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Compliance Goals in Risk Adjustment Coding

PRESENTED BY

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Presenter's Bio

Rebecca Welling, RHIT, CCS-P - Senior Director of Coding Compliance at Providence Health Plan (PHP), a not for profit Health insurance company serving 650,000 lives in the Pacific Northwest. PHP is part of Providence Saint Joseph Health, the third largest nonprofit health system in the US with services in Alaska, California, Montana, New Mexico, Oregon, Texas and Washington State. Rebecca oversees all risk adjustment programs pertinent to Medicare, Medicaid and ACA lines of business with focus on physician coding education, coder training and clinical documentation initiatives. Rebecca directs a team of highly trained HCC coders and educators that perform retrospective, prospective and RADV audits for all government related lines of business. This entails a thorough understanding of financial implications associated with an efficient and ethical risk adjustment program. Rebecca also serves in a consultative role for Population Health division in developing system wide ethical risk adjustment strategies. In addition to risk adjustment work, Rebecca oversees a team of advanced professional coders that oversee Health Plan payment policy, clinical editing for claims adjudication, provider appeal resolution and detailed coding applications.

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Presenter's Bio

Dana Brown, MBA, RHIA, CHC, CCDS, CRC – President, Reimbursement Management Consultants, Inc. (RMC) She founded RMC in 1994, with the desire to assist healthcare facilities in obtaining correct reimbursement and minimizing lost revenue through complete and accurate coding, documentation improvement, and education. In 2006 Dana was instrumental in RMC's Risk Adjustment Division. RMC was one of the few companies at that time performing HCC coding reviews.

Prior to founding RMC, Dana performed DRG Validation, Admission, and Utilization Reviews for the Oregon PRO/QIO. She has extensive management, education and coding experience spanning her 30+years in HIM. Ms. Brown's expertise in Compliance, Inpatient Coding, DRG's/MSDRG's, OIG & RAC Targets, Clinical Documentation Improvement, as well as Risk Adjustment/HCC coding round out her areas of focus at RMC. Ms. Brown's vision for RMC is to continue to support our clients with exceptional services, delivered by exceptional staff.

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Presenter's Bio

Dott Campo, RHIA, CRC - Manager, Risk Adjustment Division at Reimbursement Management Consultants, Inc. (RMC).   In this role, Ms. Campo performs Risk Adjustment/HCC coding and auditing, as well as education for coders and providers. Ms. Campo is credentialed as a RHIA or Registered Health Information Administrator from American Health Information Management Association (AHIMA). She is also a Certified Risk Adjustment Coder (CRC) in risk adjustment coding by the American Academy of Professional Coders (AAPC) which further illustrates her coding skills and expertise, specifically in risk adjustment coding. Ms. Campo expertise in the review of patient records ensures RMC clients compliance with reported HCCs, RAF scores, and appropriate reimbursement. Prior to coming to RMC in 2017, Ms. Campo held various HIM positions. Most recently, she held a position at a large regional healthcare network in which she was Quality Data Coordinator, responsible for review and abstraction of data in conjunction with CMS and TJC core measures, reporting results and education to stakeholders.

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Agenda

- What is Risk Adjustment
- Medicare Advantage, ACA & Medicaid
- How does HCC coding work?
- Documentation & Coding Guidelines
- Focus on Correct Coding
- Compliance Issues in Risk Adjustment

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What Is Risk Adjustment?

- CMS Program goal is to keep patients healthy, and accurately reimburse Health Plans that offer insurance to higher cost and sicker patients
- Patients elect to join a Medicare Advantage (MA) or ACA program through a specific health plan
- The Health Plan will receive funds annually to take care of patients for an entire calendar year (monthly payments)
- Payments to Health Plan based on the "illness burden" (chronic conditions/diagnoses), not quantity of services. Greater disease burden = greater revenue
- Health Plan in turn pays providers for care through RVU, DRG payments or shared savings contracts

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Risk Adjustment

A method used to adjust bidding and payment based on the health status and demographic characteristics.

Risk Adjustments calculations consider:
- Diseases that have significant impact on patient cost of care
- Demographic information such as age and sex
- Predictive in nature – uses information from current years to predict future year expenditures.

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Why is Risk Adjustment Done?

- To accurately reimburse providers and health plans to care for their patients - specifically higher risk patients. This is done using Risk adjustment scores AKA Risk Adjustment Factor (RAF) scores.
- Risk adjustment scores are higher for a patients with a greater disease burden, less for a healthier patient.
- The diagnosis codes reported on provider claims determine a patient's disease burden and risk score.
- Chronic conditions must be reported once per year.

> *Each January 1, the RA slate is wiped clean. All of your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.*

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Risk Adjustment is Taking Off!

- No longer just Medicare Advantage Program. Medicaid and ACA commercial plans now participate in Risk Adjustment
- Common payors with Medicare Advantage Risk Adjustment programs: Blue Cross, Providence, Kaiser, United Healthcare, Humana, Aetna …
  - 3,148 different MA plans for 2020
  - 34% of seniors insured under MA
- Some health plans in turn, share this increased revenue with providers and IPA associations
- EDUCATION for Providers is Key!

