



# Generating New Revenue in RHCs using Quality Reporting and Care Management Services



Presented by:

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**Association for Rural & Community Health**

**Professional Coding**

**(Arch Pro Coding)**

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# Who is this class designed for?

## Clinical Providers



We will use this traditional symbol for MD, DO, NP, PA, CP, RN, CNM, and others licensed and operating under their state's scope of care.

May be asked to change how they provide and report care

**KEY:** Clinical Documentation

## Management



We will use this symbol of a sun for those who manage clinical and revenue staff and make policy, hiring, and IT decisions.

Responsible for bridging the clinical > business needs of often with limited staff

**KEY:** Professional Coding

## Coders/Billers



We will use this symbol of a windmill for those who use clinical documentation to compliantly code and bill for a RHC.

Works closely with nurses/providers to capture "quality" at the time of service

**KEY:** Coding & Billing

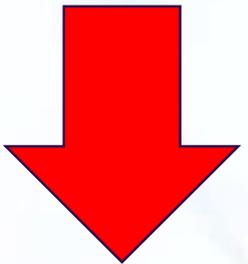
Develop a shared foundation of knowledge and get results!

*Arch Pro Coding & Gary Lucas also wish to express thanks to Shekinah Bishop, ACO Practice Specialist, of Imperium Health for some great content and perspective contained in this presentation!*

*Also - selected slides in this presentation are copyrighted by the American Medical Association and have the AMA logo at the bottom of the slides:*

***“Risk Adjustment Documentation & Coding”***

*by Sheri Poe Bernard, CCS-P, CDEO, CPC, CRC*





# Quality Reporting & Care Management for RHCs: An Overview

## Main Subjects

Provide an overview and perspective on the following key areas. Each will be discussed in more detail in at least one of the next 3 webinar sessions:

- Behavioral & Primary Care Integration intent via BHI & Psych CoCM (*CPT/HCPCS-II/ICD-10-CM*)
- Care Management Services (*CPT/HCPCS-II*)
- 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 Measurements (CPT Category II)
- Preventive medicine options (*CPT/HCPCS-II*)
- Social Determinants of Care/Population Health such as impact on lack of transportation, access to nutritional food, and housing instability (*primarily ICD-10-CM*)
- Substance/Opioid Disorders (SUD/ODU) and Medication-Assisted Therapy (MAT) (*combines CPT/HCPCS-II, and ICD-10-CM*)



# What is “quality” and why is it important?

- **QUESTION:** Should we ever change the quality of care we provide to patients based on their insurance and/or ability to pay?
- **REVENUE IMPACT:** We will acknowledge that some insurance carriers that you participate with give financial incentives to report quality (*ex. ACO Shared Savings and Performance Measures via CPT Category II codes*) while others may penalize you financially if you do not meet certain “standards” (*ex. not “closing gaps” in care*).



# What is “quality” and why is it important?

## **PURPOSE:**

- From a public health perspective - state/federal governments, non-profits, grant-based health programs, and other parties are trying to use our data from the past to predict and impact future “outcomes.”
- Additionally, existing data related to a patient’s diagnosis/previous treatments may more easily identify and encourage patients to be referred to disease-specific programs offered by us or 3<sup>rd</sup> parties.



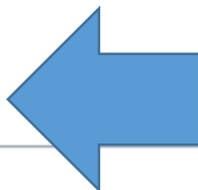
# Measuring “quality” is complicated and evolving

- Have you **experienced any push-back from your providers** over the additional coding responsibilities they have been given over the last few years?
- How much does this transition change the focus on completely and accurately documenting your care in your medical record?
- Which staff should participate in the **additional coding/reporting responsibilities** necessary for quality reporting?
- Is it necessary for us to adjust how we train our clinical providers and coders/billers?





# Sample HEDIS Measure



Interactions between CPT Category II code(s), ICD-10-CM, and HEDIS:  
See also 3008F = “BMI documented”



## 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



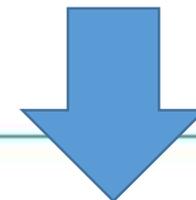
### BMI Percentile – For Members Ages 18 – 19

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

## 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.

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

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



# Public health professionals have other goals

- 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 to “prevent” chronic diseases + HEDIS
- 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.



# Primary HIPAA Code Sets: A Focus on FQHC/RHC Documentation

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on FQHC/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/ODU/MAT)	✓	✓	✓	HIGH



# What is the difference?

## Quality Reporting

- **Limited** impact on reimbursement
- Value-based Care
- ACOs and Shared Savings
- Risk Adjusted Coding
- HEDIS measures
- HCCs
- Population Health via Social Determinants of Care

## Care Management

- **High** impact on reimbursement
- **Performance Measures** via CPT Category II codes
- **Care Management Services:**
  - Reporting the Initiating Visit via E/M
  - Managing chronic disease via Preventive Medicine
  - Chronic Care Management (CCM)
  - Transitional Care Management (TCM)
  - Virtual Communication Services (VCS)
- **Behavioral Health & Primary Care Integration**
  - Behavioral Health Integration (BHI)
  - Psychiatric Collaborative Care Model (Psych CoCM)
  - Substance/Opioid Use Disorder and Medication Assisted Therapy (SUD/ODU/MAT)



