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Business Advisors for the Healthcare Industry




HCCA™
Health Care Compliance
Association

Developing a Compliant and Effective Ambulatory CDI Program

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Agenda


- Understanding the Basic Risk Adjustment Methodology
- Risk Adjustment Audits
- Tips for Compliant Risk Adjustment Coding
- Case Study – Example
- Further Suggestions for Compliant Documentation
- Conclusions
- Q & A

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Risk Adjustment: Why It's Important 

Physicians and other providers now often paid via value-based reimbursement (“VBR[s]”) models:

- ⑩ Medicare Advantage Plans
- ⑩ Bundled Payment Programs
- ⑩ Shared Savings Agreements
- ⑩ Pay for Performance Programs
- ⑩ Medicare Access and CHIP Reauthorization Act (“MACRA”) (Merit-Based Incentive Payment System [“MIPS”] and Alternative Payment Models [“APM(s)”])
 - VBRs are no longer a hypothetical possibility. They are here now!



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Key Metrics for Payment Within Value-based Reimbursement Models 

- Quality
 - Compliance with best practices
 - Antibiotic administration before surgery
 - Vaccination for pneumococcal pneumonia and the flu
 - Clinical outcomes
 - Readmission
 - Complications – hospital acquired infection, blood clots after surgery
 - Patient experience
 - HCAHPS and CGCAHPS
- Cost
 - Costs attributed to the provider
 - Costs for the patient’s care across the system

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Leveling the playing field: Risk Adjustment



- “My patients are different” – common lament by providers
 - Quality
 - My patients are more complex and non-compliant than most
 - My patients are more demanding than most
 - Cost
 - I can’t control my patients and their healthcare spending
 - My patients want the high cost diagnostic and treatment options

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Limitations of Risk Adjustment



- Doesn’t account for many socioeconomic factors
 - Poverty
 - Lack of coverage/access
 - Illiteracy
 - Lack of transportation
- Doesn’t give enough weight to behavioral health issues
 - Depression/anxiety
 - Alcohol and drug dependency

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Risk Adjustment of Quality and Cost in VBRs: How Does It Work?



- Utilization of hierarchical condition categories (HCCs)
 - HCCs
 - Chronic conditions – diabetes, hypertension, heart failure
 - Acute conditions – MI, stroke, pneumonia
 - Procedures – transplants, amputations
 - Addressing HCCs
 - M = Monitored
 - E = Evaluated
 - A = Assessed
 - T = Treated
 - Each HCC is given a weighted score and then used to determine a *population's* risk adjustment factor (“RAF”) score.

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Risk Adjustment Rules and Regulations



- Capturing HCCs on an annual basis
 - Although most HCCs are chronic conditions, they must be captured and addressed annually in order to be used for risk adjustment purposes
 - Example: Amputated limbs grow back each year if not re-documented
- Accurately defining and documenting the HCC
 - Assessment and treatment
 - Example: Diabetes mellitus, type II, on insulin
- Accurately documenting how the HCC has been addressed in the past year
 - Monitoring and evaluating
 - Example: DM II stable with hemoglobin A1C of 6

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Provider's Perspective: Too Much To Do In Too Little Time



- 15 Minute Visit
 - Address the chief complaint (NOTE: there are commonly more than one)
 - HPI, PMFSHx, ROS, PE, Assessment and Plan
 - Review old records
 - Review labs / imaging studies
 - Order new tests, treatments (e-RX)
 - Talk to family / friends
 - Address advance directives
 - Make referrals (fill out forms or call consultants)
 - Call payers about pre-authorization of referrals, tests or treatments
 - Assign the E&M code
 - Assign the ICD-10 code
 - **Address the HCCs**
 - Repeat above 20-30 times / day

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Organizational Risk : Risk Adjustment Audits (The RADV)



Step 1: The Plan is Notified of a RADV Audit

Step 2: Medical Records are Requested

Step 3: Medical Records are Reviewed

Step 4: RADV Audit Results are Released

Step 5: Payment Errors are Estimated

Step 6: Appeals

Step 7: Extrapolation of Payments

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Risk Adjustment Audits



- Providers should note that overpayments may be identified through this process and that they may be required to return these dollars to the Centers for Medicare & Medicaid Services (“CMS”).
- The risk related to RADV makes it even more important for participants in programs, like Medicare Advantage, to have a reliable and accurate process for capturing HCCs.

