

# Hierarchical Condition Category Coding

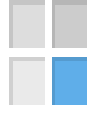
How Risk Scoring impacts Reimbursement

*Presented by:*

Rocky Mountain Health Plans

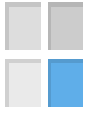
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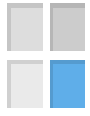
# ICD-10-CM and Documentation

- The ICD-10 code set requires more specific physician documentation and offers a much more transparent clinical footprint.
- Government payers, insurers, hospitals, health systems, medical groups and others will use ICD-10's granular data to determine accurate and fair physician compensation and reimbursement for goods and services.



# ICD-10-CM Update

- The Centers for Disease Control and Prevention (CDC) released the fiscal year (FY) **2021 ICD-10-CM code** changes.
- There are **554 code** changes which will be effective Oct. 1st, 2020 including
  - **488 new codes**
  - **47 revised codes**
  - **19 deactivated codes**
  - Adherence to the Guidelines when assigning ICD-10-CM diagnosis codes is required under HIPAA in all healthcare settings.



# Diagnosis Coding is Vital to Fair Provider Compensation

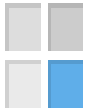
- Medical groups are signing contracts that adjust payment for a contract year based on quality measures, outcomes, utilization and the acuity of care for a patient population. The payor measures acuity of care by reviewing the patient's age, gender and medical conditions. Where does the payor get the list of medical conditions? Diagnosis codes on claims!
  - Medicare Advantage Plans, and ACA Commercial plans, base incentive payment on Risk Adjustment Factor (RAF) Scores
  - MIPS and MACRA quality programs



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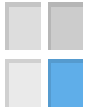
# Diagnosis Coding is Vital to Fair Funding to Insurance Plans

- The purpose of a Risk Adjustment model is to predict the future health care costs for enrollees in Medicare Advantage plans and ACA Commercial plans.
- CMS/ACA Commercial plans are then able to provide capitation payments to these plans
- Capitation payments help the health plans to enroll not only healthier individuals but those with chronic conditions or who are more seriously ill, by providing additional compensation



# HHS Payment Goals

- To help drive the health care system towards greater value-based purchasing — rather than continuing to reward volume regardless of quality of care delivered ...
- Alternative payment models include models such as Accountable Care Organizations (ACOs), bundled payments, and advanced primary care medical homes...
- Alternative payment models include:
  - models such as Accountable Care Organizations (ACOs), bundled payments, and advanced primary care medical home



# MACRA

## Medicare Access and Chip Reauthorization Act

- Merit-Based Incentive Program (MIPS)
  - Physician Quality Reporting System (PQRS)
  - Value-Based Payment Modifier (VBM)
  - Clinical Practice Improvement
  - Meaningful use of certified EHR technology
- Alternative Payment Models (APMs)
  - From 2019-2024, some providers receive a lump-sum payment
  - Increased transparency of physician-focused payment models
  - Starting in 2026, offer some providers higher annual payments
- APM Criteria
  - Coordinating care; improving quality, reducing costs.



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# Hierarchical Condition Category Model (HCC)

