CHESS HEALTH SOLUTIONS

Value-based Care Chronicle: Guide to Improving Performance

June 2025

Colorectal Cancer Screenings

Colorectal cancer is the second leading cause of deaths in the U.S., yet with early detection, it is also one of the most preventable cancers. With several tests available, tailoring the conversation to your patient's unique needs and risk factors is key to improving adherence.

Colorectal Cancer Screening Measure: The percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer.

- Colonoscopy (10 Years)
- Sigmoidoscopy (5 Years)
- CT Colonography (5 Years)
- Fit-DNA (Cologuard)

To address this care gap:

1. Start discussions earlier with patients to discuss risk and screening options
2. Convey the importance of screening for health and wellness
3. Discuss a patient's fear around colonoscopies
4. Offer support and education as patients make their decision
5. If offered a mail-in kit, provide guidance on the process and recheck timeframe
6. Record the date of previously completed screening in EMR

Closing the Quality Gap: Colorectal Cancer Screening

Colorectal Cancer Screening Quality Flyer

Helping Patients Choose the Right Screening Test

Advance Care Planning

As primary care providers, we play a crucial role in initiating and guiding end-of-life care conversations with patients. By formalizing these conversations through Advanced Directives, Durable Health Care Power of Attorneys, and Medical Orders for Scope and Treatment (MOST) forms, we can reduce inpatient utilization and overall costs.

What Forms are Available in NC?

1. NC Advanced Directives (Health Care Power of Attorney & Living Will)
2. MOST Form
3. Out of Facility DNR

How Do I Bill ACP Discussions?

There are only 2 codes to bill advance care planning discussions:

99497 - *First 30 minutes face-to-face with the patient, family member(s), and/or surrogate (minimum of 16 minutes documented)*

99498 - *Each additional 30 minutes (completion of ADs is not a requirement)*

To bill ACP discussions, you must document that the ACP was discussed. Documentation must include:

- Voluntary nature of visit
- Explanation of advance directives
- Who was present
- Time spent discussing ACP during the face-to-face encounter
- Any change in health status or health care wishes if the patient becomes unable to make their own decisions

UNDERSTANDING THE DIFFERENCE BETWEEN PALLIATIVE CARE & HOSPICE

Understanding the distinction between palliative care and hospice is crucial in guiding patients and their families through challenging times.
Read More

ADVANCE CARE PLANNING: STARTING THE CONVERSATION

Advance care planning discussions are a worthwhile endeavor and one that patients desire. Consider starting these conversations now.
Read More

CODING & BILLING ADVANCE CARE PLANNING DISCUSSIONS

ACP discussions take time. Luckily, this conversation can happen over time, in multiple appointments, and a provider can bill for their contributions.
Read More

MARIA HAYES- THE VALUE OF END OF LIFE CARE

In this episode, Mountain Valley Hospice Senior Vice President of Strategy Innovation, Maria Hayes, joins us to discuss end of life care, the difference between palliative and hospice care, and how providers can utilize these services.
Listen Now

Urinary Tract Infections

UTIs contribute to billions in healthcare spending each year and can lead to expensive hospital visits if not managed early and effectively.

Preventing UTIs starts with a proactive, team-based approach:
✅ Identify high-risk patients and mitigate risks by focusing on evidence-based strategies.
✅ Avoid antibiotics for asymptomatic bacteriuria to protect against resistance.
✅ Leverage care managers for patient monitoring, timely follow-up, and consistent patient communication.
✅ Use Zone Tools to educate patients, helping them recognize warning signs and act before symptoms escalate.

Reducing Unnecessary Utilization through UTI Prevention

Urinary Tract Infection (UTI) Educational Flyer for Medicare Patients

CODING CORNER: TRUNCATED CODING

Truncated coding refers to using a diagnosis or procedure code that's too general when a more specific one exists. Precise coding isn't just about paperwork, it drives accurate documentation, proper billing, and timely reimbursement. When codes lack detail, payers are more likely to deny claims, delay payments, or question the necessity of services. In short, **specificity matters.**

Reminders:

- All dates of service stand alone
- When submitting HCC-related diagnosis codes on the CMS-1500 claim form, ensure they are listed by clinical significance and impact on risk adjustment
- If there are more than 12 diagnosis codes, submit a secondary claim using CPT code 99499
- Truncated coding can lead to reduced or denied claims

For more detailed information on truncated coding, check out our latest article and tip sheets:

Truncated Coding Tip Sheet
2025 CMS HCC-Disease Hierarchy (Trumping Guide)
Truncated Coding: Why Precision Matters in Medical Documentation

PATIENT EDUCATION POINTER OF THE MONTH

Learning Needs Assessment

Learning Needs Assessments provide context that is necessary for behavior change. Assessments help find out what patients already know, what they want and need to learn, what they are capable of learning, and what would be the best way to teach them. When these assessments are conducted, learning is more likely to lead to behavior change.

Learn more about these assessments that help us understand, from a patient's perspective, their values, needs, and preferences: https://www.chesshealthsolutions.com/2022/07/28/patient-education-tools-learning-needs-assessments/.

Additional Resources

- Move to Value Podcast: HCC V24 to V28 Transition Explained
- CHESS Health Solutions' Pharmacist-Supported Hypertension Model Delivers 9:1 ROI, Improves Patient Outcomes

Past VBC Chronicle Editions

CHESS Education
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