MARCH 2023 | ISSUE 1

QUALITY IMPROVEMENT

A bi-monthly e-newsletter provided to share announcements, performance updates, and educational reminders for our value-based programs.

ETSUHealth

For questions, suggestions, or educational requests related to quality improvement, please contact:

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If you have a team member you would like to nominate for next issue's Quality Hero Recognition, please let us know!

INSIDE THIS ISSUE

CODING GUIDELINES FOR MEDICARE AND MEDICARE ADVANTAGE

Welcome to Medicare Visit (Initial Preventive Physical Exam)

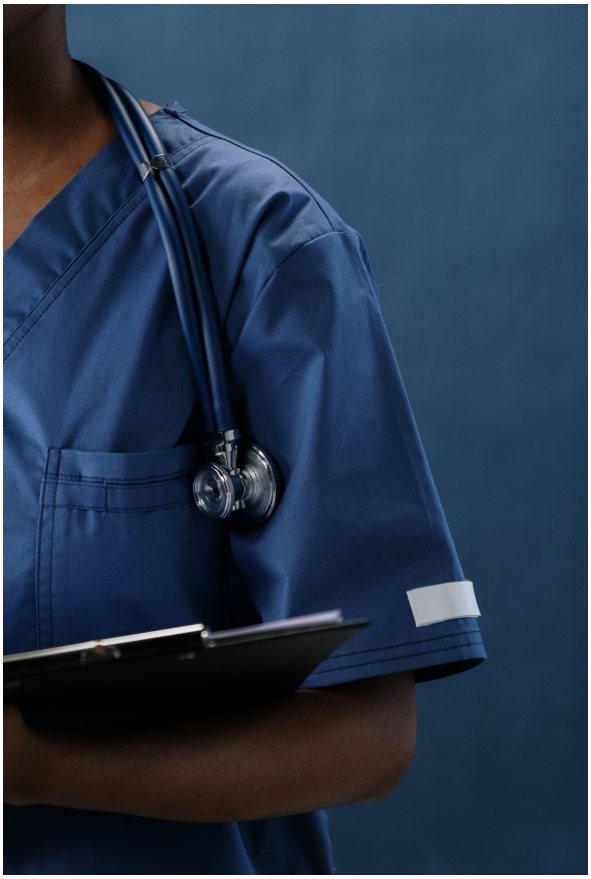
- Service can be provided once within the first 12 months of Medicare enrollment.
- Codes: **G0402**

Annual Wellness Visit (Personalized Prevention Plan Service)

- **Medicare Advantage** - AWV can occur anytime within each calendar year.
- **Traditional (Palmetto) Medicare** - Must occur minimum of 366 days after the previous year's AWV.
- Codes: **G0438** (first visit) or **G0439** (subsequent visit)

Annual Routine Physical Exam

- Service can be provided annually to Medicare Advantage patients anytime within each calendar year. Note, this service is not covered by traditional Medicare.
- Submission Codes: **99385, 99386, 99387, 99395, 99396, 99397**



IMPORTANT TIPS

- Annual Wellness Visit and Annual Routine Physical Exam may be performed on the same date of service, as long as all components of both services are documented.

- When you perform a separately identifiable, medically necessary Evaluation and Management (E/M) service with a preventive visit, you may also bill **CPT 99202-99215.**

    - E/M service is indicated when the separate problem/abnormality is significant enough to require additional work to perform the key components of a problem-focused E/M service. Please be aware that the additional E/M service is subject to the applicable co-payment for an office visit, per the patient's insurance.

    - Please address this copay during the visit to prevent confusion when the patient receives their billing statement.

NEW MEASURE FOR 2023

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Patients 18-85 years of age with diabetes (type 1 or type 2) must have:

- At least one eGFR (Estimated Glomerular Filtration Rate)
  AND
- At least one uACR (Urine Albumin-Creatinine Ratio) during the calendar year.

