Improving Quality Medical Care by Improved Accuracy in Documentation and Coding

September 2019
Improving Quality Medical Care by Improved Accuracy in Documentation and Coding

The Importance of Hierarchical Condition Category (HCC) Codes

The CMS Risk Adjustment Model

Description
After completion of the course individual will understand how increasing specificity of a diagnosis impacts Quality, Cost Efficiency, Payment and portrayal of how sick a patient is. It will take approximately 60 minutes to complete this course.

Instructions
This course is tested and guaranteed to function on an Advocate Aurora network PC
Instructions on how to navigate this course
This course does not have sound

Technical Contact
If you have technical questions please contact the Service Desk at 414-647-3520 in Milwaukee or 1-800-889-9677.

Content Contact
Vicki Ruetten
Director Quality Improvement

Created: October 2014
Reviewed:
Updated: June 2019
Improving Your Quality Rating

Noting the severity of the patient’s conditions, by being as specific in the visit diagnosis section of the encounter and in your problem lists affects ALL PATIENTS. Using the most accurate code has implications beyond billing; and effects your:

- Quality Impact Scores, CMS Quality Payment Programs (MIPS/MSSP), HEDIS Quality Scores and Public Release WCHQ scores
- Individual “Physician Compare” Public website ratings for Quality and Cost Efficiency
- Provider rating for quality and cost efficiency with Insurance Companies for patients of all ages
Consider a population of 100 Asthmatics. About 10-15% will have exercise-induced Asthma. The patient with exercise-induced asthma that has “plain” Asthma listed as a visit diagnosis, would be considered as needing a controller medication. Where, if exercise induced Asthma (ICD code of J45.990) had been used, the patient would not be included as needing a controller.

Noting this type of specificity makes a difference in a providers Quality Scores related to the treatment of Asthma with a controller. 85-90% compliance compared to 100% had the exercise induced Asthma code been used for those 10-15% of the patient population.
Medicare at a Glance

- Medicare Part A – Hospital Inpatient Services
- Medicare Part B – Outpatient/Clinic Services including Medicare Shared Savings (MSSP)
- Medicare Part C – Medicare Advantage Programs such as AARP, Blue Medicare, Health Spring and Wellness and Humana Gold
- Medicare Part D – Prescription Drugs
Background

• Prior to 2004, Medicare (CMS) paid health plans based solely on member age, sex, and location.
• In 2004, CMS began transitioning to a health plan payment system based on member health status. This ONLY applies to Medicare Part C Advantage Plans.
• This system is often called RAPS (Risk Adjusted Payment System).
• For Advocate Aurora, most of our Medicare patients will fall under the RAPS program due to our Medicare Advantage Contracts with United Health Care, Humana etc and our Medicare Shared Savings Program (MSSP) ACOs.
Hierarchical Condition Categories

Payment is based on ~83 Hierarchical Condition Categories (HCCs). Each category has ICD 10 diagnosis codes associated with the HCC. Of the ~83, there are:

- ~62 Chronic HCCs
- ~21 Acute HCCs

- **Chronic HCCs** are likely to persist year to year and Epic prompts providers to ‘refresh’ them.
- **Acute HCCs** are not considered to be persistent, and are NOT prompted to be refreshed.
- **BOTH acute and chronic HCCs** ‘count’ towards a patient’s total RAF score. This score determines for CMS how sick the patient is and how many resources are expected to be utilized.
Background

- Payments are higher for less healthy members and lower for healthy members.
- Payments are determined by diagnosis coding
- Appropriate chart documentation and diagnosis reporting is required for reimbursement
- CMS performs audits and will take premium reimbursement back if not appropriate.
HCC Payment Model

• It is essential to document completely to get reimbursement warranted by patient’s condition.
• Slight changes in the coded specificity of the diagnoses can mean BIG financial consequences.
• Payment is adjusted based on HCC codes and documentation of disease.
• In the Risk Model, reimbursement is determined by all the ICD diagnosis codes assessed and treated, NOT the E&M level.
• Each condition must be coded and assessed with appropriate plans each year.
Importance of Annually Noting as a Visit Diagnosis

How soon we forget

Physicians do not provide a complete and accurate listing of ICD codes for members, particularly those with chronic diseases. All of the conditions listed are chronic, yet only 17 percent of members with, for instance, coronary artery disease are coded with this condition in the second year and only 11 percent are coded in the third year.

Source: Reden & Anders
Risk Adjustment Factor

- Each patient is assigned a Risk Adjustment Factor (RAF)
- The RAF score is made up of:
  1. Demographic factor (age and sex)
  2. Additional factors based on Medicaid status and disability
  3. Documented select chronic conditions (HCCs)
  4. A patient can have more than one HCC
- All of the Individual’s HCCs roll-up to a RAF(Disease burden) score
Interpreting the Risk Adjustment Factor (RAF)

RAF identifies patient health status:

<table>
<thead>
<tr>
<th>Low RAF</th>
<th>High RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>May indicate a healthier population</td>
<td>May indicate members with increased health risks that were properly documented and coded</td>
</tr>
<tr>
<td>Or</td>
<td>Or</td>
</tr>
<tr>
<td>Low RAF score may <strong>falsely</strong> indicate a healthier population due to:</td>
<td>High RAF score may be inflated due to:</td>
</tr>
<tr>
<td>• Inadequate chart documentation of diagnosis</td>
<td>• Reported diagnosis not documented with an assessment/plan</td>
</tr>
<tr>
<td>• Incomplete and/or inaccurate diagnosis coded</td>
<td>• Copy and paste of the Problem List to a visit diagnosis</td>
</tr>
<tr>
<td>• Patients who were not seen</td>
<td>• Using Rule out diagnosis instead of the symptoms.</td>
</tr>
</tbody>
</table>

