# Capturing Every Dollar: Optimizing Coding and Billing for Diabetes Care in the RHC

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# Instructor


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# Agenda

RESOURCES AND REFERENCES

DOCUMENTATION AND CODING FOUNDATIONS

QUALITY METRICS

# Before We Get Started… Disclaimers

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# References and Resources

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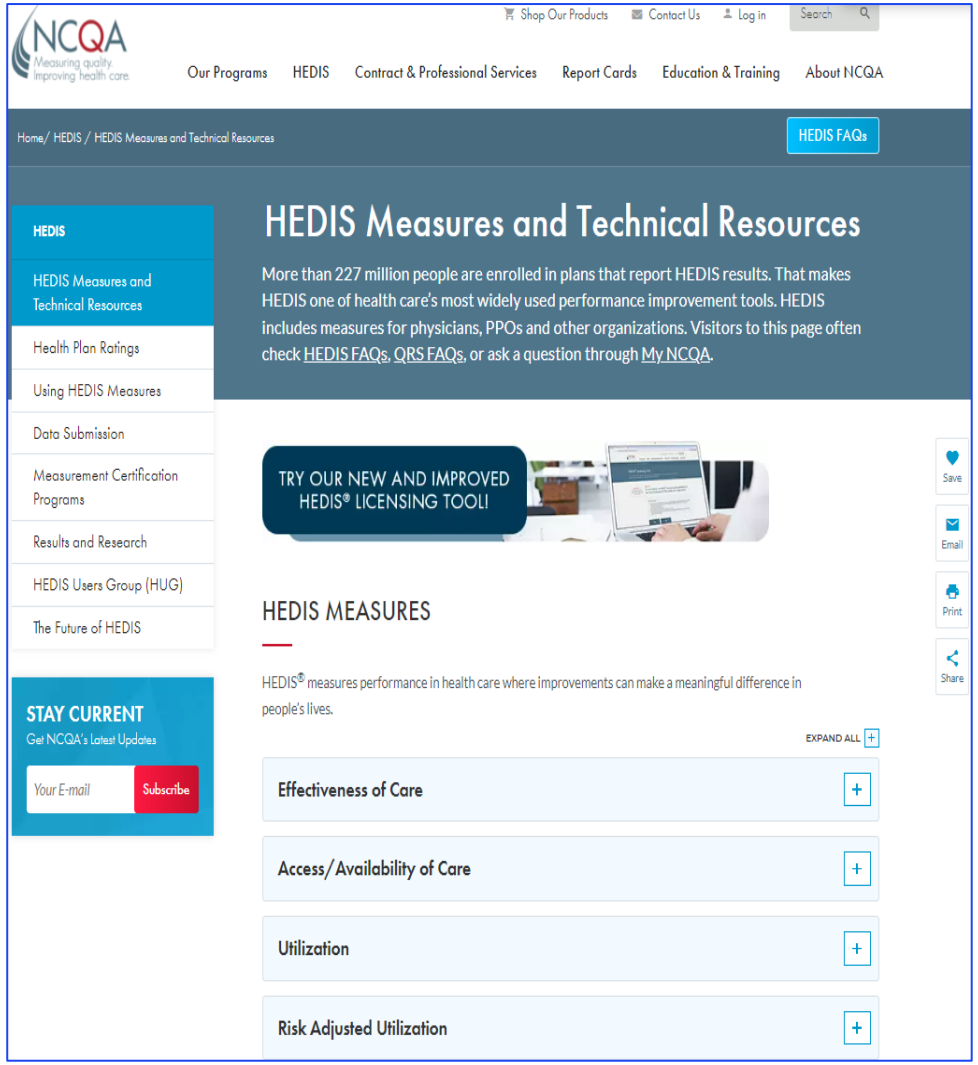
# Reference Source (National Committee for Quality Assurance - NCQA)




NCQA
Measuring quality.
Improving health care.

**Be prepared for potential slight variations between the "pure" HEDIS definition and the requirements of the Ohio CPC (and similar programs) depending on which measurement year (MY) is being referenced.**

# NCQA HEDIS Diabetes Measures

- Blood Pressure Control for Patients With Diabetes (BPD)
- Eye Exam for Patients With Diabetes (EED)
- Glycemic Status Assessment for Patients With Diabetes (GSD)
- Kidney Health Evaluation for Patients With Diabetes (KED)
- Statin Therapy for Patients with Diabetes (SPD)

# Meridian Medicaid Diabetes Related Measures

**Reference Source: Meridian Medicaid Provider Manual- Michigan 1/2025**

| Comprehensive Diabetes | | |
|---|---|---|
| **Service** | **Procedure** | **Performance Criteria*** |
| **Comprehensive Diabetes Care** | Eye Exam | Members 18 – 75 years of age with diabetes (type 1 and type 2) that had a retinal eye exam performed during the measurement year. |
| | Kidney Health Evaluation | Members 18- 85 years of age with diabetes (type 1 and type 2) that had a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR) performed during the measurement year. |
| | HbA1c Good Control (<8.0%)** | Members 18 – 75 years of age with diabetes (type 1 and type 2) that had a controlled HbA1c level (<8.0%) as of the latest reading of the measurement year. |

# Meridian Medicaid Diabetes Related Measures

**Pay for Performance:**

**Reference Source: Meridian Medicaid Provider Manual- Michigan 1/2025**

Medicaid Incentive Amounts

| HEDIS® Measure | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|
| Asthma Medication Ratio | $35 | $70 | $90 |
| Breast Cancer Screening | $20 | $40 | $50 |
| Controlling High Blood Pressure | $35 | $70 | $90 |
| Cervical Cancer Screening | $10 | $15 | $30 |
| Eye Exam for Patients with Diabetes | $35 | $70 | $90 |
| Hemoglobin A1c Control for Patients with Diabetes | $35 | $70 | $90 |
| Chlamydia Screening in Women (Total) | $20 | $40 | $50 |
| Childhood Immunizations - Combo 10 | $35 | $70 | $90 |
| Immunizations for Adolescents - Combo 2 | $35 | $70 | $90 |
| Lead Screening in Children | $20 | $40 | $50 |
| Prenatal and Postpartum Care - Postpartum Care | $35 | $70 | $90 |
| Prenatal and Postpartum Care - Timeliness of Prenatal Care | $35 | $70 | $90 |
| Well-Child Visits in the First 30 Months of Life - 6+ visits in the first 15 months of life | $35 | $70 | $90 |
| Well-Child Visits in the First 30 Months of Life - 2 visits from 15-30 months of life | $35 | $70 | $90 |
| Child and Adolescent Well-Care Visits | $10 | $15 | $30 |
| Kidney Health Evaluation for Patients with Diabetes | $20 | $40 | $50 |

