REDWOOD HEALTH COMMUNITY COALITION

Serving Sonoma, Napa, Marin & Yolo Counties

Track 1: Impactful Strategies for Documenting Complex Conditions and Social Determinants of Health

Additional Activities:

10:45 AM – 1:30 PM

*Help Squad – one-on-one PCMH and Meaningful Use Support (Innovation Room)

*Promising Practices Gallery Walk Raffle (Inside perimeter of the office)

1:00 PM

*Promising Practices Raffle (Training Room)

See the back of your agenda to participate

Capturing Risk

THROUGH CODING & DOCUMENTATION

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

Objectives for Today

- Discuss risk adjustment methodology and its relevance to patient care
- Understand how complete and accurate documentation and coding supports good patient care
- Tips for documentation and coding of common conditions seen in primary care

Value Based Care is Here to Stay

- Fee-For-Service, no link to quality
- FFS with quality link
- Alternative Models built on FFS
- Population-Based payment

Risk Adjustment

- In fully population-based payment systems, procedures (CPT codes) have no significance.
- Instead, the patient's diagnoses (ICD-10) are used to risk-adjust a standard payment amount.

Risk Adjustment Models

	Diagnosis Data	Pharmacy Data
Medicare	CMS-HCC	Rx-HCC
ACA / Commercial	HHS-HCC	HHS-HCC
Medicaid (varies by state)	CDPS, ACG, etc.	Medicaid Rx

Models based on Hierarchical Condition Category (HCC) coding predominate outside of Medicaid

Risk Adjustment Factor

Each year CMS sets a benchmark rate for Medicare Parts A&B:

County	Base Rate (PMPM)
Sonoma	$848.24
Napa	$850.67
Marin	$921.48
Yolo	$864.47

The rate is multiplied by each enrollee's CMS-HCC Risk Adjustment Factor (RAF).

Risk Adjustment Factor

The RAF is normalized to **1.0** for the entire Medicare population:

- Demographics average ~0.33
- HCC scores average ~0.67

Currently, a 0.01 increase in HCC score increases the Medicare Advantage (MA) payment ~$6 PMPM.

