Risk Adjustment and HCCs
The Impact to Coding and HIM

Wolters Kluwer Education
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Objectives

- Discuss the definitions of risk adjustment factor (RAF) and hierarchical condition categories (HCCs)
- Discuss the importance of complete documentation in the outpatient setting
- Identify the impact of clinical documentation in risk adjustment
- Identify the impact of documentation related to HCC capture and assignment
- Analyze the process for HCC auditing and provider education
Risk Adjustment Factor (RAF)
Risk Adjustment Overview

What... 
- CMS reimbursement methodology to Medicare Advantage Organizations
- Method used to adjust payment based on the health status and demographic characteristics of an enrollee

How... 
- CMS calculates a risk factor for a member based on:
  - Demographics (age, sex)
  - Chronic conditions (diagnoses)

Why... 
- Reduces CMS financial exposure by paying based on the risk of healthcare required for the conditions of the enrollees
- Offers access, quality, protection for beneficiaries, reduces adverse selection, etc.
- Prospective – uses diagnosis as a measure of health status
Diagnoses submitted by providers to MA organizations

Used to determine beneficiary risk

Determines the risk-adjusted reimbursement

CMS Risk Adjustment Methodology
Risk Adjustment Factor (RAF)

Total score of all relative factors related to one patient for a total year - derived from a combination of factors:

- **Demographics**
  - Age and either community-based or institution-based
  - Medicaid disability and interaction with age and gender

- **Disease**
  - Diagnoses reported determines HCC category
  - Interaction between certain disease categories
  - Interaction between certain disease categories and disability status
Diagnoses, HCCs and RAF

- Each Medicare Advantage (MA) enrollee is assigned a risk score based on diagnoses and demographic criteria.
- Calculated costs/payments in a given year.
- Conditions submitted annually, particularly chronic conditions.
  - ICD-10-CM codes grouped into 79 HCCs.
  - Model includes factors for age/sex, special status and HCC scores.
  - HCCs are generally additive with hierarchies and disease interactions.
Hierarchical Condition Categories (HCCs)
# Hierarchical Condition Categories (HCCs)

<table>
<thead>
<tr>
<th>CMS-HCC</th>
<th>HHS-HCC (Commercial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)</td>
<td>Developed by the Department of Health Human Services (HHS)</td>
</tr>
<tr>
<td>CMS also developed a CMS RxHCC model for risk adjustment of Medicare Part D population</td>
<td>Designed for commercial payer population</td>
</tr>
<tr>
<td>Based on aged population (over 65)</td>
<td>Includes all ages</td>
</tr>
<tr>
<td>Current year data predictive of future year risk</td>
<td>HHS-HCCs predict both medical and drug spending</td>
</tr>
<tr>
<td>Attributes</td>
<td>Medicare Advantage</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Age, gender, medical conditions</td>
</tr>
<tr>
<td>Dx Code Capture</td>
<td>Medical conditions have to be treated/addressed and documented annually or need to specify that the member no longer has the condition</td>
</tr>
<tr>
<td>Acceptable Codes</td>
<td>Conditions documented during face-to-face encounter with accepted provider types</td>
</tr>
<tr>
<td>Acceptable Encounters</td>
<td><strong>Professional, Inpatient, Outpatient</strong></td>
</tr>
<tr>
<td>Historical Conditions</td>
<td>Coded and reported conditions transfer with member</td>
</tr>
</tbody>
</table>
Hierarchical Categories

- Families or hierarchal groups/categories
- More severe or complicated illnesses in the hierarchy will trump all other in category
- The more severe or complex, the higher the value
- All comorbid conditions should be documented and coded
- Critical that all diagnoses coded to their highest specificity
- Need all current diagnoses accounted for each encounter
79 HCC Categories

