AdventHealth Affiliated Networks

2023 Provider Information Booklet

V.03.03.2023

AdventHealth Employee Plan (AHEP)

Health First Health Plans Commercial *Individual/Group* (HFHP)

Health First Health Plans Medicare Advantage (HFHP MA)

Florida Hospital Healthcare System (FHHS)

AdventHealth
feel whole®

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Section One:
Network Services

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Health Management

Health Management is a no-cost program designed to assist with value-based contract lives who have ongoing medical needs related to chronic illness. Our team of skilled professionals includes registered nurse health advisors, Whole Health Coordinators and social workers who work together to support patients with education in managing chronic illness and assistance in coordinating care between visits.

Physician Benefits

- Increased patient compliance with physician orders
- Reduced costs due to prevention of avoidable visits
- Improved continuity of care
- Increased patient satisfaction
- Customized patient care plan

Referral Process

Central Florida Division
health.management@adventhealth.com
FAX: 407-776-7980

West Florida Division
wfd.health.management@adventhealth.com
FAX: 813-929-5912

Patients who participate in Health Management are more likely to close care gaps and experience lower cost-of-care.

32%
PMPM Cost Reduction

45%
Reduced Readmissions

ED Care Coordination Center

ED Care Coordination Center (ED CCC) is a program for Central Florida Division and West Florida Division that targets certain populations with the goal of reducing inpatient admissions. A team of nurses follows members in the ED and communicates with the ED provider to offer alternatives to inpatient admission.

The most-often requested service by the ED providers is a next-day appointment with the member's PCP. This team will reach out to the member's PCP to request expedited appointments to avoid an inpatient admission and to notify the practice if one of their members is a high ED utilizer, a complicated case or needs specialist care or treatment.

For more information, contact Diane Duncan at
Dianne.Duncan@adventhealth.com
Phone: 407-517-7595

Provider Operations and Engagement

The provider operations and engagement team supports network physicians by working to enhance the physician experience with the network, with the goal of improving patient outcomes, quality and reducing the overall cost of health care.

The team is dedicated to assisting with removing barriers to patient care through education, implementation and support of population health technologies.

Population Management Advisor

Your population management advisor (PMA) is available to assist your practice as needed with contracting, credentialing and claims questions. Your PMA can provide quality measure and care-gap information specific to your attributed members. PMAs can also engage coding experts and other resources to assist as needed to achieve high performance for population health programs.

Some of the services offered are:

- Understanding specific population health payer/plan physician requirements
- Educating and supporting physicians and office staff to improve performance on specific quality measures and reduce care gaps for attributed members
- Implementing and optimizing population health technology solutions
- Assisting providers with contracting, credentialing and re-credentialing
- Working with providers to resolve claim issues for payors affiliated with FHHS

FHHS Augmentation

Several Florida Hospital Healthcare System (FHHS) providers have been invited to participate in one or more AdventHealth Physician Network clinically integrated network products (i.e., Allegiance/ Disney, Oscar, etc.). The invitation to participate in these exclusive narrow network programs is not meant for all providers but is primarily based on network adequacy and the state of Florida regulatory requirements. If you have questions, please email the respective team.

For general questions about Augmentation:

FHHS/PHSO Provider Outreach Team
PHSO.Provider.Outreach@adventhealth.com

For Augmented Providers with questions regarding a specific network:

Central Florida Provider Relations Team
AHPN.CF.NetworkOperations@adventhealth.com

West Florida Provider Relations Team
AHPN.WF.NetworkDevelopment@adventhealth.com

Section Two: **AdventHealth Employee Plans and Health First Health Plans**

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Glossary

AdventHealth Hospital system with more than 50 hospital facilities in nine states. In Florida, AdventHealth comprises over 30 hospitals and emergency rooms, 40 Centra Care urgent care locations and numerous imaging, sports rehab and other outpatient facilities.

AdventHealth Employee Plan (AHEP) The benefits plan name for AdventHealth employees and their dependents is administered by Aetna. The participating counties are in central and west Florida.

Aetna Third-Party Administrator for the population AdventHealth Employee Plan (AHEP). This includes processing and paying claims, customer service for patients and providers, care management and more.

Clinical Documentation Integrity Program This program compensates physicians for providing and documenting appropriate treatment and coordinating care for Medicare Advantage patients. Providers can earn over $200 per member per year by participating in the Health First Health Plans CDI Program.

Florida Hospital Healthcare System (FHHS) A provider network and network services team affiliated with AdventHealth.

Health First Health Plans (HFHP) An insurance company that has an Administrative Services Agreement (ASA) that partners with AdventHealth. The ASA includes claims processing and payments, customer service for providers, risk adjustment, HEDIS® monitoring and care management and provides a physician portal platform.

Health First Health Plans Commercial Plans *(formerly AdventHealth Advantage Plans)* Includes Individual plans for individuals and families as well as Group plans for small (<50 employees) and large (50+ employees) employers. Counties involved are Brevard, Flagler, Indian River, Seminole and Volusia.

Health First Health Plans Medicare Advantage (HFHP MA) *(formerly AdventHealth Advantage Plans Medicare Advantage)* Includes everything Original Medicare offers, plus additional benefits, like allowances for dental care, vision and a fitness program. As an FHHS provider, you accept this plan unless it was specifically omitted from your FHHS contract. Counties include Brevard, Flagler, Hardee, Highlands, Indian River and Volusia.

**The MA SunSaver plan has no monthly premium, no referrals required, and Part D benefits are included.*

Contact Quick Reference Guide

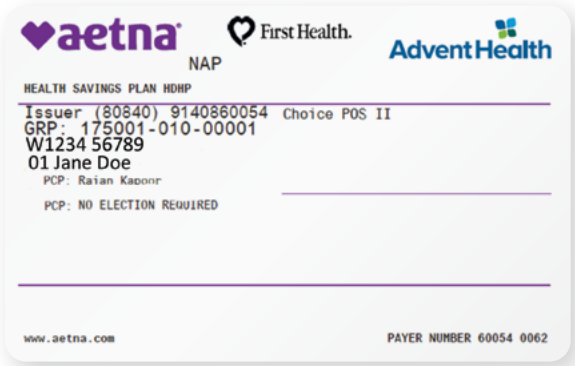
	AdventHealth Employee Plan	Health First Health Plans Medicare Advantage & Commercial
Authorizations Behavioral Health	**Aetna Behavioral Health** **Phone:** 888-632-3862 Availity.com **Fax:** 888-463-1309	**Optum Health** **MA Phone:** 877-890-6970 ProviderExpress.com **IFP Phone:** 866-323-4077
Authorizations Medical	**Aetna** **Phone:** 855-600-0032 **Fax:** 833-596-0339	**HFHP** **Phone:** 844-522-5282 hf.org/4providers **Fax:** 855-328-0059
Authorizations Pharmacy	**RX Plus Pharmacy** **Phone:** 855-600-0032 **Fax:** 833-596-0339	**CVS** **Phone:** 855-344-0903 **Fax:** 855-633-7673
Care Management	**Central Florida Division** **Email:** health.management@adventhealth.com **Fax:** 407-303-8026 **West Division** **Email:** wfd.health.management@adventhealth.com **Fax:** 813-605-4699	
Customer Service Services: Claims, benefits and eligibility	**Aetna** **Phone:** 888-632-3862	**HFHP** **MA Phone:** 844-522-5282
Hearing	*Hearing is a covered Aetna medical benefit.*	**TrueHearing** **Phone:** 855-687-9718
Provider Claims	**Aetna — Claims** Payer ID: 60054 Change Healthcare SUBMISSIONS **Phone:** 888-632-3862 **Fax:** 859-455-8650 **Mail:** PO Box 981106 El Paso, TX 79998-1106 DISPUTE **Fax:** 859-425-3379 **Attn:** CRTM **Mail:** PO Box 14463 Lexington, KY 40512	**HFHP — Claims** Payer ID: 95019 **Electronic Claims:** *Availity, Eligible or Change Healthcare* **Mail:** PO Box 830698 Birmingham, AL 35283-0698 **Fax:** 321-434-5655 DISPUTE **Mail:** Attn: Claims Resolution Unit 6450 US Highway 1 Rockledge, FL 32955
Provider Portal	**Aetna Portal** **Help Line:** 888-632-3862 Aetna.com	**HFHP Portal** **Phone:** 877-814-9909 Hf.org/4providers
Vision	**VSP** **Phone:** 800-877-7195	**Davis Vision** **Phone:** 800-77-DAVIS

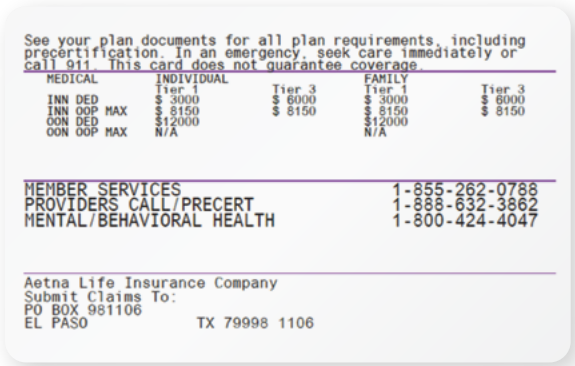
Plan Participation and ID Cards

FHHS providers are contracted to accept all Health First Health Plans, including Medicare Advantage, Individual and Group plans, and Self-Funded plans. All FHHS providers accept these contracts unless expressly excluded from your FHHS contract. AdventHealth Employee Plan is administered by Aetna.