Example: CMS Payment to MA Plan

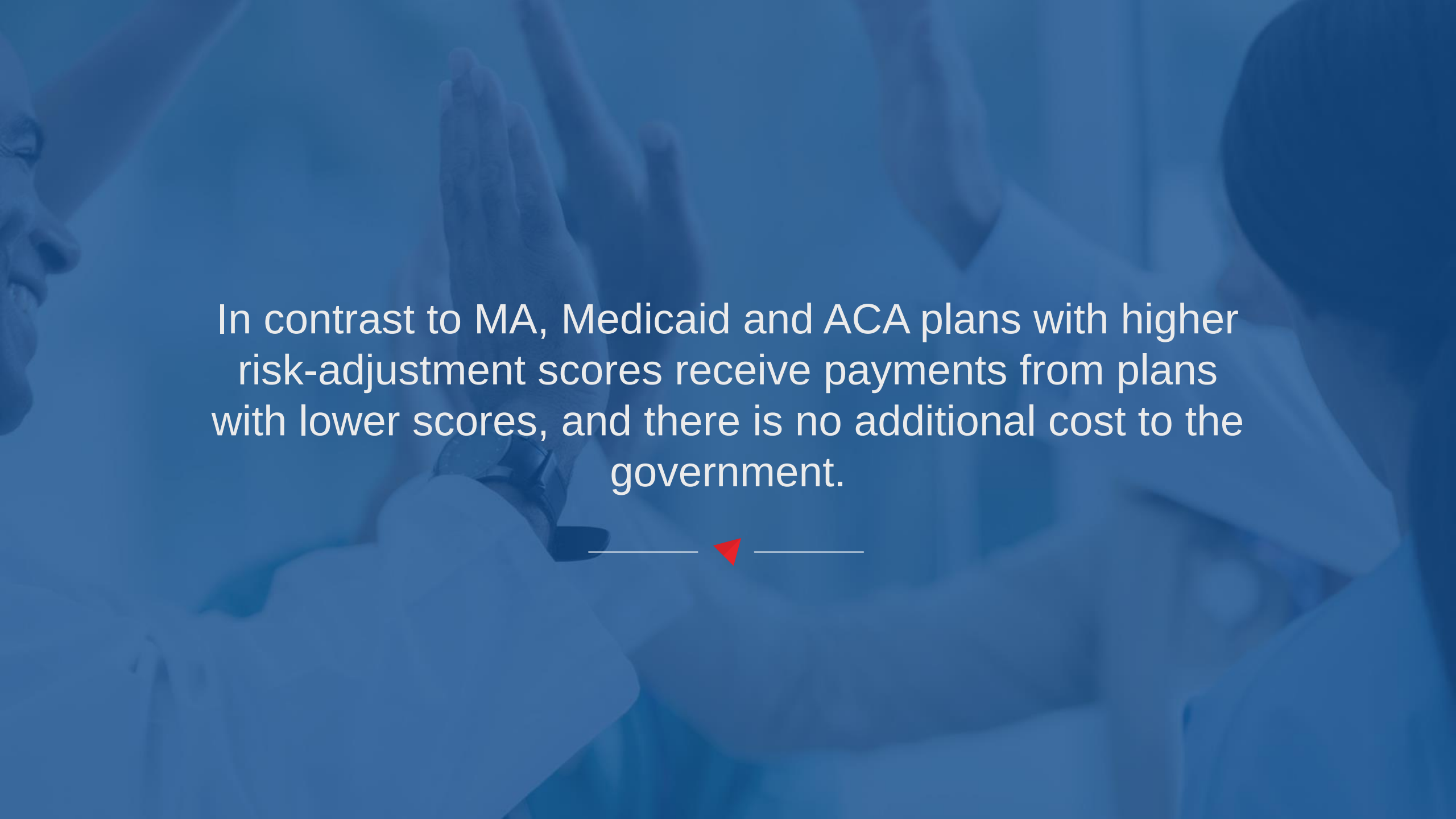
Some Diagnoses Reported		All Diagnoses Reported	
68 year old male	.300	68 year old male	.300
Dual eligible	.192	Dual eligible	.192
Type 2 DM, no complications	.097	Type 2 DM with other skin ulcer	.346
CHF, not coded		CHF, coded	.355
		Disease Interaction (DM + CHF)	.205
Risk Adjustment Factor	**.589**	**Risk Adjustment Factor**	**1.398**
PMPM Base Payment	$848	PMPM Base Payment	$848
PMPM for this Patient	$499	PMPM for this Patient	$1,186
Annual Payment	**$5,988**	**Annual Payment**	**$14,232**

Where Does the Money Go?

Higher risk adjustments are indicative of:

- A sicker, more costly population
- Complete and accurate coding

In MA, if the risk-adjusted payment exceeds the cost of care, savings must be reinvested in better benefits or lower cost-sharing.



In contrast to MA, Medicaid and ACA plans with higher risk-adjustment scores receive payments from plans with lower scores, and there is no additional cost to the government.

Significance for Providers

Complete and accurate coding allows for more meaningful data exchange among everyone involved in the patient's care:

- Identify potential problems early
- Reinforce self-care and prevention strategies
- Avoid potential drug-drug and drug-disease interactions
- Coordinate care more effectively
- Enhance quality improvement processes
- Inform allocation of resources

Every Condition, Every Year

Documentation must capture all conditions that are monitored, evaluated, addressed or treated—at each visit, or **at least once a year**.

- MA uses a prospective system in which the work done during the current year sets reimbursement for the following year
- ACA uses a concurrent system
- In either case the clock resets each January 1st

Conditions need to be captured during a **face-to-face** visit with a provider.

HCC Model Characteristics

Hierarchical:

Payment is based on more severe form of disease when less severe form is also present in reporting period