# Meridian Medicaid Diabetes Related Measures

**Pay for Performance:**
**Reference Source: Meridian Medicaid Provider Manual- Michigan 1/2025**

Medicaid Target Compliance Percentage

| HEDIS® Measure | 50th Percentile | 75th Percentile | 90th Percentile |
|---|---|---|---|
| Asthma Medication Ratio | 65.61% | 70.82% | 75.92% |
| Breast Cancer Screening | 52.20% | 58.35% | 63.37% |
| Controlling High Blood Pressure | 61.31% | 67.27% | 72.22% |
| Cervical Cancer Screening | 57.11% | 61.80% | 66.48% |
| Eye Exam for Patients with Diabetes | 52.31% | 59.37% | 63.33% |
| Hemoglobin A1c Control for Patients with Diabetes | 52.31% | 57.18% | 60.34% |
| Chlamydia Screening in Women (Total) | 56.04% | 62.90% | 67.39% |
| Childhood Immunizations - Combo 10 | 30.90% | 37.64% | 45.26% |
| Immunizations for Adolescents - Combo 2 | 34.31% | 40.88% | 48.80% |
| Lead Screening in Children | 62.79% | 70.07% | 79.26% |
| Prenatal and Postpartum Care - Postpartum Care | 79.63% | 84.23% | 88.33% |
| Prenatal and Postpartum Care - Timeliness of Prenatal Care | 78.10% | 82.00% | 84.59% |
| Well-Child Visits in the First 30 Months of Life - 6+ visits in the first 15 months of life | 58.38% | 63.34% | 68.09% |
| Well-Child Visits in the First 30 Months of Life - 2 visits from 15-30 months of life | 66.76% | 71.35% | 77.78% |
| Child and Adolescent Well-Care Visits | 48.07% | 55.08% | 61.15% |
| Kidney Health Evaluation for Patients with Diabetes | 31.89% | 40.60% | 46.76% |

# Molina Medicaid Diabetes Related Measures

**Reference Source**

**Molina Healthcare of Michigan, 2025 Medicaid Provider Manual**

## Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, preventive health screenings, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare to established health plan performance benchmarks.

# Molina Medicaid Diabetes Related Measures

**Reference Source**
**Molina Healthcare of Michigan, 2025 Medicaid Provider Manual**

## What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed
- Check that staff are properly coding all services provided
- Be sure patients understand what *they* need to do

Molina has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® survey Star Ratings measures, contact your local Molina Quality department.

# Documentation and Coding Foundations

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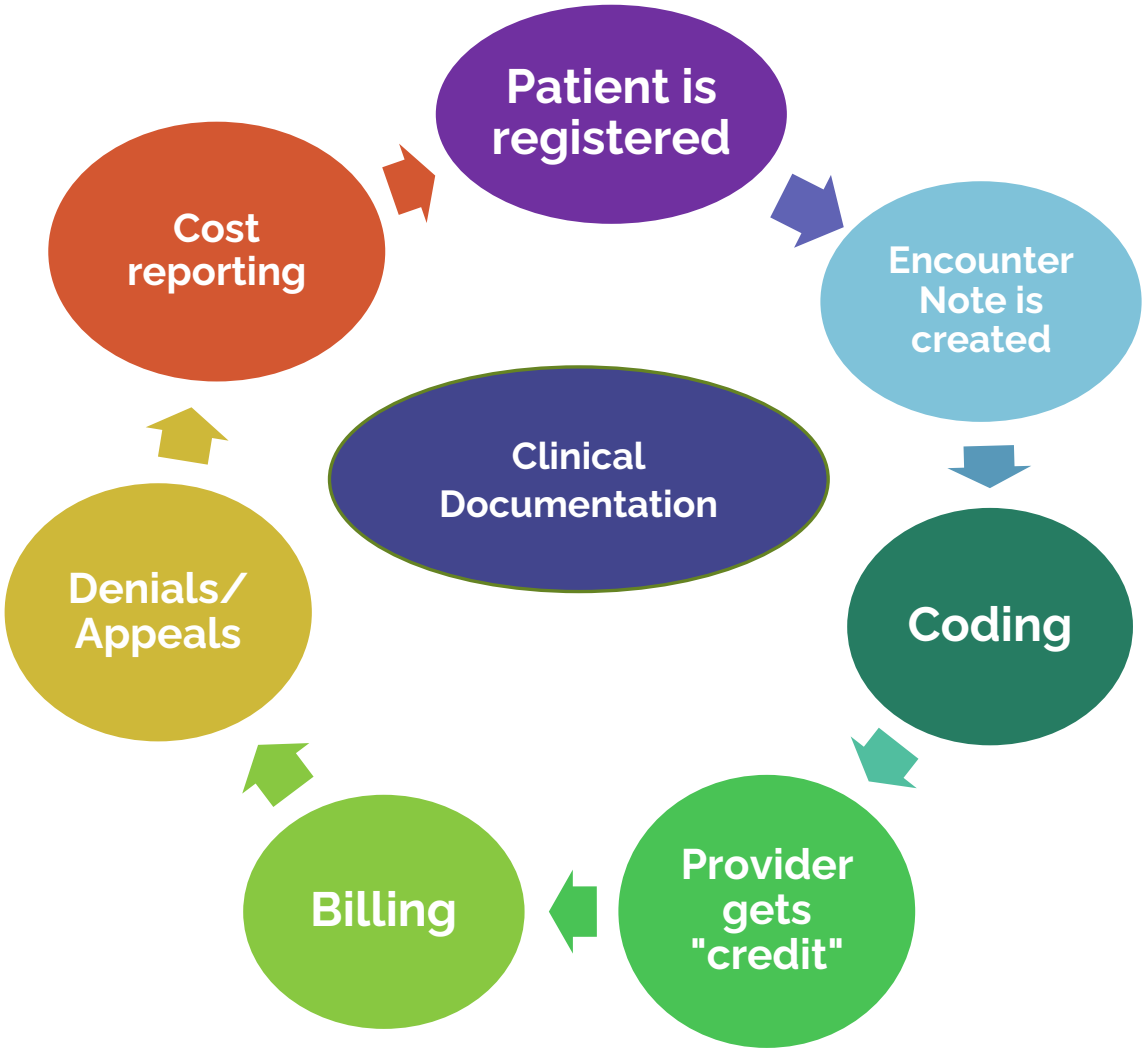
# Impact of Clinical Documentation



