Highmark Inc.

2021 UNCONFIRMED DIAGNOSIS CODE (UDC)

PROGRAM MANUAL

Created: January 2021

Send questions or comments to UDCHelp@highmark.com

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SECTION 1: OVERVIEW

The goal of Highmark Inc.'s **("Highmark")** UDC Program **("Program")** is to help ensure that quality health care is provided to Highmark Medicare Advantage and Inter-Plan Medicare Advantage members (as further detailed in Section 9: *Inter-Plan Medicare Advantage Care Management and Provider Engagement)* **("Program Members")** with complex chronic health conditions by assisting provider practices consisting of Primary Care Physicians **("PCPs")** and selected Specialties Physicians **(herein collectively identified as "Participants")** to accurately identify, treat, document and report appropriate ICD-10-CM and Hierarchical Condition Category **("HCC")** diagnosis codes to Highmark.

In order to support this Program, analytics and chart reviews are used to identify persistent (previously reported) and/or suspected diagnosis condition(s) of Program Members. Participants are asked to evaluate these diagnosis condition(s) during eligible patient encounters with their healthcare provider Centers for Medicare and Medicaid Services **("CMS")** determines to be appropriate for this activity **("CMS-eligible provider visit")** (after receiving the UDC Forms) in the calendar year. The Participants will have access to the forms, electronically, through downloadable paper or eForm **("UDC Form(s)" or "Form(s)")**, at the start of the Program year on an electronic platform **("UDC Portal")**. Participants must complete and return/submit the Forms as indicated in the instructions and Program materials. Evaluating each Program Member for the diagnosis condition(s) listed on the UDC Form helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each Program Member to CMS.

The Program will be made available to Participants that have Program Members with diagnosis condition(s) that need to be evaluated during the current year. Participants will have the potential to receive compensation **("Program Compensation")** by taking steps toward providing quality health care through assessment of the Program Members and ensuring accurate documentation of confirmed diagnosis conditions during every CMS-eligible provider visit as part of this Program. The UDC Forms contain pre-populated diagnosis conditions and require reporting on each addressed condition through the completion of the UDC Form and claims submission process. Please note: medical record documentation must accompany each UDC Form.

The Program is intended to assist with support for the accuracy of the diagnosis codes reported to Highmark and not intended to influence clinical and coding judgment.

SECTION 2: PROGRAM PROCESS

Participants agree to review each Program Member's diagnosis condition(s) to determine if the condition(s) exists. If the condition currently exists, Participants must ensure the underlying diagnosis condition is monitored, evaluated, assessed and/or treated **("MEAT")** in the current calendar year. This is accomplished by addressing every diagnosis condition presented through the UDC Program during an eligible Program Member's CMS-eligible provider visit during the current calendar year. **Participants may <u>not</u> schedule a provider visit with the Program Member for the sole purpose of completing any or all Forms; however, Participants are**

permitted to schedule appropriate appointments, when clinically appropriate, to manage the Program Members' care.

Program Compensation will be paid on a quarterly basis as further detailed in Section 8: *Program Compensation* after Highmark validates the information provided by the Participant on the Form and in the medical record documentation.

Highmark may terminate this Program or a Participant from this Program at its sole discretion at any time.

Electronic Forms:

Participants will participate in the Program through the UDC Portal. The UDC Portal allows practices to receive more timely information on unconfirmed diagnosis conditions and practice performance; improve the performance of the Program and reduces the burden of a manual, paper process. Two electronic solutions are available for Participants to select.

a. **Option 1: Downloadable Paper** – Participants will locate their UDC Forms by accessing NaviNet and selecting UDC Program. The Participant will select the Program Member being seen, print out the Form, complete it and return both the Form and the medical record documentation to Highmark as described below in step 8. When printing a UDC Form, the header will present a 30-day beginning date showing the start of the timeframe required to complete the form. If the UDC Form is not completed and submitted to Highmark within 30 days, the Form will be marked as Expired and if diagnosis conditions still exist, a new Form may be available to print.
b. **Option 2: eForm** – Participants will locate the eForm through NaviNet and selecting UDC Program. Participant will select the Program Member being seen through the UDC Portal. Participant will review the diagnosis conditions to be assessed and complete the Form electronically. Participants will attach a copy of the medical record documentation to the eForm and click submit. All information will be sent to Highmark electronically. The eForm cannot be submitted until all conditions have been addressed and the medical record documentation is attached.

Attribution will identify a member's primary source of medical treatment based on the history of evaluation and management **("E&M")** claims associated with the member. Members are assigned, or "attributed," to the practice with eligible Program providers with whom they had the highest number of visits during an 18-month time period. If a member had the same number of visits with multiple practices, the member is attributed to the practice visited most recently. Attribution is updated monthly and uses a rolling 18-month look back period. Participants receive Forms via the UDC Portal (downloadable paper or eForm) for eligible Program Members that have pre-populated unconfirmed diagnosis condition(s) to be addressed in the current year. Listed on each Form are suspected and/or persistent diagnosis code(s), diagnosis condition description(s) and other relevant data.

