CPAs & BUSINESS ADVISORS

RISK ADJUSTMENT DOCUMENTATION & CODING

1 **DEFINE RISK ADJUSTMENT**

Define Risk Adjustment and discuss program currently using.

2 **CLINICAL DOCUMENTATION AND CLINICAL DOCUMENTATION IMPROVEMENT**

We will discuss sources for clinical documentation used to determine risk adjustment and how CDI impacts.

3 **LEVERAGING TECHNOLOGY**

Ways to use technology to improve clinical documentation.

4 **RISK ADJUSTMENT POLICIES**

Discussion of policies which impact coded data.

RISK ADJUSTMENT

- Risk adjustment models used in healthcare which affect:
  - Reimbursement
  - Quality of care Reporting Metrics
  - RAF score used in many pay for performance programs

- Each risk adjustment model has its specifics but share commonality of:
  - All use ICD-10-CM diagnosis codes
  - All follow Official Guidelines for Coding and Reporting

RISK ADJUSTMENT

- Risk adjustment
  - Assists in predicting costs to provide care for patients.
  - Used to account for patients who will likely develop complications such as infection
  - Predict Readmissions

- Hierarchical Condition Categories (HCC)
  - Methodology for determining Risk adjustment Factor (RAF score)
  - Heightened visibility since Medicare Advantage Plans started to require RAF scores for reimbursement.
    - Predicts cost of care by patient based on risk of patient which equates into work it takes to care for the patient.
  - Used to risk adjust quality monitors
  - PACE – All-inclusive Care for Elderly
  - ESRD – Programs for End Stage Renal Disease

RISK ADJUSTMENT

- Risk adjustment (RA) payments are a permanent feature of the Affordable Care Act.
  - Risk adjustment offsets the law's requirement that insurers offer coverage without regard to consumer's health.
  - Understood some insurers will attract a sicker patient population.
  - ACA redirects money from insurers with healthier populations to those with more utilization.

FINAL RULE FOR RISK ADJUSTMENT IN ACA

- "Patient Protection and Affordable Care Act; Methodology for the HHS-operated Permanent Risk Adjustment Program for 2018" final rule issued December 2018
  - Final rule for 2018 was issued in response to ongoing litigation over the risk adjustment formula.
  - Litigation challenges CMS' decision to base transfers on statewide average premiums (rather than each plan's premium).
  - Issuing this rule allows CMS to continue normal operations of the RA program for 2018.
  - With the Risk Adjustment program in place, premiums can reflect differences in scope of coverage and other plan factors, not differences in the underlying health status of enrollees.
  - CMS cites the need to maintain market stability, ensure timely risk adjustment transfers, and avoid future premium increases and reduced insurer participation.

HIERARCHICAL CONDITION CATEGORIES (HCC)

Versions of HCC

- CMS HCC
  - Most familiar
- HHS HCC
  - Used by plans under the Affordable Care Act
  - Population involving children and maternity population
  - Conditions are HCC which are not under the CMS HCC version
- CDPS
  - Chronic Illness and Disability Payment System
  - Risk adjustment system for Medicaid
  - Similar to HCC model used for Medicare. Places greater emphasis on less common, but costly chronic conditions more prevalent among disabled Medicaid beneficiaries

