Documentation and Risk Adjustment

Medicare Advantage and Value-Based Health Care

Florida Blue
Your local Blue Cross Blue Shield
MEDICARE

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Points of Discussion

- Medicare Advantage & Risk Adjustment
- Benefits of Medicare Risk Adjustment
- Medicare Risk Adjustment Overview
- Hierarchical Condition Categories (HCC) Overview
- How is the Risk Score Calculated?
- Physician Role for Each Step in the Risk Adjustment Process
- Understand the Importance of Documentation and Coding Specificity
- Key Points to Remember

Original Medicare vs. Medicare Advantage

Original Medicare

PART A

- Hospital Coverage
- Skilled Nursing Facilities
- Other inpatient care

PART B

- Doctor Visits
- Lab tests
- Other outpatient services

Medicare Advantage

PART C

- Combines Parts A, B & most D plans
- May cover vision, dental, and hearing
- Healthy Extras
- Fitness
- Addresses/supports Social Determinants of Health (SDoH)

Stand-alone Plan or Medicare Advantage

PART D

- Prescription Drug Coverage
- Offered by private companies as stand-alone plan for those in Original Medicare, or as a set of benefits included with a Medicare Advantage Plan.

A Medicare beneficiary will choose coverage in either Original Medicare or a Medicare Advantage plan. They may receive their Part D prescription drug coverage from the Medicare Advantage plan or a stand-alone Part D plan.

Original Medicare vs. Medicare Advantage. Let's Compare.

Original Medicare

Basic Original Medicare by itself is just a starting point: it covers doctor visits and hospital stays. Part A covers hospital stays, Part B covers doctors' visits and Part D of Medicare covers prescription drugs. There is a monthly premium for most individuals.

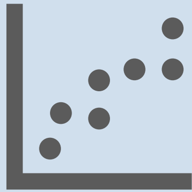
Medicare Advantage

Medicare Advantage plans support your entire well-being so you can live a better, healthier life. In one package, many plans give you Part A and Part B coverage, plus dental, vision, hearing, wellness and fitness programs. Many plans also include Part D prescription drug coverage. Most Medicare Advantage plans have lower out-of-pocket costs than Original Medicare and Supplemental Plans.

Coverage	Medicare	Medicare Advantage
Doctor Visits	✓	✓
Hospital Stays	✓	✓
Prescription Drugs		✓
Additional Benefits		✓

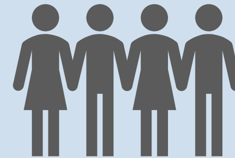
Benefits of Risk Adjustment

Medicare Risk Adjustment: Basic Overview



Risk Adjustment models (i.e., actuarial tools) predict health care cost

The Centers for Medicare & Medicaid Services (CMS) risk adjustment models predict medical care cost for Medicare Advantage (MA) patients



Each MA patient has a risk score determined by CMS based on demographic information/health status

Physician documents health status information based on medical conditions addressed during patient visits

Conditions must be explicit by physician responsible for diagnosis

Medicare Advantage Risk Adjustment Model

Additive each calendar year: January 1 – December 31

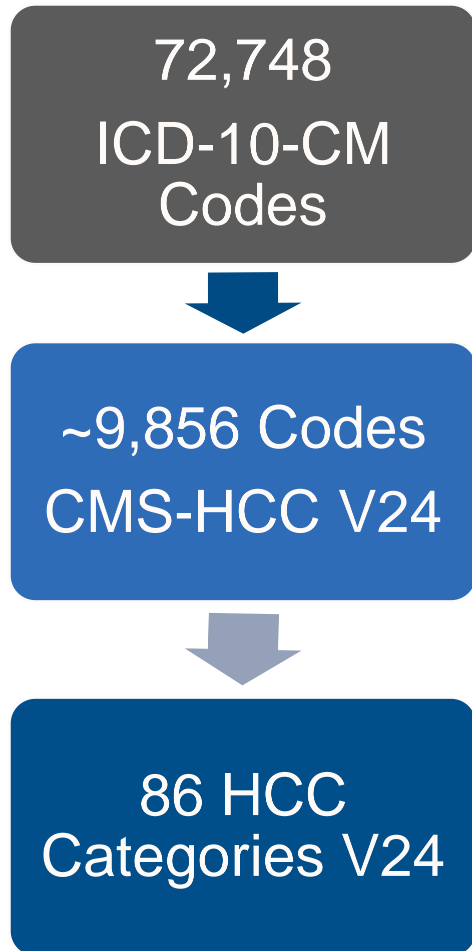
Predictive: Funds allocated in subsequent year based on current year risk scores

