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Medical Home Oversight Work Group Meeting

June 20, 2019

2018 Coding Workshop Part Deux

- Recap from June 6th Coding Workshop
- Coding Practice Variation Discussion
- Annual Wellness Visit Discussion
- Diligence in Coding Compliance
- Team Sport: Bringing Specialists into the Fold

Key Points June 6th Coding Workshop

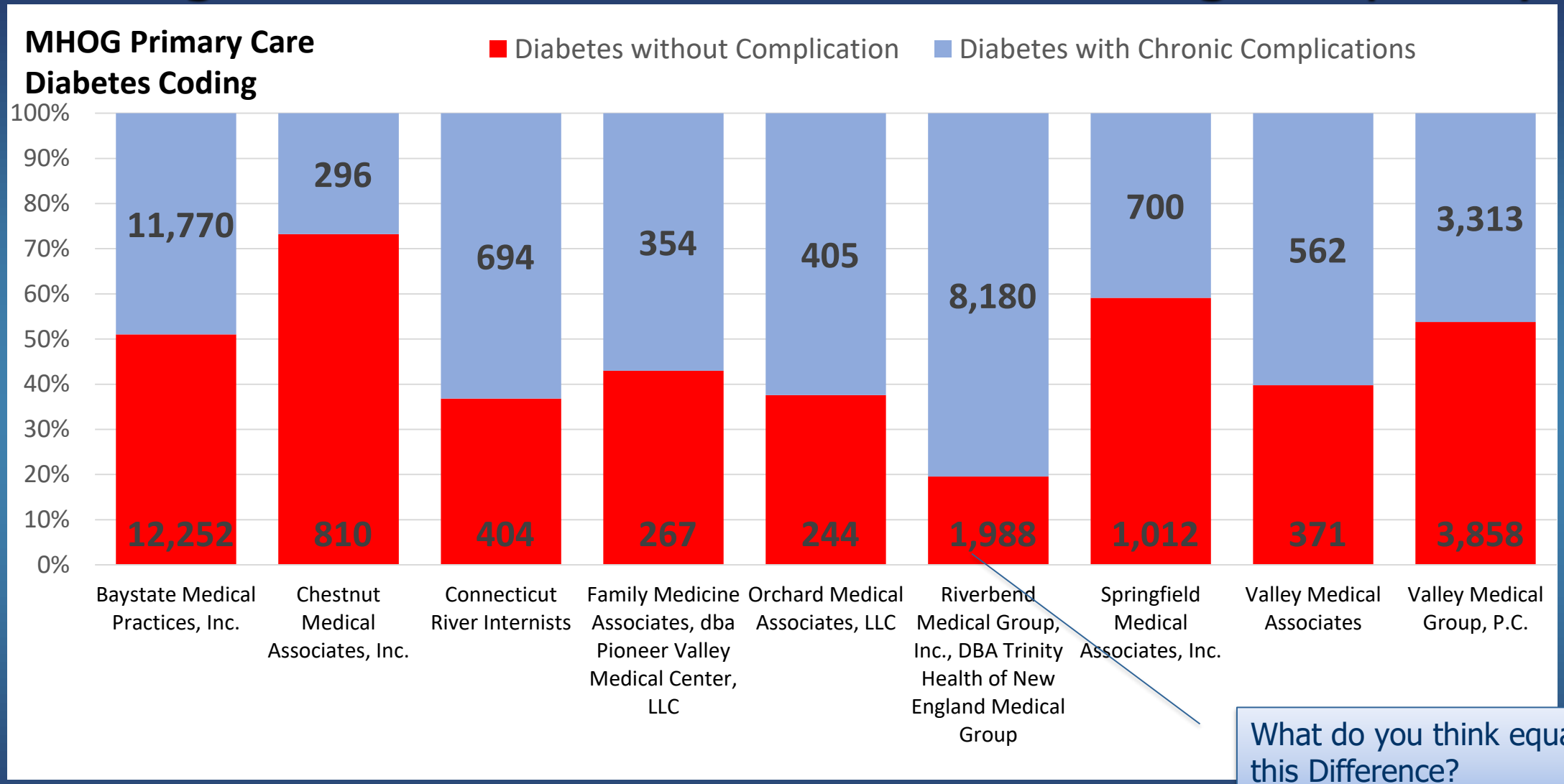
- Opportunity 1:
  - Variation in Providers' RAF capture when patients **are SEEN** in your practice (Patients Seen without RAF capture)
    - Practice Specific Tactics being discussed at Practice Performance Meetings
      - Standard Processes Necessary (EMR, Lightbeam, RAF RN ect)
      - Can't Assume Specialists are doing it
- Opportunity 2:
  - Attributed Patients that Have **NOT been seen** in a year
    - Tactic: Worklists being Generated, Top 100 HCC patients, Outreach (portals, text, standard f/u visit orders (DM)
- Opportunity 3:
  - Uncaptured Chronic Diseases (COPD, CHF, Depression)
    - Tactic: Medical Record Audit (Claims submission issues, problem list inaccuracies, ect)
- Coding Education around specific conditions (Angina, Active vs. h/o cancer, MDD)

Coding Habits Variation

- Idea Brainstormed at Previous MHOG Workgroup
- ICD 10 Codes with No RAF Value that Map to Potentially Appropriate HCC Codes
  - Directionally Accurate Opportunities
  - Useful to Provide Targeted Education to your Providers

High Variation Between Groups = Potential Opportunity

Coding Habits Variation - Diabetes Coding Frequency



What do you think equates to this Difference?

