Improving Quality Medical Care by Improved Accuracy in Documentation and Coding

September 2019

AdvocateAuroraHealth™

Improving Quality Medical Care by Improved Accuracy in Documentation and Coding

The Importance of Hierarchical Condition Category (HCC) Codes

The CMS Risk Adjustment Model

Description

After completion of the course individual will understand how increasing specificity of a diagnosis impacts Quality, Cost Efficiency, Payment and portrayal of how sick a patient is. It will take approximately 60 minutes to complete this course.

Instructions

This course is tested and guaranteed to function on an Advocate Aurora network PC

Instructions on how to navigate this course

This course does not have sound

Technical Contact

If you have technical questions please contact the Service Desk at 414-647-3520 in Milwaukee or 1-800-889-9677.

Content Contact

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Improving Your Quality Rating

Noting the severity of the patient's conditions, by being as specific in the visit diagnosis section of the encounter and in your problem lists affects ALL PATIENTS. Using the most accurate code has implications beyond billing; and effects your:

- Quality Impact Scores, CMS Quality Payment Programs(MIPS/MSSP), HEDIS Quality Scores and Public Release WCHQ scores
- Individual "Physician Compare" Public website ratings for Quality and Cost Efficiency
- Provider rating for quality and cost efficiency with Insurance Companies for patients of all ages

Asthma Quality Rating Example

Consider a population of 100 Asthmatics. About 10-15% will have exercise-induced Asthma. The patient with exercise-induced asthma that has “plain” Asthma listed as a visit diagnosis, would be considered as needing a controller medication. Where, if exercise induced Asthma (ICD code of J45.990) had been used, the patient would not be included as needing a controller.

Noting this type of specificity makes a difference in a providers Quality Scores related to the treatment of Asthma with a controller. 85-90% compliance compared to 100% had the exercise induced Asthma code been used for those 10-15% of the patient population.

Medicare at a Glance

- Medicare Part A – Hospital Inpatient Services
- Medicare Part B – Outpatient/Clinic Services including Medicare Shared Savings(MSSP)
- Medicare Part C – Medicare Advantage Programs such as AARP, Blue Medicare, Health Spring and Wellness and Humana Gold
- Medicare Part D – Prescription Drugs

Background

- Prior to 2004, Medicare (CMS) paid health plans based solely on member age, sex, and location.
- In 2004, CMS began transitioning to a health plan payment system based on member health status. This ONLY applies to Medicare Part C Advantage Plans.
- This system is often called RAPS (Risk Adjusted Payment System).
- For Advocate Aurora, most of our Medicare patients will fall under the RAPS program due to our Medicare Advantage Contracts with United Health Care, Humana etc and our Medicare Shared Savings Program (MSSP) ACOs.

Hierarchical Condition Categories

Payment is based on ~83 Hierarchical Condition Categories (HCCs). Each category has ICD 10 diagnosis codes associated with the HCC. Of the ~83, there are:

- ~62 Chronic HCCs
- ~21 Acute HCCs

- **Chronic HCCs** are likely to persist year to year and Epic prompts providers to 'refresh' them.
- **Acute HCCs** are not considered to be persistent, and are NOT prompted to be refreshed.
- **BOTH acute and chronic HCCs** 'count' towards a patient's total RAF score. This score determines for CMS how sick the patient is and how many resources are expected to be utilized.

Background

- Payments are higher for less healthy members and lower for healthy members.
- Payments are determined by diagnosis coding
- Appropriate chart documentation and diagnosis reporting is required for reimbursement
- CMS performs audits and will take premium reimbursement back if not appropriate.

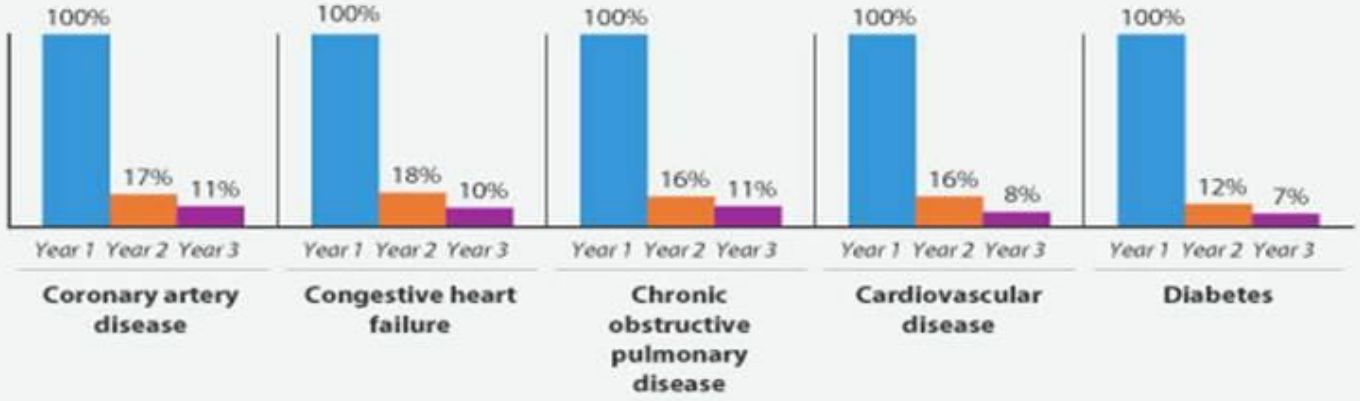
HCC Payment Model

- It is essential to document completely to get reimbursement warranted by patient's condition.
- Slight changes in the coded specificity of the diagnoses can mean BIG financial consequences.
- Payment is adjusted based on HCC codes and documentation of disease.
- In the Risk Model, reimbursement is determined by all the ICD diagnosis codes assessed and treated, NOT the E&M level.
- Each condition must be coded and assessed with appropriate plans each year.

Importance of Annually Noting as a Visit Diagnosis

How soon we forget

Physicians do not provide a complete and accurate listing of ICD__ codes for members, particularly those with chronic diseases. All of the conditions listed are chronic, yet only 17 percent of members with, for instance, coronary artery disease are coded with this condition in the second year and only 11 percent are coded in the third year.



Source: Reden & Anders

Risk Adjustment Factor

- Each patient is assigned a Risk Adjustment Factor (RAF)
- The RAF score is made up of :
  1. Demographic factor (age and sex)
  2. Additional factors based on Medicaid status and disability
  3. Documented select chronic conditions (HCCs)
  4. A patient can have more than one HCC
- All of the Individual's HCCs roll-up to a RAF(Disease burden) score

Interpreting the Risk Adjustment Factor (RAF)

RAF identifies patient health status:

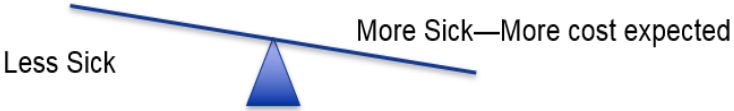
Low RAF

May indicate a healthier population

Or

Low RAF score may falsely indicate a healthier population due to:

- Inadequate chart documentation of diagnosis
- Incomplete and/or inaccurate diagnosis coded
- Patients who were not seen



High RAF

May indicate members with increased health risks that were properly documented and coded

Or

High RAF score may be inflated due to :

- Reported diagnosis not documented with an assessment/plan
- Copy and paste of the Problem List to a visit diagnosis
- Using Rule out diagnosis instead of the symptoms.

Risk Adjustment Factor Example

76 year old female with DM, PVD & CHF

76 year old female	0.426
Medicaid eligible	0.202
DM w/ vascular complications (HCC 18)	0.371
Vascular disease w/ complications (HCC 108)	0.594
CHF (HCC 85)	0.346
Disease interaction DM + CHF	0.150
Total RAF	2.089

A total RAF score of 1.0 is an average risk patient. This patient's RAF score of 2.089 indicates that they are twice as sick and therefore are expected to utilize more resources.

Determining a RAF Score

The Risk Adjustment model is **additive**.

- Takes in all qualifying diagnoses submitted to CMS in a given year for a particular patient in both the inpatient and outpatient settings.
- Adds up risk factors(HCCs) to achieve a total health status “score” for patient.

The Risk Adjustment model is **predictive.**

- Diagnoses reported this year determine resource needs for next year.
- Health status is re-determined each year.

Previous Payment Model

- Patient A: 75 year old female with breast cancer, Rheumatoid Arthritis and diabetes complicated by chronic kidney disease and PVD with foot amputation
- Patient B: 75 year old female whose only problem is mild osteoarthritis

Before this Risk Model was in place CMS paid the same amount for both patients based on only the E&M level of service and CPT procedural codes.

