# HCCS: GUARDING AGAINST UPCODING PRACTICES

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# HCC Alphabet Soup

- ACA -- Affordable Care Act (aka Obamacare)
- ACG -- Adjusted Clinical Groups (Hopkins)
- ACO – Accountable Care Organizations
- BMI – Body Mass Index
- CDPS – Chronic Illness & Disability Payment System
- EGM – Episode Grouper for Medicare
- EM – Evaluation and Management
- FFS -- Fee for Service
- HCCs -- Hierarchical Condition Categories
  - *CMS-HCC (Medicare Advantage)*
  - *HHS-HCC (ACA)*
  - *RxHCCs – Pharmacy HCCs*
- IVA – Initial (Independent) Validation Auditor
- MA -- Medicare Advantage
- MEAT -- Monitor, Evaluate, Assess, Treat
- Metals -- ACA Health Plan Options
- MRA – Medicare Risk Adjustment
- PAF -- Patient Assessment Form
- RA -- Risk Adjustment
- RADV -- Risk Adjustment Data Validation
- RAF -- Risk Adjustment Factor
- RAPS – Risk Adjustment Processing System
- RSO – Risk Score Optimization
- RVU – Relative Value Unit
- VBP – Value Based Purchasing
- ZPICs – Zone Program Integrity Contractors



# Agenda

- What are HCCs
- Who uses HCCs
- What drives reimbursement for HCCs
- What are the HCC coding and documentations fundamentals
- Where are there compliance concerns
- What are the proactive measures to guard against compliance challenges

- Resource materials

## General Comments

- We're talking about a Risk Adjusted Methodology
  - *Selected Significant Disease (SSD) Model*
  - *Serious manifestations of a disease are considered*
  - *Prospective*
  - *Valid Diagnosis Sources*
  - *Multiple Chronic Diseases considered*
  - *Disease Interactions and Hierarchies Included*
  - *Demographic/Socio-economic Variables*

Source: Baker, Newman, Noyes



## HCCs: Risk Adjusted Methodology

- Risk adjustment is:
  - *the process of modifying payments and benchmarks to reflect the degree of illness, which in turn allows payers (CMS, State Medicaid, Commercial)*
    - to estimate future spending and allows providers
    - to understand the health characteristics of their managed population.
- It is a reimbursement approach to accommodate health plans that accept members with multiple chronic conditions and address the burden of care for the patients served.

Adapted: American Academy of Family Physicians: https://www.aafp.org/fpm/2016/0900/p24.html

## Inclusions and Exclusions

- The CMS-HCC model focuses on **chronic health conditions likely to affect long-term health expenditures** and
- Purposefully **excludes:**
  - ***Non-diagnostic*** *diagnoses (e.g., a diagnosis of abdominal pain),*
  - ***Clinically insignificant*** *diagnoses (e.g., a sprain), or*
  - *Diagnoses that are* ***definitively treated*** *(e.g., acute appendicitis).*

Source: AAFP: https://www.aafp.org/fpm/2016/0900/p24.html



## What are HCCs

# HCCs: Hierarchical Condition Categories

- HCCs
  - *Several iterations*
  - *CMS-HCCs (MAO) and HHS-HCCs (M'caid and ACA)*
- Used by governmental and commercial payers
- Prospective reimbursement
  - *"The DRGs for Physician Reimbursement"*



# Two Governmental Models

CMS-HCC (Medicare Advantage)

- **Population:** ≥65 and disabled ≤65 in Medicare population
- **Prospective:** Base year diagnoses and demographics predict **next** year's spending
- Health plan payments
  - *May share with providers*
- 79 HCCs
- 2004

HHS-HCC (ACA/Medicaid Population)

- **Population:** Adult, child, and infants in "commercial" population (<65)
- **Concurrent:** Base year diagnoses and demographics predict **current** spending
- Health plan payments
  - *May share with providers*
- 131 HCCs (130 unique HCCs)
- 2014

# CMS-HCCs

- Version 22/23 CMS-HCCs
  - *Includes approximately 79* **payment** *HCCs (out of 201categories)*
  - *Only considers ~9,535 of the ~71,932 ICD-10CM codes*
    - Excludes most “unspecifieds”
    - Excludes most symptoms:
      - *Some diagnosis codes are symptoms resulting from a condition,*
      - *are causes of conditions,*
      - *indicate a history of disease rather than a current condition.*

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# Who uses HCCs

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## Who Uses HCCs - Publicly

- Medicare Advantage Organizations (MAOs) Part C
- Medicare Shared Savings Program (MSSP) ACOs
- Accountable Care Organizations (ACOs) in collaboration with a Commercial Health Plan
- Program of All-Inclusive Care for the Elderly (PACE)
- Affordable Care Act (ACA) Plans (Obamacare Plans)
- Medicaid Managed Care Programs
- Risk sharing arrangements
- Ugh*



## Who Uses HCCs -- Privately

- Population Health Organizations and
- Entities monitoring public health and outcomes
- Insurers monitoring their beneficiaries and providers for profiling and resource evaluation purposes

## Models



## The CMS-HCC Model

- Refined algorithm that incorporates a number of variables to predict cost
  - *Age*
  - *Sex*
  - *Residence*
  - *Medicare or Medicare & Medicaid*
  - *Disabilities*
  - *Conditions*
  - *Resource use (CPT/HCPCS)*
  - *Pharmacy use*
  - *Interacting diseases (e.g., COPD & CHF)*
  - *Diseases with disability status (e.g., Disability & CHF), etc.…*

Socio-Economic (Age, Sex, Residence, Medicare or Medicare & Medicaid)

## CMS uses HCCs for Several Populations

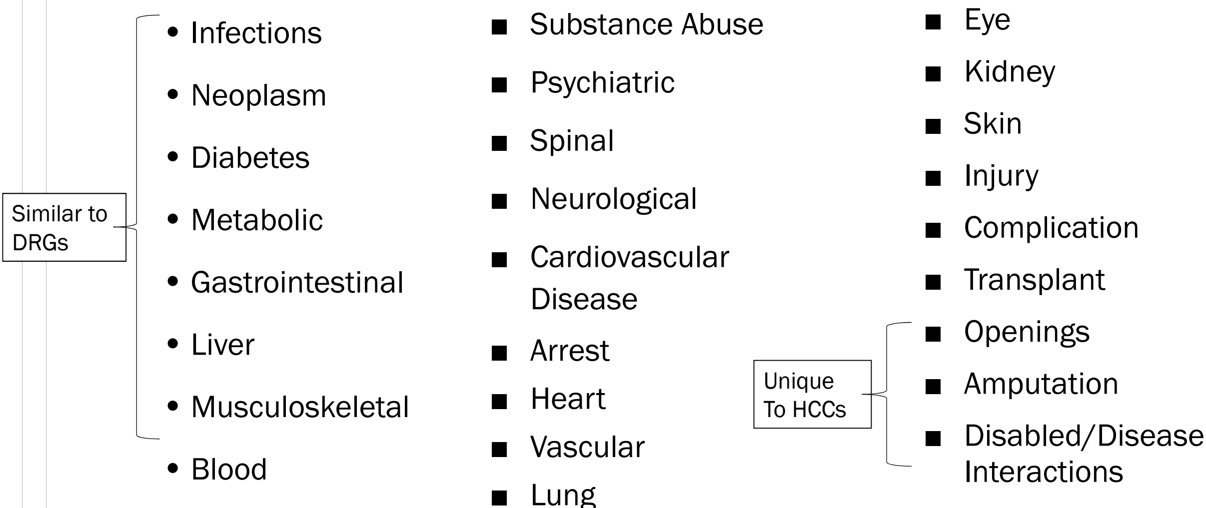
- CMS-HCCs
  - *Medicare Part C: Medicare Advantage*
  - *ESRD: Programs for End-stage Renal Disease patients*
  - *PACE: Programs for All-Inclusive Care for the Elderly*
  - *Medicare Part D: Prescription drug program*



