Minding the Gaps:

Pre-visit Planning and Electronic Billing
Close Care Gaps and Reduce Chart Requests
Across Payers

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VNSNY CHOICE Medicare Star Rating

*2019 A Consumer's Guide to Managed Long-Term Care in New York City, New York State Department of Health

Agenda

- **2021 Initiatives: VNSNY CHOICE Total (HMO D-SNP)**
  - New Member benefits and member quality screening initiative
- **Medicare Annual Risk Adjustment**
- **The Provider Role in Annual Risk Adjustment**
  - Annual comprehensive visits to close gaps
    - Review all diagnoses, update problem and medication lists
    - "MEAT" documentation standards to support annual risk adjustment
- **Strategies to Close Quality Gaps in Care**
  - MAP priority measures
    - Close quality measure gaps with CPT II codes

Appendix: Details - CMS 1500 Form, Measure Exclusion Criteria, HEDIS Telehealth update

We Care for Our Community's Health

2021
New Medicare Plan Benefits

New 2021 Member Incentive Program

Members can earn financial rewards for completing quality screenings in 2021:

- Breast cancer screening (BCS)
- Colorectal cancer screening (COL)
- Comprehensive diabetes care (CDC)
  - Retinal eye exam
  - HgA1c test
- Controlling blood pressure (CBP)
- Statin therapy for patients with cardiovascular disease - Received (SPC)
- Annual wellness visit (AWV) (all members eligible)
- Influenza vaccine (all members eligible)

THIS IS WHERE YOU BELONG

In the home you love.

In the community you know.

In the health plan designed for you.

If you need help to safely live at home, VNSNY CHOICE Total can make it easier to get the care you need. This two-in-one plan combines Medicare and Medicaid Long-Term Care plans for people who need ongoing help with daily activities, such as bathing, cooking, dressing and walking.

Benefits include:

- **$0 plan premiums**
- **$0 co-pays for medical care**
- **$0 for unlimited transportation to medical appointments**
- **$0 for skilled nursing, personal care services, rehabilitation therapy and more**
- **Consumer Directed Personal Assistance Services (CDPAS)**

You can also keep your doctors, specialists and home health aide!*

Total's New Benefits in 2021

Total has several new benefits to help you live safely in the comfort of your own home, where you belong.

Below are some benefits you can expect from VNSNY CHOICE Total

2021 Benefits Overview

	Monthly plan premium	$0
	Medicare Parts A & B services (including doctors, hospitals, clinics, labs)	$0
	Medicare Part D services (brand name and generic prescription drugs)	$0
	Over-the-counter (OTC) and grocery items	Up to $1,584/year ($132 per month) **NEW**
	Acupuncture	$0 for up to 30 visits/year & more** **NEW**
	Eye exam/Eyeglasses	$0 for routine eye exam, $300/year for eyeglasses (frames and lenses) or contacts **NEW**
	Telehealth service	$0 **NEW**
	Dental	$0 for routine and preventative care
	Transportation	Unlimited to medical appointments (to plan-approved locations)
	Long-term services and supports (including Home Health Aide, nursing and social work)	$0
	Physical therapy	$0
	Social Day Care	$0
	Worldwide coverage	Up to $50,000/year for emergency services and urgent care

*As long as the provider is in the network.
**Additional acupuncture visits for chronic low back pain covered by Medicare.

Annual Medicare Risk Adjustment

Q: Did you know that Medicare sets an "annual budget" for care based on the HCC claim codes received in the year prior?