- Infection
- Metabolic
- Lung
- Blood
- Disease Interactions
- Neoplasm
- Substance Abuse
- Eye
- Heart
- Transplant
- Diabetes
- Psychiatric
- Kidney
- Arrest
- Cerebrovascular Disease
- Gastrointestinal
- Spinal
- Skin
- Injury
- Complications
• Each ICD-10-CM code maps to one of 805 diagnostic groups (DXGs)
• DXGs are further grouped into 189 condition categories (CCs) that describe a broader set of diseases which are clinically similar and have comparable costs
• Hierarchies are imposed among related CCs, so that a person is coded for only the most severe manifestation among related diseases. For unrelated diseases, HCCs accumulate
## Impact of Documentation/Coding

### Comparison of Raw RAF Scores

<table>
<thead>
<tr>
<th>No Chronic Conditions Coded</th>
<th>Some Chronic Conditions Coded</th>
<th>All Chronic Conditions Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.437</td>
<td>76 year old female</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
<td>Medicaid eligible</td>
</tr>
<tr>
<td>Acute UTI [N39.0, no HCC]</td>
<td>0.0</td>
<td>Acute UTI [N39.0, no HCC]</td>
</tr>
<tr>
<td>DM not Coded [no HCC]</td>
<td>0.0</td>
<td>DM w/ PVD [E11.51, HCC18]</td>
</tr>
<tr>
<td>CHF not coded [no HCC]</td>
<td>0.0</td>
<td>CHF [I50.9, HCC85]</td>
</tr>
<tr>
<td>No Interaction</td>
<td>0.0</td>
<td>Interaction [DM + CHF]</td>
</tr>
<tr>
<td>Raw RAF Score*</td>
<td>0.588</td>
<td>Raw RAF Score*</td>
</tr>
<tr>
<td>0.437</td>
<td></td>
<td>0.437</td>
</tr>
<tr>
<td>0.151</td>
<td></td>
<td>0.151</td>
</tr>
<tr>
<td>0.0</td>
<td></td>
<td>0.0</td>
</tr>
<tr>
<td>0.0</td>
<td></td>
<td>0.118</td>
</tr>
<tr>
<td>0.0</td>
<td></td>
<td>0.368</td>
</tr>
<tr>
<td>0.0</td>
<td></td>
<td>0.368</td>
</tr>
<tr>
<td>0.0</td>
<td></td>
<td>0.182</td>
</tr>
<tr>
<td>Raw RAF Score*</td>
<td>1.256</td>
<td>Raw RAF Score*</td>
</tr>
<tr>
<td>1.256</td>
<td></td>
<td>1.256</td>
</tr>
<tr>
<td>1.506</td>
<td></td>
<td>1.506</td>
</tr>
</tbody>
</table>

*Estimated scores, for illustration purposes, based on 2016 CMS-HCC model relative factors for community and institutional beneficiaries*
## Sample HCCs

<table>
<thead>
<tr>
<th>HCC Category</th>
<th>Description</th>
<th>Community RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
<td>0.470</td>
</tr>
<tr>
<td>17</td>
<td>Diabetes with Acute Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.368</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
<td>0.118</td>
</tr>
<tr>
<td>189</td>
<td>Amputation Status, Lower Limb/Amputation Complications</td>
<td>0.779</td>
</tr>
</tbody>
</table>
HCCs are assigned using hospital and physician diagnoses from any of five sources:

1. Hospital inpatient–principal diagnoses,
2. Hospital inpatient–secondary diagnoses,
3. Hospital outpatient,
4. Physician, and
5. Clinically-trained nonphysician (e.g., psychologist, podiatrist).

• The CMS-HCC model does not distinguish among sources; in particular, it places no premium on diagnoses from inpatient care.
Outpatient Documentation

- Basics of high quality documentation the same in all healthcare settings
  - The importance of quality documentation intersecting all outpatient settings - including independent practices and private providers
- Outpatient CDI program
  - Staffing challenges due to volume of OP cases
  - Issues related to timing - concurrent review may not be possible
  - Organizational support - senior leadership and providers
Quality Outpatient Documentation

