# Value-Based Care for meaningful change in the PCP office

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June 2022

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**Rebecca Jaffe MD MPH FAAFP**
**Aledade Senior Medical Director**

## Learning Objectives:

1. Understand the premise around value based care vs fee for service

2. Understand the role clinicians play in establishing **benchmark**: HCC Risk Coding

3. How to make HCC Risk Coding easier with the 6D framework

4. Develop a concrete action plan to bring home to adopt in your practice to thrive in practice


**Step off the hamster wheel and take some control back.**

# The US healthcare system still rewards disease, not prevention.


**Market Reaction:** **Shift to Value-Based Healthcare** 50% Outcome-Based Medicare payments by 2018

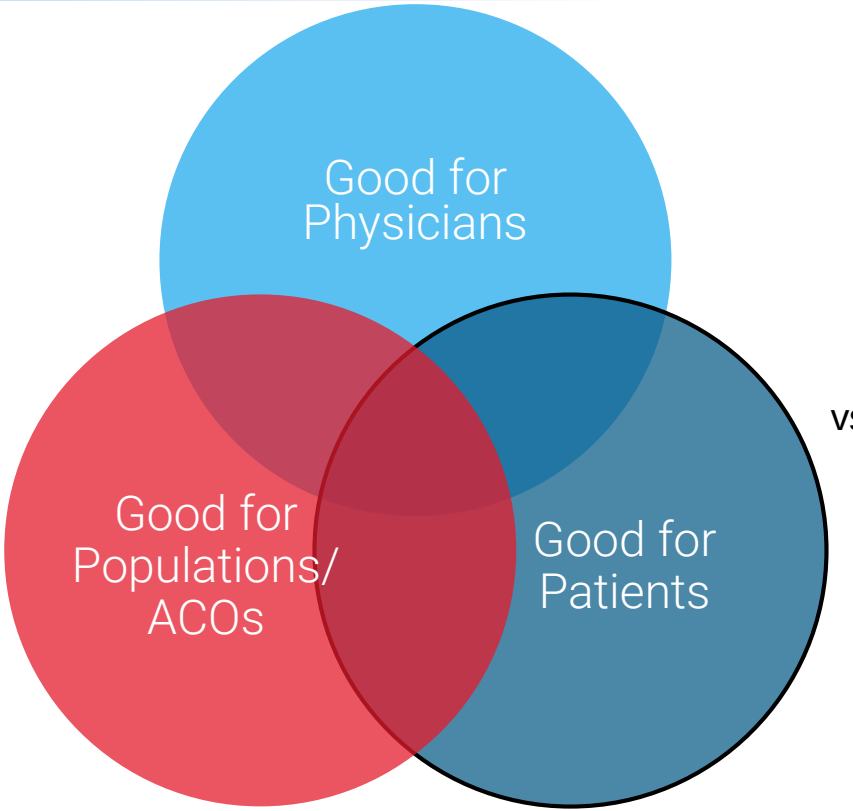
Estimated $1Trillion in healthcare waste published by the Journal of the American Medical Association (2012), McKinsey & Co. (2013), and Harvard Business Review (2015)


$$V_{(\text{VALUE})} = \frac{Q_{(\text{QUALITY})} + S_{(\text{SERVICE})}}{\$_{(\text{COST})}}$$

The National Academy of Medicine has developed a widely accepted approach that describes high-value health care as: **safe, timely, effective, efficient, equitable and patient-centered—STEEEP** for short.

The Institute for Healthcare Improvement (IHI) later translated this into a framework for action, the **Triple Aim, which is made up of better patient outcomes, improved patient satisfaction and lower costs**. The Triple Aim has since been expanded to the Quadruple Aim, which includes physician and health care professional well-being.

# Strong, independent primary care is the cornerstone of the solution

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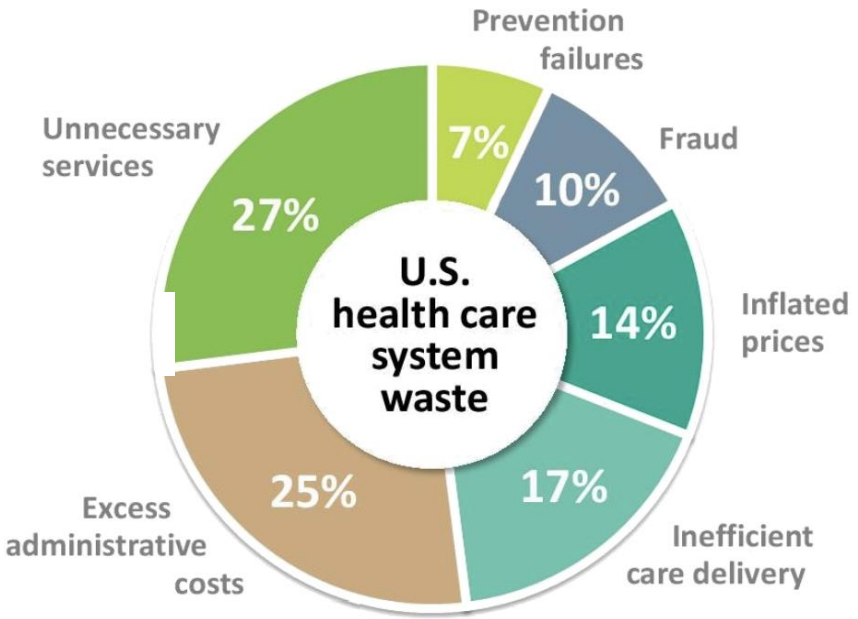
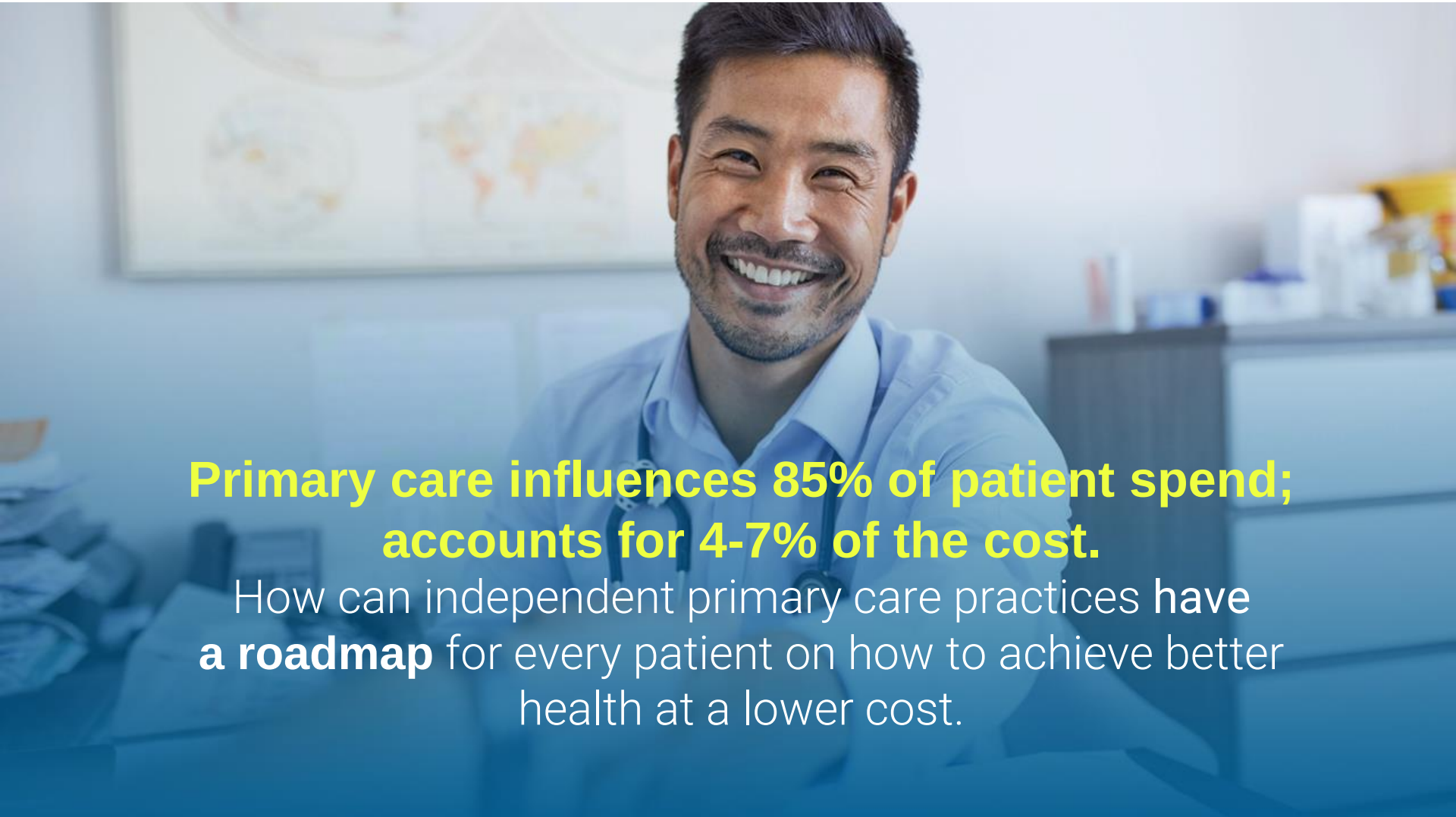



*Source: Institute of Medicine; 2009 data*


**Primary care influences 85% of patient spend; accounts for 4-7% of the cost.**
How can independent primary care practices **have a roadmap** for every patient on how to achieve better health at a lower cost.

