- Risk Adjustment Model
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Risk Adjustment and Hierarchical Condition Category Coding

❖ Risk Adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by the Centers for Medicare and Medicaid Services (CMS) in 1997. Implemented in 2003, this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual's health conditions and demographic details. The individual's health conditions are identified via International Classification of Diseases – 10 (ICD –10) diagnoses that are submitted by providers on incoming claims. There are more than 9000 ICD-10 codes that map to 79 HCC codes in the Risk Adjustment model.

❖ MA plans use Hierarchical Condition Categories (HCCs) in order to determine payment rates for diagnoses. The HCC model used for MA patients categorizes ICD-10-CM diagnosis codes into disease groups that are similar both clinically and financially. CMS creates a hierarchy so that patients' conditions are coded for the most severe manifestation among related diseases.

Hierarchical Condition Categories (HCC)

Diagnoses that are included in the Risk Adjustment model are grouped into 79 different categories known as Hierarchical Condition Categories or HCC's. Each HCC is assigned a risk-adjusted factor (RAF), which is a relative weight, similar to the inpatient DRG system.

CMS created a hierarchy so that patients' conditions are coded for the most severe manifestation among related diseases.

HCC	Description	… then drop the HCC(s) listed in this column	HCC Value Community, NonDual, Aged
8	Metastatic Cancer and Acute Leukemia	9,10,11,12	2.625
9	Lung and Other Severe Cancers	10,11,12	0.970
10	Lymphoma and Other Cancers	11,12	0.677
11	Colorectal, Bladder, and Other Cancers	12	0.301
12	Breast, Prostate, and Other Cancers and Tumors		0.146
17	Diabetes with Acute Complications	18,19	0.318
18	Diabetes with Chronic Complications	19	0.318
19	Diabetes without Complications		0.104
21	Protein-Calorie Malnutrition		0.545
22	Morbid Obesity		0.273
23	Other Significant Endocrine and Metabolic Disorders		0.228

Patient Example

care(n)care
Insurance Company, Inc.

Condition	ICD-10	HCC	RAF
65 year old female (demographics)			0.312
Malignant neoplasm of Bladder	C67.9	011	0.301
Angina	I20.9	088	0.140
DMII with nephropathy	E11.21	018	0.318
Emphysema	J43.9	111	0.328
CHF	I50.9	085	0.323
Thrombocytopenia	D69.6	048	0.221
Total			1.943

These are known conditions the patient has

Disease Interaction
CHF*DM + 0.154
CHF*COPD + 0.190

Condition	ICD-10	HCC	RAF
65 year old female (demographic)			0.312
DMII with nephropathy	E11.21	018	0.318
Emphysema	J43.9	111	0.328
Total			0.958

This is what has been captured so far this year

- ➢ Risk Adjustment diagnosis must be based on clinical medical record documentation from a face-to-face encounter

- ➢ Coded according to the ICD-10-CM Guidelines fro Coding and Reporting

- ➢ Assigned based on dates of service within the data collection period

- ➢ Submitted from an appropriate risk adjustment provider type and an appropriate risk adjustment physician data source

Documentation in the medical record is crucial and necessary to ensure excellence in healthcare. Documentation is a legal record that must hold in defense and justification of care. It is required.

MEAT the Chronic Condition

M E A T

Monitor	Evaluate	Assess	Treat
Signs	Test results	Ordering tests	Medications
Symptoms	Medication effectiveness	Discussion	Therapies
Disease progression	Response to treatment	Review records	Other modalities
Disease regression		Counseling	

All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate extender (for example, a non-physician practitioner such as a PA, NP, CNS, etc.)

Patient name, date of service (DOS) and an additional patient identifier (e.g., date of birth [DOB]) is required on every page.

Chief complaint (CC): "Follow-up" alone is not a valid CC. The documentation must describe why the patient is presenting for follow-up.

Exam: Exam driven by the patient history, describing in detail any pertinent positive findings and any chronic findings that affect the care and treatment of the patient.

