FEB 2021

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

MPM Provider Quality Newsletter

To access the materials referenced in this newsletter, go to:
www.medpointmanagement.com/provider-resources

- Click on "Quality Management Information" and then "2020 Quality Newsletters."
- All materials are listed in one PDF document.
- Please also note that MedPOINT's Reference Guides are available under "HEDIS Documents."

QM Bulletin Board – Question of the Month

What are your priority HEDIS measures for 2021 and what strategies do you plan to use?
Please share or enter a question of your own on the QM Bulletin Board by signing up at

https://qualitypoint.medpointmanagement.com

Interpreta

Need a refresher on the Interpreta quality portal? Please contact us at qualitymeasures@medpointmanagement.com, (818) 702-0100, ext. 1353, or contact your dedicated HEDIS/Stars Specialist to schedule a training.

Palliative Care Reference Sheet and Referral Form

As acute hospital admissions for patients with serious and chronic illness continues to rise, we want to remind you that Medi-Cal members can access additional help and care through the Palliative Care benefit when they are not yet ready for Hospice. Palliative Care provides:

- A special team of doctors, nurses, specialists
- Care provided together with curative treatment
- Improved quality of life for the patient/family
- An extra layer of support for the member

Please see the attached information and universal referral form. For information on enrolling qualified members, please contact your Provider Network Representative.

Plan your Preventive Care and Chronic Disease Campaigns Now!

We offer the following sample topic calendar below to help you engage consumers, educate clinicians, target outreach and improve workflows. This is just one idea to keep HEDIS top of mind and increase a culture of quality in your clinic:

JAN	Cervical Cancer	CCS - Pap Smears
FEB	Cardiovascular	CDC - Diabetes A1c<9 and BP <140/90
MAR	Colorecal	COL - Colonoscopy or FOBT
APR	Asthma	Asthma
MAY	Mental Health	Depression Registry, 6 HEIDIS Measures
JUN	Adult Wellness	Annual Wellness Visit (AWV) and Care for Older Adults (COA)
JUL	Pidiatric Wellness	WCV (age 3-11), WCC (age 3-11), CIS10 (age 2)
AUG	Adolescent Wellness	WCV (age 12-21), WCC (age 12-17), IMA2 (age 13)
SEP	Stroke/Hypertension	BP Control <140/90 and Diabetes A1c<9
OCT	Breast	BCS Mammogram
NOV	Diabetes	CDC A1c, Eye Exam, Nepropathy
DEC	Influenza/Pneumonia	Influenza/Pneumonia

IHA AMP Incentive Program

HEDIS scores not only affect the direct incentive programs offered by the health plans, they also influence the incentives from the IHA (Integrated Healthcare Association) AMP (Align.Measure.Perform) incentive program. This incentive program measures everyone by the same standards and performance benchmarks through a national standard incentive design, public reporting, and public recognition awards for top performers in the Commercial, Medicare and Medi-Cal lines of business.

Eleven California health plans participate in the AMP program for Commercial HMO, including Anthem, Blue Shield of CA, Health Net, LA Care (Covered CA) and UnitedHealthcare. Blue Shield Promise participates in Medi-Cal and Blue Shield of CA participates in Medicare Advantage. We also expect more plans to participate in Medi-Cal in the coming years. Get to know this program by visiting their website at https://www.iha.org/performance-measurement/amp-program/.

Medicare Stars Measure Updates

- **CAHPS** - CMS Stars weighting increased from 2 to 4. This is a direct reflection on patient experience. Please contact your MPM HEDIS/STARs Specialist if you want to discuss best practices in this area.
- **Health Outcome Survey (HOS Measures)** - Survey will be administered from August to November permanently.
- **Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)** - This measure is retired for 2021.

Resources

Well Care at Sick Visits Guide - MPM

Accomplishing Well-Care during sick visits is not just good for our members, it's an essential strategy for improving HEDIS scores. Please share the attached guide from MedPOINT with your staff and support a culture of quality by making sure sick visits are scheduled with enough time for well visits and also coded properly.

Optum Tools – United Health Care has provided the following excellent tools from Optum to help your practice:

- Documentation – Helpful charts on documenting to satisfy reporting requirements by condition and separate coding tip sheets on arrhythmia/sick sinus syndrome and hypertension.
- Chart on medical decision making.
- Chart on Social Determinates of Health w/codes.
- CMS Final Rate Announcement Summary

COVID Vaccine Flyer – When can your patients receive their COVID vaccine? Health Net has created the attached flyer with great information on a new website for patients to register for eligibility and schedule an appointment at MYTURN.CA.GOV. Please share this flyer with your staff.

Second Opinion – The attached Health Net Provider Update is a reminder of when a second opinion referral is needed for your Medi-Cal members.

Coming Up

- March - National Colorectal Cancer Awareness Month
- March - Save Your Vision Month
- March 23 - American Diabetes Alert Day

HEDIS Well-Care Can Be Performed at Sick Visits

Accomplishing Well-Care during sick visits is not just good for our members, it's an essential strategy for improving HEDIS scores. A full CHDP or CPSP exam is **not** required for HEDIS credit. In fact, you maybe *already* be doing the Well-Care that HEDIS requires at every office visit. By documenting **five components** and appending the appropriate ICD10 Z-code, any office visit (99202-99215) can be HEDIS Well-Care compliant. Video telehealth and, during the Public Health Emergency, telephone calls coded like office visits can also meet the measures.

Take Every Opportunity to Provide Well-Care	CPT Procedure Codes	ICD-10-CM Diagnosis Codes	HEDIS Well-Care Compliant	CHDP Visit
CHDP Well-Care Provide and document preventive care according to CHDP guidelines to allow for a higher level of reimbursement.*	99381 – 99385 99391 – 99395	[Z00.121] or [Z00.129] as the primary diagnosis code for ages 0 – 17 years. [Z00.00] or [Z00.01] for 18 years and older.	YES	YES
Sick Visit Plus HEDIS Well-Care Document preventive care at any visit by including 5 components: health history, physical and mental developmental history, physical exam and health education.*	99202 – 99215, 99461 OR 59425 – 59426 (Prenatal), 59430 (Postpartum)	[Z00.121] or [Z00.129] as the secondary diagnosis code for ages 0 – 17 years. [Z00.00] or [Z00.01] for 18 years and older. (HEDIS also allows Z00.110, Z00.111, Z00.2, Z00.3, Z02.5, Z76.1 and Z76.2.)	YES	**NO**

***Note**: Don't miss a chance to also meet the 3 **WCC** sub-measures (see box at bottom) for patients turning age 3-17 years by 12/31.