# Value-based care comes in many forms, and with greater risk comes greater reward


Level of Financial Risk

Fee For Service

Volume Based Payments

Primary Care Incentive

Performanced Based Contracts

Performanced Based Programs

Condition or Service Line Programs

Bundles & Episodes of Care Payments

Shared Savings

Shared Risk

Capitation

Accountable Care Organization Programs

Medicare Shared Savings Program

Pay For Success

Outcomes Based Payments

Degree of physician Integration & Accountability

# Accountable Care Organizations

- Groups of **doctors**, **hospitals**, and other **health care providers**
- Focused on **improving quality of care** and **health outcomes**, thereby decreasing cost
- Focus on **preventive medicine**
- Ensure that patients and populations — especially the chronically ill — get the **right care**, at the **right time** and **without harm (triple aim).**
- Avoid care that has no proven benefit or represents an unnecessary duplication of services

ACO work MUST make an **IMPACT** in order to achieve savings.
**Health outcomes must improve!**

# Accountable Care Organization

## Medicare Shared Savings Program

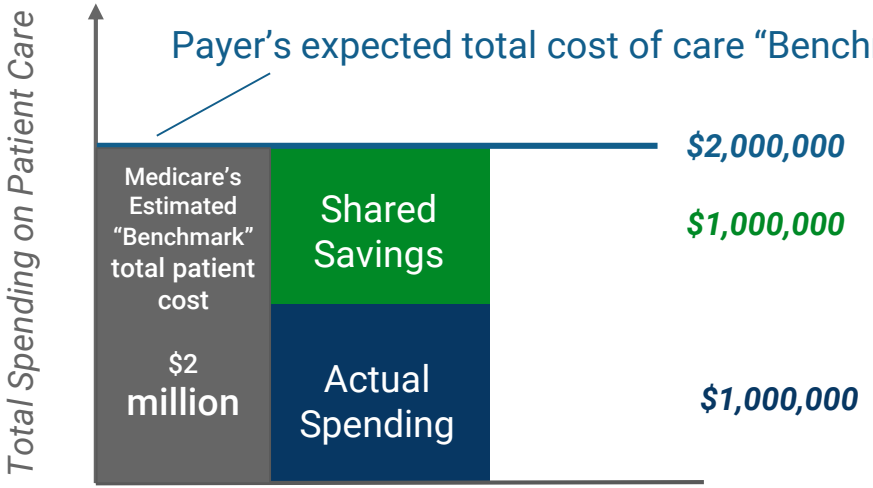
- Program that rewards ACOs who decrease their health care costs, meet performance standards on quality of care and put patients first

## Shared Savings

- With ACO improvement in care and decreased costs, a share of the savings goes to the ACO

ACO work MUST make an **IMPACT** in order to achieve savings.
**Health outcomes must improve!**

# What is Shared Savings? Your Reward for Good Care
# Benchmark is essential first step- this is in the clinician's control



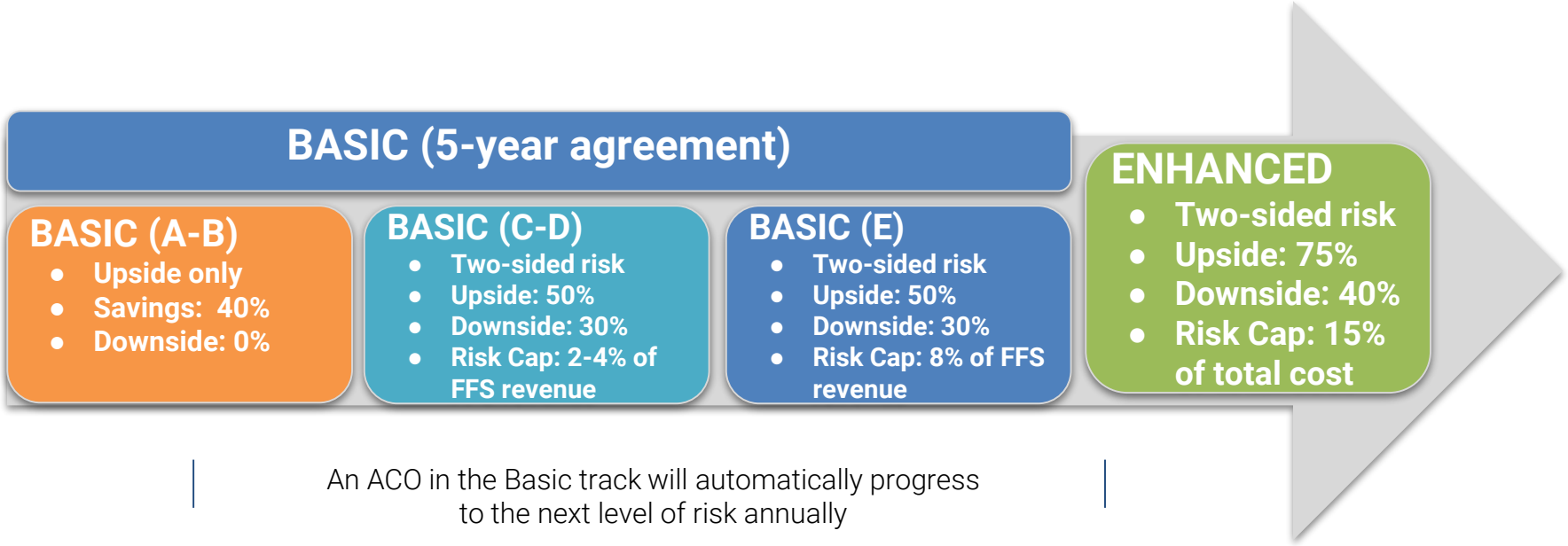

Shared savings is earned when you and your ACO peers deliver high-quality care at a lower cost than payers expect.

Beyond fee for service model.

"Finally, we are getting the credit we deserve!!"

- *Vivian Leftwich, Practice Manager for Challie Minton, Mt. Airy, NC*

## The greater the risk, the greater the reward in the Medicare Shared Savings Program.




An ACO in the Basic track will automatically progress to the next level of risk annually

# Aledade's Approach to Population Based Care:

Patients get the **right care** at the **right time** in the **right place**

| Population Segments | Aledade Core Interventions |
|---|---|
| End of Life | CACP/Palliative Care |
| High Risk patients | Case Management<br>Behavioral Health Care Coordination |
| Hospitalizations<br>ER | Transitional Care Management<br>Outreach to ED visitors |
| Chronic Conditions | Medication Management<br>Referral Management |
| Healthy & Home | Proactive Patient Outreach<br>Improved Access<br>Wellness Visits<br>Immunization & Screening |

**What does support look like**

- Centralized Support for Most Difficult to Treat Patients
- Care Coordination Strategies Tied to Existing Funding Sources
- Help Partner Identify and Pursue Quality Opportunities
- Enhanced Primary Care Access

# Value Based Fundamentals:
# **Let’s Talk about Risk and Benchmarks**

# Terminology Basics

➔ **“HCC” = Hierarchical Condition Category**

*Diagnoses that risk adjust*

- *9500/70,000+*

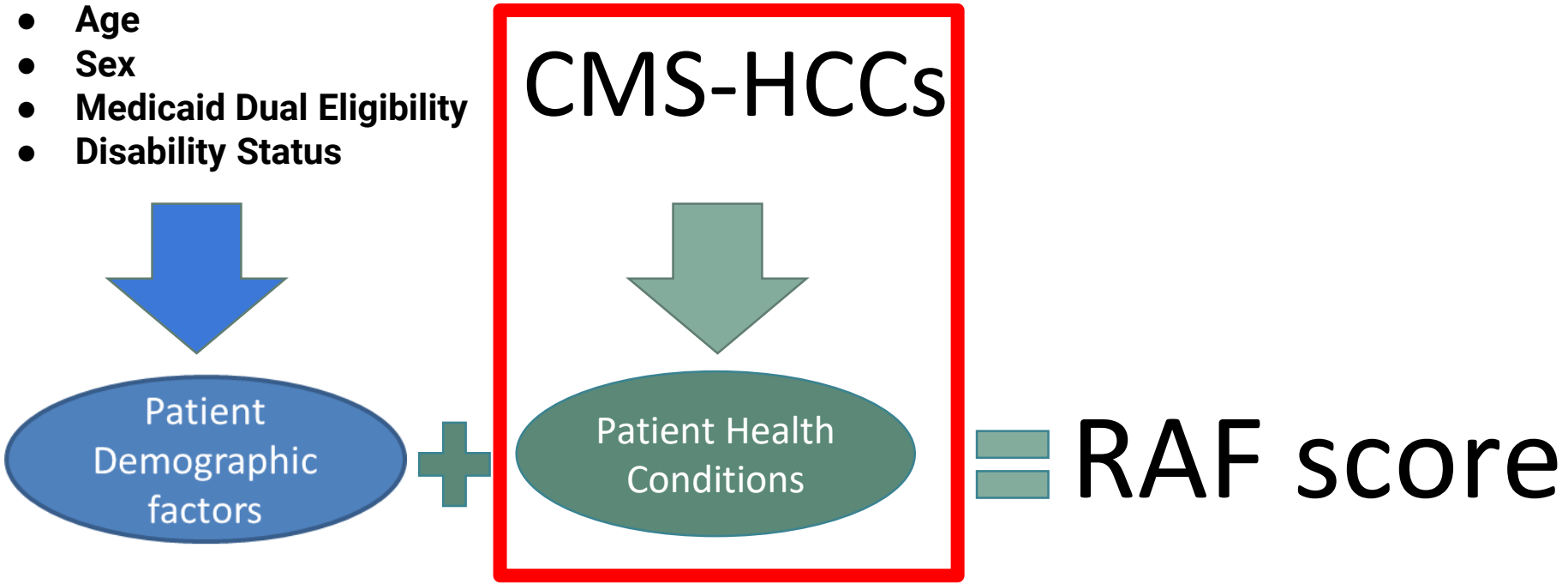
➔ **“RAF” = Risk Adjustment Factor**

*Overall (risk-adjusted) score assigned to each patient*

# Demographics + HCC Codes = RAF score

***RAF score is used to anticipate future cost to care for that condition / patient***

- **Age**
- **Sex**
- **Medicaid Dual Eligibility**
- **Disability Status**



# The Math of Risk

- Benchmark gets risk adjusted
  - If patient population has a lower HCC risk score than expected, then the benchmark is reduced
  - Lower benchmark = harder to keep spending below it

# Will these two 78 year old women have similar medical needs?

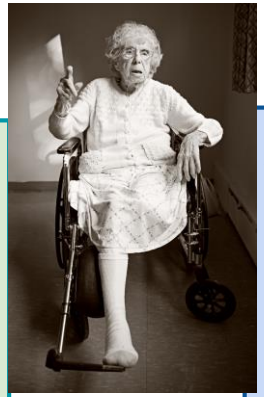
## Will these two 78 year old women have similar medical needs?

