Introduction to Medicare Advantage Risk Adjustment and Clinical Documentation Improvement

Sr. Medical Director – Dennis Hsieh, MD
Medicare Consultant – Damaris Ramirez, CPC, CRC, CPC-I
Risk Adjustment Consultant – Chelsea Coleman, COC
Introduction

• **Optum** collaborates with health care professionals and health plans towards improved health outcomes.

• **Optum** provides tools and support to assist providers in the early detection, ongoing assessment and accurate reporting of chronic conditions.

• **Optum** applies technology and health intelligence solutions that help providers accurately document and code health care services while improving the overall quality of patient care.
A More Comprehensive Approach

• Medicare Advantage members need to have all chronic conditions assessed
  
  – Provides providers with an overall health status for each patient
  
  – Results in all conditions being monitored by the provider

• Improves quality of patient care

• Complex conditions are monitored and may reduce the need for emergency care

Course Disclaimer

The information presented in this course complies with accepted coding practices and guidelines as defined in the ICD-10-CM coding book. It is the responsibility of the physician or other healthcare provider to produce accurate and complete documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-10-CM code(s) according to the guidelines. If the documentation in the medical record does not support a given code, that code cannot be used.
Agenda

• Acronyms and definitions
• CMS risk adjustment
• Definition, purpose, and process
• Patient RAF score
• Guidelines for documentation and coding
• How the data flows
• The impact of optimal documentation and coding
• The provider’s role
• Resources
Learning Outcomes

• **Understand** Medicare Advantage & Risk Adjustment

• **Identify** your role in helping place members into the appropriate “risk” category for expected resource allocation and utilization

• **Explain** the importance of various data sources and their relationship with high risk chronic conditions coding and quality reporting

• **Understand** the importance of documentation and coding specificity for Medicare Advantage members
Commonly Used Acronyms

ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification

RAPS/EDS – Risk Adjustment Processing System / Encounter Data System

CMS – Centers for Medicare & Medicaid Services

MA/RA – Medicare Advantage / Risk Adjustment

HCC – Hierarchical Condition Category

RAF – Risk Adjustment Factor

RADV – Risk Adjustment Data Validation
What is a Medicare Advantage (MA) Plan?

Patients who are eligible for Medicare have two main options: Original Medicare or Medicare Advantage

**Medicare Advantage** plans are:

- Health plan options that are approved by Medicare and are run by private companies
- Medicare pays these private plans for their members’ expected health care each month
- MA Plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Original Medicare doesn’t cover

What is MA Risk Adjustment?

**Definition**
Method used to adjust payment to Medicare Advantage health plans based on demographics as well as health status of a plan’s enrollees.

**Purpose**
Allows CMS to make appropriate and accurate payment to Medicare Advantage plans for enrollees with differences in expected costs.

**Process**
Required method used since 1997; fully implemented by 2007 with completion of 100% risk adjusted payments for Medicare Advantage organizations.

How is a patient’s risk score calculated?

Age & Gender

Disability and/or Original Reason for Entitlement

Medicaid Status

Community vs. Institutional Status

Chronic and some Acute Conditions

Patient RAF Score

Interpreting the Risk Adjustment Factor (RAF)

RAF score identifies patient health status

- Low RAF score may indicate a healthier population
- High RAF score may indicate members with increased health risks

OR

- Low RAF score may **falsely** indicate a healthier population due to:
  - inadequate chart documentation (or)
  - incomplete and/or inaccurate ICD-10-CM coding
  - patients who were not seen

- High RAF score **may be inflated** due to:
  - reported diagnoses not documented
  - overcoding (e.g., copying and pasting problem list into assessment/plan)
CMS Risk Adjustment Process Review

- Face-to-Face Visit
- Provider Properly Documents Visit
- Appropriate ICD-10-CM Code Assigned & Submitted
- Accurate Allocation of Resources for Patient Care

Detailed Documentation

Accurate Program Funding
Medicare Advantage: Why Coding Matters

Note: For PY 2016 (CMS-HCC model) CMS will use plan-specific per member per month (PMPM) out-of-pocket cost (OOPC) estimates to identify meaningful differences in beneficiary costs among the same plan types, which will be calculated for each plan offered by the same MAO in the same county.

