HCCs: The Cornerstone of the Outpatient CDI Program

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Agenda

- Medicare Advantage Plans and CMS

- Risk Adjustment: APR DRGs and HCCs

- RAF Scores
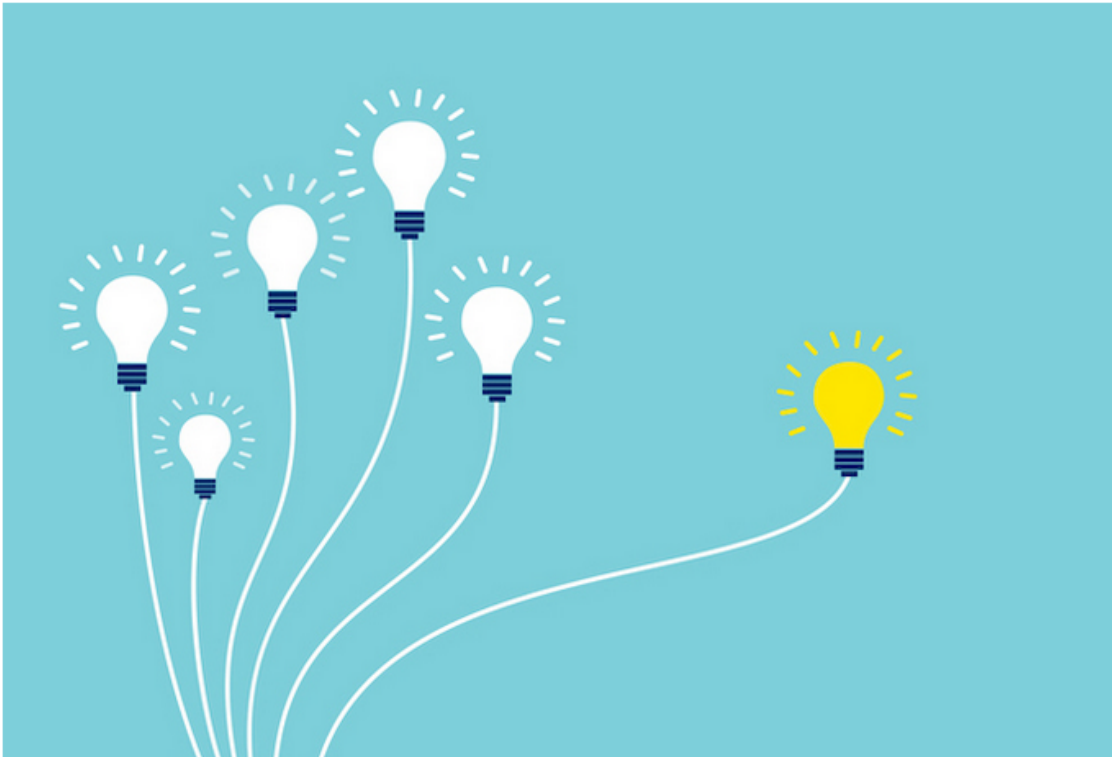
- Outpatient CDI and HCCs

- Developing a plan for HCCs

Why the buzz?

How Medicare Advantage is Leading Payers to Adopt Value-Based Care

The transition to value-based care has stalled, but the unique structure of Medicare Advantage can help payers advance to lower costs and better outcomes.

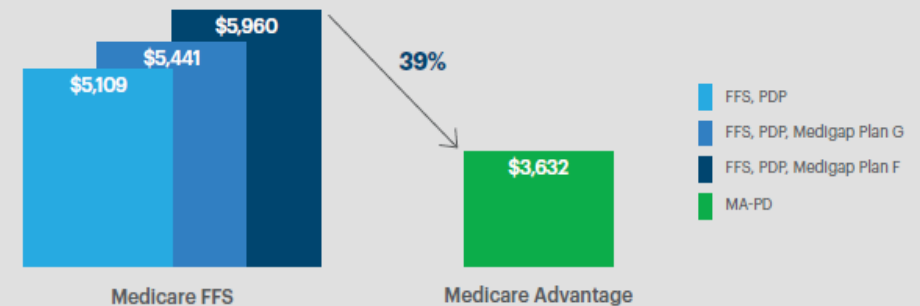## Beneficiaries in Medicare Advantage Receive Better Value and Spend 40% Less than Beneficiaries in Medicare FFS

Beneficiaries in Medicare Fee-For-Service (FFS) receive coverage for hospital and physician office services and can purchase a prescription drug plan (PDP) for drug coverage. Medicare Advantage (MA) plans cover the same services as Medicare FFS and typically offer additional protections and services, not covered by Medicare FFS, that support beneficiaries in staying healthy, improving care outcomes, and avoiding unforeseen medical costs. Compared to Medicare FFS, MA beneficiaries with chronic conditions receive more preventative care[1] and experience fewer emergency department visits and lower rates of avoidable hospitalizations.[2]

Differences in Benefits Covered By Medicare FFS and Medicare Advantage

Medicare FFS

Covers 83% of costs for:
Part A Hospital services
Part B Physician office services

VS.

Medicare Advantage

Medicare FFS

Covers 83% of costs for:
Part A Hospital services
Part B Physician office services

6% additional costs covered for:
Parts A & B services

+

Financial Protections and Enhanced Services May Include

- Part D prescription drug coverage
- Caps on annual out-of-pocket costs
- Dental, vision, and hearing coverage
- Care management programs

The estimated health care costs for a beneficiary represent a key factor in the choice between MA and FFS coverage, especially since half of Medicare beneficiaries live on fixed annual incomes below $27,000.[3] The annual health care costs[a] for a 72 year-old beneficiary of average health in MA ($3,632) are as much as 39% less than for a comparable beneficiary in FFS.[b,4]

Annual Health Care Costs for Comparable Beneficiaries, 2019

$5,109
$5,441
$5,960
39%
$3,632

Medicare FFS   Medicare Advantage

- FFS, PDP
- FFS, PDP, Medigap Plan G
- FFS, PDP, Medigap Plan F
- MA-PD

a The term "health care costs" is used throughout this brief to reflect a Medicare beneficiary's combined spending on individual premiums and out-of-pocket cost sharing for medical, pharmacy, and ancillary services. Unless otherwise stated, Medicare FFS member costs in this brief include premiums and cost sharing for FFS + Part D (PDP) coverage.
b The term "beneficiary" is used throughout this brief to reflect a Medicare-eligible senior of average age (72 years old) with average health.
c Unless otherwise noted, all analyses in this brief are based on the average Medicare-eligible beneficiary's health care utilization.