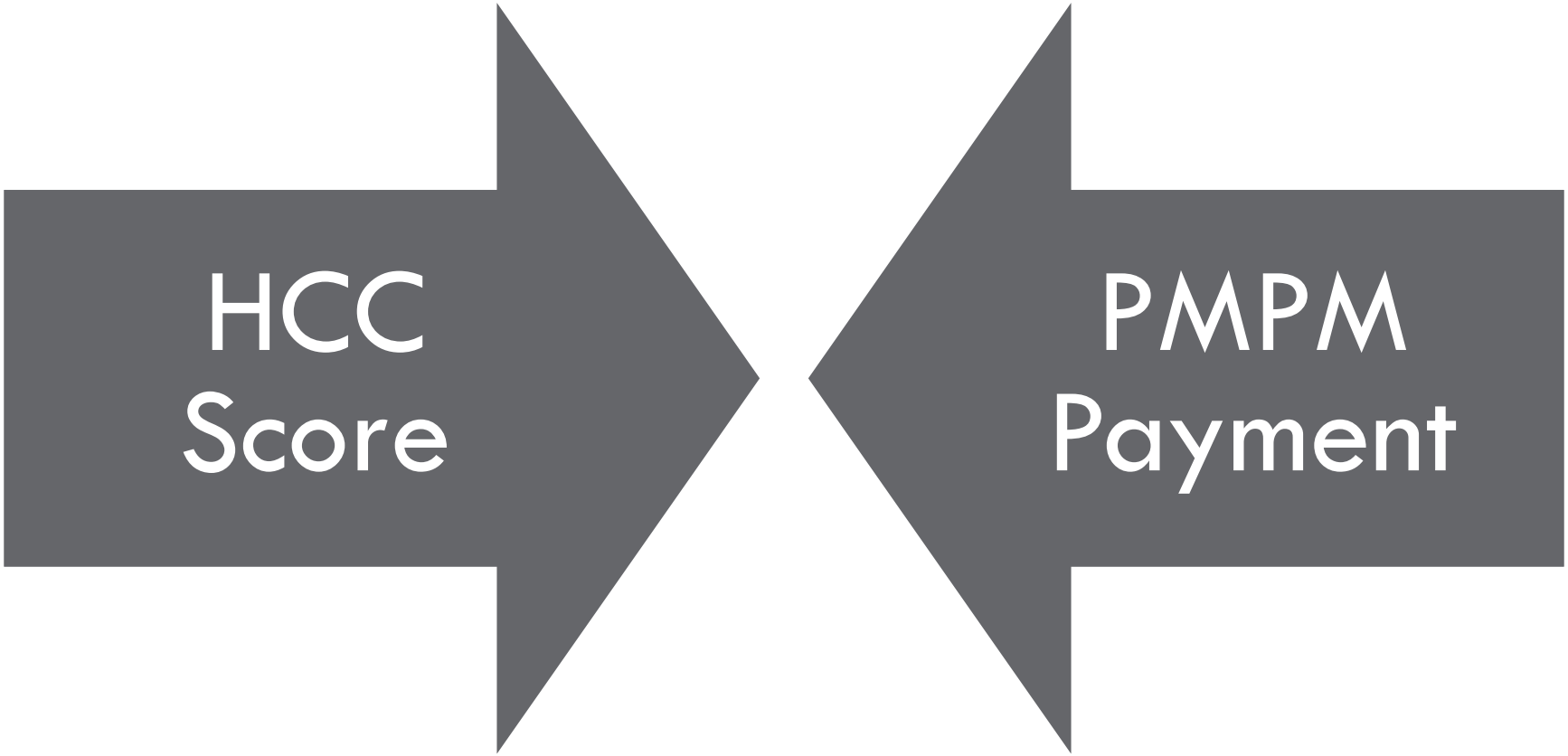
PROGRAMS THAT UTILIZE CMS HCC SCORING

MEDICARE SHARED SAVINGS PROGRAMS

Determining Benchmarks

Shared Savings/Loss Calculation

MEDICARE ADVANTAGE



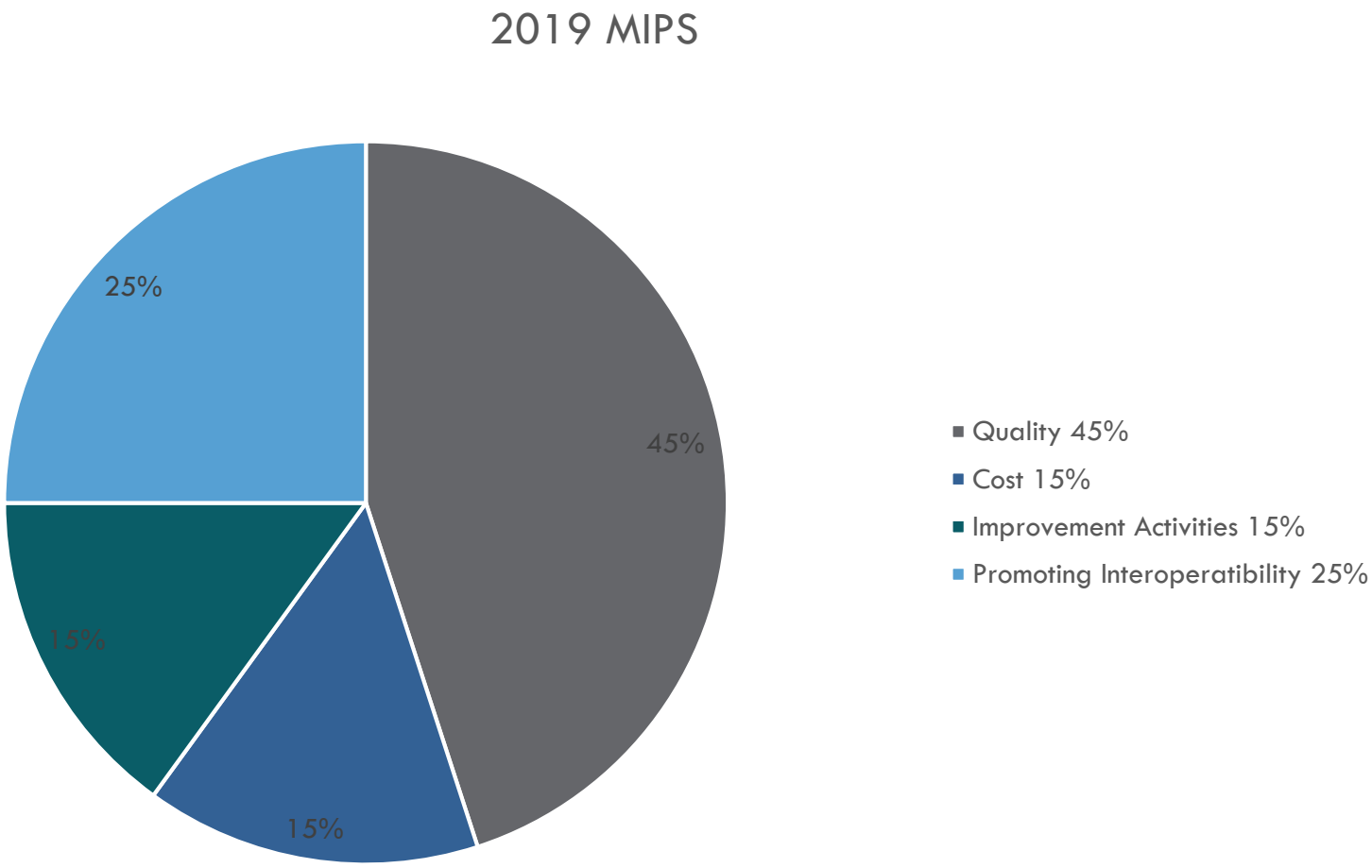
CPC+

Table 3-1
Risk Tier Criteria and CMF Payments (per Beneficiary per Month)

Risk tier	Risk score criteria	Track 1	Track 2
Tier 1	Risk score < 25th percentile	$6	$9
Tier 2	25th percentile ≤ risk score < 50th percentile	$8	$11
Tier 3	50th percentile ≤ risk score < 75th percentile	$16	$19
Tier 4	Track 1: Risk score ≥ 75th percentile Track 2: 75th percentile ≤ risk score < 90th percentile	$30	$33
Tier 5 (Track 2 only)	Risk score ≥ 90th percentile *or* Dementia diagnosis	N/A	$100

Source: CMS

MACRA – MERIT INCENTIVE PAYMENT (MIPS)



MACRA – MERIT INCENTIVE PAYMENT (MIPS)

- As in 2018, the Cost category will look at Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB).

- CMS added the following to its list of eligible clinician types:
  - Physical therapists
  - Occupational therapists
  - Qualified speech-language pathologists
  - Qualified audiologists
  - Clinical psychologists
  - Registered dietitian or nutritional professionals

  - It is projected this will increase the number of participating clinicians from 620,000 to 800,000. In turn, this would decrease the bonus or penalty amount for each individual because the amount will be split among a larger pool.

