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10:45 a.m. to 11:30 a.m.

Tennessee Academy of Family Physicians
72nd Annual Scientific Assembly
The Park Vista Doubletree Hotel, Gatlinburg, Tennessee
October 19-22, 2021

"Understanding Risk Documentation and Coding as a Strategy for Value Based Preparation"

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Presentation Objectives:

1) Understand that healthcare is moving into a value-based mindset and the business reasons behind the shift.
2) Describe the HCC redocumentation rate, its importance, and some baseline thresholds and how to meet them.
3) Know several examples of diseases where the most clinical value in HCC capture lies.

72nd Annual TNAFP Scientific Assembly

Understanding Risk Documentation and Coding as a Strategy for Value-Based Preparation

Nick Ulmer, MD CPC FAAFP

Disclaimer/Conflicts

E. G. "Nick" Ulmer, Jr., MD CPC FAAFP is the owner of the entire content of this presentation.

Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:

- NUlmer@ProtimeLLC.com or 864-684-4248 (cell/text)

The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).

- Search www.cms.gov and "Who are the MACs" to locate yours.

Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

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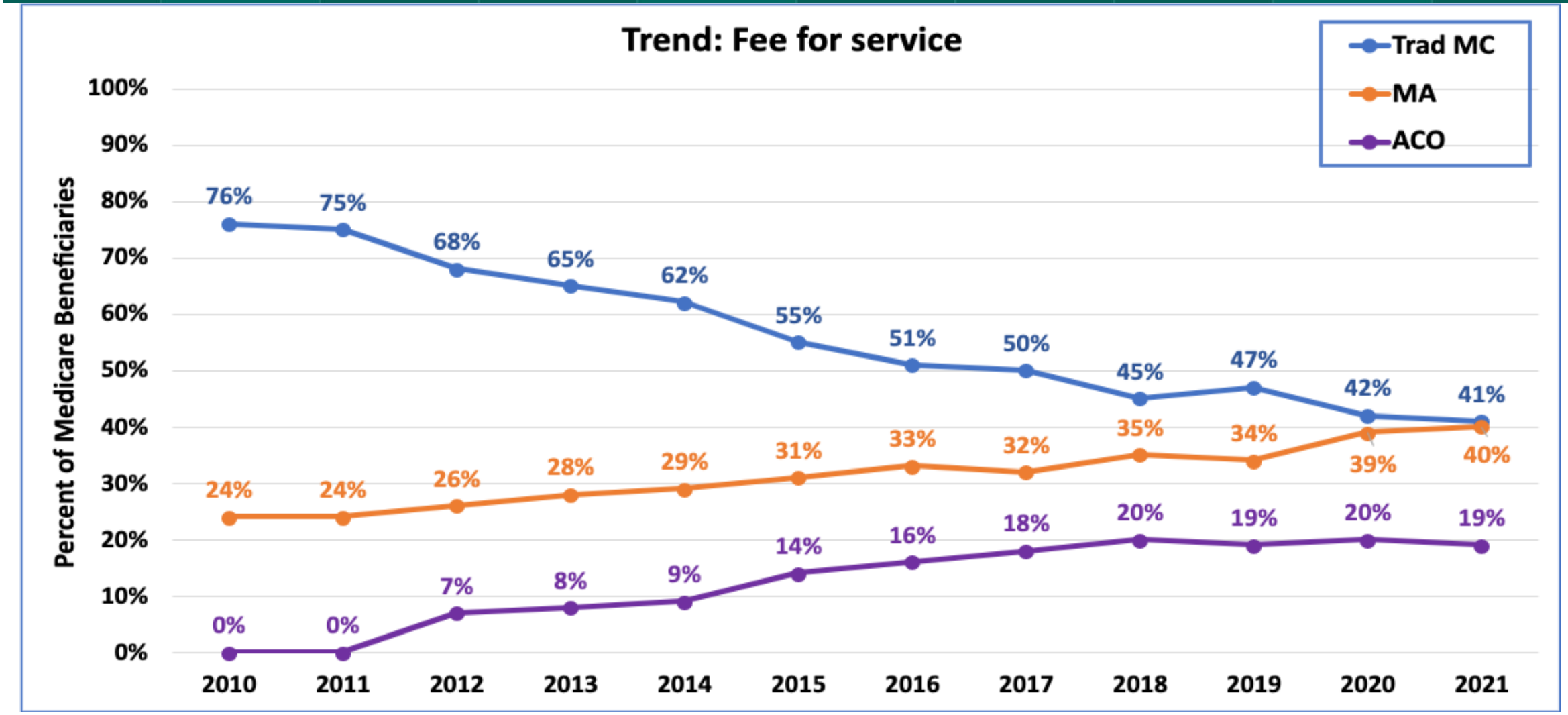
The Path to Value-Based Healthcare



Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard (December 2020), https://www.cms.gov/files/document/2021-shared-savings-program-fast-facts.pdf (PY2021), https://innovation.cms.gov/media/document/nextgenaco-py4finqualresults (PY2019 partial)

Risk Adjustment

- *Risk adjustment* is a method of adjusting payments to health plans or individual providers to account for the differences in expected health costs of individuals.
- The process accounts for known health conditions which allows for comparison of "wellness" among patients.
  - Diagnosis codes are used to determine potential risk
  - Used to predict cost of care and quality of care

The process starts over every year on January 1st

Risk Adjustment and **YOU**

- Used to evaluate and compare YOU to your peers

Higher risk scores translate into higher premiums paid by payor (CMS, etc.) to a contracted entity (ACO, Health Plan, etc.) for the patient's care.

  - Looking at the quality measures of the patients attributed to YOU, the risk score (higher is sicker) allows a more complete picture of quality patient care
  - Looking at the total cost of care for the patients attributed to YOU, the risk score (higher is sicker) allows a more complete picture of the patient's care
    - Likewise, lower risk scores associated with high cost may indicate a provider being a poor clinical manager - or having a poor ability to document the clinical picture.

- Part of our future "grade"? ... maybe our present "grade"?

Risk Adjustment and **YOU**

- CMS uses risk adjustment when calculating the relative performance of a Medicare-enrolled provider on such metrics as:
  - Per capita costs for Medicare patients attributed to the provider
  - Per capita costs for Medicare patients with specific conditions
    - Diabetes, COPD, CAD, CHF
  - Medicare Spending Per Beneficiary (MSPB)

2021 Medicare Spending Per Beneficiary (MSPB)

- Publicly reported, price standardized, risk adjusted measure. Tied to individual clinicians by NPI/TIN
  - Initially developed for the Physician Value-Based Modifier program (FY2015)
  - Updated for the Merit Based Incentive Payment System (MIPS, 2017)
- 3 days before IP "index" admission to 30 days after discharge for a spending-per-beneficiary inpatient episode of care
- All Medicare Part A and Part B services provided
  - Costs associated with the hospital stay, SNF, Home Health, Hospice Care, DME, physician and other supplies
- Risk adjustment is done by diagnosis coding
- Encourages transparency, shared with hospitals before it is posted on Hospital Compare website

Risk Adjustment and **YOU**

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    - Diabetes, COPD, CAD, CHF
  - Medicare Spending Per Beneficiary (MSPB)
  - All-cause hospital readmissions
  - MSSP ACO uses HCCs to set ACO baseline finances

What is an "HCC"?

- HCC is an acronym for Hierarchical Condition Category
  - Risk-adjustment model originally designed to estimate future health care costs for patients. Relies on ICD-10 coding to assign risk scores to patients.
  - Higher risk = sicker → more costly to care for (and harder to achieve quality scores)
- This is the risk adjustment model used mostly in the ambulatory world, but seen in the hospital conditions as well
- 84 categories with over 9,700 diagnosis codes for 2021
  - Usually identified as HCC ## (i.e., HCC 19 for DM w/o complications)
- Diseases "roll up" into a hierarchy
  - Transaminitis → Hepatitis C → Chronic Hep C → Cirrhosis → End-Stage Liver Dz

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Why is "Risk Stratification" Important?

- In the world of "population health management", the practice of medicine is being defined as
  1. Best quality
  2. Most optimal cost (cheapest)
  3. Satisfied patients
  4. Satisfied providers (physicians, NPPs, facilities)

...with a realization that sicker patients will cost more to care for and thus, a "weight" or "risk score" is needed to apply that cost credit

- Patients with more severe illnesses should have ICD-10 diagnosis codes to show the level of illness
  - Diabetes vs. Diabetes with nephropathy

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- Patients with more severe illnesses should have ICD-10 diagnosis codes to show the level of illness
  - Diabetes (0.105) vs. Diabetes with nephropathy (0.302)

What Affects the HCC Calculation?

