Introduction to Risk Adjustment, Documentation & Coding Best Practices

Disclaimer

The contents included in this presentation are for informational purposes only. The coding guidance provided does not replace the Official Coding Guidelines or professional judgment and expertise of the individual performing coding based on numerous factors including, but not limited to, documentation in the medical record, correct application of coding guidelines, and other industry recognized coding guidance.

This training is based on coding guidance from the Official ICD-10 Coding Guidelines, American Hospital Association’s (AHA) Coding Clinic, and/or Centers for Medicare and Medicaid Services (CMS). Coding guidelines and references are updated on an annual basis potentially impacting the accuracy of the content contained within this presentation. Reference official coding resources for up-to-date information.

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Introduction to Risk Adjustment, Documentation & Coding Best Practices

Learning Objectives

1. Understand foundations of coding and risk adjustment
2. Identify tips and best documentation practices for successful coding
Topics

Introduction to Risk Adjustment

Documentation & Coding Best Practices

Case Study Example
Introduction to Risk Adjustment

- Medicare Risk Adjustment
- The Risk Score
- Hierarchical Condition Categories (HCC)
- Provider’s Role
Risk Adjustment: Medicare Risk Adjustment

Medicare Advantage (MA) plans receive payment for each covered member from Centers for Medicare and Medicaid Services (CMS)

Risk Adjustment (RA) is used to adjust plan payments to ensure accurate and adequate payment to plans for providing services and covering benefits

Payment is driven by member’s Risk Score which is based on member’s predicted health status & demographic characteristics

Medicare RA CMS-HCC (Hierarchical Condition Category) model is used to risk adjust payment
Risk Adjustment: Medicare Risk Adjustment

Purpose of Risk Adjustment

• Ensures accurate and adequate payment based on expected medical costs

Without Risk Adjustment
Based on demographics alone

With Risk Adjustment
Incorporates each member’s health status reflecting costs associated with their health care needs
Risk Adjustment: The Risk Score

Calculating the Risk Score

- Each member is assigned a risk score

Demographic Characteristics
(Factors associated with age, sex, disabled status, original entitlement reason, and Medicaid eligibility)

Health Status
(Factors associated with conditions included in CMS-HCC Model)

= Risk Score
Risk Adjustment: The Risk Score

Higher risk scores represent members with a greater than average burden of illness.

Lower risk scores represent a healthier population, but may also falsely indicate a healthier population due to:

- Inadequate or incomplete chart documentation
- Incomplete or inaccurate diagnosis coding
Risk Adjustment: Hierarchical Condition Category

Disease Hierarchy
Diagnoses are included in disease groups called condition categories (CCs). Hierarchy logic imposed on certain CCs with associated factors

Diagnostic Sources
CMS only recognizes diagnoses from hospital inpatient, outpatient and physician settings

Disease Interactions
Additional factors applied for certain co-existing conditions

Prospective Model
Diagnosis from base year used to predict payment for next year

Demographic Variables
Factors associated with the member’s demographics

On Jan. 1 each year, the member’s risk score is reset for a new year of diagnosis encounter data
Risk Adjustment: Hierarchical Condition Category

Hierarchical Condition Category (HCC)

- HCCs are a grouping of clinically related diagnoses (ICD-10-CM codes) with similar cost implications
- Only those diagnoses that map to an HCC are used in risk score calculation

Source: [https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html)
Risk Adjustment: Provider’s Role

Providers **play a critical role** in helping to ensure the integrity of the data used in calculating the overall health risk of members.

- A comprehensive health status for each patient
- Accurate and complete ICD-10-CM coding for every patient, every time
- Medical record documentation sufficient to support ICD-10-CM coding
- Coding to the highest level of specificity for claim submission
- If it’s not coded... the patient doesn’t have it
Documentation and Coding Best Practices

- Documentation Recommendations
- Patient’s Name & DOS
- Co-Existing Conditions
- Specificity
- Signature & Credentials
Best Practices: Documentation Recommendations

Documentation Best Practices

Documentation should include:

- Patient’s name and date of service (DOS) on each page
- All of the patient’s conditions, including those co-existing
- Details to code each condition to the highest degree of specificity
- Treatment and/or management for each condition
- Physician’s signature, credentials, and date

Characteristics of acceptable documentation:

- Clear
- Concise
- Consistent
- Complete
- Legible
Best Practices: Specificity

History of

• “History of” indicates a condition no longer exists to coders
• Pay special attention to list headers, such as Past Medical History
• Use caution when documenting the terms, “history of”
  – Should not be used for chronic conditions receiving current treatment
  – Instead include current status, dates, treatment, etc. such as:

<table>
<thead>
<tr>
<th>Instead of Documenting...</th>
<th>Document This...</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Diabetes</td>
<td>Patient with DM since 2009</td>
</tr>
<tr>
<td>History of CHF, meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>History of COPD, meds Advair</td>
<td>COPD controlled with Advair</td>
</tr>
</tbody>
</table>
Best Practices: Treatment or Management

Treating the Condition

• Per CMS Participant Guide:
  – “Physician should code all documented conditions that co-exist at the time of the encounter/visit that require or affect patient care treatment or management.”