Calculating the Benchmark: a tale of two women

***Ms. S.*** *is a 76-year-old retired teacher.*

*She is an avid runner and coaches her 6-year-old granddaughter's soccer team. She has been a vegetarian since she turned 40.*

*She has familial hypercholesterolemia and a history of breast cancer, for which she has completed treatment. Her only current medication is a statin, which she takes regularly using a pill-reminder app on her smartphone.*



***Ms. T.*** *is a 76-year-old retired teacher.*

*She lives alone and seldom sees out of state family. She does not exercise on a regular basis and is a current smoker.*

*She has poorly controlled diabetes, hypertension, heart failure and vascular disease. She is prescribed seven medications, which she sometimes has trouble taking. She was seen in the ED several times last year, and she was admitted to the hospital five times.*

# What is the impact of Accurate and Complete Diagnosis Coding (ACDC) ?

| Ms. S: All Conditions Documented | |
|---|---|
| 76 year-old female | 0.468 |
| Familial Hyper-cholesterolemia | - |
| History of Breast Cancer | - |
| Patient Total RAF | 0.468 |
| Yearly Reserve for Care | $4,680 |

| Ms. T: No Conditions Documented (Demographics Only) | | Ms. T: Some Conditions Documented | | Ms. T: All Conditions Documented | |
|---|---|---|---|---|---|
| 76 year-old female | 0.468 | 76 year-old female | 0.468 | 76 year-old female | 0.468 |
| Medicaid eligible | 0.177 | Medicaid eligible | 0.177 | Medicaid eligible | 0.177 |
| DM not coded | - | DM (no complications) | 0.104 | DM with Vascular Manifestations | 0.318 |
| Vascular Disease not coded | - | Vascular Disease without complication | 0.298 | Vascular Disease with complication | 0.400 |
| CHF not coded | - | CHF not coded | - | CHF coded | 0.323 |
| No interaction | - | No interaction | - | + disease interaction bonus RAF (DM + CHF) | 0.182 |
| Patient Total RAF | 0.645 | Patient Total RAF | 1.047 | Patient Total RAF | 1.868 |
| Yearly Reserve for Care | $6,450 | Yearly Reserve for Care | $10,470 | Yearly Reserve for Care | $18,680 |

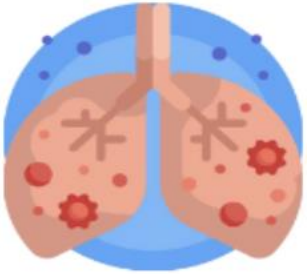
Difference of **>$12,000** in Yearly Reserve for

# Before Daily Huddle: the 6 D's of coding


Diabetes

Depression

Diet of Donuts (Obesity)



Dyspnea

Drugs (+Alcohol)

Dementia

# Memorize This: The 6 D's of Risk Coding


- **Diabetes**
  Reconsider E11.9: Diabetes Uncomplicated.
  If the patient's A1c has been >7 consider episodes of hyperglycemia.
  Consider skin, eye, renal, other vascular complications **even if** A1C is well controlled.

- **Depression**
  Reconsider F32.9 "MDD, single episode, unspecified"
  Active Depression and Depression in Remission carry the same risk weight.

- **Diet of Donuts (aka Obesity)**
  Avoid E66.9 "obesity unspecified"
  Remember BMI 35-39.9 + Comorbid Condition = Morbid Obesity (E66.01)

# The 6 D's of Risk Coding

- **Drinking and Drugs**
  - Substance Use, Abuse, and Dependence are in your office everyday.
  - Screen and Intervene
  - Remember to add opioid, benzodiazepine and alcohol use/**dependence**/remission to your problem list if applicable

- **Dyspnea**
  - Reconsider using symptom ICD-10 codes (like cough) and code the true chronic condition instead. There is only so much "rea aim.
  - COPD is risk weighted for both Medicare and s
  - Asthma is risk weighted for Commercial ONL

- **Dementia**

# Understanding M.E.A.T.

Documentation of the medical visit must indicate how the physicians are **M**onitoring, **E**valuating, **A**ssessing, **or** **T**reating the patient's chronic conditions.

| MONITOR | EVALUATE | ASSESS | TREAT |
|---|---|---|---|
| Disease Progression/Regression<br>Signs/Symptoms<br>Ordering labs/imaging<br>Referencing labs/other tests | Physical exam<br>Test/imaging reports<br>Medications<br>Treatment response | Address or Discuss:<br>Physical exam or test results<br>Condition status check<br>Counselling<br>Reviewing records | Order/Cont. Medications<br>Ordering Therapies<br>Plan for management<br>Referral to specialist |
| **Chronic HF** - stable; continue furosemide | **Type 2 DM** - poorly controlled; HbA1c recently high at 9.5 | **Type 2 DM** w/peripheral neuropathy - decreased sensation BLE monofilament test | **COPD -** worsening s/s, will check PFTs, add steroid inhaler |

***Documentation should always support the diagnosis coding with accuracy, specificity and consistency.***

# Risk Capture Fundamentals

- Diagnoses that risk adjust need to be (re-)captured every year
  - *(system resets every January 1st, assuming they are still appropriate)*

- This is a claims based process.
  - Diagnoses *must* go out on a claim to the payor.
- Documentation in note, must support the claim
- Pay attention to Acuity and Specificity with your diagnoses.

FPM resource: AAFP coding and documentation

# In summary...

- HCC risk coding is the responsibility of physicians/clinicians to let payers know **how complex the practice's patients are** through accurate and complete ICD-10 diagnosis codes. Not all carry "risk weight."

- Keep an accurate problem list to make it easier to convey an accurate and complete picture of your patient's chronic conditions to the payer at **every visit opportunity**.

- You can't out-risk code your EHR and there is nothing intuitive about risk coding. The Aledade App is a powerful tool and it's **Daily Huddle** is designed to help guide you in all aspects of value based care.

Value Based Fundamentals:
**The Annual Wellness Visit an opportunity to build the benchmark**

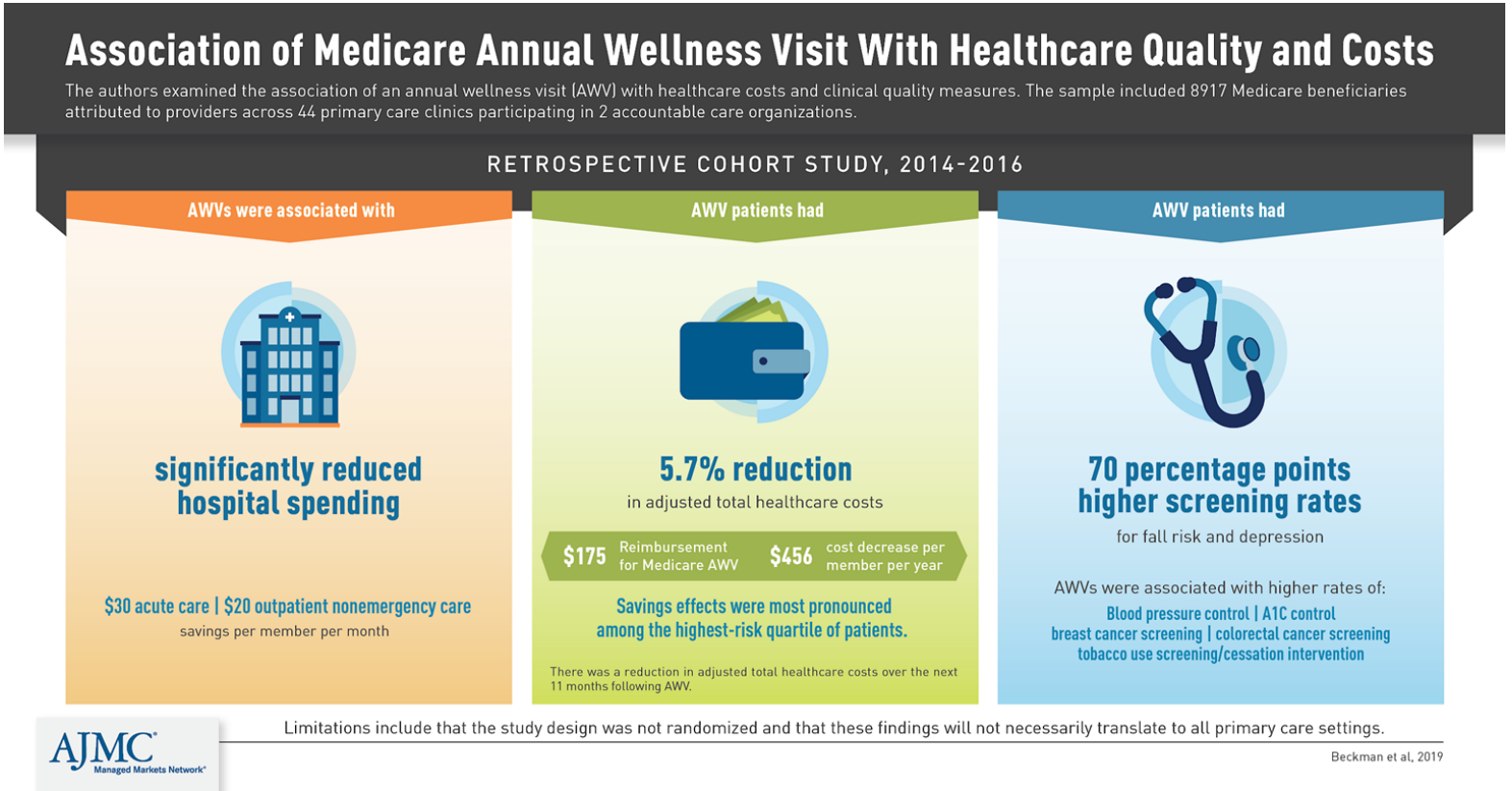
# Annual Wellness Visit- Benefits

- Opportunity to focus on screening and prevention
- Can increase attribution in MSSP, MA, and Commercial contracts
- Increased reimbursement over E/M 99213/4 or PPS rate for FQHC/RHCs
- Can be combined with follow up on chronic conditions
  - Reimbursement for both E/M and AWV for private practice, but not for FQHC/RHC
- Fully reimbursed by Medicare without patient cost-sharing
- **Can be done via telehealth if patient can report vitals**
  - Audio-only not preferred, but allowable during the public health emergency

| | | |
|---|---|---|
| 99214 | General Office Visit | $ 108, approx |
| G0402 | Welcome to Medicare (IPPE) | $ 168, approx |
| G0438 | Initial Annual Wellness Visit | $ 173, approx |
| G0439 | Subsequent Annual Wellness Visit | $ 117, approx |

**Not via telehealth**

# AJMC Article on Benefits of the AWV



# The shift to value-based care, if managed correctly, will create a lot of opportunities for independent primary care practices

## Find a strong ACO/ IPA partner

**Aledade** is a strategic partner that helps independent primary care physicians navigate the world of value-based care while supporting them in physician-led ACOs