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Why Should You Care About Risk Adjustment?

- Payment models are rapidly moving away from fee for service to value-based compensation.
- As you enter into value-based contracts, how effectively providers describe the health status of their patients determines how much the organization will be compensated for the care of that patient the following year.
- In order to evolve to value-based compensation, providers must master risk adjustment coding.

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Ref 1
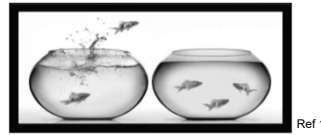
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How Does This Affect The Physician?

Complete and accurate reporting allows for more meaningful data exchange

- Identify potentially new problems early
- Reinforce self-care and prevention strategies
- Coordinate care collaboratively
- Avoid potential drug-drug/disease interactions
- Improve the overall patient health care evaluation process
- Improve office practice patterns and communication

Cont'd

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How Does This Affect The Physician?

It will also help you meet your own CMS provider obligations, which include the use of diagnosis coding standards in medical record documentation, reporting all conditions and diagnoses codes that exist on the date of an encounter and participating in CMS **Medicare Recovery Audit Contractor (RAC) and Risk Adjustment Data Validation (RADV) Audits.**

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Risk Adjustment Models

CMS-Medicare Advantage 2004	HHS- ACA/Commercial 2014	Medicaid 1997
Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)	Developed by the Department of Health Human Services (HHS)	Borrows models from Multiple Sources. HCC's, CDPS
CMS also developed a CMS RxHCC model for risk adjustment of Medicare Part D population	Designed for commercial payer population	Aggregated and budget Neutral
Based on age population (over 65)	Includes all ages	Includes all ages

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Medicare/ACA Advantage Facts

MA Facts:
- 22 million people on Medicare Advantage (MA) plan
- Nationally 34% of all Medicare beneficiaries are on an MA Plan

ACA FACTS:
- 13.7 million people enrolled in ACA insurance plans
- 11.4 million enrolled in Marketplace plans

Medicaid facts:
- Dependent on State eligibility guidelines

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The Future of Risk Adjustment!

- The Risk Adjustment "enrollments" have increased 10-fold in 10 years
- The model plan for the ACA, Medicaid (and potential pilot groups for employer-based insurance plans)
- Health Plans are getting smarter
- There is ALWAYS FRAUD!

Compliance is key – **CODE IT RIGHT**!

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Risk Adjustment Model – HCC's

- Payments made to Health Plan based on Hierarchical Condition Codes or HCC's.
- Patients are assigned HCC's based on their ICD-10 diagnosis codes submitted on claims throughout the year (all claims – providers, hospitals, etc.).
- There are 79 HCC's in the MA model.
- There are 127 HCC's in the ACA model.
- There are 268 CDPS categories in Medicaid

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HCC Reimbursement Model
How it works!

- County rate
  - Between $700-$1200 (Sacramento Co. - $901.77)
- Demographic Rate
  - (age, sex, location, eligible for Medicare/not)
- HCC/RAF score
  - Each HCC has a specific RAF score

**County rate x (demographic rate + RAF score) =
Monthly Capitation Rate**

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HCC Reimbursement Model
How it works!

- Ruby Mae lives in Sacramento, Ca. According to the CMS spread sheet, Sacramento county has a "county rate" of $901.77. She is 94 years old, still lives at home and is eligible for Medicare her demographic conversion factor is 0.85. She has uncomplicated diabetes (0.18), stable angina (0.14) and schizophrenia (0.61).
- 901.77 x 1.78
  - 1.78 (0.85 + 0.18 + 0.14 + 0.61)
- $1605.15 = Monthly capitation rate

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Risk Adjustment Coding Example

No conditions coded		Some conditions coded		All chronic conditions coded	
76-year-old female	0.442	76-year-old female	0.442	76-year-old female	0.442
Medicaid eligible	0.151	Medicaid eligible	0.151	Medicaid eligible	0.151
DM with complications	X	DM w/o complications	0.118	DM with complications	0.368
Vascular disease	X	Vascular disease	x	Vascular disease	0.299
CHF	X	CHF	x	CHF	0.368
Disease interaction (DM +CHF)	X	Disease interaction (DM +CHF)	X	Disease interaction (DM +CHF)	0.182
Total RAF	**0.593**	**Total RAF**	**0.711**	**Total RAF**	**1.810**

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Risk Score Coding Payment Example

No conditions coded		Some conditions coded		All conditions coded	
Total RAF	0.593	Total RAF	0.711	Total RAF	1.810
Medicare rate estimate	$800	Medicare rate estimate	$800	Medicare rate estimate	$800
Monthly payment (PMPM)	$474	Monthly payment (PMPM)	$569	Monthly payment (PMPM)	$1,448
Yearly payment (PMPY)	$5693	Yearly payment (PMPY)	$6,825	Yearly payment (PMPY)	$17,376