HEDIS Well-Care Measures:

- **W30.** Well-Child Visits in the First 30 Months of Life (6 visits by age 15 months plus 2 more by age 30 months)
- **WCV.** Well-Child Visit (at least 1 visit in the current year for members turning 3-21 years by 12/31)

Documentation (must have all **five components**):

1. **Health history.** Best practice is to set up templates to always include Allergies, Meds and Immunization Status which together are compliant for this component: *"**Allergies**: None; **Current Meds**: None; **Immunizations**: Up to date"*
2. **Physical developmental history.** Best practice: *"**Physical developmental history**: Appropriate for age"**
3. **Mental developmental history.** Best practice: *"**Mental developmental history**: Appropriate for age"**
4. **Physical exam.** At least **2** unrelated body systems or parts, e.g. *Vitals* and *Psych*. Telehealth exams are acceptable.
5. **Health education/anticipatory guidance.** At least 1, do Nutrition and Physical activity to meet **WCC** measure as well. Example: *"Nutrition counseling: Done today; Physical activity counseling: Done today"*

***Note**: The phrase *"Development appropriate for age"* is compliant for both physical and mental developmental history components. It's okay to add *"per parent"*. It's okay to use specific developmental milestones instead but be cautious: (1) They must be age-appropriate, (2) At least one physical milestone must clearly fall into the motor/coordination/sports category, (3) At least one mental milestone must clearly fall into the language/social/interpersonal/school performance category. ADHD symptoms do not count. Tanner stage only counts for adolescent physical development.

- **WCC. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents**

All patients seen by the health center and turning 3-17 years by 12/31 must have BMI percentile [Z68.51-Z68.54], Nutrition counseling [Z71.3] and Physical activity counseling [Z71.82] documented and coded during the current year.

- **PPC1. Timeliness of Prenatal Care (first visit in the first trimester or 42 days of enrollment in a health plan)**
- **PPC2. Postpartum Care (visit 1-12 weeks after delivery)**

For positive pregnancy test visits, document "pregnant" or "pregnancy" and use [Z34.90] Encounter for supervision of normal pregnancy, unspecified. Assessment/Plan can be anything, e.g. *"follow-up with CPSP."* **IMPORTANT**: [Z32.01] Encounter for pregnancy test, result positive, and [Z33.1] Pregnant state, incidental, do not count for HEDIS.
For sick visits 1-12 weeks postpartum, document "postpartum check" and add [Z39.2] Encounter for routine postpartum follow-up as a secondary diagnosis for HEDIS credit. Assessment/Plan can be anything, e.g. *"No concerns."*

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When Can Your Patients Get Their COVID-19 Vaccine?

GO TO **MYTURN.CA.GOV** TO REGISTER FOR ELIGIBILITY AND SCHEDULE AN APPOINTMENT

California has launched ***myturn.ca.gov*** *to help residents learn when they are eligible to receive the vaccine and schedule appointments.*

✔ **If eligible for vaccine**	**myturn.ca.gov** will allow them to schedule an appointment for a vaccination.
⊘ **If not eligible for vaccine**	**myturn.ca.gov** will allow them to register to receive an email or text alert to notify them about when they will be eligible to schedule a vaccination.

MyTurn's scheduling functionality is active in Los Angeles and San Diego counties

All other California counties will be added in the next few weeks. Residents of counties not allowing scheduling yet can still register at **myturn.ca.gov** to receive an email or text alert to notify them about when they will be eligible to schedule a vaccination.

Residents can follow these steps to schedule appointments or register for alerts:

1. Go to **myturn.ca.gov.**
2. Select language preference.
3. Input basic information including:
   - Age certification and consent statement
   - County of residence
   - Age range
   - Business/industry employed in
4. Find out if they currently qualify to receive a vaccination.

Residents without internet access, email or mobile phone

Residents who do not have access to myturn.ca.gov, or those who do not have an email address or a mobile phone, can contact the California COVID-19 hotline at 1-833-422-4255 for assistance:

- **Monday–Friday 8 a.m. to 8 p.m.**
- **Saturday–Sunday 8 a.m. to 5 p.m.**

For more information, visit myturn.ca.gov.

PROVIDER COMMUNICATIONS

21-134/FLY84615EH01w (2/21)

PROVIDER*Update*

Health Net®

CONTRACTUAL | DECEMBER 30, 2020 | UPDATE 20-1030 | 1 PAGE

Reminder: Refer Patients for a Second Opinion When Needed

A one-time consult can help relieve patient concerns and support their plan of care

Health Net* members can get a second opinion when any of the following occurs:

- Member questions the reasonableness or necessity of recommended surgical procedures
- Member questions a diagnosis or plan of care for a condition that threatens loss of life, limb, bodily function, or major damage, including a serious chronic condition
- Clinical signs are not clear or are complex, a diagnosis is in doubt due to conflicting test results, or the treating physician cannot diagnose the condition, and the member requests an additional diagnosis
- Treatment plan is in progress, but the medical condition is not improving in a reasonable amount of time based on the diagnosis and plan of care
- Member has attempted to follow the plan of care or has talked with the initial provider with serious concerns about the diagnosis or plan of care

You must authorize the care

All care must be done or authorized by the participating physician group (PPG) or the primary care physician (PCP) to be a covered benefit. Separate approvals are needed for added tests, lab or x-ray services, aside from the second opinion consult. The results must be sent to the PPG or PCP for coordination.

Second opinion consults are one-time visits

Referrals for second opinion consults must be with a qualified health care professional. This means a PCP or specialist who acts within the PCP's or specialist's scope of practice. The PCP or specialist must have the clinical background, training and skill related to the specific illness, disease or other condition listed in the request for a second opinion.

Additional information

Relevant sections of Health Net's provider operations manuals have been revised to reflect the information contained in this update as applicable. Provider operations manuals are available electronically in the Provider Library, located on Health Net's provider website at provider.healthnet.com.

If you have questions regarding the information contained in this update, contact the Health Net Medi-Cal Provider Services Center within 60 days at 1-800-675-6110.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ● Molina
  - ● Riverside
  - ● Sacramento
  - ● San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

OTH049344EH00 (12/20)

CMS final rate announcement summary for payment year 2021

Medicare Advantage

On April 6, 2020, the Centers for Medicare & Medicaid Services (CMS) released the 2021 Medicare Advantage (MA) and Part D final rate announcement, which applies to payment year (PY) for 2020 dates of service.