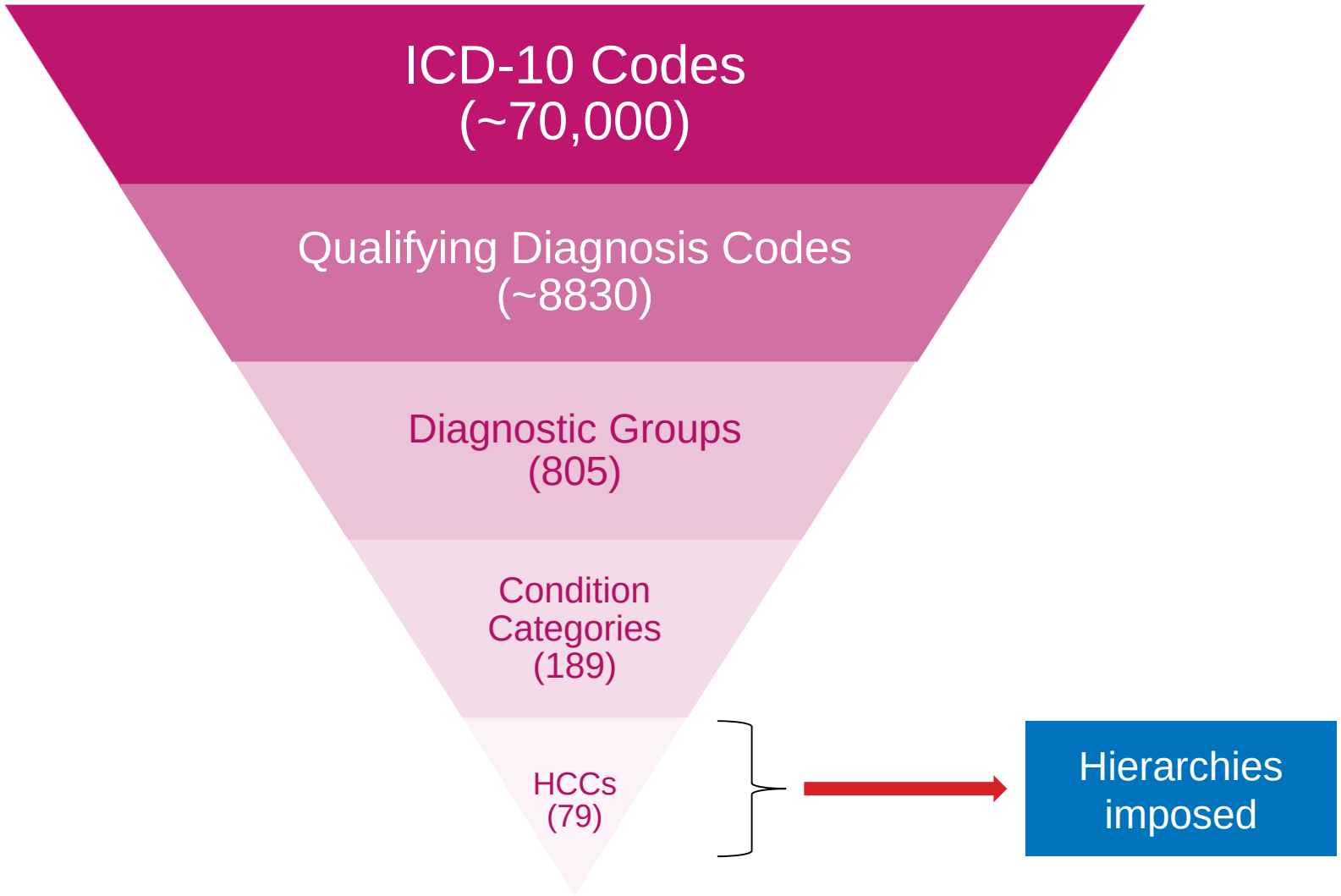
Interactive:

When certain diseases coexist, the model assigns additional payment to recognize higher morbidity and costs beyond just adding the separate conditions

Additive:

When unrelated diseases co-exist, the risk factors are added together

CMS-HCC Model V22



ICD-10 is its own Language

ICD-10 is the specific language that is used to inform CMS of the extent and severity of disease present.

- Like any language, ICD-10 must be spoken properly
- Failure to document and code correctly can lead to underpayment or overpayment

Each Condition Must Have ≥1 M.E.A.T.