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MA-HCC Examples

- HCC 1 – HIV, AIDS
- HCC 8 - 12, 46 & 48 - Malignant Neoplasms
- HCC 17 – 18- Diabetes with chronic complications
- HCC 19 - Diabetes without complications
- HCC 39 - Osteonecrosis

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ICD-10 Codes Mapped to HCC

- When a provider submits a diagnosis code such as:
  - E11.9 Type 2 diabetes mellitus without complications

    This code is mapped to **HCC 19** Diabetes

	E1169	Type 2 diabetes mellitus with other specified complication	18	Yes
1699				
1700	E118	Type 2 diabetes mellitus with unspecified complications	18	Yes
1701	E119	Type 2 diabetes mellitus without complications	19	Yes
	E1300	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	17	Yes
1702				
	E1301	Other specified diabetes mellitus with hyperosmolarity ...	17	Yes

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MA Disease Groups – HCC's

- 9,900+ ICD-10 codes in the CMS HCC model are divided into disease groups or "Hierarchical conditions"
  - **Examples of conditions:**

        -Infections   -Neoplasms

        -Diabetes   -Blood Diseases

        -Substance abuse   -Lung Diseases

        -Artificial openings/Ostomies

  - Model is not all inclusive, so many diseases are not included

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Medicare Advantage
Risk Adjustment

- Most acute conditions are not included in model:
    - Appendicitis
    - Wrist Fracture
- BUT! Some major acute conditions are:
    - Hip fracture
    - CVA (Stroke)
    - MI (Heart attack)

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ACA Disease Groups/HCC/DX

- HIV (Z21)
- Low birth weight status (P05.01-P07.39)
- Postpartum care and examination (Z39.0-Z39.2)
- Organ or tissue replaced by transplant (Z94.0-Z94.840)
- Organ or tissue replaced by other means (Z95.811-Z99.120)
- Artificial opening status (Z93.0-Z93.9)
- Other dependence on machines (Z99.11-Z99.12)
- Lower limb amputation status (Z89.411-Z89.619)
- Fitting and adjustment of artificial leg (Z44.101-Z44.129)
- Attention to artificial openings (Z43.0-z43.9)
- Long term use of insulin (Z79.4)

LOTS MORE, NOT ALL INCLUSIVE

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ACA vs. MA

- Many more Dx/Codes- Includes pregnancy, newborn complications, developmental disorders, autism, acute pancreatitis, eating disorders, etc..
- HCCs not in ACA
  - Obesity/BMI
  - Acute Kidney Injury
  - Alcohol/Substance Abuse
- Frequently found
  - Asthma

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HCC Rules

- HCC payments are additive
  - Each HCC has an individual payment
- Hierarchy trumping
  - 3 Diabetes levels
- Metastatic vs. Neoplasm
- Paid prospectively for MA, but concurrently for ACA and Medicaid
  - MA- Disease captured in 2019 are paid in 2020.
  - ACA & Medicaid: Disease captured in 2019 set payment for 2019

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Outranking/Trumping - How It works

HCC	If the HCC Label is listed in this column...	...Then drop the HCC(s) listed in this column
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
135	Acute Renal Failure	136,137
136	Chronic Kidney Disease (Stage 5)	137

How Payments are made with a Disease Hierarchy:
- In a "disease group" of HCC's such as HCC 8, 9, 10, 11, 12 (all neoplasm HCC's) – annually only the HCC with the lowest number (equates to highest reimbursement) will be paid.
- If a beneficiary triggers HCC 135 (Acute Renal Failure) and HCC136 (Chronic Kidney Disease (Stage 5)), then HCC 136 will be dropped.

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Documentation – Job # 1

Not Documented, Not Done

Ref 2

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Physician Documentation

- Accurate coding is dependent on clear and specific provider documentation in the patient's medical record.

- Code all documented conditions that exist at the time of the encounter, and require or affect patient care, treatment or management
  - -ICD-10-CM Official Guidelines for Coding and Reporting

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Physician Documentation

Compliant documentation requires:
- Signature
- Date
- Legibility
- Patient Name

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Why Coding Matters

- Inclusion of chronic conditions considered in the medical decision making for Evaluation and Management (E&M) will allow for better health management.
- Complete patient diagnosis coding allows for the member to be included in any number of quality management programs offered by the Payer.
- Appropriate diagnosis code reporting and complete clinical documentation by the provider increases the member's risk score while closing the gaps of care.
- Best Practice - Perform an annual comprehensive visit on all members. This will also allow quality, STAR and HEDIS measures to be met at one time.

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THE GOLDEN RULE

"Document for others as you would want them to document for you."

Ref 3

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EMRs Friend or Foe?

- Cut/Copy and Paste
- Drop downs
  - Code prompts/HCC prompts
  - Troublesome diagnosis
- Need to be wary
- Policies and Procedures

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Reporting a Diagnosis

Each diagnosis code must be documented, then reported **<u>once annually</u>** to be included in risk scoring.

But…only once!

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Missing Codes?

Physician offices do not always code to highest level of specificity or include all eligible diagnosis codes on claim.

Average physician claim includes 1.6 diagnosis codes per claim.

