



# CMS-HCC TRAINING FOR PROVIDERS

CODING FOR CHRONIC CONDITIONS

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## OBJECTIVES

At the end of this presentation, you will:

- Know what Risk Adjustment is and the impact it will have for your practice.
- Understand Hierarchical Conditions Categories (HCCs).
- Be familiar with correct coding and documentation guidelines.
- Understand the impact that incomplete coding can have on your practice.

## OVERVIEW

- Risk adjustment is a process used by the Centers for Medicare & Medicaid Services (CMS) that reimburses Medicare Advantage (MA) plans such as MVP Health Care, based on the health status of their members.
- Risk adjustment was implemented to pay MA plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (e.g., age and gender) as well as health status.
- The CMS risk adjustment model measures the disease burden that includes 79 HCC categories, which are correlated to diagnosis codes.
- Hierarchical Condition Categories (HCCs) are a hierarchy of condition categories that correlate or link to corresponding diagnosis categories. The number of HCCs and affected ICD-10 codes can change from year to year.
- The HCC model is made up of ICD-10 codes that typically represent costly, **chronic** diseases such as:
  - **Diabetes**
  - **Chronic kidney disease**
  - **Congestive heart failure**
  - **Chronic obstructive pulmonary disease**
  - **Malignant neoplasms**

## OVERVIEW CONTINUED

- CMS creates a hierarchy so that patients' conditions are coded for the most severe manifestation among related diseases.
- For example, there are more than a dozen diagnoses that will lead to a heart failure HCC, but payment will only be made for one. There is a trumping logic for **related** diseases, so that if the patient has metastatic cancer, the provider won't also get payment for the patient's colon cancer. However many HCCs you have, payment is made for the highest of them.
- For unrelated diseases, HCCs accumulate, so patients can have more than one HCC attributed to them. For example: the physician documents that a male patient suffers from heart disease, stroke, and cancer. Each of those diagnoses maps to a separate HCC. CMS will factor all three HCCs in when making a payment to the MA plan.
- Some diagnoses reported together – such as congestive heart failure and diabetes – will generate a higher Risk Adjustment Factor (RAF) value, resulting in higher payments. Not all diagnoses map to an HCC, however, so they will not generate a higher value.

Source: APCs Insider, October 3, 2014 <http://www.hcpro.com>

## WHY IS RISK ADJUSTMENT DONE?

- To accurately reflect the health of MVP Health Care's membership.
- Risk adjustment scores (also known as the Risk Adjustment Factor or RAF) are higher for a patient with greater disease burden, lower for a healthier patient.
- Each patient has an RAF score that includes baseline demographic elements (age/sex and dual eligibility status) as well as incremental increases based on HCC diagnoses submitted on claims from face to face encounters with qualified practitioners during the calendar year.
- HCC coding is prospective in nature. The work done this year sets the RAF and subsequent funding for next year.
- Diagnosis codes reported on your claims determine a patient's disease burden and risk score.
- Chronic conditions must be reported once per year. *Each January 1, the RA slate is wiped clean. All of your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.*

## WHY CODING MATTERS

- Inclusion of chronic conditions considered in the medical decision making for Evaluation and Management (E & M) will allow for better health management.
- Complete patient diagnosis coding allows the member to be included in any number of quality management programs offered by MVP Health Care.
- Appropriate diagnosis code reporting and complete clinical documentation by the provider increases the member's risk score while reducing the need to request medical records and or audit a provider's claim.
- Complete and accurate coding practices can minimize your administrative burden of additional paper work later.
- It is MVP's goal for each patient to have an annual comprehensive assessment.
- It is also our goal to capture each patient's current and active diagnoses on an annual basis

## HOW DOES THIS AFFECT THE PHYSICIAN?

- Complete and accurate reporting allows for more meaningful data exchange between MVP Health Care and providers to:
  - **Identify potentially new problems early**
  - **Reinforce self-care and prevention strategies**
  - **Coordinate care collaboratively**
  - **Avoid potential drug-drug/disease interactions**
  - **Improve the overall patient health care evaluations process**
  - **Improve office practice patterns and communication among the patient's health care team**
- It will also help you meet your own CMS provider obligations, which include the use of diagnosis coding standards in medical record documentation, reporting all conditions and diagnoses codes that exist on the date of an encounter and participating in CMS Medicare Recovery Audit Contractor (RAC) and Risk Adjustment Data Validation (RADV) Audits.

## PROVIDER PRACTICE IMPLICATIONS

### Step 1

- Document each patient's demographic information and clinical information in the medical record.
- Make sure you use the best practices for documentation accuracy.

### Step 2

- HHS and CMS use claim data and patient demographic information to calculate a patient's risk score.
- Complete medical record documentation and submission of all appropriate diagnosis codes, using the highest level of specificity, comes as a result of employing best practices for documentation, coding and billing.

### Step 3

- HHS and CMS review and validate risk scores through data validation audits.
- If coding is accurate and complete, provider practices are minimally disrupted, allowing greater focus on patient care and other practice aspects.
- If coding is inaccurate or incomplete, there is a higher likelihood of requests for medical records due to HHS requirements for documentation to support accurate risk score submission by insurers. More medical record requests, by HHS or a plan, means higher practice disruption, and cost inaccuracies in coding, once known, do require correction.



## WHY IS DOCUMENTATION IMPORTANT TO RA?

- Accurate risk adjusted payments relies on complete medical record documentation and diagnosis coding. This ultimately impacts the services and benefits MVP Health Care is able to provide to its membership.
- Additionally, CMS requires that all applicable diagnoses codes be reported and that all diagnoses be reported to the highest level of specificity. This must be substantiated by the medical record. Toward this end, MVP Health Care conducts medical record reviews to identify additional conditions not captured through claim or encounter data and to verify the accuracy of coding. These reviews are performed to help us make sure all required ICD-10-CM codes are duly reported to CMS.
- Finally, CMS requires that the medical record validate the diagnoses codes that have previously been reported by the physician.