Under the Risk Model the severity of the diagnoses billed out affect payment, not the E&M level of Service used.

Benefits of HCC

- Improves continuity of care by more comprehensive sharing of patients conditions.
- Accuracy of patient risk stratification and risk management.
- Predictive modeling.
- Correctly and accurately documents the severity of illness of the patient.
- Accurate documentation is important for comparative physician and hospital scorecards.

Documentation Pitfalls

- National coding guidelines state that a diagnosis cannot be coded unless it is documented and assessed in the current visit.
- A chronic condition must be restated each time it is assessed or treated. A diagnosis cannot be carried over from another visit.
- Documentation must be explicit. Assessing the signs, symptoms, or findings related to a disease isn't enough.
  "FBS 300" cannot be coded as uncontrolled diabetes.
- It is not acceptable to copy the problem list into the visit diagnoses without an assessment and plan.

CMS Mandate for Documentation and Coding

The Mandate from CMS

Any Condition that is ***taken into account*** or ***affects patient care***, ***treatment*** or ***management*** should be documented and ultimately coded.

The listing of all pertinent diagnosis codes is important!

Medical Record Documentation

- Code all documented conditions that coexist at the time of the encounter/visit. (Amputations, Dialysis, Insulin use)
- **In the Clinic Setting:** Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s) and require or affect patient care, treatment or management decisions.
- If you fail to address and document an HCC diagnosis, you are still taking care of the problem, you are just forgoing credit/recognition for the disease burden you are managing.
- If you are a PCP and a specialist is fully managing the condition, you should still address the condition and indicate the clinical status and management plan for that condition.

Medical Record Documentation (Cont.)

- Do not code conditions that were previously treated and no longer exist.
- However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Required to be a visit diagnosis annually: Stroke Sequelae, Amputations, transplant, quadriplegia etc.

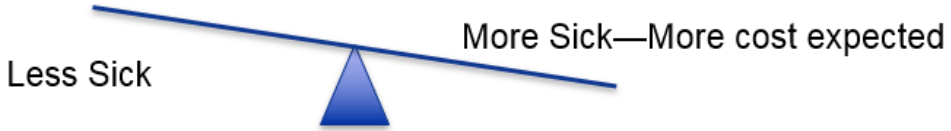
Quality Documentation

- You must document chronic conditions every year.
  - As of January 1 every year, CMS acts as if all chronic diseases are “cured.”
  - If a chronic condition is not documented and coded in a year, there is NO payment for it!
  - It is best practice to address diagnoses throughout the year at each visit. If only seeing the patient annually, the Medicare Wellness Visit is the perfect time to address all conditions the patient has.
- Documentation must be based on a face-to-face visit
- Exception – you may add a diagnosis confirmed after the visit by lab or other ancillary information IF:
  - The data is received within one week of the visit
  - You amend chart to document diagnosis, plan, and call patient

Importance of Specificity

80 year old female with an MI in the last 4 weeks, depression, diabetes, and eGFR 55, and creatinine of 1.3

General	HCC weight	Specific	HCC weight
CAD	.000	MI in last 4 weeks	.231
Depression	.000	Major Dep. Single episode	.370
Diabetes	.181	DM with renal issue	.608
		CKD stage III	.389
HCC Score	.181		1.598



Importance of Specificity

Specific Documentation & Coding Clearly Identifies the *Severity Level* of Disease and how sick your patient is.

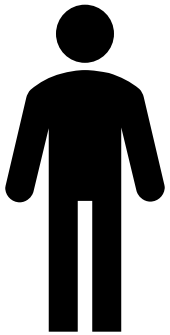
Risk Score

- Determined by the diagnosis submitted on a claim (grouped into Hierarchical Condition Categories, HCC)
- The average beneficiary has a 1.0 risk score
- Patients with higher risk scores are sicker
- Patients with lower risk scores are healthier

What is the Risk Score for your Patients?

Importance of Specificity

Specific Documentation and Coding Clearly Paints the Picture of the ***Level of Complexity*** for the Patient Encounter



Impaired FBS

Versus

Diabetes on Insulin

Versus

Diabetes on Insulin with PVD and CKD

Why Is Coding All Chronic Conditions Important?

No Conditions Coded		Some Conditions Coded		All Chronic Conditions Coded	
76 year old female	0.442	76 year old female	0.442	76 year old female	0.442
DM with complications	X	DM without complications	0.118	DM with complications	0.368
Vascular Disease	X	Vascular Disease	X	Vascular Disease	0.299
CHF	X	CHF	X	CHF	0.368
Disease Interaction (DM+CHF)	X	Disease Interaction (DM+CHF)	X	Disease Interaction (DM+CHF)	0.182
Total RAF	0.442	Total RAF	0.560	Total RAF	1.659

Importance of Specificity

Less Specific		More Specific	
ICD 10	**Condition**	**ICD 10**	**Condition**
F32.9	Depression	F32.- to F33.-	Major Depression
R25.1	Tremor	G20	Parkinson's
I10	HTN Unspecified	I11.0 & I50.-	HTN Heart Disease w HF
I125.10	Coronary Artery Dz(CAD)	I25.119	CAD with stable Angina Pectoris
I51.89	Other Spec Cardiac Disorder	I48.-	Atrial Fib – Need to note if chronic, paroxysmal, permanent or persistent.
J44.9	COPD NOS	J44.9 & J96.-	Chronic Obstructive Asthma with Chronic Respiratory Failure(on O2)
J40	Bronchitis, NOS	J42	Chronic Bronchitis

Fictional Case Study Example

Fictional Case Study Example 1

DOS: 01/12/2019
Name: Patient One DOB: 05/01/1953

Chief Complaint & HPI

65 year old female accompanied by her husband, here for routine visit, lab results

Past Medical History

Diabetes, CKD, Hyperlipidemia, HTN

ROS

Constitutional – patient notes fatigue
GU – positive for urinary frequency
MS – mild swelling in the hands and feet
other systems negative

Vitals

Ht. 69 in, Wt. 275 lbs.
BP 124/82
Temp 97.6 Pulse 78

Exam

General Appearance: Well groomed, pleasant, obese female **ENMT**: Normal **CV**: RRR; **Lungs :** clear, good breath sounds bilaterally

Assessment/Plan

1. Diabetes – currently well controlled, a1c at 5.2
2. Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. CKD – currently no change, GFR at 51
4. HTN, hyperlipidemia – both currently well controlled. Repeat labs and schedule follow up in 3 months

Electronically signed by: A. Medical Doctor, MD on 01/12/19

Fictional Case Study Example cont.

Fictional Case Study Example 1 with Improved Documentation

DOS: 01/12/2019
Name: Patient One **DOB**: 05/01/1953

Chief Complaint & HPI
65 year old female accompanied by her husband, here for routine visit, lab results

Past Medical History
Diabetes, CKD, Hyperlipidemia, HTN

ROS
Constitutional – patient notes fatigue
GU – positive for urinary frequency
MS – mild swelling in the hands and feet
other systems negative

Vitals
Ht. 69 in, Wt. 275 lbs. BMI 40.6
BP 124/82
Temp 97.6 Pulse 78

Exam

General Appearance: Well groomed, pleasant, morbidly obese female **ENMT**: Normal **CV**: RRR; **Lungs :** clear, good breath sounds bilaterally

Assessment/Plan

1. Diabetes – currently well controlled, a1c at 5.2
2. Morbid Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. CKD, Stage 3, secondary to diabetes – currently no change, GFR at 51
4. HTN, hyperlipidemia – both currently well controlled. Repeat labs and schedule follow up in 3 months

Electronically signed by: A. Medical Doctor, MD on 01/12/19

Fictional Case Study Example 1 and HCC Impact

Fictional Case Study Example 1

First Coding Scenario:

Diagnosis	ICD-10-CM	HCC Value
Diabetes w/ CKD	E11.22	18
CKD	N18.9	none
Obesity	E66.0	none
Hypertensive CKD, unspecified	I12.9	none
Hyperlipidemia	E78.5	none

Second Coding Scenario

Diagnosis	ICD-10-CM	HCC Value
Diabetes w/ Stage 3 CKD	E11.22	18
Stage 3 CKD	N18.3	138
Morbid Obesity BMI 44.0-44.9	E66.01 Z68.41	22
Hypertensive CKD, stage 3	I12.9	none
Hyperlipidemia	E78.5	none

Detailed documentation is key for accurate risk score reporting

Specific Documentation Paints a Picture for the Plan of Care

Case Review: 76 y/o female patient with uncomplicated Type 2 diabetes

RAF score is 0.555
(Less sick, well below national average of 1.0)

Accurate Documentation

Same patient : 76 y/o female patient with Type 2 diabetes with PVD, CKD III, stable HTN and CHF.

