HCC Risk Adjustment

Terminology:

- HCC
- CCV
- AHA
- RAF Score / Risk Score

What is Risk Adjustment?

Who?

Medicare Advantage Plans, Health Insurance Exchanges, others

What?

Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees

Why?

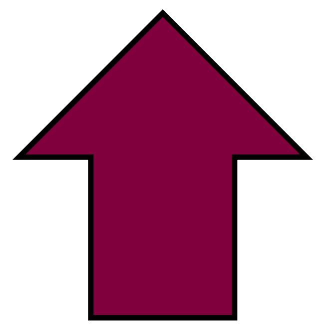
To protect against adverse selection and risk selection

How?

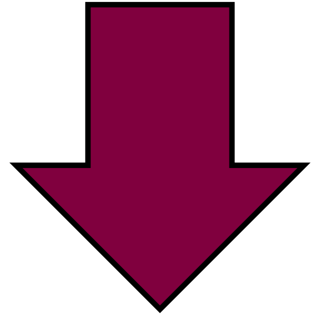
Actuarial risk based on enrollees' individual risk scores

RAF Calculation

Risk Score



Higher risk scores represent members with a higher disease burden resulting in appropriately higher reimbursement.



Lower risk scores represent a healthier population, but may also be due to:

- Poor chart documentation
- Poor diagnosis coding

Why is this important?

- Results in appropriate reimbursement
- Augments the overall patient evaluation process
- Allows us to stratify patients by risk
- Metric for considering panel size, productivity, access, and coding education efforts

Current Scope:

Plan		Attributed Lives	Gain Share	Downside Risk
Trinity Health ACO Livonia, MI	NGACO	24,876	80%/6.5	80%/6.5
Blue Cross Blue Shield Blue Care Network of Michigan	MCW	3,785	100%	91.5%-100.65%
Blue Cross Blue Shield Blue Care Network of Michigan	Healthy Saver	4,163	100%	91.5%-100.65%
PriorityHealth	MA	16,561	50%	TBD

Current State:

HCP-LAN APM Framework
Category 3A: 83%
Category 3B: 17%

17%

83%

35%

65%

FFS

APM

HCC Risk Model

- Diagnosis codes with RAF values are grouped into Condition Categories.
- Diseases within a Condition Category are clinically related and are similar in respect to cost patterns.

HCC	Description	Applicable Diagnoses to HCC Category		RAF
111	Chronic Obstructive Pulmonary Disease	• COPD • Chronic Bronchitis	• Emphysema	0.346
108	Vascular Disease	• Atherosclerosis (of native or bypass grafts with or without complications [rest pain, claudication, etc]) • Aortic Aneurysm (nonruptured) • Arterial Aneurysm	• PVD • Phlebitis and Thrombophlebitis (acute or chronic) • Embolism of Veins (acute or chronic) • Diabetic Peripheral Angiopathy	0.299

- There are 79 identified Condition Categories in 2018.

Meat Criteria

- Supporting clinical documentation must be present for all reported diagnoses.
- Diagnoses lacking MEAT criteria will not be counted for HCC purposes

M onitor
E valuate
A ssess
T reat

Accurate and complete diagnosis coding is key

- Document to the highest specificity

Example 1:

Diagnosis	RAF
Depression, NOS	0.000
Major Depressive Disorder, Single Episode, Mild	0.330

Example 2:

Diagnosis	RAF
DM2	0.118
Major Depressive Disorder, Single Episode, Mild	0.368

- ICD-10-CM classifies inadequately controlled, out of control, and poorly controlled diabetes mellitus to diabetes mellitus, by type **with hyperglycemia**

Documentation of Combination Codes

- Link Chronic Disease Manifestations to their Etiology

Example 1:

Diagnosis	RAF
Type 2 Diabetes	0.118
Chronic Kidney Disease, Stage 3	0.000
Total RAF	**0.118**

Example 2:

Diagnosis	RAF
Type 2 Diabetic, CKD, Stage 3	0.368
Total RAF	**0.368**

Documentation of Combination Codes

- ICD-10-CM now assumes a causal relationship between certain chronic conditions and many common manifestations.
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.
- Coders can now assign combination code(s) for certain chronic conditions where these causal relationship guidelines apply.

