Introduction to Risk Adjustment & HCCs

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Kathryn DeVault, MSL, RHIA, CCS, CCS-P, FAHIMA
United Audit Solutions, Inc.
Kathy.devault@uasisolutions.com

Objectives

- Discuss the meaning of risk adjustment
- Discuss the meaning of hierarchical condition categories (HCC)
- Review the history of HCCs and how they’re used in population health management and value based purchasing
- Review documentation requirements for accurate HCC capture
- Review case example
Risk Adjustment Factor (RAF)

- Risk adjustment is calculated using an actuarial tool developed to predict the cost of healthcare for covered beneficiaries/enrollees.
- A risk adjustment score is determined by using a combination of demographic information along with disease information to predict future healthcare costs for enrollees.
- The score is highest for the sickest patients as determined by a combination of factors.
Risk Adjustment Factor (RAF)

- Total score of all relative factors related to one patient for a total year - derived from a combination of two scores

Demographics
- Age and either community-based or institution-based
- Medicaid disability and interaction with age and gender

Disease
- Diagnoses reported determines HCC category
- Interaction between certain disease categories
- Interaction between certain disease categories and disability status

Who Uses Risk Adjustment?

- Medicare Advantage Plans
  - Medicare Part C
- Medicaid plans
- Commercial Carriers
- Accountable Care Organizations (ACOs)
- Part of the Total Performance Score for Value Based Purchasing

How Will Hospitals Be Evaluated?

Total Performance Score

- Hospital Efficiency: 20%
- Patient Experience: 30%
- Outcomes: 30%
- Cost/Loss: 20%

Hospitals need scores for at least two of four domains to receive a Total Performance Score.

For hospitals with at least two domain scores, the excluded domain weights will be proportionately distributed to the remaining domains to calculate the Total Performance Score.
Value Based Purchasing – Inpatient

12 Clinical Process of Care Measures

1. AMI-7a: Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8: Primary PCI Received within 90 Minutes of Hospital Arrival
3. HI-1: Discharge Instructions
4. PN-3b: Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6: Initial Antibiotic Selection for CAP in Immunocompromised Patient
6. SCIP-Inf-1: Prophylactic Antibiotic Received within One hour Prior to Surgical Incision
7. SCIP-Inf-2: Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3: Prophylactic Antibiotics Discontinued within 24 Hours After Surgery
9. SCIP-Inf-4: Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. SCIP-Inf-5: Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
11. SCIP-Card-2: Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-YTE-2: Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

Domain Weights

Efficiency 45%
Clinical Process of Care 20%
Outcome 30%
Patient Experience of Care 30%

5 Outcome Measures

1. MORT-30-AMI = Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF = Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN = Pneumonia (PN) 30-day mortality rate
4. PSI-90 = Patient safety for selected indicators (composite)
5. CLABSI = Central Line-Associated Bloodstream Infection

1 Efficiency Measure

1. MSPB-1: Medicare Spending per Beneficiary measure

Represents a new measure for the FY 2015 program that was not in the FY 2014 program.

Hierarchical Condition Categories (HCCs)
Hierarchical Condition Categories (HCCs)

**CMS HCC**
- Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)
- CMS has also developed a CMS Rx HCC model for Medicare Part D risk adjustment
- Based on over 65 population

**HHS HCC (Commercial HCC)**
- Developed by Department of Health and Human Services (HSS)
- Designed from commercial payer population
- HHS-HCCs predict the sum of medical and drug spending
- Includes all ages

CMS HCCs

- Adjusted Medicare capitation payment to Medicare Advantage Plans
- Based on the health expenditure risk of enrollees
- Current year data predictive year risk
- Diagnoses accumulated over a year
- Data from:
  - Principal diagnosis (IP)
  - Secondary diagnosis (IP)
  - Outpatient diagnoses
  - Provider office diagnoses
  - Clinically trained non-physician provider

- Physician
- Nurse Practitioner
- Physician Assistant
- CRNA
- Therapists
- Certified wound care nurse
- Psychologist
- Podiatrist
HCC Classification System

- 70,000+ ICD-10-CM codes
- 805 diagnostic groups
- 189 condition categories
- 189 hierarchical condition categories (HCCs)
- 79 categories in payment model (2014)