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What is a Medicare Advantage Plan

Medicare Advantage Plans, sometimes called "**Part C**" or "MA **Plans**," are an "all in one" alternative to Original **Medicare**. ... These "bundled" **plans** include **Medicare Part** A (Hospital **Insurance**) and **Medicare Part** B (Medical **Insurance**), and usually **Medicare** drug **coverage** (**Part** D).

Medicare Advantage plans can have limited provider networks, so you may have trouble finding a doctor or facility that accepts the specific **plan**. ... A **Medicare Advantage plan**, such as a health maintenance organization (HMO) **plan**, may require pre-authorizations and referrals.

Medicare Advantage plans can serve as your "one-stop" center for all your health and prescription drug coverage needs. Most **Medicare Advantage plans** combine medical and Part D prescription drug coverage. Many also coordinate the delivery of added benefits, such as vision, dental, and hearing care.

Risk Adjustment Data – Supporting Documentation and RADVs

- These audits target Medicare Advantage health plans.

- There are two main types of Risk Adjusted Data Validation (RADV) for CMS:

  - Random CMS RADV uses a selection process in which a Medicare Advantage (MA) plan is randomly selected for an audit.

  - Targeted CMS RADV is applied to MA plans who have raised red flags, such as a large increase in risk scores, etc.

- These audits confirm that MA organizations self-reported risk adjustment data, or diagnosis codes used to depict how sick beneficiaries are and match medical documentation to the claim.

- They have been recouping billions of dollars in improper payment.

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Risk Adjustment

- Inpatient risk adjustment using APR DRGs
- HCCs and Risk Adjustment – all sites of service

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Inpatient Risk Adjustment – MS DRGs vs APR DRGs

Diagnosis-Related Groups (DRGs) are used to categorize inpatient hospital visits severity of illness, risk of mortality, prognosis, treatment difficulty, need for intervention, and resource intensity.

MS-DRGs are Medicare's adaptation of the DRG system. There over 450 MS-DRGs with groups added or modified periodically. MS-DRGs are used for billing under Medicare's Inpatient Prospective Payment System (IPPS). MS-DRGs add a level of detail that is not found in the original DRG system. MS-DRGs have 3 levels of severity

APR DRGs are expansion of the basic DRG concept to better reflect the attributes of non-Medicare patients combined with the subdivision of each DRG into four severity of illness and risk of mortality subclasses.

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All Patient Refined Diagnosis Related Groups – APR DRG

Severity of illness (SOI)
- Extent of physiologic decompensation or organ system loss of function

Risk of mortality (ROM)
- Likelihood of dying

Resource intensity
- Relative volume and types of services used in the management of a particular disease

Admit and discharge date, age, sex, primary and secondary diagnosis and procedures and discharge status are considered in APRDRGs.

SOI and ROM are independent of each other. An 80 year-old female with pneumonia and diabetes may have a SOI of 4 and a ROM of 4, while an 18 year-old male with a similar severity pneumonia may have a SOI of 3 and a ROM of 1, based on the patient's different age and sex.

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Underlying Principle of *APR-DRGs*

Severity of illness and risk of mortality is dependent on the patient's <u>underlying problem</u>

High Severity of Illness and Risk of Mortality are characterized by <u>multiple</u> serious diseases and the **<u>interaction</u> of those disorders**

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Differences between APR-DRGs and MS-DRGs

APR DRGs:

- **Represent the entire patient population (>65% of avg hospital patients <65)**
- **Consider 4 levels of severity per APR DRG**
- **Provide granular detail for MDCs 14 – Pregnancy, Childbirth & Puerperium and 15 – Newborn and other Neonates**
- **Provides 4 levels of ROM**

MS-DRGs

- **Represent the Medicare population**
- **Consolidate severity through groups (cc/no cc; mcc/cc, no cc. etc.)**
- **Have not focused on these MDCs**
- **Does not differentiate for ROM**

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Secondary Diagnosis Impact on APR DRGs

	Option 1	Option 2	Option 3	Option 4
MS-DRG 194 RW: 0.9332	MS-DRG 871 RW: 1.8229	MS-DRG 871 RW:1.8229	MS-DRG 871 RW:1.8229	MS-DRG 871 RW: 1.8229
PDx: Pneumonia	PDx: Sepsis	PDx: Sepsis	PDx: Sepsis	PDx: Sepsis
SDx: Bacteremia	SDx: Pneumonia	SDx: Pneumonia Diastolic CHF	SDx: Pneumonia Diastolic CHF Acute Resp Failure	SDx: Klebsiella Pneum Diastolic CHF Acute Resp Failure Shock
APR DRG 139 SOI 2 ROM 1 RW: 0.6051	APR DRG 720 SOI 2 ROM 2 RW: 0.7333	APR DRG 720 SOI 2 ROM 3 RW: 0.7333	APR DRG 720 SOI 3 ROM 4 RW: 1.2367	APR DRG 720 SOI 4 ROM 4 RW: 2.7808

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What are Hierarchical Condition Categories (HCCs)?

- HCCs are a methodology first used by CMS to help predict costs for treating Medicare Advantage patients in inpatient, outpatient and office settings

- Patient demographics and diagnosis coding are used to determine risk adjustment and how much money will be allocated to a health plan for future patient treatment

- Using the CMS HCCs as a starting point, the U.S. Department of Health and Human Services (HHS) then developed a broader HCC methodology for commercial payers and now CMS uses HCCs when calculating the total performance score under the Hospital Value-Based Purchasing Program

Source: https://www.3mhisinsideangle.com/blog-post/hcc-coding-whats-the-big-deal/

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CMS HCC

- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)

- CMS also developed a CMS RX HCC model for risk adjustment of Medicare Part D population

- Based on aged population (over 65)

- Current year data predictive of future year risk

HHS HCC (Commercial HCC)

- Developed by the Department of Health and Human Services (HHS)

- Designed for the commercial payer population

- HHS-HCCs predict the sum of medical and drug spending

- Includes all ages

- Current year data used to predict current year risk

What are Hierarchical Condition Categories (HCCs)?

Chronic conditions and a limited number of major acute complications, identified by an ICD-10 code, that are associated with a "risk score"

Risk score is determined based on the most specified diagnosis captured throughout the year (i.e. type 2 diabetes vs. type 2 diabetes with diabetic nephropathy). Fully specified HCC diagnoses may carry higher risk weights than less specified diagnoses.

Patient risk scores are determined based on billed diagnoses, that must be supported by comprehensive documentation, at least once annually

This score can impact payment to healthcare organizations and shared savings incentives, meaning providers carry greater financial risk than under fee for service reimbursement.

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About HCCs

- Provider documentation drives HCCs.
- For accurate HCC coding, documentation must be complete and specific, based on a face-to-face encounter with the patient (or telehealth PHE).
- This means it is not enough to just look at test results or patient medical history to make the diagnosis determination.
- If documentation is complete, it's up to the coder to apply the correct diagnosis code. If documentation is incomplete, physician education should be provided.