Less Sick — More Sick — More cost expected
### Risk Adjustment Factor Example

76 year old female with DM, PVD & CHF

<table>
<thead>
<tr>
<th>76 year old female</th>
<th>0.426</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid eligible</td>
<td>0.202</td>
</tr>
<tr>
<td>DM w/ vascular complications (HCC 18)</td>
<td>0.371</td>
</tr>
<tr>
<td>Vascular disease w/ complications (HCC 108)</td>
<td>0.594</td>
</tr>
<tr>
<td>CHF (HCC 85)</td>
<td>0.346</td>
</tr>
<tr>
<td>Disease interaction DM + CHF</td>
<td>0.150</td>
</tr>
<tr>
<td>Total RAF</td>
<td>2.089</td>
</tr>
</tbody>
</table>

A total RAF score of 1.0 is an average risk patient. This patient’s RAF score of 2.089 indicates that they are twice as sick and therefore are expected to utilize more resources.
Determining a RAF Score

The Risk Adjustment model is **additive**.
- Takes in all qualifying diagnoses submitted to CMS in a given year for a particular patient in both the inpatient and outpatient settings.
- Adds up risk factors (HCCs) to achieve a total health status “score” for patient.

The Risk Adjustment model is **predictive**.
- Diagnoses reported this year determine resource needs for next year.
- Health status is re-determined each year.
Previous Payment Model

• Patient A: 75 year old female with breast cancer, Rheumatoid Arthritis and diabetes complicated by chronic kidney disease and PVD with foot amputation

• Patient B: 75 year old female whose only problem is mild osteoarthritis

Before this Risk Model was in place CMS paid the same amount for both patients based on only the E&M level of service and CPT procedural codes.

Under the Risk Model the severity of the diagnoses billed out affect payment, not the E&M level of Service used.
Benefits of HCC

• Improves continuity of care by more comprehensive sharing of patients conditions.
• Accuracy of patient risk stratification and risk management.
• Predictive modeling.
• Correctly and accurately documents the severity of illness of the patient.
• Accurate documentation is important for comparative physician and hospital scorecards.
Documentation Pitfalls

• National coding guidelines state that a diagnosis cannot be coded unless it is documented and assessed in the current visit.
• A chronic condition must be restated each time it is assessed or treated. A diagnosis cannot be carried over from another visit.
• Documentation must be explicit. Assessing the signs, symptoms, or findings related to a disease isn’t enough. “FBS 300” cannot be coded as uncontrolled diabetes.
• It is not acceptable to copy the problem list into the visit diagnoses without an assessment and plan.
The Mandate from CMS

Any Condition that is \textit{taken into account} or \textit{affects patient care}, \textit{treatment} or \textit{management} should be documented and ultimately coded.

The listing of all pertinent diagnosis codes is important!
Medical Record Documentation

• Code all documented conditions that **coexist** at the time of the encounter/visit. (Amputations, Dialysis, Insulin use)

• **In the Clinic Setting:** Chronic diseases **treated** on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s) and require or affect patient care, treatment or management decisions.

• If you fail to address and document an HCC diagnosis, you are still taking care of the problem, you are just forgoing credit/recognition for the disease burden you are managing.

• If you are a PCP and a specialist is fully managing the condition, you should still address the condition and indicate the clinical status and management plan for that condition.
Medical Record Documentation (Cont.)

- Do not code conditions that were previously treated and no longer exist.
- However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Required to be a visit diagnosis annually: Stroke Sequelae, Amputations, transplant, quadriplegia etc.
Quality Documentation

• You must document chronic conditions every year.
  o As of January 1 every year, CMS acts as if all chronic diseases are “cured.”
  o If a chronic condition is not documented and coded in a year, there is NO payment for it!
  o It is best practice to address diagnoses throughout the year at each visit. If only seeing the patient annually, the Medicare Wellness Visit is the perfect time to address all conditions the patient has.

• Documentation must be based on a face-to-face visit
• Exception – you may add a diagnosis confirmed after the visit by lab or other ancillary information IF:
  o The data is received within one week of the visit
  o You amend chart to document diagnosis, plan, and call patient
80 year old female with an MI in the last 4 weeks, depression, diabetes, and eGFR 55, and creatinine of 1.3

<table>
<thead>
<tr>
<th>General</th>
<th>HCC weight</th>
<th>Specific</th>
<th>HCC weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>.000</td>
<td>MI in last 4 weeks</td>
<td>.231</td>
</tr>
<tr>
<td>Depression</td>
<td>.000</td>
<td>Major Dep. Single episode</td>
<td>.370</td>
</tr>
<tr>
<td>Diabetes</td>
<td>.181</td>
<td>DM with renal issue</td>
<td>.608</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CKD stage III</td>
<td>.389</td>
</tr>
<tr>
<td>HCC Score</td>
<td>.181</td>
<td></td>
<td>1.598</td>
</tr>
</tbody>
</table>

More Sick—More cost expected

Less Sick
Importance of Specificity

Specific Documentation & Coding Clearly Identifies the *Severity Level* of Disease and how sick your patient is.
Risk Score

- Determined by the diagnosis submitted on a claim (grouped into Hierarchical Condition Categories, HCC)
- The average beneficiary has a 1.0 risk score
- Patients with higher risk scores are sicker
- Patients with lower risk scores are healthier

What is the Risk Score for your Patients?
Importance of Specificity

Specific Documentation and Coding Clearly Paints the Picture of the *Level of Complexity* for the Patient Encounter

- Impaired FBS
- Diabetes on Insulin
- Diabetes on Insulin with PVD and CKD
## Why Is Coding All Chronic Conditions Important?

