Educating Providers in Risk Adjustment from a Clinical Perspective

Presented by:
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Objectives: Educating Providers

- Learn the **importance of specific physician documentation** to generate correct ICD-10 code for assignment to appropriate Hierarchical Condition Category (HCC).

- Suggestions on **how to educate your physicians** on how to document necessary **verbiage** from a **clinical perspective**.

- Understand why improved clinical documentation **improves quality, RAF scores, and more appropriate reimbursement**.

- Relationship between accurate and precise documentation, **ICM-10 codes**, **risk adjustment**, and **STARS** measures.
1. Establish relationship of mutual respect

2. Be sure you have a **good clinical understanding** of all HCCs, associated disease processes, and clinical terminology to best educate providers.

3. Ask for **providers’ input** and concerns, identify leadership

4. Reward results: Quantify potential **financial incentives**

5. Educational programs that work with **providers’ schedules**

6. Offer **support** to help optimize risk adjustment, quality measures and data entry
Where to begin:

Understand resistance to change:

- Busy schedules
- Work overload
- Inadequate rest and self care
- Extreme chronic stress
- Possible burnout
Burnout  Z73.0

Z73.1  Type A personality

Z73.2  Lack of relaxation and leisure

Z73.3  Stress not elsewhere classified

R45.4  Irritability and anger

R45.2  Unhappiness

R45.3  Apathy

e tc....
Surgeon General Vivek Murthy, MD, MBA on Physician Burnout

“Medicine is a profession in which emotional well-being is sorely lacking...The suicide and burnout rate is very high.”

“As I think about the emotional well-being for our country, I am particularly interested in how to cultivate emotional well-being for healthcare providers. If healthcare providers aren’t well, it's hard for them to heal the people for whom they are they caring.”

“...a growing concern about emotional well-being emerged ‘from conversations I had with community members, and it is based on the science developed over the years that tells us emotional well-being is an important driver of health’.”

“But there's a growing body of science that tells us there are things we can do to develop our emotional well-being proactively, and that in turn can have a positive impact on our health.”

-Vivek Murthy, MD, MBA to MedPage Today, April 10, 2016
Effects of Physician Burnout on Outcomes and Quality

Shanafelt TD et al, Mayo Clinic, Arch Intern Med. 2012; 172(18):1377-85

45.8% of 7200 physician responders to survey of 27,000 had at least one symptom of burnout

- Front lines: FP, IM, and ER had highest incidence

Christina Maslach, PhD.
http://psychology.berkeley.edu/people/christina-maslach

“Burnout:

- emotional exhaustion
- feelings of being emotionally overextended and exhausted by one’s work
- depersonalization
- an unfeeling and impersonal response towards recipients of one’s service, care treatment or instruction
- a reduced sense of personal accomplishment”
Effects of Physician Burnout on Outcomes and Quality

Society of Critical Care Medicine, 4/2/2013, Kristine A.K. Lombardozi, MD, FACS, FCCM

“Burned out physicians may be:
Angry, irritable or impatient (*sound familiar? provider abrasion?*)
Seem to treat patients as objects or to be simply emotionally depleted

Burnout is associated with:
Medical errors
Riskier prescribing profiles

Patients cared for by burned out physicians are:
less compliant
less satisfied with their care
Increased time to full recovery”
Educating Providers

The Medicare Advantage market will continue to grow and add many new providers who are unfamiliar with risk adjustment.

Don’t assume that providers understand coding, HCCs, or STARS
Clarify: What is risk adjustment? HCCs?

The precise documentation verbiage required to generate specific 3-7 character codes for diagnosis within family of codes.

Current HCCs, weights, and affect on appropriate reimbursement for patient’s severity of illness.

Define RAF scores and show examples of impact when HCCs are accurately and specifically documented.

Necessary documentation for active problems vs. PMH.

How accurate documentation improves quality.

