7:30-8:00AM Registration and Continental Breakfast

Opening Remarks

8:15-9:00AM Peer Brainstorming Session

<table>
<thead>
<tr>
<th>Table #</th>
<th>Topic</th>
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<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Care Plans</td>
<td>6</td>
<td>Potentially Avoidable Costs</td>
</tr>
<tr>
<td>2</td>
<td>Health Information Technology</td>
<td>7</td>
<td>Dental Visits</td>
</tr>
<tr>
<td>3</td>
<td>Patient Engagement</td>
<td>8</td>
<td>Health Neighborhood Part 1 and 2</td>
</tr>
<tr>
<td>4</td>
<td>Emergency Department Visits</td>
<td>9</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>5</td>
<td>Prenatal Engagement</td>
<td>10</td>
<td>Well Visits</td>
</tr>
</tbody>
</table>

9:00-9:15AM Break

Breakout #1 9:15-10:15AM

| A | Leadership                          | Breakout #1 9:15-10:15AM | Cultural and Generational Communication | Marcia Carteret, M. Ed. | Colorado Children's Healthcare Access Program |

Patients need to be motivated to act as an integral part of their own "care team" which requires effective communication with a wide spectrum of healthcare professionals in many different care settings. This session addresses communication skills healthcare professionals can use to improve patient engagement with all patients and families. Special attention will be given to cultural, linguistic, and health literacy barriers to care.

| B | Financial                          | Future of E&M and Coding Changes | Pamela Ballou-Nelson, RN, MSPH, CMPE, PhD | Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC | Medical Group Management Associates |

On January 1, 2021, changes to CPT will affect all office based services for new or established patients that are currently reported with 99201-99215. Why is the change taking place? With the 2021 changes, there are a lot of problems with E/M being fixed. First, the 1995 and 1997 Guidelines, which often conflict, are felt by providers to be “too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels,” according to CMS’ 2017 Physician Fee Schedule Final Rule. The new changes will include a new Medical Decision Making table, and new guidance for the use of time. This session will explain how the changes will affect your practices coding, documentation, and reimbursement.

| C | Operational/ Clinical              | The Correlation Between Oral Health and Physical Health | Mark Deutchman, MD | Department of Family Medicine at the University of Colorado School of Medicine |

This session will explore the connection between oral health and overall health and how oral health can be readily integrated into medical care. Examples of programs that have been successful in Colorado and nationally will be described.
<table>
<thead>
<tr>
<th>10:15-10:30AM</th>
<th>Break</th>
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<tbody>
<tr>
<td><strong>A</strong></td>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td><strong>Ballroom</strong></td>
<td><strong>Employee Engagement and Empowerment:</strong> A Management Perspective</td>
</tr>
</tbody>
</table>
| Lori Stephenson, RN  
*Rocky Mountain Health Plans* | Kimberly Brown, MHA, BS, RT(R), CPHIMS  
*Rocky Mountain Health Plans* | Kristi Hall, MA, BS, CCM  
*Rocky Mountain Health Plans* |
| In this interactive session, participants will hear from leadership on the Practice Transformation Team about building employee engagement and empowerment. The three crucial factors to employee engagement and empowerment; attitude, trust, and respect will be reviewed and participants will leave with tips on how to take action. Attendees will have the opportunity to network and share their insights with peers in this session. |
| **B** | **Operational/ Clinical** |
| **Parlor** | **Behavioral Health Aspects of Chronic Illness Management** |
| Alexandra Hulst, PhD, LMFT  
*Rocky Mountain Health Plans* | This interactive session will be geared towards clinical staff who engage in direct patient contact, such as medical and behavioral health providers, nursing staff, medical assistants, and care managers. The presenter will provide a brief overview of evidence-based behavioral medicine interventions and practical tips for a variety of chronic health conditions seen in adult primary care. Then, participants will participate in a guided exercise to identify tangible opportunities that various members of clinical teams can use to support patients in making changes to health behaviors. |
| **11:15-11:30PM | Break |
| **A** | **Leadership** |
| **Ballroom** | **Creating a Menu of Joy** |
| Jeremy Make, MA  
*John Snow, Inc.* | Join us for a conversation on finding meaning and satisfaction in any role in healthcare. Using case studies and audience input, we’ll collaboratively create a menu of options for preventing burnout and improving morale across an organization. Note that the session will be highly interactive. |
| **B** | **Financial** |
| **Parlor** | **HCPF Alternative Payment Model** |
| Chelsea Watkins, MHA, BS, CHES  
*Rocky Mountain Health Plans* | Participants will learn about the Department of Health Care Policy and Financing (HCPF) Alternative Payment Model. Discussion will include program eligibility, how it fits into the larger Medicaid payment model, and next steps for 2020. |
| **C** | **Operational/ Clinical** |
| **Kokopelli** | **Clinical Quality Measure (CQM) Buzz Session:** Hypertension and Substance Use Disorder |
| Douglas Bolton, MSN, RN  
*Rocky Mountain Health Plans* | Bronte Smith, BS, MHA  
*Rocky Mountain Health Plans* |
<p>| In this buzz session, participants will dive into measure specifications, learn tips and tricks and explore unique attributes on CMS 137 Initiation and Engagement of Alcohol and other Drug Dependence Treatment and CMS 165 Controlling High Blood Pressure. Identify resources such as clinical recommendation statements, practice guidelines and 2020 measure updates. |
| **12:15-1:15PM | Lunch |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
<th>Facilitators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:15-1:45PM</td>
<td>Feedforward</td>
<td>Ballroom</td>
<td>Identify topics from today’s sessions that you would like to implement within your practice. Gain insight from your fellow participants on how you might go about applying your selected change plan.</td>
</tr>
<tr>
<td>1:45-2:45PM</td>
<td>Regional Accountable Entity (RAE) FAQ</td>
<td>Ballroom</td>
<td>Facilitator Anna Messinger, MHA, PCMH CCE Rocky Mountain Health Plans</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Chelsea Watkins, MHA, BS, CHES Rocky Mountain Health Plans</td>
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<td>Violet Willett Rocky Mountain Health Plans</td>
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<td>Greg Coren Rocky Mountain Health Plans</td>
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<td>Nicole Konkoly Rocky Mountain Health Plans</td>
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<td>During this session, panelists will address common questions regarding the RAE. The audience will also have an opportunity to ask questions and provide comments.</td>
</tr>
<tr>
<td>2:45-2:50PM</td>
<td>Closing Remarks</td>
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</tbody>
</table>
Engaging ALL Patients and Families In Your Medical Practice

Presenter: Marcia Carteret M.Ed.

University of Colorado School of Medicine Department of Pediatrics
CCHAP (Colorado Children’s Healthcare Access Program)
3 components to the communication challenges you face.
The Triple Threat to Healthcare Communication

**Cultural Differences**
72% of population growth in the next 20 years will come from immigrants, or the children of immigrants.

**Language Access Services**
In 2013, a record 61.8 million U.S. residents spoke a primary language other than English at home.

**Health Literacy**
The IOM estimates 90 million “average” Americans lack sufficient literacy skills to function in the healthcare system. (IOM, 2004)
Cultural Differences
72% of population growth in the next 20 years will come from immigrants, or the children of immigrants.

Culture as “boundaries of belonging”
A "particular culture" is maintained by people who interact with one another within a boundary of some kind.
You can’t have belonging without creating boundaries.

You can’t have insiders without having outsiders.
Patient Engagement is the Holy Grail!
Effective Communication
Is the Holy Grail!
Work teams set expectations & standards everyday.

Includes electronic communication!
Work teams set expectations & standards everyday
FOR PATIENTS TOO!
"You’ll be asked to rate my service after the meal, so could you give me a little hint just how much you expect from me?"
Language Access Services

In 2013, a record 61.8 million U.S. residents spoke a primary language other than English at home.
English-Speaking Ability for the Population 5 Years and Over: 2009

Population Age 5 Years and Over: 285,797,349
Speak only English at home: 228,699,523
Speak Language Other Than English at home: 57,097,826
English-Speaking Ability for the Population 5 Years and Over: 2009

Speak Language Other Than English at home: 57,097,826

English Speaking Ability

- 56.9% Very Well
- 19.6% Well
- 15.9% Not Well
- 7.5% Not At All
Spanish
35,468,501
62.1%

Asian & Pacific Island languages
8,698,825
15.2%

Other Indo-European languages
10,495,295
18.4%

Other languages
2,435,205
4.3%
Fart-hinder
I speak HEALTHCARE Jargon
This is button ALL patients and families should wear!

Please speak clearly
We routinely hand people forms... “please fill this out.”
The Triple Threat
to Healthcare Communication

Cultural Differences
72% of population growth in the next 20 years will come from immigrants, or the children of immigrants.

Language Access Services
In 2013, a record 61.8 million U.S. residents spoke a primary language other than English at home.

Health Literacy
The IOM estimates 90 million “average” Americans lack sufficient literacy skills to function in the healthcare system. (IOM, 2004)
Low Literacy: 90 million "mainstream" Americans cannot understand basic health information.

More Hospitalizations

Greater Use of Emergency Care

Poor Medication Adherence

Uncontrolled Chronic Diseases

Meaningless Consent Given

Data collection Problems - Forms, Surveys, Screenings
Sample Follow-up Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

10th

[Sampled Patient Name]
[Address]
[CITY, STATE ZIP]

Dear [Sampled Patient Name]:

Our records show that you were recently a patient at [Name of Hospital] admitted on [Date of Discharge]. Approximately three weeks ago we sent you the enclosed survey during your hospitalization. If you have already returned the survey to us, please accept our thanks and disregard this letter. However, if you have not yet completed the survey, please take a few minutes and complete it now.

Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at www.hospitalcompare.hhs.gov. These results will help consumers make important choices about their hospital care, and will help hospitals improve the care they provide.

Questions 1-22 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits. Please take a few minutes and complete the enclosed survey. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [Optional: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don’t have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxxx-xxxx. Thank you again for helping to improve health care for all consumers.

Sincerely,

[Hospital Administrator]
[Hospital Name]

Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either in the cover letter or on the front or back of the questionnaire. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.

11th

12th

15. During this hospital stay, were you given any medicine that you had not taken before?
   - Yes
   - No

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was?
   - Never
   - Sometimes
   - Usually
   - Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

18. After you left the hospital, did you go directly to your own home, to someone else’s home, or to another health facility?
   - Own home
   - Someone else’s home
   - Another health facility

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
   - Yes
   - No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
   - Yes
   - No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
   - 0 Worst hospital possible
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10 Best hospital possible
“DO NOT CHEW OR CRUSH”

“SWALLOW WHOLE or SPRinkle CONTENTS ON SMALL AMOUNT OF FOOD”

“THIS DRUG SHOULD BE TAKEN ON AN EMPTY STOMACH”

Wall Street Journal, April 2011
Effective Communication
Is the Holy Grail!
It was then that the stranger at the back of the crowd spoke.
Communication Toolkit

- Use teach-back effectively and consistently

- “Go-To” Phrases - families are so important to kids…

- Avoid “head nods” and "zero questions”

- Avoid Acronyms and $10 words ✓

- Roadmap visits

- Use ACTIVE voice. ✓
  (we remember WHEN we make an ACTIVE effort to understand it)

- Zip Lock bags and skillets
Expect Low Literacy/Language Barrier Shame

Use phrases to reduce shame:

- I know this is a lot of information to remember.

