Outpatient CDI with HCC’s

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What is Risk Adjustment?

- A corrective tool used by actuaries to level the playing field regarding the reporting of patient outcomes, adjusting for the differences in risk among specific patients.

- The process of adjusting expected volumes to account for the case mix of the facility or category being compared.
Risk Adjustment cont……

- CMS recognized a need to prospectively adjust for anticipated costs that vary across beneficiaries
  - Provide incentives to enroll high-cost individuals into managed care programs by ensuring health plans/ACOs have the resources needed to provide efficient and effective treatment

How? Develop a system to...
- Account for changes in severity & case mix over time
- Accurately set performance targets (quality & efficiency)
- Identifies patients for population health initiatives
Example of Risk Adjustment Reimbursement to a MAP……

- Combines demographic and clinical information
  - Demographic info includes age, reason for Medicare, and community status
  - Clinical information represents health status
  - Patients who have ESRD (end stage renal disease) are assigned an additional factor
- Example of Payment to a Medicare Advantage Plan

Medicare Profile

**Demographic**
- 72 yr old female, lives at home
- (1.07)

**Clinical Profile**
- (61)

Relative Risk Score
- Medical Risk = 1.23

Medicare advantage premium = $16
CMS per month/per member payment (demographic) = $208
CMS risk adjustment factor (DM with renal comps, CKD and CHF) = $785
Total Payment to MA plan per month = $992
CMS utilizes RAF scores, clinical and demographic data to provide payment to MAP’s.

MAP evaluates Dx and HCC categories, calculates risk scores, and makes capitated payment to provider.

MAP’s negotiate capitated payment rates with providers who care for higher risk patient populations.

MAP evaluates Dx and HCC categories, calculates risk scores, and makes capitated payment to provider.

Provider submits claim with all pertinent ICD10 codes, fully specified per documentation.

Dr. Z sees Patient Y for the first time this calendar year – documents current problem and all conditions being monitored and treated.

Potential delay in reimbursement if claim held for coder review to ensure all diagnoses documented prior to submission.

Potential increased cost if additional clinical staff required to perform chart review prior to patient visit to ID potential HCC conditions.
What are HCCs?

- Chronic conditions documented in the medical record, identified by an ICD-10 code, that are associated with a “risk score”
  - Not every diagnosis qualifies as an HCC (71,486 ICD-10 codes, 8830 are HCC’s)
  - Fully specified qualifying HCC diagnoses may carry higher risk weights than less specified diagnoses – i.e. diabetes vs diabetic nephropathy

- Developed by CMS to prospectively adjust for anticipated costs that vary across beneficiaries
  - Provides incentive to the Medicare Advantage Plans to enroll high-cost individuals by ensuring they have resources needed to provide efficient and effective treatment
  - Used by Medicare Advantage Plans and other commercial payers to identify the severity of risk-related conditions treated by providers participating in the plans
  - Payment to the provider is adjusted based on the risk severity of his patients
What are HCCs?

- HCCs must be captured/re-captured every calendar year in order to be factored into that patient’s annual risk score and payment.

- While this is a large focus in the ambulatory setting for physician practices, the need for capturing chronic conditions qualifying as an HCC is important for inpatients as well.
  - HCC conditions/diagnoses carry “risk factor” scores regardless of place of service.
  - While not every HCC diagnosis is a CC or MCC affecting DRG assignment, “risk” is still measured in the inpatient setting, so inclusion of chronic conditions when applicable is important for hospital quality scores.
The Difference between MS-DRGs and HCCs