Document EPDS encounter data
ICD-10 Structure

3 to 7 characters per code (varies)

--- --- .--- --- --- ---

**Category:** characters 1-3

1\(^{st}\) is letter (A-Z, except U)

2\(^{nd}\) is number

3\(^{rd}\) is generally number, some are letters

*If no further subdivisions available, category is code.*
ICD-10 Structure

6. **Subcategory**: 4-6 characters
   May be numbers or letters (upper or lowercase)

7. **Code**: 3-7 characters
   Provide available detail for coding highest number of characters

   *Avoid using unspecified codes or symptoms*

   When specificity of disease cannot be subdivided further, it is a code.
Physician Documentation Improvement

- Educate providers to expand clinical thinking to include improved documentation specificity for:
  - ICD-10-CM
  - Risk Adjustment (CMS-HCCs/MRA)
  - STARS

Providers appreciate consolidation of trainings
Rheumatoid Arthritis **Verbiage** in ICD-10

M05 Rheumatoid arthritis **with rheumatoid factor**

HCC 40

5 pages of codes ICD-10-CM manual

Familiarization with specific verbiage simplifies and streamlines provider documentation

M05._ complications- 4th character

M05.0 Felty’s syndrome
M05.1 Rheumatoid lung disease with RA
M05.2 Rheumatoid vasculitis with RA
M05.3 Rheumatoid heart disease with RA
M05.4 Rheumatoid myopathy with RA
M05.5 Rheumatoid polyneuropathy with RA
M05.6 RA with or M05.7 with RF without other organ or systems involvement
M05.8 Other RA with RF
M05.9 RA with RF unspecified (avoid using)

M05._ Joint(s)? vs multiple sites- 5th character
M05._ __ right/left?- 6th character
Rheumatoid Arthritis, DMARDs and STARS
(Disease Modifying Anti-Rheumatic Drugs)

Treatment is time sensitive:

When PCP diagnoses rheumatoid arthritis (RA) and refers to specialist for treatment, important for providers to communicate regarding time frame for initiating treatment with DMARDs for optimal results.

When diagnosis of RA is made (HCC), treatment with DMARDS is generated as a STARS measure (quality).

May require calls from PCP to specialist to arrange timely consultation, diagnostic testing, and initiation of treatment.

Update documentation in medical record to include diagnosis and treatment from specialist reports.
Physician Documentation Improvement

- **Provide tools** to improve documentation and capture HCCs

  **What do you use?**

  Ask providers how they think you came up with the potential diagnoses you are inquiring about...
Physician Documentation Improvement

Diagnosis noted in chart in the past?

Specialist consultations from the past?

Claims data?

Data Mining?

Labs/Xray reports?

Other?

Inquiries may seem more legitimate to the provider if they know where the questions are coming from.
Hierarchical Condition Categories (HCCs)

**CMS-HCC Version 22 (Medicare Advantage, Medicare Part C)**

**79 HCCs**

- The HCC categories are weighted by anticipated healthcare costs during the following year, so must be reported every year.
- 8800 of over 17,000 ICD-10 codes are included in an HCC Category.
- Medical conditions are hierarchically weighted within the categories.

**Risk Adjustment Scores** used to predict future healthcare costs by enrollee based on health status and demographics.

**CMS-RxHCC (Medicare Part D)**

**HSS-HCC (commercial payer populations)**
How are CMS HCCs calculated?

RAPS - Risk Adjustment Processing System

Demographics
- Age
- Sex
- Community vs. SNF
- Dual eligible (Medicaid)

Diseases = RAF score
- HCC categories
  - based on accurate ICD-10 codes for diagnoses
- Interaction between disease codes if applicable

Provider must assess and specifically document all diagnoses every year that are active/under treatment, or affect management of current conditions.
RAF- Risk Adjustment Factor

In addition to baseline demographics (RAF score < 1):

- **RAF Score** (higher if sicker)
  - RAF values assigned to HCCs for every relevant diagnoses
  - RAF values are additive
  - In some cases, there are extra points added for disease interactions
  - No RAF value added unless specific and accurate documentation by provider on every condition, every year
Introduce doctors to HCC Category Descriptions by relative weights

