Coding and Billing Opportunity 2022

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Agenda

- NEPHO Coding Program Update
  - Risk Adjustment Coding Capture
- Building a Patients Risk Adjustment Factor (RAF) Score
- Telehealth Program Coding Opportunity
  - Improving Patient Health Outcomes
    - Preventative Services
    - Remote Therapeutic Monitoring
- Social Determinants of Health (SDOH)
  - Top Ten SDOH Codes
- Resources

NEPHO Coding Program Update

- Working directly with providers across organization on the following areas:
  - Annual Hierarchical Condition Categories (HCC) Risk Adjustment Coding Capture
  - Education & Training on EPIC/Clinovations Encoder
  - Social Determinants of Health (SDOH) Health Equity
  - Documentation Best Practice
- NEPHO Monthly Coding/Billing Webinars Focused Content Quarter 1
  - Diabetes with complications
  - Depression and Substance and Abuse
  - Telehealth Program Enhancement
  - Documentation Best Practice
  - Coding and Billing 2022

Coding Opportunity 2022 (Driven By Audit Results)

- COPD diagnosis capture during sick visits.
- Accurately updating depression, anxiety and substance abuse on an annual basis.
- Accurately capturing Morbid obesity: weight and BMI.
- Diabetes with complications is not coding to the highest specificity – capturing complications is necessary to accurately capture a patients current health status.
- Updating the Problem List is an initiative NEPHO will be working on in 2022. The problem list drives the data providers review in EPIC through Clinovations. This is currently with TMP and Medicare only.
- Missing high risk conditions annually such as: Multiple Sclerosis (MS) G35, Cancer – prostate cancer C61 when patient is still on medication.
- Physical Exams (Annual) Coding Z00.00, the provider is not updating chronic conditions during these visits and are only coding Z00.00 (Annual Exam Encounter).
- HCCs that risk adjust when provider is prescribing medication are being missed – example: Hypertension I10, Hyperlipidemia E78.5, and Asthma J45.909.
- Begin to capture SDOH to help support patient care. These codes will help drive additional resources to support quality patient care.

Patient RAF Score Overview

- Patients with chronic conditions are assigned a risk score based on their overall health status, relative risk that the condition will worsen, and various demographic characteristics.
- The risk adjustment factor (RAF) is a statistical tool that predicts speculated healthcare cost by reported ICD-10 diagnosis codes that identify future risk.
- Risk could include hospital admissions for a chronic condition exacerbation, costly treatments, or ongoing medications that may require consistent funding.
- Providers should annually report all chronic conditions and co-morbidities to the highest level of specificity.
- The more chronic conditions a patient has, the more care may be required, so yearly reporting is crucial to ensure quality of care as well as proper funding.
- If providers do not report all conditions, money funded for a certain patient could be put into a negative balance, creating difficulties for the provider, payer, and patient.

Patient RAF Supports Management of Care

- Risk adjustment in payment models refers to the practice of accounting for the differences in the underlying risk (i.e., expected costs) of patient populations.
- It would be unfair to compare the costs incurred of a healthy member to that of a sick member without properly adjusting for the expected cost of each person based on his/her health status.
- Successful capture of risk enables obtaining a complete and accurate picture of your patients' acuity, which is critical to ensuring proper reimbursements, effectively managing costs of your high-risk members, and delivering high quality care.
- NEPHO currently works with 10 PCP practices and 1 Specialty practice to support risk adjustment coding capture. This work is ongoing and needs to be captured on an annual basis.

