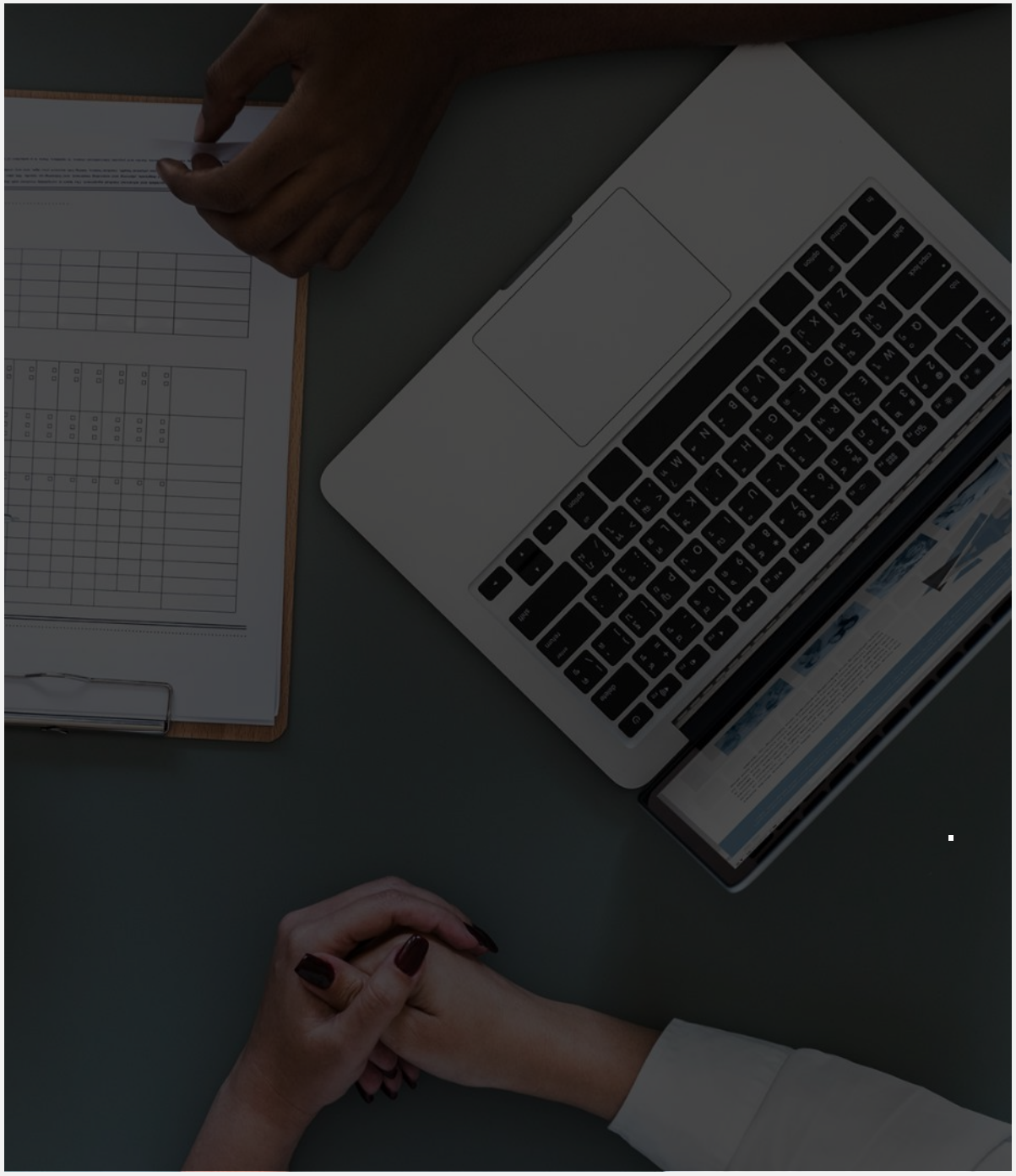
Risk Adjustment 2021

HealthCare Compliance Network

Healthcare Compliance Network educational webinar will focus on best practices and guidelines for risk adjustment and ICD-10-CM. We will highlight key documentation issues, as well as ICD-10-CM diagnosis coding guidance. Our goal is to educate you to meet or exceed CMS HCC diagnosis code capture requirements to support appropriate reimbursement.