1. HCC 8  Metastatic Cancer and Acute Leukemia (approx. +2.6)
2. HCC 46  Severe Hematological Disorders
3. HCC 157  Pressure Ulcer of Skin (Stage 4)
4. HCC 110  Cystic Fibrosis
5. HCC 106  Atherosclerosis of Extremities with Ulceration or Gangrene (approx. +1.6)
6. HCC 158  Pressure Ulcer of Skin (Stage 3)
7. HCC 82  Respirator Dependence/ Tracheostomy Status
8. HCC 70  Quadriplegia
9. HCC 27  End-Stage Liver Disease (approx. +1.1)
10. HCC 73  ALS and other Motor Neuron Disease
Introduce doctors to HCC Category Descriptions by relative weights

11. HCC 9  Lung and Other Severe Cancers (approx. + .95)
12. HCC 71  Paraplegia
13. HCC 186 Major Organ Transplant or Replacement (except renal)
14. HCC 176 Complications of Specified Implant or Graft
15. HCC 188 Artificial openings for Feeding or Elimination
16. HCC 189 Amputation Status, Lower Limb/Amputation Complications (approx. + .72)
17. HCC 21  Protein-Calorie Malnutrition
18. HCC 83  Respiratory Arrest
19. HCC 10  Lymphoma and other Cancers
20. HCC 6  Opportunistic Infections (approx. + .64)
Introduce doctors to HCC Category Descriptions by most commonly used, commonly missed or most frequent documentation errors

<table>
<thead>
<tr>
<th>HCC 8-12</th>
<th>Malignant Neoplasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 18</td>
<td>Type 2 Diabetes Mellitis with Complications</td>
</tr>
<tr>
<td>HCC 19</td>
<td>Type 2 Diabetes Mellitis without Complications</td>
</tr>
<tr>
<td>HCC 22</td>
<td>Morbid Obesity</td>
</tr>
<tr>
<td>HCC 55</td>
<td>Alcohol/Substance Dependence</td>
</tr>
<tr>
<td>HCC 58</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>HCC 85</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>HCC 88</td>
<td>Angina Pectoris</td>
</tr>
<tr>
<td>HCC 108</td>
<td>Peripheral Vascular Disease/Atherosclerosis</td>
</tr>
<tr>
<td>HCC 111</td>
<td>COPD</td>
</tr>
</tbody>
</table>
ICD-10 Documentation Specificity and HCCs

• Providers should be introduced to all HCC categories. It may not occur to them to document some conditions (blind spots, i.e. amputation, etc...).

• Educate physicians in specific documentation verbiage for most commonly used diagnoses, and thought processes for necessary specificity
  • (i.e. laterality, single/recurrent, with/without, etc...)

• Insufficient documentation and use of “without complications” or unspecified codes may be insufficient to capture HCC, even if code is valid.
I like to show them some pages from the code book
Clinical Documentation Improvement for Providers

5 Questions to ask yourself to improve documentation of patient encounter:

SADSS
Can I be more **specific**?

Many providers have documentation deficiencies for the same common diagnoses: i.e. Type II Diabetes Mellitus.

Don’t jump to code E11.9 so fast...(HCC 19)

Are there any complications due to Diabetes (Type)?
Document **Type** of Diabetes (HCC)

**Type 1** - E10._ _ _

**Type 2** - E11._ _ _
   specify if long term (current) use of insulin

**Due to underlying condition** - E08._ _ _
   eg. Cushing’s; pancreatitis (chronic is HCC)

**Drug or chemical induced** - E09._ _ _
   eg. Steroids

**Other specified diabetes mellitus** - E13._ _ _
   eg. Due to genetic defects; s/p pancreatectomy
Type of DM: E08 to E13

Complications of each type of DM: E08._ to E13._ (4th character)

Specifics of each complication of each type of DM: E08._ _ to E13._ _ (to 5th character)