## HHS-HCCs

- Used for the ACA and Medicaid Managed Care Populations
- 7,768 diagnoses grouped into Hierarchical Condition Categories (HCCs)
- Coefficients by age group: different coefficient for the same HCC for each age group
  - *Age Groups: 0-1, 2-20, 21-64*
- Coefficients reflect Medical and Rx claims
- Separate model calculated for each metal and age group (adult, child, infant)
- Concurrent (or retrospective) model (HCCs today = today's plan reimbursement)
- The denominator varies by State

# HCC Structure – Categories






# ICD-10 to CMS-HCC Map

**ICD-10-CM Codes, CMS-HCC and RxHCC Models**
Includes ICD-10 codes valid in FY2017 and FY2018.

| Diagnosis Code | Description | CMS-HCC PACE/ESRD Model Category V21 | CMS-HCC Model Category V22 | RxHCC Model Category V05 | CMS-HCC PACE/ESRD Model for 2018 Payment Year | CMS-HCC Model for 2018 Payment Year | RxHCC Model for 2018 Payment Year |
|---|---|---|---|---|---|---|---|
| A0103 | Typhoid pneumonia | 115 | 115 | | Yes | Yes | No |
| A0104 | Typhoid arthritis | 39 | 39 | | Yes | Yes | No |
| A0105 | Typhoid osteomyelitis | 39 | 39 | | Yes | Yes | No |
| A021 | Salmonella sepsis | 2 | 2 | | Yes | Yes | No |
| A0222 | Salmonella pneumonia | 115 | 115 | | Yes | Yes | No |
| A0223 | Salmonella arthritis | 39 | 39 | | Yes | Yes | No |
| A0224 | Salmonella osteomyelitis | 39 | 39 | | Yes | Yes | No |
| A065 | Amebic lung abscess | 115 | 115 | | Yes | Yes | No |
| A072 | Cryptosporidiosis | 6 | 6 | 5 | Yes | Yes | Yes |

## HCC Structure – Diabetes Category

| Category | | Relative Factor-Community | Relative Factor-Institution | Codes |
|---|---|---|---|---|
| Diabetes | HCC 17 Diabetes with acute complications | 0.318 | 0.441 | 21… |
| | HCC 18 Diabetes with chronic complications | 0.31[illegible] | [illegible]41 | 180… |
| | HCC 19 Diabetes without complications | 0.104 | 0.160 | E089 |
| | | | | E099 |
| | | | | E109 |
| | | | | E119 |
| | | | | E139 |
| | | | | Z794 |

Like a DRG wt.



## What We'll Need to Know to Assign CMS- HCCs

- Age of beneficiary
- Where they reside
- Diagnoses to map to CMS-HCC
- Interactions
- Disabled/Insurance coverage
- Special conditions: PACE/ESRD

# Characteristics of the HHS-HCCs



**TABLE 1: Final Adult Risk Adjustment Model Factors for 2018 Benefit Year**

| HCC or RXC No. | Factor | Platinum | Gold | Silver | Bronze | Catastrophic |
|---|---|---|---|---|---|---|
| *Demographic Factors* | | | | | | |
| | Age 21-24, Male | 0.178 | 0.141 | 0.098 | 0.056 | 0.049 |
| | Age 25-29, Male | 0.157 | 0.121 | 0.078 | 0.035 | 0.028 |
| | Age 30-34, Male | 0.201 | 0.155 | 0.100 | 0.046 | 0.038 |
| | Age 35-39, Male | 0.264 | 0.208 | 0.143 | 0.077 | 0.065 |
| | Age 40-44, Male | 0.334 | 0.268 | 0.193 | 0.116 | 0.102 |
| | Age 45-49, Male | 0.405 | 0.330 | 0.245 | 0.156 | 0.141 |
| | Age 50-54, Male | 0.531 | 0.443 | 0.343 | 0.237 | 0.218 |
| | Age 55-59, Male | 0.607 | 0.507 | 0.396 | 0.277 | 0.255 |
| | Age 60-64, Male | 0.695 | 0.579 | 0.453 | 0.313 | 0.288 |
| | Age 21-24, Female | 0.301 | 0.245 | 0.175 | 0.105 | 0.094 |
| | Age 25-29, Female | 0.344 | 0.278 | 0.200 | 0.120 | 0.106 |
| | Age 30-34, Female | 0.474 | 0.392 | 0.300 | 0.208 | 0.192 |
| | Age 35-39, Female | 0.564 | 0.474 | 0.374 | 0.278 | 0.261 |
| | Age 40-44, Female | 0.631 | 0.531 | 0.422 | 0.313 | 0.295 |
| | Age 45-49, Female | 0.642 | 0.538 | 0.424 | 0.306 | 0.286 |
| | Age 50-54, Female | 0.726 | 0.613 | 0.488 | 0.355 | 0.331 |
| | Age 55-59, Female | 0.723 | 0.606 | 0.477 | 0.337 | 0.311 |
| | Age 60-64, Female | 0.759 | 0.631 | 0.493 | 0.338 | 0.310 |
| *Diagnosis Factors* | | | | | | |
| HCC001 | HIV/AIDS | 0.49 | 0.409 | 0.33 | 0.259 | 0.248 |
| HCC002 | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | 8.946 | 8.776 | 8.676 | 8.721 | 8.735 |
| HCC003 | Central Nervous System Infections, Except Viral Meningitis | 5.99 | 5.904 | 5.851 | 5.871 | 5.877 |
| HCC004 | Viral or Unspecified Meningitis | 4.377 | 4.167 | 4.048 | 3.989 | 3.985 |

Metals

HCC or RxC

HHS-HCC Snapshots (2018 Benefit Yr.)

See:
*Demographic Factors
*Diagnosis Factors

# HHS-HCC Snapshots (2018 Benefit Yr.) Unique Factor: Enrollment Duration

| | *Enrollment Duration Factors* | | | | | |
|---|---|---|---|---|---|---|
| | One month of enrollment | 0.501 | 0.444 | 0.401 | 0.384 | 0.383 |
| | Two months of enrollment | 0.431 | 0.376 | 0.330 | 0.311 | 0.310 |
| | Three months of enrollment | 0.375 | 0.325 | 0.281 | 0.261 | 0.259 |
| | Four months of enrollment | 0.304 | 0.265 | 0.226 | 0.209 | 0.207 |
| | Five months of enrollment | 0.264 | 0.229 | 0.195 | 0.178 | 0.176 |
| | Six months of enrollment | 0.230 | 0.201 | 0.172 | 0.155 | 0.154 |
| | Seven months of enrollment | 0.213 | 0.188 | 0.162 | 0.146 | 0.144 |
| | Eight months of enrollment | 0.170 | 0.151 | 0.131 | 0.120 | 0.119 |
| | Nine months of enrollment | 0.116 | 0.104 | 0.093 | 0.087 | 0.087 |
| | Ten months of enrollment | 0.105 | 0.097 | 0.089 | 0.085 | 0.085 |
| | Eleven months of enrollment | 0.089 | 0.084 | 0.080 | 0.078 | 0.078 |



# HHS-HCC Snapshots (2018 Benefit Yr.) Prescription Factors

| | *Prescription Drug Factors* | | | | | |
|---|---|---|---|---|---|---|
| RXC 01 | Anti-HIV Agents | 6.543 | 6.050 | 5.725 | 5.564 | 5.539 |
| RXC 02 | Anti-Hepatitis C (HCV) Agents | 27.133 | 26.646 | 26.321 | 26.429 | 26.454 |
| RXC 03 | Antiarrhythmics | 0.118 | 0.118 | 0.118 | 0.118 | 0.118 |
| RXC 04 | Phosphate Binders | 0.630 | 0.630 | 0.630 | 0.630 | 0.630 |
| RXC 05 | Inflammatory Bowel Disease Agents | 1.929 | 1.757 | 1.642 | 1.482 | 1.450 |
| RXC 06 | Insulin | 1.474 | 1.340 | 1.204 | 1.040 | 1.006 |
| RXC 07 | Anti-Diabetic Agents, Except Insulin and Metformin Only | 0.522 | 0.456 | 0.390 | 0.305 | 0.288 |

