



RHP Insight Education Curriculum
2025 Curriculum



**Spartanburg Regional
Healthcare System**

**DIAGNOSIS SPECIFICITY:
WITH HTN AND HF**

SRHS MGC Value-Based Arrangement Education

Nick Ulmer MD CPC FAAFP



Value-Based Arrangement Education

The following is required reading as introduction to this educational session. Please pause the slides as you need to allow time to read this information



Value-Based Arrangement Education

This presentation follows our prior correspondence and meetings regarding the new value-based incentive component of the 2025 SRHS Primary Care Compensation Model. The Value-Based Incentive is detailed in the 2025 Primary Care Physician Employment agreement (Exhibit A-6).

Spartanburg Regional Healthcare System has created a Value-Based Enterprise with employed primary care physicians. Through the Value-Based Enterprise, the parties will collaborate to achieve goals for patients in the district service area. These goals include coordinating and managing care, improving the quality of care, and transition in healthcare delivery and payment to mechanisms based on the quality of care and control of cost of care.

The Value-Based Enterprise will achieve these goals through the Value-Based Activities described in the Value-Based Incentive portion of the Physician Employment Agreement. These activities include successful completion of diagnosis code training and accurate diagnosis code utilization as measured through educational chart reviews and other activities.



Value-Based Arrangement Education (cont.)

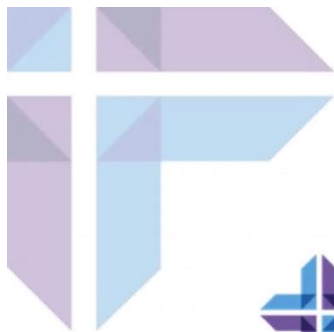
Appropriate, accurate, and specific diagnosis code utilization is a core component of medical documentation and care coordination. Proper and accurate utilization of diagnosis codes strengthen the medical documentation and ensures the patient's conditions are fully memorialized in the medical record. These activities enhance both quality of care and efforts to coordinate and manage care of patients for the District. This training module is intended to provide additional training background and resources for accurate diagnosis code utilization.

The Value-Based Enterprise reflects a collaborative process, created by regulatory agencies. MGC, and in conjunction with RHP will oversee, monitor and administer the Value-Based Enterprise's activities. Exhibit A-6 of your Physician Employment Agreement describes the governance and operation of the value-based efforts.



Value-Based Arrangement Education (cont.)

As SRHS moves into value-based clinical arrangements, the importance of documentation accuracy cannot be overstated. Previous provider educational chart reviews have shown opportunities to better align clinical thought-work with chronic condition documentation of medical necessity in our encounters. The intent of this education is to help educate providers to be more “clinically correct” in the written expression of our work with the patients we care for.



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Objectives

- Define diagnosis specificity in the pt with a hypertensive condition
- Define diagnosis specificity in the patient with Heart Failure
- Be familiar with the 2025 value-based review tool for the heart failure patient
- Show how HF and other conditions combine to show HCC disease interactions in clinical settings



Review of Basic E&M: what's needed...?

- CMS E&M Clarification: The CMS E&M Services Guide (08.2023), went into effect 01.2024
 - A chief complaint is still important. This has been removed from the CPT (Commercial) guidelines. A brief “follow-up for HTN” is enough (so stay away from “here for recheck” or just “follow up”)
 - The history and exam is still important – CMS still feels a “medically appropriate history and exam” should be present – provider can decide how much. Care team can help collect, provider still needs to validate.
 - Duration (how long), Severity (BP #, EF%, etc.), Modifying Factors (meds, diet, exercise, etc.), Asso. Features (symptoms like edema, orthopnea, etc.)

Patient here for BP flu. Diagnosed 2020. BP at home checked weekly and all below 135/85. Not exercising but 1-2x/week and trying to limit fatty foods. On Lisinopril HCTZ. No CP, SOB, edema.