- Feeling stressed out can affect our ability to remember things. Will it help if we go over this again?
Two More Tools
2. Thank you!
The End
Thank you!

www.speakupforhealth.com
Marcia Carteret
Big Changes for Evaluation and Management Coding in 2021

Nancy M Enos, FACMPE, CPC-I, CPMA, CEMC
Enos Medical Coding
Agenda

• Background
• Elimination of history and physical as elements for code selection
• Allowing physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Time
• Modifications to the Criteria for MDM
• Creation of a shorter Prolonged Services Code
Background

• Evaluation and Management are the most widely used ranges of CPT codes, as they are used by providers from all specialties.

• Services describe evaluation of the patient’s condition, and management options selected.

• Codes in this section are categorized by the type of encounter, the patient’s status, the place of service, and in some cases, the patient’s age.
Background

• Because the complexity and amount of time, labor, and resources that can go into furnish these services varies widely depending on the patient and their presenting problem(s), each category has different levels of service.

• Some E/M categories are divided into 3 levels of service, some are divided into 5 levels of service.
  
  ➢ 99231, 99232, 99233
  
  ➢ 99211, 99212, 99213, 99214, 99215
Background

- The higher the level of service, the higher the RVUs.
- The documentation must show the extra time and effort to support the higher level of service.
- Documentation Guidelines were developed by the AMA and CMS to help physicians and auditors to quantify the work and cognitive labor demonstrated by the physician in the medical record to ensure the appropriate level of service is billed.
Background

• 1995 Guidelines
  ➢ Problem-oriented history of present illness
  ➢ Review of Systems
  ➢ PFSH
  ➢ Multi-system exam
  ➢ Medical Decision Making Complexity (amount/complexity of diagnoses and data, risk of presenting problems/management options)
Background

• 1997 Guidelines
  ➢ Interval history of chronic illness(es)
  ➢ Review of Systems
  ➢ PFSH
  ➢ Detailed single-system exam
  ➢ Medical Decision Making Complexity
    (amount/complexity of diagnoses and data, risk of presenting problems/management options)
Background

• 1995 vs. 1997 Guidelines
  – Main difference – exam component

• Seven components to consider
  – Relates to the level of work performed by the physician or other qualified health care professional

  1. History
  2. Exam
  3. Medical Decision Making
  4. Counseling
  5. Coordination of Care
  6. Nature of Presenting Problem
  7. Time
Background

There are a lot of problems with E/M being fixed. First of all, the 1995 and 1997 Guidelines, which often conflict, are felt by providers to be “too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels,” according to CMS’ 2017 Physician Fee Schedule Final Rule.
Since the 1995 and 1997 guidelines were published, there have been numerous changes to the technologies and standards of medical practice used by physicians.

Electronic Health Records have afforded physicians time-saving features like note templates, but come with their own set of hazards.

There has been no consensus on what (if any) changes should be implemented in a NEW set of E/M guidelines.
Patients Over Paperwork

• On February 24th, 2017 President Donald Trump signed an Executive Order requiring every agency to establish a Regulatory Reform Task Force to eliminate “red tape.”

• As part of the order the task forces were required to evaluate existing regulations and identify candidates for repeal or modification.

• Agencies were required to measure and report their progress.
In accordance with the EO, CMS Administrator Seema Verma announced the *Patients Over Paperwork* initiative.

This initiative focused on reducing administrative burden while improving care coordination, health outcomes and patients’ ability to make decisions about their own care.
Although the goal of *Meaningful Use* incentives was to improve the quality and efficiency of patient care, certain regulations and reporting requirements have made Physician work flow more complicated, more costly, more stressful, and have eroded the Doctor-Patient relationship.

Physicians continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
The proposed changes to the Physician Fee Schedule (PFS) aimed to address those problems by proposing to streamline documentation requirements and take advantage of the latest technologies.

According to CMS these changes will reduce the documentation burden on physicians, leading to more time spent with patients and lower rates of physicians feeling burned out.
“From reporting on measures that demand that you follow complicated and redundant processes, to documenting lines of text that add no value to a patient's medical record, to hunting down records and faxes from other physicians and sifting through them, wasteful tasks are draining energy and taking time away from patients.....
“...Our system has taken our most brilliant students and put them to work clicking through screens and copying and pasting. We have arrived at the point where today's physicians are burning out, retiring early, or even second-guessing their decision to go into medicine.”

– Seema Verma, CMS Administrator
Patients Over Paperwork

- According to CMS, a survey of over 15,000 physicians showed 42% reported burnout.
- E&M Visits make up 40% of all charges for Medicare physician payments.
- Current documentation guidelines and requirements have not kept up with medical practice, and overtime unnecessary rules and requirements have placed more of a burden on physicians.
Patients Over Paperwork

• Physicians have complained that the current system is too complex and arbitrary to be easily understood.

• Providers often feel that they have to document things that were already documented by somebody else, or document things that don’t make a difference in the care of their patient.

• They also complain that they have to spend hours at the end of the day trying to complete all the required documentation.
• Easing regulations may lead to better, more meaningful medical records.

• The current guidelines which lead to excessive documentation cause the patient to be short changed, it also leads to “note bloat”, with excessive redundant and irrelevant information, making it difficult to quickly find the important information about the patient’s illness and most recent test results in order to best determine an assessment and plan for that patient.
What CMS ultimately proposed was moving from 5 levels of service for outpatient office visits to a system with just one set of requirements, and one payment level each for new and established patients.
2019 Proposed E/M Changes

• CMS would set the payment somewhere between the current reimbursement for a level 3 and a level 4 visit.

• According to CMS, most specialties would see a change in their Medicare reimbursement “in the range of 1-2 percent up or down” but they believe any negative payments would be offset by reduction in documentation burden.
AMA Response

• Some specialties stand to lose on this payment setup, especially those that see a large volume of potentially complex patients.
• The changes to documentation requirements will make things much easier for providers of all specialties, especially teaching physicians.
AMA Response

• Just because CMS is relaxing documentation requirements for level 2-4, that doesn’t mean other insurances will.

• Physicians don’t always know what insurance a patient has when they document the encounter.

• Therefore, many in the industry are not so sure the results in terms of saved time and money will be as profound as whopping 51 hours per clinician per year that CMS projects.
AMA Response

• CMS delayed a large part of their proposal until 2021, giving the AMA ample time to respond with their own proposal.

• In February the AMA CPT/RUC Workgroup on E/M presented its proposal to the CPT Editorial Panel.
AMA CPT/RUC Workgroup on E/M

• In its February 2019 meeting, the AMA CPT Editorial Panel has approved revised guidelines for new and established office or outpatient visit codes 99202-99215

• AMA changes will affect all payers, CMS changes affect Medicare/Medicaid
2020 CMS Final Physician Fee Schedule

- **Finalized** separate payment rates for 5 levels of office/outpatient visits
- **Finalized** deletion of CPT 99201 (level 1 new patient)
- **Finalized** adoption of revised CPT code descriptors (CPT codes 99202-99215)
- **Finalized** elimination of use of history and/or physical exam to select among code levels
- **Finalized** choice of time or MDM to decide level of visits
- **Finalized** payment for prolonged visit using new CPT code 99XXX & no longer recognizing CPT codes 99358-99359 for separate payment in association with E/M visits
- **Finalized** GPC1X with new descriptor (as written in proposed rule) and allow it to be reported with all visit levels
Deletion of 99201

The AMA is planning to delete 99201 from the E/M code set. That is an official code deletion, meaning it will no longer appear in the codebook after 2020.

There are some situations in which you may still need to report 99201, such as those entities that will not immediately adopt the 2021 CPT code changes:

- e.g., workers compensation payers
- Other “HIPAA exempt payers such as auto insurance
The approved revisions to 99202-99215 require that a medically appropriate history and examination be performed: beyond this requirement, the history and exam do not effect coding.

Instead, the E/M service level is chosen either by the level of medical decision making (MDM) performed, or by the total time spent performing the service on the day of the encounter.

Today, the level of scoring is based on:
- Extent of the documentation
- Medical necessity (beware of cloned history)
Allow physicians to choose whether their documentation is based on MDM or Total Time.
Medical Decision Making Revisions (99202-99215)

“Number of Diagnoses or Management Options” is changed to “Number and Complexity of Problems Addressed”

“Amount and/or Complexity of Data to be Reviewed” is changed to “Amount and/or Complexity of Data to be Reviewed and Analyzed”

“Risk of Complications and/or Morbidity or Mortality” is changed to “Risk of Complications and/or Morbidity or Mortality of Patient Management”
# Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>Problems</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>Minimal</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Code</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
</tr>
</tbody>
</table>
## Number/Complexity of Problems Addressed

<table>
<thead>
<tr>
<th>Problems</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 self-limited or minor problem</td>
<td>2 or more self-limited or minor problems; 1 stable chronic illness; 1 acute, uncomplicated illness or injury</td>
<td>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; 2 or more stable chronic illnesses; 1 undiagnosed new problem with uncertain prognosis; 1 acute illness with systemic symptoms; 1 acute complicated injury</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; 1 acute or chronic illness or injury that poses a threat to life or bodily function</td>
</tr>
</tbody>
</table>
# Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>Problems</th>
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<td>Code</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
</tr>
</tbody>
</table>
Amount/Complexity of Data Analyzed

• This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter.

• Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data is divided into three categories:

  1. Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)

  2. Independent interpretation of tests.

  3. Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source
## Amount/Complexity of Data Analyzed

<table>
<thead>
<tr>
<th>Min</th>
<th>Limited</th>
<th>Moderate</th>
<th>Extensive (must meet 2/3)</th>
</tr>
</thead>
</table>
|     | - Any combination of 2 from the following:  
  - Review of prior external note(s) from each unique source  
  - Review of the result(s) of each unique test  
  - Assessment requiring an independent historian(s) | - Any combination of 3 from the following:  
  - Review of prior external note(s) from each unique source  
  - Review of the result(s) of each unique test  
  - Ordering of each unique test  
  - Assessment requiring an independent historian(s)  
  - Independent interpretation of a test performed by another physician/other qualified health care professional  
  - Discussion of management or test interpretation with external physician/other qualified health care professional | - Any combination of 3 from the following:  
  - Review of prior external note(s) from each unique source  
  - Review of the result(s) of each unique test  
  - Ordering of each unique test  
  - Assessment requiring an independent historian(s)  
  - Independent interpretation of a test performed by another physician/other qualified health care professional  
  - Discussion of management or test interpretation with external physician/other qualified health care professional |

---

**ENOS Medical Coding**
Amount/Complexity of Data Analyzed

- An **external physician** or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty.

- An **independent historian** is an individual (e.g., parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary.
Amount/Complexity of Data Analyzed

• When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service.

• When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service.
<table>
<thead>
<tr>
<th>Problems</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>Minimal</td>
<td>Limited</td>
<td>Moderate</td>
<td>Extensive</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>MDM</td>
<td>Straightforward</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Code</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
</tr>
</tbody>
</table>
## Risk of Complications and/or Morbidity or Mortality

<table>
<thead>
<tr>
<th>Risk</th>
<th>Minimal</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Low</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>Moderate</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
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<td>High risk of morbidity from additional diagnostic testing or treatment</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
</tbody>
</table>

*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
- 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
Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>Problems</th>
<th>Minimal</th>
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<th>High</th>
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<td>Code</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 5</td>
</tr>
</tbody>
</table>
Allow physicians to choose whether their documentation is based on **MDM** or **Total Time**
• Beginning with *CPT 2021* and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes.