AdventHealth Employee Plan (AHEP)

HFHP


aetna First Health. AdventHealth
NAP
HEALTH SAVINGS PLAN HDHP
Issuer (80840) 9140860054 Choice POS II
GRP: 175001-010-00001
W1234 56789
01 Jane Doe
PCP: Raian Kapoor
PCP: NO ELECTION REQUIRED
www.aetna.com
PAYER NUMBER 60054 0062


See your plan documents for all plan requirements, including precertification. In an emergency, seek care immediately or call 911. This card does not guarantee coverage.

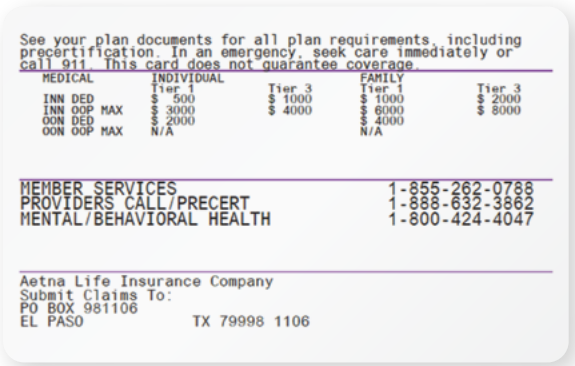
MEDICAL	INDIVIDUAL		FAMILY	
	Tier 1	Tier 3	Tier 1	Tier 3
INN DED	$ 3000	$ 6000	$ 3000	$ 6000
INN OOP MAX	$ 8150	$ 8150	$ 8150	$ 8150
OON DED	$12000		$12000	
OON OOP MAX	N/A		N/A	

MEMBER SERVICES 1-855-262-0788
PROVIDERS CALL/PRECERT 1-888-632-3862
MENTAL/BEHAVIORAL HEALTH 1-800-424-4047

Aetna Life Insurance Company
Submit Claims To:
PO BOX 981106
EL PASO TX 79998 1106

Traditional


aetna First Health. AdventHealth
NAP
TIER 1: PCP $25 SPC $50
TIER 2: PCP $40 SPC $65
Issuer (80840) 9140860054 Choice POS II
GRP: 175001-020-00001
W1234 56789
01 Jane Doe
PCP: NO ELECTION REQUIRED
PCP: NO ELECTION REQUIRED
www.aetna.com
PAYER NUMBER 60054 0062


See your plan documents for all plan requirements, including precertification. In an emergency, seek care immediately or call 911. This card does not guarantee coverage.

MEDICAL	INDIVIDUAL		FAMILY	
	Tier 1	Tier 3	Tier 1	Tier 3
INN DED	$ 500	$ 1000	$ 1000	$ 2000
INN OOP MAX	$ 3000	$ 4000	$ 6000	$ 8000
OON DED	$ 2000		$ 4000	
OON OOP MAX	N/A		N/A	

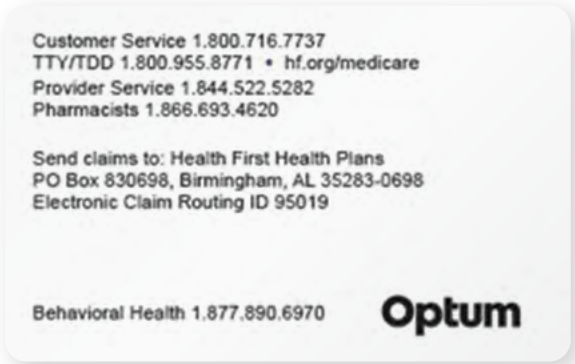
MEMBER SERVICES 1-855-262-0788
PROVIDERS CALL/PRECERT 1-888-632-3862
MENTAL/BEHAVIORAL HEALTH 1-800-424-4047

Aetna Life Insurance Company
Submit Claims To:
PO BOX 981106
EL PASO TX 79998 1106

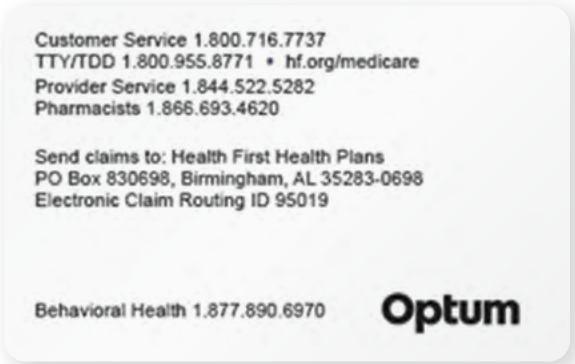
Health First Health Plans (HFHP)

For plans beginning Jan. 1, 2023.

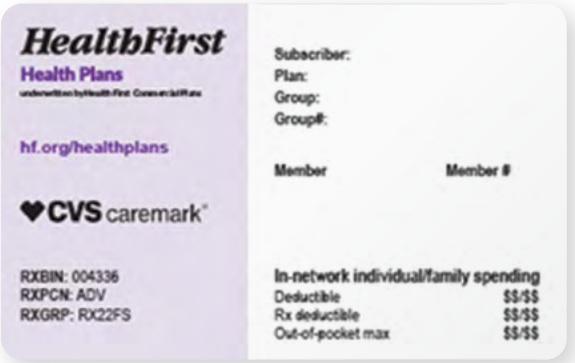
HFHP Medicare Advantage (MAPD)

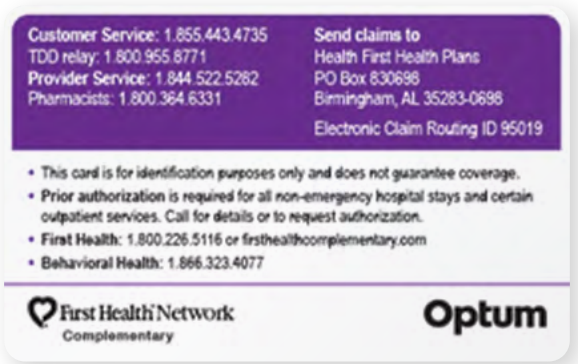


HFHP Medicare Advantage (MA)



HFHP Individual and Family Plans





Colorectal Cancer (CRC) Screening Using DNA Analysis (Cologuard™)

Background

To meet the Healthcare Effectiveness Data and Information Set (HEDIS) *Quality of Care* measures, members between 45 and 75 years of age are required to have a documented screening colonoscopy or flexible sigmoidoscopy. A screening colonoscopy meets HEDIS measures for a period of 10 years, while a flexible sigmoidoscopy meets the measure for five years. In the event a member does not want to have a screening colonoscopy, colorectal cancer screening can be achieved by stool DNA analysis (Cologuard™). While a colonoscopy is considered the "gold standard" for screening, DNA analysis (Cologuard™) would meet HEDIS criteria for a period of three years. The member should be counseled that if the results are positive, a diagnostic colonoscopy should be performed as a follow-up visit. Effective Sep. 1, 2018, this screening no longer requires prior authorization.

