



How Coding and Quality Work Together: A Focus on Preventive Care

Michelle Hoover, RHIA, CCS

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Objectives

- Explore the changing landscape of healthcare as the focus shifts from fee-for-service models into new quality-based payment models.
- Define the Annual Wellness Visit and understand its value and importance in primary care.
- Understand how the Annual Wellness Visit provides the mechanism to collect data for an accurate risk score through effective HCC coding.
- Explore how population health data will be used to assist in the prevention of disease before chronic conditions emerge and how predictive data enhances a patient's quality of life.

Objectives

- Define the Chronic Care Management model and how the service transforms the delivery of care from reactive care focused on exacerbation of chronic illnesses to a delivery model aimed to proactive care with an engaged patient population.
- How coding for the AWW and CCM improves patient outcomes, meets quality reporting requirements and ultimately increases revenue.

Changing Landscape in Healthcare

The rise of quality-based payment systems have caused a ripple effect in healthcare: the focus has shifted away from fee-for-service payment models to those that focus on the delivery of quality care, managing patient populations, and improving patient outcomes.

- ***Medicare Access and CHIP Reauthorization Act (MACRA)*** introduced two quality based payment tracks: The Merit Based Incentive Payment System (MIPS), and Alternative Payment Models (APMs).
- ***Alternative Payment Models*** provide added incentive payments for quality outcomes and cost efficient care. APMs may apply to a specific condition, a care episode, or a population.

Changing Landscape in Healthcare (cont.)

- ***Patient Centered Medical Home (PCMH)*** emphasizes care coordination and patient engagement to transform primary care. PCMHs can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.
- ***Transforming Clinical Practice Initiative (TCPI)*** was created by CMS to assist practices as they transition from traditional fee-for-service models to new quality-based payment systems.
- ***Accountable Care Organizations (ACOs)*** are increasing in popularity-currently there are 838 active ACOs nationwide.

How Coding and Quality Work Together

Coding

Coding Accuracy
Highest Level of Specificity
Risk Adjustment

QPP

Process to Capture Quality Measures
Annual Wellness Visit

Preventive Care

Annual Wellness Visit
Chronic Care Management
Advanced Care Planning

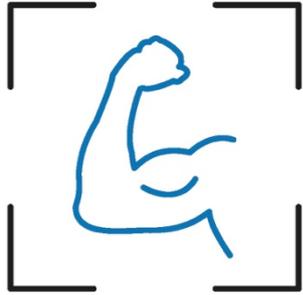
Population Health

Chronic Care Management
Shared Decision Making
Patient Education

New Focus on Preventive Care

- If value-based payment models are the foundation of today's healthcare, then consider preventive care the framework of patient care. Preventive care is the structure that will support keeping patients healthy as possible and prevent the chronically ill from getting sicker.
- As organizations transition into value-based payment models, clinics can transform practices around preventive care and screening services that will benefit them financially as well as helping them understand how to treat complex, high-risk patients in a new environment.

Proactive Care vs. Reactive Care



Annual Wellness Visit

Medicare's Annual Wellness Visit (AWV) is a way for your practice to keep patients as healthy as possible. The AWV addresses gaps in care and enhances the quality of care you deliver. A personalized prevention plan created for the Medicare beneficiary is a way to improve patient engagement and promote preventive care.



Chronic Care Management

Medicare introduced Chronic Care Management (CCM) as a clinical model aimed at overcoming limitations and gaps in the treatment of chronic illness. Utilizing CCM transforms the delivery of care away from reactive care (*focused on exacerbation of chronic diseases*) to a delivery model aimed to proactive care with an engaged patient population.

Why is the Annual Wellness Visit Different?

The AWV is not the typical “hands on” physical exam, but it is an opportunity for a provider to:

- Focus on patient’s overall health status
- Assess the patient’s quality of life
- Screen for depression, substance misuse, and detect chronic illness
- Engage with patients on a regular basis, and detect emerging health and safety risks
- Review the patient’s complete medication list and identify any potential adverse drug events
- Document Advanced Care Planning

Types of Annual Wellness Visits

Initial Preventive Physical Exam (IPPE)

- Commonly known as the “Welcome to Medicare” visit
- Once in a lifetime benefit for Medicare Part B enrollees
- Medicare beneficiaries within the first 12 months of Medicare enrollment
- No co-pay or deductible for patient



Types of Annual Wellness Visits (cont.)