More detail about specifics of each complication E08._ _ _ to E13._ _ _ (to 6th or 7th character)
Document Specifics of Complications

i.e. E11.3_ _ _

Type 2 DM with ophthalmic complications requires 5 to 7 characters

Refer to ophthalmology consultation for accurate dx documentation

If no further subdivisions available, category is code.
Combination Codes

Type 2 Diabetes Mellitus with Kidney Complications E11.2

E11.21 Type 2 DM with diabetic nephropathy

E11.22 Type 2 DM with diabetic Chronic Kidney Disease
+ 2nd code representing stage CKD (N18.1-N18.6)
  Stage 4, Stage 5 and ESRD Risk Adjust- HCC

E11.29 Type 2 DM with other diabetic kidney complication
  eg. Type 2 DM with renal tubular degeneration

Document dialysis status Z99.2-HCC
**E11.52** Type II DM with diabetic peripheral angiopathy **with gangrene**

ICD-10: **1 five character code**
ICD-9: previously **2 codes** for DM with peripheral angiopathy
*(3 codes if with gangrene)*

**E11.59**- with other circulatory complications (+ code other)

**E11.51** Type II DM with diabetic peripheral angiopathy **without gangrene**
Diabetes with Complications HCC 18

Document:

- **DM with hyperglycemia/hypoglycemia**
- **DM with skin complications E11.62_**
  - Diabetic dermatitis/diabetic necrobiosis lipoidica
  - DM with foot ulcer E11.621
    
    use additional code to identify site L97.4_ _, L.97.5_ _
  - DM with other skin ulcer E11.622
    
    use additional code to identify site L97.1_ _ - L97.9_ _
    
    L98.41_ - L98.49_
  - DM with other skin complications E11.628
- **DM with oral complications E11.63_**
  - Periodontal disease/other
- **DM with diabetic arthropathy E11.61_**
  - Neuropathic/Charcot’s joints/other
Ulcers: Accurate and detailed description including location, size, depth, right/left

- E11.621: **Type 2** diabetes mellitus with **foot ulcer**
- L97.424: **Non-pressure** chronic ulcer of left heel and midfoot with necrosis of bone
A: Acuity/Chronicity

Document if problem is:

Acute? Chronic? Acute on chronic?

PMH (past medical history) vs. active/under treatment?

Affecting care of current condition?

Why on meds?
**A: Acuity/Chronicity**

PMH- how it was taught in medical school vs. how it is used in risk adjustment documentation

Make sure the doctors are clear about the difference. They must understand why to carefully document medical problems and chronic conditions that are active/under treatment. Chart must support the diagnoses.
1st chart incomplete: “Hep B” (no valid ICD-10 code)

2nd chart specified: B18.1 “chronic Hepatitis B”
(without delta agent is coded if not specified with)
Documentation needed for Viral hepatitis (B15-B19):

Chronic Hepatitis B (HCC 29) risk adjusts in perpetuity, but must be assessed and documented including a treatment plan every year.
Documentation needed for Viral hepatitis (B15-B19):

**Type** of Hepatitis: A, B, C, E, other, unspecified

**Acute** vs. **Chronic**

With/without **hepatic coma**

With/without **delta agent**

Familiarization with specific verbiage simplifies and streamlines provider documentation
Other chronic illnesses that risk adjust in perpetuity but must be assessed and specifically documented with treatment plan every year:

- HCC 1  HIV/AIDS
- HCC 40  Lupus/Rheumatoid Arthritis (vs. “arthritis”)
- HCC 85  Heart Failure
- HCC 111  COPD
- HCC 108  Atherosclerosis
- HCC 186  Transplants (except renal)
- HCC 188  Stomas and artificial openings
- HCC 189  Amputation (leg or foot)

Chart/diagnostic code must be updated if any complications develop...
Other chronic illnesses that risk adjust in perpetuity (even if in remission) but must be assessed and specifically documented with a treatment plan every year:

HCC 55  Alcohol/Drug Dependence
- Must be dependency to risk adjust (vs. use or abuse)
- Educate providers to review medications they prescribe and identify and document drug dependencies

HCC 58  Major Depression
- “Depression” is inadequate documentation
Documentation affects Risk Adjustment

HCC 58  Major Depression

**Document Episode:**
Major Depressive Disorder, single episode F32.
Major Depressive Disorder, recurrent F33.

**Document Severity:**
Mild
Moderate
Severe (single episode is **HCC** only if severity is documented)
**With/Without** Psychosis

**Document Partial/Full Remission** (if applicable)

**Major Depression risk adjusts (HCC)** if document every year
Even if in remission and no longer on medication
D: Is the diagnosis **Due to** coexisting/comorbid condition?