# Quality Reporting

- **Value-based Care** – moving away from FFS/Per Diem payments towards paying based on clinical outcomes and disease prevention
- **ACOs and Shared Savings** – you can get money for assuming some of the financial risk and staying under a “benchmark”
- **Risk Adjusted Coding** – how Medicare/Medicaid managed care can bill CMS for more money for complex patients that require more care



**OVERALL LOW IMPACT ON DIRECT REIMBURSEMENT**

# Quality Reporting

- **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 an insurer’s “risk pool.”
- **HEDIS measures** – used by carriers to determine if you have performed certain pre-defined services to “close gaps” for eligible patients to promote overall health
- **Population Health via Social Determinants of Care** – tracking ICD-10-CM codes related to access to food and adequate housing, for example, that may affect overall health and access to programs designed to give aid to those who need it most

← OVERALL LOW IMPACT ON DIRECT REIMBURSEMENT →

# Care Management Services (aka Managing Chronic Care)

- **Performance Measures** – found in the back of the CPT and transitioning from non-revenue “optional” codes to revenue-generated codes often relaying documented history items gathered (*ex. tobacco use assessed 1000F*), exam and testing results (*ex. BMI documented 3008F*), services provided not represented by normal CPT/HCPCS-II codes (*ex. patient screened for high-risk behavior 4293F*).
- **Care Management Services** – primarily using newer E/M and HCPCS-II codes (*ex. 99490 vs. G0511*) to identify work that may not occur during a patient visit, but rather between face-to-face visits or via phone or personalized health records.
- **Preventive Medicine Services** – using CPT/HCPCS-II codes to show the ongoing performance of various services to monitor chronic diseases on an annual or periodic basis (*ex. AWW, IPPE, DSMT, smoking cessation, diabetes self-mgt training*)
- **Behavioral Health Integration & Psych. Collaborative Care Model** – a subset of care management services that involves payment for a full 30 days of integrated care between mental health and/or primary care providers + getting paid for the provision of programs designed to help patients diagnosed by substance disorders.

← **OVERALL HIGH IMPACT ON DIRECT REIMBURSEMENT** →



# Which payers does “quality” apply to in an FQHC/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.



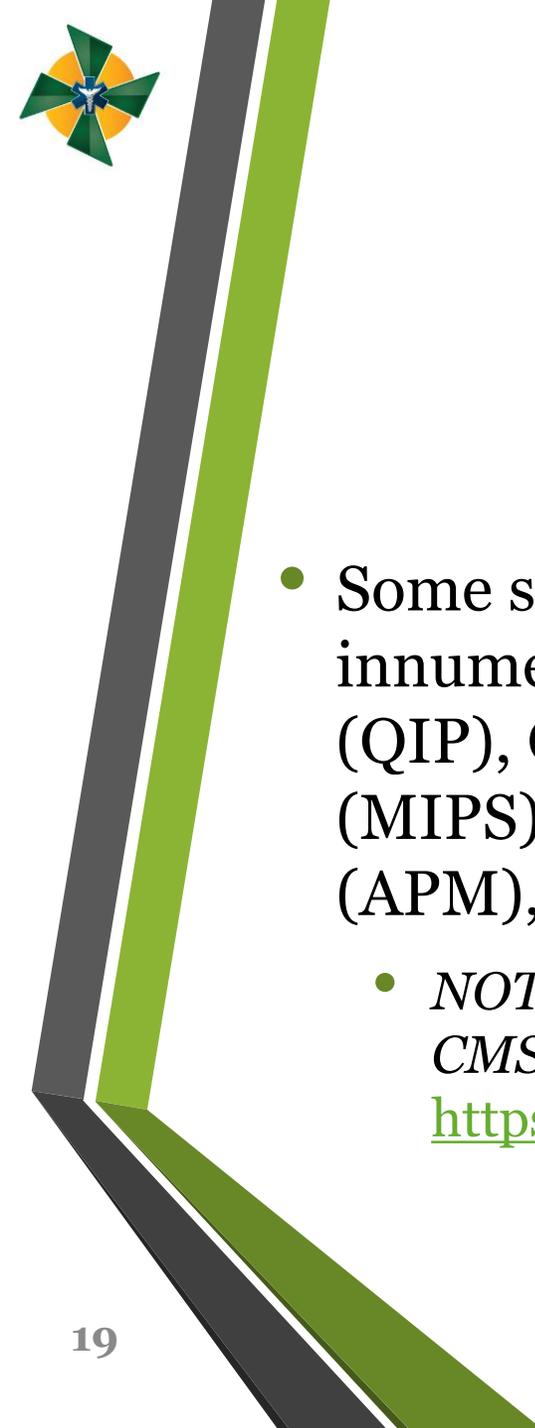
A key element in the success of Medicare Advantage is ensuring that payments to plans reflect the relative risk of the people who enroll. A critical tool that CMS uses to accomplish that goal is the use of risk adjustment models which adjust payments based on the characteristics and health conditions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

**SOURCE:** <https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/downloads/advance2019part1.pdf>



# Who may “pay” for reporting quality?

- Some Medicaid Carriers (see CPT Category II codes)
- State/County Governments
- Private Pay
- State/Federal Grants through HRSA including a recent distribution of \$352,289,768 in grants to 1,232 health centers!
  - Fiscal Year 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) Awards at <https://bphc.hrsa.gov/programopportunities/fundingopportunities/sud-mh/fy2018awards/index.html>
  - “Rural Communities Opioid Response Program-Implementation FAQs” at <https://www.hrsa.gov/rural-health/rcorp/faqs>



