Quality and Coding Accuracy Provider Training

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1.
Purpose

Goal of Quality and Coding Accuracy Provider Training:

To capture complete and accurate patient health information.

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Enabling Providers

- Enable providers to report complete patient health information.
  - Quality of Care Measures
  - Significant and chronic diagnoses
    - → "Risk Adjustment" diagnoses
- Educate providers and medical coding staff as to proper coding for claims.
- Submitting this data on claims reduces the need for medical record retrieval/review.

Initial Focus

- Initial focus is on the following conditions and quality-of-care measures:
  - Controlling Blood Pressure (CBP)
  - Glycemic Status Assessment for Patients with Diabetes (GSD)
  - Cervical Cancer Screening (CCS)
- Additional conditions and measures will be forthcoming.

2.
Data & Coding Opportunities

Patient health data can be captured through the inclusion of key medical codes on claims.

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Procedural Coding

- Current Procedural Terminology (CPT) Category II Codes
  - Four digits + "F" – Example: **0001F**
  - Included as "procedures" on the claim, though they are more for information/reporting purposes than actual procedures performed.
  - Report CPT Category II codes in addition to evaluation & management and any other procedures performed.
  - "Describe clinical components that may be typically included in evaluation and management services or clinical services… may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law."

CPT Category II Codes

- **Patient Management Codes** (examples)
  - **0513F** ***Elevated blood pressure plan of care, documented***
  - **0517F** ***Glaucoma plan of care, documented***
  - **0529F** ***Interval of 3 or more years since patient's last colonoscopy, documented***
  - **0545F** ***Plan for follow-up care for major depressive disorder, documented***

CPT Category II Codes

- **Patient History Codes** (examples)
  - **1000F** ***Tobacco use assessed***
  - **1015F** ***COPD symptoms assessed or respiratory symptom assessment tool completed***
  - **1111F** ***Discharge medications reconciled with the current medication list in outpatient medical record***
  - **1220F** ***Patient screened for depression***

CPT Category II Codes

- **Physical Examination Codes** (examples)
  - **2000F *Blood pressure measured***
  - **2001F *Weight recorded***
  - **2014F *Mental status assessed***
  - **2015F *Asthma impairment assessed***
  - **2022F *Dilated retinal eye exam with interpretation by ophthalmologist/optometrist documented and reviewed; with presence of retinopathy***
  - **2023F *…; without presence of retinopathy***

CPT Category II Codes

- **Diagnostic/Screening Processes or Results Codes** (examples)
  - **3011F *Lipid panel results documented and reviewed***
  - **3014F *Screening mammography results documented and reviewed***
  - **3017F *Colorectal cancer screening results documented and reviewed***
  - **3044F *Most recent hemoglobin A1c level less than 7.0%***
  - **3051F *Most recent HbA1c*** *[from 7.0% to 7.9%]*
  - **3052F *Most recent HbA1c*** *[from 8.0% to 9.0%]*
  - **3046F *Most recent HbA1c level greater than 9.0%***

CPT Category II Codes

- **Diagnostic/Screening Processes or Results Codes** (examples)
  - **3074F** ***Most recent systolic BP <130***
  - **3075F** ***Most recent systolic BP 130-139***
  - **3077F** ***Most recent systolic BP >=140***
  - **3078F** ***Most recent diastolic BP <80***
  - **3079F** ***Most recent diastolic BP 80-89***
  - **3080F** ***Most recent diastolic BP >=90***

Diagnosis Coding (ICD-10-CM)

- Correct diagnosis codes are vital for providing an accurate picture of patient health.
- Proper diagnostic information prompts disease management programs and contributes to completeness and continuity of care.

3.
Quality Care Measures

California mandates a set of quality measures– required elements of patient care– which should be met.

It is up to providers to provide and document this care.

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Controlling Blood Pressure (CBP)

- Based upon the **last** BP taken within each year ("Measurement Year" or "MY").
- Patient must have 2 instances of Hypertension documented before/on the date of the last BP.
- Patients 18 to 85 years of age.
- **Compliance with this measure calls for BP below 140/90.**
- If multiple BPs are taken on the same day, we can use the lowest systolic & the lowest diastolic numbers.
- A range of numbers is not acceptable; e.g. "Pt states home BP has been 130-140/70-80," or "Home BP has been in the 130s/70s."
- Also record patient Race and Ethnicity (Hispanic/Latino or not); "Unknown" is an acceptable option, but please document this information when known.

Controlling Blood Pressure (CBP)

- Patient BP taken at home is acceptable if done on a digital device.
- BP cannot be used from inpatient or ER notes.
- BP is still recorded, even if patients are “excluded” because of any of the following during MY:
  - Had a diagnosis of CKD5 or ESRD.
  - Had dialysis, nephrectomy, kidney transplant.
  - Were pregnant.
  - Received palliative or hospice care, or expired.
  - Were admitted to non-acute facility.

