# CLINICALLY INTEGRATED NETWORK (CIN)
# PHYSICIAN NEWSLETTER
## FOCUS on QUALITY and DOCUMENTATION

**The Quality Health Alliance (QHA) Leadership team is thrilled to announce the appointment of Cheryl Jackson, MD, FACP, as Regional Medical Director for our CIN, effective October 13, 2025.**

Dr. Jackson will serve in a part-time capacity to provide leadership support and direction for the clinical functions of the clinically integrated network. Specifically, Dr. Jackson will oversee the clinical initiatives for our high priority alternative payment models (APMs), including the Medicare Shared Savings Program and the Medicare and Commercial APMs with Independence Blue Cross.

Dr. Jackson brings a wealth of leadership and clinical experience to this role. Dr. Jackson joined Trinity Health Mid-Atlantic (THMA) in 2019 as the Lead Physician for the Mercy Senior Health Clinic in West Philadelphia before serving as Medical Director of Primary Care for the THMA Medical Group. Additionally, Dr. Jackson is the Primary Investigator for QHA's most recent grant through Independence Blue Cross's Clinical Care Innovation Grant program, which highlights the team's interdisciplinary approach to heart failure patient management. Dr. Jackson will also still serve the Philadelphia community as a Primary Care Physician at the Eastwick office during her scheduled clinic days. We request your partnership and enthusiasm as we officially welcome Dr. Jackson to our leadership team in a formal capacity.

If you are interested in setting up a meeting with Dr. Jackson, please contact your CIN manager.

# Chronic Obstructive Pulmonary Disease (COPD) – Documentation and Coding

According to our THMA data, COPD is the second under diagnosed metric. This is not surprising, as it is frequently underdiagnosed nationwide. The American Lung Association estimates that COPD affects 11.7 million adults and accounts for hundreds of thousands of emergency department visits annually, costing the healthcare system tens of billions of dollars each year. COPD represents a group of chronic, progressive lung diseases that obstruct the airways in lungs: asthma, chronic bronchitis, and emphysema. Accurate documentation is important for proper coding and care of COPD. With no cure, the focus on COPD is on slowing progression, managing symptoms, and preventing complications such as infection, pulmonary hypertension, and heart issues.

**When documenting, it is important to document and code:**

- **The type of COPD:** Asthma (chronic obstruction), bronchitis (chronic), emphysema

- **The severity/status:** Acute on chronic exacerbation, stable, etc.

- **Any associated conditions or co-morbidities:** Hypercapnia, hypoxia, chronic respiratory failure, diabetes, cardiac disease

- **Tobacco use and/or exposure:** Related smoking use, history or exposure

- **Infection:** Lower acute respiratory infection and the infectious agent, if known.

## LINKING DOCUMENTATION
Ensure all related conditions and treatments to the condition are linked in the documentation, including oxygen.

## ASSESSMENT AND PLAN
The primary care physician's inclusion of COPD in the assessment is important even with specialist management.

*For example: "Chronic emphysematous bronchitis – Stable. Lungs clear. Mild SOB. Patient follows with pulmonologist."*

## SPECIFICITY
The diagnosis of COPD is broad and non-specific and does not identify the type of COPD or any associated condition(s). Therefore, describing each COPD-related diagnosis to the highest level of specificity is extremely important.

**The following are COPD Coding Examples:**

## CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| ICD 10 CODE | DIAGNOSIS | RAF VALUE |
|---|---|---|
| J44.0 | COPD with acute lower respiratory infection<br>*Add Additional code to identify infection | 0.329 |
| J44.1 | COPD with acute exacerbation | 0.335 |
| J44.9 | COPD, unspecified<br>*Includes asthma w/COPD, chronic bronchitis w/ emphysema,<br>and chronic obstructive asthma | 0.328 |

Use additional reporting code when applicable- tobacco use (Z72.0), tobacco dependence (F17.X),
history of tobacco dependence (Z87.891), exposure to environment tobacco smoke (Z77.22)

