# Digging Deeper into HCC Coding
# Transcript from Live Session

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Quality Insights
Quality Innovation Network

Laurie Fink: Good afternoon everyone and welcome to today's webinar, Digging Deeper into HCC Coding. My name is Laurie Fink and I'm a communications specialist with Quality Insights and will serve as the host for today's session. We will get started in just a few moments but first I'd like to review a few housekeeping items. All participants entered today's webinar in a listen only mode. Should you have a question during the presentation, we ask that you please type it into either the Q & A box for the chat box at the right of your screen. We will address your questions throughout the presentation and also at the end as time allows.

Laurie Fink: Today's webinar is being recorded, the recording along with the slide deck and a transcript of the webinar will be posted on the Quality Insights website, as well as the Quality Insights QPP support center website as soon as possible. These resources will be placed on the archived events pages.

Laurie Fink: It is now my pleasure to introduce you to Monica Wright who is our guest speaker for today's session. Monica joins us from Medical Revenue Cycle Specialists and has over 20 years of experience in medical coding, billing and practice management. She's taught medical coding and billing at the community college level and continues to teach physicians, managers and staff of private medical practices and within hospital settings and holds multiple certifications.

Laurie Fink: Also joining us later on in the presentation is Kem Tolliver. Kem has been providing strategic and operational leadership to medical practices and hospitals for over 20 years. Kem is the president of Medical Revenue Cycle Specialists which is an organization that leads healthcare organizations in practice management and RCM improvements, coding, training and education, payer contracting, EMR optimization and new practice start up.

Laurie Fink: So without further ado, I will go ahead and hand over the presentation to Monica.

Monica Wright: Thanks Laurie. So, to start off with just some housekeeping. Here's some information that Laurie just told you about both myself and then about Kem. So, let's get started. The learning objectives of this webinar are to dig a little bit deeper into what the risk adjustment model is. So you have an understanding of how it's going to be used in the physician practice. So we're going to start with a history of risk adjustment. We're going to go into how the data is collected, how the scores are calculated, how it has been used historically and how it's being used now. We'll take a look at MIPS cost reporting, advanced APM's and ACO's and then we'll discuss what changes a practice needs to make to be ready for

their upcoming changes. As Laurie mentioned, we will stop periodically for questions within the presentation, so feel free to submit them in the chat box as we go, as well as at the end.

Monica Wright: So, to start with let's look at the risk adjustment model. We need to discuss the overall model before we can look at HCC's in particular. The risk adjustment model is an insurance strategy. It's used to predict how much the insurance company will pay for services over the course of a year. So, it was set up to determine profitability of contracts. Does Aetna want a Medicare Advantage contract? Well, how much is Medicare offering to pay for the year and how much does Aetna think they're going to have to pay for those covered lives. So this is a way for them to mitigate risk when they're determining whether or not they want to get involved in these contracts.

Monica Wright: So how it works is typically Medicare and there's some other places that are using this that we'll talk about, will have that set amount of money and say okay, this year, for this population, we're going to pay this much money to cover these covered lives. So, Medicare then gives that money to the Medicare Advantage plan or the insurance contractor and says, “Here you go. This is all we're giving you. You have to make this work for the year for these members.” Then the Medicare Advantage plan or the insurance contractor pays the providers, the facilities, the suppliers for the services rendered to the beneficiaries. So, it's acting like a middle man. But what it does is it keeps things budget neutral for CMS and for the larger program because they've set a budget of this is how much we're going to pay this year and that's all they pay. The risk falls on the middle man or on the insurance contractor to make that profitable.

Monica Wright: So, is this a new concept? We've been hearing a lot about it lately. It's really coming into focus, but no, it's not new. It's actually been around for more than 20 years. It was mandated in 1997, first used around 2003, 2004 because it's a good indicator of what the annual cost is per beneficiary.

Monica Wright: So this started with the Balanced Budget Act of 1997 which mandated risk adjustment for the Medicare Advantage program. It was phased in, starting about that 2003, 2004 mark and became 100% risk adjustment using the HCC's starting in 2008. So that's how long we've been dealing with risk adjustment. Although, up to now, it's been mainly on the insurance side. It's been a tool as we just saw on the slide for CMS to give contracts to insurance carriers to then run their Medicare Advantage programs.

