Components of Value-Based Care

September 14, 2019
Janis Coffin, DO, FAAFP, FACMPE, PCMH CCE
Chief Transformation Officer
Professor, Department of Family Medicine
Medical College of Georgia
AU Health

Objectives

I. **Recognize the difference between fee-for-service and value-based care**

II. **High-level recognition of the Quality Payment Program (QPP):**
   I. Merit-Based Incentive Program (MIPS)
   II. Alternative Advanced Payment Models (A-APMs)

III. **Recognize and describe the components of value-based care:**
   I. **Chronic Care Management (CCM)**
   II. Transitional Care Management (TCM)
   III. Remote Patient Monitoring (RPM)
   IV. Annual Wellness Visits (AWV)
   V. Clinical Documentation and Hierarchical Condition Categories (HCC)

Fee-For-Service to Value-Based Care

- **Fee-for-service** (FFS) is a payment model where services are unbundled and paid for separately.
- This gives an incentive for physicians to provide more treatments because payment is dependent on the ***quantity*** of care, rather than ***quality*** of care.
- **Value-Based Care (VBC)** is a reimbursement model based on **quality** and **cost outcomes** rather than the **quantity** of services provided
- Gives incentives and payments to physicians to improve outcomes, processes and cost reduction for their population they serve
- The shift from FFS to VBC provides physicians and clinical teams to be directly responsible for clinical outcomes

Changing to a New Paradigm

Today	Future
Treating Sickness / Episodic	Managing Populations
Fragmented Care	Collaborative Care
Specialty Driven	Primary Care Driven
Isolated Patient Files	Integrated Electronic Records
Utilization Management	Evidence-Based Medicine
Fee for Service	Shared Risk/Reward
Payment for Volume	Payment for Value
Adversarial Payer-Provider Relations	Cooperative Payer-Provider Relations
“Everyone For Themselves”	Joint Contracting

The Shift from Volume to Value

Volume Based

Payment: Fee-for-Service

Providers reimbursed for number of interventions performed (e.g., lab tests, x-rays, procedures, etc.)

Incentives: Order/perform as many interventions as possible to maximize reimbursement

Focus: Individual patient episode

Role of Provider: Siloed approach based on specialty-driven interactions

Value Based

Payment: Outcomes based

Providers reimbursed on health outcomes (i.e., was patient readmitted within 30 days? Did patient condition improve following intervention?)

Incentives: Keep patients healthy and reduce unnecessary interventions

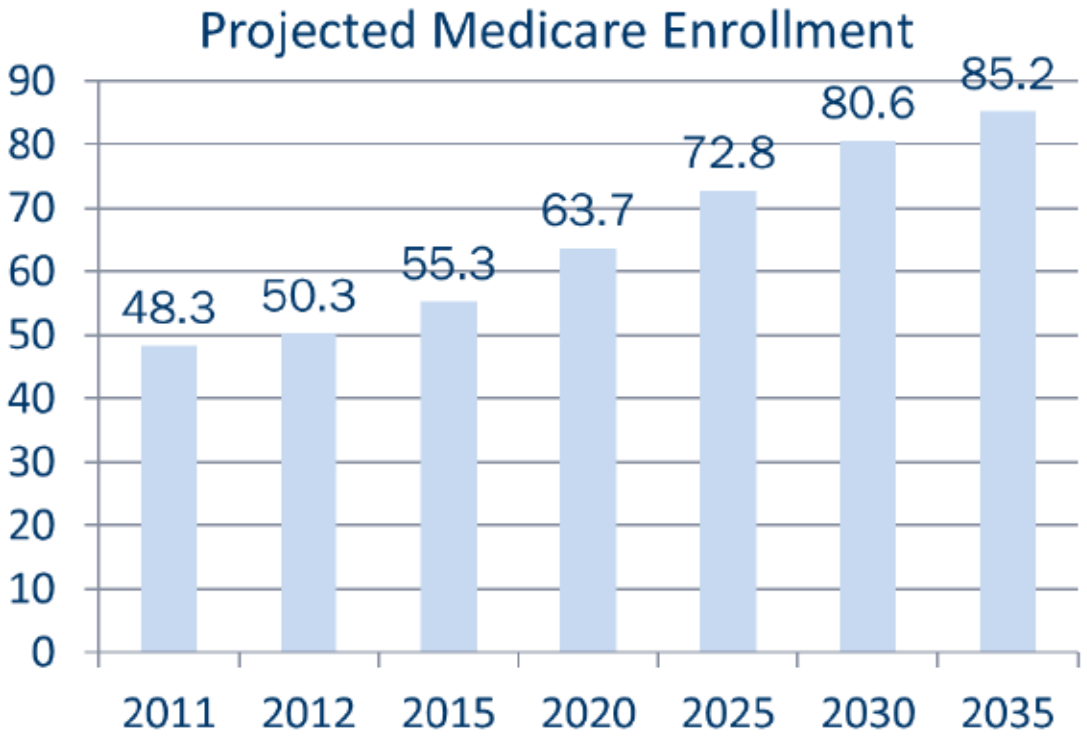
Focus: Outcomes across continuum of care

Role of Provider: Team-based across care continuum

Why Now for Value-Based Care??

Regulatory Pressures	• QPP • Bundled Payments • Quadruple Aim
Consolidation & Financial Risk	• Commercial • Medicaid/Managed Medicaid • Medicare Advantage
Rise of Consumerism	• Patients have more choices • Patients are less loyal • Interoperability
Demographic Shift	• Medicare aging in • Millennials

MEDICARE ENROLLMENT CONTINUES TO GROW



Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

- 10k new beneficiaries enroll in Medicare every day.
- Number of beneficiaries in Medicare is projected to double by 2035.

Projected Medicare enrollment (in millions)

AMERICAN COLLEGE of CARDIOLOGY

Quality Payment Program

- *Medicare Access and CHIP Reauthorization Act of 2015*
- *Referred to as the Quality Payment Program (QPP)*
- *Year 1 began on January 1, 2017*

OBJECTIVES:

1. *Ending the Sustainable Growth Rate (SGR) for Medicare payments for health care provider's services*
2. *Created a new framework for rewarding health care providers for giving better care not just MORE care (Value from Volume)*
3. *Combined existing quality programs into one new system*

- *Rewards Practices for Patient-Centered Care through the use of data through two ways:*
  - *Merit-Based Incentive Payment System (MIPS)*
  - *Advanced Alternative Payment Models (APMs)*

Quality Payment Program - Paths

Merit-Based Incentive Payment System (MIPS): eligible clinicians report to Medicare for four categories:

- *Quality*
- *Cost*
- *Improvement Activities*
- *Advancing Care Information*

- *These categories are weighted, and physician/physician groups receive an Overall Performance Score (0 – 100)*
- *This score is adjusted either positively, negatively or neutrally based on performance score*
- *Score is compared to all other eligible clinicians/groups participating in MIPS*

Advanced Alternative Payment Models (APMs): payment model that provides incentives or reimbursement based on quality and cost outcomes; takes on nominal risk

- *Examples of APMs:*
  - *Medicare Shared Savings Program, Track 2 & 3*
  - *CPC+*
  - *Next Generation ACO*

- *APMs do not attest to the QPP program and receive an automatic 5% increase on Medicare Part B payments*

Quality Payment Program

MIPS

MIPS includes the following categories:

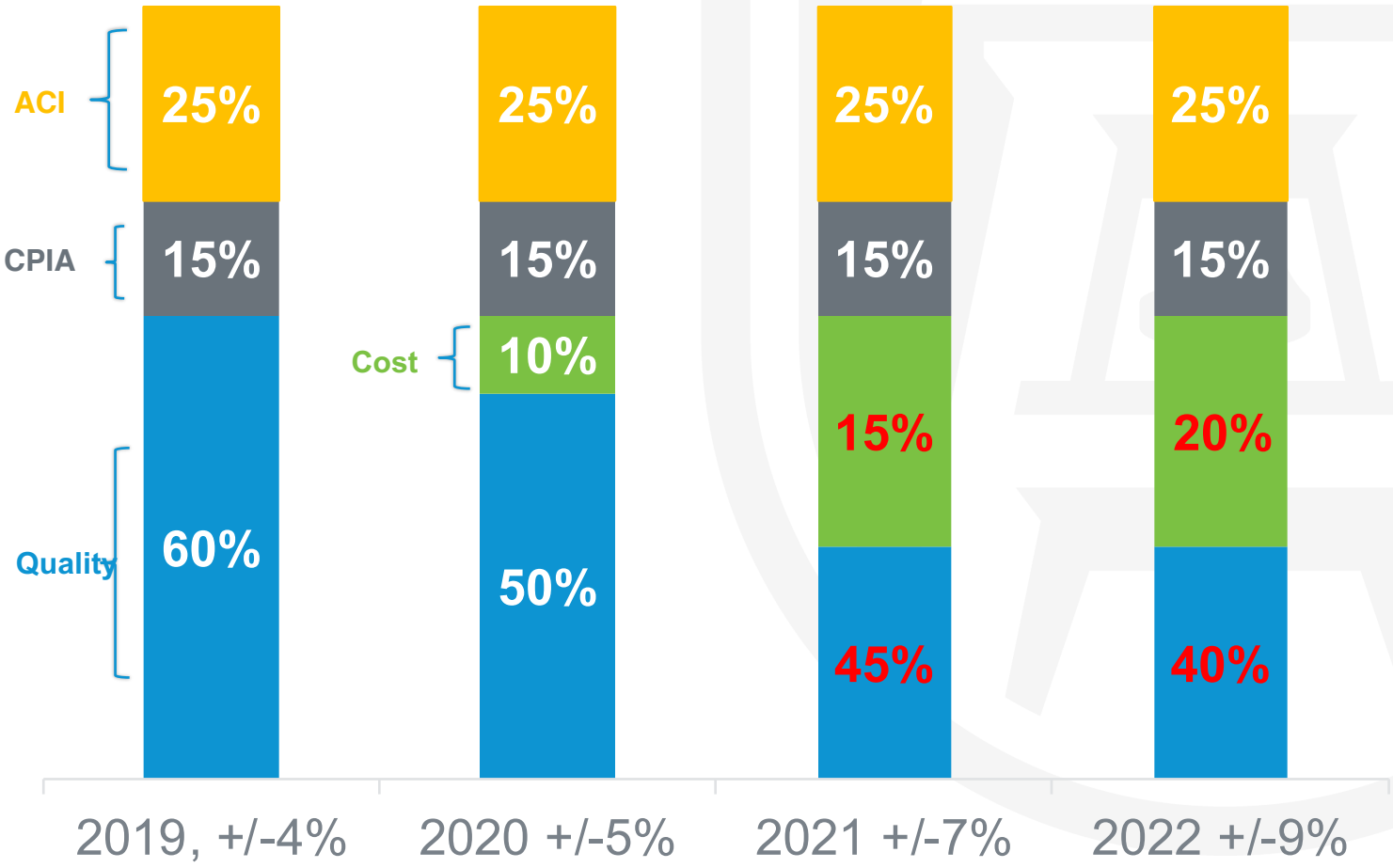
- Quality (PQRS)
- Advancing Care Information (MU)
- Cost (Value-Modifier)
- Improvement Activities (NEW)

Advanced APMs

To Participate in Alternative Payment Model:

- Use of CEHRT
- Payment based on Quality Measures
- Financial Risk or Medical Home Model

What is at stake financially?