# The Medical Record

- According to CMS, §482.24(c)(1) *All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.*
- CMS states "*providers should submit adequate documentation to ensure that claims are supported as billed*" and that each note must "stand alone" to support services claimed.
- When "Incident-To" billing is employed, know the rules (*ex. established patients with established problems and compare scope of services*). NGS Incident To Services
- The medical record is the proof you may need to support payment and prevent claims of fraud/abuse.
- The medical record also serves as a legal document beyond billing to include malpractice/liability scenarios.
- The medical record provides continuity of care for the patient.

# CMS Signature Requirements

CMS suggests that a “timely” record entry is one that occurs within 24-48 hours. Occasionally, up to 72 hours is acceptable. Many payers require this as a CoP.  Check your individual payer agreements.

Medicare Documentation Signature Timeliness Palmetto

Medical Record Entries: What Is Timely and Reasonable?

| | |
|---|---|
| What should I do if I have not signed an order or medical record? | You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner’s signature is missing from the medical record, submit an attestation statement from the author of the medical record. Your contractor may offer specific guidance regarding addenda to medical records. |

Complying with Medicare Signature Requirements

## CPT Category I Codes

Introduction

Evaluation and Management (99xxx, 98xxx)

Anesthesia (0xxxx)

Surgery (1xxxx – 6xxxx)

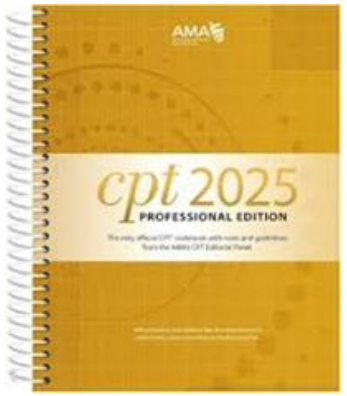
Radiology (7xxxx)

Pathology and Laboratory (8xxxx)

Medicine (9xxxx) – see assorted eye exam codes such as 92227-92229

Appendix A-O – *check out A for modifiers and B for changes*

Alphabetic Index – *never code from the index!*




## CPT Category II Codes

Modifiers – 1P, 2P, 3P, 8P

Composite Measures 0001F – 0015F

Patient Management 0500F – 0575F

Patient History 1000F – 1220F

Physical Examination 2000F – 2050F

Diagnostic/Screening Processes/ Results 3006F – 3573F

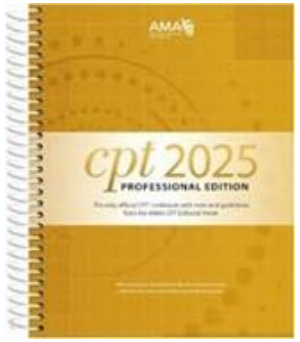
Therapeutic, Preventive, or Other Interventions 4000F – 4306F

Follow-Up or Other Outcomes 5005F – 5100F

Patient Safety 6005F – 6045F

Structural Measures 7010F – 7025F

# Main research items for CPT-II codes used for “Performance Measurement” reporting




**“Supplemental Tracking Codes”**

**“Facilitate data collection”**
Codes that have an evidence base from 12 external organizations.

**“Use of these codes is optional”**
Most payers follow HEDIS (NCQA) Measures

**Codes xxxxF**
*“These codes are not required for correct coding and are not a substitute for CPT-I codes.”*

**Superscripted numbers in each code**
Which professional organization creates and maintains the codes.

**No guidance on how to report is in the CPT**
Expect variation in how/when to report and on which claim form and for what “fee.”

**Know your contractual agreements**
Follow the guidance as it gets updated over time!

# CPT Category II codes are dependent on the patients underlying condition(s)


- **Blood Pressure Measured 2000F, 3074F-3080F (BPD)** = Assorted most recent blood pressure ranges for patients (DM) (also other conditions)
- **Physical Examination 2022F-2033F (EED)** = Assorted retinal eye exams with or without evidence of retinopathy (DM)
- **Diagnostic/Screening Processes or Results 3044F-3052F (GSD)** = Assorted codes for the most recent A1c (HbA1c) level lower than 7% or up to>9%. (DM)
- **Kidney Health Evaluation for Patients With Diabetes : 3060F – 3062F (KED)** = Assorted codes for who received
  - a kidney health evaluation, defined by an estimated glomerular filtration rate
  - (eGFR) and a urine albumin-creatinine ratio (uACR).
- **Statin Therapy for Patients with DM (G9664-G9665, G9781 (SPD)** =Assorted codes for patients with DM without ASCVD who received statin therapy and their adherence to the medication