Monica Wright: So here is a sample of the Medicare Managed Care Manual, Chapter 7, on risk adjustment. The link is on the bottom of the slide. So this indicates what the risk adjustment models are set to be used for in the Medicare program. They're used to calculate risk scores, to predict beneficiaries’ health expenditures relative to the average beneficiary. The risk scores are then used to adjust payments and bids based on health status and demographic characteristics and they're using this both in the Medicare Advantage program and now in the prescription drug program as a component of their bidding process.

Monica Wright: The guidelines go on to state what the risk adjustment's used for. If there's standardized bids, so each plan can bid for the average Medicare beneficiary. It compares the bids based on populations, so if we're looking at a plan that's covering a specific population, what does that change. So, it can add payment plans adjusted to those characteristics. There's separate risk adjustment models that they're looking at for Part A and Part B and then we've got the Part C and Part D that we've talked about. Then there's segmenting off the sub-populations. So, this risk adjustment model in the CMS world is growing.

Monica Wright: So, the evolution of risk adjustment. So, it started out with the Balanced Budget Act of 1997, we're talking about basically Medicare Advantage plans, some Medicaid. The ACA, the Affordable Care Act of 2010 extended the risk adjustment model to be a required component of all exchange plans. They all have to have some element of risk. So they might not be fully risk related but there's some element of risk that those insurances are taking on. The MACRA, the Medicare Access and CHIP Reauthorization Act of 2015 repealed the sustainable growth rate. For those of you that have been around awhile, you know the sustainable growth rate was how we got more money in the Medicare fee schedule every year. It was the percentage that the fee schedule could go up. With that repealed, Medicare became a budge neutral program.

Monica Wright: So how do you handle a budget neutral program? Well, they started to handle it with MIPS. With the quality program and with the bonuses or the penalties based on how you do for participating in the MIPS program it helps it remain budget neutral. Because the penalties that are being lost are being paid to the providers that are doing well and getting the bonuses and you've no longer got that increase in fee schedule structure. Because some providers will do better and some will do worse. It also allowed bonus payments for the APM participation and we'll talk about that a little bit more a little later.

Monica Wright: So who's using risk adjustment now? Well we have the Medicare Advantage plans, we have the Affordable Care Act plans, we have Medicaid and we even have some commercial carriers and accountable care organizations. Why? Why are we doing this? Why have we changed the emphasis? Well, I'm sure all of you are familiar with the shift from the fee for service world to a value based payment model. There are a couple of reasons for doing this.

Monica Wright: One, is to avoid adverse selection. What adverse selection means is that only sicker patients purchase insurance. So what that does, if you look at risk from an insurance standpoint, if you think about it from the standpoint of home owners insurance. Your home owners insurance the company insures multiple home owners and say the average price of the house that they insure is $200,000. They are only asking you to pay a portion of what it would cost to replace that house. If every house burnt down that that insurance was covering that year, that insurance would not be able to pay for all of those losses because they amount that they were taking from each person would not be enough to cover. There would be enough to cover two, maybe three because when the whole group is paying in a portion to cover the whole. So that's what happens with

adverse selection. When only sicker patients purchase insurance, there aren't any premiums coming in from well patients that aren't using the benefit so the insurance companies lose. They lose money because they're paying out all of the benefits and they're not getting the premiums to come in to cover them.

Monica Wright: The other area they're trying to avoid is risk selection. Risk selection is when employers actually make plans less desirable for the higher risk enrollees trying to make up a patient population that is that healthier population that's not going to use the care and therefore the insurance makes money. So the idea behind this change in emphasis is to even the playing field. It's to be sure that the insurances are getting reimbursed and this will come down physicians being reimbursed too for those patients that cost more and getting less money for the patients that cost less, redistributing the funds. So, the lower risk funds are now being redistributed to the higher risk patients so that everything evens out and we have an even playing field.

Monica Wright: So when we're looking at risk adjustment today, there are new CMS advanced payment models coming down the pike right now. I'm sure some of you have been aware of the webinars that CMS has been doing. There's a primary care model. There's a direct contracting model. All of these APMs require some element of risk. Some of them up to 100% risk assumption to get involved in these models. So CMS is really pushing this risk and it is coming and it's going to continue to come.