RAF score is 2.013
(More sick and above national average of 1.0)

RAF Scores Based on Provider Documentation (same patient)

Conditions with limited specificity	All conditions documented with appropriate DX codes
76 y/o female 0.437	76 y/o female 0.437
DM without complication (E11.9) 0.181	DM with vascular Complications 0.368
Vascular disease not coded	Peripheral vascular disease unspecified: 0.299
HF not coded	HF coded 0.368
No disease interaction (HTN/CKD) (Diabetes/HF)	HF and renal interaction 0.317 Hypertensive CKD Stage 4 – 0.224
TOTAL RAF 0.618	**TOTAL RAF 2.013**

Linkage HTN & Heart Disease

There is a presumed causal relationship between hypertension, chronic kidney disease and or heart failure, unless the provider clearly states the conditions are unrelated. The combined morbidity is ***best*** quantitatively represented in the RAF score when these three conditions are connected together as a single combined diagnosis term instead of three separate diagnoses. In Epic these conditions should be documented on the Encounter Diagnosis list using a ***combination diagnosis*** term.

If the patient has HTN, CKD and Heart failure it's important to use the combination code and not mention HTN, CKD and Heart Failure separately as HTN by itself does not risk adjust.

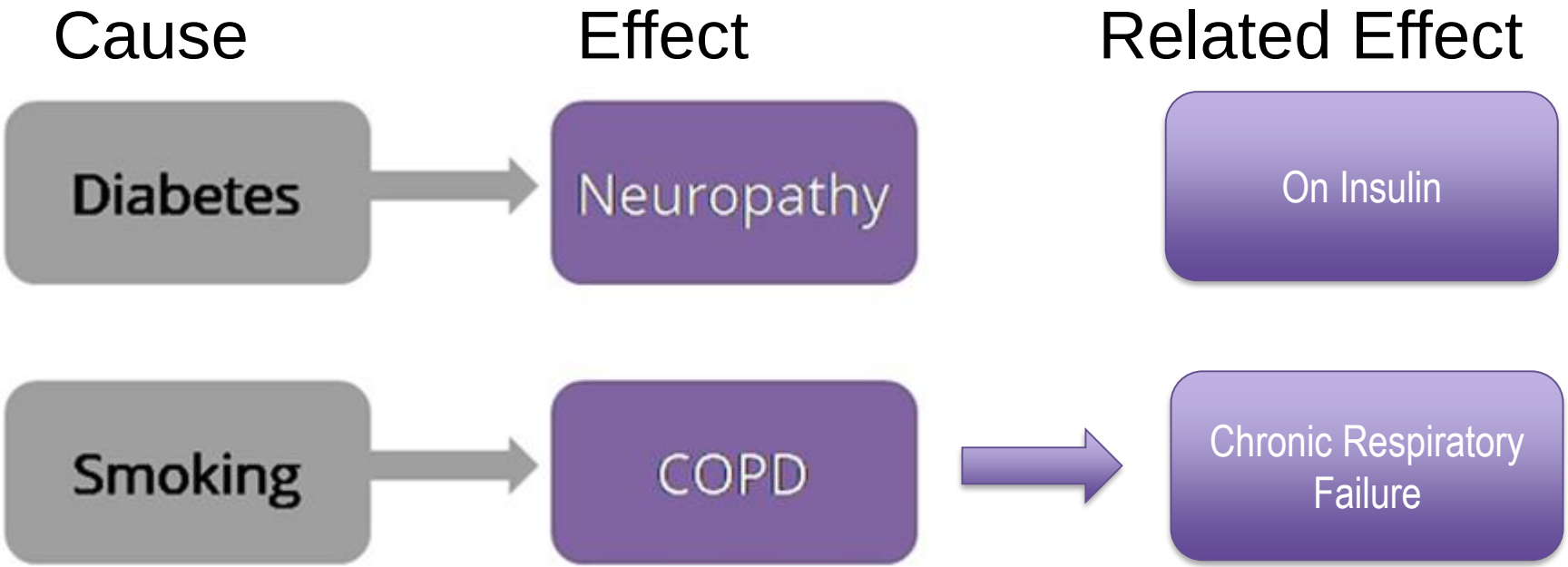
Coronary Artery Disease and Angina

- Myocardial Infarction – list the acute diagnosis only during the first 4 weeks following an AMI, otherwise use History of Acute Myocardial Infarction
- Search in Epic using “acute myo inf” or “hist acute myo inf”
- Is the patient on a long-term nitrate? If yes, then the patient is receiving medical treatment for stable angina
- An appropriate long-term management diagnoses is Coronary Artery Disease with Stable Angina

Depression (major depressive disorder)

- Use Major Depression family of diagnoses (de-stigmatize “major”)
- If a patient is sufficiently ill to have a PHQ9 of >=5 and is prescribed an anti-depressant, they have major depression
- Depressed mood, anhedonia, sleep disturbance, appetite change, irritability, fatigue, poor concentration, guilt, suicidal ideation
- Initial episode = > 2 weeks of symptoms
- Subsequent episode = absence of symptoms for > 2 months, then relapse
- Remission (partial/full) = absence of some/all symptoms for > 2 months. Without this specificity, the Depression term does NOT risk adjust.
- Search in EPIC using “maj dep”
- Depression without specificity does not risk adjust.

Document Cause and Effect Relationships



Visit Diagnoses would be: Diabetes with neuropathy. Current Use Insulin COPD with Chronic Respiratory Failure

Common Annually Overlooked Diagnoses

- Artificial Feeding or Eliminator Openings
- Quadraplegic/Hemiplegic status
- Morbid Obesity
- Amputations
- Chronic Respiratory Failure
- Stable COPD
- Chronic Skin Ulcers

Diabetes Mellitus

Complications of diabetes are under-reported

E11.9 is over-reported

- Diabetes Mellitus, code E11.9 without mention of complication is appropriate at times.
- However, if complications exist, code to the specific complications and manifestations.

Diabetes Mellitus-Underlying Disease

Coding of Underlying Disease (Etiology) and manifestation

In ICD 10 Diabetes Mellitus and underlying diseases are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

As many codes within this particular category should be used to describe all the complications of the disease ***E11.2-E11.6***

Do not use uncontrolled diabetes.

Providers must specify diabetes as hyperglycemia or hypoglycemia in the progress note and code selection.

Diabetes Mellitus-Underlying Disease

What System is being Affected?

E11.**2-** Diabetes with **renal** manifestations

E11.**3-** Diabetes with **ophthalmic** manifestations

E11.**4-** Diabetes with **neurological** manifestations

E11.**5-** Diabetes with **peripheral circulatory** disorders

E11.**6-** Diabetes with **other specified** manifestations

E11.**8-** Diabetes with **unspecified** complications

Be sure to append Z79.4 for long term (current) use of Insulin (except Type I)

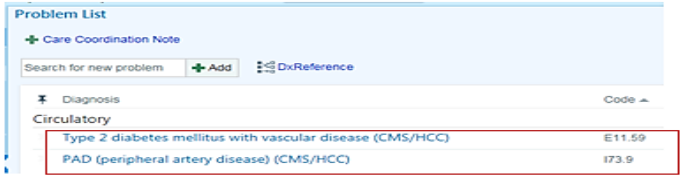
Additive Effect

Description	RAF	
Diabetes with Renal or Peripheral Circulatory Manifestations	0.508	Same HCC Category
Diabetes with Neurologic or Other Specified Manifestations	0.408	
Diabetes with Acute Complications (1)	0.339	
Diabetes with Ophthalmologic or Unspecified Manifestations	0.259	
Polyneuropathy	0.327	
Vascular Disease with Complications	0.610	Same HCC Category
Vascular Disease	0.316	
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.252	
Chronic Ulcer of Skin, except Decubitus	0.449	
Amputation Status, Lower Limb/Amputation complications	0.678	

Note: If patient has more than one diagnosis in the same HCC category, the highest weighted diagnosis & each complication HCC is used to calculate the overall RAF score. Example from above: 0.508 + 0.327 + 0.610 + 0.252 + 0.449 + 0.678 = 2.82

Use Diagnosis Calculator to Add Multiple HCCs Automatically

If you do NOT utilize the calculator, you would need to use the Diabetes with Circulatory diagnosis term **AND** the PAD term to apply the TWO HCC's #18 and #108.



