Arch Pro Coding's

Best Practices for Reporting Quality Measures in the Rural Health Clinic Setting

October 2020

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Association for Rural & Community Health Professional Coding
Metro-Atlanta, GA

EDUCATION :: CERTIFICATION :: AUDIT SUPPORT ::
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In conjunction with:

Louisiana Rural Health Association

Speaker

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TARGET AUDIENCE

Clinical Providers

Do you document 100% of what is done (CPT/HCPCS-II) and why (ICD-10-CM) according to the official guidelines?

Facility Leadership

Do you ensure that your facility codes/captures 100% of the services you perform for your cost report and patients?

Coding/Billing/Quality

Do you get paid 100% of what you should (*and no more than allowed*) and understand differing payer rules?

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WHO WE HELP

Rural Health Clinics (RHC)

Independent vs. Provider-based changes a lot of CMS billing rules.

Federally Qualified Health Centers (FQHC)

Can be in either a rural OR urban Health Professional Shortage Area (HPSA).

Critical Access Hospitals (CAH) and Small Rural Hospitals

We now offer a separate live or online self-study option for those in small rural PPS or CAH facilities – get certified!

Get certified as Rural or Community Health – Coding & Billing Specialist (RH-CBS/CH-CBS) or CAH-CBS

What path do we all share?

This course will give you chances to see who is involved in the process of reporting quality & care management.

GREET:

Staff/nurses gather start the process

Are we an "office" or a RHC for this visit?

"Sick" or preventive visit (*or both*)?

Inform patient of coinsurance responsibility?

PREPARE:

Are you truly ready?

Know your code manuals?

Is the superbill updated?

Have you researched past issues fully?

Have we established a shared foundation of knowledge?

TREAT:

Primary provider documents + "superbill"

Is the note timely, complete, and accurate?

Were procedures performed?

Linking diagnoses to services?

Access to CPT/ICD-10-CM guidelines?

CODE:

Work together to code each encounter fully

Superbill vs. Patient Receipts vs. EOBs?

Cost reporting needs met?

Provider or managers responsibility for full encounter coding?

BILL & REPORT QUALITY:

Getting paid everything you deserve

Using varying billing rules to adjust bill type and applying modifiers?

Understand different bundling & global billing rules?

Appealing denied claims?

Welcome Managers & Clinical Providers

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You have primary responsibility (*among many others*) to document, track, report, and get paid correctly for the valuable services you provide.

Are you:

… responsible for the financial health of your facility that are based on rules you need more knowledge about? Is your cost report accurate?

… an employed provider who just wants to know the rules so you can place your focus on clinical care?

… signing participation contracts with insurance companies with little understanding of their impact on your mission and financial goals?

… dealing daily with EHR/IT systems that were supposed to make life easier but have proven to make things more challenging?

Welcome Coders/Billers/ Quality Staff

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You have primary responsibility to ensure that PRIOR to submitting a bill or quality measure that you have a fully *completed and timely* medical record of each clinical encounter that:

… documents the full scope of diagnostic and therapeutic services provided and the supplies used?

… helps us give the patient a "receipt" of everything that was done (*i.e. CPT/HCPCS-II codes*) and why (*i.e. ICD-10-CM codes*)?

… helps nurses and quality staff capture and report "quality" at the time of visits – but nobody ever explained proper coding guidelines to your nursing staff?

… ensures that we aren't leaving money on the table in the new world of Value-Based Care?

Which payers does “quality” apply to in a RHC?

December 27, 2017

NOTE TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model

Medicare Advantage has been successful in providing Medicare beneficiaries with options so that they can choose the healthcare that best fits their individual health needs. The Medicare Advantage program demonstrates the value of private sector innovation and creativity and CMS is committed to continuing to strengthen Medicare Advantage by promoting greater innovation, transparency, flexibility, and program simplification.

A key element in the success of Medicare Advantage is ensuring that payments to plans reflect the relative risk of the people who enroll. A critical tool that CMS uses to accomplish that goal is the use of risk adjustment models which adjust payments based on the characteristics and health conditions of each plan’s enrollees.

SOURCE: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2019part1.pdf

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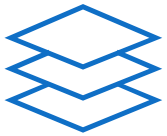
MEDICARE BASICS

You are most likely NOT required to gather and submit quality data and performance measures to “regular” Medicare Part B patients. It is necessary to maintain close contacts with your MCOs, your state primary care associations, and your Medicaid carriers to find out what they want, when they want it, and how they want it reported. Expect little consistency between carriers.

Part A



In general it covers hospital care, skilled nursing facility, nursing home care, hospice, and home health services. Sometimes called “facility services”.

Part B

RHCs are Part B providers even though we primarily use a claim form associated with Part A. Our patients must have valid Part B coverage to bill your MAC.

Part C

Essentially combines Parts A & B (and sometimes Part D) into one plan and is generically referred to as a Medicare Managed Care Organization (MCO) and is run by a private insurance company and NOT your MAC..

Part D

A broad term for Medicare Prescription Drug coverage. There are many different Part D plans. When combined with a Medicare MCO it may be called a MA-PD plan.

RHCs are typically participating providers with Parts B & Part C plans.

SUPERBILL: Revenue or Compliance?

It is likely that you have recently moved from a paper superbill (i.e. encounter form) to an electronic version. Was it just a scan of the old paper form that has codes that have changed? Do our providers lean too heavily on favorites lists?

PATIENTS: Does it serve as the patient's receipt? Do they get something that has everything that was done (CPT/HCPCS-II) and why (ICD-10-CM) or trying to understand their EOB from their insurer?

PROVIDERS: Are your providers "coding" on the superbill or "billing"?

CFOs & MANAGERS: How possible is it that your facility is not capturing everything from a "coding" perspective and are under-reporting your TRUE COSTS (CPT/HCPCS-II) and the actual complexity of your patient population (ICD-10-CM). Are you maximizing opportunities to get revenue from quality reporting & care management services?

CODING/BILLING/QUALITY: Is the clinical note closed and signed before codes are entered into your billing systems? Does anyone review the completed note before the bill is created? Are you confident that providers are aware of the full code definition of CPT/HCPCS-II, or ICD-10-CM codes or that their superbill may not give them the info they need?