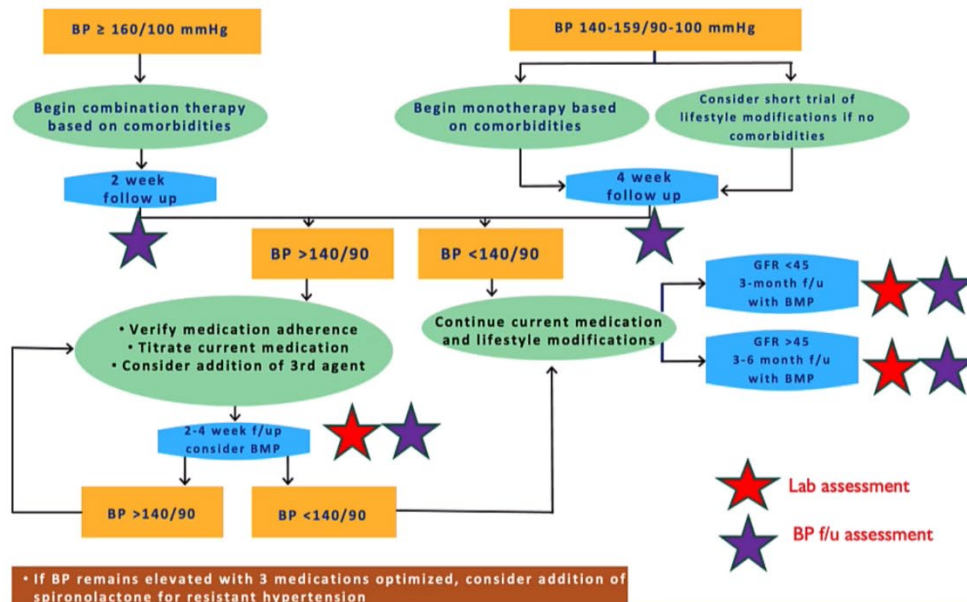
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 - Duration (how long), Severity (BP #, EF%, etc.), Modifying Factors (meds, diet, exercise, etc.), Asso. Features (symptoms like edema, orthopnea, etc.)
 - Exam should touch on the organ system(s) affected at least to include vital signs

131/77 68 176#

Alert, NAD. Lungs- clear CV- regular, no murmurs

CMS 2023, August MLN006764





HFrEF Treatment

For ALL patients:
 ACE Inhibitor or ARB or ARNI
 AND Evidence based Beta Blocker
 AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
 AND SGLT2 inhibitor



Initiate loop diuretic
 (dose prn or daily as clinically indicated)



Titrate ACE/ARB/ARNI, BB, Aldosterone Antagonist to target doses as clinically tolerated
 Continue diuretic prn or daily
 Follow up symptoms q1-6 months and prn

	Starting Dose	Target Dose
ARNI: *starting dose and timing dependent on current ACE/ARB dose		
Sacubitril/Valsartan (Entresto®)	24/26mg twice daily	97/103mg twice daily
ACE Inhibitors		
Enalapril	2.5mg twice daily	10mg twice daily
Lisinopril	2.5mg once daily	20-40mg once daily
Captopril	6.25mg three times daily	50mg three times daily
ARBs		
Valsartan (Diovan®)	20-40mg twice daily	160mg twice daily
Candesartan (Atacand®)	4-8mg once daily	32mg once daily
Losartan (Cozaar®)	25mg once daily	50-100mg once daily
Evidence Based Beta Blockers		
Bisoprolol	2.5mg once daily	10mg once daily
Carvedilol (Coreg®)	3.125mg twice daily	25mg twice daily
Metoprolol Succinate (Toprol XL®)	12.5-25mg once daily	200mg once daily
Aldosterone Antagonist		
Spirinolactone	12.5-25mg once daily	25-50mg once daily
Eplerenone (Inspra®)	12.5-25mg once daily	25-50mg once daily



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 - Exam should touch on the organ system(s) affected at least to include vital signs
 - With time-based, time needs to be documented specifically, but CMS can still look at the documentation to see if it meets “medical necessity”. So, even with time-based billing, we need to have a good, clinically pertinent story

CMS 2023, August MLN006764



Educational Review of Clinical HF Visits: info needed?

- We (Kellyn Provance from RHP) will be doing educational reviews to be used in the 2025 Value-Based education – we will provide feedback of the findings
- The things we will look for are very basic and common



Educational Review of Clinical HF Visits: info needed?

1. Does the patient have heart failure? Is it on the problem list? Is it coded correctly?
2. Was an ejection fraction performed within the last 24 months? What was last EF and date?
3. If a cardiologist is on the case, is their name added to the Care Team?
4. What was the last blood pressure (date and value) and if it was >140/>90 was hypertension documented in problem list?
5. What was the K⁺, eGFR, and Cr date collected and value (<12 mo)
6. Was CKD diagnosed if eGFR was <60? Correctly?
7. Last BMI date/value and if >35 was morbid obesity diagnosed?
8. On a Statin? If not, is adverse event related to statins documented?
9. Smoking status addressed? Was cessation discussed if a current smoker?
10. Were Advance Directives addressed in last 12 months?
11. Influenza or pneumonia vaccine addressed/given/declined?
12. Is the next appointment within three months of the last appointment?