For PY 2021, CMS will use 75% of the 2020 CMS-HCC model for the risk score calculation, which will be blended with 25% of the previous 2017 (V22) model.

The 2021 rate announcement does not catalog CMS' actions related to the coronavirus disease 2019 (COVID-19) outbreak.

The following may have implications for providers who see members of Medicare Advantage plans:

Revisiting Hierarchical Condition Categories (HCC) included in recent years

1. Dementia with complications (HCC 51)
   - Codes include: **F01.51**, **F02.81**, **F03.91**, **G91.0–G91.9**
2. Dementia without complications (HCC 52)
   - Codes include: **A81.00–A81.9**, **E75.00–E75.4**, **F01.50**, **F02.80**, **F03.90**, **F04**, **G13.2–G13.8**, **G30.0–G30.9**, **G31.01–G31.9**, **G93.7**, **I67.3**
3. Substance use disorder, mild, except alcohol and cannabis (HCC 56)
   - Codes include: **F11.10, F11.11, F13.10, F13.11, F14.10, F14.11, F15.10, F15.11, F16.10, F16.11, F18.10, F18.11, F19.10, F19.11**
4. Reactive and unspecified psychosis (HCC 58)
   - Codes include: **F23, F28, F29**
5. Personality disorders (HCC 60)
   - Codes include: **F44.0, F44.1, F44.81, F48.1, F60.0–F60.9**
6. Chronic kidney disease, moderate (stage 3) (HCC 138)
   - The single code of **N18.3** falls into this category
7. Pressure ulcer of skin with partial thickness skin loss (HCC 159)
   - Codes include: **L89.002**, **L89.012**, **L89.022**, **L89.102**, **L89.112**, **L89.122**, **L89.132**, **L89.142**, **L89.152**, **L89.202**, **L89.212**, **L89.222**, **L89.302**, **L89.312**, **L89.322**, **L89.42**, **L89.502**, **L89.512**, **L89.522**, **L89.602**, **L89.612**, **L89.622**, **L89.812**, **L89.892**, **L89.92**

These materials include items that Optum believes may be of interest to many MAOs but do not constitute legal or compliance advice. MAOs should consult their own legal and compliance advisors as to the impact of the full Rate Announcement on their own operations.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2020: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2021: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors

Optum360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City, UT: 2019.

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Documenting to satisfy reporting requirements

With the implementation of ICD-10-CM came the need for greater detail in clinical documentation. Specific documentation aids in effectively identifying, categorizing and communicating severity of conditions to better track quality of care, validate medical necessity, and predict future health care expenditures. The ICD-10-CM Official Guidelines for Coding and Reporting reiterate the importance of good documentation, "The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved."[1] The Guidelines also set the expectation for correct coding, stating that "Each healthcare encounter should be coded to the level of certainty known for that encounter."[1]

This tool outlines the required elements of the language of documentation for some of the more common chronic conditions, which will lead to coding that is both accurate and complete. This type of documentation will minimize coder query and can also help expedite claims processing, resulting in more timely payment. When possible, we included practical examples of documentation that satisfy reporting requirements. Documenting in this way will also result in better communication of the conditions being treated or considered when treating, better portrayal of medical necessity for appropriate reimbursement, improved communication between clinicians, better continuity of care and improved patient outcomes.

The importance of documentation

- Documentation should be clear, concise and legible.
- CMS requires submission of risk adjusting diagnosis codes:
  - From a face-to-face or audio-visual telehealth visit with physician or other approved provider.
  - Within the reporting period each calendar year.
- Document conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment and/or management.
- Diagnoses cannot be coded from diagnostic reports alone. The review and pertinent findings of the diagnostic reports should be documented in the progress note.

Documentation examples

- Chest x-ray completed 4/10/20, confirms COPD, continue Ipratropium as prescribed
- Diabetes type 2 hypoglycemia, CKD 4 stable eGFR 20
- Rheumatoid arthritis, stable on Enbrel
- Hypertensive heart disease, stable, seeing cardio tomorrow
- Patient's BMI has increased since last visit from 42 to 43, patient has class III obesity, right foot amputation 3 years ago contributes to their severe due to limited mobility

Language of documentation

- Diagnosis codes reported must be supported by documentation in the medical record. It is recommended to identify evidence of monitoring, evaluating, assessing/addressing and/or treating (M.E.A.T.).
- Utilize adjectives to specify conditions documented & coded such as: severity, site, stage, laterality, episode, type, complications, comorbidities, insulin status or amputation status.

MONITOR	EVALUATE	ASSESS/ ADDRESS	TREAT
• Status	• Signs and/or symptoms	• Counseling about condition	• Prescription: Start, continue, stop, change
• Disease progression	• Response to treatment	• Review specialist's notes	• Referral to specialist
• Adherence to treatment plan	• Lab or radiology reports	• Complications	• Order labs and/or radiology testing

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Diabetes[2,4]

When documenting diabetes, specify:

- **Type of diabetes:** Type 1, type 2, secondary – drug or chemical induced (document first poisoning or adverse effect specific to drug), due to underlying condition (document first the underlying condition), postprocedural or due to genetic defects
- **Control status:** "Controlled;" if "inadequately controlled," "out of control" or "poorly controlled" (diabetes, by type, with hyperglycemia); if "uncontrolled," specify as hyperglycemic or hypoglycemic
- **Complications or any other body systems affected:** There is a presumed causal relationship regarding "diabetes with" many manifestations (complications), unless documentation clearly states the conditions are unrelated. "Diabetes with chronic kidney disease" – document also the stage of CKD; "diabetes with an ulcer" – document also the ulcer by type, laterality, site and depth; "diabetes with glaucoma" – document also the type, stage and affected eye; other diabetic complication – specify the complication including stated or implied relationship (for example, "diabetic CAD")
- **Treatment:** Insulin use and/or oral antidiabetic or hypoglycemic drugs, and non-insulin injection.

