Risk Adjustment
Medicare and Commercial

Transform your thinking about documentation and coding
Introduction

In a time of continual regulatory reform and the evolution of payer/provider reimbursement models, are you potentially at risk?

- Is your practice being disrupted by having to frequently correct coding errors?
- Does your documentation and coding truly reflect the health status of your patients?
- Are you receiving accurate compensation based on the risk of your patient population?

Today’s discussion will focus on the importance of accurate medical documentation and coding, and how this can translate to quality data that promotes the financial health of your practice and the health of your patients.
Content

1. Why does accurate coding matter to your practice and your patients?
   • What is risk adjustment?
   • How does it work?

2. How can accurate coding affect your practice?

3. How can you ensure your practice isn’t at risk?
   • How can you best prepare your practice?
   • How can Florida Blue help?
Medicare Risk Adjustment (MRA) and Commercial Risk Adjustment (CRA) Programs

MRA
- Administered by the Center for Medicare and Medicaid Services (CMS).
- Risk Adjustment payments are made to Medicare Advantage plans.
- Medicare Advantage plans reimburse physician groups with whom they are in risk-sharing relationships according to contractual agreements.
- Provides tools to predict health care costs based on relative actuarial risk of enrollees in risk adjustment-covered plans.
- Minimizes the incentive for health plans to select enrollees based on health status.
- Encourages competition based on quality improvements and efficiency, mitigating the impact of potential adverse selection\(^1\) and stabilizing premiums.
- Assesses health plans by the amount of accrued risk partly measured by the chronic conditions present within their patient populations.

CRA
- Either the state or federal government (Department of Health & Human Services) will be responsible for operating risk-adjustment models.
- Insurers pay in/out based on the risk associated with their individual and small group enrollees.
- As a result, the risk-adjustment model redistributes money from insurers with healthier patient populations to those with sicker patient populations.

1. Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher-than-average costs are adversely selected. Source: HHS Risk Adjustment Model, May 7, 2012 (Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Department of Health & Human Services) [http://cciio.cms.gov/resources/files/fm-1c-risk-adj-model.pdf](http://cciio.cms.gov/resources/files/fm-1c-risk-adj-model.pdf)
## Risk Adjustment Models and Hierarchical Condition Categories (HCCS)

### 2016 CMS Hierarchical Condition Category Model
- 69,828 ICD-10 Codes
- 8,830 Diagnosis Codes
- 79 HCCs

### 2016 HHS Hierarchical Condition Category Model
- 69,828 ICD-10 Codes
- 7,685 Diagnosis Codes
- 127 HCCs

### Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>MRA HCC</th>
<th>CRA HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>8, 9, 10, 11, 12</td>
<td>8, 9, 10, 11, 12, 13</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>17, 18, 19</td>
<td>19, 20, 21</td>
</tr>
<tr>
<td>BMI and Morbid Obesity</td>
<td>22</td>
<td>Does not risk adjust, but must document twice a year for quality measures</td>
</tr>
<tr>
<td>Chronic Hepatitis</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>Major Depression</td>
<td>58</td>
<td>88</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>85</td>
<td>130</td>
</tr>
<tr>
<td>Ischemic or Unspecified Stroke</td>
<td>100</td>
<td>146</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>108</td>
<td>154</td>
</tr>
<tr>
<td>COPD</td>
<td>111</td>
<td>NA</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>136, 137</td>
<td>187, 188</td>
</tr>
<tr>
<td>Artificial Openings</td>
<td>188</td>
<td>253</td>
</tr>
<tr>
<td>Amputation Status</td>
<td>189</td>
<td>254</td>
</tr>
<tr>
<td>Asthma</td>
<td>NA</td>
<td>161</td>
</tr>
</tbody>
</table>
Risk Score Calculation

Patients’ risk scores are calculated by summing demographic and disease burden factors, weighted by their estimated marginal contributions to total risk.

Example:

1. 57 year-old patient visits physician.

2. Physician documents patient’s demographic information and disease burden in the medical record.

3. Using corresponding claims data, CMS and/or HHS calculates risk scores. Patients’ risk scores are calculated by summing demographic and disease burden factors, weighted by their estimated marginal contributions to total risk.

Baseline: Average price for individual (indexed cost) = $1,000

Female, 57 = 0.5 risk factor = $500
Condition A = 0.7 risk factor = $700

Risk Score = 0.5 + 0.7 = 1.2
Individual costs 120% of indexed cost, or approximately $1,200

4. Key to payment and/or the redistribution of funds is the validation of risk adjustment data submitted by the health plan, which relies on medical record documentation and claims submissions. CMS and HHS employ a multi-step data validation audit process, performed at random, to ensure diagnoses are substantiated by medical records.