Monica Wright: MIPS cost reporting now uses HCC's to determine costs. The accountable care organizations, the ACA plans are making capitation payments based on risk. That's where the physician part of this equation comes in, is a lot of the plans, especially with ACO's and some of these other APM's that you may be getting in, especially in primary care but the direct contracting model under CMS is for specialists as well, you're going to start getting capitated payments. You're only going to get so much money for your patient population. Those capitated payments are going to be based on risk adjustment. We're going to get into a little bit more about how that works.

Monica Wright: So, we're going to do a survey here just to give me an idea of who is on the line. How much risk are your providers willing to take? Do your practices currently participate in an APM, an AOC or risk adjusted capitation plan? Is this something that's completely new to you or are you doing it? So, are you participating yes or no? If you could answer the poll question for me. While we're waiting for that, Laurie, now is probably a good time to see if there are any questions that have come in.

Laurie Fink: There have been no questions thus far.

Monica Wright: Okay. Then we'll just wait for the poll.

Monica Wright: Okay, so 67% of you are involved. So you are seeing this come down the pike and you are familiar with what's going on. Okay, good. So, let's delve a little bit further into how this risk is determined that the insurance company is taking on and that your providers will be taking on. So we're using this risk adjustment model which it the tool the estimate the expected costs. So, how does it do that? So, they're saying we're going to determine how much each patients going to cost, what are they looking at? What gives them that information? Well first, they're looking at demographics, then they're looking at Medicaid eligibility and they're looking at health status. They're using HCC's or hierarchical condition categories to weight the illnesses by severity to make the determination on health status. We're going to get into that in more detail.

Monica Wright: But to start with let's look at demographics. I'm going to put up another poll question here. It's kind of a general question, just off the top of your head, who would you say has more risk, an 82 year old male or a 68 year old female? This is one of the things that the insurance companies are looking at. Which beneficiary would be more likely to have higher health costs?

Monica Wright: Just waiting for the results. 59% of you said the 82 year old male, 36% said the 68 year old female. So this is the first thing that they're taking into account when they're determining the costs that the patients going to incur for the insurances. So the first thing they do is they look at these statistics, they look at the demographic information. They determine that in most cases, the older patients tend to get weighted a little bit higher than younger patients just because as a general rule, the demographic would indicate that the older patient may have more risk.

Monica Wright: The second piece we're going to look at and we'll do another quick poll here, again, is Medicaid eligibility. So, as a general rule, who would be the higher risk patient? The 82 year old male that just has Medicare or the 82 year old male who's a dual eligible Medicare/Medicaid beneficiary? While we're waiting for the poll results, the reason for this one, you might think okay what does it matter? We're dealing with the same age patient that is on Medicare. But, what we're looking at here is Medicaid can be for income, obviously, but Medicaid can also be for chronic conditions. It can also be for patients with ESRD, it can be for sicker patients that end up on Medicare and Medicaid. So, most of you 79% said the dual eligible would be at the higher risk. So, that is correct. In this case there is an additional amount of risk factor that is assigned for a patient who is Medicaid eligible.

Monica Wright: Okay, so now let's talk about those hierarchical condition categories which are the biggest piece of the puzzle when we're talking about the health status of these patients. So, the HCC's end up being a case mix, not unlike a DRG if you're familiar with inpatient hospital billing. They group together patients that are similar clinically and by class patterns and they do this using ICD-10 codes. The focus is on chronic and severe illnesses.

Monica Wright: There are two different sets of HCC's. There are HCC's from CMS that were set up for the Medicare Advantage world that are focused on patients that are 65 years or older. There are HHS or Health and Human Services HCC's that were set up for all ages, which are used by commercial and the ACA plans and so they have some diagnoses that are meant for a younger population. There are 79 HCC's under CMS and 127 HCC's under the HHS side.

Monica Wright: So let's take a look at what some of those HCC's are, this is not an exhaustive list but I just wanted to give you some ideas of the types of things you're looking for. So, in the HHS side, when we're looking at the younger patients you can see we're looking at things like Downs Syndrome and Autistic Disorder and Cleft Lip, Cleft Palate. So you can see where these would hit a younger population. This does not mean that they don't include the HCC's that CMS does because they do. But these are just some of the additional codes that HHS gives us.