Chronic kidney disease (CKD)

When documenting CKD, specify:

- **Underlying cause:** Diabetes or hypertension. If CKD is unrelated to diabetes or hypertension, document the cause, if known.
- **Stage of CKD:** Stage 1, stage 2 (mild), stage 3 (moderate - 3a, 3b, unspecified), stage 4 (severe), stage 5 or end-stage renal disease (ESRD). Avoid documenting a range of severity, such as "moderate to severe." The diagnosis of CKD cannot be coded from diagnostic reports alone. Clearly state review of reports and pertinent findings including the GFR.
- **Presence of:** A/V fistula or shunt for dialysis; complication due to renal dialysis access device, implant or graft (such as embolism, hemorrhage, infection, occlusion, pain, stenosis or thrombosis)
- **Dialysis dependence:** Hemodialysis or peritoneal dialysis
- **Associated diagnoses/conditions:** "Diabetes with," "hypertension with" or "secondary hyperparathyroidism due to CKD" and state the stage of CKD
- **Transplant status:** Kidney transplant status (for those patients who still have some form of CKD, document the current stage of the CKD posttransplant)

Hypertension

When documenting hypertension, specify:

- **Type:** "Essential hypertension," "hypertension secondary to renal artery stenosis," "renovascular hypertension," "drug resistant," accelerated," etc.
- **Acuity of hypertension:** "Hypertensive urgency"
- **Systemic involvement:** "Hypertension with ventricular hypertrophy," "hypertension with diastolic dysfunction," "hypertension with heart failure" and state the type and severity of heart failure (systolic, diastolic, combination, acute, chronic, acute-on-chronic) or "hypertension with chronic kidney disease" and state the stage of CKD
- **Underlying cause:** For example: underlying renal conditions or hormonal disorders, sedentary lifestyle, excessive amounts of alcohol, stress, etc.
- **Tobacco Use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Heart failure[2,4]

When documenting heart failure, specify:

- **Underlying cause:** "Chronic diastolic failure due to hypertension," "heart failure due to hypertension with chronic kidney disease," "hypertension with chronic diastolic heart failure," coronary artery disease (CAD), diabetes, cardiomyopathy, endocarditis, heart valve disorders, cardiac arrhythmias, congenital defects, thyroid disorders, alcohol and illicit drug use, HIV, AIDS, chemotherapy
- **Comorbidities:** For example: renal insufficiency, diabetes, atrial fibrillation, chronic obstructive pulmonary disease, sleeping disorders, anemia, iron deficiency, etc.
- **Circumstance:** Postprocedural
- **Specific type(s), if known:** "Left ventricular failure," "systolic heart failure," "diastolic heart failure," "combined systolic and diastolic heart failure," "rheumatic heart failure," "right heart failure," "biventricular heart failure," "high output heart failure," "end stage heart failure," or "other heart failure."
- **Severity:** Acute, chronic, acute-on-chronic, cardiac arrest

If a provider documents, "congestive heart failure," it will be coded to heart failure, unspecified.

Arteriosclerosis (coronary artery disease [CAD] and peripheral arterial disease [PAD])

When documenting arteriosclerotic disease, specify:

- **Comorbidities:** Diabetes, alcoholism, dyslipidemia, hypertension, obesity, severe stress, etc.
- **Site (vessel):** Aorta, cerebral, carotid, coronary, extremities, mesenteric, pulmonary, renal, vertebral, etc.
- **Laterality:** Right, left, bilateral
- **Severity:**
  CAD: With or without angina
  ASPVD: Manifestations (intermittent claudication, rest pain, ulceration, gangrene); if ulceration, document the type, laterality, site and depth
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

CAD[4]

When documenting atherosclerotic heart disease with angina pectoris, include the following:

- **Cause:** Assumed to be atherosclerosis; document if there is another cause
- **Stability:** "Stable angina pectoris," "unstable angina pectoris"; if "angina equivalent," document the associated symptoms
- **Vessel:** Note which artery (if known) is involved and whether the artery is native or autologous (for example, mammary, radial, etc.), chronic total occlusion of coronary artery
- **Graft involvement:** If appropriate; and if a bypass graft was involved in the angina pectoris diagnosis, also note the original location of the graft and whether it is autologous or biologic
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

PAD

When documenting PAD, include the following:

- **Cause:** Diabetic, arteriosclerotic/atherosclerotic
- **Site of disease (vessel):** If native, name of vessel; if bypass graft, autologous, nonautologous biological, nonbiological
- **Manifestations:** Intermittent claudication, rest pain, ulceration – specify type, laterality, site, severity–gangrene
- **Laterality:** Right, left, bilateral
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Stroke and sequelae of stroke

When documenting stroke, specify:

- **Type:** Embolic, hemorrhagic, ischemic, occlusive, stenotic, thromobotic
- **Site (vessel):** Cerebral (middle cerebral artery, anterior cerebral artery, posterior cerebral artery, cerebellar artery, other artery), precerebral (vertebral artery, basilar artery, carotid artery, other artery)
- **Laterality:** Right, left, bilateral
- **Circumstance:** In evolution, intraoperative (whether during cardiac surgery or during other surgery), postprocedural (following cardiac surgery or following other surgery)
- **Residuals of prior stroke (specify deficit):** Cognitive deficit – specify exact type; speech and language deficit, monoplegia of upper or lower limb, hemiplegia and hemiparesis, other paralytic syndrome, other sequela (apraxia, dysphagia – specify type; facial weakness, ataxia, other – specify)
- **Score:** National Institutes of Health Stroke Scale score
- **Substance Use/Exposure:** Alcohol abuse or dependence; any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Chronic obstructive pulmonary disease (COPD)

When documenting COPD, specify:

- **Type:** For example, asthma with COPD – also document the asthma by severity, frequency and level of exacerbation; chronic asthmatic bronchitis, chronic obstructive bronchitis, chronic bronchitis with emphysema, and chronic obstructive tracheobronchitis
- **Severity:** Acute exacerbation, hypoxia, hypercapnia or chronic respiratory failure
- **Circumstance:** Sepsis, shock, respiratory failure, emphysema, obesity hypoventilation syndrome, severe obesity, amyotrophic lateral sclerosis (ALS), restrictive diseases such as interstitial fibrosis and thoracic deformities
- **Infection:** Any lower acute lower respiratory infection and the infectious agent, if known
- **Cause:** Identify any additional lung disease due to external agent and specify agent (for example, organic dust, chemical, gases, fumes, vapors, ventilation system, etc.)
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Arrhythmias[4]

When documenting arrhythmias, include the following:

- **Location:** Atrial, ventricular, supraventricular, etc.
- **Rhythm name:** Flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.
- **Acuity:** Acute, paroxysmal, chronic, etc.
- **Cause:** Hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCl, etc.
- **Other:** Document any other abnormality of heartbeat (tachycardia, bradycardia – document if adverse effect of a drug and specify drug; palpitations)

- continued on other side -

Major depressive disorder (MDD)

When documenting MDD, specify:

- **Episode type:** Single or recurrent
- **Severity:** Mild, moderate, severe
- **Symptoms:** Presence or absence of psychotic symptoms or features (An MDD diagnosis cannot be coded from the PHQ-9 score alone).
- **Remission status:** Full or partial

Obesity and body mass index (BMI)

When documenting obesity, specify:

- **Type:** Overweight, obese, morbidly (severely) obese, morbid obesity with alveolar hypoventilation (Pickwickian's), obesity hypoventilation syndrome
- **Cause:** Due to excess calories, drug-induced obesity – specify drug
- **Weight and the BMI:** BMI codes can be assigned from the dietician's or other caregiver's documentation, but the provider must document the obesity condition (for example, morbid obesity)
- **Associated comorbid conditions:** For example, hypertension, diabetes, COPD

Protein-calorie malnutrition (PCM)

When documenting PCM, specify:

- **Severity:** Mild (first degree), moderate (second degree), severe (third degree); avoid documenting a range of severity, such as "moderate to severe;" if documenting cachecxia, document underlying cause, if known
- **Associated conditions:** Alcohol abuse and/or dependence, alcoholic hepatitis, anemia, cancer, celiac disease, CHF, cirrhosis, cystic fibrosis, dementia, depression, ESRD, liver disease, obesity, pancreatitis

Rheumatoid arthritis (RA)

When documenting rheumatoid arthritis, specify:

- **Type:** Juvenile, seronegative, seropositive (presence of rheumatoid factor), other
- **Joint(s) affected by RA:** Specific joint or multiple sites
- **Laterality:** Right, left, bilateral
- **Systemic involvement:** Rheumatoid: carditis, lung involvement, myopathy, polyneuropathy, splenoadenomegaly and leukopenia, vasculitis, visceral involvement

The following references were used to create this document:
Optum360 ICD-10-CM: Professional for Physicians 2021. Salt Lake City, UT: 2020.

1. *DHHS. ICD-10-CM Official Guidelines for Coding and Reporting FY 2021.* Centers for Disease Control and Prevention. cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf. Published October 1, 2020. Accessed November 17, 2020.
2. CMS. ICD-10: Clinical Concepts for Family Practice. Centers for Medicare & Medicaid Services. cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ListservClinicalConcepts.pdf. Accessed November 17, 2020.
3. CMS. ICD-10: Clinical Concepts for Internal Medicine. Centers for Medicare & Medicaid Services. cms.gov/medicare/coding/icd10/downloads/icd10clinicalconceptsinternalmedicine1.pdf. Accessed November 17, 2020.
4. CMS. ICD-10: Clinical Concepts for Cardiology. Centers for Medicare & Medicaid Services. cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf. Accessed November 17, 2020.
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Documentation and coding tips: Arrhythmia and sick sinus syndrome

Medicare Advantage

ICD-10-CM	Description	HCC
I47.-	Paroxysmal tachycardia • Add a 4th character: 0=reentry ventricular arrhythmia, 1=supraventricular tachycardia, 2= ventricular tachycardia, 9=paroxysmal tachycardia, unspecified	96
I48.-	Atrial fibrillation and flutter • Add a 4th and/or 5th character(s): 0=paroxysmal atrial fibrillation, 11=long-standing persistent atrial fibrillation, 19=other persistent atrial fibrillation, 20=chronic atrial fibrillation, unspecified, 21=permanent atrial fibrillation, 3=typical (type 1) atrial flutter, 4=atypical (type 2) atrial flutter, 91=unspecified atrial fibrillation, 92=unspecified atrial flutter	96
I49.01	Ventricular fibrillation	84
I49.02	Ventricular flutter	84
I49.9	Cardia arrhythmias, unspecified	Not an HCC
R00.7	Bradycardia, unspecified	Not an HCC

Consider documenting secondary hypercoagulable state (**D68.69**) in patients with atrial fibrillation, on anticoagulants. Document and link the underlying condition, in this case atrial fibrillation, as the cause of the hypercoagulable state.

ICD-10-CM	Description	HCC
I49.5	**Sick sinus syndrome (SSS)** • Sinoatrial node dysfunction • Autosomal dominant or recessive SSS • Brady-tachy syndrome • Coronary sinus rhythm disorder • Chronotropic incompetence with sinus node dysfunction	96
Z95.0	Presence of cardiac pacemaker	Not an HCC
Z95.810	Presence of automatic (implantable) cardiac defibrillator	Not an HCC
Z86.79	Personal history of other diseases of the circulatory system (history of sick sinus syndrome)	Not an HCC

- A code is assigned for the sick sinus syndrome (SSS) when it is documented as being controlled by a pacemaker.
- If a pacemaker, automatic cardioverter/defibrillator (AICD), cardiac resynchronization pacemaker (CRT-P), or bi-ventricular defibrillator (CRT-D) is present, document what the underlying rhythm was that necessitated placement of the cardiac device.
- Dysrhythmias treated with an implantable cardioverter defibrillator (AICD) can be documented and coded separately.[1]

Documentation and coding examples

Secondary hypercoagulable state due to AFib, will continue to monitor. Her INR is therapeutic on the current dose of warfarin. AFib stable, continue beta blocker

- **I48.91** Unspecified atrial fibrillation
- **D68.69** Other thrombophilia (secondary hypercoagulable state)
- Z79.01 Long-term (current) use of anticoagulants

Sick sinus syndrome stable with dual chamber permanent pacemaker.

- **I49.5** Sick sinus syndrome
- Z95.0 Presence of cardiac pacemaker

Consider reviewing Optum tools related to coexisting conditions such as hypertension, COPD and stroke, if applicable.

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2021: cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.