<u>This is low!</u>

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Documentation

- Documentation in a patient's medical record must be by a qualified health care provider. This must be a MD, DO, NP, or PA
- Documentation must support a FACE to FACE visit
- Documentation must support the presence of the condition and indicate the provider's assessment and/or plan for management

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Where Can You Find Diagnosis Codes?

Anywhere in the medical record!

As long as the condition is supported by MEAT, and reflects <u>objective findings from the physician</u>, you may use all areas of the medical record including PMH, HPI, or Final Assessment,

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Audit Tools for Documentation
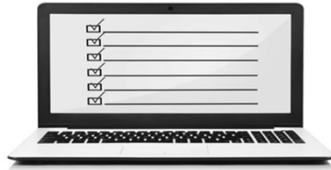
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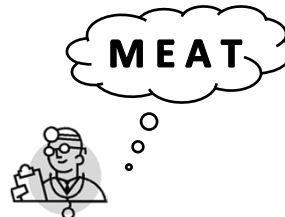
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The "M.E.A.T" Auditing Approach

- Documentation must prove that the patient's condition(s) were:
  - **M**onitored
  - **E**valuated
  - **A**ddressed
  - **T**reated

Review documentation to find specific elements that constitute **MEAT**.

MEAT

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More on MEAT

Monitor	Signs/Symptoms
	Disease progression/regression
Evaluate	Medication & effectiveness Responses to treatment
	Test results and lab work
Address	Order tests or lab work
	Discuss results
	Counsel
	Review records
Treat	Prescribe / Alter medication
	Start / Initiate therapies

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T.A.M.P.E.R

Along with MEAT, the following is also used in coding:

- **T**reatment
- **A**ssessment
- **M**onitor/Medicare
- **P**lan
- **E**valuate
- **R**eferral

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Elements of TAMPER

Treat	Prescribe or alter medications	Treatment is presumed to be evidence of evaluation of the condition, and existence of the diagnosis.
	Initiate or adjust therapies	
	Start other modalities	
Assess	Document current diagnosis	
	Order tests or diagnostic studies	
	Discuss, Counsel or Advise	
Monitor	Signs	
	Symptoms	
	Disease progression	
	Disease regression	
Plan	Document the future care	
Evaluate	Effectiveness of medication(s)	
	Response to treatment	
	Test results	
Refer	Referred to	
	Follow up	

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Utilizing MEAT and TAMPER

- Controversial
- Not "official" guidance
- Adopted by many to assist in proper code capture

- RMC is neutral on MEAT/TAMPER

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Specificity Counts

Coding guidelines state diagnosis codes are to be used at their highest level of detail. Documentation is key to accomplishing this.

What condition does the patient actually have?				
If your assessment says:	**It codes to:**	**Or…**	**If your assessment says:**	**It codes to:**
"*Depression*"	- **F32.9**, Depressive disorder, not elsewhere classified	→	"*Mildly severe recurrence of major depression*"	- **F33.0**, Major depressive disorder, recurrent episode, mild
"*Dysrhythmia*"	- **I49.9**, Cardiac dysrhythmia, unspecified	→	"*Atrial fibrillation*"	- **I48._**, Atrial fibrillation
"*Bronchitis*"	- **J40**, Bronchitis, not specified as acute or chronic	→	"*Chronic obstructive bronchitis*"	- **J44.9**, Obstructive chronic bronchitis

If a condition is a specific disorder, or is chronic or recurrent, use that terminology.

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ICD-10 Coding in RA

Ref 5

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Challenges in ICD-10 Coding

- Transition from ICD-9 to ICD-10 in 2015
- Training on the new codes and coding guidelines was mixed
  - Some providers/coders/HIM people received extensive training
  - Others received little to no training
- The lack of knowledge of the current codes/guidelines can lead to compliance issues

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Targets For Improvement

Documentation Targets for ICD-10:
  - Laterality – Left/right
  - Muscle/vessel specificity
  - Side of dominance (left, right, ambidextrous – dominant and non-dominant too!)
  - Specific site, side and type, for fractures
  - Type of Encounter – Initial, Subsequent, Sequela
  - Cause of Injury (poisoning vs adverse effect)

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Targets for Improvement

Targets for Improvement & Moving Forward!!
- Acute vs Chronic
- "History of" …Stroke, MI, Cancer
- Unaddressed Diagnoses (historical)
- Conditions treated by specialist

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Targets for Improvement

Coding:
- Know and adhere to the national coding guidelines ("Official Coding Guidelines")
- Need to isolate reasons why some codes are not captured or captured when they should not be.
- Diabetic Manifestations are frequently overlooked.
  - Can code both E11.22- Diabetic Chronic Kidney Disease 3 (HCC 18) AND N18.3 Chronic Kidney disease, stage 3 (HCC 138)
- Historic conditions should <u>not</u> be coded
  - Old CVA, Old MI, History of Cancer (no longer under treatment)

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Targets for Improvement

Coding (continued):

- Chronic conditions not coded if the patient is being seen for another complaint.
- Chronic conditions are being managed by a specialist, so the PCP does not code them, these can be coded!

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Focus on Correct Coding

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Use the Guidelines!

