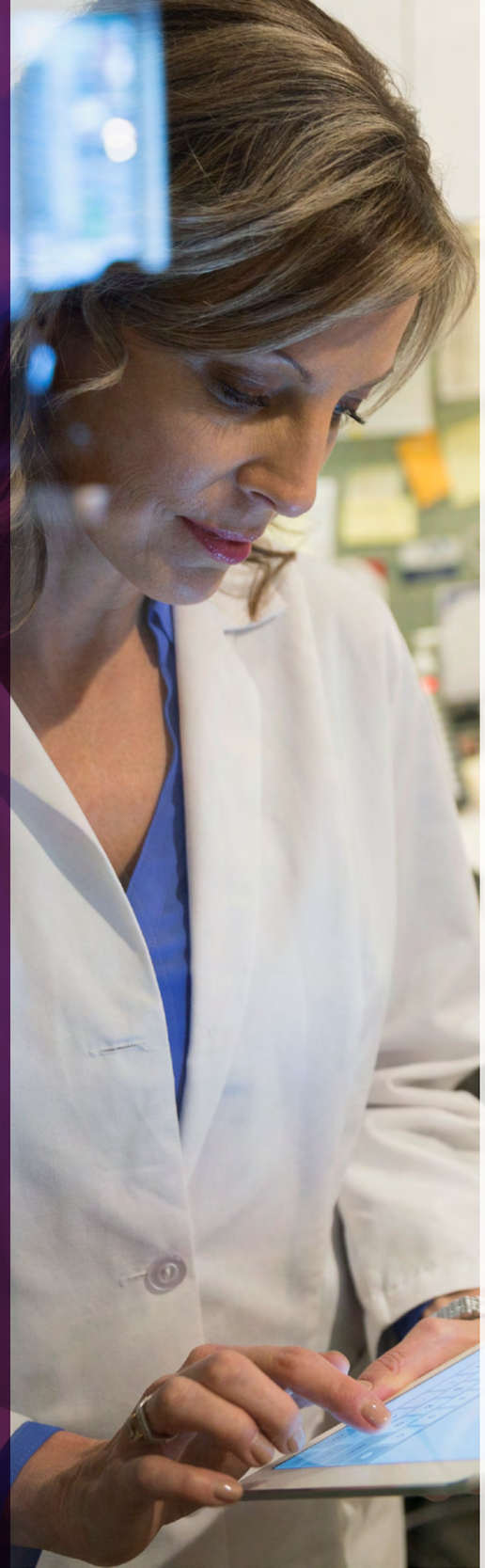
UPMC HEALTH PLAN

Provider Partner Update

December 2022

What's inside:



Provider directory updates and required attestation

As you know, UPMC Health Plan requires all providers to verify their provider directory information at least every 90 days (quarterly). This allows us to comply with CMS/DHS/PID requirements to maintain accurate directories—as well as the federal No Surprises Act (effective Jan. 1, 2022). Accurate directories are the primary way our members find in-network care.

UPMC Health Plan quality programs also require provider directory verification as a condition of participation and payment. In addition, failure to attest every 90 days may result in further action per your participating provider agreement.

Ways to keep your information current

At the beginning of each quarter, LexisNexis will be reaching out through one or more of its three communication channels (phone, fax, or online) to verify that your provider information is accurate.

You can visit the provider directory to ensure that your provider information and office details are up to date and accurate. Here is the information that must be reviewed/updated/verified:

- Ability to accept new patients
- Street address
- Phone number
- Office hours
- Hospital privileges
- If you would like to indicate in the provider directory that your practice offers telehealth services
- Any other information that affects your availability to our members

You can view your information by searching the online directory for your name at **upmchealthplan.com/find.** You can make updates to your information at **upmchealthplan.com/providers/change.html.**

If you have any questions, need help with your updates, or need to change your contact information, please contact your physician account executive or email **providernetworkinquiries@upmc.edu.**

Thank you for your support in this ongoing effort!

LexisNexis cannot change your product participation or the services contracted by your practice. If you have questions or concerns regarding product participation or contracted services, contact your physician account executive.

Patient Safety and Technology Assessment chart

The Patient Safety and Technology Assessment Committee (TAC) meets regularly to review medical technology. The TAC decides which existing medical and medical prior authorization policies need to be updated or amended or if new policies need to be developed. All policies undergo an annual review.

The following chart details recent TAC decisions. Please refer to each policy (available at **upmchealthplan.com/providers**) for complete indications and limitations. The policies have effective dates listed in the key below the chart. You can view upcoming changes to medical policies at **upmchp.us/ProviderRLDocs.**