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Risk Adjustment Factor

The Risk Adjustment Factor (RAF) or (RF) is the total score of all relative factors related to one patient for a total year submitted from the following sources:

- Principal diagnosis hospital inpatient
- Secondary diagnosis hospital inpatient
- Hospital outpatient
- Physician
- Clinically-trained non-physician (psychologist or phychiatrist)

Source: MS-DRG Training Guide and Quick Reference Guide Quality -Hierarchical Condition Category (HCC)

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Risk Adjustment Factor

In addition to diagnoses, considerations (adjustments) are made for:

- Age
- Living arrangement (community or institution based)
- Medicaid disability status and interaction with age and sex
- HCC category based on reported diagnoses and conditions
- Interaction between certain disease/condition categories
- Interaction between certain disease categories and disability status

Source: MS-DRG Training Guide and Quick Reference Guide Quality -Hierarchical Condition Category (HCC)

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CHF – HCC Example

Sample of 46 ICD-10 CHF-related diagnoses that map to CMS-HCC #85

CMS-HCC Category	HCC Description	Community RAF	ICD-10 Diagnosis Code	ICD-10 Description
85	Congestive Heart Failure (CHF)	0.331	I5020	Unspecified systolic (congestive) heart failure
			I5021	Acute systolic (congestive) heart failure
			I5022	Chronic systolic (congestive) heart failure
			I5023	Acute on chronic systolic (congestive) heart failure
			I5030	Unspecified diastolic (congestive) heart failure
			I5031	Acute diastolic (congestive) heart failure
			I5032	Chronic diastolic (congestive) heart failure
			I5033	Acute on chronic diastolic (congestive) heart failure
			I5040	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
			I5041	Acute combined systolic (congestive) and diastolic (congestive) heart failure
			I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure

Sources of data used to calculate the RAF score

Diagnoses

- Included in current risk adjustment model
- Valid provider
- Valid data collection method

Providers

- Physicians
- Nurse Practitioners
- Certified RN Anesthetists
- Physician Assistants
- Psychologist
- Psychiatrist

Services Excluded

- DME
- Laboratory
- Diagnostic Radiology

Provider types

- Hospital, Inpatient
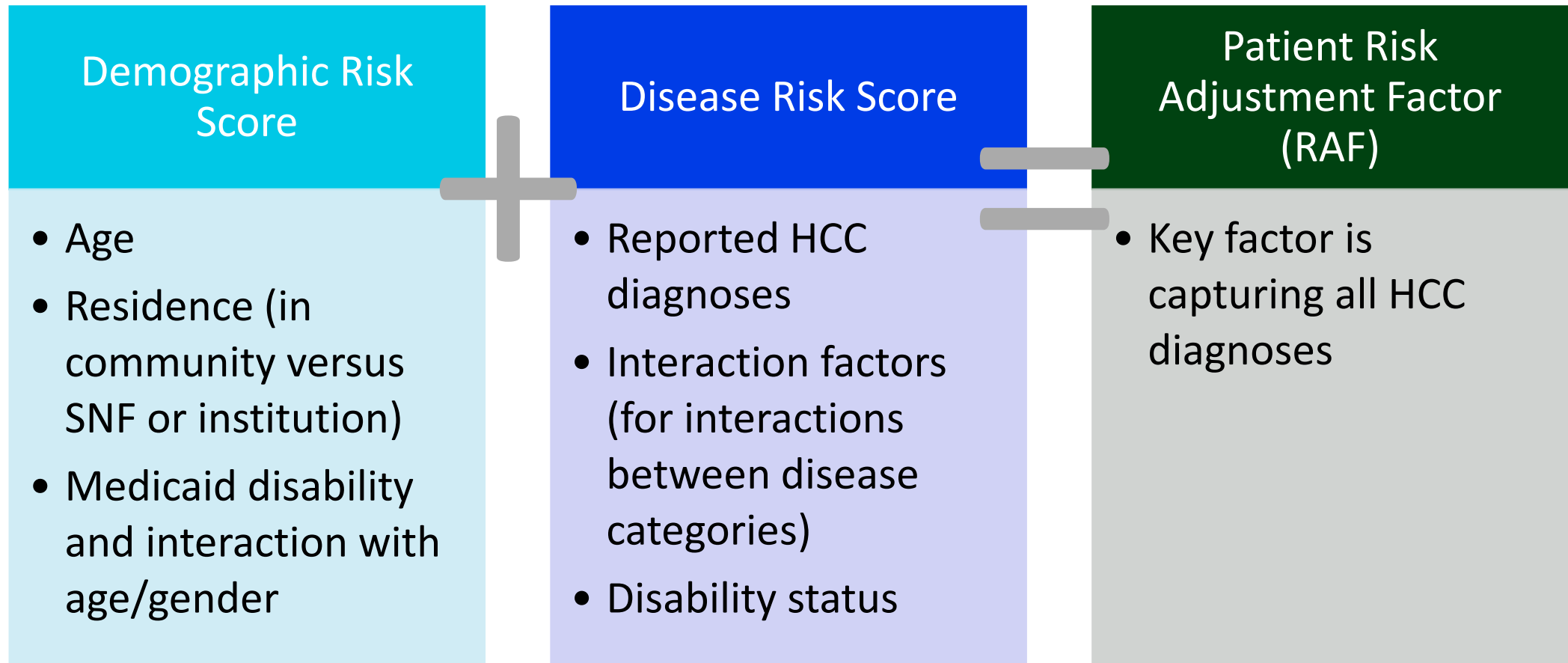- Hospital, Outpatient
- Physicians

Exclusions

- Hospice
- SNF
- Home Health
- Free Standing Ambulatory Surgery Centers

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MEAT rule for documenting chronic conditions

|	
Monitor	Signs, symptoms, disease progression, disease regression
Evaluate	Review of test results, medication effectiveness, response to treatment (e.g., stable, improving, exacerbation, worsening, or poor)
Assess/Address	Ordering tests, discussion, review records, counseling
Treatment	Referral, medication(s), planned surgery, therapies, other modalities

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Typical RAF Patient Scenario