Components of Value-Based Care

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Remote Patient Monitoring (RPM)
- Annual Medicare Wellness Visit (AWV)
- Hierarchical Condition Categories (HCC)

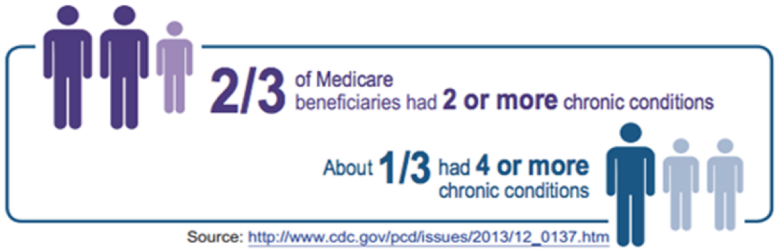
Chronic Care Management

Chronic Care Overview:

- Half of all adult Americans have a chronic condition – 117 million people
- One in four Americans have 2+ chronic conditions
- 7 of the top 10 causes of death in 2014 were from chronic diseases
- People with chronic conditions account for 86% of national healthcare spending
- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered care

CMS and Chronic Care

- Medicare benefit payments totaled $597 billion in 2014
- Two-thirds of Medicare beneficiaries have 2+ chronic conditions
- 99% of Medicare spending is on patients with chronic conditions
- Annual per capita Medicare spending increases with beneficiaries' number of chronic conditions



What is Chronic Care Management (CCM)?

- Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist and/or Certified Nurse Midwife) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Timed services – threshold amount of clinical staff time performing qualifying activities is required per month
- CCM is a critical component of primary care that contributes to better health and care for individuals
- CCM requires more centralized management of patient needs and extensive care coordination among practitioners and providers

CCM Coding Summary

BILLING CODE	PAYMENT (PFS NON-FACILITY)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
Non-Complex CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised or monitored	Ongoing oversight, direction and management
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
CCM Initiating Visit (AWV, IPPE, TCM or Other Face-to-Face E/M)	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Transitional Care Management (TCM)

CMS Definition:

"The management of (Medicare) patient's transition from an inpatient to a community setting. Contact with the patient within 2 business days following discharge, and a face-to-face visit within either 7 or 14 calendar days of discharge depending on the complexity of the medical decision-making involved in the patient's care."

- Code 99495 - for moderately complex cases seen within 14 days ~ $160 reimbursement
- Code 99496 - for highly complex cases seen within 7 days ~ $225 reimbursement
- 20% patient coinsurance and deductible apply

TCM Requirements

TCM period begins on the date of discharge and continues for 29 days:

There are three required elements:

- An interactive contact (telephone, portal, email or face-to face) with patient and/or caregiver within 2 business days of discharge, **M-F excluding holidays**
  - Prompt interactive communication
  - Clinical staff under general supervision[1]

- Medication reconciliation and management performed no later than the date of the face-to-face visit

- 7 or 14 Day follow up office visit (based on medical complexity as determined by Physician or Advance Practice Provider)

TCM Management Requirements

- 7 day visit for highly complex - extensive number of possible diagnoses and/or management of options, extensive complexity of medical data (e.g., tests) to be reviewed, and a high risk for significant complications, morbidity and/or mortality, as well as co-morbidities.

- 14 day visit for moderately complex – multiple diagnoses and/or management of options, moderate complexity of medical data (e.g. tests) to be reviewed and moderate risk of complications, morbidity or mortality as well as co-morbidities.

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Remote Patient Monitoring (RPM)

- **Remote patient monitoring:** technology to enable monitoring of patients outside of conventional clinical settings, which may increase access to care and decrease healthcare delivery costs.
- Incorporating RPM in chronic disease management can significantly improve an individual's quality of life.
- CMS is recognizing the role that new communications technologies play in increasing patient engagement and reducing unnecessary costs

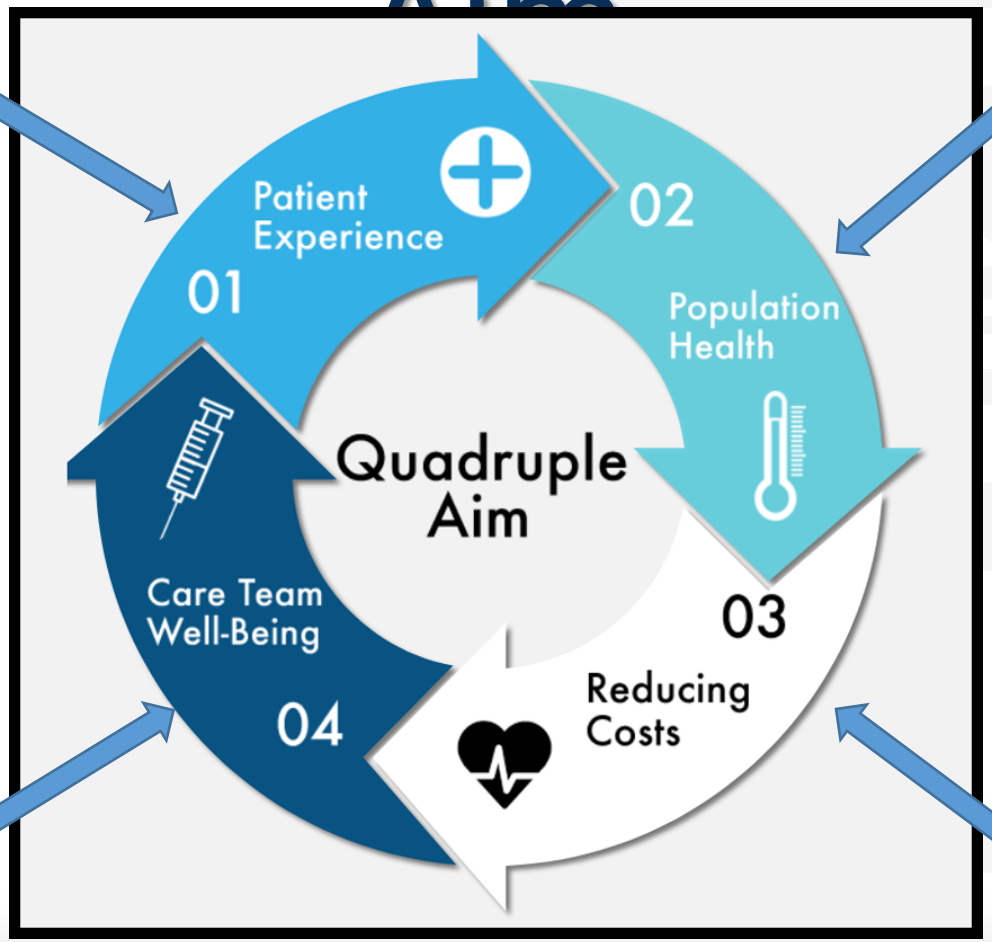
Remote Patient Monitoring Billing Codes

- **CPT code 99091:** collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.
- **CPT code 99453:** Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
- **CPT code 99454:** Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
- **CPT code 99457:** Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