A: Each January 1, the member's risk score is reset for a new year, and next year's budget for their care is rebuilt with this year's claims.
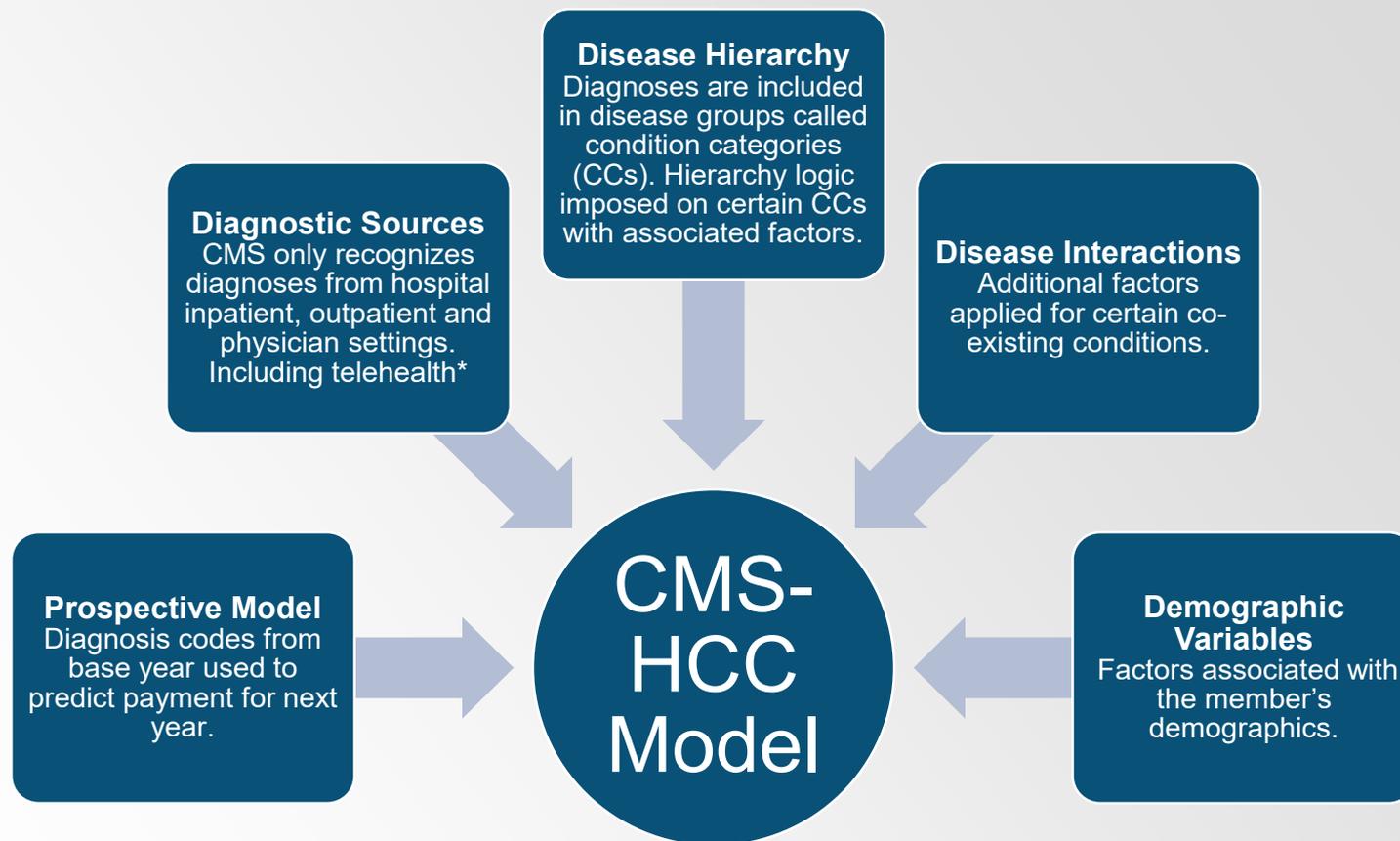
Annual Medicare Risk Adjustment

Medicare Advantage (MA) plans receive payment for each covered member from Centers for Medicare and Medicaid Services (CMS).

Risk Adjustment (RA) is used to ensure accurate and adequate payment to plans for providing services and covering benefits for members.

Payment is driven by members' Risk Scores, which are based on their predicted health status and demographic characteristics.

Medicare RA CMS-HCC (Hierarchical Condition Category) model is used to risk adjust payment.

Hierarchal Condition Category (HCC) Model

Disease Hierarchy
Diagnoses are included in disease groups called condition categories (CCs). Hierarchy logic imposed on certain CCs with associated factors.

Diagnostic Sources
CMS only recognizes diagnoses from hospital inpatient, outpatient and physician settings. Including telehealth*

Disease Interactions
Additional factors applied for certain co-existing conditions.

Prospective Model
Diagnosis codes from base year used to predict payment for next year.

CMS-HCC Model

Demographic Variables
Factors associated with the member's demographics.