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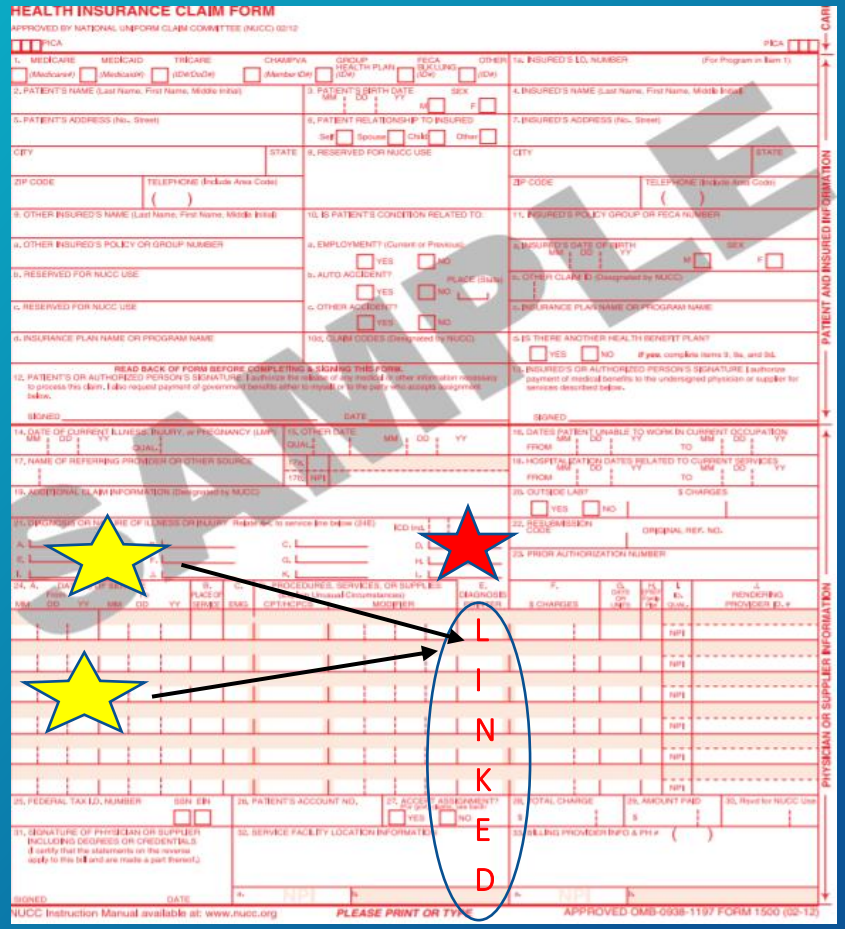
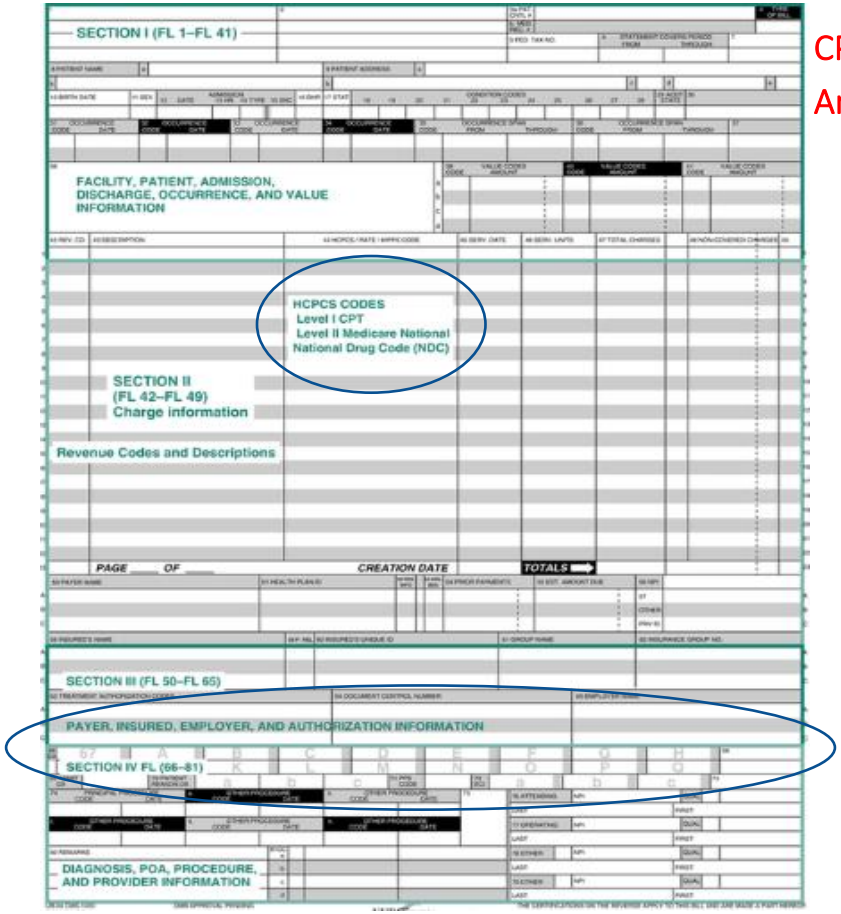
COMPARE :: CMS 1500
(aka the "HCFA")

Primarily used by RHCs who are reporting claims to commercial and non-Medicare carriers expecting to receive a Fee-for-Service payment for non-RHC services such as the technical component of diagnostic tests.



CONTRAST :: CMS 1450
(aka the "UB")

Used for RHCs submitting claims to Medicare (*and some Medicaid carriers*) for valid "encounters" when expecting the AIR/PPS rate and unlike the other form requires Type of Bill Codes and Revenue Codes.



CPT & HCPCS-II
And ICD-10-CM

N O T L I N K E D

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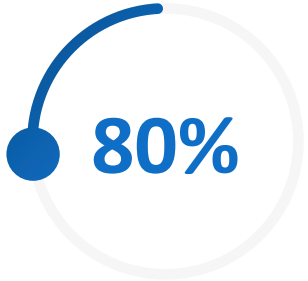
How Well Do You?

Analyze your operations, identify which EHR/IT systems are involved, engage your vendors, and don't be afraid to change!

Patient arrives for visit – are we truly ready?

Managers have a focus here to make sure you are prepared, educated, fully staffed, and have the reference materials you need. Front desk staff have a key role in coding & billing and insurance verification.

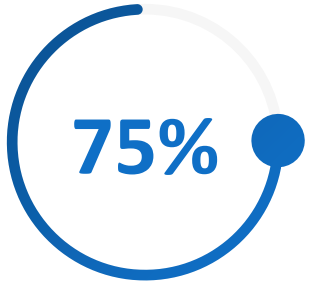


Work together to code all encounters fully?

A lot clearly depends on when the documentation is completed compared to the visit. Does the patient ever get a complete listing of the "what was done and why"?

Providers document according to guidelines?

EHRs can help but confusing screen designs and pop-up warnings can distract providers from focusing on reporting "quality" care and meeting revenue needs.



Getting paid what you deserve and no more?

There is a big difference between how Medicare, Medicaid, and commercial carriers (i.e. Managed Care) pay claims. The bills will look different! Are you leaving revenue on the table available for care management?

In order to be prepared to fully document and report quality it is necessary to build a shared foundation of knowledge between providers, managers, and coder/billers.

Does each facility/nurses station have each of the CURRENT federally-mandated HIPAA Code Sets used by RHCs or are you too dependent on software?

Do you have access to and understand the contents of key Medicare Updates, Policy & Benefits Manuals such as chapters 9, 13, 15, and 18?

Do you have full awareness of how each of your participation contracts (ex. Medicaid and Managed Care) requires you to report quality, bill for services, in order to legally maximize revenue?

Overview of Quality Reporting

QUALITY & CARE MANAGEMENT: What do we need?

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on RHC Revenue
Care Management Services	✓	✓		HIGH
CPT Category II Performance Measures	✓			MEDIUM
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchal Conditions Categories (HCC)			✓	LOW
HEDIS measures	✓	✓	✓	LOW
Population Health Prevention via Social Determinants of Care			✓	**n/a**
Primary Care & Behavioral Health Integration (ex. SUD/OUD/MAT)	✓	✓	✓	HIGH

Public health professionals have other goals

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Monitoring clinical outcomes for chronic diseases to save more lives and make sure people get the care and support they need,

- Monitoring pre-hypertension and pre-diabetes patients to "prevent" chronic diseases often by reporting HEDIS measures and HCC codes.

Making sure that patient "risk pools" are spread out fairly amongst Medicaid and commercial insurers to meet federal and state insurance rules,

- Risk Adjusted coding + Hierarchical Conditions Categories (HCC)

Determining the effectiveness and optimum use of referrals for various state/federal initiatives designed to "close the loop" on social services and to determine patient eligibility for available social programs.

- See also – Substance/Opioid Use Disorders (SUD/OUD), Medication Assisted Therapy (MAT), and developing Peer Recovery Coach programs.

What is Value-based Care?

Value-based Care and similar reimbursement models differ significantly from the Fee-for-Service and encounter-based care (*i.e. per diems*) we are used to at RHCs.

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- Instead of paying us for what we do - we may get reimbursed for 'efficiency and effectiveness" compared to others and to national standards used by CMS.
- CMS and more commercial payers are looking to Accountable Care Organizations (ACO) using various Medicare Shared Savings Programs and/or Patient-Centered Medical Homes (PCMH). CMS is underway with a required transition to this model!
- Clinical outcomes are measured based on things like reduced hospital readmissions, increased use of approved preventive care, and use of certified health IT systems to increase and facilitate data collection.
- **BEWARE:** There appears to be some conflicting motivations in this newer area of healthcare when you compare what "quality" means to insurers vs. providers vs. patients!

Quality Reporting for RHCs :: An overview of where to find the codes

- Hierarchical Conditions Categories (HCC) concepts also known as “Risk Adjusted Coding” (*solely ICD-10-CM*)
- Healthcare Effectiveness Data & Information Set (HEDIS) measures (*combines CPT, HCPCS-II, and ICD-10-CM*)
- “Performance Measures” come from the back of the AMA’s CPT and are used in addition to regular CPT/HCPCS-II codes *(CPT Cat. II codes)*
- Social Determinants of Care/Population Health such as impact on lack of transportation, access to nutritional food, and housing instability being gathered to aid public health getting the right resources to the right patients (*solely ICD-10-CM*)

Quality Reporting Basic Definitions

Value-based Care – Moving away from FFS/Per Diem payments towards paying based on clinical outcomes and disease prevention.

ACOs and Shared Savings – By being a "member" of an ACO you can get money for assuming some of the financial risk and staying under a "benchmark" of expected costs.

HCCs – Ensuring that your diagnosis codes fully reflect the complexity of patients in order to "risk adjust" for those patients requiring more care than normal in a "risk pool." For those paid a Per-Member-Per-Month amount – these key HCC ICD-10-CM codes can change payments at the individual patient level via a Risk Adjustment Factor (RAF).