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Strong HCC/RAF Management: The Key Success Factor for Performance in Value-Based Contracts



- Contracts Adjust Payments for Patients Based On Clinical Complexity
 - CMS uses Risk Adjustment Factor (RAF) scores to measure complexity
 - RAF = Objective Representation of “My Patients are Sicker”
- Patients with High RAF Scores Create the Greatest Opportunity to:
 - Reduce Cost of Care
 - Improve Quality of Care
 - Optimize Interdisciplinary Care
- Use RAF Data to Prioritize and Focus Efforts
 - Point of Care
 - Practice
 - Organization
- RAF Management Goals:
 - Achieve Optimal Risk Adjustment Factor (RAF) Scores for the Population
 - Compress the Time to Achieving Optimal RAF Each Year
 - Improve the Productivity, Efficiency, and Effectiveness of Resources

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Tips for Compliance with HCC/RAF Management

- Documentation Accuracy
 - Failure to document in a way that allows HCCs to be captured or recaptured leaves providers—who are intent on demonstrating the average complexity or severity of illness of the patients they serve—short.
 - Providers should learn the key elements that they need to document for the clinical conditions seen most frequently in their practice, e.g. Diabetes Mellitus (Type I or II, Controlled or Uncontrolled, Recent labs e.g. HbA1c, Complications e.g. nephropathy or retinopathy)
- Staff Support of Risk Adjustment Documentation
 - Workflows that pull historical HCCs and present these to the provider prior to a patient’s visit
 - Workflows that schedule patients with high RAF scores for annual wellness exams or follow-up visits
 - Workflows that schedule patients with certain HCCs, e.g. chronic diseases, for follow-up care, e.g. chronic care management programs

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Further Tips for Compliance with Risk Adjustment

- Support of Risk Adjustment Through Technology
 - Over 9,000 ICD-10 codes are grouped into multiple HCC groupings
 - Artificial intelligence (“AI”) systems and natural language processing (“NLP”) can be combined with in-workflow guides to prompt providers as to the necessary elements that need to be documented in order for HCCs to be captured
 - Automating RA (HCC capture) process can improve accuracy and ensure compliance with rules and regulations
- Avoiding bad documentation habits
 - Cutting and pasting
 - Use of templates
 - Over documentation (the auditors won’t be fooled)

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Clinical Documentation: Key to Compliance with RA

Top 10 fails in documentation*:

1. **Failing to capture HCCs at least once every 12 months.**
2. Failure to ensure the medical record contains a legible signature with credential. For example, determine whether such as the electronic health record was unauthenticated (not electronically signed).
3. Failure to ensure the diagnosis codes being billed and the actual medical record documentation match.
4. **Failure to document according to the M.E.A.T. principles. Diagnoses need to be monitored, evaluated, assessed/addressed, and treated.**
5. Failing to annually document status V codes and chronic conditions.
6. Failing to use a linking statement or document a causal relationship for manifestation codes.
7. **Failing to add any diagnosed HCCs or RxHCCs (prescription drug HCCs) to both the chronic problem list and the acute assessment**
8. **Failing to evaluate each of the HCCs/RxHCCs on a semiannual basis for updates.**
9. Failing to review all specialist documentation related to cardiology, master discharge summaries, radiology, specialty correspondence, pulmonary, echocardiograms, and x-rays, laboratory results, and previous encounters.
10. Failing to submit more than the standard four ICD-10-CM codes.