- Demographic variables
  - Age
  - Gender
  - Socioeconomic factors
  - Disability status
    - Disabled beneficiaries < 65 living in community, nursing home, etc.
  - Original reason for entitlement
    - Identifies those over 65 who "disabled into Medicare" before 65
  - Insurance status
    - Commercial, Medicare, Medicaid or Dual-Eligible
- Diagnoses

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CMS continually in review and modeling

But, This is Not About "Coding"…

- The Evaluation and Management codes (99202-99215, Medicare Wellness, etc.) do not apply
- This relates to ICD-10 diagnosis codes
- This is about aligning the appropriate amount of monies to care for individuals – with sicker patients getting more money allotted
- Ensures that providers manage cost and provide quality at the same time

ICD-10-CM Diagnoses: HCC Basics

- All clinical conditions that affect the patient are to be assigned each year as CMS does an annual "clearing of the slate" for each patient
  - "The leg does not grow back"
- The diagnosis needs to be supported by the documentation
  - Multiple chronic conditions with resultant elevated HCC risk score, but only one 99213 office visit all year
- The diagnoses are additive to get the HCC score
  - So if it is clinically pertinent, make sure that the diagnosis is "active" (on the bill) at least once a year (MWV is best time)
- If seen but not in diagnosis, no credit. BMI 40+ → is an HCC risk score. But needs to be A/P.
- But, not all diagnosis codes are linked to HCCs
  - The codes that help predict cost the most accurately are
  - The most serious manifestations of a condition is considered

Risk Adjustment Calculation

- Based on documentation and coding of certain diagnosis codes every calendar year
- Numerical value for each diagnosis is added to produce the risk adjusted factor (RAF)
  - Average patient of average health RAF = 1.0
  - Healthy patient RAF < 1.0
  - Patient with multiple illnesses RAF > 1.0
  - *$$ is assigned to these numbers, adjusted yearly*

    ~$9,350 = 1.0 for this example

- *Source: HCPro Risk Adjustment Boot Camp/RTI CMS data 2013-14. Accessed 03-2017

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Disease State: CKD

- Avoid "Chronic Kidney Disease, unspecified" if stage is known
- CKD is defined as
  - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
  - GFR: At least 2 eGFRs < 60 cc/min/1.73m^2 for > 3 months
- Stage I normal, GFR > 90ml/min
- Stage II mild, GFR 60-89ml/min
- *Stage III* mod GFR 30-59 ml/min +.069**
- *Stage IV severe GFR 15-29 ml/min +.289*
- *Stage V kid. failure with < 15 ml/min +.289*

** 2019*

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- *Stage V* *kid. failure with < 15 ml/min* *+.289*

** 2019*

Acute Renal Failure has a risk score of 0.435

Diabetes Focus: Disease State

- 57% of diabetics have systemic complications
- Document the Diabetes type
  - DM type I **E10.~~**
  - DM type II **E11.~~**
  - DM drug or chemical induced **E09.~~**
  - DM due to underlying condition **E08.~~**
- The control status: hypo-/hyperglycemia, not "uncontrolled"
- Complications: nerve, eye, GI, renal, etc.
- Treatment, especially with insulin (Z79.4) (HCC 19)

Diabetes Focus: HCC score

- Diabetes with acute complication 0.302
  - BS 322, DKA, A1c 10.1
- Diabetes with chronic complication 0.302
  - DM with B peripheral LE numbness mid-foot distally (…or, if on insulin)
- Diabetes without complication 0.105
  - 43% of the time
- The difference annualized with the correct HCC is 0.197 or $1,841* each diabetic patient that falls into this category
  - For 100 incorrect DM patients is $184,100 over a year of "lost premium" to manage this population

“After hospital” vetting …

- As patients come in for post-acute office visits, it is more imperative that ever to vet/add pertinent diagnoses to the patient’s chart (ie, drop the bill with these diagnoses)
- Responsibility lies with us to evaluate these conditions in the ambulatory space
- Risk capture methodology is shifting towards more responsibility in the outpatient space to have the “correct” diagnoses submitted

Key Areas *Not* to Miss (Yearly)

- Amputations (AKA, BKA, toes) and how it affects functional state
- BMI, especially 40+ with a plan to address
- Asthma and pulmonary conditions
- CHF: specifying type (systolic or diastolic) and condition (acute/chronic)
- Ostomy: urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- Transplanted organs: heart, liver, lung, pancreas, bone marrow (not kidney!) and status
- Functional quadriplegia: complete inability to move due to disability (not neuro)
- Stage III, IV, and V kidney disease
- Acute DM complications: symptomatic w/ BS <70 or BS > 140mg/dl or DKA or DM with complications (nephropathy, retinopathy, neuropathy, etc.)
- Rheumatoid Arthritis

