PROVIDER UPDATE

QUARTERLY CONNECTION

Trinity Health Plan of Michigan

Parkinsons Coding Tips

There are two ways to specify the type of Parkinson's disease present in a member:

- Motor fluctuations: Variations in motor function characterized by alternating periods of symptom control and symptom recurrence.
- Dyskinesia: Abnormal involuntary movements that may range from mild to severe in intensity.

Use the following codes to specify:

G20.A1 Parkinson's disease without dyskinesia, without mention of fluctuations

G20.A2 Parkinson's disease without dyskinesia, with fluctuations

G20.B1 Parkinson's disease with dyskinesia, without mention of fluctuations

G20.B2 Parkinson's disease with dyskinesia, with fluctuations

G20.C Parkinsonism, unspecified

G21.11 Neuroleptic induced parkinsonism

G21.19 Other drug induced secondary parkinsonism

G21.2 Secondary parkinsonism due to other external agents

G21.3 Postencephalitic parkinsonism

G21.4 Vascular parkinsonism

G21.8 Other secondary parkinsonism

G21.9 Secondary parkinsonism, unspecified

Open Enrollment Season

Open Enrollment season begins October 15th. Remind members to review their benefit options and make any needed changes to ensure they have the coverage that best meets their needs.

We're Here To Serve You.

Trinity Health Plan of Michigan is a Medicare Advantage plan, fully owned by Trinity Health. It's designed to provide our members with a more seamless health care experience, while also making it easier for health care teams to coordinate and deliver the best possible care. **LEARN MORE**

Provider Service Center 800-991-9907 (TTY: 711)

1 Trinity Health Plan of Michigan is a Medicare Advantage organization with a Medicare contract. Enrollment in Trinity Health Plan of Michigan depends on contract renewal. Benefits vary by county.

The Medication Adherence "Critical Window": Why Action Now Matters More Than Ever

As we move into the fall, medication adherence becomes one of the most important opportunities to improve health outcomes for our Medicare Advantage members. This is also the most critical time of year for providers, care teams and pharmacies to identify members at risk of falling out of compliance.

For members taking medications for diabetes, hypertension and cholesterol management, adherence is more than a quality measure. Maintaining consistent medication use helps prevent complications, reduce hospitalizations and improve overall health outcomes.

Why this time of year is so important

Medication adherence measures are calculated based on a member's Proportion of Days Covered (PDC) throughout the calendar year. To be considered adherent, members must maintain a PDC of 80% or greater.

As the year progresses, members who experience gaps have less time to recover. By late September, many members who miss refills may no longer have enough remaining days in the year to achieve or return to the 80% adherence threshold, even if they resume taking their medication.

In other words, every missed refill between now and year-end has a significant impact.

Common reasons members fall out of adherence

Providers play a vital role in identifying barriers before they lead to prolonged gaps in therapy. Common challenges include:

- Forgetting to refill medications
- Transportation barriers
- Cost concerns
- Medication side effects
- Changes in therapy that are not communicated to the pharmacy
- Members believe they no longer need the medication because they "feel fine"
- Delays in scheduling follow-up appointments

What providers can do today

The good news is that timely intervention can make a difference. During every member encounter, consider:

Reviewing medication lists
Confirm that members are actively taking all prescribed medications and discuss any barriers to adherence.

Address refill needs before they become gaps
Members with less than a 30-day supply remaining should be encouraged to refill medications promptly.

Prescribe 90-day supplies when appropriate
Longer refill durations help reduce opportunities for missed refills and improve medication continuity.

Encourage mail-order or automatic refill programs
These options can eliminate transportation barriers and reduce the likelihood of missed fills.

Communicate medication changes promptly
If a therapy is discontinued or changed, ensure the pharmacy has updated information to prevent unnecessary adherence gaps.

Engage high-risk members
Members with a history of nonadherence, multiple chronic conditions or recent care transitions may benefit from additional outreach and follow-up.

Every refill counts

As we enter the final months of the year, there is little margin for delayed action. Members who are currently approaching a critical adherence threshold may lose the opportunity to achieve compliance if refill gaps persist. Your efforts to reinforce medication adherence, identify barriers and encourage timely refills can have a meaningful impact on both member health outcomes and overall quality performance.

Together, we can help ensure our members stay on track, stay healthier and finish the year strong.

