Educating Providers in Risk Adjustment from a Clinical Perspective

Presented by:
Marian J. Wymore, MD, CPC

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.

Educating Providers

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

R45.4
Irritability and anger

Z73.2
Lack of relaxation and leisure

R45.2
Unhappiness

Z73.3
Stress not elsewhere classified

R45.3
Apathy

etc....

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. Lombardozzi, 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

Physician Documentation Improvement

- 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

1st is letter (A-Z, except U)

2nd is number

3rd 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

4M05 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

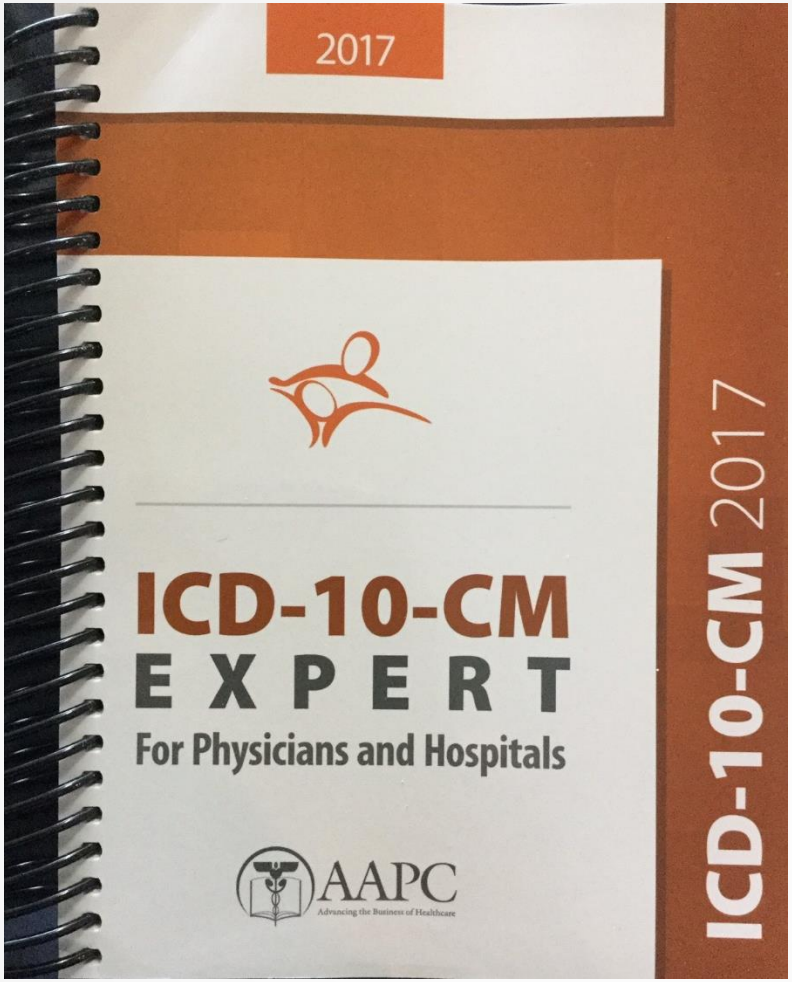
HCC 8-12	Malignant Neoplasm
HCC 18	Type 2 Diabetes Mellitis with Complications
HCC 19	Type 2 Diabetes Mellitis without Complications
HCC 22	Morbid Obesity
HCC 55	Alcohol/Substance Dependence
HCC 58	Major Depressive Disorder
HCC 85	Heart Failure
HCC 88	Angina Pectoris
HCC 108	Peripheral Vascular Disease/Atherosclerosis
HCC 111	COPD

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**.



E11- 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

SADSS

S: 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

Document Specifics of Complications (HCC 18)

4 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 opthalmology 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**

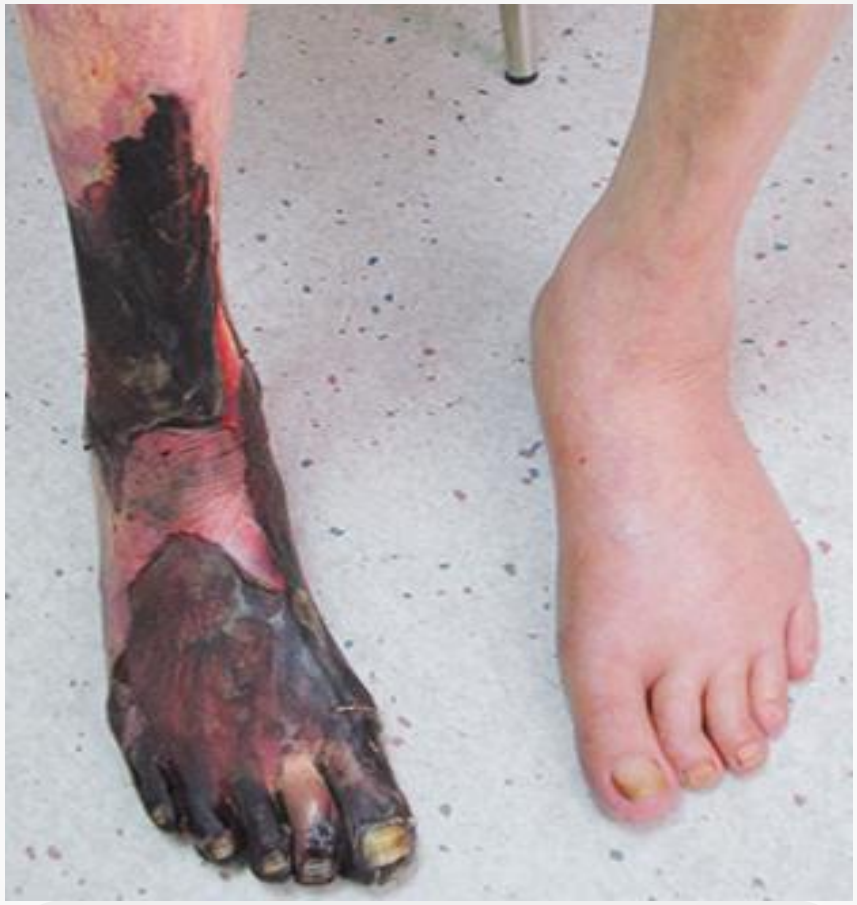
E11.29 Type 2 **DM with other diabetic kidney complication**