High Freq = Potential Opportunity for more Accurate Coding

* # = Dx codes billed, not patients

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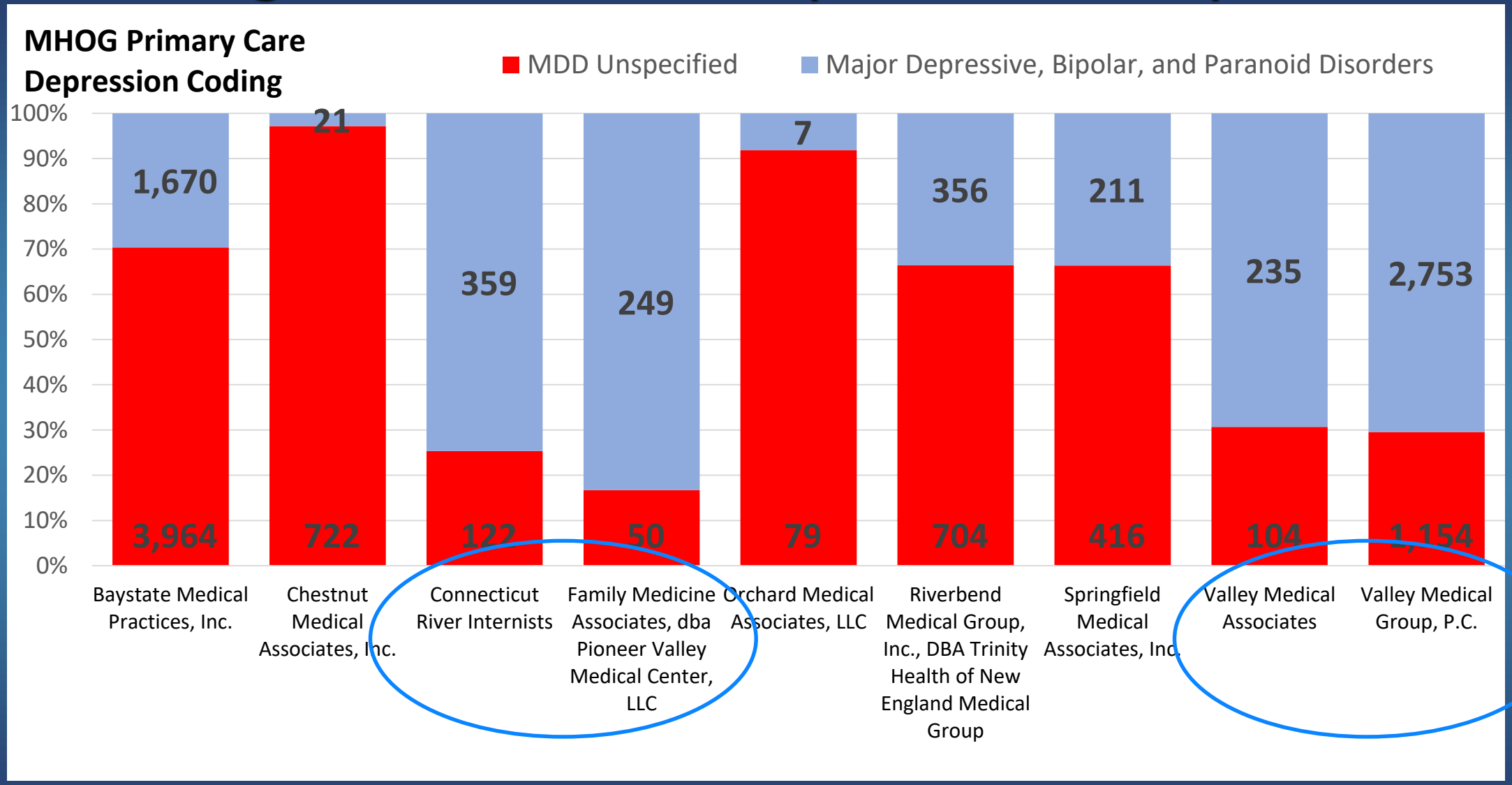
Coding Habits – MDD Unspec vs. MDD Specified



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Depression Education

ICD-10 Documentation Considerations

Major depression documentation should specify whether it is a single episode or recurrent, the current degree of depression, the presence of psychotic features or symptoms and remission status (partial, full) when applicable.
A diagnosis of Major depressive disorder, single episode (F32.-) or Major depressive disorder, recurrent episode (F33.-) can be based on a patient meeting 5 of the 9 criteria on a PHQ-9, at least 1 of which must be depressed mood or loss of interest/pleasure.

- Documentation should include a narrative of whether the depression is mild, moderate, or severe to assign an appropriate ICD-10 diagnosis. This can be established based off the documentation and discussion of the PHQ-9
  - Mild depression is considered for a PHQ of 5-9
  - Moderate depression is considered for a PHQ of 10-19
  - Severe depression is considered for a PHQ of 20-27

ProviderMatters – Physician Tip Sheet

Risk Adjustment Coding Tip Sheet – Major Depressive Disorder

Overview

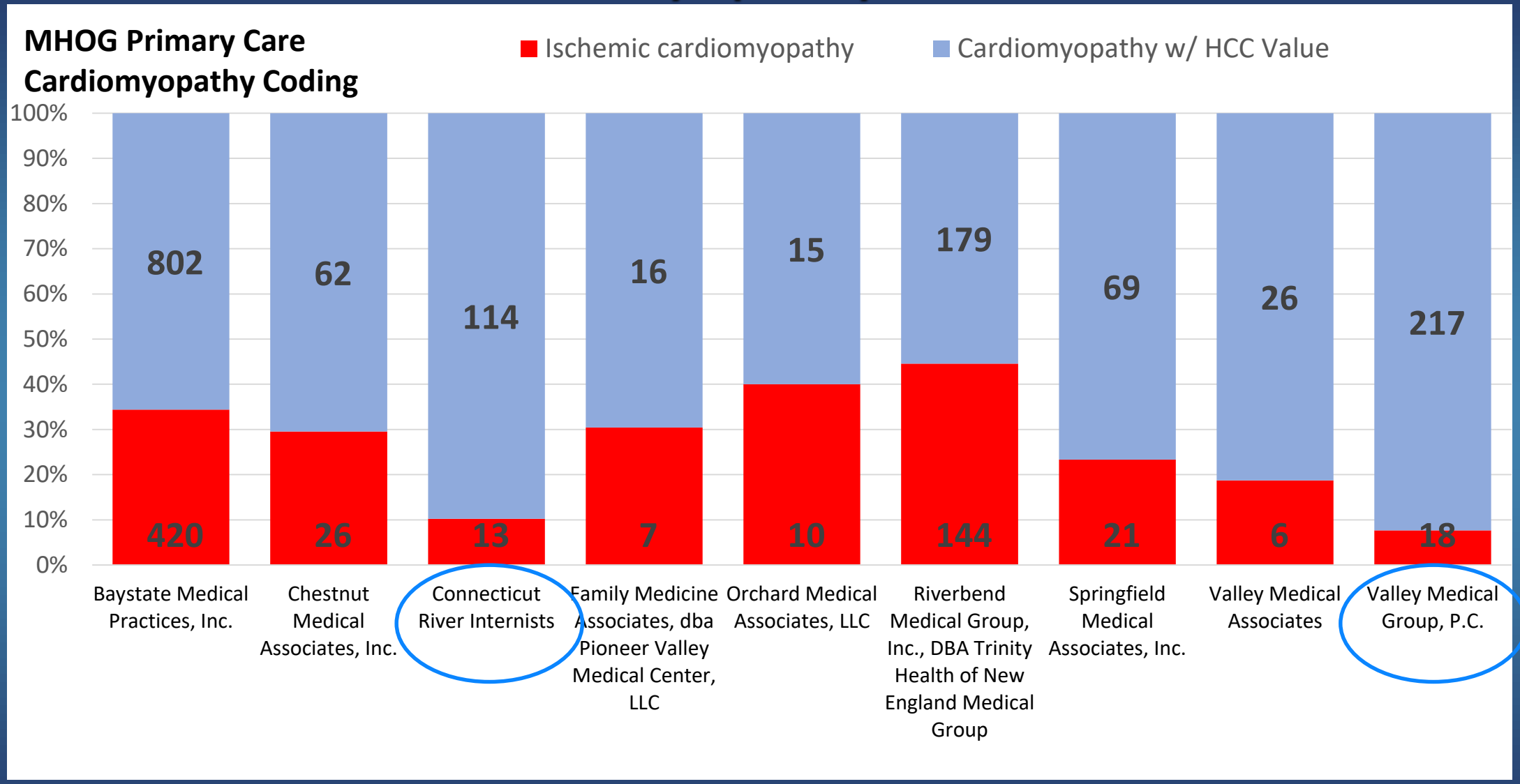
- Depression is classified in ICD-10 as Major depressive disorder. Highlighted below focuses on Major Depressive Disorder, categories F32 and F33.
- Major Depressive disorders should be reported when documented, assessed and/or treated
- Documenting to the highest level of known specificity ensures that the appropriate diagnosis is assigned.
- How to provide supporting documentation
  - Include the diagnosis within the impression and plan with an associated plan of treatment or assessment
  - Link the diagnosis to a medication or status update
  - Address if patient has been referred to an outside provider or practice
  - Discuss whether education was provided
  - Discuss if additional test or labs were ordered.