# Related quality areas likely 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 FQHCs/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>*



# So in all of your free-time at the office...



# So who is responsible?

## Clinical Providers



### ACTION ITEMS & GETTING RESULTS:

**Document 100% of services you perform in a timely and complete manner.**

**KEY: Clinical Documentation**

## Management



### ACTION ITEMS & GETTING RESULTS:

**Coordinate the capture of 100% of CPT/HCPCS-II/ICD-10-CM codes that are documented according to guidelines whether billable or not.**

**KEY: Professional Coding**

## Coders/Billers



### ACTION ITEMS & GETTING RESULTS:

**Get 100% of the revenue you are entitled to but no more than is allowed.**

**KEY: Coding & Billing**

**Develop a shared foundation of knowledge and get results!**

# Submission to CMS

- **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 from the AMA Store



# Hot Topics in Training for Quality Reporting

What needs to be a focus when dealing with these issues?

- **HEDIS**- Should have a clinical background, be a EHR “super-user”, understand CPT/HCPCS-II, ICD-10-CM and have direct access to CMO who may “adjust” the clinical approach based on the patient’s insurance requirements known as “closing gaps”.
- **HCC**- Heavy ICD-10-CM implications and in-depth knowledge of their “Official Guidelines for Coding and Reporting” also known as “Risk Adjusted Coding”
  - Find out which categories your managed care companies are focusing on for that year – usually 5-8 areas like diabetes, pain management, heart disease, etc..



# Basic Info –

## Healthcare Effectiveness Data & Information Set (HEDIS)

- **Broken into 5 areas that go FAR BEYOND coding:** *Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, Health Plan Descriptive Information*
- Some facilities are beginning to hire or outsource what the industry calls **“HEDIS Abstractors”** to dive into the medical record for a facility to help report measures and identify potential documentation gaps where care may have been provided but not documented or coded correctly.
  - Most FQHCs/RHCs won't be able to cost-justify this expense as of now and must allocate existing staff to perform these duties.
  - The more you can capture at the time of service, or prior to billing, the better!



# Basic Info –

## Healthcare Effectiveness Data & Information Set (HEDIS)

- Any insurer that is NCQA-certified performs their reviews during the same period of each year that some call “HEDIS season”
  - **January-May** = carriers request data and/or medical records for review to validate the care provided
  - **June** = results should be transmitted to the carriers
  - **July** = NCQA releases data on commercial plans through their Quality Compass<sup>®</sup>
  - **Sept-Oct** = NCQA releases data on Medicare/Medicaid plans
  - Reviews are performed via administrative reviews (i.e. claims history), hybrid reviews (i.e. medical record reviews uploaded with a “requested 5-7 day response time”), and patient surveys.
- Don’t forget that some HEDIS data is released that identifies how each insurance plan is performing in making sure their members are getting the “proper” care.
  - Carriers are incentivized heavily as it can influence patients choosing their plans!



# Sample HEDIS Measures – Adult Medicine

## 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

## BREAST CANCER SCREENING (BCS) ● ● ●

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

# 2019 CMS Hierarchical Condition Categories (HCC)

Different categories address different body systems or condition related issues

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

\*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>

# 2019 HCC Hierarchy

Accurate and thorough coding should always be the highest priority

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



*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	<b>Metastatic Cancer and Acute Leukemia</b>
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

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



# Care Management Services: General Information

- Care management is a general term that refers to a variety of services that, according to the AMA in their CPT® are “*management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional....(that) include:*”
  - *Establishing, implementing, revising, or monitoring the care plan,*
  - *Coordinating the care of other professionals and agencies, and*
  - *Educating the patient or caregiver about the patient’s condition, **care plan**, and prognosis.”*



# How often are most care management services provided?

- For example, codes 99487, 99489, 99490, and 99491 are only reported **once per calendar month** by whoever is responsible for the care plan.
- Since these codes almost always report the services of the entire care team it is important to work with your IT/EHR vendors to determine the best way to **document and track the total time** that such services are performed to make sure you meet documentation guidelines.
- Per the CPT® “E/M services may be reported separately by the same (provider) during the same calendar month.”
- That said – depending on the payer you may need to use HCPCS-II codes (ex. G0511 to Medicare) and payment rules as far as how and when you submit claims could differ by payer!



# Before we can report most Care Management Services to a payer...

- Medicare puts a requirement on most Care Management Services to **obtain the patient's consent** prior to reporting the services since the patient may have coinsurance requirements.
  - After all, these services often take place in between patient visits and they may not understand the value of them being performed!
- The service where the patient's consent is gathered and the patient is informed of the nature of the Care Management Services is typically referred to as the **Initiating Visit**.
- Please notice that though we will mostly be referring to CMS guidelines for proper reporting – we will also identify how commercial carriers and Medicaid may want them reported **if different from CMS guidelines!**



# Documenting the CMS “Initiating Visit”

- First, please check to see if your commercial carriers and Medicaid has similar requirements to obtain the patient’s consent and how to report the initiating visit, if required.
- Qualifying visits for CMS can be regular “problem-oriented” E/M codes, an Initial Preventive Medicine Exam (IPPE), or an Annual Wellness Visit (AWV) that meet CMS documentation and coding requirements.
- **Patient must have current Part B coverage**, must be documented by a “**qualified provider**” who would otherwise be able to report a payable visit, and be done in an **authorized location**: namely the rural/community health center, the patient’s home (for *certain homebound patients*), Part A covered skilled nursing facilities, and/or qualified assisted living.