• Time may be used to select a code level in office or other outpatient services *whether or not* counseling and/or coordination of care dominates the service.
Time

- For coding purposes, time for these services is the **total time on the date of the encounter**.
- It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter.
- This includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff.
Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)
Time Exception- CMS Rule

• Crucially, CMS requires practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

• However, CMS is eliminating its requirement that physicians must spend at least 50% of the face time on counseling and/or coordination of care, and document this explicitly. CMS will now allow E/M level selection based on a simple statement of total face time spent for the encounter.
<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Typical Time</th>
<th>2021 Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>15-29</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>30-44</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>45-59</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>60-74</td>
</tr>
<tr>
<td>99211</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td>10</td>
<td>10-19</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>20-29</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>30-39</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>40-54</td>
</tr>
</tbody>
</table>
New Prolonged Services Code

• The CPT Editorial Panel created a new code for Prolonged Services. This new code would capture shorter prolonged services (15 minute increments).
• The new code would only be reported with new and established patient office visit codes when the code selection is based on time spent. This means it is only applicable to codes 99205 and 99215.

  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; each 15 minutes

• For example, the add-on code could be reported once for a new patient visit that lasts 75-89 minutes and for an established patient visit that lasts 55-69 minutes
• Additional units may be added as needed
Additional E/M Documentation Changes

• Restructuring E/M guidelines into three sections:
  1. Guidelines Common to All E/M Services
  2. Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care and Home E/M Services”
  3. Guidelines for Office or Other Outpatient E/M Services, to distinguish the new reporting guidelines for the Office or Other Outpatient Services codes 99202-99215
• Adding new guidelines that are applicable only to Office or Other Outpatient codes (99202-99215);
  – adding a Summary of Guideline Differences table of the differences between the different sets of guidelines
• Revising existing E/M guidelines to ensure there is no conflicting information between the different sets of guidelines
• Adding definitions of terms associated with the elements of MDM applicable to codes 99202-99215
• Adding a MDM table that is applicable to codes 99202-99215
• Defining total time associated with codes 99202-99215
• Adding guidelines for reporting time when more than one individual performs distinct parts of an E/M service
Does this affect all E/M levels of Service?

The proposed changes (CMS) and Published changes (AMA) specify codes for Office or Other Outpatient visits:

- 99202-99205
- 99211-99215

Do not apply these changes to all other Evaluation and Management subsections, and remind providers that their documentation must meet the requirements for each CPT code, based on:

- Location
- Type of Service
- Patient Status
Collaboration with CMS

The Editorial Panel shared its approved E/M documentation changes with CMS for review, and possible implementation in the Medicare Physician Fee Schedule for 2020 and 2021.

This means that the elimination of history and exam as key components when selecting an E/M service level for 99202-99215 is almost certain to become a reality, no later than 2021. Be aware of the “time” difference.

This should reduce the overall documentation burden for providers, but the sole emphasis on MDM means that this element (or time) will need to be documented scrupulously to support the chosen level of service.
Summary

• This is an ongoing process, make no changes now
• Understand the differences between guidelines from AMA, CMS, and other payers
• When providers sign a contract with a payer, they must follow the current guidelines and policies specific to the contract
• Medicare may produce HCPCS code(s) with specific guidance for Medicare-contracted providers to follow (watch for G codes)
Summary

• Eliminate history and physical as elements for code selection
• Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Time
• Modifications to the Criteria for MDM
• Deletion of CPT code 99201
• Creation of a shorter Prolonged Services Code
Where do we go from Here?

- The CPT Editorial Committee will also meet in February 2020
- We may see even more E/M changes following the summary from those meetings
Resources

Nancy M Enos, FACMPE, CPMA, CPC-I, CEMC is an independent consultant with the MGMA Health Care Consulting Group and a principal of Enos Medical Coding. Mrs. Enos has 40 years of experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice, Nancy Enos Medical Coding (www.nancyenoscoding.com).

As an Approved PMCC and ICD-10 Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-9 and ICD-10 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including National, State and Sectional MGMA conferences, and at hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She serves as a College Forum Representative for the American College of Medical Practice Executives.

About the Speaker

Nancy@enosmedicalcoding.com
401-486-8222
The Oral-Systemic Connection

Advanced Practice Conference – Rocky Mountain Health Plans
November 8, 2019
Mark Deutchman MD
CU School of Medicine
CU School of Dental Medicine
Why are we talking about this?

- Oral health IS connected to overall health across the lifespan
- The mouth IS part of the body
- Medical and oral health clinicians need to communicate
What determines our health?
Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%

http://www.huffingtonpost.com/lloyd-i-sederer-md/health-care_b_4455582.html
The Disconnect

• Most patients have a medical home; many fewer have dental home
• Children are 2.5 times more likely to lack dental coverage than medical coverage
• Dentists per capita declining
• Few pediatric dentists
• >90% of physicians think oral health should be addressed at well visits, yet...
  • Surveys of physicians
    • > 50% had little or no oral health training
    • Only 9% could answer 4 simple questions correctly
    • Averaged <2 hours of oral health training
Access to care .....  

• 43 Million in U.S. have no medical insurance; 150 million have limited or no dental insurance  
• In Colorado, 6 counties have no dentist at all and 9 counties have no dentist that participates in Medicaid  
• In Colorado, 42% of adults and 30% of children report no dental insurance  
• Medicare has very very limited adult dental benefits  
• In Colorado, Medicaid provides some limited adult dental benefits
Key Concepts:

Oral-Systemic Links Across the Lifespan

1. Elementary school child with poor school performance
2. 56 year old diabetic with poor blood sugar control
3. 26 year-old pregnant woman with preterm labor
4. 66 year old woman with breast cancer about to start chemotherapy
5. 61 year old man who recently had a heart attack (acute coronary syndrome)
6. 48 year old man with a sore on his tongue
7. 11 year-old developmentally delayed boy with a seizure disorder
8. 82 year old nursing home resident with dementia
What do these people have in common?

• They have oral conditions that affect their systemic health ..... or ......
• They have systemic conditions that affect their oral health
• Regardless of which came first, we as medical providers must recognize and address BOTH
• Personal behavior is the most essential element of prevention and treatment
Key concept #1: Early childhood caries

- Most common chronic Dz of childhood
- Erosion of dental enamel resulting in cavities
  - Implications for development, nutrition and self-esteem
  - Complications: pain, abscesses, cellulitis
- Vertically transmitted, infectious, preventable
- Expensive
- Relationship to poverty
- Relationship to oral hygiene and dietary patterns
- Predicts adult oral health
The Caries Etiology Triad

Oral bacteria *(Mutans Strep)* break down dietary sugars into acids which eat away the tooth.
Caries is EASY to recognize

White spots = demineralization

Brown spots = enamel erosion
Severe Caries
Facial Cellulitis
Disease Management

The Caries Balance / Imbalance

Disease Indicators

White Spots
Restorations < 3 yrs
Enamel Lesions
Cavities / Dentin

Risk Factors

Bad Bacteria
Absence of Saliva
Destructive Lifestyle Habits

Protective Factors
Saliva & Sealants
Antibacterials
Fluoride / Ca^{2+} / PO_4^{3-}
Effective Lifestyle Habits
Risk-based Reassessment

Health

Caries Disease Progression

Remineralization
Key concept #2: Oral hygiene and diet

- Polymicrobial environment
- Plaque and calculus
- Enamel physiology: de- and re-mineralization
- Intraoral sugar metabolism – sweet, sticky things
- Brushing, flossing
- Fluoride: systemic and topical
- Oral effects of common Rx: xerostomia etc.
Key concept #3: Periodontal disease

- Age of onset – young adulthood
- Anatomic features: pockets and the periodontal ligament
- Complications
- Relationship to oral hygiene, diet, alcohol and tobacco
- Prevention and treatment
- Inflammation link to:
  - Diabetes, Vascular disease, Obesity, Rheumatologic disease
  - Adverse pregnancy outcomes, Cancer treatment complications
Anatomy of a Tooth
Chronic Periodontitis

• Infection and inflammation induce loss of bone and tooth attachment
• Rare in children, present in 50% of adults
• Can start in teen years
• Smoking a major risk
• **BEHAVIORAL** Prevention:
  • good oral hygiene
  • brushing *and* flossing
  • avoid tobacco
Adult oral disease: Periodontitis

• Etiology:
  • Chronic plaque at gum line
  • Bacterial infection
  • Host inflammatory response

• Three types:
  • Gingivitis
  • Chronic periodontitis
  • Aggressive periodontitis
Inflammation & host response

Macrophages

Neutrophils

Toxins

Anaerobic bacteria in plaque

Circulating inflammatory mediators
- IL-1
- TNFα
The Oral-Systemic Link

• Good evidence for oral/systemic link
  • Infective endocarditis (8% of cases)
  • Prosthetic device infection
  • Diabetes

• Emerging evidence for oral/systemic link
  • Obesity
  • Coronary artery disease
  • Adverse pregnancy outcome
    • Preterm birth and low birth weight
    • Preeclampsia
  • Lower respiratory disease
Diabetes

• Poor glycemic control is associated with a threefold increased risk of having periodontitis in diabetics Vs controls

• Diabetics with good glycemic control have no significant increased risk of periodontal disease

• Chronic infection (like periodontal disease) complicates glucose control
Obesity

• Fat tissue releases TNFα and IL6 which potentiate inflammation, including periodontal disease
• TNFα also causes insulin resistance
• The relationship between obesity and oral disease is therefore complex and includes diabetes
Coronary Heart Disease & Stroke

- CHD and periodontitis are associated, but causation is not clear
- Inflammatory cytokines implicated in atherogenesis are also produced by periodontitis
- Dental plaque organisms have been found in vascular plaque and induce platelet aggregation
- Systemic antibody response to periodontitis is associated with CHD
- Smoking is associated with both
- Both share elevated CRP levels
Lower respiratory Disease

• Chronic aspiration of oral bacteria
  • Chronic obstructive pulmonary DZ
  • Acute pneumonia

• Hospitalized/ventilated patients are particularly at risk.
  • Oral care protocol interventions lead to an 89.7% reduction in ventilator associated pneumonia
Iatrogenic: xerostomia

• Decreased saliva promotes periodontal disease
• Many medications reduce salivary flow
  • steroids
  • antihistamines
  • diuretics
  • antihypertensives
  • anticholinergics
  • antidepressants
Iatrogenic

- Gingival hyperplasia – phenytoin
- Osteonecrosis – bisphosphonates
- Stomatitis and mucositis – cancer chemotherapy and radiation therapy
- Candidiasis – steroids
- Periodontal disease – nifedipine in Type II diabetics and immunosuppressives
- Dental erosions due to GI reflux – progesterone, nitrates, beta and Ca++ blockers
- Dental caries: sugar-containing medications
Cognitive and behavioral problems affecting self-care in older adults

- Self-care deficits
- Chronic disease burden / multiple medications
- Dietary changes
- Compliance difficulty: medications, oral hygiene
- Dependence on caregivers
- Chewing and swallowing difficulty: nutrition
- Lack of understanding leading to resistance to care
Key concept #4: Oral cancer

- Epidemiology
- Relationship to HPV
- Relationship to alcohol and tobacco
- Consequences of late diagnosis
Oral Cancer and pre-cancer

- Alcohol and tobacco increase risk of oral cancers – including spit tobacco
- Role of HPV infection
- Early lesions may be asymptomatic
- Sites we must look at: Lateral tongue, floor of mouth, inside of lips
Neglected Areas

