CODING & COMPLIANCE INITIATIVES, INC.

Montana Primary Care Association

Value-Based Health Care

Agenda

- Overview of version 28 changes
- Documentation of specific diagnosis codes
- Make sure the documentation includes the ‘MEAT’
- Assessment/Plan
- Queries

Summary

- Section 1853(a)(1)(C) of the Social Security Act (the Act) requires CMS to risk-adjust payments made to MAOs. CMS pays each MAO a monthly amount for each beneficiary enrolled in an MA plan, which is adjusted to account for differences in health status amongst enrolled beneficiaries. This adjustment is referred to as "risk adjustment." Risk-adjusted payments are based on medical diagnoses submitted by the MAOs that, by long-standing regulations, must be supported in the Medicare enrollees' medical records to ensure accurate payment. Risk adjustment strengthens the MA program by ensuring that accurate payments are made to MAOs based on the health status and demographic characteristics of their enrolled beneficiaries, and that MAOs are paid appropriately for their plan enrollees (that is, less for healthier enrollees who are expected to incur lower health care costs, and more for less healthy enrollees who are expected to incur higher health care costs).
- Source: https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet

Version 28 Changes

- CMS stated that the rationale used to remove diagnoses considered the following:
  - The inability of the condition to actually predict costs
  - The conditions in which the coefficients were small or thought to be insignificant
  - The conditions that are uncommonly seen
  - The conditions without “well specified” diagnostic coding criteria

HCC Eliminated Codes

- Significant diagnoses that are identified to be eliminated include:
  - Acute kidney failure
  - Angina pectoris
  - Atherosclerosis of the extremities
  - Protein calorie malnutrition
  - Amputation of toe

HCC Codes

- Significant diagnoses that were proposed to be added include:
  - Anorexia nervosa, bulimia nervosa
  - Severe, persistent asthma
  - Malignant pleural effusion
  - Alcoholic hepatitis with and without ascites
  - Toxic liver disease with hepatitis
  - Primary sclerosing cholangitis
  - Other cholangitis
  - Obstruction of the bile duct
  - Malignant ascites

Changes

- The relative factors have also been adjusted. One significant change in the hierarchy related to hierarchy for diabetes (V28: HCC 35, 36, 37, 38). This hierarchy now has four levels, with HCC 35 classifying transplant of the pancreas followed by the HCCs reflecting:
  - Diabetes with severe acute complications
  - Diabetes with chronic complications
  - Diabetes with glycemic, unspecified or no complications

- HCCs 36, 37, and 38 offer the same relative factor or impact to patient's risk score. Presently, HCC 17, diabetes with acute complications, offers a higher impact than HHCs 18 and 19, classifying diabetes with chronic or no complications.

Version 28

- 115 Hierarchal Condition Categories (HCC)
- 7,700 ICD-10 codes
  - 2,236 Codes Removed
  - 209 Codes Added

Codes Removed

- Subsequent Encounter – 7th character D
- Sequela Encounter – 7th character S
- Drug-induced conditions
- Complications of Medical Care
- Other

Documentation

- Chronic Kidney Disease – need to document the stage
- Heart Failure - Acute, Chronic, Acute on chronic, or Unspecified, Type of Heart Failure
- Depression – single episode or recurrent. Mild, moderate, severe
- Anxiety Depression – providers must specify (i.e., anxiety with depression or vice versa)

Documentation

- Heart Disease

HCC Category	Description
222	End-Stage Heart Failure
223	Heart Failure with Heart Assist Device/Artificial Heart
224	Acute on Chronic Heart Failure
225	Acute Heart Failure (excludes Acute on Chronic)
226	Heart Failure, Except End-Stage and Acute

Documentation

- Heart Failure
  - Specify acuity – acute, chronic, acute on chronic
  - Identify the type of failure – systolic, diastolic, combined, etc.

  - When the patient is being seen for another condition, **if the heart failure affects the patient care, treatment or management,** the heart failure should be documented and coded – connect the dots!

