NATIONAL RURAL HEALTH RESOURCE CENTER

Flex Coordinator
Learning Collaborative
Week 4

Success In Healthcare Transformation

How to Demonstrate Value: Hierarchal Condition Category Coding

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June 11, 2019

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

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Webinar Series

1. Healthcare Transformation: Understanding Payment and Delivery Reform

2. Success in Transformation: How Population Health can grow Primary Care (the leader of healthcare transformation).

3. Delivery Reform for Payment Reform: Practice Transformation

4. How to demonstrate Value: Hierarchal Condition Category Coding

5. Return on Investment to Value Based Care

6. The Big Picture-RESULTS MATTER

Context

- Building on the first 3 webinars: CMS has a compelling reason to transform from volume to value.
- The first step is Population Health strategies. The second step is proper documentation and HCCs (what?).
- How does documentation connect with payment and delivery reform? How does it apply to population health strategies?

Measurement of Cost and Quality resides in the Data

data

MUST

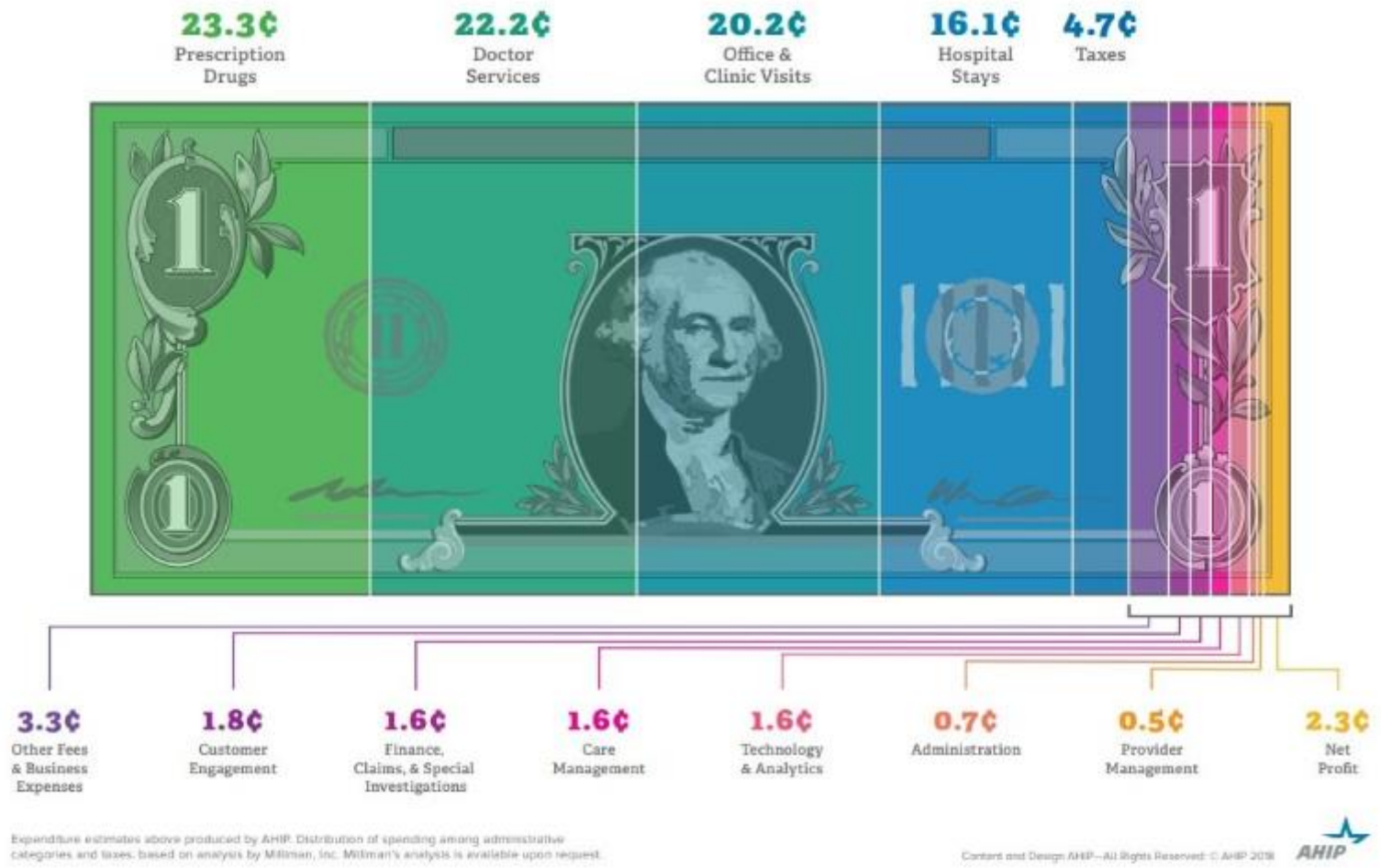
reflect your story

in order to demonstrate

value

Thinking from a Payor perspective

81.8 cents for the medical Budget!