Top Hierarchical Condition Categories (HCC)

- HCCs are captured when ICD-10 codes are captured during patient visits. Each HCC is mapped to an ICD-10 code. Along with demographics (such as age and gender), insurance companies use HCC coding to assign patients RAF score. Payers can use a patient's RAF score to predict health care costs. A patient with multiple chronic conditions would be expected to have higher health care utilization and costs than a healthy/low risk patient.
  - Major depressive and bipolar disorders
  - Asthma and pulmonary disease
  - Diabetes
  - Specified heart arrhythmias
  - Congestive Heart Failure
  - Breast and prostate cancer
  - Other Cancer: Colorectal, breast, kidney (examples)
  - Rheumatoid arthritis

Documentation Helps Build Patient RAF Score

- Identify a specific medical reason or focus for the visit (e.g., worsening or new symptoms).
- Document the rationale for ordering tests or referrals.
- Describe how the patient/caregiver has managed chronic conditions from the previous visit to present or explain acute symptoms; status of three chronic conditions may be used for History of Present Illness (HPI) credit.
- Include within the assessment and plan the provider's clinical impression, condition status, and treatment plan for each diagnosis assessed that day.
- Summarize the patient's health (e.g., improved, worsening, not responding as expected) and document services performed, treatments recommended, medication management, education/counseling, and goals of care conversations.
- Represent the patient complexity, overall patient risk level, and any aggregating factors or psychosocial challenges.
- Document initiation of, or changes in, treatment.
- Include patient and nursing instructions, therapies, and medications.

Medicare Hierarchical Condition Category (RxHCC)

- RxHCC condition categories describe major diseases and are broadly organized into body systems. Like the HCC model, they're also categorized into hierarchies. The Top RxHCC that should be captured with a medication update are the following:

Condition	ICD-10 Code
Hypothyroidism	**E03.9**
Coronary Artery Disease (CAD)	**I25.10**
Hypertension	**I10**
Hyperlipidemia	**E78.5**
Asthma	**J45.909**
Generalized Anxiety Disorder	**F41.1**
Age related osteoporosis without current pathological fracture	**M81.0**
Most Migraine Diagnoses	**G43.001-G43.919**

Coding Capture Example

- Patient has his annual exam visit. He has Type 2 diabetes that is being controlled through diet and salt intake. His A1c is at goal. He is taking Lisinopril for his hypertension and has hyperlipidemia. He has stopped smoking and is eating a low fat diet that has helped reduce his lipid levels. He is currently seeing urology for his thyroid cancer that was identified this past year. Overall he is following his treatment plan. I have encouraged weight lose due to his obesity and BMI is >40. I will plan to see him in 3 months for his follow-up and hope to see weight reduction.
  - Coding by provider:
    - Diabetes Type 2: E11.9
    - Hypertension: I10
    - Thyroid Cancer: C73
  - Accurate Coding Capture:
    - Thyroid Cancer: C73
    - Diabetes Type 2 with complications: E11.69
      - Hypertension: I10
      - Hyperlipidemia: E78.5
      - Morbid Obesity E66.01
        - BMI>40: Z68.41

Telehealth Improving Management of Patient Care

- A telehealth visit eliminates all of the distractions of a busy medical office environment. The patient and the provider can focus on the present concern.
- There are obstacles that can get in the way of getting in to see your provider. Transportation can be expensive and time-consuming. It may be difficult or unaffordable to get time off from work. Many patients have child or elder care responsibilities that are not easy to offload. These challenges may make someone less likely to make a needed appointment and more likely to cancel. Telehealth can offer another opportunity to keep your appointment and see your provider.
- The option of telehealth visits makes it easier for the provider and patient to create a comprehensive treatment plan that may address needs not always met in an office setting. Telehealth visits can be made to discuss medication management or review test results. Lifestyle coaching can be part of the plan for patients working to manage their weight, diabetes, or stop smoking.
- Following up after a visit for an acute condition is an important part of recovery in many situations. They give the provider the chance to verify that the diagnosis was correct and that the treatment plan is working.
- Eliminating the need for every encounter to involve an office visit eases the load and allows for more frequent monitoring and greater compliance with the treatment plan.
- It is important to monitor patients who are on medications, especially long-term treatment, but it may not seem worth an office visit, especially if everything seems to be going well.