Monica Wright: There are 79 CMS HCC's, again mainly these chronic illnesses. You can see diabetes has several on here, end stage liver disease, a couple more, vascular disease, COPD, acute renal failure. There are some of the types of conditions that contribute to health status that are looked at to say okay, this is probably going to be a sicker patient that's going to need more medical care.

Monica Wright: So how do we get to these HCC's? So we have 79 HCC's that are a generic term such as acute renal failure. How did we get there? We get there by using ICD-10 codes. So each HCC is assigned a whole set of ICD-10 codes that supports that HCC. Here's an example of a couple, there are more codes than this, trust me that go with this HCC. But diabetes with acute complications, here are some of the examples of the codes, the ICD-10 codes that would reach this HCC. Now, these lists are available on the CMS website. So you can go in and search risk adjustment and then there are excel files that give you every HCC and every ICD-10 code that would be assigned to that HCC.

Monica Wright: Now the next thing that they look at is trumping conditions. So, you're looking at the patient's health status and you're saying okay, so this patient is in acute renal failure, it's acute on chronic and they also have chronic kidney disease. So when they're looking at the severity of the patient, they're saying okay, when you have diseases like this that are so clearly related, they're not going to give credit for all of them. So they have what they call trumping conditions. The most severe of the conditions is counted in calculating the risk and the ones that are less severe that are related are not. So, in this example, you would only report acute renal failure, well, sorry, let me take that back. You would still report them ICD-10's but they would only give an HCC for acute renal failure, not the chronic kidney disease stage five because the acute renal failure is the more severe HCC.

Monica Wright: The other thing that you get credit for when we're looking at this and we're going to see how this all plays out together, we're going to put it together in just a minute, are disease interactions. There's an additional risk factor added when two diseases are reported with known interactions. For example when you

report a patient that has both CHF and diabetes with chronic complications, there's an additional risk granted because those two diseases interact. So you get the HCC for CHF, you get the HCC for diabetes and then you get an additional risk factor for the interaction between those two diseases. So this is how they build to show a patient that is probably going to cost more to the program over the course of the year. Need more visits.

Monica Wright: So how does it work? So, we have all these things that build up to make this risk adjustment factor. This risk adjustment factor determines the health status of the patient. So we have all of these different factors that we're looking at, that we're putting together to kind of get a full picture of what we can use as a predictor of how much healthcare this patient will use.

Monica Wright: So this risk adjustment factor is then put into a number. It has to be something that can be calculated so they came up with a numeric system to figure out how to rate patients. So, they use a factor, starting with a factor of one. A factor of one is a patient that uses average number of resources per year. Anything that has a number greater than one is going to be a patient that's going to use more than average resources anyone with a number less than one will be a patient that uses less than average resources.

Monica Wright: So what does that mean? A factor of one has been estimated at $10,000 in medical costs per year. So, if you have a patient who comes up with a factor of one, that's what we're looking at when we're guesstimating how much they're going to cost the system. They're going to cost them $10,000 for the course of the year for all of their medical care.

Monica Wright: So let's take a look at some HCC's and see what they do to the reimbursement when we're looking at these risk factors. So we're going to start with our 82 year old male. Our 82 year old male is given a risk adjustment factor of .561 just for the age of the patient. In our first example, the patients seen for low back pain. So there's no HCC associated with low back pain. So we have a total score of .561, which using our factor of one is less than one. Okay, so we're underneath that. Our second example, we have our 82 year old male that comes in and he still has low back pain but now we know he also has CHF. So the CHF does have an HCC which gives us more of a risk adjustment factor. We get to add .323 to this total patient's risk. So now this patient's score is .884.

Monica Wright: Our final patient, we have this 82 year old male who has low back pain, still has CHF but now is also reporting CKD stage five. So now we have two different HCC's that can be reported on this day and you can report more than one per visit, you can report up to five as long as they're not related and trumping. So, in this case, this patient is now up to 1.121 on that risk adjustment score. So, we reached a score greater than that one for this patient with a couple of chronic conditions.

Monica Wright: So what does that look like in terms of money? So if we have an insurance company that's trying to insure these three patients in their population, it's a

small population but for examples sake. We know that our factor of one is $10,000, they're going to estimate that for these three patients we're looking at 2.566 risk factor, so the insurance can expect to spend $25,660 per year for these three patients. So, they can use that amount of money to say okay, Medicare's offering us $27,000 to cover these lives, we think we can do that with them and maybe a little bit of profit or no that's not enough money, we want $30,000 to be sure, if something happens we have a profit margin. So that's how that can be used.

