PENNSYLVANIA CLINICAL NETWORK PLAYBOOK

2021/2022

Dear Colleagues,

The PA Clinical Network Quality Team has again developed a 2021 Playbook for you to use as a reference during the year when caring for your patient panel.

This years' theme of 'cinema' has a different focus than the 2020 Playbook. The foundation was built last year on the HEDIS measures and criteria used by many of the payor's Value Based Contracts (VBC). Although this information is important, many payors are also including utilization and patient satisfaction as measurements for the coming year.

As we all know, the holistic approach to patient care is best when we see the whole picture of the patient. This year's focus is on making certain medical costs are kept in line and utilization of emergency rooms and urgent care occur when appropriate.

The goal of the Quality Team remains the same, to keep your processes as efficient and streamlined as possible while achieving the best quality outcomes.

Should you have any questions on any of the information in this tool, please feel free to contact us.

We look forward to our continued partnership and building upon our relationship.

Best,

Traci Petrino, MHA

Traci Petrino
Director Clinical Outcomes

Lisa Strohm, RN

Lisa Strohm
Director Clinical Outcomes

NCQA reviews and updates measures for quality on a yearly basis. For 2021, the major updates included:

UPDATED:

- Addition of Telehealth verbiage for 40 measures as a way to provide service and support health care during the COVID-19 pandemic

RESTRUCTURED:

- Revised Controlled Blood Pressure measure (CBP) to include self-reported readings using a digital device (not a manual blood pressure cuff)
- Changed W15 (Well Child visits in First 15 months of life) to include ages for children from birth to 30 months of age.
    - Renamed measure to W30
    - Requirements are for 6 visits in the first 15 months of life: then 2 visits between ages 15 months and 30 months
- Consolidated the Adolescent Well Child visit (AWC) with the Well Child Visits ages 3-6 (W34).
    - This is now known as WCV (Well Child Visits)
    - Requirements are for one well visit on an annual basis
- Weight Assessment for Well Child Checks (WCC) can now include self-reported BMI Index, height, and weight. Practices are still responsible for calculating the BMI percentile
- Removed Emergency Department visits that converted to observation stays. This pertains to the Emergency Department Utilization (EDU)
-

RETIRED:

- Retired ABA (Adult BMI) measurement.
    - This does not mean though that you do not have to obtain a BMI on all patients at least once during the calendar year
- Medication Management for People with Asthma (MMA)
- Medication Reconciliation Post-Discharge (MRP)
    - Medication Reconciliation is now included in the TRC (Transition of Care) measure and should still be conducted with patients upon discharge from an inpatient setting
- Osteoporosis Testing in Older Women (OTO)
- Children and Adolescent to Primary Care Practitioners (CAP)
- Disease modifying Therapies for Rheumatoid Arthritis (ART)
- CDC-Nephrology retired for Commercial and Medicaid ONLY. Still used for Medicare

NEW MEASURES:

- Kidney Health Evaluation for Patients with Diabetes (KED)
    - All product lines. Percentage of Members 18-85 with Type I and Type II Diabetes who received an estimated Glomerular filtration Rate (eGFR) and a Urine Albumin – Creatinine ratio (uACR) during the calendar year
- Osteoporosis Screening in Older Women (OSW)
    - Medicare only. Percentage of women ages 65-75 who received osteoporosis screening

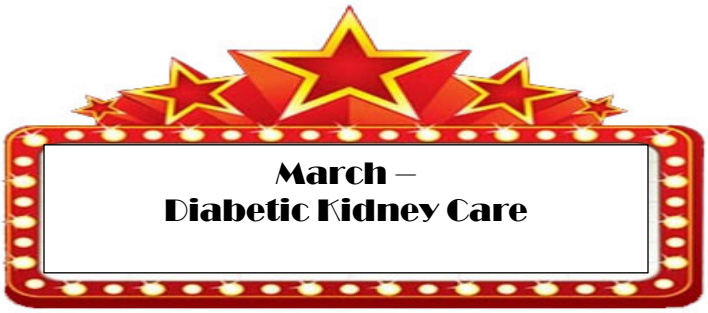
CAHPS surveys are an integral part of CMS' efforts to improve healthcare in the United States.
Every health payor engages a vendor on their behalf to survey their membership's experience with their Primary Care Physician, Specialists, and other functions within the Health Plan.