- Document cause and effect
- Lots of combination codes in ICD-10
Documentation for Combination Codes

Document complications as *cause and effect*

“due to___” “with___” “diabetic___” “hypertensive”

*Can’t code* “possible”, “probable”, “consistent with”, or “and”

4 I11 Hypertensive heart disease HCC 85

I11.0 Hypertensive heart disease **with** heart failure
use additional code to identify type of heart failure (I50.-)

I11.9 Hypertensive heart disease **without** heart failure

Provider must document that heart failure is “due to” hypertension.

This is not automatically assumed as in the case of
I12 Hypertensive chronic kidney disease codes HCC 136.
S: Does medical record support dx?

- history
- physical findings
- assessment
- treatment plan
- medication
- current year? HCC-Risk Adjustment

Example: hemiparesis

Update EMR

Not sufficient to code a more specific diagnosis without chart documentation to back it up.
EMR: Support Diagnosis

Problem list and PMH often **extensive** and **automatically regenerated** in new progress note.

Listed diagnoses not assessed on DOS **may appear to be PMH**.

**Don’t contradict** documentation within the progress note i.e. “functional quadraparesis”

Providers should document:
- **any active conditions assessed at time of service**
- **at least annually** for **HCCs** (hierarchical condition categories).
EMR: Support Diagnosis

**Update medical record** when additional or more specific diagnoses made from test results, ER, inpatient, specialists’ consultation reports, or other provider visits since last DOS.

Specific diagnostic code choices in electronic records may not be sufficiently detailed if **truncated/abbreviated** (eg. Mobile app on cell phone).

**Resist temptation to choose first choice on autofill search.**

Don’t chart anything unless it was actually **done that day** (or is written as an addendum)
Provider should document:

Any Associated Diagnoses or Conditions that are affecting care of current condition, decision making, treatment or management

Includes:

- diabetes mellitus, CKD, CHF
- all acute and chronic medical conditions
- active malignancy
- HIV/AIDS/immunocompromised complications or manifestations
- pregnancy
- neurologic, musculoskeletal, vascular or congenital disorders
- severe dermatologic disorder
- injuries or poisonings
- mental illness or substance abuse
- infections
- signs & symptoms (avoid using unless diagnosis not known)
SADSS

S: Any quality measures to address?

STARS
**STARS** Medicare Five-Star Quality Rating System

Examples:

**Weighted x1:**
- Breast/colorectal screening
- Annual flu shot
- Assess: BMI

**Weighted x3:**
- Plan for all cause readmission
- Review high risk meds:
- Med compliance - diabetes/HTN/statins

**Weighted x1.5**
- **Patient reported outcomes** (including improving or maintaining physical and mental health)
- **Patient** satisfaction
ICD-10 Documentation, HCCs and STARS Measures

- When providers document diagnoses to the highest level of specificity, and capture all appropriate HCCs, there will be more STARS measures to fulfill on.

  Examples:
  - Type 2 Diabetes Mellitus
  - Rheumatoid Arthritis

- Educate providers on actionable STARS measures and support their efforts to help patients realize these goals.

- Important to maintain STARS ratings of 3.0 or greater, optimally 4.5 to 5.

- Medicare is emphasizing quality care and will continue to raise the bar.

Inadequate STARS ratings may jeopardize contracts.
Additional STARS measures and tests because of diagnosis of DM:

- **HgbA1C** (screen for control of blood sugar)
- **Ophthalmologic exam q 2 year** (q 1 yr if abnormal)
- **Urine microalbumin/Cr ratio** (screen for nephropathy/CKD)
- **eGFR and serum Cr** (screen for CKD)

Screening tests may reveal complications, then accurate physician documentation will result in appropriate ICD-10 combination code assignment and additional risk adjustment.
Expand Clinical Thinking

**Vital Signs:** Great place to start!
- BP?
- BMI? high/low?

BMI 40 or greater is Morbid Obesity **HCC 22**
BMI 35-40 risk adjusts *(HCC 22)* only if provider documents severe *(or morbid)* obesity

What else does BMI > 35 make you think of clinically?
Diabetes, osteoarthritis, sleep apnea, HTN, etc...