# FQHC/RHC must report the initiating visit within 1 year of reporting care management

## E/M codes such as 99201-99215 (excluding 99211)

- Refer to the [CMS Evaluation and Management Services Guide](#) for the documentation guidelines
- **Initial Preventive Physical Exam (IPPE) code G0402**
  - Refer to the CMS Fact Sheet [CMS Initial Preventive Physical Exam Fact Sheet](#) for documentation guidelines rather than billing guidance since it is written for FFS providers.
- **Annual Wellness Visit (AWV) codes G0438-G0439**
  - Refer to the CMS Fact Sheet [CMS Annual Wellness Visit Fact Sheet](#) for documentation guidelines rather than billing guidance since it is written for FFS providers.
- **NOTE:** For Federally Qualified Health Centers reporting the IPPE/AWV as the initiating visit be sure to refer also to the PPS codes G0466-G0470 and the [CMS Qualifying Visit List for FQHCs](#).
  - RHCs do not use these 2 codes for the IPPE/AWV.



# Key reference info for FQHC/RHC

- For Medicare's guidelines for reporting TCM and other Care Management Services in the [CMS Benefits Policy Manual Chapter 13 – section 230](#)

## **Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services**

**Table of Contents**  
*(Rev. 252, 12-07-18)*

### **230 – Care Management Services** *(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)*

Care management services are RHC and FQHC service and *include transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), and psychiatric collaborative care model (CoCM) services. The RHC and FQHC face-to-face requirements are waived for these care management services. Effective January 1, 2017, care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.)* Except for TCM services, care management services



# Transitional Care Management (TCM)

- The goal of TCM is often stated to **lower preventable hospital readmissions** by:
  - establishing a smooth transition from an inpatient stay **between various care providers**,
  - establishing a coordinated plan with the patient's primary care provider(s) via **direct patient contact within 2 days of the discharge** and performing a **face-to-face visit occurs within either 7 or 14 days** following the discharge.
- The service must be reported within 30 days of the patient's discharge and must include medication reconciliation no later than the date of the post-discharge face-to-face visit.
- For FQHC/RHC billing Medicare - if the TCM face-to-face visit occurs on the same date as another payable service only one PPS/AIR rate will be paid.



# Transitional Care Management (TCM)

- According to the AMA's CPT® guidelines the reporting provider “provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activities of daily living support by providing **first contact and continuous access.**”
- Though typically TCM follows a hospital discharge, it may also be reported in transitions from rehab hospitals, long-term acute care, observation stays, or skilled nursing facility discharges with a focus on the **timely creation and exchange of continuity of care document(s)** with other practitioners and providers other than the discharging provider.
- Through **effective communications with the admitting/discharging provider**, the patient should be informed that they will be contacted **within 2 days of their discharge** by your facility to discuss the inpatient stay and to schedule a follow-up **visit within either 7 or 14 days** after the discharge.



# Prior to reporting TCM

- Direct and interactive communication (*phone, in person, or electronic*) with the patient **must be within 2 days of their discharge date**. If two or more reasonable attempts to reach the patient within 2 days of discharge are made but are unsuccessful and all other TCM criteria are met TCM may be reported making sure to document that the attempts were made.
- The contact within the 2-day window **must be more than simply scheduling the follow-up appointment** and would typically include and document the type(s) of services they had during their admission, what the discharge diagnosis was, and what follow-up services they may need.
  - Be sure to carefully identify any **new, revised, or expected prescriptions and/or expected drug interactions** that may arise from the inpatient stay in order to meet medication reconciliation requirements that should be performed at least by time of the patient visit.



## **During the face-to-face visit be sure to document per CPT documentation guidelines:**

- medication reconciliation,
- referrals made to other providers,
- identification of community resources available to the patient,
- any contacts made with other providers to coordinate the care,
- instructions for continuing care to family members who may be present,
- patient education materials given to the patient,
- labs and/or diagnostic tests performed (may code separately),
- DME ordered or discontinued.



# Coding for TCM

- **Assign CPT code 99495 if:**
  - Documenting medical decision making of at least *moderate complexity* during the service period.
  - Performed a face-to-face visit, **within 14 calendar days** of discharge.
- **Assign CPT code 99496 if:**
  - Documenting medical decision making of at least *high complexity* during the service period.
  - Performed a face-to-face visit, **within 7 calendar days** of discharge.

## NOTES:

- Only one qualified clinical provider may report TCM services on a patient following a discharge. **The same provider who discharged the patient may report TCM services**, but the required face-to-face visit cannot take place on the same day as the actual discharge day management services.
- The phone call and visit should include documentation about the type(s) of services they had during their admission, what the discharge diagnosis was, and what follow-up services they may need or were ordered by the discharging provider.



# When reporting TCM do not also code...

**See the CPT for the full listing**...but here are a few highlights if they are performed during the period of time covered by the TCM codes:

- **93792** – Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring
- **93793** – Anticoagulant management
- **99487-99489/G0511** – Any chronic care management code during the period of captured by the TCM service codes.



# Virtual Communications Services (VCS)

**Purpose:** The purpose of VCS is to aid community/rural health providers who engage in “**virtual check-ins**” via telephone or evaluate and interpret images/audio submitted by patients **for over 5 minutes** for condition(s) unrelated to recent visits and that do not result in an immediate visit.