Preventative Services

- **Smoking Cessation**
  - 99406(Intermediate)-Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes and up to 10 minutes
  - 99407(Intensive)-Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes
  - Medicare covers 2 cessation attempts per 12mo.
  - **99406 4x a year/99407 4x a year= 8 sessions per year**
  - You may bill via telehealth for smoking cessation.
  - A modifier 25 may be appropriate to append to the primary E/M visit code – These are time based codes so time needs to documented
- **Nutrition/Diabetes/Weight Management**
  - 99401 to 99404:Preventative medicine counseling and/or risk factor reduction intervention (s) provided to an individual, up to 15 minutes has been added to counsel Medicaid beneficiaries regarding the benefits of receiving the COVID-19 vaccine
  - Codes can be billed at only one visit for each beneficiary per day, but there are not quantity limits for the number of times this education is provided to an individual beneficiary

Preventative Services

- **Nutrition/Diabetes/Weight Management**
  - Providers must bill CPT 99401-99404 with a CR modifier and there is no requirement for a specific diagnosis code
  - 99401 Preventive counseling or risk factor reduction: 15 minutes
  - 99402 Preventive counseling or risk factor reduction: 30 minutes
  - 99403 Preventive counseling or risk factor reduction: 45 minutes
  - 99404 Preventive counseling or risk factor reduction: 60 minutes
  - Per CPT preventive medicine coding guidelines, “modifier 25 should be added to the Office Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service.
- **CPT 97802**: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes, initial 1 unit=15 minutes **Maximum of 2 hours (8 units) per year**
- **CPT 97803**: Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes, subsequent 1 unit=15 minutes **Maximum of 1 hour (4 units) per day**
  - **Coverage is allowed for up to four hours per calendar year**

Preventative Services

- G0447 – face-to-face behavioral counseling for obesity, 15 minutes
  - Medicare covers screening for adult beneficiaries with obesity, defined as Body Mass Index (BMI) equal to or greater than 30. Those who meet these criteria are eligible for:
  - One face-to-face visit every week for the first month;
  - One face-to-face visit every other week for months 2-6; and
  - One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement during the first 6 months
  - For beneficiaries who do not achieve a weight loss of at least 3 kg (6.6 pounds) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.
  - Medicare does not allow the billing of other services provided on the same day as an obesity counseling visit.

Remote Therapeutic Monitoring (RTM)

- Remote patient monitoring (RPM) increases the capacity for physicians to treat more patients. Organizations should be embracing RPM services to improve patient healthcare outcomes.
- RTM brings is the ability for patients to self-report data.
- Self-reported data would enable inclusion of monitoring non-physiologic metrics such as pain levels and medication adherence, which may or may not typically be captured and transmitted through existing equipment.
- RTM program could provide healthcare practitioners with a more holistic view of patient progress. Additionally, it has the potential to boost patient engagement, as they would be participating more interactively with the system.
- RTM opens the eligibility pool for reimbursement to a greater number and wider variety of healthcare practitioners.
- RTM rules indicate that nurses and physician therapists could be the primary billers for these codes. This could be beneficial for physical therapists, occupational therapists, SLPs, clinical psychologists, and other practitioners not currently eligible to bill for RPM.

Remote Therapeutic Monitoring (RTM) Services

RTM is designed for the management of patients using medical devices that collect non-physiological data. Data around indicators such as therapy/medication adherence, therapy/medication response, and pain level can be collected and billed under the new RTM codes that include the following:

- **98975:** RTM (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment.
- **98976 :** RTM (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
- **98977:** RTM (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
- **98980:** RTM treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
- **98981:**Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes

Workflow Process To Improve Coding Opportunity

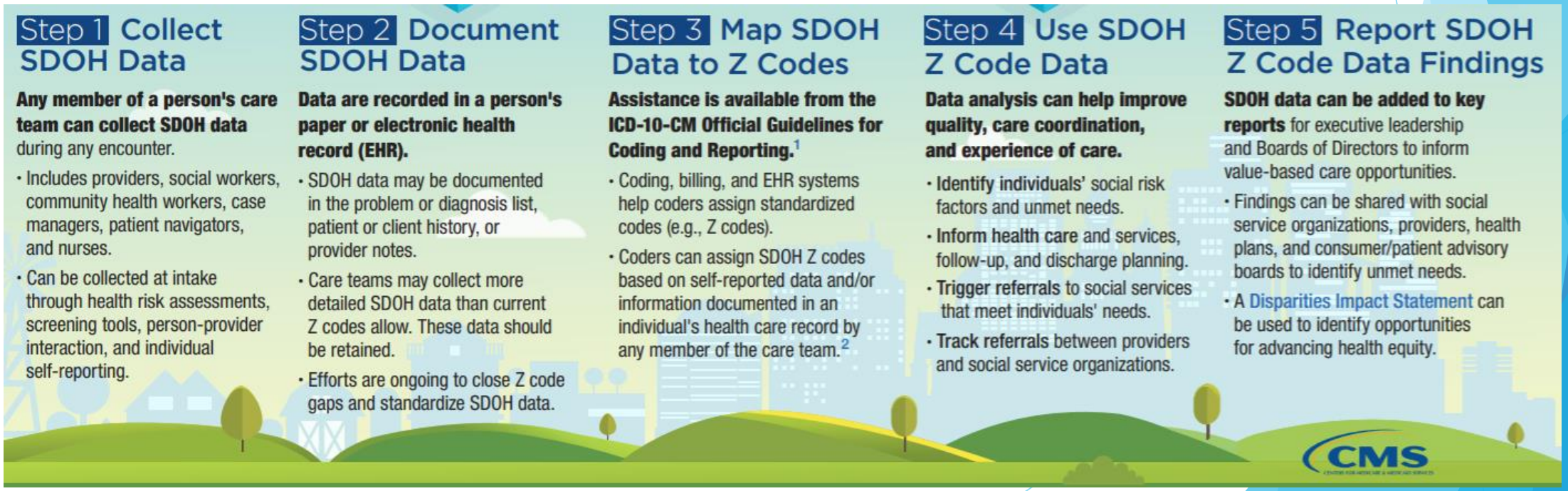
- Coding Capture is a Team effort annually:
  - Patient self reporting
  - Front end staff can help ensure demographics are up to date, SDOH information is updated annually, identify new conditions to update provider
  - Clinical staff can engage patients to self report conditions, discuss SDOH, and address challenges that can impact management of care
  - Back end staff can identify gaps in accurate patient health status, help close gaps to improve coding capture
  - Builds a stronger relationship between patient & practice/provider
- Quarterly Meetings with Administration & Providers:
  - Manage patient coding gaps in a timely manner
  - Identify coding opportunity trends (example; diabetes w/complications)
  - Offer coding education to help improve coding to the highest specificity
  - Supporting continuity of care between PCPs & Specialists

Social Determinants of Health (SDOH) Overview

- The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:
  - Income and social protection
  - Education
  - Unemployment and job insecurity
  - Working life conditions
  - Food insecurity
  - Housing, basic amenities and the environment
  - Early childhood development
  - Social inclusion and non-discrimination
  - Structural conflict
  - Access to affordable health services of decent quality

SDOH Coding Guidelines

- **Updates to the ICD-10-CM Official Coding Guideline state:**
  - Documentation by Clinicians Other Than the Patient's Provider, has made assigning SDOH-related Z codes easier. These updates allow for the use of health record documentation from clinicians involved in the care of the patient who are not the patient's provider since the information represents social information rather than medical diagnoses. Additionally, patient self-reported documentation may be used to assign SDOH-related codes as long as the patient information is signed-off by and incorporated into the health record by either a clinician or provider.
  - **Capturing SDOH Z Codes:**



SDOH Documentation Updates

- SDOH should be reported when the information is documented, and that this information may be obtained from the following documentation sources:
  - The patient's provider (physician, nurse practitioner)
  - Clinicians other than the patient's provider whose documentation is included in the official medical record (social workers, community health workers, case managers, nurses)
  - Patient self-reported documentation, as long as the documentation is signed-off by and incorporated into the medical record by either a clinician or a provider
  - The new guidelines focus on Medical Decision Making (MDM), and are intended to more closely reflect the provider's actual work performed in treating a patient's conditions. Depending on the significance of the impact of a patient's socioeconomic situation on his or her diagnostic or treatment options, the encounter may be considered moderate risk.