*Diagnoses from telehealth claims are Risk Adjustment eligible only when both audio and visual components are used during the encounter.
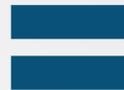
We Care for Our Community's Health

Risk Score Calculation

Demographic Factors (associated with age, sex, disabled status, original entitlement reason, and Medicaid eligibility)
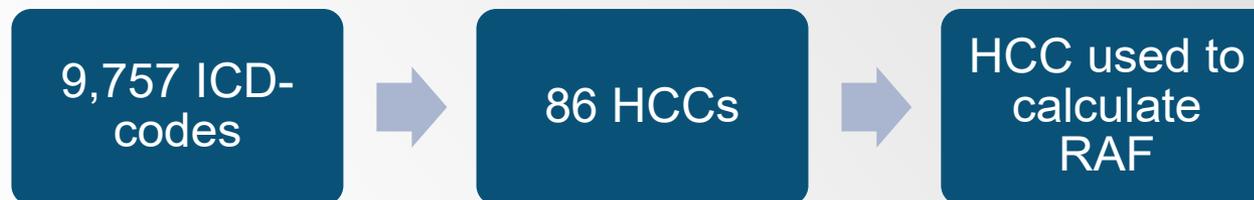
+

Health Status (associated with chronic conditions included in CMS-HCC Model)

=

Member's Risk Score

Hierarchal Condition Categories (HCC)

- For 2021, there are 9,757 ICD-10-CM diagnoses that map to 86 HCCs.
  - Claim codes received in the CY for these 86 HCCs only are used to set the budget for each member's care in the next year.

- A coefficient or "weight" is assigned to each category.

- Disease interactions provide additional coefficients to help with offsetting the additional cost burden of caring for these members with multiple chronic conditions.

9,757 ICD-codes	→	86 HCCs	→	HCC used to calculate RAF

https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsrisk-adjustors/2021-model-softwareicd-10-mappings

The Risk Score

Each member is assigned a risk score which measures their relative illness risk. These risk scores are used to adjust payments for each beneficiary's expected expenditures. Simply put, they create the budget for care.

Higher risk scores represent members with a greater than average burden of illness.

Lower risk scores, if coded correctly, represent members with a lower-than-average burden of illness.

BUT

They could also indicate incomplete HCC coding and/or supporting documentation for patients with a higher illness burden.

HCC Coding and the Risk Score

- Medicare uses a "Risk Adjustment Factor" (RAF) multiplier to "build the budget" annually.

- Example:
  - ICD-10: Z68.37 BMI of 37.2 (not an HCC code):
    RAF = 0

  - ICD-10: EE66.01 & Z68.37 Morbid Obesity (only obesity code among 86 HCC codes):
    RAF = 0.365

The Provider Role in Annual Medicare Risk Adjustment

Scheduling annual wellness visits allows time to address all quality measure and HCC gaps.

The Provider Role in Risk Adjustment

How providers can help ensure the integrity of data used in calculating risk:

✓ **A comprehensive health status for each patient**
- Best addressed during an annual wellness visit (AWV)

✓ **Medical record documentation sufficient to support ICD-10-CM coding**
- Monitoring/Evaluating/Assessment/Treatment ("MEAT") standards

✓ **Accurate and complete ICD-10-CM coding for every patient, every time**
- Update problem and medication lists, review of all consult notes, lab/procedure results, discharge summaries

✓ **Coding to the highest level of specificity for claim submission**
- Ensuring that as diseases progress, complications and comorbidities are captured in coding annually. (CHOICE can provide member's historical diagnoses that can be leveraged during their AWV.)

Remember: Each January 1, the member's risk score is reset for a new year, and next year's budget for their care is rebuilt with this year's claims.

AWV: Gap Closing Workflows

Pre-visit Planning

- **Flag chart prior to AWV**
  - **Updates/changes in diagnoses/HCCs**
    - Specialty consult notes (e.g., new vascular complications)
    - Lab/test results (e.g., CAD on angioplasty report)
    - Discharge plans (e.g., new CHF diagnosis)
  - **Time to update problem and medication lists**
    - All previous diagnoses, procedures/surgeries e.g., amputations, CABG
  - **Quality Measure gaps in care to be addressed**
    - Close gaps with **CPT/CPT II Codes** and prevent medical record requests
    - CHOICE provides monthly member specific GIC reports and can provide historical dx information to assist in completing Risk Adjustment
    - CHOICE can assist with CM scheduling AWV
- **Evaluate for exclusion criteria**
  - To remove member from quality measure for Frailty and Advanced Illness or ICD10 diagnoses (e.g., bilateral mastectomy)

AWV: HCC Risk Adjustment
Why is Code Specificity Important?