<table>
<thead>
<tr>
<th>MS-DRGs</th>
<th>CMS-HCCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only 1 assigned per Inpatient discharge</td>
<td>More than 1 HCC can be assigned per encounter</td>
</tr>
<tr>
<td>Sequencing is a critical component</td>
<td>No sequencing involved</td>
</tr>
<tr>
<td>All principal diagnoses (ICD-10) map to a MS-DRG</td>
<td>Not all diagnoses (ICD-10) map to an HCC</td>
</tr>
<tr>
<td>Procedures can impact assignment</td>
<td>Procedures not included</td>
</tr>
<tr>
<td>Code only from physician documentation with few exceptions</td>
<td>Can use various provider types’ &amp; specialties’ documentation*</td>
</tr>
<tr>
<td>Only applicable to Inpatient coding and reimbursement</td>
<td>Outpatient and Inpatient settings involved</td>
</tr>
</tbody>
</table>
Condition Types/Diagnoses that map to CMS HCC’s

- High-cost medical conditions (heart disease, current cancers, hip fractures)
  - Highest weighted diagnoses are HIV, sepsis, opportunistic infections & cancers
- Acute, chronic, status codes, etiology & manifestation
  - e.g. = Hip fracture, COPD, status amputation of great toe, diabetic neuropathy
- Common conditions, rare conditions, conditions that can be cured, non-curable, congenital and acquired
  - Must be current & impact the encounter in terms of requiring either monitoring, evaluation, assessment, or treatment (MEAT)
HCCs in the Spotlight – Why the Buzz?

- Providers facing positive or negative payment incentives from Medicare beginning in January 2017
  - MACRA/MIPS instituted – will impact provider payments beginning in 2019
  - Focused heavily on documentation and diagnosis codes submitted on claims to Medicare

- Providers who are members of ACO’s are at risk for negative reimbursement if “high-risk” conditions are not properly documented and reported
HCCs in the Spotlight – Why the Buzz?

- Hospitals are rapidly acquiring physician practices and assuming the coding and billing functions of those practices
  - Need for “inpatient” coders to learn outpatient coding rules in order to properly capture and report diagnoses, with the focus on HCC diagnoses due to MIPS reimbursement

- Hospitals must capture “risk” scores in the form of HCC diagnoses in order to positively impact their reimbursement as well as their standing in the community
  - Where “chronic” conditions that did not qualify as a CC or MCC may not have been coded before, the need for these additional codes to be supported in the documented and recorded on the claim is now equally important
As Mr. Poehling’s lawyer, Mary Inman, described it, the government would pay UnitedHealth $9,580 a year for enrolling a 76-year-old woman with diabetes and kidney failure, for instance, but if the company claimed that her diabetes had actually caused her kidney failure, the payment rose to $12,902 — an additional $3,322. Ms. Inman is with the law firm of Constantine Cannon in San Francisco.

Need for documentation to provide clinical indicators, supporting criteria, and evidence of HCC conditions.
Documentation Requirements for Eligible Reporting

- Diagnoses must be documented
  - Coders cannot interpret labs or assume a diagnosis based on prescribed meds or MD orders

- Diagnoses should be documented to the highest level of specificity
  - Increases the likelihood of the condition mapping to a higher-weighted HCC (Example: Diabetes)

- Diagnoses must be documented in a document coders are permitted to code from
  - i.e. can’t code current conditions from problem lists, medical history, or super bills
  - can’t use documents that could propose “rule out” diagnoses – i.e. labs or x-rays

- Supporting clinical documentation for all reported diagnoses (M.E.A.T)
  - Monitor - Signs, symptoms, disease progression or regression
  - Evaluate - Review of test results, medication effectiveness, response to treatment – i.e. “stable,” “improving,” “exacerbation,” “worsening,” “poor”
  - Assess - Ordering tests, discussion, review records, counseling
  - Treatment - Referral, medication(s), planned surgery, therapies
Documentation of HCCs

- Supporting clinical documentation for all reported diagnoses

- “M.E.A.T” Criteria
  - Monitor - Signs, symptoms, disease progression or regression
  - Evaluate - Review of test results, medication effectiveness, response to treatment
    i.e. “stable,” “improving,” “exacerbation,” “worsening,” “poor”
  - Assess - Ordering tests, discussion, review records, counseling
  - Treatment - Referral, medication(s), planned surgery, therapies