# Review CPT Category II exclusion modifiers to identify reasons why the measurement was not performed


## AAPC Appendix D
## CPT® Category II Modifiers

| Modifier | Modifier Description, Definition, Explanation, and Tips |
|---|---|
| 1P | **Performance Measure Exclusion Modifier due to Medical Reasons**<br>**Definition:** Append modifier 1P to a quality reporting code to indicate the patient's medical status prevents the provider from performing the action specified by a quality measure.<br>**Explanation:** You should append modifier 1P to a quality reporting code when medical reasons keep the provider from completing the action a quality measure requires.<br>For instance, if the measure tracks performance of a test on a limb, but the patient no longer has that limb because of amputation, you should append 1P to the appropriate quality code to indicate medical reasons stopped the provider from performing the action. Similarly, you should append 1P if the measure tracks prescription of a drug that the provider doesn't prescribe because the patient is allergic to it.<br>You should not use modifier 1P unless listed as a reportable option for the specific quality code you're reporting.<br>**Tips:** This modifier is called an exclusion modifier because it excludes the patient from a quality measure's denominator, which is the eligible patient population.<br>Various exclusion modifiers are available for quality reporting:<br>1P, Performance Measure Exclusion Modifier due to Medical Reasons<br>2P, Performance Measure Exclusion Modifier due to Patient Reasons<br>3P, Performance Measure Exclusion Modifier due to System Reasons<br>For 1P, medical reasons may include a contraindication based on the patient's specific medical history. For 2P, an example of a patient reason is that the patient refuses a service because he does not want to pay for it. An example of the system reasons under 3P is that the entity does not have the equipment needed for the service.<br>Append modifier 8P, Performance Measure Reporting Modifier, Action Not Performed, Reason Not Otherwise Specified, when a provider does not perform the action for an eligible patient and does not document the reason why.<br>You should not use any of these modifiers unless the modifier is listed as a reportable option for a specific quality code. |
| 2P | **Performance Measure Exclusion Modifier due to Patient Reasons**<br>**Definition:** Append modifier 2P to a quality reporting code to indicate that patient reasons, such as refusal, prevent the provider from performing the action specified by a quality measure.<br>**Explanation:** You should append modifier 2P to a quality reporting code when patient reasons keep the provider from completing the action a quality measure requires.<br>For instance, if a measure requires a test or service that the patient refuses to have because of financial or religious reasons, you would append 2P to the appropriate quality code to indicate patient reasons stopped the provider from performing the action.<br>You should not use modifier 2P unless listed as a reportable option for the specific quality code you're reporting.<br>**Tips:** This modifier is called an exclusion modifier because it excludes the patient from a quality measure's denominator, which is the eligible patient population.<br>Various exclusion modifiers are available for quality reporting:<br>1P, Performance Measure Exclusion Modifier due to Medical Reasons<br>2P, Performance Measure Exclusion Modifier due to Patient Reasons<br>3P, Performance Measure Exclusion Modifier due to System Reasons<br>For 1P, medical reasons may include a contraindication based on the patient's specific medical history. For 2P, an example of a patient reason is that the patient refuses a service because he does not want to pay for it. An example of the system reasons under 3P is that the entity does not have the equipment needed for the service.<br>Append modifier 8P, Performance Measure Reporting Modifier, Action Not Performed, Reason Not Otherwise Specified, when a provider does not perform the action for an eligible patient and does not document the reason why.<br>You should not use any of these modifiers unless the modifier is listed as a reportable option for a specific quality code. |

1P - 2P

AAPC APPENDIX D CPT® CATEGORY II MODIFI

**To supplement the AMA's CPT, AAPC has a nice guide with additional perspective.**

- **1P** = Performance Measure Exclusion Modifier due to **Medical Reasons**
- **2P** = Performance Measure Exclusion Modifier due to **Patient Reasons**
- **3P** = Performance Measure Exclusion Modifier due to **System Reasons**
- **8P** = …reason not otherwise specified

**AAPC Appendix D CPT Category II Modifiers**

# 2025 ICD-10-CM Official Guidelines for Coding and Reporting

ICD-10-CM diagnostic code set guidelines relevant to this training:

- Be sure to review Section I. Subsection C. Chapter 9. Paragraph a8 and a9 information about how to code for ***uncontrolled versus controlled hypertension*** and other causal relationships with other heart or kidney involvement (***I10-I1A***).

- Be sure to review Section I. Subsection C. Chapter 4 for information about how to code for ***type of diabetes mellitus, body system affected, and any complications affecting that body system***.

# Official ICD-10-CM Guidelines Review

- **<u>Section I</u>**: ***A. Conventions of ICD-10***
  - Conventions of ICD-10-CM
  - Alphabetic Index and Tabular List
  - Format and Structure
  - Use of Codes for Reporting Purposes
  - Placeholder Character
  - 7th Characters
  - Abbreviations (Index and Tabular)
  - Punctuation
  - Use of "And", "With", "See Also", "Code Also"
  - "Other and Unspecified" Codes, "Includes" and "Excludes"
  - Etiology/Manifestation Conventions (e.g., *"code first", "use additional code", "in diseases classified elsewhere"*
  - Default codes