Monitored

- Signs, symptoms, disease progression, disease regression (BP 120/80; A1c 5.5; lipid panel normal)

Evaluated

- Review of results, medication effectiveness, response to treatment (stable, improving, exacerbation, worsening, poor)

Assessed/Addressed, or

- Ordering tests, discussion, records review, counseling (stump well healed, ostomy site w/o infection, appears clean & dry)

Treated

- Referral, medication, planned surgery, therapies, other modalities (DM controlled on insulin; taking Fosamax for osteoporosis; taking tamoxifen for breast cancer)

Coding Best Practices

Instead of creating one comprehensive plan for each patient, document like this:

- Diagnosis #1, status, plan
- Diagnosis #2, status, plan
- Diagnosis #3, status, plan

If it's a new condition:

- Diagnosis, how you reached diagnosis, plan

Coding Issues in Primary Care

Diabetes	Major Depression
CAD/IVD	Abuse and Dependence
Late Effects of Stroke	“Status” Conditions
Morbid Obesity	

Diabetes

Complications of diabetes are the most frequently omitted conditions in medical records. Most patients with DM >5 years have complications.

Documentation must include:

- Type of diabetes
- Status (if uncontrolled, must specify as hyperglycemic or hypoglycemic)
- If complicated, the complication must be linked (DM with neuropathy for example)
- CKD, Skin Ulcers, and Long-Term use of Insulin require an additional ICD-10 code with linkage in the documentation

Diabetes

Diagnosis	ICD-10	HCC Value*
DM2, Uncomplicated	E11.9	.104
DM2, with complications	E11.1x – E11.8x	.318

*for illustrative purposes only – HCC value changes frequently

Once diagnosed, diabetes does not go away unless:

- Initial diagnosis was erroneous
- Due to a secondary cause (which is uncommon and coded differently)

CAD / IV

Ischemic vascular diseases is the most underdiagnosed serious condition in community clinic patients

In addition to history and physical, the diagnosis often hides in:

- Medication list (nitrates, warfarin, aspirin)
- EKG and echocardiogram
- Chest X-ray (aortic ectasia and calcifications)
- ABI or Doppler results

CAD / IV

Diagnosis	ICD-10	HCC Value
Atherosclerotic heart disease	I25.10	.0*
Old myocardial infarction	I25.2	.0*
Angina pectoris	I20.9	.140
Arrhythmias	I44.xx – I48.xx	.268
Abdominal aortic aneurysm	I71.4	.298
Peripheral vascular disease	I73.9	.298
Pulmonary hypertension	I27.0	.323
Congestive heart failure	I50.xx	.323

*Does have Rx-HCC value (explained later)

Once diagnosed, IVD does not go away unless:

- Initial diagnosis was erroneous
- Definitively treated and symptom-free off medication (uncommon)

Hypercoagulable State

Many patients with atrial fibrillation or a history of previous thrombosis or embolism are considered to have a hypercoagulable state (D68.xx, HCC .221).

If the provider determines a hypercoagulable state is present (based on CHADS score or other testing) this should be documented and coded because it puts the patient at significantly increased risk, whether or not they choose to be treated.

Stroke / CVA

As with MI, “stroke” should only be coded during the acute period. More than half of stroke patients have residual deficits (I69.xxx). These sequelae should be coded as specifically as possible.

Diagnosis	ICD-10	HCC Value
Weakness	M62.xx	.0
Stroke/TIA without residual deficits	Z86.73	.0*
CVA with hemiparesis / hemiplegia, right dominant side	I69.351	.538
Non-CVA paralytic disorders	G81 – G83	0.131 – 1.147

*Does have Rx-HCC value (explained later)