Total score of all relative factors related to one patient for a total year

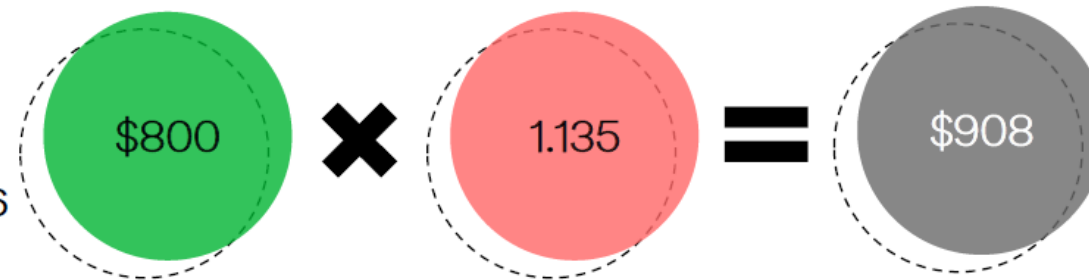| Demographic Risk Score	Disease Risk Score	Patient Risk Adjustment Factor (RAF)
• Age • Residence (in community versus SNF or institution) • Medicaid disability and interaction with age/gender	• Reported HCC diagnoses • Interaction factors (for interactions between disease categories) • Disability status	• Key factor is capturing all HCC diagnoses

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Understanding the RAF & affect on reimbursement

Hypothetical example:

CMS-HCC expenditure predictions and risk score for a community-residing, 76 year old woman with AMI, angina pectoris, COPD, renal failure, chest pain and ankle sprain

RAF weight for Demographic info
0.437

+

RAF weight for disease burden
0.698

=

1.135
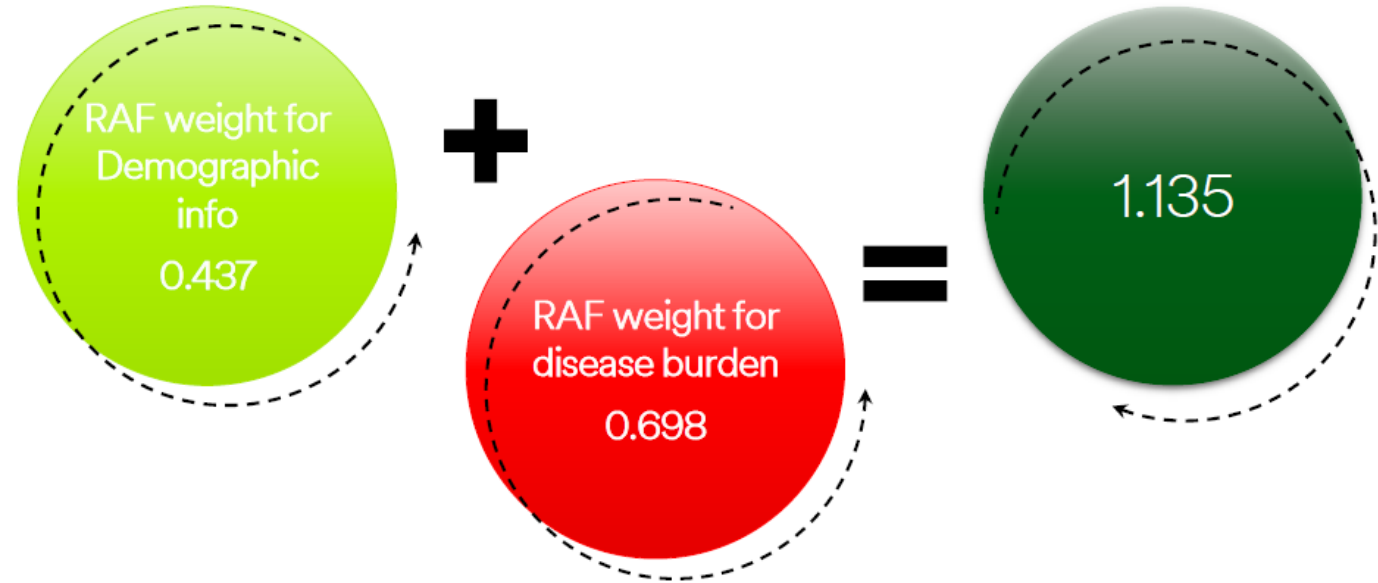
Total PMPM* Payment $800 (Illustrative Purposes) x RAF Score
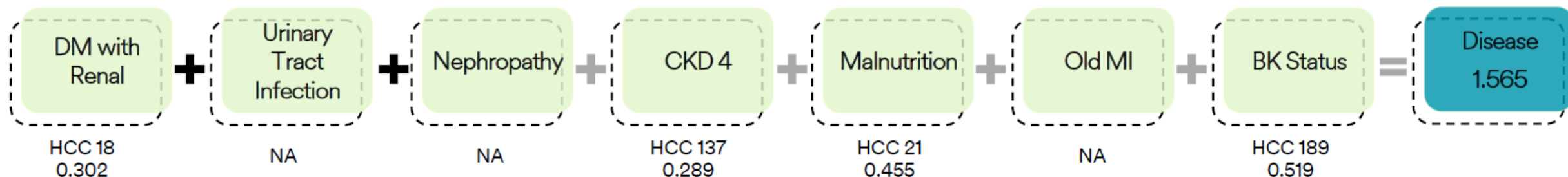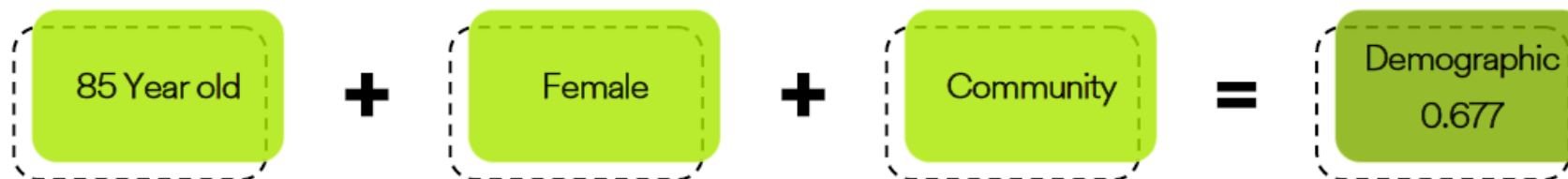
$800

×

1.135

=

$908

*Per member per month
*Annualized payment = $10,896

What should be coded and reported to the plan

Example: 85 year old white female, Diabetic with symptoms of UTI

85 Year old + Female + Community = Demographic 0.677

DM with Renal		Urinary Tract Infection		Nephropathy		CKD 4		Malnutrition		Old MI		BK Status		Disease 1.565
HCC 18 0.302	+	NA	+	NA	+	HCC 137 0.289	+	HCC 21 0.455	+	NA	+	HCC 189 0.519	=	