- “T.A.M.P.E.R” Criteria
  - Treatment
  - Assessment
  - Monitor / Medications
  - Plan
  - Evaluate
  - Referral
How HCCs are Coded

- HCCs work on Hierarchies
  - The most severe presence of a qualifying condition has the highest rated HCC category

- For Example:
  - Diabetes (type 1 or 2)
    - No complications: HCC 19 (0.018)
    - Complications such as CKD, retinopathy, cataracts, neuropathy, ulcers, etc.: HCC 18 (0.368)
    - Complications such as coma, hyperosmolarity, ketoacidosis: HCC 17 (0.368)
Hierarchy of Diabetes

**HCC 17 (0.368)**
Diabetes with Acute Complications

- DM (types 1 or 2 or induced) with
  - Coma or
  - Hyperosmolarity or
  - Ketoacidosis

**HCC 18 (0.368)**
Diabetes with Chronic Complications

- DM (types 1 or 2 or induced) with
  - Nephropathy; CKD; other kidney complication; retinopathy; cataract; neuropathy; other neuro complication; peripheral angiopathy; neuropathic arthropathy; dermatitis; ulcer; periodontal disease; hyperglycemia; hypoglycemia without coma

**HCC 19 (0.018)**
Diabetes without Complications

- DM (types 1 or 2) with
  - No complications
## Importance of Documentation

<table>
<thead>
<tr>
<th>No Chronic Conditions Documented</th>
<th>Chronic Conditions Documented, Not Fully Specified</th>
<th>Chronic Conditions Documented, Fully Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>76 year old female</td>
<td>76 year old female</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible</td>
</tr>
<tr>
<td>Acute UTI (N39.0 – no HCC)</td>
<td>Acute UTI (N39.0 – no HCC)</td>
<td>Acute UTI (N39.0 – no HCC)</td>
</tr>
<tr>
<td>DM not documented</td>
<td>DM (E11.9, HCC 19)</td>
<td>DM w/ PVD (E11.51, HCC 18)</td>
</tr>
<tr>
<td>CHF not documented</td>
<td>CHF (I50.9, HCC 85)</td>
<td>CHF (I50.9, HCC 85)</td>
</tr>
<tr>
<td>No Condition Interactions</td>
<td>Interaction DM and CHF</td>
<td>Interaction DM and CHF</td>
</tr>
<tr>
<td>RAF Score</td>
<td>0.588</td>
<td>1.256</td>
</tr>
<tr>
<td></td>
<td><strong>$5,644</strong></td>
<td><strong>$12,057</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$14,457</strong></td>
<td></td>
</tr>
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</table>

*Assuming the CMS Annual Base Rate is $9,600

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Documentation from an Outpatient Encounter

75 y/o female presents for ankle sprain and follow-up

Assessment and plan:
1. Ankle sprain—ice, avoid NSAIDs due to CKD. Check BMP.
2. Colon cancer—s/p colectomy and liver bx. Following with heme/onc for chemo. Check CBC, LFTs.
3. Type 2 DM—insulin adjusted.
4. CAD—CP at rest, cardiology eval, increase beta blocker.
5. Hypertension—continue current meds.
# HCC Weights and Expected Reimbursement

<table>
<thead>
<tr>
<th>Factor/diagnosis</th>
<th>HCC</th>
<th>HCC weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 year old female</td>
<td>Demographics</td>
<td>0.437</td>
</tr>
<tr>
<td>C18.9 Malignant neoplasm colon</td>
<td>11 – Colorectal, bladder and other cancers</td>
<td>0.317</td>
</tr>
<tr>
<td>E11.9 Type 2 DM</td>
<td>19 – Diabetes without complications</td>
<td>0.118</td>
</tr>
<tr>
<td>N18.9 CKD</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td>I20.8 Angina</td>
<td>88 – Angina pectoris</td>
<td>0.141</td>
</tr>
<tr>
<td>S93.402A Ankle sprain</td>
<td>---</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Risk</strong></td>
<td></td>
<td><strong>1.013</strong></td>
</tr>
<tr>
<td><strong>Expected cost/reimbursement</strong></td>
<td></td>
<td><strong>$7200.00</strong></td>
</tr>
</tbody>
</table>
Improved Documentation