**This list is not all inclusive but at least one element should be included with a diagnosis to provide medical necessity.*

- Provider documentation must include a narrative of Major Depression.
  - A diagnosis cannot be abstracted from clinical information within the record by a coder; the statement must be documented by the provider.

Coding Documentation Best Practices

Ischemic Cardiomyopathy vs. All Other CM



Substance Use, Abuse & Dependence[1]

Use	Abuse	Dependence
• Any consumption of alcohol or drugs • May or may not lead to problems with abuse or dependence	• Pattern of continued use or misuse • Continued use of drugs or alcohol even when it causes problems	• Addiction to alcohol or drugs • Inability to stop • Trying to quit causes physical withdrawal symptoms

Types of substances include: alcohol, opioids, cannabis, cocaine and other stimulants, tobacco, hallucinogens and inhalants

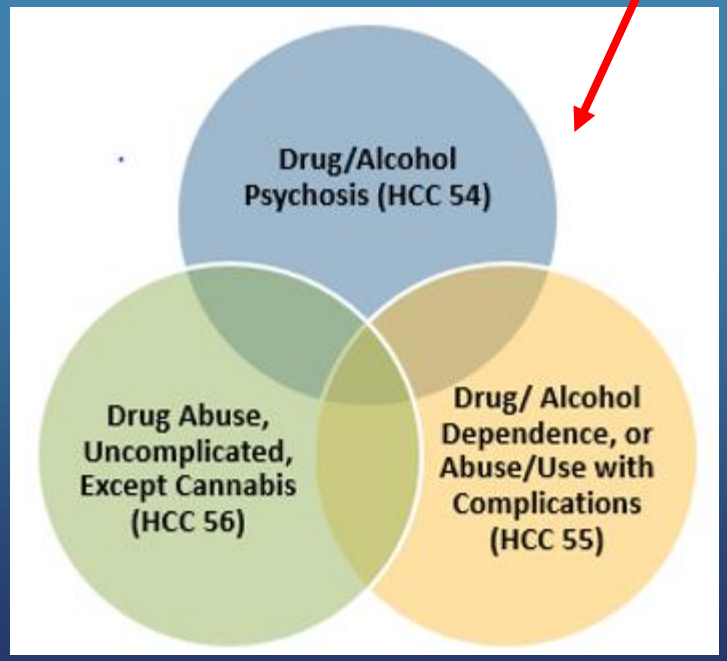
*_.90 Substance use, uncomplicated has no HCC value

Any complication DOES risk adjust

Use/abuse/dependence complications:
Sleep, mood, withdrawl, anxiety, sexual, intox, delirium, other

Likely Opportunity – BUT WE DONT GET THESE CLAIMS!

** Show up as "Suspected" on Lightbeam Facesheets (EMR)



F10.9_ Alcohol use, unspecified
- With intoxication
  - Uncomplicated, delirium, unspecified
- With alcohol-induced mood disorder
- With alcohol-induced psychotic disorder
  - Delusions, hallucinations, Unspecified
- With alcohol-induced persisting amnestic disorder
- With alcohol-induced persisting dementia
- With other alcohol-induced disorders
  - Anxiety disorder
  - Sexual dysfunction
  - Sleep disorder
  - Other alcohol-induced disorder
- With unspecified alcohol-induced disorder