Agenda

In this webinar, we will cover the basics of Risk Adjustment Coding and Documentation including:

- What is risk adjustment coding?
- Risk adjustment code categories & current model
- Top ten HCC risk adjustment codes
- Case study examples
- Key documentation points & best practices for risk adjustment.
- Question & Answers

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Model ensures that there are adequate resources to care for our high-risk Medicare Advantage members. The MRA Model utilizes a reimbursement method commonly referred to as Risk Adjustment Factor Hierarchical Condition Categories (RAF-HCC) to adjust capitation payments to health plans.

Prospective audit

Prospective audits review diagnoses from past year visits to predict payments for the following year.

Demographic Factor

Demographic factor is used as a measure of the patient's health status.

Disease Factor

RAF Score or risk adjustment factor scores are used to predict the cost for a healthcare organization to care for a patient.

Category Groups

Disease groups contain clinically related diagnoses with similar cost implications.

Documentation

Diagnosis sources are cited from documentation of the patient's, radiology scans, inpatient and outpatient visits and medications.

Provider/Coding Impact

- Codes must be submitted by a “designated” provider (i.e. Physician, APP)
- Codes must be submitted each calendar year. (i.e., Amputated toe, evaluate and document every year)
- Codes submitted must be based on a Face-to-face encounter with the patient
- Includes all visit types: outpatient, office, emergency room etc.
- Risk adjustment is supported with specific diagnosis, associated status, plan and treatment must be clearly documented.

Documentation

Documentation should demonstrate complete and concise picture of the patient's condition. Treatment Plan should link conditions to medications. Document all conditions that co-exist at the time of the visit and how they impact current care and treatment

Specified vs. Unspecified

- ICD10 Hepatitis C, unspecified (No HCC)
- ICD10 Hepatitis C, acute (No HCC)
- ICD10 Hepatitis C, chronic (HCC-29)

Always code to the highest specificity. Documentation should support your reported level of specificity.

History vs. Current

History of CA vs. Current CA

History codes should **NOT** be assigned if a prophylactic drug is given as part of current cancer treatment.

Current codes should document date of onset, progression, treatment plan, medication, radiology and patient's medical team involved in the disease.

Providers Role

Documentation should demonstrate complete and concise picture of the patient's condition.

Document all conditions that co-exist at the time of the visit and how they impact current care and treatment.

Treatment plan should link conditions to medications

Providers must report the ICD-10 diagnosis codes to the highest level of specificity.

Excellent documentation is reflective of the "thought process" of provider when treating patients.

Key Documentation Points

Per the ICD-10-CM Official Guidelines for Coding & Reporting: Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment or management. Diagnoses must be supported with MEAT.

MEAT

- Monitor
- Evaluation
- Assessment
- Treatment

TAMPER

- Treatment
- Assessment
- Monitor or Medicate
- Plan
- Evaluate
- Referral

Do not code conditions that were previously treated and no longer exist.

History codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Acceptable Clinicians

Medical Doctors (MD) (DO)
Nurse Practicioners (NP)
Physician Assistant (PA)
Specialist with the above accreditations

Excluded Clinicians

Registered Nurse (RN)
Registered Dietitian (RD)
Medical Assistant (MA)

How do you apply MEAT/TAMPER to your documentation

- You may report all diagnosis codes that are current and addressed.
- TCM visit, still pay attention to those codes recently reported. Patient may still have symptoms
- Determine your level of service- consider those conditions which were treated and address in addition to comorbidities that impact the complexity of the chronic condition.
- Providers be specific in your documentation.
- Your Assessment and Plan should describe the status of the chronic condition, details that impacted care. Status: stable, improving, worsening, controlled etc.
- Even if that condition is controlled, document how and why it is controlled.