Annual Wellness Visit

- Patient is no longer within 12 months of Medicare enrollment
- Patient has not received either an IPPE or AWWV within the past 12 months
- Includes a Personalized Prevention Plan of Service (PPPS)
- No co-pay or deductible for patient
- Does not require a specific diagnosis



Chronic Care Management

- In 2015, Medicare introduced Chronic Care Management (CCM) as a clinical model aimed at overcoming limitations of acute care for the treatment of chronic illness.
- According to the CDC, chronic diseases account for an estimated 83% of total U.S. health spending and virtually all (99%) of Medicare's expenditures are for beneficiaries with at least one chronic condition.
- CCM was born from the ineffectiveness of fragmented care and an increasing bias towards the treatment of acute illness that often overwhelms the subtle, complex and gradual development of chronic diseases.

Chronic Care Management

In 2016, a year after CCM was introduced, the service was already beginning to demonstrate increased revenue, quality patient outcomes, and significant cost savings. Several studies of the CCM proved:

- 25% reduction in hospitalizations
- 28% reduction in ED visits
- 36% reduction in readmissions
- 21% reduction in average monthly Medicare Part A and B expenditures
- 20% reduction in mortality
- 50% or greater reduction in depressive symptoms
- 66% fewer nursing home placements

Why Do We Code?

- As the landscape of healthcare rapidly changes, the HIM professional will need to adapt and consider how coded information will be used in a system that rewards quality patient outcomes over the traditional focus on quantity of services.
- How will the paradigm shift affect how we code for:
 - Population Health Management
 - Clinical Quality Reporting
 - Reimbursement and Revenue

Coding for Population Health Management

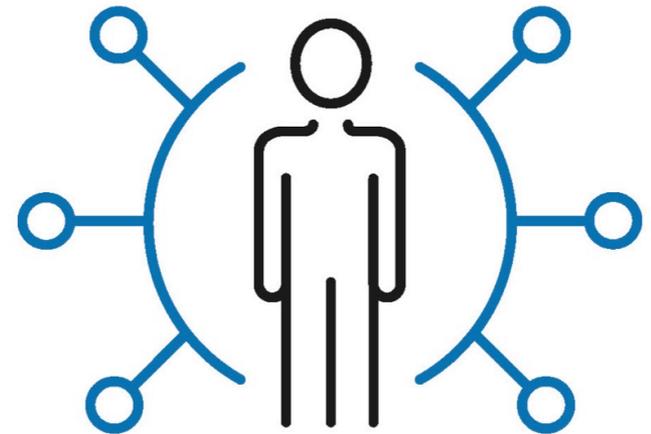
Population Health Management

- Every code we assign to a patient tells their story. As we collect data we are essentially creating a snapshot of the patient's medical history, current health risks, and conditions.
- Population health management is an opportunity for HIM professionals to translate the language of coding into actionable information to understand patient populations.
- ICD-10 codes can explain how many patients in a population have diabetes, heart disease, or hypertension and allows organizations to customize their staff, or develop targeted educational material for their patients. ***Remember-population health management can begin with one patient and one ICD-10 code.***

Population Health Data

In addition to collecting codes, population health is based on key data elements such as:

- Number and type of chronic diseases
- History of high utilization
- Frequent hospitalizations or emergency department visits
- Mental health or substance abuse diagnoses
- Advanced age
- Socioeconomic factors
- High Risk Medications



Health Risk Assessment

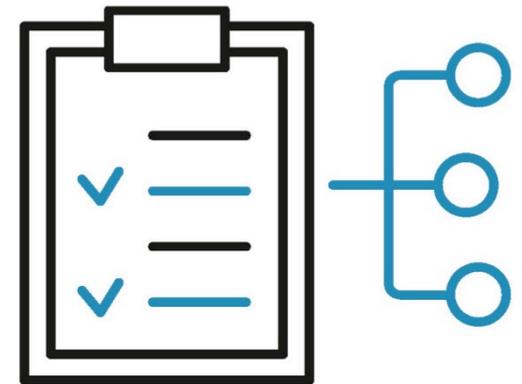
The AWW encourages patients to take an active role in managing their health, and improve their well-being and quality of life. This is accomplished by evaluating beneficiaries' current health and behaviors, followed by advice on ways to become healthier.