## What We'll Need to Know to Assign HHS- HCCs

- Age of beneficiary
- Diagnoses to map to HHS-HCC
- Interactions
- Plan type (which metal?)
- How long the individual has been a beneficiary



## HCCs: Diagnosis Driven

- Thrive on ICD-10 because of ICD-10's specificity
- Built on **DIAGNOSES** (not CPTs)
  - More than 50% of the HCCs are MCCs or CCs.
  - Model typically **excludes:**
    - *Symptoms and* ***CONDITIONS THAT ARE PAST OR RESOLVED***
    - *"****UNSPECIFIEDS****" (e.g. lacking laterality, episode of care, severity, manifestation linkage, etc.)*
- CDI and Querying will be important.
  - *Compliance Caution*

# Source of Documentation to Support HCCs



# HCCs Are Derived From Inpatient and Outpatient Sources

Hospitals
Physicians

- The source of HCCs:
  - *From Hospital (regardless of hospital type) encounters*
    - Hospital inpatient, principal and secondary diagnoses
    - Hospital outpatient diagnoses
    - The codes on the hospital claim are linked to the attending physician and surgeon reflected in the abstract/claim and to the patient's HCCs
  - *Outpatient Settings diagnoses*
    - Clinics, ED, Hospital Ambulatory Surgery, Physician Offices, etc.

## HCCs Are Derived From Inpatient and Outpatient Sources

- Face-to-Face
- Documented by a **CMS-approved clinician:**
  - Physicians, Nurse Practitioners, Physician Assistants
  - Clinically trained non-physicians (e.g., psychologists, podiatrists)
    - *Providers defined by state (varies)*
  - Next Slide

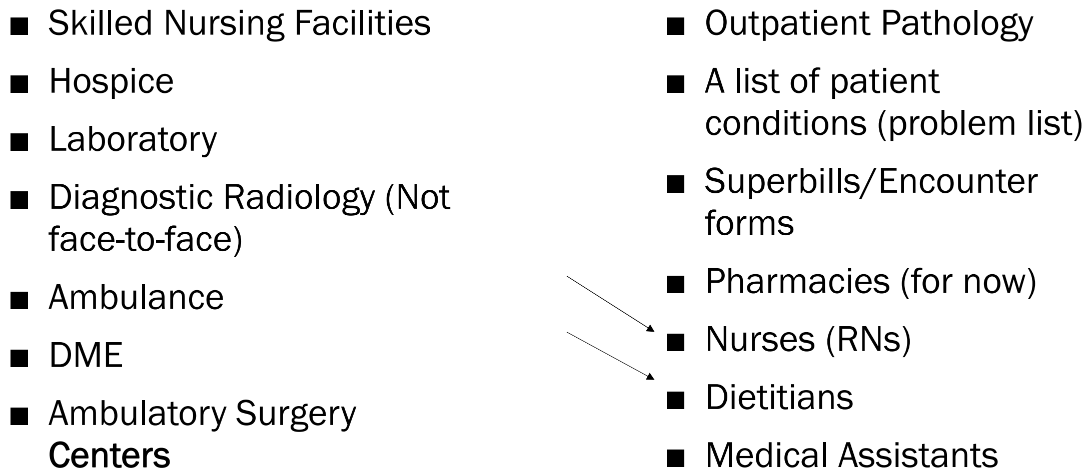


**Acceptable Physician Specialty Types for**
**2019 Payment Year (2018 Dates of Service)**
**Risk Adjustment Data Submission**

| CODE | SPECIALTY | CODE | SPECIALTY | CODE | SPECIALTY |
|---|---|---|---|---|---|
| 1 | General Practice | 27 | Geriatric Psychiatry | 77 | Vascular Surgery |
| 2 | General Surgery | 28 | Colorectal Surgery (formerly Proctology) | 78 | Cardiac Surgery |
| 3 | Allergy/Immunology | 29 | Pulmonary Disease | 79 | Addiction Medicine |
| 4 | Otolaryngology | 33* | Thoracic Surgery | 80 | Licensed Clinical Social Worker |
| 5 | Anesthesiology | 34 | Urology | 81 | Critical care (intensivists) |
| 6 | Cardiology | 35 | Chiropractic | 82 | Hematology |
| 7 | Dermatology | 36 | Nuclear Medicine | 83 | Hematology/Oncology |
| 8 | Family Practice | 37 | Pediatric Medicine | 84 | Preventive Medicine |
| 9 | Interventional Pain Management (IPM) | 38 | Geriatric Medicine | 85 | Maxillofacial Surgery |
| 10 | Gastroenterology | 39 | Nephrology | 86 | Neuropsychiatry |
| 11 | Internal Medicine | 40 | Hand Surgery | 89* | Certified Clinical Nurse Specialist |
| 12 | Osteopathic Manipulative Medicine | 41 | Optometry | 90 | Medical Oncology |
| 13 | Neurology | 42 | Certified Nurse Midwife | 91 | Surgical Oncology |
| 14 | Neurosurgery | 43 | Certified Registered Nurse Anesthetist | 92 | Radiation Oncology |
| 15 | Speech Language Pathologist | 44 | Infectious Disease | 93 | Emergency Medicine |
| 16 | Obstetrics/Gynecology | 46* | Endocrinology | 94 | Interventional Radiology |
| 17 | Hospice And Palliative Care | 48* | Podiatry | 97* | Physician Assistant |
| 18 | Ophthalmology | 50* | Nurse Practitioner | 98 | Gynecologist/Oncologist |
| 19 | Oral Surgery (dentists only) | 62* | Psychologist | 99 | Unknown Physician Specialty |
| 20 | Orthopedic Surgery | 64* | Audiologist | C0 | Sleep Medicine |
| 21 | Cardiac Electrophysiology | 65 | Physical Therapist | C3 | Interventional Cardiology |
| 22 | Pathology | 66 | Rheumatology | C5 | Dentist |
| 23 | Sports Medicine | 67 | Occupational Therapist | C6 | Hospitalist |
| 24 | Plastic And Reconstructive Surgery | 68 | Clinical Psychologist | C7 | Advanced Heart Failure And Transplant Cardiology |
| 25 | Physical Medicine And Rehabilitation | 72* | Pain Management | C8 | Medical Toxicology |
| 26 | Psychiatry | 76* | Peripheral Vascular Disease | C9 | Hematopoietic Cell Transplantation And Cellular Therapy |

* Indicates that a number has been skipped.

## HCCs Are **NOT** derived From these Sources

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## Hierarchy Rules

- Similar between both CMS-HCCs and HHS-HCCs
- Consistent among the populations served by CMS-HCCs (PACE, ESRD, Rx)

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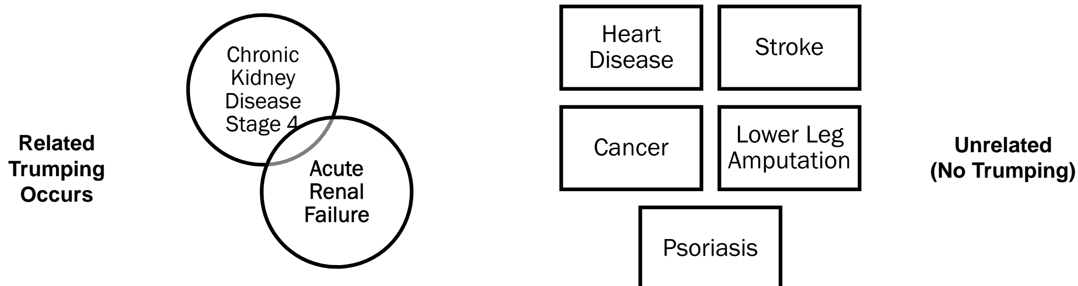
# Related and Unrelated Conditions

- Facilitates the unique assessment of each patient.
- **Trumping:** When 2 or more conditions are documented from the same category, the one that is more severe or complex will trump the other conditions.