1. The record does not contain a legible signature with provider credentials
2. The highest degree of specificity was not assigned the most precise code to fully explain the narrative description of the symptom or diagnosis in the medical chart
3. A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record
4. Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT)
5. Chronic conditions, such as renal insufficiency are not documented as chronic
6. Lack of specificity
7. The electronic health record was unauthenticated (not electronically signed)
8. Status of cancer is unclear. Treatment is not documented
9. Chronic conditions or status codes aren't documented in the medical record at least once per year
10. A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code

Top 10 risk adjustment documentation errors

Key points can prevent help you ensure your visit is properly documented to support your code capture. Your focus should be providing the clearest picture for your assessment and management of the patient's conditions.

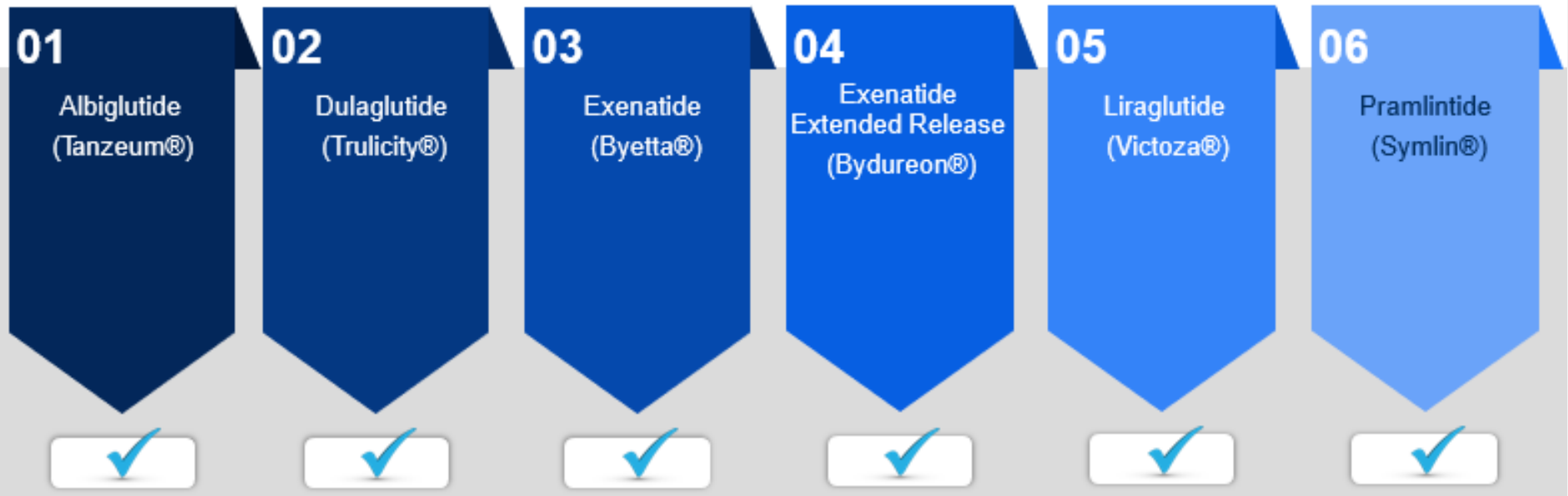
Education & Documentation

Clinicians & coders need to know the basics. Accurately capture and code comorbidities. Monitor for opportunities to improve. Close “gaps” in care

Instead of documenting	Document with more specificity
History of CAD with angina	Patient with CAD with stable angina, nitro prn
History of CHF	Diastolic CHF, stable on Lasix
History of COPD	COPD well controlled with Advair
Unspecified DM	DM type 2, controlled on Humalog, A1C 5.1, good diet and exercise
TCM - history of pneumonia	Patient recently d/c displaying symptoms of crackling in lungs, coughing, etc.

