

# Unlocking HCC Coding Mastery: Team-Based Learning Workshop for Family Physicians

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## Materials for presentation



## Disclosure

We have no actual or potential conflict of interest in relation to this program/presentation.

## Learning Objectives

- Define HCC coding , how it is different from CPT coding and how complexity varies in the two different rubrics.
- Describe how HCC codes are captured and reported
- Identify the various opportunities for Family Medicine physicians in the risk adjusted value-based world moving forward.

ChenMed has been **transforming healthcare** and improving health outcomes for more than **35 YEARS**

# Value-Based Care

## PRIMARY CARE REVOLUTION



America's  
**SCALABLE  
HEALTHCARE  
SOLUTION**



Giving Physicians  
**A PURPOSE**



**ACCOUNTABILITY  
FOR OUTCOMES**



Proven  
**RESULTS**

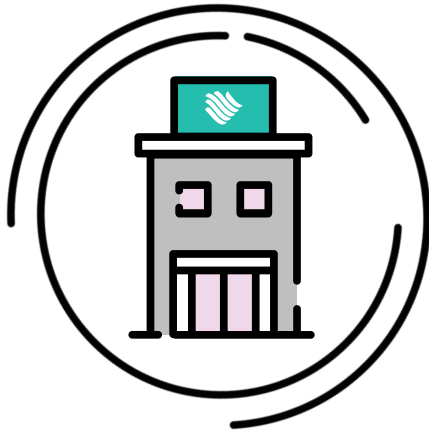


**COMMITTED TO**

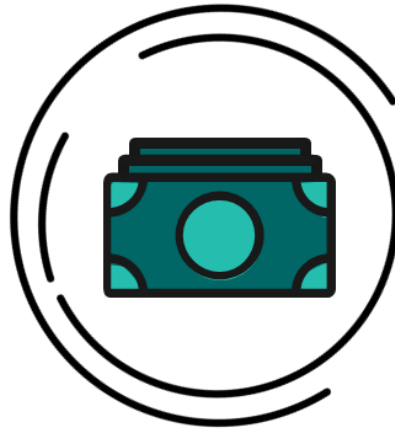


**OWNING FULL RISK**

## What We Do



Operate **130**  
primary care  
centers across  
**15** states



**Take global full risk for  
Medicare Advantage**  
and dual eligible  
members in multiple  
plans



We focus on providing  
**affordable, quality**  
**patient-centered care that**  
**delivers better health**  
**outcomes**, to seniors with  
multiple chronic conditions.

# ChenMed Centers



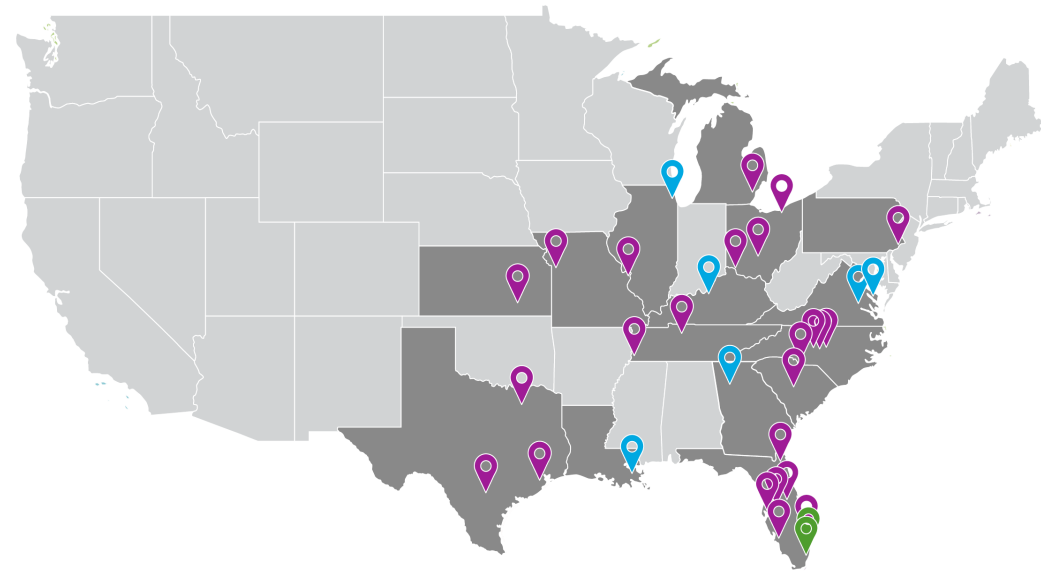
More than  
**125**  
centers



**15**  
States



And  
growing!