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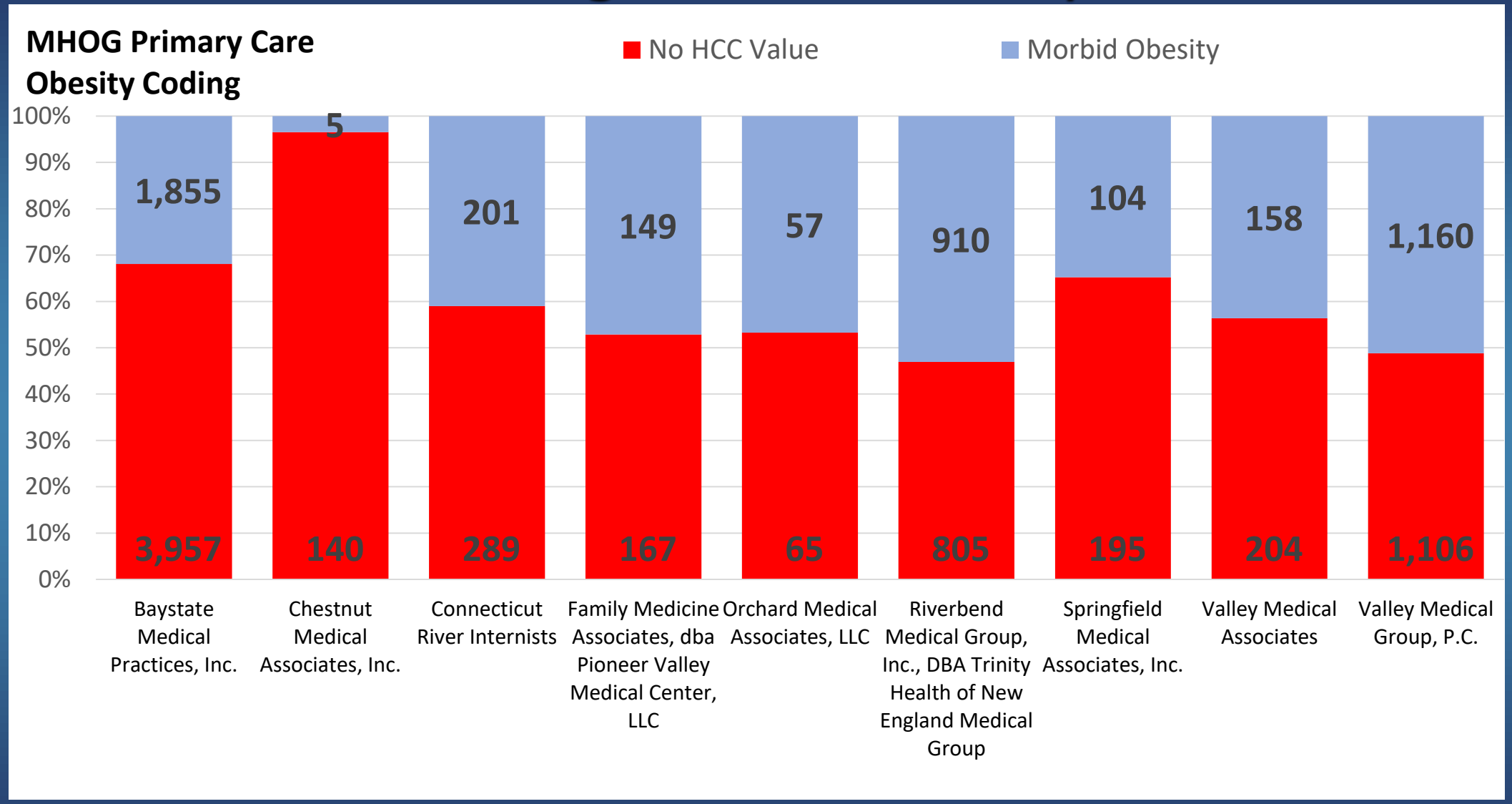
Coding Habits - Obesity



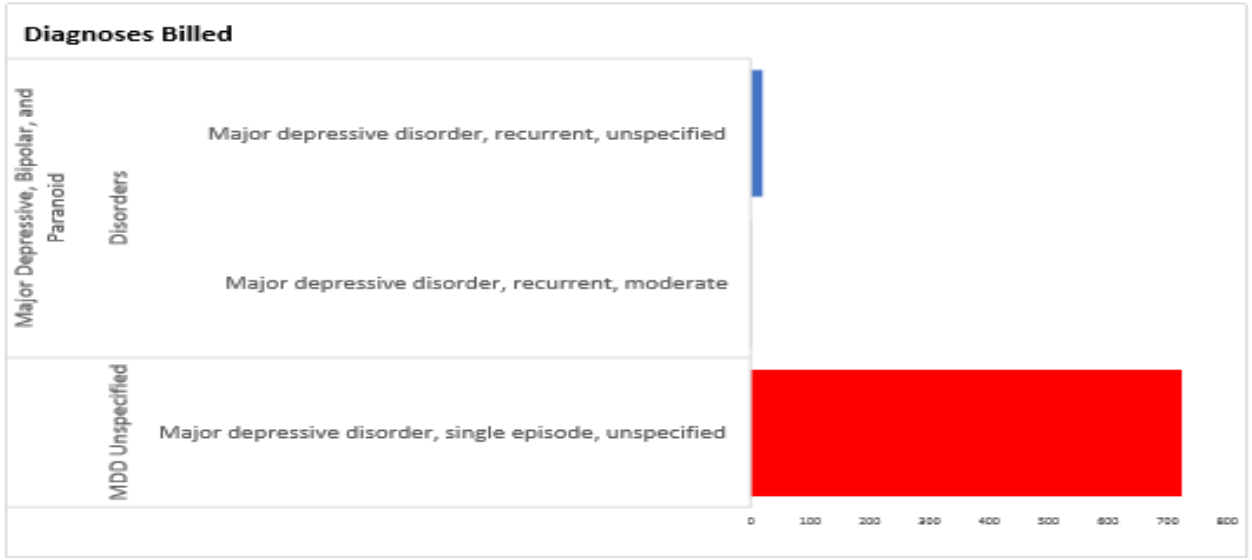
Morbid Obesity

- Overweight/Obesity Coding Documentation
  1. Severity — Overweight, Obese, or Morbid Obesity
  2. Contributing factors — Excessive calories or Drug induced
  3. Symptoms/Findings/Manifestations — BMI and/or Comorbid Condit and/or Alveolar hypoventilation
- Morbid Obesity (NIH): 100 lbs or more >IBW, OR BMI of 40 or greater, OR
  - ***BMI ≥ 35 + ≥ 1 comorbid conditions***
    - ***ie DM, OSA, HTN, hyperlipidemia, arthritis, venous stasis***
  - Morbid Obesity HCC: No codes for BMI of 35.0 to 39.9
    - BMI of 35.0 – 39.9 not generally considered morbidly obese
    - However, clinician determines whether patient has comorbid conditions and if so, documents "morbid obesity"
    - Coding professionals may not make this determination on their own

- E66.01, Morbid (severe) obesity due to excess calories
- E66.2, Morbid (severe) obesity with alveolar hypoventilation
- Z68.41, Body mass index (BMI) 40.0-44.9, adult
- Z68.42, Body mass index (BMI) 45.0-49.9, adult
- Z68.43, Body mass index (BMI) 50-59.9, adult
- Z68.44, Body mass index (BMI) 60.0-69.9, adult
- Z68.45, Body mass index (BMI) 70 or greater, adult

Upcoming Performance Mtgs: Opportunities By Group/Provider

Coding for Depression with HCC value vs. Depression without



Potential Annual Value If More Decriptive Codes Are Utilized

Based on $272PMPM

$1,380,672.00

Annual Wellness Visit Utilization

- Do you do AWV?
  - Why or why not?
  - AWV Templates or process suggestions?