HEDIS measures – Used by carriers to determine if you have performed certain pre-defined diagnostic/therapeutic services to "close gaps" for eligible patients to promote overall health and to help carriers show the state/federal governments that they are providing "quality" care.

Risk Adjusted Coding – How Medicare/Medicaid managed care plans can bill CMS for more money for complex patients that require more care than the "average" patient.

Sample impact of HCC coding on payments to MCO/MAO

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EXAMPLE

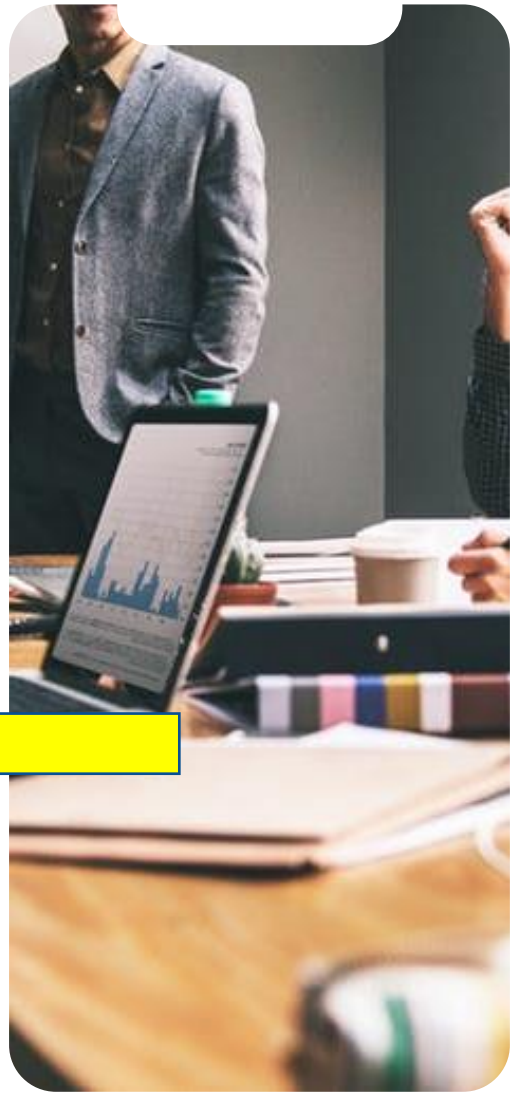
Martin McNally is an MA patient whose comorbidities are tallied into a RAF score for HCCs. He does not subscribe to Part D (prescription coverage).

RISK/PAYMENT FACTOR	HCC	RAF
66-year-old male	(community, nondual, aged)	0.300
Congestive heart failure (CHF)	85	0.323
Prostate cancer	12	0.146
Diabetes mellitus (DM), complicated	18	0.318
Peripheral vascular disease	108	0.298
Below-knee amputation	189	0.588
Morbid obesity	22	0.273
Interaction CHF & DM	NA	0.154
Total RAF		**2.400**

Nondual
A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

If we assume a CMS capitated rate for McNally's locality of $800 per month, the MAO would receive a payment of $9,600 per year for an enrollee without risk diagnoses. Multiply the capitated rate ($9,600) by 2.400 (McNally's RAF) to determine the CMS payment to the MAO to cover McNally's care. The total is $23,040 annually. RxHCCs would be calculated separately and added to payment, if the patient subscribed to Part D.

A patient with McNally's comorbidities would be at higher risk for resource-intensive care, including hospitalization. The MAO would pay for such care.



Source:
"AMA Risk Adjustment Documentation and Coding – by Sheri Poe Bernard (2018)

Sample HEDIS Measure

Adult Body Mass Index Assessment (ABA)

Percentage of members ages 18–74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

SUPPLEMENTAL DATA YES! ACCEPTED

BMI Percentile – For Members Ages 18 – 19	
ICD-10 Diagnosis	Z68.51, Z68.52, Z68.53, Z68.54

Body Mass Index – For Members Ages 20 and Older	
ICD-10 Diagnosis	Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45

Interactions between CPT Category II code(s), ICD-10-CM, and HEDIS:

See also 3008F = "BMI documented"

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Sample Risk Adjustment via HCC

Part C Risk Factors

Demographics contribute to RA calculations. In this example, we compare rates for a married couple with the same chronic illnesses: chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The husband, who is significantly older than his wife, is also disabled and living in an assisted-care center. Because his condition is more complex, it carries more risk and risk-adjusts at nearly twice the rate of his wife's condition.

PATIENT	AGE FACTOR	COPD HCC 111	CHF HCC 85	DISABLED, CHF, IN INSTITUTION	TOTAL RAF*
Martha Jones, 69, who lives at home	0.312	0.328	0.323	–	0.963
Matthew Jones, 92, disabled and lives in assisted living	0.964	0.305	0.191	0.321	1.781

Source:
"AMA Risk Adjustment Documentation and Coding – by Sheri Poe Bernard (2018)

Accountable Care Organization (ACO) & Shared Savings :: Basics and References

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- Defined by CMS as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve."
    - "*When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program*"
- Establishing accurate initial benchmarks, monitoring ongoing performance, and revising/adjusting "benchmarks" has a significant impact on your levels of potential Shared Savings! The benchmark is a dollar amount set by CMS. They look at the currently attributed beneficiaries and develop an expectation (or "benchmark") of how much they expect the total cost of care will be.
- Obviously, if risk scores are higher, then CMS would expect the cost of care will be higher. Shared savings are experienced when actual expenditures are lower than that expectation or benchmark.
    - HINT: Risk scores are mainly tracked through Risk Adjusted Coding via HCCs!
- SUMMARY: So the higher your benchmark is (*as impacted by your diagnoses and previous utilization*), the more room there is underneath it to achieve "shared savings" through effective teamwork intended by the ACO models.

Accountable Care Organization (ACO) Basics and References

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"When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."

Great resources can be found at CMS's Innovation models webpage with videos, FAQs, Case Studies, and a Care Coordination Toolkit at https://innovation.cms.gov/initiatives/aco/

ACO Revenue Issues

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- There may appear to be an issue with facilities that have recently improved their billing revenue which could impact the benchmark, but most carriers are focusing on ICD-10-CM complexity at this point.

- Some ACOs and carriers monitor the entire ACOs member healthcare facilities rather than just yours – for example, you may not have a mammography machine, but you must work with your "network" to make sure referrals are made and patients get the service.

- May include use of a patient portal to help patients increase awareness of and participation in their full scope of care by accessing portions of their medical record.
  - Be sure to see the new Care Management Services called Virtual Communication Services (VCS) that are "sometimes" covered by Medicare for when a provider reviews information a patient entered into the patient portal – there are potentially billable codes for Medicare, Medicaid, and commercial payers!

Submission to CMS

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- A risk-adjustment processing system (RAPS) is a data center for CMS, and MAOs are permitted to submit diagnostic updates to the system. These updates are corrections.
- MAOs review claims data and determine if diagnoses are missing from the claims of patients with long-standing chronic conditions.
- MAOs may commission risk-adjustment auditors to review physician or hospital coding to determine whether ICD-10-CM diagnostic coding was correct and complete.
- The claims are updated during certain time periods called “sweeps.”
- **Remember, MAOs are held accountable for the contents of physician and hospital claims.**

SOURCE: *“Risk Adjustment Documentation & Coding” by Sheri Poe Bernard, CCS-P, CDEO, CPC, CRC available from the AMA Store (red emphasis above added by Arch Pro Coding)*

Sample ACO scores and areas of interest

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	CMS Risk Score (Q3 2017)
CHC 1	0.800
CHC 2	0.827
CHC 3	0.815
CHC 4	0.980
CHC 5	0.837
CHC 6	0.941
CHC 7	0.854
CHC 8	0.944
CHC 9	0.885
CHC 10	0.852
CHC 11	0.797
CHC 12	0.989
CHC 13	0.848
CHC 14	0.916
CHC 15	0.913
CHC 16	0.349
CHC 17	0.839
CHC 18	0.725
CHC 19	0.887
Average	**0.842**

