DHMP PROVIDER NEWSLETTER

DENVER HEALTH MEDICAL PLAN INC.™

January 17, 2025

Denver Health Medical Plan Risk Adjustment 2025: Medicare and Exchange

As of January 1, the health status for all Medicare members has been reset!

Medicare members are considered **completely healthy until diagnosis codes are reported** on claims, so it is essential that providers capture all **current and active diagnoses for each member**, as well as re-capture any **diagnoses related to each member's chronic conditions.** This helps ensure that DHMP has the resources needed to provide quality care to our members.

Additionally, any diagnoses captured in telephone-only visits do not count towards risk adjustment. Please make every effort to **see Medicare members in person at least once during 2025!**

Each year, the list of Hierarchical Condition Categories (HCCs) and Risk Adjustment Factor Score (RAF) for each patient are 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, which 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.

Including:

- All conditions that are relevant to a member's current care
- Review all relevant conditions annually.
- Chronic conditions (diabetes, heart failure, COPD)
- Active status conditions (amputations, ostomy)
- Pertinent past conditions (previous cancers, previous stroke)
- Accurately document and use correct codes for active treatment vs "history of"
- All conditions being treated with medication.

Use the MEAT acronym to ensure that the most complete and accurate information is being documented: • Monitor: must indicate that you asked about the current status of the condition; signs and symptoms; disease progression or regression. • Evaluate: exam results; lab/imaging findings; medication effectiveness; patient response to treatment. • Assess/Address: note the current medical status of the member's condition; order tests; give patient education; review records; counsel patient and family members. • Treat: record the treatment plans; medications, therapies, procedures, modalities.

Coding Discrepancies:

2025 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 2025, There are 420 overall updates in the CPT 2025 code set, including 270 new codes, 112 deletions, and 38 revisions.

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, descriptors for telephone services codes (99441-99443) were deleted and a new family of codes was created for telemedicine services that includes synchronous audio-video E/M for new patients (98000-98003) and established patients (98004-98007) and synchronous audio-only E/M for new patients (98008-98011) and established patients (90012-90015). A new code, 90016, was introduced for virtual check-in visits.

Medicine

- There are three new influenza virus vaccine product codes: 90637 is for quadrivalent (qIRV), mRNA; 30 mcg/0.5 mL dosage; 90638 is for quadrivalent (qIRV), mRNA; 60 mcg/0.5 mL dosage; and 90695 is for H5N8, derived from cell cultures.
- Three new add-on codes were created for a vasoreactivity study (+93896), emboli detection without intravenous microbubble injection (+93897), and venous-arterial shunt detection with intravenous microbubble injection (+93898). All are performed with a complete transcranial Doppler (TCD) study of intracranial arteries (93886).
- Code 96040 for medical genetics and genetic counseling services was deleted and a new code (96041) was created in its place.

All coding updates can be found at:

AMA releases CPT 2025 code set | American Medical Association

2025 CPT® Coding Updates - AAPC Webinar

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