The following details out the Program process:

1. Participants must ensure that all diagnosis condition(s), both persistent and suspected, are addressed during a CMS-eligible provider visit with the Program Member and respond with the current status for each condition(s). UDC Forms may not be completed by looking back at previously completed encounters (chart mining) to perform gap closure. Chart mining will not be eligible for Program Compensation.

2. Participants must submit a copy of the medical record documentation from the CMS-eligible provider visit (s) during which the Program Member was evaluated for the diagnosis condition(s) on the Form.

    a. For Participants using downloadable paper Form, multiple Form pages could be issued for a single Program Member. This will happen if a Program Member has more diagnosis conditions than are able to fit on a single Form page. Participants must submit a copy of the medical record **with each Form page** being returned to Highmark.

    b. The supporting medical record may include documentation from a Specialist who saw the Program Member for a CMS-eligible provider visit type in the current calendar year.

3. To complete the UDC Form, Participants are to follow the instructions provided with the solution. If the Program Member is deceased, has left the Participant's practice or is no longer insured by Highmark, Participants should shade or select the "Deceased or Not a Patient of this Practice" field on the Form and return it to Highmark. This field is located immediately below the Program Member information. These Program Members will be marked as "Ineligible" for the Program and will not be eligible for Program Compensation.

4. If the diagnosis condition(s) listed for a Program Member is (are) a current active diagnosis condition(s), Participants must shade or select the "Confirmed Active" response and ensure the documentation in the medical record supports that condition. If the diagnosis code listed on the Form is different than the final diagnosis evaluated, Participants must write or enter the corrected diagnosis code in the spaces provided.

5. If the diagnosis condition(s) listed for a Program Member is (are) resolved, no longer active in the current year, or never existed for the Program Member, the Participant must shade or select the "Resolved or Never Existed" response.

6. If the Participant is unable to make a definitive conclusion regarding a diagnosis after reviewing the condition with the patient during the encounter, the Participant must shade or select the "Further Evaluation is Required" response and ensure the documentation in the medical record shows the condition was reviewed and what additional action will be taken to get to a definitive answer. Participants do not need to complete the Form again once a definitive answer is obtained. Information received on a claim (or lack of information received) will support the further evaluation findings.

7. Other diagnoses evaluated during the CMS-eligible provider visit but not pre-populated on the Form should not be written on the Form, but should be included on the claim submitted for that encounter.

8. Participants must follow the established instructions to submit downloaded paper UDC Forms.

    a. Forms can be returned either by secure fax to 717-635-4591 or by secure email to diagnosisgapclosure@highmark.com.

    b. If the Participants are sending multiple Forms at one time, the submission should be ordered with each Form immediately followed by its supporting medical record documentation, then the next Form and its supporting documentation, and so on. The participant can send a maximum of 200 pages at a time.

9. Forms and medical record documentation may be sent as soon as they are completed. All forms will expire 30 days after the date they are started or printed.
10. All forms started must be completed in their entirety before the forms can be submitted to Highmark for review. Additional forms may be made available throughout the year for Program Members based on newly identified diagnosis conditions. Frequently reviewing reports and the online portal for new forms is highly recommended.
11. Participants must submit a claim to Highmark listing all active diagnosis codes for all diagnosis conditions confirmed during the Program Member's CMS-eligible provider visit.
12. Highmark will review the medical records submitted by the Participants to ensure that all diagnosis conditions marked "Confirmed Active" or "Further Evaluation Required" have been properly documented.
13. Participants will receive the established Program Compensation amount upon completion and validation of all Forms assigned to a Program Member as further detailed in Section 8: *Program Compensation*.

SECTION 3: PARTICIPATION

As a condition of participation, all Participants will have in effect, all contractual documents as may be required by Highmark, in its sole discretion, including, without limitation, a Blue Shield Participation Agreement, and a Medicare and/or Medicare Advantage Provider Agreement.

Participants will not be permitted to participate in both the UDC Program and the Risk Score Accuracy ("RSA") Program concurrently.

By participating in this voluntary program, Participants agree to the terms and conditions of the Program.

SECTION 4: PROGRAM MEMBERS AND IMPACT

The Program will not affect any Program Member's benefit design regardless of Participant involvement in the Program. Highmark and/or the Participant, as applicable, agree that individuals participating in Highmark's Medicare Advantage plans (including, but not limited to, HMO and PPO) and/or Inter-Plan Medicare Advantage members (as further detailed in Section 9: *Inter-Plan Medicare Advantage Care Management and Provider Engagement)*, are covered as Program Members pursuant to the Program. Highmark may require other Program criteria that will be set forth in an appropriate agreement or the Program administrative requirements, as applicable.