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# Trumping

**Table VI-4. Disease Hierarchies for the 2017 CMS-HCC Model**

| Hierarchical Condition Category (HCC) | If the Disease Group is Listed in this column… | …Then drop the Disease Group(s) listed in this column |
|---|---|---|
| | **Hierarchical Condition Category (HCC) LABEL** | |
| 8 | Metastatic Cancer and Acute Leukemia | 9,10,11,12 |
| 9 | Lung and Other Severe Cancers | 10,11,12 |
| 10 | Lymphoma and Other Cancers | 11,12 |
| 11 | Colorectal, Bladder, and Other Cancers | 12 |
| 17 | Diabetes with Acute Complications | 18,19 |
| 18 | Diabetes with Chronic Complications | 19 |
| 27 | End-Stage Liver Disease | 28,29,80 |
| 28 | Cirrhosis of Liver | 29 |
| 46 | Severe Hematological Disorders | 48 |
| 54 | Drug/Alcohol Psychosis | 55 |
| 57 | Schizophrenia | 58 |
| 70 | Quadriplegia | 71,72,103,104,169 |
| 71 | Paraplegia | 72,104,169 |
| 72 | Spinal Cord Disorders/Injuries | 169 |
| 82 | Respirator Dependence/Tracheostomy Status | 83,84 |
| 83 | Respiratory Arrest | 84 |
| 86 | Acute Myocardial Infarction | 87,88 |
| 87 | Unstable Angina and Other Acute Ischemic Heart Disease | 88 |
| 99 | Cerebral Hemorrhage | 100 |
| 103 | Hemiplegia/Hemiparesis | 104 |
| 106 | Atherosclerosis of the Extremities with Ulceration or Gangrene | 107,108,161,189 |
| 107 | Vascular Disease with Complications | 108 |

HCC 19: E089: Diabetes mellitus due to underlying condition without complications

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## The "Re-set"



## CMS-HCCs are INDIVIDUALIZED

Not so for HHS-HCC (ACA/Com)

- **PROSPECTIVE:** CMS-HCCs for MA Enrollees treated **this** year serve as the predictor of resources (costs) that will be incurred **next** year
  - *May be adjusted by age and residence change and other major conditions documented within prior 12 months*
- Each year the list of HCCs for each given patient is **"re-set."**

# Annual Re-set for CMS-HCCs: Overlooked Diagnoses

- Amputations,
- Artificial Openings (Ostomies),
- Asthma,
- Pulmonary Disease (On Oxygen),
- Chronic Skin Ulcer,
- CHF,
- Drug Dependent,
- Metastatic Cancers,
- Obesity,
- Rheumatoid Arthritis, and
- Specific Type Of Major Depressive Disorder.

Source: 3M Aggregated Claims Data

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# Annual Re-set for RxHCC: Overlooked Diagnoses

| RxHCC | Diagnoses/ICD-10 Code |
| --- | --- |
| 134 | Major depressive disorder, single episode, unspecified/F32.9 |
| 188 | Old myocardial infarction/I25.2 |
| 187 | Essential (primary) hypertension/I10 |
| 166 | Most Migraine diagnoses/G43.001-G43.919 |
| 87 | Age related osteoporosis without current pathological fracture/M81.0 |

| RxHCC | Diagnoses/ICD-10 Code |
| --- | --- |
| 68 | Gastroesophageal reflux disease without esophagitis/K21.9 |
| 45 | Pure hypercholesterolemia/E78.00 |
| 42 | Hypothyroidism, unspecified/E03.9 |
| 226 | Mild persistent asthma, uncomplicated/J45.30 |
| 226 | Mild intermittent asthma, uncomplicated/J45.20 |
| 315 | Psoriasis vulgaris/L40.0 |

Source: Health Alliance: https://provider.healthalliance.org/coding-counts-post/rxhcc-model/

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## Reset Conundrum

- CMS's HCC Goal: To more effectively manage patients with chronic conditions and be able to predict the costs of care for this population.
- If the provider does a good job….



## Capturing the Diagnoses/HCCs Annually

- UPDATING THE PATIENT'S INFO: Annual health assessment very important.
  - *Patient incentives—Compliance Caution*
- Reviewing other providers' documentation?
- Documentation is key.

## The Risk Adjustment Factor (RAF) Underlying Factor of Reimbursement



## Relative Factors and Status of the Patient

- HCCs recognize the complexity of care for insureds and segments the population:
  - *Living in the community*
  - *Living in an institution*
  - *Aged*
  - *Disabled*
  - *Income restrictions*

## CMS-HCC Model Relative Factors for Community and Institutional Beneficiaries

Socio-Economic

Relative Factor or Coefficient

| Variable | Description Label | Community, NonDual, Aged | Community, NonDual, Disabled | Community, FBDual, Aged | Community, FBDual, Disabled | Community, PBDual, Aged | Community, PBDual, Disabled | Institutional |
|---|---|---|---|---|---|---|---|---|
| 90-94 Years | | 0.857 | – | 1.186 | – | 0.822 | – | 0.964 |
| 95 Years or Over | | 0.976 | – | 1.268 | – | 1.038 | – | 0.781 |
| **Medicaid and Originally Disabled** | | | | | | | | |
| Medicaid | | – | – | – | – | – | – | 0.062 |
| Originally Disabled, Female | | 0.244 | – | 0.172 | – | 0.126 | – | – |
| Originally Disabled, Male | | 0.152 | – | 0.192 | – | 0.105 | – | – |
| **Disease Coefficients** | **Description Label** | | | | | | | |
| HCC1 | HIV/AIDS | 0.312 | 0.288 | 0.585 | 0.500 | 0.550 | 0.232 | 1.747 |
| HCC2 | Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock | 0.455 | 0.532 | 0.596 | 0.811 | 0.409 | 0.417 | 0.346 |
| HCC6 | Opportunistic Infections | 0.435 | 0.704 | 0.548 | 0.919 | 0.482 | 0.765 | 0.580 |
| HCC8 | Metastatic Cancer and Acute Leukemia | 2.625 | 2.644 | 2.542 | 2.767 | 2.442 | 2.582 | 1.143 |
| HCC9 | Lung and Other Severe Cancers | 0.970 | 0.927 | 0.973 | 1.025 | 0.955 | 0.879 | 0.727 |
| HCC10 | Lymphoma and Other Cancers | 0.677 | 0.656 | 0.713 | 0.761 | 0.667 | 0.577 | 0.401 |
| HCC11 | Colorectal, Bladder, and Other Cancers | 0.301 | 0.352 | 0.332 | 0.361 | 0.325 | 0.400 | 0.293 |
| HCC12 | Breast, Prostate, and Other Cancers and Tumors | 0.146 | 0.202 | 0.159 | 0.190 | 0.152 | 0.182 | 0.199 |
| HCC17 | Diabetes with Acute Complications | 0.318 | 0.371 | 0.346 | 0.431 | 0.354 | 0.423 | 0.441 |
| HCC18 | Diabetes with Chronic Complications | 0.318 | 0.371 | 0.346 | 0.431 | 0.354 | 0.423 | 0.441 |
| HCC19 | Diabetes without Complication | 0.104 | 0.128 | 0.097 | 0.160 | 0.098 | 0.136 | 0.160 |

Community vs. Institutional-Where beneficiary resides
FB=Full Benefit; PB=Partial Benefit; Dual means coverage under M'care & M'caid
FB Dual beneficiaries qualify for a full range of M'care and M'caid services including LTC.