DOCUMENTATION AND CODING

DOCUMENTATION → CODED DATA → RISK

- CMS requires all conditions be documented and reported at least once during each calendar year to be counted/considered for risk

- All diagnosis codes submitted must be documented in the record as a result of a face-to-face visit.
  - i.e. Diagnoses on orders for Lab and Radiology are not counted in risk adjustment.

- Condition(s) must be explicitly stated in the medical record by the provider who is legally accountable for establishing the patient's diagnosis

SOURCES OF CLINICAL DOCUMENTATION & OPPORTUNITIES FOR DOCUMENTATION IMPROVEMENT

CLINICAL DOCUMENTATION

Inpatient

- Documentation for assignment of MS-DRGS & APR-DRGS
  - Principal Diagnosis
  - MCC
  - CC
  - Severity diagnoses
  - Procedures

    - 2018 Final Rule Changes
      - Eliminated special grouper logic which identified certain principal diagnoses as its own CC/MCC
      - First step in CMS's intent to revise CC/MMC grouper logic

    - Future of MCC/CC list
      - CMS to take a comprehensive look at the CC and MCC lists in FY 2019, per 2018 Final Rule

CLINICAL DOCUMENTATION

Inpatients

- Medical necessity for stay

- Clinical Validation
  - Clinical review of the case to see whether the patient truly possesses the conditions that were documented in the medical record.

  - More than only the diagnosis documented
    - Clinical indicators to support the diagnosis documented in conjunction.

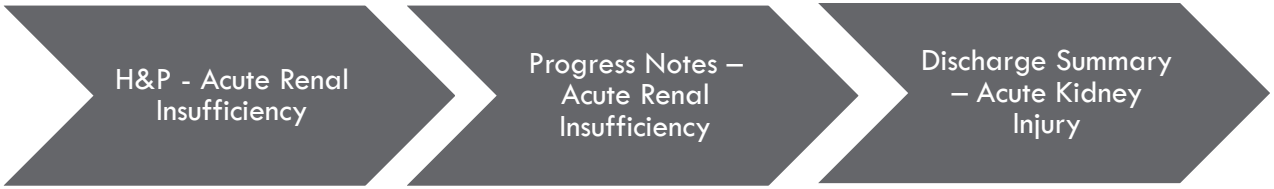
  - More clinical validation denials than true coding denials

- Diagnoses documented and coded on inpatients used in calculation of
  - Risk Adjustment for Cost Category under MIPS (Merit Based Incentive Payment System)

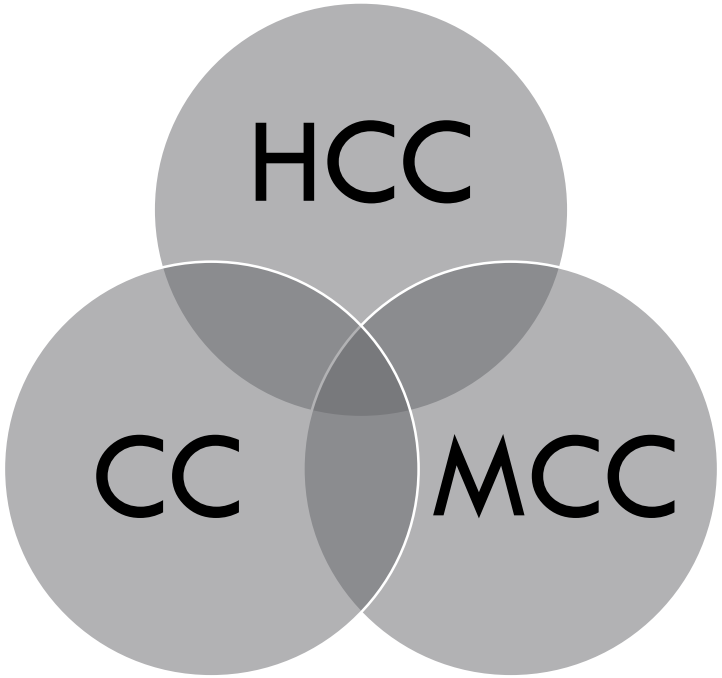
CLINICAL DOCUMENTATION

Inpatients

- Multiple Providers and Extended Length of Stay with Potential for Conflicting Documentation
  - Between Providers
    - Attending
    - Consultant
    - Surgeon
  - Between Documents
    - H&P
    - Progress Notes
    - Discharge summary
  - If diagnosis has changed documentation needs to support the change