0.677 + 1.565 = RAF 2.242 × PMPM $800 = $1793

*Per member per month $1793
*Annualized payment = $1793 x 12 = $21,516

How specificity impacts CMS HCCs and RAF scores

Specificity Impact	Diagnoses		Examples
DOES NOT impact the HCC/RAF	1. Secondary cancers 2. Malnutrition 3. Hepatic failure 4. Cirrhosis 5. Chronic hepatitis 6. Osteomyelitis 7. Osteonecrosis 8. Rheumatoid arthritis	9. Schizophrenia 10. Epilepsy 11. Resp. failure 12. Atrial fib/flutter 13. COPD 14. Emphysema 15. Heart failure	• Severe / Moderate / Mild / Unspecified Malnutrition all under HCC 21 • Twenty-seven ICD-10 codes related to respiratory failure HCC 84 o Acute / Chronic / Acute and Chronic / Unspecified Respiratory Failure

DOES impact the HCC/RAF	1. Diabetes
	2. Angina
	3. Pneumonia
	4. Renal failure unspecified
	5. Chronic kidney disease unspecified
	6. Pressure ulcer unspecified
			• Chronic kidney disease:
			   o Stages 1 and 2 are not HCCs
			   o Stage 3, 4 and Stage 5 are HCCs
			• Different HCCs for diabetes with:
			   o Acute complications (HCC 17)
			   o Chronic complications (HCC 18)
			   o Without complications (HCC 19)

The most critical factors is ensuring providers are aware of the full historical HCC diagnosis list

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HCC Risk Adjustment Factor Methodology Example

78-year-old male, community based, managing chronic conditions

2019 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2019	
Demographic score: 2019	0.466
HCC 18: Diabetes w/retinopathy	0.302
HCC 22: Morbid Obesity	0.250
HCC 40: Rheumatoid arthritis	0.401
HCC 85: Dilated cardiomyopathy	0.331
HCC 111: COPD	0.335
HCC Interaction Score: CHF—COPD	0.190
HCC Interaction Score: Diabetes—CHF	0.154
Total RAF Score	2.429

2020 Risk Adjustment Factor (RAF) Score Diagnoses documented/billed during visits in 2020	
Demographic score: 2020	0.466
HCC 18: Diabetes w/retinopathy	0.302
HCC 22: Morbid Obesity	0.250
Total RAF Score	1.018
2020 Missing RAF Score	1.411

Capitated Pay Per Member Per Month (PMPM):
- $800 PMPM x 2.429 RAF = $1943
- $800 PMPM x 1.018 RAF = $814

$13,548 Annual

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Common gaps and key steps in capturing HCCs

Face-to-face patient visit

Visit Types
- Hospital inpatient and outpatient
- Physician office

Exclusions:
- Hospice
- SNF
- Home health
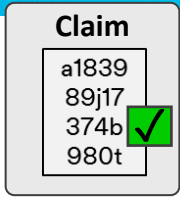- Free-standing ASC

Physician addresses and diagnoses condition(s)

Providers
- Physicians
- NP, CRNA
- Psychologist/Psychiatrist

Services Excluded:
- DME
- Laboratory
- Diagnostic radiology

## Dx coded and itemized in claim

Claim
a1839
89j17
374b
980t

Requirements
- Each HCC diagnosis submitted in a claim once per calendar year
- Must be supported by documentation in visit note

- Patients missing HCCs do not have visits scheduled
- No way to identify patients
- No easy process to schedule at-risk patient for a visit

- Physician doesn't know what patient information is contained in disconnected EMRs
- Not all HCC-diagnoses are captured/documented

- Physician notes an HCC-diagnosis but does not code for it
- Providers trained to code diagnoses for pro-fee billing, not HCC capture
- 80-90% of office visits coded by providers with no coder review

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HCCs must be treated, documented, coded, and billed at some point across care settings

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HCC gaps across a population

Analysis of Medicare Beneficiaries Annual Visits

8.5%
16.3%
20.7%
54.4%

- ■ IP Admit
- ■ Only Outpatient Visit
- ■ Only Physician Visit
- : ■ No Visits in Calendar Year
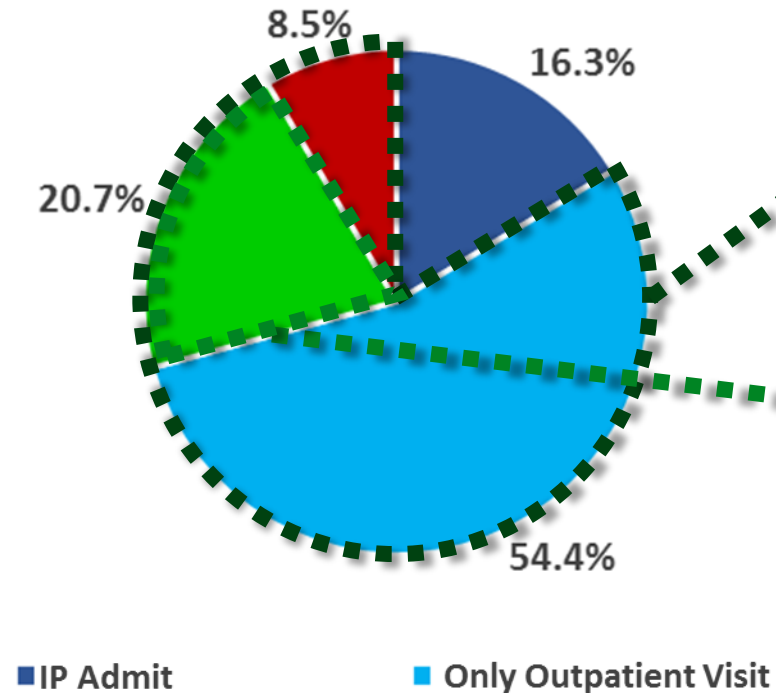
*IP admission patients may have also had a physician office or outpatient visit as well in the calendar year

**Patient receiving outpatient care or physician visits had no other visit types in the calendar year

Outside the Hospital

- CDI programs today focus on IP acute admissions
- Little to no documentation review and physician guidance in OP or office settings
- Patients are seen across many sites of service and data can be disparate

Physician Office

- 80-90% of office visits are coded by providers with no coder review
- Physicians focus on CPT not complete diagnosis billing
- Reviewing a patient's chronic disease history prior to the visit can help the physician accurately document all of the patient's disease burden.