- eg. Type 2 DM with renal tubular degeneration

Document dialysis status Z99.2-**HCC**

With

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)

Without

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**

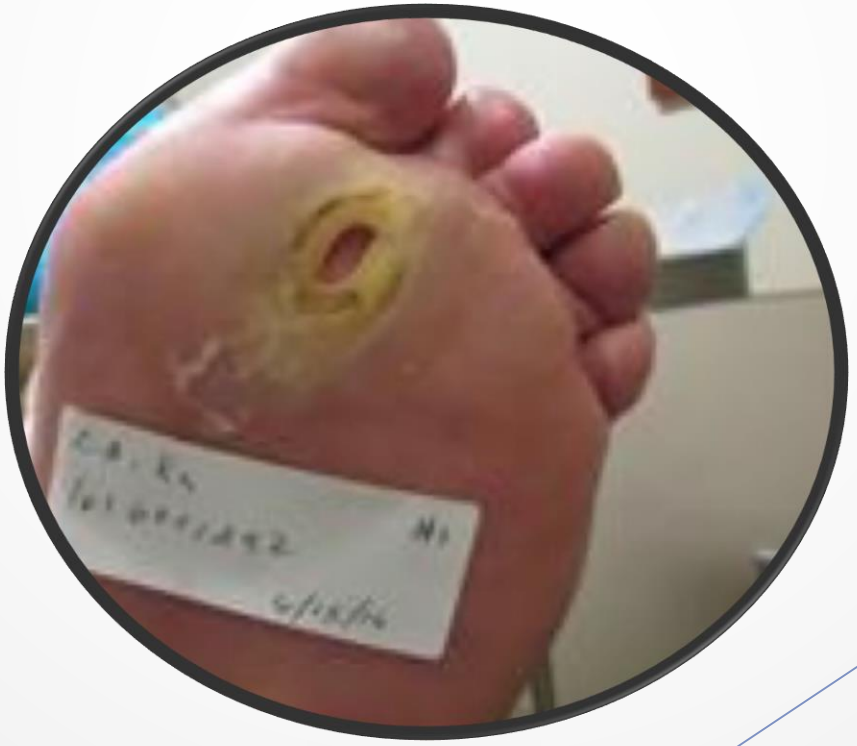
    use additional code to identify site L97.4_ _, L.97.5_ _
  - DM with other skin ulcer **E11.622**

    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**



SADSS

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?

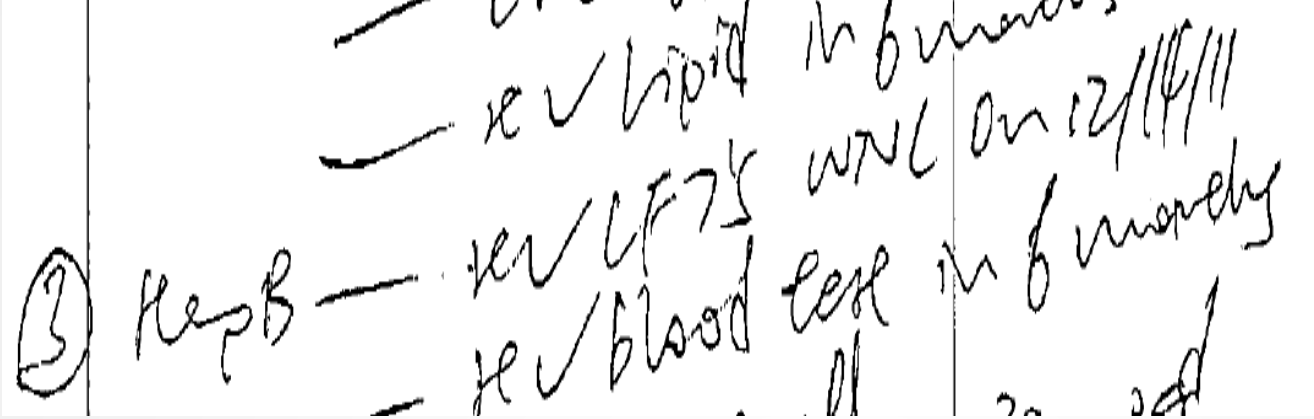
Why on meds?