# Virtual Communications Services (VCS)

- For Medicare's guidelines for reporting TCM and other Care Management Services in the [CMS Benefits Policy Manual Chapter 13 – section 240](#)

## Medicare Benefit Policy Manual Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Table of Contents  
(Rev. 252, 12-07-18)

### *240 – Virtual Communication Services*

*(Rev. 252, Issued: 12-07-18, Effective: 01-01-19, Implementation: 01-02-19)*

*Virtual communication services are RHC and FQHC services and include communications-based technology and remote evaluation services. The RHC and FQHC face-to-face requirements are waived when these services are furnished to an RHC or FQHC patient.*

**NOTE for FQHC/RHC:** It should be noted that you must use caution when researching VCS for getting paid by Medicare since there are codes used by non-FQHC/RHC providers with similar definitions (G2010 and G2012). As we will show - FQHC/RHC will report the VCS with code G0071.



# Documentation & Coding for VCS – 1 of 2

- VCS refers to providers who receive contact via non-face-to-face “communication technology-based” (*i.e. a virtual check-in via phone*) from an established patient lasting more than **5 minutes or more** regarding a condition(s) **NOT related to a visit in the past 7 days** and that **does not result in an appointment in the next 24 hours** or next available appointment slot.
- The contact must be initiated by the patient if using the “virtual check-in” element.
- For commercial carriers or non-FQHC/RHC providers this info refers to code G2012 whereas a FQHC/RHC would use code G0071.



# Documentation & Coding for VCS – 2 of 2

- Another type of VCS refers to providers who interpret and follow-up with patients within 24 hours of when patients send them pictures/video for conditions NOT originating from a related E/M service within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest appointment slot.
- ACOs often utilize a patient portal where they can send information/pictures/videos to their provider – if you are using this “store-and-forward” technique to report VCS the information must be reviewed within 24 hours of its submission by the patient.
- For commercial carriers or non-FQHC/RHC providers this info refers to code G2010 whereas a FQHC/RHC would use code G0071.



# Documentation needs for VCS

- Document that no appointment was made within 24 hours or for the first available time slot.
- Any details discussed such as medications, recommendations, and referrals.
- Total time for the interaction was over 5 minutes.
- Any updates made to existing treatment plans.



# Researching VCS using CMS FAQs

CMS prepared an **8-page set of frequently asked questions** (FAQ) that is specific for FQHC/RHC providers. Go get it at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

**Virtual Communication Services in Rural Health Clinics (RHCs) and**

**Federally Qualified Health Centers (FQHCs)**

**Frequently Asked Questions**

**December 2018**



# Billing Issues for VCS

- This service is not intended by CMS to be for new patients, but the billing provider does not need to be a provider that the patient has seen previously.
- Though it is recognized that nurses and other staff can participate in certain other types of Care Management Services, these VCS services must be performed personally by an authorized CMS provider including physicians, PA, NP, CNM, CP, and CSW.
  - Nurses, health educators, or other clinical staff that provide similar services should not report this service under the provider's billing number as incident-to.
- The FQHC/RHC practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.



# Billing for VCS

- For non-Medicare payers you should likely use HCPCS-II codes G2010 or G2012 and they may have similar reimbursement.
- For Medicare patients FQHC/RHC are required to utilize HCPCS-II code **G0071** and it is not paid via the PPS/AIR systems, rather they are paid at the average CMS fee schedule amount for the G2010 and G2012 codes or a flat fee **~\$13-14** with a 20% patient coinsurance amount.

# Performance Measures

- **Performance Measures** via CPT Category II codes
  - Revenue or Compliance?
  - Is there an IT-only solution?
  - What are exclusion criteria and when do I use CPT Category II modifiers?
  - Overview and look at the AMA “Clinical Topics Listing” for documentation details on:
    - Diabetes
    - Hypertension and Chronic Coronary Heart Disease
    - Preventive Services
    - Lipid Control
    - Smoking/Tobacco Use
    - *(and where you can get hundreds more!)*



# CPT Cat. II codes – revenue or quality compliance?

## YES!

### Revenue

- Though supplemental/optional in the past many Medicaid Managed Care Plans (and others) are incentivizing us to submit test results and other CPT Cat. II codes on a periodic basis!
- For example – we have seen carriers offering \$10 four times a year to report the patient's A1C levels if they are diabetic – that's \$40 for each patient!
  - See codes 3044F-3046F

### Compliance

- Quite simply, these measures are used by some carriers and state/federal programs to monitor the effectiveness of their programs, measure effectiveness to validate that grant monies are spent wisely, and that results are achieved.



# Reporting Performance Measures

- The codes used for this area of quality reporting first appeared in the AMA CPT® manual many years ago as “a set of *supplemental* codes that can be used for *performance measurement*... (and) the use of these codes is *optional*...(and) *are not required for correct coding* and may not be used as a substitute for Category I codes.”
- “It is anticipated that the use of Category II codes for performance measurement will *decrease the need for record abstraction and chart review, and thereby minimize administrative burden* on physicians....”



# Grab Your HCPCS Level I Manual – the CPT

The CPT (*which is known as HCPCS level I*) consists of 3 “categories”:

## Category I: 5-digit numeric-only codes

- These are the codes you are most familiar with such as 99213, 99397, 69210

## Category II: 5-digit alphanumeric codes ending in “F”

- Optional for coding but what about Medicare/Medicaid Managed Care and quality?