- What (if any) tactics do you use to incent providers?

Accurate HCC Coding Compliance & Accuracy - CRITICAL

Coding Guidelines

Provider Documentation must note/address ***AT LEAST*** ONE of the following parameters in their visit note (Monitoring, Evaluation, Assessment, and/or Treatment) for each ICD-10 Diagnosis code billed for.

Monitoring
- How is the individual doing?
- Are there new signs or symptoms?
- Conceptually represents ongoing surveillance of the condition(s).

Evaluation
- What is the current state of the condition?
- What is the provider's judgment of the condition currently?
- This can be the review of results or the treatment outcomes.

Assessment
- How will the condition(s) be evaluated or estimated?
- This can be documentation of prior records review, counseling, or ordering further studies.

Treatment
- What care is being offered or what is being done to help the patient with the condition(s)?
- This can be a medication, a diagnostic study, or a therapeutic service.

- **Monitor:** signs, symptoms, disease progression, disease regression
- **Evaluate:** test results, medication effectiveness, response to treatment
- **Assess/Address:** ordering tests, discussion, review records, counseling
- **Treat:** medications, therapies, other modalities

Coding Tips

- "History of" Conditions = no RAF, since they no longer exist
  - Were medically or surgically treated and now resolved
- Current conditions:
  - Currently symptomatic or controlled with treatment (medication or other), but are not resolved

Angina: patient on med controlling his angina & is doing well
In the A&P, the documentation indicates:

Angina, no recent episodes, continue medication.

This would be appropriately coded as a current condition

Coding Specifics: Active vs h/o Cancer

Active vs. historical cancer definitions

Cancer is considered active when:

- The patient is currently and actively being treated and managed for cancer. Scenarios demonstrating active cancer treatment/status include:
  - Current chemotherapy, radiation, or anti-neoplasm drug therapy
  - Current pathology revealing cancer
  - A newly diagnosed patient awaiting treatment
  - Affirmation of current disease management
  - Refusal of therapeutic treatment by patient or watchful waiting
- The cancerous organ has been removed or partially removed and the patient is still receiving ongoing treatment such as chemotherapy or radiation.

Cancer is considered historical when:

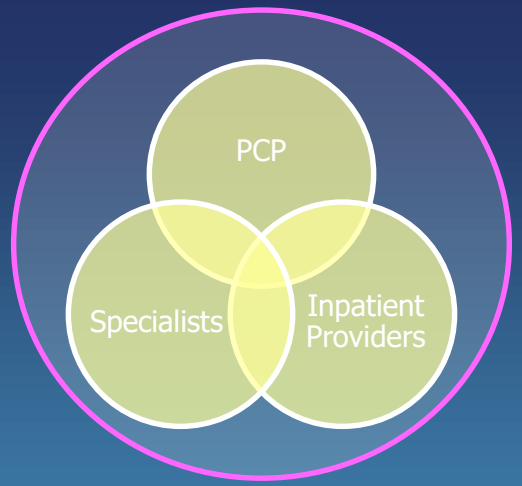
- The cancer was successfully treated and the patient isn't receiving treatment.
- The cancer was excised or eradicated and there's no evidence of recurrence and further treatment isn't needed.
- The patient had cancer and is coming back for surveillance of recurrence.
- The patient is currently on adjuvant therapy (like Lupron or Tamoxifen) for prophylactic purposes.

Guidelines for documentation and coding

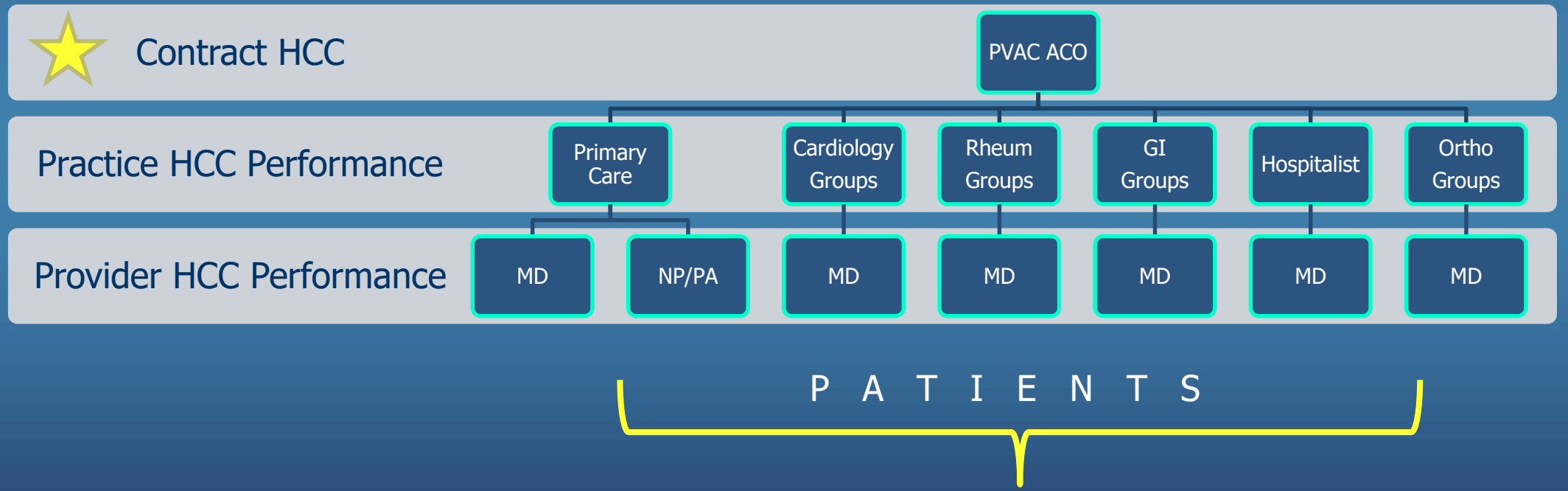
Clear provider documentation is essential for accurate code selection. When you document and select diagnosis codes for a visit with a patient who currently has or had cancer, keep the following information in mind:

Clearly document the following information:

- Type of cancer:
  - Malignant primary and all secondary metastases
  - Carcinoma in situ or benign
- Location of cancer (including laterality if applicable)
- Status of cancer (active or historical):
  - Avoid using a "history of" statement if the patient is currently receiving active treatment for the cancer. Document the cancer as "active" if the patient had the cancer removed, but is still receiving active treatment for the site.
- For active cancers, document the current treatment. If the patient refused treatment or is under watchful waiting, document the reason and the progress, if known.
- If the patient is on adjuvant therapy, indicate if it's prescribed for treatment or prophylactic purposes.
  - If the patient is taking medication to treat the cancer (even after it was removed), code the cancer as active.
  - If patient is taking medication for prophylactic purposes to ensure that treated cancer doesn't come back, code the cancer as historical.
- Select a code from the Personal History section of the ICD-10 coding book if the cancer is documented as historical:
  - Z85. for personal history of malignant neoplasm
  - Z86.01 for personal history of benign neoplasm
  - Z86.00 for personal history of carcinoma-in-situ



HCC Capture is a Team Sport
(with individual accountability)



Strategy: Create a Structure to Share Accountability Across the Silos

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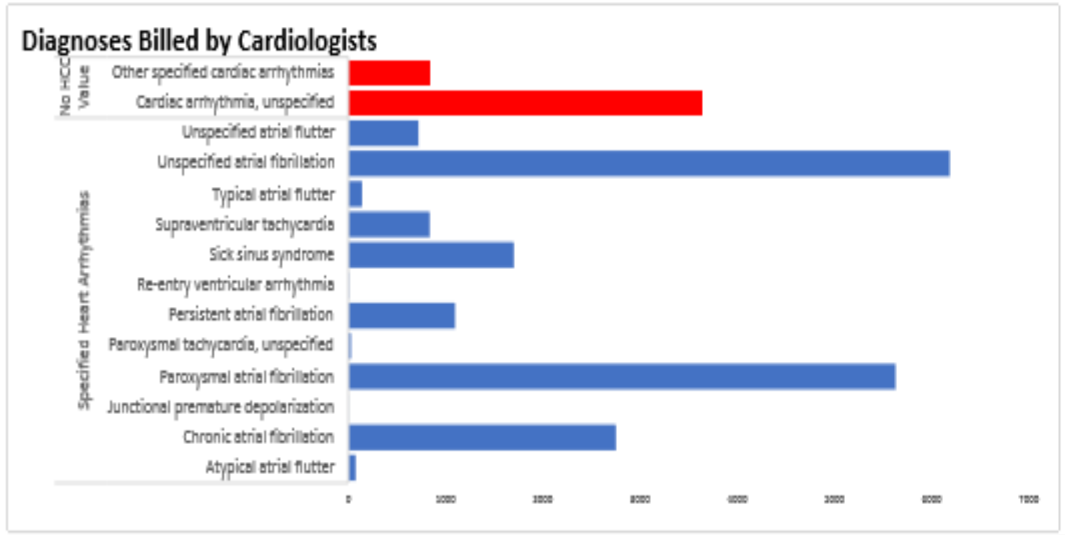
Specialist Coding Work: Everyone's Accountable

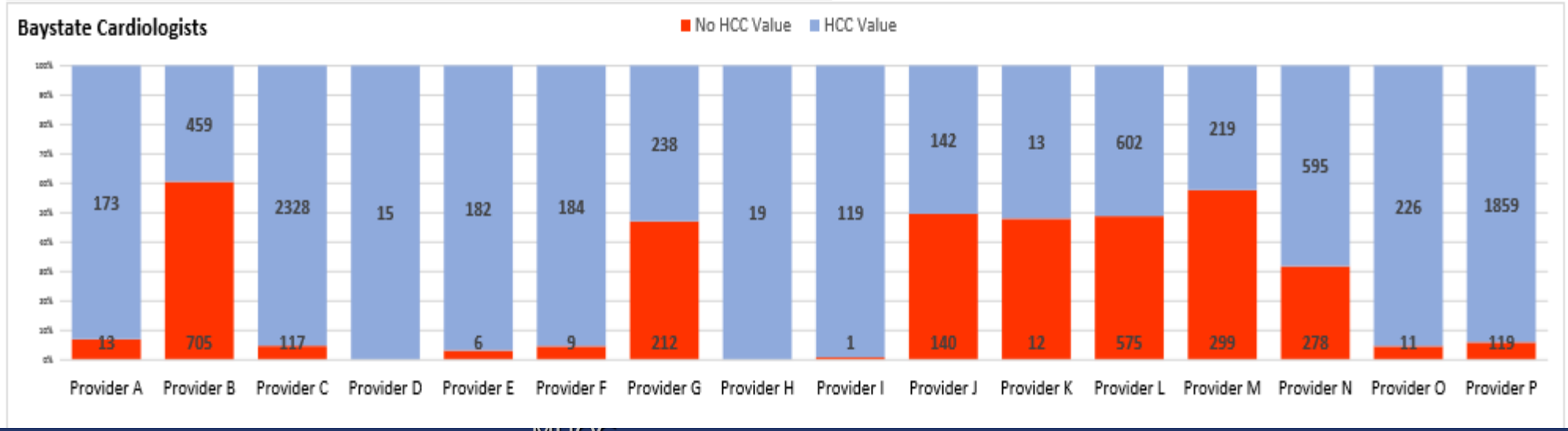
- GI
- Cardiology
- Rheumatology
- PMR
- Orthopedics
- Urology
- Ob/GYN
- Renal
- Oncology
- Hospitalists