In the case where a patient has more than one Diabetes Commorbidity, it is important that at **least one** Diabetes with commorbidity diagnosis (circulatory, nephropathy etc) to apply the Diabetes with Complications HCC #18 and then a term/diagnosis for each of the respective commorbities (PAD, IVD, Diabetic Retinopathy etc) listed separately. This is so that that the higher level Diabetes HCC and EACH additional co-morbidty HCCs are accounted for and get applied to the patients severity risk.

Example of Diabetes with PAD, Retinopathy and CKD. Note that 4 HCCs are applied.

Diagnosis	Code
Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene (CMS/HCC)	E10.51
Diabetic retinopathy (CMS/HCC)	E11.319
Stage 4 chronic kidney disease (CMS/HCC)	N18.4
Peripheral angiopathy (CMS/HCC)	I73.9

Medicare Advantage Total HCC Applied

Total HCCs Applied

MA HCC 18-APPLIES DM CHRONIC COMP

MA HCC 22-APPLIES MORBID OBESITY
MA HCC 58-APPLIES MAJOR DEPRESSIVE,BIPOLAR,AND PARANOID DISORDERS
MA HCC 108-APPLIES VASCULAR DISEASE
MA HCC 137-APPLIES CHRONIC KIDNEY DISEASE (SEVERE,STAGE 4)

Example of Epic Diagnosis Calculator

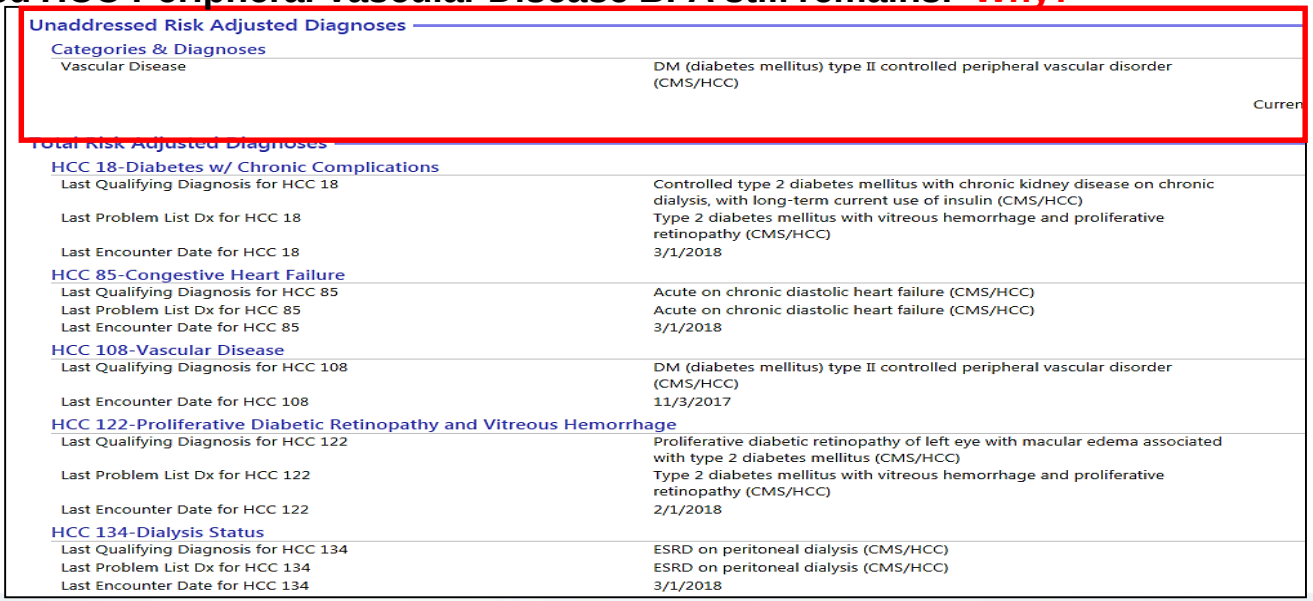
The Diabetes **Calculator is your tool/friend**. The calculator will auto-associate multiple ICD 10 codes and combination HCC's for you, based on what you pick from within the calculator.

For example:

If a patient has Diabetes with PAD, you would choose in the complication detail section PAD and the calculator will assign the Diabetes with complications HCC #18 and in the ***background the calculator will auto associate*** the respective PAD ICD 10 diagnosis and HCC #108.

Case Example Pt with unaddressed HCC

Below is a patient who came in for their Diabetes visit on 3/1/2019. At the time of the visit the patient had the following conditions addressed: Diabetes, ESRD on Dialysis and Peripheral artery disease. The visit diagnoses utilized included Diabetes with Chronic Complications and CKD on Dialysis. **An unaddressed HCC Peripheral Vascular Disease BPA still remains. Why?**



Unaddressed Risk Adjusted Diagnoses

Categories & Diagnoses	
Vascular Disease	DM (diabetes mellitus) type II controlled peripheral vascular disorder (CMS/HCC)

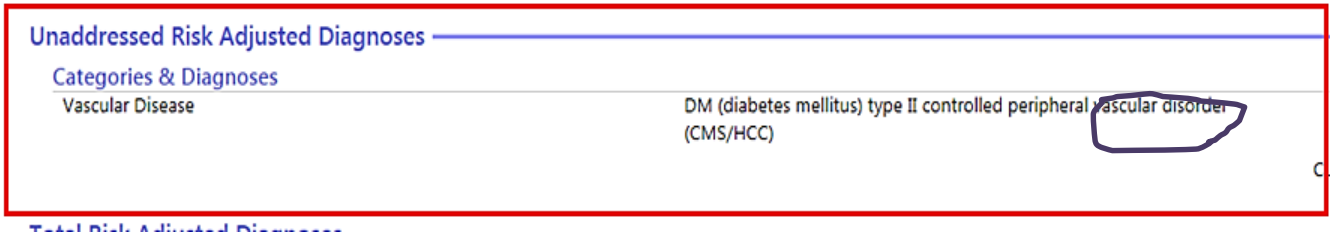
Curren

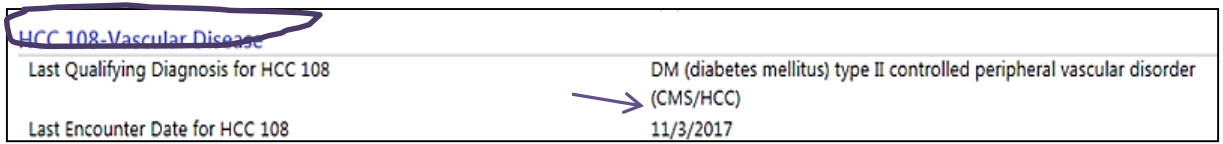
Total Risk Adjusted Diagnoses

HCC 18-Diabetes w/ Chronic Complications	
Last Qualifying Diagnosis for HCC 18	Controlled type 2 diabetes mellitus with chronic kidney disease on chronic dialysis, with long-term current use of insulin (CMS/HCC)
Last Problem List Dx for HCC 18	Type 2 diabetes mellitus with vitreous hemorrhage and proliferative retinopathy (CMS/HCC)
Last Encounter Date for HCC 18	3/1/2018
HCC 85-Congestive Heart Failure	
Last Qualifying Diagnosis for HCC 85	Acute on chronic diastolic heart failure (CMS/HCC)
Last Problem List Dx for HCC 85	Acute on chronic diastolic heart failure (CMS/HCC)
Last Encounter Date for HCC 85	3/1/2018
HCC 108-Vascular Disease	
Last Qualifying Diagnosis for HCC 108	DM (diabetes mellitus) type II controlled peripheral vascular disorder (CMS/HCC)
Last Encounter Date for HCC 108	11/3/2017
HCC 122-Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	
Last Qualifying Diagnosis for HCC 122	Proliferative diabetic retinopathy of left eye with macular edema associated with type 2 diabetes mellitus (CMS/HCC)
Last Problem List Dx for HCC 122	Type 2 diabetes mellitus with vitreous hemorrhage and proliferative retinopathy (CMS/HCC)
Last Encounter Date for HCC 122	2/1/2018
HCC 134-Dialysis Status	
Last Qualifying Diagnosis for HCC 134	ESRD on peritoneal dialysis (CMS/HCC)
Last Problem List Dx for HCC 134	ESRD on peritoneal dialysis (CMS/HCC)
Last Encounter Date for HCC 134	3/1/2018

Answer to Why…

In the case of diabetes, each complication must be listed out separately. The Diabetes with Chronic Condition (CC) visit diagnosis is needed just once, but every CC needs to be listed separately. In this case the Diagnosis of Diabetes with Circulatory AND a visit diagnosis of PAD needs to be listed or the use of the Diabetes calculator to include peripheral vascular disorder is needed so that both the Diabetes CC HCC and the Vascular HCC is captured.