Domain	Measure Number	Measure Name	2017 Est Quality Performance Denominator	Numerator	Rate	P4P Phase	2017 GPRO Score	Target GPRO Score
Preventive Health	ACO-14	Preventive Care and Screening: Influenza Immunization	558	297	53.23	P	1.40	1.55
	ACO-15	Pneumonia Vaccination Status for Older Adults	615	297	48.29	P	1.25	1.25
	ACO-16	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	599	540	90.15	P	2.00	2.00
	ACO-17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	616	558	90.58	P	2.00	2.00
	ACO-18	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	516	398	77.13	P	1.70	1.70
	ACO-19	Colorectal Cancer Screening	605	270	44.63	P	1.25	1.70
	ACO-20	Mammography Screening	590	328	55.59	P	1.40	1.70
	ACO-42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease*	573	441	76.96	R	2.00	2.00
At Risk Population	ACO-40	Depression Remission at Twelve Months*	68	5	7.35	R	2.00	2.00
	Diabetes Composite	ACO - 27: Hemoglobin A1c Poor Control ACO - 41: Diabetes—Eye Exam*	600	164	27.33	P	0.00	1.40
	ACO-27	Hemoglobin A1c Poor	600	137	22.83	N/A	N/A	N/A
	ACO-41	Diabetes—Eye Exam*	600	198	33.00	N/A	N/A	N/A
	ACO-28	Hypertension (HTN): Controlling High Blood Pressure					1.40	1.55
	ACO-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	319	273	85.58	P	1.85	2.00

Hierarchal Condition Categories (HCC) :: Summary

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Should be considered as the primary method to capture the Risk Adjustment needs of primarily Medicare/Medicaid managed care plans via ICD-10-CM codes using ___historical claims___ data and ___"hybrid" methods___ that may include onsite or virtual audits by payers.

Hierarchal Conditions Categories (HCC) ties together around _9500_ ICD-10-CM codes into around ~80 different categories and is primarily used for Medicare Advantage and/or PACE patients.

These HCCs are assigned a value that when combined with all diagnoses helps a carrier assign a ___"risk score"___ to each individual patient being evaluated by the plan.

These scores are updated annually and requires everyone associated with the clinical documentation and coding processes to learn, understand, and apply the ICD-10-CM's "Official Guidelines for Coding & Reporting" to help (*typically*) Medicaid Managed Care organizations ___"close gaps"___.

Sample comparison and hierarchy tying to a patient's risk score

HCC	HCC Description	Weight*
1	HIV/AIDS	0.344
2	Septicemia, Sepsis, SIRS/Shock	0.428
6	Opportunistic Infections	0.446
8	Metastatic Cancer and Acute Leukemia	2.654
9	Lung and Other Severe Cancers	1.027
10	Lymphoma and Other Cancers	0.675
11	Colorectal, Bladder, and Other Cancers	0.309
12	Breast, Prostate, and Other Cancers and Tumors	0.153
17	Diabetes with Acute Complications	0.307
18	Diabetes with Chronic Complications	0.307
19	Diabetes without Complication	0.106
21	Protein-Calorie Malnutrition	0.554
22	Morbid Obesity	0.262
23	Other Significant Endocrine and Metabolic Disorders	0.212
27	End-Stage Liver Disease	0.913
28	Cirrhosis of Liver	0.381
29	Chronic Hepatitis	0.153
33	Intestinal Obstruction/Perforation	0.243
34	Chronic Pancreatitis	0.308
35	Inflammatory Bowel Disease	0.315
39	Bone/Joint/Muscle Infections/Necrosis	0.431
40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.426
46	Severe Hematological Disorders	1.394
47	Disorders of Immunity	0.683
48	Coagulation Defects and Other Specified Hematological Disorders	0.214
54	Substance Use with Psychotic Complications	0.368
55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	0.368
56	Subtance Use Disorder, Mild, Except Alcohol and Cannabis	0.368
57	Schizophrenia	0.606
58	Reactive and Unspecified Psychosis	0.546
59	Major Depressive, Bipolar, and Paranoid Disorders	0.353
60	Personality Disorders	0.353
70	Quadriplegia	1.338
71	Paraplegia	1.121
72	Spinal Cord Disorders/Injuries	0.519
73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	1.026
74	Cerebral Palsy	0.354
75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/ Inflammatory and Toxic Neuropathy	0.491
76	Muscular Dystrophy	0.533
77	Multiple Sclerosis	0.441
78	Parkinson's and Huntington's Diseases	0.686
79	Seizure Disorders and Convulsions	0.277
80	Coma, Brain Compression/Anoxic Damage	0.575
82	Respirator Dependence/Tracheostomy Status	1.051
83	Respiratory Arrest	0.404
84	Cardio-Respiratory Failure and Shock	0.314
85	Congestive Heart Failure	0.310
86	Acute Myocardial Infarction	0.220
87	Unstable Angina and Other Acute Ischemic Heart Disease	0.219
88	Angina Pectoris	0.143
96	Specified Heart Arrhythmias	0.271
99	Cerebral Hemorrhage	0.276
100	Ischemic or Unspecified Stroke	0.276
103	Hemiplegia/Hemiparesis	0.498
104	Monoplegia, Other Paralytic Syndromes	0.368
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	1.537
107	Vascular Disease with Complications	0.401
108	Vascular Disease	0.305
110	Cystic Fibrosis	0.509
111	Chronic Obstructive Pulmonary Disease	0.335
112	Fibrosis of Lung and Other Chronic Lung Disorders	0.216
114	Aspiration and Specified Bacterial Pneumonias	0.612
115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.164
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.232
124	Exudative Macular Degeneration	0.522
134	Dialysis Status	0.474
135	Acute Renal Failure	0.474
136	Chronic Kidney Disease, Stage 5	0.284
137	Chronic Kidney Disease, Severe (Stage 4)	0.284
138	Chronic Kidney Disease, Moderate (Stage 3)	0.068
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	2.112
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.153
161	Chronic Ulcer of Skin, Except Pressure	0.551
162	Severe Skin Burn or Condition	0.262
166	Severe Head Injury	0.575
167	Major Head Injury	0.143
169	Vertebral Fractures without Spinal Cord Injury	0.508
170	Hip Fracture/Dislocation	0.406
173	Traumatic Amputations and Complications	0.249
176	Complications of Specified Implanted Device or Graft	0.609
186	Major Organ Transplant or Replacement Status	0.855
188	Artificial Openings for Feeding or Elimination	0.581
189	Amputation Status, Lower Limb/Amputation Complications	0.567

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*Weight based on Community-Based Aged/ Non-Dual Risk Factor | Factor may be slightly different for other beneficiaries https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

Weight based on Community-Based Aged/ Non-Dual Risk Factor | Factor may be slightly different for other beneficiaries https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

Sample HCC Hierarchy Examples

The HCC model ranks diagnoses into categories that represent conditions with similar cost patterns. Some conditions will "trump" or override other conditions.

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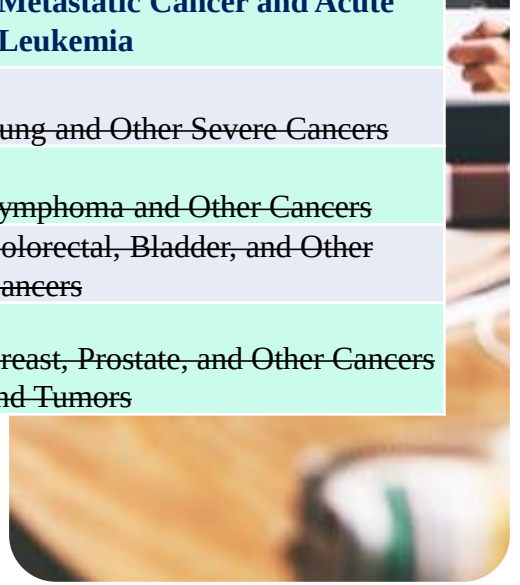
HCC	If the Disease Group is Listed in this column…	…Then these conditions will not contribute to HCC Score
8	Metastatic Cancer and Acute Leukemia	9, 10, 11, 12
9	Lung and Other Severe Cancers	10, 11, 12
10	Lymphoma and Other Cancers	11, 12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18, 19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28, 29, 80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
54	Substance Use with Psychotic Complications	55, 56
55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	56
57	Schizophrenia	58, 59, 60
58	Reactive and Unspecified Psychosis	59, 60
59	Major Depressive, Bipolar, and Paranoid Disorders	60
70	Quadriplegia	71, 72, 103, 104, 169
71	Paraplegia	72, 104, 169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83, 84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87, 88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Intracranial Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107, 108, 161, 189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111, 112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135, 136, 137, 138
135	Acute Renal Failure	136, 137, 138
136	Chronic Kidney Disease, Stage 5	137, 138
137	Chronic Kidney Disease, Severe (Stage 4)	138
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158, 161
158	Pressure Ulcer of Skin with Full Thickness Skin	161
166	Severe Head Injury	80, 167

When a condition is reported with a higher HCC value…Any reported condition within the same disease hierarchy with a lower value will be dropped.

