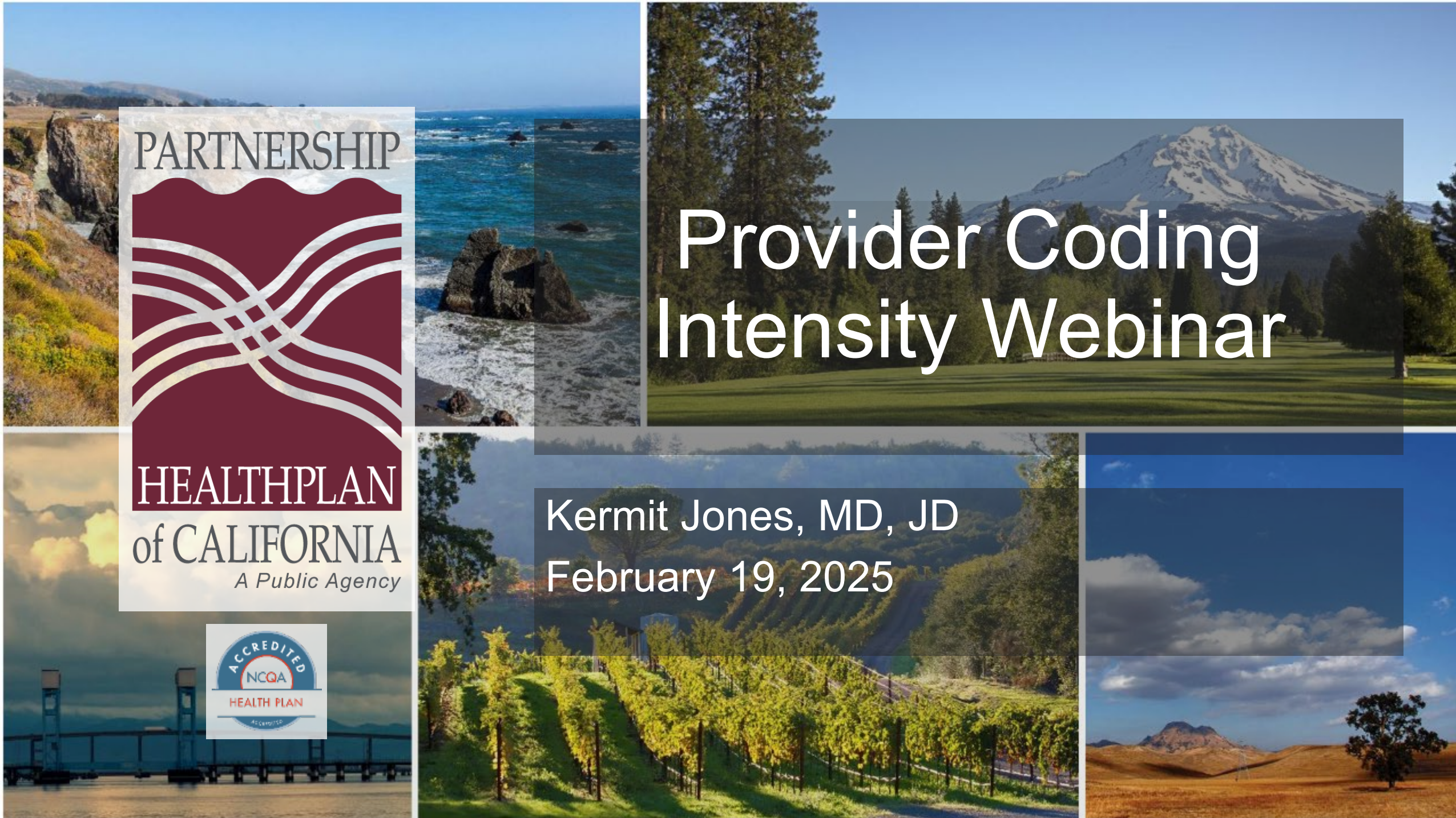

Provider Coding Intensity Webinar

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Learning Objectives

- Participants will be able to differentiate between the different types of codes.
- Participants will be able to distinguish between examples where a patient has or has not been coded utilizing an “acuity” approach.
- Participants will be able to identify complex coding examples and generate patient coding inclusive of a sample patient’s complex conditions.

Agenda

Different Coding Categories in Health Care

The Hierarchical Condition Categories (HCC) System and its Significance

HCC and Specific Examples

HCC and Value Based Care in the Clinical Context

- Coding Intensity and Partnership Context
- Coding Intensity and Dual Eligible Special Needs Plan (D-SNP) Implications
- Questions
- Next Steps

What is Coding Intensity?