Provider Quick Tip

Now is the time to focus on members with fewer than 30 days remaining on their prescriptions or recent refill gaps. A refill completed today may be the difference between achieving and missing the 80% adherence threshold by year-end.

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Helping Members Stay Protected This Flu Season

During flu season, providers play a critical role in ensuring members receive timely vaccinations. A simple reminder during office visits or preventive care discussions can help protect older adults from serious illness and reduce avoidable hospitalizations.

Why flu vaccination matters for older adults

Adults age 65 and older are at higher risk for severe complications from influenza due to age-related changes in the immune system. During most flu seasons, older adults account for many flu-related hospitalizations and deaths. CDC estimates indicate that 50% to 70% of seasonal flu-related hospitalizations and 70% to 85% of flu-related deaths occur among people age 65 and older.

Annual flu vaccination remains the most effective way to reduce the risk of influenza and its potentially serious complications. Studies have shown that flu vaccination can help prevent illness, reduce the severity of disease, decrease hospitalizations and lower the risk of death among those who become infected.

The provider's influence

Research consistently shows that a recommendation from a trusted healthcare provider is one of the strongest factors influencing whether members receive recommended vaccines. Many older adults view their primary care provider as their most reliable source of health information.

Providers can improve vaccination rates by:

- Reviewing vaccination status at every member encounter
- Discussing the benefits of annual flu vaccination
- Addressing common misconceptions and vaccine hesitancy
- Encouraging members to receive their vaccine early in the season and during their in-person wellness visits if possible and convenient
- Educating members on alternative locations where they can receive the flu vaccine

Key messages to share with members

When discussing flu vaccination with members, consider reinforcing these points:

- Flu can lead to serious complications, especially in older adults
- The flu vaccine is updated each year to help protect against circulating strains
- Vaccination can reduce the risk of illness, hospitalization and severe outcomes
- Even if a vaccinated person gets the flu, symptoms are often less severe
- Getting vaccinated also helps protect family members, caregivers and the broader community

Don't forget other important vaccines

While flu vaccination is a key focus during the fall and winter months, providers should also encourage members to stay current on other recommended immunizations. As adults age, their immune systems become less effective at fighting infections, increasing their risk for serious illness and complications.

Use flu vaccine conversations as an opportunity to review whether members are current on:

- COVID-19 vaccines, as recommended for their age and risk factors
- RSV vaccination, which can help protect older adults from severe respiratory illness
- Pneumococcal vaccines to help prevent pneumonia and other serious pneumococcal infections
- Shingles (herpes zoster) vaccination, which can prevent painful and potentially long-lasting complications
- Tdap or Td boosters to maintain protection against tetanus, diphtheria and pertussis

A simple step with significant impact

By incorporating vaccine discussions into routine care and outreach efforts, providers can help improve member health outcomes, reduce flu-related complications and support a healthier flu season for entire communities. Review members' vaccination status and encourage eligible members to schedule their annual flu vaccine as soon as possible.

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Provider Demographic Tools and the Importance of Informing the Health Plan

Accurate provider information is essential to ensuring a smooth experience for providers, members and our health plan. When provider demographic and practice information is not kept up to date, it can lead to administrative challenges, claim delays, member frustration and disruptions in care. Trinity Health Plan of Michigan offers several resources to help providers manage their information, access claims and eligibility details and maintain efficient payment processes.

Provider Portal

Providers can use the **THP Medicare Provider Portal** to access important self-service tools, including:

- Member eligibility verification
- Claims status inquiries
- Other provider resources and information

Electronic Funds Transfer (EFT)

Trinity Health Plan of Michigan partners with PNC Healthcare and ECHO Health to offer electronic payment options through the Claim Payments & Remittances (CPR) service.

Electronic Funds Transfer (EFT) allows providers to receive payments directly into their bank account, offering a secure and efficient reimbursement method. Providers can enroll or update their payment preferences through ECHO Health.

To enroll in EFT, providers will need:

- Banking account information
- An ECHO payment draft number
- The corresponding payment amount for enrollment authentication

Providers can enroll by visiting the **ECHO Health EFT Enrollment website**. This site also allows enrollment for EFT services across multiple participating payers.