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Telemedicine/Telehealth coding direction

CMS expanded scope of telehealth services, March 18, 2020
- Physician office visits conducted via two-way audio/video
- Expanded to include urban areas
- Pending expansion to include rural clinics and FQHCs as distant sites

Telecommunication Tools:

Mobile devices and apps that allow real-time audio and video communication include:

FaceTime, Skype, Updox, Vsee, Zoom for Healthcare, Coxy.me
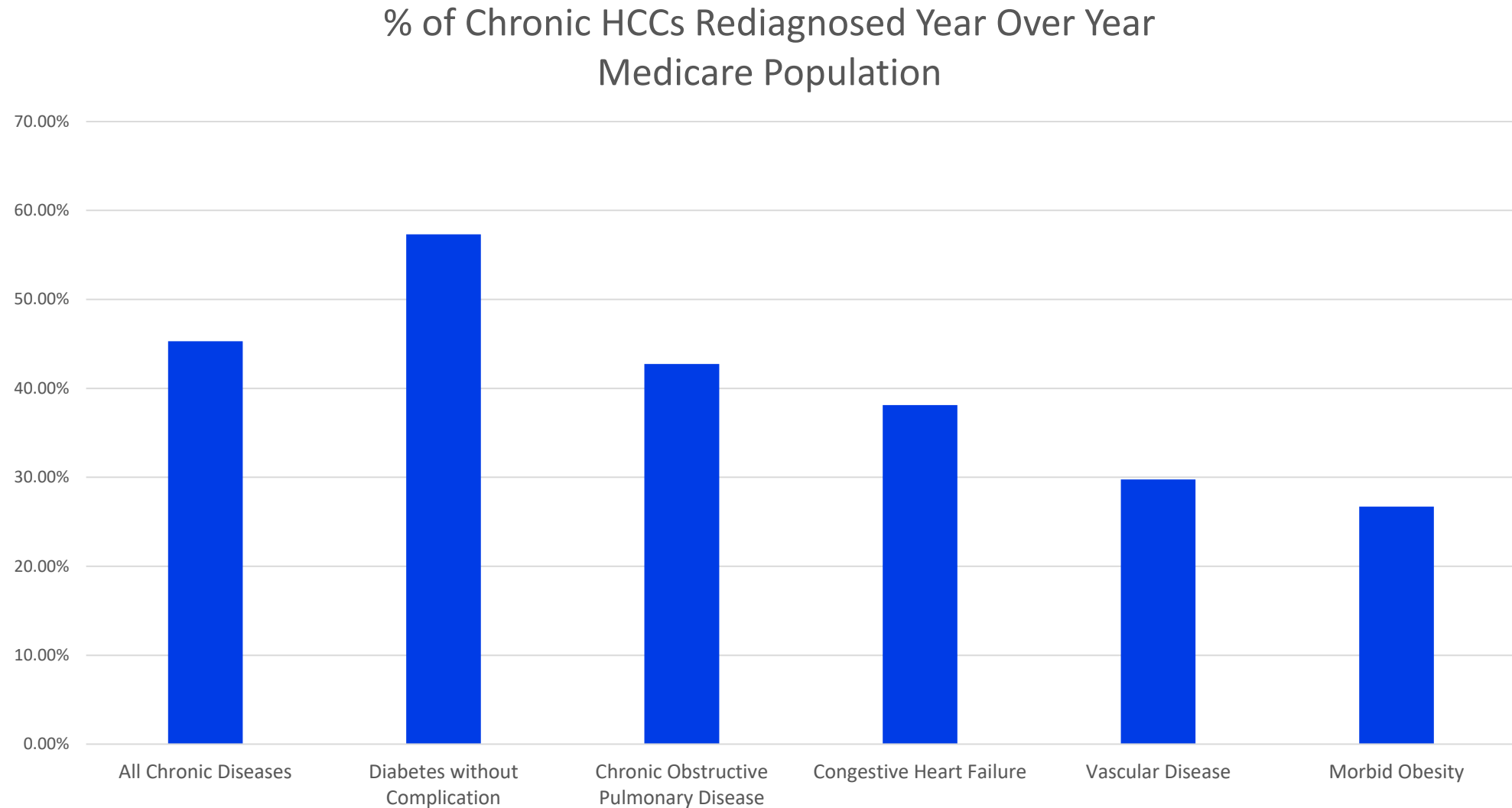
and Google G Suite Hangouts Meet.

Acceptable non secure:

Apple Face Time, Facebook Messenger video chat, Google Hangouts video or Skype

Not allowed:

Facebook Live, Twitch, TikTok

Chronic disease is re-diagnosed only 45% of the time

% of Chronic HCCs Rediagnosed Year Over Year
Medicare Population

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Common HCC Diagnoses

Top 10 Most Under-Documented HCCs

> Amputations
> Artificial openings
> Asthma and pulmonary disease
> Chronic skin ulcer
> Congestive heart failure
> Drug dependence
> Metastatic cancers
> Morbid obesity
> Rheumatoid arthritis
> Specific type of major depressive disorder

Source: 3M aggregated claims data

Top 10 Most Over-Documented HCCs

> Conditions that have been surgically corrected (e.g., abdominal aortic aneurism)
> Diabetes with complications
> Malnutrition
> Nephritis
> Pathological fractures (e.g., old pathological fractures reported as current)
> Pneumococcal pneumonia (e.g., unspecified pneumonia reported as pneumococcal)
> Polyneuropathy (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
> Primary site cancers (e.g., indicating historical conditions as current)
> Strokes (e.g., indicating acute stroke instead of late effect of stroke)
> Vascular disease (e.g., reported as current when no treatment, evaluation or monitoring is documented)

Source: 3M aggregated claims data

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What is ambulatory CDI? How is it defined?

- Reviewing documentation to ensure medical necessity of procedures performed
- Focus on diagnoses impacting Hierarchical Condition Categories (HCCs) that impact Medicare Advantage payment
- Solidification of patient status in ED/observation (i.e., outpatient or inpatient)
- Review of local coverage determinations (LCD) or national coverage determinations (NCD) to avoid denial of Part B facility and provider payment for expensive outpatient surgeries or injections/infusions
- Review of APC codes and modifiers to improve clean claim rate

Ambulatory CDI comparison to inpatient

One Size Does not Fit All

Five ways the setting changes CDI activities

	Outpatient and Professional	Inpatient
Timing	Brief encounters, hours if not minutes before discharge; limited documentation	Encounter spans days, allowing for concurrent CDI; multiple documents
Objective	Priority on charge capture, reducing rework, denials, and appeals	Focus on PDx, MCC and CC, SOI, and case mix
Staffing	Professional services may be coded real-time by the physician and sent directly to PMS	Bench of coding, clinical documentation specialists, and auditors
Code sets for payment	Payment is usually based on procedures (CPT, E/M levels, and APC), although diagnoses determine medical necessity	Payment varies based on diagnosis coding (ICD-10-CM)
Payment reform	Attention to medical necessity, clinical validation, and HCCs/chronic conditions	Attention to POA, PSIs, other quality measures

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Most frequent coding and documentation errors

☒ Unbundling codes

☒ Not checking NCCI edits with multiple codes

☒ Overusing modifier 22

☒ Improper reporting of injection codes

☒ <mark>Missing active HCC diagnoses</mark>

☒ Upcoding

☒ Missing or inappropriate modifiers

☒ Time-based infusions and hydration

☒ Reporting unlisted codes without documentation

☒ Use of unspecified codes

How do you stay compliant?