The difference between the **risk score** a group of beneficiaries would be assigned if enrolled in a Medicare Advantage plan compared to their risk scores if they were in fee for service (FFS).

More broadly, it is part of the value-based payment model where plans are incentivized for outcomes by Centers for Medicare & Medicaid Services (CMS).

It is based on the premise that a Medicare Advantage plan has an incentive to accurately capture the complex clinical background of its patients so that CMS accurately sees and understands its patient population.

Documentation

What CMS sees on paper...

…versus reality.

Accurate documentation and coding helps CMS see your patients clearly.

Coding Intensity is NOT…

Over coding

Fraud
Intentional misrepresentation to gain an unauthorized financial benefit.

Waste
Abuse of resources to the detriment of the United States government.

Abuse
A questionable practice, inconsistent with accepted medical or business practices leading to unnecessary costs or not providing best value.

Benefits of Accurate Coding

Inclusion of chronic conditions considered in the medical decision making for evaluation and management will allow for better health management.

Complete diagnosis allow the patient to be included in potential quality incentive programs.

It is Partnership's goal for all D-SNP members to have an annual wellness visit to increase engagement and quality of care.

Patient Benefits

1. Increase engagement through the annual wellness visits.
2. Encourage prevention and treatment for chronic conditions.
3. Increase the likelihood of appropriate care coordination efforts.
4. Avoid potential drug/disease interactions.
5. Improve communication among the patient's health care team or interdisciplinary care team.
6. Improve overall patient care

Provider Benefits

CMS provider obligations include:

- The use of diagnosis coding standards in medical record documentation.
- Reporting all conditions and diagnoses codes that exist on the date of an encounter.
- Participating in CMS Medicare Recovery Audit Contractor and Risk Adjustment Data Validation Audits.

Different Health Care Coding Categories

ICD-10-CM

International Classification of Diseases, 10th Edition, Clinical Modification.

An alphanumeric classification system of three to seven characters organized into chapters based on body system or condition.

There are approximately 70,000 ICD codes.

Examples:

I chapter: circulatory system disease (I00-I99)

I10: essential (primary) hypertension

I11.0: hypertensive heart disease with heart failure

CPT Codes

Current Procedural Terminology – different from ICD-10 codes, in that CPT codes focus on services and ICD focuses on diagnosis.

Over 10,000 CPT codes, divided into three (3) categories and these categories then divided into sections based on specialty and procedure location.

- CPT code 10060 – procedure for draining a skin abscess
- CPT code 35600 – Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure

Different Health Care Coding Categories

E/M Codes

Evaluation and Management – apply to qualified provider visits and services involving evaluating and managing patients in office, outpatient, hospital, home care and preventive services.

Found in the CPT code range 99202 – 99499.

Even what would be considered “small” E/M coding mistakes can cause major compliance and payment issues.

Z Codes

Category of ICD-10 codes capturing factors influencing health status or reasons for contact with health services, such as social, economic, or environmental determinants of health.

HCC Coding System

A risk-adjustment model designed by CMS in 2004 to estimate future health care costs for patients and properly estimate patient complexity.

Hierarchical Condition Categories (HCC)

Identify serious conditions: HCCs are used to identify patients with serious or chronic conditions.

Assign risk scores: A patient's health conditions and demographics are used to assign a risk factor score.

Adjust payments: The payer pays more for unhealthy patients and less for healthy patients. This ensures that insurance companies can't profit by dropping unhealthy patients.

How Do HCC Codes Work?

Identify serious conditions

- Coding at the appropriate acuity level helps accurately identify and anticipate patient's medical needs.

Assign risk scores

- Patients can then be assigned a risk score which reflects needed interventions and future care.

Adjust payments

- Unhealthy patients are not biased against unfairly because of their need for more intensive care based on their acuity.

Hierarchical Condition Categories (HCC)

A risk-adjustment prediction model designed to estimate future health care costs for patients and properly estimate patient complexity.

It relies on ICD-10-CM codes supplied by providers to health plans to assign risk scores to patients.

HCC factors in demographics such as age, gender, chronic and serious health conditions.

It is an algorithmic coding system that results in a risk adjustment factor score, and this score is used to predict future costs and health care utilization related to the patient.