SADSS

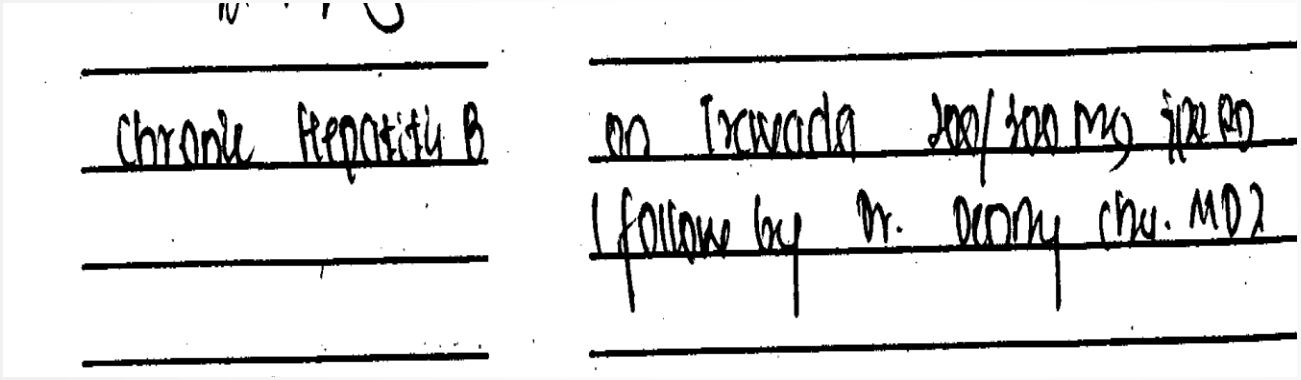
A: Acuity/Chronicity

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 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

SADSS

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.

SADSS

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 **HCC**s (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**

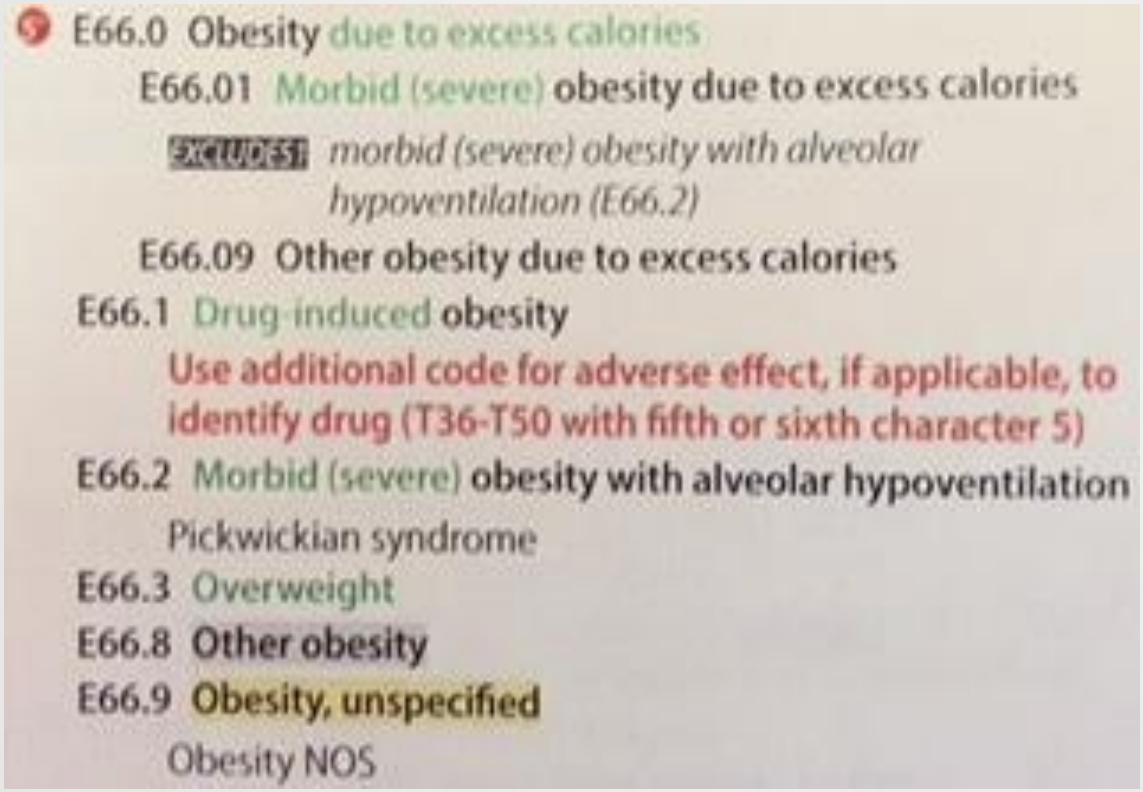
ICD-10-CM

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?

Document Coexisting Conditions and Complications

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