## Category III: 5-digit alphanumeric codes ending in “T”

- Required when Category 1 code does not exist
- These are temporary codes with a 5 year “sunset” rule and they then go away or become Category I codes.



# When do we need to list Category II codes?

- It will be **highly variable by facility** and is primarily based on your participation agreements with Medicare Advantage, Medicaid Managed Care, and commercial plans who may “require” or “encourage” this type of reporting.
- In a perfect world, your EHR vendor can design modules that auto-magically pulls such key data from your completed medical encounter such as BMI being calculated or tobacco-use assessment performed. **Good luck!**
- What they are really **trying to determine is a ratio** of how many eligible people got “X” of who is considered “eligible”.
  - 0% through 100% with a targeted amount or minimum threshold to be reached that will impact future payment rates or incentive monies.
  - This can be done at an individual provider level, for an entire facility, or for an entire network or facility type (ex. ACOs, FQHCs, and RHCs).



# Sample request for CPT Cat. II codes

## Diabetes – HbA1c Test and Control

### Incentive Programs:

WellCare, Passport, Anthem EPHC

### Measurement Description:

Patients who are 18 to 75 years old with diabetes (Type 1 or Type 2) who had an HbA1c test reported and a result value of the test reported.

### Coding:

Specific CPT codes must be submitted for the health plan to recognize the Hemoglobin A1c test was performed. The codes below will be captured through claims.

#### CPT:

83036 (done in doctor's office)

or

83037 (done in ~~doctor's office~~ or home with FDA home-approved device)

**\*\*\*ALERT\*\*\*:** Specific CPT II codes must also be submitted for the health plan to recognize the value of the HbA1c test. The codes below will be captured through claims.

#### CPT II:

3044F (Result value of <7.0)

3045F (Result value of 7.0-9.0)

3046F (Result value of >9.0)



# CPT Category II code sections

- Modifiers
- **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 code section highlights

- **Patient History 1000F** = Tobacco use assessed (CAD, CAP, COPD, PV) (DM)
- **Patient History 1031F** = Smoking status and exposure to 2<sup>nd</sup> 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)



# CPT Category II Diagnostic/Screening Processes or Results

- **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%
- **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



# Other CPT Category II code highlights

- **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



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



# First, access the full disease measures from the AMA before reporting these measures

- “To promote understanding of these codes and their associate users are referred to the Alphabetical Clinical Topics Listing, **which contains information about performance measurement exclusion modifiers, measures, and the measure’s source.**”
- “Cross-references to the measures associated with each Category II code and their source are included for reference in the Alphabetical Clinical Topics Listing....at <https://www.ama-assn.org/media/50621/download>”
- “Users should review the complete measure(s) associated with each code prior to implementation”
  - **Get them from the AMA list AND the carrier that requires them – BUT heads-up it is around 387 pages so use the search feature and hyperlinks to navigate easier!**



# Sample sneak peek of the full measures found at <https://www.ama-assn.org/media/50621/download>

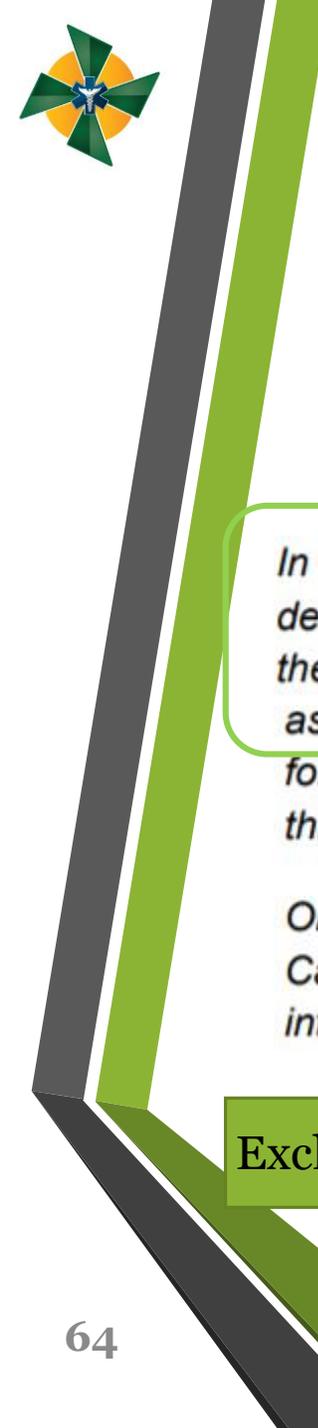
## Alphabetical Clinical Topics Listing



Updated August 9, 2019

The following listings note the latest clinical condition and measure additions, deletions, and revisions that have been approved for posting as of July 1, 2019. Each clinical topic and measure displayed within this listing below is hyperlinked to the specific clinical topic or measure listing in the Index of Alphabetic Clinical Topics document. In addition, the heading notes the specific date in which the measures that follow were originally posted.

**Important:** The Alphabetic Measure Index is a web-based, alphabetical listing of clinical conditions and topics with which the measures and codes are associated. It appears only on the Category II code website and provides an overview of the performance measures, a listing of CPT Category II codes that may be used with each measure, as well as any applicable reporting instructions. It is intended to be used as a crosswalk to the Category II codes section to allow users an overview of the measures and the Category II codes that should be used with each measure and to link the Category II codes to the specific measures and measure sets from which these codes were derived. The clinical conditions or topics are listed in alphabetical order within the Measure Index to allow rapid access to the conditions/topics currently included in the Category II code set. This document is intended as a dynamic document and is updated to include the latest information regarding Category II coding.