Improving Patient Health Care Outcomes

- The acknowledgment of these social, economic, and environmental issues is integral to providing value-based care. Some examples of social determinants of health include, but are not limited to:
- Availability of resources to meet daily needs (safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Transportation options
- Public safety
- Social support
- Socioeconomic conditions (concentrated poverty and the stressful conditions that accompany it)
- Language/Literacy
- Access to emerging technologies (cell phones, telehealth)
- Availability of community-based resources
- When the assessment and plan is developed with consideration of these social determinants of health, the documentation should clearly describe the circumstances and how they affect the patient's treatment or management.

SDOH Coding Capture Strategy

- **Telehealth:** Identify potential issues such as; transportation and childcare barriers, telehealth connections (via care coordinators, registered nurses and online physician consults) can explore obstacles and discuss situations that might be impacting a person's health care plan.
- **Post Discharge Check-In:** After a patient is discharged from a hospital or care facility, reviewing and addressing social determinants of health can help prevent ED visits and impatient readmissions. Does the person have a strong social network, access to healthy food, and a plan for medication management – this can be reviewed with the patient after discharge to improve recovery outcomes.
- **SDOH Patient Mailing**: A SDOH mailing could be sent directly to patients that have a scheduled visit. The paperwork could be completed prior to the appointment and returned via mail or brought in at visit. The information collected would be added to the patient EHR.
- **SDOH MyChart Update**: Patients have the opportunity now to access their medical record and update SDOH information. SDOH could be transmitted electronically by email and updated by practice administration. Patient data could also be captured within MyChart directly if access is approved/developed to capture this information.

SDOH Z Codes

- Z55.5 Less than a high school diploma
- Z58 Problems related to physical environment
- Z58.6 Inadequate drinking-water supply
- Z59.00 Homelessness unspecified
- Z59.01 Sheltered homelessness
- Z59.02 Unsheltered homelessness
- Z59.4 was revised from “Lack of adequate food and safe drinking water” to
  - Z559.4 “Lack of adequate food”
- Z59.41 Food insecurity
- Z59.48 Other specific lack of adequate food
- Z59.81 Housing instability, housed
- Z59.811 Housing instability, housed with risk of homelessness
- Z59.812 Housing instability, housed, homelessness in past 12 months
- X59.819 Housing instability, housed unspecified
- Z59.89 Other problems related to housing and economic circumstances

NEPHO Top 10 SDOH Codes

- Z56.0: Unemployment unspecified: **Example**: Patient was laid off from job
- Z56.6: Physical and mental strain related to work: **Example**: Patient works 3 jobs to manage home
- Z56.89: Other problems related to employment: **Example**: Patient is on disability due to recent injury
- Z63.0:Problems in relationship with spouse or partner: **Example**: Patient is separated from spouse
- Z63.3: Absence of family member: **Example**: Patient has recently gone through a divorce
- Z63.4: Disappearance and/or death of family member: **Example**: Husband/Wife passed away a year ago
- Z62.810: Personal history of physical and sexual abuse in childhood: **Example**: Patient experienced sexual abuse from 6-12 years by family member
- Z62.898: Other specified problems related to upbringing: **Example**: Patient does not speak to biological father
- Z63.7: Stressful events affecting family household: **Example**: Patient is having issues with teenage children
- Z72.3: Lack of physical exercise: **Example**: Patient does not exercise

Resources

- **Shawn.m.bromley@lahey.org & Jessica.m.bryan@lahey.org**
- https://yes-himconsulting.com/everything-you-need-to-know-about-the-hcc-risk-adjustment-models/
- https://www.foley.com/en/insights/publications/2021/07/cms-new-remote-therapeutic-monitoring-codes
- https://chironhealth.com/blog/telemedicine-used-improve-patient-outcomes/
- https://blog.optimize.health/new-remote-therapeutic-monitoring-cpt-codes
- https://health.gov/healthypeople/priority-areas/social-determinants-health