Plan Coverage Cologuard Criteria

- Covered once every three years
- Medicare Advantage: Age 50 to 85 years
  Individual/Family Member: Age 45 to 85 years
- Is asymptomatic (no signs or symptoms of colorectal disease, including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test)
- At average risk of developing CRC; no personal history of adenomatous polyps, CRC or inflammatory bowel disease, including Crohn's disease and ulcerative colitis; no family history of CRC or adenomatous polyps, familial adenomatous polyposis or hereditary nonpolyposis CRC

Order

For oncology colorectal screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result use CPT 81528. *(Ref. HCPCS Code and CPT © Codes)*

Prior Authorization

Effective Sep. 1, 2018, this service no longer requires prior authorization if criteria above is met.

Note: Fecal Occult Blood Test (FOBT): Guaiac (gFOBT) or immunochemical (FIT) are also options for annual screenings; however, screening colonoscopy is preferred.

HealthFirst
Health Plans

2023 Medication Adherence Guide

Cholesterol Management, Diabetes and Blood Pressure Management

Oct. 24, 2022

Drug Class	Brand Name	Generic Name	Health First Formulary	Formulation Covered	Medicare Tier	Health First Health Plan Medicare Advantage Plan 30-day Copay	Health First Health Plan Medicare Advantage Plan 90-day Copay	30-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660	90-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660
CHOLESTEROL MANAGEMENT									
Statins	Altoprev	lovastatin	Y	Generic	Tier 1	$0	$0	$	$
	Zocor	simvastatin	Y	Generic	Tier 1	$0	$0	$	$
	Pravachol	pravastatin	Y	Generic	Tier 1	$0	$0	$	$
	Lescol XL	fluvastatin	Y	Generic	Tier 1	$0	$0	$$	$$$$
	Crestor	rosuvastatin	Y	Generic	Tier 1	$0	$0	$	$$
	Lipitor	atorvastatin	Y	Generic	Tier 1	$0	$0	$	$
	Livalo	pitavastatin	Y	Brand	Tier 4	Up to $90	Up to $270	$$$$	$$$$$$
	Ezallor Sprinkle	rosuvastatin	Y	Brand	Tier 4	Up to $90	Up to $270	$$$$	$$$$$$
	Zypitamag	pitavastatin	Y	Brand	Tier 4	Up to $90	Up to $270	$$$$	$$$$$$
	Altoprev 24hr	lovastatin	Y	Brand	Tier 5	33%	33%	$$$$$$	$$$$$$
Statin Combo	Caduet	amlodipine-atorvastatin	Y	Generic	Tier 1	$0	$0	$	$
	Vytorin	ezetimibe-simvastatin	Y	Generic	Tier 1	$0	$0	$$	$$$$
DIABETES									
Biguanides	Glucophage	metformin	Y	Generic	Tier 1	$0	$0	$	$
	Glucophage XR	metformin ER	Y	Generic	Tier 1	$0	$0	$	$
	Fortamet	metformin ER (Osm)	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$$	$$$$$$
	Glumetza	metformin ER (MOD)	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$$$	$$$$$$
Thiazolidinedi-ones	Actos	pioglitazone	Y	Generic	Tier 1	$0	$0	$$	$$$
	Avandia	rosiglitazone	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$	$$$$$
DPP-4 Inhibitors	Onglyza	saxagliptin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$$	$$$$$$
	Tradjenta	linagliptin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Januvia	sitagliptin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Nesina	alogliptin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$$

COST	$ = $20-50	$$ = $51-150	$$$ = $151-300	$$$$ = $301-500	$$$$$ = $501-1,000	$$$$$$ = +$1,000

Continued: 2023 Medication Adherence Guide Cholesterol Management, Diabetes and Blood Pressure Management

Drug Class	Brand Name	Generic Name	Health First Formulary	Formulation Covered	Medicare Tier	Health First Health Plan Medicare Advantage Plan 30-day Copay	Health First Health Plan Medicare Advantage Plan 90-day Copay	30-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660	90-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660
DIABETES *(continued)*									
SGLT2	Farxiga	dapagliflozin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Invokana	canagliflozin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$$	$$$$$$
	Jardiance	empagliflozin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Steglatro	ertugliflozin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$$
GLP-1	Starlix	nateglinide	Y	Generic	Tier 1	$0	$0	$	$$
	Victoza	liraglutide	Y	Brand	Tier 3	up to $45	up to $135	$$$	$$$$
	Prandin [DSC]	repaglinide	Y	Generic	Tier 1	$0	$0	$$	$$$
	Adlyxin	lixisenatide	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$$	$$$$$$
	Ozempic	semaglutide	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Rybelsus	semaglutide	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Bydureon/ Byetta	exenatide	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Trulicity	dulaglutide	Y	Brand	Tier 3	Up to $45	up to $135	$$$$$	$$$$$$
Alpha Glucosidase Inhibitor	Precose	acarbose	Y	Generic	Tier 2	up to $15	up to $45	$	$
D2 Receptor Agonist	Cycloset	bromocripitine	Y	Brand	Tier 4	up to $90	up to $270	$$	$$$
Sulfonylureas	Glucotrol	glipizide	Y	Generic	Tier 1	$0	$0	$	$
	Glucotrol XR	glipizide er	Y	Generic	Tier 1	$0	$0	$	$
	Glynase	glyburide	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$	$
	Amaryl	glimepiride	Y	Generic	Tier 1	$0	$0	$	$
Combos	Metaglip [DSC]	glipizide-metformin	Y	Generic	Tier 1	$0	$0	$	$
	Glucovance [DSC]	glyburide-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$	$
	Kazano	alogliptin-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$$
	Actoplus Met	pioglitazone-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$
	Segluromet	ertugliflozin-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$	$$$$$
		repaglinide-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$	$$$$$
	Jentadueto	linagliptin-metformin	Y	Brand	Tier 3	up to $45	up to $135	$$$	$$$$$
	Jentadueto XR	linagliptin-metformin XR	Y	Brand	Tier 3	up to $45	up to $135	$$$	$$$$$
	Janumet	sitagliptin-metformin	Y	Brand	Tier 3	up to $45	up to $135	$$$	$$$$$
	Janumet XR	sitagliptin-metformin XR	Y	Brand	Tier 3	up to $45	up to $135	$$$	$$$$$

COST $ = $20-50 | $$ = $51-150 | $$$ = $151-300 | $$$$ = $301-500 | $$$$$ = $501-1,000 | $$$$$$ = +$1,000

Continued on next page.

Continued: 2023 Medication Adherence Guide Cholesterol Management, Diabetes and Blood Pressure Management

Drug Class	Brand Name	Generic Name	Health First Formulary	Formulation Covered	Medicare Tier	Health First Health Plan Medicare Advantage Plan 30-day Copay	Health First Health Plan Medicare Advantage Plan 90-day Copay	30-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660	90-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660
DIABETES *(continued)*									
Combos *(continued)*	**Invokamet**	canagliflozin-metformin	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$
	Invokamet XR	canagliflozin-metformin XR	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$
	Synjardy	empagliflozin-metformin	Y	Brand	Tier 3	up to $45	up to $135	$$$$	$$$$$
	Xigduo XR	dapagliflozin-metformin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Duetact	pioglitazone-glimepiride	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$$
	Trijardy	empagliflozin-linagliptin and metformin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Glxyambi	empagliflozin and linagliptin	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
	Synjardy XR	empagliflozin-metformin XR	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$
BLOOD PRESSURE MANAGEMENT									
ACE	**Accupril**	quinapril	Y	Generic	Tier 1	$0	$0	$	$
		benazepril	Y	Generic	Tier 1	$0	$0	$	$
		fosinopril	Y	Generic	Tier 1	$0	$0	$	$
		trandolapril	Y	Generic	Tier 1	$0	$0	$	$
		moexipril	Y	Generic	Tier 1	$0	$0	$	$$
	Prinivil, Zestril	lisinopril	Y	Generic	Tier 1	$0	$0	$	$
	Altace	ramipril	Y	Generic	Tier 1	$0	$0	$	$
		enalapril	Y	Generic	Tier 1	$0	$0	$	$
		perindopril	Y	Generic	Tier 1	$0	$0	$	$$
		captopril	Y	Generic	Tier 1	$0	$0	$	$
ARB		candesartan	Y	Generic	Tier 1	$0	$0	$$	$$$
	Cozaar	losartan	Y	Generic	Tier 1	$0	$0	$	$
		eprosartan	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$$
		irbesartan	Y	Generic	Tier 1	$0	$0	$	$$
	Micardis	telmisartan	Y	Generic	Tier 1	$0	$0	$	$$
	Diovan	valsartan	Y	Generic	Tier 1	$0	$0	$	$$
	Edarbi	azilsartan	Y	Brand	Tier 4	up to $90	up to $270	$$$	$$$$$
	Benicar	olmesartan	Y	Generic	Tier 1	$0	$0	$	$$
Direct Renin Inhibitor		aliskiren	Y	Generic	Tier 2	up to $15	up to $45	$$$	$$$$$