Adding a new provider to an existing group

When a contracted provider group wishes to add a new provider under its existing agreement, the **Join Our Network (JTN) form** should be used.

Updating existing demographic information

Providers should also notify Trinity Health Plan of Michigan whenever there are changes to existing demographic information, such as:

- Practice location or address changes
- Phone or fax number updates
- Changes to office hours
- Tax identification information updates
- Provider roster changes
- Other practice-related demographic information

Timely submission of these updates helps ensure provider directories remain accurate and operational processes continue without interruption. Please use the **Provider Information Change Form** to do so.

Why timely updates are important

Keeping provider information current benefits providers, members and the health plan by helping to:

- Prevent delays in patient care
- Reduce claim denials and payment issues
- Minimize the need for appeals and claim corrections
- Decrease administrative burdens, including phone calls and paperwork
- Improve the member experience and reduce frustration

Accurate demographic data also supports provider directory compliance requirements and helps members access the correct provider information when seeking care.

Partnering for better service

Trinity Health Plan of Michigan encourages providers to regularly review and update their practice information. Utilizing available resources such as the Provider Portal, EFT enrollment through ECHO Health and the appropriate provider update processes helps ensure a better experience for all.

By keeping us informed of changes as they occur, providers play a vital role in supporting efficient operations and ensuring members receive the care and information they need without unnecessary delays.

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Breast Cancer Awareness Month: Leading with Compassion

Breast Cancer Awareness Month is an important opportunity for providers to encourage preventive care while recognizing that conversations about cancer can be deeply personal. Many members may have experienced breast cancer themselves, cared for a loved one with the disease or felt anxious about screening results.

A compassionate approach begins with listening. Providers can help members feel supported by acknowledging concerns, answering questions with empathy and emphasizing that screening is a proactive step toward protecting their health.

Rather than focusing on fear, frame mammograms and other recommended screenings as tools that can help detect breast cancer earlier, when treatment is often more effective.

When discussing breast health with members:

- Encourage age-appropriate breast cancer screenings based on current clinical recommendations
- Ask about barriers to care, such as transportation, cost concerns, scheduling challenges or fear of results
- Provide clear, easy-to-understand information about what members can expect during screenings
- Recognize and respect cultural, personal and family experiences that may influence healthcare decisions
- Remind members that preventive care is an act of self-care and an important investment in their long-term health

A simple, supportive message can make a meaningful difference:

"We care about your health and well-being. If you're due for a mammogram or have questions about breast cancer screening, we're here to help. Taking time for preventive care today can help support your health for years to come."

Some members may delay mammograms because of modesty concerns, discomfort with the screening process or previous negative healthcare experiences. Providers can help by creating a supportive environment, explaining what to expect during screenings and reassuring members that these feelings are common. A compassionate conversation can help reduce barriers and encourage timely screening.

Here are some example phrases to use to begin the conversation:

- "Let's take a few minutes to review your recommended screenings and make sure you're up to date."
- "Many women have questions about mammograms. How do you feel about breast cancer screening?"
- "If you've been putting off a mammogram, you're not alone. I'm here to talk about any concerns you may have."
- "My goal is to help make preventive care as comfortable and convenient as possible. Is there anything holding you back from scheduling a mammogram?"

By combining education with empathy, providers can help members feel empowered, informed and supported throughout their preventive care journey during Breast Cancer Awareness Month.

Reminders for Rural Health Clinic (RHC) Providers and Interim Rate Letters

Effective April 1, 2016, Rural Health Clinics (RHCs) are required to report a HCPCS code for each service furnished, along with an appropriate revenue code. For claims with dates of service on or after April 1, 2016, RHCs should follow the reporting requirements for modifier CG found in MLN Matters Article SE1611.

If you have any questions, please consult the Frequently Asked Questions (FAQs) at **RHC Reporting Requirements**.

Additionally, an interim rate letter is used to determine reimbursement for services. Submit your new Centers for Medicare & Medicaid Services (CMS) Interim Rate Letter (IRL) to ensure you're reimbursed at the correct per diem rate.

Please refer to your contract language with Trinity Health for the provider's responsibility to inform the plan of any rate changes.

Do You Have Access to our Provider Portal?

Through the Provider Portal, you can:

- Verify eligibility of members
- Verify member claims history
- View member payment status, and more!

GET ACCESS TODAY

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