## FLORIDA

Broward  
Fort Myers  
Jacksonville  
Lakeland  
Miami-Dade  
Orlando  
Palm Beach  
Tampa

## GEORGIA

Atlanta  
Savannah

## ILLINOIS

Chicago

## KANSAS

Wichita

## KENTUCKY

Louisville

## LOUISIANA

New Orleans

## MICHIGAN

Detroit

## MISSOURI

Kansas City  
St. Louis

## NORTH CAROLINA

Burlington  
Charlotte  
Greensboro  
Winston Salem

## OHIO

Cincinnati  
Cleveland  
Columbus

## PENNSYLVANIA

Philadelphia

## SOUTH CAROLINA

Columbia

## TENNESSEE

Memphis  
Nashville

## TEXAS

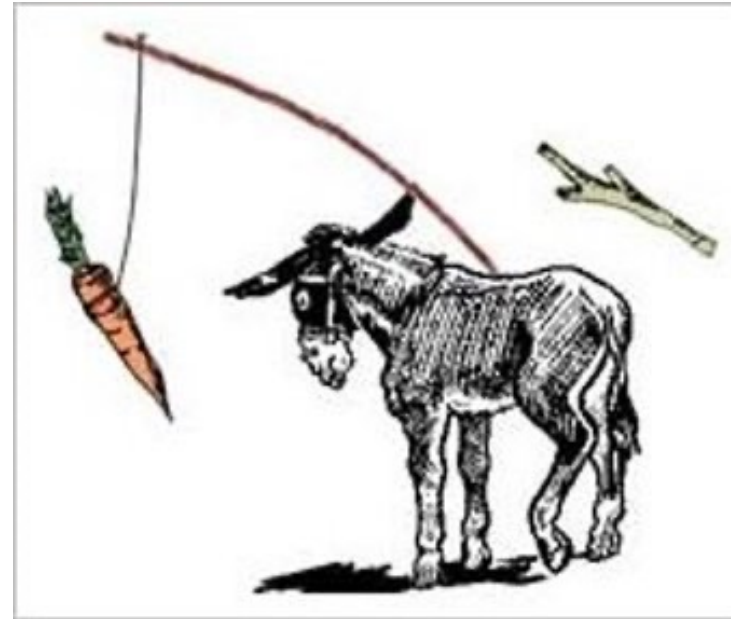
Dallas  
Houston  
San Antonio

## VIRGINIA

Richmond  
Tidewater

## • **The Future for Value Based Care – how will we get there?**

“All Medicare fee-for-service beneficiaries will be in a care relationship with **accountability** for quality and total cost of care by 2030.” – CMS Innovation Center





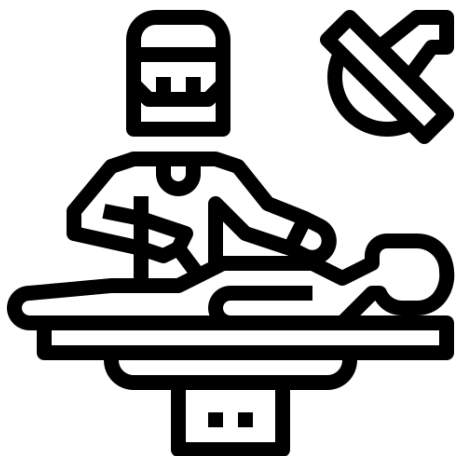
# Complexity

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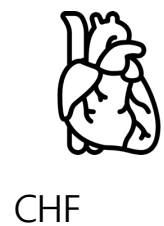