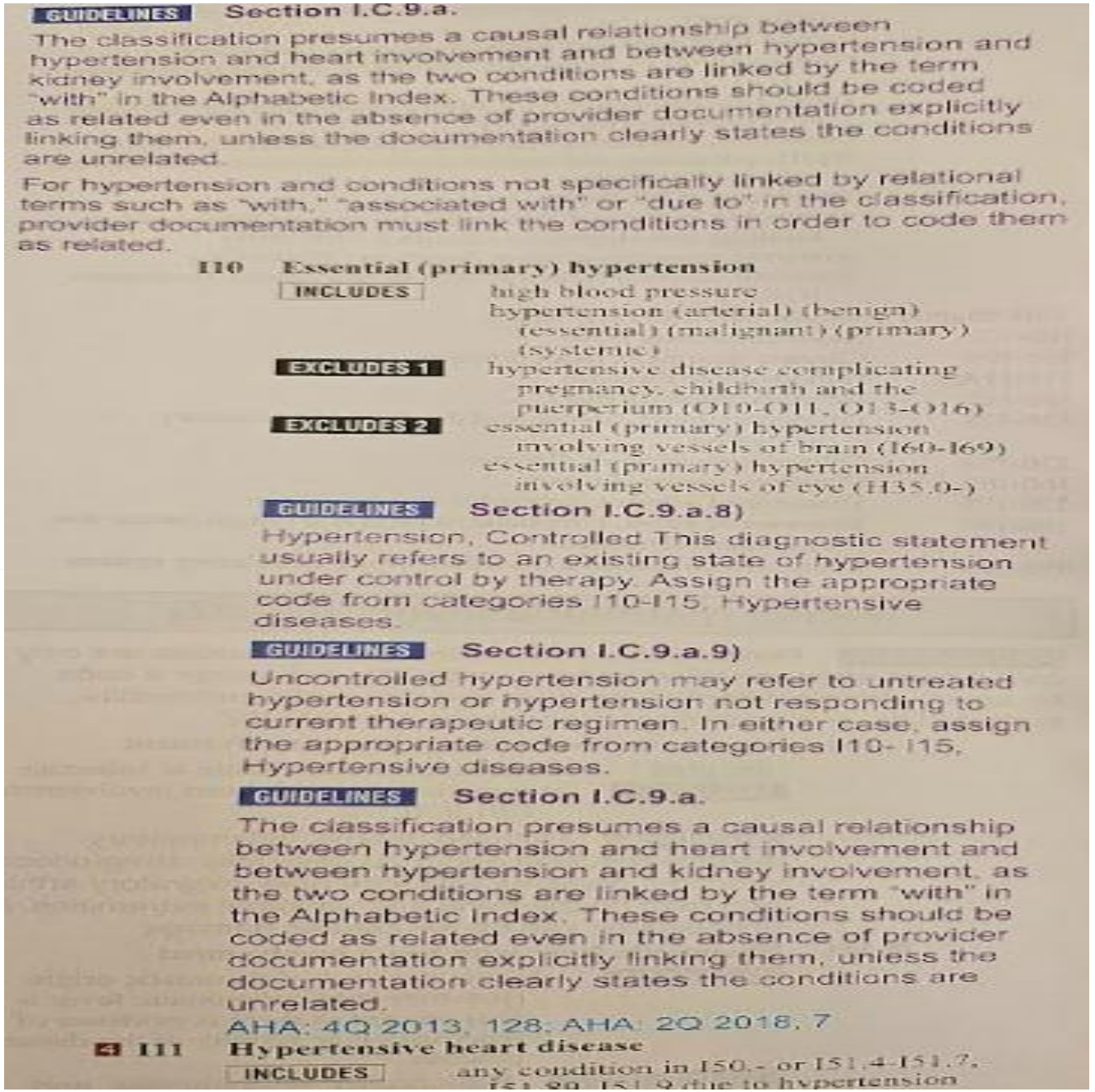
# Official ICD-10-CM Guidelines Review

- **Section I**: ***B. General Coding Guidelines***
  - Locating ICD-10 codes, levels of detail in coding
  - Codes A00.0-T88.9, Z00-Z99.8, U00-U85
  - Signs and Symptoms
  - Conditions that **are** integral part of disease process
  - Conditions that **are not** integral part of disease process
  - Multiple coding for a single condition
  - Acute and Chronic conditions
  - Combination codes
  - Sequela (late effects)
  - Impending or threatened conditions
  - Reporting same diagnostic code more than once
  - Laterality
  - Documentation by Clinicians Other than the Patient's Provider
  - Documentation of Complications of Care
  - Borderline Diagnosis
  - Use of Signs/Symptoms/Unspecified Codes
  - Use of External Cause Codes
  - Use of Z codes

# Official ICD-10-CM Guidelines Review

- **<u>Section I:</u> C. *Chapter Specific Coding Guidelines***
  - Chapter 4: Endocrine, Nutritional & Metabolic Diseases (E00-E89)
    - Diabetes is in this Section (E08-E13)
  - Chapter 7: Diseases of the Eye and Adnexa (H00-H59)
  - Chapter 9: Disease of the Circulatory System (I00-I99)
    - Hypertension is in this Section (I10-I15)
  - Chapter 14: Diseases of the Genitourinary System (N00-N99)
    - Chronic kidney disease is in this section )N18.1 – N18.9)
  - Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00-Z99)
    - Encounter for screening for other diseases and disorders is in this section (Z13.0 –Z13.9)

# Locating ICD-10-CM “instructional notations” is key – do not just perform an alphabetical Volume 2 Index search



GUIDELINES Section I.C.9.a.

The 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," "associated with" or "due to" in the classification, provider documentation must link the conditions in order to code them as related.

**I10 Essential (primary) hypertension**

INCLUDES high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

EXCLUDES 1 hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

EXCLUDES 2 essential (primary) hypertension involving vessels of brain (I60-I69)
essential (primary) hypertension involving vessels of eye (H35.0-)

GUIDELINES Section I.C.9.a.8)

Hypertension, Controlled This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign the appropriate code from categories I10-I15, Hypertensive diseases.

GUIDELINES Section I.C.9.a.9)

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories I10- I15, Hypertensive diseases.

GUIDELINES Section I.C.9.a.

The 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.

AHA: 4Q 2013, 128; AHA: 2Q 2018, 7

**I11 Hypertensive heart disease**

INCLUDES any condition in I50.- or I51.4-I51.7, I51.89, I51.9 due to hypertension

# Quality Measure Details

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**Factual**
*Some measures are simply asking you to report what you have supporting data for in the medical record.*

**vs.**

**Did we perform?**
*Some measures are asking if you performed certain diagnostic or therapeutic services.*

# Blood Pressure Control for Patients with Diabetes (BPD)

- **Measure:** Assesses the percentage of members 18–75 years of age with diabetes (type 1 or type 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

- **Why it Matters:** Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to more serious health conditions, including high blood pressure. People with diabetes are especially prone to high blood pressure because of the amount of insulin in their body. From 2017–2020 data, 70.8% of individuals with diabetes had a systolic blood pressure of ≥140 mm Hg or a diastolic blood pressure of ≥90 mm Hg or were on prescription medication for their high blood pressure. Proper blood pressure management is essential to avoid further complications, including heart attack, stroke, kidney disease and blindness. With support from health care providers, patients can manage their blood pressure to maintain a healthy and productive life.