Visit & Quadruple Aim

- Improved Patient Satisfaction
- Proactive Care

- Improved outcomes
- Disease Management



- Improved Care Team Satisfaction
- Improved workflow efficiency

- Decreased cost of care
- Disease Detection & Maintenance

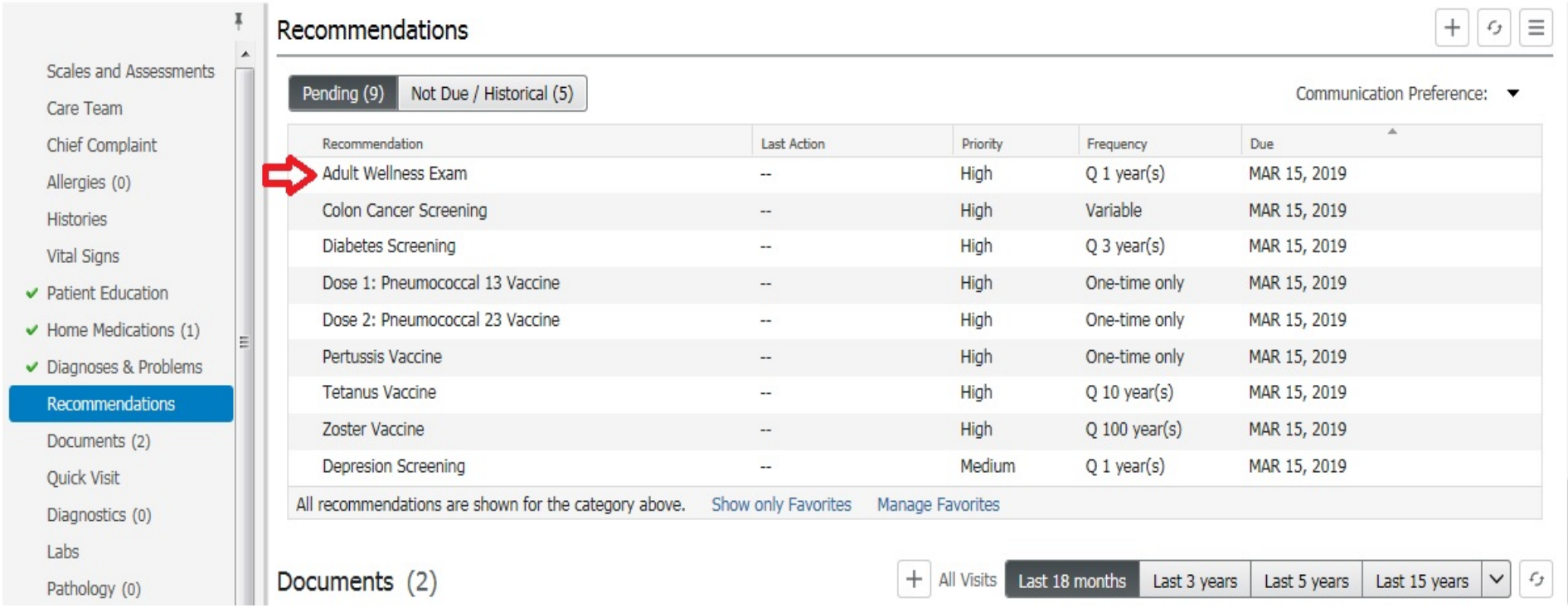
Importance of AWVs

- *Free covered preventive services when performed at the AWV*
  - *Breast Cancer Screenings*
  - *Colorectal Cancer Screening*
  - *Depression Screenings*
- *Proactive care leads to early disease detection and identification of patient barriers that impact their care*
  - *Fall screening*
  - *Social Determinants*
- *Improvement of quality metrics that are reflected in Medicare STARS ratings (now publicly reported)*
- *Collapsed E/M Rates in 2021*
  - *NEW Patient Level 2 – 4 = $130*
  - *EST Patient Level 2 – 4 = $90*
  - *AWV codes are not impacted by this!*
- *Important for our learners*
  - *Not prepared for private practice or other progressive health systems*

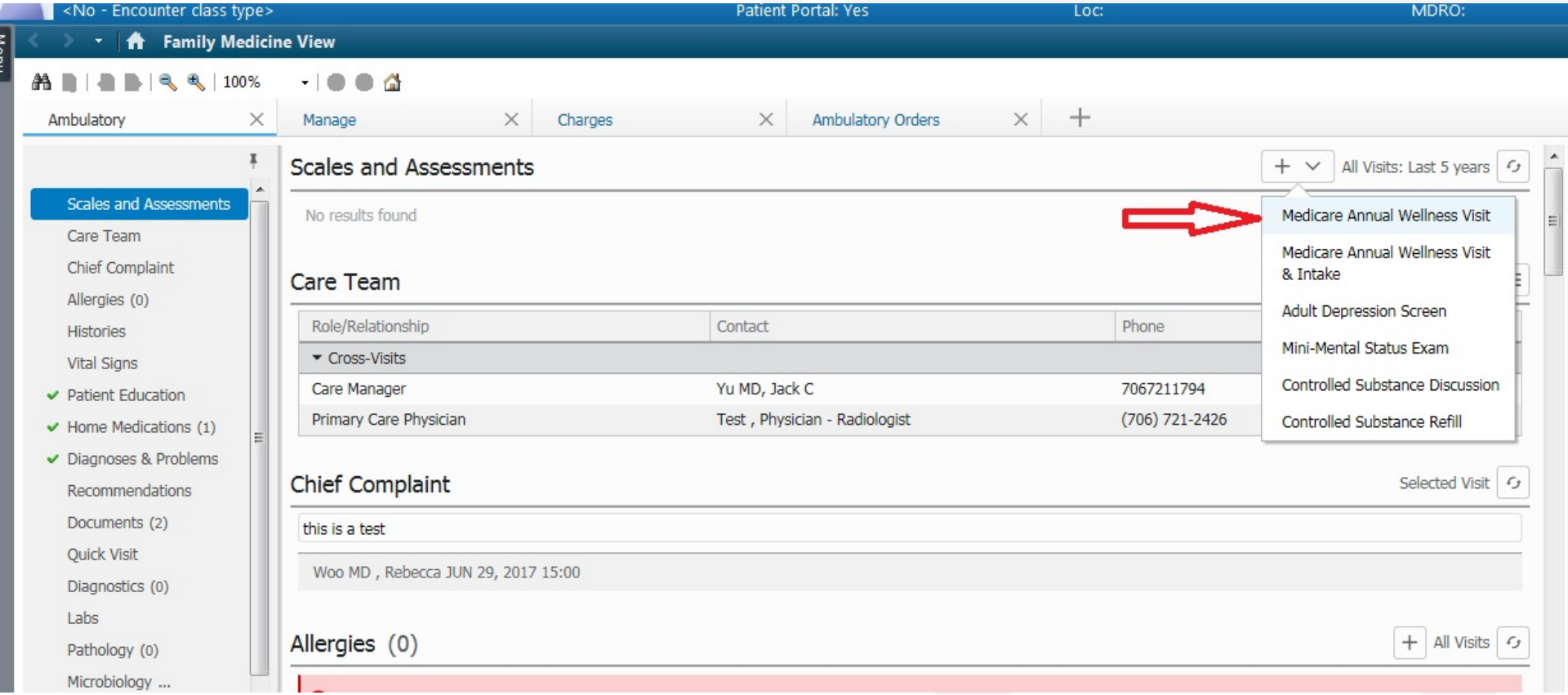
Annual Wellness Visit Coding & Reimbursement

Annual Wellness Visit Services	CPT Code	Medicare Reimbursement, Part B	wRVU
Annual Wellness Visits, Initial	G0438	$ 166.66	2.43
Annual Wellness Visits, Subsequent	G0439	$ 112.36	1.50
Depression Screenings	G0444	$ 9.47	0.18

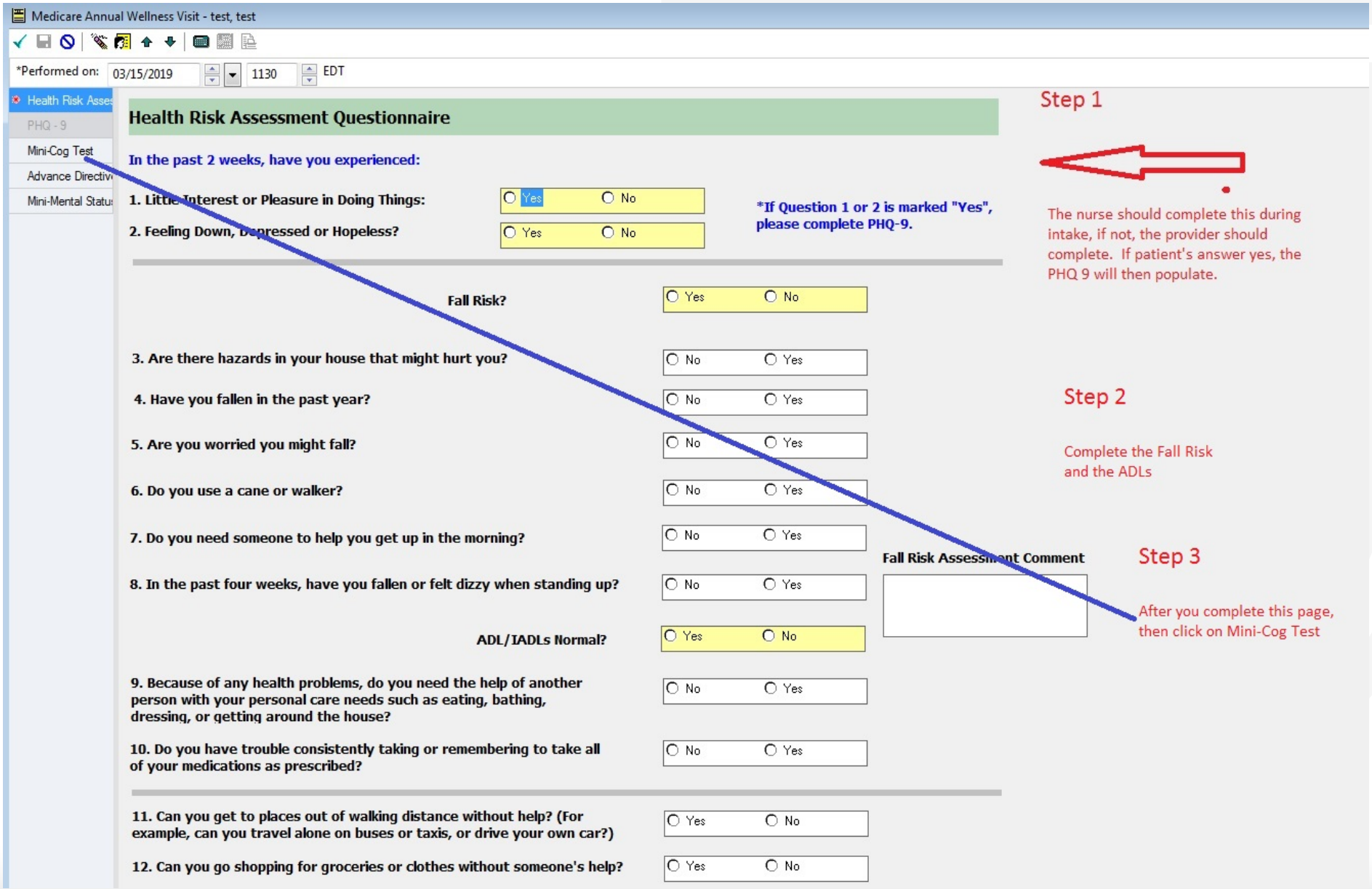
E/M CPT	Medicare Reimbursement, Part B	wRVU
99213	$ 50.62	0.97
99214	$ 78.01	1.50