HCC	Code Description	Weight	Retained Code
HCC 8	Metastatic Cancer and Acute Leukemia	2.654	**Metastatic Cancer and Acute Leukemia**
HCC 9	~~Lung and Other Severe Cancers~~	~~1.027~~	~~Lung and Other Severe Cancers~~
HCC 10	~~Lymphoma and Other Cancers~~	~~0.675~~	~~Lymphoma and Other Cancers~~
HCC 11	~~Colorectal, Bladder, and Other Cancers~~	~~0.309~~	~~Colorectal, Bladder, and Other Cancers~~
HCC 12	~~Breast, Prostate, and Other Cancers and Tumors~~	~~0.153~~	~~Breast, Prostate, and Other Cancers and Tumors~~

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf



Sample HCC Case Study

A 78 year old male with Type II DM that is controlled with diet.

- He is being followed by a nephrologist for his kidney issues caused by DM and receives dialysis 3 days a week.
- Mr. Jones also has Hypertension with CHF which has been in control with continued use of his medication.
- In 2008 Mr. Jones had his prostate removed due to prostate cancer and successfully completed all of his prostate cancer treatment.
- Urinalysis performed today shows white cells, Mr. Jones is positive for a UTI.

Not Coded to the highest level of specificity in ICD-10	
N39.0 UTI	
E11.9 Type II DM w/o complications (HCC 19)	**0.106**
N18.9 CKD Unspecified	
I10 Essential Primary HTN	
I50.9 CHF NOS (HCC 85)	**0.31**
Z85.46 Personal History of Prostate Cancer	
Z99.2 Dialysis Status (HCC 134)	**0.474**
Calculated HCC Score:	**0.89**

Coded to the highest level of specificity in ICD-10-CM:	
N39.0 UTI	
E11.22 DM II with diabetic CKD (HCC 18)	**0.307**
N18.6 End stage renal disease (HCC 136)	**0.284**
I13.2 Hypertensive Heart and CKD w/HF w/ Stage 5 CKF or ESRD (HCC 85) (HCC 136)	**0.284**
I50.9 CHF NOS (HCC 85)	**0.31**
Z85.46 Personal History of Prostate Cancer	
Z99.2 Dialysis Status (HCC 134)	**0.474**
Calculated HCC Score:	**1.375**

SOURCE: Thanks to Shekinah Bishop, ACO Practice Specialist, of Imperium Health

Can your providers see their “Base Code” notes?

M02 Postinfective and reactive arthropathies

Code first underlying disease, such as:
congenital syphilis [Clutton's joints] (A50.5)
enteritis due to Yersinia enterocolitica (A04.6)
infective endocarditis (I33.0)
viral hepatitis (B15-B19)

Excludes1: Behçet's disease (M35.2)
direct infections of joint in infectious and parasitic diseases classified elsewhere (M01.-)
postmeningococcal arthritis (A39.84)
mumps arthritis (B26.85)
rubella arthritis (B06.82)
syphilis arthritis (late) (A52.77)
rheumatic fever (I00)
tabetic arthropathy [Charcôt's] (A52.16)

M02.0 Arthropathy following intestinal bypass

M02.00 Arthropathy following intestinal bypass, unspecified site

M02.01 Arthropathy following intestinal bypass, shoulder

M02.011 Arthropathy following intestinal bypass, right shoulder

Such notes are likely **not visible to providers** who only use an electronic index to simply search keywords or primarily use pre-populated favorites lists!

Official ICD-10-CM Guidelines Review

Section I: A. Conventions of ICD-10

- Conventions of ICD-10-CM
- Alphabetic Indexing and Tabular Listings
- Format and Structure
- Use of Codes for Reporting Purposes
- Placeholder Character
- 7th Digit Characters
- Abbreviations (Index and Tabular)
- Punctuation
- Use of "And", "With", "See Also", "Code Also"
- "Unspecified" Codes, "Includes" and "Excludes"
- Etiology/Manifestation Conventions (e.g., *"code first", "use additional code", "in diseases classified elsewhere")*
- Default codes and Syndromes

Official ICD-10-CM Guidelines Review

Section I: B. General Coding Guidelines

- Locating ICD-10 codes, levels of detail in coding
- Codes A00.0-T88.9, Z00-Z99.8
- Signs and Symptoms
- Conditions that are integral part of disease process
- Conditions that are not integral part of disease process
- Multiple coding for a single condition
- Acute and Chronic conditions
- Combination codes
- Late effects (sequela)
- Impending or threatened conditions
- Reporting same diagnostic code more than once
- Laterality
- Documentation for BMI and Pressure Ulcer stages

Official ICD-10-CM Guidelines Review

Section I: C. Chapter Specific Coding Guidelines

Chapter 1: Infectious and Parasitic Disease (A00-B99)

Chapter 2: Neoplasms (C00-D49)

Chapter 3: Diseases of Blood and Blood Forming Organs (D50-D89)

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

- Diabetes is located in this Section (E08-E13)

Chapter 5: Mental and Behavioral Disorders (F01-F99)

Chapter 6: Diseases of the Nervous System and Sense Organs (G00-G99)

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)

Chapter 9: Disease of the Circulatory System (I00-I99)

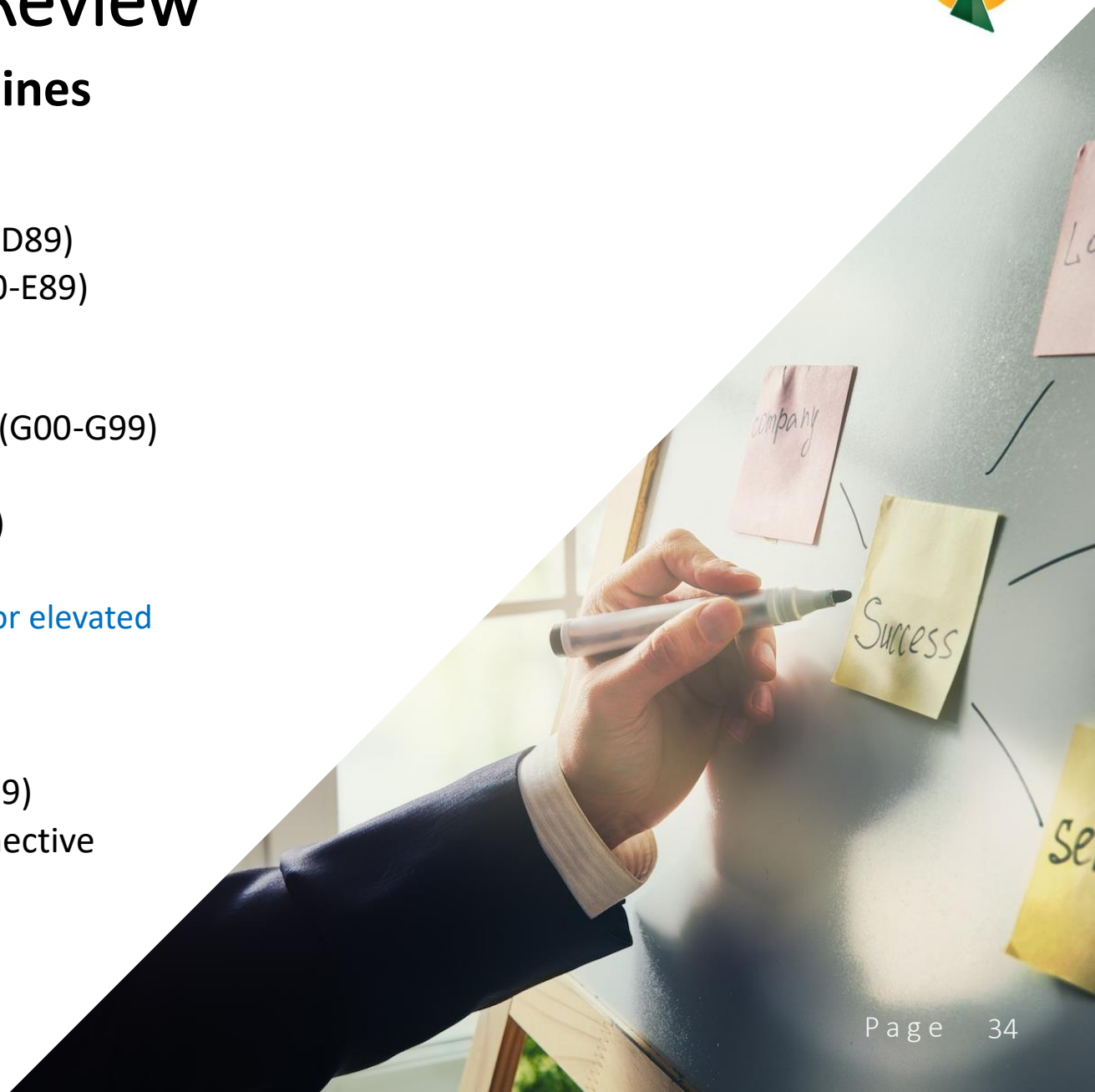
- Hypertension is in this Section (I10-I15) but see also R03.0 for elevated BP w/out hypertension