Title – Policy #	Products	Policy Change Description/Summary of New Policy
Injections for Pain Management – MP.090**	All	Under Indications, removed requirement for six months or longer for chronic pain symptoms for SI injections. Added Stenosing tenosynovitis as an indicator for code 20550 and increased limit to one digit per side per calendar year same day bilateral allowed. CPT codes 64490 64491 64493, and 64494 are one unilateral injection per level, maximum of two levels per visit but increased to a maximum of four visits per calendar year.
Injections – Trigger Point and Epidural – MP.098**	All	Codes 62320, 62321, 62322, 62323, 64479, and 64483 to be allowed three times per calendar year (up from two). Other editorial changes.
Private Duty Nursing-Commercial and CHIP – MP.PA.050**	CM and CHIP	Removed codes S9123 and S9124 and replaced with codes T1002 and T1003.
Milk Bank, Human Donor (HDMB) Services, Outpatient – MP.PA.108**	CM, MA, and CHIP	Language was added to clarify Indication #5 criteria. The remainder of the changes were editorial.
CardioMEMS Heart Failure Monitoring System – MP.PA.103**	All	This is a new policy.
Hypoglossal Nerve Stimulators – MP.PA.126**	All	The minimum age for Commercial was changed to 18 from 21. No changes to any other lines of business.
Orthopedics, Upper Limb – Hand/Wrist – MP.180**	All	Editorial and formatting updates throughout and minor updates to specific indications for tendon sheath incision/excision hand flexor, tendon transfer hand/forearm, and ulnar nerve compression at wrist. Coding updates: CPT 25111, 25112, and 26055 added the following ICD-10: M1A.041, M1A.042, M1A.9XX1, M10.041, M10.042, M10.9, M24.841, M24.842, M1A.9XXO. CPT 26160 added the following ICD-10: M1A9XX0. CPT 25310, 25312, 25315, 25316, 26483, 26485, 26489, 26490, 26492, 26497 and 26498 added the following ICD-10: M24.841, M24.842. Removed M65.31 and M65.32 for CPT 26055 and 26160.
Prostate Needle Biopsy, Adult – MP.185**	All except CHIP	Distinction between "initial" and "repeat" removed. Code 55706 no longer considered E/I for all lines of business. Other editorial changes.
Experimental and Investigational Services – MP.PA.079**	All	Minor editorial change; moved section on coding required for correct claims submission to bottom of Indications section. Language in MA Variations was modified to add: "Upon request through Program Exception from the member's treating provider, UPMC ISD medical directors will consider circumstances identified by the provider in which treatment may provide significant benefit for the member and/or be a more cost-effective intervention."
Pancreatectomy with Islet Cell Transplantation – MP.PA.095**	All	Editorial revision clarifying that policy allows coverage only for CPT 48160. Coding changes: Seven other procedure codes were moved to E&I code list (noting potential MC coverage for G0341-G0343 only with enrollment in NIH-supported research. Codes 0584T-0586T and S2102 are E&I and are not FDA approved.
Outpatient Physical Therapy – MP.PA.129**	All except CHIP	CHIP was removed from the Line of Business grid. Added physical therapy assistants under the proper supervision of physical therapist under Policy. Added some definitions and removed one that was already defined in another definition. Under Limitations #17, Hippotherapy was added and removed all the indications that stated if covered for Medicare or not. Under Variations, removed all the language regarding services that can be found in NCDs or LCDs and added the appropriate references. Code was removed that was not covered.
Not Medically Necessary – Medicare – MP.151**	MC	CPT code 43285 will be covered for removal of LINX device (change from E&I status).
Skilled Nursing and Personal Care Shift Services – Medical Assistance – MP.PA.050.1*	MA	Replaced codes S9123 and S9124 with code T1002 and T1003 to adhere to 15-minute units for personal care services.
Gender Affirmation Surgery – Commercial, Medicare, CHIP – MP.PA.102.1*	CM, MC, and CHIP	Unlisted CPT code 17999 was added for laser hair removal. Significant edits include: definitions were added; qualifications of electrolysis providers were liberalized/clarified; language modified throughout to clarify existing coverage and documentation requirements, especially for criteria for stand-alone permanent hair removal and other independent gender affirming services (relevant CPT codes were noted for these for reference as well); Information for Review requirements were clarified corresponding to the modifications made in Indications. CPT code 19324 was removed due to the deletion of the code.
Air Conduction Hearing Aids and Devices – MA 21 and Over – MP.PA.116*	MA and CHC	ICD-10 codes H90.0 and H90.2 were added. The remainder of changes were editorial.
Home Accessibility DME – Medical Assistance and Community HealthChoices – MP.PA.120*	MA and CHC	Added reference to policy MP.PA.010 – DME-General for repairs and replacements. Reworded the first specific indication and reformatted. Added UPMC Community HealthChoices to lines it was needed and added other qualified practitioner in places where discusses order physician. Removed the sentence regarding program exceptions requests from the coding area.
Endoscopy, Upper, Adult only – MP.PA.122*	All	This policy is being retired.
Benign Skin Lesion Removal – MP.195*	All	This is a new policy.

CT Angiography of Chest, Heart, and Coronary Arteries – MP.150**	All	Extensive rewriting, new title; with the addition of CPT 75572 and 75573 with covered ICD-10 codes, the policy governs four imaging procedures; the separate MC diagnosis code list for CPT 75574 is merged into a single list for all LOB (since no applicable LCD/LCA here); and E&I codes section expanded. Also, quarterly coding updates were incorporated into this annual review.
Orthopedics, Upper Limb – Elbow – MP.181*	All	Updated Indications for elbow epicondyloplasty and ulnar nerve compression regarding pre-procedure treatments. Policy is now less restrictive.
Diagnostic Nasal/Sinus Endoscopy – MP.186*	All	This is a new policy.
Pelvic Organ Prolapse – MP.188*	All	This is a new policy.
Panretinal Photocoagulation, Adult – MP.191*	All except CHIP	For CPT code 67228: Delete ICD 10 code H35.00. Add H35.011, H35.012, H35.013, and H35.062. Editorial changes to medical background, specific indications and limitations. Clarified criteria for very severe non-proliferative diabetic retinopathy (NPDR) to indicate you need two of the findings.
Tonsillectomy, Adult – MP.193*	All except CHIP	ICD-10 E66.2 was added as a covered diagnosis.
Debridement Services – MP.196*	All	This is a new policy.

***This policy is effective Dec. 31, 2022.*
**This policy is effective Jan. 1, 2023.*

Coming soon: Formulary updates effective Jan. 1, 2023

Please review updated information for the prescription drugs covered under each plan.

UPMC Health Plan Commercial Plans

View Advantage Choice formulary updates:
upmchp.us/acformularychanges

View Your Choice formulary updates:
upmchp.us/ycformularychanges

UPMC *for Life* plans

View UPMC *for Life* formulary updates:

- UPMC *for Life*: MC Complete Care – **upmchp.us/MCcompletecareRxformulary**
- UPMC *for Life* Premier Rx: MC Advantage Rx – **upmchp.us/MCadvantageRxformulary**
- UPMC *for Life* Complete Care (HMO SNP): MC Premier Rx – **upmchp.us/MCpremierRxformulary**

Exception request options

Requests for exceptions can be submitted to Pharmacy Services by one of the following methods:

- Online: Via SureScripts ePA or through the portal at **upmc.promptpa.com**
- Phone: **1-800-979-8762**
- Fax: **412-454-7722**
- Forms can be found at: **upmchp.us/ProviderPharmacyPAForms**

Questions?

Please contact your physician account executive if you have questions about any of these updates.

Preventive care changes for 2023

Effective Jan. 1, 2023, UPMC Health Plan will no longer reimburse for procedures billed with codes from the UPMC *for Life* enhanced benefit fee schedule listed below.

This change is consistent with the Center for Medicare and Medicaid (CMS) Medicare fee schedule. Claims with these codes will be denied with no member liability.

HCPCS/CPT code*	Short description
99385	PREV VISIT NEW AGE 18-39
99386	PREV VISIT NEW AGE 40-64
99387	PREV VISIT NEW PAT 65+ YRS
99395	PREV VISIT EST AGE 18-39
99396	PREV VISIT EST AGE 40-64
99397	PREV VISIT EST PAT 65+ YR

However, we will continue to offer full coverage for annual wellness visits (AWV).

Annual physical exam vs. the annual wellness visit

- **Annual physical exam** – This is an assessment of health. The primary purpose is to look for **health problems.**
- **Annual wellness visit** – This is an assessment of overall health and well-being. The primary purpose is **prevention**—either to develop or update personalized prevention plans.

UPMC *for Life* encourages members to get their annual wellness visit. This important visit gives you the time you need to catch up with your patients and create or update their personal care plan. Plus, all UPMC *for Life* members can earn a **$30 reward card** for completing an annual wellness visit either in the office or through telehealth!