Why and How Will MRA and CRA Affect Physicians?

**Why will physicians be affected?**

Risk adjustment relies on physicians to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient.

**How will physicians be affected?**

- **Financial Health of Your Practice**
  Accurate medical records and diagnosis code capture on claims and encounter data the first time helps reduce the administrative burden of adjusting claims. For physicians involved in risk-sharing arrangements, it also ensures more accurate payments and reflection based on the severity of illness burden.

- **Opportunities to Improve Care Practice**
  Accurate risk capture improves high-risk patient identification and the ability to reach out and engage patients in disease and care management programs and care prevention initiatives. It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.
Connection Between Patient Health and Cost of Care

Capturing risk accurately is important to ensure accurate payment for providers that are in a risk-sharing relationship.

Example from the American Medical Association:

- The cost of diabetes treatment ranges from $28 – $5,111, with an average of $556.
- If physicians treat lower-risk diabetic patients and receive the average payment, they would mostly likely be overcompensated.
- By comparison, physicians who treat higher-risk diabetic patients would be left largely uncompensated for treating those patients if they receive the average amount.
- Risk adjustment is a method to fix this issue. Payment will accurately reflect the risk represented based on the severity of the patient’s condition.

Medical record documentation and accurate coding are critical to appropriately assess risk and ensure proper payment.

Source: American Medical Association, “Evaluating and Negotiating Emerging Payment Options”, 2012
Care Practice and Patient Health: *Intervention Strategies*

Prospective risk analytics based on medical coding help decide which intervention strategy will work best on a patient-by-patient basis.

- Messaging and Outreach
- Medical Record Review
- Medication Management
- Patient Visit Support

Source: Innovalon Webinar, 3/27/2013, The Value of Bridging the Gap Between Retrospective, Prospective Risk Adjustment, and Clinical and Quality Outcomes
Florida Blue Health Care Quality Programs

- **Comprehensive Quality & Risk Program**
  - Focuses on Medicare Advantage HMO and PPO members who have clinical, care and/or quality gaps which need to be closed.
  - Each identified member will have an associated Comprehensive Quality & Risk Health Assessment Form available to the assigned or attributed physician.
  - Comprehensive Quality & Risk Health Assessment Form will be displayed in Availity.

- **Health Risk Assessments**
  - Members who haven’t seen a primary care physician during a 12 month period or are home bound qualify for a health risk assessment.
  - Health risk assessments are performed by a nurse practitioner, physician’s assistant, or physician.
  - A summary of the results are given to the member. The member’s physician will receive results as well.

- **HEDIS and STARS**
  - Improves health outcomes for our members.
  - Improves member experience and how they feel about the quality of care they receive from both Florida Blue and their providers.
  - Enhances provider engagement with our members.
  - Ensures diagnoses and quality measures documented in medical records are captured for submission to CMS, performance reporting, and prospective initiatives.
Comprehensive Quality & Risk Health Assessment Form

**Comprehensive Approach**

- Targeted Medicare Advantage HMO/PPO members who have care and/or quality gaps
- Collecting and documenting patient conditions and satisfying care and quality measures
- Facilitates review and management by the physician
- Pre-populated member information, indication of chronic conditions, outstanding care and/or quality measures
- Form accessed from the physician’s activity dashboard on Availity.com
- Easy to navigate and initiative web-based form
- Physician completes, signs, dates, and submits the form electronically

**Benefits**

- Alert notifications from Availity indicating any updates to the panel roster
- Reports for prioritized outreach to patients needing a comprehensive annual wellness visit
- Process consistency
- Efficient management of the member’s health assessment
- Eases the completion process and improves the quality of information collected
- Maintains document integrity and security
- Reduces costly paper handling and manual routing
Medical Records Review and Audit

- Retrospective and value-based provider audits are performed to review provider’s coding practices and proactively identify both deficiencies and opportunities where Florida Blue can provide effective feedback and education to the provider group.
- The goal of these audits is to validate that all risk conditions applicable to the member are captured within the progress notes along with assessment and treatment options for each.
- This review and audit process ensures compliance with the Centers for Medicare & Medicaid (CMS) and the U.S. Department of Health and Human Services (HHS) Risk Adjustment Data Validation requirements by verifying diagnosis codes previously submitted to CMS and/or HHS via claims data.
- If diagnosis codes previously submitted are not supported in the medical record, the required corrections must be submitted to CMS and/or HHS accordingly.
Top 10 Risk Adjustment Documentation and Coding Errors

1. The **medical record does not contain a legible signature with credentials** - Sign documentation and include patient’s name, date of birth, and date of service on every page of the assessment form.