Chapter 10: Diseases of the Respiratory System (J00-J99)

Chapter 11: Diseases of the Digestive System (K00-K94)

Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00-L99)

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)



Official ICD-10-CM Guidelines Review

Section I: C. Chapter Specific Coding Guidelines (cont'd)

Chapter 14: Diseases of the Genitourinary System (N00-N99)

Chapter 15: Pregnancy, Childbirth, Pueperium (O00-O9A) OB, Delivery and Postpartum Services

Chapter 16: Newborn (Perinatal) Guidelines (P00-P96) Newborn services and reporting stillborns

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

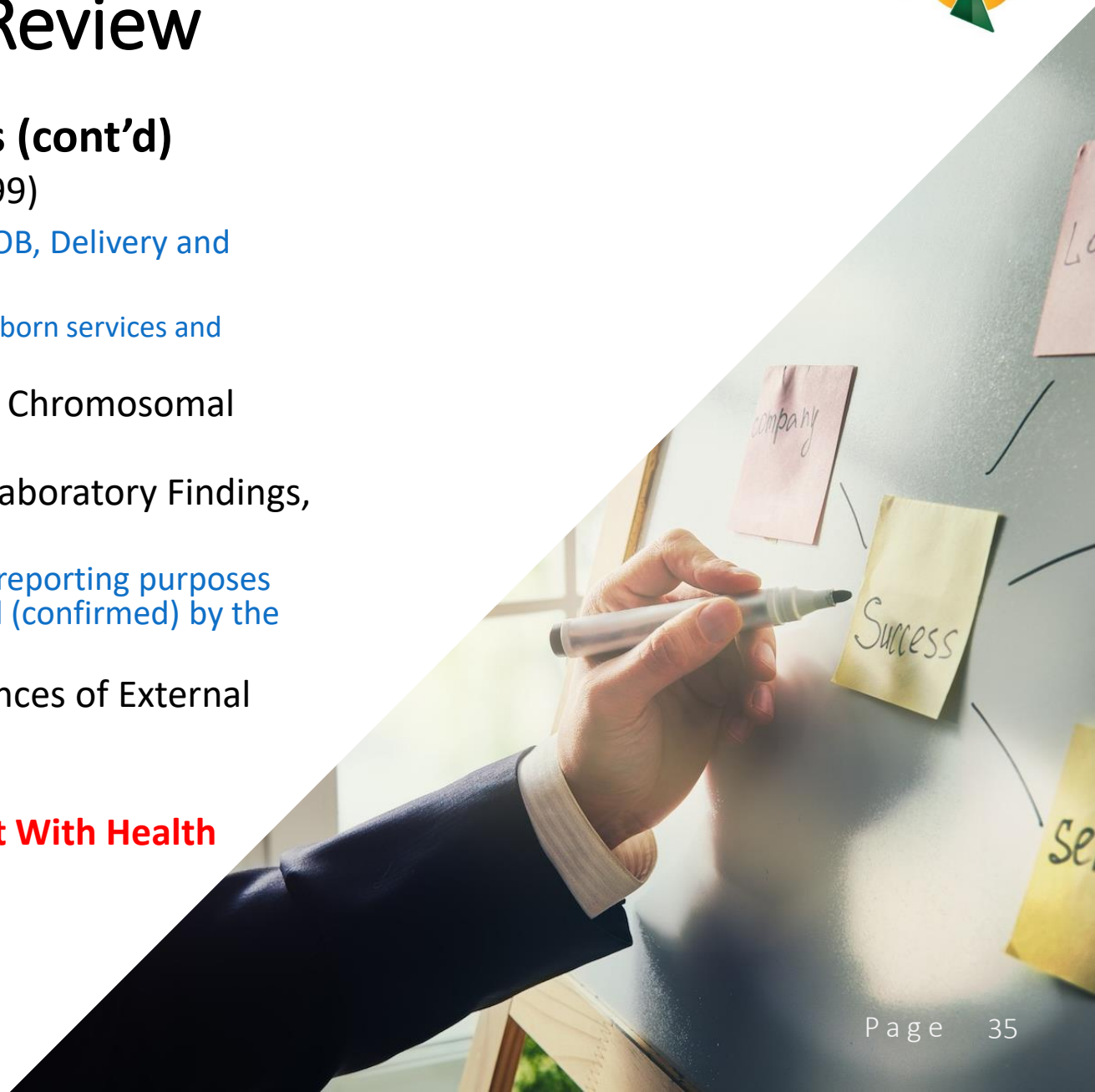
Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

> Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)

Chapter 20: External Causes of Morbidity (V01-Y99)

Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)



Why we must learn to love the ICD-10-CM

- Focus on the "*Official Guidelines for Coding & Reporting*" for the most educational benefits
  - "Shared Savings", Risk Adjustment via HCC, HEDIS
  - Use of unspecified codes?
  - The definition of "and" is provided in the guidelines – build a solid foundation of the rules then build detailed and tailored education for providers.
- Where in the documentation can you pull diagnoses? (ex. HPI vs. ROS vs. Assessments) – ever heard of "MEAT"?
- How many diagnoses must/can go on each claim?

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Medical Note States:	Coder and CMS Interpretation:
H/O CHF	CHF has resolved
CHF Compensated	CHF active and stable
History of Angina	Angina has resolved
Stable Angina Nitrostat® PRN	Angina is stable on active treatment
H/O Afib	Afib has resolved
Afib controlled on digoxin	Afib is stable on active treatment
Prostate Cancer s/p Chemotherapy	Prostate cancer is eradicated Documentation does not indicate when patient completed chemotherapy
Prostate Cancer Lupron® Injections Q3mo	Prostate cancer is active with active treatment

If your patient has an **active condition** documentation must reflect the correct story.
"History of" language should not be used.

Diagnoses that often default to “Unspecified” due to the use of non-specific language

Example	Document specificity such as
Arrhythmia	**TYPE:** SSS, Tachy-brady syndrome, Afib, A-Flutter, Tachycardia, Bradycardia
CKD	**STAGE:** Stage I-V, ESRD
Heart Failure	**TYPE:** Systolic, Diastolic, Combined **SEVERITY:** Acute, Chronic, Acute on Chronic
Depression	**TYPE:** Situational, Major Depression, Manic, Seasonal, Severe
Major Depression	**EPISODE:** Single, Recurrent **SEVERITY:** Mild, Moderate, Severe, In Remission, Unspecified
Arthritis	**TYPE:** Rheumatoid, Degenerative, Inflammatory, Psoriatic
Atherosclerosis	**LOCATION:** Coronary Artery, Extremities, Graft, Aorta

Basic Info ::
Healthcare Effectiveness Data & Information Set (HEDIS)

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There are now around a hundred measures that are updated annually and are created and maintained by the National Committee for Quality Assurance (NCQA) and used by CMS.

These are often made up by a combination of related CPT/HCPCS-II, and ICD-10-CM codes and must be submitted on a periodic basis depending on the insurer's desired timeframe as per your participation agreement with them.

Typically measured retrospectively as a percentage of "eligible" patients who could have received key medical services compared to how many actually received it by an analysis of de-identified HIPAA patient data.

- The numerator is the number of people who met the measure's criteria.
- The denominator is the number of people who qualified to potentially receive the service(s).
- There are unique modifiers that are necessary, for example, if we have to identify that certain patients are ineligible to be measured – for example, we do not need to record BMI on pregnant patients.

Sample HEDIS Measures :: Adult Medicine

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CARE FOR OLDER ADULTS - FUNCTIONAL STATUS ASSESSMENT (COA) P4P

The percentage of adults 66 years and older who had each of the following during the measurement year:

- Advance care planning.
- Medication review.
- Functional status assessment.
- Pain assessment.

