DHMP PROVIDER NEWSLETTER

DENVER HEALTH MEDICAL PLAN INC.™

January 17, 2024

Risk Adjustment in 2024: Medicare and Exchange

As of January 1st, the health status for all risk adjusted members is reset. This includes Medicare Advantage, and members on Colorado Option, Exchange, and new Peak region plans.

Each year, the list of Hierarchical Condition Categories (HCCs) and Risk Adjustment Factor Score (RAF) for each patient is reset. Denver Health Medical Plan, Inc. (DHMP) members are considered **completely healthy until diagnosis codes are reported** on claims.

In order for DHMP to receive Federal and State compensation for the care of its members, providers should:

- Fully document and accurately code the evaluation and management of all severe and chronic conditions to ensure a full, complete and accurate clinical record of the patient's condition.
- Reflect the work involved in caring for the patient, particularly those with complex and challenging health issues.

Documentation Guidelines:

- Providers should document each clinical diagnosis to the highest degree of specificity per encounter, including all complications and/or manifestations, and including clear links to causal conditions.
- Only confirmed conditions should be documented; no rule-out conditions or abnormal findings without clinical significance.
- All known conditions, including chronic conditions, that affect the care and treatment of the patient at least once per year should be noted.
- Providers should specifically document the condition and clinical significance, and pertinent changes using terminology such as decreased, increased, worsening, improving, unchanged or abnormal findings.

Additionally, for Medicare Advantage members, any diagnoses captured in telephone-audio only visits **do not** count towards risk adjustment. However, services provided using interactive audio and video telecommunications systems that permit real-time interactive communications **do** count toward risk adjustment. Physicians or qualified Non-Physician Practitioner (NPP), please make every effort to see Medicare Advantage members face-to-face at least once during 2024!

2024 Current Procedural Coding (CPT®) Changes to Professional Services

Each new year brings new, revised, and deleted CPT codes and coding guidelines that become effective January 1. For 2024, there are 230 new codes, 70 revised codes, and 49 deleted codes. There are no code changes for anesthesia, the integumentary system, the digestive system, the male genital system, or the auditory system. The most significant changes are in the sections for Evaluation and Management (E/M) services, the phrenic nerve stimulation system, lab and pathology, COVID-19 and RSV vaccinations, and Category III Codes. Below are the E/M and Medicine changes.

Evaluation and Management

In the E/M section, code descriptors for office and other outpatient visit codes (99202-99215) were revised to remove the time ranges to be consistent with other E/M codes. For example, the descriptor for 99213 now reads "... 20 minutes must be met or exceeded." This editorial change doesn't change the time associated with each code.

Also in this section, E/M guidelines were added to split/shared visits. CPT® states that the substantive part of the encounter using Medical Decision Making (MDM):

... requires that the physician(s) or other QHP(s) made or approved the management plan **for the number and complexity of problems addressed at the encounter** and takes responsibility for that plan with its inherent **risk of complications and/or morbidity or mortality of patient management**. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM.

Data is also covered in the guidelines, which is the third element of E/M. If the code selection is based on time, the provider who spent most of the time would report the service in a split/shared visit.

Guidelines were also added to clarify how to report multiple E/M services on the same date. For example, hospital inpatient and observation care and nursing facility visits are "per day" services. If the patient is seen multiple times during the same day in the same setting by a provider of the same specialty and subspecialty in the same group practice, a single E/M code is reported. A review of the E/M guidelines in detail is needed for proper E/M coding.

Also in this section, two nursing facility codes were revised to change the time for 99306 from 45 minutes to 50 minutes and 99308 from 15 minutes to 20 minutes.

CPT® is **not** changing the descriptor to 99211 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. You will continue to use this code per usual in 2024.

Medicine

Two new codes were created for Respiratory Syncytial Virus (RSV) in the immune globulins subsection of the medicine section for the monoclonal antibody, seasonal dose. The code is selected based on dose: 90380 describes a 0.5 mL dose and 90381 describes a 1 mL dose. There are two new vaccine supply codes for RSV. Code 90679 describes reF, subunit, and bivalent, for intramuscular use. Code 90683 describes preF, recombinant, subunit, and adjuvanted, for intramuscular use.

There have been many changes to the COVID-19 vaccine codes that are not included in the CPT® 2024 code book because the changes were made after the code book was printed.

A new vaccination administration code, 90480, was approved for reporting the administration of any COVID-19 vaccine for any patient (pediatric or adult), replacing all previously approved specific vaccine administration codes. The new administration code includes counseling.

There are three new Pfizer vaccine product codes: 91318 is for patients who are 6 months through 4 years; 91319 is for patients who are 5 years through 11 years; and 91320 is for patients who are 12 years and older.

There are two new Moderna vaccine product codes: 91321 is for patients who are 6 months through 11 years and 91322 is for patients who are 12 years and older.

The new codes went into effect on Sept. 11, 2023. All previously approved COVID-19 vaccine supply and administration codes will be deleted from the CPT® code set effective Nov. 1, 2023. All the changes can be found on the AMA website and in the AAPC blog. The changes are also covered in CPT® Assistant Erratum for Special Edition: August Update, also available on the AMA website.

Reminder: Do not code "Diabetes with complications" and "Diabetes without complications" on the same encounter.

Elevate Medicare Advantage Healthy Food Benefit

Elevate Medicare Advantage offers a healthy food benefit is part of the Special Supplemental Benefits for the Chronically Ill, and not all members qualify. As a member qualifies based on having one or more of these approved chronic conditions.

- Chronic alcohol and other dependency
- Autoimmune disorder
- Cancer
- Cardiovascular disorders
- Chronic heart failure
- Diabetes
- Dementia
- End-stage liver disease
- End-stage renal disease (ESRD)
- Severe hematologic disorder
- HIV/AIDS
- Chronic lung disorder
- Chronic and disabling mental health conditions
- Neurologic disorder
- Stroke

Members who are not identified can self-attest if they believe they qualify, but it's only good for 12 months. As part of the attestation, members acknowledge that they need to visit their doctor to get diagnosed for their condition to remain eligible after 12 months. A list of approved HCC codes is available at DenverHealthMedicalPlan.org/for-providers.

If you have questions about the program or qualifications, visit our website at DenverHealthMedicalPlan.org/medicare/flexcard or you can email MedicareDHMP@dhha.org.

If you have any questions regarding this training or risk adjustment in general, contact:

- Clinical Documentation Integrity (CDI) Team at **DL_CDI@dhha.org**; or
- DHMP's Risk Adjustment Team at **DL_Risk.Adjustment @dhha.org**

Reference: ICD-10-CM Expert for physicians 2024