2. The **electronic health record (EHR) was unauthenticated** (not electronically signed).

3. The **highest degree of specificity was not assigned the most precise ICD-10 code** to fully explain the narrative description of the symptom or diagnosis in the medical chart.

4. A **discrepancy was found between the diagnosis codes being billed vs. the actual written description in the medical record**. If the record indicates depression, NOS (F32.9 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter claim is major depression (F32.0-F32.5 Major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.

5. **Documentation does not indicate** the diagnoses are being managed, evaluated, assessed or addressed, and treated. (MEAT)

6. **Status of cancer is unclear**. Treatment is not documented.

7. **Chronic conditions**, such as hepatitis or renal insufficiency, are **not documented as chronic**.

8. **Lack of specificity** (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).

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.
Accurate Medical Record Documentation and Code Capture

Medical coding of patient encounters is only as good as the underlying medical record documentation.

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data.
- Diagnoses cannot be inferred from physician orders, nursing notes, or lab or diagnostic test results; diagnoses need to be in the medical record.
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year).
- Each diagnosis needs to conform to ICD-10 coding guidelines.
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease).
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.
Documentation for Accurate Coding

- Documentation for chronic conditions must indicate how physicians are monitoring, evaluating, assessing or addressing, and treating chronic conditions.
- Each diagnosis must have an assessment and plan using sample language.
- The statement “History of” in diagnosis coding terms means that the patient no longer has that condition.
- Do not document “History of” any disease that currently exists. However, “History of” is acceptable when documenting status conditions such as an amputation.

<table>
<thead>
<tr>
<th>Monitor</th>
<th>Evaluate</th>
<th>Assess</th>
<th>Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Signs</td>
<td>• Medications</td>
<td>• Ordering tests, diagnostics, labs</td>
<td>• Medications</td>
</tr>
<tr>
<td>• Symptoms</td>
<td>• Therapies</td>
<td>• Discussion</td>
<td>• Therapies</td>
</tr>
<tr>
<td>• Disease progression</td>
<td>• Other modalities</td>
<td>• Reviewing records</td>
<td>• Other modalities</td>
</tr>
<tr>
<td>• Disease regression</td>
<td>• Test results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medications</td>
<td>• Medication effectiveness</td>
<td>• Counseling</td>
<td></td>
</tr>
<tr>
<td>• Referrals to specialists or</td>
<td>• Response to treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disease management programs</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Florida Blue Quality Revenue Program Management
Documentation and Coding: *Cancer*

**Current Cancer**
- Receiving treatment for symptoms
- Document any treatment such as chemotherapy, radiation or adjunct therapy
- Patient elects not to have treatment
- Code the malignant neoplasm including the affected site

**History of Cancer**
- Report “personal history of malignant neoplasm”
- If a patient’s presenting problem, signs or symptoms may be related to the cancer history or if the cancer history impacts the plan of care, report the history code

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Type of CA</th>
<th>ICD-10-CM</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>84 year-old woman s/p mastectomy for breast cancer, on Tamoxifen</td>
<td>Current</td>
<td>C50.919</td>
<td>0.154</td>
</tr>
<tr>
<td>Prostate CA on Lupron</td>
<td>Current</td>
<td>C61</td>
<td>0.154</td>
</tr>
<tr>
<td>History of Dukes A colon cancer, no recurrence, no current treatment</td>
<td>History</td>
<td>Z85.038</td>
<td>0.000</td>
</tr>
<tr>
<td>Personal history of malignant neoplasm, kidney</td>
<td>History</td>
<td>Z85.528</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Medicare Risk Adjustment Case Example

**Patient**: Sally Jones   DOB: 12/1/38   DOS: 10/11/12

Patient is a 72 year-old female with UTI symptoms. Patient c/o fatigue, low energy and poor appetite. Patient is status post MI 18 months ago. Patient appears frail and with mild malnutrition. Has lost 23 pounds in the last 4 months. Patient has been complaining of pain with urination, weakness, and has had dry, itchy skin for the past several months. U/A done today shows WBC’s, leukocyte esterase, and microalbuminuria. Serum creatinine is 1.5.