Coding for Arrhythmia with HCC value vs. Arrhythmia without



Potential Annual Value If More Decriptive Codes Are Utilized

$4,750,164.00



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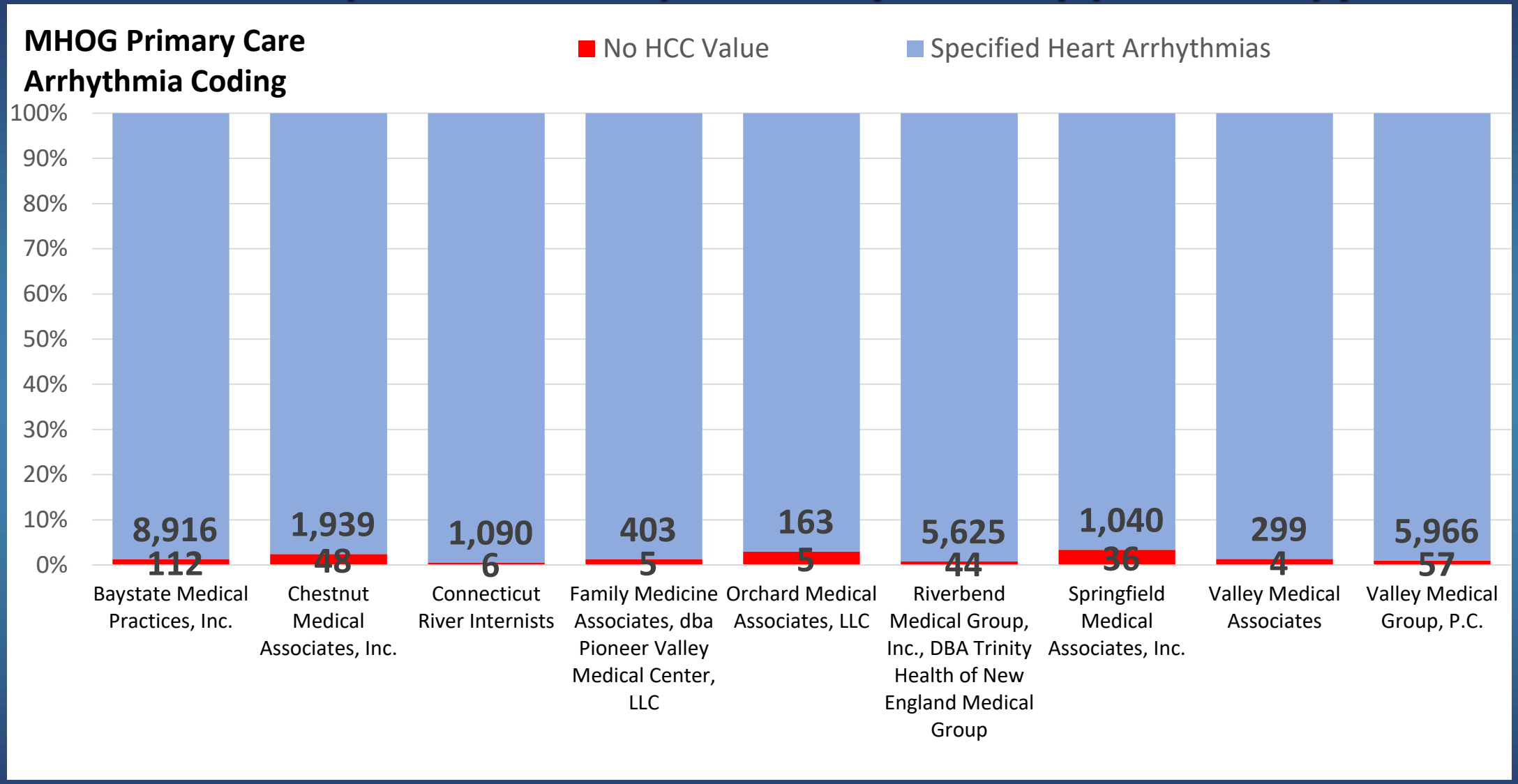
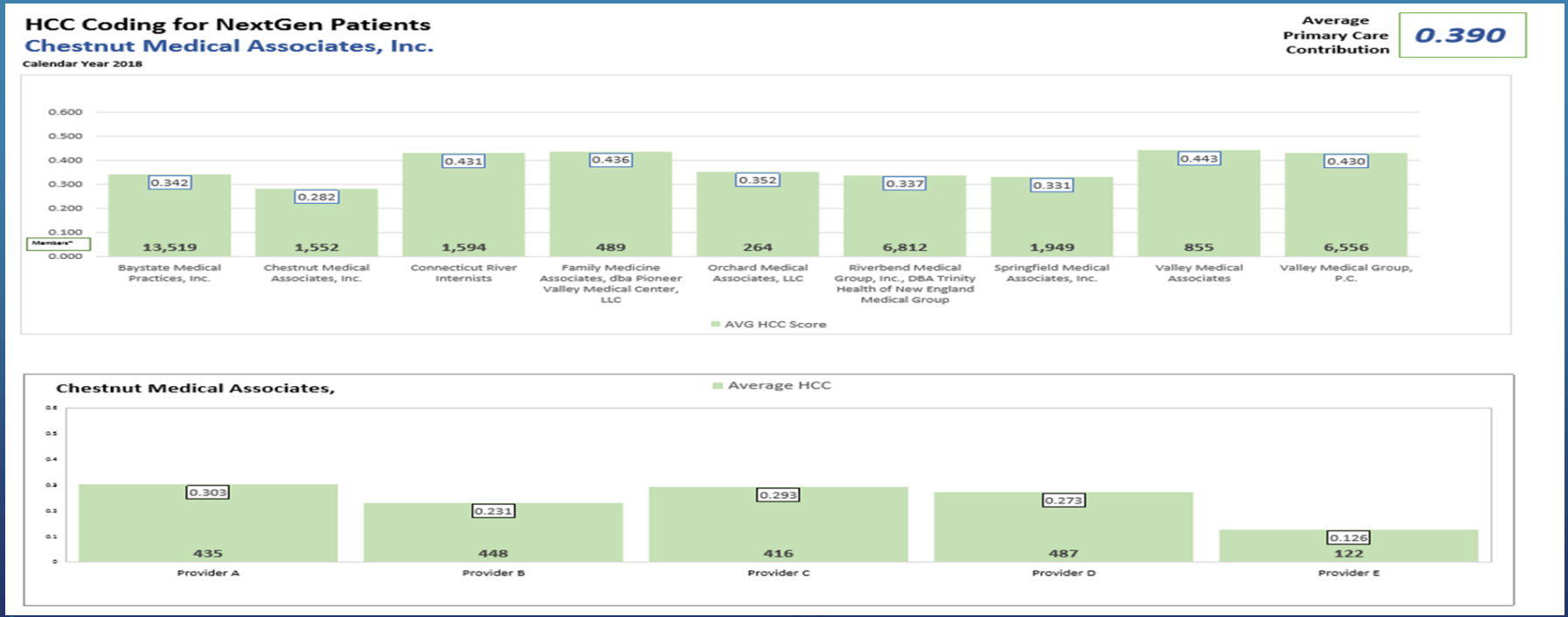
Primary Care Arrhythmia (little opportunity)



Coding Tips & Next Steps

- NEW: CKD 3 (GFR 30-59) Now Risk Adjusts
- New Primary Care Coding Cards Available For Distribution
- Depression Coding Educational Sheet
- Practice Specific Discussion and Data at Upcoming Performance Meetings