Cardiovascular Conditions v24 → v28 HCC Updates

- Saw some of the biggest changes in the Version 24 → Version 28 transition
- Vascular diseases
 - Atherosclerotic disease with intermittent claudication is now not risk adjusted, only the rest pain PAD – native or bypass – counts for HCC risk
 - Thoracic/Abd Aorta, Renal artery aneurysm risk-assigned only if *ruptured*
 - Venous stasis ulcers can sometimes clot and develop an ulcer – if so, it now has HCC risk.



Cardiovascular Conditions

- Saw some of the biggest changes in the Version 24 → Version 28 transition
- ASCVD
 - Cardiomyopathy due to drugs, no risk now; other c-myopathies OK
 - Angina pectoris is only risk adjusted if unstable angina
 - SVT is no longer risk adjusted but all other abnormal rhythms are



Correctly Coding the Condition: HTN

- Basic hypertension ICD-10 code is I10, but there no risk score is associated with uncomplicated hypertension. Recall CMS and tell a good (but brief) “story”
- CMS recognizes disease interaction between hypertension, chronic kidney disease and heart failure and attributes risk factors for these interactions. Demonstrate the severity of illnesses you are managing by capturing (hx, exam, MDM) all conditions that apply to your patient.
- *Always consider the causal relationship between HTN & Chronic Kidney Disease, HTN & Heart Failure, or a combination of all three.*
 - Code first the hypertensive CKD, hypertensive heart failure, or the hypertensive heart failure with CKD then the stage of CKD and/or heart failure acuity



Disease State: CKD

- Avoid “Chronic Kidney Disease, unspecified” if stage is known
- Chronic Kidney Disease is defined as
 - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
 - GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR **albumin/Cr > 30mg/g****

**recommended method to assess albuminuria



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 - GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR **albumin/Cr > 30mg/g****
- Stage I normal, eGFR > 90ml/min N18.1
- Stage II mild, eGFR 60-89ml/min N18.2
- *Stage III** *mod* *eGFR 30-59 ml/min* *+.127** N18.30 or N18.31 or N18.32
- *Stage IV* *severe* *eGFR 15-29 ml/min* *+.514* N18.4
- *Stage V* *kid. failure with eGFR < 15 ml/min* *+.815* N18.5 (ESRD 18.6, Z99.2 dialysis)

* 2019

**recommended method to assess albuminuria



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 - GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR **albumin/Cr > 30mg/g****
- Stage I normal, eGFR > 90ml/min • Prove stability before assigning condition
- Stage II mild, eGFR 60-89ml/min • Add ICD10 Dx code to problem list
- **Stage III*** **mod eGFR 30-59 ml/min +.127*** • Educate patients as to the “why”
- **Stage IV** **severe eGFR 15-29 ml/min +.514** • If comorbid, add to base code
- **Stage V** **kid. failure with eGFR < 15 ml/min +.815** • Reassess each year to insure correct

* 2019

**recommended method to assess albuminuria



HF and CKD Disease Interaction

- The base HTN diagnosis again adds no HCC risk.
- HTN LVH due to the HTN that is not affecting function, is simple cardiomyopathy (LVH) (aka “hypertensive heart disease”) – also NO risk



HTN and HF

- The base HTN diagnosis again adds no HCC risk: 110.0
- HTN LVH due to the HTN that is not affecting function, is simple cardiomyopathy (LVH) W/O HF– also NO risk 111.9
- If the HTN was the cause of chronic kidney disease, **the CKD does** add HCC risk (for discussion, assume stage IIIa/IIIb, less than III is not risk adjusted)
 - Adds 0.127 to the risk score



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- **Stage III* mod eGFR 30-59 ml/min +.127***
- ~~Stage IV severe eGFR 15-29 ml/min +.511~~
- Stage V kid. failure with eGFR < 15 ml/min +.815

- 112.9 HTN w/ CKD: no HCC
- N18.31 CKD Stage III: 0.127

* 2019

**recommended method to assess albuminuria



Other Comorbid States to Hypertension?

Any associated conditions like

-chronic kidney disease?
-heart failure?