Documentation

- CAD
  - Cause – assumed to be the atherosclerosis; document if there is another cause
  - Angina involvement – with out without angina
  - Angina Stability – stable angina pectoris, unstable angina pectoris – if angina equivalent document the associated symptoms
  - Tobacco use/exposure – any related tobacco use, abuse, dependence, past history, or exposure (secondhand, occupational, etc.).
  - Presence of hypertension

Documentation

- Angina Pectoris
  - Cause – Atherosclerosis or post infarction (use appropriate codes)
  - Angina Stability – stable angina pectoris, unstable angina pectoris – if angina equivalent document the associated symptoms
  - Tobacco use/exposure – any related tobacco use, abuse, dependence, past history, or exposure (secondhand, occupational, etc.).
  - Presence of hypertension

Documentation

- Hypertension
  - Type – Essential hypertension, hypertension secondary to renal artery stenosis, renovascular hypertension, drug resistant, accelerated, etc.
  - Systemic Involvement – hypertension with diastolic dysfunction, hypertension with heart failure (state the type and severity of the heart failure) or hypertension with CKD (state the stage of CKD).
  - Underlying cause – underlying renal conditions or hormonal disorders, sedentary lifestyle, excessive amounts of alcohol, stress, etc.
  - Tobacco use/exposure – any related tobacco use, abuse, dependence, past history, or exposure (secondhand, occupational, etc.).

Documentation

- I1A.0 - Resistant hypertension
  - Refers to blood pressure of a patient with hypertension that remains above goal in spite of the use of anti-hypertensive medications.
  - Assign code I1A.0 resistant hypertension, as an additional code when a parent treatment resistant hypertension treatment resistant hypertension or true resistant hypertension is documented by the provider.
  - A code for the specific type of existing hypertension is sequenced first, if known.

Documentation

- Uncontrolled Diabetes - Per AHA Coding Clinic Article First Quarter 2017, there is no default code for “uncontrolled diabetes,” and the provider must document whether hyperglycemic or hypoglycemic. If documentation does not identify the type, query the provider for clarification. If unable to query the provider, uncontrolled diabetes should be coded to Diabetes Mellitus, uncomplicated by type.

Documentation

Diagnosis	Casual Relationship present with DM
1. Hypertensive Retinopathy 2. Diabetes	No, provider specifically documents another cause for retinopathy.
1. Diabetes 2. Hypertensive CKD	Yes, per coding guidelines, CKD can be linked to both Diabetes and Hypertension
1. Skin Ulcer 2. CKD 3. DM	Yes, per coding guidelines manifestations may be linked to diabetes.
1. Diabetes Type II 2. Neuropathy	Yes, per coding guidelines manifestations may be linked to diabetes.

Documentation

- Best practice is to link the diagnoses, even when there is a casual relationship.

- Example:
  - Diabetes with neuropathy

Documentation

- Diabetes with Hypertension:
  - Although these conditions could occur together and be related, unless the documentation clearly shows a cause-and-effect relationship, do not link diabetes and other condition if not typically a known manifestation of diabetes.

Documentation

- Diabetes

HCC Category	Description
35	Pancreas Transplant Status – RAF – 0.949
36	Diabetes with Severe Acute Complications – RAF – 0.166
37	Diabetes with Chronic Complications – RAF – 0.166
38	Diabetes with glycemic, unspecified or no complications – RAF – 0.166

HCC Category	Description
	Bipolar disorder, in full remission, most recent episode manic
	Bipolar disorder, in full remission, most recent episode depressed
	Bipolar disorder, in full remission, most recent episode mixed
	Major depressive disorder, single episode, mild
	Major depressive disorder, single episode, in partial remission
	Major depressive disorder, single episode, in full remission
	Major depressive disorder, recurrent, mild
	Major depressive disorder, recurrent, in partial remission
	Major depressive disorder, recurrent, in full remission

