

Risk Adjustment Coding-Part 1

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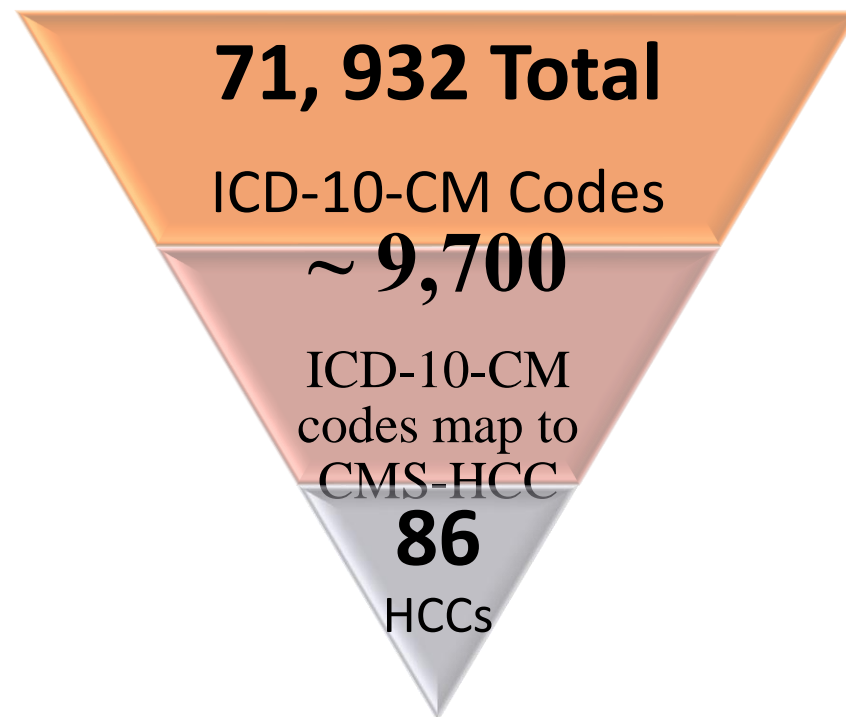
Polling Questions

Risk Adjustment



HCC in Medicare

- CMS started in 2004
- Each HCC has a factor assignment with relative weight (0.04 – 2.48)
- Only diagnosis mapping to HCCs are used in RAF calculation (not all diagnosis “risk adjust”)
- $1 + 1 \neq 2$, although some coexisting conditions create a Disease Interaction Factor
- Some HCCs trump others



Risk Adjustment

- Each attributed member is assigned a Risk Adjustment number
 - In Medicare this is called a RAF and based on Hierarchical Conditional Categories (HCC)
 - In Commercial contracts they use proprietary adjustment tools to determine a risk adjustment
- After apply demographic data, Risk adjustment/RAF uses previously reported conditions to predict total cost of care for current year

Provider's Role

- Documentation in progress note must support ICD-10 codes
- Standard: (1) M.E.A.T. in (2) HPI, Physical Exam, Tx Plan and/or Discussion and (3) include in Assessment/Plan
- Presence in Problem List, Med List or Past Med HX is NOT enough
- Diagnosis – documented & submitted at least annually
- Once appropriate care has been delivered, *then* how to code for that care becomes important
- Code to highest degree of specificity

ACO Team Role

- Educate providers and support staff on importance of risk adjustment
- Pre-Visit Planning (MA, RN)
 - Review prior year encounters with specialists
 - Review Problem list
 - Notify provider of chronic conditions
- Post-Visit Review (Coder)
 - Review for accurate documentation to support diagnosis
 - Collaborate with provider for diagnosis specificity

2020 RAF Coding Examples

No Conditions Coded	Coded Low Level of Specificity	Coded Appropriately
76 y/o female (0.449)	same	same
No DM codes (X)	E11.9 DM w/o complications (0.105)	E11.51 DM w/peripheral angiopathy (0.615)
No Vascular diseases coded (X)	I73.9 PVD coded (0.300)	Included in combo code E11.51
No CHF Coded (X)	No CHF Coded (X)	I50.9 CHF (0.320)
No Disease Interaction (X)	No Disease Interaction (X)	CMS Disease interaction (CHF + DM) (0.192)