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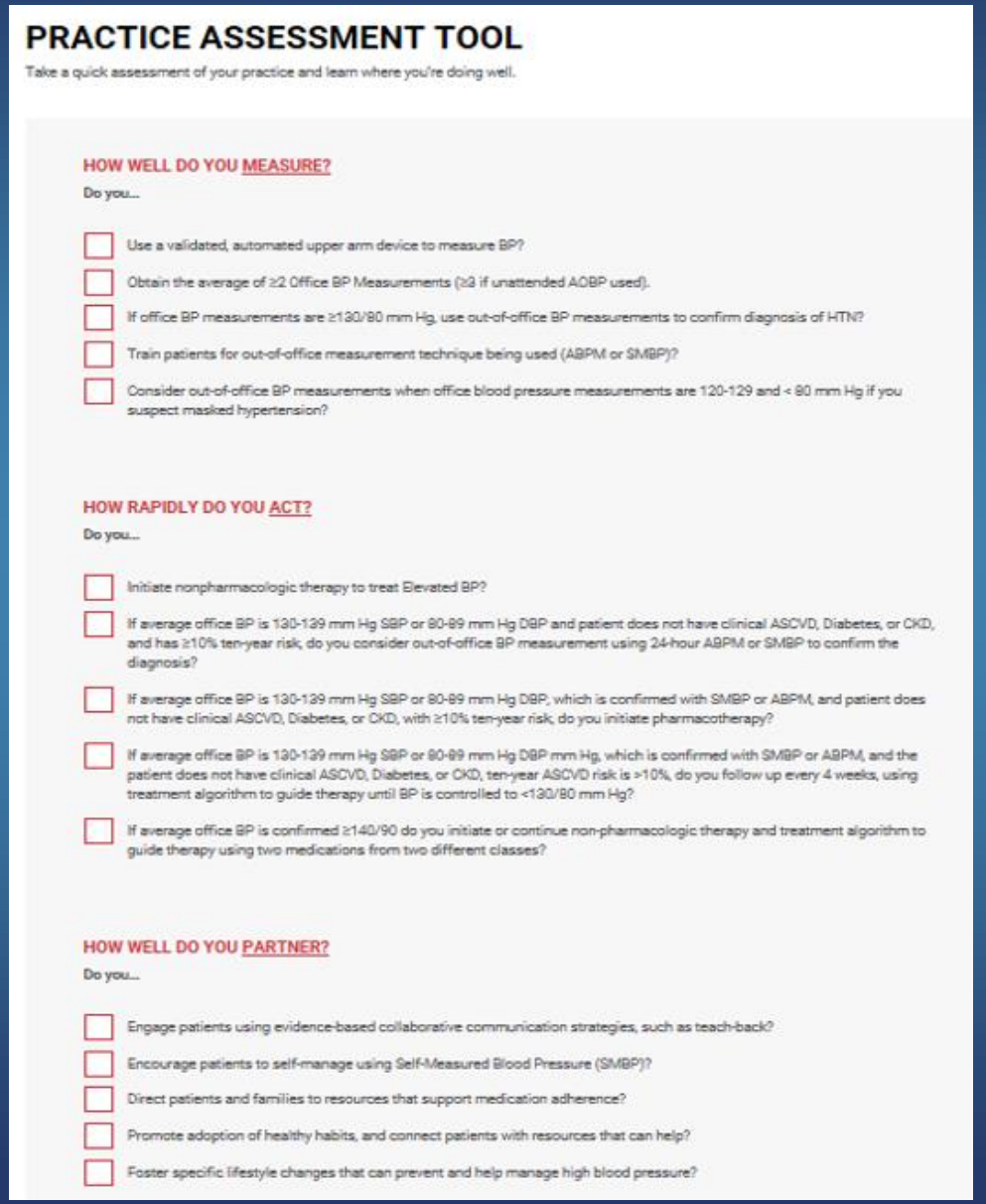
MHOG Hypertension Workgroup Summary & F/U

AHA TargetBP Program: M.A.P

1. MEASURE: BP Accurately Every Time
   - So Providers Trust the Data and therefore ACT on it
   - Protocols and Tips from TargetBP Provided
2. ACT: Rapidly to address high blood pressure readings
   - Overcome the Clinical Inertia
   - Sample Titration Algorithms and Re-Visit Timeframes
3. PARTNER: With patients & families for self-management
   - Sample Patient Information

- Practice TargetBP/HTN Management ToolKit
- Simplified and Implementable Approach
- 2 Month Assessment with Practice Assessment Tool



PRACTICE ASSESSMENT TOOL

Take a quick assessment of your practice and learn where you're doing well.

HOW WELL DO YOU MEASURE?

Do you...

- ☐ Use a validated, automated upper arm device to measure BP?
- ☐ Obtain the average of ≥2 Office BP Measurements (≥3 if unattended AOBP used).
- ☐ If office BP measurements are ≥130/80 mm Hg, use out-of-office BP measurements to confirm diagnosis of HTN?
- ☐ Train patients for out-of-office measurement technique being used (ABPM or SMBP)?
- ☐ Consider out-of-office BP measurements when office blood pressure measurements are 120-129 and < 80 mm Hg if you suspect masked hypertension?

HOW RAPIDLY DO YOU ACT?

Do you...

- ☐ Initiate nonpharmacologic therapy to treat Elevated BP?
- ☐ If average office BP is 130-139 mm Hg SBP or 80-89 mm Hg DBP and patient does not have clinical ASCVD, Diabetes, or CKD, and has ≥10% ten-year risk, do you consider out-of-office BP measurement using 24-hour ABPM or SMBP to confirm the diagnosis?
- ☐ If average office BP is 130-139 mm Hg SBP or 80-89 mm Hg DBP, which is confirmed with SMBP or ABPM, and patient does not have clinical ASCVD, Diabetes, or CKD, with ≥10% ten-year risk, do you initiate pharmacotherapy?
- ☐ If average office BP is 130-139 mm Hg SBP or 80-89 mm Hg DBP mm Hg, which is confirmed with SMBP or ABPM, and the patient does not have clinical ASCVD, Diabetes, or CKD, ten-year ASCVD risk is >10%, do you follow up every 4 weeks, using treatment algorithm to guide therapy until BP is controlled to <130/80 mm Hg?
- ☐ If average office BP is confirmed ≥140/90 do you initiate or continue non-pharmacologic therapy and treatment algorithm to guide therapy using two medications from two different classes?

HOW WELL DO YOU PARTNER?

Do you...

- ☐ Engage patients using evidence-based collaborative communication strategies, such as teach-back?
- ☐ Encourage patients to self-manage using Self-Measured Blood Pressure (SMBP)?
- ☐ Direct patients and families to resources that support medication adherence?
- ☐ Promote adoption of healthy habits, and connect patients with resources that can help?
- ☐ Foster specific lifestyle changes that can prevent and help manage high blood pressure?

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