# Complexity

## Service--CPT



## Patient-HCC



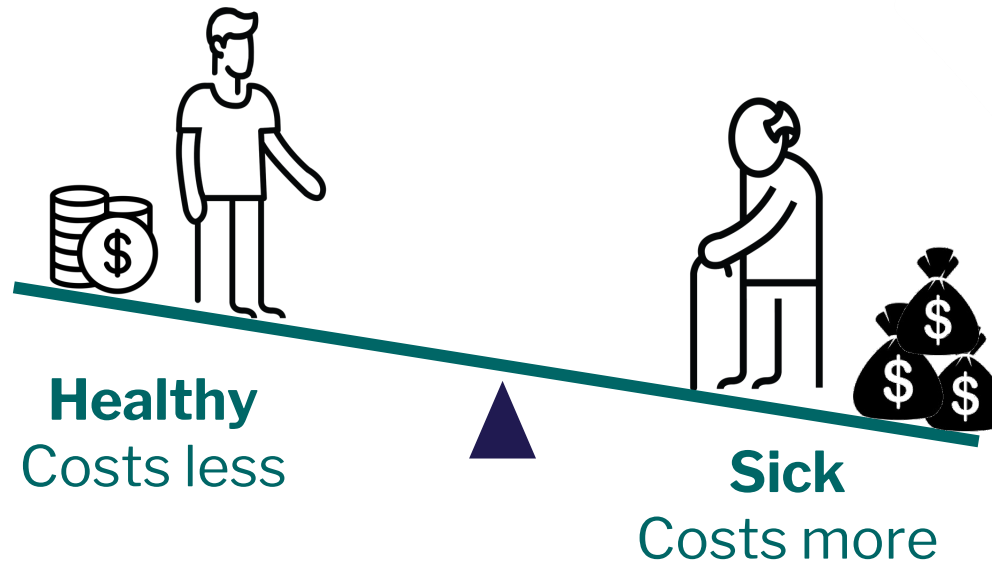


# Risk

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# Medical Risk

Sicker patients use more services and therefore are “riskier.”



# What is Medical Risk Adjustment – Why is it Important?

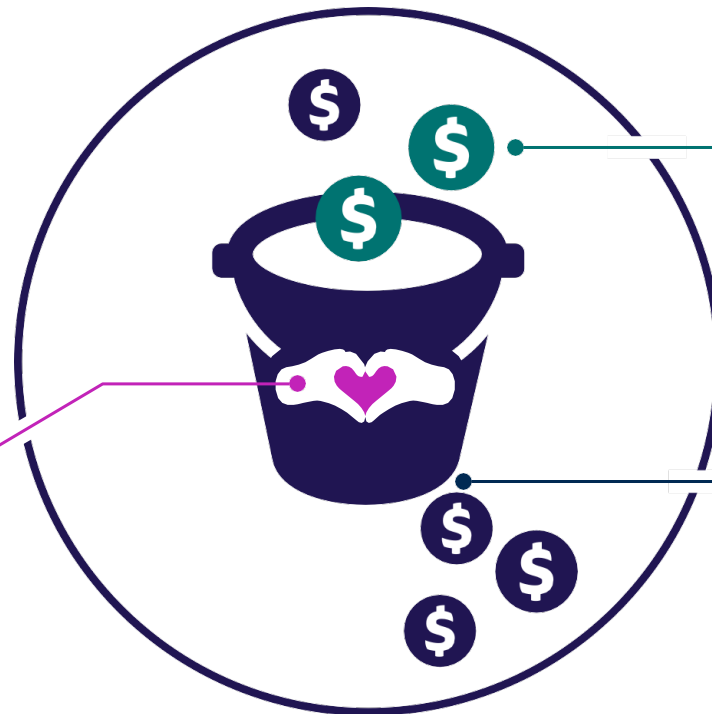


# The Full-Risk Value-Based Care Business Model

## How the money flows

What's left in this bucket at the end of the year is what you get to keep.