Diabetes Mellitus-Underlying Disease

A patient with Type II controlled Diabetes that has treatment for a manifestation of the disease should have ***both conditions coded***:

- PVD and mild non-proliferative retinopathy **due to** Diabetes Mellitus
  - E11.**5**1 Diabetes with peripheral circulatory disorder w/o gangrene
  - E11.**3**2 Diabetes Type II with retinopathy
  - The linkage has been documented with "**due to**" with the ***4th*** digit assigned on the **E11 code**.

Diabetes Mellitus-Underlying Disease

Be specific

If the same scenario from the previous slide was documented as:

1. Diabetes
2. PVD
3. Retinopathy

- Code **E11.9** Diabetes ***without mention of complications***
- Code I73.9 Peripheral vascular disease, unspecified
- Code **H35.00**

With this example, there is nothing indicating that the PVD or Retinopathy is ***due to*** the diabetes. The coding must be more generic in this case.

Documentation Requirements

- Notes must clearly link plan and disease
- A list of problems without an assessment and plan should not be coded
- Use the MEAT acronym to document
  - Monitor (Signs and Symptoms, disease progression/regression)
  - Evaluate (Test results, Response to treatment/medications)
  - Assess (Orders, discussion, counseling, review of results)
  - Treat (Ordering of Medications, Tests, Therapy, Service To)

Documentation Requirements

- Supports medical necessity
- Validates that services were provided
- Ensures continuity of care
- Verifies that services provided are reported with accuracy
- Both ***coding*** and ***documentation*** must be in sync on any day of service
- Legal document

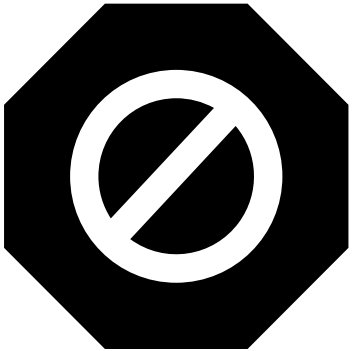
Documentation Requirements

Progress note should always include:

- Documentation to the greatest degree of certainty for each diagnosis
- Documentation of all complications/manifestations including the causal language (e.g. diabetic, hypertensive, due to)
- Documentation of known conditions from a consultant or specialist, lab values, radiology results, discharge summaries
- Documentation of all chronic conditions at least once per year
- Documentation of any chronic condition that affects the care and treatment of the patient on that date of service[1]
- Conditions should be coded to the highest degree of specificity for that encounter/visit

Avoid Unspecific Codes!

- Avoid Unspecified Codes.
- Approximately 9% of current ICD-10 codes are “unspecified.”
- For every unspecified code, there are more specific codes that can be used for that condition.



Documentation Requirements

- The listing of Diagnoses is not enough; there must be evaluation.
- The medical record must thoroughly document all conditions ***evaluated***.
- Evaluative documentation would include statements such as:

  - **Document status of Diagnosis**
    - **Condition worsening - document any treatment/referral**
    - **Condition improving**
  - **Tests ordered - document which tests**
  - **Tests reviewed - bring pertinent findings into progress note**

Documentation Examples for “Assessment” and “Plan”

“Assessment” examples: stable, improved, tolerating meds, deteriorating, noncompliant, levels rising.

“Plans” can be simple: monitor, refer, continue current meds, control diet, exercise, better compliance.

Avoid “History of”

“History of” means the patient is cured, is not being treated, and has no clinical evidence of the disease. Document effects if applicable such as Left Hemiparesis due to previous stroke.

Do not use:

- “History of CHF” to indicate compensated CHF – ***should use CHF***
- “History of Atrial Fibrillation” to indicate A-fib controlled by medication - ***should use A-fib converted to normal sinus rhythm***
- “History of MI” to indicate previous acute MI – ***should use “Old MI” after acute period***

Using Symbols and Oblique References

- ↑BP does not mean hypertension; it means a single instance of elevated blood pressure
- “FBS was 220” does not document the diagnosis of Diabetes
  - It does allow the physician to make the diagnosis, the difference is important!
- “1.5 Creatinine” does not document the diagnosis Chronic Renal Failure - but may allow the physician to make the diagnosis

These abbreviations indicate abnormalities, not diagnoses.

Even if it is obvious, the diagnosis must be stated explicitly

Charting Advice

- Submit chronic disease codes annually: Evaluate each chronic condition diagnosis at least once annually. Any care or treatment should be captured in the current year's medical record.
- Avoid "rule outs:" Do not diagnose conditions with "rule out" or "suspected" but diagnose those conditions with the highest level of certainty for that patient visit.
- Use of test results: The result of a test can be used to confirm a diagnosis only if the physician writes a progress note that interprets the test and makes a diagnosis.
- Provide support for diagnoses: It is not enough to state that a patient has a particular diagnosis. There should be evidence in the medical record to support that diagnosis.

Charting Advice

These are some of the terms that document the evaluation of a condition for good medical record documentation:

- “Stable on meds”
- “Condition worsening – medication adjusted”
- “Tests ordered – documentation reviewed”
- “Condition improving”

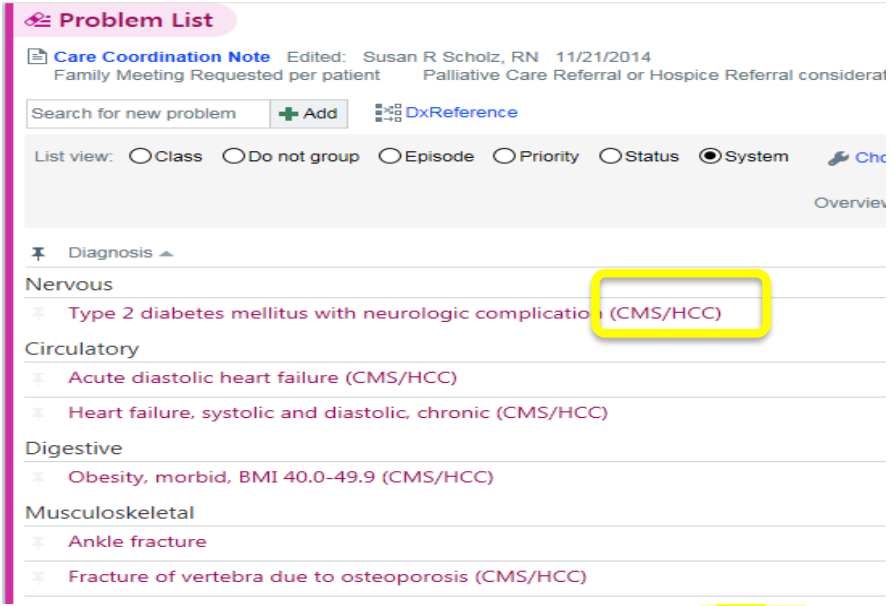
> Listing medications and prescriptions in a medical record ***does not*** meet documentation requirements to indicate that an evaluation for a condition was performed.

Checking off a code or listing a diagnosis on a medical record problem list does not meet documentation requirements. A diagnosis must be in the medical record progress note along with an evaluation in order to fully meet documentation requirements.

EPIC TOOLS AVAILABLE

How Do I Identify a HCC Diagnosis?

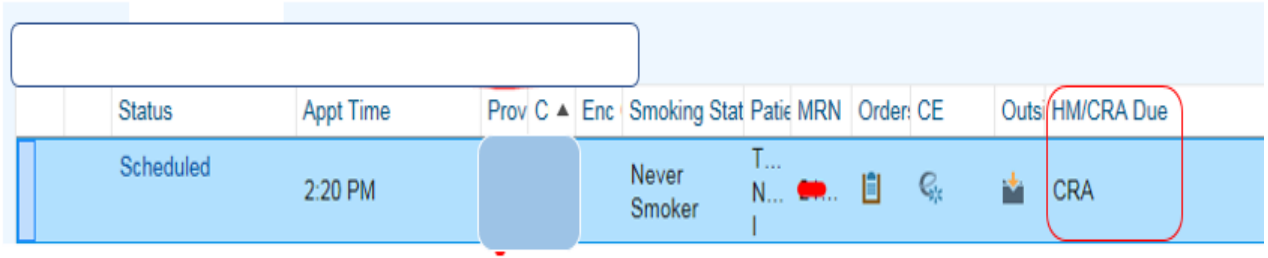
Diagnosis Suffix (CMS/HCC) on the Problem List



Name	ICD-10-CM	HCC Model Category - Primary Co
Mild recurrent major depression (CMS/HCC)	F33.0	59
Major depressive disorder, recurrent episode, mild (CMS/HCC) (aka DEPRESSION)	F33.0	59

How Do I know if there is HCC to Address?