SECTION 5: DATA AND REPORTING

To monitor progress, the Participants will receive reports that will indicate the Participant's cumulative performance in the Program based on returned Forms through a specific date in time **("Progress Reports")**. That "as of" date will be included on the Summary page of the report. Forms determined ineligible for reimbursement due to errors on the returned Form or insufficient medical record documentation will be identified on the Progress Report with a reason the Form does not meet compensation requirements. Primary Care Participants with access to the Quality Blue User Interface via NaviNet will be able to review these reports through

the interface every other week. Specialist Participants can access their Progress Reports through the Provider Facing Analytics tool. If a Participant cannot access their Progress Reports, the Participant may contact UDCHelp@Highmark.com for assistance. Program Compensation information is included on the Compensation Detail page of the Progress Reports.

SECTION 6: MEDICAL COST AND PROGRAM TARGETS

Medical cost performance will not be measured in the Program; however, it is anticipated that accurately reporting Program Member diagnosis condition(s) and ensuring that each diagnosis condition is monitored, evaluated, assessed and/or treated annually will help improve the quality of care and may reduce future cost of care.

Participants should strive to accurately complete and return sixty percent (60%) or more of the Forms sent by the end of the year. 2021 UDC Program Forms will be accepted by Highmark through January 10, 2022.

SECTION 7: ENHANCED ANNUAL WELLNESS VISIT (EAWV) PROGRAM

If a Participant also participates in the Enhanced Annual Wellness Visit **("eAWV")** Program, activity in the two programs will be compared before the UDC quarterly Program Compensation payment is made. If the Participant has completed an eAWV for a Program Member first and later completes a UDC Form for the same Program Member within the same program year, the Participant will only receive reimbursement for the eAWV at the appropriate level. For additional information, please refer to the 2021 Enhanced Annual Wellness Visit Program Manual.

SECTION 8: PROGRAM COMPENSATION

Participants will be compensated based on the level of effort spent addressing each condition for their Program Member population, for the purposes of the Program, over the course of the calendar year. Participants will be compensated at the same rate for activity conducted by their respective clinicians.

Program Compensation is driven by:

- **Evaluation of suspect conditions**: Compensates activity related to the preparation of and evaluation and documentation of suspect conditions that would not otherwise be required but for the Program. Acknowledging that the level of effort to evaluate a suspect condition is consistent regardless of how condition is dispositioned, payment is uniform.
    - o Suspected conditions confirmed or resolved/never existed will be compensated at $100 per condition
- **Evaluation of persistent conditions**: Compensates activity related to the preparation of, and evaluation and documentation of persistent conditions that would not otherwise be required but for the Program. Given that confirmation, documentation, review and monitoring for treated persistent conditions requires

more activity, higher compensation is rewarded for treated persistent conditions. Addressing and denying persistent conditions is also compensated, but the lesser activity is compensated at a lesser rate.

- o Persistent conditions confirmed will be compensated at $100 per condition
- o Persistent conditions resolved/never existed will be compensated at $25 per condition

- **Further evaluation required/needed:** Conditions that require further evaluation will be compensated at $25 per condition.

Example of how compensation will be measured when addressing each condition type:

Suspect Conditions		***Compensation***
Condition 1	Confirmed	$100
Condition 2	Resolved/Never existed	$100
Condition 3	**	$25
Condition 4	N/A	$0
		$225

Persistent Conditions		***Compensation***
Condition 1	Confirmed	$100
Condition 2	Resolved/Never existed	$25
Condition 3	**	$25
Condition 4	N/A	$0
		$150

**Further evaluation required/needed

Participants will receive disbursements for participation in this Program at the Practice level. This disbursement will be separate from other disbursements. Disbursements will be issued on a quarterly basis based on prior quarter performance. Quarterly payments will be paid out approximately 60 days after the prior quarter end. (Timing of payments may be subject to delay depending on volume and operational processing times).

Highmark reserves the right to adjust compensation for activity related to the Program based on documentation of conditions addressed, the ability of Participants to receive and respond to suspect/persistent condition data, and based on the needs and requirements to conform to any applicable regulations impacting the Program.

SECTION 9: INTER-PLAN MEDICARE ADVANTAGE CARE MANAGEMENT AND PROVIDER ENGAGEMENT

The purpose of the Inter-Plan Medicare Advantage Care Management and Provider Engagement Program is to improve care management and data sharing strategies for the Medicare Advantage Member population for out of area **("OOA")** Blue Shield **("BS")** plans whose members are hosted by Highmark.

The 2021 UDC Program is structured to support and improve the coordination of care on BS Medicare Advantage Members within the Highmark provider network **("Hosted Members")**. Highmark will be including Hosted Members from other Blues Plans who live in Highmark BS service area. For additional information please refer to the Inter-Plan Medicare Advantage Care Management and Provider Engagement Program Manual which can be found on NaviNet and the Provider Resource Center under Value Based Reimbursement Programs/Medicare Advantage Stars.