Glycemic Status Assessment for Patients with Diabetes (GSD)

- **Two rates are reported for this measure:** below 8% (control) or greater than 9% (poor control).
- The poor control rate (>9%) is a **reverse** measure; **a lower rate is better.**
  - This rate is on the DHCS MCAS.
- The most recently reported HgbA1c determines which rate the member falls into:

Measure Sort	Measure Description	EP	Num	Rate
GSD1	Glycemic Status <8.0%	3,902	779	19.96%
GSD2	Glycemic Status >9.0%	3,902	2,926	74.99%

Glycemic Status Assessment for Patients with Diabetes (GSD)

- Patient must have two documented diagnoses of diabetes in the medical record; or one diagnosis of diabetes plus one dispensation of insulin or antihyperglycemic medications.
- Patients 18 to 75 years of age.
- Documentation must give the date the test was performed/collected/ reported, and the result.
- “Patient is in for checkup, A1c 7.0.” – This does not provide the date that the A1c test was done.
- Also record patient Race and Ethnicity (Hispanic/Latino or not); “Unknown” is an acceptable option, but please document this information when known.

Glycemic Status Assessment for Patients with Diabetes (GSD)

- HgbA1c result is still recorded, even if patients are “excluded” because of any of the following during MY:
  - Patients with Frailty and Advanced Illness.
  - Patients living in long term care.
  - Patients who received palliative or hospice care.
  - Patients who expired.

Cervical Cancer Screening (CCS)

- Screening for cervical cancer using either of the following:
  - For patients 21-64 yo, [endo]cervical Pap smear in three-year period (MY and 2 previous years).
    - → "Thin prep" is acceptable.
  - For patients 30-64 yo:
    - → Cervical high-risk human papillomavirus (hrHPV) test ("HPV test" is adequate documentation) in the past 5 years, with or without cervical cytology/Pap smear.
    - → Reflex testing/ASCUS testing is acceptable for this component.
- Documentation must give the date the test was performed/collected/reported, and the **result** (negative/positive/unclear/abnormal/normal).

Cervical Cancer Screening (CCS)

- Unacceptable cytology tests:
  - No cervical cells present / Sample is not adequate for review.
  - Cervical biopsy.
  - Wet prep.
  - Vaginal Pap smear
- Unacceptable hrHPV tests:
  - Biopsies.
  - Serology HPV test.

Cervical Cancer Screening (CCS)

- Results are still recorded, even if patients are “excluded” because of any of the following during MY:
  - Documented hysterectomy & provider documentation that the patient no longer requires Pap testing/cervical cancer screening.
  - Documentation of hysterectomy and of **vaginal** Pap smear.
  - Patient without cervix:
    - → Complete hysterectomy/total hysterectomy (TAH/TVH)
    - → Vaginal hysterectomy
    - → Radical [vaginal] hysterectomy
    - → Pelvis evisceration/exenteration
    - → Acquired absence of cervix
    - → Cervical agenesis
    - → Vaginal Cuff with documentation of hysterectomy

Cervical Cancer Screening (CCS)

- Results are still recorded, even if patients are "excluded" because of any of the following during MY:
  - Patient not Assigned Female at Birth (AFAB).
  - Patient received palliative or hospice care, or expired.

Compliance with Quality Measures

CBP

- ***BP greater than 140/90*** (80% of noncompliant cases)
- ***No BP found in medical record in MY*** (19%)
  - *Primarily due to a predominance of telephone encounters and telehealth encounters due to the COVID Health Emergency.*
- ***Patients non-adherent with antihypertensive medications.***

GSD

- ***HgbA1c between 8.0% and 9.0%*** (39%)
- ***HgbA1c greater than 9.0%*** (28%)
- ***No HgbA1c found in medical record MY*** (33%)

4.
Risk Adjustment Diagnoses

Set of significant and/or chronic diagnoses which generally correspond to HEDIS/Quality Measures (e.g. Diabetes, Hypertension, Cancer) and which carry a greater burden of care. Coding these diagnoses to the greatest possible specificity affects both patient care and reimbursement.

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CDPS “Model”

The list of 22,000 ICD-10-CM diagnosis codes which are Risk Adjusting. Developed & maintained at UCSD.

Documenting Patient Conditions

- No one expects providers to memorize the Model!
- Some guidance on what to include in documentation to ensure that Risk Adjustment guidelines are met:
  - Be sure to Monitor, Evaluate, Address, and/or Treat (MEAT) all patient conditions **at least once per year.**
  - Document the attention given to each condition and the medical decision making required– get “credit” for your work.

Documenting Patient Conditions

- Document (and code) to the greatest possible specificity:
  - Site
  - Laterality
  - Stage or progression
  - Associated manifestations/complications
  - Specific type or variation of condition
  - Underlying infection or causal condition(s)

Documenting Patient Conditions

- Documentation does not have to be lengthy or tedious:
  - *DM2 with neuropathy, stable, continue Metformin.*
  - *Rheumatoid arthritis, both knees, worsening pain, follow-up with Dr. Jones next week.*
  - *Decubitus ulcer, right heel, stage 1, dressing changed in office.*
  - *Moderate persistent asthma w. exacerbation, worsening. Patient non-adherent with prescription inhaler.*
  - *HTN, 135/86, at goal, continue diet and exercise.*

Risk Adjustment Coding – Issues Noted

- Conditions documented and treated but not coded in the record.
- Missed combination coding; e.g. DM in the presence of various complications is an assumed causal link and prompts the use of a combination code, such as:
  - E11.22 DM2 with CKD
  - E11.36 DM2 with cataract
  - E11.42 DM2 with neuropathy
  - E11.51 DM2 with peripheral angiopathy

Q&A

Thank you!