<table>
<thead>
<tr>
<th>No Conditions Coded</th>
<th>Some Conditions Coded</th>
<th>All Chronic Conditions Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>76 year old female</td>
<td>0.442</td>
</tr>
<tr>
<td>DM with complications</td>
<td>DM without complications</td>
<td>0.118</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>Vascular Disease</td>
<td>X</td>
</tr>
<tr>
<td>CHF</td>
<td>CHF</td>
<td>X</td>
</tr>
<tr>
<td>Disease Interaction (DM+CHF)</td>
<td>Disease Interaction (DM+CHF)</td>
<td>X</td>
</tr>
<tr>
<td>Total RAF</td>
<td>Total RAF</td>
<td>0.560</td>
</tr>
<tr>
<td>Total RAF</td>
<td></td>
<td>1.659</td>
</tr>
</tbody>
</table>

AdvocateAuroraHealth™
## Importance of Specificity

<table>
<thead>
<tr>
<th>ICD 10</th>
<th>Condition</th>
<th>ICD 10</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.9</td>
<td>Depression</td>
<td>F32.- to F33.-</td>
<td><strong>Major</strong> Depression</td>
</tr>
<tr>
<td>R25.1</td>
<td>Tremor</td>
<td>G20</td>
<td>Parkinson's</td>
</tr>
<tr>
<td>I10</td>
<td>HTN Unspecified</td>
<td>I11.0 &amp; I50.-</td>
<td>HTN Heart Disease <em>w HF</em></td>
</tr>
<tr>
<td>I125.10</td>
<td>Coronary Artery Dz(CAD)</td>
<td>I25.119</td>
<td>CAD with stable Angina Pectoris</td>
</tr>
<tr>
<td>I51.89</td>
<td>Other Spec Cardiac Disorder</td>
<td>I48.-</td>
<td>Atrial Fib – Need to note if chronic, paroxysmal, permanent or persistent.</td>
</tr>
<tr>
<td>J44.9</td>
<td>COPD NOS</td>
<td>J44.9 &amp; J96.-</td>
<td>Chronic Obstructive Asthma <em>w</em> Chronic Respiratory Failure(on O2)</td>
</tr>
<tr>
<td>J40</td>
<td>Bronchitis, NOS</td>
<td>J42</td>
<td><strong>Chronic Bronchitis</strong></td>
</tr>
</tbody>
</table>
Fictional Case Study Example 1

DOS: 01/12/2019
Name: Patient One DOB: 05/01/1953

Chief Complaint & HPI
65 year old female accompanied by her husband, here for routine visit, lab results

Past Medical History
Diabetes, CKD, Hyperlipidemia, HTN

ROS
Constitutional – patient notes fatigue
GU – positive for urinary frequency
MS – mild swelling in the hands and feet other systems negative

Vitals
Ht. 69 in, Wt. 275 lbs.
BP 124/82
Temp 97.6 Pulse 78

Exam
General Appearance: Well groomed, pleasant, obese female
ENMT: Normal CV: RRR; Lungs: clear, good breath sounds bilaterally

Assessment/Plan
1. Diabetes – currently well controlled, a1c at 5.2
2. Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. CKD – currently no change, GFR at 51
4. HTN, hyperlipidemia – both currently well controlled. Repeat labs and schedule follow up in 3 months
Fictional Case Study Example 1 with Improved Documentation

DOS: 01/12/2019  
Name: Patient One DOB: 05/01/1953

Chief Complaint & HPI  
65 year old female accompanied by her husband, here for routine visit, lab results

Past Medical History  
Diabetes, CKD, Hyperlipidemia, HTN

ROS  
Constitutional – patient notes fatigue  
GU – positive for urinary frequency  
MS – mild swelling in the hands and feet  
other systems negative

Vitals  
Ht. 69 in, Wt. 275 lbs. BMI 40.6  
BP 124/82  
Temp 97.6 Pulse 78

Exam  
**General Appearance:** Well groomed, pleasant, morbidly obese female  
**ENMT:** Normal CV: RRR; Lungs: clear, good breath sounds bilaterally

Assessment/Plan  
1. Diabetes – currently well controlled, a1c at 5.2
2. Morbid Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. CKD, Stage 3, secondary to diabetes – currently no change, GFR at 51
4. HTN, hyperlipidemia – both currently well controlled. Repeat labs and schedule follow up in 3 months

Electronically signed by: A. Medical Doctor, MD on 01/12/19
### Fictional Case Study Example 1

**First Coding Scenario:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/ CKD</td>
<td>E11.22</td>
<td>18</td>
</tr>
<tr>
<td>CKD</td>
<td>N18.9</td>
<td>none</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.0</td>
<td>none</td>
</tr>
<tr>
<td>Hypertensive CKD, unspecified</td>
<td>I12.9</td>
<td>none</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
<td>none</td>
</tr>
</tbody>
</table>

**Second Coding Scenario**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/ Stage 3 CKD</td>
<td>E11.22</td>
<td>18</td>
</tr>
<tr>
<td>Stage 3 CKD</td>
<td>N18.3</td>
<td>138</td>
</tr>
<tr>
<td>Morbid Obesity BMI 44.0-44.9</td>
<td>E66.01</td>
<td>22</td>
</tr>
<tr>
<td>Hypertensive CKD, stage 3</td>
<td>I12.9</td>
<td>none</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
<td>none</td>
</tr>
</tbody>
</table>

**Detailed documentation is key for accurate risk score reporting**
Specific Documentation Paints a Picture for the Plan of Care

Case Review: 76 y/o female patient with uncomplicated Type 2 diabetes

RAF score is 0.555 (Less sick, well below national average of 1.0)
Accurate Documentation

Same patient: 76 y/o female patient with Type 2 diabetes with PVD, CKD III, stable HTN and CHF.