> 9,500 diagnosis codes fall in 86 hierarchical condition categories (HCCs)

Each HCC category value counted and reported annually

Patients' risk score resets every January 1

Hierarchical Condition Categories (HCCs)

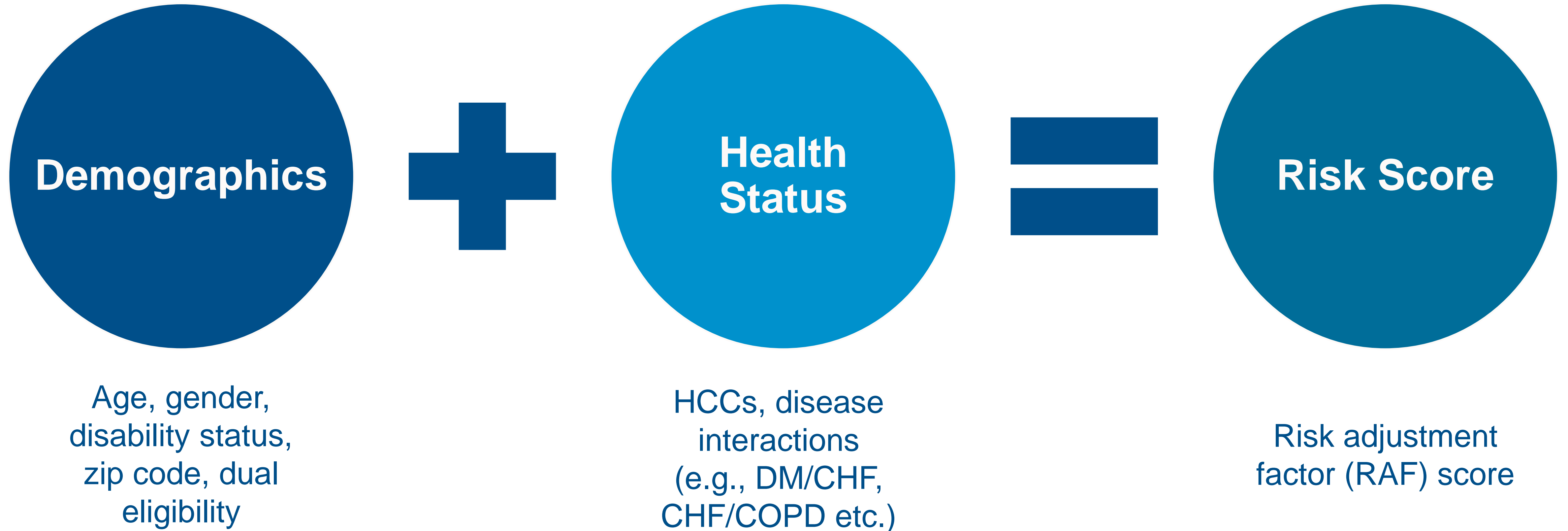


Description	CMS-HCC Category V24
HIV/AIDS	1
Cancer	8, 9, 10, 11, 12
Diabetes	17, 18, 19
BMI and Morbid Obesity	22
Vascular Disease	108
COPD	111
Chronic Kidney Disease	136, 137 138
Artificial Openings	188
Amputation Status	189

*Subset of all available HCC categories; see cms.gov for full list

- HCCs are diagnoses with similar clinical complexity/expected annual care costs
- Enables CMS cost predictions for annual patient care

How is the Patient's Risk Score Calculated?