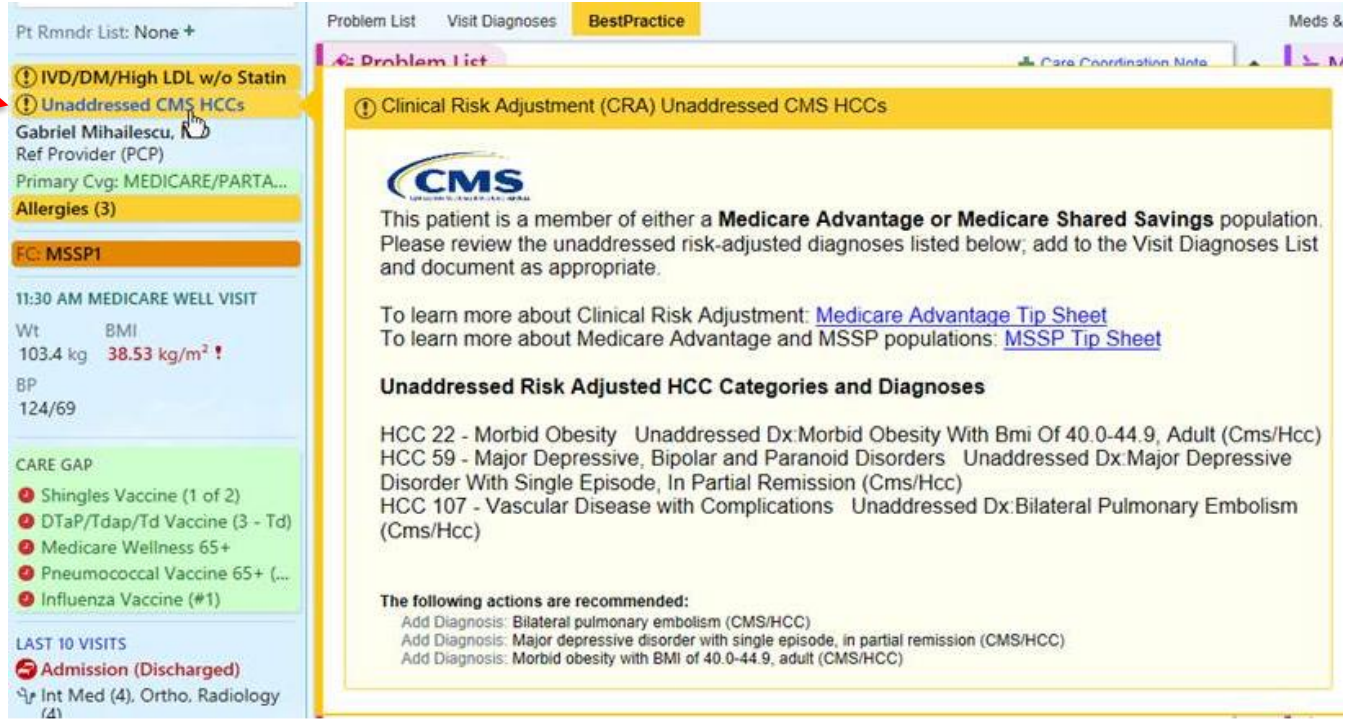
1. My Schedule ICON (HM/CRA), when present indicates there is an open HCC to address



2. Do I have an Open HCC Best Practice Advisory? The Best Practice Advisory (BPA) is available to remind you of diagnoses that need to be addressed this year.

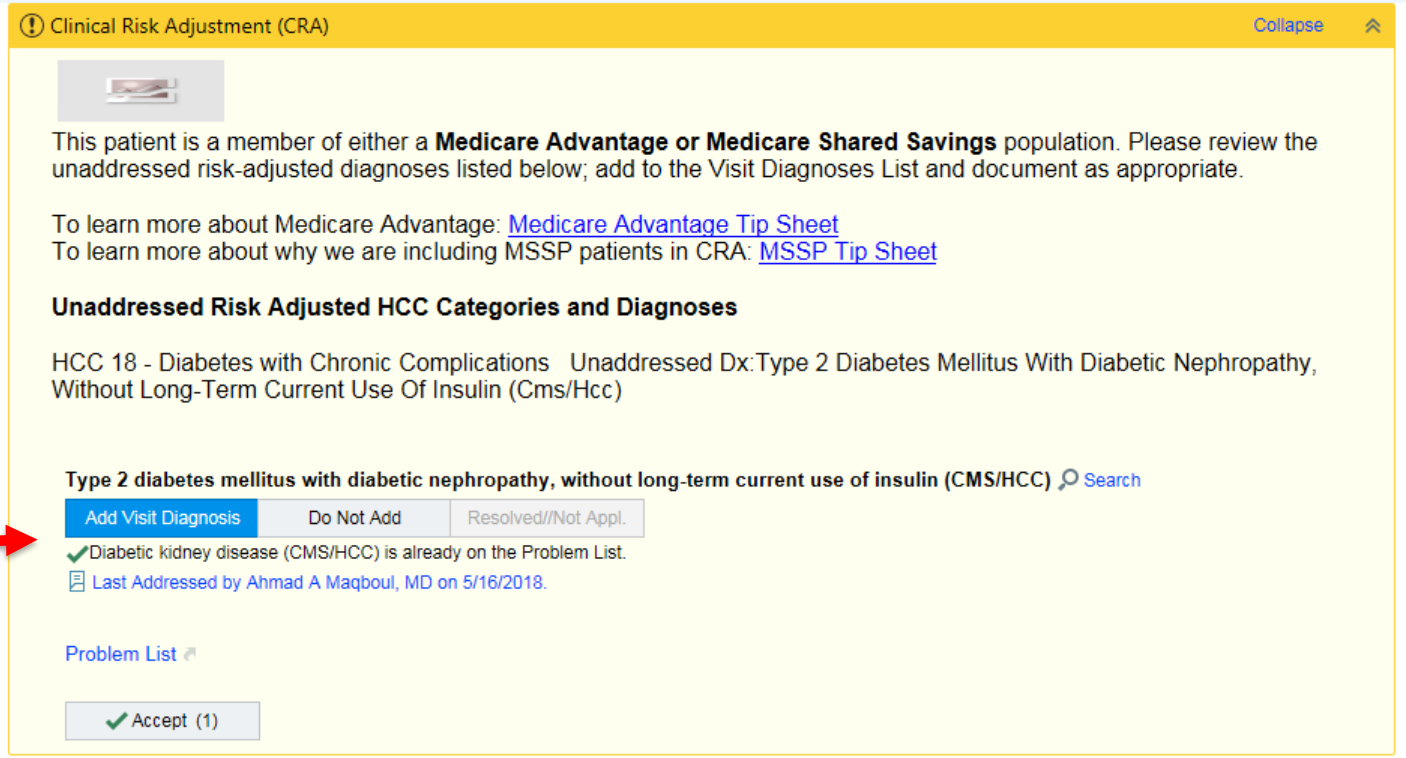
EPIC Best Practice Advisory(BPA)

- The Advisory will indicate the risk adjusted diagnoses that were used in a face-to-face encounter in the past 3 years and have not yet been coded this year.