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Origins of Medicare Risk Adjustments and HCC Coding

In 2004, Medicare implemented a system of paying Medicare Advantage (MA) plans that gave them greater incentive than fee-for-service (FFS) providers to report diagnoses.

In order to reward health plans for attracting sicker-than-average enrollees, and to discourage plans from constructing business models designed to avoid risk, Medicare and other payers have increasingly turned to diagnosis-based risk adjusted payment systems in which health plans are ***paid more for enrollees expected to need more care.***

Risk Adjustment

Risk adjustment

A method used to adjust payment based on the health status and demographic characteristics of a beneficiary

Risk adjustment calculations consider:

- Diseases that have significant impact on patient cost of care (Total Spend)
- Demographic information such as age and sex

Predictive in nature:

- Information from current year to predict future year expenditures

Why is Risk Adjustment Done?

To accurately reflect the health of the beneficiary:

- Risk adjustment scores are higher for a patient with a greater disease burden, less for a healthier patient

- The 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 your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.

How is the risk score developed?

The Risk Adjustment Factor (RAF score) is set for each patient and includes:

- Baseline demographic elements (age/sex, dual eligibility status)

- 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 you do in this year sets the RAF and subsequent funding for next year

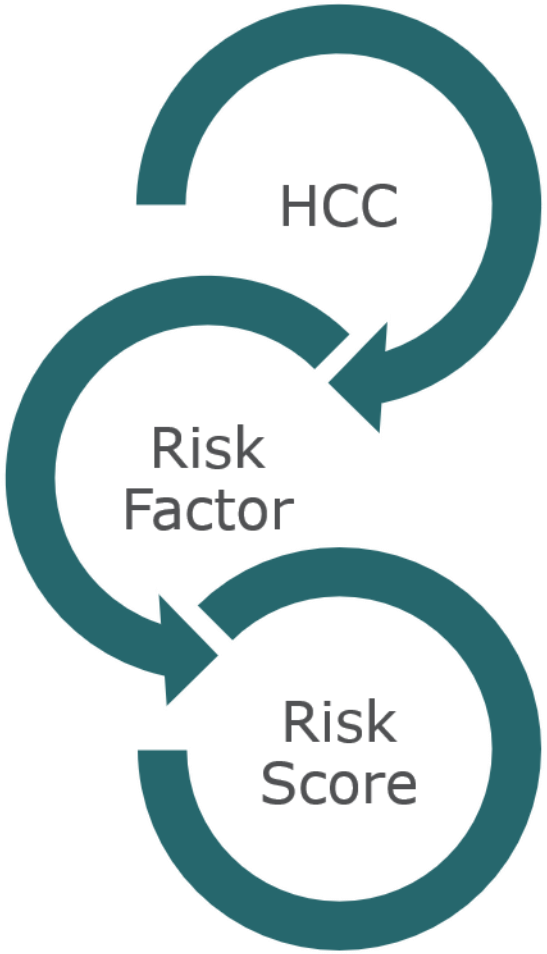
What is HCC?

HCC (Hierarchical Condition Categories):

an implementation of Risk Adjustment and are used to capture medical status and history in many risk models (including the current risk models used by CMS and ACA requirements).

The CMS risk adjustment model measures the disease burden that includes 70 HCC categories, which are correlated to diagnosis codes. For HCCs, *conditions and diseases are organized into body systems and similar disease process.*

How is HCC used to determine the risk factor?



- In HCC methodology, certain diagnoses (i.e., ICD-10-CM codes) are assigned an HCC according to the nature and severity of the diagnosis.
- These HCCs in turn are also assigned a risk factor.
- A patient's risk score is generated by adding together the risk factors for the various HCCs they qualify for (with hierarchies preventing multiple diagnoses in the same disease group from inappropriately increasing the risk score).

Risk Adjustment Coding Example

No conditions coded		Some conditions coded		All chronic conditions coded	
76-year-old female	0.442	76-year-old female	0.442	76-year-old female	0.442
Medicaid eligible	0.151	Medicaid eligible	0.151	Medicaid eligible	0.151
DM with complications	X	DM w/o complications	0.118	DM with complications	0.368
Vascular disease	X	Vascular disease	x	Vascular disease	0.299
CHF	X	CHF	x	CHF	0.368
Disease interaction (DM +CHF)	X	Disease interaction (DM +CHF)	X	Disease interaction (DM +CHF)	0.182
Total RAF	**0.593**	**Total RAF**	**0.711**	**Total RAF**	**1.810**

Primary Care Encounter Example

Patient with diabetes and polyneuropathy:

- ✓Right great toe amputated several years ago.
- ✓Continues to smoke.
- ✓Patient brought in multiple records from other providers.
- ✓In addition to refill of meds, you counseled for 5 minutes regarding smoking cessation.
- ✓You spend 35 minutes reviewing and summarizing the outside records and include that in the visit note.

RAF Score With and Without HCC Coding

Which road to take?