To learn more about the annual wellness visit as well as other preventive screenings and rewards, visit our website at **upmchp.us/medicare-preventive-care.**

Stay tuned for more information

You will receive a letter with additional details regarding code changes 30 days prior to the change being effective.

UPMC Health Plan does not practice medicine or exercise control over the methods or professional judgments by which providers render medical services to members. Nothing in these materials should be construed to supersede or replace the clinical judgment of a provider.

The provider of care is ultimately responsible for providing accurate and compliant information on all submission of claims and/or billing information.

Biosimilars are here

UPMC Health Plan always is looking for ways to improve the value and affordability of our members' health care benefits. Historically, controlling cost in the area of biologic drugs has been challenging.

However, the recent launch of lower-cost biosimilars for these high-cost biologic drugs provides a path to significant cost savings for members/patients, providers, and payers. Since biosimilars are highly similar to and have no clinically meaningful differences from their existing FDA-approved reference products, they offer the same level of safety and quality you are used to experiencing with the reference products.

Effective Jan. 1, 2023, UPMC Health Plan will begin preferring certain biosimilars in addition to the already-covered reference products. For UPMC Health Plan (Commercial/Exchange), UPMC *for Kids* (CHIP) and UPMC *for Life* (Medicare/Special Needs Plan) formularies, the updates apply to the following chemical entities: bevacizumab, trastuzumab, infliximab, rituximab, pegfilgrastim, filgrastim, and epoetin alfa. For UPMC *for You* (Medical Assistance) and UPMC Community HealthChoices (CHC) formularies, the updates apply only to the following chemical entities: bevacizumab, trastuzumab, and rituximab. Any member with a current, active authorization on file for the chemical entity who switches to a preferred biosimilar or reference product will not need an updated authorization.

Regarding UPMC *for You* and UPMC Community HealthChoices: In Pennsylvania, all Medicaid managed care organizations and fee-for-service (FFS) models must utilize a statewide preferred drug list (PDL) and follow the formulary coverage as determined by the Department of Human Services (DHS) for drugs included on the PDL.

The DHS Statewide PDL, including coverage status for infliximab, pegfilgrastim, filgrastim, and epoetin alfa products, may be accessed at **papdl.com.**

Chemical entity	Preferred products
BEVACIZUMAB	AVASTIN MVASI
TRASTUZUMAB	HERCEPTIN TRAZIMERA
INFLIXIMAB	REMICADE INFLIXIMAB RENFLEXIS
RITUXIMAB	RITUXAN RUXIENCE
PEGFILGRASTIM	NEULASTA UDENYCA
FILGRASTIM	NEUPOGEN NIVESTYM
EPOETIN ALFA	PROCRIT RETACRIT EPOGEN

Berwick Hospital closure

On Oct. 14, 2022, Berwick Hospital closed.

Berwick Hospital
701 East 16th St.
Berwick, PA 18603

UPMC Health Plan has sent letters to patients affected by the closure. Berwick Hospital will continue to provide geriatric inpatient psychiatric services at this location.

Digital pediatric lifestyle services available through Prescription for Wellness

Prescription for Wellness provides an operationally friendly mechanism for providers to prescribe health coaching and care management resources to their patients who are UPMC Health Plan members. Patients and families of all ages have access to several core lifestyle services, and personalized sessions based on their individual needs.

Healthy Families is family-centered coaching designed to empower parents to shape the health of their families through healthy habits and skills. For patients who prefer a digital experience, Healthy Families is now available for patients 16 years old and older on our RxWell mobile app.

Through RxWell, patients have access to:

- Personalized, evidence-based programs.
- Digital support from a live health coach via chat.
- Tracked progress to assist with identifying patterns of behavior.
- Proven results—patients may see results in just one month.

The Healthy Families program is delivered via the app with support from a digital lifestyle health coach via asynchronous chat. Participants work though a total of four chapters within this curriculum:

1. **Finding a Focus** – This sets program expectations, introduces the six healthy habit changes, and asks participants to select a focus.
2. **Mindful Parenting** – Participants learn about cultivating acceptance, mindfulness, and the benefits of these skills in parenting.
3. **Family Mindfulness** – Participants learn six mindfulness exercises for children.
4. **Keeping it Going** – Participants learn about managing and reframing discouraging thoughts.

Providers that would like to refer their patients for RxWell are encouraged to use the free text option within the "Special Considerations" category to document patient preference for the digital app in addition to selecting Healthy Families. Patients will need to have access to a mobile device and email address to participate in RxWell programs.

For more information on Prescription for Wellness, contact your physician account executive or email director Jamie Delu at **RxforWellness@upmc.edu.**

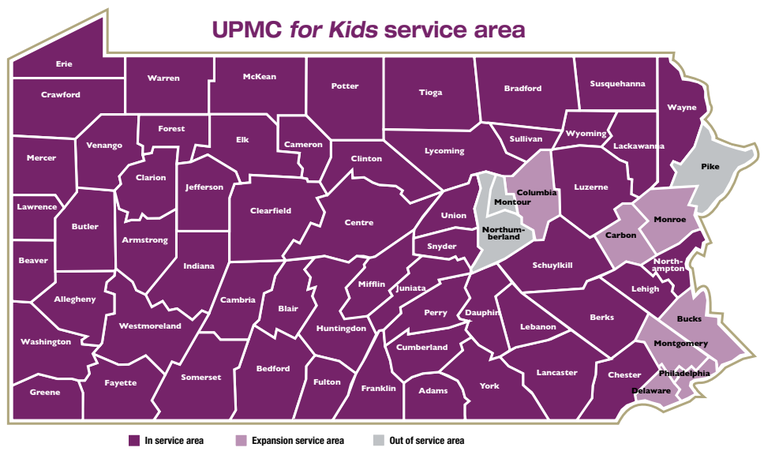
UPMC *for Kids* has expanded into seven additional Pennsylvania counties

UPMC *for Kids*, UPMC Health Plan's Children's Health Insurance Program (CHIP) plan, has expanded into seven additional counties across Pennsylvania to include Bucks, Carbon, Columbia, Delaware, Monroe, Montgomery, and Philadelphia. Effective Dec. 1, 2022, comprehensive high-quality health insurance coverage is available to even more children and teens throughout the state.

chip Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

UPMC *for Kids*
Affiliate of UPMC Health Plan

UPMC *for Kids* service area



Pennsylvania's Children's Health Insurance Program (CHIP) is available to all uninsured children and teens (up to age 19). Regardless of family income, every uninsured child and teen who is not eligible for Medical Assistance can have comprehensive health insurance. CHIP covers doctor visits, emergency and urgent care, hospital admissions, behavioral health care, prescriptions, dental and eye care, and more. Many families will not have to pay for CHIP. Families with higher incomes will have low monthly premiums and copayments for some services. Copay amounts are included on the child's member ID card.