# Codes for Blood Pressure Control for Patients with Diabetes

**Factual**

## Primary Source

- HEDIS MY2025 Blood Pressure Control for Patients with Diabetes (BPD)

## Billing Code Type

- For Diabetes with Hypertension diagnoses and/or CPT-II codes

## Key Billing Codes

- BP = CPT-II codes

| Systolic | | Diastolic | |
|---|---|---|---|
| Most recent BP <130 | 3074F | Most recent BP <80 | 3078F |
| Most recent BP 130-139 | 3075F | Most recent BP 80-89 | 3079F |
| Most recent BP ≥ 140 | 3077F | Most recent BP ≥ 90 | 3080F |

# Eye Exam for Patients with Diabetes (EED)

- **Measure:** Assesses the percentage of members 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam..

- **Why it Matters:** Diabetes is a chronic condition marked by high blood sugar due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious health conditions, including vision loss and blindness.[1] Diabetes is the leading cause of new cases of blindness among adults 18–64 years of age.[2] Adults with diabetes should receive regular eye exams to help detect and manage visual complications.[3] Regular eye exams are the best way to reduce the risk of blindness and maintain a healthy and productive life.

# Codes for Eye Exam for Patients with Diabetes

**Did we perform it?**

## Primary Source

- HEDIS MY25 – Eye Exam for Patients with Diabetes (EED)

## Billing Code Type

- CPT-II codes to indicate retinal eye exam
- CPT Codes 92227-92228 should give you credit for performing the service if claims data is used.

**92227** = Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral

**92228** =Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral

## Key Billing Codes

**2022F** = **Dilated** retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with** evidence of retinopathy (DM)

**2023F** = **without** evidence of retinopathy (DM)

**2024F** = **7 standard field stereoscopic retinal photos** with interpretation by an ophthalmologist or optometrist documented and reviewed; **with** evidence of retinopathy (DM)

**2025F** = **without** evidence of retinopathy (DM)

**2026F** = **Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos** results documented and reviewed; **with** evidence of retinopathy (DM)

**2033F** = **without** evidence of retinopathy

**3072F** = Low Risk for Retinopathy (no evidence of retinopathy in the previous year) (DM)

# Glycemic Status Assessment for Patients With Diabetes (GSD)


- **Measure:** This measure assesses the percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:
  - Glycemic status <8.0%.
  - Glycemic status >9.0%.

- **Why it Matters:** Diabetes is one of the most costly and highly prevalent chronic diseases in the United States (U.S.). Approximately 38 million U.S. adults have diabetes; 8.7 million of these cases are undiagnosed. Complications from the disease cost the country nearly $413B annually. Diabetes is the eighth leading cause of death in the U.S. and killed approximately 103,294 people in 2021.2 Many complications such as heart disease, stroke, blindness, kidney failure and amputation can be prevented if diabetes is detected and addressed in the early stages.
- Glycemic control is management of blood sugar levels to reduce the risk of microvascular complications (eye, kidney and nerve diseases). The American Diabetes Association (ADA) recommends assessing glycemic status with HbA1c measurement or GMI using continuous glucose monitoring (CGM) data from a CGM device worn by a patient for at least 14 days. The ADA also recommends standardized reports from CGM devices, such as the ambulatory glucose profile. Guidance for interpreting CGM data, including GMI, is included in the ADA guidelines.

# Codes for Glycemic Status Assessment for Patients with Diabetes

**Factual**

## Primary Source

- **HEDIS MY25 – Hemoglobin A1c Control for Patients with Diabetes: Poor Control (HBD)**

## Billing Code Type

- **CPT-II codes to identify HbA1c levels (numerator)**
- **CPT code 93036** Hemoglobin; glycosylated (A1C). *Revenue opportunity-no credit for HEDIS*

## Key Billing Codes

- HbA1c less than 7% = **3044F**
- HbA1c greater than 9% = **3046F**
- HbA1c greater than or equal to 7.0% and less than 8.0%= **3051F**
- HbA1c greater than or equal to 8.0% and less than or equal to 9.0%= **3052F**

# Kidney Health Evaluation for Patients With Diabetes (KED)

- **Measure:** This measure assesses whether adults 18–85 years of age with diabetes (type 1 and type 2) received a kidney health evaluation, including a blood test for kidney function (estimated glomerular filtration rate [eGFR]) and a urine test for kidney damage (urine albumin-creatinine ratio [uACR]) during the measurement year.

- **Why it Matters:** Diabetes is the leading cause of chronic kidney disease (CKD)—approximately 1 in 3 adults with diabetes has CKD. CKD happens when an individual's kidneys are damaged and unable to filter blood as well as usual. As many as 90% of people with CKD do not know they have it, because it often has no symptoms. CKD gets worse over time and can lead to heart disease, stroke and kidney failure. For these reasons, annual monitoring of kidney health is crucial for people with diabetes. Primary detection (kidney health evaluation) and management of kidney disease can prevent these complications and can stop or slow further kidney damage.

# Codes for Kidney Health Evaluation for Patients With Diabetes

**Did we perform it?**

## Primary Source

- **HEDIS MY25 – Kidney Health Evaluation for Patients with Diabetes (KED)**

## Billing Code Type

- **CPT-II codes to identify evaluation of kidney health status**
- **CPT codes: 82565 Creatinine with eGFR plus 82570 Creatinine; urine and 82043 Albumin; urine**

  *Revenue opportunity-no credit for HEDIS*

## Key Billing Codes

- Positive microalbuminuria test result documented and reviewed (DM)= **3060F**
- Negative microalbuminuria test result documented and reviewed (DM)= **3061F**
- Positive macroalbuminuria test result documented and reviewed (DM) = **3062F**

# Statin Therapy for Patients with Diabetes (SPD)


- **Measure:** This measure assesses the percentage of members 40–75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:
  - Received Statin Therapy- patients who were dispensed at least one statin medication of any intensity.
  - Statin Adherence 80%. Patients who remained on a statin medication of any intensity for at least 80% of the treatment period.