- **Basic Medicare Advantage PMPM**
  - Plan Base PMPM Payment

- **Multiplied by:**
  - Clinically complex patient

- **HCC Codes:**
  - HCC 108 PVD
  - HCC 58 MDD
  - HCC 111 COPD
  - HCC 18 DM
  - HCC 22 Morbid Obesity
  - HCC 55 Addiction

- **Validation:**
  - Documented treatment of complex needs with appropriate DX codes

- **No documentation:**
  - Addressing complex needs (i.e. M.E.A.T.) with appropriate DX codes

- **Equates to:**
  - More equitable funding to the MAO to support high risk medical resource utilization

- **Equates to:**
  - Reduced Funding
Risk Adjustment Overview Example

The Risk Adjustment Model

- **Is a “Predictive” Model**
  - 2017 payment based on 2016 DOS
- **Is an “Additive” Model**
  - includes all qualifying diagnoses from various categories within the model

### Example:

- 76-year-old female
- Medicaid FB dual eligible
- Diabetes
- Vascular disease
- Ulcers
- CHF

### Calculations:

- **76-Year-Old Female (aged)**
  - Medicaid FB Dual Eligibility: 0.611

- **Vascular Disease (DM with vascular disease; aka peripheral angiopathy)**
  - E11.51 (HCC 18): 0.346
  - E11.51- (HCC 108): 0.324

- **CHF**
  - I50.9 (HCC 85): 0.355

- **Disease Interaction (CHF + DM)**
  - 0.205

**RAF Score = 2.598**
Example:
- 76-year-old female
- Medicare & Medicaid eligible
- Diabetes
- Vascular disease
- CHF

Risk Adjustment Overview: Example

<table>
<thead>
<tr>
<th>Age/Sex Demographics</th>
<th>High Risk Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diabetes w/ vascular complications (HCC 18) 0.346</td>
</tr>
<tr>
<td></td>
<td>Vascular disease (i.e. diabetic peripheral angiopathy) (HCC 108) 0.324</td>
</tr>
<tr>
<td></td>
<td>CHF (HCC 85) 0.355</td>
</tr>
<tr>
<td></td>
<td>Disease Interaction (DM + CHF) 0.205</td>
</tr>
</tbody>
</table>

76-year-old female
Community, FB dual aged 0.611

Total RAF 1.841
# 2017 RAF Coding Examples (2017 CMS-HCC Model)

<table>
<thead>
<tr>
<th>All conditions coded appropriately</th>
<th>Some Conditions coded – low level of specificity</th>
<th>No conditions coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female (Community, Full Benefit, Aged)</td>
<td>76 year old female (Community, Full Benefit, Aged)</td>
<td>76 year old female (Community, Full Benefit, Aged)</td>
</tr>
<tr>
<td>0.611</td>
<td>0.611</td>
<td>0.611</td>
</tr>
<tr>
<td>Diabetes w/ vascular complications</td>
<td>Diabetes w/o complications</td>
<td>No diabetes coded</td>
</tr>
<tr>
<td>0.346</td>
<td>0.097</td>
<td>X</td>
</tr>
<tr>
<td>Vascular disease (i.e. diabetic peripheral angiopathy)</td>
<td>Vascular disease</td>
<td>No vascular disease coded</td>
</tr>
<tr>
<td>0.324</td>
<td>0.324</td>
<td>X</td>
</tr>
<tr>
<td>CHF</td>
<td>No CHF coded</td>
<td>No CHF coded</td>
</tr>
<tr>
<td>0.355</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Disease interaction (DM + CHF)</td>
<td>No disease interaction</td>
<td>No disease interaction</td>
</tr>
<tr>
<td>0.205</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total RAF</td>
<td>Total RAF</td>
<td>Total RAF</td>
</tr>
<tr>
<td>1.841</td>
<td>1.032</td>
<td>0.611</td>
</tr>
</tbody>
</table>
The CMS Directive

The Mandate from CMS

Any Condition that is **taken into account** or affects patient care, **treatment** or **management** should be documented and ultimately coded.

Chronic Conditions

–**Outpatient Coding**: Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

–“Code all documented conditions that coexist at the time of the encounter/visit, and **require or affect patient care, treatment, or management.**”

The **POWER** of the Diagnosis Code

- **Report**
  - The condition in a quantifiable way

- **Support**
  - Complexity of Services

- **Validate**
  - Medical Necessity

- **Identify**
  - Conditions for Quality Care

May *help predict* anticipated costs of caring for Medicare Advantage members

**Diabetes**
Claims Data **IMPACTS** Chronic Condition Reporting

Many Conditions may have an Additive Effect on Risk Adjustment

- Diabetes & manifestations
- Protein-calorie malnutrition
- Active treatment for cancer
- Chronic lung disorders
- Major organ transplant
- Hypertensive diseases
- Major depression
- Ostomy status and attention to cardiovascular conditions
- Morbid obesity & BMI
- Lower limb amputations
- Renal dialysis
Documentation Improvement **Impacts** Coding Intensity

Many **chronic conditions** that have an impact on risk adjustment are often under-documented. Consider these improvements if appropriate:

- Diabetes **w/o a complication** vs. Type of diabetes **with a complication**
- Chronic Kidney Disease vs. Chronic Kidney Disease **Stage ____**
- Heart Failure vs. Hypertensive CKD stage ____ **with heart failure**
- PAD/PVD vs. **atherosclerosis** of (site, laterality, and severity)
- COPD vs. COPD exacerbation or with infection
- BMI alone vs. Morbid Obesity **with BMI**
- Major Depressive Disorder, unspecified vs. MDD (episode & severity)

*The above are examples only, document and code to the highest level of specificity that reflects the patient’s condition(s).*

- Correctly sequencing diagnoses
  - In order of acuity: 1\(^{st}\) – what’s being treated; 2\(^{nd}\) – what’s considered when treating (e.g. chronic conditions, status conditions, historical conditions)
Are You Coding Correctly?