**PMH**: Type II diabetes, chronic kidney disease secondary to diabetes, history of BKA skin intact at stump, no erythema, History of MI. Previous UTI 4 months ago with a serum creatinine of 1.6. Lab results at that time revealed stage 2 CKD.

**A/P**: Diabetes-Metformin 500 mg b.i.d. Bactrim for UTI. Malnutrition- Ensure b.i.d. and nutrition consult. RTC in 6 weeks. Referral made to Dr. Smith (Nephrologist) for CKD.

**Note**: Electronically signed by John Anderson, MD 10/11/2012  0814
Medicare Risk Adjustment Case Example, continued

Coding Example 1: Typically submitted ICD-10-CM codes for the office visit

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Condition</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.9</td>
<td>DM w/o Complication Type II</td>
<td>19 (HCC-C)</td>
</tr>
<tr>
<td>N39.0</td>
<td>Urinary Tract Infection</td>
<td>Does not risk adjust</td>
</tr>
</tbody>
</table>

Coding Example 2: Opportunities for additional risk adjustment code reporting

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Condition</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.22</td>
<td>DM Type II with Chronic Kidney Disease</td>
<td>18 (HCC)</td>
</tr>
<tr>
<td>N18.2</td>
<td>CKD Stage II</td>
<td>Does not risk adjust</td>
</tr>
<tr>
<td>E44.1</td>
<td>Malnutrition of mild degree</td>
<td>21 (HCC)</td>
</tr>
<tr>
<td>N39.0</td>
<td>Urinary Tract Infection</td>
<td>Does not risk adjust</td>
</tr>
<tr>
<td>I25.2</td>
<td>Old MI/ History of MI</td>
<td>Does not risk adjust</td>
</tr>
<tr>
<td>Z89.519</td>
<td>Amputation, below knee</td>
<td>189 (HCC)</td>
</tr>
</tbody>
</table>
Demonstrating a causal relationship:
Explicitly state in the medical documentation a cause-and-effect relationship between chronic conditions and associated manifestations.
A causal relationship is specified by the words “due to”, “associated with”, “complicated by”, or “secondary to”.

Example:
Patient is seen for Diabetes Mellitus Type 2, with advanced Diabetes and renal manifestations caused by Diabetes, i.e., Diabetic Nephropathy
To show a causal relationship, the physician should note labs and urine test results and document:
• Diabetic Nephropathy; or
• Nephropathy due to Diabetes Mellitus

If provider documents the following, then the highest specificity code will be captured:
  o Diabetic Nephropathy (E11.21)
  o CKD Stage 3 due to Diabetes (E11.22 and N18.3)

If a causal relationship is not clearly indicated in the progress notes, the conditions will be coded separately and the highest specificity code will be missed.
Documentation Exercise: *Linking Diagnoses*

**Scenario**

Patient presents with:
- Severely diminished renal function (GFR = 14)
- Macroalbuminuria (albumin > 300)
- HTN
- Diabetes

Based on the information above, in order to capture diagnoses of CKD, HTN and diabetes to the highest level of specificity, how should this be documented in the medical record?

A. Hypertension
B. Stage 5 Chronic Kidney Disease
C. Diabetes Type II with Diabetic Chronic Kidney Disease

**Answer**

**Correct answer: A, B, and C**

Based on documentation, provider noted chronic kidney disease stage 5 and linked it to the diabetes.

Coder can select the highest level of specificity code as per documentation:

- HTN with **CKD5** (I12.0)
- Diabetes with **CKD5** (E11.22 and N18.5)

Example given shows complete documentation to support Hypertensive Chronic Kidney Disease and Diabetes with Renal Manifestations.
How Can Physicians Best Prepare for the Risk-Adjusted Environment?

- **Develop internal repetitive checkpoints** for most common documentation and coding errors prior to claim or encounter submission.
- **Standardize processes** for accurate medical record documentation and coding across clinicians and non-clinicians to minimize disruption to practice flow.
- **Utilize tools and resources** provided by Florida Blue to identify and remediate incomplete or inaccurate coding.
- **Review practice impact and continued opportunities** to improve clinical documentation and accurate code capture.
Connect With Us

For information about risk adjustment, visit the Florida Blue Risk Adjustment Process webpage.

Interested in learning about documentation and coding best practices? We offer live webinars and education courses. Visit Availity Learning Center at Availity.com to find a calendar of upcoming webinar sessions and education materials or email us at RiskAdjustmentTraining@floridablue.com