With UPMC for Kids, families have in-network access to the top-ranked hospitals of UPMC. Our network includes 40 UPMC hospitals, more than 29,000 physicians (including specialists), and more than 100 community and neighborhood hospitals. It also includes more than 65,000 pharmacies nationwide. Children enrolled in CHIP are required to select a primary care provider. This can be a pediatrician, a family practitioner, or an internal medicine doctor. A referral is not required for a child to see a specialist who participates in the UPMC *for Kids* network.

Applying for CHIP is easy, and our dedicated UPMC *for Kids* team can help. A parent or legal guardian can apply for CHIP for their child(ren) by calling us at **1-800-978-8762 (TTY: 711)** Monday through Friday from 8 a.m. to 6 p.m. They can also apply online by visiting the state COMPASS website at **compass.state.pa.us.**

For more information on UPMC *for Kids*, contact your physician account executive or network manager, or call UPMC *for Kids* Provider Services at **1-800-650-8762** (option 2) Monday through Friday from 8 a.m. to 5 p.m. You can also find additional information about UPMC *for Kids* on Provider OnLine at upmchealthplan.com/providers or the UPMC *for Kids* website at **upmchealthplan.com/forkids.**

Note: All in-network providers who render, order, refer, or prescribe items or services to CHIP members are required to have a valid PROMISe™ ID (also known as MMIS provider ID) from the state of Pennsylvania. A provider must register for a PROMISe ID at each service location where he or she provides services to CHIP enrollees. To apply for a PROMISe ID, enroll additional service locations, or check the status of your application, visit **provider.enrollment.dpw.state.pa.us.**

Health care Fraud and Abuse laws

The False Claims Act
Statute: 31 U.S.C. §§ 3729–3733

The Anti-Kickback Statute
Statute: 42 U.S.C. § 1320a–7b(b) Safe Harbor Regulations: 42 C.F.R. § 1001.952

The Physician Self-Referral Law
Statute: 42 U.S.C. § 1395nn Regulations: 42 C.F.R. §§ 411.350–.389

The Exclusion Authorities
Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5 Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)

The Civil Monetary Penalties Law
Statute: 42 U.S.C. § 1320a–7a Regulations: 42 C.F.R. pt. 1003

Criminal Health Care Fraud Statute
Statute: 18 U.S.C. §§ 1347, 1349

For more information on these laws, please visit:
oig.hhs.gov/compliance/physician-education/01laws.asp

Tune in to season 2 of *Good Health, Better World*

Episodes focus on behavioral health

GH,BW good health, better world

Join Dr. Ellen Beckjord as she discusses some of health care's most important (and often challenging) topics:

- **Laying the foundation for behavioral health** with Diane Holder and Dr. James Schuster
- **Building resilience through trauma-informed care** with Dr. Kimberly Blair and Dr. Lyndra Bills
- **Adolescent and pediatric behavioral health** with Dr. Johanna Vidal-Phelan and Dr. Abigail Schlesinger
- **Opening up about addiction** with Dr. Michael Lynch and Dr. Antoine Douaihy
- **Behavioral health and resilience in the workplace** with Jim Kinville and Nancy Mckee
- **What is integrated care?** with Dr. Alin Severance and Dr. Charles Jonassaint
- **Supporting the mental health of older adults** with Perri and Dr. Shannah Tharp-Gilliam
- **Innovation in behavioral health treatment** with Dr. Matthew Hurford and Dr. Geoffrey Neimark

Listen to season 2 now to catch up on all the episodes.

CME webinar: 988 Suicide and Crisis Lifeline (recorded)

What the webinar will cover*

Pennsylvania and its approach to 988 will:

- Provide medical professionals with information and data related to suicide.
- Offer background on the National Suicide Prevention Lifeline, a national toll-free resource for anyone to call during a mental health crisis, including its new 988 phone number that gives Pennsylvanians access to 24/7 crisis support.
- Educate providers on the lifeline's support, prevention, and crisis resources.
- Highlight the importance of educating patients, families, and communities about the lifeline.

Presenters:

- Matthew B. Wintersteen, PhD, Associate Professor, Director of Research, Thomas Jefferson University/ Jefferson Medical College, Department of Psychiatry & Human Behavior
- Alin Severance, MD, Medical Director, Behavioral Health Services, UPMC Health Plan; Associate Medical Director, Community Care Behavioral Health Organization

Watch now

Watch the recording of the webinar.

Provider is responsible for verifying CME eligibility.

**This activity is approved for AMA PRA Category 1 Credit™ and ANCC. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.*

Collaborating to improve completion of well-child and dental visits

To support both our members and provider partners in scheduling well and dental visits, UPMC *for You* will continue our outreach campaign to parents and guardians of our pediatric members throughout 2022. Our goal for these calls is to help families stay up to date on annual preventive visits.

We have engaged Clark Resources outbound call center to conduct this outreach on our behalf.

Clark Resources provides the following services to Medical Assistance households:

- An agent reminds the caregiver of the need for well and/ or dental visits for all children in the household.
- The agent then attempts to schedule needed appointments with provider of choice via a three-way call. If the member doesn't have a primary care provider (PCP) or primary dental provider (PDP), the agent will help the caregiver find a participating provider near their home address.
- Agents confirm with the caregiver that they do not have any concerns with transportation to and from the scheduled appointment(s). If needed, the agent will connect the member with Medical Assistance Transportation Program (MATP) to arrange transportation to the scheduled appointment(s).
- Once Clark Resources schedules an appointment, the agent will note it in the UPMC *for You* system. The member will receive reminder calls in advance of the appointment, in addition to any reminders from your office.

To support this effort, please let your office staff know about these outreach calls. A positive experience with scheduling can build cooperation and solidarity among members, your staff, and UPMC *for You*. We hope this collaboration between the Health Plan, PCPs, and members will have a positive effect on the completion of both well-child and dental visits for our members ages 3-21.

UPMC VirtualCare is expanding into Small Groups

UPMC Health Plan is excited to announce that UPMC VirtualCare, the innovative product initially offered on the Individual Marketplace, will expand into the Small Group market for coverage starting Jan. 1, 2023. UPMC VirtualCare offers low-cost care options and the choice to see providers virtually or in-person.

UPMC VirtualCare will be offered in the Small Group market with Partner Network only in Allegheny and Erie counties. UPMC VirtualCare will continue to be offered in the Individual Market with the Partner and Select Networks in Allegheny, Beaver, Bulter, Fayette, Washington and Westmoreland counties.

With UPMC VirtualCare, members have:

- $0 virtual visits for PCP, behavioral, urgent care*, and wellness.**
- Reduced cost-share for virtual specialist visits.
- Competitive premiums.
- Access to top-quality providers.
- The choice to see their participating provider in-person with a cost-share.
- The option to receive mail order maintenance medications.

