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EVOLVE YOUR PRACTICE FOR TOMORROW'S PATIENTS

CRITICAL CONVERSATIONS

Boost MIPS scores while improving osteoarthritis patient management

By **LISA A. ERAMO, MA** *Contributing author*

HIGHLIGHTS

- **Osteoarthritis functional and pain assessments help meet the overarching goal of MIPS to improve outcomes and reduce costs.**
- **Ask patients to come into the office early to get the forms filled out, to prevent EHR headaches later.**

Although there's no cure for osteoarthritis, it's certainly possible for primary care physicians to not only help their patients manage symptoms, but also improve reimbursement for doing so

The debilitating chronic condition affects more than 30 million adults in the United States, according to the CDC. Functional and pain assessments—something many physicians perform regularly—are critical because they help target interventions that ultimately improve patients' quality of life.

These assessments can also boost payments under the Merit-based Incentive Payment System (MIPS), one of two participation tracks under the federal law that seek to reform Medicare payments while improving outcomes and reducing costs.

To satisfy MIPS criteria, physicians must report CPT code 1006F (indicating that they performed an assessment for function and pain) along with one of the following osteoarthritis diagnosis codes:

- M15.-Polyosteoarthritis
- M16.-Osteoarthritis of hip
- M17.-Osteoarthritis of knee
- M18.-Osteoarthritis of first carpometacarpal joint
- M19.-Other and unspecified osteoarthritis

Physicians aren't required to use validated assessment instruments to get credit under MIPS. The only requirement is that the instrument assess pain and various functional elements including a patient's ability to perform activities of daily living. For example, physicians can use a standardized scale or ask patients to complete a questionnaire such as Short Form-36 or American Academy of Orthopaedic Surgeons Hip and Knee Questionnaire. Acceptable pain assessments include the following:

- Visual Analog Scale
- Patient-Reported Outcomes Measurement Information System (PROMIS)
- Numeric Pain Rating System

Acceptable functional assessments include the following:

- General quality of life: Veterans RAND 12, PROMIS (PROMIS 10 or PROMIS Computerized Adaptive Test), or EuroQol-5D
- Foot and ankle: Foot and Ankle Ability Measure or Foot and Ankle Disability Index
- Knee (anterior cruciate ligament): International Knee Documentation Committee Subjective Knee Form or Marx Activity Rating Scale
- Knee (osteoarthritis): Knee Injury and Osteoarthritis Outcome Score (KOOS) or KOOS Jr.

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Osteoarthritis documentation tips

Anissa Calhoun, COC, CPC, a coding specialist in Boston, says physicians should document the following details for osteoarthritis:

1. **Type of osteoarthritis (i.e., polyosteoarthritis, primary, post-traumatic, or secondary).**
2. **Affected joints (i.e., hip, knee, first carpometacarpal joint, shoulder, elbow, wrist, hand, ankle, or foot).**
3. **Laterality (i.e., left, right, bilateral, or unilateral).**

Generally speaking, payers are looking for specificity at all times, says Calhoun, adding that many physicians continue to document "osteoarthritis" without any additional information. "We had that grace period after ICD-10 went into effect when insurance companies were flexible with unspecified codes," she says. "But now that time is over, and insurers are starting to require more information."

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- **Hip (osteoarthritis): Hip Disability and Osteoarthritis Outcomes Survey (HOOS) or HOOS Jr.**
- **Shoulder: American Shoulder and Elbow Surgeons Standardized Shoulder Assessment Form, Oxford Shoulder Score, or Single Assessment Numeric Evaluation**
- **Shoulder (instability): ASES or Western Ontario Shoulder Instability Index**
- **Elbow, wrist, and hand: Disabilities of the Arm, Shoulder, and Hand Score (DASH) or Quick-DASH**

ASSESS FOR FUNCTION & PAIN

Osteoarthritis functional and pain assessments help meet the overarching goal of MIPS to improve outcomes and reduce costs because these assessments help to identify patients who can benefit from early intervention, says James Daniels, MD, MPH, a primary care physician in Quincy, Ill. Daniels served on the American Academy of Orthopaedic Surgeons committee that helped develop the osteoarthritis MIPS measure.