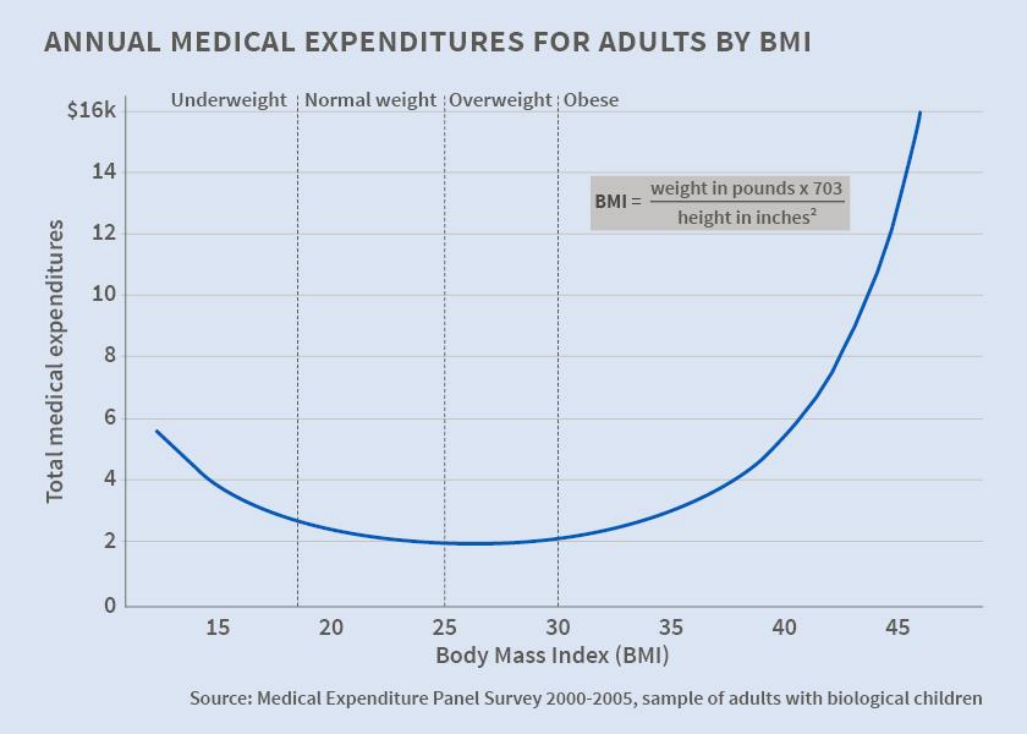
Morbid (Severe) Obesity

Morbid obesity is associated with significantly increased health care costs. Be sure to re-document with BMI annually (E66.01, HCC .273).

Criteria:

- BMI ≥40
- BMI ≥35 with obesity-related comorbidities (CHF, DM, HTN, sleep apnea, etc.)
- Applies to age 15 years and older

BMI status codes (Z68.xx) can by documented by ancillary staff but only a provider can diagnose morbid obesity.



Major Depressive Disorder

DSM-5 criteria or a screening tool such as PHQ-9 must be used to document a current depressive episode. Follow-up at least annually. Be as specific as possible—avoid using “unspecified”.

Diagnosis	ICD-10	HCC Value
Anxiety	F41.9	.0*
Other depressive episodes	F32.89	.0*
Major depression, unspecified	F32.9, F33.9	.0*
Major depression, single episode, full remission	F32.5	.395

*Does have Rx-HCC value (explained later)

Abuse and Dependence

Alcohol and drug abuse have no HCC value. Consider whether the patient has dependence or a substance-included disorder.

Hallmarks of dependence include:

- Compulsion and Dysfunction
- Tolerance and Withdrawal

Most tobacco users shouldn't be coded as dependent whereas a COPD patient who smokes probably should.

Abuse and Dependence

If the substance dependence has resulted in health problems, always code both. For example:

- Alcohol dependence, and
- Alcoholic cardiomyopathy

Diagnosis	ICD-10	HCC Value
Opioid abuse, uncomplicated	F11.10	.0
Opioid dependence, in remission*	F11.21	.420
Alcohol-induced sleep disorder	F10.982	.383

*Code annually – “once an addict, always an addict”

“Status” Conditions

Chronic quiescent conditions must also be documented and coded annually:

- HIV status (B20)
- Amputations (Z89.4xxx)
- Ostomy (Z93.x)
- Transplant status (Z94.x)
- Dialysis status (Z99.2)

Rx-HCC

A complementary* risk adjustment system infers diagnoses from prescriptions, including some that are not part of diagnosis-based HCC:

Asthma	Kidney transplant status
CAD	Migraine headache
Dementia	Osteoporosis
GERD	Psychiatric disorders
Glaucoma	Skin disorders
Hyperlipidemia	Thyroid disorders
Hypertension	TIA

*Medi-Cal uses Medicaid Rx alone but is expected to follow other states in adopting diagnosis-based risk adjustment

Coding Pitfalls

Codes **will not** be captured from the problem list

Diagnoses **cannot** be coded if documented as:

- Probable
- Suspected
- Questionable
- Rule out
- Working diagnosis

Cancer **can only** be coded if under treatment or palliative care:

- Hormonal therapy (tamoxifen and Lupron) counts as treatment
- C79.xx should be coded if metastatic disease (HCC value 2.484)
- Z85.xxx should be coded if cancer in remission, off treatment

Strongly consider asking a coder to review your documentation!