HCC Examples

HCC 17: Diabetes with Acute Complications (e.g., urinary frequency because A1C is 12)

HCC 18: Diabetes with Chronic Complications (e.g., peripheral neuropathy)

HCC 19: Diabetes without Complications (e.g., a new diagnosis with A1C of 6.5)

HCC 9: Lung and Other Severe Cancers

HCC 8: Metastatic Cancer and Acute Leukemia

A lower HCC number corresponds to more severe, complex, and likely more costly disease categories

HCC Example

HCC 37 – Diabetes with chronic complication.

Diagnosis description	ICD-10 Code	HCC
Diabetes with neuropathy	E11.40	HCC 37
Diabetes with retinopathy	E11.39	HCC 37
Diabetes with nephropathy	E11.29	HCC 37

Disease Specificity

Use the highest level of specificity when documenting and coding conditions.

Diagnosis code DOES NOT risk adjust	Diagnosis code DOES risk adjust
Chronic kidney disease unspecified N18.9	Chronic kidney disease, stage 3 N18.3
Unspecified viral Hepatitis C B19.20	Chronic viral Hepatitis C B18.2
Cardiac Arrhythmia unspecified I49.9	Chronic atrial fibrillation I48.2
Bronchitis, not specified J40	Chronic bronchitis J42

Importance of Documentation in Risk Adjustment

Proper documentation ensures correct ICD-10 coding.

Provider's documentation statement	ICD-10 Code	HCC
Patient with pneumonia	J18.9	No HCC
Patient with pneumonia due to streptococcus pneumonia	J13	115
Patient with pneumonia due to methicillin susceptible staphylococcus aureus	J15.211	114

Common Challenges in HCC Coding

Complexity

The system is complex, with numerous codes and categories to navigate.

Documentation

Accurate HCC coding relies on thorough and precise medical documentation. Incomplete documentation can lead to coding errors.

Up-to-date knowledge

HCC codes and guidelines are periodically updated. Staying current ensures accurate coding.

How Does HCC Relate to Risk Adjustment Factor Scores?

CMS creates the risk adjustment factor score by assigning a normalized numerical weight to each HCC based on historical cost data from Medicare FFS.

This weight reflects the extra cost that specific condition would cost the healthcare system.

The weights are then combined with demographic data (e.g., age, sex) to calculate an individual's overall risk score.

This risk adjustment factor is then used to adjust the per member per month (PMPM) Medicare Advantage plan payments for members based on geographic area.

Those PMPM are then used by health plans to help provide more resources for to deliver care to members.

ICD-10 Code Use in Risk Adjustment

Detailed

- 70,000 ICD-10 Codes
- 7,770 ICD-10 codes in CMS HCC v28 model
- 115 HCC Categories
- Risk adjustment factor

Simplified

- Diagnosis codes
- Risk adjustment factor
- Risk adjustment reimbursement

Translating Diseases

Let's consider this example:

A 72-year-old male, not previously disabled, who is dually eligible (V28 HCCs):

- HCC 37 Diabetes with chronic complications
- HCC 48 Morbid obesity
- HCC 155 Major depression
- HCC 226 Heart Failure
- HCC 238 Specified Heart Arrhythmias
- HCC 254 Monoplegia

The base rate begins at 1.0 before HCC calculations.

Adapted from Doctus Tech at https://www.doctustech.com/CalculatingReimbursementFromHCC/ on 17 Dec 2024.

Translating Diseases

RAF is calculated based on patient demographics, HCC, condition interactions, and total number of HCCs divided by a normalization factor.

In addition, the quotient is multiplied by an Medicare Advantage coding adjustment factor and the base rate to equal a yearly payment.

Adapted from Doctus Tech at https://www.doctustech.com/CalculatingReimbursementFromHCC/ on 17 Dec 2024.

Translating Diseases

FACTORS	RAF
Age group (70-74 years), full dual	0.626
HCC 37	0.186
HCC 48	0.300
HCC 155	0.316
HCC 226	0.406
HCC 238	0.407
HCC 254	0.297
TOTAL	**2.533**

Adapted from Doctus Tech at https://www.doctustech.com/CalculatingReimbursementFromHCC/ on 17 Dec 2024.

Translating Diseases

CURRENT BASELINE	RAF
TOTAL = 2.533	----
Disease combinations (diabetes and CHF *and* CHF and arrhythmias)	0.323
# of HCCs	0.071
CURRENT RAF	**2.927**
Normalized RAF x (1 – MA Coding Adjustment Factor) = FINAL RAF	2.714
Difference between uncoded patient and accurate coding	1.714

Adapted from Doctus Tech at https://www.doctustech.com/CalculatingReimbursementFromHCC/ on 17 Dec 2024.