BMI may be coded from medical record, but provider **must document any associated conditions** that support diagnosis of morbid obesity
ICD-10-CM
Chapter 4: Endocrine, Nutritional, and Metabolic Diseases
E66 Overweight and Obesity

**Code first** obesity complicating pregnancy, childbirth and the puerperium, if applicable (099.21-)

**Use additional code** to identify BMI if known (Z68.-)
Specify Malnutrition E 40-46

**BMI alone inadequate!**

- document “malnutrition” or “cachexia”
- document degree/severity

Protein-calorie malnutrition **HCC 21**

- **mild** E44.1
- **moderate** E44.0
- Unspecified **severe** (protein-calorie) E43

Specify if:

- Malabsorption (no longer risk adjusts) K91.2
- Following GI surgery K91.2
- Intrauterine, etc...
- Neglect (child, infant) T76.02
More ICD-10 Verbiage

- Additional characters required- red #
- **Code first underlying disease**
  - eg. E53.8 vitamin B12 deficiency
    - + G32.0 Subacute combined degeneration of spinal cord in diseases classified elsewhere (**HCC**)
- **Use additional code**
- Includes/excludes
- With/Without (eg. gangrene)
- **Mild, Moderate, Severe** (eg. Malnutrition)
- **Single episode, recurrent** (eg. Major Depression)
- **Temporality** (eg. Old MI now > 4 weeks)
COPD - HCC 111

use additional code to identify:

- exposure to environmental tobacco smoke (Z77.22)
- history of tobacco use (Z87.891)
- occupational exposure to environmental tobacco smoke (Z57.31)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)
Documentation of Cancer
HCC 8-12

Document Activity versus PMH:

- Active malignancy risk adjusts (excludes most skin CA and in-situ tumors)
  - Acute/Chronic malignancy? (eg. leukemia, lymphoma)
  - Remission status? partial/full (leukemia, lymphoma, multiple myeloma still risk adjust when in remission)
  - Active or ongoing treatment: HCC if ongoing treatment including meds eg. Tamoxifen/Lupron

Document Malignant/ Benign/ In-Situ:

- Type/Location/Laterality/Morphology
- Primary/Secondary
- Document each tumor if multiple
- Grade/Stage
- Metastatic to? Lymph node involvement?
- Residual?
Is malignancy complicated by?

- Cachexia

- Pancytopenia/Thrombocytopenia/Neutropenia
  
  Specify etiology if known:
  
  Cyclic neutropenia?
  
  Neutropenic fever?
  
  Drug/chemo induced?
  
  Due to? neoplasm, infection, etc…

**Risk Adjusts:** sicker cancer patient

greater severity of illness (SOI)
Peer Pressure

If Severity of Illness (SOI) is inadequately documented by provider:

- Morbidity & mortality will appear excessive
- Quality will appear low
- Risk Adjustment payments will not reflect the costs associated with the treatment and management of the sicker patients

Show physicians data on how they stack up against others (and what data is publically available...)
Positive Reinforcement

1. Respect and acknowledgment for actions taken by providers/results

2. Share data often

3. Competition: *comparison* with self, peers, ratings

4. Financial incentives

5. Emphasize *quality*/providers want to do a good job

6. Satisfaction with work/well being

7. Support providers with staff and tools
Going pretty well...
Oops…. S70.01XA Contusion of right hip
W04.XXXA fall while being carried or supported by another person (A for initial encounter after extension X alert)

Place of occurrence of the external cause-Y92.51 private commercial establishments
Activity code-Y93.41 activity, dancing
Blood alcohol level-Y90.0 less than 20mg/100ml

Bone density? Osteoporosis management is a STARS measure