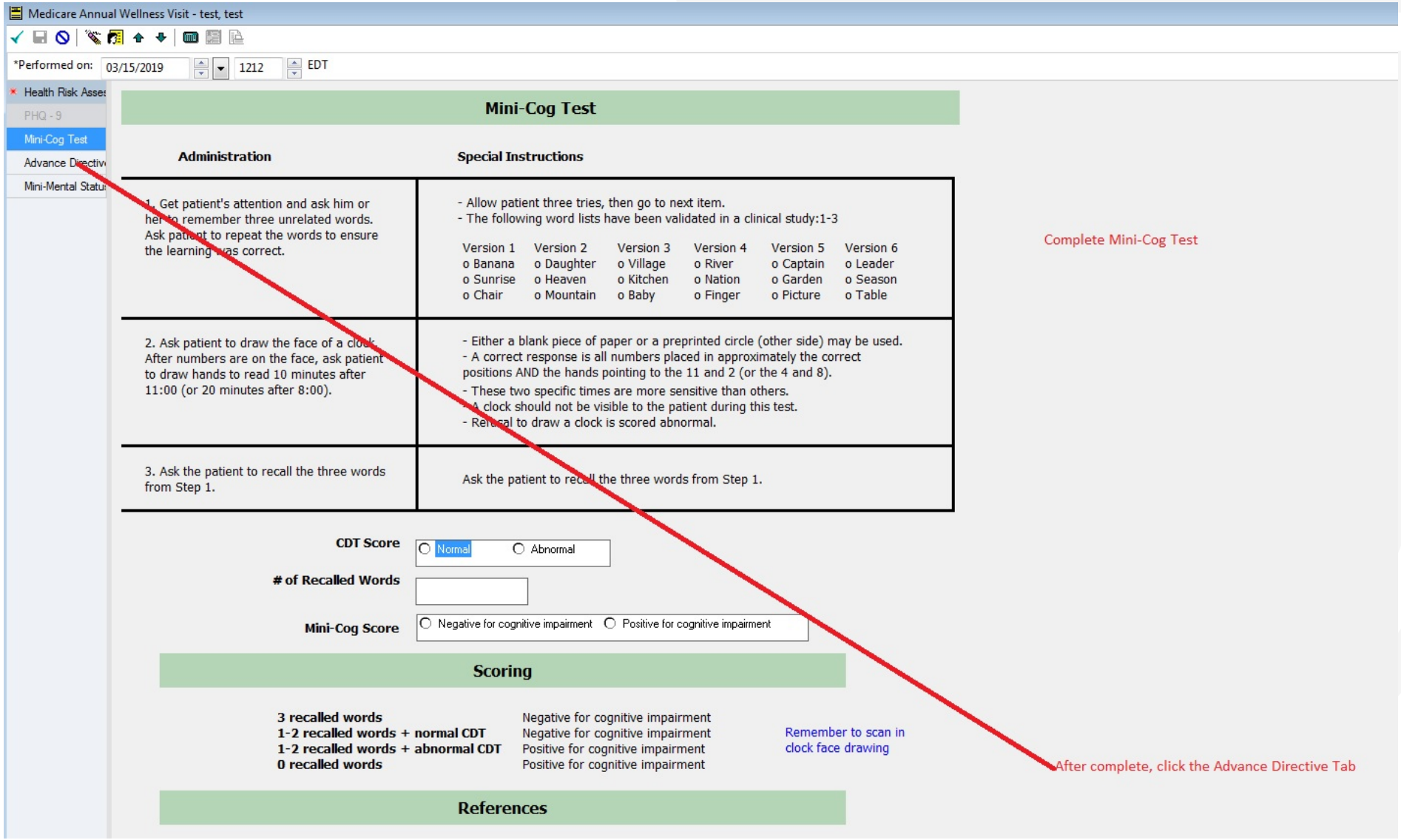


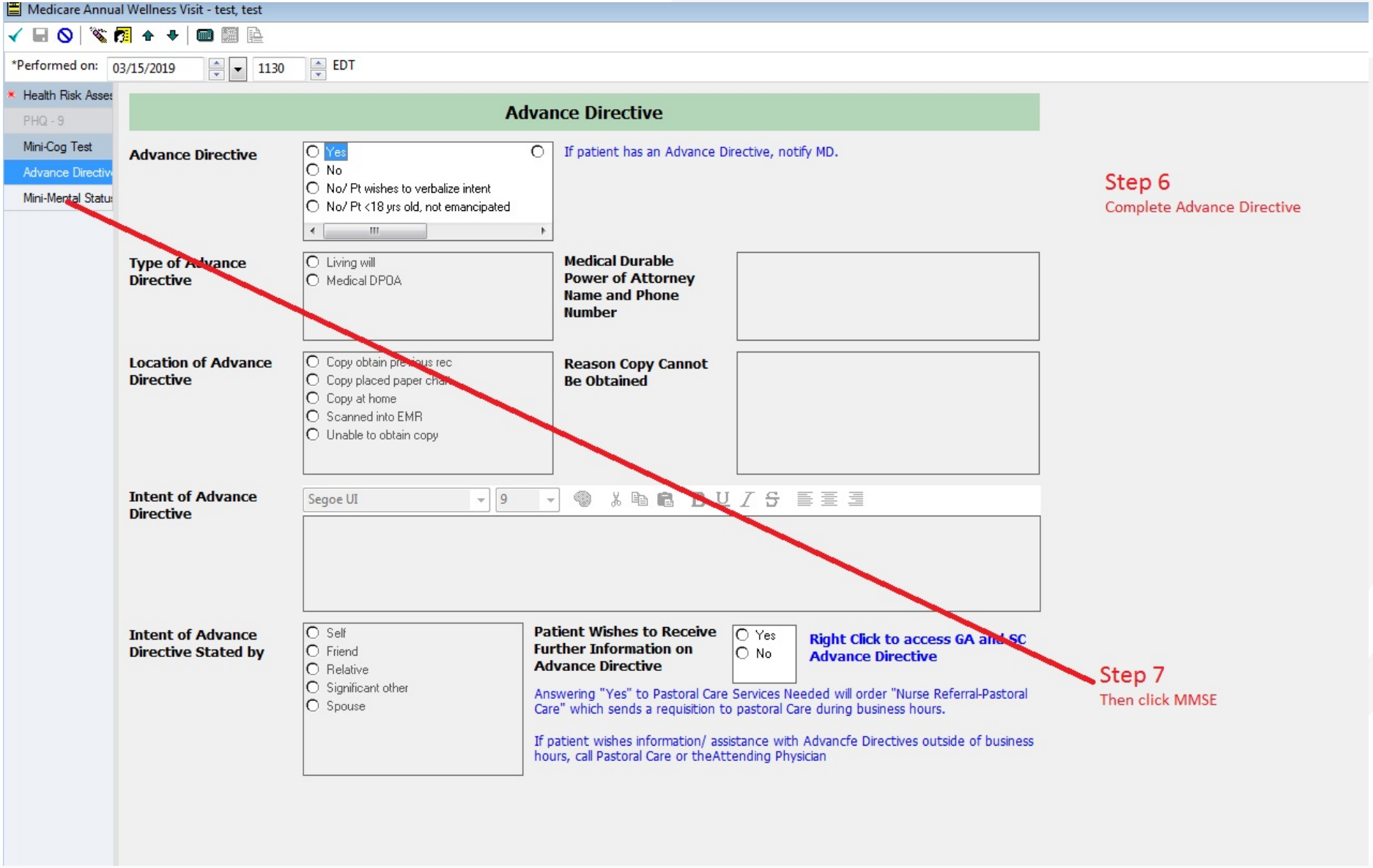
You will know if a patient is due for an adult wellness from the Recommendations Tab in Cerner. It will also list other services that are due (Colon Cancer screening may not be accurate, along with vaccinations if done outside of AU)