- Lateral tongue
- Under tongue
- Behind lips
- Floor of mouth
Cancer in Hidden areas
Integrating Oral Health

Knowledge: Oral-systemic connection key concepts

Skills: Risk Assessment, Oral exam, F1 varnish

Attitudes: Interprofessional care
Oral Health Interventions in Primary Care

1. **ASK** about oral health risk factors and symptoms of oral disease.
2. **LOOK** for signs that indicate oral health risk or active oral disease.
3. **DECIDE** on the most appropriate response.
4. **ACT** offer preventive interventions and/or referral for treatment.
5. **DOCUMENT** as structured data for decision support and population management.
Risk assessment is a routine part of what we already do in primary care

Ask the same way we assess multiple other aspects of our patients’ health and includes many overlaps:

- Tobacco
- Alcohol
- Nutrition
- Personal hygiene
- Sexual behavior
- Accident prevention
Define the patient’s balance between risk factors and protective factors

• Risk factors:
  • Prevalence of oral disease in the family
  • Dietary habits
  • Oral hygiene habits

• Protective factors:
  • Dental home
  • Fluoride exposure in water, by supplements or topical
  • Dietary patterns
  • Oral hygiene habits
<table>
<thead>
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<th></th>
<th>Infants and Children</th>
<th>Pregnancy</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Assessment:</strong></td>
<td>Diet</td>
<td>Diet</td>
<td>Diet</td>
</tr>
<tr>
<td>Ask about</td>
<td>Oral hygiene</td>
<td>Oral hygiene</td>
<td>Oral hygiene</td>
</tr>
<tr>
<td></td>
<td>Family oral health</td>
<td></td>
<td>Tobacco, Alcohol / Drugs</td>
</tr>
<tr>
<td><strong>Screening:</strong></td>
<td>Look for Caries</td>
<td>Look for</td>
<td>Periodontal Dz, Oral cancer</td>
</tr>
<tr>
<td>Look for</td>
<td></td>
<td>Periodontal Dz</td>
<td>Medications</td>
</tr>
<tr>
<td><strong>Counsel</strong></td>
<td>Parental care</td>
<td>Self-care</td>
<td>Self-care</td>
</tr>
<tr>
<td><strong>Decide and act</strong></td>
<td>Fluoride Dental visit</td>
<td>Rinses Xylitol Dental visit</td>
<td>Rinses Xylitol Biopsy Dental visit</td>
</tr>
</tbody>
</table>
Clinical Evaluation Knee to Knee Exam
Fluoride Varnish
Medical-Dental Collaboration

• Oral health training for medical providers will increase referral to dentists
• Expanded medical knowledge for dental providers will increase referral to medical providers
• Challenges:
  • Medical providers are already busy
  • Medical providers may have difficulty identifying dentists taking referrals
  • General dentists may be reluctant to see young children
  • Dentists may be reluctant to treat pregnant women
Successes in Oral Health Integration and prevention of oral disease
Community water fluoridation (CWF)
Dental Sealants
Cavity Free At Three

PATRICIA BRAUN MD, MPH, PEDIATRICIAN

Read Dr. Braun's Research demonstrating that Four fluoride varnishes by age Three reduces Early Childhood Caries (ECC).

Join us and help Colorado kids become

**CAVITY FREE AT THREE**

Medical Professionals:

- Implement AAP and USPSTF Grade B recommendations for preventing dental caries in infants and toddlers.
- Receive free certification training to obtain reimbursement from Colorado Medicaid and CHIP for oral health services.
CO-LOCATION OF SERVICES
Colorado Medical-Dental Integration Project

• Five-Year Initiative
• Launched in 2014
• Integrated dental hygienists in medical practices to provide preventive services
Grantees – Colorado Medical-Dental Integration Project
Services Offered

- Risk assessment & screenings
- Oral health instruction
- Fluoride varnish application
- Cleanings
- Sealants
- X-rays
- Scaling & Root Planing
- Referrals & case management
COOPERATIVE PRACTICE & REFERRAL PROTOCOLS
MORE Care

- Three states involved
- Learning Collaborative
- Emphasis on quality improvement
- Integration of oral health into primary care practice and development of oral health referral networks

Bridging the Gap

**What we know**
- Focus on prevention
- Assess and manage risk
- Support behavior change
- Activate a dental referral system

**What we do**
- Applying evidence
- Changing processes
- Training workforce
- Educating parents
- Using information technology
- Aligning payment

**THE GAP**
- Little focus on self-management
- Leave out the mouth
- Surgical intervention model predominates
- Outcome based care is a rarely seen model
MORE Care Pediatric Pathway

**MEDICAL**

Oral Health at Well Child Visit
- Review medical/dental histories
- Perform Oral Health Evaluation (HEENT)
- Document findings and management plan, including referrals
- Apply fluoride varnish
- Review current prescriptions for opportunities to optimize oral health, as needed

Oral health – Risk based instruction
- Conduct counseling to decrease or maintain low oral health risk (risk factor identification)
- Set self management goals
- Follow up and develop referral plan

**DENTAL**

Dental Care Appointment
- Review medical/dental histories
- Complete Caries Risk Assessment and assign status (Low/Moderate/High)
- Conduct Preventive Dental Care Appointment
- Create treatment plan focused on disease management

Disease Management
- Complete counseling aimed at prevention and/or stabilization of disease (self management goals)
- Establish re-care appointments according to patient needs
- Initiate and sustain patient-centered interprofessional communication

**Cooperative Tasks**
- Coordinate care with bi-directional referral system
- Initiate, develop and improve interprofessional communication
- Create shared outcomes through collaborative interprofessional practice
- Develop joint treatment planning and record keeping

**Measurement Concepts**

| Fluoride Varnish Application | Self-Management Goal Setting | Oral Health Evaluation (Risk Assessed) | Referral Completion Verification |
TELEHEALTH
SMILES Dental Home Project

http://www.caringforcolorado.org/smiles-dental-project
Providing care in non-traditional settings
Building Equity Through Telehealth Reach (BETTR Direct Project)

The University of Colorado School of Dental Medicines seeks to demonstrate a sustainable business model for private dental offices, that will:

- result in less “empty chair time” for local dentists
- increase representation of Medicaid patients in local private clinics
- offer a clear return on investment for private dentists
Emerging preventive issue
- Silver Diamine Fluoride

Dead bacteria kill living bacteria – “zombie effect”
EVIDENCE - SILVER DIAMINE FLUORIDE

• 12 Randomized Clinical Trials (RCTs) with 1,816 patients treated with SDF

• 6 RCTs on caries arrest
  ➢ Approx. 90% arrest with 2x per year application
  ➢ 40-80% arrest with 1x per year application

• 6 RCTs on caries prevention
  ➢ 70-80% prevention in children, applied only to lesion
  ➢ 25-70% prevention, outperforms everything by far
Emerging preventive issue
- Interim Therapeutic Restoration
INTERIM THERAPEUTIC RESTORATION (ITR)
Caries Experience by Race/Ethnicity: 3rd Grade, Colorado

Percentage of Third Grade Students with Caries Experience

- The percentage of white students with caries experience has decreased since 2011, while the data suggest an increase among black students.
- A significant gap of 30 percentage points separates white students from black students.

Source: CDPHE, Basic Screening Survey
New Mothers, Colorado

- 43 percent of black, non-Hispanic women who just gave birth and needed a dental visit did not get one.
- The data suggest that the proportion of women who needed dental care and are not receiving it decreased across each racial and ethnic group except black, non-Hispanic women.

Source: CDPHE, Pregnancy Risk Assessment Monitoring System.
Adult Tooth Loss, Colorado

Percentage of Adults who Lost Six or More — But Not All — Teeth Due to Decay or Periodontal Disease

- Over one in 10 (11.4%) black adults surveyed in 2016 had lost six or more teeth due to oral disease compared with only 6.6 percent of white adults.
- Each racial and ethnic group experienced a decrease between 2014 and 2016 with the exception of black, non-Hispanic adults.

Source: CDPHE, Behavioral Risk Factor Surveillance System
Objectives

- Define leadership using A.R.T.
- Identify and reflect on opportunities for improvement in A.R.T. within your own leadership style.
- Identify strategies that can be deployed in your practice which accelerate employee engagement and empowerment.
Leadership for Accelerating Engagement & Empowerment

- Attitude
- Respect
- Trust
Clinical Program Development and Evaluation Mission: In alignment with the RMHP Mission and Strategic Plan, we facilitate the ongoing improvement in health care delivery to our Members through progress toward achievement of the Quadruple Aim through quality improvement efforts that strive to optimize effective processes and minimize system barriers that focus on Member behavior and practice culture.

Clinical Program Development and Evaluation Vision: In alignment with the CPDE mission we facilitate and develop a growing community network of advanced practices who are equipped to provide high value/whole person care and facilitate effective health plan utilization of this resource in concert with our value based contract strategy.
INSIGHT.....

What insights have you had about attitude?

• Take the next 3 minutes to write down 1 -3 insights you have had.

• Take 3 minutes to share your insights at your table and what action you might be able to take.
Respect

Remember
Empathy
Sincerity
Patience
Equity
Compassion
Truthfulness
INSIGHT.....

What insights have you had about respect?

• Take the next 3 minutes to write down 1 - 3 insights you have had.

• Take 3 minutes to share your insights at your table and what action you might be able to take.
Trust

Boundaries
Reliability
Accountability
Vault
Integrity
Nonjudgement
Generosity
What insights have you had about trust?

• Take the next 3 minutes to write down 1 -3 insights you have had.

• Take 3 minutes to share your insights at your table and what action you might be able to take.
Questions
OVERVIEW

What is behavioral medicine?

What are behavioral medicine interventions?

What does the evidence say?

How does this fit into my job?
WHAT IS
BEHAVIORAL
MEDICINE?
Behavioral medicine is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation.

(SOCIETY OF BEHAVIORAL MEDICINE, n.d.)
WHY DOES BEHAVIORAL MEDICINE MATTER?
Behavioral Patterns (40%)
Health Care (10%)
Social & Environmental Factors (20%)
Genetic Predisposition (30%)

(SCHROEDER, 2007)
IF I COULD GET GOOD NEWS INSTEAD OF BAD NEWS

THAT WOULD BE GREAT
WHAT ARE THE GOALS OF BEHAVIORAL MEDICINE?

IMPROVE HEALTH & QUALITY OF LIFE

PREVENT ILLNESS

REDUCE SYMPTOMS OF ILLNESS
WHO CAN PRACTICE BEHAVIORAL MEDICINE?