No Conditions Coded	RAF	Some Conditions Coded	RAF	All Conditions Coded	RAF
76 year old female	0.468	76 year old female	0.468	76 year old female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
Diabetes not coded	0	Diabetes no complications	0.118	Diabetes w/vascular complications	0.368
Vascular disease not coded	0	Vascular disease no complications	0.299	Vascular disease w/ complications	0.41
CHF not coded	0	CHF not coded	0	CHF coded	0.368
No disease interaction	0	No disease interaction	0	Disease Interaction Bonus RAF (DM +CHF)	0.182
Patient Total RAF	**0.645**	Patient Total RAF	**1.062**	Patient Total RAF	**1.973**
Yearly Reserve for Care	**$5,418**	**Yearly Reserve for Care**	**$8,921**	**Yearly Reserve for Care**	**$16,573**

Note: For illustration purposes only. Should not be used for financial inference.

AWV: Risk Adjustment Documentation

Documentation is key. If it has not been documented, it cannot be coded.

Documentation should include:

- Patient's name and date of service (DOS) on each page
- All of the patient's conditions, including those co-existing
- Details to code each condition to the highest degree of specificity, i.e., reference to results of lab, tests, procedures, and discharge summaries
- *Treatment and/or management for each condition addressed during the encounter (what is the treatment plan for this condition?)*
- Physician's signature, credentials, and date

It is the provider's responsibility to provide clear, legible documentation of a diagnosis, which can then be translated to a code for external reporting.

"MEAT" Documentation Standards for Risk Adjustment/HCC Coding

M – **Monitoring** signs, symptoms, disease progression, disease regression
- Ex.: If CHF is stable, continue current Lasix and ACE dosages.

E – **Evaluating** test results, medication effectiveness, response to treatment
- Ex.: For Type 2 DM, review A1c results with patient.

A – **Assessing/Addressing** ordered tests, discussion, review records, counseling
- Ex.: For patient's ulcerative colitis, note that patient sees Dr. Smith for management.

T – **Treating** medications, therapies, other modalities
- Ex.: For tobacco use, counsel patient on risks and ways to quit.

"MEAT" Documentation Standards for Risk Adjustment/HCC Coding

NOTE: A list of diagnoses, or past medical history is not acceptable or valid per official coding guidelines, as it does not meet the **definition** of an assessment or treatment plan:

- **Assessment:** a skilled evaluation of the patient and/or relevant health information (e.g., lab results) to appraise conditions, disorders, and/or a patient's overall state
- **Treatment Plan:** follows an analytical process of patient/health information to establish a course of care

Telehealth: Must document in the provider visit note that both audio and visual technology was used during the encounter for HCC updates

- The documentation must include:
  - the start/stop times of the medical visit.
  - the virtual visit site/location, i.e., use modifiers (eg; mod 95) as needed to indicate virtual visits vs. in office site.
  - the encounter type as audio-video, e.g., "Audio-Visual AV telehealth visit"

Electronic Quality Measure Gap Closing: CPT/CPT II codes

CPT II Codes
Close Gaps in Care with Claims

- **Category II codes** provide clinical details, e.g. lab values, usually included in evaluation and management or clinical services and are not associated with any relative value. **Category II codes** are billed with a $0.00 **billable** charge amount.

- These codes provide clinical data that can close gaps via claims/administratively to prevent the need for medical record review.

Annual Measures: Workflow Opportunities

Priority Quality Measures: COA
Care of Older Adults (Medication Review)
All COA measures gaps can be closed during a telehealth visit where the CPT II code is used preventing the need for medical record review. **Interventions:** ▪ Schedule in-person or telehealth visit. ▪ Submit the applicable CPT II codes from the same visit to close both **Medication Review CPT II 1160F** and **Medication List CPT II 1159F.**
Care of Older Adults (Pain Assessment)

Interventions:
▪ Schedule in-person or telehealth visit.
▪ Submit applicable CPT II code to close gap:
  ▪ **CPT II code 1125F** (to indicate member has pain present)
  ▪ **CPT II code 1126F** (to indicate member has no pain present)

