic tests or health care treatment or services at a facility such as a hospital or diagnostic testing facility.

Why is this important for physicians?

In 2013, the Oregon Legislature passed Senate Bill 683. The law required health practitioners (including physicians) when making referrals to a facility for a diagnostic test or health care treatment or service, to inform the patient that the patient may receive the test, treatment or service at a different facility of the patient’s choice.

Notably, the primary focus on the law was on referral practices inside large health care institutions. The problem, however, is that the law could be interpreted very broadly and charged the various licensing boards with authority to discipline licensees for non-compliance.

The law also directed the Oregon Health Authority to engage in rulemaking about the form and manner of how a practitioner was to inform their patients.

The rulemaking process was challenging, and the original “notification rule” was softened to reduce the administrative burden on physician practices. In late 2014, however, OHA engaged in another round of rulemaking and the notification rule was brought back in a different form.

What should physician practices do?

OMA continues to advocate on improvements to the law and the rules, and OMA generally supports the practice of physicians communicating reasonable options to patients and letting patients make informed decisions about where to receive health care services.

Under this current rule, physicians are required to notify the patient at various points in their care about their referral options. It is important to note that this notification is only required when a referral is made for a diagnostic test or service that will be performed at a facility, which is defined as a hospital, outpatient clinic owned by a hospital, ambulatory surgical center, freestanding birthing center or a facility that receives Medicare reimbursement as an independent diagnostic testing facility.
We do not want to see physicians unfairly targeted for licensure discipline for failing to adhere to rule details and so the following compliance steps are suggested:

**Step One**

Review the updated rules [here](#); the rule section that was specifically updated in 2015 was OAR 333-072-0215.

**Step Two**

Implement a notification process for patients when they establish care with your clinic. This notification can be done in writing (given as part of your new patient packet) or orally.

**Step Three**

Print out and post in waiting or exam rooms, the suggested wall posting, located [here](#) and on Page 3 of this toolkit.

**Step Four**

At the time a referral is made to a *facility*, let the patient know they have a choice and simply note that in the chart.

The requirement that a health care practitioner notify a patient if referring to an entity in which the practitioner has a financial interest (5% or more) remains in effect and must be noted in the chart in the same way as you would for a referral to a facility.

**Step Five**

Check back with OMA from time to time to see if the law or rules have changed (because they may change again).

If you have questions, you may contact the OMA’s Compliance Team at (503) 619-8000.

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"OMA Toolkit" is an informational resource from the Oregon Medical Association and is not intended as legal advice. If you need legal advice, we highly recommend you hire a good lawyer (please call OMA’s compliance team at 503-619-8000 if you need some contacts)
Oregon’s Notice of Patient Choice

Our patients come first. We value your right to make choices about your health care. When we refer you for a diagnostic test or health care treatment or service, we do so based upon our best clinical judgment.

You have a choice. As a patient you do have a choice and when we refer you to a facility for a diagnostic test or health care treatment or service, you may choose to receive the diagnostic test or health care treatment or service at a facility other than the one we recommend.

Choose carefully. As with all services, whether at the facility we recommend or at one of your choosing, you are responsible for determining your own insurance benefits and the financial obligations of your choice.

We are here to help. If you do choose a different facility, we are glad to show you where you can find the contact information for your insurance company on your insurance card. This will help you verify your insurance benefits for the facility you choose.

This notice is required by Oregon Health Authority administrative rule OAR 333-072-0215 and may be subject to change. If you have questions about this notice please let us know.
OMA Toolkit: Virtual Credit Card Payment Transparency

What is this toolkit about?

House Bill 3021, passed in the 2015 Oregon legislative session, requires insurers who use virtual credit card payments or any other form of electronic fund transfers (EFT) for reimbursing physicians to notify the practitioner in advance of any fees associated with the payment. This toolkit is meant to help you understand the different types of EFT and what Oregon’s new law means for virtual credit card payments.

Why is HB 3021 and EFT important to our clinic?

In recent years, provider payments from health plans have transitioned from paper checks to electronically submitted payments, such as ACH EFT (Automated Clearing House Electronic Funds Transfer), wire transfers, and insurer-issued virtual credit cards.

Virtual credit card (VCC) payments are subject to the highest transaction and processing fees, often up to 5%, which are automatically deducted from the total amount a provider is contractually allowed to receive. Prior to the passage of HB 3021, the provider was required to “opt-out” of VCC payments every time a payment was received, for each individual payment.

Starting in January 2016, insurers who pay via a virtual credit card or any other electronic funds transfer, may pay using this method only if all of the following criteria are met:

1) **Advance notification of fees.** The insurer must notify the provider, in advance, of the fee or other charges associated with the use of the VCC or any other percentage-based fee payment.

2) **Alternative payment option.** The insurer must offer an alternative payment method that does not impose fees, such as a paper check.

3) **Provider opt-in.** The provider or provider’s staff must agree to the payment of that claim using that payment method.

Providers should expect to be notified by an insurer in advance that the payment is a VCC and they should be given the option to reject the payment.

How do I know which electronic funds payment is best for my clinic?

The term “EFT” encompasses any transfer of funds using an electronic terminal including: credit cards, wire transfers, virtual credit card programs and bank-account-to-bank-account payments. You need to carefully evaluate your options and understand that in an electronic business world, your most cost-effective option may be to research and adopt an EFT method. The following steps are a suggested way to evaluate and select an electronic funds payment method.
Step One

Evaluate your choices by starting with a review of your health plan contracting terms. Health plans may seek to require other payment methods, such as VCC, within their contracts in order to avoid using ACH EFT. Make sure you review your health plan contracts for any restrictions in payment methods and avoid signing contracts with inflexible payment terms.

Step Two

Gain a solid understanding of ACH EFT because this HIPAA regulated method of payment, when selected by a provider, is required to be honored by health plans (effective January 2014). Due to federal oversight, the ACH EFT payment option cannot charge percentage-based fees and the health plan must make the payment available to provider at no additional cost beyond the nominal, per-transaction processing fees of the banking network (approximately $0.34). See additional resources below for more information on ACH EFT.

Step Three

Make an informed decision. If ACH EFT is a good fit for your practice, read enrollment terms, ensure that a health plan may not inappropriately debit funds from your account by working with your bank to set up debit restrictions, and review whether to select the option of choosing CCD+ format to process and reconcile the payments received.

Step Four

If you choose another method of payment and want to guard against VCC payments, ensure that you train staff who are processing payments to differentiate between patient and health plan credit card payments to avoid mistakes in unintentionally accepting health plan VCC payments and getting stuck with those higher transaction fees.

Additional Resources

1. HB 3021:  
https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB3021/Enrolled

2. NACHA EFT Frequently Asked Questions:  
https://healthcare.nacha.org/healthcareEFTFAQs


“OMA Toolkit” is an informational resource from the Oregon Medical Association and is not intended as legal advice. If you need legal advice, we highly recommend you hire a good lawyer (please call OMA’s compliance team at 503-619-8000 if you need some contacts).