Total RAF = 0.449

***Financial Impact=\$1,293.12**

Total RAF = 0.854

***Financial Impact=\$2,459.52**

Total RAF = 1.576

***Financial Impact=\$4,538.88**

*Approximate annual professional premium

Diabetes

E11.9 DM2, uncomplicated (0.105) **vs. E11.-** DM2 with <insert complication> (0.315)

E11.59 DM w/other circulatory complication (0.315)

- Add code to specify
 - I10 hypertension
 - I25.10 ASHD of native coronary artery without angina (CAD)

E11.69 DM2 w/other specified complication (0.315)

- Add code to specify
 - E78.5 dyslipidemia or hyperlipidemia
 - N52.1 erectile dysfunction in dzs elsewhere
 - B37.- thrush or candidiasis (oral, vaginal)
 - **M90.5- osteonecrosis or M86.67- chronic osteomyelitis foot/ankle**

Document and bill ALL DM codes

- **DM combination codes**
 - Value from 2-3 HCC categories = 0.307 - 0.536
 - **E11.2-** DM2 with diabetic nephropathy, CKD, other
 - **E11.3-** DM2 with retinopathy – multiple options
 - **E11.4-** DM2 with diabetic neuropathy (mono, poly, other)
 - **E11.5-** DM2 with circulatory complications
 - **E11.6-** DM2 with other specified complications
 - Need to document and bill add'l code for CKD, ulcers, other

DM with hyperglycemia, ketoacidosis

- E11.65 DM2 with hyperglycemia
 - Suggest: A1c > 9 or other hyperglycemia
- Remember: Z79.4 Long-term (current) use of insulin
- For linked or combo conditions, document causal relationship to allow code selection such as:
 - Due to
 - Related to
 - Complicated by
 - Caused by

BMI, Morbid Obesity

- BMI \geq 40 (0.270)
 - **E66.01 Morbid Obesity**
 - **Z68.41 - Z68.45 BMI \geq 40**

- BMI 35 - 40 + related co-morbid condition
 - **E66.01 Morbid Obesity (0.270)**
 - DM, heart disease, cancer, hypertension, dyslipidemia, liver and gallbladder disease, sleep apnea, etc.
 - when co-morbid condition is caused by or related to obesity

 - **E66.2 Morbid Obesity with alveolar hypoventilation (Pickwickian syndrome) (0.270)**
 - A rare disorder
 - Insufficient ventilation leading to hypercapnia (early sign: cyanosis)
 - Typically diagnosed inpatient as requires ABGs
 - **Not the same as G47.33 Obstructive Sleep Apnea (OSA)**

However...

- OSA + BMI \geq 35-40 = **E66.01 Morbid Obesity (0.270)**
 - Must document causation “OSA due to morbid obesity”

AWV Documentation

- CHPA can review AWV for feedback
 - Check all the required elements of an AWV
 - Make sure all active conditions are listed in the note and in the A/P
- New conditions cannot be simply listed without first being addressed in record (may add E/M or at next visit)
 - Document: assessment, plan, status, treatment, etc.
- May amend AWV after visit for (missed) established conditions - within 30 days of visit

Key Take-Aways

- Document a member's status is crucial to risk adjustment calculations.
- Capture all current and active diagnoses. For chronic conditions, they must be captured on an annual basis.
- All documentation that support submitted diagnosis codes must be complete and accurate enough to stand alone.
- In the time of Covid-19, be sure to capture all relevant diagnosis codes for members.

Risk Adjustment Pilot

Seeking 3-5 clinics to participate in this pilot

- In order to participate the CHC must:
 - Provide access to EHR system/patient schedule to CHPA
 - Offer the ability to have CHPA “message” providers via EHR with HCC coding suggestions
 - Have providers give feedback re: suggestions after record is audited by CHPA
 - Agree to have CHPA educate providers re: risk adjustment coding at the clinic level and/or individual provider level after reviewing medical records
 - Purpose:
 - Review all patients prior to their visit with the provider
 - Message provider prior to patient coming in
 - Suggest additional HCC codes found in record but not addressed in Assessment/Plan and added to Problem List
 - Process:
 - Review current chronic problem list
 - Scan any resolved conditions for in remission
 - Identify any acute, not active or no longer in treatment conditions that need to be removed
 - Suggest updating to more specific code (DM manifestations, chronic vs. acute, etc)

Questions?

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