Trinsic
Clinically Integrated Network
An Intermountain Health and UCHealth Company

Three Tips to Increase Your Quality Score

With the year quickly coming to a close, this Tip Sheet shares best practice workflows around measures that must be completed by year end. For each measure, we provide a reminder of what is required along with workflows to help improve quality performance.

Kidney Health Evaluation for Patients with Diabetes (KED)

How the Measure is Defined

Number of members between the ages of 18-85 with a diagnosis of diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ration (uACR), during the measurement year.

Best Practice Workflows

For patients who **have not** completed their annual kidney function screening test:

- Place a lab order for both an **eGFR** (blood) and **uACR** (urine).

For patients who **have** completed their annual kidney function screening test:

- Document the following information within the patient's chart: **date(s) or service, test(s) performed, and result(s) of test.**

Most POC tests do not provide enough specificity, returning a semi-quantitative albumin result. The recommendation is to send the patient's urine sample to the lab for testing and increased specificity. POC tests returning values associated CPT 82044 NO LONGER meet the measure. POC tests need to return quantitative results associated with CPT 82043. Clinics should evaluate the specificity of the POC tests they are using to determine if the test meets the requirements of the measure by checking with the manufacturer.

Use frailty and advanced illness ICD-10 codes as appropriate to remove a patient from this measure.

Controlling Blood Pressure (CBP)

How the Measure is Defined

Percentage of patients between the ages of 18-85 with a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Best Practice Workflows

Complete and code for a blood pressure reading at every visit. It is acceptable to take multiple readings and take combination of the lowest of the lowest values if readings done at the same visit. Document repeat blood pressure readings in Vitals.

Ensure the patient's feet are flat on the floor and their elbow is at the same level as the heart.

Submit two of the following CPTII quality codes in addition to a corresponding hypertension diagnosis code:

- 3074F (systolic <130 mmHg)
- 3075F (systolic 130-139 mmHg)
- 3077F (systolic ≥140 mmHg)
- 3078F (diastolic <80 mmHg)
- 3079 (diastolic 80-89 mmHg)
- 3080F (diastolic ≥90 mmHg)

Use frailty and advanced illness ICD-10 codes as appropriate to remove a patient from this measure.

Glycated Hemoglobin (A1C)

How the Measure is Defined

Percentage of patients between the ages of 18-75 with a diagnosis of diabetes whose most recent A1c test during the measurement year is <8.0

Best Practice Workflows

Complete a DM checklist for each visit with a diabetic patient, including pre-visit planning tasks.

If using point of care testing:

- Document the date of service, result, and type of test together in the patient's chart
- Code using the appropriate quality code on the claim associated with the lab test

If using external laboratories for testing:

- Document the date of service, result, and type of test together in the patient's chart
- Submit the appropriate quality code on the first visit after the lab test was completed (if both occur during the same calendar year)

CPT II codes to close the care gap:

- 3044F (HbA1c < 7.0%)
- 3051F (HbA1c = 7.0 – 7.9%)
- 3052F (HbA1c = 8.0 – 9.0%)
- 3046F (HbA1c > 9.0%)

Use frailty and advanced illness ICD-10 codes as appropriate to remove a patient from this measure.

For additional workflow information reach out to your Network Engagement Manager.

Transforming care together.