Y-O-U!
WHAT ARE BEHAVIORAL MEDICINE INTERVENTIONS?
# Behavioral Interventions

## Lifestyle Changes
- Improve nutrition
- Increase physical activity
- Stop smoking
- Use medications appropriately
- Practice safer sex
- Eliminate or reduce alcohol and drug use

## Training
- Coping
- Relaxing
- Self-monitoring
- Managing stress
- Managing time
- Managing pain
- Solving problems
- Setting priorities
- Communication skills

## Social Support
- Group education
- Caregiver support & training

(Society of Behavioral Medicine, n.d.)
WHAT WORKS

- EMPATHY
- ACKNOWLEDGING AMBIVALENCE
- ENGAGING SOCIAL SUPPORT SYSTEM
- SMALL GOALS BASED ON PRIORITIES, VALUES

WHAT DOESN'T WORK

- PERSUADING
- INSTILLING FEAR OR SHAME
- ONE-SIZE-FITS-ALL PLANS, EXPECTATIONS
WHAT DOES THE EVIDENCE SAY?
BRIEF INTERVENTIONS IN PRIMARY CARE

(FUNDERBURK ET AL., 2018)
KEY OPPORTUNITIES – BRIEF BH PROVIDERS

INSOMNIA, SLEEP DISORDERS

PHYSICAL ACTIVITY

(FUNDERBURK ET AL., 2018)
KEY OPPORTUNITIES — BRIEF BH PROVIDERS

INSOMNIA, SLEEP DISORDERS

PHYSICAL ACTIVITY

HEALTH ANXIETY, SOMATIZATION

MEDICATION ADHERENCE

PAIN, MIGRAINES

SEXUAL HEALTH

(FUNDERBURK ET AL., 2018)
TRUE OR FALSE:

MOTIVATIONAL INTERVIEWING DELIVERED IN PRIMARY CARE IS ENOUGH TO REDUCE >5% OF BODY WEIGHT FOR MOST PATIENTS.

(WADDEN ET AL., 2014)
TRUE OR FALSE:

MOTIVATIONAL INTERVIEWING DELIVERED IN PRIMARY CARE IS ENOUGH TO REDUCE >5% OF BODY WEIGHT FOR MOST PATIENTS.

(WADDEY ET AL., 2014)
QUIZ TIME:

WHAT PERCENTAGE OF ADULTS WITH A CHRONIC ILLNESS DO NOT TAKE MEDICATIONS AS PRESCRIBED?

30-50%

(Kini et al., 2018)
<table>
<thead>
<tr>
<th>Patient education</th>
<th>Medication regimen management</th>
<th>Clinical pharmacist consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioral tx, motivational interviewing</td>
<td>Medication taking reminders</td>
<td>Incentives to promote adherence</td>
</tr>
</tbody>
</table>

(Kini et al., 2018)
### Medication Adherence

<table>
<thead>
<tr>
<th>Patient education</th>
<th>Medication regimen management</th>
<th>Clinical pharmacist consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioral tx, motivational interviewing</td>
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</tr>
</tbody>
</table>

(Kini et al., 2018)
“I feel like I’m failing at keeping my A1c in check.”

“My family just doesn't understand how hard I'm trying to lose weight, and it just doesn't seem to be working.”

“All these pills are overwhelming.”
“I feel like I'm failing at keeping my A1c in check.”

“My family just doesn't understand how hard I'm trying to lose weight, and it just doesn't seem to be working.”

“All these pills are overwhelming.”

“A lot of people with _ feel that way. You're not alone. This is really hard.”

“Tell me about something else hard in your life you were able to accomplish.”

“What can we do to help make this a little less stressful?”
Pros: status quo
Cons: status quo

Pros: change
Cons: change
I'm thankful to have a family who takes eating as seriously as I do.
That's how you devour a whale, Doug, one bite at a time.
HOW DOES THIS FIT INTO MY JOB?
## Behavioral Interventions

### Lifestyle Changes
- Improve nutrition
- Increase physical activity
- Stop smoking
- Use medications appropriately
- Practice safer sex
- Eliminate or reduce alcohol and drug use

### Training
- Coping
- Relaxing
- Self-monitoring
- Managing stress
- Managing time
- Managing pain
- Solving problems
- Setting priorities
- Communication skills

### Social Support
- Group education
- Caregiver support & training
• Biggest challenge with giving tasks to entire team?

• How will you plan to implement in your clinic?
TAKE-AWAYS

• Helping patients make behavioral changes to prevent illness & reduce symptom interference with life is EVERYONE'S job in primary care.

• What is one thing you will try next week?
LIFESTYLE MEDICINE
MANAGING DISEASES OF LIFESTYLE IN THE 21ST CENTURY
GARRY EGGER / ANDREW BINNS / STEPHAN ROSSNER
THANK YOU!

EMAIL

Alexandra.Hulst@rmhp.org
Creating a Menu of Joy

November 8, 2019

Jeremy Make
(303) 262-4307
JMake@JSI.com
EHR Joys

- E-prescribing
- Reviewing patient information
- Ability to share patient records/lab results
- Conduct drug/allergy checks
- Incorporate clinical lab test results
Unjoy

- ↑ medical errors
- ↑ chaos
- ↓ patient outcomes
- ↓ patient satisfaction
- ↓ patient adherence
- ↓ teamwork
- ↓ professionalism
- ↑ 50% of are now experiencing burnout
Unjoy

- ↑ legal interventions/lawsuits
- ↑ self-diagnosing/medicating
- $1,262,297
- ↑ mental health issues including substance use and suicide (400 human lives every year)
Root Causes

• Excessive workload
• Misinformed patients
• High patient volume
• Long wait times
• Anticipating conflict/confrontation with patients
• Bullying/judgmental colleagues
• Belittlement
• Racism, systemic/implicit biases
• Professional, cultural, social, and geographical isolation for rural providers
• Managed care budgets and bureaucracy
• Lack of autonomy
• Complaint process (blame and punishment)

• Lack of faculty role models, experiences of isolation, and sexism (for female providers)
• Competition between providers
• Shortage of healthcare professionals
• Lack of accountability
• Dr. Google
• Lack of hospital beds
• Constraints of practice management
• Space design
• Work/life balance
• Lack of exercise/sleep/healthy eating habits
• Cumbersome EHRs
Solutions

1. Ask staff, “What matters to you?”

2. Identify unique impediments to joy in work

3. Commit to a systems approach to making joy in work a shared responsibility at all levels of the organization

4. Use improvement science to test approaches to improving joy in work in your organization
Seeking Joy

1. What brings you joy in your work? Satisfaction? Meaning?
2. Story of colleague appreciation
3. Experience with a patient
Offering Input

1. How can someone at your organization share feedback, formally or informally?
2. How do you engage patients in sharing feedback, formally or informally?
3. One barrier to satisfaction for you personally
Solutions

• Team-based care
• Patient & family advisory council
• Immediate feedback ("What could I have done better?")
• Daily team huddles with non-clinical items
• Clinician “float pools” for life events or locum tenens
• Assess clinician satisfaction and well-being
• Schedule flexibility and clinician control
• Mindfulness and resilience training
• Wellness committee and infrastructure (salad club?!)”
• Employee input
• Rapid, clear, actionable feedback after asking permission ("Can I give you some feedback?")
• Recognize daily work, reward “over-the-top” work
• Vocalize compassion: “I appreciate this,” “I’m grateful I get to work with you,” “I trust you to do that”
• Learner-centered model of employee discipline/restorative justice

Added to from Allison Winkler’s AMA Joy in Medicine Webinar, 12/13/17
Works Cited


Schutte, L. What you don’t know can cost you. Journal of Association of Staff Physician Recruiters. Summer 2012. aspr.org/?696


Other Resources

Redesign your practice. Reignite your purpose.
AMA's Practice Improvement Strategies.

Browse modules

Module Categories

Patient Care
16 Modules

Workflow and Process
14 Modules

Leading Change
7 Modules

Professional Well-Being
5 Modules

Technology and Finance
8 Modules

Looking for modules?
Try our Practice Assessment tool.
Start Assessment
Creating a Menu of Joy

Jeremy Make
(303) 262-4307
JMake@JSI.com
Department of Health Care Policy & Financing: Alternative Payment Model

Chelsea Watkins, MHA
November 8, 2019
Objectives

• Explain the APM program.
• Discuss how the APM fits into the larger Medicaid picture.
• Understand who is eligible in 2020 and beyond.
• Explain how RMHP can assist practices as the RAE.
Where did the APM come from?

The Affordable Care Act provided federal funding, known as the 1202 bump, for a temporary increase in primary care rates starting in 2013. When the federal funding expired on December 31st of 2014, the General Assembly of Colorado chose to continue the 1202 bump with State General Fund dollars. **The APM is a transformation of the 1202 bump.**

The Department’s budget request for fiscal year 2017-18 asked for a continuation of the 1202 bump with the addition of a value proposition. **The APM is that value proposition.**
What are the goals for the APM?

1. Provide long-term, sustainable investments into primary care;

2. Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to primary care medical providers (PCMPs), and;

3. Align with other payment reforms across the delivery system.
How does it fit into the Medicaid Payments?

RAE Payment Umbrella

RAE
- RAE Medical Home Payments (Tier)
- KPI Quarterly Performance Payments (Tier)
- APM FFS% Enhancement

RAE PRIME
- PRIME Global Payment
- PRIME Shared Savings
- FFS for non-E&M codes

Medicaid FFS
- State Pays
- RMHP Pays
- RMHP Pays
- State Pays
- RMHP Pays
- RMHP Pays

Note: Behavioral health payments not depicted above
Who is eligible?

- PCMPs in the RAE
  - Primary Care Medical Practitioner (includes internal medicine, pediatrics, geriatrics, obstetrics, gynecology)
  - Enrolled as a Health First Colorado (Colorado's Medicaid) provider
  - Licensed and able to practice in Colorado
  - Hold a MD, DO, or NP provider license
  - Community Mental Health Centers and HIV infectious disease practitioners may qualify with approval.
- Must have more than $30,000 in annual billing associated with services defined in the APM code set
Who is eligible?

APM Code Set consists of the following categories of primary care codes:

• LARC
• Cardiovascular system
• Immunization administration
• E&M - Outpatient
• E&M - Nursing facility
• E&M - DomiCiliary, rest home
• E&M - Home visits
• E&M - Preventive medicine
• E&M - SBIRT
• OB/GYN
• Depression Screening

89 TOTAL codes
Who is eligible?

<table>
<thead>
<tr>
<th>Practice Transformation Programs</th>
<th>Eligibility Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>No programs/PCMH</td>
<td>CY2019</td>
</tr>
<tr>
<td>SIM</td>
<td>CY2020</td>
</tr>
<tr>
<td>CPC+</td>
<td>CY2021</td>
</tr>
</tbody>
</table>
What is this program?

- **Points-Based System** • the State assigns points per measure
- **You choose the measures annually**
- **You submit measure performance annually**
- **If you hit a certain point threshold, then you earn a certain percent enhancement on your FFS rates for the APM code set**

<table>
<thead>
<tr>
<th>APM Quality Score range</th>
<th>% FFS Enhancement</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 46</td>
<td>&lt; 1%</td>
</tr>
<tr>
<td>47 - 93</td>
<td>1% - &lt; 2%</td>
</tr>
<tr>
<td>94 - 140</td>
<td>2% - &lt; 3%</td>
</tr>
<tr>
<td>141 - 190+</td>
<td>3% - 4%+</td>
</tr>
</tbody>
</table>
What does that ACTUALLY mean I have to do?