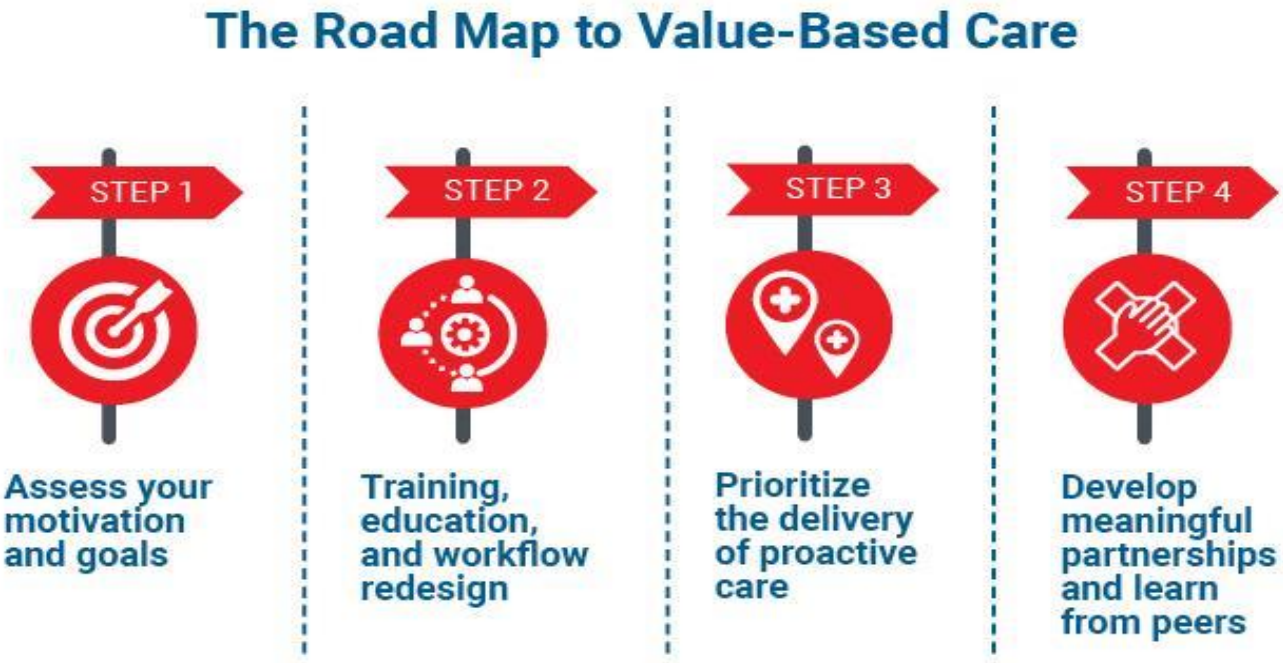
### Fee for Service

- Quantity of services
- Individual patient
- utilization

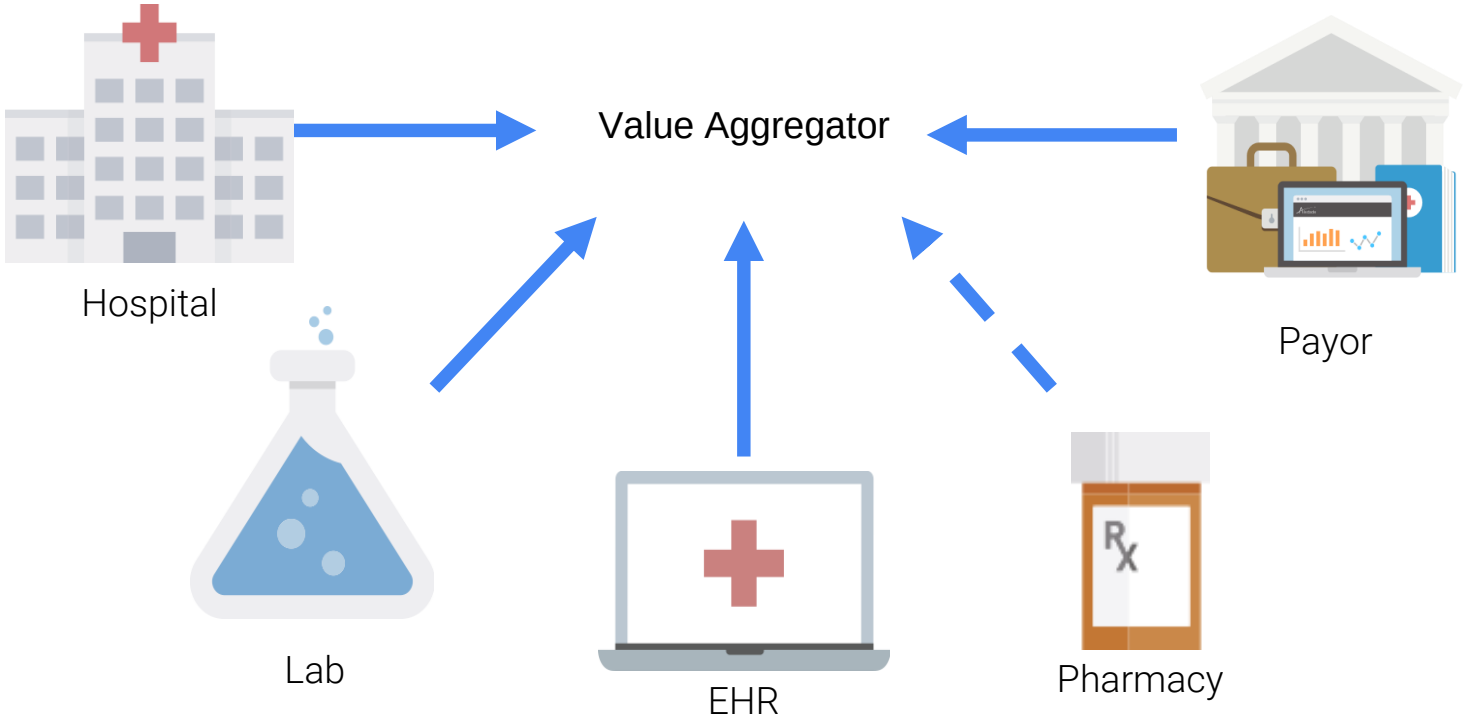
### Value-Based Care

- Quality of services
- Access and prevention
- Balancing patient utilization
- Reducing readmissions
- Total cost of care

# Follow a clear road map to success in value-based care for primary care practices.



# Aggregator Data Platform: Technology Assessment



# Core 4: Focusing on Key Quality Initiatives

**Attribution + Wellness**
**Quality Improvement, Prevention + Care Gaps**

The best quality metric is a true connection to primary care. The Aledade App enables a thorough assessment of risk factors and discussions on wellness education and advance care planning.

**Transitions of Care + TCM Visits**
**ED Follow Up**

We have found it takes 7 Transitional Care visits to avoid 1 readmission. We have integrated hospital and claims data for recent ED and hospital patients, with easy-to-use post-discharge workflows.


**Diagnosis Documentation**
**Clinical Service Alignment**

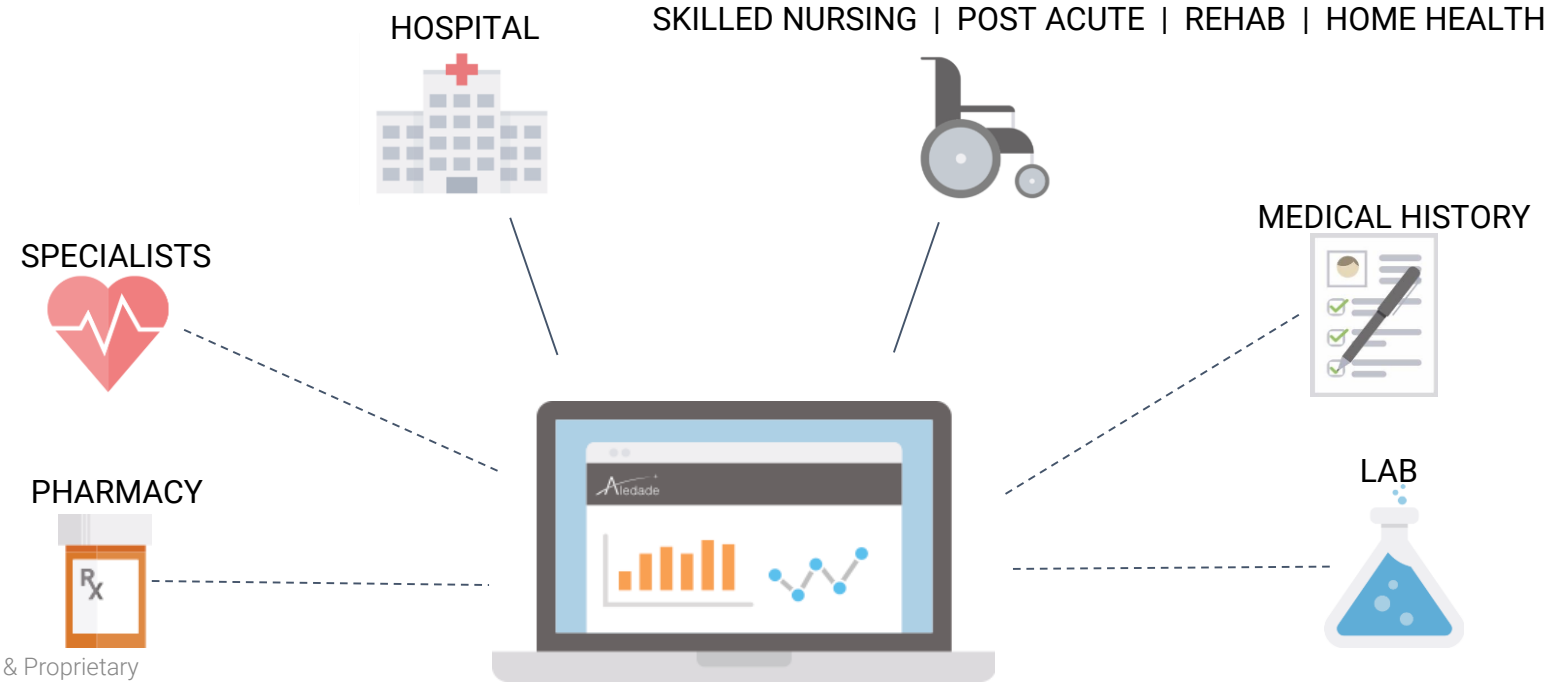
Aligning patients with the right clinical initiatives. Practices who preview risk suggestions are 2 to 3 times more likely to capture risk adjustment opportunities during the patient's visit.