Medical decision-making:
Assessment that documents the diagnosis, its status and any causal relationships (e.g., diabetic, due to diabetes). Assessment that documents not only conditions being treated, but any chronic conditions that affect the care and treatment of the patient.

Plan that specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.

Authentication: *Paper record:* Authentication by the provider author of the progress note which includes a legible name and credential, a hand-written signature and the date signed. *EMR:* Authentication by the provider author of the progress note, password-protected to that provider only, at the end of the note (for example, authenticated by, approved by), including typed name and credential and the date authenticated.

- Recapture chronic conditions every year
    - Conditions we know the patient has – Problem list, conditions treated last year and still monitored and/or treated
    - Conditions others have documented – Hospital, Consults, and Radiology
- Capture the low hanging fruit
    - High prevalence conditions
    - Conditions in remission
    - Frequently over-looked conditions
- Identify new diagnosis
    - New conditions that develop
    - Existing conditions no one identified in the past
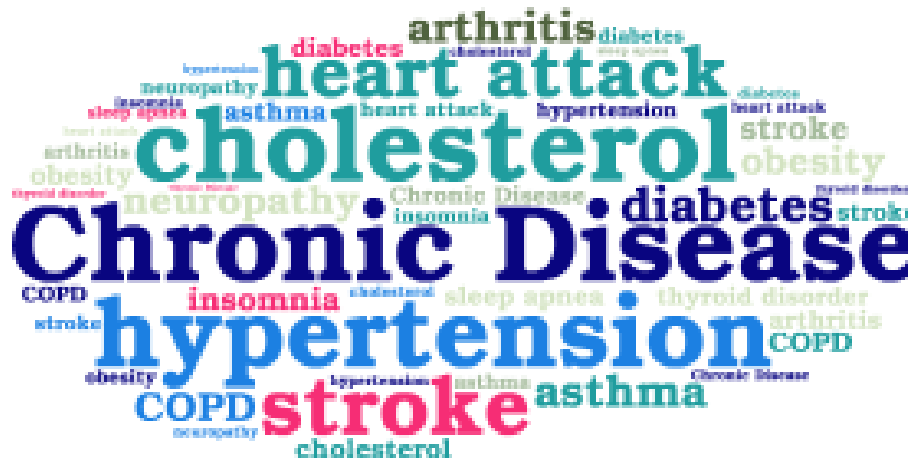
Stable vs. Resolved

- Classic chronic conditions that may improve
  - Diabetes ("**Improved or managed with life style changes**")
  - CHF ("**Manage risk factors**" "**Stable or Improved - continue monitoring**")
  - Angina ("**stable, refill Nitroglycerin**")

- Resolved
  - Anything considers cured by treatment
    - Sick Sinus Syndrome with pacemaker
    - AAA s/p repair
  - Inpatient only
    - CVA
    - MI (can code up to 4 weeks post discharge)

High Prevalence Conditions

- Diabetes Mellitus (type 2) with Complications **E11.-**
  - **Chronic Kidney Disease E11.2-**
  - **Peripheral Angiopathy E11.5**
  - **Neuropathy E11.4-**
- COPD **J44.9**
- Senile Purpura **D69.2**
- Morbid Obesity **E66.01**
- Major Depression **F32.-, F33.-**
- Congestive Heart Failure **I50.-**
- Atrial Fibrillation, Chronic **I48.2**
- Rheumatoid Arthritis **M06.9**

BY 2020, A PROJECTED

81 MILLION AMERICANS

WILL HAVE MULTIPLE CHRONIC CONDITIONS

Conditions in Remission

- ## Major Depression, Single, Full Remission **F32.5**
  - Patient has had two or more depressive episodes in the past but has been free from depressive symptoms for several months. This category can still be used if the patient is receiving treatment to reduce the risk of further episodes.

- ## Alcohol Dependence, in Remission **F10.21**
  - After an alcoholic has successfully stopped drinking for a period of time or has changed the pattern of use to one that does not meet the criteria of dependence, a diagnosis of alcohol dependence may still apply but the condition will be classified as in remission.