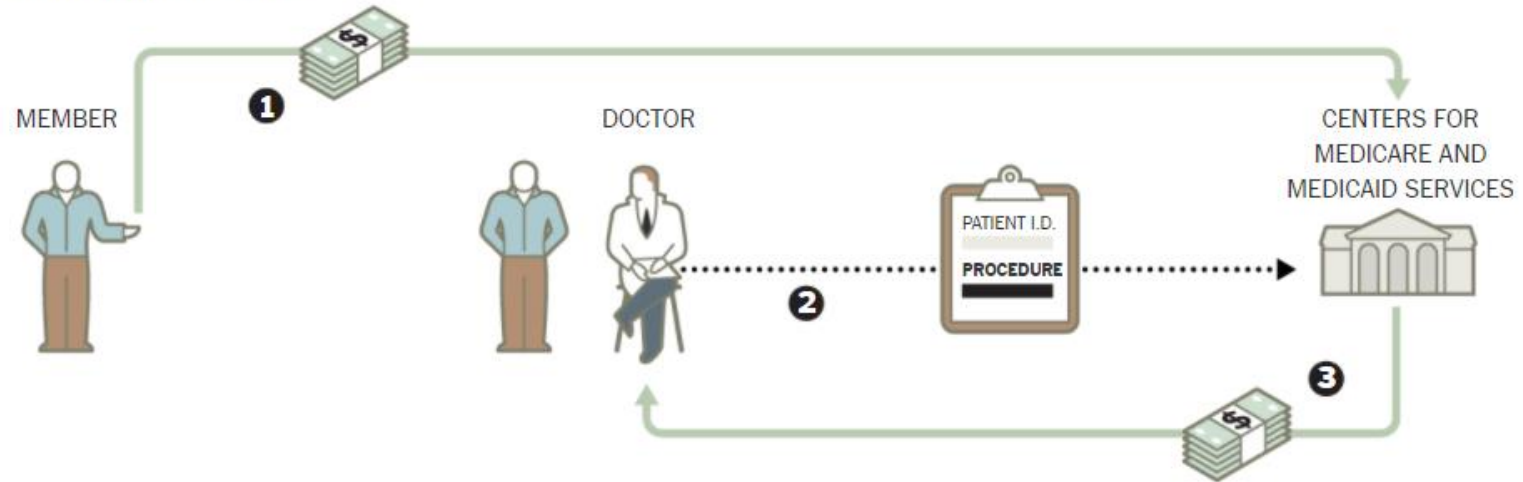
- Medicare Advantage Plans (aka Medicare Part C) have been paid under an HCC model since 2004.
- HCC is a **risk adjustment** model which identifies patients with serious acute or chronic illnesses and assigns a *risk factor* score to the beneficiary based on the patient's demographics and medical history.
- The government contracts with for-profit insurers to manage health care for these patients, and pays insurers a yearly fee for each member they enroll.

***The higher the risk score, the higher the annual fee.***



# Fee for Service

## Traditional Medicare



1. members pay a monthly premium to the Centers for Medicare and Medicaid Services (C.M.S.), whether or not they visit a doctor. C.M.S. also receives funding from U.S. taxpayers.

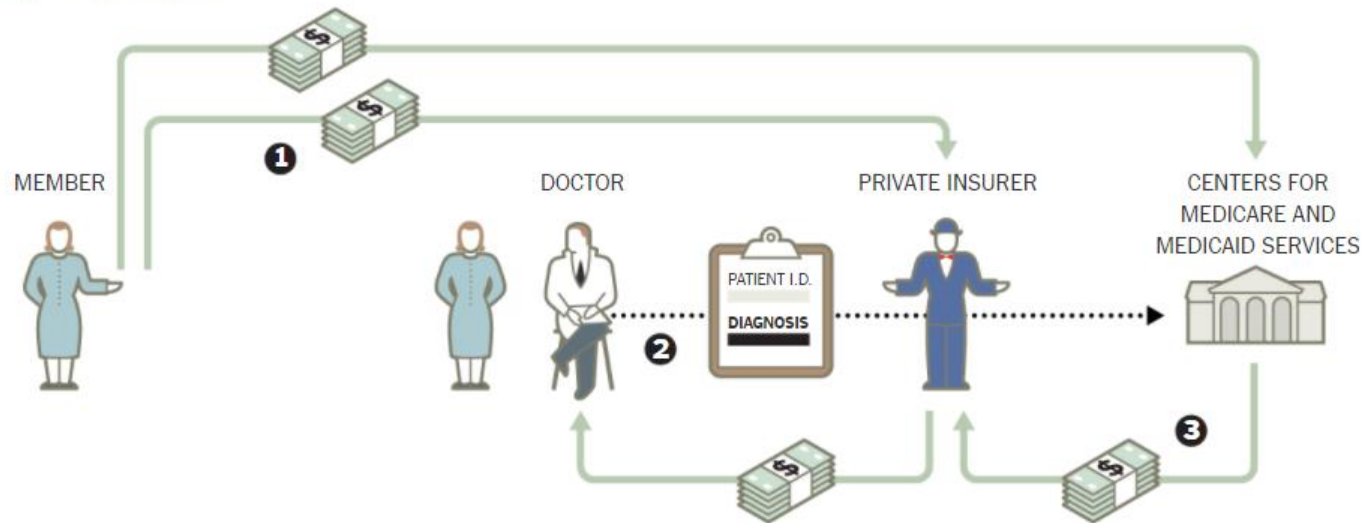
2. If members see a doctor, the doctor sends a copy of their medical claim to C.M.S., to get paid.