The Doctor Patient relationship is the key to plugging...



Patients + Dx+  
HCC/MRA

There's a Hole in  
My Bucket!

- Hospital/ED Costs- Part A.
- Professional Fees- Part B.
- Drugs- Part D.



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# Medical Risk Adjustment

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## Medical Risk Adjustment

### Medical Risk Adjustment On a Per Patient Basis

#### HEALTH STATUS



69k Possible  
DX Codes (ICD 10)



9k Risk Adjust

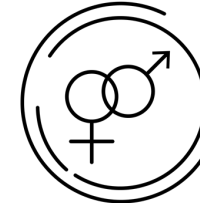


79 CMS HCC Codes

#### DEMOGRAPHICS



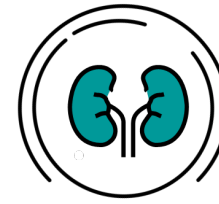
Dual: Yes/No



Gender



Home vs.  
SNF/LTC



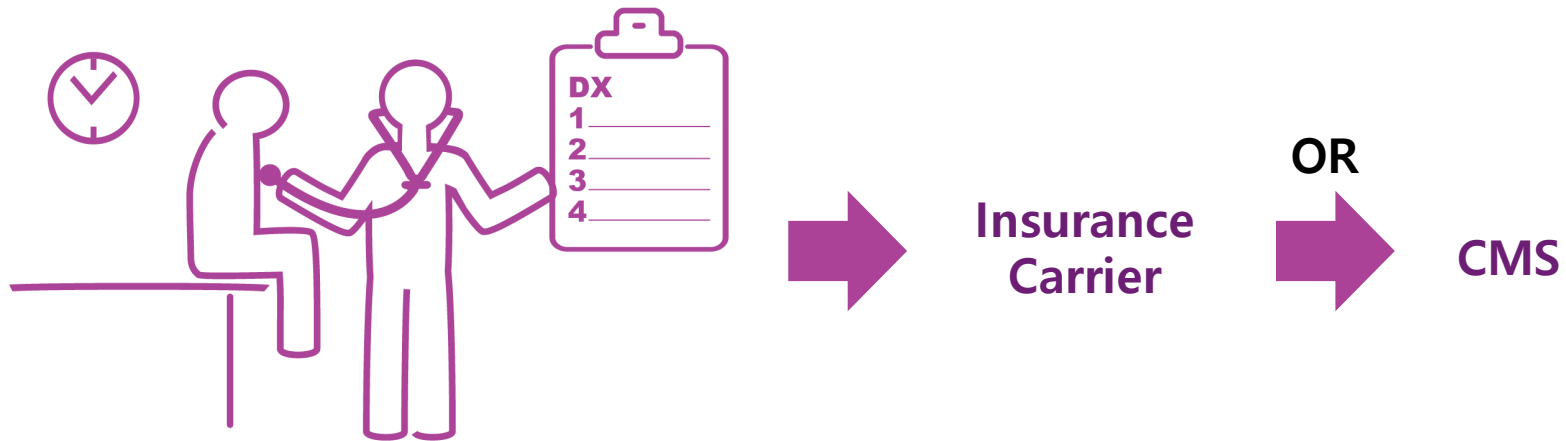
ESRD

**RAF x Baseline = Adjusted Baseline  
Resets Every Year**






# How to Communicate HCC Scores



- 1 Documenting on problem list helps but does not communicate to Insurance and CMS
- 2 Be as specific as possible (**HCC48, RAF 0.186**)  
Difference in obesity (**No HCC score, RAF 0**) versus morbid obesity = \$2,232) **For Year**