CPT	HCPCS
99483	G0438, G0439

Sample HEDIS Measures :: Peds

ADOLESCENT WELL-CARE VISITS (AWC)

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

CPT	HCPCS	ICD-10
99384 - 99385, 99394 - 99395	G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

Sample HEDIS Measures :: Women's Health

ArchProCoding
Association for Rural & Community Health Professional Coding

BREAST CANCER SCREENING (BCS) P4P P4P P4P

The percentage of women 50–74 years of age who had one or more mammograms to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

CPT	HCPCS	ICD-10 (FOR A HISTORY OF BILATERAL MASTECTOMY)
77055 - 77057, 77061 - 77063, 77065 - 77067	G0202, G0204, G0206	Z90.13

RELATED Quality Areas Outside of our Scope

○ ○ ○

Some states may “volun-tell” you to participate in other quality programs with innumerable names and abbreviations such as: Quality Improvement Plans (QIP), Quality Payment Programs (QPP), Merit-based Incentive Programs (MIPS), MACRA, CMS’ Meaningful Measures, Alternative Payment Models (APM), and more.

*NOTE: Most RHCs are exempt from MIPS unless meeting exceptions found in CMS’ “*Support for Small, Underserved, and Rural Practices” document found here: https://qpp.cms.gov/about/small-underserved-rural-practices

.

Is there an IT-only Solution?

Or do we have to work closely together with a shared vision?

○ ○ ○

There are **Electronic Quality Management Systems (e-QMS)** that are enterprise software systems designed to aid in the capture and reporting of quality measures.

- See the CMS Fact Sheet on this subject here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CQM_PI_FactSheet.pdf
- See additional info for eligible facilities related to e-CQMs here: https://ecqi.healthit.gov/eh-cah-ecqms
- Critical Access Hospitals (CAH) and eligible hospitals must report on at least 4 of 16 CMS Clinical Quality Measures (CQM or e-CQM) measures using self-selected data from one quarter of the year using certified electronic health record technology (CEHRT) (i.e. Meaningful Use).

Check out the **National Committee for Quality for Quality Assurance (NCQA)** for “approved” options that use evidence-based data and interoperability standards to ”measure care and drive improvement.”

NOTE: NCQA also writes and manages the *HEDIS measures and standards for Patient-Centered Medical Homes*!

What coding software will NOT do for you

- The **AMA's CPT** is the ONLY physical manual where key documentation guidelines are found – these key notes are not licensed by the AMA for use in any other CPT manual nor software product.

- Though the **HCPCS-II manual** does not contain many documentation notes – if you aren't familiar with them by reviewing key definitions with your full team – you would never know which words to look up and will miss that revenue or reporting opportunity.

- Can your providers see key "base code notes" you can see with studying the **ICD-10-CM** physical manuals? Are they simply doing a keyword look-up and assigning codes without being aware of the "ICD-10-CM Official Guidelines for Coding & Reporting"?

CPT Category I Codes

Introduction
Know the rules and guidelines!

Evaluation and Management (99xxx)

Anesthesia (0xxxx)

Surgery (1xxxx – 6xxxx)
Know surgical package, modifiers, NCCI, etc.

Radiology (7xxxx)
Know modifiers TC and -26

Pathology and Laboratory (8xxxx)

Medicine (9xxxx)

Appendix A-O – *go look at appendix A and B*

Alphabetic Index – *never code from the index!*

CPT Category II Codes
"Performance Measures"

Modifiers – 1P, 2P, 3P, 8P

Composite Measures 0001F – 0015F

Patient Management 0500F – 0575F

Patient History 1000F – 1220F

Physical Examination 2000F – 2050F

Diagnostic/Screening Processes/ Results 3006F – 3573F

Therapeutic, Preventive, or Other Interventions 4000F – 4306F

Follow-Up or Other Outcomes 5005F – 5100F

Patient Safety 6005F – 6045F

Structural Measures 7010F – 7025F

CPT Category II :: Know the main source material well!

CPT Category II codes are “a set of ***supplemental tracking codes*** that can be used for performance measurement”

“These codes are intended to facilitate data collection about the quality of care rendered ***by coding certain services and test results*** that support nationally established performance measures and that have an evidence base as contributing to quality patient care.”

“The use of these codes is ***optional***. The codes are ***not required for correct coding*** and may not be used as a substitute for Category I codes.”

Are these codes used for Revenue or Quality Reporting compliance?

CPT Category II code section highlights

- **Patient History 1000F** = Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
- **Patient History 1031F** = Smoking status and exposure to 2nd hand smoke in the home assessed (asthma) – see also 1032F-1039F
- **Patient History 1125F and 1126F** = Pain severity assessed (present vs. not present)
- **Physical Examination 2000F** = Blood pressure measured (CKD and DM)
- **BMI 3008F** - Body Mass Index (BMI) documented (PV)
- **Physical Examination 3044F-3046F** = Documentation of most recent hemoglobin A1c levels, less than 7%, 7-9%, or greater than 9%

CPT Category II code section highlights

- **For CAD & DM see 3048F-3050F** – Most recent LDL-C less than, equal to, or greater than 100-129mg/dL.

- **Diagnostic/Screening Processes or Results 3074F-3080F** – Systolic pressure readings below 130, 130-139, over 140 mmHg
- **Therapeutic, Preventive, or Other Interventions 4000F-4001F, 4004F** = Tobacco use cessation counseling vs. drug therapy

- **Therapeutic, Preventive, or Other Interventions 4035F-4040F** – assorted vaccinations administered or recommended

- **Therapeutic, Preventive, or Other Interventions 4060F-4065F** – assorted Behavioral Health medication issues

- **Follow-up or Other Outcomes 5005F** – Patient counseled on self-examination for new or changing moles

CPT Category II :: Items for your additional research

- Work closely with your vendors to see what can be automatically captured from discrete EHR data plus investigate any IT issues (*i.e. $.01 charges and CMS1450/1500 claim form issues*) with your clearinghouses who may not be expecting these codes.

- Unfortunately, we haven't seen consistent guidance from payers on how they want these codes reported. Some will take the codes on a claim for the PPS rate on the CMS1450 (such as various Medicaid carriers) while others requires them to be reported on CMS1500 forms.

- Surround yourselves with qualified, well-educated, supported, and (*hopefully*) certified staff who work together to help your facility meet all external requirements on reporting.

Before submitting any CPT Category II code(s)…

In order for a patient to be included in the numerator for a particular performance measure, a patient must meet the denominator inclusion criteria for that measure. Prior to coding, users must review: (1) the complete description of the code in the Category II section of the CPT codebook and website; and (2) the specification documents of its associated performance measure as found on the measure developer's website. The superscripted number that follows the specific title for the performance measure directs users to the footnotes at the bottom of each page of this appendix. The footnotes identify the measure developer and the developer's Web address.

*Only modifiers 1P, 2P, 3P, and 8P can be used with Category II codes. Other modifiers may **not** be used with Category II codes. In addition, the modifiers included within the Category II code section and Appendix H are only intended to be used when parenthetical notes, guidelines, or reporting language specifically allow their use.*