RAF score is 2.013
(More sick and above national average of 1.0)
## RAF Scores Based on Provider Documentation (same patient)

<table>
<thead>
<tr>
<th>Conditions with limited specificity</th>
<th>All conditions documented with appropriate DX codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 y/o female 0.437</td>
<td>76 y/o female 0.437</td>
</tr>
<tr>
<td>DM without complication (E11.9) 0.181</td>
<td>DM with vascular Complications 0.368</td>
</tr>
<tr>
<td>Vascular disease not coded</td>
<td>Peripheral vascular disease unspecified: 0.299</td>
</tr>
<tr>
<td>HF not coded</td>
<td>HF coded 0.368</td>
</tr>
<tr>
<td>No disease interaction (HTN/CKD) (Diabetes/HF)</td>
<td>HF and renal interaction 0.317 Hypertensive CKD Stage 4 – 0.224</td>
</tr>
<tr>
<td><strong>TOTAL RAF 0.618</strong>                <strong>TOTAL RAF 2.013</strong></td>
<td></td>
</tr>
</tbody>
</table>
There is a presumed causal relationship between hypertension, chronic kidney disease and or heart failure, unless the provider clearly states the conditions are unrelated. The combined morbidity is best quantitatively represented in the RAF score when these three conditions are connected together as a single combined diagnosis term instead of three separate diagnoses. In Epic these conditions should be documented on the Encounter Diagnosis list using a combination diagnosis term.

If the patient has HTN, CKD and Heart failure it’s important to use the combination code and not mention HTN, CKD and Heart Failure separately as HTN by itself does not risk adjust.
Coronary Artery Disease and Angina

• Myocardial Infarction – list the acute diagnosis only during the first 4 weeks following an AMI, otherwise use History of Acute Myocardial Infarction
• Search in Epic using “acute myo inf” or “hist acute myo inf”
• Is the patient on a long-term nitrate? If yes, then the patient is receiving medical treatment for stable angina
• An appropriate long-term management diagnoses is Coronary Artery Disease with Stable Angina
Depression (major depressive disorder)

• Use Major Depression family of diagnoses (de-stigmatize “major”)
• If a patient is sufficiently ill to have a PHQ9 of >=5 and is prescribed an anti-depressant, they have major depression
• Depressed mood, anhedonia, sleep disturbance, appetite change, irritability, fatigue, poor concentration, guilt, suicidal ideation
• Initial episode = > 2 weeks of symptoms
• Subsequent episode = absence of symptoms for > 2 months, then relapse
• Remission (partial/full) = absence of some/all symptoms for > 2 months. Without this specificity, the Depression term does NOT risk adjust.
• Search in EPIC using “maj dep”
• Depression without specificity does not risk adjust.
Visit Diagnoses would be: Diabetes with neuropathy. Current Use Insulin COPD with Chronic Respiratory Failure
Common Annually Overlooked Diagnoses

• Artificial Feeding or Eliminator Openings
• Quadraplegic/Hemiplegic status
• Morbid Obesity
• Amputations
• Chronic Respiratory Failure
• Stable COPD
• Chronic Skin Ulcers
Complications of diabetes are under-reported

- Diabetes Mellitus, code E11.9 without mention of complication is appropriate at times.
- However, if complications exist, code to the specific complications and manifestations.
Coding of Underlying Disease (Etiology) and manifestation

In ICD 10 Diabetes Mellitus and underlying diseases are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

As many codes within this particular category should be used to describe all the complications of the disease **E11.2-E11.6**

*Do not use uncontrolled diabetes.*

*Providers must specify diabetes as hyperglycemia or hypoglycemia in the progress note and code selection.*
Diabetes Mellitus - Underlying Disease

What System is being Affected?

E11.2- Diabetes with **renal** manifestations
E11.3- Diabetes with **ophthalmic** manifestations
E11.4- Diabetes with **neurological** manifestations
E11.5- Diabetes with **peripheral circulatory** disorders
E11.6- Diabetes with **other specified** manifestations
E11.8- Diabetes with **unspecified** complications

*Be sure to append Z79.4 for long term (current) use of Insulin (except Type I)*
Additive Effect

<table>
<thead>
<tr>
<th>Description</th>
<th>RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes with Renal or Peripheral Circulatory Manifestations</td>
<td>0.508</td>
</tr>
<tr>
<td>Diabetes with Neurologic or Other Specified Manifestations</td>
<td>0.408</td>
</tr>
<tr>
<td>Diabetes with Acute Complications (1)</td>
<td>0.339</td>
</tr>
<tr>
<td>Diabetes with Ophthalmologic or Unspecified Manifestations</td>
<td>0.259</td>
</tr>
<tr>
<td>Polyneuropathy</td>
<td>0.327</td>
</tr>
<tr>
<td>Vascular Disease with Complications</td>
<td>0.610</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>0.316</td>
</tr>
<tr>
<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
<td>0.252</td>
</tr>
<tr>
<td>Chronic Ulcer of Skin, except Decubitus</td>
<td>0.449</td>
</tr>
<tr>
<td>Amputation Status, Lower Limb/Amputation complications</td>
<td>0.678</td>
</tr>
</tbody>
</table>

Note: If patient has more than one diagnosis in the same HCC category, the highest weighted diagnosis & each complication HCC is used to calculate the overall RAF score. Example from above: $0.508 + 0.327 + 0.610 + 0.252 + 0.449 + 0.678 = 2.82$
Use Diagnosis Calculator to Add Multiple HCCs Automatically

If you do NOT utilize the calculator, you would need to use the Diabetes with Circulatory diagnosis term **AND** the PAD term to apply the **TWO** HCC’s #18 and #108.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 diabetes mellitus with vascular disease (CMS/HCC)</td>
<td>E11.10</td>
</tr>
<tr>
<td>PAD (peripheral artery disease) (CMS/HCC)</td>
<td>I73.9</td>
</tr>
</tbody>
</table>

In the case where a patient has more than one Diabetes Comorbidity, it is important that at least one Diabetes with comorbidity diagnosis (circulatory, nephropathy etc) to apply the Diabetes with Complications HCC #18 and then a term/diagnosis for each of the respective comorbidities (PAD, IVD, Diabetic Retinopathy etc) listed separately. This is so that the higher level Diabetes HCC and **EACH** additional co-morbidity HCCs are accounted for and get applied to the patient's severity risk.