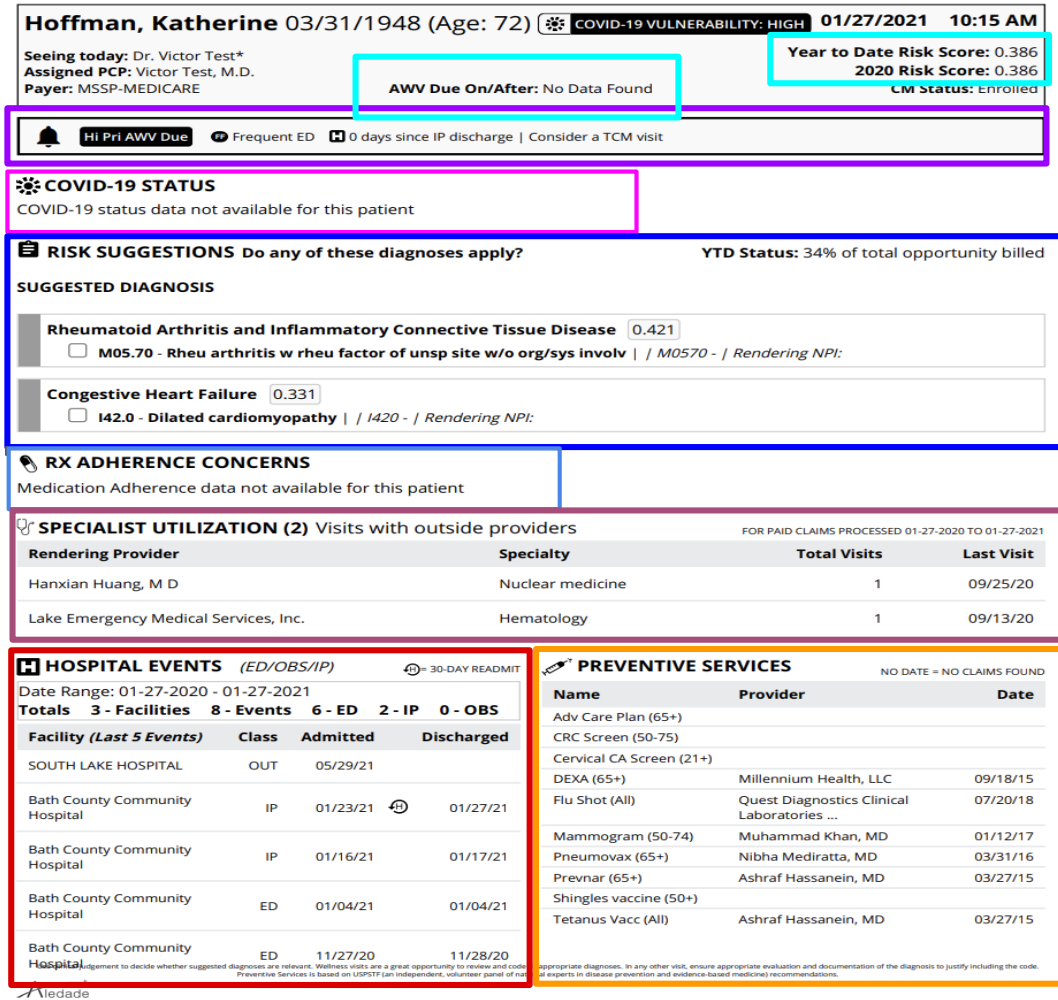
**Aledade Care Solutions**
**High Value Specialist Referrals**

Using data to help practices offer patients high-quality complementary care, like high value referral management and Comprehensive Advance Care Planning.

# How do practices succeed? The Aledade App.

The app is Aledade's population health software. It aggregates patient data in order to provide actionable insights into patient care.





**Hoffman, Katherine** 03/31/1948 (Age: 72) COVID-19 VULNERABILITY: HIGH 01/27/2021 10:15 AM

**Seeing today:** Dr. Victor Test*
**Assigned PCP:** Victor Test, M.D.
**Payer:** MSSP-MEDICARE

**AWV Due On/After:** No Data Found

**Year to Date Risk Score:** 0.386
**2020 Risk Score:** 0.386
**CM Status:** Enrolled

Hi Pri AWV Due | Frequent ED | 0 days since IP discharge | Consider a TCM visit

**COVID-19 STATUS**
COVID-19 status data not available for this patient

**RISK SUGGESTIONS** Do any of these diagnoses apply? **YTD Status:** 34% of total opportunity billed

**SUGGESTED DIAGNOSIS**

**Rheumatoid Arthritis and Inflammatory Connective Tissue Disease** 0.421
M05.70 - Rheu arthritis w rheu factor of unsp site w/o org/sys involv | / M0570 - / Rendering NPI:

**Congestive Heart Failure** 0.331
I42.0 - Dilated cardiomyopathy | / I420 - / Rendering NPI:

**RX ADHERENCE CONCERNS**
Medication Adherence data not available for this patient

**SPECIALIST UTILIZATION (2)** Visits with outside providers — FOR PAID CLAIMS PROCESSED 01-27-2020 TO 01-27-2021

| Rendering Provider | Specialty | Total Visits | Last Visit |
|---|---|---|---|
| Hanxian Huang, M D | Nuclear medicine | 1 | 09/25/20 |
| Lake Emergency Medical Services, Inc. | Hematology | 1 | 09/13/20 |

**HOSPITAL EVENTS** *(ED/OBS/IP)* — 30-DAY READMIT

Date Range: 01-27-2020 - 01-27-2021
**Totals** 3 - Facilities 8 - Events 6 - ED 2 - IP 0 - OBS

| Facility *(Last 5 Events)* | Class | Admitted | | Discharged |
|---|---|---|---|---|
| SOUTH LAKE HOSPITAL | OUT | 05/29/21 | | |
| Bath County Community Hospital | IP | 01/23/21 | 30 | 01/27/21 |
| Bath County Community Hospital | IP | 01/16/21 | | 01/17/21 |
| Bath County Community Hospital | ED | 01/04/21 | | 01/04/21 |
| Bath County Community Hospital | ED | 11/27/20 | | 11/28/20 |

**PREVENTIVE SERVICES** — NO DATE = NO CLAIMS FOUND

| Name | Provider | Date |
|---|---|---|
| Adv Care Plan (65+) | | |
| CRC Screen (50-75) | | |
| Cervical CA Screen (21+) | | |
| DEXA (65+) | Millennium Health, LLC | 09/18/15 |
| Flu Shot (All) | Quest Diagnostics Clinical Laboratories ... | 07/20/18 |
| Mammogram (50-74) | Muhammad Khan, MD | 01/12/17 |
| Pneumovax (65+) | Nibha Mediratta, MD | 03/31/16 |
| Prevnar (65+) | Ashraf Hassanein, MD | 03/27/15 |
| Shingles vaccine (50+) | | |
| Tetanus Vacc (All) | Ashraf Hassanein, MD | 03/27/15 |

...judgement to decide whether suggested diagnoses are relevant. Wellness visits are a great opportunity to review and code ... appropriate diagnoses. In any other visit, ensure appropriate evaluation and documentation of the diagnosis to justify including the code.
Preventive Services is based on USPSTF (an independent, volunteer panel of nat... ...al experts in disease prevention and evidence-based medicine) recommendations.

Medade

**Notice the Daily Huddle info and use it:**

AWV status/risk

Alert bar

Covid status

Diagnosis Suggestions

Rx adherence

Specialist Utilization

Hospital Events (IP/ED/Obs)

Preventive Services

# Value Based Fundamentals:
# **Let’s Talk about Quality**

# Metrics that matter 2022

#001 HbA1C less than 9

#134 Screening for Depression & Follow up Plan

#236 Controlling High BP- less than 139/89

#318 Falls: Screening for future fall risk

#110 Influenza immunization

#226 Tobacco Use Screening & Cessation Intervention

#113 Colorectal Cancer screening

#112 Breast Cancer screening

#438 Statin Therapy for the Prevention & Treatment of CVD

#370 Depression Remission at 12 months

CAHPS

# Proposed Metrics for 2023 not adopted (may be delayed to 2024)

3 measures on the new quality proposal are:

- diabetes A1C<9
- depression screening and follow up
- controlling high blood pressure

For ALL patients and ALL payers

3 claims based measures:

- Hospital-Wide, 30-day, All- Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups
- Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS
- CAHPS Survey

# Value Based Fundamentals:
# **Let’s Talk about TCM (Transitional Care Management)**

# Transitional Care Management (TCM): ie prevent readmissions

- ***Interactive contact*** (or documentation of 2 failed attempts) with patient/caregiver within 2 business days of discharge
- High complexity ***medical decision making*** + TCM visit within **7 calendar days** of discharge =99496 (7/6)
- Moderate complexity ***medical decision making*** + TCM visit within **14 calendar days** of discharge =99495 (4/5)
- Review of the ***discharge summary/information***
- ***Medication reconciliation*** no later than date of visit
- Additional **non-face-to-face work** by either the ***clinical staff or billing provider*** during the 30-day service period

# **TCM Calendar:** Understanding Clarified & Example

| Example 1 | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **Week One** | **Discharge Day** | **Outreach day 1** | **Outreach day 2** | | | | |
| Week One | **Billing Day 1** | **Billing day 2** | **Billing day 3** | **Billing day 4** | **Billing day 5** | **Billing day 6** | **Billing day 7** |
| Billing code wk 1 | **99496** | **99496** | **99496** | **99496** | **99496** | **99496** | **99496** |
| **Week Two** | Billing Day 8 =99495 | Billing Day 9 =99495 | Billing Day 10 =99495 | Billing Day 11 =99495 | Billing Day 12 =99495 | Billing Day 13=99495 | Billing Day 14=99495 |

| Example 2 | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| **Wk 1** | | | | | **Discharge Day** | | |
| **Wk1** | | | | | **Billing day 1 =99496** | **Billing day 2 =99496** | **Billing day 3 =99496** |
| **Wk 2** | **Outreach day 1** | **Outreach day 2** | | | | | |
| **Wk 2** | **Billing day 4 =99496** | **Billing day 5 =99496** | **Billing day 6 =99496** | **Billing day 7 =99496** | **Billing day 8 =99495** | **Billing day 9 =99495** | **Billing day 10 =99495** |
| **Wk 3** | **Billing day 11 =99495** | **Billing day 12 =99495** | **Billing day 13 =99495** | **Billing day 14 =99495** | | | |

**Outreach Call- 48 hours (2 business days, weekend does not count)** **Timing for billing. Day 1= Discharge day**

# TCM Medical Decision making

https://www.aafp.org/fpm/2010/0700/p10.pdf

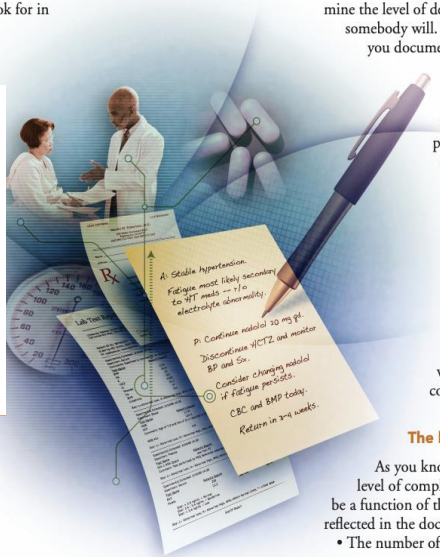
THINKING ON PAPER:

# Documenting Decision Making

Robert L. Edsall and Kent J. Moore

Where medical decision making is concerned, Medicare's Documentation Guidelines for Evaluation and Management (E/M) Services are more striking for what they leave unsaid than for what they say. They do tell you what a reviewer would look for in determining the level of your decision making. However, unlike the guidelines for documenting history and exam, they don't tell you enough to figure out the level yourself, thereby leaving you to guess whether your documentation supports the claim you submit.

But *somebody* other than you has to be able to determine the level of decision making – and if you're audited, somebody will. The purpose of this article is to help you document and quantify what you're thinking about during patient encounters, so that you and a reviewer might reach the same conclusion about the level of decision making your note supports and so that you can confidently claim the payment you're entitled to. If you'd like to review the rest of the guidelines, see the articles on history documentation in our March/April 2010 issue (http://www.aafp.org/fpm/2010/0300/p22.html) and exam documentation in our May/June 2010 issue (http://www.aafp.org/fpm/2010/0500/p24.html). The table on the next page shows how medical decision making combines with history and exam to determine code selection.