COST $ = $20-50 | $$ = $51-150 | $$$ = $151-300 | $$$$ = $301-500 | $$$$$ = $501-1,000 | $$$$$$ = +$1,000

Drug Class	Brand Name	Generic Name	Health First Formulary	Formulation Covered	Medicare Tier	Health First Health Plan Medicare Advantage Plan 30-day Copay	Health First Health Plan Medicare Advantage Plan 90-day Copay	30-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660	90-day supply: Rx cost contribution toward entering the coverage gap (donut hole) beginning at $4,660
BLOOD PRESSURE MANAGEMENT *(continued)*									
Combos		enalapril-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
	Accuretic	quinapril-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
	Zestoretic	lisinopril-hydrochlorothiazde	Y	Generic	Tier 1	$0	$0	$	$$
		amlodipine-benazepril	Y	Generic	Tier 1	$0	$0	$	$$
	Lotensin HCT	benazepril-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
		fosinopril-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
	Hyzaar	losartan-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
	Avalide	irbesartan-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$	$$
		captopril-hydrochlorothiazide	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$
	Atacand HCT	candesartan-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$$	$$$
	Tarka	trandolapril-verapamil	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$$
	Micardis HCT	telmisartan-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$$	$$$$
	Twynsta	telmisartan-amlodipine	Y	Generic	Tier 1	$0	$0	$$	$$$$
	Diovan HCT	valsartan-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$$	$$$
	Exforge	amlodipine-valsartan	Y	Generic	Tier 1	$0	$0	$	$$
	Edarbyclor	azilsartan-chlorthalidone	Y	Brand	Tier 4	up to $90	Up to $270	$$$	$$$$$
	Benicar HCT	olmesartan-hydrochlorothiazde	Y	Generic	Tier 1	$0	$0	$	$$
	Exforge HCT	amlodipine-valsartan-hydrochlorothiazide	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$	$$$
	Azor	amlodipine-olmesartan	Y	Generic	Tier 1	$0	$0	$$	$$$
	Tribenzor	omesartan-amlodipine-hydrochlorothiazide	Y	Generic	Tier 1	$0	$0	$$	$$$
	Tekturna HCT	aliskiren-hydrochlorothiazide	N	Non-Formulary	Non-Formulary	Non-Formulary	Non-Formulary	$$$$	$$$$$$
	Entresto	sacubitril/valsartan	Y	Brand	Tier 3	up to $45	up to $135	$$$$$	$$$$$$

COST	$ = $20-50	$$ = $51-150	$$$ = $151-300	$$$$ = $301-500	$$$$$ = $501-1,000	$$$$$$ = +$1,000

Provider Portal

Health First Health Plans (HFHP)

The Provider Portal will help you find in-network experts, lab facilities and more by searching the provider directory. Additionally, get easy access to provider manuals for all markets, policies for clinical guidelines, reimbursement policies and required forms.

To view any member information, you will need to log in. The 2023 Provider Portal (administered by HealthTrio) will contain any dates of service on or after January 1, 2023.

Benefits of having your own access to the HFHP Provider Portal

- ✓ Check member eligibility
- ✓ Check status of claims
- ✓ Submit prior authorizations electronically
- ✓ Sign up for electronic payments
- ✓ Review members' clinical information
- ✓ Connect your staff to your organization (practice) account and grant permission to complete tasks in the portal

Create Your New 2023 HFHP Provider Portal Account

As of November 1, 2022, you may create your Provider Portal account. Please Note: Account sharing is not permitted and the first associate to register will be established as the practice's "Practice (Local) Administrator." The Organization Manager has the ability to approve access for all others within the practice.

1. **Go** to Hf.org/4providers, click **Log-in** and select **"Provider Portal: 2023 — MA/IFP Plans."**

2. Select **Register Here** *(If you had an account in 2021, you can use the same login credentials)*
   - Complete the **User Information** (select next) — **Office Information** (select next).
   - The **Registration Summary** — confirm the office and user information (select Finish to proceed).
   - The **Registration Created** section will show you the User ID (select next).
   - The **Registration Complete** indicates the user is now ready to log in.

3. After the Health Plan has approved access, the user will receive an email to log in.

The Provider Portal helpline is 877-814-9909.

Submit a Medical Authorization Request

Health First Health Plans (HFHP)

To submit a Medical Authorization request, log in to the provider portal at Hf.org/4providers. You can begin to submit Prior Authorizations as of Dec. 12, 2022, for dates of service (DOS) on or after Jan. 1, 2023.

- Authorizations tab > Select the ***Authorization Request Form***
- Fax this form to **855-328-0059**

For any members admitted to an inpatient setting in 2022 and will remain admitted in 2023, HFHP will assume ownership of authorization effective Jan. 1, 2023.

When to use the Authorization Form:

- Pre-service, in-network medical authorizations that are reviewed by Health First Health Plans
- Concurrent or post-service auth for ER to inpatient admission

When not to use the Authorization Form:

- × Authorizations for DOS in 2023 previously approved by Oscar, Optum or eviCore, which will be honored
- × Out-of-network physician or facility request
- × Spinal pain injections no longer require authorization
- × To find an in-network provider or facility
- × PT/OT for IFP will not require Prior Auths until 20th visit has occurred

Claim Submission

Health First Health Plans (HFHP)

HFHP Medical Services Payor ID: 95019

Optum Behavioral Health Services Payor ID: 87726

Electronic Claims

Electronic claims should be submitted by using **Availity, Eligible** or **Change Healthcare**.

For any issues setting up the ability to submit claims electronically, please contact the billing vendor to ensure that they have the new HFHP payor ID in their system.

Paper Claims

If a claim cannot be submitted electronically, a paper UB-04 or CMS 1500 form should be submitted to:

Health First Health Plans
PO Box 830698
Birmingham, AL 35283-0698
Fax: 321-434-5655

CMS 1500 Form: Required for all physician services claims, including internal medicine, gynecology and psychiatry. The International Classification of Diseases (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise noted.

UB-04 Form: Required for all institutional services claims. All field information is required unless otherwise noted.

If unlisted or miscellaneous codes are used, notes and/or a description of the services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment. Claims received with unlisted or miscellaneous codes that have no supporting documentation may be denied, and the member may not be held liable for payment.

Submitting Disputes

Health First Health Plans (HFHP)

Provider disputes are preferred to be submitted electronically through our online provider web portal. The portal is available 24 hours a day, seven days a week.

By Electronic Submission (preferred):

1. Log in to the provider portal at Hf.org/4providers
2. Click on Claims

By Mail:

Health First Health Plans:

Attn: Claims Resolution Unit
6450 US Highway 1
Rockledge, FL 32955

For questions about the dispute process, please review the Provider Manual, talk to your provider network representative or contact our customer service department at: **844-522-5282.**

Provider Disputes and Corrected Claims

Health First Health Plans (HFHP)

Disputes

Providers who would like to make an inquiry may contact HFHP via phone, web, email, fax or letter sent to the address specified on the EOP. Inquiries leading to the submission of adjusted claims or late submissions will be reviewed according to the timelines set forth in the Claims Submission section.

A provider wishing to submit a payment dispute may do so using the Dispute Resolution Form or other written format submitted by mail, or electronically via the provider portal. A copy of the Dispute Request Form can be found on Hf.org/4providers under Provider > Claims. If additional information is requested to resolve a dispute, this will trigger the Dispute Resolution Process. Once the Dispute Request Form is received, HFHP will resolve or seek additional information to resolve disputes within 60 calendar days. If HFHP requests additional information to resolve a dispute, the provider has 30 calendar days to respond. Upon receipt of all requested information, HFHP will then resolve or seek additional information needed within 60 calendar days.