Medicare requires a patient to complete a comprehensive *Health Risk Assessment (HRA)* to evaluate their current health status, evaluate risk of disease or disability, and assess and safety risks in their home.

Health Risk Assessment (cont.)

Medicare does not require a specific HRA form, but the document must meet the following requirements:

- *Demographic data*
- Self-assessment of health status
- *Psychosocial and Behavioral Risks*
- Activities of Daily Living (ADL) – dressing, bathing, walking, shopping, *medication management*, housekeeping



Health Risk Assessment Data

The AWW is the opportunity for organizations to identify chronic diseases that may have been overlooked—a patient’s Health Risk Assessment identifies:

Chronic diseases that may not have been documented

- Studies show that “un-coded” patients use less primary care than coded patients. Instead of managing chronic conditions in primary care, un-coded patients have higher rates of emergency department visits and have high inpatient admission rates.

Identify High Risk Patients

- The AWW captures codes able to stratify risk in your patient population and creates a workflow to capture codes for Hierarchical Condition Category (HCC) risk coding. HCC coding is essential for effective population health management and success in value based payment models.

Minimum Requirements of the AWW

Other minimum requirements of the AWW include:

- Vitals such as height, weight, blood pressure, and BMI
- List of current providers and medical equipment suppliers
- Document the *patient's medical history* and family medical history
- Evaluate the patient for potential *risk factors for depression*
- Review the patient's functional ability and safety including *screening for fall risk, home safety and hearing impairment*

Minimum Requirements of the AWW (cont.)

Other minimum requirements of the AWW include:

- Screen the patient for any *cognitive impairment* the patient might have
- *Screen for potential substance misuse* such as alcohol, tobacco, or narcotics
- Establish a written screening schedule, such as a checklist for the next 5-10 years as needed
- Provide personalized health advice to the patient and make appropriate referrals to health education or preventive counseling services

Results - Population Health

- Increasing the utilization of the AWW allows organizations to collect enough data to determine prevalent diseases in your patient population -coded ICD-10 data will determine who your patients are, and why they are being treated.
- Identifying your patient population allows you to design patient education or hire new staff based on patient needs.



Results – Population Health (cont.)

- The AWW will help identify any “un-coded” patients in your patient population – coding previously un-coded chronic diseases will give your silent patient population the opportunity to receive care. This patient population may have fallen into the “tyranny of the urgent” trap – these patients may have been treated for years for urgent needs and chronic conditions are not prioritized.
- The AWW is the perfect opportunity to collect demographics, status codes and history codes needed to build an accurate risk score through HCC coding.
- Collecting real time data through a Health Risk Assessment helps to identify and empanel patients for CCM.

Coding for Quality Reporting

What is the Quality Payment Program?

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) combines three legacy incentive programs into the Quality Payment Program. The legacy programs include:
 - Meaningful Use
 - Physician Quality Reporting System (PQRS)
 - Value Based Payment Modifier
- There are two ways to participate in the Quality Payment Program:
 - Merit-Based Incentive Payment System (MIPS)
 - Alternative Payment Models (APMs)

Merit Based Incentive Payment System

MIPS Performance Categories for Year 2 (2018)



Quality Measures for Preventive Care

| Quality Measure | QPP | HEDIS | ACO |
|--|-----|-------|-----|
| Screening for Fall Risk | ✓ | ✓ | ✓ |
| Screening for Depression | ✓ | ✓ | ✓ |
| Influenza Immunization | ✓ | ✓ | ✓ |
| Pneumococcal Vaccination | ✓ | ✓ | ✓ |
| Screening for High Blood Pressure | ✓ | ✓ | ✓ |
| Screening for Tobacco Use and Intervention | ✓ | ✓ | ✓ |
| Medication Reconciliation | ✓ | ✓ | ✓ |