Correctly Coding the Condition: HF

- Basic HF (I50) has the same HCC risk score as the more specific types of HF, like “systolic” (I50.2) or diastolic (I50.3).
 - These are “constrained” in v28 HCC, so all the same HCC weight (0.360)
- We still recommend coding to the highest degree of specificity specific to each encounter regardless of the HCC weight
- Recall CMS recommends a “basic” amount of documentation
 - Cardiac symptoms (DOE, CP), recent ED visits/hospitalization, medication compliance (and the use of ACE/ACE-I, ARB, Diuretics, ?beta blocker), assessment review (Echo – 2 yr), weight ck, Cardiologist and plan of care. etc.



HTN and HF

- The base HTN diagnosis again adds no HCC risk.
- HTN LVH due to the HTN that is not affecting function, is simple cardiomyopathy (LVH) – also NO risk
- If the HTN was the cause of chronic kidney disease, **the CKD does** add HCC risk (for discussion, assume stage IIIa or IIIb, less than III is not risk adjusted)
 - Adds 0.127 to the risk score
- HTN *with* the resultant **HF does add HCC risk** (due to the HF component). Capture the HF to the highest degree of specificity (acute/chronic, reduced/preserved EF, etc.)
 - Adds 0.360 to the risk score: HF diagnosis is “constrained” (all 0.360 - even unspecified)



Disease Interaction “HCC Math”

- | | |
|---|-------|
| ▪ Hypertensive Nephropathy (I12.9) Stage I → 4 | 0.000 |
| ▪ (Hypertension) <u>Kidney Disease, Stage IIIa</u> (N18.31) | 0.127 |
| ▪ Hypertensive Cardiomyopathy (Ht Dz) w/ HF (I11.0) | 0.360 |

The combination of the heart failure and the chronic kidney disease evaluated in the same encounter is seen as a comorbid disease interaction and adds HCC risk to the encounter. *No additional ICD 10 diagnoses are required* as the combination of the two diseases in the same encounter automatically adds the disease interaction HCC weight.



Disease Interaction “HCC Math”

▪ Hypertensive Nephropathy (I12.9) Stage I → 4	0.000
▪ (Hypertension) <u>Kidney Disease, Stage IIIa</u> (N18.31)	0.127
▪ Hypertensive Cardiomyopathy (Ht Dz) w/ HF (I11.0)	0.360
▪ Disease interaction between HF and CKD	0.176
Total HCC risk for condition	0.663

The combination of the **heart failure** and the **chronic kidney disease** evaluated in the **same encounter** is seen as a **comorbid disease interaction** and adds **HCC risk to the encounter**. *No additional ICD 10 diagnoses are required* as the combination of the two diseases in the same encounter automatically adds the disease interaction HCC weight.



Disease Interaction “HCC Math”

- Heart Failure – constrained, still document to highest specificity!!

Disease interactions

Make sure to assess/manage HF at every encounter that it is present in your patients!

▪ Heart Failure and Diabetes	0.112
▪ Heart Failure and chronic lung disorder	0.078
▪ Heart Failure and kidney	0.176
▪ Heart Failure and specified heart arrhythmias	0.077
▪ Chronic lung disorder and cardiorespiratory failure	0.254
▪ Substance Disorder and psychiatric	0.087



Disease Interaction “HCC Math”

Disease interactions defined:

- HF and DM -- all types
- HF and chronic lung d/o – COPD, trnsplnts, CF, Pulm Fibrosis, asthma (if severe, persistent)
- HF and kidney – III-V
- HF and specified heart arrhythmias – SSS, Afib/flutter, Ht Block, etc., (but not SVT)
- Chronic lung disorder and cardiorespiratory failure – home O₂, Trach status
- Substance Disorder and psychiatric – opioids/anxiolytics, **severe** major depression (note psychosis)



Closing

- HCC coding should mean to the clinician a chance to capture disease specificity to show the complexity of the patient/population that is being managed. (“my patients are sicker”)
- Use of HCC diagnosis codes should be mirrored with documentation of the clinical thought-work that goes into an encounter where you show active management of a condition. (“think in ink”)
- Capture in the A/P all the conditions being managed at a visit – and especially focus on those CMS noted with disease interactions
 - HF (#1), Chronic lung diseases (add respiratory failure), DM, CKD, anxiety/depression/opioids and all forms of heart arrhythmias (not SVT)

Thanks for participating in the 2025 Value-Based Incentive Education!!



Diagnosis Specificity with HTN and HF

- Thanks for taking this session!
- Good Luck on the post test!

- Nick Ulmer, MD CPC FAAFP
 - EUlmerMD@srhs.com



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