At any time during the Dispute Resolution Process, either party may request to meet and confer by telephone. If the meet and confer process does not resolve the dispute, either party may submit the dispute to binding arbitration in accordance with the terms of the provider's contract.

Appeals Process

In cases where an authorization request is denied, the enrollee or the enrollee's authorized representative will have an opportunity to appeal the decision. The appeal will be handled through a structured appeals process and a licensed physician not involved in the initial coverage decision will review the appeal. Upon resolution of every appeal, a resolution letter is sent to the member, which, in the case of an adverse determination, will include information regarding any additional appeal rights the member might have and instructions on how to dispute the determination. A copy of this letter will also be faxed to the provider and the member's authorized representative, if applicable.

Any appeal of a denied utilization review (UR) decision, in which the services were determined not to be medically necessary, should be filed within 60 days (for MA members) or 365 days (for IFP members) from original decision of the provider's receipt of the denial (adverse determination). In order to file an appeal, the provider should specify they are seeking to file an appeal of a denied UR decision with the Clinical Review team, whether the appeal is submitted via telephone or in writing. The provider may submit a one-page Appeal Form, along with additional clinical information in order to file an appeal.

In Florida, members or their authorized representatives may request an Independent Medical Review of disputed health care services if they believe that health care services have been improperly denied, modified, or delayed by HFHP or one of its contracting practitioners.

Corrected Claims

Providers may submit an updated claim within one (1) year of the date the services were rendered/discharged. Providers must submit a corrected claim when previously submitted claim information has changed (e.g. procedure codes, diagnosis codes, dates of service, etc.). When a claim is submitted as a correction or replacement, the entire claim must be submitted.

Electronic Corrected Claims

Electronic corrected claims must be submitted with frequency code 7 in Element CLM05-3 (Claim Frequency Type Code). Updated claim submissions that do not have these codes may be denied as duplicate submissions.

Paper Corrected Claims

Paper CMS 1500 corrected claim submissions must use frequency code 7 under Item 22 (Resubmission Code) and the corresponding original reference code field must list the original payor claim ID. Paper UB-04 corrected claims must be submitted with Claim Frequency Type 7 as the third digit under Type of Bill (Form Locator 04).

P.O. Box 830698
Birmingham, AL 35283-0698

Requests for Additional Information

During the claims adjudication process, HFHP may request additional information—such as medical records, acquisition invoices or itemized bills— from the provider in order to better ascertain financial liability and whether or not the services on the claim should be reimbursed. Any requests for more information will be made within timelines set by state regulation or the provider's contract with HFHP.

Guidelines for Additional Information

The following content guidelines for medical records and itemized bills will ensure timely processing of claims requiring additional information. All requested documents must be legible and must present the information in a way that can be reasonably interpreted. Medical Record Content Complete medical records requested for the purpose of claim payment must include the content outlined below only for the requested dates of service. The content is as follows, but is not limited to:

- Member demographics
- Biographical information
- Consultation reports including specialist consultations
- History & physical examination
- Daily clinician notes
- Laboratory reports
- Vitals
- Medication list
- Imaging results, if applicable
- Diagnostic tests
- Preventative health records including immunizations
- Operative notes, if applicable
- Inpatient/ER discharge summary reports, if applicable
- Progress or office visit notes, if applicable

Providers should refer to their respective contracts for timelines when submitting requested additional information for claims. Unless a different timeline is specified in the contract, providers must submit the requested information with the associated Explanation of Payment (EOP) and/or a copy of the information request letter, within 35 calendar days of the initial request. If all requested documentation is not received within this timeframe, the claim will be denied. The member cannot be held financially responsible for claims denied due to the provider's failure to submit requested documentation.

Section Three:
Clinical Documentation Integrity and Risk Adjustment

▲ Back to Contents

Introduction

Evolution to Value

As we continue to move toward a value-based and patient-centered health care environment, diagnosis coding is becoming vital to physicians, health care professionals and payers to establish the complexity of the patient's health status, medical decision-making and ultimately reimbursement.

Accurately capturing each patient's health status by coding to the highest level of specificity for their active conditions supports the quality and optimization of patient care. The following sections provide example assessments/plans, documentation requirements and ICD-10 diagnosis coding tips for some of the most commonly reported chronic conditions.

Why focus on documentation and coding integrity?

- Support and meet clinical quality measurement initiatives and requirements
- Improve the overall health status and continuity of care for patients
- Optimize a healthy revenue cycle and claims processing
- If it hasn't been documented, it hasn't been done
- Just because it's documented, doesn't mean it's supported. Codes without support are non-compliant

Why is clinical documentation integrity (CDI) needed?

- Ensure that patients are treated at least once a year for all chronic conditions
- Improve coordination of care by making sure all conditions are tracked by the primary care physician and treated by the appropriate specialist
- Ensure complete and accurate registries to be used in case management programs for population health to improve the accuracy of value-based payments to providers by appropriately capturing disease burden of populations

Why is documenting conditions every year necessary?

A patient's risk adjustment factor (RAF) is based on the health conditions they have, as well as demographic factors. An accurate RAF score and expected level of risk depend on complete documentation and correct coding of the patient's medical record.

The Centers for Medicare & Medicaid Services (CMS) requires that health care providers identify all conditions the patient may have (specifically, those that may fall within a hierarchical condition category [HCC]) at least once per calendar year to support an accurate RAF score for the patient.

Health First Health Plans Medicare Advantage

Medicare Advantage (MA) is one of the available plans under Health First Health Plans. As an FHHS provider, you accept this plan unless it was specifically omitted from your FHHS contract. Occasionally, CMS conducts audits of participating physicians; therefore, it is important that you tell your patients that you accept Health First Health Plans Advantage Plans MA products.

Clinical Documentation Integrity (CDI) Program

Health First Health Plans Advantage Plans primary care providers (PCP) who see more than one Medicare Advantage patient have an opportunity to participate in the Clinical Documentation Integrity (CDI) program. This program compensates physicians for providing and documenting appropriate treatment and coordinating care for Medicare Advantage patients. Providers can earn over $200 per member per year by participating in the Health First Health Plans Advantage Plans CDI Program.

Participation in the program is simple. There are four components: The Comprehensive Health Assessment (CHA) referral, completion of the Documentation Recapture Opportunity CDI form, quality (HEDIS) care gaps and pharmacy (STARS) care gaps. Providers can start earning compensation at any time by referring their patients to schedule a CHA with Matrix, the Health First Health Plans Advantage Plans CHA vendor, via **matrixforme.com**. Health First Health Plans Advantage Plans CDI program providers will receive forms for each MA patient where there are open care gaps. These forms will be available via paper or access through a web-based tool. To receive compensation, after patients are seen in the office and appropriate information is gathered at the point of care, CDI forms will need to be completed in the web-based tool or returned

to Health First Health Plans. Payments will be mailed quarterly to the group under your Employer Tax ID Number. For providers new to the program, some initial training is required.

If you have questions about the CDI program or would like to participate, please email phsocdi.raf@adventhealth.com or contact your Provider Network Representative.

** The total compensation opportunity will vary based on the number of measures for which a patient is eligible.*

Diabetes Mellitus

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Diabetes Mellitus Type II, unspecified (E11.9_)
- DMII with renal complications (E11.2_)
- DMII with ophthalmic complications (E11.3_)
- DMII with neurologic complications (E11.4_)
- DMII with periph. circulatory complications (E11.5_)
- DMII with other specified complications (E11.6_)

Example | Diabetes with Hyperglycemia

Assessment & Plan

Diabetes is not controlled, and the patient is unable to keep blood sugar (BS) low enough. Will adjust insulin and see the patient for follow up in two weeks. Asked patient to keep a log of daily BS during this time.

ICD-10 CM Codes

- E11.65 – Type 2 diabetes mellitus with hyperglycemia
- Z79.4 – Long-term (current) use of insulin

Documentation & Coding Tips

- Use E11 as a default — if the type of diabetes is not documented or documentation states patient uses insulin.
- Hyperglycemia — poorly controlled diabetes; patient with elevated BS or elevated A1c should be coded type2 diabetes with hyperglycemia, E11.65.
- Provider must specify hyper/hypoglycemia.
- Z79.4 — code to indicate patient uses insulin. Note: if patient has type 1 diabetes, do not use Z79.4 as insulin use is presumed.
- All diabetic complications are weighted with a roughly three times greater RAF score than diabetes without complications. To code conditions as being diabetic complications/manifestations, the medical record documentation must present a specific causal relationship between the two conditions. Examples of such a causal relationship include: with, in relation to, related with, diabetic, due to, etc.
- There are exceptions to the causal relationship rule. Please refer to the ICD-10 code book for guidelines.