- **Why it Matters:** Diabetes is a complex group of diseases marked by high blood sugar due to the body's inability to make or use insulin. Diabetes can lead to serious complications. Thirty-eight million (11.6%) Americans had diabetes in 2021, and 1.2 million adults were newly diagnosed with diabetes. Patients with diabetes have elevated cardiovascular risk due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places patients at a significant risk for developing ASCVD.
  - Primary prevention for cardiovascular disease is an important aspect of diabetes management. The risk of an adult with diabetes developing cardiovascular disease is two times higher than that of an adult without diabetes. In addition to being at a higher risk for developing cardiovascular disease, patients with diabetes tend to have worse survival after the onset of cardiovascular disease. The CDC estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes.
  - Numerous studies have demonstrated the efficacy of statins in reducing cardiovascular risk. The use of statins for primary prevention of cardiovascular disease in patients with diabetes, based on their age and other risk factors, is recommended by guidelines from the American Diabetes Association (ADA) and the American College of Cardiology/American Heart Association (ACC/AHA). Cholesterol lowering medications, such as statins, are among the most commonly prescribed drugs in America, accumulating $17B in sales in 2012. In the United States, 22% of adults (45 and older) take statins. Evidence shows statin use decreases cardiovascular mortality in patients with established cardiovascular disease, and total mortality rates. Primary and secondary prevention trial data strongly support starting lipid-lowering therapy with a statin in most patients with type 2 diabetes.

# Codes for Statin Therapy for Patients With Diabetes


## Primary Source

- **HEDIS MY25 – Statin Therapy for Patients with Diabetes (SPD)**

## Billing Code Type

- **HCPCS II codes to identify diabetic patients receiving statin therapy and their adherence**
- **CPT code: 80061 - Lipid panel.** This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)

## Key Billing Codes

- Patients who are currently statin therapy users or received an order (prescription) for statin therapy = **G9664**
- Patients who are not currently statin therapy users or did not receive an order (prescription) for statin therapy = **G9665**
- Documentation of medical reason(s) for not currently being a statin therapy user or receiving an order (prescription) for statin therapy (e.g., patient with statin associated muscle symptoms or an allergy to statin medication therapy, patients who are receiving palliative or hospice care, patients with active liver disease or hepatic disease or insufficiency, patients with end stage renal disease [ESRD] or other medical reasons) = **G9781**

# Other Codes Related to Diabetes

**Billing Code Types**

**CPT codes:**

- **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate = 99497**
  - **Each additional 30 minutes (List separately in addition to code for primary procedure) = 99498**

*Cost sharing for ACP is waived when performed/billed with an AWV.*

- **Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days= 99091**

**HCPCS II codes:**

- **Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes = G0136** (every 6 months, must have a trigger/need identified)
- **Diabetes outpatient self-management training services, individual, per 30 minutes = G0108**
- **Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes = G0109** *RHCs can include the cost of providing DSMT in their annual cost report for inclusion in their all-inclusive payment rates. However, DSMT does not constitute a separate RHC visit and is not paid separately.*
- **Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear and (4) patient education = G0245**

# New in 2025 - Care Coordination Services in RHC

Starting January 1, 2025, care coordination services (previously care management services) provided in RHCs/FQHCs will include Advanced Primary Care Management Services (APCM) in the suites of care coordination services as well as Transitional care management (TCM), Chronic care management (CCM), Principal care management (PCM), Chronic pain management (CPM), General behavioral health integration (BHI), Remote physiologic monitoring (RPM), Remote therapeutic monitoring (RTM), Community Health Integration (CHI), Principal Illness Navigation (PIN) and Principal Illness Navigation Peer-Support (PIN-PS).

RHCs/FQHCs will report the individual CPT/HCPCS base codes and add-on codes for each of the care coordination services which will replace HCPCS code G0511. These services will be paid at the national non-facility PFS payment rates.

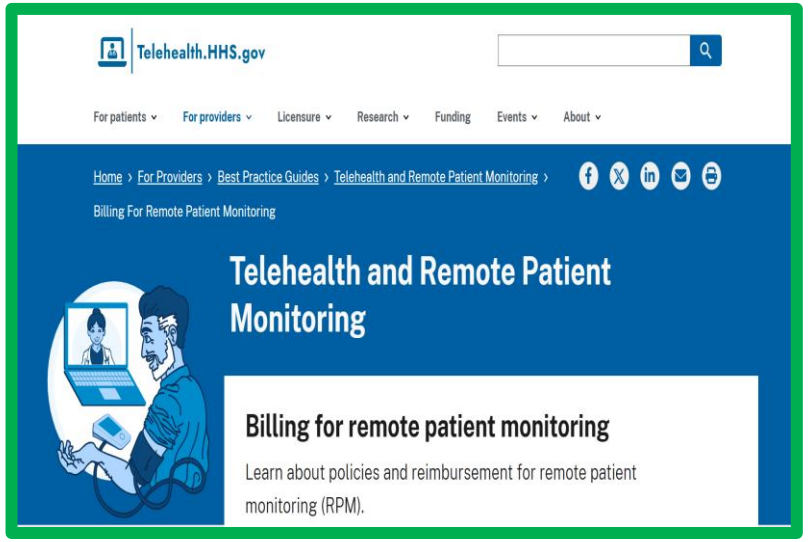
For those RHCs and FQHCs that need additional time to update their billing systems, they may continue to bill G0511 until July 1, 2025. For those that are ready, you may bill the individual HCPCS codes starting January 1, 2025. RHCs/FQHCs should do one or the other on a facility basis.

