HCC Education Series: Introduction to Risk Adjustment

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HealthCare Partners, IPA
HealthCare Partners, MSO

Value of Risk Adjustment to Members & Physicians

Members

Better Resource Allocation:

- Risk adjustment ensures that healthcare plans have the necessary funds to manage patients with chronic or severe conditions.

Improved Access to Care:

- With accurate risk scores, plans can better manage care coordination and resources, leading to improved access to necessary treatments and services.

Quality of Care:

- Accurate risk adjustment can lead to better care management and outcomes, particularly for high-risk patients.

Physicians

Enhanced Quality of Care:

- With accurate risk adjustment, physicians can ensure their patients receive the right level of care and resources, leading to better outcomes.

Professional Recognition:

- Proper documentation reflects the complexity and quality of care provided, potentially improving performance metrics and recognition.

Financial Incentives:

- Participating in value-based care initiatives tied to risk adjustment can lead to enhanced compensation for high-quality care.

What contributes to the patient's RAF score?

Inpatient
Hospital data **~15% of Acute Dx** (hospital stays longer than 24 Hrs.)

Outpatient
Hospital data **~85% of Chronic Dx** (except lab and radiology)

Face to Face (Including Telehealth)
Physician and practitioner visit data: MD, DO, DPM, DC, OD, PA, NP, CNS, Nurse-midwives and independently practicing physical therapists. ***Note*:** No Face to Face visit is required for anatomical pathology services.

- Documentation in the visit note must meet coding guidelines (**D**iagnosis, **S**tatus and **P**lan).
- Audio/Video for telehealth

Excluded data sources:
SNF, Dialysis, Hospice facility charges, clinical lab, diagnostic radiology, ambulance, DME, Prosthetics and orthoptists, and Ambulatory *Surgery* Centers.

How do Physicians Impact Risk Adjustment?

Accurate Documentation:

- Documenting every relevant diagnosis is crucial. Even if a condition is stable, it should be recorded annually to ensure it counts towards the risk score.

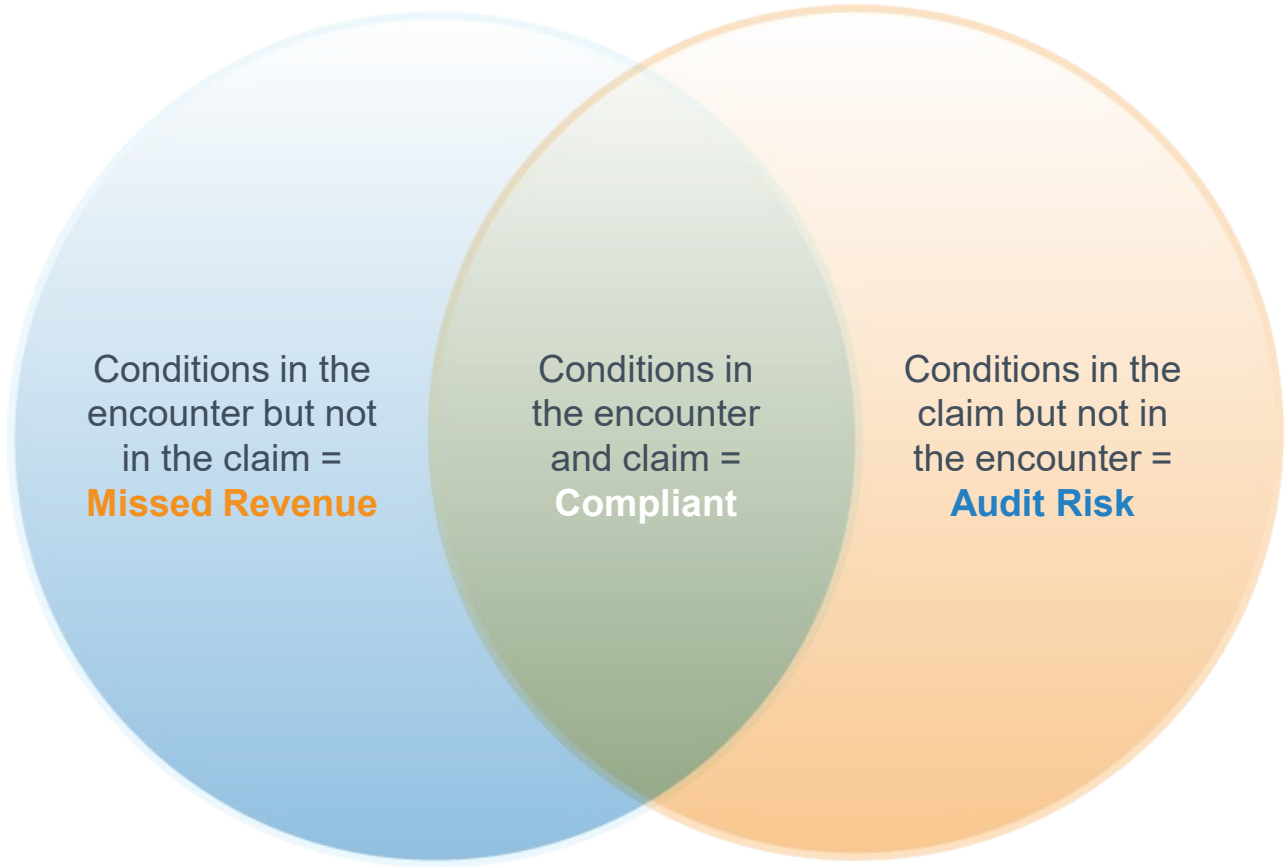
Accurate Coding:

- Use precise ICD-10 codes that fully capture the patient's condition. Avoid unspecified codes where more specific options are available.

Impact:

- Under-coding or over-coding can lead to inaccurate risk scores, affecting both reimbursement and patient care.

CMS- Hierarchical Conditions Category (HCC) Model



- Conditions must be submitted **annually**, including all chronic conditions
- Over **9,500 ICD-10** Diagnosis codes are grouped into **86 HCCs** (V24 model) to 115 HCCs (V28 model).
- HCCs are **families of conditions** or hierarchical groups of categories
- Each **disease group** (category) has an associated **coefficient/weight**
- Weights are **additive** across major categories
- More severe or complicated conditions in the family will **trump** all others in the same family

HCC Model At Work

Diagnosis Description	ICD-10 CM Code	V24 CMS-HCC Model	V28 CMS-HCC Model
Type 2 Diabetes with Ketoacidosis without coma	E11.10	17	36
Type 2 Diabetes with Chronic Kidney Disease	E11.22	18	37
Type 2 Diabetes without Complications	E11.9	19	38

*In the following table, Type 2 Diabetes without Complications (HCC 19) maps to a lower HCC Category than Type 2 Diabetes with Diabetic Chronic Kidney Disease (HCC 18).

Therefore, it is imperative that the diagnoses are **documented and coded to the highest level of specificity, if known.**

Importance of Annual Diagnosis Capture

- Accurate risk scores assignment by CMS relies on accurate and complete medical record documentation collected from providers each calendar year
- All current health conditions, including those that coexist, **need to be reported at least once every year since they do not carry over to the next year.**
    - **C**hronic Diagnoses: CHF, DM, CKD, COPD, etc.
    - **O**stomy: Colostomy, Gastrostomy, Cystostomy, etc.
    - **A**mputations: Toes, AKA, BKA, etc.
    - **S**eizures
    - **T**ransplants: Stem Cell, Liver, Heart, Lung, Kidney, etc.
- If chronic conditions such as Diabetes or COPD are not reported annually, it indicates that the condition has resolved and no longer exists
- Remember: all chronic conditions even if stable need to be readdressed and captured each year!

Best Practices for Documentation

Documentation Requirements for Compliance

A compliant medical records **must** include the following:

- Face to Face or Telemedicine Visit
  - Telemedicine must include platform and consent
- Patient Name
- Patient DOB or any 2nd Identifier
- Date of Service
- Rendering Provider Name and Credentials
- Rendering Provider Signature (Signature stamps are no longer acceptable-Effective December 31, 2008)
- Legible Chart (Handwritten Notes)

What is M.E.A.T?