- Accuracy of ICD-10-CM code assignment
  - Specificity impacts HCC assignment
- Accuracy of CPT coding assignment
  - Procedural specificity in the outpatient setting
- Accuracy of Ambulatory Payment Classification (APC) assignment
  - OPPS
  - Based on documentation
Quality Outpatient Documentation, continued

- Appropriate reimbursement
  - High quality documentation just as important in the OP setting
- Accuracy of quality scores
  - Quality documentation needed for accurate capture of OP quality scores
- Determination of medical necessity
  - Based on completeness of documentation
- Reduction of claims denials
  - Often the result of missing/incomplete documentation
Risk vs. FFS Reimbursement

- Physicians paid on FFS; bill services based on CPT procedure codes.
- Diagnosis codes minimally used only to match procedures; no comprehensive or highest level of accuracy.
- CMS assigns plan payments for patients based on risk (not as reimbursement of services).
- Higher specificity of diagnosis code(s) better define financial risk.
- CMS will only pay for health conditions being currently managed.
• Diagnoses must be captured in a face-to-face setting
• Diagnoses must be documented in the health record appropriate identification, date, and provider signature
• Complications or manifestations of a disease process must be clearly linked to that condition
Documentation Requirements

- Example of specific reporting rules:
  - ✓ Chronic diseases can continue to be reported on an on-going bases as long as receiving treatment and care for the condition
  - ✓ Diagnoses that receive care and management during the encounter can be reported
  - ✓ Diagnoses that have resolved or are no longer treated should not be listed
  - ✓ Malignancy can be reported as long as receiving active treatment
  - ✓ Be careful using problem list diagnoses that have been resolved
Documentation Tips

- Document all cause and effect relationships
- Include all current diagnoses as part of the current medical decision making and make note of them in the note on every visit
- Each note needs date, signature and credentials
- Document history of heart attack, status codes, etc.
- Only document diagnoses as “history of” or “PMH” when they no longer exist or are not a current condition
### Documentation Tips

<table>
<thead>
<tr>
<th>Don’t document...</th>
<th>If the patient has...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Major depression, recurrent, mild</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Chronic bronchitis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Chronic obstructive asthma</td>
</tr>
<tr>
<td>Vertebral fracture</td>
<td>Vertebral fracture, pathological</td>
</tr>
<tr>
<td>CVA with weakness</td>
<td>History of CVA with residual dominant side hemiplegia</td>
</tr>
<tr>
<td>Obesity</td>
<td>Morbid obesity with BMI of 40.2</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Poorly controlled diabetes type 2</td>
</tr>
</tbody>
</table>
Impact to Providers

- Use **specific** ICD-10 diagnosis codes to convey the true seriousness of the conditions being addressed for all types outpatient visits
- Documentation includes:
  1. Identify the diagnosis as a current or ongoing problem, as opposed to a past medical history or previous condition
  2. Choose the most specific diagnosis code while ensuring it is supported in documentation
All documented diagnoses should be coded - review chief complaint and HPI documentation carefully

Physician’s specific wording determines whether a condition is current for the particular encounter

A “history of” statement can be interpreted as historical only and no longer existing, or as a current ongoing problem that has been present for a long time

Do not code conditions noted only in the problem list or medical history unless the condition meets the TAMPER criteria
Documentation

• All relevant diagnoses should be reported at least once per year for each patient
• Annually, on January 1, patient diagnosis information is reset in preparation for a new year of diagnosis encounter data
• Per claim, confirm how many diagnosis codes are allowed in your system and ensure all applicable diagnosis codes are submitted for each patient during the calendar year
• Chronic conditions affect the management of the patient, even when the patient is presenting with a straightforward illness that would appear unrelated to the chronic condition

• “History of” conditions are informational unless it’s documented how the patient’s care was impacted by that history

• Conditions can only be coded/reported if there is documentation that the condition has affected the patient’s treatment and management on that particular encounter
TAMPER Documentation

- Ensure there is at least one element of TAMPER documented for each coded condition
  - T = Treatment
  - A = Assessment
  - M = Monitor/Medicate
  - P = Plan
  - E = Evaluate
  - R = Referral