TOM WHITE/9 SURF STUDIOS

## The big picture

As you know, the CPT manual considers the level of complexity of medical decision making to be a function of three variables, and this division is also reflected in the documentation guidelines:

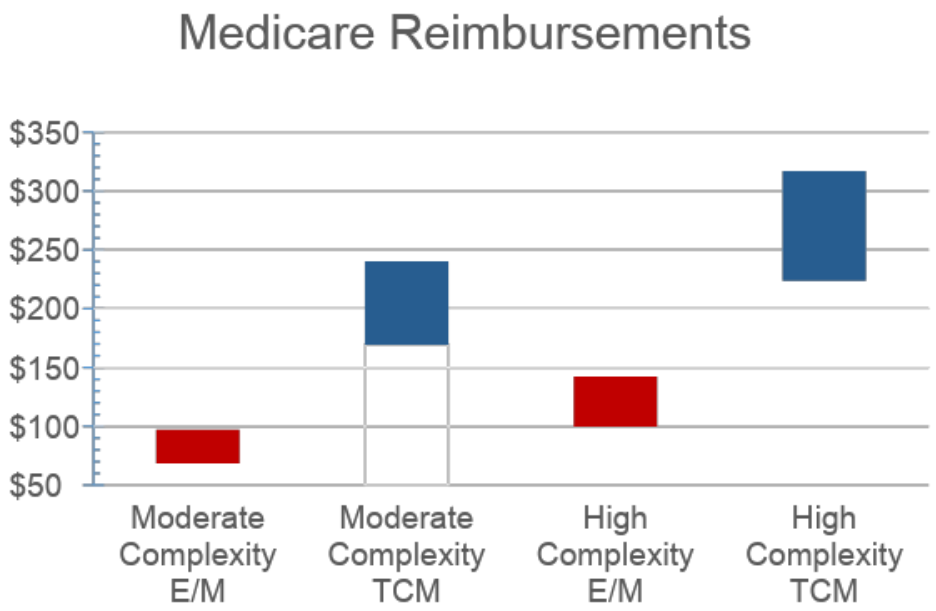
- The number of potential diagnoses and management



## THE ELEMENTS OF MEDICAL DECISION MAKING

| Type of decision making | Diagnoses or management options | Data to be reviewed | Risk |
|---|---|---|---|
| Straightforward | Minimal | Minimal or none | Minimal |
| Low complexity | Limited | Limited | Low |
| Moderate complexity | Multiple | Moderate | Moderate |
| High complexity | Extensive | Extensive | High |
| | At least two criteria must be met or exceeded. | | |

# One TCM Visit Receives Higher Reimbursements than One E/M Visit for Medicare




## Revenue Enhancement:

**$100.97 - $143.03**

for each moderate complexity patient

**$123.77 - $179.49**

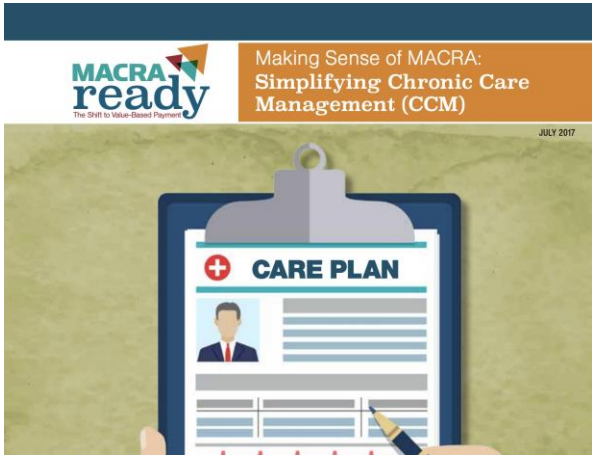
for each high complexity patient

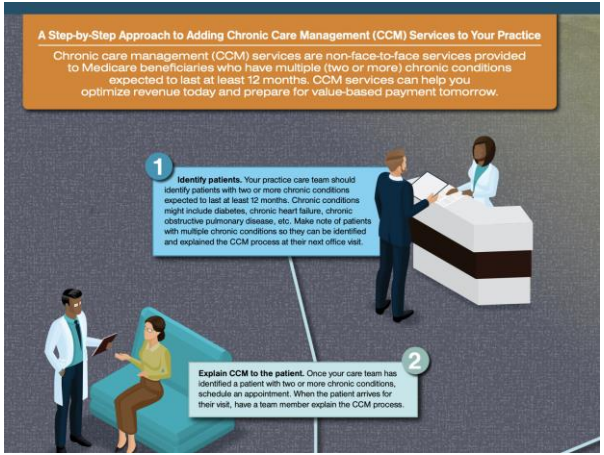
*These estimations do not apply to FQHCs and RHCs

Data Source: 2020 Physician Fee Schedule (https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx)

# Value Based Fundamentals:
# **Let’s Talk about Care Management**

# Chronic Care Management




https://www.aafp.org/dam/AAFP/documents/practice_management/restricted/macra-ccm-supplement.pdf

# Why is CCM important to Practices?

- ➔ **Improves care coordination**
  - ◆ Gives patients **support they need** between office visits
- ➔ **Improved care for patients**
  - ◆ Supports patient **adherence**
  - ◆ **Improves** patient satisfaction
  - ◆ **Decreases** emergency department visits
  - ◆ **Decreases** hospitalizations
- ➔ Helps patients feel more connected
- ➔ Sustains and grows your practice
  - ◆ **Additional resources** to help your practice care for high risk, high needs patients

# Documentation of CM

CCM services must be documented in the electronic health record (EHR). Covered services include, but are not limited to:

- Management of chronic conditions
- Management of referrals to other providers
- Management of prescriptions
- Ongoing review of patient status
- Time spent



https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/chronic-care-management.html

# CCM Coding

The four CPT codes used to report CCM services are:

- 994**90** non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
- 994**87** complex CCM is a 60-minute timed services provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making.
- 994**89** is each additional 30 minutes (cannot be billed with CPT code 99490)
- 994**91** CCM services provided personally by a physician or other qualified health care professional for 30 minutes.

# CCM FAQs

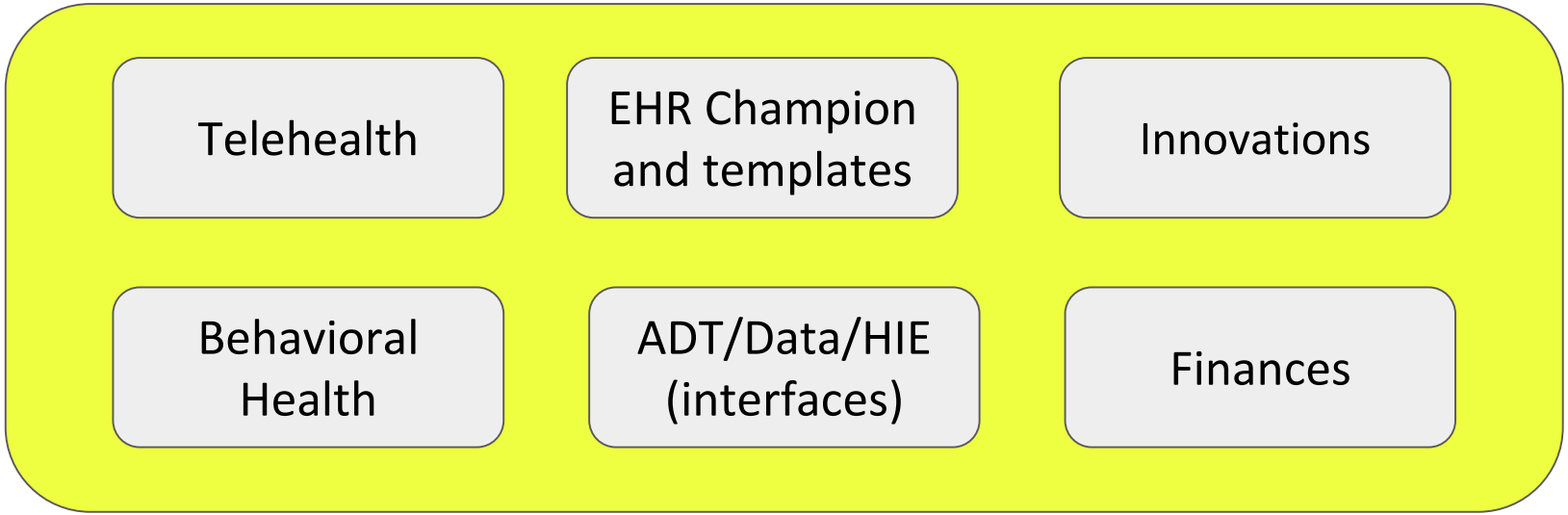
## Can you do CCM with Telehealth?

- ★ Chronic care management is the provision of non-face-to-face care management services and telehealth is not necessary; there are instances where telehealth is used for CCM as a method of teaching a beneficiary 'how' to use it!

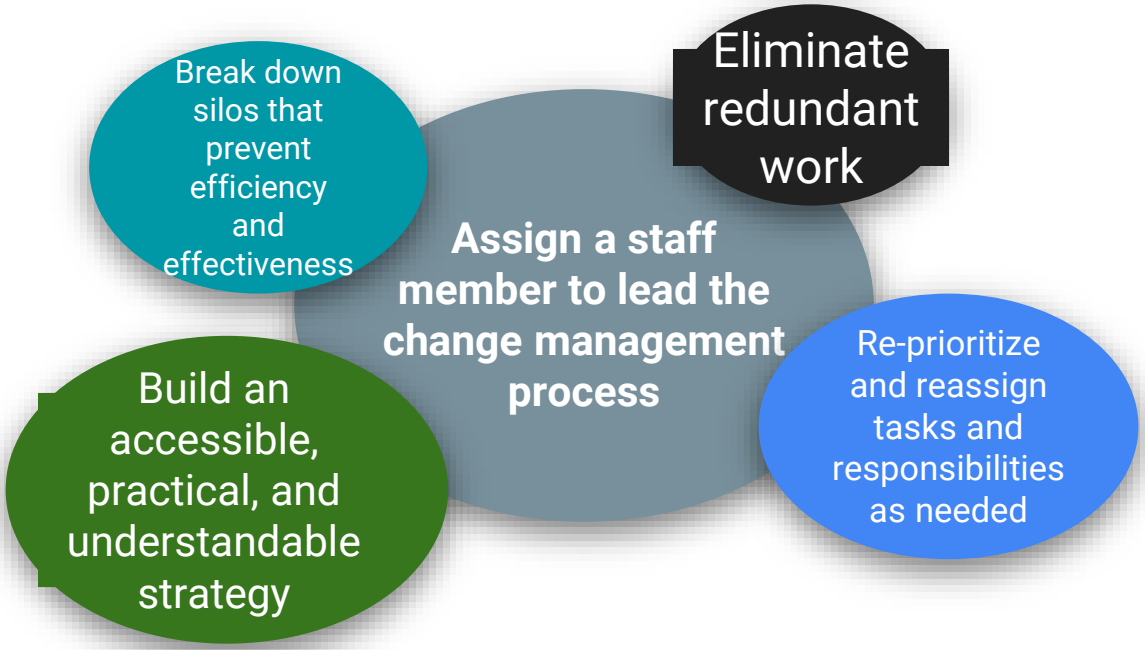
**If a patient who is enrolled in the CCM program comes in for a face-to-face E/M visit, can the minutes spent working non-face-to-face on referrals/home health after the patient leaves the office count toward CCM minutes?**

- ★ Yes, the time spent on care coordination activities once the patient leaves/between visits counts!