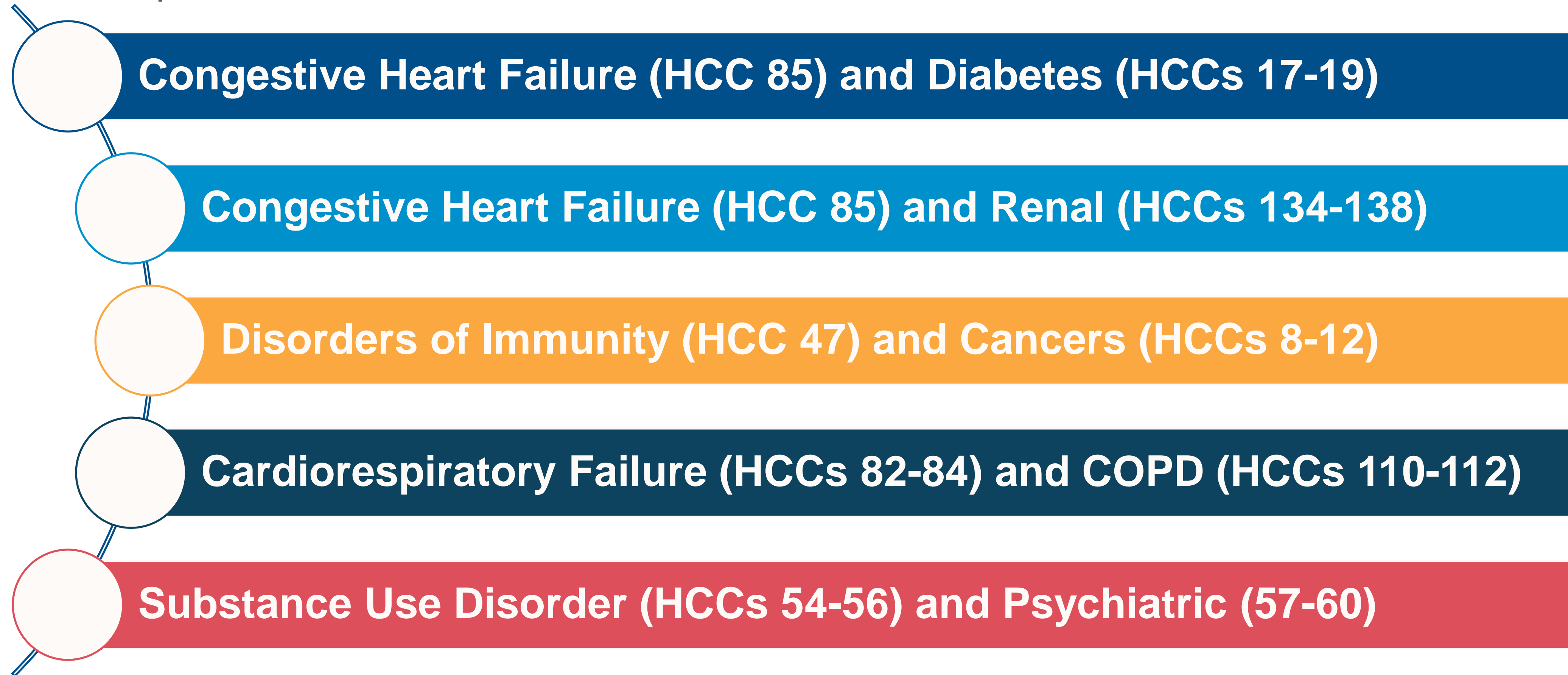
As defined by CMS:

- Risk adjustment predicts future health care expenditures of individuals based on diagnoses and demographics.

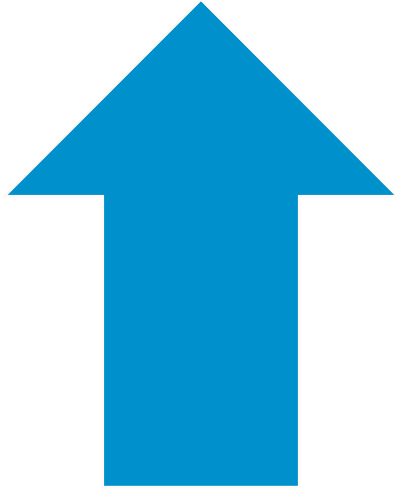
Disease Interactions

Additive Risk Adjustment factors based on chronic conditions adds incrementally to risk adjustment factor (RAF) scores

Some examples are below



RAF Identifies Patient Health Status

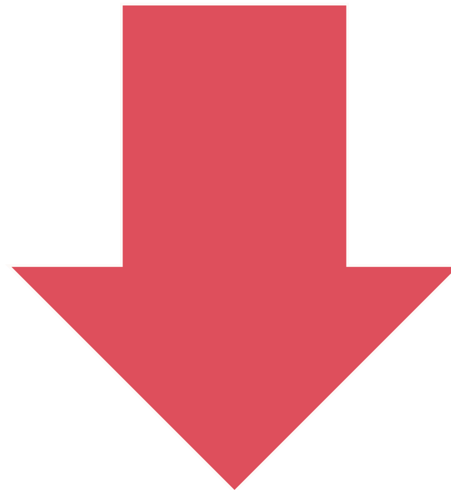


Higher risk scores represent patients with a greater burden of illness

High RAF score **may be inflated** due to:

- Submission of non-supported diagnosis codes
- Over coding
  - For example, copy/paste problem list into assessment/plan with resolved conditions

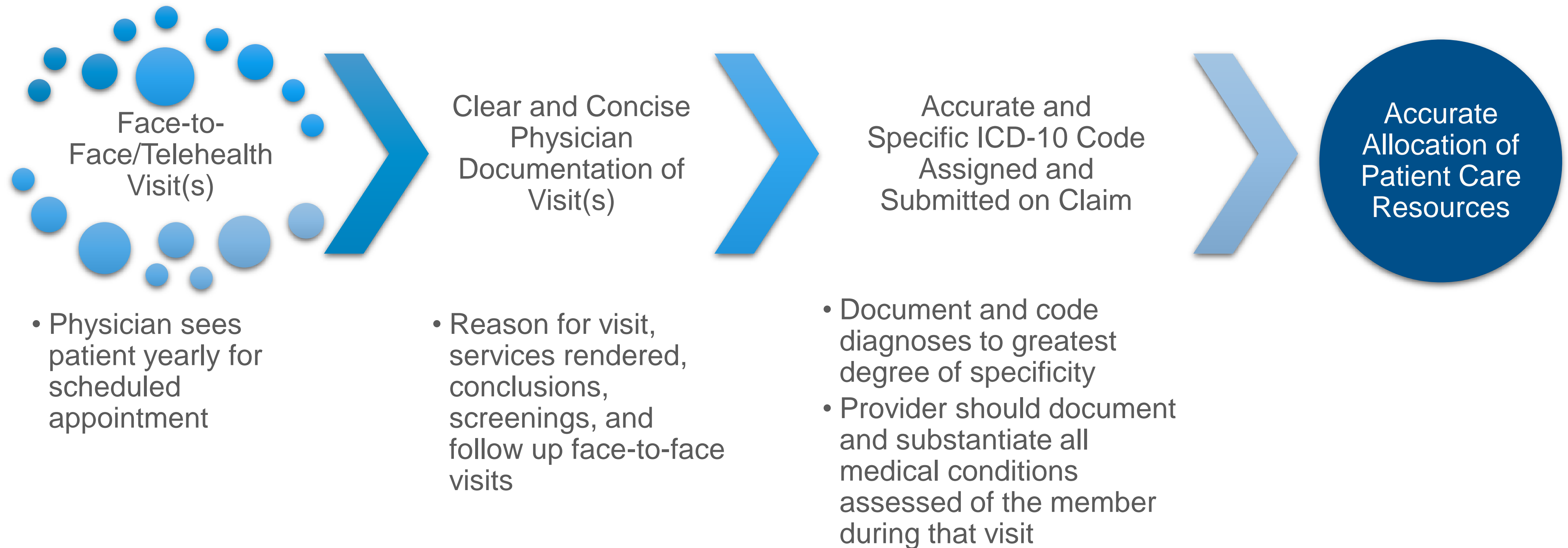
Lower risk scores represent healthier population



Low RAF score may **falsely** indicate a healthier population due to:

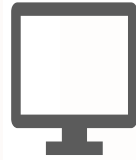
- Inadequate chart documentation
- Incomplete, inaccurate ICD-10-CM coding
- Patients not seen

Medicare Risk Adjustment Process and the Physician's Role



Top Errors In Risk Adjustment

Illegible signatures



Unauthenticated Electronic Health Records (EHR)

Lack of highest degree ICD-10 code specificity

Documentation and diagnosis code do not match

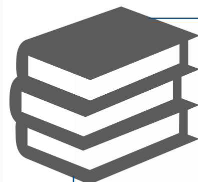
Lack of being monitored, evaluated, assessed or treated (MEAT)