## SPECIFYING ASTHMA

| CODE | DIAGNOSIS |
|---|---|
| J43.2X | Mild intermittent asthma |
| J45.3X | Mild persistent asthma |
| J45.4X | Moderate persistent asthma |
| J45.5X | Severe persistent asthma |
| J45.50* | Severe persistent asthma, uncomplicated |
| J45.51** | Severe persistent asthma w/ acute exacerbation |
| J45.52*** | Severe persistent asthma, status asthmaticus |
| J45.90 | Unspecified asthma |
| J45.901 | Unspecified asthma with (acute) exacerbation |
| J45.902 | Unspecified asthma with status asthmaticus |

**Be sure to check for 6th character:**

0 = Uncomplicated*

1 = Acute exacerbation**

2 = Status asthmaticus

## EMPHYSEMA CLASSIFICATION

| ICD 10 CODE | DIAGNOSIS | RAF VALUE |
|---|---|---|
| J43 | Emphysema | 0.319 |
| J43.0 | Unilateral pulmonary emphysema | 0.319 |
| J43.1 | Panlobular emphysema | 0.319 |
| J43.2 | Centrilobular emphysema | 0.319 |
| J43.8 | Other emphysema | 0.319 |
| J43.9 | Emphysema, unspecified (used for emphysematous bleb or bullous disease) | 0.319 |

Emphysema classifies category J43 and is a more specific type of COPD.

As a reminder, payors require annual documentation and coding of all chronic conditions.
Reference- AAPC ICD-10-CM Expert Coding book

# What Counts as Adherence?
# A Closer Look at the Metrics Behind the Meds

**Understanding how adherence is measured—and why it matters for your quality scores**
At some point in your career, you've likely had someone reach out with concerns about your patients and their adherence to medications. This article will give you the why, the what, and the how behind the medication adherence measures emphasized by Medicare.

**Why Does This Matter?**[i]
Several studies have shown that improved adherence to these classes
of medications reduces the cost of care and improves patient outcomes.

**What Medications Are Included in These Metrics?**[ii]
These metrics are divided into three separate measures:
- Medication Adherence for Hypertension (MAH) Includes angiotensin-converting enzyme inhibitors
  (e.g., lisinopril), angiotensin receptor blockers (e.g., losartan), and direct renin inhibitors (e.g., aliskiren).
- Medication Adherence for Diabetes (MAD) Includes most medications used to treat diabetes, excluding insulin.
- Medication Adherence for Cholesterol (MAC) Focuses on adherence to statin medications.

**How Is Someone Determined to Be Adherent?**[iii]
Payers use pharmacy claims to calculate the Proportion of Days Covered (PDC) an estimate of how
many days in the year a patient had access to their medication. To be included in these metrics, patients must:
- Be 18 years or older
- Have filled the relevant medication at least twice in a calendar year

The goal is for the patient to have medication available for at least 80% of the year,
which equals 292 days (or 293 days in a leap year).

**How Is It Calculated?**
1. Total days' supply of medication dispensed to the patient (based on pharmacy claims)
2. Divide by the total number of days in the year
3. Multiply by 100 to get the percentage

Example:
A patient fills two 90-day supplies of simvastatin in one year, totaling 180 days of coverage.
$(180 \div 365) \times 100 = 49.3\%$
This patient had medication coverage for 49.3% of the year, which falls below the adherence threshold.

## References

[i]Ramachandran, S., Nsiah, I., Parikh, M.A. et al. Differences in the relationship between medication adherence and payer medical costs across three quality measures: results of a cohort study among medicare advantage beneficiaries. BMC Health Serv Res 25, 1078 (2025). https://doi.org/10.1186/s12913-025-13331-2

[ii]Pharmacy Quality Alliance. 2025 PQA MEASURE MANUAL. February 2025. Alexandria, VA.