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# Risk Adjustment Factor: RAFs

- The RAF score for an individual patient represents **all** of the hierarchical condition categories (HCCs) that have been submitted for that person to CMS during the course of a <u>calendar year.</u>[3]
  - *Like a DRG relative weight (for a single encounter) but instead for a Patient (for the entire year…all encounters)*
  - *Like APCs in that patient may have several HCCs*
  - *Nothing compels patients to stay with one provider because the payment is made to MAO who in turns pays the providers*
- It is the sum of relative factors or coefficients

Compliance Caution

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3. Adapted from: McDermott Will & Emery & Central Massachusetts Independent Physician Association

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# Risk Adjustment Factor Example

| ICD-10 Codes | HCC Group | Demographic Factor | Relative Factors |
|---|---|---|---|
| Community Factor, Aged | | Female 70-74 years | 0.374 |
| E109 Type-1 Diabetes mellitus w/o complications | HCC 19 | Diabetes w/o complication | 0.104 |
| I5021 Acute systolic (congestive) heart failure | HCC 85 | Congestive heart failure | 0.323 |
| | Interaction HCC 85 | Diabetes/CHF | 0.154 |
| | | Risk Adjustment Factor | 0.955 |
| | | Est. Payment (reimbursement value) | $8,771.68/yr.; $730.97/mo. |
| Note: Based on proposed V22 HCCs and Base Payment (~$9,185); Est. Payment = 0.955 x $9185 http://www.hfni.com/assets/HCC_risk_adjustment_051215.pdf; 2017 Risk Factors | | | |

Adapted Example from 3M



# Risk Adjustment Coding Example

| **NO conditions coded** | **Coefficient** | **SOME conditions coded** | **Coefficient** | **ALL chronic conditions coded** | **Coefficient** |
|---|---|---|---|---|---|
| 76-year old female | 0.442 | 76-year old female | 0.442 | 76-year old female | 0.442 |
| Medicaid eligible | 0.151 | Medicaid eligible | 0.151 | Medicaid eligible | 0.151 |
| DM with complications | Not Coded | DM **w/o** complications | 0.118 | DM with complications | 0.368 |
| Vascular disease | Not Coded | Vascular disease | Not Coded | Vascular disease | 0.299 |
| CHF | Not Coded | CHF | Not Coded | CHF | 0.368 |
| Disease interaction (DM+CHF) | Not Coded | Disease interaction (DM+CHF) | Not Coded | Disease interaction (DM+CHF) | 0.182 |
| Total RAF | **0.593** | Total RAF | **0.711** | Total RAF | **1.810** |

| **Using the $9,185 Base Payment** | **$5,446.71** | **$6,530.54** | **$16,624.85** |
|---|---|---|---|

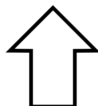
Source: Premera Blue Cross

## Why a Risk Adjustment Factor (RAF)?

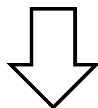
- **To pay** health plans **for the risk** of the beneficiaries they enroll, instead of paying an average amount.
  - *To recognize enrollees with differences and their individual expected costs.*
  - ***Does recognize physicians/providers who treat sicker patients!*** ☺
    - ***Think profile***



## RAFs



Higher RAFs represent patients with a greater than average burden of illness



Lower RAFs represent healthier patients or may not accurately represent the population served due to:

- In adequate or incomplete chart documentation
- Inaccurate  or incomplete diagnosis coding

 Source: Resnik; http://www.trianglemedicalgroup.com/raf2017.pdf 

## Top 10 Most Over-Documented HCCs

1. Conditions that have been surgically corrected (e.g., abdominal aortic aneurysm)
2. Diabetes with complications
3. Malnutrition
4. Nephritis
5. Pathological fractures (e.g., old pathological fractures reported as current)
6. Pneumococcal pneumonia (e.g., unspecified pneumonia reported as pneumococcal)
7. Polyneuropathy (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
8. Primary site cancers (e.g., indicating historical conditions as current)
9. Strokes (e.g., indicating acute stroke instead of late effect of stroke)
10. Vascular disease (e.g., reported as current when no treatment, evaluation, or monitoring is documented.

Source: 3M Aggregated claims Data



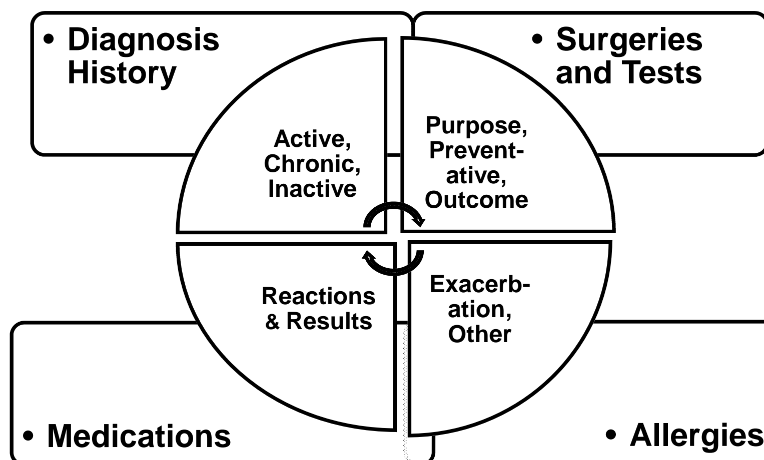
## CMS-HCC Model Algorithm

- Reimbursement Logic
  - *Does not distinguish among sources of diagnoses*
    - Places **no premium on a diagnosis from inpatient care over one from outpatient care.**
    - Just need to meet the documentation rules

# Documentation Tips



# Documentation Is Key



## Documentation that drives an HCC

- During the encounter conditions must **MEAT**:
  - *Monitored,*
  - *Evaluated,*
  - *Assessed, **and/or***
  - *Treated*
- TAMPER[tm]
  - *Created by Brian Boyce*
  - *Treatment, Assessment (Affect*), Monitor/Medicate, Plan, Evaluate, or Referral.*

TAMPER is trademarked by Brian Boyce, ION Healthcare

*Affect added by Dr. Erica Remer



## HCCs

- It's all about the documentation of the **CMS-approved clinicians.**
  - **Accuracy and specificity can bump to higher weighted HCC**
    - Diabetes,
    - Angina,
    - Pneumonia,
    - Renal Failure,
    - CKD,
    - Pressure Ulcer

Outpatient CDI

# Documentation Guidelines for HCCs

- Date of Service, Patient Name, and an additional patient identifier (e.g., Date of birth) is required on every page. [1,2]
- Chief Complaint: **"Follow Up" alone is not a valid CC.** The documentation must describe **why the patient is presenting** for follow up. Ex: Follow up for diabetes [3]

1. CMS, "2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide." Leading through Change, Inc. 2008. 1-49.
2. The Joint Commission. Patient Safety Goals.
3. CMS. "1995 Documentation Guidelines for E/M Services. " 1999. Medicare Learning Network.