Frequently Overlooked Conditions

- Atherosclerosis of Aorta **I70.0**
  - Review radiology reports (body of the note)
  - Add to chronic problems (suggest include "chest x-ray 2003")
- Protein Calorie Malnutrition **E44.-**
  - Patients with a BMI of ≤ 18.9
  - Albumin < 3.5
- Obesity Hypoventilation Syndrome **E66.2**
  - Patients with a BMI of ≤ 35
  - Comorbid OSA
- Amputation Status **Z89.-**
  - Physical Exam findings
- Ostomy Status **Z93.-**
  - Physical Exam findings

Identify New Diagnosis

Chronic Respiratory Failure J96.1-
- Hypoxemia due to a pulmonary condition is chronic respiratory failure by definition.**NOTE that this does not apply to nocturnal hypoxemia in the setting of OSA or to non-respiratory causes like CHF.
- Patients who are supposed to wear their oxygen 24/7 but don't, may still be classified as "chronic respiratory failure" patients.

Thrombocytopenia D69.6
- A complete blood count of fewer than 150,000 platelets

Pulmonary Hypertension I27.2
- Can be located on an ECHO or Radiology report

Tortuous Artery I77.1
- Can be located on Radiology Report

Correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, use current valid diagnosis and procedure codes and code them to the highest level of specificity.

Encounter Data is the most valuable
- Claims data
- Provides authentication for diagnoses submitted
- Potential for maximizing code capture

CMS Stricture Rules for Rebilling Claims
- Claims should be rebilled in there entirety
  - Including all diagnoses submitted on original claim
  - CMS-1500 standard claim form and accepts 12 diagnoses
- CMS voids the first claim billed
 - Replaced with second claim billed

Risk Score Calculations

CMS and UHC have begun tracking the actual DOS a patient was seen compared to the timely filing of claims.

- The timely filing period for both paper and electronic Medicare claims is 12 months, or one calendar year, after the date of service.
    - UHC is reviewing claims billed ≥ 90 days after the DOS

- If claims are not timely filed this opens a door for a RADV audit
    - The Centers for Medicare and Medicaid Services (CMS) perform risk adjustment data validation audits on patients' medical records. Risk adjustment data validation (RADV) is the process of verifying diagnosis codes submitted for payment are supported by medical record documentation.

- ALL documentation of a face-to-face encounter must be signed and authenticated
    - Audits and lack of signature requirements allows for CMS financial take backs

Steps for Physician Practices
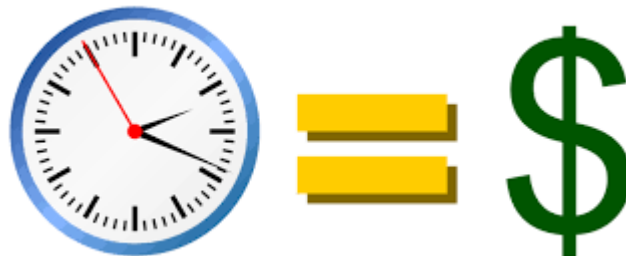
❑ Ensure that you are capturing all appropriate HCC's on the claim with supporting documentation in the medical record

❑ Review and update NPI and Taxonomy information and keep up to date

❑ Ensure that you are using valid CPT and ICD-10-CM codes in your encounter data now and in the future

❑ Submit claims on ALL face-to-face encounters with a qualifying provider

❑ Ensure that you are submitting encounters on the correct forms

❑ Timely filing of claims

 Goal - Eliminate errors that will prevent a claim from being processed thereby increasing the opportunity for the HCC's to reach CMS for processing.

Steps for Physician Practices

❑ Document and capture all chronic conditions annually.

❑ Manage your patient population

❑ Clean up your problem list to accurately reflect all chronic conditions

❑ Submit all assessed and treated conditions through claims, including BMI status

The Golden Rule …

"If it's not documented by the physician/provider, it didn't happen."

In healthcare compliance and in coding, there is no deviation from this principle. We can't code it if it isn't documented, and thus we can't bill for it.

Questions

Please submit coding and documentation questions to RAFeducation@ntsp.com