[iii]Quality Measures: Tracking adherence rates for hypertension, oral diabetes medication and cholesterol. America's Pharmacist. June 2014. Available at: https://www.ncpa.co/issues/APJUN14-Quality_Measures.pdf
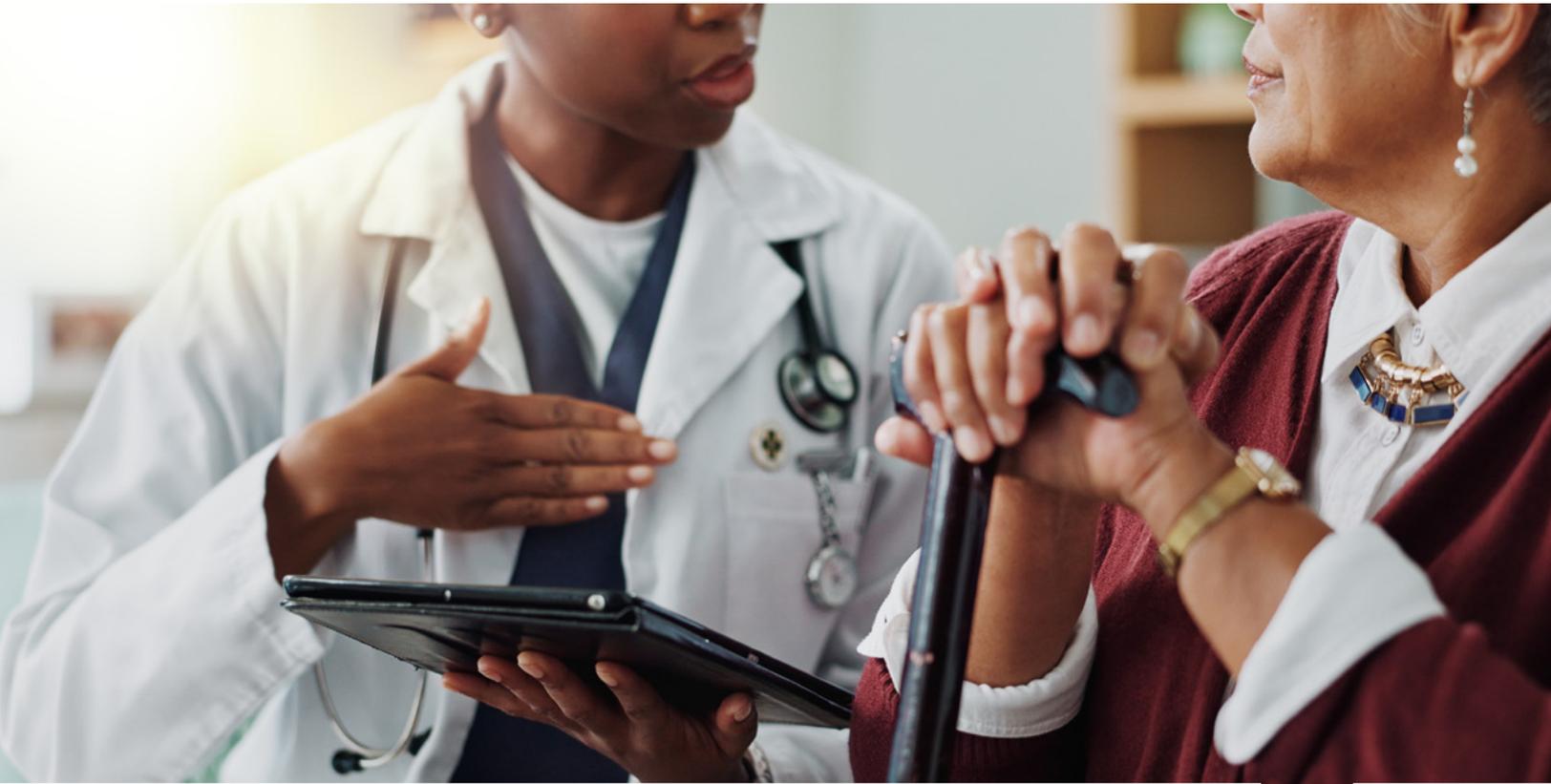
To learn more about Quality Health Alliance or to join the organization, **please contact your CIN Manager, shown below.**

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