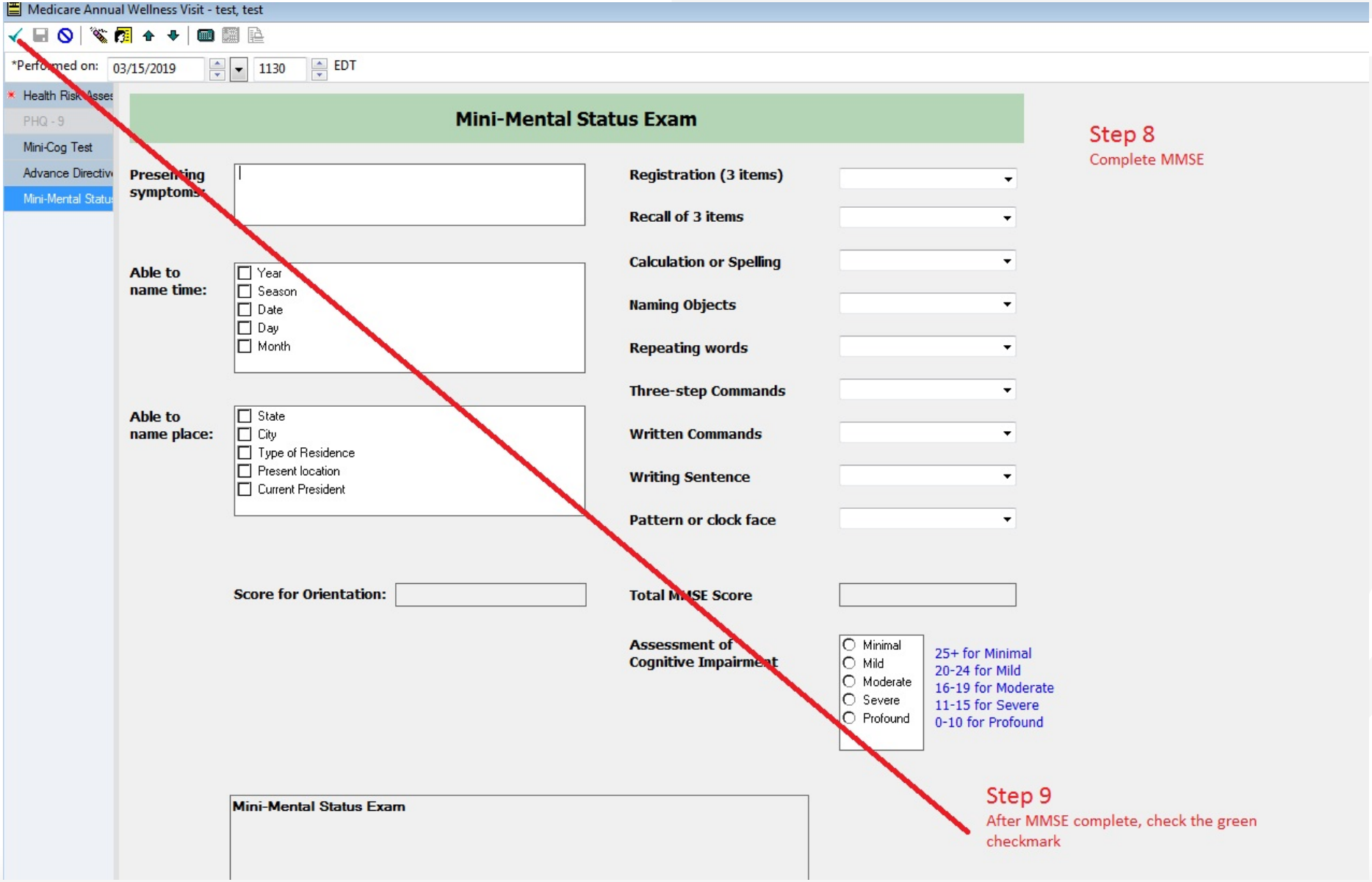


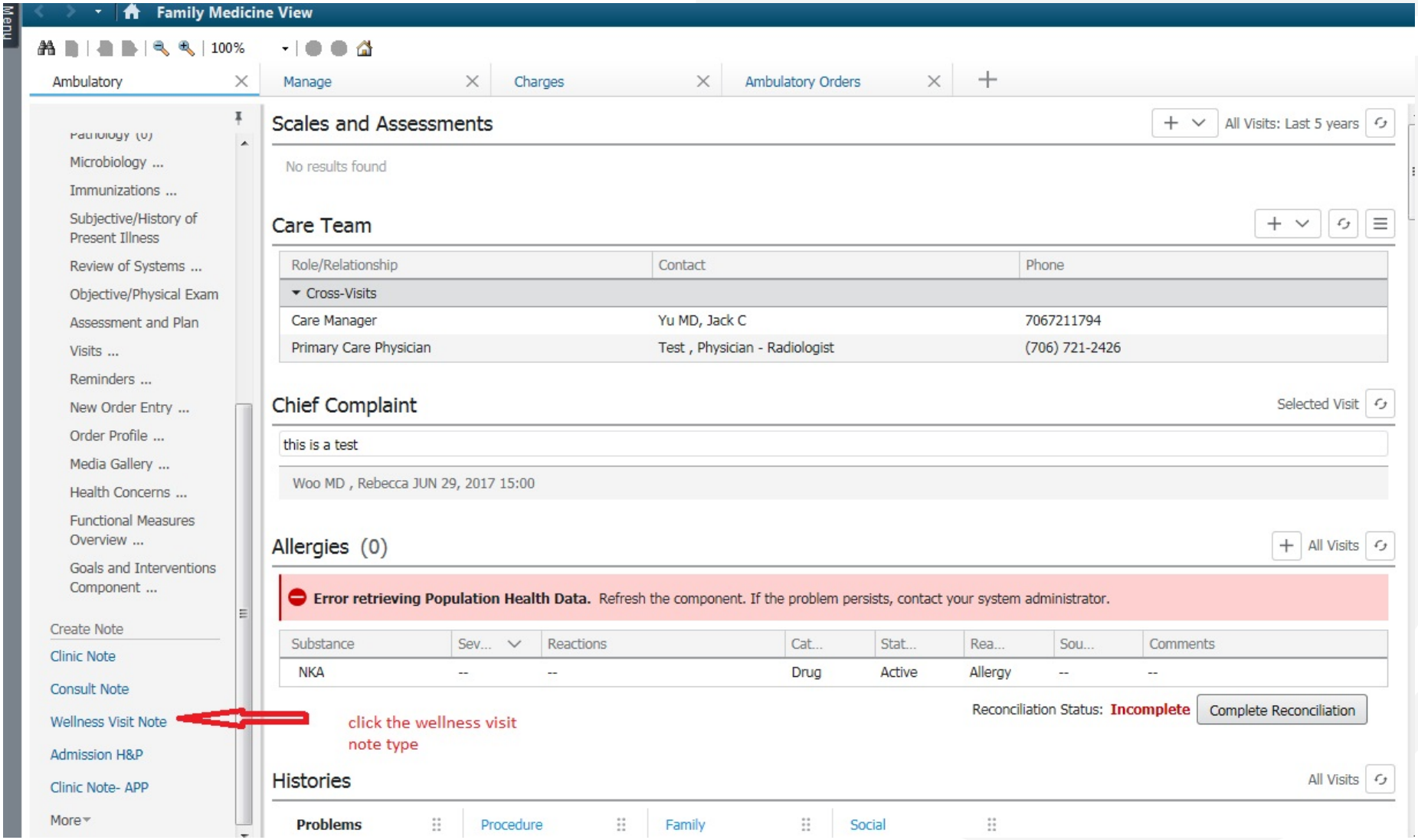
Go to Scales and Assessments and then click on Medicare Annual Wellness Visit

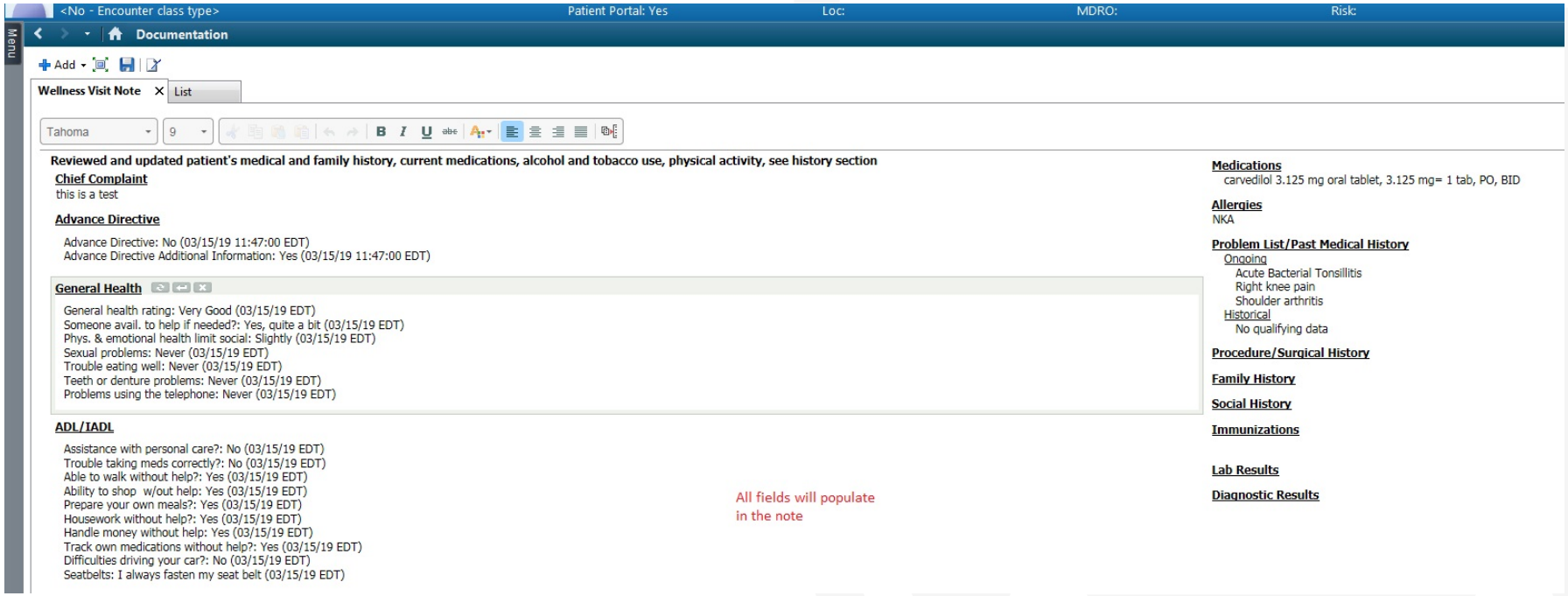

Medicare Annual Wellness Visit - test, test
*Performed on: 03/15/2019 1130 EDT
Health Risk Asses
PHQ - 9
Mini-Cog Test
Advance Directiv
Mini-Mental Statu
Health Risk Assessment Questionnaire
In the past 2 weeks, have you experienced:
1. Little Interest or Pleasure in Doing Things: Yes No
2. Feeling Down, Depressed or Hopeless? Yes No
*If Question 1 or 2 is marked "Yes", please complete PHQ-9.
Fall Risk? Yes No
3. Are there hazards in your house that might hurt you? No Yes
4. Have you fallen in the past year? No Yes
5. Are you worried you might fall? No Yes
6. Do you use a cane or walker? No Yes
7. Do you need someone to help you get up in the morning? No Yes
8. In the past four weeks, have you fallen or felt dizzy when standing up? No Yes
ADL/IADLs Normal? Yes No
9. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? No Yes
10. Do you have trouble consistently taking or remembering to take all of your medications as prescribed? No Yes
11. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?) Yes No
12. Can you go shopping for groceries or clothes without someone's help? Yes No
Fall Risk Assessment Comment
Step 1
The nurse should complete this during intake, if not, the provider should complete. If patient's answer yes, the PHQ 9 will then populate.
Step 2
Complete the Fall Risk and the ADLs
Step 3
After you complete this page, then click on Mini-Cog Test