Risk Adjustment Diabetes Mellitus

- Diabetes Mellitus and the use of Insulin, oral hypoglycemics, and **injectable** non-insulin drugs
- If the patient is treated with both insulin and an **injectable** non-insulin antidiabetic drug, assign codes
- Z79.4, Long-term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.
- If the patient is treated with both oral hypoglycemic drugs and an **injectable** non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.899, Other long-term (current) drug therapy.
- Avoid using unspecified DM with or without complication. Always code to the highest level of specificity.



Risk Adjustment - Hypertension

Hypertension – casual relationship between hypertension and heart involvement.

Hypertension and Kidney involvement also has casual relationship

In the alphabetic index the conditions are linked by the word "with"

Hypertension and other conditions that are not specifically linked by "with" or "due to" should be supported by the provider documentation in order to code them as related

Always should be coded as related unless the provider clearly documents and stated the conditions are not related

Risk Adjustment Chronic Kidney Disease

Hypertensive Heart & Chronic Kidney Disease is assigned from category I14, when there is hypertension with both heart and kidney involvement.

If heart failure is present, assign an additional code from I50 to identify the type of heart failure

The appropriate code from category N18, CKD should be used as a secondary code from category I13 to identify the stage of CKD

For patient's with both acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

Assign codes from category I12: hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18. Chronic Kidney disease (CKD) are present
CKD should not be coded as hypertensive if the provider indicated the CKD is not related to the hypertension.

Always sequence according to the circumstances of the admission/ encounter.

Case Study #1

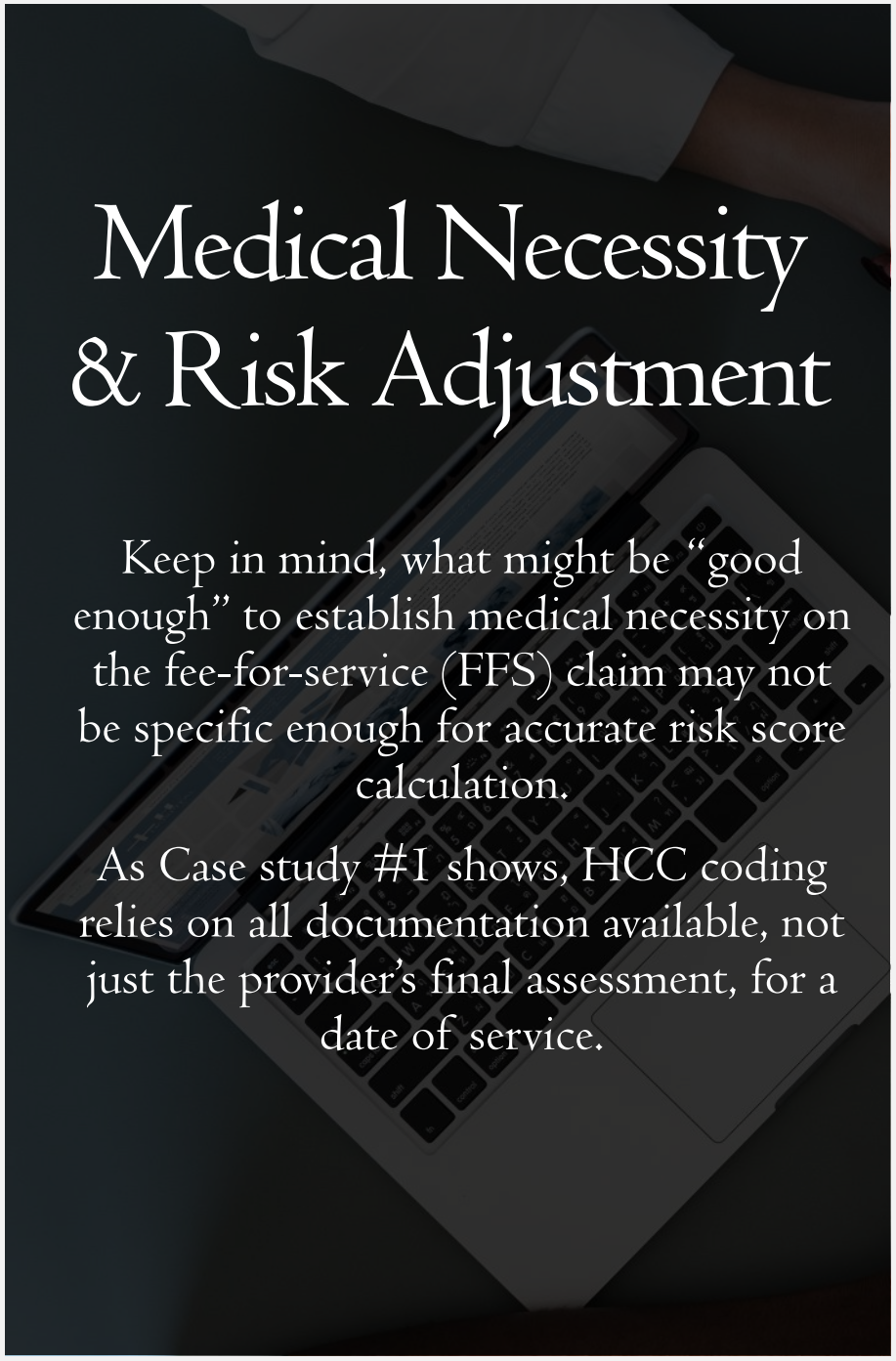
A provider documented in the medical record details about their 65-year-old patient who recently enrolled in an MAO. Patient came in for her Welcome to Medicare office visit. Of special note, the medical assistant documented a depression screen result of 11 which indicated possible moderate depression. The patient had a diagnosis of depression in the problem list and had been on an antidepressant for about six months with no notable improvement. The physician addressed the questionnaire with the patient, asked some more pertinent questions, and listed moderate recurrent major depression in the final assessment.