Are you a provider in the Partner or Select Network? Here are some helpful things to know.

- UPMC VirtualCare members are likely to request virtual visits given the cost savings in their plan design. Members are not required to have virtual visits before seeking in-person care. The modality in which care is delivered is determined by the provider and the patient, as clinically appropriate.
- Adult well-visits are covered at 100 percent for UPMC VirtualCare members via telehealth and in-person.
- Members can use the UPMC Health Plan provider directory to confirm their provider is telehealth-enabled.
- Providers can conduct virtual visits with their patients on their existing telehealth platform.
- Reimbursement is the same for visits conducted virtually and in-person.

**$0 virtual urgent care services and UPMC Children's AnywhereCare are provided on UPMC AnywhereCare.*

UPMC Health Plan members located in Pennsylvania at the time of a virtual visit may select a UPMC-employed provider or a provider from Online Care Network II PC (OCN), subject to availability and discretion of the provider. UPMC Health Plan members located outside of Pennsylvania will receive service from OCN. OCN is not an affiliate of UPMC. During the COVID-19 emergency, UPMC *for Kids,* UPMC Community HealthChoices, and UPMC *for You* members located outside of Pennsylvania will receive service from OCN. After the COVID-19 emergency, UPMC AnywhereCare virtual visits will not be covered services when UPMC *for Kids*, UPMC Community HealthChoices, and UPMC *for You* members are traveling outside of Pennsylvania.

UPMC Children's AnywhereCare is available only to patients who are in Pennsylvania. In order for a child to have a UPMC Children's AnywhereCare visit, the child's parent or legal guardian must be with the child during the video portion of the visit, and the child and parent or legal guardian must be in Pennsylvania during the visit. Members who are outside of Pennsylvania at the time of service may select the standard UPMC AnywhereCare module and receive care from a provider employed or contracted by Online Care Network II PC (OCN) at the discretion of the provider. OCN is not an affiliate of UPMC.

***100 percent coverage refers to eligible office visits and adult well-visit services that otherwise constitute covered services. All coverage is subject to the terms of UPMC Health Plan policy and the member's benefit plan.*

Listening to and acting on feedback

Our goal is to verify that our members have access to high-quality care. As a partner in care, you are key in helping us achieve this goal. Surveys give us actionable information that can help improve our members' health care experiences and ensure this level of care.

Gathering feedback

Every year, UPMC Health Plan members provide anonymous feedback on their health care experiences in these ways:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Commercial, Medicaid, Medicare, and CHIP members
- The Qualified Health Plan Enrollee Experience survey (QHP) for Marketplace members

Meeting accreditation requirements

These surveys are required to maintain ratings and accreditations:

- National Committee for Quality Assurance (NCQA) accreditation
- NCQA ratings

Centers for Medicare and Medicaid Service (CMS) star ratings

Reviewing the results[1]

While we know that you provide excellent care to our members, there are always areas for improvement in patient care. The answers to these questions from the 2021 CAHPS surveys identify these areas.

- **Getting care quickly**
  - o When you needed care right away, how often did you get care as soon as you needed?
  - o When you made an appointment for a check-up or routine care at a doctor's office or clinic, how often did you get an appointment as soon as you needed?
- **Getting needed care**
  - o How often was it easy to get the care, tests, or treatment that you needed?
  - o How often did you get an appointment to see a specialist as soon as you needed?
- **Care coordination**
  - o How often did your doctor have your medical records or other information about your care?
  - o How often did you get test results as soon as you needed them?
  - o How often did someone from your personal doctor's office follow up with test results?
  - o How often did you and your personal doctor talk about all the prescription medicines you were taking?
  - o Did you get the help you need from your personal doctor's office to manage your care among these different providers and services?
  - o How often did your personal doctor seem informed and up to date about care you got from specialists?
- **Annual flu vaccine**
  - o Have you had a flu shot since July 1?

To view the CAHPS survey for each line of business, please visit:

- Commercial: **upmchp.us/cahps22-commercial**
- UPMC for You, adult: **upmchp.us/cahps22-ma-adult**
- UPMC for You, child: **upmchp.us/cahps22-ma-child**
- UPMC for Kids: **upmchp.us/cahps22-chip**
- UPMC for Life: **upmchp.us/cahps22-medicare**
- UPMC Community HealthChoices: **upmchp.us/cahps22-chc**
- Marketplace: **upmchp.us/cahps22-qhp**

As always, thank you for making outstanding care a priority.

[1]Please note that the CAHPS survey varies slightly depending on the member's insurance plan. For example, the survey for individual plan members is different from the survey for Medicaid members.

QUALITY CORNER

Take steps to limit opioid prescribing

Know what alternatives to offer and which resources to leverage

Michael J. Lynch, MD
Associate Professor of Emergency Medicine
UPMC Health Plan Quality and Substance Use Disorder Services Medical Director
Director, UPMC Medical Toxicology Telemedicine Bridge Clinic
Emergency Department, Medical Toxicology, and Addiction Medicine Attending Physician

It's no secret that opioid misuse and abuse have been on the rise for quite some time in the United States—yielding dire consequences over decades. According to the Centers for Disease Control and Prevention (CDC), more than 564,000 people died from overdoses involving any opioid, including prescription and illicit opioids, from 1999–2020.[1]

Despite gains in awareness, a reduction in stigma, and an increase in treatment methods and modalities, deaths from opioids continue to rise. Data indicate that opioids were involved in more than 68,000 deaths in 2020, which was 8.5 times the number of opioid-involved overdose deaths in 1999.[2,3]

While many individuals have been hard at work trying to reduce misuse and abuse—and deaths from it—we still have a long way to go. As providers dedicated to improving our patients' health and their lives, it is incumbent upon us to help our patients in this area as well. It's imperative to be vigilant toward patients with chronic pain to whom you currently prescribe or are considering prescribing opioids. Chronic pain is often defined as pain that lasts longer than months or past the time of normal tissue healing.[4] The first and best place to start is attempting to assess which patients could be at risk of misusing or abusing opioids.

Assess and mitigate risk

No single tool can definitively predict or eliminate the risk of opioid misuse in a patient prescribed opioids. However, providers have access to these and other screening or risk assessment tools that have been validated for primary care use to help determine whether a patient might be at higher risk for misuse or abuse of opioids.