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The new buzzword in CDI…

- **Redocumentation**
  - Get the right clinical diagnosis to the correct severity and then support that in the medical record
  - Recapture it EVERY year – if appropriate
    - The leg does not grow back, but the stroke may have resolved … or the DVT now may be absent, etc.
  - The clearing of the risk score at year end makes this an every-year event
  - What is a good redocumentation goal….? Ask you payors to run your report (if your EMR cannot) and then have them benchmark you
    - This is not fraud and can be shared as a best practice for the region
- When ….? MWV or CPX, but focus on getting it as early in year as able

Don’t fear the HCC risk capture process

- Medicare Advantage plans with higher risk-assigned patients can have more revenues to manage the plan
  - Higher risk → sicker patients → more resources → more $$ needed
- Why the negative press….?
  - Risk Adjustment Fraud: $2.5 BILLION in 2018 (9th yr > $2B)
  - Anthem (03/2020) – “millions” in inappropriate payments. Add codes, but not deleting inappropriate diagnosis codes

https://www.medicareinteractive.org/get-answers/medicare-fraud-and-abuse/medicare-fraud-and-abuse-overview/fraud-defined
https://constantinecannon.com/practice/whistleblower/whistleblower-types/healthcare-fraud/risk-adjustment-fraud/
https://healthpayerintelligence.com/news/doj-launches-lawsuit-against-anthem-for-risk-adjustment-fraud
https://healthpayerintelligence.com/news/doj-recovers-2.5b-in-healthcare-fraud-false-claims-in-2018

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- OUR JOB: **Code CORRECTLY** with *the most specific diagnosis supported with documentation* in the record

What are the most OVERdocumented HCCs…?

- Surgically corrected conditions (AAA repair)
- Malnutrition that is now not
- Strokes that are not acute
- Embolic diseases (DVT) - post thrombotic syndrome w ulcer, yes
- Vascular diseases (abnormal ABI, no treatment/symptoms noted)
- Cancers that are no longer (thyroid cancer post removal)
- CKD (stage III from last year, that for this year is Stage II)

Case Discussion

65-year-old with a history of R breast ductal CIS. S/P mastectomy. On Tamoxifen. Has had progressive nausea and anorexia for the past several months. Oncology is concerned. BMI is 17, she appears wasted today.

20 pack-year smoker, but none for 15 years. Uses maintenance inhaler for her advanced lung dz (no O_2) and no rescue MDI since last visit 2 months ago. Blood sugars are 80-130 fasting. A1c was 7.4 two mo ago, but her LE (mid-shins down) are still numb and burn from the condition.

No issues with tachycardia. Afib. is controlled with Verapamil. Last EKG 8 mo ago was NSR and she is regular today. She refuses Warfarin and cannot afford the newer agents.

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Score the HCC

Risk factor	No chronic conditions	Cancer of Breast	COPD	Malnutrition	Chronic Afib	DM w complication
65 y/o female Community-based	0.321	0.321	0.321	0.321	0.321	0.321
Hx of Breast CA	0.000					
Cancer, breast present or Rx'd		0.153	0.153	0.153	0.153	0.153
Malnutrition				0.554	0.554	0.554
Tobacco, remission	0.000					
DM w Chronic Complication						0.307
COPD			0.335	0.335	0.335	0.335
Chronic afib					0.271	0.271
**Total RAF score	0.321	0.474	0.809	1.363	1.634	1.941
Predicted Annual Cost	$3,001	$4,431	$7,563	$12,743	$15,277	$18,148

Base payment rate $9350

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Closing comments

- Clinically Correct Documentation to Capture Severity…
- KEY in both the Ambulatory or Inpatient space
- Ambulatory:
  - Capturing the highest degree of clinical specificity increases our risk score
  - Risk is tied to revenues and when quality scores are reported, our "grade" can be impacted
- OUR JOB: Be CLINICALLY CORRECT in our documentation capture and in our medical management of the patients we care for

Closing

- The tale of the elephant

Closing

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…..don't be tied down any longer, remove the "stake" and strive for correct coding to start getting paid for what you do.

Questions

Thanks!!!

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