Monica Wright: On the flip side, looking at it from a provider perspective, if we're looking at a capitated plan, our first patient dealing with a plan that is doing the payment per month based on a risk factor would only be $467.50 per month per capitation. Whereas, our third examples with the two HCC's would be $934.17 a month. So this can be done depending on the type of risk adjusted plan that you're in. Either just like this to where your payments per month will vary based on the health status of your patients or as kind of a blended rate where that would be taken into consideration by the overall and divided out for an average per patient rate that you would get per month.

Monica Wright: Okay, so Laurie any questions now before we go into how you would determine the patient costs that you're dealing with?

Laurie Fink: No, I'm not seeing any questions.

Monica Wright: Okay. So we'll move on. So, how do you determine the patient costs when you're looking at that, like the capitated example I just gave? Well these conditions, these diagnoses are reviewed over the course of a year. Not every HCC will be captured at every visit. It's not going to happen, the patients don't come in every time for every condition that's wrong with them. Some things come up during the year, you don't always see chronic conditions, if there's a sick visits and it doesn't have to be. We're just trying to capture the overall health of the patient so over the course of a year, hopefully, you will see the patient for every condition that they have. Now, these risk adjustment factors reset every year. So it doesn't matter that the patient has a truly chronic condition that's not going away, take CHF for example. In January, according to the risk model it's gone, they don't have it anymore. Until you tell them again that they have it. So it's very important that these conditions get reported every year.

Monica Wright: Now, when we're doing this again it's a year set up, so your payments not going to vary per visit, it's not going to be like oh, I just reported CHF so now my payments going to up. That's not how it works. It's looked at again over the course of the year. So the next year it may vary, especially if you didn't report a chronic condition this year that the patient had the year before. Perhaps peripheral vascular disease, then that patient's health status would seem to go down even though the patient didn't. But as far as the insurance is concerned then they're not going to pay as much.

Monica Wright: Okay, so the next area where you're being affected right now by risk adjustment is the cost factor for MIPS. Clinicians are being assessed on their cost management performance and this started in 2018. It's happening now. These cost measures are risk adjusted, so higher cost benchmarks are achieved when care is provided to higher risk populations. So, overall, when you're reporting your diagnoses on your patients and they're being taken into effect for your overall patient population, if you're reporting the diagnoses that go to the HCC's then you're telling CMS we're seeing sicker patients. CMS is going to risk adjust and reflect that when they're determining your costs. They're going to say okay, based on what you've told us of your patient population and that would be for any provider that had seen that patient in that year gets the overall health status of that patient, then you are doing average costs for patients that are that sick. If you don't report those HCC's, those diagnoses that give you those higher risk adjustments during the course of the year, then when we get to this cost of care, as far as CMS is concerned, these are average patients. They don't have a lot of chronic conditions, you're not seeing patients that are really sick.

Monica Wright: But your costs look really high because you are treating patients that are really sick it's just not being reflected. So it's really important for everyone, this is kind of a group effort, to get the health status correct for the patient population. Those HCC's are reported so that CMS is accurately determining your patient population when they determine your cost of care.

Monica Wright: The cost factors are being done two ways. The first is the Medicare spending per beneficiary. This is done looking specifically at episodes of care and the episode is the period immediately prior to, during and following a hospital stay. So they're paying attention to hospital stays and readmissions. The second piece is the total per capita costs. This is the standardized, annualized risk adjusted, specialty adjusted measure. So this is looking at everything for your solo practitioner or your group by tax ID to say based on the health status of all of these patients where does your cost fall among other providers. We're seeing this now, this is something that you're dealing with. It's a hard thing to track. I mean you don't have this information in front of you to know what's going to happen with your cost factor. Those of you that participated with PQRS years ago, you might have your QRUR reports from years ago as an idea of something to look up against. They don't release them anymore, you can't find them on the Medicare website anymore. But if you had them from previous years you could look at that to kind of get an idea of where your cost factors may fall.