Annual Wellness Visit

The annual wellness visit is an excellent opportunity to develop a care plan for the year while ensuring important diagnoses are refreshed and coded properly.

Health plan AWV forms are useful if your routine encounter submission process limits the number of diagnoses.

Where Diagnoses Often Hide

- Patient Questionnaire
- Problem List
- Medication List
- Lab Results
- Radiology Results
- Consult Notes
- DME

Improper Upcoding

- Submitting diagnoses with no support in the medical record for existence in that year
- Claiming current treatment for conditions better characterized by “history of”
- Targeted coding, i.e. excessive focus on high value diagnoses

RADV Audits

CMS conducts Risk Adjustment Data Validation (RADV) Audits to ensure proper HCC coding:

- 201 charts with HCC value are sampled
- Results are extrapolated to the entire plan enrollment
- Plans must refund the estimated overpayment to CMS

Intentional efforts to “game the system” may be subject to the False Claims Act.

Other Applications of Coding

Risk stratification:

- Identification of high-risk patients for case management and other interventions

Optimal provider panel size

Social determinants of health:

- ICD-10 codes in the Z55 – Z65 range are increasingly used by payers to identify patients in need of additional support

Health Homes Program

- Authorized by Section 2703 of the Affordable Care Act
  - California's participation authorized under AB 361 (2013)
  - DHCS has announced that enrollment will begin on July 1, 2018
- Federal funds cover 90% of the cost for two years
  - The California Endowment has agreed to cover the remaining 10%
- Intensive care management for the highest risk 3-5% of the Medi-Cal population
- Reimbursement will be through a supplemental PMPM payment

Health Homes Program Eligibility

At least one acuity/complexity criteria:

- Chronic homelessness
- Risk stratification level >3 (to be explained by DHCS)
- One inpatient stay or 3 ED visits in the last year

Two or more of these chronic conditions:

- Asthma, CAD, CHF, Chronic liver disease, COPD, Dementia, DM, Substance abuse disorder, Traumatic brain injury

Or one of these chronic conditions and risk of developing another:

- Asthma with risk of developing BMI >25, Depression, DM, Substance abuse disorder
- Hypertension with risk of developing CAD, CHF, COPD, DM

Value and Coordination

NOT VOLUME AND DUPLICATION

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction


QUESTIONS?