A CAHPS survey asks patients to report on their experiences with a range of health care services. The survey can be presented to an adult or a child. Some Health Plans mail the survey and expect it to be returned to the vendor, others use a telephonic outreach to the members to obtain the information.

What you can do to help increase satisfaction:

- Keep you patients well-informed consumers to be able to make better health care decisions
    - Provide handouts and electronic links/websites for patients to learn about disease processes, drug interactions, healthy lifestyles
- Patient portals, through your practice website, can help patients:
    - Schedule appointments
    - Receive test results
    - Correspond with the doctor
    - Know hours of operation
- Timely response to patients to provide answers to questions
- Keeping appointments available during the day for sick visits/urgent visits
- Encouraging staff to be helpful, courteous, and respectful even on those hectic days where there is not enough staff, and everyone is asking questions

These are best practice techniques that can lead to increased patient satisfaction. Typically, Health Plans survey their membership starting in late summer, early fall and continue through to the following February/March.



Diabetic kidney disease is a type of kidney disease caused by diabetes. Diabetes is the leading cause of kidney disease. One of the side effects of diabetes includes damage and weakening of the blood vessels in the kidneys.

To monitor kidney function in diabetics, it is recommended a microalbumin or a urine test for protein/albumin be done at least on an annual basis. Screening includes an assessment of eGFR and a measurement of urinary protein excretion – the spot UACR.

NCQA has updated the diabetic kidney criteria:

- Added Kidney Health Evaluation for Patients with Diabetes (KED)
  - Commercial, Medicaid population
  - Evidence of both an eFGR and uACR (quantitative urine albumin test and a urine creatinine test with services dates four or less days apart)
- CDC Nephropathy (only reported for Medicare product line)
  - A nephropathy screening or monitoring test
  - Evidence of treatment for nephropathy or ACE/ARB therapy
  - Evidence of stage 4 chronic kidney disease
  - Evidence of ESRD or dialysis
  - Evidence of nephrectomy or kidney transplant
  - A visit with a nephrologist

Billing Codes:

- Urine protein test:
  - CPT:
    - 81000-81003, 81005, 82042-82044, 84156
  - CPT II:
    - 3060F, 3061F, 3062F
  - LOINC:
    - 11218-5, 12842-1, 13705-9, 13801-6, 13986-5, 13992-3, 12956-7, 12957-5, 12958-3, 14959-1, 1753-3, 1754-1, 1755-8, 1757-4, 17819-4, 18373-1, 20454-5, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 2887-8, 2888-6, 2889-4, 2890-2, 29946-1, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43606-3, 43607-1, 44292-1, 47558-2, 49002-9, 49023-5, 50209-6, 50561-0, 50949-7, 51190-7, 53121-0, 53525-2, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 57735-3, 5804-0, 58448-2, 58992-9, 60678-0, 63474-1, 6941-9, 6942-7, 76401-9, 77253-3, 77254-1, 77940-5, 9318-7
- Nephropathy treatment:
  - ICD-10:
    - E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29, I12.0, I12.9, I13.0, I13.10, I13.11, I13.2, I15.0, I15.1, N00.0-N00.9, N01.0-N01.9, N02.0-N02.9, N03.0-N03.9, N04.0-N04.9, N05.0-N05.9, N06.0-N06.9, N07.0-N07.9, N08, N14.0-N14.4, N17.0-N17.2, N17.8, N17.9, N18.1-N18.6, N18.9, N19, N25.0, N25.1, N25.81, N25.89, N25.9, N26.1, N26.2, N26.9, Q60.0-Q60.6, Q61.00-Q61.02, Q61.11, Q61.19, Q61.2-Q61.5, Q61.8, Q61.9, R80.0-R80.3, R80.8, R80.9
  - CPT II:
    - 3066F, 4010F