UNDERSTANDING THE INTERRELATIONSHIP



42% overlap between HCCs and CCs
16% overlap between HCCs and MCCs

CLINICAL DOCUMENTATION

Outpatient

- Documentation to support services reported with CPT codes
  - Diagnoses for diagnostic tests
  - Diagnoses for therapeutic procedures
  - Diagnoses taken into consideration when treating patient

- Documentation for medical necessity of diagnostic procedures
  - NCD
  - LCD

CLINICAL DOCUMENTATION

Outpatient

- Documentation for medical necessity of therapeutic procedures
  - IV Hydration
    - Dehydration; volume loss/impairment
  - Support of medical indicators and criteria met defined in policy
    - Bariatric Surgery

- Documentation for medical necessity of medical visits
  - ER visit
  - Observation encounter

- Documentation of diagnoses taken into consideration when diagnosing or treating patient
  - Risk adjustment
  - Chronic conditions the patient has

CLINICAL DOCUMENTATION

Physician

- Documentation to Support E/M Level

- Medical necessity
  - Overarching criteria for physician levels is medical necessity

- Documentation of diagnoses taken into consideration when treating patient
  - Risk adjustment
  - Documentation of chronic conditions

CLINICAL DOCUMENTATION IMPROVEMENT (CDI) IN INPATIENT SETTING

- Many facilities have implemented

- Best practice for inpatient CDI:
  - Assure documentation of diagnoses are supported with risk, clinical indicators and treatment
  - Support of Principal diagnosis
  - Support of secondary diagnoses to include:
    - MCC
    - CC
    - Severity diagnoses
    - Chronic conditions which impact encounter and risk for patient
  - Clarify conflicting and ambiguous information
  - Procedure documentation

CLINICAL DOCUMENTATION IMPROVEMENT (CDI) IN INPATIENT SETTING

- Goal of inpatient CDI is to be real time while patient is in the hospital
- Inpatient CDI requires a good understanding of clinical indicators, treatment, and understanding of ICD-10 coding convention and rules
- Inpatient CDI should go beyond a focus of only the MS-DRG or APR-DRG assignment

EXPANDING CLINICAL DOCUMENTATION IMPROVEMENT (CDI) IN OUTPATIENT SETTING

Challenges

- No immediate return on investment for CDI in outpatient setting
- Clinical information spread across a variety of system which may or may not interface with each other
- Multiple providers documenting from a variety of settings with inconsistent processes across settings
- Physicians unaware of the need for improving clinical documentation of diagnoses in the OP setting
- Outpatient CDI requires a different thought process

EXPANDING CLINICAL DOCUMENTATION IMPROVEMENT (CDI) IN OUTPATIENT SETTING

Overcoming Challenges

- No immediate return on investment for CDI in outpatient setting
  - Understand the impact on risk adjustment and overall payment impact
  - Denials occur in outpatient setting – enlist CDI help to prevent denials
- Clinical information spread across a variety of system which may or may not interface with each other
  - Addressing these challenges will not only improve documentation for overall risk adjustment but assure continuity of care among providers
- Multiple providers documenting from a variety of settings with inconsistent processes across settings
  - CDI program can help these issues and provide a road map of where to begin setting standards

EXPANDING CLINICAL DOCUMENTATION IMPROVEMENT (CDI) IN OUTPATIENT SETTING

Overcoming Challenges

- Physicians unaware of the need for improving clinical documentation of diagnoses in the OP setting
  - Physicians are thinking about the chronic conditions which the patient has when treating and prescribing medications. We need to assist them in assuring they are documenting and getting credit for the diagnoses which are impacting the patient

- Outpatient CDI requires a different thought process
  - Inpatient CDI is often acute conditions. OP CDI is chronic conditions and conditions that co-exist and impact care and treatment of the patient.