Provider coded:
Z00.01 Encounter for general adult medical examination with abnormal findings and F32.9 Major depressive disorder, single episode, unspecified.

The claim was paid; however, during a routine audit as outlined in the office's clinical documentation improvement plan, an auditor noticed that the provider did not accurately code to the highest specificity.

While this change in diagnosis coding would not affect the payer's decision about medical necessity and payment, it does affect the risk score calculation of the patient.

Incorrect Code
F32.9 = no mapping to CMS-HCC/no risk score
Correct Code
F33.1 = CMS-HCC 59/score value of 0.309



Medical Necessity & Risk Adjustment

Keep in mind, what might be "good enough" to establish medical necessity on the fee-for-service (FFS) claim may not be specific enough for accurate risk score calculation.

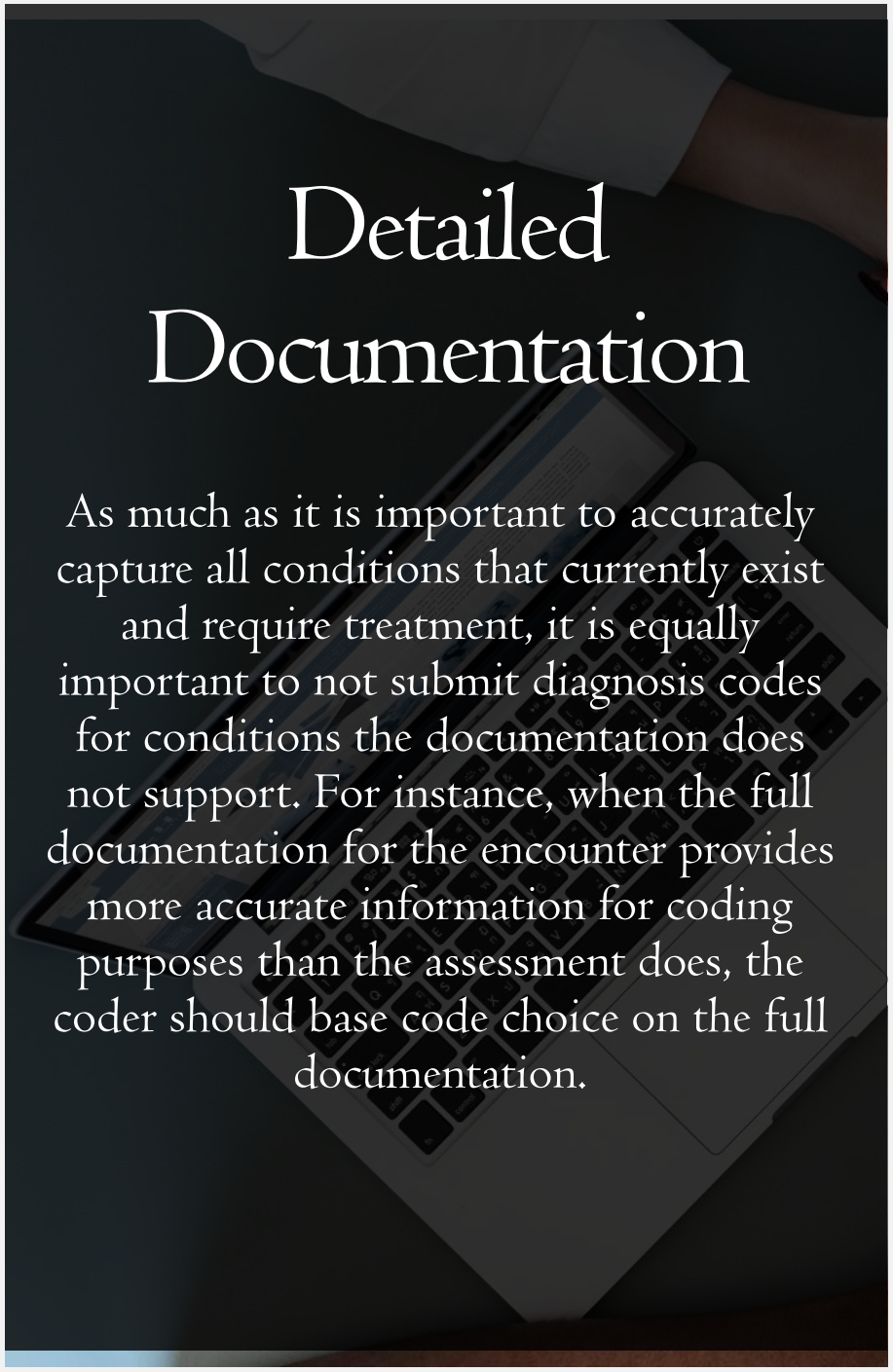
As Case study #1 shows, HCC coding relies on all documentation available, not just the provider's final assessment, for a date of service.

Case Study #2

A 72-year-old male patient presented to the office for a routine follow-up of ongoing residual left-sided weakness due to his stroke last year. A detailed exam was performed. The patient stated he was feeling well, was taking his medications as prescribed, and had help at home to aid with his limited walking stability and other Activities of Daily Living. He refused a wheelchair or physical therapy at this time. The provider listed stroke in the final assessment.

Upon review the risk adjustment coder knew of *AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS* guidance, which instructs coders to code weakness due to stroke as hemiparesis. The coder also applied ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.9.d, concerning coding sequelae of cerebrovascular disease to capture the late effect of the stroke instead of coding an acute cerebrovascular infarction (I63.9 *Cerebral infarction, unspecified*) after the acute phase of the stroke has resolved.

Incorrect Code
I63.9 = CMS-HCC 100/score value of 0.230
Correct Code
I69.354 = CMS-HCC 103/score value of 0.437



Thank You

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