- Coding must be in accordance w/national coding guidelines (the Official Coding Guidelines "OCG"):
  - *ICD-10 CM Official Guidelines for Coding and Reporting*
  - https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM
  - Located in all code books
  - Updated frequently
- CMS (MA) and HHS (ACA) have HCC specific HCC guidelines

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Use the Guidelines!

- Even with National Coding Guidelines, CMS/HHS HCC specific guidelines there are still grey areas
- Each entity should create internal guidelines
- Supplement CMS/HHS not contradict
  - Creating more definition of the grey areas
  - Gives the coders a more specific set of guidelines
    - Allows for higher accuracy

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Use the Guidelines!

- Coding Clinic
  - Quarterly Published Guidance
  - Official as per HIPAA
  - Advice from Coding Clinic goes hand in hand with OCG
  - Entities can submit questions – via email to AHA Coding clinic

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Frequently Not Coded Conditions

- CHF
- Angina
- Atrial Fibrillation
- COPD
- Compression Fractures
- Seizure Disorder
- Hx of Alcoholism (not etoh "abuse")

- Psychoses
- Rheumatoid Arthritis
- Polymyalgia Rheumatica (PMR)
- History of Amputation
- Transplant Status
- Dialysis Status

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Coding Focus: Diabetes

**Diabetes Mellitus and Associated Manifestations –
A.K.A Diabetes <u>With</u>**

According to the ICD-10-CM Official Guidelines for Coding and
Reporting, the term "with" means "associated with" or "due to," when it
appears in a code title, the Alphabetic Index, or an instructional note in the
Tabular List, and this is how it's meant to be interpreted when assigning
codes for diabetes with associated manifestations and/or conditions. The
classification assumes a cause-and-effect relationship between diabetes and
certain diseases of the kidneys, nerves, and circulatory system. Assumed
cause-and-effect relationships in the classification are not necessarily the
same in ICD-9-CM and ICD-10-CM……… continued…..

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Coding Focus: Diabetes

……..<u>**However**</u>, if the physician documentation specifies diabetes mellitus is
not the underlying cause of the other condition, the condition should not be
coded as a diabetic complication. When the coder is unable to determine
whether a condition is related to diabetes mellitus, or the ICD-10-CM
classification does not provide coding instruction, it is appropriate to query the
physician for clarification so that the appropriate codes may be reported. (See
ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.15.)

* See Coding Clinic, First Quarter 2016, Page 11 for full details

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Coding Focus: Diabetes

Diabetes Mellitus and Associated Manifestations

Example from the Alphabetic Index:

Diabetes, diabetic (mellitus) (sugar) E11.9

"With"

amyotrophy E11.44

arthropathy NEC E11.618

autonomic (poly) neuropathy E11.43

cataract E11.36

Charcot's joints E11.610

chronic kidney disease E11.22

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Coding Focus: Diabetes

Diabetic Manifestations are frequently overlooked
EXAMPLE:

- **E11.21, Type 2 diabetes mellitus with diabetic nephropathy** (HCC 18)
  - **N18.5, Chronic Kidney disease (stage 5)** (HCC 136)
  - Only CKD stages 3,4, 5 and End stage renal disease are HCC valid

- **E11.621, Type 2 diabetes mellitus with foot ulcer** (HCC 18)
  - **L97.511, Non-pressure chronic ulcer of right foot limited to breakdown of skin (HCC 161)**

- **E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene** (HCC 18)
  - **I73.9, Peripheral angiopathy (PVD)** (HCC 108)
  - Both same HCC but both should be coded

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Coding Focus: NEOPLASMS

- Malignant neoplasms are to be coded when the patient is receiving <u>any</u> care or **MEAT**

- If the patient is refusing treatment, the provider may still be addressing the condition and the appropriate neoplasm code should be assigned.

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Coding Focus: Metastatic NEOPLASMS

Caution:

- Be careful when coding metastatic neoplasms, as documentation may not be clear as to whether it is the primary or secondary site.
- Investigate whether it is metastatic "to" breast (secondary) or metastatic "from" breast (primary)
  - **Important because metastatic neoplasm (HCC 10) carries a higher HCC than the primary neoplasm (HCC 12)**

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Coding Focus: History of Neoplasm

- Caution when assigning a code for history of malignant neoplasm.
- If patient is receiving treatment (i.e.. Chemo) for a neoplasm that has been excised – assign a neoplasm code, C00 – D49.
- If patient is no longer receiving treatment for neoplasm – assign a personal history of neoplasm code from category Z85

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Coding Focus: Breast Cancer

- **When to code breast cancer**
  - Patient is receiving active treatment
  - Breast cancer has reoccurred
  - Patient elects to not treat
  - Patient chooses palliative care

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Coding Focus: Alcohol and Drug Abuse (MA)

- Code what is documented, and document accurately!
  - "Dependent" is HCC
    - "non-dependent" is not HCC
    - "alcoholism" is HCC
- Without documentation, coder must default to "non-dependent" (no HCC)