Risk Adjustment

- Making accurate payments to MAOs is part of CMS' responsibility to ensure accurate payments across the Medicare program and ensures continued access to benefits and services for people with Medicare while safeguarding federal taxpayer dollars.
- **Studies and audits** done separately by CMS and the HHS Office of Inspector General (OIG) **have shown that medical records do not always support the diagnoses reported by MAOs**, which leads to **billions** of dollars in overpayments and increased costs to the Medicare program. RADV audits are the main corrective action for those improper payments. Through RADV audits, a sample of beneficiary medical records are provided by MAOs, and CMS reviews those records to verify that diagnoses reported for risk adjusted payments are accurate and supported in the medical record. Risk adjustment **discrepancies can be aggregated to determine an overall level of payment error**, ***which can then be extrapolated***.
- The HHS-OIG also undertakes audits of MAOs, similar to RADV audits, as part of its oversight functions. CMS can collect the improper payments identified during those HHS-OIG audits, including the extrapolated amounts calculated by the HHS-OIG.

MEAT

- M – Monitoring
  - How is the individual doing?
  - Are there new signs or symptoms?
  - Conceptually represents ongoing surveillance of the condition(s)

- E – Evaluation
  - What is the current status of the condition?
  - What is the provider's judgement of the condition currently?
  - This can be the review of the results or the treatment outcomes

MEAT

- A – Assessment
  - How will the condition(s) be evaluated or estimated?
  - This can be documentation of prior review, counseling or further studies

- T – Treatment
  - What care is being offered or what is being done to help the patient with the conditions(s)?
  - This can be a medication, a diagnostic study, or a therapeutic service

Final Assessment and Plan

- What conditions are you managing for this patient encounter?
  - What is the status of the condition?
  - What conditions are being managed by a specialist ***that impact the risk and/or management options (relevant to this encounter)?***
- What is the plan of care (monitoring)?
  - Continue xxx medication
  - Ordered CT of abdomen/pelvis – will contact patient with the results

Final Assessment and Plan

- Examples:
  - HTN – at goal today. Continue Lisinopril as directed
  - Stage 4 CKD – GFR and creatinine trend doing well, continue xx medication as directed. Continue monitoring sodium intake and increasing water intake
  - Hypothyroidism – not at goal – patient still symptomatic. Will increase Levothyroxine to xxx
  - Wellness / Preventive – patient provided with prevention health plan, immunization current UTD, encouraged low carb/sugar diet and walk or aerobic exercise 30 minutes 5 days/week. Anticipatory guidance provided as outlined in the note.

Queries

- It may be necessary for your team to send you a query. For example:
  - a documented diagnosis that appears to be no longer valid, but the documentation does not confirm the condition as ruled out/eliminated/resolved
  - clarification of an uncertain diagnosis that has been copy pasted/copy forwarded from a previous visit
  - clarification of an unspecified diagnosis

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About CCI

- CCI assists our clients improve their documentation quality, coding and billing accuracy, and compliance with health care regulations www.ccipro.net

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Ms. Sulzberger is a Licensed Practical Nurse, Certified Professional Coder and ICD-10 Trainer. She received her Bachelors of Science degree in Business Administration from Mid America Nazarene University. Ms. Sulzberger received her nursing license in 1994 and was a practicing clinician at Saint Luke's Health System for several years before transferring to the internal compliance/audit area. She became credentialed as a Certified Professional Coder in 1996 and assisted the Saint Luke's Health System with performing medical record chart audits to verify the accuracy of the internal coding and claims processing.

Ms. Sulzberger spent approximately six years as a coding/billing consultant with National accounting and consulting firms (BKD, Grant Thornton) before becoming the President of Coding & Compliance Initiatives, Inc. (CCI) in April 2003. Ms. Sulzberger assists her clients with improving their operational performance in a variety of critical outcome areas, including coding/billing, corporate compliance, charge capture processes, etc. Ms. Sulzberger works with a variety of health care providers including hospitals, physician practices, and rural health clinics in their daily compliance and operational activities.

Ms. Sulzberger presents locally and nationally on coding topics as well as developing specialized training programs to meet the needs of her clients. Shellie recently was credentialed through American Institute of Healthcare Compliance as a Certified ICD-10 Trainer.