Improvement Activities

The AWW also assists provider fulfill the requirements for the Improvement Activity category including:

- Depression and alcohol misuse screening
- Diabetes screening
- Implementation of fall screening and assessment programs
- Implementation of medication reconciliation practice improvements
- Participation in Million Hearts Campaign
- Tobacco screening

Cost

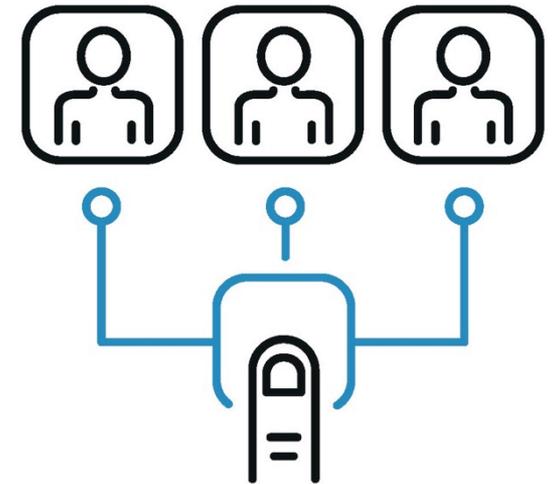
The cost performance category uses Medicare claims data to collect Medicare payment information for beneficiaries during a specific time period.

In year 2 of MIPS, Medicare will calculate two measures:

- Total per Capita Cost (TPCC) measure uses Medicare Part A and Part B claims to calculate the annual *risk adjusted* per capita costs for beneficiaries attributed to an individual clinician or group
- Medicare Spending per Beneficiary (MSPB) measure determines what Medicare pays for services performed by an individual clinician for the time period immediately *before, during* and *after* a patient's hospital stay. MSPB uses *risk adjustment* to calculate the expected cost for each episode.

Hierarchical Condition Category Coding

- Medicare currently uses Hierarchical Condition Category (HCC) Coding to calculate risk – however with the rise of value based payment systems HCC coding is becoming an essential tool to capture a Risk Adjustment Factor (RAF) score
- CMS will be using HCC coding methodology to calculate MSPB and TPCC in the Cost category – clinics and health systems will need to accurately reflect the acuity and complexity of their patient population
- So, the opportunity to collect HCC codes (and affect hospital payments) falls directly on office based physicians – if claims data reveals low RAF scores it will be difficult to justify consistently high costs associated with patient care



Risk Adjustment Factor Score

The total RAF is based on:

- Patient's Disease Complexity
- Demographic Factors (Age, Gender and Residence)
- Medicare or Dual Eligibility Status
- Number of Chronic Diseases

The higher the patient's RAF score, the higher the assumed risk of your patient population

HCC Coding Example

| Miss Kitty | No Conditions Coded | All Conditions Coded |
|----------------------------------|---------------------|----------------------|
| 76 y/o Female | 0.448 | 0.448 |
| Dual Eligibility | 0.163 | 0.163 |
| DM w/o complications | X | X |
| DM w/ complications | X | 0.368 |
| Vascular Disease | X | 0.299 |
| CHF | X | 0.368 |
| Disease Interaction (DM and CHF) | X | 0.182 |
| TOTAL | 0.611 | 1.828 |

HCC Coding Example (cont.)

Miss Kitty

No Conditions Coded

- RAF Score 0.611 x Average Cost Per Patient \$11,021 = \$6,733.83

All Conditions Coded

- RAF Score 1.828 x Average Cost Per Patient \$11,021 = \$20,146.38

A patient with a RAF of 1.0 incurs average Medicare costs. A patient with a RAF greater than 1.0 is likely to have higher costs and a patient with a RAF score lower have costs below average.

HCC Coding explains the gap between reality and what Medicare thinks your patient population looks like...