"We've got an aging population. This means the volume of patients with osteoarthritis is rapidly expanding," says Daniels, who is also professor of family medicine and orthopedic surgery at Southern Illinois School of Medicine in Carbondale, Ill. Osteoarthritis assessments can help physicians intervene and potentially improve long-term outcomes, reduce hospitalizations due to falls, and prevent expensive surgeries such as hip or knee replacements.

In many cases, functional and pain assessments paint a more accurate picture of a patient's experience than a diagnostic image, says Fotios Koumpouras, MD, a rheumatologist and assistant professor of medicine at Yale University in New Haven, Conn. Koumpouras often sees cases in which an X-ray reveals minor disease, but the patient reports significant pain or loss of function that requires intervention.

However, physicians also need to be aware of the potential for inflated pain scores due to the presence of comorbid conditions, says Koumpouras. "We know by studies that individuals with depression, for example, will score worse on the pain assessments not necessarily due to their primary disease but because of comorbid conditions that affect their answers and perception of what's going on," he says. In these cases, physicians may need to address the underlying depression in order to improve osteoarthritis symptoms.

Still, the assessments are a good first step to get patients on the right course of treatment, says Nitin Damle, MD, an internist at South County Internal Medicine in Wakefield, R.I., and past president of the American College of Physicians. Half of his patients over age 50 have some degree of osteoarthritis. "[The assessments] give us a better idea of how to manage the osteoarthritis with anti-inflammatories, physical therapy, weight reduction, stretching, tai chi, balance exercises, or a combination of all of these," he says.

Aside from helping physicians meet the relevant MIPS measure, osteoarthritis functional and pain assessments can help justify to payers why patients may need physical therapy, says Daniels. The information also helps orthopedists to whom patients are referred. "The orthopedists don't need to start from scratch, which probably saves a visit or two in terms of trying different methods," he adds.

Finding the time for patients to complete these assessments—and then incorporating that information into the EHR—is a challenge, says Koumpouras. Some EHR vendors may be able to load the assessments so physicians can send them to patients via the portal for completion prior to their appointments.

Asking patients to come into the office in advance of their scheduled appointment time to complete the forms using the digital pen or completing the forms on paper and scanning them into the EHR may also be an option.

Carl Franzetti, DO, a primary care physician at Riverdale Family Practice in New York City, hopes to use his EHR kiosk to help perform the assessments. Between 70 and 80 percent of his patients over the age of 30 have some form of osteoarthritis. "Ideally, we want the patient to come in and go right to the kiosk to answer a series of questions that populates in the chart right away," he adds.

The goal is to have as much information as possible in the EHR prior to the physician stepping into the exam room so he or she can spend time recommending treatment rather than collecting information, he says.

Manage rheumatoid arthritis and related quality metrics

By **LISA A. ERAMO, MA** *Contributing author*

Approximately 1.5 million people in the United States have rheumatoid arthritis, according to the Arthritis Foundation. Prescribing a disease-modifying anti-rheumatic drug (DMARD) for patients with rheumatoid arthritis not only helps alleviate symptoms, but it may also help physicians trigger performance-based bonuses from certain commercial payers.

That's because rheumatoid arthritis is a condition included in the 2018 Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of commercial insurers to measure physicians' performance on care and service.

Many payers tie physician bonuses directly to their ability to satisfy HEDIS requirements—in this case, the ability to dispense at least one ambulatory prescription for a disease-modifying anti-rheumatic drug for patients with rheumatic arthritis ages 18 and older

PRESCRIBING DMARDs

Early intervention is critical for patients with rheumatoid arthritis, and it's also something that payers increasingly must report as a HEDIS measure. If physicians can show that they provide high-quality, evidence-based care—either through prescribing DMARDs or working with rheumatologists to co-manage care—payers might provide physicians with a performance bonus, says Colleen Gianatasio CPC, CRC, risk adjustment quality and education program manager at Capital District Physician's Health Plan in Albany, N.Y.

Physicians—particularly those in rural areas without easy access to rheumatologists—need to feel comfortable recognizing the signs and symptoms so they can prescribe first-line standard medications, such as methotrexate, says Fotios Koumpouras, MD, a rheumatologist and assistant professor of medicine at Yale University.

"The first thing is to pick up the phone and call the rheumatologist," he says. "A quick phone call can actually make the internist feel more comfortable to initiate a treatment plan."