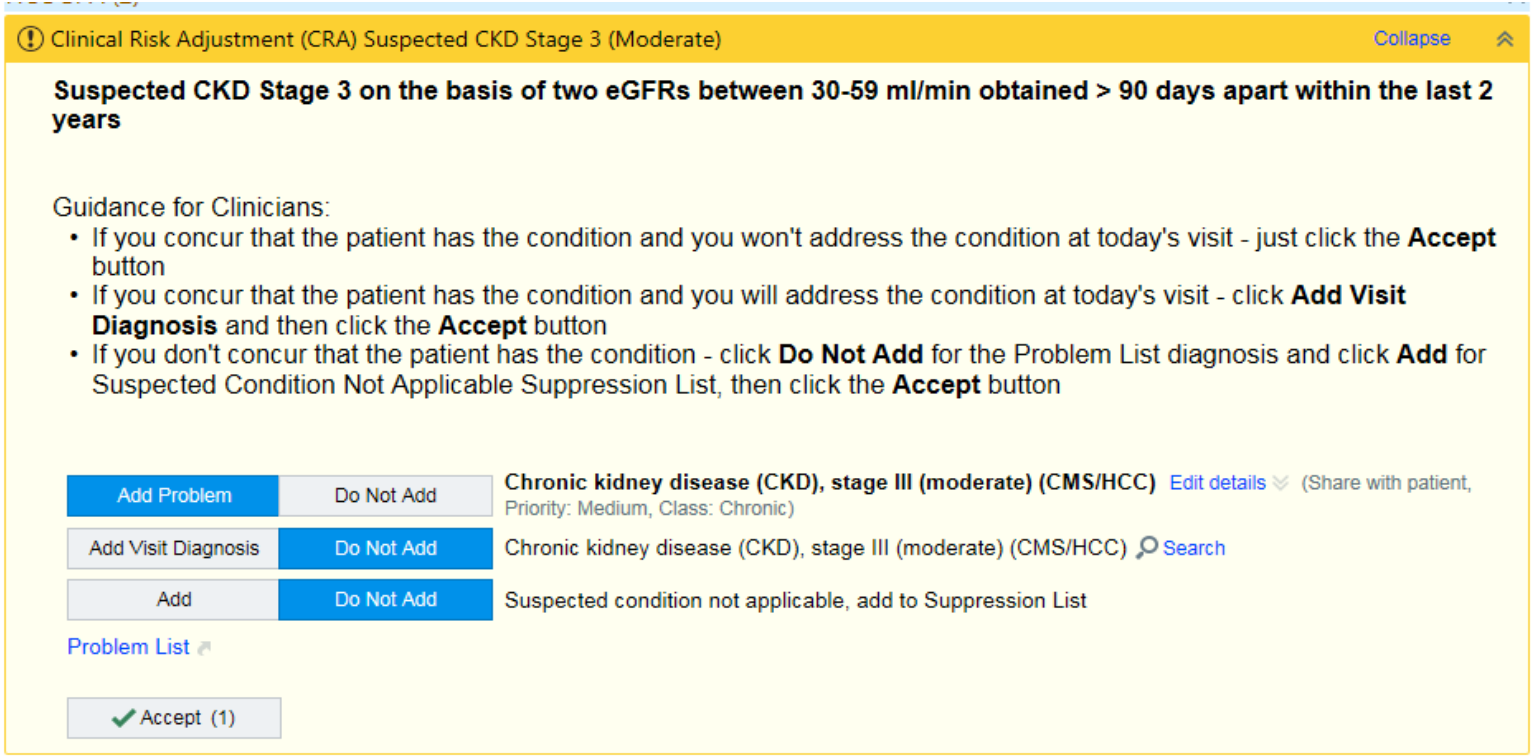


HCC Best Practice Advisory

From within the BPA you can take several actions



Suspected Condition Advisory

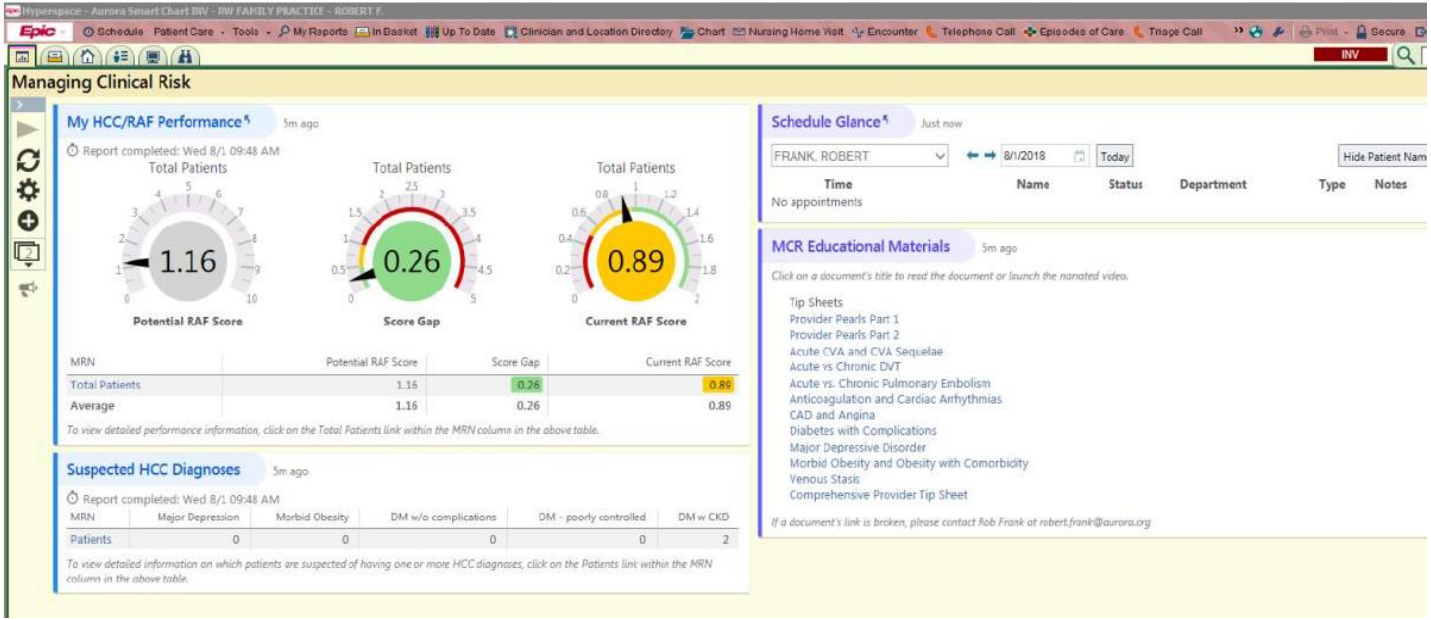


Impact of Best Practice Advisory

- The Best Practice Advisory will help you decrease the gap between current HCC score and potential HCC score.
- Help ensure that patients with HCC diagnoses are seen regularly to monitor their conditions, which in turn can help maximize reimbursement for their care.
- Allow you to quickly suppress diagnoses that are no longer active and provide an improved and efficient means to address and add active conditions to the visit diagnosis.
- Improve the accuracy of how sick the patient is and reflect the patient's chronic conditions annually.
- Improve your Quality Scores.

Clinical Risk Dashboard for Providers

The Clinical Risk Adjustment (CRA) dashboard in Epic was created to aggregate “all things CRA” in a single location within the EMR for easy and convenient accessibility by clinicians.
The content consists of performance summaries, links to pertinent Reporting Workbench reports, and links to CRA educational materials. It is a one-stop source of “stuff” related to HCC & RAF.



All Provider's Role

- Review the diagnosis codes in the Best Practice Advisory
- Assess each diagnosis and document the assessment & plan in the progress note
- Update the problem list & visit diagnosis with appropriate specificity of diagnosis codes as applicable
- If applicable, you may need to select a more specific diagnosis code than listed in the refresh box
- If unable to address at current encounter, schedule a future office visit to address the chronic conditions and update the problem list in the EHR.