Results

- Success in value-based payment systems such as MIPS requires primary care providers to be proactive identifying, documenting, and managing their patients' health risk. Incentives and bonuses may be available to those who are successful at this; negative payment adjustments may await those who aren't.
- The Quality Payment Program is specifically designed to award preventive care and improve patient outcomes – The AWV meets 18 measures in the Quality Category and CCM meets over 30 Quality measures. Additionally, both services also fulfill requirements for Medicare Advantage plans and ACOs.
- Providers will be measured and reimbursed based on patient outcomes – the AWV and CCM will provide better care with minimal changes in current workflow

Coding for Revenue

Business Case for Annual Wellness Visit

- Annual Wellness Visits have high RVUs and reimbursement rates, especially when combined with additional preventive care services
- Medicare allows a provider to bill an evaluation and management visit the same day so a patient will not need an additional appointment for an emerging condition such as a upper respiratory infection or management of a chronic illness
- Collecting patient information or administering preventive screenings may be done by the nursing staff, medical assistants or mid level providers
- Advanced Care Planning may be performed on the same day as an Annual Wellness Visit with no co-pay or deductible for the patient
- Opportunity to organize risk pools in your practice and calculate risk scores for your patient population

Annual Wellness Visit Codes

| HCPCS Code | Description | National Payment Amount |
|------------|---|-------------------------|
| G0402 | Initial Preventive Exam “Welcome to Medicare Visit” | \$169 |
| G0438 | Initial Annual Wellness Visit | \$175 |
| G0439 | Subsequent Annual Wellness Visit | \$119 |
| G0442 | Alcohol Misuse Screening | \$18 |
| G0444 | Annual Depression Screening | \$18 |
| G0513 | Prolonged Preventive Service (1 st 30 min.) | \$66 |
| G0514 | Prolonged Preventive Service (additional 30 min.) | \$66 |
| 99213 | Office Visit-Established Patient | \$74 |
| 99214 | Office Visit-Established Patient (moderate decision making) | \$109 |
| 99497 | Advanced Care Planning (30 min.) | \$86 |
| 99498 | Advanced Care Planning (additional 30 min.) | \$75 |

Business Case for Chronic Care Management

- Chronic Care Management reimburses clinics for work they are currently doing for their patients—phone calls, medication reconciliation, and updating care plans are included in CCM.
- As of January 2018, there are 59,176,406 Medicare beneficiaries and CMS projects the total number of beneficiaries will reach 80 million by 2030. As more and more members of the “Baby Boomer” generation become beneficiaries we will need to change the way we look at healthcare and expenditures.
- CCM allows providers to treat chronic conditions on a routine basis and patients have the opportunity to have frequent communications with their healthcare team. Studies have shown CCM reduces disease burden, lowers inpatient admissions and improves overall outcomes.

Chronic Care Management Codes

| HCPCS Code | Short Description | National Payment Amount |
|------------|---|-------------------------|
| 99490 | CCM (20 min. of clinical staff time-per calendar month) | \$42 |
| 99487 | Complex CCM (60 min. of clinical staff time-per calendar month) | \$94 |
| 99489 | Complex CCM (each additional 30 min. of clinical staff time-per calendar month) | \$47 |
| G0506 | CCM Care Planning | \$64 |
| G0505 | Cognition and functional assessment | \$238 |

AWV Return on Investment

Scenario: Monthly revenue from 20 AWV's per month (example):

| AWV Services | National Payment Amount | New Revenue |
|--|-------------------------|---------------|
| 4 Initial Preventive Exams | \$169 | \$676 |
| 6 Initial AWV Exams | \$175 | \$1050 |
| 10 Subsequent AWV Exams | \$119 | \$1190 |
| 10 Depression Screenings (billed separately from subsequent AWV) | \$18 | \$180 |
| 10 Alcohol Misuse Screenings (billed separately from subsequent AWV) | \$18 | \$180 |
| 2 Prolonged Preventive Services | \$66 | \$132 |
| 3 Advanced Care Planning | \$86 | \$172 |
| Total | | \$3580 |