https://www.beckershospitalreview.com/finance/8-most-common-coding-errors.html

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CDI drivers by setting

Hospital Outpatient	Emergency Department	Ambulatory Surgery	Physician Offices
• Revenue shift IP to OP • Growth in OP visits • Acquisition of physician practices • HCC risk payments	• Medical necessity • Time capture (e.g., infusions) • Charge capture validation • Present on admission • Observation patient status (admit to inpatient or outpatient discharge)	• Medical necessity • Screening vs diagnostic Px • Conservative therapy (alternatives exhausted) • Operative note to have post-op Dx and correct CPT Codes • IP only procedures	• Documentation missing or incomplete • Dates and times • Medical necessity • Conflicting problem lists • Clones; copy/paste • Denials
HCC Capture Across the Continuum			

Overall goals:
Shift focus from fee for service to pay for performance/quality
Accurate reimbursement
HCC Capture
Achieve complex documentation required for coding and billing
Prevent denials
Support accurate quality measures
Support continuity of care

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HCC Management: What are the Drivers?

- Are you currently engaged in risk-based contracts and reporting HCCs, ACO's?

- What gap(s) exist in your current HCC review process and reporting?

- How do you currently educate providers on documentation requirements, HCCs, and other compliance regulation?

- Has your organization conducted a targeted analysis to quantify the size of managed care payments received, or gaps and opportunities?

- Are all providers in your practices engaged in HCC diagnosis reporting, or do you concentrate on any specialties in addition to primary care?

- Do you use any technology today – from EHR or otherwise – for managing HCCs?

What problem are we trying to solve?

"What diagnoses even count as HCCs? You have to make the coding work easier."

"Remind me what diagnoses I need to review for my patient during the visit. Help me to get it right the first time."

"Why can't the computer tell me the correct ICD-10 codes based on my documentation?
I try to capture the patient story in my notes."

"Which patients have the greatest opportunity for HCC capture remaining this year? Our RAF scores do not reflect the actual population severity of illness."

"We need a workflow to review patients **before** their annual well visit."

"We're trying to build an OCDI program but don't have the resources to cover our growing risk-based reimbursement population."

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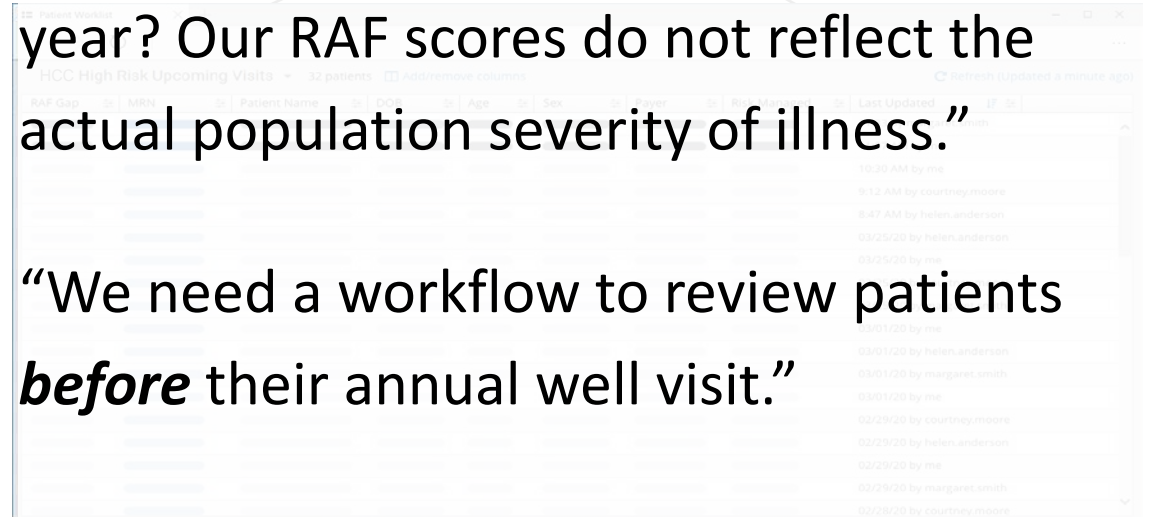
Managing HCCs – The Challenges

How hospitals use HCCs (or need to)

1/3 monitor HCCs for value-based programs

2/3 look for HCCs solutions to identify patients with diagnosis and risk score gaps

Only 1/7 know how well their physicians actually capture HCC diagnoses

Biggest HCC hurdles

Implementing HCCs into current processes — **62.2%**

Documenting highest disease categories — **55.9%**

Coding accurately based on patient data — **54.1%**

Top 4 HCC needs from healthcare organizations

1 Identify patients with gaps in diagnoses and risk scores

2 An easy way to prioritize patients with missing diagnoses

3 The capability to review a patient's health history quickly and efficiently

4 Physician workflows that identify gaps in DX documentation at point of care

Source: Ongoing HIMSS Analytics Research Study "Hierarchical Condition Categories (HCCs)" (February 2017)

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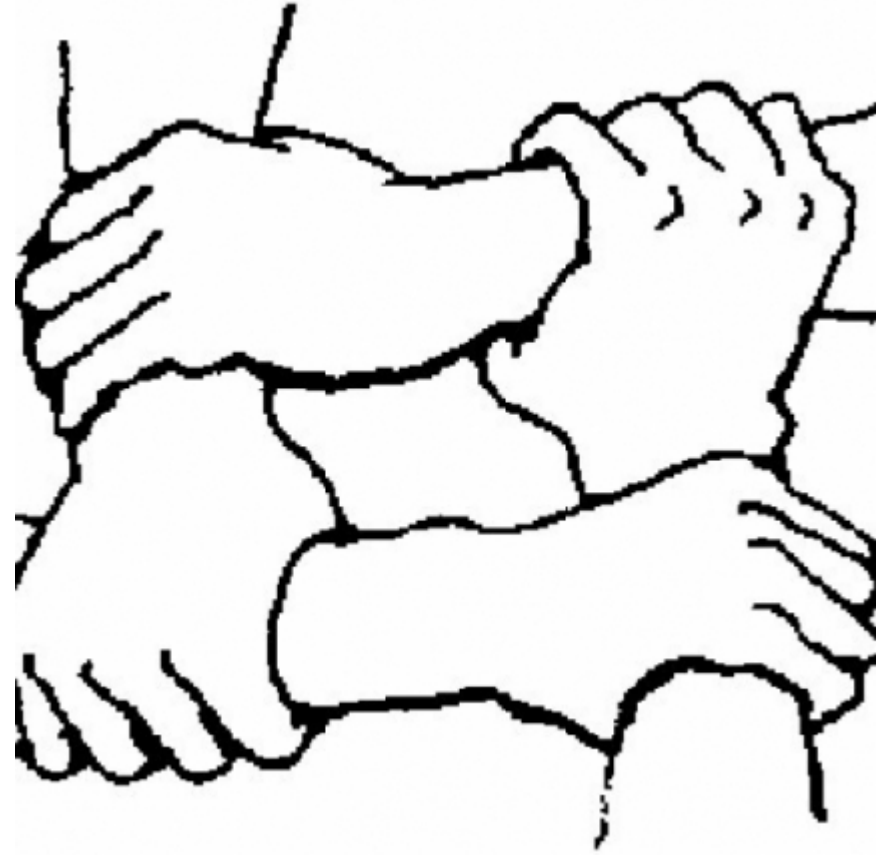# Obstacles related to accurate capture of Hierarchical Condition Categories (HCCs)