Optum360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City: 2021.
1. AHA Coding Clinic, Vol. 33, 2019; Q1

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Documenting and Coding Tips: Hypertension

Medicare Advantage

The ICD-10-CM classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertension and conditions not specifically linked by relational terms such as "with" or "due to" in the classification, provider documentation must link the conditions in order to code them as related.[1]

When documenting hypertension, specify (if applicable):

Type: "Essential hypertension," "hypertension secondary to renal artery stenosis," "renovascular hypertension," "drug resistant," accelerated," etc.
Acuity of hypertension: "Hypertensive urgency"
Systemic involvement: "Hypertension with diastolic dysfunction," "hypertension with heart failure" and state the type and severity of heart failure (systolic, diastolic, combination, acute, chronic, acute-on-chronic) or "hypertension with chronic kidney disease" and state the stage of CKD
Underlying cause: For example: underlying renal conditions or hormonal disorders, sedentary lifestyle, excessive amounts of alcohol, stress, etc.
Tobacco Use/Exposure: Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Heart failure	
I50.1	Left ventricular failure,unspecified (*HCC 85*)
I50.2-	Systolic (congestive) heart failure *(HCC 85)*
I50.3-	Diastolic (congestive) heart failure *(HCC 85)*
I50.4-	Combined systolic (congestive) and diastolic (congestive) heart failure *(HCC 85)*
I50.81-	Right heart failure *(HCC 85)*
I50.82	Biventricular heart failure *(HCC 85)*
I50.83	High output heart failure *(HCC 85)*
I50.84	Other heart failure *(HCC 85)*
I50.9	Heart failure, unspecified (congestive heart disease, congestive heart failure NOS [CHF]) *(HCC 85)*

Essential (primary) hypertension	
I10	Essential (primary) hypertension *(Not an HCC)*
I10 includes high blood pressure in addition to benign, arterial, malignant and systemic hypertension.	
Hypertensive heart disease	
I11.0	Hypertensive heart disease with heart failure (HCC 85)
I11.9	Hypertensive heart disease without heart failure (Not an HCC)
Hypertensive chronic kidney disease	
I12.0	Hypertensive CKD with stage 5 CKD or end stage renal disease (*HCC 136*)
I12.9	Hypertensive CKD with stage 1 through stage 4 CKD, or unspecified CKD (*Not an HCC*)
Hypertensive heart and chronic kidney disease	
I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified CKD *(HCC 85)*
I13.10	Hypertensive heart and CKD without heart failure, with stage 1 through stage 4 CKD, or unspecified CKD (*Not an HCC*)
I13.11	Hypertensive heart and CKD without heart failure, with stage 5 CKD, or end stage renal disease (*HCC 136*)
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 CKD, or end stage renal disease (*HCC 85 and 136*)
Chronic kidney disease	
N18.1	Chronic kidney disease, stage 1 (*Not an HCC*)
N18.2	Chronic kidney disease, stage 2 (mild) (*Not an HCC*)
N18.30 +	Chronic kidney disease, stage 3 unspecified (*HCC 138*)
N18.31 +	Chronic kidney disease, stage 3a (*HCC 138*)
N18.32 +	Chronic kidney disease, stage 3b (*HCC 138*)
N18.4	Chronic kidney disease, stage 4 (severe) (*HCC 137*)
N18.5	Chronic kidney disease, stage 5 (*HCC 136*)
N18.6	End stage renal disease (*HCC 136*)

Per the ICD-10-CM Official Guidelines for Coding and Reporting FY 2021: "A dash (-) at the end of an alphabetic index entry indicates that additional characters are required. Even if a dash is not included at the alphabetic index entry, it is necessary to refer to the tabular list to verify that no 7th character is required." The bolding of the ICD-10-CM codes represents categories, subcategories or codes that map to the CMS-HCC risk adjustment model for payment year 2021: cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.

Codes marked with a + directly after them represent new additions to the FY 2021 ICD-10-CM code classification.

1. Optum360 ICD-10-CM: Professional for Physicians 2021. Salt Lake City: 2020.

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Evaluation and Management (E/M)

This piece is intended for use as a teaching aid only. For a complete Evaluation and Management audit tool, please refer to the CPT® Evaluation and Management (E/M) code and guideline changes, effective January 1, 2021, at ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf.[1]

History and/or Exam: Office or other outpatient services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination is determined by the provider reporting the service; however, this is not a required element in selection of E/M services.

Medical Decision Making: Choose the highest level of service supported. The medical decision making risk is the same for **New** and **Established** patients.

E/M TOOL REFERENCE GUIDE

MEDICAL DECISION MAKING (MDM)

Level of MDM (two out of three elements must be met or exceeded)

ELEMENTS OF MDM	❑ STRAIGHT-FORWARD	❑ LOW	❑ MODERATE	❑ HIGH
Number and Complexity of Problems Addressed	❑ **Straight-forward or Minimal** ❑ 1 self-limited or minor problem	❑ **Low** ❑ 2 or more self-limited or minor problems; (or) ❑ 1 stable chronic illness; (or) ❑ 1 acute, uncomplicated illness or injury.	❑ **Moderate** ❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or) ❑ 2 or more stable chronic illnesses; (or) ❑ 1 undiagnosed new problem with uncertain prognosis; (or) ❑ 1 acute illness with systemic symptoms; (or) ❑ 1 acute complicated injury.	❑ **High** ❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or) ❑ 1 acute or chronic illness or injury that poses a threat.
Amount and/or Complexity of Data to be Reviewed and Analyzed * Each unique text, order or document contributes to the combination of 2 or a combination of 3 in **Category 1** (as listed under the Limited, Moderate and Extensive selections)	❑ **Minimal or None** **For Minimal, only 1 of the following:** ❑ Review of prior external note(s) from each unique source. ❑ Review result(s) of each unique test (panel is a single test). ❑ Ordering of each unique test (panel is a single test).	❑ **Limited** Must meet the requirements of **at least 1 out of 2** categories **Category 1: Tests and documents** *Any combination of 2 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * (or) **Category 2**: ❑ Assessment requiring an independent historian(s). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	❑ **Moderate** Must meet the requirements of **at least 1 out of 3** categories **Category 1: Tests, documents or independent hisorian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or appropriate source (not separately reported).	❑ **Extensive** Must meet the requirements of **at least 2 out of 3** categories **Category 1: Tests, documents or independent hisorian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or ppropriate source (not separately reported).
Risk of Complications and/or Morbidity or Mortality of Patient Management (From additional diagnostic testing or treatment)	❑ **Minimal risk of morbidity** **Examples only** ❑ Elastic bandages ❑ Superficial dressings	❑ **Low risk of morbidity** **Examples only** ❑ OTC drugs ❑ Minor surgery w/o identified risk factors ❑ PT, OT therapy, IV fluids w/o additives ❑ IV fluids w/o additives	❑ **Moderate risk of morbidity** **Examples only** ❑ Prescription drug management ❑ Decision regarding minor surgery with identified patient or procedure risk factors ❑ Decision regarding elective major surgery without identified patient or procedure risk factors ❑ Diagnosis or treatment significantly limited by social determinants of health	❑ **High risk of morbidity** **Examples only** ❑ Drug therapy requiring intensive monitoring for toxicity ❑ Decision regarding elective major surgery with identified patient or procedure risk factors ❑ Decision regarding emergency major surgery ❑ Decision regarding hospitalization ❑ Decision not to resuscitate or to de-escalate care because of poor prognosis

- continued on next page -

Use the following tables to select appropriate CPT codes based on the results obtained from the Medical Decision Making table.
Medical Decision Making: Appropriately document the services provided then select the service code that best matches that documentation. The medical decision making risk is the same for **New** and **Established** patients.