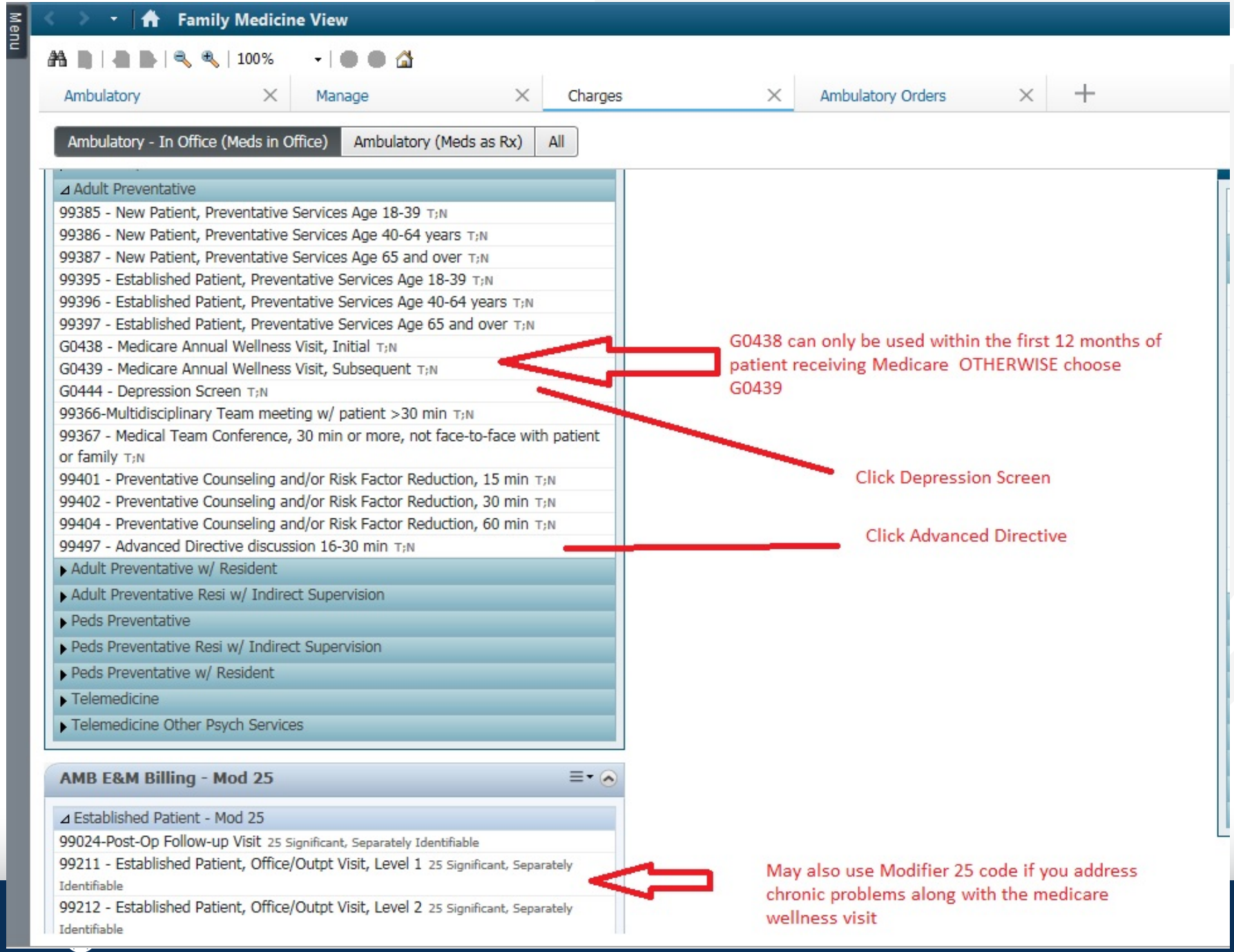

Medicare Annual Wellness Visit - test, test
*Performed on: 03/15/2019 1212 EDT
Health Risk Asse
PHQ - 9
Mini-Cog Test
Advance Directiv
Mini-Mental Statu
Mini-Cog Test
Administration
Special Instructions
1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct.
- Allow patient three tries, then go to next item.
- The following word lists have been validated in a clinical study:1-3
Version 1 Version 2 Version 3 Version 4 Version 5 Version 6
o Banana o Daughter o Village o River o Captain o Leader
o Sunrise o Heaven o Kitchen o Nation o Garden o Season
o Chair o Mountain o Baby o Finger o Picture o Table
2. Ask patient to draw the face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).
- Either a blank piece of paper or a preprinted circle (other side) may be used.
- A correct response is all numbers placed in approximately the correct positions AND the hands pointing to the 11 and 2 (or the 4 and 8).
- These two specific times are more sensitive than others.
- A clock should not be visible to the patient during this test.
- Refusal to draw a clock is scored abnormal.
3. Ask the patient to recall the three words from Step 1.
Ask the patient to recall the three words from Step 1.
CDT Score
Normal
Abnormal
# of Recalled Words
Mini-Cog Score
Negative for cognitive impairment
Positive for cognitive impairment
Scoring
3 recalled words Negative for cognitive impairment
1-2 recalled words + normal CDT Negative for cognitive impairment
1-2 recalled words + abnormal CDT Positive for cognitive impairment
0 recalled words Positive for cognitive impairment
References
Complete Mini-Cog Test
Remember to scan in clock face drawing
After complete, click the Advance Directive Tab


Medicare Annual Wellness Visit - test, test
*Performed on: 03/15/2019 1130 EDT
Health Risk Asses
PHQ - 9
Mini-Cog Test
Advance Directiv
Mini-Mental Statu
Advance Directive
Advance Directive
Yes
No
No/ Pt wishes to verbalize intent
No/ Pt <18 yrs old, not emancipated
If patient has an Advance Directive, notify MD.
Type of Advance Directive
Living will
Medical DPOA
Medical Durable Power of Attorney Name and Phone Number
Location of Advance Directive
Copy obtain previous rec
Copy placed paper chart
Copy at home
Scanned into EMR
Unable to obtain copy
Reason Copy Cannot Be Obtained
Intent of Advance Directive
Segoe UI
9
Intent of Advance Directive Stated by
Self
Friend
Relative
Significant other
Spouse
Patient Wishes to Receive Further Information on Advance Directive
Yes
No
Right Click to access GA and SC Advance Directive
Answering "Yes" to Pastoral Care Services Needed will order "Nurse Referral-Pastoral Care" which sends a requisition to pastoral Care during business hours.
If patient wishes information/ assistance with Advancfe Directives outside of business hours, call Pastoral Care or theAttending Physician
Step 6
Complete Advance Directive
Step 7
Then click MMSE


Medicare Annual Wellness Visit - test, test
*Performed on: 03/15/2019 1130 EDT
Health Risk Asses
PHQ - 9
Mini-Cog Test
Advance Directive
Mini-Mental Status
Mini-Mental Status Exam
Presenting symptoms:
Able to name time:
Year
Season
Date
Day
Month
Able to name place:
State
City
Type of Residence
Present location
Current President
Score for Orientation:
Registration (3 items)
Recall of 3 items
Calculation or Spelling
Naming Objects
Repeating words
Three-step Commands
Written Commands
Writing Sentence
Pattern or clock face
Total MMSE Score
Assessment of Cognitive Impairment
Minimal
Mild
Moderate
Severe
Profound
25+ for Minimal
20-24 for Mild
16-19 for Moderate
11-15 for Severe
0-10 for Profound
Mini-Mental Status Exam
Step 8
Complete MMSE
Step 9
After MMSE complete, check the green checkmark


Family Medicine View
100%
Ambulatory
Manage
Charges
Ambulatory Orders
Microbiology ...
Immunizations ...
Subjective/History of Present Illness
Review of Systems ...
Objective/Physical Exam
Assessment and Plan
Visits ...
Reminders ...
New Order Entry ...
Order Profile ...
Media Gallery ...
Health Concerns ...
Functional Measures Overview ...
Goals and Interventions Component ...
Create Note
Clinic Note
Consult Note
Wellness Visit Note
Admission H&P
Clinic Note- APP
More
Scales and Assessments
All Visits: Last 5 years
No results found
Care Team
Role/Relationship
Contact
Phone
Cross-Visits
Care Manager
Yu MD, Jack C
7067211794
Primary Care Physician
Test , Physician - Radiologist
(706) 721-2426
Chief Complaint
Selected Visit
this is a test
Woo MD , Rebecca JUN 29, 2017 15:00
Allergies (0)
All Visits
Error retrieving Population Health Data. Refresh the component. If the problem persists, contact your system administrator.
Substance
Sev...
Reactions
Cat...
Stat...
Rea...
Sou...
Comments
NKA
--
--
Drug
Active
Allergy
--
--
Reconciliation Status: Incomplete
Complete Reconciliation
click the wellness visit note type
Histories
All Visits
Problems
Procedure
Family
Social


<No - Encounter class type>
Patient Portal: Yes
Loc:
MDRO:
Risk:
Menu
Documentation
Add
Wellness Visit Note
List
Tahoma
9
Reviewed and updated patient's medical and family history, current medications, alcohol and tobacco use, physical activity, see history section
Chief Complaint
this is a test
Advance Directive
Advance Directive: No (03/15/19 11:47:00 EDT)
Advance Directive Additional Information: Yes (03/15/19 11:47:00 EDT)
General Health
General health rating: Very Good (03/15/19 EDT)
Someone avail. to help if needed?: Yes, quite a bit (03/15/19 EDT)
Phys. & emotional health limit social: Slightly (03/15/19 EDT)
Sexual problems: Never (03/15/19 EDT)
Trouble eating well: Never (03/15/19 EDT)
Teeth or denture problems: Never (03/15/19 EDT)
Problems using the telephone: Never (03/15/19 EDT)
ADL/IADL
Assistance with personal care?: No (03/15/19 EDT)
Trouble taking meds correctly?: No (03/15/19 EDT)
Able to walk without help?: Yes (03/15/19 EDT)
Ability to shop w/out help: Yes (03/15/19 EDT)
Prepare your own meals?: Yes (03/15/19 EDT)
Housework without help?: Yes (03/15/19 EDT)
Handle money without help: Yes (03/15/19 EDT)
Track own medications without help?: Yes (03/15/19 EDT)
Difficulties driving your car?: No (03/15/19 EDT)
Seatbelts: I always fasten my seat belt (03/15/19 EDT)
All fields will populate in the note
Medications
carvedilol 3.125 mg oral tablet, 3.125 mg= 1 tab, PO, BID
Allergies
NKA
Problem List/Past Medical History
Ongoing
Acute Bacterial Tonsillitis
Right knee pain
Shoulder arthritis
Historical
No qualifying data
Procedure/Surgical History
Family History
Social History
Immunizations
Lab Results
Diagnostic Results