Legend: ■ Significant ■ Somewhat significant ■ Insignificant ■ N/A, we don't capture HCCs

Obstacle	Significant	Somewhat significant	Insignificant	N/A, we don't capture HCCs
Physicians not educated to document/ redocument chronic conditions	28.57%	41.18%	12.61%	17.65%
Physicians lack adequate supportive technology	21.01%	29.41%	30.25%	19.33%
Lack of CDI staff/inability to cover encounters/HCC capture	22.69%	30.25%	27.73%	19.33%
Incomplete or inaccurate EHR problem list	50.42%	26.05%	5.04%	18.49%
Having the right data during documentation (i.e., patients' historic chronic conditions)	31.93%	36.13%	14.29%	17.65%
Insufficiently trained CDI staff/lack of chart review or coding expertise	10.92%	21.85%	44.54%	22.69%

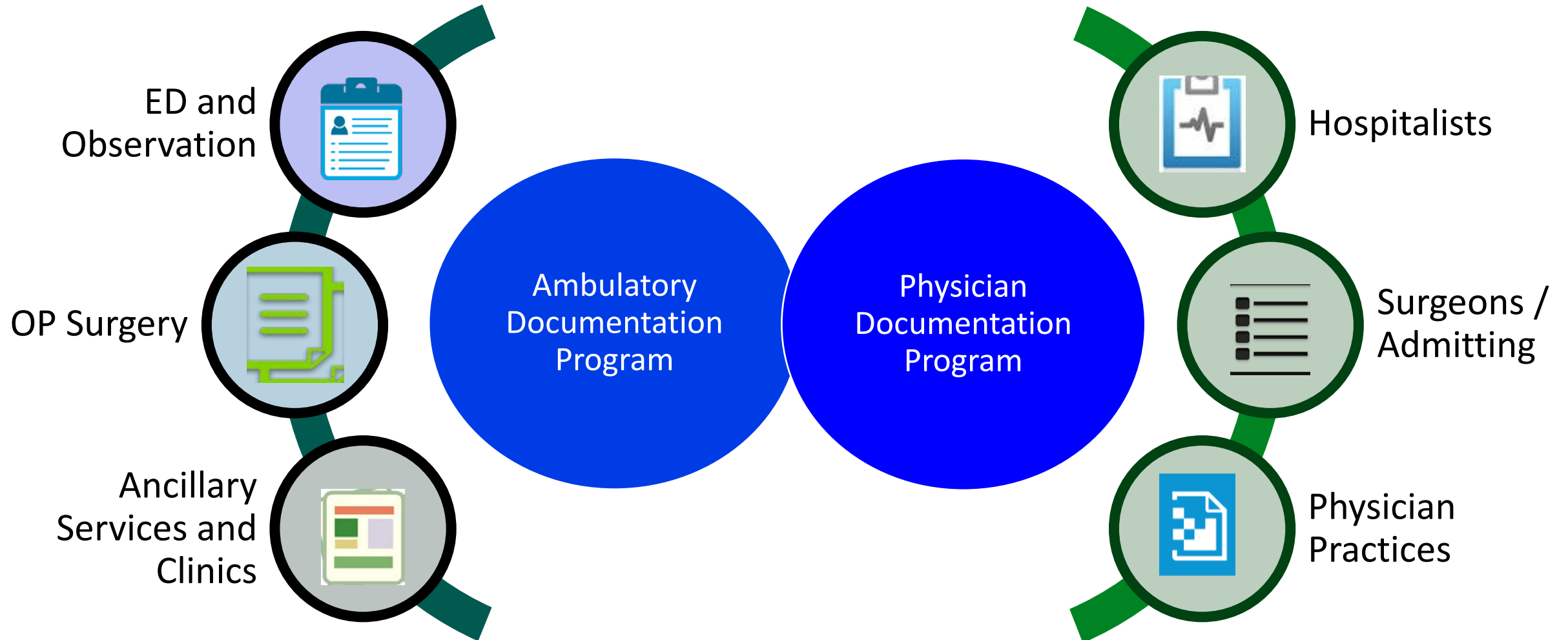Answered = 119
Skipped = 0

acdis.org.

Who Can Assist with accurate HCC Reporting?

Everybody!

- Physician Champions

- System Leadership

- Providers

- Professional Coders

- Inpatient/Outpatient Coders

- Inpatient CDI

- Outpatient CDI

Outpatient CDI and HCCs Across all care settings

ED and Observation

OP Surgery

Ancillary Services and Clinics

Ambulatory Documentation Program

Physician Documentation Program

Hospitalists

Surgeons / Admitting

Physician Practices

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CDI Pre-Visit Review for HCC Management

Pre-visit review outcome goals:

- Recapture

- Advanced Disease Capture

- New Capture

- Compliance Capture

CDI Activities

- Identify HCC diagnoses missing for the current year

- Prioritize patients for scheduling and case management based on missing Dx and RAF

- Capture all appropriate HCC diagnoses and monitor the change in RAF

- Retrospective review

Applying technology to HCC Management

- Implement end to end software and technology to support your HCC Management Program, leveraging artificial intelligence and automation as a part of the solution and integration into the EMR and physician's workflow is essential.

Technology should:
- Provide worklists to prioritize patients to be reviewed / scheduled for visit based on gap in RAF scores
- Pre-bill Review for all patient diagnoses (from claims AND documentation) and whether or not they have been captured in a claim this calendar year.
- Create physician notifications detailing conditions still to be captured this year. Include in your solution a way to be able to provide a Proactive, patient-specific notification, that is shown to provider automatically when they open the patient chart.
- Retrospective review post-office visit for final coding
- Robust reporting for measuring the performance of the program

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Questions

3M Science. Applied to Life.™

Thank you

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