Status of cancer is unclear

Unclear documentation of chronic conditions

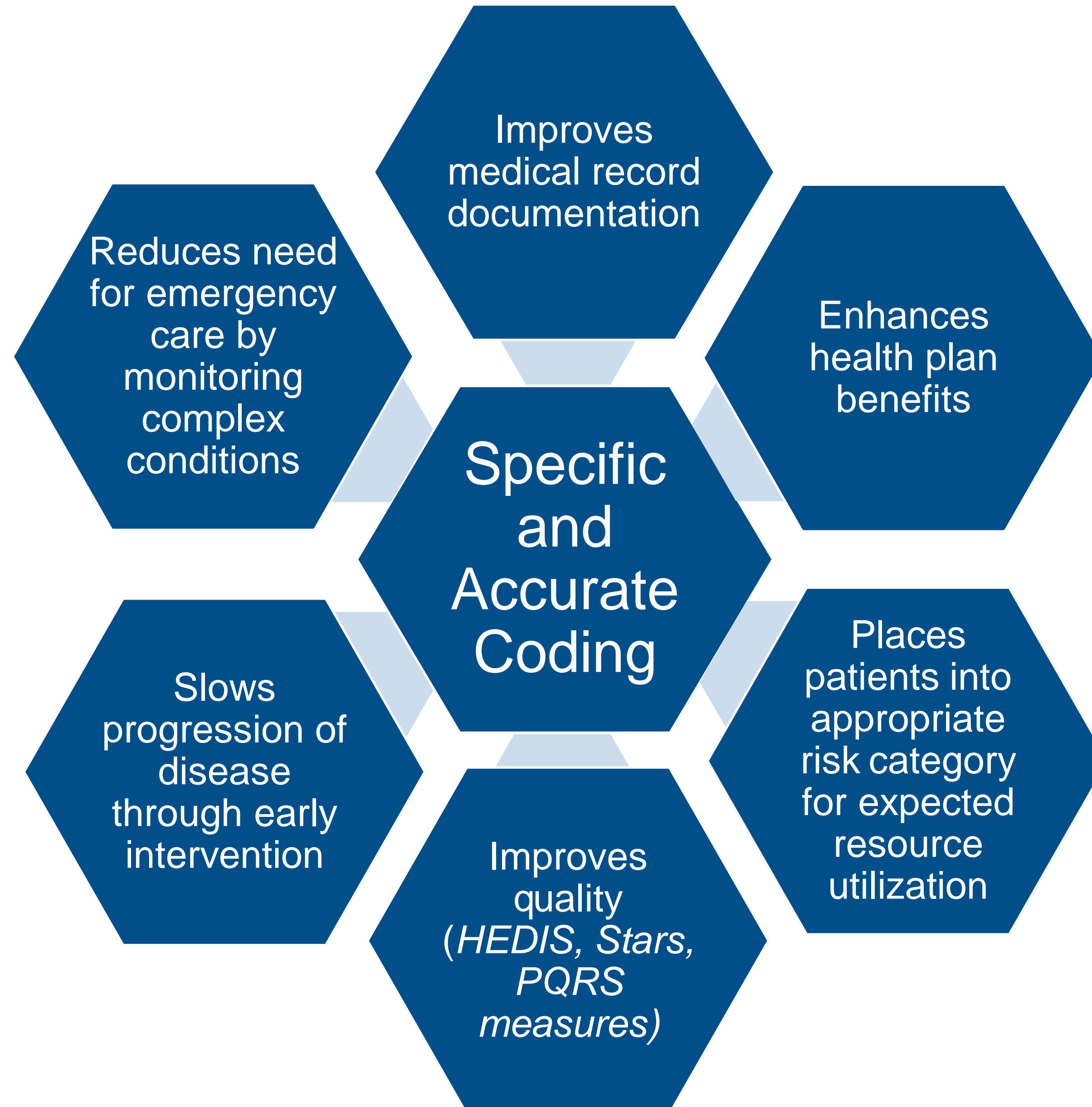
Lack of annual documentation

Lack of specificity



Incorrect manifestation code

Purpose of Specific & Accurate Documentation



Examples of MEAT

MEAT	Support	Disease Example	Documentation Examples
Monitor	• Symptoms • Disease progression/regression • Ordering of tests • Referencing labs/other tests	CHF DJD, hip Hyperlipidemia	Stable. Will continue same dose of Lasix and ACE inhibitor Pain Controlled with current medication Lipid Profile ordered
Evaluate	• Review of test results • Medication effectiveness • Response to treatment • Physical exam findings	Type 2 DM Decubitus Ulcer	BS log and A1c results of 7.5% reviewed with the patient from lab work 6/4/15 Relay wound measurement in exam
Assess/ Address	• Discussion, review records • Counseling • Acknowledging • Documenting status/level of condition	Peripheral Neuropathy Ulcerative Colitis	Decreased sensation of BLE by monofilament test Stable. Managed by Dr. Smith
Treat	• Prescribing/continuation of medications • Surgical/other therapeutic interventions • Referral to specialist for treatment/consultation • Plan for management of condition	Tobacco Abuse GERD	Advised on risks; smoking cessation counseling No complaints. Symptoms controlled on current medication