1) **Choose your measures (select 10)**
   - Structural
   - Performance
     - Claims
     - ECQMs

2) **Improve and work on the measures you selected during the performance year.**

3) **Submit measures end of performance year for evaluation.**

4) **Payment will change at the beginning of the next fiscal year.**
For example:

- **Practice ABC is eligible in 2020.**
- **They selected the following measures in December 2019 for PY2020:**
  - **Structural:** Care Compacts, ED Hospital follow-up, risk stratification
  - **eCQMs:** Diabetes A1C, Depression screening and follow-up, controlling high blood pressure, maternal depression screening, Diabetes foot exam
  - **Claims:** Breast cancer screening, colorectal cancer screening
## Points by Measure

**Point breakdown:**

<table>
<thead>
<tr>
<th>Type</th>
<th>Measure</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>Care Compacts</td>
<td>20</td>
</tr>
<tr>
<td>Structural</td>
<td>ED/Hospital Follow-Up</td>
<td>40</td>
</tr>
<tr>
<td>Structural</td>
<td>Risk Stratification</td>
<td>50</td>
</tr>
<tr>
<td>eCQM</td>
<td>Diabetes A1c</td>
<td>50</td>
</tr>
<tr>
<td>eCQM</td>
<td>Controlling HTN</td>
<td>50</td>
</tr>
<tr>
<td>eCQM</td>
<td>Depression Screening and Follow-Up</td>
<td>30</td>
</tr>
<tr>
<td>eCQM</td>
<td>Maternal Depression Screening</td>
<td>30</td>
</tr>
<tr>
<td>eCQM</td>
<td>Diabetes Foot Exam</td>
<td>10</td>
</tr>
<tr>
<td>Claims</td>
<td>Breast Cancer Screening</td>
<td>20</td>
</tr>
<tr>
<td>Claims</td>
<td>Colorectal Cancer Screening</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>330</strong></td>
</tr>
</tbody>
</table>

(CAUTION: breakdown above is for PY2019. We are still waiting for 2020 measure release with point values)
Measure Improvement

- Improve upon the measures in 2020
  - **Structural measures have documentation guidance from state**
    - Care compacts: at least 1 example of a care compact with a specialist and 1 example of a care compact with behavioral health provider
    - ED/Hospital follow-up: documented process for ED and hospital follow-up (including timeframe and documented process for identifying which ED/hospital visits the practice has determined require follow-up
    - Risk stratification: documented risk stratification methodology and documented process used to identify and provide care management for patients, based on risk stratification
Measure Improvement

• Improve upon the measures in 2020
  • Performance measures
    • eCQMs
      • Data validity
      • Reporting
      • Quality improvement (workflows, PDAS, etc.)
    • Claims
      • Workflows
      • Billing/Coding accuracy

• How do you succeed in eCQMs and Claims?
  • Y1 • Pay for Reporting
  • Y2 • Pay for Improvement
Reporting Measures – end of PY

Structural

- RAES will collect and verify documentation

eCQMs

- Report via the eCQM solution tool by Health Data Colorado

Claims

- HC Pf will complete reporting from claims
## Practice Performance - Example

<table>
<thead>
<tr>
<th>Type</th>
<th>Measure</th>
<th>Points</th>
<th>Pass/Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural</td>
<td>Care Compacts</td>
<td>20</td>
<td>Pass</td>
</tr>
<tr>
<td>Structural</td>
<td>ED/Hospital Follow-Up</td>
<td>40</td>
<td>Fail</td>
</tr>
<tr>
<td>Structural</td>
<td>Risk Stratification</td>
<td>50</td>
<td>Fail</td>
</tr>
<tr>
<td>eCQM</td>
<td>Diabetes A1c</td>
<td>50</td>
<td>Pass</td>
</tr>
<tr>
<td>eCQM</td>
<td>Controlling HTN</td>
<td>50</td>
<td>Pass</td>
</tr>
<tr>
<td>eCQM</td>
<td>Depression Screening and Follow-Up</td>
<td>30</td>
<td>Pass</td>
</tr>
<tr>
<td>eCQM</td>
<td>Maternal Depression Screening</td>
<td>30</td>
<td>Pass</td>
</tr>
<tr>
<td>eCQM</td>
<td>Diabetes Foot Exam</td>
<td>10</td>
<td>Pass</td>
</tr>
<tr>
<td>Claims</td>
<td>Breast Cancer Screening</td>
<td>20</td>
<td>Pass</td>
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<tr>
<td>Claims</td>
<td>Colorectal Cancer Screening</td>
<td>30</td>
<td>Pass</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>330</strong></td>
<td><strong>240</strong></td>
</tr>
</tbody>
</table>

![APM Quality Score range and % FFS Enhancement](image)

%FFS Enhancement will be effective as of July 1, 2021 for PY2020.
Annual Timelines

- Measure Selection
- Performance Year
- Measure Reporting
- FFS Enhancement
- Measure Selection
- Performance Year
- Measure Reporting
What can RMHP do for you?

- Assist with measure selection to ensure alignment
- Assist with process improvement to ensure your success in the program
- Review documentation for structural measures and offer feedback
- Assist with ECQ M reporting capabilities
- Answer program questions
- Take feedback to the State in regards to program design/measures
- Communicate with practices in regards to any changes with the APM
- Collaborate with HDCO for ECQM reporting
- Assist with reporting to the State and HDCO
What’s next?

- **Waiting for eligibility of practices from the State**
  - Hint: if you're a SIM-ONLY practice, you will probably become eligible for 2020
- **Waiting on measure/point finalization from the State**

December:

- **Select measures** • State will email a SurveyLink
  - RMHP will be reaching out to you to help with measure selection, but if you want assistance sooner than later, email chelsea.watkins@rmhp.org
- **Begin thinking about process improvement for 2020 to meet the measures you selected**
Where can I find more information?


- Stay tuned for updated Survival Guide released by the State!

- Look for more information the 2020 RMHP RAE Resource Guide • released early December!

- RMHP, as the RAE, can help with any questions and be the communication vehicle with the State
Get Involved

• **Sign-up for monthly newsletters!**
  - Email Mindy Patton ([mindy.patton@rmh.org](mailto:mindy.patton@rmh.org))
  - Give me your email address after the presentation

• **Attend in the monthly Value-based Contracting Office Hours**
  - **Third Tuesday every month from 12:15-1:15pm**
  - 2020 Registration Link: https://zoom.us/meeting/register/43605906784eb34f7510d14dafa9e911
Contact

Chelsea Watkins
Clinical Informaticist
(Chelsea.Watkins@rmhp.org)

Annie Schudy
Clinical Informaticist
(annie.Schudy@rmhp.org)
Questions?
Objectives

• Develop and explore a deeper understanding of measures CMS 137 Initiation and Engagement of Alcohol and other Drug Dependence Treatment and CMS 165 Controlling High Blood Pressure.

• Identify resources such as clinical recommendation statements, practice guidelines and measure specifications on CMS 137 and CMS 165
Test Your Knowledge
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

1. What age group does this measure apply to?

2. A patient must complete a screener to be added into the denominator? True/False

3. This measure address vaping? True/False

4. This measure addresses medication-assisted therapy? True/False

https://www.cdc.gov/nchs/data/databriefs/db329-h.pdf
Drug Overdose Rates – CO 1999-2016

Figure 1. Drug Poisoning Deaths in Colorado, 1999-2016

Source: Vital Statistics Program, Colorado Department of Public Health and Environment

https://www.coloradohealthinstitute.org/research/death-drugs
### Area Profile
State: Colorado

<table>
<thead>
<tr>
<th>Category</th>
<th>Population</th>
<th>Health Measure</th>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Other Drug Use</td>
<td>Adults</td>
<td>Binge Drinking - Adults (%)</td>
<td>2017</td>
<td>18.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heavy alcohol consumption - Adults (%)</td>
<td>2017</td>
<td>6.7</td>
</tr>
<tr>
<td>High school students</td>
<td></td>
<td>Alcohol use, current - High School Students (%)</td>
<td>2017</td>
<td>28.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Binge drinking - High School Students (%)</td>
<td>2017</td>
<td>16.0</td>
</tr>
</tbody>
</table>

https://www.colorado.gov/pacific/cdphe/vision-data-tool
# Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (CMS 137/NQF 0004)</th>
</tr>
</thead>
</table>
| **Description** | Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported:  
a. Percentage of patients who initiated treatment within 14 days of the diagnosis.  
b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. |
| **Initial Patient Population** | Patients age 13 years of age and older who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency during a visit between January 1 and November 15 of the measurement period. |
| **Numerator** | Numerator 1: Patients who initiated treatment within 14 days of the diagnosis  
Numerator 2: Patients who initiated treatment and who had two or more additional services with an alcohol, opioid, or other drug abuse or dependence diagnosis within 30 days of the initiation visit |
| **Denominator** | Equals Initial Population |
| **Exclusions/Exceptions** | Patients with a previous active diagnosis of alcohol, opioid or other drug abuse or dependence in the 60 days prior to the first episode of alcohol or drug dependence  
Exclude patients whose hospice care overlaps the measurement period. |
| **Links** | Measure Specifications  
Colorado Opioid Summary  
Integrating Addiction and Primary Care Services |

## Program Suites & Targets

<table>
<thead>
<tr>
<th></th>
<th>PRIME Required Measure</th>
<th>RAE 2.72%</th>
<th>CPC+ N/A</th>
<th>RMHP Programs Practice Driven</th>
</tr>
</thead>
</table>

## KPI Call Out

| SUD ED Utilization (Regional): | Y5 – 25.1 visits PKPY | Y6 – 19.5 visits PKPY |

### Practice Workflow

1. Consider creating a practice workflow to screen for potential substance use during visits. Examples of screening tools include:  
   AUDIT (Alcohol Use Disorders Identification Test) – Adults  
   DAST-10 (Drug Abuse Screening Test) – Adults/Adolescents  
   ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) – Adults/Adolescents/Pediatric  
   CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) – Adolescent/Pediatric
2. Institute a process to address substance use during visits.  
3. Create a standardized process to follow, after diagnosis, that includes scheduling follow up or creating a referral. Note – integrated behavioral health visits count toward this measure.  
4. Ensure that your EMR can track treatment initiation and follow up visits.

### Did ya know? Tips/Tricks

- The intake period, which captures new episodes of alcohol or drug dependence, is Jan 1 – Nov 15 of the measurement period. The Nov 15 cut-off date ensures that all services can occur before the measurement period ends.  
- The initiation visit is the first visit for AOD treatment within 14 days after a diagnosis of AOD dependence.  
- Treatment includes inpatient AOD admissions, outpatient visits, intensive outpatient encounters or partial hospitalization.

### Why care?

- There are more deaths, illnesses and disabilities from substance abuse than from any other preventable health condition.  
- In 2011, an estimated 22.5 million persons (8.7% of the population aged 12 or older) were classified with substance dependence or abuse. ([ECOJ Measure Rationale, 2019](#))
CMS 137: Initiation and Engagement of Alcohol and other Drug Dependence Treatment

Version 8:

• Treatment initiation now includes either a treatment intervention or medication.
• The two or more additional services can now include treatment interventions or a medication.
• For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.
• The two additional interventions (or a medication) now must occur within 34 days of the initiation visit.
Test Your Knowledge
Controlling High Blood Pressure

1. Which age group does this measure apply to?

_____________________________________

2. What BP is considered controlled, per this measure?
   a. <200/100
   b. <120/80
   c. <140/90
   d. <110/125

3. If a patient is diagnosed with essential hypertension (for the first time) in the month of October, are they included in the denominator for this measurement period?
   Y/N
## Controlling High Blood Pressure

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Controlling High Blood Pressure (CMS 165/NQF 0018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90) during the measurement period.</td>
</tr>
<tr>
<td>Initial Patient Population</td>
<td>Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure &lt; 140 mmHg and diastolic blood pressure &lt; 90 mmHg) during the measurement period.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Initial Patient Population</td>
</tr>
</tbody>
</table>
| Exclusions/Exceptions | - Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period.  
- Exclude patients with a diagnosis of pregnancy during the measurement period.  
- Exclude patients whose hospice care overlaps the measurement period. |

### Fun Links
- Measurement Specifications
- Clinical Guidelines
- CDC Hypertension Statistics

### Program Suites & Targets

<table>
<thead>
<tr>
<th>PRIME CQM</th>
<th>PRIME HEDIS</th>
<th>RAE</th>
<th>CPC+</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>70.94%</td>
<td>70.94%</td>
</tr>
</tbody>
</table>

### KPI Call Out
Recent data for RAE Region 1 shows $3.7 million in Potentially Avoidable Costs attributed to hypertension.