Note this list is not all-inclusive. Please refer to the ICD-10-CM codebook for the complete list. Diabetes, diabetic (mellitus) — E11 with:

- Amyotrophy — E11.44
- Arthropathy — NEC E11.618
- Polyneuropathy — E11.42
- Cataract — E11.36
- Charcot's joints — E11.610
- Chronic kidney disease (CKD) — E11.22
- Circulatory complication — NEC E11.59
- Foot ulcer — E11.621
- Gangrene — E11.52
- Gastroparesis — E11.43
- Hyperglycemia — E11.65 (Coma — E11.641)
- Hyperosmolarity — E11.00 (Coma — E11.01)

Cancer

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Secondary malignant neoplasm of brain (C79.31)
- Acute myeloblastic leukemia, not having achieved remission (C92.00)
- Acute promyelocytic leukemia, not having achieved remission (C92.40)
- Acute myelomonocytic leukemia, not having achieved remission (C92.50)
- Secondary malignant neoplasm of bone (C79.51)
- Secondary malignant neoplasm of bone marrow (C79.52)
- Malignant neoplasm of unspecified part of bronchus or lung (C34.9)*
- Multiple myeloma not having achieved remission (C90.00)
- Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites (C85.88)
- Other specified types of non-Hodgkin lymphoma, unspecified site (C85.80)
- Malignant neoplasm of colon, unspecified (C18.9)
- Malignant neoplasm of bladder, unspecified (C67.9)
- Malignant neoplasm of rectum (C20)
- Malignant neoplasm of unspecified site of female breast (C50.9)*
- Malignant neoplasm of prostate (C61)
- Malignant neoplasm of thyroid gland (C73)

** Documentation should reflect site or body part as well as laterality.*

Example | Secondary Malignant Neoplasm of Bone

Assessment & Plan

Metastatic bone cancer originating from breast cancer. Breast cancer was eradicated four years ago. The patient is doing well with the current pain management regimen. A follow up with the patient will be scheduled for after the next round of radiation.

ICD-10 CM Codes

- C79.51 – Secondary malignant neoplasm of bone
- Z85.3 – Personal history of malignant neoplasm of breast

Documentation & Coding Tips

- When a secondary cancer is coded and the primary cancer is still present, the primary cancer should be coded as well; if the primary cancer has been completely eradicated, it should not be coded as active. A history code should be considered.
- Cancer (except those coded to categories [C80-C95] for which treatment is no longer received) would be coded with a Z code for history of malignant neoplasm. Likewise, any cancer stated to have been completely eradicated would be coded to a Z code.

Pulmonary

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- COPD, unspecified (J44.9)
- COPD with acute lower respiratory infection (J44.0)
- COPD with acute exacerbation (J44.1)
- Emphysema, unspecified (J43.9)
- Unspecified chronic bronchitis (J42)

Example | COPD With Acute Exacerbation

Assessment & Plan

Patient has acute exacerbation of COPD with acute bronchitis due to patient smoking. Advised on smoking cessation. Increased prednisone, prescribed antibiotic and increased nebulizer treatments to every two to four hours. Follow up in five days or sooner if symptoms worsen.

ICD-10 CM Codes

- J44.0 – COPD with acute lower respiratory infection
- J44.1 – COPD with (acute) exacerbation
- J20.9 – Acute bronchitis, unspecified
- F17.218 – Nicotine dependence, cigarettes, with other nicotine induced disorders

Documentation & Coding Tips

In the scenario presented in the A&P, four codes are required:

1. COPD with acute exacerbation
2. COPD with acute bronchitis
3. Acute bronchitis
   - J20.9 and J44.0 – are necessary to correctly code acute bronchitis with COPD
   - J44.0 – note: use additional code to identify the infection
   - J20.9 – added to identify the infection, acute
   - J44.1 – additional code to identify the COPD exacerbation
4. A cause-and-effect relationship must be documented to assign code F17.218. If a cause-and-effect relationship is not documented, use code F17.210 (nicotine dependence, unspecified, uncomplicated).

If the causative organism is known and documented, use code specified organism code under J20, acute bronchitis.

Congestive Heart Failure

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Heart failure, unspecified (I50.9)
- Other restrictive cardiomyopathy (I42.5)
- Primary pulmonary hypertension (I27.0)
- Other secondary pulmonary hypertension (I27.2)
- Other specified pulmonary heart diseases (I27.89)

Example | Congestive Heart Failure

Assessment & Plan

The primary care physician can code for CHF if care is coordinated with the cardiologist. The assessment and plan can be related to care coordination.

ICD-10 CM Codes

- I50 – Heart failure
- I50.1 – Left ventricular failure
- I50.2 – Systolic (congestive) heart failure
- I50.3 – Diastolic (congestive) heart failure
- I50.4 – Combined systolic and diastolic heart failure
- I50.9 – Heart failure, unspecified

Documentation & Coding Tips

First code whether heart failure is due to an underlying condition such as:

- Hypertension
- Hypertension with chronic kidney disease
- Rheumatic heart failure
- Heart failure following surgery
- Complication abortion or ectopic or molar pregnancy
- Obstetric surgery and procedures

Link heart failure to its underlying condition — Link heart failure to the underlying hypertensive chronic kidney disease with stage 1 through 4 CKD. The medical record should notate a causal relationship between these conditions.

The type of heart failure should be documented as:

- Diastolic
- Systolic
- Combined/mixed diastolic/systolic
- Left ventricular

Rheumatoid Arthritis and Infectious Connective Tissue Disease

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Rheumatoid arthritis, unspecified (M06.9)
- Inflammatory polyarthropathy (M06.4)
- Sacroiliitis, not elsewhere classified (M46.1)
- Sicca syndrome, unspecified (M35.00)
- Sicca syndrome with keratoconjunctivitis (M35.01)
- Polymyalgia rheumatica (M35.3)
- Progressive systemic sclerosis (M34.0)
- CR(E)ST syndrome (M34.1)
- Systemic sclerosis, unspecified (M34.9)
- Other psoriatic arthropathy (L40.59)
- Systemic lupus erythematosus, organ or system involvement unspecified (M32.10)
- Polymyositis, organ involvement unspecified (M33.20)

Example | Rheumatoid Arthritis

Assessment & Plan

Patient presents with pain, swelling and stiffness of joints in the hand which is found to be a flare of their rheumatoid arthritis. Reviewed patient's Disease-Modifying Antirheumatic Drug (DMARDs) medication routine and sending patient for Disease Activity Score 28 (DAS28).

ICD-10 CM Codes

- M05._ Code Category — Rheumatoid arthritis with rheumatoid factor
- M06._ Code Category — Other rheumatoid arthritis
- M07 — Enteropathic Arthropathies

Documentation & Coding Tips

Over 400 ICD-10 Codes that allow for greater detail including:

- Type: RA with rheumatoid factor, other rheumatoid arthritis, enteropathic, arthropathies.
- Anatomic location: Shoulder, elbow, wrist, hand, hip, etc.
- Laterality: Right, left, unspecified.

Morbid Obesity

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Morbid (severe) obesity due to excess calories (BMI greater than or equal to symbol 40.2) (E66.01). Please specify in documentation that the patient has obesity due to excess calories.
- BMI Ranges (Z68.41 – Z68.45)
- Morbid (severe) obesity with alveolar hypoventilation (E66.2)

Example | Body Mass Index (BMI)

Assessment & Plan

Morbid obesity recorded BMI ≥ 40.2, and the patient admits to overeating. Discussed dietary changes and reduced caloric intake at length. Will schedule consult appointment with our registered dietitian. Type 2 diabetes without complications and A1c is within normal limits. Patient to continue current medication.

ICD-10 CM Codes

- E66.01 – Morbid (severe) obesity due to excess calories
  Z68.41 – BMI 40.0 - 44.9, adult
- E11.9 – Type 2 diabetes mellitus without complications
  Z71.3 – Dietary counseling and surveillance

Documentation & Coding Tips

- Any clinician can document BMI in the patient's medical record.
- Physicians, and other health care professionals, must document the condition and its medical significance (i.e., overweight/ morbid obesity).
- Two codes should be reported for conditions coded to E66. _, overweight and obesity along with code for documented BMI.