Emergency Department utilization is a responsibility and a challenge that all physicians face. It is important for practices to communicate to their patients what hours of operation the practice is open, what to do if a patient has an urgent need, and when it is appropriate and necessary to visit an emergency department for care.

Most payors have a 24/7 nurse line that can be found on the back of the insurance card.

Patients should be educated to go to the Urgent Care center for limited low risk conditions or circumstances such as:

- Symptoms that your physician would treat, but their office is closed (holiday/after-hours/weekend)
- Flu-like symptoms
- Cough/congestions/sore throat
- Sprains/strains
- Small cuts that may require stitches

Patients should be educated to go to the ER for conditions that a lay person would find to be life threatening or could result in lasting or significant injury. Examples include:

- Chest pain
- Difficulty breathing
- Numbness on one side
- Slurred speech
- Fainting/change in mental status
- Serious burns
- Head/eye injury
- Concussion/confusion
- Broken bones/dislocated joints
- Severe cuts/hemorrhaging

Primary Care Physicians have a responsibility to ensure all their patients are understanding of how important health care is to their overall sense of well-being. Although a PCP is not able to be with their patients 24/7/365, educating patients and understanding their healthcare literacy is vital to healthy outcomes.

Since most PCPs no longer follow their patients during a hospitalization, it is important that they know when a patient has been admitted and ultimately discharged from the hospital to make certain they are scheduling a follow up visit within the first 7 to 14 days after discharge. Statistics have shown that those patients who do follow up with their PCP after discharge have a higher incidence of remaining at home and not having a subsequent admission within the 30 days following the discharge.

During the follow up visit, the PCP should be checking the following:

- Patient understanding and knowledge of the disease
- Updating medications to include new medications after hospitalization and discontinued medications to ensure no contraindications exist (medication reconciliation)
- Ensuring patients are following up with and/or confirming additional services such as DME items, therapies, case management, etc.
- Reassessing social determinants of health that may impact the recovery of the patient

Post-discharge visits can be accomplished through telehealth, preferably with a video conferencing system or Face-time. Remember to bill the appropriate codes for credit that these services have been accomplished.

The Medicare Wellness Visits is a covered visit that allows you as a provider to dedicate time for a health risk assessment and prevention screening strategies.

Patients who are age 65 and older with Medicare insurance are eligible, as are people who are younger than age 65 with disabilities with Medicare insurance.

It is important to communicate to the patient that the Annual Wellness Visit is free. However, if the visit identifies other needed services or the patient requests that other acute health issues are addressed during the visit, cost-sharing may be necessary. Some payors will allow you to bill an annual wellness visit on the same day as an acute visit, provided your clinical notes and documentation show both were completed.

The visit should include discussion on:

- health risks,
- prevention and screenings,
- updating immunizations,
- current medication review,
- nutritional counseling,
- screening for cognitive impairment/depression,
- assessment for bladder incontinence, falls, and physical activity.
- Advance care planning

Billing Codes:

- Annual Wellness Visit
  - CPT II:
    - G0438: Initial AWV
    - G0439: Subsequent AWV
    - G0402: Initial Preventive Physical Exam
    - G0468: Federally qualified health center visit that includes an AWV or IPPE
- Advanced Care Planning
  - CPT II:
    - 1123F: Advanced care planning discussed and documented advance care plan or surrogate maker documented in the medical record (DEM) (GER, Pall Cr)
    - 1124F: Advanced care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provider an advance care plan (DEM) (GER, Pall Cr)
    - 1157F: Advance care plan or similar legal document present in the medical record (COA)
    - 1158F: Advance care planning discussion documented in the medical record (COA)
  - ICD 10:
    - Z66: Do not resuscitate
- Functional Status
  - CPT II:
    - 1170F: Functional status assessed
- Medication Review
  - CPT II:
    - 1159F: Medication list documented in medical record
    - 1160F: Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record
- Pain Assessment
  - CPT II:
    - 1125F: Pain severity quantified; pain present
    - 1126F: Pain severity quantified; no pain present
- Fall Risk
  - CPT II:
    - 1100F: patient screened for future fall risk; documentation of 2 or more falls in the past year or any fall with injury in the past year
    - 1101F: patient screened for future fall risk documentation of no falls in the past year or only 1 fall without injury in the past year
  - Patient meets exclusion:
    - CPT II:
      - 1100F-1P, 1101F-1P: patient not screened for future fall risk, medical reasons
- Improving Bladder Control
  - CPT II:
    - 1090F: Presence or absence of urinary incontinence assessed (use for negative result only)
    - 0509F: Urinary incontinence plan of care documented
- Monitoring Physical Activity
  - CPT II:
    - 1003F: Level of activity assessed
  - ICD 10:
    - Z71.82: Exercise counseling

Patients that are on medications for chronic conditions, such as Diabetes, Congestive Heart Failure, Hypertension, etc. should be monitored closely for compliance in taking these prescribed medications as well as filling the prescription orders on a routine basis.

Most payors have a pharmacy benefit that allows patients to receive medications via mail order and at a discounted rate. The mail order drug comes directly to the patient at the prescribed time period and provides convenience to the patient, so they don't have to travel outside in inclement weather and pandemic situations to retrieve the medication.

If a patient has had a negative experience with a medication such as a statin, there are exclusion codes that the payor will need to know so adherence is not counted against the practice.

Reports are available with most payors that will provide a listing of patients who have not been compliant with their statins, cholesterol, and diabetic medications. Ask your Director of Clinical Outcomes if you need help with reviewing the medication adherence reports.

An ounce of prevention is worth a pound of cure. This saying, attributed to Benjamin Franklin, can be applied to healthy outcomes today and the simple tasks of obtaining preventive services can help in detecting disease processes before they become overwhelming.

Mammograms, cervical cancer screenings, colo-rectal screenings, along with eye exams for patients with diabetes can help detect underlying issues at early stages. Many studies have been published to demonstrate that patients with early detection are less likely to succumb to the illness.

In most health plans, preventive care does not carry a co-payment or a deductible. In other words, the preventive services must be provided free of cost-sharing.

Mammograms:

- Adult females over 40
- 30% of women fail to get routine mammogram screenings
- In 2009, ¾ of breast cancer deaths occurred in women who did not undergo yearly mammograms

Cervical Cancer Screening:

- Adult females ages 21-65
- Yearly exams are recommended with cervical cytology screening for HPV every 5 years

Colo-rectal Screening:

- Adults 50-75
- Screening can be done by colonoscopy (good for 10 years), sigmoidoscopy (good for 5 years), Cologuard (good for 3 years) or FIT/FOBT (annually)

Retinopathy Screening:

- A retinal or dilated eye exam is an important annual screening as diabetes can damage the small arteries in the eye

Chart chasing. By HEDIS definitions it means to find that specific chart for a patient to help satisfy a gap in care. This process has almost become obsolete due in part to the advances of the use of CPT II codes for various measure values and services.

Unfortunately, not every practice bills with the appropriate CPT II codes and that is a disadvantage for many practices in closing gaps in care. For example, having a necessary service, such as preventive care, done by a specialist or external agency may require a practice to hunt down the results just to get credit for the patient having the service performed.

This is a year long event that requires a bit of strategy around how the practice manages patient health outcomes. If your practice refers patients out for colonoscopies, mammograms, cervical cancer screening, diabetic eye exams, it is important to document when the referral was made. Retrieving the records from these external providers will require some investigative work unless they are billing the correct and appropriate CPT II codes.