• Quick-Pick Lists, Common Lists, Favorites Lists can be misleading:
  ➢ Such utilities may be efficient but may not be always accurate
    - Such coding utilities may be defaulting to unspecified codes if not continually updated
    - The descriptor of unspecified codes may not fully satisfy the diagnostic statement on a case-by-case basis

Document — to the greatest degree of certainty based on your clinical judgment and code to that same level of specificity

• Copying and pasting your entire problem list into your A/P is unacceptable
  - Code only the known conditions you’re treating or considering when treating
CMS Expectations
Provider’s Role
CMS Expectations: Provider Role in Documentation

Risk adjustment diagnoses submitted for accurate reimbursement and screenings must be:

- Documented in the medical record from a **face-to-face** encounter
- Coded per ICD-10-CM Official Guidelines for Coding and Reporting
- Coded per Appropriate CPT Category I and Category II codes and HCPCS codes and modifiers where applicable
- Addressed and submitted **annually**
CMS Expectations: Provider Role

Progress note documentation overall requirements:

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concise</td>
<td>• reason for the face-to-face visit</td>
</tr>
<tr>
<td>Consistent</td>
<td>• services rendered</td>
</tr>
<tr>
<td>Complete</td>
<td>• conclusions, screenings and follow-up</td>
</tr>
<tr>
<td>Logical</td>
<td>• documentation supporting that the patient is being monitored, evaluated,</td>
</tr>
<tr>
<td></td>
<td>assessed and/or treated for the condition(s) listed based on clinical</td>
</tr>
<tr>
<td></td>
<td>rationale and/or plan of care based on clear (legible) notes</td>
</tr>
<tr>
<td>Authenticated</td>
<td>• by the servicing provider (signature &amp; professional credentials)</td>
</tr>
<tr>
<td>Name &amp; Date</td>
<td>• on each page of the progress note</td>
</tr>
</tbody>
</table>
Progress note documentation: Assessment Section

**Specificity**
- Document each clinical diagnosis to the **greatest degree of certainty and specificity** per encounter
  - Document all complications and/or manifestations including the causal language (e.g. diabetic, hypertensive, due to … if using handwritten notes)

**All Known Conditions**
- Document **confirmed conditions**.
  - Merge specified conditions from consult notes & discharge summaries
  - Abnormal findings are not coded from labs/radiology, etc. unless clinical significance is documented by the physician

**All Chronic Conditions Yearly**
- Document all **chronic conditions** at least **once per year**

**All Problem Pertinent Chronic Conditions**
- Document any **chronic condition** that affects the care and treatment of the patient on that date of service

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Documentation Findings: Evaluative Language

In addition to documenting the diagnoses, it is **recommended** to use the S.O.A.P. format and to document evidence of **M. E. A.T.**\(^1,2\)

- **Monitoring** (or)
  - Example: Monitoring of drug interactions, underdosing, overdosing\(^2\)

- **Evaluation / Assessment** (or)
  - Evaluation of care provided *(Refer to the 1995 & 1997 E&M Documentation Guidelines)*\(^1\)
  - Evaluation performed by a physician or a non-physician professional (e.g., PA, NP)\(^1,2\)

- **Treatment**
  - Document and code all co-existing conditions at each encounter affecting care, treatment or management\(^2\)
  - ICD-10-CM codes are used to describe the clinical reason for a patient’s treatment\(^2\)

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Locking Progress Notes

• Importance of locking progress the notes in EMR systems
  – To protect the integrity of the medical record; prevent unauthorized access or alterations.¹

• Timeframe required for locking progress notes
  – It is recommended to lock progress notes when the provider signs the note to authenticate it; however, under circumstantial situations, this may not always be desirable.
  – Although there is no official regulation, many organizations have created policy to have electronic charts locked usually within 48 to 72 hours but no longer than 30 days from the DOS to comply with HIPAA and security standards.²


Where to Find Information on Medicare Risk Adjustment

Medicare risk adjustment information

Includes:
- Evaluation of the CMS-HCC Risk Adjustment Model
- Model diagnosis codes
- Risk Adjustment model software (HCC, RxHCC, ESRD)
- Information on customer support for risk adjustment

Can be found at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

The ICD-10-CM to HCC mappings

Can be found at:

The revised relative factors, coefficients and disease interactions

Can be found in the 2017 Announcement at:

Pages 77-84
Coding Disclaimer

This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the “thought process” of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 3, 2017, CMS announced the CMS-HCC Risk Adjustment model for payment year 2018 driven by 2017 dates of service. For more information see: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf, and https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html.

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Any Questions?