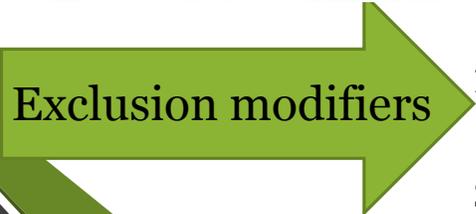
# Before submitting any CPT Cat. II code...

<https://www.ama-assn.org/media/50621/download>



*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>



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.



# For example – here are some new diabetes issues that became effective October 1, 2019

## Physical Examination

▲2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; <u>with evidence of retinopathy (DM)<sup>2,4</sup></u>	Released: July 1, 2019 Effective: October 1, 2019	First Appearance of revision in CPT codebook: <b>CPT 2020</b>
●2023F	<u>without evidence of retinopathy (DM)<sup>2</sup></u>	Released: July 1, 2019 Effective: October 1, 2019	First Appearance of revision in CPT codebook: <b>CPT 2020</b>
▲2024F	7 standard field stereoscopic <u>retinal</u> photos with interpretation by an ophthalmologist or optometrist documented and reviewed; <u>with evidence of retinopathy (DM)<sup>2,4</sup></u>	Released: July 1, 2019 Effective: October 1, 2019	First Appearance of revision in CPT codebook: <b>CPT 2020</b>

AMA source page 5: <https://www.ama-assn.org/practice-management/cpt/category-ii-codes>

# Sample Preventive Care in the Clinical Topics Listing

## Preventive Care & Screening (PV)

Brief Description of Performance Measure & Source and Reporting Instructions	CPT Category II Code(s)	Code Descriptor(s)
<p>*Includes use of any type of tobacco            ** Cessation counseling intervention includes brief counseling (3 minutes or less) and/or pharmacotherapy</p> <p><b>Denominator:</b> All patients aged 18 years and older  <b>Exclusion(s):</b> Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)</p> <p><b>Percentage</b> of patients aged 18 years and older who were screened at least once during the two year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user</p> <p><b>Reporting Instructions:</b> For patient with appropriate exclusion criteria report 4004F with modifier 1P. If patient does not smoke or use any type of tobacco report only 1036F.</p>	<p>1036F</p>	<p>Current tobacco non-user</p>
<p><b>Obesity Screening<sup>1</sup></b>            Whether or not the patient aged 18 years and older has a body mass index (BMI) documented</p> <p><b>Numerator:</b> Patients for whom body mass index (BMI) is documented</p> <p><b>Denominator:</b> All patients aged 18 years and older  <b>Exclusion(s):</b> Documentation of medical reason(s) (eg, patient is non-ambulatory), patient reason(s) (eg, patient declined), or system reason(s) (eg, equipment not available) for not documenting body mass index (BMI)</p> <p><b>Percentage</b> of patients aged 18 years and older for whom body mass index (BMI) documented at least once during the two-year measurement period</p> <p><b>Reporting Instructions:</b> For patient with appropriate</p>	<p>3008F</p>	<p>Body Mass Index (BMI), documented</p>

*ArchPro note: See also the ICD-10-CM Base Code Z68 for specific codes for the actual BMI level.*

# From the AMA Category II Clinical Topics Listing Diabetes and A1C measurement (page 119 of 387)

Diabetes (DM) Brief Description of Performance Measure & Source and Reporting Instructions	CPT Category II Code(s)	Code Descriptor(s)
<p><b>A1c Management</b> <sup>4</sup></p> <p>Whether or not patient received one or more A1c test(s)</p> <p><b>Numerator:</b> Patients who received one or more A1c test(s)</p> <p><b>Denominator:</b> Patients with diagnosed diabetes 18-75 years of age</p> <p><b>Percentage</b> of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s).</p> <p><b>Exclusion(s):</b> NONE</p> <p><b>Reporting Instructions:</b> 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.</p> <p>▶ To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F. ◀</p>	<p>3044F</p> <p>▶ 3051F ◀</p> <p>▶ 3052F ◀</p> <p>3046F</p>	<p><i>Most recent hemoglobin A1c (HbA1c) level &lt; 7.0%</i></p> <p>▶ Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% ◀</p> <p>▶ Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% ◀</p> <p><i>Most recent hemoglobin A1c (HbA1c) level &gt; 9.0%</i></p>

**Refer to the CPT 2020 code updates per AMA!**

23	Cat II-Diabetes Care	●304XF●305XF D3045F	Accepted addition of codes 304XF, 305XF to allow reporting for different levels of HbA1c; deletion of 3045F	January 1, 2020
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# Possible CPT Cat. II codes for Diabetes

## Diabetes (DM)

### Brief Description of Performance Measure & Source and Reporting Instructions

### CPT Category II Code(s)

### Code Descriptor(s)

#### Eye Examination <sup>4</sup>

Whether or not patient received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year if patient is at low risk\* for retinopathy

**Numerator:** Patients who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year, if patient is at low risk\* for retinopathy

**Denominator:** Patients with diagnosed diabetes 18-75 years of age; Low risk patient (defined as a patient who had no evidence of retinopathy in the prior year) must have had an evaluation in the prior year