- TAMPER can be found in any section of the patient record.
For each patient:

- All current diagnoses reported at the highest level of specificity based on provider documentation
- The more categories of diagnoses reported over a year creates a higher risk score
- Only one diagnosis per category is used in the risk score calculation
  - If both angina and AMI are reported in one year, only the AMI is scored as it is at a higher level of specificity within the Heart category
Outpatient Documentation
Risks
Documentation Risks

• Unacceptable documentation sources for risk adjustment coding/reporting:
  • Super bills
  • Referral forms
  • Encounter forms
  • Patient-only reported conditions
  • Non face-to-face encounter notes
  • Stand-alone patient problem list
Documentation Risks

• Cloned notes
  • Copy and paste of previous visit information
  • Mismatch of information and treatment

• Medical necessity
  • Need to monitor LCD changes and ensure documentation updated accordingly

• ICD-10-CM code specificity
  • CDI can prompt greater specificity as applicable
Documentation Risks

- E/M levels
  - Often undercoded due to fear of denial or audit
  - Trained CDI specialist can identify both undercoding and overcoding trends
- Bundling and modifier use
  - Issues specific to CPT
  - Potential for significant reimbursement impact
HCC Audits
200 Providers/2000 Records … issues identified:

- Incomplete or illegible records
- Coding from a super bill
- Coding from a problem list
- Reporting only primary diagnosis
- Use of generic or unspecified codes
- Coding history of as current
- Not linking manifestations and complications
- Overlooking chronic conditions
Chief Complaint: Routine physical

HPI: The patient is a 63 year old white male who comes to the office for his wellness exam. H/O gout, takes no medication. Refers to having visual problems for the last 5 months.

Lifestyle modification discussed at length with the patient that include 1.5 sodium daily diet, daily exercise, smoking cessation, balanced diet. If symptoms worsen to return for further evaluation.
Physical Examination


Psychiatric: Normal affect and mood. Responds to questions appropriately. No suicidal thoughts or ideation.

HEENT and Neck: Abnormalities: Mouth – Cavities, dental (aside from above listed, all others normal)

Thorax and Lungs: Chest: symmetrical with equal expansion. No pain, tenderness, or masses upon palpation. Lungs: clear to auscultation and percussion. Breath sounds equal bilaterally. No wheezes, rales (crackles), or rhonchi. No dullness to percussion.
Physical Examination

Heart, Pressures, and Pulses: Cardiovascular – Normal S1 and S2. Absent of S3 and S4. Regular rate without murmurs, rubs, heaves, or thrills. Peripheral pulses symmetrical and 2+ throughout.

Breasts and Axillae: Deferred

Abdomen: **Abnormalities: on inguinal area had redness coloration compatible with fungus.**

Back: Straight and symmetrical. No abnormal spinal curvatures notes. No costovertebral angle tenderness.

Anus and Rectum: Deferred

Extremities: No clubbing, cyanosis or edema. Pulses 2+ bilaterally

Musculoskeletal: Upper and lower extremities symmetrical, full range of motion noted without joint tenderness, swelling or deformities noted.
Today’s Diagnosis and Assessment:

- B35.1 Onychomycosis
- M10.9 Gout, unspecified
- Z00.00 Routine Medical Exam
- M19.90 Unspecified Osteoarthritis, unspecified site
- R73.09 Other abnormal glucose
- Z68.22 BMI, 22.0-22.9, Adult

Do you agree based on the documentation?
Common Misconceptions

• Delaying implementation of an OP CDI program
• Trusting clinicians (or software) to code correctly
• Overlooking the need to audit documentation and coding regularly
• Coding diseases and conditions without supporting documentation
• Keeping references and resources current
• Believing education is complete
References

• CMS website – www.cms.gov
• Expanding CDI to Physician Practices, *Journal of AHIMA*, May 2016
• Benefits and Barriers for Outpatient CDI Programs, *Journal of AHIMA website*, May 27, 2016
Questions?

Thank you!!

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