Mental Health

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Bipolar disorder, unspecified (F31.9)
- Major depressive disorder, single episode, unspecified (PHQ-9: 10 – 27) (F32.9)
- Major depressive disorder, recurrent, unspecified (PHQ-9: 10 – 27) (F33.9)

Example | Major Depression

Assessment & Plan

A comprehensive medication reconciliation, including documentation of each medication: indication, length of treatment, benefits, side effects and plan for continued treatment is sufficient documentation of TAMPER (treat, assessment, monitor/medicate, plan, evaluate, referral) to support coding it on a claim.

ICD-10 CM Codes

- F32._ — Major depressive disorder, single episode
- F33._ — Major depressive disorder, recurrent

Major Depression ICD-10 Codes:

F32.0 *Major depressive disorder,* **single episode, mild**

F32.1 *Major depressive disorder,* **single episode, moderate**

F32.2 *Major depressive disorder,* **single episode, severe without psychotic features**

F32.3 *Major depressive disorder,* **single episode, severe with psychotic features**

F32.4 *Major depressive disorder,* **single episode, in partial remission**

F32.5 *Major depressive disorder,* **single episode, in full remission**

F32.9 *Major depressive disorder,* **single episode,** ***unspecified***

F33.0 *Major depressive disorder,* **recurrent, mild**

F33.1 *Major depressive disorder,* **recurrent, moderate**

F33.2 *Major depressive disorder,* **recurrent severe without psychotic features**

F33.3 *Major depressive disorder,* **recurrent, severe with psychotic symptoms**

F33.4 *Major depressive disorder,* **recurrent, in remission**

F33.40 *Major depressive disorder,* **recurrent, in remission,** ***unspecified***

F33.41 *Major depressive disorder,* **recurrent, in partial remission**

F33.42 *Major depressive disorder,* **recurrent, in full remission**

F33.8 *Other* **recurrent** *depressive disorders*

F33.9 *Major depressive disorder,* **recurrent,** ***unspecified***

Documentation & Coding Tips

- Per DSM-5 guidelines, to document major depression, the medical record must show that the patient has suffered loss of function for a minimum of two weeks. At least five symptoms need to be present during the same two-week period to diagnose major depression. List all signs of depressed mood and notate how long these symptoms have been present, document severity and episode.
- Depression and anxiety do not risk adjust, but major depression does, even a single episode.
- Documentation for depression must include:
  - Episode (single or recurrent)
  - Severity (mild, moderate, severe)
  - Presence of any associated symptoms (with or without psychotic features)
  - Clinical status of current episode (in partial or full remission)

Heart Arrhythmia

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

- Unspecified atrial fibrillation (I48.91)
- Sick sinus syndrome (I49.5)
- Bradycardia, unspecified (R00.1)
- Ventricular tachycardia (I47.2)
- Unspecified atrial flutter (I48.92)
- Supraventricular tachycardia (I47.1)
- Atrioventricular block, complete (I44.2)

Example | Atrial Fibrillations/Atrial Flutter

Assessment & Plan

Patient has experienced intermittent episodes of irregular heartbeat over the past year causing shortness of breath. Paroxysmal atrial fibrillation (PAF) recorded on Holter monitor. Patient is also being treated for hypertension. Patient admits to non-compliance with taking medicines. Stressed importance of compliance with patient. Follow up in one week. Patient had myocardial infarction (MI) six months ago.

ICD-10 CM Codes

- I48.0 — Paroxysmal atrial fibrillation (PAF) I10 — Essential (primary) hypertension
- T46.5X6D — Underdosing of other antihypertensive drugs, subsequent encounter Z91.12 — Patient's intentional underdosing of medicine regimen
- I25.2 — History of myocardial infarction (MI)

Documentation & Coding Tips

Atrial fibrillation (AF) is broken down into four categories.

1. Paroxysmal — Terminates within seven days.
2. Persistent — Sustained more than seven days and is subject to rhythm control to maintain normal sinus rhythm (NSR) via medication.
3. Permanent (Chronic) — NSR cannot be sustained. Physicians and other health care professionals or patient cease further attempts to maintain NSR.
4. History AF — AF in the past but now NSR, and the patient is not taking medicine to maintain NSR .

Atrial flutter (AFL) is broken down into two categories.

1. Type I (typical)
2. Type II (atypical)

Reference: AHA Coding Clinic, First Quarter 2019: Pacemaker is considered as part of treatment for SSS, so if condition is still present being monitored and managed, it should be reported. Sick sinus syndrome may be controlled with a pacemaker, the condition itself is still considered to be present and reportable as a chronic condition. Documentation should clearly indicate the presence of both and the impact on patient care.

Vascular Diseases

Consider the following common, risk-adjusted ICD diagnoses for Medicare patients.

- Peripheral vascular disease, unspecified (I73.9)
- Other pulmonary embolism without acute cor pulmonale (I26.99)
- Unspecified atherosclerosis of native arteries of extremities, right leg (I70.201)
- Unspecified atherosclerosis of native arteries of extremities, left leg (I70.202)
- Unspecified atherosclerosis of native arteries of extremities, bilateral legs (I70.203)
- Abdominal aortic aneurysm, without rupture (I71.4)
- Atherosclerosis of aorta (I70.0)

Example | Peripheral Vascular Disease

Assessment & Plan

Patient had intermittent claudication and was sent for ankle-brachial index test (ABI). ABI came back abnormal, diagnostic of peripheral vascular disease (PVD). Patient will begin taking aspirin and smoking cessation was discussed, as that can make it worse.

ICD-10 CM Codes

- I73._ Code Category — Other peripheral vascular diseases

Documentation & Coding Tips

To document most specifically for PVD, include these components in documentation.

- Location of vein/artery
- Whether the vein/artery is native or a graft (and type of graft if known)
- Complications such as intermittent claudication, ulceration or rest pain
- Laterality (left, right or bilateral) and specify if one or both sides are affected by complicating conditions of atherosclerosis

ICD-10 I73._ Code Category:

- I73 Other peripheral vascular diseases
- I73.0 Raynaud's syndrome
  - — I73.00.....without gangrene
  - — I73.01.....with gangrene
- I73.1 Thromboangiitis obliterans (Buerger's disease)
- I73.8 Other specified peripheral vascular diseases
- I73.9 Peripheral vascular disease, unspecified

Chronic Kidney Disease

Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

Diabetes and high blood pressure are the two main causes of chronic kidney disease (CKD). Diabetes causes damage to many organs, including the kidneys and heart, as well as blood vessels, nerves and eyes. Hypertension, if poorly controlled, is a leading cause of heart attacks, strokes and CKD.

Example | Chronic Kidney Disease

Assessment & Plan

Bloodwork completed on April 8, 2021. Patient eGFR 19=CKD IV due to HTN and DMII. Albuminuria 260. Referred patient to nephrology for persistent hyperkalemia/metabolic acidosis and recurrent kidney stones. Assess for future kidney dialysis.

ICD-10 CM Codes

- N18._ Code Category - Chronic Kidney Disease (CKD)

Documentation & Coding Tips

Based on severity, CKD is designated by Stages 1 through 5.

- N18.2, Stage 2 — Mild CKD
- N18.30, Stage 3 — Moderate CKD unspecified
- N18.31, Stage 3A — Moderate CKD
- N18.32, Stage 3B — Moderate CKD
- N18.4, Stage 4 — Severe CKD
- N18.6, Stage 5 — End-stage renal disease (ESRD) or end-stage renal failure

Typically, ESRD patients will have kidney function between 10 to 15%. If the provider documents both a stage of CKD and ESRD, only code N18.6 should be assigned.