# Documentation Guidelines for HCCs

- Physical exams should be specific to the condition
  - *If the patient has lung cancer and the physicians documentation does not indicate whether they are currently in treatment or are in surveillance, the documentation could be considered invalid*
  - *The exam should describe any pertinent findings and any chronic findings that affect the care and treatment of the patient.* [3,4]

3. CMS. "1995 Documentation Guidelines for E/M Services. " 1999. Medicare Learning Network.
4. National Center for Health Statistics 2011 1-107. www.cdc.gov/nchs/icd/icd9cm_addenda_gudlines.htm

# Documentation Guidelines for HCCs

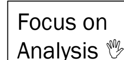
- Medical Decision Making:
  - *Assessment that* **documents the diagnosis***, its status and any causal relationships (e.g., psoriasis, due to arthritis; CHF, due to hypertension).* [3,4]
  - *Assessment that documents not only conditions being treated, but* ***any chronic conditions that affect the care and treatment of the patient.*** [3,4]
  - ***Plan*** *that specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.* [3]

3. CMS. "1995 Documentation Guidelines for E/M Services. " 1999. Medicare Learning Network.
4. National Center for Health Statistics 2011 1-107. www.cdc.gov/nchs/icd/icd9cm_addenda_gudlines.htm



# Documentation Guidelines for HCCs

- Lab, x-rays, and procedures should be appropriate to the condition.
- Medications should be reviewed and **medications** appropriate for the condition **should be present** <u>**in the visit**</u> **documentation.**
- Authentication:
  - *Paper Record: Authentication by the provider. Progress note includes* ***<u>legible</u>*** *<u>name and credential</u>, a hand-written signature and the date signed*
  - *EMR: Authentication by the provider. Password protected to that provider only, at the end of the note, including typed name, credential and date authenticated.* [1]




1. CMS, "2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide." Sec. 7.2.4.2. p. 7-16.

## Documentation that drives an HCC

- **Co-existing conditions include ongoing conditions,** such as diabetes, congestive heart failure, multiple sclerosis, hemiplegia, Parkinson's disease, atrial fibrillation, COPD, etc.
  - ***Conditions are generally managed by ongoing medication*** *and…*
  - *Have the* ***potential for acute exacerbations*** *if not treated properly, particularly if the patient is experiencing other acute conditions.*

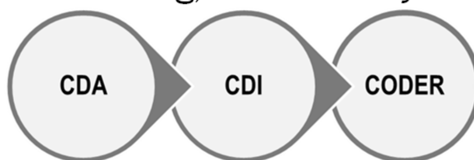


## Documentation that drives an HCC

- Do Code: All documented conditions that **coexist at the time of the encounter/visit**, and require or affect patient care **treatment** or management.
- Do NOT code: **conditions** that were previously treated and **no longer exist.**
  - *Are we assisting with cleaning up problem lists?*
  - *Can we adjust the problem lists?*
    - *(Not according to AHIMA)*

## Documentation Guidelines impact on the Coder ✋

- What do these elements mean for the coder?
  - *Coder-Analyst: Before coding a condition the Coder will need to ensure the "valid" documentation is there. Assess data integrity.*
  - *Coder-CDIS: Before coding, obtain clarity needed to code*



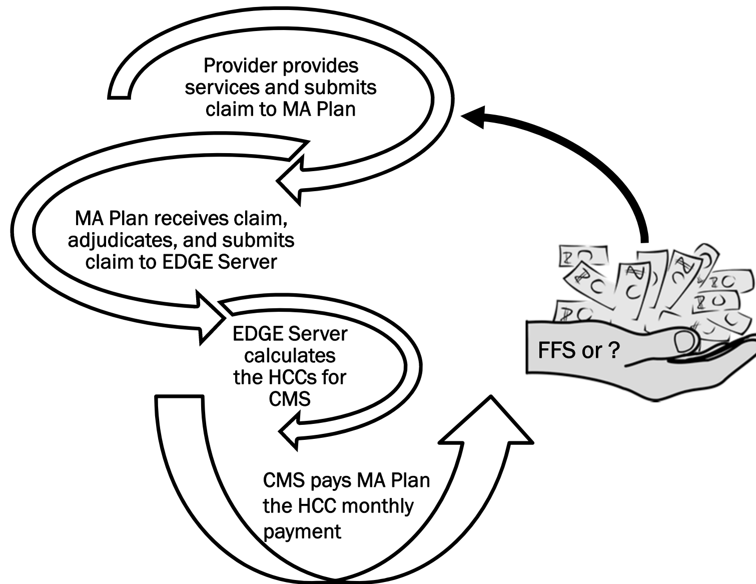

  - *Clinical Documentation Coding Integrity Specialist (CDCIS)*



## No problem getting provider compliance.

# NOT!

# Where're the Bucks?






# HCCs: Isn't this Physician Reimbursement?

- Is it really physician reimbursement?
- Why should physicians care?
- How does the physician benefit?

## What's in it for the Provider?

- Continue to be paid FFS
- Negotiate directly with MAO
- Participate in an ACO or other risk model
  - *Model must have an MAO or risk sharing partner that is the payer*
    - Defined sharing of the CMS (or ACA or Medicaid) payment
- Patient's SOI and ROM
- Profile



## External Auditors

# Types

- IVA: Independent Validation Auditors (Hired by the Health Plan to pre-audit)
- RADV: Risk adjusted data validation Auditors (Work for CMS)



# IVA vs. RADV Audits

- RADV (Risk Adjustment Data Validation) Audits
  - ***Auditor working for CMS to validate the IVA or MA Health Plan data***
  - *Report findings to CMS*
  - *CMS Adjusts payments to Health Plan*
  - *If it finds potential fraud → Zone Program Integrity Contractors (ZPICs)*
- RADV and ZPIC audits – 100 members and extrapolate from those findings
- ZPIC can refer to DOJ/FBI

# Risk Adjustment Data Validation (RADV) Auditors

- Goal of the audit: To identify any discrepancies by comparing risk adjustment diagnosis data submitted by a MAO via encounters and claims to the actual documented services and care.
- Audits are a mandatory requirement for MAOs
- Two Type of RADV Audits
  - *National*
  - *Contract Level*



# National vs. Contract Level RADV Audits

## National

- Randomly select ~1,000 MA beneficiaries across all MA contracts
- Findings are used to report Medicare Part C national error rate to Congress
- No financial penalty imposed

## Contract Level

- Randomly select ~200 beneficiaries from each of 30 MA plans
- Select plans with past problematic data validation findings
- Unusual increase in Risk Scores (RAFs)
- Failed to comply with National audit
- Financial penalties—Oh Yeah!

## External Auditors

- RADV (Risk Adjustment Data Validation) Auditors
  - *Health record with LEGIBLE signature AND credentials*
  - *EHR with authentications/electronically signed*
    - Or contains a CMS-generated Attestation for this date of service
  - *Documentation that includes ICD-10 attributes and supports the diagnosis billed*
  - *Documentation that indicates a condition as being monitored, evaluated, assessed, or treated (MEAT)*
  - *Conditions treated (MEAT) are coded/reported on an annual basis*
  - *Diagnosis coded to the highest level of specificity (and supports an HCC and the HCC reported)*
  - *Cancer status is clear and the cancer treatment is documented*



## What Are the Findings

- Early Reports:
  - *Medicare paid too much ~60% of the time*
  - *Risk scores were too high ~80% of the time*
  - *Couldn't confirm diagnoses ~40% of the time*

## What are the Findings

Where did these results Come from? National or Contract Level audit?

- In 2014, Medicare paid about $160 billion to MA organizations to provide health care services for approximately 16 million beneficiaries. CMS, which administers Medicare, estimates that about 9.5 percent of its payments to MA organizations were improper, according to the most recent data—primarily stemming from unsupported diagnoses submitted by MA organizations. CMS currently uses RADV audits to recover improper payments in the MA program.

https://www.gao.gov/products/GAO-16-76

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## What are the Findings

- The 2016 Medicare Part C gross improper payment estimate was 9.99 percent, or $16.18 billion. The Part C payment error rate reflects errors in risk adjustment data (clinical diagnosis data) submitted by Part C plans to CMS for payment purposes. Specifically, the estimate reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

https://waysandmeans.house.gov/wp-content/uploads/2017/07/20170719OS-Testimony-Morse.pdf

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# Typical IVA & RADV Findings

- Patient identification missing on documents submitted.
- The paper record does not contain a legible signature with credentials.
- The EHR entry was unauthenticated or the e-signature did not have all the elements (provider name and credentials).
- Unspecified diagnoses were used when a more precise code could have been applied based on the documentation in the chart.
- Discrepancies between diagnosis billed vs. diagnosis documented in the record.
- Diagnoses billed cannot be supported by MEAT.
- Status of cancer was unclear or treatment was not documented.
- Chronic conditions reported/claimed, were not documented as “chronic” in the record and/or were not documented at least once per year.
- Manifestations were not linked for certain conditions, but coded as if they were.