Adding CCM Return on Investment

Scenario: After integrating AWV and additional preventive care services the practice identifies 50 patients eligible for monthly CCM services (example):

| Services | National Payment Amount | Revenue |
|---|-------------------------|---|
| 20 CPT 99490 (20 minutes) | \$42 | \$840 |
| 30 CPT 99487 (60 minutes) | \$94 | \$2820 |
| 5 CPT 99489 (additional 30 minutes for complex CCM) | \$47 | \$235 |
| 3 CCM Care Planning G0506 | \$64 | \$192 |
| 1 Cognition and Functional Assessment | \$238 | \$238 |
| Total CCM Service Revenue | | \$4325 |
| Including Total AWV Revenue (\$3580) | | \$7905 monthly \$94,860 yearly |

Results - Revenue

- The AWW and CCM creates a sustainable revenue stream for a clinic with significant reimbursement potential.
- Revenue generated from the AWW and CCM can be reinvested back into the practice. Using population health management tools, a practice has the opportunity to hire clinical staff needed to treat their patient population. If a clinic primarily treats diabetic patients, the clinic may consider hiring a Certified Diabetes Educator or a Nutritionist based on their unique needs.
- The AWW and CCM services aligns with the goals of value-based payment systems-utilizing both services gives practices an advantage for quality reporting. A clinic would have the tools they need to receive a positive payment adjustment for MIPS reporting and succeed in other value-based payment systems such as ACOs or APMs.

Questions?

“Treatment without prevention is simply unsustainable.”

-Bill Gates

Contact Us

Michelle Hoover, RHIA, CCS

Michelle.Hoover@area-g.hcqis.org

601-957-1575 ext. 225

atom Alliance

<http://atomalliance.org/>

Quality Innovation Networks

<http://www.qualitynet.org/>



Resources

- [Models of Care for High Need, High Cost Patients: An Evidence Synthesis](#)
http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/oct/mccarthy_models_care_high_need_high_cost_patients_appendix_b.pdf?la=en
- [2018 HEDIS Quality Measures](#)
<http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2018>
- [ACO Quality Measures](#)
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Shared-Savings-Program-Quality-Measures.pdf>
- [Medicare's Quality Payment Program](#)
<https://qpp.cms.gov/>

Resources (cont.)

- [2018 Merit-based Incentive Payment System \(MIPS\) Cost Performance Category Fact Sheet](https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf)
<https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Cost-Performance-Category-Fact-Sheet.pdf>
- [Health Insight Quality Innovation Network Annual Wellness Visit Implementation Guide](https://healthinsight.org/tools-and-resources/send/412-strengthening-primary-care/1575-awv-implementation-guide)
<https://healthinsight.org/tools-and-resources/send/412-strengthening-primary-care/1575-awv-implementation-guide>
- [Medicare Enrollment Dashboard](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html)
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html>
- [Chronic Care Management-\\$50 Billion Market](http://www.healthcareitnews.com/news/chronic-care-management-50-billion-market-more-hype-reality)
<http://www.healthcareitnews.com/news/chronic-care-management-50-billion-market-more-hype-reality>

Resources (cont.)

- [RVU Calculator](#)

<https://www.aapc.com/practice-management/rvu-calculator.aspx>

- [Study Finds 50% of Practices That Don't Offer Medicare Annual Wellness Visits are Taking a Revenue Hit](#)

<https://www.fiercehealthcare.com/practices/medicare-annual-wellness-visits-practices-revenue>

- [Prolonged Service Codes for Medicare Preventive Services](#)

<http://www.codingintel.com/prolonged-services-codes-medicare-preventive-medicine-services-g0513-g0514/>

- [Chronic Care Management Changes for 2017](#)

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf>

Resources (cont.)

- [Escaping the Tyranny of the Urgent by Delivering Planned Care](#)

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf>

- [Medicare Spending Per Enrollee, by State](#)

<https://www.kff.org/medicare/state-indicator/per-enrollee-spending-by-residence/?currentTimeframe=0&sortModel=%7b%22colId%22:%22Location%22,%22sort%22:%22asc%22%7d>

- [Risk Score Calculator](#)

<http://www.hccuniversity.com/risk-score-calculator/>

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