Nitin Damle, MD, an internist in Wakefield, R.I., agrees. "The more we can communicate with rheumatologists, the better we can be at managing the problems that arise," he says. "If we need to change a medication, for example, that's much easier to do when there's a collegial relationship."

Having a collegial relationship with rheumatologists not only helps physicians meet MIPS and HEDIS measures, it can also assist

HIGHLIGHT

Chronic care management (CCM) programs can help open the lines of communication with rheumatologists. With CCM, practices have already created workflows that promote frequent communication with specialist.

"The more [primary care physicians] can communicate with rheumatologists, the better we can be at managing the problems that arise."

—NITIN DAMLE, MD, INTERNIST, WAKEFIELD, R.I.

with Accountable Care Organization (ACO) quality reporting, says Gregory Steinmetz, MD, a primary care physician at Associates Primary Care Medicine in Warwick, R.I.

For example, to fulfill its obligations under an ACO contract, Steinmetz's practice previously had to report whether patients with rheumatoid arthritis were prescribed a DMARD. Insurers sent the practice lists of patients diagnosed with rheumatoid arthritis, and someone from the practice had to call each patient's rheumatologist to obtain documentation confirming DMARD treatment. Creating a relationship that promotes the ongoing exchange of information can help practices meet this quality metric more easily, he says.

Chronic care management (CCM) programs can help open the lines of communication with rheumatologists to obtain this information, says Gianatasio. That's because with CCM, practices have already created workflows that promote frequent communication with specialists who help co-manage chronic conditions, including arthritis. "We really encourage communications between our primary care physicians and specialists," she says. "We still see a major gap between them. At least once a year, you really should be asking for charts from the specialist." ◘

Rheumatoid arthritis documentation tips

Rheumatoid arthritis is a hierarchical condition category (HCC), meaning it holds risk-adjustment value under the CMS-HCC payment model. As such, Colleen Gianatasio CPC, CRC, risk adjustment quality and education program manager at Capital District Physician's Health Plan in Albany, N.Y., says physicians should document the following details to ensure accurate reimbursement:

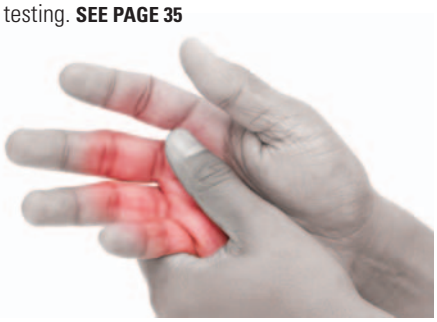
- **With or without rheumatic factor.**
- **Affected joints (i.e., shoulder, elbow, wrist, hand, hip, knee, ankle, foot, vertebrae, or multiple sites).**
- **Laterality (i.e., left or right).**
- **Complications (i.e., splenoadenomegaly, leukopenia, rheumatic lung disease, rheumatoid vasculitis, rheumatoid heart disease, rheumatoid myopathy, or rheumatoid polyneuropathy).**
- **With or without involvement of other organs and systems.**

Medication prescribed to treat the rheumatoid arthritis. Linking the medication to the disease (e.g., "Patient has rheumatoid arthritis and is under reasonable control with Methotrexate") gives physicians credit under risk-adjustment models and for HEDIS purposes, says Gianatasio. Physicians should document this every time they see the patient to refill his or her medication, she says. If the patient if seeing a rheumatologist, document "Patient with rheumatoid arthritis is stable and is being followed by Dr. X." Without this documentation, it appears to payers as though there's a gap in care.

+ MORE AHEAD

Clinical Economics

How to identify rheumatoid arthritis in primary care. The important role of primary care and tips on examinations, classification criteria, and laboratory testing. **SEE PAGE 35**



IN CASE YOU MISSED IT

"It always seems like medicine is 10 to 20 years behind. It has to catch up or we're not going to provide these patients the services they want."

PAYAL BHANDARI, MD, PRIMARY CARE PHYSICIAN, SAN FRANCISCO

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"If a patient needs a test, they need a test. My medical advice is not going to change, but it's not helpful to them if they can't pay to get it."

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LINDA GIRGIS, MD, PRIMARY CARE PHYSICIAN, SOUTH RIVER, N.J.

70% **of consumers focus on healthcare once they feel financially stable**

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