Monica Wright: Then of course we all know, are very aware of the MIPS financial impact right now for year, the possible bonus or penalty is going up. So, for 2019, we're still at 4% which was based on 2017 reporting. Right now we're reporting in 2019, so when we see this bonus or penalty in 2021 it's going to be 7%. Then next year it's going up to 9%. So this is important. It is making a difference to your bottom line. So you want to be sure that you're reporting as much as you can to try to mitigate any issues with cost based on risk adjustment.

Monica Wright: Laurie any questions?

Laurie Fink: Nope, no questions as of yet.

Monica Wright: Okay. So let's shift to how the insurance companies are getting their information. How are they collecting this HCC information? Well they're collecting it from your billing. They're collecting ICD-10 codes that you put on your bills. Then, at some point during the year, they're reviewing provider reports for reporting accuracy. So you might be getting letters from your commercial payers, especially the Medicare Advantage plans that say we are requesting records from you for the purpose of evaluating HCC's or for risk adjustment. So, at that point in time they're looking at your provider's documentation to see if you justified the ICD-10 code that you sent through them for billing.

Monica Wright: So, when we look at the data source of how this information is obtained, it's kind of the reverse of how the payment came down initially. The data is coming from you. The data is coming from providers, facilities and suppliers. You are feeding that information up to the insurance contractor, the Medicare Advantage plan, who in turn is giving that information to CMS. So your data is essential. CMS is more and more determined to get accurate data. They want to see that they are properly putting health statuses to beneficiaries to be sure that we know the accurate costs of what we're doing.

Monica Wright: So, from that standpoint CMS does data validation audits. They have the Medicaid and the Medicare Advantage plans submit records. How do they do this? Well, obviously the health insurance plans don't keep all these records, so the health insurance plans are required to go back to the provider and say hey, we're being audited, we need you to send us your records. It's actually your provider's documentation that's being audited in these audits to determine if it meets the guidelines for the HCC's that the insurance companies are being paid on. So, in this scenario, even though it's not necessarily an audit like you would think of a CPT evaluation and management audit, still your data is being looked at by these insurance companies by CMS. If these Medicare Advantage plans are getting marked down from CMS based on your provider's data which will eventually flow back down the hill. The insurance providers may decide they don't want your provider contracted anymore. They could, who knows there aren't really any penalties on the ICD-10 side yet but that's something that could come if there are penalties that end up flowing downhill.

Monica Wright: So what do providers need to do? What are we looking for? What is it important that providers understand with this change to risk adjustment? First and most important is to improve the accuracy of diagnosis documentation and coding. You want to be sure we have these ICD-10 codes that are very specific, you want to take advantage of that. Be sure the documentation is as specific as possible and that they coding that you're doing reflects that. We want to use the highest level of specificity in the ICD-10 codes. As we saw that chronic renal failure has a HCC but only for stage four and stage five. So, if your documentation just says CKD and that's it then it doesn't matter what stage the patient actually has, it's

not documented, you're not going to get credit for the HCC. So, it's really important that we've got the specificity.

Monica Wright: Document comorbidities because a lot of these chronic conditions, that's what they are. It might not be the main reason you're seeing the patient for that day but diabetes and CHF almost always affect any other condition you're treating for the patient. Check your Medicare Advantage and ACA plan guidelines to see if they pay for comprehensive annual visits. We all know Medicare has the Medicare wellness visit which isn't truly a physical. But some of these other plans actually have more of a physical exam allowed in which case that's your perfect opportunity to be sure you're capturing all of the chronic diagnoses that the patient may have.

Monica Wright: So, let's talk a little bit about documentation. So I've told you what needs to be there but how? What do you need to document? What needs to be there for you to meet these HCC requirements? First, the documentation must come from a face to face encounter. The documentation must be properly signed. If it's not signed, they cannot use that encounter. Patients name must be on all pages or clear if it came out of an EMR that it's all the one patient. The diagnoses must be clearly documented. Coders can't interpret. We can't see a lab and say oh, based on that A1C they must have diabetes, can't do that. It's got to be clearly documented. It should be coded to the highest level of specificity and again I mentioned a little bit earlier, there can be more than one HCC per encounter. You can capture more than one. Now again, you're only going to capture what the patients being seen for that day. So if it has absolutely nothing to do with why they're there, then no you're not going to capture it that visit. That's fine because you have a year to capture all the HCC's. There will be another visit I'm sure if the patient really has chronic conditions that they're coming back for that chronic condition.

