Value Based Coding in a Changing Environment

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ICD-10-CM Update

- Effective October 1, 2017 the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) added or updated approximately 1,943 diagnosis codes in the ICD-10-CM coding classification.
- This large number of new codes is due to the partial freeze on updates prior to the October 1, 2015 implementation of the code set.
- There are also updates to the 2017 ICD-10-CM Official Guidelines for Coding and Reporting that impact medical record documentation, code selection and sequencing.
  - Adherence to the Guidelines when assigning ICD-10-CM diagnosis codes is required under HIPAA in all healthcare settings.

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ICD-10-CM and Documentation

- With ICD-10 comes a new dawn in physician documentation and 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.

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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 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.
- CMS is 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

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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…
- Specifically they want to:
  - move 30% of Medicare payments into alternative payment models by the end of 2016 and 50% by the end of 2018,
  - move 85% of Medicare payments to a model tied to quality or value by 2016, and 90% by 2018.
- Alternative payment models include:
  - models such as Accountable Care Organizations (ACOs), bundled payments, and advanced primary care medical home

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MACRA

- 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.

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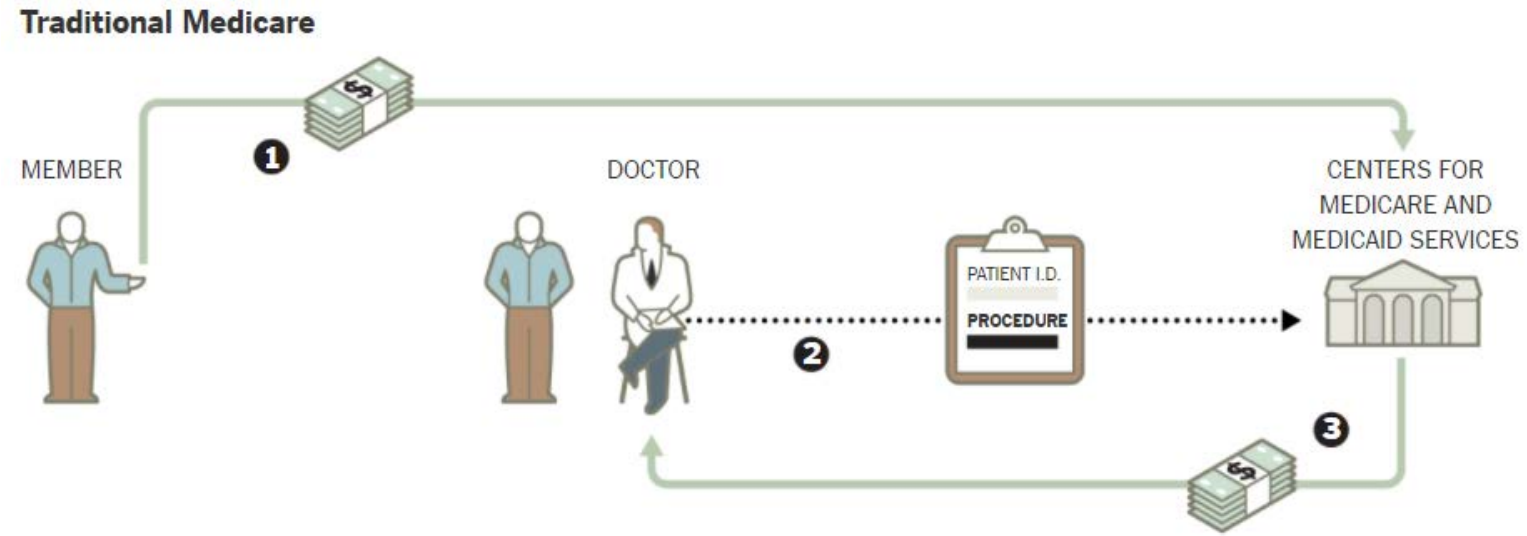
Hierarchical Condition Category Model (HCC)



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.