• Document details as to how the conditions(s) impact care
**Best Practices: Provider Signature & Credentials**

**Hand Written**
- Legible signature or initials, including credentials
- For example:
  - Phil N. Good, MD or
  - PNG, MD

**Electronic**
- Electronic signature, including credentials
- Requires authentication by responsible provider, for example:
  - “Finalized by”, “Authenticated by”, “Electronically signed by”
- Must be password protected and used exclusively by the individual physician

**Stamps**
- Per CMS, not acceptable as of 2010
Best Practices: Importance of Documentation

Why *Documentation and Coding* is Important for Anthem and providers

- Assures all of the patient’s medical conditions are addressed
- Improves communication between physicians, hospitals and other health care professionals
- Supports proper claim payment, reducing denials
- Used in research and education
- Accurate coding of conditions is needed for appropriate Risk Adjusted payment
- Documentation is key... if not documented, it cannot be coded
Case Study

- Medical Record Example
- Code Assignment
- Risk Score Impact
Case Study: Medical Record Example (Fictional)

DOS: 02/24/16
Justin Tyme, DOB: 01/04/1950

Chief Complaint & HPI
Medicare Wellness Visit, 66 yr. old male here for annual wellness visit with known history of diabetes, neuropathy, and major depression.

Past Medical History
DM, Neuropathy, MDD, Congestive Heart Failure, Traumatic toe amputation (2011)

ROS
As noted in HPI, all other systems negative

Vitals
Ht 64 in, Wt 240 lbs, BMI: 42.5

Exam
General appearance: Patient is obese, ENMT: Normal, Abdomen: No abdominal tenderness, and Musculoskeletal: Foot exam reveals decreased sensation, great toe amputation

Assessment/Plan
1. Medical Screening Exam- preventive care discussed
2. DM II- stable, continue current treatment plan
3. Neuropathy- stable, continue current treatment plan
4. Major Depression- stable, continue treatment plan

Electronically signed by: Phil N. Good, MD on 02/24/16
Case Study: Code Assignments with Risk Score Impact

<table>
<thead>
<tr>
<th>Condition</th>
<th>I-10</th>
<th>HCC</th>
<th>Factor*</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 year old, male</td>
<td>--</td>
<td>--</td>
<td>0.288</td>
</tr>
<tr>
<td>Medical Screening</td>
<td>Z13.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>DM uncomplicated</td>
<td>E11.9</td>
<td>19</td>
<td>0.118</td>
</tr>
<tr>
<td>Neuropathy</td>
<td>G62.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Major Depression</td>
<td>F32.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>BMI 42.5</td>
<td>Z68.41</td>
<td>22</td>
<td>0.365</td>
</tr>
<tr>
<td>Great Toe Amputation</td>
<td>Z89.419</td>
<td>189</td>
<td>0.779</td>
</tr>
</tbody>
</table>

**Risk Score** 1.55

*Factors based on 2014 CMS-HCC Model for Community Beneficiaries

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<tr>
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<td>--</td>
<td>0.288</td>
</tr>
<tr>
<td>Medical Screening</td>
<td>Z13.9</td>
<td>n/a</td>
<td>--</td>
</tr>
<tr>
<td>Diabetic Neuropathy</td>
<td>E11.40</td>
<td>18</td>
<td>0.368</td>
</tr>
<tr>
<td>Major Depression, <em>Mild</em></td>
<td>F32.0</td>
<td>58</td>
<td>0.330</td>
</tr>
<tr>
<td><em>Morbid</em> Obesity</td>
<td>E66.01</td>
<td>22</td>
<td>0.365</td>
</tr>
<tr>
<td>BMI 42.5</td>
<td>Z68.41</td>
<td>22</td>
<td>above</td>
</tr>
<tr>
<td><em>Left</em> Great Toe Amputation</td>
<td>Z89.412</td>
<td>189</td>
<td>0.779</td>
</tr>
<tr>
<td><em>Congestive Heart Failure</em></td>
<td>I50.9</td>
<td>85</td>
<td>0.368</td>
</tr>
<tr>
<td>+ Disease interaction factor with DM &amp; CHF</td>
<td></td>
<td></td>
<td>0.182</td>
</tr>
</tbody>
</table>

**Risk Score** 2.68
Closing: Importance of Medicare Risk Adjustment

Risk Adjustment **benefits** Anthem, Patients, and Providers!

- Ensures plans have the resources needed to provide treatment to high-cost patients
- Identification for the need of disease management interventions
- Helps close quality care gaps
- Emphasizes the importance of accurate coding and medical record documentation
- Allows for a more meaningful exchange between Anthem and Providers
References & Resources

• Centers for Medicare & Medicaid Services (CMS) Announcements and Documents
  – https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

• Centers for Medicare & Medicaid Services (CMS) Risk Adjustment

• Medicare Managed Care Manual 100-16, Chapter 7 – Risk Adjustment

• ICD-10-CM Official Guidelines for Coding and Reporting

• Customer Service and Support Center (CSSC) Operations- Risk Adjustment Processing System
Questions?

Thank you for attending today’s session!