Menu
Family Medicine View
100%
Ambulatory
Manage
Charges
Ambulatory Orders
Ambulatory - In Office (Meds in Office)
Ambulatory (Meds as Rx)
All
Adult Preventative
99385 - New Patient, Preventative Services Age 18-39 T;N
99386 - New Patient, Preventative Services Age 40-64 years T;N
99387 - New Patient, Preventative Services Age 65 and over T;N
99395 - Established Patient, Preventative Services Age 18-39 T;N
99396 - Established Patient, Preventative Services Age 40-64 years T;N
99397 - Established Patient, Preventative Services Age 65 and over T;N
G0438 - Medicare Annual Wellness Visit, Initial T;N
G0439 - Medicare Annual Wellness Visit, Subsequent T;N
G0444 - Depression Screen T;N
99366-Multidisciplinary Team meeting w/ patient >30 min T;N
99367 - Medical Team Conference, 30 min or more, not face-to-face with patient or family T;N
99401 - Preventative Counseling and/or Risk Factor Reduction, 15 min T;N
99402 - Preventative Counseling and/or Risk Factor Reduction, 30 min T;N
99404 - Preventative Counseling and/or Risk Factor Reduction, 60 min T;N
99497 - Advanced Directive discussion 16-30 min T;N
Adult Preventative w/ Resident
Adult Preventative Resi w/ Indirect Supervision
Peds Preventative
Peds Preventative Resi w/ Indirect Supervision
Peds Preventative w/ Resident
Telemedicine
Telemedicine Other Psych Services
G0438 can only be used within the first 12 months of patient receiving Medicare OTHERWISE choose G0439
Click Depression Screen
Click Advanced Directive
AMB E&M Billing - Mod 25
Established Patient - Mod 25
99024-Post-Op Follow-up Visit 25 Significant, Separately Identifiable
99211 - Established Patient, Office/Outpt Visit, Level 1 25 Significant, Separately Identifiable
99212 - Established Patient, Office/Outpt Visit, Level 2 25 Significant, Separately Identifiable
May also use Modifier 25 code if you address chronic problems along with the medicare wellness visit

You want to provide as many services as possible at this visit, as Medicare pays 100% if ordered/done at the AMWV

Recent News on March 15, 2019

Medicare Beneficiaries Pay Nothing For "Annual Wellness Visits," But May Be Responsible For The Entire Cost Of Physicals.

Kaiser Health News (3/15) reported that federal law prohibits Medicare "**from paying for annual physicals, and patients who get them may be on the hook for the entire amount." However, "beneficiaries pay nothing for an 'annual wellness visit,' which the program covers in full as a preventive service."** The article said that over time, "preventive services have gradually been added to the program, and the Affordable Care Act established coverage of the annual wellness visit. Medicare beneficiaries pay nothing as long as their doctor accepts Medicare."

Additional Information can be found on the CMS website:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PreventiveServicesPoster.pdf

AWV Documentation Requirements

I. Health Risk Assessment
II. Beneficiary's Medical & Family History
III. Beneficiary's current list of health care providers & suppliers
IV. Cognitive Functioning Assessment
V. Preventive Screening Schedule
VI. Beneficiary's Risk Factors
VII.Socio-economic and behavioral health referrals as needed
VIII. Advanced Care Planning

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

Clinical Documentation is the Foundation for success in Value- Based Healthcare

- Accuracy throughout the notes
- Details in the HPI
- Unique and Accurate Physical Exams
- Correct Diagnosis Codes (ICD-10)
- Accurate Problems List
- Documentation of Quality Measures

Move to Value

Risk Adjustment Model for MSSP & ACO Patients CMS- Hierarchical Condition Category (HCC) Coding

(CMS-HCC) Model

- The CMS-HCC model uses demographics and a diagnosis-based medical profile captured during all clinician encounters—both inpatient and outpatient—to produce a health-based measure of future medical need.

Risk adjustment is the tool used to predict health care costs (your budget) .

A RAF score is a reflection of how sick a patient is and what resources may be needed to provide healthcare for the patient.

- **RAF scores determine reimbursement and aid us in identifying the patients who need more outreach and particular care models. Average RAF 1.0**

Move to Value

How is Risk Adjustment Calculated?

- RAF scores are calculated from: Demographics and a diagnosis-based profile (**HCC diagnoses**) via **claims data**.
- The CMS Risk Adjustment model does not carry a patient's chronic conditions into the next calendar year. ALL chronic conditions must be re-documented **every calendar year** during a **face-to-face visit**.
  - This includes chronic conditions that do not change from year-to-year.
- **Each diagnosis assessed (HCC or not) at a specific date of service must:**
  - **be relevant to the visit**
  - **have supporting documentation in the medical record describing how each diagnosis is being managed, evaluated, assessed or treated.**
    - **This is called "Meeting the MEAT."**
    - **Document the status and treatment for each assessed diagnosis for every visit.**
- **Reimbursement is determined by accurate documentation in the medical record and diagnosis code reporting.**

Move to Value

If your Goal is: Success in Value Based Agreements

Clinical Documentation Improvement will directly impact:

RAF Scores

Quality Scores

Medical Loss Ratio

Revenue Cycle

Move to Value

Meeting the M-E-A-T!
Monitor, Evaluate, Address or Treat!

EACH and EVERY coded and billed diagnosis must have supporting documentation in the note for the date of service. Give **status** and **treatment plan** for each diagnosis, outside of the prepopulated fields and the assessment. Indicate how you have:

- **M**onitored the condition
- **E**valuated the condition
- **A**ddressed the condition
- **T**reated the condition

Move to Value

What are HCC Diagnoses ?

HCC : Hierarchical Condition Category

Each HCC diagnosis is given a weight (a numerical score), which is used to calculate the RAF (Risk Adjustment Factor) score, which in turn is used to calculate reimbursement for that patient's healthcare costs. (PMPM)

"Hierarchical" indicates that some categories of diagnoses rank "higher" than others (supersede others). Credit is granted for the higher of the categories coded.

Example:

In January a patient was diagnosed with Prostate Cancer (HCC12) contributing 0.154 to the RAF score. Later in July, he was diagnosed with Prostate Cancer with Bone Metastases. This is from HCC 8 (with a coefficient of 2.484) The HCC 8 will count, but the HCC 12 will not.

Common HCC Diagnoses

- Diabetes Mellitus with or without complications
- Vascular Disease
- Heart Failure
- Cancer
- Major Depression, Bipolar Disorder, & Paranoid Disorders
- Chronic Obstructive Pulmonary Disease
- Rheumatoid Arthritis
- Angina Pectoris
- Specific Heart Arrhythmia
- Morbid Obesity

RAF	HCC	DX	TYPE 2 DIABETES MELLITUS
0.105	19	E119	Type 2 diabetes mellitus without complications
	TYPE 2 DM WITH KIDNEY COMPLICATIONS		
0.305	18	E1121	with diabetic nephropathy
0.305	18	E1122	with diabetic chronic kidney disease *Use additional code for CKD*
0.305	18	E1129	with other diabetic kidney complication
	TYPE 2 DM WITH NEUROLOGICAL COMPLICATIONS		
0.305	18	E1140	with diabetic neuropathy, unspecified
0.305	18	E1141	with diabetic mononeuropathy
0.305	18	E1142	with diabetic polyneuropathy
0.305	18	E1143	with diabetic autonomic (poly)neuropathy
0.305	18	E1149	with other diabetic neurological complication
	TYPE 2 DM WITH CIRCULATORY COMPLICATIONS		
0.305	18	E1151	with diabetic peripheral angiopathy without gangrene
0.305	18	E1152	with diabetic peripheral angiopathy with gangrene
0.305	18	E1159	with other circulatory complications
	TYPE 2 DM WITH OTHER COMPLICATIONS		
0.305	18	E11610	with diabetic neuropathic arthropathy
0.305	18	E11620	with diabetic dermatitis
0.305	18	E11621	with foot ulcer *Use additional code for foot ulcer - L97 series -*
0.305	18	E11622	with other skin ulcer
0.305	18	E11628	with other skin complications
0.305	18	E11630	with periodontal disease
0.305	18	E11638	with other oral complications
0.305	18	E11649	with hypoglycemia without coma
0.305	18	E1165	with hyperglycemia
0.305	18	E1169	with other specified complication
0.105	19	Z794	Long term (current) use of insulin

Clinical Examples

Clinical Example #1

CC: A 74 y/o female presents for follow up of COPD, anticoagulation, and a worsened cough.

HPI: The patient has some issues with paperwork regarding her Albuterol and Atrovent nebulizers. She is past due for follow up and has been noncompliant with her medical care. When called for an appointment she stated that she "just hoped to live that long to make it to the appointment." We stressed the importance of checking her INR and of other routine care. She is clearly benefitting from the nebulizers, but still refuses to see a pulmonologist. She states that she fell on the driveway and broke her right great toe 3 weeks ago. She is asking for a Chest x-ray today because of her worsening cough.

<u>Medications:</u>
Imdur, Spiriva, Nitrostat, Albuterol, Coumadin, Mirtazapine, Citalopram, Alprazolam, Trazodone, Simvastatin, Diltiazem, & Ipratropium.

<u>PMH</u>:
Asthma, Hypertension Hypercholesterolemia, Cataracts, Mitral Valve Prolapse, Coronary Artery Disease, Anxiety, DVT x 3 and PE in the past Tricuspid valve disorder Chronic UTI's

Move to Value

Assessing the Correct Diagnoses

Assessment:

- **Z86.718 History of DVT**
- **Z79.01 Long term (current) use of Anticoagulant therapy**
- **J44.9 COPD**
- **R05 Cough**
- **M79.674 Pain of the Right Great Toe**

Comments:

- **It is recommended to code "Chronic DVT" rather than "History of DVT."**
- **ICD-10 code from I82.--- category along with the appropriate Z code for the anticoagulation therapy would be most appropriate.**
- **COPD is appropriately coded and supported in the documentation. R05 & M79.674 are supported and appropriate.**
- **Consider coding Major Depressive Disorder recurrent (F33.--)**
- **Consider addressing and coding the CAD with Angina (I25.119).**

Move to Value

Calculating the RAF Score

Characteristic or diagnosis	RAF	RAF Potential
74 y.o. female community residing, non-dual aged Medicare patient	0.381	0.381
COPD (J44.1 & J44.9) Captured on prior encounters	0.346	0.346
CAD with Angina I25.119	0 Angina not coded	0.141
I82.-- Chronic Deep Vein Thrombosis	0 for History of DVT code (Z86.718)	0.299
F33.1 Major Depressive Disorder, recurrent, moderate	0 not coded	0.330
Estimated RAF score	0.727	1.497
Reimbursement example PMPM	$618	$1,272

Move to Value

Clinical Document Inquery (CDI) Hospital Setting

- ***60-year-old male presented to the emergency department with acute dyspnea due to acute on chronic systolic heart failure***
- ***Comorbid conditions: Hypertension, diabetes, hyperlipidemia, left bundle branch block, paroxysmal atrial fibrillation***
- ***On physical exam was in moderate respiratory distress, tachypnea with O2 sats in the 80s on room air treated with 100% nonrebreather***

	BEFORE QUERY				AFTER QUERY
DRG	293 without cc/mcc			**DRG**	**291 with MCC**
DRG Severity Weight	0.9588			**DRG Severity Weight**	**1.4759**
Principal Dx:	Acute combined CHF			**Principal Dx:**	Acute combined CHF
Secondary Dx:	HTN			**Secondary Dx:**	**Acute Hypoxic Respiratory Failure**
	hypoxemia				HTN
	DM2				hypoxemia
	LBBB				DM2
					LBBB
Principal Surgery				**Principal Surgery**	
LOS	3.5			**LOS**	**4.5**
SOI	1			**SOI**	**3**
ROM	2			**ROM**	**3**
Revenue	$9,181			**Revenue**	**$14,133**

Importance of Accurate Coding of Severity of Illness

At the American College of Cardiology 2018 Cardiovascular Summit in Las Vegas, Linda Gates-Striby, CCS-P, ACS-CA, and Ty Gluckman, MD, stressed how complete and accurate documentation, including for severity of illness and comorbidities, can affect reimbursement.