STATIN USE QUALITY MEASURES

Two statin use measures that heavily impact our Medicare and Medicare Advantage value-based care programs are:

	Statin Use in Persons with Diabetes (SUPD)	Statin Therapy for Patients with Cardiovascular Disease (SPC)
Measure Compliance:	Patients age 40–75 with at least two pharmacy fills of a diabetes medication during the calendar year are expected to receive at least one fill of a statin medication.	Male patients age 21–75 and female patients age 40–75 identified as having clinical atherosclerotic cardiovascular disease (ASCVD) are expected to receive at least one moderate-to-high intensity statin medication.
Exclusions:	Hospice/Palliative care	Hospice/Palliative care
	End-Stage Renal Disease (ESRD)	End-Stage Renal Disease (ESRD)
	Pregnancy, lactation, or fertility therapy	Pregnancy or In vitro fertilization (IVF)
	Polycystic Ovarian Syndrome (PCOS)	Dispensed at least one prescription for clomiphene
	Cirrhosis - *(K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69)*	Cirrhosis - *(K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69)*
	Pre-Diabetes - *(R73.03)*	Myalgia - *(M79.1, M79.10, M79.18)*
	Myositis - *(M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9)*	Myositis - *(M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9)*
	Rhabdomyolysis - *(M62.82)*	Rhabdomyolysis - *(M62.82)*
	Myopathy - *(G72.0, G72.89, G72.9)*	Myopathy - *(G72.0, G72.89, G72.9)*
		Patients age 66 and older with applicable advanced illness and frailty diagnoses

Exclusion codes must be re-assessed and submitted on a claim each calendar year.

HCC CODING FOR MORBID OBESITY

Many definitions for morbid obesity exist, but National Institutes of Health (NIH) recognizes clinically severe obesity as **BMI ≥40 (or BMI ≥35 with related comorbid conditions)**. Providers should report both the correct BMI code and the relevant morbid obesity code, and document appropriately.

Please note, BMI is a screening tool, and the diagnosis of morbid obesity must be made by the provider based on the patient's condition(s), clinical criteria, and professional judgement.

To increase HCC risk scoring, morbid obesity must be coded in addition to the secondary BMI code. BMI diagnoses carry no HCC value, and per ICD-10-CM guidelines, BMI codes should only be assigned when there is an associated, reportable weight diagnosis. Summarily, only utilize codes indicating HCC, and avoid use of non-specific codes (e.g., xxx.9).

E66.01 - Morbid (severe) obesity due to excess calories (HCC code)
E66.2 - Morbid (severe) obesity with alveolar hypoventilation (HCC)

DOCUMENTATION

Coders cannot infer a diagnosis of morbid obesity from a BMI value. Within the note, the provider must document a brief statement to substantiate that the morbid obesity diagnosis was monitored, evaluated, assessed and/or treated during the encounter.

Below are a few examples of appropriate documentation:

Morbid obesity, BMI 52:

- Discussed decreasing sugar intake
- Discussed limiting second portions
- Order CMP today

Morbid obesity, BMI 37:

- Discussed effect of weight on increased cardiovascular risk
- Patient to start increasing exercise (walking) as tolerated

QUALITY HERO RECOGNITION

Medication Mix-up

Internal Medicine case manager, Karen Myers, discovered a medication error while working a medication adherence report. By catching this early, she was able to possibly prevent an adverse outcome for our patient.

"On reviewing a medication adherence report, I noticed a one-day difference in claims for an ACE and an ARB. Both scripts were filled for 90 days. Upon review of the specialists' note, the ACE had been discontinued a few weeks earlier due to decreased kidney function. The ARB was initiated at a recent office visit; however, it appeared that the ACE had not been discontinued at the pharmacy. I called the pharmacy, and confirmed that they had not only filled both prescriptions one day apart, but that they had delivered the prescriptions to the patient's home. A call to the patient confirmed that she was, indeed, taking both medications. After contacting the clinic, it was confirmed that the ACE should have been discontinued. I called the patient back and asked her to stop the ACE, and gave her my direct line for future concerns/questions. Patient communication was relayed back to the specialty provider, as well as the primary care provider, and the ACE prescription was discontinued at the pharmacy."