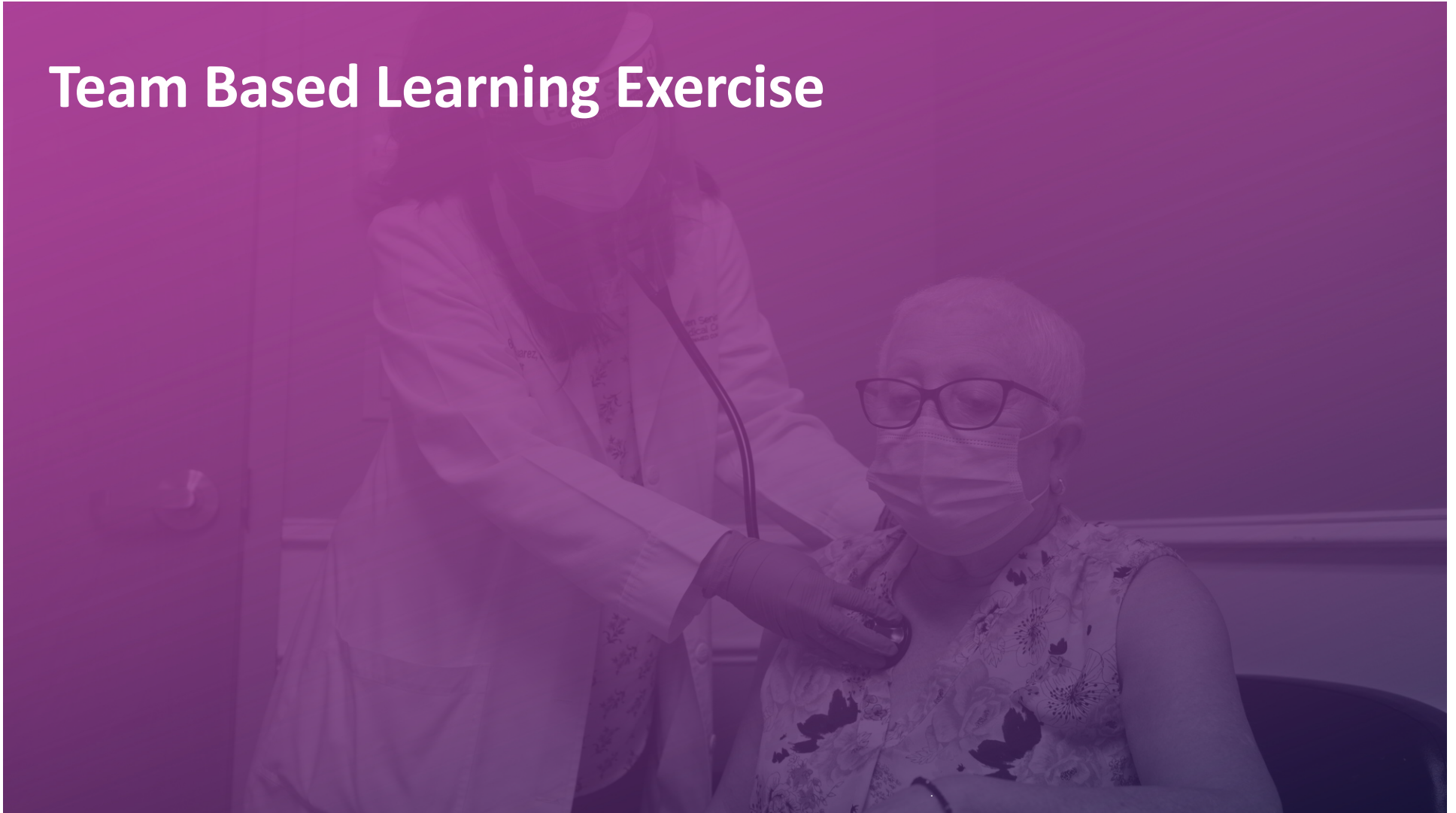
## The Board is Wiped Clean Every Year

- Amputated limbs grow back
- COPD patients suddenly are cured
- Patients are no longer diabetic
- Kidneys all function normally
- Everyone is no longer morbidly obese
- Etc.