Example of Diabetes with PAD, Retinopathy and CKD. Note that 4 HCCs are applied.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene (CMS/HCC)</td>
<td>E10.51</td>
</tr>
<tr>
<td>Diabetic retinopathy (CMS/HCC)</td>
<td>E11.319</td>
</tr>
<tr>
<td>Stage 4 chronic kidney disease (CMS/HCC)</td>
<td>N18.4</td>
</tr>
<tr>
<td>Peripheral angiopathy (CMS/HCC)</td>
<td>I73.9</td>
</tr>
</tbody>
</table>

**Medicare Advantage Total HCC Applied**

**Total HCCs Applied**

- MA HCC 18-APPLIES DM CHRONIC COMP
- MA HCC 22-APPLIES MORBID OBESITY
- MA HCC 58-APPLIES MAJOR DEPRESSIVE,BIPOLAR,AND PARANOID DISORDERS
- MA HCC 108-APPLIES VASCULAR DISEASE
- MA HCC 137-APPLIES CHRONIC KIDNEY DISEASE (SEVERE,STAGE 4)
The Diabetes Calculator is your tool/friend. The calculator will auto-associate multiple ICD 10 codes and combination HCC’s for you, based on what you pick from within the calculator.

For example:
If a patient has Diabetes with PAD, you would choose in the complication detail section PAD and the calculator will assign the Diabetes with complications HCC #18 and in the background the calculator will auto associate the respective PAD ICD 10 diagnosis and HCC #108.
Below is a patient who came in for their Diabetes visit on 3/1/2019. At the time of the visit the patient had the following conditions addressed: Diabetes, ESRD on Dialysis and Peripheral artery disease. The visit diagnoses utilized included Diabetes with Chronic Complications and CKD on Dialysis. An unaddressed HCC Peripheral Vascular Disease BPA still remains. Why?
In the case of diabetes, each complication must be listed out separately. The Diabetes with Chronic Condition (CC) visit diagnosis is needed just once, but every CC needs to be listed separately. In this case the Diagnosis of Diabetes with Circulatory AND a visit diagnosis of PAD needs to be listed or the use of the Diabetes calculator to include peripheral vascular disorder is needed so that both the Diabetes CC HCC and the Vascular HCC is captured.
A patient with Type II controlled Diabetes that has treatment for a manifestation of the disease should have both conditions coded:

- PVD and mild non-proliferative retinopathy due to Diabetes Mellitus
  - E11.51 Diabetes with peripheral circulatory disorder w/o gangrene
  - E11.32 Diabetes Type II with retinopathy
  - The linkage has been documented with “due to” with the 4th digit assigned on the E11 code.
Diabetes Mellitus - Underlying Disease

Be specific

If the same scenario from the previous slide was documented as:

1. Diabetes
2. PVD
3. Retinopathy
   • Code **E11.9** Diabetes *without mention of complications*
   • Code **I73.9** Peripheral vascular disease, unspecified
   • Code **H35.00**

With this example, there is nothing indicating that the PVD or Retinopathy is *due to* the diabetes. The coding must be more generic in this case.
Documentation Requirements

• Notes must clearly link plan and disease
• A list of problems without an assessment and plan should not be coded
• Use the MEAT acronym to document
  o Monitor (Signs and Symptoms, disease progression/regression)
  o Evaluate (Test results, Response to treatment/medications)
  o Assess (Orders, discussion, counseling, review of results)
  o Treat (Ordering of Medications, Tests, Therapy, Service To)
Documentation Requirements

• Supports medical necessity
• Validates that services were provided
• Ensures continuity of care
• Verifies that services provided are reported with accuracy
• Both **coding** and **documentation** must be in sync on any day of service
• Legal document
Documentation Requirements

Progress note should always include:

• Documentation to the greatest degree of certainty for each diagnosis
• Documentation of all complications/manifestations including the causal language (e.g. diabetic, hypertensive, due to)
• Documentation of known conditions from a consultant or specialist, lab values, radiology results, discharge summaries
• Documentation of all chronic conditions at least once per year
• Documentation of any chronic condition that affects the care and treatment of the patient on that date of service¹
• Conditions should be coded to the highest degree of specificity for that encounter/visit
Avoid Unspecific Codes!

• Avoid Unspecified Codes.
• Approximately 9% of current ICD-10 codes are “unspecified.”
• For every unspecified code, there are more specific codes that can be used for that condition.
Documentation Requirements

• The listing of Diagnoses is not enough; there must be evaluation.
• The medical record must thoroughly document all conditions evaluated.
• Evaluative documentation would include statements such as:

  • Document status of Diagnosis
    • Condition worsening - document any treatment/referral
    • Condition improving
  • Tests ordered - document which tests
  • Tests reviewed - bring pertinent findings into progress note
Documentation Examples for “Assessment” and “Plan”

“Assessment” examples: stable, improved, tolerating meds, deteriorating, noncompliant, levels rising.

“Plans” can be simple: monitor, refer, continue current meds, control diet, exercise, better compliance.
Avoid “History of”

“History of” means the patient is cured, is not being treated, and has no clinical evidence of the disease. Document effects if applicable such as Left Hemiparesis due to previous stroke.

Do not use:
• “History of CHF” to indicate compensated CHF – should use CHF
• “History of Atrial Fibrillation” to indicate A-fib controlled by medication - should use A-fib converted to normal sinus rhythm
• “History of MI” to indicate previous acute MI – should use “Old MI” after acute period
Using Symbols and Oblique References

- BP does not mean hypertension; it means a single instance of elevated blood pressure.
- “FBS was 220” does not document the diagnosis of Diabetes. It does allow the physician to make the diagnosis, the difference is important!
- “1.5 Creatinine” does not document the diagnosis Chronic Renal Failure - but may allow the physician to make the diagnosis.

