Colorectal Screening
Quality Reporting
Equals
Quality Care

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Colorectal Screenings

• Colorectal cancer (CRC) is a leading cause of cancer mortality worldwide.

• Colorectal cancer mortality has declined slightly in the last 10 years, and the decrease appears to be accelerating.

• This decline is due in large part to screening and early detection.
Screening Options

• Fecal occult blood testing (FOBT) remains a mainstay of average-risk screening despite limitations in sensitivity and specificity.

• Colonoscopy - cost of colonoscopy is coming down, cost-benefit models suggest that the yield from colonoscopy may be significantly greater than the difference in cost among the various surveillance methods.

• Colonoscopy is increasingly recommended more strongly as a screening alternative.
Breakdown of Screening Data
Education

- College graduate: 67%
- Some college/Associates: 62%
- High School Graduate: 54%
- < High School: 45%
Preventive Services Resource

DEPARTMENT OF HEALTH AND HUMAN SERVICES • Centers for Medicare & Medicaid Services

PREVENTIVE SERVICES

SELECT A SERVICE FOR CODES AND BILLING INFORMATION

Some of the services listed include codes you may provide via telehealth – this symbol designates these services.

This educational tool provides the following information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare). For additional guidance on the use of diagnosis codes, go to the Claims Processing Manual, Publication 100-04, Chapter 10 on the Centers for Medicare & Medicaid Services (CMS) website.

NOTE: We return preventive services next eligible dates for many of these services when you request Medicare eligibility. If you do not currently get this data, contact your eligibility service provider to determine availability. Refer to the frequently asked questions section of this document for information on how to request the next eligible date.

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Colorectal Cancer Screening

Effective January 1, 2016, use CPT code 81528 when billing for the Cologuard™ test (note that your MAC will accept HCPCS code G0464 for claims with dates of service on or before December 31, 2015).

Only laboratories authorized by the manufacturer to perform the Cologuard test may bill for this test.

HCPCS/CPT Codes

- 00810: Anesthesia for lower intestinal endoscopic procedures, enoscope introduced distal to duodenum
- 81528: Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
- 82270: Blood, occult, by peroxidase activity (eg, guaiac), qualitative: feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
- G0104: Flexible Sigmoidoscopy
- G0105: Colonoscopy (high risk)
- G0106: Barium Enema (alternative to G0104)
- G0120: Barium Enema (alternative to G0105)
- G0121: Colonoscopy (not high risk)
- G0328: Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous
- G0464: Colorectal cancer screening, stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

ICD-10-CM Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance.

For Cologuard Multitarget Stool DNA (sDNA) Test, use Z12.11 and Z12.12

Who Is Covered

For colorectal cancer screening using Cologuard — a Multitarget Stool DNA (sDNA) Test:

All Medicare beneficiaries:
- Aged 50 to 85 years;
- Asymptomatic; and
- At average risk of developing colorectal cancer

For screening colonoscopies, FOBTs, flexible sigmoidoscopies, and barium enemas:

All Medicare beneficiaries:
- Aged 50 and older who are at normal risk of developing colorectal cancer; or
- At high risk of developing colorectal cancer
Colorectal Cancer Quality Measure

Measure #113 (NQF 0034): Colorectal Cancer Screening – National Quality Strategy Domain: Effective Clinical Care

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.
Quality Reporting
Sample Calculations

**Reporting Rate** =

Performance Met (a = 3 patients) + Performance Exclusion (b = 2 patients) +
Performance Not Met (c = 2 patients) = 7 patients / 8 eligible patients = 87.50%

**Performance Rate** =

Performance Met (a = 3 patients) / Reporting Numerator = 7 Patients – Performance Exclusion (b = 2 patients) = 3 patients / 5 patients = 60%
Pathways to Quality Reporting

Thinking outside of the box:
Chronic Care Management

- Patient with 2 or more chronic conditions placing patients at risk of serious complications or death
- Non face to face encounters
- NP/PA/Midlevels/RN/LPN can call once a month 20 minutes
- Proactive approach to reduce rep
- Monthly revenue impact could be $42
Chronic Care Management

• Works very well with MIPS pathways as patient with multiple comorbidities are identified
• Reflects complexities of care with likelihood of increasing benchmark expenditures
• Annual revenue impact could be close to $210,000 for 500 patients
Advance Care Planning

• Every Medicare patients should be given opportunity of understanding ACP thru MDs

• Now billable and reimbursed

• Revenue impact could be close to $140 depending geographical location and variables

• May need to be done more than once if patient’s condition or social circumstances change
Transitional care management

• For any patient discharged from hospitalization, need to be seen within a week or contact to be made via phone.