Diagnosis Tips & Tricks – Morbid Obesity

- Morbid Obesity is diagnosed when a patient has either of the following criteria:
  - BMI ≥ 40
  - BMI 35 - 39.9 **with** obesity related comorbid condition(s)
    - Arthritis
    - Sleep Apnea
    - High Blood Pressure
    - High Cholesterol
    - Type 2 Diabetes
    - Venous Stasis Disease
    - Soft Tissue Infections
    - Congestive Heart Failure
    - Fatty Liver Syndrome
    - Gall Bladder Disease
    - Depression
    - Stroke or Stroke Risk
    - Inability to Carry Out Daily Activities
    - Psychosocial Stress From Obesity
    - GERD

Diagnosis Tips & Tricks – Cancer

- Current Malignancy versus Personal History
  - When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.
  - When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, assign the "personal history of malignant neoplasm" code.
- Tamoxifen Treatment versus Prevention
  - If the patient is receiving Tamoxifen to treat the malignancy, code to active cancer.
  - If the patient is receiving Tamoxifen for prevention purposes following eradication of malignancy, code to personal history of cancer.

Diagnosis Tips & Tricks – Stroke

Acute Stroke vs History/Late Effects

- Acute stroke is only coded during the initial episode of care. After an initial stroke incident, generally one of two scenarios will exist. Either the patient will have deficits from the stroke (conditions left behind such as paralysis) or will make a recovery without any long-lasting effects.
- If the patient recovers without any lingering problems related to the stroke, the code would be Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits.
- If the patient has deficits present after the discharge from the initial acute care episode, all deficits are coded to Sequelae of stroke (subcategory I69.3-). Category I69.- is to be used to indicate conditions in I60.- to I67.- as the cause of the sequelae. The "sequelae" include conditions specified as such or as residuals which may occur at any time after the onset of the causal condition.

Diagnosis Tips & Tricks – Stroke

Example	Description	Appropriate ICD-10-CM Code(s)
Office visit to evaluate dysphagia from a stroke one month ago	Follow-up for evaluation of stroke with late effect.	**I69.391 -** Dysphagia following cerebral infarction **R13.10 -** Dysphagia, unspecified
Office visit to evaluate right sided hemiparesis from a stroke seven months ago.	Follow-up for evaluation of stroke with late effect.	**I69.351 –** Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
Office visit following hospital discharge for stroke without any residual deficits	History of TIA (or CVA)	**Z86.73 –** Personal history, transient ischemic attack (TIA), and cerebral infarction without residual deficits

- For hemiplegia, hemiparesis and monoplegia following stroke, be sure to identify whether the patient is right handed, left handed or ambidextrous.
- Per AHA Coding Clinic 2017: "Unilateral weakness" that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis or hemiplegia.
  - Documentation clearly associating weakness of an extremity due to a CVA would be coded to Monoplegia of ____ limb following cerebral infarction (I69.33x).

Additional Diagnoses to Consider

- There are diagnoses in the HCC model that carry a RAF value, but are not treated or acknowledged because they just exist.
  - Amputation status = RAF 0.779
  - Ostomy status = RAF 0.651
    - (Respiration, Feeding or elimination)
  - Transplant status = RAF 0.891
- These diagnoses should be reported at least once each calendar year for accurate risk score calculation.

CMS requires all HCC diagnoses to be evaluated and reported each and every year the condition is present.

Questions?

References

- The Centers for Medicare & Medicaid Services: Evaluation of the CMS-HCC Risk Adjustment Model Final Report
- Risk Adjustment Training – ionHealthcare
  - Brian Boyce, BSHS, CPC, CPC-I
- Risk Adjustment Predictive Modeling, Documentation & Capture of Diagnosis Codes – AAPC 2014
  - Brian Boyce, BSHS, CPC, CPC-I
- AHA Coding Clinic