E/M OFFICE OR OTHER OUTPATIENT VISIT CODES

CPT	History and/or Exam	MDM	Time *(in minutes)*
NEW PATIENT			
99201	Deleted		Less than 15
99202	As medically appropriate	Straightforward	15-29
99203	As medically appropriate	Low level	30-44
99204	As medically appropriate	Moderate level	45-59
99205	As medically appropriate	High level	60-74
***99417**	Prolonged services - for services 75 minutes or longer (in 15 minute increments)		75+
ESTABLISHED PATIENT			
99211	Minimal problems		Less than 10
99212	As medically appropriate	Straightforward	10-19
99213	As medically appropriate	Low level	20-29
99214	As medically appropriate	Moderate level	30-39
99215	As medically appropriate	High level	40-54
***99417**	Prolonged services - for services 55 minutes or longer (in 15 minute increments)		55+

*CPT ® code 99417 (G2212 for Medicare Billing) – Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure, which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service. Code 99417 may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. A prolonged service unit of less than 15 minutes should not be reported.

Prolonged services - new patient

Total duration of new patient office or other outpatient services (use with 99205)	Code(s)
Less than 75 minutes	Not reported
75-89 minutes	99205 x 1 and 99417 (Medicare G2212) x 1
90-104 minutes	99205 x 1 and 99417 (Medicare G2212) x 2
105 or more minutes	99205 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Prolonged services - established patient

Total duration of established patient office or other outpatient services (use with 99215)	Code(s)
Less than 55 minutes	Not reported
55-69 minutes	99215 x 1 and 99417 (Medicare G2212) x 1
70-84 minutes	99215 x 1 and 99417 (Medicare G2212) x 2
85 or more minutes	99215 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Time is determined based on total time spent on the day of the encounter, which can include cumulative time from mulitple providers under the same tax ID number.

Activities that a provider can count toward total time include:

- Prepare for the patient visit (for example, review test results).
- Obtain and/or review separately-obtained patient history.
- Perform a medically necessary examination and/or evaluation.
- Counsel and educate the patient, a family member or a caregiver.
- Orders for tests, medicine or additional services
- Refer or communicate with other health care professionals.
- Enter clinical information in the patient's medical record *(not counted if entered another day)*.
- Interpret and share test results with the patient, a family member or a caregiver.
- Coordinate patient care (not reported separately).

The following references were used to create this document:
Current Procedural Terminology CPT 2021. Professional ed. Chicago, IL: American Medical Association, 2020. Print. CPT is a registered trademark of the American Medical Association.
1. Ama-assn.org. 2020. CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed October 19, 2020.

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Social Determinants of Health (SDOH)

Social determinants of health such as housing, food security, and transportation can have an immense impact on the physical and mental health of patients. Capturing SDOH data can help to improve patient outcomes which may assist patients with barriers related to housing and transportation, social support, health literacy, nutritional support and financial assistance.

By addressing these determinants, providers can identify patients who may need assistance with additional resources potentially available through their health plan and/or local community. It is vital that these determinants are accurately documented and coded, when applicable, to assist in identifying patients who may qualify for needed resources.

Please note that these codes are for supplemental reporting purposes and should not be used as primary diagnosis codes. Additionally, the list of determinants and their diagnosis codes below is not all-inclusive, please consult the ICD-10-CM code book for additional applicable codes.

Problems related to housing and economic circumstances	
Example Question: Describe your current living and financial situation. Do you have transportation to attend appointments and other necessary activities?	
Document and code if applicable:	
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating, restriction of space, technical defects in home preventing adequate care, unsatisfactory surroundings)
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution (boarding-school resident)
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (isolated dwelling, foreclosure on loan, problems with creditors)
Z59.9	Problems related to housing and economic circumstances, unspecified
Z75.3	Unavailability and inaccessibility of health care facilities

Problems related to education and literacy	
Example Question: Do you experience language barriers?	
Document and code if applicable:	
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Problems Related to Employment and Unemployment	
Example Question: Do you need/want help finding or keeping work or a job?	
Document and code if applicable:	
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment (difficult conditions at work)
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Problems Related to Social Environment & Lifestyle	
Example Question: Do you have family and/or community support with day-to day activities such as preparing meals, shopping, bathing, managing finances, etc.? Do you feel lonely or isolated? In the last month how many times have you consumed alcoholic drinks or used tobacco products? How often have you felt down, depressed, or hopeless? Are you able to exercise regularly?	
Document and code if applicable:	
Z60.0	Problems of adjustment to life-cycle transitions (empty nest syndrome, phase of life problem, problem with adjustment to retirement)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problems related to social environment, unspecified
Z72.0	Tobacco use
Z72.3	Lack of Physical Exercise
Z72.4	Inappropriate diet and eating habits
Z72.6	Gambling and betting
Z72.811	Adult antisocial behavior
Z72.820	Sleep Deprivation
Z72.821	Inadequate sleep hygiene
Z72.89	Other problems related to lifestyle (self-damaging behavior)

Other Problems related to Primary support group, including family circumstances	
Example Question: Do you feel safe at home? Do you feel regularly under stress at home?	
Document and code if applicable:	
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member (bereavement)
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support Group
Z63.9	Problems related to primary support group (relationship disorder)
Z65.9	Problem related to unspecified psychosocial circumstances

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The following references were used in creating this document:
Optum 360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City, UT: 2019.
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Palliative Care Quick Reference Sheet