BEST PRACTICE WORKFLOW AND TOOLS TO UTILIZE

Prior to the Visit

Provider Role	Tool to Use	Tool Function
Prior to the Visit/Pre-charting Functionality		
Identify patients in our risk contracts	Financial Class in Orange Identified in the Banner, HM/CRA column on the schedule	Identifies any patient with unaddressed or suspected risk diagnoses
Review risk codes that have not yet been addressed this year	CRA Unaddressed BPA	Add relevant diagnoses to the visit diagnosis and/or problem list section or resolve diagnoses no longer active
Review suspected risk codes that have not been addressed this year	CRA Suspected BPA	Add relevant diagnoses to the visit diagnosis and/or problem list section or suppress diagnoses by **adding** to the suppression list
Reconcile external problem list	Reconcile Outside Information	Add external relevant diagnoses to our problem list, discard non relevant ones
Review internal problem list	Problem List	Validate accuracy of internal problem list

During the Visit

Provider Role	Tool to Use	Tool Function
During the Visit/Identify the Severity of Your Patient by Providing Accurate, Complete Documentation		
Update internal problem list	Problem List, Visit Diagnosis	Add any additional new visit diagnoses that were address at visit to the problem list
Order any necessary Screenings, Immunizations, Lab	Health Maintenance, Best Practice Advisories	To capture deficient codes and close any missing quality and HEDIS gaps
Document an Assessment that includes chronic conditions that affects the care and treatment of the patient	MEAT acronym to ensure complete documentation	**M**onitor (signs & symptoms, disease progression/regression) **E**valuate (results, medication effectiveness, response to tx) **A**ssess (ordering test, review records, counseling) **T**reat (medications, therapies, other modalities)
Document a Plan that specifies the treatment for each condition listed in the assessment		
Document any coexisting diagnoses that require or affect the care, treatment or management of the patient at the time of the encounter (amputations, dialysis, insulin)		
Document any known conditions that are being managed by specialist by indicating the clinical status and management of the plan		
Code all conditions to their highest degree of specificity	Use the Epic Calculators/Groupers	

Visit Closure and Between Visits

Provider Role	Tool to Use	Tool Function
Visit Closure		
Schedule Annual MWV	Level of Service	Ensure PSR knows which next visit to schedule
Schedule Chronic Condition Follow Up Visit	Level of Service	Ensure PSR knows which next visit to schedule
Identify Your Risk Score		
Evaluate your real-time current RAF score compared to your potential RAF score	Clinical Risk Adjustment Dashboard	Identify patients attributed to you as the PCP

Best Practice Workflow Summary

Provider Role	Tool to Use	Tool Function
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APP IL Aligned Providers Only:

On E-clinical Works
For Tools and Resources Reference APP PRO

- To Access go to APP.AdvocateHealth.com
- At toolbar, select **Tools and Resources**
- Select **Clinical Risk Adjustment**
- Choose any of the training documents, coding tips or information about the CDI Team

Summary

- Code only chronic diseases that are documented and assessed on that visit.
- Be specific in your diagnosis; always include an evaluative statement.
- Be explicit in linking the primary disease and the complication.
- Always code and document the complication separately.
- Link the treatment to the diagnosis.

Diagnosis Specificity How it Effects your Quality and Cost Efficiency Ratings

Noting the severity of the patient's conditions, by being as specific in the visit diagnosis section of the encounter and in your problem lists affects ALL PATIENTS (not just Medicare Advantage patients). Using the most accurate code has implications beyond billing; such as:

- Your AHC Care Management Impact Score, CMS QPP/MACRA, HEDIS Quality Scores, Public Release WCHQ scores
- Your Rating for Quality and Cost Efficiency with insurance companies and public websites for patients of all ages

The next slide gives an example of a patient with Diabetes. The example shows what a difference using "Vanilla/Plain" Diabetes versus Diabetes with Renal Manifestations and what impact this has on your Quality Ratings, Reimbursement and Cost Efficiency Ratings.

Patient Scenario of How this Works

Patient with Diabetes(E11.9) Patient Severity Score 0.9576=$1000 Per Member Per Month (PMPM)/ $12,000/yr you receive to take care of this patient. *(Patient has DM related Peripheral Vascular Disease) not billed out. Severity Score could have added 0.8534 or $3,072 /yr. Leading to a missed opportunity in reimbursement to cover the care we provided)*

Quality Metrics for Diabetes: Yearly Urine Micro, eye and foot exam, Statin-to prevent cardiac events, Flu Shot, A1c x2 and BP. If not controlled, bring back in 3-6 months.

Patient does not get flu shot during their November visit with the PCP (*Quality*) and is not on a Statin (*Quality*) and foot exam missed (*Quality*).

1 month later…

Patient calls the office on a Friday Morning with fever, coughing and feeling faint and has a lesion on the foot that they did not mention at the last visit (DM foot exam not done at previous visit) that now is draining. Patient requests to be seen today.

Patient referred to ED/Urg Care (*Adding Cost*). Dx: Flu which causes pressure on heart condition, leading to MI due to IVD – Admitted (*Cost*), Lesion requires Wound Care specialist. (*Cost*) (*Remember $12,000/yr you have to take care of the patient based on the Severity of the diagnoses billed out*)

Patient Returns to the office post discharge. Diagnosis Diabetes when should have been Diabetes with previous MI (I21.3) and Foot Ulcer (E11.621) (*Severity/Risk*) Severity Score should have been 2.854=$2000PMPM/ $24,000/yr. to take care of this patient

Overview of Previous Scenario

Topic	Case Example without all the HCC Diagnoses noted and Quality Metrics Missed	Case Example with al l the HCC Diagnoses Noted
Total Reimbursement Paid to take care of this patient.	Diabetes with no CC: $12,000 per year	Diabetes with CKD IV, PVD, Foot Ulcer and IVD $24,000 per year
Quality: Flu Shot, Foot Exam	75% (F)	80% (A)
Quality: Annual Urine Micro. If CKD billed out patient is excluded from the Measure.	80% (F)	100% (A)
HCC/RAF Score: > 1 is sicker than the national norm.	0.9576 (Less Sick Patient)	2.854 (Sicker Patient)
Cost Efficiency Rating is a ratio of the providers cost incurred against how sick HCC/Diagnoses the patient has. <0.90 is considered good.	Cost of Care 1.5 over the norm. (Too Expensive). This is due to the provider ordering tests, medications and consults for a Diabetic with Ulcers & CKD w/o billing it out.	0.85 below the norm. (Cost Efficient)
Grand Total:	Payment Loss of: 12,000 Public Reporting of Poor Quality Public Reporting of Too Costly	Payment Gain : Public Reporting top qrtle Cheaper Care for Patient

Bottom Line

- Reimbursement impacted and it may not cover the cost of our care.
- Cost Efficiency Ratio Impacted
- Quality Rewards, Value Based Modifier, CMS MACRA/QPP, WCHQ and other Public Reports also impacted.
- Only top performers remain whole in quality/efficiency ratings and payment.

Illinois location

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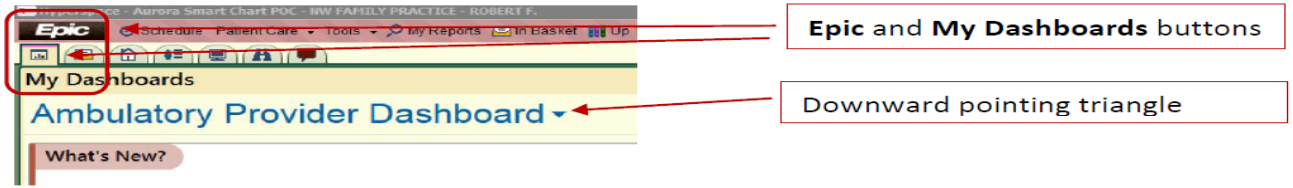
Where Can I Learn More?
Epic CRA Dashboard Tip Sheet

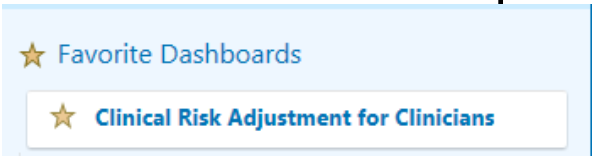
1. In Epic find your Clinical Risk Adjustment (CRA) Dashboard



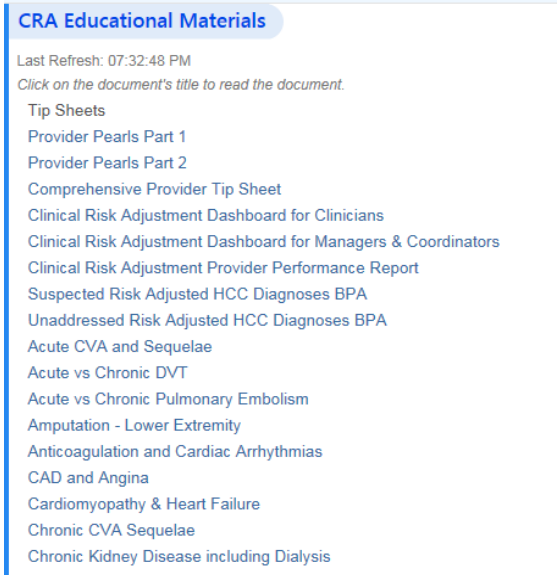
2. Click on the Downward Pointing Triangle (see above) and in the search area type in clin risk adj and under content type select Dashboards

Where Can I Learn More? CRA Dashboard (continued)

3. Click on the star next to the report to make it a favorite



4. Educational materials for Clinical Risk Adjustment are located on the right side of the dashboard. Select to open the tip sheet for a specific topic



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