Monica Wright: So what are you looking to document? The rule of thumb with HCC's is you're looking to document M.E.A.T., which stands for Monitor, Evaluate, Assess, and Treat. So under monitor we're looking for signs and symptoms. Evaluate, test results, current medications, response to the treatment. Assess, order tests, counseling, review records. Treatment, medications, therapies, procedures. So you want to show that the condition is being treated on that day. Again, we can't count an HCC unless the patient is being seen for treatment of that condition.

Monica Wright: Terms that convey M.E.A.T.s in your documentation, stable, improving, weaning, decompensating, okay these are the types of things that would come up in a plan that would indicate that the patient was seen for these conditions on that day. This is the status of that condition, you have to give a status of the condition for it to be included in the note.

Monica Wright: Any format is acceptable as long as the M.E.A.T. is clearly documented. So it doesn't matter if it's a SOAP note, if there's another format that works better with your EMR, that's fine. Abbreviations should be standardized so that their

meaning is clear. You want to be sure that you're not using something that you use in your office but could be misconstrued because if they can't determine exactly what you're supposed to mean, then they can't use it. Each documented diagnosis should have an assessment and plan. This is where you have to watch your problem lists. Just because it's listed in a laundry list problem list that the EMR happens to put on the note doesn't mean you're going to get credit for it in that visit. They're looking for an assessment and plan of that condition that day. That laundry list, problem list shouldn't be what's going out on your bill either. It should be specific to the assessment and plan for that day.

Monica Wright: Again, conditions must be treated and documented at least once a year to receive HCC credit. You can report up to five per visit. A history of a condition does not count, it must be actively treated. So be aware of history of, for example DVT. History of DVT is not going to count. It would have to be clearly documented as chronic DVT to continue to get credit. Conditions can only be reported if the documentation supports the condition effected the management of that patient during that particular encounter. So again, comorbidities count but they have to clearly be comorbidities to what's going on or it needs to be an annual assessment where you are looking at multiple conditions.

Monica Wright: Be sure you're documenting causal relationships. To receive credit for complications, the diagnoses must be linked. Words like due to, associated with, secondary, diabetic, and hypertensive. A patient with diabetes and neuropathy, you're not going to get credit for the HCC for diabetes with complications with that. You need to say the patient with diabetic neuropathy in order to get credit for the diabetes with complications. You want to be sure that they're linked. If you want more information on how to do this in your documentation we did have another webinar last month that went into more detail of what should be in the documentation to justify these relationships.

Monica Wright: Be aware of your problem list, analyze it, and review the problem. Compare the problem lists to the assessments. Is there anything unspecified in the problem list that shouldn't be there because it's really a much more specific condition. Note any discrepancies between the problem list and the documentation and note any obvious documentation deficiencies. This will help you be able to see where you might be lacking, what diagnoses you might not be getting credit for because things aren't being documented with enough detail.

Monica Wright: Okay, so I have one last poll question. Because this is probably the big one, so, this is all comes to payment and money and saving money but does risk adjustment improve outcomes? So, I have a couple of multiple choice here and let me know what you think. For risk adjustment, can it improve the healthcare evaluation? It can identify a patient's health status. It can reinforce prevention. It can emphasize chronic care management or it can do all of the above.

Laurie Fink: Monica while people are entering their answers we did a question submitted from one of our attendees, I'll go ahead and read that to you now.

Monica Wright: Sure.

Laurie Fink: Given that we don't get the CMS MIPS cost information until after the performance year, how would you suggest tracking HCC coding throughout the performance year?

Monica Wright: I think the biggest thing to do is some level of internal audit. Just to review the documentation compared to the ICD-10 codes that are going out the door. There has to be some education with physicians or with coders to be sure that you're documenting to the level of specificity to meet the HCC's. I know a lot of times the physicians might document very well, for example, the chronic kidney disease stage five, but because of the problem list or how the EMR's set up they're just pushing out the door CKD unspecified. That's a good place to start. Start with your, if you can run a list of your most commonly used diagnosis codes and if you look at the HCC's and you get diagnosis codes like unspecified CKD, which is a diagnosis that more than a good portion of the time can hit an HCC but it's not being captured. That's a good place to look and do some education, check, the documentation see what's there and educate whoever is entering those diagnosis codes to be sure that it's right.