Difference between Palliative Care & Hospice

Palliative Care	Hospice Benefits
End of life 1-2 and/or chronic/ complex disease	End of life 6 months
Symptom relief concurrent with curative	Symptoms relief. NO curative (for terminal illness)
PCP, Specialist, & Palliative Consultant	Hospice team including physician
Integrated team approach: MD/ NP/ RN/ SW	Integrated team pus aides, Chaplin, and respite benefit
Focus: Transition from Curative only to symptoms management & goals of care	Focus: Symptom relieve by the hospice team with NO curative treatment of the terminal illness
Advance Directive POLST discussion	Advance directive POLST

How does palliative care help referring providers

- Provides additional "eyes and ears" on the patient
- Trained staff assist patients in articulating goals and preferences
- Trained staff assist patients in completing advance directives and similar documents
- Trained staff screen for, assess, and help manage difficult symptoms
- Trained staff with time to provide spiritual and emotional support to patients and families
- Saves you time while improving patient satisfaction with care

Program Eligibility

What is palliative care in Medi-Cal? ("SB 1004")

California's Senate Bill 1004 (2014) requires Medi-Cal managed care plans to ensure access to palliative care services for eligible members Implemented January 1, 2018 for adults, expanded to pediatrics in 2019

General Palliative Care Eligibility

- Increased use of hospitals or emergency departments for disease and symptom management
- Advanced or late stage of illness and not enrolled in hospice
- Death within one year is not unexpected
- Maybe receiving curative treatment and/or treatment is no longer effective
- Member will try in home or outpatient management prior to using the ED
- Member will participate in advance care planning

Palliative Care Referral Forms

In partnership with the Coalition for Compassionate Care of California (CCCC), a universal referral form was created with four major health plans in LA County.

Blue Shield Promise, La Care Health Plan, Molina, Health Net

PALLIATIVE CARE REFERRAL & SCREENING TOOL

Created by the Coalition for Compassionate Care of California in collaboration with health plan partners:

blue california Promise Health Plan | L.A. Care HEALTH PLAN | MOLINA HEALTHCARE | Health Net

Referral Date _____

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First

Phone #: _____ Address: _____ City: _____ Zip: _____

ID/CIN Number: _____ Male ___ Female ___ Date of Birth: _____ Age: _____

Language / Ethnicity: _____ Name of PCP: _____

Health Plan: _____ LOB: ☐Medicare ☐Medi-Cal ☐Commercial ☐PPO

Location: ☐Hospital _____ ☐SNF _____ ☐Home ☐Other: _____

REFERRING/ATTENDING PROVIDER:

Provider Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Office Contact: _____

____ Patient meets basic eligibility/screening guidelines or **other** health plan specific diagnostic criteria for a full Palliative Care Service Evaluation (**see reverse side**).

____ Current referral prompted by:

- ☐ Patient is using the hospital and ER to manage symptoms
- ☐ Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting)
- ☐ Inadequate home, social, family support

____ Pertinent history, medical records, test results, x-rays, etc. attached.

Was member or authorized representative informed of this referral? ☐Yes ☐No

Physician Name/Signature: _____ Date: _____

REFERRING PATIENT FOR PALLIATIVE CARE SERVICE EVALUATION:

Please mark faxes CONFIDENTIAL. Please send from secure email.

☐ **Blue Shield Promise - fax # 323-889-2109** email: **BSCPHP_PalliativeCare@blueshieldca.com**

☐ **Health Net/CHW - fax # 844-907-0436** email: **CareConnections@HealthNet.com**

☐ **LA Care - fax # 213-438-4866** email: **MLTSS@LACare.org**

☐ **Molina - fax # 562-499-6105** email: **MHC_CM_My_Care@MolinaHealthCare.com**

PLEASE TURN THE PAGE FOR ELIGIBILITY/SCREENING GUIDELINES

PALLIATIVE CARE SCREENING CRITERIA

Disclaimer: *The criteria noted below are the Medi-Cal minimal criteria. Medi-Cal members may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. Exceptions to these criteria are optional based on specific health plan policy and line of business (Medi-Cal, Medicare, PPO, HMO, etc.). Health Plan will review referrals for most appropriate care or program.*

Section 1: Adults

A. General Eligibility Criteria (*Must meet ALL*)

- ☐ **Using/expected to use the hospital and/or ED to manage their illness**
- ☐ **Advanced illness with decline**
- ☐ **Death within one year is not unexpected**
- ☐ **Medical therapy has been appropriate as desired by the patient**
- ☐ **Member will try in home or outpatient management prior to using the ED**
- ☐ **Member will participate in advance care planning**

B. Disease Specific Criteria (*Must meet ONE*)

- ☐ **CHF**
  - ✓ *NYHA class III or IV or hospitalized for CHF with no further invasive interventions planned, and*
  - ✓ *Ejection fraction < 30% or significant co-morbidities*
- ☐ **COPD**
  - ✓ *FEV1 < 35 % predicted or*
  - ✓ *Oxygen requirement ≥ 3 L / min*
- ☐ **Advanced cancer**
  - ✓ *Stage III or IV solid organ cancer, lymphoma, or leukemia and*
  - ✓ *Karnofsky Performance Scale ≤ 70% or has failed two lines of standard therapy.*
- ☐ **End stage liver disease**
  - ✓ *Irreversible liver damage, Albumin < 3.0 and INR 1.3 and*
  - ✓ *Ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, or*
  - ✓ *Evidence of irreversible liver damage and MELD score of > 19*
- ☐ **Other:** _____

Section 2: Pediatrics

A. General Eligibility Criteria (*Must meet ALL*)

- ☐ **The member is under age 21**
- ☐ **The family and/or legal guardian agrees to the provision of pediatric palliative care services**
- ☐ **Member has a life-threatening illness**

B. Disease Specific Criteria (*Must meet ONE*)

- ☐ **Conditions for which curative treatment is possible, but may fail,** *e.g. Advanced or progressive cancer or complex and severe congenital or acquired heart disease.*
- ☐ **Conditions requiring intensive long-term treatment aimed at maintaining quality of life,** *e.g. Human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy.*
- ☐ **Progressive conditions for which treatment is exclusively palliative after diagnosis,** *e.g. Progressive metabolic disorders or severe forms of osteogenesis imperfecta.*
- ☐ **Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications,** *e.g. Extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms.*
- ☐ **Other:** _____

SUBMIT PERTINENT HISTORY, MEDICAL RECORDS, TEST RESULTS