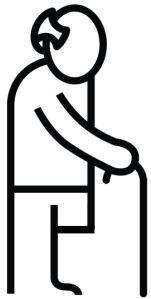
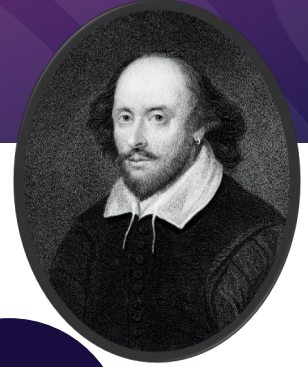
A hand holding a sponge is shown wiping a chalkboard. The chalkboard has some faint, illegible markings on it. The hand is wearing a white sleeve.

If you don't document and communicate via a bill it goes away each year.

# Team Based Learning Exercise



# Much Ado About Noting



Year  
1

Absence of lower extremity  
noted

DX: 289.61  
HCC: 0.598  
Revenue: -----

Year  
2

Amputation not noted

DX: -----  
HCC: -----  
Revenue: \$7176

Year  
3

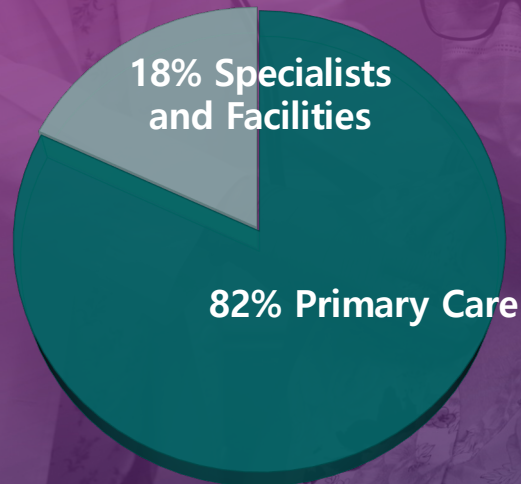
No diagnosis noted in Year 2  
*Limb must have grown back!*

DX: -----  
HCC: -----  
**Revenue: \$0!!!**

Every diagnosis code must be noted and billed for every year or it will fall off the following year

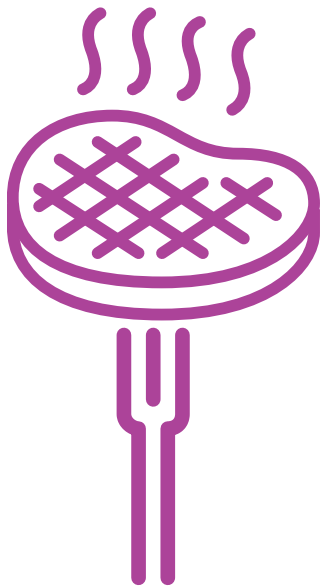
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82% of HCC codes come from primary care



# Valid HCC Coding Requires

- Face to Face Visit
- Status or Condition
- Plan of Action



## M.E.A.T– documentation mnemonic

**M:** Monitor--signs, symptoms, disease progression, disease regression

**E:** Evaluate--test results, medication effectiveness, response to treatment

**A:** Assess/Address--ordering tests, discussion, review records, counseling

**T:** Treat--medications, therapies, other modalities



## Do Not Code Non-Definitive Conditions

Don't use:

- Probable
- Possible
- Questionable

**"People are now paying for your opinion, you no longer have the luxury of guessing, it is your *Best Professional Opinion*"**

**James Q. Miller, MD**



## Where's Waldo

B19.20 Hepatitis C, unspecified (No HCC)—RAF—0 Status or Condition

B17.10 Hepatitis C, acute (No HCC)—RAF—0

B18.2 Hepatitis C, chronic (HCC 65)—RAF 0.185  
(\$2,220) added to take care of patient next year)



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## Again, Why Care?