## COMMERCIAL RISK ADJUSTMENT

- CMS is now looking to commercial plans to implement risk adjustment as a valuable method to identify and prepare for high-risk patients. Commercial Risk Adjustment (CRA) is one of three new premium stabilization programs, established by the Affordable Care Act (ACA), for the individual and small group commercial markets for products sold on and off the Exchange.
- CRA encourages health plans to focus on quality improvements, efficiency and the stabilizing of premiums designed to prevent adverse selection.
- CMS is responsible for operating the risk adjustment programs. CMS reviews each health plan's claims data for the calendar year to establish an overall "risk factor" for the health plan.
- The "risk factor" is determined based on diagnosis coding supported by medical record documentation. CMS will validate the health plan's risk factor through medical record chart audits. Risk scores for the health plan will be adjusted as necessary.
- The HCCs used for Medicare and commercial risk adjustment are different.
- For commercial risk adjustment, the U.S. Department of Health and Human Services (HHS) employs the HCC grouping logic used in the Medicare risk adjustment program, but with HCCs refined and selected to reflect the expected risk adjustment population.

## COMPARISON OF HHS AND CMS MODELS

	Medicare Advantage	Commercial	Implications
Attributes	Age, gender, medical conditions	Age, gender, medical conditions and financial status for those who qualify for cost sharing reductions. The model also includes demographic attributes and product information	Commercial risk adjustment requires additional data capture for demographics
Dx Code Capture	Medical conditions have to be treated/addressed and documented annually or need to specify that the member no longer has the conditions		Chronic conditions not documented annually are not captured in risk scores
Acceptable Codes	Conditions documented during face-to-face encounter with accepted provider types		Same, therefore easier in establishing provider practices
Acceptable Encounters	Professional, inpatient and outpatient		Same, therefore easier in establishing provider practices
Historical Conditions	Coded and reported conditions transfer with member	No member-level data transferred between plans	For commercial risk adjustment, all conditions need to be documented annually and when plan changes

## PROVIDER PREPARATION STEPS



## DIAGNOSIS CODING GUIDELINES

- ICD-10 INCLUDES Official Guidelines for Coding and Reporting. Adherence to these guidelines is required under HIPAA.
- Documentation must show that condition was:
  - Monitored – Signs, symptoms, disease progression, disease regression
  - Evaluated – Test results, medication effectiveness, response to treatment
  - Assessed/Addressed – Ordering tests, discussion, review records, counseling
  - Treated – Medications, therapies, other modalities
- A diagnosis code may only be reported if it is explicitly spelled out in the medical record:
  - No coding from problem lists, super bills, or medical history
  - Treatment is prima fascia evidence of a diagnosis – if you are treating, it therefore exists

## COMMON CODING ERRORS

- Medical record does not contain a legible signature.
- Electronic medical record (EMR) was unauthenticated (not electronically signed).
- Highest degree of specificity was not assigned the most precise ICD-10 to fully explain to narrative description of the symptom or diagnosis in the medical chart.
- Documentation does not indicate the diagnosis is being monitored, evaluated, assessed/addressed, or treated (MEAT).
- Status of cancer is unclear. Treatment is not documented.
- Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
- Lack of specificity (e.g., an unspecified arrhythmia) is coded rather than the specific type of arrhythmia).
- Chronic conditions or status codes aren't documented in the medical record at least once per year.
- A link or causal relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

## MEDICAL RECORD DOCUMENTATION HELPFUL TIPS

- All chronic conditions must be assessed and reported annually
  - Ex: CHF, Diabetes, COPD
- Co-existing acute conditions
  - Ex: Protein calorie malnutrition
- Active status conditions
  - Ex Amputations, HIV, dialysis
- Pertinent past conditions
  - Ex: Old MI and other underlying medical problems
- Medications that may indicate conditions
- Specific rather than general information
  - Ex: Major depression rather than depression, if applicable
- Causality
  - Ex: Diabetic neuropathy, not diabetes and neuropathy
- Highest level of specificity
- Support documentations of conditions
  - Ex: Stable, controlled, uncontrolled, poorly controlled, improving, worsening, etc.

## MEDICAL RECORD DOCUMENTATION “HISTORY OF”

- “History of” means the patient no longer has the condition
- Frequent documentation errors regarding use of “History of “
  - Coding a past condition as active
  - Coding ‘history of’ when condition is still active
- Exception: It is appropriate to document/code “history of” when documenting some status conditions ( e.g. Amputation)
- Examples:

Incorrect Documentation	Correct documentation
H/O CHF, Meds Lasix	Compensated CHF, stable on Lasix
H/O angina, meds nitroquick	Angina, stable on nitro
H/O COPD, meds Advair	COPD Controlled w/Advair



## MEDICAL RECORD DOCUMENTATION CHRONIC CONDITIONS

- Over the years, several chronic conditions seem to fall off of claims submissions.
- For patients with chronic conditions, we recommend at least two office visits yearly to facilitate assessment and monitoring of complete information.
- All existing chronic illnesses should be documented in the medical record and have had an assessment and a plan of care.

Sample	Language
<u>Assessment</u>	<u>Plan of Care</u>
Stable	Monitor
Improved	D/C Meds
Tolerating Meds	Continue Current Meds
Deteriorating	Refer

# MVP Healthcare

## Certificate of Approval

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Name

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