- **The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R).** This 24-item self-report instrument aids providers in predicting aberrant medication-related behaviors among chronic pain patients.[5] Because it is both for initial assessment and for use in patients who are on long-term opioid therapy, it is a longer format and includes questions such as:[6]
  - How often have you felt a need for higher doses of medication to treat your pain?
  - How often have you worried about being left alone?
  - How often have you been in an argument that was so out of control someone got hurt?
  - How often have you had to borrow pain medications from your family or friends?
  - How often have others suggested that you have a drug or alcohol problem?
- **The Current Opioid Misuse Measure (COMM):** This 17-item self-report instrument can be used to help in the identification of aberrant opioid-related behavior in patients with chronic pain who are on opioid therapy. The COMM-9 is a shorter, validated version. This tool can be administered to patients on opioid therapy at regular intervals to contribute to ongoing risk assessment. The COMM includes items such as:
  - In the past 30 days, how often have you had trouble thinking clearly or had memory problems?
  - In the past 30 days, how often have you seriously thought about hurting yourself?
  - In the past 30 days, how often have you needed to take pain medications belonging to someone else?
  - In the past 30 days, how often have you had to take more of your medication than prescribed?

While these are valuable tools that help inform the decision of whether to prescribe opioids for chronic pain or not and what kind of monitor and surveillance might be needed, it is important to remember that, like any other tool, it is only one piece of that decision-making process. There are other options that you can offer to patients through shared decision making.

Offer alternative interventions

Chronic pain itself can essentially become its own condition in addition to being a manifestation of an underlying cause due to the physical and psychological impact of living with chronic pain. Management options can vary depending on the patient's coping abilities and their co-occurring conditions—whether they are mental or physical health conditions. While there is no one-size-fits all approach, for many patients, alternatives to opioids are a viable option to explore.

- **Antidepressants.** In addition to helping with mood, certain antidepressants can assist with pain perceptions and signaling in the brain. Duloxetine, a serotonin and norepinephrine reuptake inhibitor (SNRI) used to manage major depressive disorder (MDD) and generalized anxiety disorder (GAD) is also used to manage fibromyalgia, diabetic peripheral neuropathy, and chronic musculoskeletal pain.[7] Venlafaxine, FDA approved to treat and manage symptoms of depression, social anxiety disorder, and cataplexy, can also be used off label for fibromyalgia, diabetic neuropathy, and complex pain syndromes.[8]
- **Anti-inflammatories and acetaminophen.** While these are common and well-known over-the counter medications, they may be an option to help certain patients manage chronic pain. For example, acetaminophen is thought to be as effective as NSAIDs for the management of mild-to-moderate osteoarthritis pain and is the recommended first-line therapy by the American College of Rheumatology (ACR).[9] Topical anti-inflammatory medications anesthetics like lidocaine can be effective for some patients, depending upon the etiology of their pain.
- **Psychological therapies.** While they differ in their approaches, therapies such as operant-behavioral therapy, cognitive-behavioral therapy, mindfulness-based stress reduction, and acceptance and commitment therapy can all help patients with chronic pain build skills to help them enhance their self-management abilities.[10]
- **Physical therapy.** Movement therapies, like physical therapy, may also be a nonpharmacological treatment option for patients experiencing chronic pain. Manual therapy, a specialty field within physical therapy, can serve as a valuable component of a comprehensive treatment plan that combines interventions that interact to help to influence clinical response.[11]
- **Interventional therapies.** Interventional therapies including intra-articular and epidural steroid injections, nerve blocks, and ablation can provide relief for many patients. Risks and potential benefits should be evaluated and discussed with patients. Consultation with a pain management specialist can inform decision-making and delivery of these specialized interventions.
- **Alternative therapies.** In some cases, practices like massage, yoga, acupuncture, meditation, and mindfulness can even be effective in helping to manage and cope with chronic pain when the cause of the pain cannot be eliminated.[12]

Deciding to prescribe

Deciding to prescribe opioids is a significant decision that needs to be carefully considered by weighing the benefits against the risks. Some conditions where opioids are commonly prescribed to treat chronic pain may include:

- Pain related to sickle cell disease.
- Cancer.
- Palliative care.
- End-of-life care.

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If you decide to prescribe opioids for chronic pain management, the CDC recommends the following guidance:

1. **Use immediate-release opioids when starting.** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/ long-acting (ER/LA) opioids.
2. **Use the lowest effective dose.** When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
3. **Prescribe short durations for acute pain.** Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

The risks of higher dose opioids

The higher the daily dose of prescribed opioid, the higher the risk of these and other potential issues:[14]

- Overdose
- Fractures
- Addiction
- Constipation and ileus
- Sedation

What about low back pain?

Functional musculoskeletal back pain and disk disease are common causes of chronic pain and chronic disability, as well as the need for chronic pain management, which has historically included opioids and contributed to the staggering amount of people who are prescribed opioids for low back pain. According to a study that used nationally representative 2009–2010 National Health and Nutrition Examination Survey data on back pain that was collected as part of the arthritis questionnaire found that 18.8 percent of adults ages 20–69 with chronic low back pain had taken at least one prescription opioid in the past 30 days.[15]

What course can providers take to help patients with low back pain? Imaging may seem like the next logical step. In fact, imaging is not always the answer for low back pain either. While there are certainly indications that make imaging necessary, for many patients, particularly young adults with acute sort of back strains and discomfort without neurologic deficits or complicating factors, initial imaging is rarely indicated. Very young and older patients with back pain should be more likely to be imaged, as they are more likely to have an unusual source of pain, including compression fractures and complication of malignancy. Imaging needs to be performed in consideration of potential etiologies of pain based on history and physical exam. If there is an obvious musculoskeletal source of the pain that can be identified, imaging may not be necessary.

Initial treatment should focus on symptomatic care with anti-inflammatories; rest; and topical ice followed by heat, stretching, and physical therapy when needed. In most cases low back pain should be adequately treated with those interventions. If pain is not responding to typical interventions, is worsening, or is becoming associated with any neurologic deficits, then imaging becomes necessary.

Set clear expectations up front

Patients may sometimes expect that opioids will completely relieve their pain, but this is not the case or the goal. The goal of opioid therapy is to bring pain to a point where it's tolerable so that patients can maintain their function and quality of life. Setting expectations that no therapy, including opioids, should be expected to completely eradicate pain associated with the chronic painful condition is a critical first step in making opioid therapy part of a pain management plan.

Before prescribing an opioid, particularly for chronic pain, have a discussion based on the patient's chronic pain condition and outlook.

- **Resolution or improvement expected.** If you are helping a patient manage a painful condition that can be resolved or improved sufficiently, explain that opioid therapy is not intended to be chronic, but a short-term treatment for a severe manifestation. It is essential to set the expectation that initiation of opioid therapy is temporary and should not be anticipated to be an ongoing or long-term part of their pain management plan.
- **Improvement not expected.** If you are helping a patient manage a chronic condition where you don't anticipate improvement due to the progressive nature of the disease, you should exhaust or optimize all other options for managing pain and the underlying condition prior to having a careful discussion with the patient about initiating opioid therapy.