Why Are Risk Adjustments Done?

- To accurately reflect the health of Partnership's membership.
- Each patient has a risk adjustment factor score that includes their baseline information (sex, age, dual status) as well as incremental increases based on HCC diagnoses submitted on claims from face-to-face encounters with qualified practitioners.
- HCC coding is prospective in nature.
  - Work done this year sets the risk adjustment factor for next year.
  - Chronic conditions must be reported every year.
  - Each January 1, the risk adjustment is wiped clean. All patients are considered healthy until reported otherwise.

Best Practices Summary

- Update HCCs annually through the annual wellness visit
- Support for the diagnosis must be documented in the patient's chart
- Only ICD-10 codes are used, no procedure codes are considered
- Ongoing conditions must be re-assessed each year. All coding resets on January 1.
- Only diagnoses by an approved provider in a face-to-face visit are eligible

Best Practices Summary

MEAT Criteria for Documentation

MEAT stands for Monitor, Evaluation, Assess, Treatment

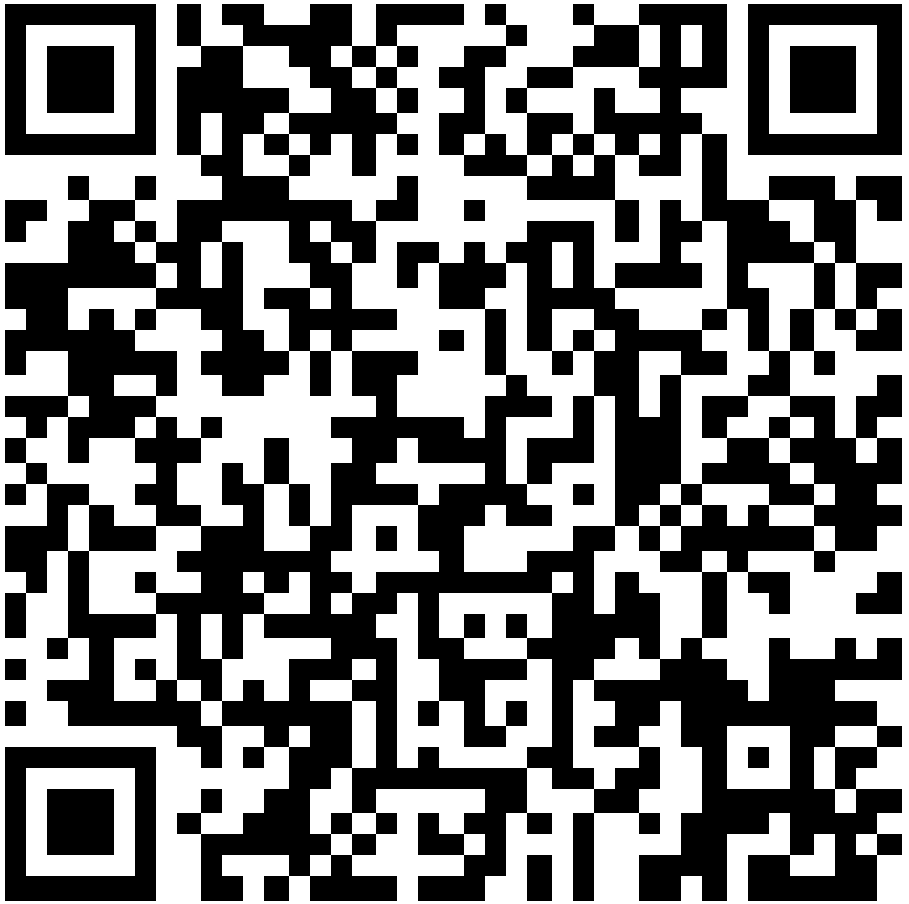
- The MEAT criteria helps establish the presence of a diagnosis during an encounter and ensures proper documentation and HCC conditions.
- Documentation of MEAT
  - Monitor: signs and symptoms, progression/regression, surveillance
  - Evaluation: physical exam findings, test results, medication effectiveness
  - Assess: review of records, counseling, acknowledging
  - Treatment: tests ordered, medications prescribed, specialist referral completed

Documentation and Best Practices Summary

Providers must diagnose conditions after assessing them	Example of what **not** to do: blood pressure of 135/85, no adjustment of medication, but a diagnosis of hypertension was not documented
ICD-10 diagnosis codes cannot be listed alone without a description	Example of what **not** to do: documenting asthma by writing J45.909

Questions

Evaluation



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