Monitor	Signs, Symptoms, Disease Progression, home monitoring, routine follow up visits and referencing labs
Evaluate	Evaluating through Physical Exams, presence or absence of physical manifestations, test results, effectiveness of medications, response to treatment
Assess	Discussion of the severity or current status (stable, controlled, worsening) of a condition, ordering tests and labs, review of records, counseling
Treat	Prescribing/changing and renewing medications and/or therapies, other therapeutic interventions, referral to specialists, dietary changes, any plan for management of conditions

- Document chronic conditions by utilizing the acronym **M.E.A.T** (Monitor, Evaluate, Assess, Treat)
- At **least one MEAT criteria** is needed to capture a diagnosis for Risk Adjustment

Importance of Accurate and Complete Documentation

Member

No documentation

Demographics		RA score
Female, 73 FB dual, aged, community		0.519
Diagnosis	**HCC**	**RA score**
Interactions		**RA score**
TOTAL RA score*		**0.519**

Poor documentation

Demographics		RA score
Female, 73 FB dual, aged, community		0.519
Diagnosis	**HCC**	**RA score**
Diabetes w/o complications	19	0.107
obesity	N/A	0
Renal insufficiency	N/A	0
History of congestive heart failure	N/A	0
Interactions		**RA score**
TOTAL RA score*		**0.626**

Complete documentation

Demographics		RA score
Female, 73 FB dual, aged, community		0.519
Diagnosis	**HCC**	**RA score**
Diabetes with chronic kidney disease (CKD)	18	0.340
Morbid obesity	22	0.383
Chronic kidney disease stage 4	137	0.260
Congestive heart failure	85	0.371
Status post right great toe amputation	189	0.795
Interactions		**RA score**
Congestive heart failure * diabetes		0.192
TOTAL RA score*		**2.860**

Health Status Codes

- **Status codes** (Z Codes) are used to report information about a patient that can impact their treatment or access to care.
- A circumstance or problem that is present which influences the person's health status but is not itself a current illness or injury.
- There are around 71 "Z" codes that map to an HCC for the V24 and/or V28 HCC Model. These include:

Diagnosis Description	ICD-10 CM Code	CMS-HCC V24 Model	CMS-HCC V28 Model
Long-term (Current) Use of Insulin	Z79.4	19	38
Acquired Absence of Right leg above Knee (Above Knee Amputation)	Z89.611	189	409
Colostomy Status	Z93.3	188	463
BMI 40-44	Z68.4	22	48
Pancreas Transplant Status	Z94.83	186	35
Dependence on Renal Dialysis	Z99.2	134	N/A

“History Of”

- Documenting a condition as “**History Of**” indicates that the condition is **no longer active or it has been resolved.**
- If a diagnosis is documented as “History Of” in the chart but there is an active treatment or status and plan listed for it, the **condition is still considered “Active”**
- Active chronic conditions such as COPD, Sick Sinus Syndrome, CHF and CKD are often documented as “PMHx of” in the History of Present Illness, Chief Complaint and even in the Assessment and Plan.
- When a chronic condition is listed in the Past Medical History and there is an active treatment being used to treat it, be sure to address it during the encounter.

“History Of” means the condition has been resolved and is no longer considered active.

If any of the four criteria below are present for any diagnosis documented in the chart, then the condition is considered active and not a “History of”

Best Practices for Integrating Feedback

Amendments are done after documentation is completed and signed by the provider. They include addendums, corrections, late entries, deletions and retractions.

Amendments to the medical record should **occur at least between 60-90 days** after the encounter.

Time limit to file claims is one calendar year after the DOS (Applied to services on or after 1/1/2010)

HCP will assist in submitting corrected medical records if the office prefers not to send an amended claim.

Addendum: Provides information not available at the time the original document was created. The addendum should include the following items:

- Current Date
- Reason for the addendum or clarification of the information being added.
- Signature of Provider who made the addendum

Correction: A single line is made through the inaccurate information and the correct information is inserted instead. Corrected entries should include:

- Signature or initials of provider and the date the deletion was made
- Date and time of correction
- Reason for correction
- Initials of provider making the correction

Risk Adjustment Workflow Integration

Making Risk Adjustment a Routine Part of Care

Strategy 1: Enhance Documentation with EHR Prompts

- Consider using EHR prompts or alerts to support the annual review and documentation of chronic conditions, ensuring comprehensive patient care.

Strategy 2: Streamline Patient Visits with Quick Reviews

- Integrating a brief review of the patient's medical history during visits can help ensure that ongoing conditions are consistently documented, without adding extra time to your workflow.

Strategy 3: Foster Team Collaboration in Documentation

- By involving your nursing team or other care members in the documentation process, you can create a collaborative approach that supports accurate and thorough recording of diagnoses.

Outcome: These strategies can seamlessly integrate into your current practice, helping to ensure that all relevant diagnoses are captured, which ultimately enhances both patient care and appropriate reimbursement.