• Needs to be seen multiple times to prevent risk of rehospitalization.

• On 30th day 99495 or 99496
Smoking cessation

• Identifying tobacco smoking is one of the PQRS measures

• For those known to be nicotine users, smoking cessation counseling is one of the PQRS intervention needed to be reported

• Multiple encounters may be needed, reimbursable depending on duration of encounter
Chronic Care Management and Payment Reforms

• CCM is organizing framework to address health at individual level and population health.

• Covers non face-to-face services.

• Multiple chronic conditions (at least 2 or more)

• Chronic conditions placing patient at risk of death

• Comprehensive care services plan established, revised or modified as needed

• The higher the number of conditions, the higher the cost of care
Labwork

Impression

- Chronic ischemic heart disease
- Cancer of Lung - Reviewed all available workup.
- Cancer.

Plan

- CAD(ischemic heart disease): Care plan formulated and disease-relevant materials shared. Monthly reassessment, chest pain/dyspnea symptoms, clinical status, physician/ER visits, and medication compliance, to be performed. Care coordination, including symptom management, in conjunction with primary physician and cardiologist.
- All active and current medical problems, medication list, allergies, smoking status and vital signs, were reviewed and taken into account for the formulation of the comprehensive care plan.
- CCM program details were shared with the patient.
- Improved access, medication, and disease management through the CCM program was discussed with the patient.
- Lifestyle modification for primary, and secondary, disease prevention was carried out in detail.
- Medication reconciliation was performed.
- Patient agrees for the plan of action.
- Patient agrees to participate in the CCM program and is enthusiastic about the collaborative nature of the program.
- Performance status was reviewed.
- Smoking cessation counseling and lifestyle modification for primary and secondary disease prevention was carried out in detail.
- Age appropriate cancer screening and prevention measures were discussed.
- Cancer: Care plan formulated with patient. Disease-related materials shared on prior visit during therapy plan formulation. Monthly reassessment to be done for clinical status and medical compliance. Care coordination to be performed with primary physician as needed.
Chronic care management (CCM) and payment reforms: Nothing to lose; all to gain

<table>
<thead>
<tr>
<th>Process</th>
<th>Cross cutting into Payment reforms</th>
<th>APM</th>
<th>MIPPS-VBC</th>
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<tbody>
<tr>
<td>Cross sectional care across providers</td>
<td>Reduced ER visit/hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive care plans</td>
<td>IOM Care plan (APM, OCM)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Structured data recording</td>
<td>EHR-MUII</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Expanded access to care</td>
<td>OCM requirement; reduces cost</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Multiple chronic conditions</td>
<td>Appropriates for additional cost of care (from $2000 to $36,000)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Direct patient contact</td>
<td>Improves satisfaction</td>
<td>✓</td>
<td>✓</td>
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APM - Alternative Payment Model
MIPPS-VBC - Medicare Improvement Plan for Patients with End Stage Renal Disease - Value Based Coverage
OCM - ω-Comprehensive Care Model
Organizing CCM

• Comprehensive care plans
• Consent
• Capture all eligible patients weekly
• Make list of all enrolled patients
• Divide call list between clinical care team
• Maintain call logs
Current Pilots with Actual Practice

• **BCBS Pilot:**
PMPM care coordination fees, 29 patients since October 2015. Additional cognitive service codes reimbursements (Advance care planning, patient education, genetic counseling, weekend extra rates, nutrition services)

• **CCM:**
Over 600 patient enrolled, with seamless coordination of care; monthly revenue stream (over $20K; reduced ER visits and registering higher severity of case leading to increased allowance for spend

• **In talks with two other major payers**
Non E/M cognitive services can be additive

- Meets PQRS reporting requirement (Tobacco cessation, depression and alcohol use screening)
- Reflects true complexities of care
- Increases possible benchmark expenditure allowance
- Reduced re-hospitalization
- Revenue impact could be between $700-1000 annually
# Rewards of Whole Person Care

## Non E/M Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Reimbursement</th>
</tr>
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<tbody>
<tr>
<td>99490</td>
<td>Chronic Care Management</td>
<td>$42</td>
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<tr>
<td>99495 – 96</td>
<td>Transitional Care Management</td>
<td>$168 - $238</td>
</tr>
<tr>
<td>99497 – 98</td>
<td>Advance Care Planning</td>
<td>$140</td>
</tr>
<tr>
<td>99406 – 07</td>
<td>Smoking Cessation Counseling</td>
<td>$14 - $33</td>
</tr>
<tr>
<td>G0442 – G0444</td>
<td>Depression and Alcohol Use Screening (Counseling)</td>
<td>$17 - $25</td>
</tr>
</tbody>
</table>
Thank You

Q & A