*Frequently cases coded to **F10.20, Alcohol dependence, uncomplicated** (HCC 55) – but "dependence" not stated.*

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Coding Focus: Hepatitis (MA/ACA)

Viral Hepatitis Terminology

- Common types:
  - Hepatitis A – "infectious hepatitis"
  - Hepatitis B – "serum hepatitis"
  - Hepatitis C – highly likely to progress and cause cirrhosis, liver failure, liver cancer
- Less common types:
  - Hepatitis D – Only occurs in associated with Hep B
  - Hepatitis E – less likely to progress to chronic hepatitis

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Coding Focus: Hepatitis (MA/ACA)

Documentation to appropriately code Hepatitis
- **TYPE** (viral type)
- **SEVERITY** (acute or chronic)
- **ASSOCIATED "with (or without) hepatic coma"**

If Hepatitis B
- **ASSOCIATED "with (or without) type D co-infection"**
  (hepatitis delta or delta-agent)

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Coding Focus: Hepatitis (MA/ACA)

Timeframe for Hepatitis

　　　Acute – < 6 months of symptoms

　　　Chronic – 6 months + of symptoms

- To code timeframe, it needs to be documented
- If documentation states that patient has both chronic & acute, assign a code for both.

Hepatitis carrier is one whose symptoms have cleared, but the disease is still found in blood. Documentation must state that patient is a "carrier" and cannot be inferred because no symptoms are listed. **Z22.5, Carrier of viral hepatitis (No HCC)**

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Coding Focus: Myelodysplastic Syndrome (MA/ACA)

Myelodysplastic Syndrome (MDS), D46.9 is a blood and marrow disease that occurs when the bone marrow does not make enough healthy blood cells and the marrow cells are damaged.

Myelodysplasia of the spinal cord is a congenital anomaly and coded to Q06.1

Review the documentation and confirm the diagnosis with MEAT from the provider. NEVER ASSUME!

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Potential MEAT: Myelodysplastic Syndrome (MA/ACA)

- Patient receiving care from either a hematologist or oncologist.
- Observation of blood cell counts{ CBC)
- Transfusion and chelation therapy
- Erythropoiesis-stimulating agents(ESAs) and other growth factors
- Anti thymocyte globulin(ATG) therapy
- Drug therapy (Azacytidine and decitabine)
- Chemotherapy
- Allogenic stem cell transplantation
- Clinical trials

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Coding Focus: Lymphoma (MA/ACA)

- Lymphoma patients who are in remission are still considered to have to lymphoma and should be assigned with the appropriate code from C81 – C88
  - However, if "history of" documented, assign history (Z) code
- AHA **Coding Clinic** for ICD-9-CM, 1992, second quarter, page 3

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Coding Focus: Morbid Obesity & BMI (MA)

- A non-provider (RN, MA) may document the BMI, but to report the BMI (as a secondary diagnosis), a related diagnosis (overweight, obesity, morbid obesity) must be documented by the provider.

Example:
- Vital signs: BMI: 42.1. Provider documentation states patient is "overweight".
  - **E66.3, Overweight** (No HCC) *BUT ALSO INCLUDE*
  - **Z68.41, Body mass index 40.0-44.9, adult (HCC 22)**

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Coding Focus: Depression (MA)

- Depression, NOS is coded F32.9 – no HCC
- Depression & Anxiety is coded F41.8 – no HCC

Improve documentation!
- **F33.0 is Major depressive disorder, recurrent** (HCC 55).
  - Which is the code for recurrent episodes of depressive reaction, and likely the case for instances when "depression, NOS" is documented

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Coding Focus: Chronic Kidney Disease (MA/ACA)

- CKD is often a complication of another serious condition, (i.e.. Diabetes mellitus, hypertensive heart disease).

- In ICD-10 these complications should be captured with the combination code.

- Review the Index and Tabular carefully!

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Coding Focus: Chronic Kidney Disease (MA/ACA)

- **ICD-10-CM Classifies CKD based on severity. The severity of the CKD is designated by stages 1-5**
  - N18.1 Chronic kidney disease, stage 1
  - N18.2 Chronic kidney disease, stage 2 (mild)
  - N18.3 Chronic kidney disease, stage 3 (moderate)*/-
  - N18.4 Chronic kidney disease, stg 4 (severe) */**
  - N18.5 Chronic kidney disease, stage 5*/**
  - N18.6 End stage renal disease */**

  *=MA; **=ACA; -= no HCC

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Coding Focus: Dialysis Status (MA/ACA)

Review documentation for dialysis treatment, frequently these codes are not assigned but can be HCC 134 on MA.