# Contract Level Scoring

- The audit score is calculated by assigning points to identified conditions of non-compliance: 0 points to observations, 1 point to each Corrective Action Required (CAR), 2 points to each Immediate Corrective Action Required (ICAR), and dividing the sum of these points by the number of audit elements tested. The following is the formula for calculating the audit score:
- Audit score = (# CARs) + (# of ICARs X 2) / # of audited elements tested
- Lower the score the better

Source: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAuditResults.html

# Score Results (Excerpt)

Source: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAuditResults.html

| Sponsor Name | Overall Audit Score | Number of CARs | Number of ICARs | Number of Audit Elements Tested | Audit Year | Enforcement Action Issued? | Audit Status |
|---|---|---|---|---|---|---|---|
| Advantage Health Solutions | 1.00 | 27 | 1 | 29 | 2012 | No | Closed |
| Aegon N.V. | 1.06 | 13 | 2 | 16 | 2014 | No | Closed |
| Aetna, Inc. | 1.62 | 30 | 2 | 21 | 2013 | Yes | Closed |
| Aetna, Inc. | 0.82 | 8 | 3 | 17 | 2015 | No | Closed |
| Affinity Health Services Holdings, Inc. | 1.44 | 15 | 4 | 16 | 2017 | Yes | Validation in Progress |
| AHMC | 1.70 | 24 | 5 | 20 | 2015 | Yes | Closed |
| Alameda Alliance for Health | 1.69 | 44 | 0 | 26 | 2012 | No | Closed |
| AllCare Health, Inc. | 1.08 | 12 | 1 | 13 | 2017 | No | Validation in Progress |
| AlohaCare | 1.86 | 31 | 5 | 22 | 2014 | Yes | Closed |
| American Health (Triple S Management Corp.) | 1.00 | 30 | 0 | 30 | 2012 | No | Closed |

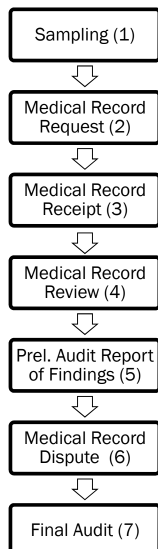


# RADV Audit Appeal Process

- Regulations include a **RADV appeal process,** a document dispute process, and a procedure for obtaining physician-signature attestations
  - 42 CFR § 422.311

Source: CMS, MA Plan Payment Data Initiatives, CMS Priorities for 2011, 2010

# RADV Process




Notes:

- Limited appeal process
  - *Hearing by CMS Designated officer*
  - *Review by CMS Administrator/designee*
  - *Review by CMS Administrator at his/her discretion*
- No new medical record documentation is allowed (post submission queries)
- Two Appeal Options
  - *Medical record review determination*
  - *Payment error calculation*

Source: CMS, MA Plan Payment Data Initiatives, CMS Priorities for 2011, 2010



# CMS's Medical Record Reviewer Guidance

- Contract Level Risk Adjustment Data Validation Medical Record Reviewer Guidance (9/17/17) at:
  - *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/Coders-Guidance.pdf*
- For Audits after 9/27/17
  - *CMS will select a subset of Part C contracts for the annual RADV audit cycle*
  - *Enrollees are sampled from each selected MA contract*
  - *MA plan is required to submit medical records to support all CMS-HCC in the sampled beneficiaries' risk scores for the payment year*
  - *MAOs may appeal eligible medical record determinations through an administrative review process.*

## CMS's Medical Record Reviewer Guidance

- For Audits after 9/27/17-Continue
  - *The MAO must request copies of the records from hospitals and physicians/practitioners.*
    - Reimbursed?
  - *The records submitted must be:*
    - For the correct beneficiary
    - For an acceptable provider (clinician) type (and specialty)
    - For dates of service within the collection period
    - Have valid signatures and credentials (may allow attestation forms)
    - Coded in accordance with official conventions and guidelines
  - *When assessing the coding, the Official Guidelines are used.*



## Not Acceptable

- Signature stamp (? ADA)
- Signature line blank
- Date of service outside the range of the collection period
- Invalid clinician
- Crossed out wording on the CMS-Generated Attestation
- Unacceptable electronic signatures verbiage
  - *Administratively signed by*
  - *Dictated but not signed*
  - *Electronic signature on file*
  - *Signed by not reviewed…*

# Not Acceptable

- Ruled out conditions
- Unsupported observation status (documentation and orders state observation)
- List of problems written by the patient
- Problem list is a list of code numbers without the narrative
- SNF record with no physician documentation
- Health Risk Assessments completed by the patient.
- Diagnoses on a referral form.
- Diagnosis only appears on a script.
- Superbills
- Query forms that are not part of the official medical record.
- Poorly scanned documents (unreadable)



# Not Acceptable or Questionable

- Signature at the beginning of a report
- Legibility (may ask for attestation)
- Credentials (may require add'l research by the auditor)
- Undated
- Inpatient records must have an admission and discharge date.
- Lack DOS: It is not acceptable to submit conditions from documents with a date of dictation only.
- Documentation from non-face-to-face clinicians: diagnostic radiologists, lab results
- Incomplete inpatient records-lacking discharge summary or discharge note
- Telephone contacts

## RADV Audits

- Conducted regularly
- Findings are extrapolated to total enrollment*

**Example:**
-10,000 members in the MA Plan with annual reimbursement of $50,000,000
-RADV audit identifies an overpayment rate of $250 or 5% on **ONE** patient
-The repayment to Medicare **IS NOT** $250
-The repayment **IS $2,500,000**

Source: Baker, Newman Boyes

- If intentional, fines may be issued: Triple damages (similar to False Claims Act)

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## CMS RADV vs. HHS HRADV Differences

**CMS RADV**

- Approximately 30 plans annually
- 2-3 years post payment
- Any face-to-face encounter by an approved provider can be used as support
- Up to five (5) best records to support an HCC

**HHS HRADV**

- All participating plans
- 6 months post payment
- Only dates of service submitted on the EDGE server can be used as support
- As many DOS submissions as the Plan wants, as long as they were submitted on the EDGE server

Source: Baker, Newman, Noyes

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## Internal Auditing: Identifying Suspicious Behavior-A Must

- South Florida physician added chronic condition……. To every patient
  - *Isaac K. A. Thompson (Delray Beach, South Florida) plus 3 other Palm Beach County doctors, two medical clinics, and a practice group*
  - *Thompson was indicted in 2015 (fraudulent coding 1/2006 to 6/2013)*
    - Sentenced to 46 months in prison; 2 years supervised release
  - *Upcoded cases and applied false diagnoses*
    - **Thompson falsely diagnosed 387 Medicare Advantage beneficiaries with ankylosing spondylitis.**
    - The diagnoses resulted in Medicare paying approximately $2.1 million in excess fees, with about **80 percent** going to Thompson under his fee arrangement with Humana.