Put a pain contract in place

A pain contract or agreement should be put in place to ensure patient safety given the risks associated with opioid therapy. Pain contracts minimize the risk of miscommunication and ensure that patients and providers are on the same page in regard to opioid therapy by setting expectations and boundaries at the outset of therapy such as:

- Be open and honest in discussing the measures you are going to implement to manage that risk, including urine drug screens.
- Set expectations around the safe and proper storage of opioids—stressing the potential for them to be lost or stolen.
- Let the patient know that when called upon, they should be able to provide a pill count of how many are left to ensure that the count of the pills is consistent with what would be expected.

Establishing these expectations verbally and in writing ahead of time helps do two critical things:

1. It impresses upon the patient how vital the maintenance element of a pain contract is in keeping their treatment plan as safe as possible.
2. It reminds them that they are entering into a therapy that is an escalation in care that carries with it risk and with that risk comes responsibilities.

Remember that pain contracts are a two-way street. The contract should also:

- Include language acknowledging that you will assess the patient's response to therapy and make adjustments as needed with the goal of optimizing their function and maintaining tolerable pain. Specify that adjustments may or may not include increasing doses of opioids.
- Lay out the reasons why you would no longer prescribe opioids due to safety concerns. Specify that there will be no abrupt discontinuation of opioid therapy without cause.

Ensure safe tapering

Like starting opioid therapy, the decision to taper opioid therapy should be very carefully weighed and considered—including the risks and the benefits. Abrupt tapering or discontinuation of opioid therapy in physically dependent patients can cause acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide. There may also be an increased risk of seeking or buying illicit opioids including fentanyl.

Tapering needs to be entered into cautiously and done slowly using **CDC guidelines for tapering.** There should be a good reason to start this process. The decision should not simply be based upon a dose that happens to be high, including higher than 90 morphine equivalents per day.

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Certainly, there are valid reasons for tapering. As patients get older or develop additional comorbidities or start on other medications, the relative risk of opioid therapy could change over time and, as such, tapering needs to be considered in these cases. If there is evidence of misuse or adverse effects associated with opioid therapy, including respiratory depression or uncontrolled constipation, tapering should also be considered. Whatever the reason, the discussion needs to be open and honest about why you are considering tapering to help facilitate buy-in, understanding, and willingness from the patient.

In cases where tapering is necessary and agreed upon in collaboration with the patient, then it should take place very slowly with frequent check-ins to assess the patient's response. Further, there should be consideration of adding or adjusting nonopioid pharmaceutical and nonpharmaceutical interventions, which might include psychological treatments for coping with this change.

Use resources to help with tapering

Primary care providers can consider referral to a pain specialist who could assist with the tapering process. Physicians can also have e-consults with our UPMC chronic pain specialists to review medical records and get tapering recommendations in the electronic health record.

The Pennsylvania Department of Health offers training as part of the Prescription Drug Monitoring Program, including modules that cover tapering approaches. Physicians can also reference national guidelines from pain associations and the CDC.

Make a difference in the opioid epidemic

As providers, we strive to make a difference in our patients' lives by helping improve their health outcomes. Our definition and duties must always include the careful prescribing of all medications when indicated—especially opioids, whether high or low dose. When we work together to educate and safeguard our patients to the best of our ability, we can make a difference in curbing the opioid epidemic.[16]

References

1. Centers for Disease Control and Prevention. Opioid data analysis and resources. Reviewed June 1, 2022. Accessed Nov. 2, 2022. cdc.gov/opioids/data/analysis-resources.html#:~:text=The%20first%20wave%20began%20with,increasing%20since%20at%20least%201999.&text=The%20second%20wave%20began%20in,in%20overdose%20deaths%20involving%20heroin.
2. Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths — United States, 2013–2019. MMWR Morb Mortal Wkly Rep 2021;70:202–207. DOI: dx.doi.org/10.15585/mmwr.mm7006a4.
3. Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. wonder.cdc.gov
4. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. DOI: dx.doi.org/10.15585/mmwr.rr6501e1
5. Finkelman MD, Kulich RJ, Zacharoff KL, Smits N, Magnuson BE, Dong J, Butler SF. Shortening the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R): A Proof-of-Principle Study for Customized Computer-Based Testing. Pain Med. 2015 Dec;16(12):2344-56. doi: 10.1111/pme.12864. Epub 2015 Jul 14. PMID: 26176496; PMCID: PMC4706778.
6. Ibid.
7. Dhaliwal JS, Spurling BC, Molla M. Duloxetine. [Updated 2022 Jun 5]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan. ncbi.nlm.nih.gov/books/NBK549806/
8. Singh D, Saadabadi A. Venlafaxine. [Updated 2022 Oct 10]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan. ncbi.nlm.nih.gov/books/NBK535363/
9. Am J Med. 1998 Jul 27;105(1B):45S-52S. doi: 10.1016/s0002-9343(98)00073-4.
10. Sturgeon JA. Psychological therapies for the management of chronic pain. Psychol Res Behav Manag. 2014 Apr 10;7:115-24. doi: 10.2147/PRBM.S44762. PMID: 24748826; PMCID: PMC3986332.
11. Coronado RA, Bialosky JE. Manual physical therapy for chronic pain: the complex whole is greater than the sum of its parts. J Man Manip Ther. 2017 Jul;25(3):115-117. doi: 10.1080/10669817.2017.1309344. Epub 2017 Jun 12. PMID: 28694673; PMCID: PMC5498791.
12. National Center for Complementary and Integrative Health. Chronic pain: in depth. Updated Sept. 2018. Accessed Nov. 2, 2022. nccih.nih.gov/health/chronic-pain-in-depth
13. Centers for Disease Control and Prevention. CDC guideline for prescribing opioids for chronic pain. Accessed Nov. 4, 2022. cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf
14. Baldini A, Von Korff M, Lin EH. A Review of Potential Adverse Effects of Long-Term Opioid Therapy: A Practitioner's Guide. Prim Care Companion CNS Disord. 2012;14(3):PCC.11m01326. doi: 10.4088/PCC.11m01326. Epub 2012 Jun 14. PMID: 23106029; PMCID: PMC3466038.
15. Shmagel A, Ngo L, Ensrud K, Foley R. Prescription medication use among community-based U.S. adults with chronic low back pain: A crosssectional population based study. J Pain 19(10):1104–12. 2018.
16. U.S. Department of Health and Human Services. Guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid. Reviewed Oct. 10, 2019. Accessed Nov. 3, 2022. hhs.gov/opioids/treatment/clinicians-guide-opioid-dosage-reduction/#:~:text=Risks%20of%20rapid%20tapering%20or,distress%2C%20and%20thoughts%20of%20suicide

Quality improvement best practice insights

Topic: Use of Opioids at High Dosage

Measure: The proportion of members 18 years old and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for ≥ 15 days during the measurement year. A lower rate for this measure indicates better performance.