All conditions documented and coded appropriately		Chronic conditions not documented and non-specific		Chronic conditions not documented or coded	
76 year old female	0.437	76 year old female	0.437	76 year old female	0.437
Medicaid female aged	0.151	Medicaid female aged	0.151	Medicaid female aged	0.151
Demographic RAF total	0.588	Demographic RAF total	0.588	Demographic RAF total	0.588
DM with chronic manifestation (HCC 18)	0.368	DM documented as uncomplicated (HCC 19)	0.118	DM not documented but clinically supported	X
Congestive heart failure (HCC 85)	0.368	CHF not documented but clinically supported	X	CHF not documented but clinically supported	X
Disease interaction (DM + CHF)	0.182	No disease interaction	X	No disease interaction	X
Total risk score	1.506	Total risk score	0.706	Total risk score	0.588
Total risk score value	$13,554	Total risk score value	$6,354	Total risk score value	$5,292

Source: American College of Cardiology and Linda Gates-Striby, CCS-P, ACS-CA; reprinted with permission.

HCC tips

- ***ALL* conditions "reset" at the beginning of the calendar year**
- ***"History of" or "PMH" statement mean condition has resolved in CMS interpretation***
- ***Documentation in HPI or Assessment and Plan contributes to support***
  - ***NOT problem list, PMH, PE, ROS***
- ***Uncertain diagnoses do not count (probable, rule out, etc.,)***
- ***Causality needs to be clear***
  - ***i.e. "secondary to" or "due to"***
  - ***Does not count to use a comma or "and"***
- ***Unspecified is better than not at all***
- ***You do not have to actively manage to code for diagnosis***

Additional Information and Webcasts

1) Annual Wellness Visits
    a. Content - https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/awv.html
    b. Webcast - https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/awv/getting-paid.html
2) Hierarchical Condition Categories
    a. Content - https://www.aafp.org/practice-management/payment/coding/hcc.html
        i. https://www.aafp.org/journalpdfrestricted/fpm/2018/0300/p21.pdf
    b. Webcast - https://www.aafp.org/practice-management/payment/coding/hcc/hcc-crash-course-webinar.mem.html
3) Chronic Care Management
    a. Content – https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/chronic-care.html
    b. Webcast - https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/chronic-care/ccm-paid-for-best.html
4) Transitional Care Management
    a. Content - https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/tcm.html
    b. Webcast - https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/tcm/webcast.html

Hospital profile

Back to Results

General information | Survey of patients' experiences | Timely & effective care | Complications & deaths | Unplanned hospital visits | Use of medical imaging | Payment & value of care

AU MEDICAL CENTER

1120 15TH STREET
AUGUSTA, GA 30912
(706) 721-6569

Overall rating : ☆●●●●

Learn more about the overall ratings
View rating details

Distance : 0.3 miles

Add to My Favorites
Map and directions for

General information

- Hospital type : Acute Care Hospitals
- Provides emergency services : Yes
- Participates in : Nursing Care Registry, General Surgery Registry
- Able to receive lab results electronically : Yes
- Able to track patients' lab results, tests, and referrals electronically between visits : Yes
- Uses outpatient safe surgery checklist : Yes
- Uses inpatient safe surgery checklist : Yes
- Uses hospital survey on patient safety culture : Yes

View rating - details

This table shows how individual hospitals perform compared to all hospitals across the country for each of the seven groups or categories of quality measures that make up the Hospital Compare overall rating.

Above the national average is better for all categories.

Category	National Average Comparison
	AU MEDICAL CENTER
Mortality	Same as the national average
Safety of Care	Below the national average
Readmission	Below the national average
Patient Experience	Below the national average
Effectiveness of Care	Same as the national average
Timeliness of Care	Below the national average
Efficient use of Medical Imaging	Below the national average

Questions?????

RAF	HCC	DX	MORBID OBESITY
0.244	22	E6601	Morbid (severe) obesity due to excess calories
0.244	22	E662	Morbid (severe) obesity with alveolar hypoventilation
0.244	22	Z6841	Body mass index (BMI) 40.0-44.9, adult
0.244	22	Z6842	Body mass index (BMI) 45.0-49.9, adult
0.244	22	Z6843	Body mass index (BMI) 50-59.9 , adult
0.244	22	Z6844	Body mass index (BMI) 60.0-69.9, adult
0.244	22	Z6845	Body mass index (BMI) 70 or greater, adult

RAF	HCC	DX	HEART FAILURE
0.130	88	I20.9	Angina
0.337	85	I27.0	Pulmonary HTN
0.337	85	I27.81	Cor Pulmonale (chronic)
0.337	85	I42.9	Cardiomyopathy
0.337	85	I501	Left ventricular failure
0.337	85	I5020	Unspecified systolic (congestive) heart failure
0.337	85	I5021	Acute systolic (congestive) heart failure
0.337	85	I5022	Chronic systolic (congestive) heart failure
0.337	85	I5023	Acute on chronic systolic (congestive) heart failure
0.337	85	I5030	Unspecified diastolic (congestive) heart failure
0.337	85	I5031	Acute diastolic (congestive) heart failure
0.337	85	I5032	Chronic diastolic (congestive) heart failure
0.337	85	I5033	Acute on chronic diastolic (congestive) heart failure
0.337	85	I5041	Acute combined systolic (congestive) and diastolic (congestive) heart failure
0.337	85	I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
0.337	85	I5043	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
0.337	85	I509	Heart failure, unspecified

RAF	HCC	DX	CHRONIC KIDNEY DISEASE
0	NA	N181	Stage 1, CKD
0	NA	N182	Stage 2, CKD
0	NA	N183	Stage 3, CKD
0.288	137	N184	Stage 4, CKD
0.288	136	N185	Stage 5, CKD
0.288	136	N186	Stage 6, CKD

RAF	HCC	DX	DIALYSIS
0.456	134	Z992	Dependence on renal dialysis
0.456	134	Z9115	Patient's noncompliance with renal dialysis

RAF	HCC	DX	COPD
0.336	111	J42	Chronic Bronchitis
0.336	111	J43.9	Emphysema
0.336	111	J41.0	Smokers Cough
0.336	111	j440	COPD with acute lower respiratory infection
0.336	111	j441	COPD with acute exacerbation
0.336	111	j449	COPD, unspecified

RAF	HCC	DX	PROTEIN-CALORIE MALNUTRITION
0.493	21	E46	Protein-calorie malnutrition
0.493	21	R64	Cachexia

RAF	HCC	DX	CARDIOVASCULAR
0.269	96	I470	Re-entry ventricular arrhythmia
0.269	96	I471	Supraventricular tachycardia
0.269	96	I472	Ventricular tachycardia
0.269	96	I479	Paroxysmal tachycardia, unspecified
0.269	96	I480	Paroxysmal atrial fibrillation
0.269	96	I481	Persistent atrial fibrillation
0.269	96	I482	Chronic atrial fibrillation
0.269	96	I483	Typical atrial flutter
0.269	96	I484	Atypical atrial flutter
0.269	96	I4891	Unspecified atrial fibrillation
0.269	96	I4892	Unspecified atrial flutter
0.269	96	I492	Junctional premature depolarization
0.269	96	I495	Sick sinus syndrome

RAF	HCC	DX	PSYCHIATRIC
0.595	57	F20.9	Schizophrenia
0.595	57	F25.9	Schizoaffective Disorder
0.520	58	F304	Manic episode in full remission
0.520	58	F308	Other manic episodes
0.520	58	F309	Manic episode, unspecified
0.520	58	F319	Bipolar disorder, unspecified
0.520	58	F324	Major depressive disorder, single episode, in partial remission
0.520	58	F33.9	Major depression, recurrent
0.520	58	F348	Other persistent mood [affective] disorders
0.520	58	F349	Persistent mood [affective] disorder, unspecified
0.520	58	F39	Unspecified mood [affective] disorder

RAF	HCC	DX	DRUG DEPENDENCE
0.344	55	F1020	Alcohol dependence, uncomplicated
0.344	55	F1021	Alcohol dependence, in remission
0.344	55	F1220	Cannabis dependence, uncomplicated
0.344	55	F1120	Opioid dependence, uncomplicated

RAF	HCC	DX	ACQUIRED ABSENCE
0.521	189	Z89411	Acquired absence of right great toe
0.521	189	Z89412	Acquired absence of left great toe
0.521	189	Z89421	Acquired absence of other right toe(s)
0.521	189	Z89422	Acquired absence of other left toe(s)
0.521	189	Z89431	Acquired absence of right foot
0.521	189	Z89432	Acquired absence of left foot
0.521	189	Z89441	Acquired absence of right ankle
0.521	189	Z89442	Acquired absence of left ankle
0.521	189	Z89511	Acquired absence of right leg below knee
0.521	189	Z89512	Acquired absence of left leg below knee
0.521	189	Z89611	Acquired absence of right leg above knee
0.521	189	Z89612	Acquired absence of left leg above knee