* *Holly J. Cassano, CPC, is CEO of ACCUCODE Consulting, LLC, of Leesburg, Fla.*

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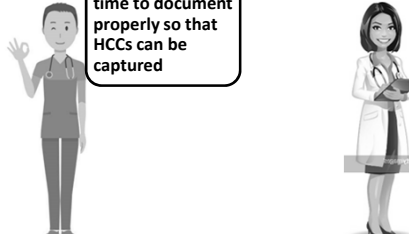
Case study – Example

- 67 year old female visits her primary care physician for an annual wellness visit
 - Her PCP uses an AI system to read the medical records and extracts the following HCCs – diabetes, hypertension and heart failure
 - The physician then further documents each of the above conditions as to its type and status
 - The physician also documents the testing and treatment ordered for each of the above conditions
 - The following conditions are captured
 - Diabetes mellitus type II, controlled with insulin with a stable Hgb A1C,
 - Systemic hypertension with controlled BP of 130 / 80 on a thiazide diuretic
 - Chronic systolic heart failure with an EF of 45% by echo
 - The above HCCs are then appropriately weighted and contribute to the provider's overall RAF score
 - When the provider's performance is compared to others the above HCCs and the RAF score is used to adjust the quality and cost performance data to take into account the complexity and severity of illness in the provider's patient population.

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Compliant Risk Adjustment: The Provider's Perspective

Provider A	Provider B
82% of diabetic patients have hemoglobin A < 9	82% of diabetic patients have hemoglobin A < 9
RAF score – X Provider A cares for a complex set of patients with high severity of illness but doesn't take the time to document properly so that HCCs can be captured	RAF score – 2X <ul style="list-style-type: none">ⓐ Provider B cares for more complex patients, who are at higher risk than does provider Aⓑ Provider B may also get paid more under certain VBRs than provider A if his / her compensation is determined by their quality or cost performance• Other benefits to Provider B<ul style="list-style-type: none">ⓐ Prestige among peers (Can truthfully claim to care for sicker patients)ⓑ Satisfaction that care to patients is of proven (documented) value, i.e. high quality / low costsⓓ Greater employability, as RAF score likely to be taken into account by employers going forward





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Summary and Conclusions


- Clinical documentation improvement programs around risk adjustment coding can benefit hospitals, healthcare systems and physician practices.
- The advent of sophisticated information technology (IT) systems to support clinical documentation efforts can help clinical documentation improvement (CDI) programs attain a higher level of performance and compliance.
- This outcome will prove especially important after the introduction of many value-based reimbursement plans.


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Questions and Answers 



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With over 30 years in the healthcare arena, he has developed significant experience and knowledge in this industry. Before joining Coker, Dr. Knight served in several executive roles for Palmetto Health in Columbia, South Carolina. There, he oversaw Palmetto Health’s employed physician network, ambulatory services division (rehab, lab, home health, hospice care and imaging) and helped to develop and manage their clinical integration program. Earlier, he was Palmetto Health Richland’s vice president for medical affairs.

Dr. Knight graduated from Stanford University with a Bachelor of Arts degree in Human Biology and received his Doctor of Medicine degree, cum laude, from the University of Oregon Health Science Center’s School of Medicine. He earned a Master of Business Administration from the University of Massachusetts at Amherst. Mac holds fellowships in the American College of Physicians, the Society of Hospital Medicine, and the American College of Healthcare Executives.

Dr. Knight oversees Coker’s Revenue and Quality Integrity (RQI) services, which offer expert services around coding, compliance and clinical documentation to healthcare organizations of all types. Dr. Knight serves as Coker Group’s chief medical officer and works on a variety of projects where his clinical background and knowledge of clinical operations can bring additional value to the client. He has a particular expertise in population health management, clinical care process design, cost accounting, clinical integration and clinical documentation/coding improvement.

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