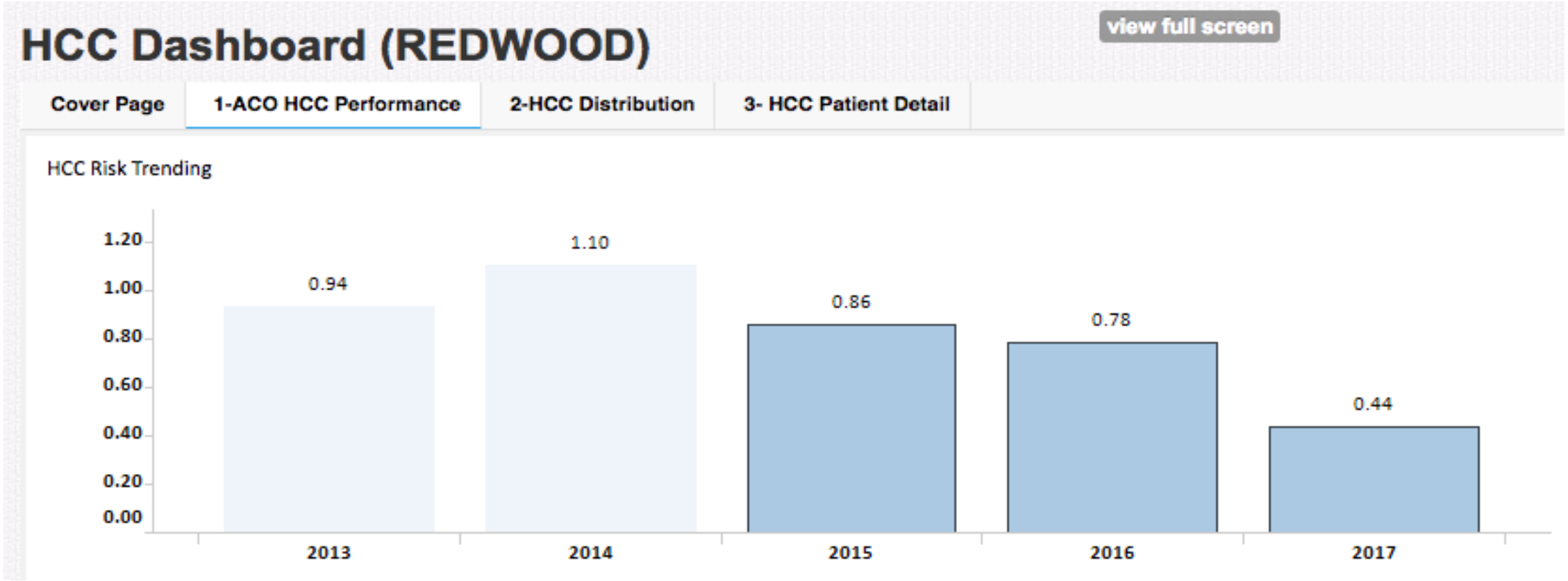

THANK YOU

RCHC Support for Coding

Current RCHC Programs

- MedPoint Contract – RCHN Health Centers
- RCCO – SRCHC, WCHC
- SDOH Work Group
- PHP data sharing / analytics