Care of Older Adults (Functional Assessment)
Interventions: ▪ Schedule in-person or telehealth visit. ▪ Submit applicable **CPT II code 1170F** (Functional status assessed).
Care of Older Adults (Advanced Care Plan)
Interventions: ▪ Schedule in-person or telehealth visit. ▪ Submit applicable **CPT II code 1123F-1124F; 1157F-1158F**

Hospital/SNF Event-Driven Measure: Workflow Opportunities

Priority Quality Measure
MRP (Medication Reconciliation Post Discharge)

This measure is driven by an inpatient hospital or SNF event. Only members with a hospital/SNF discharge fall into the measure. The care gap can be closed with either a CPT or CPT II code.

Interventions:

1. Check hospital admission/discharge report daily.

2. Schedule visit within 7-14 days (or within 30 days at the latest) post-discharge to document medication reconciliation.

3. Close gaps/report medication reconciliation during visit by using **CPT/CPT II codes:**
   - **1111F** – Discharge medications reconciled with the current medication list in the outpatient medical record (visit within 30 days of discharge)
   - **99495** – Transitional care management services with moderate complexity (face-to-face visit within 14 days of discharge)
   - **99496** – Transitional care management services, with high complexity (face-to-face visit within 7 days of discharge)

Diagnosis-Related Measures: Workflow Opportunities

Priority Quality Measure
Comprehensive Diabetes Care – HgA1c Control

Compliance for the following measures can change throughout the year, depending on member adherence or test results. The CDC HgA1c measure is based on the most recent test of the year, and the value can be reported with a CPT II code.

Interventions to close gaps:
1. Review medical record for HgA1c value in MY.
   - If no HgA1c test in MY, review medical record for appropriate exclusion codes (frailty/advanced illness) and use exclusion codes during an in-person or telehealth visit if appropriate, to remove member from measure.
   - If member should not be excluded, schedule member for in-person POC test or telehealth visit to discuss sending them a lab prescription.
   - Assist member in scheduling or completing testing.

2. Use the appropriate **CPT II code (3044F, 3046F, 3051F, 3052F)** during the visit to close gap administratively if value documented.

Diagnosis-Related Measures: Workflow Opportunities

Priority Quality Measure
Controlling Blood Pressure

Compliance for the CBP measure can change throughout the year, depending on member adherence or test results. The CBP measure is based on the most recent BP reading of the year. The BP value can be member-reported during a telehealth visit. Care gap (BP reading) can be closed with a CPT II code.

Interventions:

- Review medical record for appropriate exclusion codes (frailty/advanced illness) and use exclusion codes during an in-person or telehealth visit if appropriate, to remove member from measure.

- Schedule telehealth visit for members with digital BP devices for member reporting of BP during visit.

- Schedule in-person or in-home visit for members without a digital BP device who should not be excluded from measure.

- Submit applicable **CPT II code** for member/provider-reported BP reading documented during the visit: **3074F, 3075F, 3077F-3080F.**

Actions for Gap Closure – Details

Complete (mammography, colonoscopy) and compliant (HgA1c) test results may be securely faxed to VNSNY CHOICE at 646-640-2862 or call your Provider Service rep to arrange secure FTP.

Measure Name	CPT/CPT II Codes	Exclusion Codes

Medication Reconciliation Post Discharge	▪ **Within 7 days post-discharge: 99496**
	  ▪ **Between 8-14 days: 99495**
	  ▪ **Between 15-30 days: 1111F**
		N/A

Comprehensive Diabetes Care – Blood Sugar Controlled	**3044F (<7.0%); 3046F (>9.0%);** **3051F (≥7.0% - <8.0%);** **3052F (≥8.0 – ≤9.0%)**	Advanced Illness + Frailty codes
Controlling Blood Pressure	**3074F (S<130); 3075F (S = 130-139);** **3077F (S> 140); 3078F (D<80);** **3079F (D = 80-89); 3080F (D≥ 90)**	Advanced Illness + Frailty codes
Care for Older Adults – Medication Review	**Medication Review CPT II 1160F &** **Medication List CPT II 1159F** **both CPT codes required on same claim**	N/A
Colorectal Cancer Screening	N/A	Colon cancer diagnosis or Advanced Illness + Frailty codes
Breast Cancer Screening	N/A	Bilateral mastectomy diagnosis or Advanced Illness + Frailty codes
Medication Adherence for Hypertension	N/A	N/A
Medication Adherence for Cholesterol	N/A	Intolerance diagnoses (myalgia, myositis, myopathy, rhabdomyolysis) or Advanced Illness + Frailty codes

Summary: Importance of Risk Adjustment

Risk adjustment is important for CHOICE members – and providers!