Identify members who met both of the following criteria during the measurement year:

- Two or more opioid dispensing events on different dates of service
- ≥ 15 total days covered by opioids

Measurement period: Jan. 1, 2022, through Dec. 31, 2022

Exclusion criteria:

- Members in hospice or using hospice services anytime during the measurement year
- Members with cancer (Malignant Neoplasms Value Set)
- Members with sickle cell disease (Sickle Cell Anemia and HB-S Disease Value Set)
- Member receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)

Services to close gap: The goal is to avoid prescribing opioids at a high dose.

Best practice recommendations

1. Identify patients in your practice who are taking opioids at a high dosage (daily MME ≥ 90 mg) and reassess benefits and risk of pain regimens.
2. Consider tapering or discontinuing opioid therapy if the patient does not have a clinically meaningful improvement in pain and function, shows signs of overdose risk, or demonstrates signs of substance use disorder.
3. Evaluate continued opioid therapy with patients every three months, or more frequently.
4. Regularly consult PDMP, Pennsylvania's prescription drug monitoring program, to ascertain whether a patient is receiving controlled substances from multiple providers and/or pharmacies.
5. For opioid-naïve patients needing treatment for acute pain, consider alternative pain management treatments in place of opioids when appropriate, such as NSAIDS, massage therapy, etc.
6. When prescribing an opioid, prescribe the lowest effective dose of immediate-release opioids for only the expected duration of pain severe enough to require opioids.
7. Educate patients on the risk of long-term use of opioids and use opioid treatment agreements to reduce prescription misuse.

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Topic: Use of Imaging Studies for Low Back Pain

Measure: The percentage of members 18-75 years old with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

This measure is reported as an inverted rate. A higher score indicates the appropriate treatment of low back pain (the proportion of members for whom imaging studies did not occur).

Identify all members 18 to 75 years old as of Dec. 31 of the measurement year who had any of the following during the intake period:

- An outpatient visit (Outpatient Value Set), observation visit (Observation Value Set) or an ED visit (ED Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visits (Physical Therapy Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telephone visit (Telephone Visit Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- E-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

For each member identified above, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Measurement period: Jan. 1, 2022, through Dec. 3, 2022

IESD: Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.

Exclusion criteria:

- Members in hospice or using hospice services anytime during the measurement year
- Member receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (six months) prior to the IESD.
- Members who had cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:

  -Malignant Neoplasms Value Set

  -Other Neoplasms Value Set

  -History of Malignant Neoplasms Value Set

  -Other Malignant Neoplasm of Skin Value Set
- Members who had recent trauma (Trauma Value Set) any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- Members who have been diagnosed with Intravenous drug abuse (IV Drug Abuse Value Set) any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- Members with a Neurologic Impairment (Neurologic Impairment Value Set) any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- Members with HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.
- Members with Spinal Infections (Spinal Infection Value Set) any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- Members with major organs transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- Members with prolonged use of corticosteroids (90 consecutive days of corticosteroid. treatment any time during the 366-day period that beings 365 days prior to the IESD and ends on the IESD).
- Members with Osteoporosis, Osteoporosis Therapy (Osteoporosis Medication Therapy Value Set; Long-Acting Osteoporosis Medications Value Set) or a dispensed prescription to treat Osteoporosis (Osteoporosis Medications List) any time during the member's history through 28 days after the IESD.
- Members with a fragility fracture (Fragility Fracture Value Set) any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- Members who have had Lumbar surgery (Lumbar Surgery Value Set) any time during the member's history through 28 days after the IESD.
- Members who have Spondylopathy (Spondylopathy Value Set) any time during the member's history through 28 days after the IESD.
- Members 66 years old and older as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advances illness criteria to be excluded:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptoms Value Set) during the measurement year.
  2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (the diagnosis must be on the discharge claim) on different dates of service , with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim.
     - A dispensed dementia medication (Dementia Medication List).

Services to close gap: The desired outcome for this measure is that members will not have an imaging study within 28 days of a principal diagnosis of low back pain.

Best practice recommendations:

1. Provide education to help patients understand that most back pain is short-lived and will go away in a few weeks.
2. Reinforce those tests such as X-rays, CT scans, and MRIs are usually not necessary unless symptoms have persisted for more than six weeks, and treatment is not helping.
3. Consider recommending over-the-counter medications and the use of heat or ice to relieve symptoms as needed.
4. Encourage walking to help strengthen back muscles.

Best practice recommendations are suggestions and should not be construed to replace the judgment of a clinical provider.

ICD-10-CM coding and documentation insights

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Addressing chronic conditions during an acute visit

With cold and flu season upon us, providers may experience an increase in acute visits. Even though care is predominantly directed toward the acute condition (such as sinusitis, flu, or bronchitis), chronic conditions that are affected by the care or treatment of the acute condition should be documented and reported for the encounter. ICD-10-CM guidelines advise us to *"code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management."*

Prescribed antibiotics, over-the-counter cold and flu medication, cough medication, antihistamines, decongestants, and other factors can affect chronic conditions such as diabetes, chronic kidney disease, heart disease, hypertension, asthma, and COPD, to name a few. The acute condition itself can also affect the chronic condition.

It is important for providers to document the reason for addressing, managing, or treating the chronic condition affected by the acute condition and/or the treatment for the acute condition. If documented properly, the chronic conditions are valid reportable diagnoses for the acute encounter.

Example documentation

Encounter diagnoses	Documentation
Sinusitis [J01.90] COPD/Emphysema [J43.9]	Prescribed OTC decongestant will continue with room humidifier and warm/moist compresses. Will closely monitor for increased wheezing, cough, chest tightness, or SOB to prevent exacerbation.
Strep Throat [J02.0] Type 2 Diabetes [E11.9]	Prescribed Amoxicillin, RTO in 7 days if no improvement. Monitor blood sugar levels due to infection and amoxicillin therapy for strep throat.

When a chronic condition or even a transplant status in a patient is taken into consideration for the provider's medical decision-making during an encounter and is documented as such, the ICD-10-CM code for the chronic condition or transplant status should be reported.

Mandatory training for Medicare SNP providers

The Centers for Medicare & Medicaid Services (CMS) require all Medicare Special Needs Plan (SNP) providers to complete the Model of Care (MOC) Training every year. The MOC describes the structure and process by which health care services are delivered to SNP members.

For your convenience, UPMC Health Plan has developed a brief online training module on the MOC for our SNP product, UPMC *for Life* Complete Care (HMO-SNP), formerly known as UPMC *for Life* Dual.

To complete the training, go to **upmchp.us/snpmoc.** You will need your tax identification number to sign up.

If you have any questions or concerns, contact your physician account executive or call Provider Services at **1-866-918-1595.**

This training must be completed by Jan. 15, 2023.

Thank you for your continued support and the care you provide for our members!

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The provider of care is ultimately responsible for providing accurate and compliant information on all submission of claims and/or billing information.

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