Tips for obtaining external health information:

- Develop a close relationship with various specialists who understand the importance of sending testing results on your patients and refer your patients to them for care
- Educate your patients to provide information on which specialist they saw and the date of the service. This information can be documented in your EMR as a reminder to follow up within 2-4 weeks after the scheduled appointment
- If staffing permits, schedule the specialist appointments at the time of check-out. This allows for immediate information on the date/time of the specialist appointment

Cardiovascular disease and diabetes are both prevalent and costly. Interventions and therapies that reduce morbidity and mortality associated with both disease process could have a huge impact on clinical outcomes.

HEDIS measures for both Statin Therapy for Patients with Cardiovascular Disease (SPC) and Stain Use in Persons with Diabetes (SPD). Payors will generally provide practices with data on patients who are not compliant in filling and using their statin prescriptions.

Educating patients in understanding why it is important to continue with their prescribed medications is key to compliance. The cost of an emergency room visit or hospitalization for a cardiovascular event can be astronomical. Most payors require their Members to have some cost share in these services. Most pharmacy benefit managers can provide discount medications to patients to help in the cost.

For the SPC measure, HEDIS/NCQA does allow for an exception to the continued use if the patient experiences adverse side effects from the statin (i.e. myopathy, myalgia, rhabdomyolysis). The corresponding ICD10 Diagnosis Exclusion Codes should be reported to the payor in order to have the patient removed from the measure.

Antibiotics are important medications. It would be difficult to overstate the benefits of penicillin and other antibiotics in treating bacterial infections, preventing the spread of disease and reducing serious complications of disease.

However, the overuse and misuse of antibiotics are key factor contributing to antibiotic resistance. The general public, doctors, and hospitals all play a role in ensuring proper use of the medications and minimizing the development of antibiotic resistance.

Payors have started to include the HEDIS measures of Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Appropriate Treatment for Upper Respiratory Infection (URI) and Appropriate Testing for Children with Pharyngitis (CWP) in their Value Based contracts. All are utilization-based measures that provide an overview on the number of sore throat screenings completed or antibiotic prescriptions written and filled for diagnoses related to URI and/or Bronchitis/Bronchiolitis.

Educating patients on when an antibiotic will work and when it won't are important steps to curb the over-prescribing of antibiotics. Sending patients home without medicine is not always popular with patients, but it is helpful in cutting down on unnecessary antibiotic use. Communicate to your patients if symptoms persist for longer than two weeks and/or get significantly worse, then testing is recommended for diagnostic purposes.

The end of the year brings the opportunity to assess your patient panels and review gaps in care that were not completed earlier in the year.

Call patients early in the month to schedule appointments for A1c, microalbumin, blood pressures, eye exams, and any well checks that may have been canceled or missed.

If the results from earlier in the year were elevated, it may be an opportunity to re-check the patient.

Submit evidence of these important quality measures based on the payer's instructions.

Measure	Tips
Controlling High Blood Pressure	If the blood pressure is high at the beginning of the appointment, re-take at the end.
Diabetic - A1c	Only the last reading of the year counts toward gap closing.
Diabetic – Eye Exam	Contact optometrists/ophthalmologist for documented visit and results.
Diabetic – Nephropathy /KED	Schedule a urine albumin test (lab values) and/or eGFR/uARC.
Colorectal cancer screening	If a colonoscopy was not completed, an FOBT or Cologuard can be used for credit. Or call gastroenterologist for report from the study.
Medication Reconciliation	Review records to ensure patient seen within 30 days of discharge.

Exclusions	Tips
Hospice, Frailty, Medication intolerance, Anaphylactic shock, Cancers, etc.	If patients have any listed exclusions for any measures, send appropriate documentation to insurance carrier for credit on the measure.