- Ensures CHOICE has resources needed to provide care/treatment to high cost members.

- Helps identify members in need of disease management interventions.

- Helps to close quality gaps in care.

- Emphasizes the importance of clinical documentation to support accurate coding.

- Allows for more meaningful partnership between CHOICE and providers.

- Strengthens provider and plans ability to work towards value based programs.

Visit the VNSNY CHOICE Provider Website!

Notices, News, and Updates:

- Guideline and Policy Updates
- Provider Toolkit
- Claims, Billing, and Payments
- Credentialing

Link to telehealth coding guidance:

www.vnsnychoice.org/for-health-professionals-overview/notices-news-and-updates/

Thank You!

Please contact me for:

- Individual practice education on your topic choice
- Information on individual practice gaps in care reports or EMR data sharing

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Cell: 347-413-2875

Appendix

CMS-1500 Form:
Diagnosis Codes and Pointers

CMS-1500 Form:
Diagnosis Codes and Pointers

- Previously, the **CMS-1500 form** for reporting claims supported four diagnosis codes per claim. To reduce paper and electronic claims from splitting, the CMS-1500 form was modified to support up to 12 diagnosis codes per claim.

- Although 12 diagnosis codes are now allowed per claim, **only four diagnosis codes are allowed to be pointed to per individual procedure**).

- See next slide for more detailed information about how to use diagnosis **codes** and diagnosis **pointers**.

- See example of a CMS-1500 paper form (Slide 36).

CMS-1500 Form:
Diagnosis Codes and Pointers

How to use diagnosis codes and pointers

- To document the full extent of a patient's illness or injuries on the CMS-1500, especially during the period of Risk Adjustment HCC coding refresh at the beginning of the year, up to 12 place holders for **diagnosis codes** are available on the form under **Box 21** (see next slide).

- Because only a maximum of four **diagnosis pointers** is allowed under **Box 24E** for each procedure being claimed, there can be up to 8 additional "floating diagnoses" that may be captured on the form for each procedure.

- These extra diagnosis codes in Box 21 may be related to the patient's charges but are unable to be pointed to (as four are already pointing to the procedure), or they may be additional diagnoses related to the Medical Decision Making (MDM) of the visit as current other comorbidities.

CMS-1500 Form
Diagnosis Codes and Pointers

Note: Box 21 (above) can be populated with 12 diagnosis codes, each assigned a letter from A-J.

Box 24E (right) will allow no more than four diagnosis pointers – four letters (e.g., ABCD) – pointing to the diagnosis codes in Box 21.

CMS-1500 Form

<u>**Resources**</u>

More about Diagnosis Codes and Pointers
- ionhealthcarepulse.com/2018/01/23/maximum-diagnosis-codes-submission-on-claim-forms/

CMS-1500 Form Instruction Manual
- www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v3.pdf

Exclusion Criteria Details

Advanced Illness and/or Frailty Exclusion Criteria

In 2018, NCQA allowed additional exclusions to HEDIS Star Measures for patients with advanced illness and frailty.

- **Advanced illness** codes (e.g., ICD10CM C25.4 Malignant neoplasm of endocrine pancreas) include **conditions**, such as metastatic cancer, heart failure and late stage kidney disease, and medications for dementia; codes must be billed in the measurement year or the year prior.

- **Frailty codes** include **equipment** that is typically submitted on claims such as hospital beds, wheelchairs and oxygen, (e.g., HCPCS E1140 Wheelchair), but also codes that are not always routinely included on claims (e.g., R26.2 Difficulty in walking); codes must be billed in the current measurement year.

- Patients age **66–80 must have both advanced illness and frailty** to be excluded from the measure. Patients 81 and older quality for exclusion with frailty alone.