Z99.2, Dependence on renal dialysis (HCC 134-MA only)

   Also the same code for a patient with a surgically created arteriovenous fistula for the purpose of dialysis – even if treatment hasn't started

Z91.15, Patient's noncompliance with renal dialysis (HCC 134 – MA only)

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Coding Focus: CVA

- Cerebrovascular accident (CVA) is decreased blood to the brain which causes an infarction.
- This condition is acute.
- CVA and Stroke are often used interchangeably
- Acute CVA codes rarely occur in the outpatient setting – unless the patient develops CVA while in clinic and is transferred to the Hospital for inpatient care.
- Documentation of history of stroke w/o neurological deficits – assign **Z86.73, personal history of TIA, and cerebral infarction without residual deficits** (No HCC)

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Coding Focus: Sequela of CVA

- **I69, Sequelae of cerebrovascular disease** codes are used for neurological deficits caused by CVA, or diseases classifiable to I60-I67.
- Common sequelae of CVA is hemiplegia/hemiparesis or monoplegia. ICD-10 requires documentation of "dominance" of the affected side. If documentation does not indicate dominance, select code based on the following:
  - Left side is affected – default is non-dominant
  - Right side is affected – default is dominant
  - Ambidextrous patients – default is dominant

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Coding Focus: Sequela of CVA

- Coding Clinic, Vol.2 No 1 1st Qtr. 2015:

  "Unilateral weakness that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis/hemiplegia."

  Example patient - History of left hemisphere stroke; patient has right-sided weakness (I69.351)

The patient with history of CVA, and hemiparesis. Together, this makes them classifiable as late effects/sequelae CVA/Stroke that is appropriate to category I69.

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Coding Focus: Hemiparesis vs Hemiplegia

- **Hemiplegia** is the *paralysis* of one side of the body
- **Hemiparesis** is the *weakness* of one side of the body

Documentation MUST state "hemiplegia" or "hemiparesis" to assign a code from category **G81.-** (HCC 103)

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Coding Focus:
Pulmonary Embolism

- Pulmonary embolism may be an acute event or chronic condition, not based on timeframe, but on provider documentation.
- **Coding for anticoagulant use**
- Patient may be treated with anticoagulant to treat chronic pulmonary embolism (HCC), or personal history of PE (No HCC). Review documentation!
- Be sure to assign **Z79.01, Long term (current) use of anticoagulants** if pertinent (No HCC)

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Coding Focus:
Peripheral Vascular / Artery Disease

- Peripheral **vascular** disease is a condition that results in reduced blood flow to the extremities.
- Peripheral **artery** disease is a more specific diagnosis for the same condition.
- PVD, PAD and intermittent claudication index to **I73.9, Peripheral vascular disease, unspecified** (HCC 108, MA only) with an EXCLUDES1 note referring to atherosclerosis of the extremities.

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Coding Focus:
Peripheral Vascular / Artery Disease

- PAD caused by atherosclerosis of the extremities must be reported with codes that describe:
  - Etiology
  - Site
  - Manifestation/complication

EXAMPLES:

- **I70.219 Atherosclerosis of native arteries of extremities, with intermittent claudication, unspecified extremity** (HCC 108)
- **I70.741 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of thigh** (HCC 106)
- **E11.51 Type 2 DM with diabetic peripheral angiopathy without gangrene** (HCC 18)

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Coding Focus: Fractures

- Fractures to the hip and femur can be captured as HCC

ICD-10 specificity now requires more clinical concepts to be addressed in the documentation.

- **Site**
- **Laterality**
- **Type of fracture**
- **Displaced / Not Displaced**
- **Closed / Open (Gustilo classification)**
- **Encounter (Initial, subsequent…)**

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Coding Focus: Compression Fractures

- Compression fractures can be traumatic or pathologic/nontraumatic.
- Fracture terminology:
  - Spontaneous = pathologic
  - Chronic = current fracture
- Healing or healed compression fractures should be assigned a code from **Z87.31-, personal history of (healed) nontraumatic fracture**

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Coding Focus: Osteoporosis

- Age-related osteoporosis is a systemic condition.
- Cannot code compression fracture + osteoporosis (stated separately) and get a pathological fracture, there must be documentation linking the conditions to each other. ICD index:

    Osteoporosis(female) (male)   M81.0

        with current pathological fracture   M80.00

        age-related   M81.0

        » with current pathologic fracture   M80.00

        » carpus   M80.04-

        » clavicle   M80.01-

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Coding Focus: Atrial Fibrillation with Pacemaker (or Ablation)

The utilization of a Pacemaker, or Ablation for Atrial Fibrillation is intended to stop the arrhythmia. In some patients this is not always the case.

- Atrial Fibrillation documented in chart
  - If mention of Pacemaker (or Ablation) and no other care documented, do not code.
  - If documentation of medication (Lasix, Metoprolol, etc..), even with the mention of pacemaker (or ablation), code the Atrial Fibrillation.

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Coding Focus: Ventilation Status

- If a patient is admitted and ends up intubated due to a medical condition, that would not be coded as dependence on ventilator (ventilation)
- But if a patient comes in already on long term use of ventilation, the status code, Z99.11 – Dependence on respirator (ventilator) status, would be coded.

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Coding Focus: Amputation Status/Presence of Ostomy

- Correct coding of both Amputation and Ostomy Status depends on where the condition was noted.
  - HPI, A/P, Physical Exam, etc.. within a chart note
  - Coding the condition from an Op Note, when the procedure occurs is not acceptable. It would be coded on subsequent encounters.