3. C.M.S. pays the doctor. Traditional Medicare compensates doctors according to the procedures they perform — lab tests, scans, operations, etc.

SOURCE: Walsh, Mary Williams. "A Whistle-Blower Tells of Health Insurers Bilking Medicare." *The New York Times*. The New York Times, 15 May 2017. Web. 13 June 2017.

# Risk Based Model

## Medicare Advantage

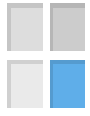


**1.** Members also pay a monthly premium to C.M.S., and often a separate premium to a private insurance company.

**2.** If members see a doctor, the doctor sends a copy of the medical report to the private insurer, who then pays the doctor.

**3.** C.M.S. pays the private insurer a base rate for each member. If the private insurer tells C.M.S. that the member required treatment for certain conditions, C.M.S. pays the insurer more.


SOURCE: Walsh, Mary Williams. "A Whistle-Blower Tells of Health Insurers Bilking Medicare." *The New York Times*. The New York Times, 15 May 2017. Web. 13 June 2017.



# Enrollment Continues to Grow

- More than **24 million** people are now enrolled in Medicare Advantage plans, up from 11 million in 2010.
- The Congressional Budget Office (CBO) projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to about 51 percent by 2030.
- ***Over one-third*** (36%) of all Medicare beneficiaries have chosen Part C Plans over the traditional fee-for-service Medicare Program.
- The government pays insurers, on average, **\$10,000** per year per person.

SOURCE: Walsh, Mary Williams. "A Whistle-Blower Tells of Health Insurers Bilking Medicare." *The New York Times*. The New York Times, 15 May 2017. Web. 13 June 2017



# Hierarchical Condition Category Model (HCC) Calculations

- Each patient is assigned a Risk Adjustment Factor (RAF) score
  - RAF scores are based on:
    - Patient's age and sex
    - Medicaid or disability status
    - Total of all chronic conditions and disease interactions
- RAF identifies the patient's health status
  - Lower RAF indicates healthier patient
  - Higher RAF indicates sicker patient
  - Average FFS patient has a score of 1.00



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# How does HCC Affect Payment?

- RAF scores are “additive”:
  - All qualifying diagnoses are included in the RAF score
  - Risk factors are added to achieve “total” RAF score
- RAF scores are “predictive”
  - Codes reported this year determine payments for next year
  - Health status is re-determined each year, therefore codes must be submitted every year to be counted
    - The RAF for each patient is “reset” every year
- Payment is made per HCC category (not per diagnosis code)



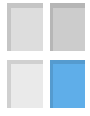
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# Which ICD-10 Codes to report

- For 2020, there are 10,946 ICD-10 codes, that map to 102 HCC Categories. Many Commercial models vary on the HCC categories included
- For example:
  - **HCC136 – Chronic Kidney Disease, Stage 5**
    - I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
    - I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
    - I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
    - N18.5 Chronic kidney disease, stage 5
    - N18.6 End stage renal disease

# Common HCC Category/Weight

Condition	ICD-10 Code	HCC Category	Weight
Diabetes with hyperglycemia	E11.65	HCC18	0.318
HTN with CFH	I11.0	HCC85	0.323
Prostate cancer	C61	HCC12	0.146
Morbid Obesity	E66.01	HCC22	0.273
Protein-calorie malnutrition	E46	HCC21	0.545
Smokers cough	J41.0	HCC111	0.328
Chron's disease	K50.90	HCC35	0.294
Rheumatoid Arthritis	M06.9	HCC40	0.423
Major Depression, recurrent	F33.9	HCC58	0.395
Parkinson's Disease	G20	HCC78	0.585



# How Diagnosis Codes Affect Payment

HCC	DX	RAF Score	Annual Payment
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A patient is seen in your office.