# Additional areas to consider



# Implement change management within your practice



# Thriving in practice through adversity- TOP 10 things to do

1. **Goal setting** - set specific, smaller, realistic measurable goals that are time limited, and share the goals with your staff
2. Financial outlook for the year and **diversify income streams**, consider VBC
3. Evaluate your **practice business plan** or create one if you don't have one
4. Assess and reassess your payor panel, talk with your biller
5. Know Physician Fee Schedule changes
6. **Telehealth** strategies and best practices
7. **Focus on prevention**, eg AWV, patient access/hours
8. **Mark your progress** - **in VBC ACDC (accurate and complete diagnosis coding)** set a schedule when you will revisit this
9. **Get a good partner** to help and keep you accountable to help you sustain change
10. **Take steps to recognize burnout**, build staff morale, ensure staff safety/PPE - find your ikigai, commit to self compassion, reframing, gratitude, finding rewarding work


Questions?
Thank you.
bjaffe@aledade.com

# Addendum information

April 2022

| ICD-10 | Type 2 Diabetes Complication | Notes |
|---|---|---|
| E11.21 | DM2 with **diabetic nephropathy** (microalb/Cr ratio > 30 µg/mg) | |
| E11.22<br>E11.40 | DM2 with **diabetic chronic kidney disease** (consider if eGFR <90 and proteinuria present)<br>DM2 with **diabetic neuropathy, unspecified** | **If applicable, also code CKD Stage 3/4/5 (N18.30, N18.31, N18.32/N18.4/N18.5 respectively)** |
| E11.42 | DM2 with **diabetic polyneuropathy/diabetic peripheral neuropathy** | |
| E11.43<br>E11.51 | DM2 with **diabetic gastroparesis**<br>DM2 with **peripheral angiopathy/PVD w/o gangrene*** | *Carries additional weight of 0.3 assigned to PVD without requiring separate diagnosis submission for PVD |
| E11.52 | DM2 with **peripheral angiopathy/PVD with gangrene*** | *Carries additional weight of 0.3 assigned to PVD without requiring separate diagnosis submission for PVD |
| E11.59<br>E11.620 | DM2 with **other circulatory complication**<br>DM2 with **diabetic dermatitis** | Note that "other circulatory complication" is not the most complete and accurate code if that complication is PVD - in this case, select most |

## Diabetes specific ICD-10 codes

| | | |
|---|---|---|
| E11.621 | DM2 with **foot ulcer*** | *Automatically carries additional weight of 0.3, though in this case you should also document and submit the right ulcer diagnosis for ICD10 completeness |
| E11.622<br>E11.630 | DM2 with **other skin ulcer**<br>DM2 with **periodontal disease** | *Automatically carries additional weight of 0.5, though in this case you should also document and submit the right ulcer diagnosis for ICD10 completeness |
| E11.649 | DM2 with **hypoglycemia w/o coma** | |
| E11.65 | DM2 with **hyperglycemia, uncontrolled** | |
| E11.69 | DM2 with **other specified complication:** Some common complications include dyslipidemia (E78.5), erectile dysfunction (N52.9) and osteomyelitis (M86.9) | **When using E11.69, you must ALSO submit the ICD10 code for the other specified complication, even if it does not hold risk weight** |
| E11.610<br>E11.36 | DM2 with **diabetic neuropathic arthropathy (Charcot's)** DM2 with **diabetic cataract** | |
| E11.3519 | DM2 with **proliferative diabetic retinopathy with macular edema,** unspecified eye | *Carries additional weight |
| E11.3599 | DM2 with **proliferative diabetic retinopathy without macular edema,** unspecified eye | *Carries additional weight |
| E11.311 | DM2 with **unspecified diabetic retinopathy with macular edema** | |
| E11.319 | DM2 with **unspecified diabetic retinopathy without macular edema** | |

# Additional diabetes codes

# Depression HCC Sheet

## Risk Coding Quick Reference Guide: Behavioral Health

*The psychiatric illnesses with risk weight fall into four main categories: Depression, Bipolar Disorder, Schizophrenia and the Personality Disorders.*

### Major Depressive Disorder (& In Remission):

The formal term for a diagnosis of depression is Major Depressive Disorder. When using this diagnosis, it is important to include a specifier: mild, moderate or severe. **Avoid the terms "unspecified" and "other." These are inaccurate terms and carry no risk weight.** If you aim for clinical accuracy, this will result in risk score maximization.

Patient self-reported symptoms, as measured by validated rating scales, are an appropriate way to categorize the severity of depression, as well as the level of response to treatment and whether the patient has achieved full or partial remission. The PHQ-9 is the most widely-used scale. The PHQ-2 is a *screening tool* for patients who have *not* previously been diagnosed with Depression. Patients who have been previously diagnosed with Depression or who newly screen positive on the PHQ-2 should be given a PHQ-9.

A PHQ-9 score of 4 or less indicates Remission. **Depression that is in remission carries the same risk weight as an active diagnosis of depression.** When a patient who has previously been diagnosed with Major Depressive Disorder (aka "Depression") has improved to the point that no depressive symptoms at all remain present, the correct diagnosis is Major Depressive Disorder in Full Remission. If a patient has a score of less than 4, but still has a few minor symptoms of depression present, this is Major Depressive Disorder in Partial Remission. It is also acceptable to diagnose remission without using a PHQ-9 just by asking a patient if they feel any depressive symptoms, such as low mood, impaired sleep, impaired appetite or suicidal ideation, and if there are none -- and this corresponds with the provider's clinical impression – to diagnose Depression in Remission. Items that may also be considered when differentiating between full and partial remission without using a PHQ-9 include asking about any residual impairments in social and work functioning. The term "History of Depression" is overly vague and carries no risk weight.

| PHQ-9 Score | Diagnosis |
|---|---|
| 0-4 | 1. If no prior history of Depression and being used for screening: No Diagnosis<br>2. If there is a prior diagnosis of depression: Major Depression in Remission |
| 5-9 | Major Depression, mild |
| 10-14 | Major Depression, moderate |
| 15-19 | Major Depression, moderate or severe |
| 20-27 | Major Depression, severe |

It is important to specify Depression severity. This can be done by using the PHQ-9 score or by estimating based on clinical impression. You can find the PHQ-9 at http://www.cqaimh.org/pdf/tool_phq9.pdf

**Depression in Remission carries the same risk weight as active Depression.**

### Risk Coding for Depression, Single Episode

| Instead of.. | | Consider any one of these (Each hold a risk weight of 0.3) | |
|---|---|---|---|
| ICD-10 | Description | ICD-10 | Description |
| F32.9 | Major Depressive Disorder, single episode, unspecified | F32.0 | Major Depressive Disorder, Single Episode, mild |
| | | F32.1 | Major Depressive Disorder, Single Episode, moderate |
| F32.89 | Other specified depressive episode | F32.2 | Major Depressive Disorder, single episode, severe |
| F32.8 | Other depressive episodes | F32.4 | Major Depressive Disorder, single episode, in partial remission |
| | | F32.5 | Major Depressive Disorder, single episode, in full remission |

### Risk Coding for Depression, Recurrent, or In Remission

| Instead of... | | Consider any one of these (Each hold a risk weight of 0.3) | |
|---|---|---|---|
| ICD-10 | Description | ICD-10 | Description |
| Z86.59 | History of Depression | F33.0 | Major Depressive Disorder, recurrent, mild |
| | | F33.1 | Major Depressive Disorder, recurrent, moderate |
| | | F33.2 | Major Depressive Disorder, recurrent, severe |
| | | F33.40 | Major Depressive Disorder, recurrent, in remission, unspecified |
| | | F33.41 | Major Depressive Disorder, recurrent, in partial remission |
| | | F33.42 | Major Depressive Disorder, recurrent, in full remission |

****Anxiety:** Anxiety disorders (Generalized Anxiety Disorder, Panic Disorder, PTSD, etc.) **do NOT hold risk weight with MSSP, but they may with commercial populations.** Many EHRs display F41.8 (ICD-10: "Other specified anxiety disorder") as "Depression with Anxiety" but since it is an anxiety disorder rather than a depressive disorder, it does not hold weight in MSSP populations.

**Bipolar Disorder:** All ICD-10 diagnoses for Bipolar Disorder (F30.xx and F31.xx) carry risk weight. There are no terms related to these disorders that will result in an unweighted risk code.

**Psychotic Disorders:** All ICD-10 diagnoses for Schizophrenia and Schizoaffective Disorder (F20.x and F25.x) carry risk weight. There are no terms related to these disorders that will result in an unweighted risk code.

**Personality Disorders:** All ICD-10 diagnoses for Personality Disorders (F60.xx) carry risk weight. There are no terms related to these disorders that will result in an unweighted risk code.

- ✓ F60.0 Paranoid personality disorder
- ✓ F60.1 Schizoid personality disorder
- ✓ F60.2 Antisocial personality disorder
- ✓ F60.3 Borderline personality disorder
- ✓ F60.4 Histrionic personality disorder
- ✓ F60.5 Obsessive-compulsive personality disorder
- ✓ F60.6 Avoidant personality disorder
- ✓ F60.7 Dependent personality disorder
- ✓ F60.81 Narcissistic personality disorder
- ✓ F60.89 Other specific personality disorders
- ✓ F60.9 Personality disorder, unspecified

### Summary of Behavioral Health HCCs:

| Hierarchical Condition Category | Weight |
|---|---|
| Major Depressive, Bipolar and Paranoid Disorders | 0.3 |
| Schizophrenia | 0.5 |
| Personality Disorders | 0.3 |

Providers should rely on their independent medical judgment to decide whether suggested diagnoses are relevant and should ensure appropriate medical evaluation and documentation of the diagnosis to justify including the code. Diagnoses that are entered at Wellness visit should be accurate but do not require supporting documentation, making these visits an ideal opportunity to review and code all appropriate patient diagnoses. The risk weights displayed here refer specifically to risk adjustment methodology used in Medicare.