Hierarchical Condition Categories (HCCs)

79 Condition Categories (Examples)

- Infection
- Neoplasm
- Diabetes
- Metabolic
- Liver
- Gastrointestinal
- Musculoskeletal
- Blood
- Substance Abuse
- Psychiatric
- Spinal
- Neurological
- Heart
- Arrest
- Cerebrovascular Disease
- Vascular
- Lung
- Eye
- Kidney
- Injury
Diagnosis Code Value

• In risk adjustment models diagnosis codes carry a risk adjustment value (RAF in the HCC model)
• Similar to the concept of RVU assigned to CPT codes
• The more severe or complex a diagnosis, the higher its value
• If two or more diagnoses are documented from the same category, the diagnosis that is more severe or complex will trump any others

HCCs and Coding

RISK SCORE OF 1.0
• Risk score of 1.0 reflects the Medicare-incurred expenditures of an average beneficiary

HIERARCHIES
• Within each category, there are hierarchies that represent more advanced and costly conditions in a higher coefficient

INTERACTIONS
• There are additional factors to account for disease interaction and disabled status

<table>
<thead>
<tr>
<th></th>
<th>Diabetes</th>
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<tbody>
<tr>
<td><strong>HCCs</strong></td>
<td></td>
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<tr>
<td>Without Complications</td>
<td></td>
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<tr>
<td>HCC 17</td>
<td></td>
</tr>
<tr>
<td>Weight 0.182</td>
<td></td>
</tr>
<tr>
<td>With Chronic Complications</td>
<td></td>
</tr>
<tr>
<td>HCC 18</td>
<td></td>
</tr>
<tr>
<td>Weight 0.474</td>
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<tr>
<td>With Acute Complications</td>
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</tr>
<tr>
<td>HCC 19</td>
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<tr>
<td>Weight 0.474</td>
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</tbody>
</table>
# Impact of Documentation/Coding

## Comparison of Raw RAF Scores

<table>
<thead>
<tr>
<th>Conditions Coded</th>
<th>76 year old female</th>
<th>Medicaid eligible</th>
<th>Acute UTI [N39.0, no HCC]</th>
<th>DM not Coded [no HCC]</th>
<th>CHF not coded [no HCC]</th>
<th>No Interaction</th>
<th>Raw RAF Score*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Chronic Conditions Coded</strong></td>
<td>0.437</td>
<td>0.151</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td><strong>0.588</strong></td>
</tr>
<tr>
<td><strong>Some Chronic Conditions Coded</strong></td>
<td>0.437</td>
<td>0.151</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td><strong>1.074</strong></td>
</tr>
<tr>
<td><strong>All Chronic Conditions Coded</strong></td>
<td>0.437</td>
<td>0.151</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td><strong>1.506</strong></td>
</tr>
</tbody>
</table>

*Estimated scores, for illustration purposes, based on 2014 CMS-HCC model relative factors for community and institutional beneficiaries
Documentation Requirements

- Diagnoses must be captured in a face-to-face setting
- Diagnoses must be documented in the health record appropriate identification, date, and provider signature
- Example of specific reporting rules:
  - Chronic diseases can continue to be reported on an on-going bases as long as receiving treatment and care for the condition
  - Diagnoses that receive care and management during the encounter can be reported
  - Diagnoses that have resolved or are no longer treated should not be listed
  - Malignancy can be reported as long as receiving active treatment
  - Be careful using problem list diagnoses that have been resolved

Disease Specific Requirements

- Cancer reporting
  - Primary malignancy that has been eradicated or excised is report as history once treatment is completed
  - Secondary malignancy currently receiving treatment can be reported by site of the metastasis
  - Leukemia is reported by type and acuity with ‘in remission’ included on the list
  - Personal history of malignancies, leukemia and lymphoma can be reported
Disease Specific Requirements

- Complications or manifestations of a disease process must be clearly linked to that condition
- Substance use is reported as Use, Abuse or Dependence
  √ Dependence can be reported as ‘in remission’