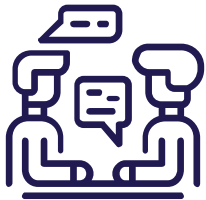
- Remember the golden rule: he/she who controls the gold makes the rules.
- Important for primary care doctors to take control



# What to Do with this New Found Knowledge?



**Learn more** – prepare not to survive but to thrive in risk contracts– ACO's, Primary Care First, Making Care Primary, ACO Reach, Medicare Advantage risk programs, and others to come



**Be confident** – in the importance of generalist physicians and make your case to administrators, specialists etc.

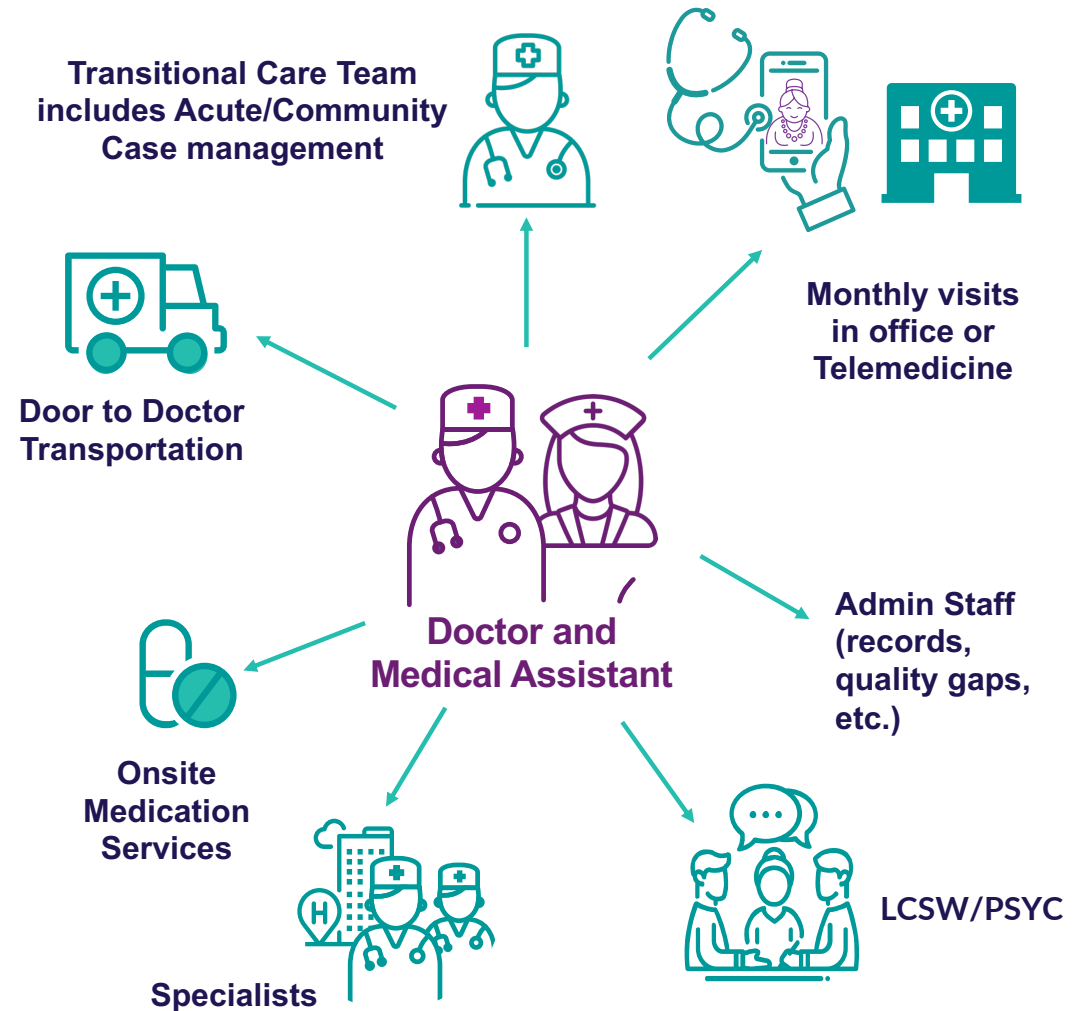


**Be prepared** – problems risk adjust because they cost more to take care. Most of these are not problems that can be cured, but problems that must be managed and NO ONE is more capable than a generalist physician to do this. This is about producing more healthy days for the patient, not more RVU's for the health system