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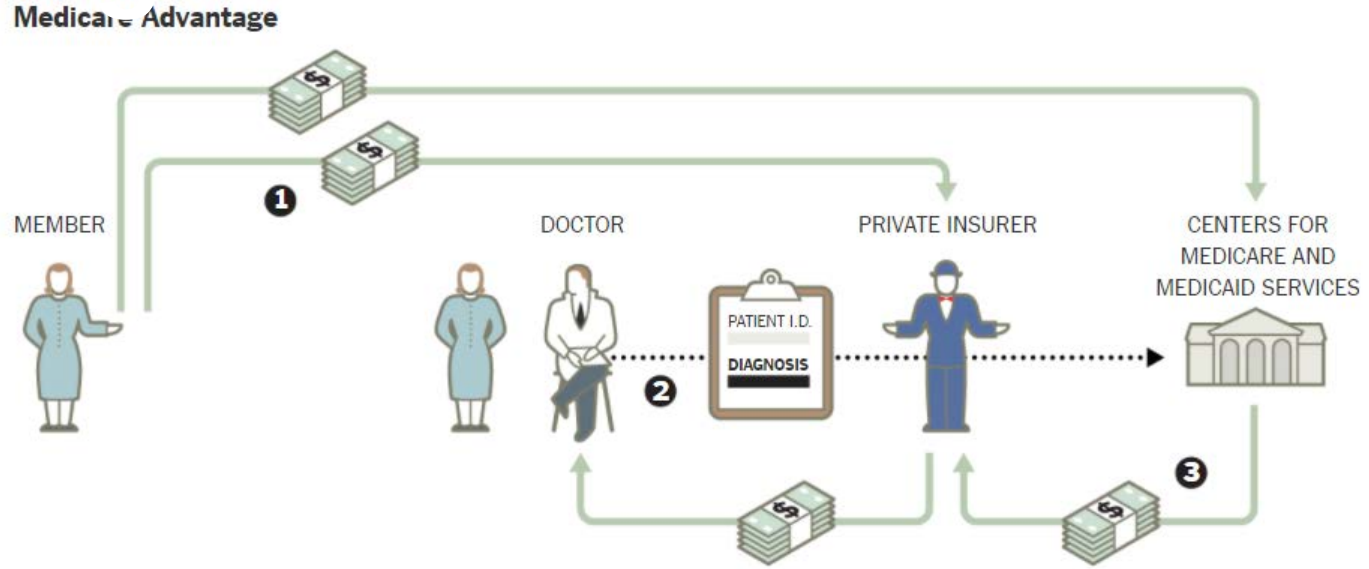
Hierarchical Condition Category Model (HCC)



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.

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Hierarchical Condition Category Model (HCC)

- More than **17 million** people are now enrolled in Medicare Advantage plans, up from 11 million in 2010.
- Nearly ***one-third*** 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.

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Hierarchical Condition Category Model (HCC)

- 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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Hierarchical Condition Category Model (HCC)

- 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

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How does HCC Affect Payment?

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How Diagnosis Codes Affect Payment

A patient is seen in your office. Pt is a 64 year old disabled female. She has Type II diabetes and Diabetic Chronic Kidney Disease. 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.

HCC	DX	RAF Score	Annual Payment

TOTAL PAYMENT: $37,416

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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 9,000 ICD-10-CM codes map to 79 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

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Common HCC Categories

- Chronic Kidney Disease
- Diabetes Mellitus
- Hypertension
- Peripheral Arterial Disease (PAD)
- Major Depressive Disorders
- Stroke and Late effects of prior Stroke
- Chronic Conditions
- History of Heart Attack
- Renal Dialysis Status
- Tracheostomy Status
- Respirator Dependence
- Lower Limb Amputee
- Organ Transplant Status
- Asymptomatic HIV Status
- Protein Calorie Malnutrition
- Alcohol Dependence & Drug Dependence

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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

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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

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Common Coding or Diagnosis 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
- Codes not properly sequenced
- 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 AWV?
- Electronic Medical Record was not authenticated or signed appropriately
  - Medical record does not have legible signature or appropriate credentials

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RADV Audits

- Risk Adjustment Data Validation (RADV)
- 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

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Coding/Documentation Tips

- Document all current conditions evaluated
- 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

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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

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About the speaker:

Nancy M Enos, FACMPE, CPC-I, CEMC is an independent consultant with the MGMA Health Care Consulting Group. 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.

As an Approved PMCC Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses and consultative services. Nancy frequently speaks on coding, compliance and reimbursement issues.

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