Detailed Documentation is Key

- Reason for the Encounter
- Include Results and Findings
- Preventive Screenings
- Immunizations
- Recommendations
- Treatment Plan
- Referrals
- Medications Refilled
- Follow up visits
- Preventive vs. Sick Visit
- CC: F/U or Refills
- Non-Standard Abbreviations
- Acute vs. Chronic
- Active vs. Resolved
- Diagnoses without a Plan
- Pending Tests
- Missing Exams
- Incomplete Notes
Documentation Tips

- Document all cause and effect relationships
- Include all current diagnoses as part of the current medical decision making and make note of them in the note on every visit
- Each note needs date, signature and credentials
- Document history of heart attack, status codes, etc.
- Only document diagnoses as “history of” or “PMH” when they no longer exist or are not a current condition

Significance to Providers

- Using specific ICD-10 diagnosis codes will help convey the true seriousness of the conditions being addressed on each visit
- Documenting these involves:
  1. Identifying the diagnosis as a current or ongoing problem, as opposed to a past medical history or previous condition
  2. Choosing the most specific diagnosis code while also being sure that is supported in documentation
Coding from CC or HPI

• All documented diagnoses should be coded - review chief complaint and HPI documentation carefully
• Physician’s specific wording determines whether a condition is current for the particular encounter
• A “history of” statement can be interpreted as historical only and no longer existing, or as a current ongoing problem that has been present for a long time
• Do not code conditions noted only in the problem list or medical history unless the condition meets the TAMPER criteria

Documentation for Coding

• Chronic conditions affect the management of the patient, even when the patient is presenting with a straightforward illness that would appear unrelated to the chronic condition
• “History of” conditions are informational unless it’s documented how the patient’s care was impacted by that history
• Conditions can only be coded/reported if there is documentation that the condition has affected the patient’s treatment and management on that particular encounter
TAMPER Documentation

• Ensure there is at least one element of TAMPER documented for each coded condition
  • T = Treatment
  • A = Assessment
  • M = Monitor/Medicate
  • P = Plan
  • E = Evaluate
  • R = Referral
• TAMPER can be found in any section of the patient record

Documentation Goals

• For each patient:
  ▫ Report all current diagnoses at the highest level of specificity based on physician documentation
  ▫ The more categories of diagnoses reported over a year creates a higher risk score
  ▫ Only one diagnosis per category is used in the risk score calculation
    ▪ If both angina and AMI are reported in one year, only the AMI is scored as it is at a higher level of specificity within the Heart category
HCC Audits

Audit Example

200 Providers/2000 Records ....issues identified:

- Incomplete or illegible records
- Coding from a super bill
- Coding from a problem list
- Reporting only primary diagnosis
- Use of generic or unspecified codes
- Coding history of as current
- Not linking manifestations and complications
- Overlooking chronic conditions
Chief Complaint: Routine physical

HPI: The patient is a 63 year old white male who comes to the office for his wellness exam. H/O gout, takes no medication. Refers to having visual problems for the last 5 months. Lifestyle modification discussed at length with the patient that include 1.5 sodium daily diet, daily exercise, smoking cessation, balanced diet. If symptoms worsen to return for further eval.

Case Example, continued

Physical Examination
Constitutional: General appearance: well-developed, well-nourished, well-groomed, normal habitus, no obvious deformities noted. No acute distress.
Psychiatric: Normal affect and mood. Responds to questions appropriately. No suicidal thoughts or ideation.
HEENT and Neck: Abnormalities: Mouth – Cavities, dental (aside from above listed, all others normal)
Thorax and Lungs: Chest: symmetrical with equal expansion. No pain, tenderness, or masses upon palpation. Lungs: clear to auscultation and percussion. Breath sounds equal bilaterally. No wheezes, rales (crackles), or rhonchi. No dullness to percussion.
Case Example, continued

Physical Examination

Case Example, continued

Today’s Diagnosis and Assessment:
• 110.1 Onychomycosis
• 274.9 Gout, unspecified
• V70.0 Routine Medical Exam
• 715.98 Osteoarthritis unspecified other sites (chronic condition)
• 790.29 Other abnormal glucose
• V85.1 BMI between 19-24 Adult

Do you agree based on the documentation?
Questions?

Thank you!!

Kathryn DeVault
Kathy.devault@uasisolutions.com