- Document any underlying cause of CKD such as diabetes or hypertension
- Code first any associated diagnoses/conditions: diabetic chronic kidney disease (E10.22, E11.22) and hypertensive CKD (I12.-, I13.-)
- Document if the patient is dependent on dialysis HCC Z99.2
- Document any associated diagnoses/conditions

Risk Adjustment Factor Tip Sheet

1. Consider the following common, risk-adjusted ICD-10 diagnoses for Medicare patients.

Diabetes Mellitus

- Diabetes Mellitus Type II, unspecified (E11.9)
- DMII with renal complications (E11.2_)
- DMII with ophthalmic complications (E11.3_)
- DMII with neurologic complications (E11.4_)
- DMII with periph. circulatory complications (E11.5_)
- DMII with other specified complications (E11.6_)

Cancer

- Secondary malignant neoplasm of brain (C79.31)
- Acute myeloblastic leukemia, not having achieved remission (C92.00)
- Acute promyelocytic leukemia, not having achieved remission (C92.40)
- Acute myelomonocytic leukemia, not having achieved remission (C92.50)
- Secondary malignant neoplasm of bone (C79.51)
- Secondary malignant neoplasm of bone marrow (C79.52)
- Malignant neoplasm of bronchus or lung (C34.9_)
- Multiple myeloma not having achieved remission (C90.00)
- Other specified types of non-Hodgkin lymphoma, lymph nodes of multiple sites (C85.88)
- Other specified types of non-Hodgkin lymphoma, unspecified site (C85.80)
- Malignant neoplasm of colon, unspecified (C18.9)
- Malignant neoplasm of bladder, unspecified (C67.9)
- Malignant neoplasm of rectum (C20)
- Malignant neoplasm of female breast (C50.9_)
- Malignant neoplasm of prostate (C61)
- Malignant neoplasm of thyroid gland (C73)

Pulmonary

- COPD, unspecified (J44.9)
- COPD w acute lower respiratory infection (J44.0)
- COPD w (acute) exacerbation (J44.1)
- Emphysema, unspecified (J43.9)
- Unspecified chronic bronchitis (J42)

Congestive Heart Failure

- Heart failure, unspecified (I50.9)
- Cardiomyopathy, unspecified (I42.9)
- Other restrictive cardiomyopathy (I42.5)
- Primary pulmonary hypertension (I27.0)
- Other secondary pulmonary hypertension (I27.2)
- Other specified pulmonary heart diseases (I27.89)

Rheumatoid Arthritis and Infectious Connective Tissue Disease

- Rheumatoid arthritis, unspecified (M06.9)
- Inflammatory polyarthropathy (M06.4)
- Sacroiliitis, not elsewhere classified (M46.1)
- Sicca syndrome, unspecified (M35.00)
- Sicca syndrome with keratoconjunctivitis (M35.01)
- Polymyalgia rheumatica (M35.3)
- Progressive systemic sclerosis (M34.0)
- CR(E)ST syndrome (M34.1)
- Systemic sclerosis, unspecified (M34.9)
- Other psoriatic arthropathy (L40.59)
- Systemic lupus erythematosus, organ or system involvement unspecified (M32.10)
- Polymyositis, organ involvement unspecified (M33.20)

Morbid Obesity

- Morbid Obesity (BMI ≥40) (E66.01)
- BMI Ranges (Z68.41 – Z68.45)
- Morbid (severe) obesity with alveolar hypoventilation (E66.2)

Mental Health

- Bipolar disorder, unspecified (F31.9)
- Major depressive disorder, recurrent, unspecified (PHQ- 9: 10 – 27) (F33.9)
- Major depressive disorder, single episode, unspecified (PHQ-9: 10 – 27) (F32.9)

Heart Arrhythmia

- Unspecified atrial fibrillation (I48.91)
- Sick sinus syndrome (I49.5)
- Ventricular tachycardia (I47.2)
- Unspecified atrial flutter (I48.92)
- Supraventricular tachycardia (I47.1)
- Atrioventricular block, complete (I44.2)

Vascular Diseases

- Peripheral vascular disease, unspecified (I73.9)
- Other P.E. w/o acute cor pulmonale (I26.99)
- Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity (I82.409)
- Abdominal aortic aneurysm, without rupture (I71.4)
- Unspecified atherosclerosis of native arteries of extremities, unspecified extremity (I70.209)
- Atherosclerosis of aorta (I70.0)

2. Bill all active diagnoses by attaching ICD-10 codes to the claim for the encounter.

3. Document an assessment and plan for each of the active diagnoses from step 1.

Review information with patient

Valid Examples of an Assessment and Plan

- Diabetes is not controlled, and the patient is unable to keep blood sugar (BS) low enough. Will adjust insulin and see the patient for follow up in two weeks. Asked patient to keep a log of daily BS during this time.
- Morbid obesity recorded BMI ≥ 40.2, and the patient admits to overeating. Discussed dietary changes and reduced caloric intake at length. Will schedule consult appointment with our registered dietitian. Type 2 diabetes without complications and A1c is within normal limits. Patient to continue current medication.

4. Reconcile the problem list based on all active conditions from this evaluation.

Risk Adjustment Factor Tip Sheet

The following 83 disease categories impact risk-adjustment factor scores.

Code	Name
HCC1	HIV/AIDS
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
HCC6	Opportunistic Infections
HCC8	Metastatic Cancer and Acute Leukemia
HCC9	Lung and Other Severe Cancers
HCC10	Lymphoma and Other Cancers
HCC11	Colorectal, Bladder, and Other Cancers
HCC12	Breast, Prostate, and Other Cancers and Tumors
HCC17	Diabetes with Acute Complications
HCC18	Diabetes with Chronic Complications
HCC19	Diabetes without Complications
HCC21	Protein-Calorie Malnutrition
HCC22	Morbid Obesity
HCC23	Other Significant Endocrine and Metabolic Disorders
HCC27	End-Stage Liver Disease
HCC28	Cirrhosis of Liver
HCC29	Chronic Hepatitis
HCC33	Intestinal Obstruction/Perforation
HCC34	Chronic Pancreatitis
HCC35	Inflammatory Bowel Disease
HCC39	Bone/Joint/Muscle Infections/Necrosis
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease

Code	Name
HCC46	Severe Hematological Disorders
HCC47	Disorders of Immunity
HCC48	Coagulation Defects and Other Specified Hematological Disorders
HCC51	Dementia with Complications
HCC52	Dementia Without Complications
HCC54	Substance Use with Psychotic Complications
HCC55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications
HCC56	Substance Use Disorder, Mild, Except Alcohol and Cannabis
HCC57	Schizophrenia
HCC58	Reactive and Unspecified Psychosis
HCC59	Major Depressive, Bipolar, and Paranoid Disorders
HCC70	Quadriplegia
HCC71	Paraplegia
HCC72	Spinal Cord Disorders/Injuries
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
HCC74	Cerebral Palsy
HCC75	Myasthenia Gravis/Myoneural Disorders, Inflammatory and Toxic Neuropathy
HCC76	Muscular Dystrophy
HCC77	Multiple Sclerosis
HCC78	Parkinson's and Huntington's Diseases
HCC79	Seizure Disorders and Convulsions
HCC80	Coma, Brain Compression/Anoxic Damage

Code	Name
HCC82	Respirator Dependence/Tracheostomy Status
HCC83	Respiratory Arrest
HCC84	Cardio-Respiratory Failure and Shock
HCC85	Congestive Heart Failure
HCC86	Acute Myocardial Infarction
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease
HCC88	Angina Pectoris
HCC96	Specified Heart Arrhythmias
HCC99	Intracranial Hemorrhage
HCC100	Ischemic or Unspecified Stroke
HCC103	Hemiplegia/Hemiparesis
HCC104	Monoplegia, Other Paralytic Syndromes
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC107	Vascular Disease with Complications
HCC108	Vascular Disease
HCC110	Cystic Fibrosis
HCC111	Chronic Obstructive Pulmonary Disease
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders
HCC114	Aspiration and Specified Bacterial Pneumonias
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess

Code	Name
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC124	Exudative Macular Degeneration
HCC134	Dialysis Status
HCC135	Acute Renal Failure
HCC136	Chronic Kidney Disease (Stage 5)
HCC137	Chronic Kidney Disease, Severe (Stage 4)
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC161	Chronic Ulcer of Skin, Except Pressure
HCC162	Severe Skin Burn or Condition
HCC166	Severe Head Injury
HCC167	Major Head Injury
HCC169	Vertebral Fractures without Spinal Cord Injury
HCC170	Hip Fracture/Dislocation
HCC173	Traumatic Amputations and Complications
HCC176	Complications of Specified Implanted Device or Graft
HCC186	Major Organ Transplant or Replacement Status
HCC188	Artificial Openings for Feeding or Elimination
HCC189	Amputation Status, Lower Limb/Amputation Complications

Notes

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