Team Collaboration Points in Risk Adjustment

Collaboration Points

Nurses\Medical Assistants: Play a crucial role in gathering initial patient information and can assist in ensuring that all relevant conditions are thoughtfully noted, contributing to a comprehensive patient record.

Billers\Coders: Provide valuable expertise by reviewing documentation to ensure it accurately reflects the patient's health status. They can collaborate with providers to clarify any details, helping to align the coding with clinical documentation.

Administrative Staff: Support the overall process by ensuring that records are meticulously complete and up to date, facilitating smooth billing and accurate reflection of the care provided.

HCP Provider Relations: If you have any documentation or coding questions, please direct them to your reps and they will forw.ard it to our coding team

CMS-HCC V28 Model

Severe Persistent Asthma

Diagnosis	ICD-10 Code	HCC Category (V24)	HCC Category (V28)
Severe Persistent Asthma, Uncomplicated	J45.50	N/A	279

- Severe Persistent Asthma should be documented when the asthma is uncontrolled even with daily treatment.

- Uncontrolled Asthma is defined as:
  - ❖ Frequent exacerbations
  - ❖ Symptoms appearing more than 2x per week
  - ❖ Medications needed more than 2x per week
  - ❖ Activity limitations

- Patients with a previous diagnosis of COPD should be considered for a diagnosis of Severe Persistent Asthma when:
  - ❖ Patient is on step 4 or step 5 therapy (Classification of Asthma)
  - ❖ Clinical features are more consistent with asthma than COPD

End Stage Heart Failure

- *End Stage heart failure is the refractory or persistent symptoms of heart failure despite guideline-directed medical therapy (GDMT) and can develop into systolic (HFrEF) or diastolic (HFpEF) heart failure

- **Guideline Directed Medical Therapy (GDMT)** consists of 4 drug classes including ACE (class A), Beta Blockers (class B) antihypertensive medications (class C) and Diuretics (class D).

- **Criteria for diagnosis End-stage HFrEF (Systolic Heart Failure)**:
  - ❖ Patient receiving **maximally tolerated GDMT**

  (Note: Some with advanced heart failure are often unable tolerate optimal GDMT due to certain conditions. Being a poor prognostic sign, this further supports a diagnosis of end-stage heart failure).

  - ❖ **NYHA Functional Class III-IV heart failure**
    - ❖ EF< 35%

- Criteria for diagnosing End stage HFpEF (Diastolic Heart Failure):
  - ❖ Patient receiving maximally tolerated treatment
  - ❖ **NYHA Functional Class III-IV heart failure**
  - ❖ EF≥ 50%

Specific Type of Heart Failure	ICD-10 CM Code	HCC Category (V24)	HCC Category (V28)
End Stage Congestive Heart Failure	I50.84	85	222

CMS-HCC Model V28 for Medicare Risk Adjustment General Facts

- CMS-HCC Model V28 is the newest HCC model that will be 100% fully implemented by PY 2026.

Date of Service Year	Payment Year	V24	V28
2023	2024	67%	33%
2024	2025	33%	67%
2025	2026	0%	100%

- New model includes 115 HCCs and 200 new diagnosis codes
- HCC Categories are now associated with a new numbering logic
- Decrease in RAF scores compared to V24 model, this will be noted during PY2025
- Numerous diagnoses will lose their HCC status including PVD, Toe Amputation, Dialysis Status and Angina Pectoris.
- Several diagnoses have been relegated to an HCC such as Benign Carcinoid tumors, Severe Asthma, Anorexia/Bulimia and Retinal Vein Occlusion.

Boost Your Practice with an AWV Clinic!

Convenient Setup: Host an AWV Clinic in your office—HCP and HNYMPC handle all the abstracting and pre-visit preparations.

Expert Care Onsite: A HNYMPC Nurse Practitioner will assess the patient right in your office.

Seamless Coordination: We work with your office to arrange the visit, ensuring minimal disruption to your workflow.

No Impact on Your AWV Incentive: This assessment won't prevent the patient from receiving an AWV with their provider, and you will still receive the AWV incentive.

Clear Communication: The results from the HNYMPC assessment are shared directly with you.

No Cost to Patients: Patients enjoy the service at no charge.

Earn Extra Revenue: Your practice receives a stipend for every patient seen!

For more details, contact Marc Schnall at 516-580-6217

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