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

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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

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CMS-HCCs

- Version 22/23 CMS-HCCs (AKA PCCs)
  - *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….*

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

Similar to DRGs

- Infections
- Neoplasm
- Diabetes
- Metabolic
- Gastrointestinal
- Liver
- Musculoskeletal
- Blood

- Substance Abuse
- Psychiatric
- Spinal
- Neurological
- Cardiovascular Disease
- Arrest
- Heart
- Vascular
- Lung

- Eye
- Kidney
- Skin
- Injury
- Complication
- Transplant

Unique To HCCs

- Openings
- Amputation
- Disabled/Disease Interactions

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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

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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.

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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

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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

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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

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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

- Skilled Nursing Facilities
- Hospice
- Laboratory
- Diagnostic Radiology (Not face-to-face)
- Ambulance
- DME
- Ambulatory Surgery **Centers**
- Outpatient Pathology
- A list of patient conditions (problem list)
- Superbills/Encounter forms
- Pharmacies (for now)
- Nurses (RNs)
- Dietitians
- Medical Assistants

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.

Related Trumping Occurs

Chronic Kidney Disease Stage 4

Acute Renal Failure

Heart Disease

Stroke

Cancer

Lower Leg Amputation

Psoriasis

Unrelated (No Trumping)

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Trumping

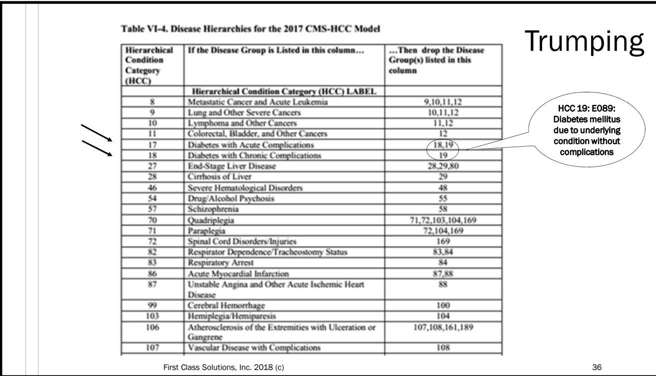

Table VI-4. Disease Hierarchies for the 2017 CMS-HCC Model

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

Annual Re-set for RxHCC: Overlooked Diagnoses

RxHCC Diagnoses/ICD-10 Code	RxHCC Diagnoses/ICD-10 Code
134 Major depressive disorder, single episode, unspecified/F32.9	68 Gastroesophageal reflux disease without esophagitis/K21.9
188 Old myocardial infarction/I25.2	45 Pure hypercholesterolemia/E78.00
187 Essential (primary) hypertension/I10	42 Hypothyroidism, unspecified/E03.9
166 Most Migraine diagnoses/G43.001-G43.919	226 Mild persistent asthma, uncomplicated/J45.30
87 Age related osteoporosis without current pathological fracture/M81.0	226 Mild intermittent asthma, uncomplicated/J45.20
	315 Psoriasis vulgaris/L40.0

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

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.

 Chart Source: HCC Basics. Banner Health Network 7/6/16

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 calendar year.[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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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			

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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

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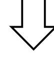
Why a Risk Adjustment Factor (RAF)?

- **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.

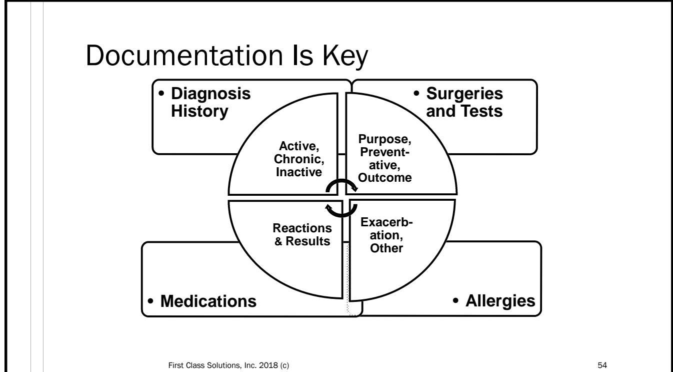
Source: 3M Aggregated claims Data

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*
- TAMPERtm
  - *Created by Brian Boyce*
  - *Treatment, Assessment (Affect*), Monitor/Medicate, Plan, Evaluate, or Referral.*

TAMPER is trademarked by Brian Boyce, ION Healthcare

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*Affect added by Dr. Erica Remer

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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

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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.