Medical Record Documentation Helpful Tips

Tip	Example
A condition only exists when documented.	Diagnoses do not carry over visit to visit or year to year.
Code condition as many times as patient receives care and treatment for the condition.	Do not code for conditions that were previously treated and no longer exist.
Code conditions when documentation states, ”condition is being monitored and treated by a specialist.”	“Patient on Coumadin for atrial fibrillation; followed by Dr. Hill”
Document and code status conditions at least once/year.	Transplant status, amputation status, dialysis status, chemotherapy status, artificial opening status /maintenance
Do not code unconfirmed diagnoses.	Probable, possible, suspected, working diagnosis
Be sure diagnosis code(s) billed are consistent with medical record documentation.	A&P lists I10 only with no description Cannot list ICD-10 code alone Must document the word *hypertension* somewhere in the medical record

Current vs. History of

“History of” means patient no longer has condition

- Documentation errors regarding use of “History of “
  - Coding a past condition as active
  - Coding “history of” when condition is still active
- Exception: It is appropriate to document/code “history of” when condition is truly historical (e.g. History of amputation)

Progress Note States	CMS Interpretation
H/O CHF	CHF has resolved
CHF Compensated, continue Lasix	CHF active and stable
History of Angina	Angina has resolved
Stable Angina, continue atenolol	Angina is stable on active treatment
H/O AFIB	AFIB has resolved
AFIB controlled on digoxin	AFIB is stable on active treatment
Prostate Cancer s/p Chemotherapy	History of prostate cancer. No further treatment
Prostate Cancer, adjuvant Lupron Injections Q3mo	Prostate cancer is active with active treatment

Medicare Risk Adjustment Case Example

Patient: Sally Jones DOB: 12/1/38 DOS: 10/11/19

Patient is a 72-year-old female with UTI symptoms. Patient c/o fatigue, low energy and poor appetite. Patient is status post MI 18 months ago. Patient appears frail and with mild malnutrition. Has lost 23 pounds in the last four months. Patient has been complaining of pain with urination, weakness, and has had dry, itchy skin for the past several months. U/A done today shows WBC's, leukocyte esterase, and microalbuminuria. Serum creatinine is 1.5.

PMH: Type II diabetes, chronic kidney disease secondary to diabetes, history of BKA skin intact at stump, no erythema, History of MI. Previous UTI four months ago with a serum creatinine of 1.6. Lab results at that time revealed stage 2 CKD.

A/P: Diabetes-Metformin 500 mg b.i.d., Bactrim for UTI. Malnutrition- Ensure b.i.d. and nutrition consult, RTC in six weeks, Referral made to Dr. Smith (Nephrologist) for CKD.

Note: Electronically signed by Physician Name, MD 10/11/2019 0814

Medicare Risk Adjustment Case Example (continued)

Coding Example 1: Typically submitted ICD-10-CM codes for the office visit

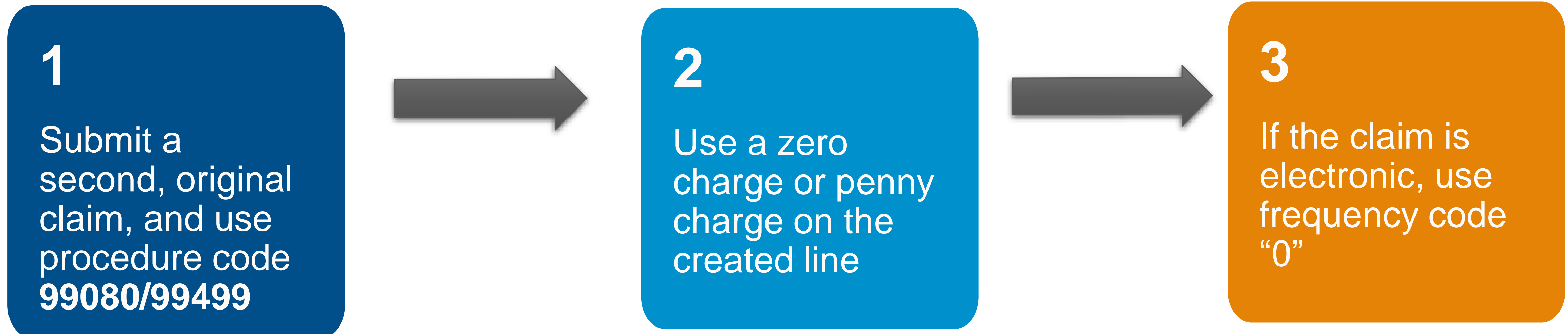
ICD-10-CM Code	Condition	HCC
E11.9	DM w/o Complication Type II	19 (HCC-C)
N39.0	Urinary Tract Infection	Does not risk adjust