LEVERAGING TECHNOLOGY

EHR tools can improve clinical documentation and increase accuracy of code assignment if used correctly!

- Templates
  - Capture specific clinical information for commonly treated illness
    - Describe clinical signs and symptoms
    - Workup
    - Treatment
    - Etiology
  - Prompts that may tie into a template
    - Diabetes template for example prompts provider if recent eye exam was done or if an appointment needs to be made

LEVERAGING TECHNOLOGY

EHR tools can improve clinical documentation and increase accuracy of code assignment if used correctly!

- Alerts
  - Appears when a specific patient's account is accessed
  - Chronic conditions which require ongoing medication managed by provider
  - Alert programmed to list the chronic condition and medication patient is currently on

- Other workflows
  - Flagging previously documented diagnoses that need to be readdressed
  - Identifying suspected conditions based on results or medications/treatments

OPERATIONALIZING HCC SCORING PROBLEM LISTS

Useful Problem List	Where Problem Lists Fail
Problem oriented, patient centered focus	Laundry List of all diagnoses and procedures
Specific diagnoses	Symptoms and unspecified conditions
Defined what goes on the list	Users decide what and what not to include
Roles are defined • Who can contribute to problem list • Who is responsible for problem list management	Everyone responsible and nobody responsible
Single entry of conditions	Duplicate entries
Process for maintaining list is integrated with clinician workflow	Separate process for updating the problem list

An accurate problem list helps providers identify ongoing chronic conditions and can play a significant role in improving patient care.

DEVELOPING RISK ADJUSTMENT POLICIES

- All facilities and practices must follow coding conventions and guidelines when assigning diagnoses codes
  - ICD-10-CM Coding Manual
    - Directives in coding manual take precedence
  - ICD-10-CM Coding Guidelines
    - Guidelines are a set of rules developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM code book.
  - Coding Clinic for ICD-10-CM & ICD-10-PCS
    - Quarterly newsletter published by American Hospital Association's Central Office
    - Advice provided is result of formal cooperative effort between AHA, American Health Information Management Association, Centers for Disease Control and Prevention, National Center for Health Statistics and CMS
    - Set of rules developed to accompany and complement official conventions and instructions provided. To be used as an official resource when the classification and the guidelines do not provide direction.

DEVELOPING RISK ADJUSTMENT POLICIES

Policy development specific to Organization

- Family history
  - Determine which family history diagnoses will be reported and if there are specific scenarios for reporting
- Physician supporting documentation for "history of" diagnoses
  - Diagnosis is documented as history of, but further documentation supports the condition exists. Use full documentation to determine code assignment.
    - Diagnostic statement states – History of Rheumatoid Arthritis
    - Body of document indicates Liver panel to be drawn in one week to evaluate if hepatotoxicity occurring with use of Methotrexate for RA.
- Query policy
  - Most hospitals have for inpatients
  - Expand to the outpatient business
  - Expand to the physician clinic
  - Provide guidance for cases coders should query on

THE CASE FOR HIGH QUALITY CLINICAL DOCUMENTATION

- Continuity of Care for Patient
- Meeting Regulatory Requirements
- Demonstrating and Measuring Quality of Care
- Obtaining Appropriate Reimbursement at Time of Service
- Quality Payment Program
  - MIPS – Merit-Based Incentive Program
  - APM – Advanced Payment Models
- Preventing Denial of Services Provided

THE CASE FOR HIGH QUALITY CLINICAL DOCUMENTATION

- Coding Validation Audits
  - MAC – Medicare Administrative Contractors
  - CERT – Comprehensive Error Rate Testing
  - RAC – Recovery Audit Contractors
  - ZPIC – Zone Program Integrity Contractors
  - MRAC – Medicaid Recovery Audit Contractors
  - Third Party Payers – Commercials
  - RADV – Risk Adjustment Data Validation

QUESTIONS?

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