Pt is a 64 year old disabled female. She has Type II diabetes with nephropathy.

Patient also has congestive heart failure and Stage IV CKD (GFR 24 ml/min Filtration).

Patient is obese with a BMI of 56, is on insulin and is paraplegic.

**TOTAL PAYMENT: \$38,426**

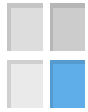




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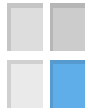
# How to Achieve Accurate RAF Payment

- The Annual Health Assessment is very important
  - Remember to list chronic conditions annually, even if primary management is by a consultant or specialist
- Adequate documentation is critical
- Accurate risk adjustment payment relies on:
  - Complete medical record documentation
  - Accurate and specific diagnosis coding
- Depression documentation:
  - “run of the mill” depression/anxiety has no HCC weight
  - Major depression must be specified and document ***Diagnostic and Statistical Manual of Mental Disorders*** criteria



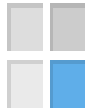
# Steps to take in your Practice

- Identify HCC Categories that are clinically meaningful
  - What chronic diseases do your sickest patients have?
  - HCC Diagnosis categories are well defined
  - Specific diseases/conditions are grouped to each category
  - More than 10,000 ICD-10-CM codes map to 102 HCCs in the current risk adjustment model.
  - Diagnosis codes are excluded from mapping when they do not predict future cost or are vague or variable in diagnosis, coding or treatment
  - Example- symptom codes or osteoarthritis



# What supports coding for HCC?

- Following official ICD-10 Guidelines
- Medications from Med list linked to condition in the note
  - Ex: Prednisone 5 mg PO daily for asthma
- Notes that reflect test results in the note
  - Ex: chest x-ray confirms pneumonia
- Condition was Monitored, Evaluated, Assessed or Treated.  
Think MEAT
- Do not report a diagnosis code that was not addressed during the encounter or documented in the note



# Often Missed Diagnoses

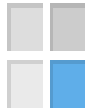
- Z68.-BMI
- E78.5 Hyperlipidemia, unspecified
- E11.9 Type 2 diabetes mellitus without complications
- E03.9 Hypothyroidism, unspecified
- F32.9 Major depressive disorder, single episode, unspecified
- I48.91 Unspecified atrial fibrillation
- E66.9 Obesity, unspecified
- J45.909 Unspecified asthma, uncomplicated
- F41.9 Anxiety disorder, unspecified
- I50.9 Heart failure, unspecified
- D64.9 Anemia unspecified
- L53.9 Erythematous condition, unspecified



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# Common Coding or Diagnosis Errors

- Missing diagnosis codes
- No documentation to support diagnosis billed
- Chronic conditions not coded or assessed
- Not enough specificity of disease
  - Patient is diabetic and on insulin – documentation does not indicate patient has Type 1 or type 2
- Cause and effect coding not present
  - “Due to”, “associated with”, “manifested by”, “secondary to”
- Use of “history of” when current condition exists
- Codes not properly sequenced



# Common Documentation Errors

- Diagnosis listed on problem list but not noted in the note
- Medication listed in Medication List but condition not mentioned or linked in the note
  - Lisinopril but HTN not documented or coded
- BMI status and level of Obesity missing
- Status of cancer is not clear or no treatment is documented



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# Common Coding or Diagnosis Errors

- Active health status missing
  - CABG, amputation, congenital diseases, Downs syndrome, transplant status
- Long term use of medication for chronic diseases missing
  - Coumadin, ASA, insulin, etc...
- Pertinent family and social elements
  - family history of cancer, DM, HTN, MI, sudden cardiac death, congenital diseases
- Acquired organs or Amputations are not documented
  - Kidneys, toes, feet, etc....