Coding Example 2: *Opportunities for additional* risk adjustment code reporting

ICD-10-CM Code	Condition	HCC
E11.22	DM Type II with Chronic Kidney Disease	18 (HCC)
N18.2	CKD Stage II	Does not risk adjust
E44.1	Malnutrition of mild degree	21 (HCC)
N39.0	Urinary Tract Infection	Does not risk adjust
I25.2	Old MI/ History of MI	Does not risk adjust
Z89.519	Amputation, below knee	189 (HCC)

Submitting Supplemental or Additional Diagnoses

When your practice management system will not allow you to bill more than four diagnosis codes on a claim or you need to bill supplemental diagnoses:



99080/99499 Process Important Reminders

Submit supplemental claims within 180 days of original E&M date of service to meet timely filing limit deadlines

Capitated payment arrangements: Do not submit date span claims for office services (Place of Service 11)

CMS requires documentation, coding, claim submissions to align to each individual date of service and face-to-face encounter

Original date of service for which supplemental information is submitted require evaluation and management CPT code

Key Points to Remember

CMS-HCCs are prospective

Diagnoses must be coded according to ICD-10-CM guidelines

Support for the diagnoses must be documented according to the CMS guidelines

CMS-HCCs are derived from ICD-10-CM codes

Acceptable data sources – hospital inpatient/outpatient facilities, and physicians

Slate is wiped clean every January 1

Diagnoses must be documented from a face-to-face or telehealth visit

Code all conditions affecting patient care

Florida Blue Medicare Risk Adjustment Programs

Program	Description
Retrospective Review Audit	Provider groups go through random audits throughout the year, via statistically valid samples of submitted claims and member charts
Clinical Documentation Improvement Program (CDI)	Improve PCP documentation, ICD-10 coding by actionable CMS compliant queries in acceptable CMS medical record addendum/amendment 30-day post visit time frame
In-Home Health Risk Assessments	Patients who have not seen a PCP during a 12-month period, or are home bound, qualify for a health risk assessment performed by a nurse practitioner, physician's assistant, or physician
Chart Procurement	Operational service to retrieve medical records for risk adjustment and quality
	Medical records are scanned, retrieved, processed from various sources into/from electronic medical record systems

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Risk Adjustment Process

Risk adjustment, a component of Medicare Advantage and the Affordable Care Act (ACA), helps align payments to health plans with the risk characteristics of people enrolled in each plan.

Accurate risk adjustment relies on comprehensive, face-to-face health assessments of patients. These assessments result in appropriate medical record documentation and diagnosis coding. The diagnosis codes are then submitted to the health plan on a claim and used to determine the level of risk associated with the patient.

Florida Blue has risk adjustment programs in place that align with our commitment to ensuring that quality of care is maintained through the physician-patient relationship. These programs help identify care and coding opportunities that can help prevent and/or detect conditions and encourage members to schedule health screenings, tests and vaccines.

RPM Revenue Program Management

For More Information

If you have questions or want to learn more about risk adjustment refer to the following:

For information about risk adjustment, visit the floridablue.com provider webpage.

- Learn documentation/coding best practices
- See on-demand webinars/education courses at **availity.com**
- Please send any questions to **riskadjustmenttraining@floridablue.com**

Appendix

CMS.gov

AHA Coding Clinic for ICD-10

American Academy of Professional Coders (AAPC)

American Health Information Management Association (AHIMA)

ICD-10 Official Guidelines for Coding Reporting FY 2020

CMS Medicare Risk Adjustment Information

Thank You!