Documentation with greater specificity from that same outpatient encounter

75 y/o female presents for ankle sprain and follow-up

Assessment and plan:

1. Ankle sprain—**acute**, ice avoid NSAIDs due to CKD. Check BMP.
2. Colon cancer **with liver mets** — **active**, s/p colectomy and liver bx. Following with heme/onc for chemo. Check CBC, LFTs.
3. Type 2 DM **with diabetic CKD 4** — **stable**, insulin adjusted.
4. CAD — **unstable angina, active**, cards referral, increase beta blocker.
# New HCC Weights and Expected Reimbursement

<table>
<thead>
<tr>
<th>New Diagnosis</th>
<th>HCC</th>
<th>HCC weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 year old female</td>
<td>Demographics</td>
<td>0.437</td>
</tr>
<tr>
<td>C18.9 Malignant neoplasm of colon</td>
<td>11 – colorectal, bladder and other cancers</td>
<td>xxxx</td>
</tr>
<tr>
<td>C78.7 Secondary neoplasm of liver</td>
<td>8 – Metastatic cancer and acute leukemia</td>
<td>2.484</td>
</tr>
<tr>
<td>E11.22 – Type 2 DM with diabetic CKD</td>
<td>18 – Diabetes with chronic complication</td>
<td>0.368</td>
</tr>
<tr>
<td>N18.4 – CKD</td>
<td>137 – CKD severe Stage 4</td>
<td>0.224</td>
</tr>
<tr>
<td>I20.0 Unstable angina</td>
<td>87 – unstable angina and other acute ischemic heart disease</td>
<td>0.258</td>
</tr>
<tr>
<td>S93.402A Ankle sprain</td>
<td>000</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total risk</strong></td>
<td></td>
<td><strong>3.771</strong></td>
</tr>
<tr>
<td><strong>Expected cost/reimbursement</strong></td>
<td></td>
<td><strong>$26,379.00</strong></td>
</tr>
</tbody>
</table>
HCC Discovery Questions

- What is your organization’s current interest in HCC capture, and why?
- How are you capturing the usage / reporting of HCCs today?
- What gap(s) exist in your current process and current reporting?
- Is your organization using any type of technology to track reporting today?
- What percent of reimbursement is from Medicare advantage plans vs. risk scoring from ACO?
- Are all providers in your practices engaged in HCC diagnosis reporting? (In other words, do all specialties participate or just certain ones?)
HCC’s with Natural Language Understanding

- HCC Code Notification
  - Documentation of an HCC diagnosis
- HCC Supported
  - Evidence of the treatment, assessment, and support of the HCC diagnosis
- HCC Unsupported
  - Audit risk for HCC conditions
- HCC Opportunity
  - Evidence to get to a higher HCC category
- HCC ICD Opportunity
  - Evidence to get to an ICD-10 code that qualifies as an HCC
- Documentation Improvement
  - Evidence of need of documentation improvement
HCC Provider Focus

Workflow

- Physician documents with speech or typing
- NLU evaluates in real-time (as they speak or type)
- Provides suggested ICD-10 Codes
- Identifies any HCC opportunities and makes suggestions
- Focused on High Value Areas
- Targeting specialties for full coverage next
HCC Back End CDI Focus

1. Identify and validate documented HCCs

2. Audit to ensure Monitor Evaluate Assess Treat (MEAT) compliance is supported

3. Visit prep workflow prioritized by
   a. Upcoming patients
   b. RAF score opportunities

4. Patient condition registry for problem list reconciliation
Questions?

Thank you!