# Be as specific with your depression diagnoses documentation

HCPs should accurately code what is clinically appropriate and documented; all codes, whether weighted or not, need to be supported by documentation reflecting MEAT.

| Single Episode | | Recurrent Depression | |
|---|---|---|---|
| F32.0 | Major depressive disorder, single episode, mild | F33.0 | Major depressive disorder, recurrent, mild |
| F32.1 | Major depressive disorder, single episode, moderate | F33.1 | Major depressive disorder, recurrent, moderate |
| F32.2 | Major depressive disorder, single episode, severe | F33.2 | Major depressive disorder, recurrent, severe |
| F32.4 | Major depressive disorder, single episode, in partial remission | F33.41 | Major depressive disorder, recurrent, in partial remission |
| F32.5 | Major depressive disorder, single episode, in full remission | F33.42 | Major depressive disorder, recurrent, in full remission |
| **Non-Specific Codes** | | **Codes where there may be a more specific option** | |
| F33.8 | Other recurrent depressive disorders | Z86.59 | History of Depression |
| F33.9 | Major depressive disorder, recurrent, unspecified | F32.8 | Other depressive episodes |
| F33.40 | Major depressive disorder, recurrent, in remission, unspecified | F32.9 | Major depressive disorder, single episode, unspecified |
| F34.9 | Persistent mood (affective) disorder, unspecified | F32.89 | Other specified depressive episode |
| F39 | Unspecified mood (affective) disorder | F41.8 | Other specified anxiety disorders (some EHRs also label this as “Anxiety with Depression”) |

Depression in partial remission is defined as: some symptoms of the previous major depressive episode are present, full criteria are not met.

# Obesity, Morbid (E66.01) (Diet of Donuts) HCC Sheet

## Quick Reference Guide: Body Mass Index and Obesity

Note: Providers should rely on their independent medical judgment to decide whether suggested diagnoses are relevant. Wellness visits are an excellent opportunity to review and code all appropriate patient diagnoses. In any visit, ensure appropriate medical evaluation and documentation of the diagnosis to justify including the code. The HCC risk weights displayed here refer specifically to risk adjustment methodology used in Medicare. Risk adjustment methods vary for other payers, but diagnosis coding should be as complete and specific as possible to accurately convey risk.

**To successfully use ICD-10 codes to satisfy quality measures and/or risk stratification:**

1) **Use the BMI Z-code**. Submission of a Z-code is the only way to meet this measure for commercial contracts. Further, any of the Z-codes that indicate BMI ≥ 40 map to the HCC category of "morbid obesity," which carries a risk weight of 0.273. There is no need to submit an additional diagnosis of "morbid obesity" if a Z-code representing BMI ≥ 40 is submitted.

| | | |
|---|---|---|
| BMI ≤ 19.0 (Z68.10) | BMI 30.0-30.1 (Z68.30) | **BMI 40.0-44.9 (Z68.41)** |
| BMI 20.0-20.9 (Z68.20) | BMI 31.0-31.9 (Z68.31) | **BMI 45.0-49.9 (Z68.42)** |
| BMI 21.0-21.9 (Z68.21) | BMI 32.0-32.9 (Z68.32) | **BMI 50.0-59.9 (Z68.43)** |
| BMI 22.0-22.9 (Z68.22) | BMI 33.0-33.9 (Z68.33) | **BMI 60.0-69.9 (Z68.44)** |
| BMI 23.0-23.9 (Z68.23) | BMI 34.0-34.9 (Z68.34) | **BMI ≥ 70.0 (Z68.45)** |
| BMI 24.0-24.9 (Z68.24) | BMI 35.0-35.9 (Z68.35) | **Bolded codes have an HCC weight of 0.3.** |
| BMI 25.0-25.9 (Z68.25) | BMI 36.0-36.9 (Z68.36) | |
| BMI 26.0-26.9 (Z68.26) | BMI 37.0-37.9 (Z68.37) | |
| BMI 27.0-27.9 (Z68.27) | BMI 38.0-38.9 (Z68.38) | |
| BMI 28.0-28.9 (Z68.28) | BMI 39.0-39.9 (Z68.39) | |
| BMI 29.0-29.9 (Z68.29) | | |

2) **Code for Morbid (severe) obesity due to excess calories (E66.01).** This code carries a weight of 0.3, and can be applied when:
   a. **BMI >40**
   b. **BMI >35 and patient has an obesity-related comorbidity**. In this scenario, the ICD-10 code for the comorbid condition must also be submitted. Conditions commonly considered to be comorbidities in this context include:
      a) Arthritis
      b) Sleep Apnea
      c) High Blood Pressure
      d) High Cholesterol
      e) Type 2 Diabetes
      f) Venous Stasis Disease
      g) Soft Tissue Infections

3) **Code for Morbid (severe) obesity with alveolar hypoventilation (E66.2). This** code carries a weight of 0.3. The diagnosis should be considered when BMI >30, and the patient has OSA, a serum bicarbonate >27 mEq/L, and a $PaCO_2$ >45.

BMI Z code+ comorbid condition=E66.01

**Bill all three ICD-10 codes to build the MEAT.**

# Substance Abuse HCC Sheet: screen, intervene and make it seen

## Risk Coding Quick Reference Guide: Substance Use

**All** listed diagnoses carry a risk weight of 0.3

| ALCOHOL | |
|---|---|
| Alcohol Use Disorders – Most common HCC-weighted diagnoses: | |
| F10.929 | Alcohol use, unspecified with intoxication, unspecified |
| F10.94 | Alcohol use, unspecified with alcohol-induced mood disorder |
| F10.988 | Alcohol use, unspecified with other alcohol-induced disorder |
| F10.1X | Alcohol **Abuse**: all Abuse diagnoses are weighted, *other than*: |
| F10.2X | Alcohol **Dependence**: all Dependence diagnoses are weighted, including: |
| • F10.20 | • Alcohol dependence, uncomplicated |
| • F10.21 | • Alcohol dependence, in remission |

**AVOID:** F10.10 Alcohol Abuse, uncomplicated F10.11 Alcohol Abuse, in remission

| OPIOIDS | |
|---|---|
| Opioid Use Disorders – Most common HCC-weighted diagnoses: | |
| F11.929 | Opioid use, unspecified with intoxication, unspecified |
| F11.93 | Opioid use, unspecified with withdrawal |
| F11.94 | Opioid use, unspecified with opioid-induced mood disorder |
| F11.988 | Opioid use, unspecified with other opioid-induced disorder |
| F11.1X | Opioid **Abuse**: all Abuse diagnoses are weighted, including: |
| • F10.20 | • Opioid abuse, uncomplicated |
| • F11.11 | • Opioid abuse, in remission |
| F11.2X | Opioid **Dependence**: all Dependence diagnoses are weighted, including: |
| • F11.20 | • Opioid Dependence, uncomplicated |
| • F11.21 | • Opioid Dependence, in remission |

**AVOID:** F11.90 Opioid use, unspecified, uncomplicated

| SEDATIVES, HYPNOTICS, ANXIOLYTICS | |
|---|---|
| Sedative, hypnotic, or anxiolytic **Use** disorders – Most common: | |
| F139.39 | Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified |
| F13.988 | Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder |
| F13.1X | Sedative, hypnotic, or anxiolytic **Abuse**: all diagnoses are weighted, including: |
| • F13.10 | • Sedative, hypnotic, or anxiolytic abuse, uncomplicated |
| • F13.11 | • Sedative, hypnotic, or anxiolytic abuse, in remission |
| F13.2X | Sedative, hypnotic, or anxiolytic **Dependence**: all diagnoses are weighted, including: |
| • F13.20 | • Sedative, hypnotic or anxiolytic dependence, uncomplicated |
| • F13.21 | • Sedative, hypnotic or anxiolytic dependence, in remission |

**AVOID:** F13.90 Sedative, hypnotic, or anxiolytic use, uncomplicated

| CANNABIS | |
|---|---|
| Cannabis Disorders: Most Common Weighted Codes from **Use, Abuse** and **Dependence** | |
| F12.988 | Cannabis use, unspecified, with other cannabis-induced disorder |
| F12.188 | Cannabis abuse with other cannabis-induced disorder |
| F12.20 | Cannabis dependence, uncomplicated |
| F12.21 | Cannabis dependence, in remission |
| F12.288 | Cannabis dependence with other cannabis-induced disorder |

| COCAINE | |
|---|---|
| Cocaine Disorders: Most Common Weighted Codes from **Use, Abuse** and **Dependence** | |
| F14.10 | Cocaine abuse, uncomplicated |
| F14.11 | Cocaine abuse, in remission |
| 14.188 | Cocaine abuse with other cocaine-induced disorder |
| F14.20 | Cocaine dependence, uncomplicated |
| F14.21 | Cocaine dependence, in remission |
| F14.288 | Cocaine dependence with other cocaine-induced disorder |

| OTHER | |
|---|---|
| F15.988 | Other stimulant **use**, unspecified with other stimulant-induced disorder |
| F15.10 | Other stimulant **abuse**, uncomplicated |
| F15.11 | Other stimulant **abuse**, in remission |
| F15.188 | Other stimulant **abuse** with other stimulant-induced disorder |
| F15.21 | Other stimulant **dependence**, in remission |
| F19.988 | Other psychoactive substance **use**, unspecified with other psychoactive substance-induced disorder |
| F19.10 | Other psychoactive substance **abuse**, uncomplicated |
| F19.11 | Other psychoactive substance **abuse**, in remission |
| F19.21 | Other psychoactive substance **dependence**, in remission |

To meet criteria for **substance dependence**, three or more of the following must have been present together any time during the previous year:

- A strong desire or sense of compulsion to take the substance
- Difficulties controlling substance-taking behavior in terms levels of use
- A physiological withdrawal state when substance use has ceased or been reduced, or use of substances taken with the intention of avoiding withdrawal
- Tolerance: increased use of the substances is required to achieve effects originally produced by lower doses
- Neglect of pleasures or interests because of substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
- Persisting with substance use despite evidence of harmful consequences, such as harm to the liver through drinking, or depressive mood consequent to periods of substance use (if the user could be expected to be aware of the harm).

**Substance abuse** is any pattern of substance usage that does not qualify as dependence but that leads to hazardous behaviors, impairments in health, or failure to fulfill responsibilities such as at work or family life.

**Substance Use** is a term without a clear definition and is best used only when patient preference or similar factors lead a clinician to try to avoid the more specific terms of Dependence or Abuse

Providers should rely on their independent medical judgment to decide whether suggested diagnoses are relevant and should ensure appropriate medical evaluation and documentation of the diagnosis to justify including the code. The HCC risk weights displayed here refer specifically to risk adjustment methodology used in Medicare. Risk adjustment methods vary for other payers, but diagnosis coding should be as complete and specific as possible to accurately convey risk.

# AAFP Telehealth toolkit - launched Sept 2020


https://www.aafp.org/dam/AAFP/documents/practice_management/telehealth/2020-AAFP-Telehealth-Toolkit.pdf

# References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**Diagnosis Coding for Value-Based Payment: A Quick Reference Tool**

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**Preparing for Value-Based Payment: Five Essential Skills for Success**

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