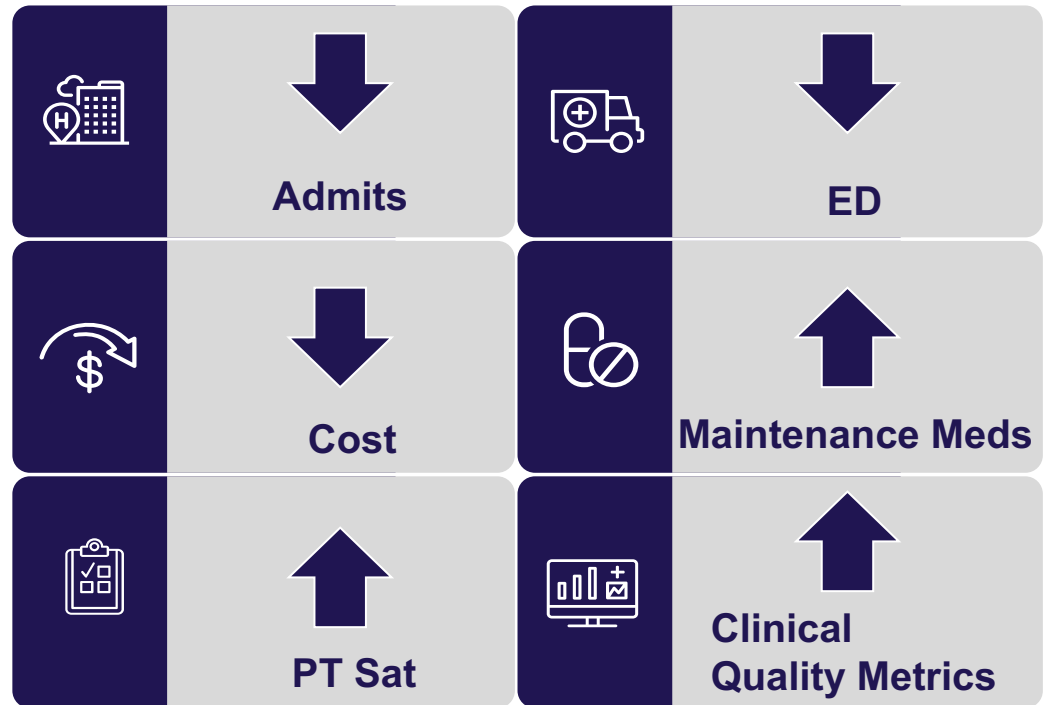
A Successful Approach:

# The Care Team of the Future

- 450 patients
- Monthly PCP visits/phone calls
- 10x more face time/yr.—some virtual
- Weekly staff calls



# High Touch Care = Better Outcomes




# Connect with us!


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 **re**imagine  
the way you  
**PRACTICE**  
medicine





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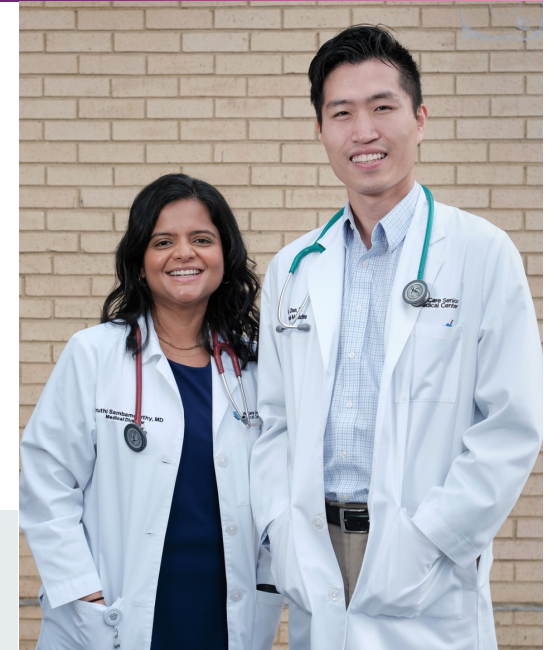


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