ICD-10	Description	RAF
J44.9	COPD	.328
E11.9	DM Unspec	.118
Total risk=		**.446**

AMERICAN ACADEMY OF FAMILY PHYSICIANS

ICD-10	Description	RAF
J44.9	COPD	.328
Z99.81	Oxygen Dep	
J96.11	Chronic Resp Failure w/ hypoxia	.318
E11.65	DM w/ hyper-glycemia	.318
Total optimized risk=		**.964**

Risk Adjustment Data Validation

- RADV audits *validate the accuracy of diagnoses* submitted by MA plans
- Medicare, Medicaid, and Dept. of Health and Human Services (Exchanges) will require annual RADV audits
- If you treated a member whose name appears in a RADV audit, you provide the requested medical records

Success = accurate chart notes to support every chronic condition you report

Average error rate nationally is 20–30%

Documentation pitfalls: Qualifying language

Under ICD-9 guidelines, *"Personal history (of)" means a past medical condition that no longer exists*

"History of" is an often misused descriptor. ***Never*** use this term to describe a condition that the patient still has

Frequently seen examples:

- "History of CHF" misused to indicate compensated CHF
- "History of Afib" misused to indicate atrial fibrillation controlled by medication or pacemaker

PREMERA BLUE CROSS

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Accurate Coding

Documentation must be complete and specific based on a face-to-face encounter with the patient. 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 done

M.E.A.T.

MONITOR - signs, symptoms, disease progression, disease regression

EVALUATE - test results, medication effectiveness, response to treatment

ASSESS - ordering tests, discussion, review records, counseling

TREAT - medications, therapies, other modalities

Premera Blue Cross MA: Enhanced Annual Wellness Visits

- A typical visit lasts 45-60 minutes, at no-cost to the patient, including preventive labs •
- The goal is to see every Medicare patient every year and for this service to be billed once per calendar year •
- The benefit refreshes January 1 of every year; no need to wait 365 days between visits •
- In addition to the traditional AWV CPT codes G0438 and G0439, Premera allows for an additional code of S0250 (3.0 RVU) to cover the extra time of assessing chronic conditions
- Visits need to be performed by a primary care physician, contracted nurse practitioner, or PA

Premera Blue Cross MA: During an Enhanced Annual Wellness Visit

- Document patient's current chronic conditions and ongoing treatment plans
- Conduct preventive screenings for conditions such as high blood pressure, diabetes, depression, and heart disease
- Review medications
- Schedule preventative treatments: colonoscopy, blood work, mammogram, etc.
- Complete lab work as necessary
- Use a pre-populated template from Premera

Fax chart notes to us at the end of the visit to receive payment

Premera Blue Cross MA: Benefits of Annual Wellness Visit

- Allows for accurate reporting/submission of patient's chronic conditions to Medicare in the current year
- Maintains best practice of seeing your patients at least once a year
- Allows opportunity to identify care gaps and create a plan of care for the year
- Ensures acceptable medical record documentation in the case of a Risk Adjustment Data Validation (RADV) audit. Compliance with Star Measures is also required by CMS.

Essential takeaways for today and tomorrow

To *comply* with CMS regulations, provide the best and most *efficient service* to your patients, and *receive the reimbursements* you deserve, physicians and practices must master HCC coding.

- Risk adjustment will become a more prevalent part of a provider's patient care
- The importance of consistent, accurate, and complete documentation in the medical record can't be overemphasized
- Documentation and specificity are the keys to success

HCC Best Practices

Focus on accuracy

CMS can and will deny claims for a lack of "diagnosis specificity," so it is in your best interest to provide the most complete and accurate information. Take a long, hard look at your practice. Make sure you have systems in place to capture the necessary information about your patients' conditions and the services you provide. Reflect that information in your reporting and billing.

HCC Best Practices continued

Understand your patient population

If you serve Medicare patients, it's more than likely that many of them have been diagnosed with diabetes, vascular disease, or one or more of the other most common HCC diagnoses. Take a look at your patients and determine who belongs in what diagnosis category. Also, work with your administrative and clinical staff to place the right patients with the right diagnosis, and keep up-to-date, accurate records.

HCC Best Practices further

Capture comorbidities

To make sure you are providing all necessary services to a patient and to avoid claims denial for a lack of "diagnosis specificity," be sure to capture every diagnosis. For example, if one of your patients has diabetes, but also hypertension and depression, make sure all conditions are captured. Remember: CMS requires that clinicians provide proof of the risks associated with each patient, and the HCC payment structure is based on accurate reporting. A record can have more than one HCC code.

Report every year

The CMS risk management model is built on reviewing a previous year's health status to predict the following year's health expenses. That means physicians and practices must report their information to CMS every year. Get in the habit of using HCC codes and submitting accurate information in a timely fashion.

Resources

- Medicare Advantage: Risk Adjustments Coding
  - Premera Blue Cross
- HCC Crash Course: Absorbing the Impact
  - American Academy of Family Practice

    Barbara L. Hays, CPC, CPCO, CPMA, CRC, CPC-I, CEMC, CFPC, FELLOW

    Samuel L. Church, MD, MPH, CPC-A, CRC, FAAFP
- Understanding Hierarchical Condition Categories (HCC)
  - Formativ Health, 2018

Questions?

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