Source: http://www.palmbeachpost.com/news/news/crime-law/delray-doctor-accused-of-medicare-fraud-falsely-di/nqdxK/; and www.publicintegrity.org/print/19397



## Findings

- IVA (Initial Validation Auditor) and RADV Audits uncovering **documentation and coding deficiencies**
  - ***The documentation does not support the diagnoses***
  - ***Not compliant with the HCC "Valid" Documentation Rules***
- Providers may need to anticipate some take-back of payments from MA Health Plans
- Payer response

## Payer Response

- Pursuant to Section 5.M. of this Addendum, Provider certifies that the diagnosis codes submitted to Company for Medicare Members that Company is required to submit to CMS will be accurate, complete and truthful ("Certification"). Provider acknowledges and agrees that Company may impose a penalty on Provider not to exceed five thousand dollars ($5,000) for each instance that Provider submits a diagnosis code to Company for a Medicare Member that does not comply with this Certification because the diagnosis code was not submitted in the format described in 42 CFR § 422.310 or any subsequent or additional federal regulations. For purposes of this Section, "diagnosis code" shall mean an International Classification of Diseases [ICD]…code….



## Internal Audits Need to Report ALL Findings

- August 2016, the Ninth Circuit reopened the Swoben case (Swoben v. United Healthcare, No. 13-56746 (9th Cir. 2016))[2];
- James Swoben alleged that multiple MA organizations, including United, routinely performed retrospective reviews that were structured:
  - *(1) to identify services that were under-coded, allowing the organizations to up-code and, in turn, increase their payments under the HCC-RAF program; but*
  - *(2) to avoid the identification of over-coded services that, if corrected, would decrease payments under the HCC-RAF program.*

## Internal Audits Need to Report ALL Findings

- Swoben alleged that the defendants' use of one-sided retrospective reviews to identify under-coding instead of **two-sided retrospective reviews to identify both under-coding and over-coding** meant that the MA organizations were either:
  - *(1) acting in deliberate ignorance of the truth or the falsity of their certifications, or*
  - *(2) were acting in reckless disregard for the truth or the falsity of their certifications.*

*https://www.sheppardhealthlaw.com/2017/02/articles/doj/unitedhealth-group/*



## Internal Audits Need To Report ALL Findings

- 2/2018: The U.S. Department of Justice (DOJ) and whistleblower lawsuit, **United States of America ex rel Benjamin Poehling v. Unitedhealth Group Inc.**, against UnitedHealth Group (United) and its subsidiary, UnitedHealthcare Medicare & Retirement—the nation's largest provider of Medicare Advantage (MA) plans.
- The suit accuses United of operating an **"up-coding" scheme** to receive higher payments under MA's risk adjustment program. The complaint alleges that United fraudulently collected "hundreds of millions—and likely billions—of dollars" by claiming patients were sicker than they really were.
- Originally **filed in 2011 by a former United finance director** under the False Claims Act (FCA). Pursuant to the FCA, the case was sealed for five years while the DOJ investigated the claims.

## Internal Audits Need To Report ALL Findings

- United employed chart reviewers to review medical records and mine them for additional diagnosis codes the medical providers did not originally report. United then **submitted the additional diagnoses to CMS for additional risk adjustment payments.**
- The Government alleges that since at least 2005, Defendants have known of their obligations with respect to risk adjustment data. **They knew they were obligated to make good faith efforts to delete the invalid codes and engage in Chart Reviews that "looked both ways" to identify both additional codes to submit and codes to delete.**
- **United conducted "one-way" Chart Reviews**, ignored unsupported codes UGH Managing Defendants submitted to CMS on their behalf, and retained risk adjustment payments to which they were not entitled.
- https://dlbjbjzgnk95t.cloudfront.net/1017000/1017956/poehling.pdf



## Proactive Measures to Minimize Compliance Concerns

## Proactive Measures

1. Documentation Education – All providers and their scribes
2. Record contents – Employ "deficiency" analysis
3. Outpatient CDI (semi-concurrent) by the Coding Team
   a) *Monitor for zealots*
4. Routine audits:
   a) *Throughout the year*
   b) *Prior to close of year*
5. Monitor contractual arrangements between providers and payers
   a) *Incentives that create temptations*
   b) *Gotcha clauses*



## The Good (Already discussed the Bad and Ugly)

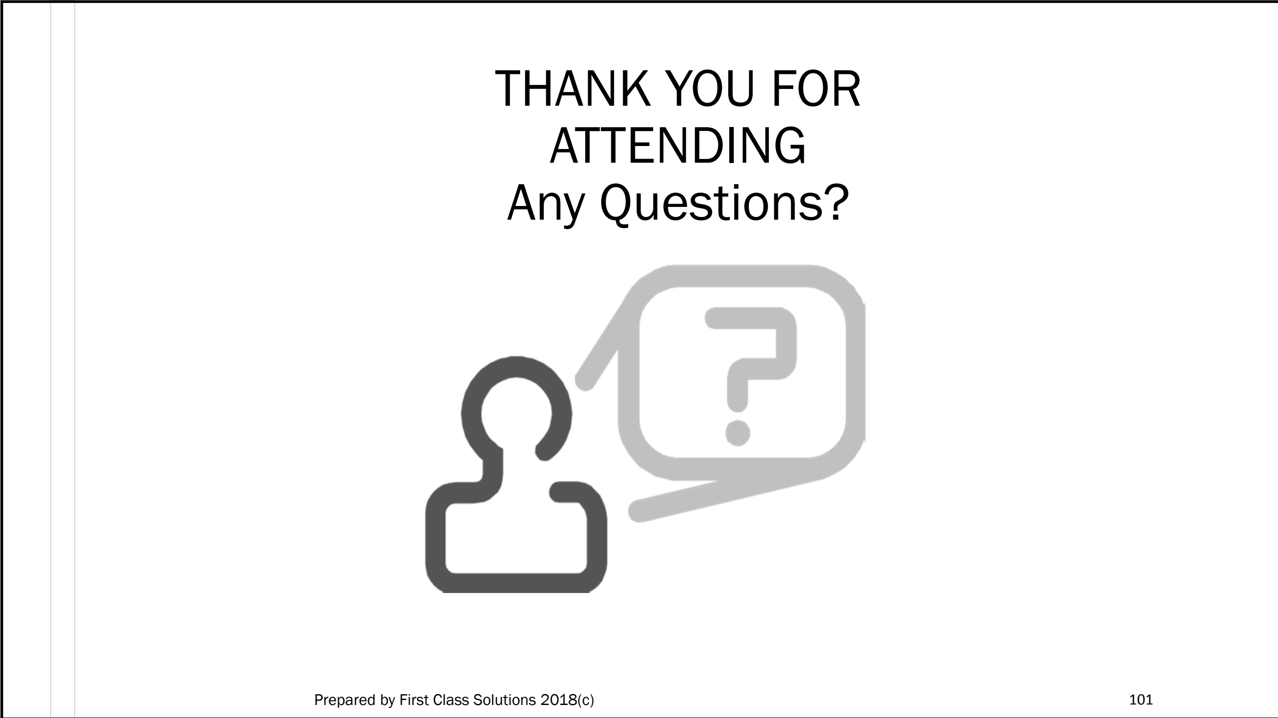
## Why Use HCCs – Could They Solve Some of Today's Healthcare Concerns

- Based on diagnoses
- Link together the episode of care for the individual
- Links the longitudinal treatment of patients
- Research started in 1988 to establish a M'care payment for an Episode of Illness (EOI)
  - *DRGs (1983), Physicians (1993), SNFs (1998), APCs (2000), ASC (2008), …*
- Consider other dimensions
  - *Predictive?*
  - *Preventative?*
  - *Prolonging?*



## Closing Thoughts

- What is the future of E&M codes?
- Could HCCs replace DRGs?




Resources

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## About the Speaker

*Ms. Dunn is a Past AHIMA President and recipient of AHIMA’s 1997 Distinguished Member and 2008 Legacy Awards. She is Chief Operating Officer of St. Louis-based, First Class Solutions, Inc., a national health information management consulting firm providing coding compliance and coding support services and HIM operational consulting services for hospitals, physician practices, and SNFs.*

*A two-time graduate of St. Louis University, Rose is active in ACHE, AICPA, HFMA, and AHIMA. Ms. Dunn is the author of several texts and hundreds of published articles.*

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