RCCO Data 2013 - Present

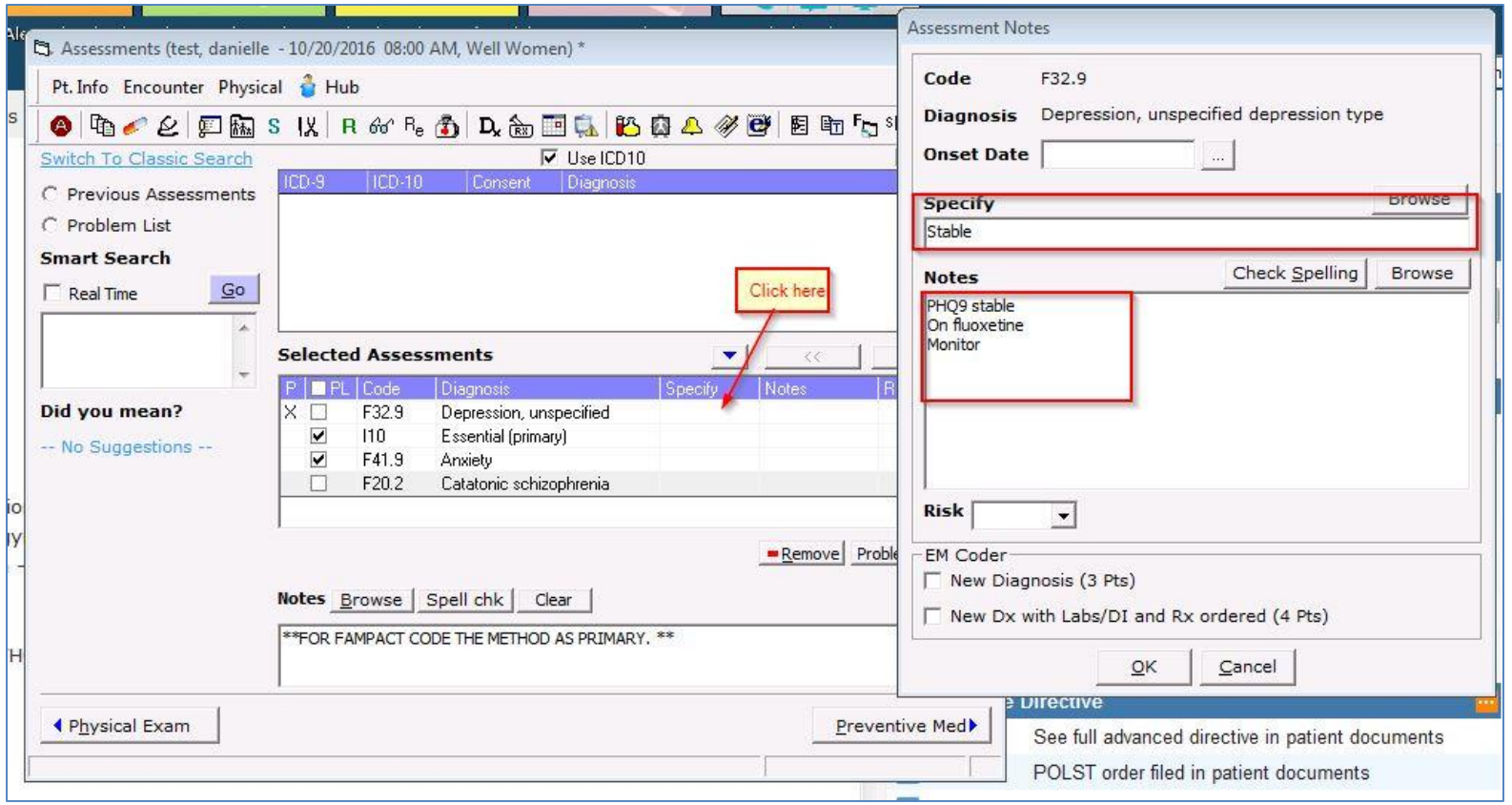


Principles of Coding and Documenting Risk

1. Document the MEAT
2. Click all the Red Arrows in eCW
3. Know your high HCC value codes
4. Think about Essential linkages
5. Do an Annual wellness exam
6. Layer in social determinants of health

eCW Assessment Window

1. Chart each assessment
2. Click on the status line and insert specify and plan



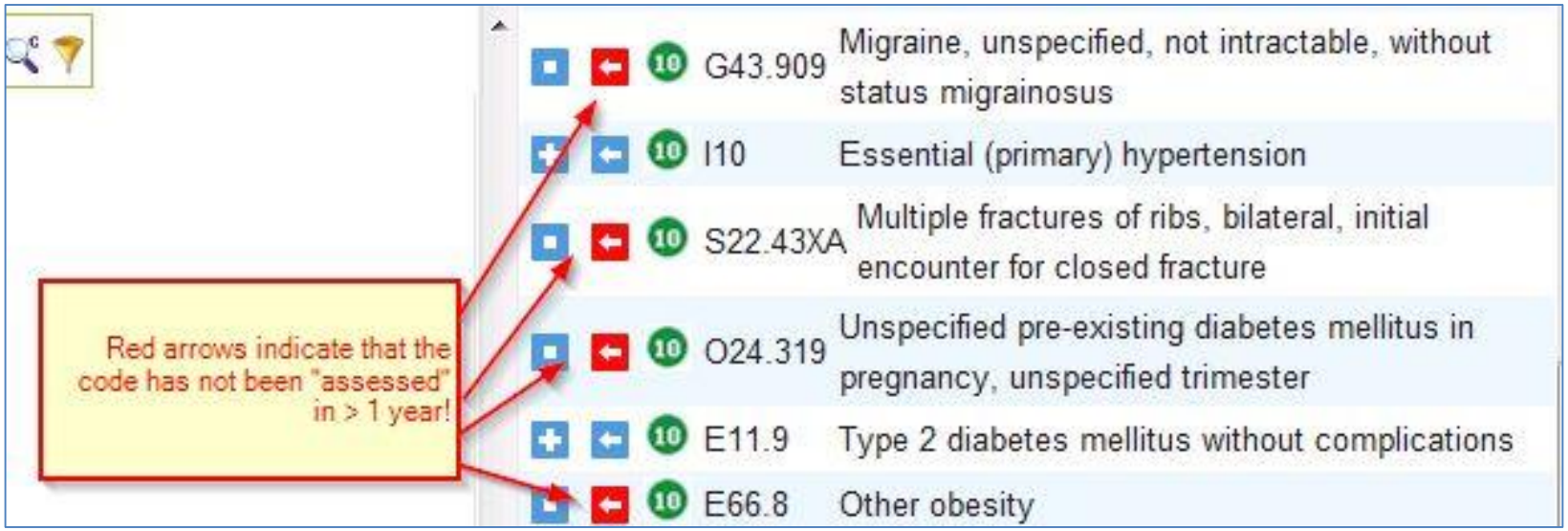
Click all the red buttons

Each code for any chronic condition needs to be assessed (billed) at least once every year!

Consider each “red” problem:

1. Is this still a problem for the patient?
2. Is it coded to it’s highest level of complexity?

Red buttons in eCW



More Opportunities to Work Together

- Well visit workflows, templates, order sets
- HCC analytics
- Others?