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Compliance Issues: What to watch for

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Common Coding Errors

- Medical record does not contain a legible signature and credentials.
- Electronic medical record (EMR) was unauthenticated (not electronically signed).
- Highest degree of specificity was not assigned; the most precise ICD-10 to fully explain, a narrative description of the symptom or diagnosis in the medical chart.
- Documentation does not indicate the diagnosis is being monitored, evaluated, assessed/addressed, or treated (MEAT).

- Status of cancer is unclear. Treatment is not documented.

Cont'd

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Common Coding Errors

- Chronic conditions such as hepatitis or renal insufficiency, are not documented as chronic.

- Lack of specificity (see previous slide)

- Chronic conditions or status codes aren't documented in the medical record at least once a year
- A link or causal relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

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Compliance Issues in RA:

- Reporting Accurate Codes
- Who's doing the Coding?
- Coder Education
- Provider Education
- Internal & External Audits
- Tips, Tricks & Tools

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Reporting Accurate Codes

Overall Goal:

Report accurate & compliant data/codes!
- Ensure you are using the most recent ICD-10 codes

How can we do this?
- Audit the data
- Use credentialed coders/auditors
- Use compliant tools

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Who's Doing the Coding!?

Who is doing the Coding/Auditing? These individuals are the "Gatekeepers" of good coding, data and reimbursement.

Ideally: Experienced & Credentialed Coders (<u>required</u>)

Credentials from either association:
– AHIMA – American Health Information Management Association (RHIA, RHIT, CCS, CCS-P)
– AAPC – American Academy of Professional Coders (CPC, COC, CRC, etc..)

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Coder/Auditor Education

Key to success - education!
1) Initial RA/HCC education and training
2) Initial quality reviews of work by experienced coder
3) Work performed in accordance with organization policies
4) Regular reviews
5) Ongoing education
6) Focus on quality coding, not upcoding or down coding
7) Coding guidelines change regularly – keep current!
8) Credential maintenance is required

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Provider Education

Key to success - education!

Depending on Organization, education may come in many forms for providers.

1. Initial education for new Providers
2. Regular education for all Providers – either general RA coding related education or targeted results rom sample audits (by Provider)
3. Trending of statistics by Provider (or Clinic, Specialty, etc.) can be helpful in isolating weak areas. These can then become areas to target for education.

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Internal & External Audits

For Compliance purposes, organizations must do compliance auditing (See OIG Compliance Program Guidance for Medicare +Choice Organizations – 1999).

– Auditing can be performed internally, external or combination
– External important to show due-diligence
– 100% or Probe audits
– Issues identified need to be corrected and monies returned
– Done in accordance with Compliance Plan of the Organization
– Education & Feedback from audits given to Providers and Coders/Auditors as appropriate.

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Tips, Tricks & Tools

#1 Tip – Hire the RIGHT People!
- Not all coders are alike – find the most experienced and credentialed Team
- If doing Provider Education – get educators! Coders that like to educate Providers.
- Test, interview, ask pointed questions, do they fit in with your corporate culture?
- The success of your program rests with your Team!

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Trips, Tricks & Tools

#2 Tip – Have written Coding Guidelines
- All coders/auditors must for the "OCG" (Official Coding Guidelines)
- If no "OCG" for a specific issue, Team must develop internal Coding Guidelines. These should be well thought out and even vetted by writing Coding Clinic if needed
- Update regularly
- Educate Team on Guidelines and Updates

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Tips, Tricks & Tools

#3 Tip – **Audit & Educate Regularly**

- – Audits are important for Compliance, but also to isolate areas needing education
- – Educate Coders & Provider
- – Audit for over coding and under coding
- – Perform follow-up audits as needed
- – Refund money as appropriate

This is **SUPER** important – to have a Compliant Program

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Tips, Tricks & Tools

Develop performance reports for your doctors

- • Coding recapture rates- What was coded last year and what you have coded this year
- • Coder feedback reports for problem areas
- • RAF trend reports

Negotiate better rates, or shared savings contracts with your payers because you do such an awesome job coding!

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Tips, Tricks & Tools

Use of NLP (Natural Language Processor)

- NLP's very commonly used in performance of coding audits
- Use can vary from organization to organization
- Can be used to isolate encounters with potential errors (potential codes to delete or potential codes to add)

Use of Pre, Post encounter risk adjustment tools to "scrub" medical record for hidden conditions, and ensure accurate documentation

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Tips, Tricks & Tools

Use of NLP (Natural Language Processor) continued:

PRO's for Using an NLP:

- Cost savings
- Efficient use of Coder/Auditor times
- Great for targeting specific issues

CON's for Using NLP:

- Savings can be diminished if rework required by coders
- Only typed chart notes accepted (or higher accuracy rates)

Bottom-line – do your homework to determine if NLP is right for you!

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In Summary

- Coding must represent patient profile of care and treatment rendered
- Documentation is KEY!
- Utilize and follow National Coding Guidelines
- Audits are key for Compliance

- **Proper documentation and accurate coding will result in appropriate and compliant reimbursement**

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THANK YOU

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Questions?

We LOVE THEM! Please email us @

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