### Practice Workflow
2. Build a registry or tracking system to support tracking.  
3. Verify your practice’s ability to recall or follow-up with hypertensive patients.

### Did ya know? Tips/Tricks
- There are nine ICD-10 codes for primary hypertension and five for secondary hypertension. However, only one – I10 Essential Hypertension – triggers a patient to be in the denominator.  
- The follow-up visit must be a visit with a provider to count for this measure (a nurse visit does not count).  
- Remember: only the last BP recorded counts for this measure. If no blood pressure is recorded during the measurement period, the patient’s blood pressure is assumed "not controlled."  
- Prior to labeling a person with hypertension, it is important to use an average based on ≥2 readings obtained on ≥2 occasions to estimate the individual’s level of BP.

### Why care? Add Updated Info
- A person who has HBP is four times more likely to die from a stroke and three times more likely to die from heart disease (CDC, 2012).  
- Data from 2011-2012 found that 17.2% of US adults are not aware they have hypertension.  
- By 2030 approximately 41.4% of US adults will have hypertension. This is an increase of 8.4% from 2012 estimates.  
- The estimated annual average direct and indirect cost of HBP from 2012 to 2013 was $51.2 billion (Benjamin et al., 2017). Total direct costs of HBP is projected to increase to $200 billion by 2030 (Benjamin et al., 2017).
Percent of adult Coloradans with high blood pressure by region, 2013.

The prevalence of high blood pressure ranged from 18% to 32% in regions of Colorado.

In general, the prevalence of high blood pressure was highest in Eastern Colorado.
Accurate blood pressure measurement is very important. Population wide, small inaccuracies in blood pressure measurement can have considerable consequences. Underestimating true blood pressure by 5 mm Hg would mislabel more than 20 million Americans with prehypertension when true hypertension is present, and would be a 25% increase over current levels of fatal strokes and fatal myocardial infarctions for these individuals. *(Handler, 2009)*

Common factors affecting accuracy of blood pressure measure:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Magnitude of systolic/diastolic blood pressure discrepancy (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking or active listening</td>
<td>10/10</td>
</tr>
<tr>
<td>Distended bladder</td>
<td>15/10</td>
</tr>
<tr>
<td>Cuff over clothing</td>
<td>5–50/</td>
</tr>
<tr>
<td>Cuff too small</td>
<td>10/2–8</td>
</tr>
<tr>
<td>Smoking within 30 minutes of measurement</td>
<td>6–20/</td>
</tr>
<tr>
<td>Paralyzed arm</td>
<td>2–5/</td>
</tr>
<tr>
<td>Back unsupported</td>
<td>6–10/</td>
</tr>
<tr>
<td>Arm unsupported, sitting</td>
<td>1–7/5–11</td>
</tr>
<tr>
<td>Arm unsupported, standing</td>
<td>6–8/</td>
</tr>
</tbody>
</table>
CMS 165: Controlling High Blood Pressure

Version 8.5:
Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period

In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure.
Panelist Introductions
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CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes

This document includes the following CPT E/M changes, effective January 1, 2021:

- E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215
- Revised Office or Other Outpatient E/M codes 99202-99215

For the complete version of E/M Introductory guideline changes, Office or Other Outpatient (99202-99215) code changes, Prolonged Services code (99354, 99355, 99356, 99XXX) and guideline changes, see Complete E-M Guideline and Code Changes.doc.

Note: this content will not be included in the CPT 2020 code set release

Category I
Evaluation and Management (E/M) Services Guidelines
Guidelines Common to All E/M Services

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021 and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service.

When time is used to select the appropriate level for E/M services codes, time is defined by the service descriptors. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician’s or
other qualified health care professional’s time is spent in the supervision of clinical staff who perform the face-
to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of a service for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and/or other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate add-on code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

- **Total time on the date of the encounter (office or other outpatient services [99202-99205, 99212-
99215]):** For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).

Physician/other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

**Services Reported Separately**

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician’s interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making.
The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

**Guidelines for Office or Other Outpatient E/M Services**

**History and/or Examination**

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 treating physician or other qualified health care professional reporting the service. The care team may collect information and the patient or caregiver may supply information directly (eg, by portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of office or other outpatient services.

**Number and Complexity of Problems Addressed at the Encounter**

One element in the level of code selection for an office or other outpatient service is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect medical decision making. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

Definitions for the elements of medical decision making for office or other outpatient services are (see Table 2 Levels of Medical Decision Making):

- **Problem**: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

- **Problem addressed**: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient’s medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being ‘addressed’ or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

- **Minimal problem**: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician’s or other qualified health care professional’s supervision (see 99211).

- **Self-limited or minor problem**: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.
**Stable, chronic illness:** A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). ‘Stable’ for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, non-insulin dependent diabetes, cataract, or benign prostatic hyperplasia.

**Acute, uncomplicated illness or injury:** A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

**Chronic illness with exacerbation, progression, or side effects of treatment:** A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

**Undiagnosed new problem with uncertain prognosis:** A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

**Acute illness with systemic symptoms:** An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for ‘self-limited or minor’ or ‘acute, uncomplicated.’ Systemic symptoms may not be general, but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

**Acute, complicated injury:** An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

**Chronic illness with severe exacerbation, progression, or side effects of treatment:** The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

**Acute or chronic illness or injury that poses a threat to life or bodily function:** An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

**Test:** Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set.

**External:** External records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization.

**External physician or other qualified healthcare professional:** An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty.
It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

**Independent historian(s):** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

**Independent Interpretation:** The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.

**Appropriate source:** For the purpose of the Discussion of Management data element, an appropriate source includes professionals who are not health care professionals, but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

**Risk:** The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as ‘high’, ‘medium’, ‘low’, or ‘minimal’ risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

**Morbidity:** A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

**Social determinants of health:** Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

**Drug therapy requiring intensive monitoring for toxicity:** A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent, but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold.
Instructions for Selecting a Level of Office or Other Outpatient E/M Service

Select the appropriate level of E/M services based on the following:

1. The level of the medical decision making as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

Medical Decision Making

Medical decision making includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. Medical decision making in the office and other outpatient services code set is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. This data includes medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not separately reported. It includes interpretation of tests that are not separately reported. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Data is divided into three categories:
  - Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)
  - Independent interpretation of tests.
  - Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source
- The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient’s problem(s), the diagnostic procedure(s), treatment(s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Four types of medical decision making are recognized: straightforward, low, moderate, and high. The concept of the level of medical decision making does not apply to code 99211.

Shared medical decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

Medical decision making may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not be counted in the medical decision making when selecting a level of office or other outpatient service. When the physician or other qualified professional is reporting a separate service for discussion of management with a physician or other qualified health care professional, the discussion is not counted in the medical decision making when selecting a level of office or other outpatient service.
The Level of Medical Decision Making table (Table 2) is to be used as a guide to assist in selecting the level of medical decision making for reporting an office or other outpatient E/M service code. The table includes the four levels of medical decision making (ie, straightforward, low, moderate, high) and the three elements of medical decision making (ie, number and complexity of problems addressed, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of medical decision making, two of the three elements for that level of medical decision making must be met or exceeded.

Table 2: Level of Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>Code</th>
<th>Level of MDM (Based on 2 out of 3 Elements of MDM)</th>
<th>Elements of Medical Decision Making</th>
<th>Risk of Complications and/or Morbidity or Mortality of Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99212</td>
<td></td>
<td>Low</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Limited</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99213</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.
- Category 1: Tests and documents
  - Any combination of 2 from the following:
    - Review of prior external note(s) from each unique source*;
    - review of the result(s) of each unique test*;
    - ordering of each unique 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)
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>• 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</td>
</tr>
<tr>
<td>99214</td>
<td>Moderate</td>
<td>(Must meet the requirements of at least 1 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)</td>
</tr>
<tr>
<td>99205</td>
<td>High</td>
<td>• 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 to life or bodily function</td>
</tr>
<tr>
<td>99215</td>
<td>Extensive</td>
<td>(Must meet the requirements of at least 2 out of 3 categories) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);</td>
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<td></td>
<td></td>
<td>or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)</td>
</tr>
</tbody>
</table>

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Evaluation and Management

Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care or initial nursing facility care.

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226. For observation or inpatient care services (including admission and discharge services), see 99234-99236.

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Coding Tip

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Determination of Patient Status as New or Established Patient

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

CPT Coding Guidelines, Evaluation and Management, Definitions of Commonly Used Terms, New and Established Patient

New Patient

(99201 has been deleted. To report, use 99202)

★▲99202  Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★▲99203  Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
★▲99204  Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★▲99205  Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

(For services 75 minutes or longer, see Prolonged Services 99XXX)

Established Patient

▲9921  Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

★▲99212  Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

★▲99213  Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

★▲99214  Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

★▲99215  Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes or longer, see Prolonged Services 99XXX)
Prolonged Services

Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)

Codes 99354-99357 are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient, observation or outpatient setting, except with office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215). Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient’s floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure. Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period.

Codes 99354-99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes 99356-99357 are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient’s floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.

Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.

Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

The use of the time-based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99XXX.

For prolonged total time in the Office or Other Outpatient Services, use 99XXX.

The following table illustrates the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the inpatient or observation setting beyond the usual service time.
<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes (30 minutes - 1 hr. 14 min.)</td>
<td>99356 X 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)</td>
<td>99356 X 1 AND 99357 X 1</td>
</tr>
<tr>
<td>105 or more (1 hr. 45 min. or more)</td>
<td>99356 X 1 AND 99357 X 2 or more for each additional 30 minutes.</td>
</tr>
</tbody>
</table>

**99354** Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202-99215])

(Use 99354 in conjunction with 90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483)

(Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99415, 99416, 99XXX)

**99355** each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99355 in conjunction with 99354)

(Do not report 99355 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99415, 99416, 99XXX)

**99356** Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)

(Use 99356 in conjunction with 90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)

**99357** each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99357 in conjunction with 99356)

**Prolonged Service Without Direct Patient Contact**

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215). For prolonged time without direct patient contact on the date of office or other outpatient services, use 99XXX. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to-face encounter.
This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time without direct patient contact reported in other services such as care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other qualified health care professional (99491), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/internet/electronic health record consultations (99446-99452), or on-line digital evaluation and management services (9X0X1, 9X0X2, 9X0X3).

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services Without Direct Face-to-Face Contact</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes (30 minutes - 1 hr. 14 min.)</td>
<td>99358 X 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)</td>
<td>99358 X 1 AND 99359 X 1</td>
</tr>
<tr>
<td>105 or more (1 hr. 45 min. or more)</td>
<td>99358 X 1 AND 99359 X 2</td>
</tr>
</tbody>
</table>

Do not report 99358, 99359 when performed during the service time of codes 99495 or 99496, if reporting 99495 or 99496.
Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision

Codes 99415, 99416 are used when a prolonged evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.

Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous. Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.

Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date. Prolonged service of less than 45 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes. The typical face-to-face time of the primary service is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 25 minutes, and 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed. When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.

Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour. Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Codes 99415, 99416 may be reported for no more than two simultaneous patients. The use of the time-based add-on codes requires that the primary E/M service has a typical or specified time published in the CPT code set.

For prolonged services by the physician or other qualified health care professional, see 99354, 99355, 99XXX. Do not report 99415, 99416 with 99354, 99355, 99XXX.

Facilities may not report 99415, 99416.

#499415 Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)

(Use 99415 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)

(Do not report 99415 in conjunction with 99354, 99355, 99XXX)

#499416 each additional 30 minutes (List separately in addition to code for prolonged service)

(Use 99416 in conjunction with 99415)

(Do not report 99416 in conjunction with 99354, 99355, 99XXX)
The Total Duration of Prolonged Services Table illustrates the correct reporting of prolonged services provided by clinical staff with physician supervision in the office setting beyond the initial 45 minutes of clinical staff time:

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 45 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>45-74 minutes (45 minutes - 1 hr. 14 min.)</td>
<td>99415 X 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)</td>
<td>99415 X 1 AND 99416 X 1</td>
</tr>
<tr>
<td>105 or more (1 hr. 45 min. or more)</td>
<td>99415 X 1 AND 99416 X 2 or more for each additional 30 minutes.</td>
</tr>
</tbody>
</table>

**Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service**

Code 99XXX is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services (ie, 99205, 99215). Code 99XXX is only used when the office or other outpatient service has been selected using time alone as the basis and only after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded. To report a unit of 99XXX, 15 minutes of additional time must have been attained. Do not report 99XXX for any additional time increment of less than 15 minutes.

Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time.

For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, see 99415, 99416. Do not report 99XXX in conjunction with 99205, 99215 and prolonged services time.

Prolonged services of less than 15 minutes total time on the date of the office or other outpatient service (ie, 99205, 99215) is not reported.

**★✦●99XXX**  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; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

(Use 99XXX in conjunction with 99205, 99215)

(Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)

(Do not report 99XXX for any time unit less than 15 minutes)
<table>
<thead>
<tr>
<th>Total Duration of New Patient Office or Other Outpatient Services (use with 99205)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 75 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>75-89 minutes</td>
<td>99205 X 1 and 99XXX X 1</td>
</tr>
<tr>
<td>90-104 minutes</td>
<td>99205 X 1 and 99XXX X 2</td>
</tr>
<tr>
<td>105 or more</td>
<td>99205 X 1 and 99XXX X 3 or more for each additional 15 minutes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 55 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>55-69 minutes</td>
<td>99215 X 1 and 99XXX X 1</td>
</tr>
<tr>
<td>70-84 minutes</td>
<td>99215 X 1 and 99XXX X 2</td>
</tr>
<tr>
<td>85 or more</td>
<td>99215 X 1 and 99XXX X 3 or more for each additional 15 minutes.</td>
</tr>
</tbody>
</table>
The

BRAVING INVENTORY

**Boundaries** | You respect my boundaries, and when you’re not clear about what’s okay and not okay, you ask. You’re willing to say no.

**Reliability** | You do what you say you’ll do. At work, this means staying aware of your competencies and limitations so you don’t over promise and are able to deliver on commitments and balance competing priorities.

**Accountability** | You own your mistakes, apologize, and make amends.

**Vault** | You don’t share information or experiences that are not yours to share. I need to know that my confidences are kept, and that you’re not sharing with me any information about other people that should be confidential.

**Integrity** | You choose courage over comfort. You choose what is right over what is fun, fast, or easy. And you choose to practice your values rather than simply professing them.

**Nonjudgment** | I can ask for what I need, and you can ask for what you need. We can talk about how we feel without judgment.

**Generosity** | You extend the most generous interpretation possible to the intentions, words, and actions of others.
DARING GREATLY
LEADERSHIP MANIFESTO

leader /ˈlɪdər/ n: Anyone who holds her- or himself accountable for finding potential in people and processes.

WE WANT TO SHOW UP, WE WANT TO LEARN AND WE WANT TO INSPIRE.

WE ARE HARDWIRED FOR CONNECTION, CURIOSITY, AND ENGAGEMENT.

WE CRAVE PURPOSE, AND WE HAVE A DEEP DESIRE TO CREATE AND CONTRIBUTE.

WE WANT TO TAKE RISKS, EMBRACE OUR VULNERABILITIES, AND BE COURAGEOUS.

WHEN LEARNING AND WORKING ARE DEHUMANIZED – WHEN YOU NO LONGER SEE US AND NO LONGER ENCOURAGE OUR DARING, OR WHEN YOU ONLY SEE WHAT WE PRODUCE OR HOW WE PERFORM – WE DISENGAGE AND TURN AWAY FROM THE VERY THINGS THAT THE WORLD NEEDS FROM US: OUR TALENT, OUR IDEAS, AND OUR PASSION.

WHAT WE ASK IS THAT YOU ENGAGE WITH US, SHOW UP BESIDE US, AND LEARN FROM US.

FEEDBACK IS A FUNCTION OF RESPECT; WHEN YOU DON’T HAVE HONEST CONVERSATIONS WITH US ABOUT OUR STRENGTHS AND OUR OPPORTUNITIES FOR GROWTH, WE QUESTION OUR CONTRIBUTIONS AND YOUR COMMITMENT.

ABOVE ALL ELSE, WE ASK THAT YOU SHOW UP, LET YOURSELF BE SEEN, AND BE COURAGEOUS. DARE GREATLY WITH US.

from Daring Greatly by Brené Brown Copyright © 2019 Brené Brown, LLC.
Dear (patient),

We recently receive a report showing that you were seen in a local Emergency Room. We sincerely hope that you are feeling much better. **If you did call your provider first and were instructed to go to the Emergency Room, thank you for calling.** If you did not call your provider before going to the Emergency Room, please consider doing so in the future.

This letter is to request our patients to call our office first, before going to the Emergency Room, unless your condition is life threatening.

**If your condition is life threatening, please go directly to the Emergency Room or call 911.**

We want to make sure you are aware of our business or clinic hours, Monday-Friday, 7:30 am to 5:00 pm, as well as Saturday hours one time a month. We also have providers available for questions and advice of an urgent nature 24 hours a day, 7 days a week via our usual phone number, (970)241-7600.

We know that accidents don't always happen during office hours. We have included a brochure to help guide your decisions as to when to seek immediate care, and where to go. Please refer to the brochure if you are not sure if we can meet your needs. Western Medical Associates can treat most illnesses and minor injuries with less waiting time and only a fraction of the cost of a hospital emergency room visit.

Please call for an appointment if we can help you avoid an unnecessary emergency room visit and expense.

Please, call us first! We are happy to serve you.

**Melissa Schmalz, DO**       **Mark Twardowski, DO**
**Brett Lindau, DO**       **Roy Mears, DO**       **Thomas Moore, DO**
**Amanda Coltrinari, FNP**       **Sylvia Saunders, FNP**       **Deb Twardowski, ANP-BC**
Rocky Mountain Health Plans (RMHP) works with knowledgeable and experienced **Care Coordinators** in your community to get you the care you need, when you need it — at no cost to you.

**Care Coordinators can:**

- Find a primary care or behavioral health provider for you or a loved one
- Arrange transportation to your provider visits
- Attend provider visits with you
- Explain your benefits and what your coverage means
- Connect you to local community resources that might be right for you
- Help you complete applications for housing, SNAP, and other assistance programs

To contact a Care Coordinator, call RMHP at **888-282-8801 (TTY: 711)**. 
Para asistencia en español llame al **888-282-8801**.
At Rocky Mountain Health Plans (RMHP), we want to provide you with the tools to help you best serve your patients — and our Members. The below table illustrates measures and KPIs for Dental Visits.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>KPI: Dental Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Percentage of members who received professional dental services, including services from both medical and dental claims</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Distinct count of members who received at least one dental service within the 12-month evaluation period</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Distinct count of members enrolled in the ACC on the last day of the last month of the 12-month evaluation period</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>Dental visits counted in the numerator are included in CDT codes (D0000 to D9999)</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Population exclusion: Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period</td>
</tr>
<tr>
<td><strong>Measure Specifications</strong></td>
<td>Please refer to the Department of Health Care Policy and Financing’s KPI Methodology document for the full measure specifications. The Dental code value sets can be found here under the “Performance measurement” section. The KPI Methodology is subject to changes made by the Department.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>Coding for Dental Services, Cavity Free at Three Training (free), Smiles For Life Training (free), RAE Dental Benefits (DentaQuest), Dental Resources</td>
</tr>
<tr>
<td><strong>KPI Baseline and Targets</strong></td>
<td>RAE Region 1 Baseline SFY 17-18 performance for members with full Medicaid residing in each RAE Region: 33.384% Level 1 Target: 1%-5% increase above baseline receives 75% of payment Level 2 Target: &gt;5% increase above baseline receives 100% of payment</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Calculated monthly by IBM Watson using fee-for-service claims; data is reported monthly for a rolling 12-month period (90 days claims run out)</td>
</tr>
<tr>
<td><strong>Practice Interventions for Improvement</strong></td>
<td>• Educate patients on importance of dental care • Educate staff and providers on the link between oral health and physical health • Complete the dental training programs for primary care providers, enabling the provision of oral screenings, oral exams, fluoride, etc. in the primary care setting • Develop a referral loop workflow for patients referred out to dental service; review list of patients not obtaining dental services and seek to identify and address barriers for patients not obtaining appropriate dental care • Develop a resource list for the practice including dental providers, types insurances accepted, clinic hours, emergency dental services, etc.</td>
</tr>
<tr>
<td><strong>Tips for Using Data</strong></td>
<td>• Using the IBM Watson Data Analytics Portal for this measure, identify patients on the “not served” list to identify patients who have not had a dental service during the evaluation period • Use a referral tracking mechanism in your practice to close the loop, address no-shows, etc., if referring out for dental services</td>
</tr>
</tbody>
</table>

Revised November 2019
A Menu of Joy
( Strategies for increasing staff satisfaction and reducing burnout in healthcare)

1. Team-based care
2. Patient & family advisory council
3. Immediate feedback (“What could I have done better?”)
4. Daily team huddles with non-clinical items
5. Clinician “float pools” for life events or locum tenens
6. Assess clinician satisfaction and well-being
7. Schedule flexibility and clinician control
8. Mindfulness and resilience training
9. Wellness committee and infrastructure (salad club?!) 
10. Employee input
11. Rapid, clear, actionable feedback after asking permission (“Can I give you some feedback?”)
12. Recognize daily work, reward “over-the-top” work
13. Vocalize compassion: “I appreciate this,” “I’m grateful I get to work with you,” “I trust you to do that”
14. Learner-centered model of employee discipline/restorative justice
15. Teaching
16. Friendship
17. Walking outside
18. Expressions of:
   • Love
   • Respect
   • Empathy
19. Empowerment
20. Teamwork
21. Thanking
22. “It’s important to me that I help”
23. Food and drink
24. Team building activities
25. Friendly competitions
26. Communication
27. Stay interviews
28. Onboarding
29. Recognizing important life events for the team (weddings, baby showers, birthdays)
30. Clearly defining roles and expectations
31. Scheduled check-ins with immediate team to make sure that values and priorities are consistent and communicated
32. “3 Good Things”: scan last 24 hours and identify 3 positive/good things that happened to you – share with someone or write them down