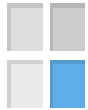


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# Tips for Documentation Improvement

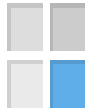
- Do not report ICD-10-CM codes from the problem list (See Assessment and Plan) and remember the acronym MEAT
- Remember to report each HCC/RAF reportable condition “At least once a year”.
  - Do you have a plan to ensure each Medicare Advantage member comes in annually for their AWW?
- Electronic Medical Record was not authenticated or signed appropriately
  - Medical record does not have legible signature or appropriate credentials





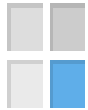
# RADV Audits

- Risk Adjustment Data Validation (RADV)
  - Notes are routinely audited in the “fee-for-service” process to ensure documentation supports CPT codes
  - Similarly, notes are audited in Risk Adjustment programs to ensure proper clinical documentation for ICD-10 codes
- CMS audits Medicare Advantage (MA) plans for accuracy of risk-adjustment payments
- Compares accuracy of coding to medical record
- MA plans can be audited annually
- When audited will be required to submit medical records to substantiate coding



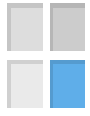
# Coding/Documentation Tips

- Document all current conditions evaluated
  - Clearly stated in the Assessment and Plan
  - Supported “up top” in the history and exam sections of the note
- Document and code the status of all chronic conditions at least annually
  - Ex. COPD, CHF, Diabetes
  - Ex. Controlled, Uncontrolled, Stable, improving, worsening
- Only code signs/symptoms if definitive diagnosis does not exist
- Code to highest level of specificity
  - Ex. Major depressive disorder vs. depression
  - Ex. Morbid Obesity vs. Obese or Overweight
- Code all co-existing acute conditions
  - Ex. Protein calorie malnutrition
- Code pertinent past conditions
  - Ex. Old MI



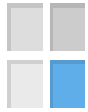
# Coding/Documentation Tips

- Document conditions for prescriptions given
  - 20 mg Lisinopril for HTN
  - 5 mg Prednisone PO daily for asthma.
  - 20 mg Citalopram for major depression
- Document conditions for tests ordered
- Document conditions for referrals given
- Code all status conditions
  - Amputee, Acquired limb, Dialysis, HIV status
  - Angina, stable on Nitro
  - Compensated CHF, stable on Lasix
  - CPOD controlled with Avair



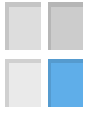
# Key Takeaways

1. Coding depression: Please avoid the non-specific ICD-10 codes (F32.9) and instead use the most specific ICD-10 codes possible (F32.0-mild, F32.1-moderate, F32.2-severe).
2. Document conditions every year: HCC scores reset on the 1<sup>st</sup> of the new year-all conditions must be documented every year, otherwise they are not considered.
3. Document in the assessment: ICD-10 codes and conditions must be in the assessment portion of the note. Narrative discussion and active problem lists are not considered.



# Key Takeaways

4. Updating active problem list: You may be flagged if a chronic condition continues to appear on the active problem list but is not addressed in this year's visits. If it is no longer relevant, consider removing from the list or coding as historical.
5. **MEAT** Criteria: You can document a code if you are **M**onitoring, **E**valuating, **A**ssessing, or **T**reatment. Ex: "DM monitored by endocrinologist". You are monitoring by getting regular note updates from the specialist.
6. Codes on claim: You may submit up to 12 ICD-10 codes per claim for RMHP and most other insurances.



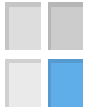
# Parting Thoughts

- Does your practice have a Compliance Program?
  - Include Risk Adjustment Audits to validate clinical documentation
  - Use audit results to provide education to all clinicians and coders
  - Continue to audit CPT coding documentation
- Monitor patient visits to ensure annual reporting



# Questions?





# About the Speaker



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**Nancy M Enos, FACMPE, CPMA, CPC-I, CEMC** is an independent consultant with the MGMA Health Care Consulting Group and a principal of Enos Medical Coding. Mrs. Enos has 40 years of experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice, Enos Medical Coding ([www.enosmedical.com](http://www.enosmedical.com))

As an Approved PMCC and ICD-10 Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-10 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including National, State and Sectional MGMA conferences, and at hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She serves as a College Forum Representative for the American College of Medical Practice Executives.