Monica Wright: Okay, so everyone says all of the above and that is correct. I mean this might seem like a lot of information that it may be a difficult way to do things but we're trying to get to, if you think about population health, we're trying to get to the status of the whole patient. So, can this improve the healthcare evaluation? Yes, because you're trying to look at the whole patient, you're trying to find out all of their chronic conditions. The things that could affect their health in the long run. It's identifying the health status of these patients. It can reinforce prevention if there is some possible medical family history, if you have that. If you're getting that information. A patient with chronic conditions getting treatment before they get to the exacerbation and the hospitalization. It absolutely emphasizes chronic care management, again for that reason, for getting the patients in, getting them seen, getting it documented that they have the conditions. Being sure that we're keeping them out of the hospital.

Monica Wright: So, some final thoughts. Specificity should be the new normal. Comorbidities matter. Capture all of these conditions yearly. Consider internal auditing as a tool to be sure that these diagnoses are being captured appropriately. Remember that your documentation is affecting insurance plans and at some point in time they can turn the tables on that. So, you want to be sure that you are documenting as appropriately as you can, especially as we get away from perhaps all the auditing of the CPT codes with Medicare's new E & M rules. There's going to be some auditing that still comes into play because this is going to be something else that comes up.

Monica Wright: Any other questions?

Laurie Fink: We don't have any more question submitted, oh, yep we just got one. Next question asks where can we get the list of HCCs again, please?

Monica Wright: If you go to CMS.gov, the CMS website and you type in risk adjustments. Then you'll get a whole page of, it's literally a bunch of excel files and they're mappings is what they call, they're called the mappings. If you look at the mappings it will give you all the HCC's and all the diagnoses that go to the HCC's. They're done yearly, they have years on them.

Laurie Fink: All right, next question is, are there any tips or tricks for clinicians to quickly identify the proper specificity? A lot of times unspecified codes are chosen because it's quick and easy.

Monica Wright: Unfortunately, that is the case. The issue really comes down to how the ICD-10 codes are being chosen. I know ICD-10 being as cumbersome as it is, we got away from having unlisted on the super bill because there were just too many to be able to track. A lot of the EMR's though it's much easier, like you said, to click on that unspecified code than to dig down to the next level. It really comes down to perhaps identifying a couple of key ones. Again, running a report to see your unspecified diagnosis list. Look at a couple of the keys that could be more specific and then looking at the documentation and doing some training around what's the easy way to get to it from your EMR. Is it knowing the first letter and the first two digits of the code? Is it knowing you put in this abbreviation instead of just saying CHF you have to put in diastolic or something first? See based on your situation what the best way is to kind of tackle that. Because unfortunately it's not going to be uniform, it's going to be based on how everyone else out there is capturing the data.

Laurie Fink: All right, Monica, I'm not seeing any additional questions.

Monica Wright: Okay, well I'm going to turn the end of the presentation here over to Kem for a minute.

Kem Tolliver: Hi everyone and Monica, thank you so much. That was very insightful and I hope that everyone gained some new tidbits of information. I just wanted to tell you a little bit about Medical Revenue Cycle Specialists and also thank Quality Insights for allowing us to present this program to you. We are based in the Maryland, D.C., Virginia area and we've kind of been, you've been given information about the types of services that we provided during our introduction. So, I won't go too much further into that. We can go onto the next slide.

Kem Tolliver: We do provide support to private medical practices in our area and outside of this area. We're happy to provide any assistance to anyone who may need it. We can go to the next slide. Again, this is a list of the services that we provide. We do a ton of training and education. We assist practices with understanding their payer contracts, the terms, the guidelines and their fee schedules. So again, we'd be happy to assist you if you need any additional support in those areas, to include chart audits. You can go to the next slide.

Kem Tolliver: This is our contact information. If you'd like to reach out to us, feel free to do so. I believe the slides from the program will be available to everyone who has attended today. So, thank you.

Laurie Fink: Thank you, Monica and Kem, and thank you so much for everyone who joined us today. I did put a link in the chat window for where the recording of this session and also the slide deck will be posted. Most likely those will be available by the end of the week. Just a quick reminder that when you close out of today's session you will be automatically directed to a very brief evaluation. We ask that you please take a moment to complete it and we greatly appreciate your feedback and all your comments. So thanks again for joining us today, have a great rest of the day. This session is now concluded. Thanks.



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