Frail Elderly and Advanced Illness Quality Measure Exclusions

Measures	Exclusion for Members		
	≥65 with advanced illness and frailty	≥80 with frailty	≥65 in Medicare living long-term in nursing home
Breast Cancer Screening	✓	N/A[1]	✓
Colorectal Cancer Screening	✓	N/A[1]	✓
Controlling High Blood Pressure	✓	✓	✓
Osteoporosis Management in Women Who Had a Fracture	✓	✓	✓
Comprehensive Diabetes Care	✓	N/A[1]	✓
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	✓	✓	✓
Persistence of Beta-Blocker Treatment After a Heart Attack	✓	✓	✓
Statin Therapy for Patients with Cardiovascular Disease	✓	N/A[1]	✓
Statin Therapy for Patients with Diabetes	✓	N/A[1]	✓

[1]Measure does not include members age 80 and older.

Frailty Value Set

- Use diagnostic codes from Frail Elderly Value Set for an administrative/claim-based exclusion (if member will have at least two visits during measurement year during which the diagnosis is submitted).

OR

- Provide medical record for supplemental data exclusion.

Frail Elderly
Quality Measure Exclusions

Resources

Improving care for those with advanced illness and frailty
- blog.ncqa.org/improving-care-advanced-illness-frailty/

NCQA Updates Quality Measures for HEDIS® 2019
- www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2019/

We Care for Our Community's Health

HEDIS Measure ICD-10 Exclusion Codes

Breast cancer screening (BCS)

- Patients are excluded from the measure if they have a history of bilateral mastectomy. Include the following ICD-10 diagnosis code(s) on the claim as appropriate:

ICD-10 Code	Description
Z90.13	Acquired absence of bilateral breasts and nipples
Z90.12	Acquired absence of left breast and nipple
Z90.11	Acquired absence of right breast and nipple

HEDIS Measure ICD-10 Exclusion Codes

Colorectal cancer screening (COL)

- Patients are excluded from the measure if they have a history of colorectal cancer. If the member has a history of colorectal cancer, please include the following ICD-10 diagnosis code(s) to the claim, as appropriate.

ICD-10 Code	Description
Z85.038	Personal history of other malignant neoplasm of large intestine
Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

HEDIS Measure ICD-10 Exclusion Codes

Statin therapy for patients with cardiovascular disease (SPC)

- Patients who can't tolerate statin medications are excluded from the measure. Document intolerance in their medical record and submit a claim using the appropriate ICD-10 code:

ICD-10 Codes	Condition
M79.1-M79.18	Myalgia
M60.80-M60.819;M60.821-M60.829; M60.831- M60.839;M60.841-M60.849; M60.851- M60.859;M60.861-M60.869; M60.871-M60.9	Myositis
G72.0, G72.2, G72.9	Myopathy
M62.82	Rhabdomyolysis

NCQA HEDIS Technical Specifications Telehealth Updates (MY2020/2021)

Updated Telehealth Guidance for 2020 and 2021

- Updates to these 40 measures are reflected in the HEDIS Volume 2 Technical Specifications, published on July 16, 2020. Telehealth revisions are outlined in each measure specification's "Summary of Changes" section.

- Link to the NCQA's Summary of Changes.

- In this document, we are providing telehealth updates on 4 of our focus measures for the Medicare Star program based on the NCQA HEDIS Volume 2 Technical Specifications.
    - Care for Older Adults: Medication Review
    - Care for Older Adults: Pain Assessment
    - Controlling Blood Pressure
    - Medication Reconciliation post Discharge

- Questions: please contact the Quality Management team at VNSNY CHOICE (QualityManagement@vnsny.org)

Annual Measures: Workflow Opportunities

The following measures are addressed once annually. As soon as the claim for the appropriate screening or assessment is received by CHOICE, the measure gap will be marked as compliant/closed. Please find suggested workflows for improved outcomes below.

Measure Name	Codes	Important Notes
Care of Older Adults – Medication Review		
Interventions: ▪ Schedule in-person or **a telephone visit, e-visit, or virtual check-in** ▪ Test, Service or Procedure to close care opportunity: medication review or dated clinician's note that says the member is not taking any medications.	▪ Use CPT II codes: to close gap administratively: ▪ Medication Review CPT II 1160F and Medication List CPT II 1159F both CPT codes required on same visit DOS claim ▪ For a **telehealth visit**, use the **place of service '02'**; or use a **'95' modifier** to the CPT code	▪ <u>Always clearly document the date of service of the medication review or notation of no medications.</u> ▪ Medication list must be included in the medical record and medication review must be completed by a prescribing provider or clinical pharmacist. ▪ A medication list, signed and dated during the measurement year by the appropriate practitioner type – prescribing practitioner or clinical pharmacist – meets compliance.