**These abbreviations indicate abnormalities, not diagnoses.**

*Even if it is obvious, the diagnosis must be stated explicitly.*
Charting Advice

• Submit chronic disease codes annually: Evaluate each chronic condition diagnosis at least once annually. Any care or treatment should be captured in the current year’s medical record.
• Avoid “rule outs:” Do not diagnose conditions with “rule out” or “suspected” but diagnose those conditions with the highest level of certainty for that patient visit.
• Use of test results: The result of a test can be used to confirm a diagnosis only if the physician writes a progress note that interprets the test and makes a diagnosis.
• Provide support for diagnoses: It is not enough to state that a patient has a particular diagnosis. There should be evidence in the medical record to support that diagnosis.
These are some of the terms that document the evaluation of a condition for good medical record documentation:

- “Stable on meds”
- “Condition worsening – medication adjusted”
- “Tests ordered – documentation reviewed”
- “Condition improving”

Listing medications and prescriptions in a medical record does not meet documentation requirements to indicate that an evaluation for a condition was performed.

Checking off a code or listing a diagnosis on a medical record problem list does not meet documentation requirements. A diagnosis must be in the medical record progress note along with an evaluation in order to fully meet documentation requirements.
EPIC TOOLS AVAILABLE
How Do I Identify a HCC Diagnosis?

Diagnosis Suffix (CMS/HCC) on the Problem List
How Do I know if there is HCC to Address?

1. My Schedule ICON (HM/CRA), when present indicates there is an open HCC to address

2. Do I have an Open HCC Best Practice Advisory? The Best Practice Advisory (BPA) is available to remind you of diagnoses that need to be addressed this year.
The Advisory will indicate the risk adjusted diagnoses that were used in a face-to-face encounter in the past 3 years and have not yet been coded this year.
HCC Best Practice Advisory

From within the BPA you can take several actions.
Suspected Condition Advisory

Clinical Risk Adjustment (CRA) Suspected CKD Stage 3 (Moderate)

Suspected CKD Stage 3 on the basis of two eGFRs between 30-59 ml/min obtained > 90 days apart within the last 2 years

Guidance for Clinicians:
- If you concur that the patient has the condition and you won’t address the condition at today’s visit - just click the Accept button
- If you concur that the patient has the condition and you will address the condition at today’s visit - click Add Visit Diagnosis and then click the Accept button
- If you don’t concur that the patient has the condition - click Do Not Add for the Problem List diagnosis and click Add for Suspected Condition Not Applicable Suppression List, then click the Accept button

Chronic kidney disease (CKD), stage III (moderate) (CMS/HCC) Edit details (Share with patient, Priority: Medium, Class: Chronic)
Chronic kidney disease (CKD), stage III (moderate) (CMS/HCC) Search
Suspected condition not applicable, add to Suppression List

Accept (1)
Impact of Best Practice Advisory

- The Best Practice Advisory will help you decrease the gap between current HCC score and potential HCC score.
- Help ensure that patients with HCC diagnoses are seen regularly to monitor their conditions, which in turn can help maximize reimbursement for their care.
- Allow you to quickly suppress diagnoses that are no longer active and provide an improved and efficient means to address and add active conditions to the visit diagnosis.
- Improve the accuracy of how sick the patient is and reflect the patient’s chronic conditions annually.
- Improve your Quality Scores.
The Clinical Risk Adjustment (CRA) dashboard in Epic was created to aggregate "all things CRA" in a single location within the EMR for easy and convenient accessibility by clinicians. The content consists of performance summaries, links to pertinent Reporting Workbench reports, and links to CRA educational materials. It is a one-stop source of "stuff" related to HCC & RAF.
All Provider’s Role

- Review the diagnosis codes in the Best Practice Advisory
- Assess each diagnosis and document the assessment & plan in the progress note
- Update the problem list & visit diagnosis with appropriate specificity of diagnosis codes as applicable
- If applicable, you may need to select a more specific diagnosis code than listed in the refresh box
- If unable to address at current encounter, schedule a future office visit to address the chronic conditions and update the problem list in the EHR.
BEST PRACTICE WORKFLOW AND TOOLS TO UTILIZE
## Prior to the Visit

<table>
<thead>
<tr>
<th>Provider Role</th>
<th>Tool to Use</th>
<th>Tool Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients in our risk contracts</td>
<td>Financial Class in Orange Identified in the Banner, HM/CRA column on the schedule</td>
<td>Identifies any patient with unaddressed or suspected risk diagnoses</td>
</tr>
<tr>
<td>Review risk codes that have not yet been addressed this year</td>
<td>CRA Unaddressed BPA</td>
<td>Add relevant diagnoses to the visit diagnosis and/or problem list section or resolve diagnoses no longer active</td>
</tr>
<tr>
<td>Review suspected risk codes that have not been addressed this year</td>
<td>CRA Suspected BPA</td>
<td>Add relevant diagnoses to the visit diagnosis and/or problem list section or suppress diagnoses by adding to the suppression list</td>
</tr>
<tr>
<td>Reconcile external problem list</td>
<td>Reconcile Outside Information</td>
<td>Add external relevant diagnoses to our problem list, discard non relevant ones</td>
</tr>
<tr>
<td>Review internal problem list</td>
<td>Problem List</td>
<td>Validate accuracy of internal problem list</td>
</tr>
</tbody>
</table>
During the Visit