**Exclusion(s):** NONE

**Percentage** of patients who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year

**Reporting Instructions:** Only one of these codes should be reported.

▶ 2022F ◀

▶ Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy ◀

▶ 2023F ◀

▶ without evidence of retinopathy ◀

OR

▶ 2024F ◀

▶ 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy ◀

▶ 2025F ◀

▶ without evidence of retinopathy ◀

OR

▶ 2026F ◀

▶ Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results





# Eligible CPT Cat. II codes for pre-diabetes screening for patients with DSP (page 133 of 387)

## Distal Symmetric Polyneuropathy (DSP)

**Brief Description of Performance Measure & Source and Reporting Instructions**

**CPT Category II Code(s)**

**Code Descriptor(s)**

**Diabetes/Pre-Diabetes Screening for Patients with DSP<sup>8</sup>**  
Whether or not the patient age 18 years and older diagnosed with distal symmetric polyneuropathy had screening tests for diabetes (eg, fasting blood sugar test, hemoglobin A1C, or a 2 hour Glucose Tolerance Test) reviewed, requested, or ordered when seen for the initial evaluation for distal symmetric polyneuropathy



**Numerator:** Patients who had screening tests for diabetes (eg, fasting blood sugar test, hemoglobin A1C, or a 2-hour Glucose Tolerance Test) reviewed, requested, or ordered when seen for an initial evaluation for distal symmetric polyneuropathy

3754F

Screening tests for diabetes mellitus reviewed, requested, or ordered

**Denominator:** All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy

1119F

Initial evaluation for condition

**Exclusion(s):** Documentation of medical (eg, patient already has a diagnosis of diabetes, patient has a known medical condition to cause neuropathy, patient had previous diabetes screening), patient (eg, patient declines to undergo testing), or system (eg, patient does not have insurance to pay for testing) reason(s) for not reviewing, requesting, or ordering diabetes screening tests

1501F

Not initial evaluation for condition

**Reporting Instructions:**

For all patients meeting denominator criteria, report either 1119F or 1501F.

When 1119F is reported, also report 3754F.



For clinical info on the diagnosis of DSP/Diabetes/Neuro pathy etc. see <https://www.podiatrytoday.com/blogged/closer-look-ada%E2%80%99s-recommendations-distal-symmetric-polyneuropathy>

# Other selected CPT Cat. II codes for Asthma

Medicare Part B allows 2 individual tobacco cessation attempts per year using 99406-99407.

Each attempt can include up to four intermediate or intensive sessions (up to 8x per year)

Asthma		
Brief Description of Performance Measure and Source and Reporting Instructions	CPT Category II Code(s)	Code Descriptor(s)
<p><b>Tobacco Use – Intervention<sup>1</sup></b> Whether or not the patient aged 5 through 50 years with a diagnosis of asthma identified as a tobacco user and received tobacco cessation intervention during the measurement period</p> <p><b>Numerator:</b> Patients (or their caregivers) who received tobacco use cessation intervention</p> <p>Note: Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator compliant whether or not the primary caregiver is the source of second hand smoke in the home.</p> <p><b>Denominator:</b> All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users*</p> <p>*Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.</p> <p><b>Exclusion(s):</b> None</p> <p><b>Reporting Instructions:</b> Report 1032F or 1033F to indicate tobacco use status. If 1032F (tobacco smoker OR currently exposed to secondhand smoke), report 4000F OR 4001F to indicate type of tobacco use cessation intervention.</p> <p>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</p>	<p>4000F</p> <p>4001F</p> <p><b>Denominator Codes</b></p> <p>1032F</p> <p>1033F</p>	<p>Tobacco use cessation intervention, counseling</p> <p>Tobacco use cessation intervention, pharmacologic therapy</p> <p>Current tobacco smoker OR currently exposed to secondhand smoke</p> <p>Current tobacco non-smoker AND not currently exposed to secondhand smoke</p>





# CPT Category II codes for Obesity

## Preventive Care & Screening (PV)

### Obesity Screening<sup>1</sup>

Whether or not the patient aged 18 years and older has a body mass index (BMI) documented

**Numerator:** Patients for whom body mass index (BMI) is documented

**Denominator:** All patients aged 18 years and older

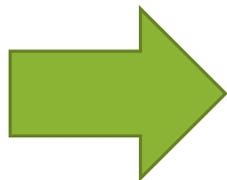
**Exclusion(s):** Documentation of medical reason(s) (eg, patient is non-ambulatory), patient reason(s) (eg, patient declined), or system reason(s) (eg, equipment not available) for not documenting body mass index (BMI)

**Percentage** of patients aged 18 years and older for whom body mass index (BMI) documented at least once during the two-year measurement period

**Reporting Instructions:** For patient with appropriate exclusion criteria report 3008F with modifier 1P, 2P, or 3P.

3008F

Body Mass Index (BMI), documented





# IN SUMMARY:

## Performance Measurement Using CPT Category II Codes

- ✓ In addition to being a “superuser” of your 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.
- ✓ 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 just used to measure performance against the “requirements” of the insurance plan(s) that you participate with.



# IN SUMMARY:

## Performance Measurement Using CPT Category II Codes

- ✓ 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.
- ✓ The AMA publishes excellent details on each measure that can be updated more than once a year!
- ✓ These codes can sometimes be tied to existing payable services (*ex. smoking cessation with 99406*) and existing diagnosis categories (*ex. ICD-10-CM code section Z68.xx*).

# The End ?

Or is there more to your educational journey?





# ArchProCoding

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## **Instructor**

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