**MLN909188 CCM Services**

Listing of CPT codes on pages 9-11

# Valuable Resources


[Information for Rural Health Clinics]




[Telehealth and Remote Patient Monitoring]

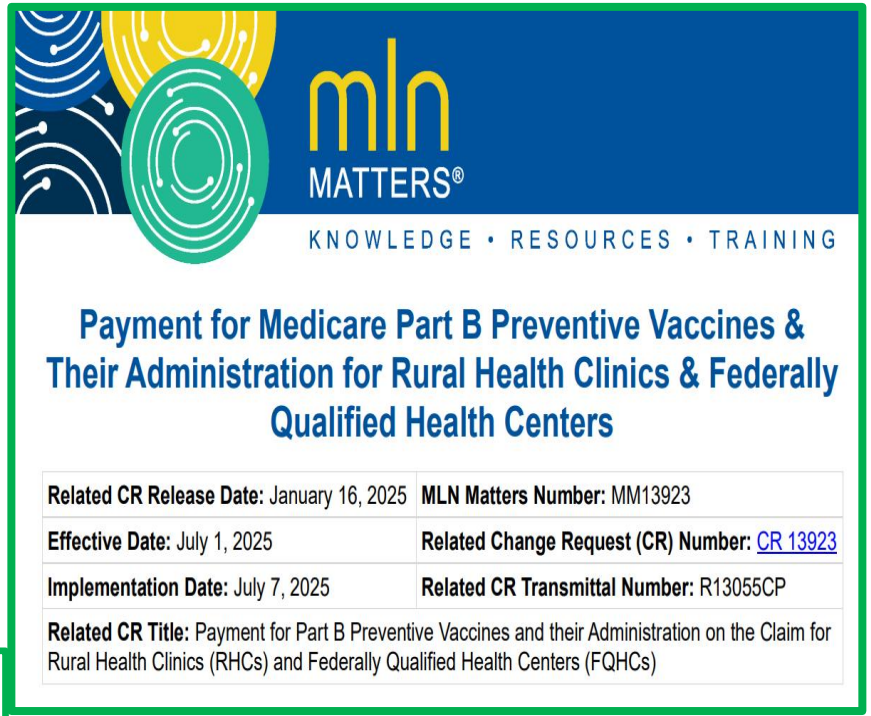
## Billing Medicare as a safety-net provider

Find out what Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are able to bill Medicare for when it comes to telehealth.

**On this page:**

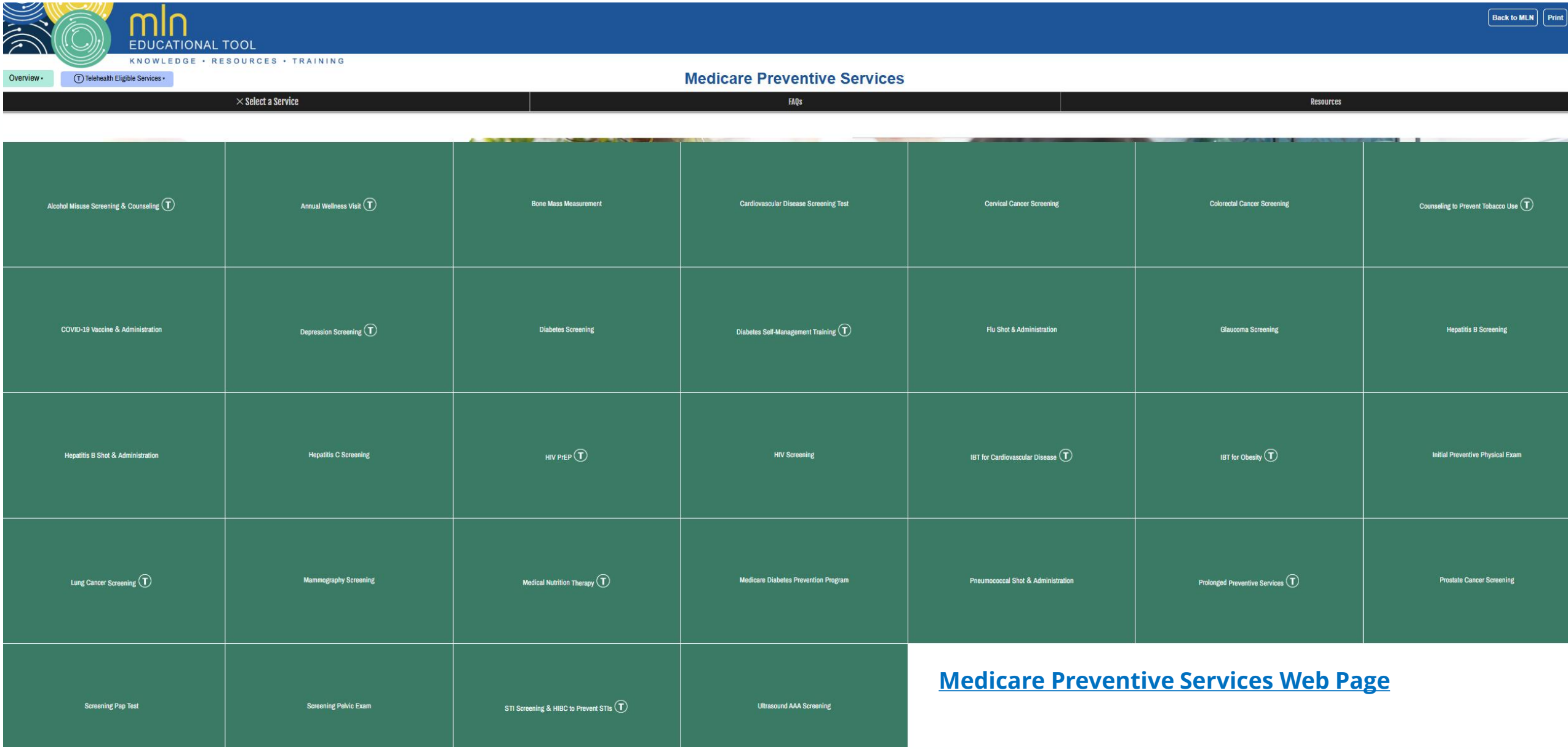
- Telehealth policy updates for RHCs and FQHCs
- Telehealth codes for RHCs and FQHCs
- Remote Patient Monitoring services

[Billing Medicare as a Safety-Net Provider]




[Payment for Part B Preventive Vaccines and Administration in RHC]

# CMS Preventive Services




[Medicare Preventive Services Web Page]

# Discussion

ArchProCoding
RURAL & COMMUNITY HEALTH