<table>
<thead>
<tr>
<th>Provider Role</th>
<th>Tool to Use</th>
<th>Tool Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the Visit/Identify the Severity of Your Patient by Providing Accurate, Complete documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Update internal problem list</td>
<td>Problem List, Visit Diagnosis</td>
<td>Add any additional new visit diagnoses that were address at visit to the problem list</td>
</tr>
<tr>
<td>Order any necessary Screenings, Immunizations, Lab</td>
<td>Health Maintenance, Best Practice Advisories</td>
<td>To capture deficient codes and close any missing quality and HEDIS gaps</td>
</tr>
<tr>
<td>Document an Assessment that includes chronic conditions that affects the care and treatment of the patient</td>
<td>MEAT acronym to ensure complete documentation</td>
<td>Monitor (signs &amp; symptoms, disease progression/regression) Evaluate (results, medication effectiveness, response to tx) Assess (ordering test, review records, counseling) Treat (medications, therapies, other modalities)</td>
</tr>
<tr>
<td>Document a Plan that specifies the treatment for each condition listed in the assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document any coexisting diagnoses that require or affect the care, treatment or management of the patient at the time of the encounter (amputations, dialysis, insulin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document any known conditions that are being managed by specialist by indicating the clinical status and management of the plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code all conditions to their highest degree of specificity</td>
<td>Use the Epic Calculators/Groupers</td>
<td></td>
</tr>
</tbody>
</table>
### Visit Closure and Between Visits

<table>
<thead>
<tr>
<th>Provider Role</th>
<th>Tool to Use</th>
<th>Tool Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule Annual MWV</td>
<td>Level of Service</td>
<td>Ensure PSR knows which next visit to schedule</td>
</tr>
<tr>
<td>Schedule Chronic Condition Follow Up Visit</td>
<td>Level of Service</td>
<td>Ensure PSR knows which next visit to schedule</td>
</tr>
<tr>
<td>Evaluate your real-time current RAF score compared to your potential RAF score</td>
<td>Clinical Risk Adjustment Dashboard</td>
<td>Identify patients attributed to you as the PCP</td>
</tr>
</tbody>
</table>

**Identify Your Risk Score**
# Best Practice Workflow Summary

## Prior to the Visit/Pre-charting Functionality

<table>
<thead>
<tr>
<th>Provider Role</th>
<th>Tool to Use</th>
<th>Tool Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients in our risk contracts</td>
<td>Financial Class in Orange Identified in the Banner, HM/CRA column on the schedule</td>
<td>Identifies any patient with unaddressed or suspected risk diagnoses</td>
</tr>
<tr>
<td>Review risk codes that have not yet been addressed this year</td>
<td>CRA Unaddressed BPA</td>
<td>Add relevant diagnoses to the visit diagnosis and/or problem list section or resolve diagnoses no longer active</td>
</tr>
<tr>
<td>Review suspected risk codes that have not been addressed this year</td>
<td>CRA Suspected BPA</td>
<td>Add relevant diagnoses to the visit diagnosis and/or problem list section or suppress diagnoses by adding to the suppression list</td>
</tr>
<tr>
<td>Reconcile external problem list</td>
<td>Reconcile Outside Information</td>
<td>Add external relevant diagnoses to our problem list, discard non relevant ones</td>
</tr>
<tr>
<td>Review internal problem list</td>
<td>Problem List</td>
<td>Validate accuracy of internal problem list</td>
</tr>
</tbody>
</table>

## During the Visit/Identify the Severity of Your Patient by Providing Accurate, Complete Documentation

<table>
<thead>
<tr>
<th>Update internal problem list</th>
<th>Problem List, Visit Diagnosis</th>
<th>Add any additional new visit diagnoses that were address at visit to the problem list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order any necessary Screenings, Immunizations, Lab</td>
<td>Health Maintenance, Best Practice Advisories</td>
<td>Monitor (signs &amp; symptoms, disease progression/regression)</td>
</tr>
<tr>
<td>Document an Assessment that includes chronic conditions that affects the care and treatment of the patient</td>
<td>MEAT acronym to ensure complete documentation</td>
<td>Treat (medications, therapies, other modalities)</td>
</tr>
<tr>
<td>Document a Plan that specifies the treatment for each condition listed in the assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document any coexisting diagnoses that require or affect the care, treatment or management of the patient at the time of the encounter (amputations, dialysis, insulin)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document any known conditions that are being managed by specialist by indicating the clinical status and management of the plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code all conditions to their highest degree of specificity</td>
<td>Use the Epic Calculators/Groupers</td>
<td></td>
</tr>
</tbody>
</table>

## Visit Closure

<table>
<thead>
<tr>
<th>Schedule Annual MWV</th>
<th>Level of Service</th>
<th>Ensure PSR knows which next visit to schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule Chronic Condition Follow Up Visit</td>
<td>Level of Service</td>
<td>Ensure PSR knows which next visit to schedule</td>
</tr>
</tbody>
</table>

## Identify Your Risk Score

| Evaluate your real-time current RAF score compared to your potential RAF score | Clinical Risk Adjustment Dashboard | Identify patients attributed to you as the PCP |
APP IL Aligned Providers Only:

On E-clinical Works
For Tools and Resources Reference
APP PRO

• To Access go to APP.AdvocateHealth.com
• At toolbar, select **Tools and Resources**
• Select **Clinical Risk Adjustment**
• Choose any of the training documents, coding tips or information about the CDI Team
Summary

• Code only chronic diseases that are documented and assessed on that visit.
• Be specific in your diagnosis; always include an evaluative statement.
• Be explicit in linking the primary disease and the complication.
• Always code and document the complication separately.
• Link the treatment to the diagnosis.
Noting the severity of the patient’s conditions, by being as specific in the visit diagnosis section of the encounter and in your problem lists affects ALL PATIENTS (not just Medicare Advantage patients). Using the most accurate code has implications beyond billing; such as:

- Your AHC Care Management Impact Score, CMS QPP/MACRA, HEDIS Quality Scores, Public Release WCHQ scores
- Your Rating for Quality and Cost Efficiency with insurance companies and public websites for patients of all ages

The next slide gives an example of a patient with Diabetes. The example shows what a difference using “Vanilla/Plain” Diabetes versus Diabetes with Renal Manifestations and what impact this has on your Quality Ratings, Reimbursement and Cost Efficiency Ratings.
Patient Scenario of How this Works

Patient with Diabetes (E11.9) Patient Severity Score 0.9576 = $1000 Per Member Per Month (PMPM)/ $12,000/yr you receive to take care of this patient. (Patient has DM related Peripheral Vascular Disease) not billed out. Severity Score could have added 0.8534 or $3,072 /yr. Leading to a missed opportunity in reimbursement to cover the care we provided)

Quality Metrics for Diabetes: Yearly Urine Micro, eye and foot exam, Statin-to prevent cardiac events, Flu Shot, A1c x2 and BP. If not controlled, bring back in 3-6 months.

Patient does not get flu shot during their November visit with the PCP (Quality) and is not on a Statin (Quality) and foot exam missed (Quality).
1 month later…

Patient calls the office on a Friday Morning with fever, coughing and feeling faint and has a lesion on the foot that they did not mention at the last visit (DM foot exam not done at previous visit) that now is draining. Patient requests to be seen today.

Patient referred to ED/Urg Care *(Adding Cost)*. Dx: Flu which causes pressure on heart condition, leading to MI due to IVD – Admitted *(Cost)*, Lesion requires Wound Care specialist. *(Cost)* *(Remember $12,000/yr you have to take care of the patient based on the Severity of the diagnoses billed out)*

Patient Returns to the office post discharge. Diagnosis Diabetes when should have been Diabetes with previous MI (I21.3) and Foot Ulcer (E11.621) *(Severity/Risk)* Severity Score should have been 2.854=$2000PMPM/$24,000/yr. to take care of this patient
### Overview of Previous Scenario

<table>
<thead>
<tr>
<th>Topic</th>
<th>Case Example without all the HCC Diagnoses noted and Quality Metrics Missed</th>
<th>Case Example with all the HCC Diagnoses Noted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Reimbursement Paid to take care of this patient.</td>
<td>Diabetes with no CC: $12,000 per year</td>
<td>Diabetes with CKD IV, PVD, Foot Ulcer and IVD $24,000 per year</td>
</tr>
<tr>
<td>Quality: Flu Shot, Foot Exam</td>
<td>75% (F)</td>
<td>80% (A)</td>
</tr>
<tr>
<td>Quality: Annual Urine Micro. If CKD billed out, patient is excluded from the Measure.</td>
<td>80% (F)</td>
<td>100% (A)</td>
</tr>
<tr>
<td>HCC/RAF Score: &gt; 1 is sicker than the national norm.</td>
<td>0.9576 (Less Sick Patient)</td>
<td>2.854 (Sicker Patient)</td>
</tr>
<tr>
<td>Cost Efficiency Rating is a ratio of the providers cost incurred against how sick HCC/Diagnoses the patient has. &lt;0.90 is considered good.</td>
<td>Cost of Care 1.5 over the norm. (Too Expensive). This is due to the provider ordering tests, medications and consultations for a Diabetic with Ulcers &amp; CKD w/o billing it out.</td>
<td>0.85 below the norm. (Cost Efficient)</td>
</tr>
<tr>
<td>Grand Total:</td>
<td>Payment Loss of: 12,000 Public Reporting of Poor Quality Public Reporting of Too Costly</td>
<td>Payment Gain: Public Reporting top qrtle Cheaper Care for Patient</td>
</tr>
</tbody>
</table>
Bottom Line

- Reimbursement impacted and it may not cover the cost of our care.
- Cost Efficiency Ratio Impacted
- Quality Rewards, Value Based Modifier, CMS MACRA/QPP, WCHQ and other Public Reports also impacted.
- Only top performers remain whole in quality/efficiency ratings and payment.
Illinois location

Accordion - 3 Panels (Including Introduction)

Last Modified: Sep 10, 2019 at 09:36 AM

**PROPERTIES**

Show interaction in menu as:  Multiple Items

Allow user to leave interaction:  At any time

Prev/Next player buttons go to:  Slide in presentation

Edit in Engage  Edit Properties
Illinois location con't

Accordion - 3 Panels (Including Introduction)

Last Modified: Sep 10, 2019 at 09:35 AM

**PROPERTIES**

Show interaction in menu as:  Multiple Items

Allow user to leave interaction:  At any time

Prev/Next player buttons go to:  Slide in presentation

Edit in Engage  Edit Properties
WI Location

Accordion - 2 Panels (Including Introduction)

Last Modified: Sep 10, 2019 at 10:01 AM

PROPERTIES

Show interaction in menu as: 
- Multiple Items

Allow user to leave interaction: 
- At any time

Prev/Next player buttons go to: 
- Slide in presentation

Edit in Engage

Edit Properties
WI Location Con't

Accordion - 2 Panels (Including Introduction)

Last Modified: Sep 10, 2019 at 10:07 AM

PROPERTIES

Show interaction in menu as:  Multiple Items
Allow user to leave interaction:  At any time
Prev/Next player buttons go to:  Slide in presentation

Edit in Engage  Edit Properties
1. In Epic find your Clinical Risk Adjustment (CRA) Dashboard

2. Click on the Downward Pointing Triangle (see above) and in the search area type in clin risk adj and under content type select Dashboards
3. Click on the star next to the report to make it a favorite

4. Educational materials for Clinical Risk Adjustment are located on the right side of the dashboard. Select to open the tip sheet for a specific topic
Exit

Once you have completed viewing this presentation, please close the window by clicking **EXIT** in the upper right hand corner of the screen.