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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

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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

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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** **in the visit documentation**.
- Authentication:
  - *Paper Record: Authentication by the provider. Progress note includes* ***legible*** *name and credential, 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]

Focus on Analysis

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

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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.*

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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)*

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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)*

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No problem getting provider compliance.

NOT!

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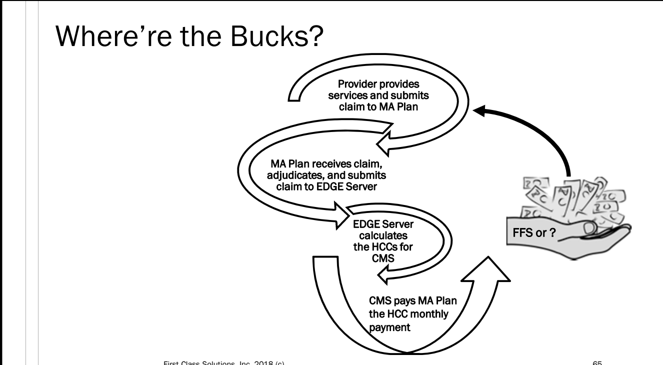
Where're the Bucks?



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HCCs: Isn't this Physician Reimbursement?

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

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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

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.

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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

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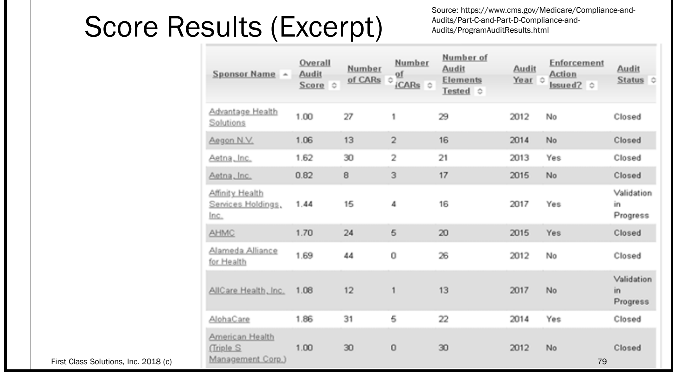

Score Results (Excerpt)

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

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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

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RADV Process

Sampling (1) → Medical Record Request (2) → Medical Record Receipt (3) → Medical Record Review (4) → Prel. Audit Report of Findings (5) → Medical Record Dispute (6) → Final Audit (7)

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

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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)

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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

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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

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?

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THANK YOU FOR ATTENDING
Any Questions?

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Resources

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References

- CMS Announcement for 2017 CMS-HCCs. Viewed online on 12/24/17 at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf
- Fernandez, Valerie. "Ins and Outs of HCCs." Journal of AHIMA 88, no. 6 (June 2017): 54-56. Viewed online on 12/10/17 at http://bok.ahima.org/doc?oid=302154
- Fontenot, C. and Szydlowski, J. "Medicare Payment Update." Viewed online on 12/24/17 at: http://www.npaonline.org/sites/default/files/PDFs/Medicare%20Payment%20Update_0.pdf

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References

- Hierarchical Condition Categories 2017. Viewed online on 12/23/17 at https://hmsa.com/portal/provider/ICD10CM_Hierarchical_Condition_Categories_(HCC)_List.pdf
- Medicare Managed Care Manual. Viewed online on 12/24/17 at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf
- "PACE and Medicare Risk Adjustment." National PACE Association. Viewed online on 12/10/17 at http://pace.techriver.net/website/article.asp?id=808
- FAQs on HCCs: http://www.hccuniversity.com/coding-faqs/
- Unraveling the Mystery of HCCs: http://www.mmplusinc.com/news-articles/item/unraveling-the-mystery-of-hccs

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References

- Schamp, Richard. "Clinical Documentation Improvement in PACE." Viewed online on 12/10/17 at: https://www.capstoneperformancesystems.com/articles/clinical-documentation-improvement-in-pace/
- Table 1: CMS-HCC Model Relative Factors for Community and Institutional Beneficiaries. (2017) Viewed online on 12/24/17 at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf
- Table 4: Disease Hierarchies for the 2017 CMS-HCC Model (Trumping Table) Viewed online on 12/24/17 at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf

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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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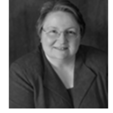

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