The following measures are addressed once annually. As soon as the claim for the appropriate screening or assessment is received by CHOICE, the measure gap will be marked as compliant/closed. Please find suggested workflows for improved outcomes below.

Measure Name	Codes	Important Notes
Care of Older Adults – Pain Assessment		
Interventions: ▪ Schedule in-person or **a telephone visit, e-visit, or virtual check-in** ▪ Test, Service or Procedure to close care opportunity: standardized pain assessment tool and results; or Date and notation of "no pain" in the medical record after the member's pain was assessed	▪ Use CPT II codes: to close gap administratively: 1125F-26F ▪ For a **telehealth visit**, use the **place of service '02'**; or use a **'95' modifier** to the CPT code.	▪ <u>Always clearly document the date of service of the pain assessment or the notation that the member's pain was assessed</u>. ▪ Pain assessment must be completed within the measurement year. ▪ A pain assessment conducted in an acute inpatient setting will not meet compliance.

Diagnosis-Related Measures: Workflow Opportunities

Compliance for the following measure can change throughout the year, depending on member adherence or test results. CBP is based on the most recent/last test of the year. Please find suggested workflows for improved outcomes below

Measure Name	Codes	Important Notes
Controlling Blood Pressure		
Interventions: ▪ Schedule **telephone visits, e-visits and virtual check-ins** for members with digital BP devices for member reporting of BP during visit ▪ Schedule in-person or in-home visit for members without a digital BP device ▪ Test, Service or Procedure to close care opportunity: BP reading taken during an outpatient visit, nonacute inpatient event or digitally stored and transmitted from a remote monitoring device interpreted by the provider and logged in the member's medical record. **New for 2020/2021 measurement year, member taken and reported BP reading from a digital device.**	▪ Submit applicable CPT II code for member/provider-reported BP reading: 3074F, 3075F, 3077F-3080F ▪ For a **telehealth visit**, use the **place of service '02'**; or use a **'95' modifier** to the CPT code.	▪ <u>Always list the date of service and BP reading together for in-person or telehealth visits.</u> ▪ BP reading must be the latest performed within the measurement year.

Hospital/SNF Event-driven Measures: Workflow Opportunities

The following measure is driven by an inpatient hospital or SNF event; only members with a hospital/SNF discharge fall into the measure. Please find suggested workflows for improvement below.

Measure Name	Codes	Important Notes
Care of Medication Reconciliation Post Discharge		
Interventions: ▪ Task staff member to check hospital admission/discharge report daily and to call all newly discharged members to schedule an in-person or **telehealth visit** within 7, 14, or 30 days post-discharge	▪ Use the TCM CPT Code: visit within 7 days (99496) or 14 days (99495) post-discharge to close the medication reconciliation measure included in these visit codes ▪ Use CPT II code (1111F) to close the medication reconciliation gap if the visit occurs days 15-30 post-discharge ▪ For a **telehealth visit**, use the **place of service '02'**; or use a **'95' modifier** to the CPT code.	▪ Medication reconciliation can be conducted by a prescribing practitioner, clinical pharmacist or registered nurse. ▪ Medication reconciliation must be completed on the date of discharge or 30 days afterward. ▪ Medication reconciliation can be documented if there is Evidence that:– A member was seen for a post-discharge follow-up. – Medication review or reconciliation was completed at the appointment. ▪ A medication list must be present in the outpatient record to fully comply with the measure.

References and Resources

CMS References

Centers for Medicare & Medicaid Services (CMS) Risk Adjustment
- www.cms.gov/Medicare/Health-Plns/MedicareAdvtgSpecRateStats/Risk-Adjustors

Medicare Managed Care Manual 100-16, Chapter 7 – Risk Adjustment
- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

Customer Service and Support Center (CSSC) Operations- Risk Adjustment Processing System
- www.csscoperations.com/internet/csscw3.nsf/T/Encounter%20and%20Risk%20Adjustment%20Program%20(Part%20C)

Risk Adjustment Resources

ICD-10-CM Official Guidelines for Coding and Reporting
- www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

ICD10 HCC Model Mappings
- www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsrisk-adjustors/2021-model-softwareicd-10-mappings