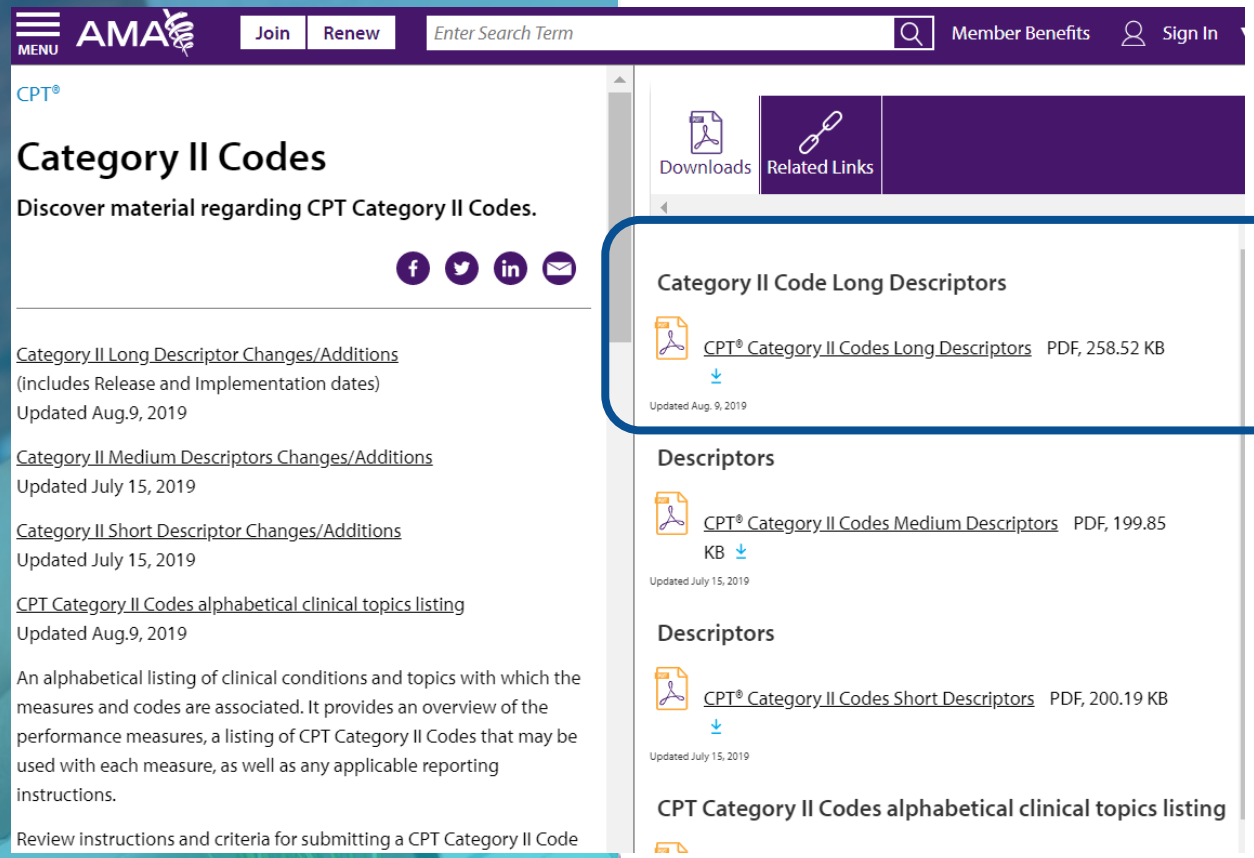
Exclusion modifiers

1P = Exclusion due to medical reasons (ex. absence of limb, drug interaction)

2P = Exclusion due to patient reasons (ex. patient declined, financial/religious)

3P = Exclusion due to system reasons (ex. resources not available, insurance issues)

CPT Category II codes may be updated more often than annually :: how will you keep up?



Go visit: https://www.ama-assn.org/practice-management/cpt/category-ii-codes

CPT® Category II Codes

AMA AMERICAN MEDICAL ASSOCIATION

The following codes are an excerpt of the Current Procedural Terminology (CPT®) Category II codes set that were most recently approved by the CPT Editorial Panel. These codes are provided to identify and distinguish those codes that were added to the Category II code set since the latest printing of the CPT codebook (CPT 2019). Therefore, the codes noted within this Web listing will include only those codes that are not listed in the latest edition of the CPT codebook. For a complete list of all of the existing Category II codes, this list should be appended to the codes in the latest edition of the CPT code set.

Sample from the AMA Category II Clinical Topics Listing :: Diabetes and A1C measurement

Diabetes (DM)		
Brief Description of Performance Measure & Source and Reporting Instructions	**CPT Category II Code(s)**	**Code Descriptor(s)**
A1c Management [4] Whether or not patient received one or more A1c test(s) **Numerator:** Patients who received one or more A1c test(s) **Denominator:** Patients with diagnosed diabetes 18-75 years of age **Percentage** of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s). **Exclusion(s):** NONE **Reporting Instructions:** In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed. ►To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F.◄	*3044F* ►3051F◄ ►3052F◄ *3046F*	*Most recent hemoglobin A1c (HbA1c) level < 7.0%* ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%◄ ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%◄ *Most recent hemoglobin A1c (HbA1c) level > 9.0%*

Refer to the CPT 2020 code updates per AMA!

23	Cat II-Diabetes Care	●304XF●305XF **D**3045F	**Accepted addition** of codes 304XF, 305XF to allow ~~reporting~~ for different levels of HbA1c; **deletion** of 3045F	January 1, 2020

CPT Cat. II codes for Hypertension and description of Performance Measure

Hypertension		
Brief Description of Performance Measure and Source	**CPT Category II Code(s)**	**Code Descriptor(s)**
Blood Pressure Control[1] Whether or not the patient aged 18 years and older with a diagnosis of hypertension has a blood pressure reading less than 140 mm Hg systolic and less than 90 mm Hg diastolic OR a blood pressure reading greater than or equal to 140 mm Hg systolic and less than 90 mm Hg diastolic and prescribed 2 or more anti-hypertensive agents during the most recent visit		
For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org	3074F	Most recent systolic blood pressure < 130 mm Hg
Numerator:	3075F	Most recent systolic blood pressure 130 to 139 mm Hg
Patients with a blood pressure < 140/90 mm Hg	3077F	Most recent systolic blood pressure ≥ 140 mm Hg
OR Patients with a blood pressure ≥ 140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during the most recent office visit	3078F	Most recent diastolic blood pressure < 80 mm Hg
Denominator: All patients aged 18 years and older with a diagnosis of hypertension	3079F	Most recent diastolic blood pressure 80 – 89 mm Hg
Exclusion(s): Documentation of medical (eg, allergy, intolerant, postural hypotension, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or system (eg, financial reasons, other system reason(s)) reason(s) for not prescribing 2 or more anti-hypertensive medications	3080F	Most recent diastolic blood pressure ≥ 90 mm Hg
Reporting Instructions: For the systolic blood pressure value, report one of the three systolic codes; for the diastolic blood pressure value, report one of the three diastolic codes. If 3077F or 3080F are reported AND two or more anti-hypertensive agents are prescribed or currently taking, also report 4145F. For patient with appropriate exclusion criteria report 4145F with modifier 1P, 2P, or 3P.	4145F	Two or more anti-hypertensive agents prescribed or currently being taken

CPT Cat. II codes for Lipid Control/Cholesterol

Chronic Stable Coronary Artery Disease (CAD)
Diabetes (DM)
Chronic Kidney Disease (CKD)

These measures for high/low cholesterol levels are found in several disease categories and use similar measures. Be sure to check for a full listing of exclusions, documentation requirements, and reporting instructions! Below is just a sample from a few areas in the ~387 pages – use the Search feature!

Lipid Control[1]		
Whether or not the patient aged 18 years and older with a diagnosis of CAD has an LDL-C result less than ` 100 mg/dL OR has an LDL-C result greater than or equal to 100 mg/dL and a plan of care is documented to achieve LDL-C less than 100 mg/dL, which includes prescription of a statin, at a minimum	3048F	Most recent LDL-C < 100 mg/dL
For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org	3049F	Most recent LDL-C 100 - 129 mg/dL
Numerator:	3050F	Most recent LDL-C greater than or equal to 130 mg/dL

IN SUMMARY :: Performance Measurement Using CPT Category II Codes

- In addition to being a “superuser” of you EHRs -- it is likely that your quality review staff/nurses will need basic and intermediate training on clinical documentation, professional coding, and even billing for various insurers in order to locate and interpret our quality compliance needs and requirements.

- Though previously considered voluntary, supplemental, and optional codes – many managed care carriers are “asking” for these codes to be submitted on a periodic basis for specified disease categories or for specific segments of your patient population.

- Carriers have widely varying policies on how/when to submit these codes and if they are payable or are just used to measure performance against the “requirements” of the insurance plan(s) that you participate with.

- Some carriers allow these codes to be submitted on the same date of service as other traditional visits, but some want it on a separate claim with $.01 on the claim line – others want a “claim” to be submitted as informational-only using either a CMS1450 or CMS1500 form equivalent.

QUALITY & CARE MANAGEMENT: What do we need?

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on RHC Revenue
Care Management Services	✓	✓		HIGH
CPT Category II Performance Measures	✓			MEDIUM
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchal Conditions Categories (HCC)			✓	LOW
HEDIS measures	✓	✓	✓	LOW
Population Health Prevention via Social Determinants of Care			✓	**n/a**
Primary Care & Behavioral Health Integration (ex. SUD/OUD/MAT)	✓	✓	✓	HIGH

WHO SHOULD BE INVOLVED?

Managers

Who offers financial incentives for reporting Performance Measures using CPT Category II codes?

Prepare electronic or paper tools to trigger the rooming nurse to communicate with the provider when it is necessary to meet UDS, CPT-II, or other quality measures.

Coordinate closely with the Chief Medical Officer (CMO)!

Quality Reporting/Nurses

Work together to develop an effective method where your clinical providers know how to report potentially billable services DIFFERENTLY than quality measures.

Have we documented any Care Management Services in between visits like TCM or VCS? Will we be updating a Care Plan?

Clinical Providers

We recognize that this new Value-based world makes it feel as though you do not have full control over the scope of care you provide and that some quality measurement issues take valuable time away from your day – thanks for helping!

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Thanks for your attention - Now is our time to shine!

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