Introduction to Commercial Risk Adjustment

Florida Blue Provider Education

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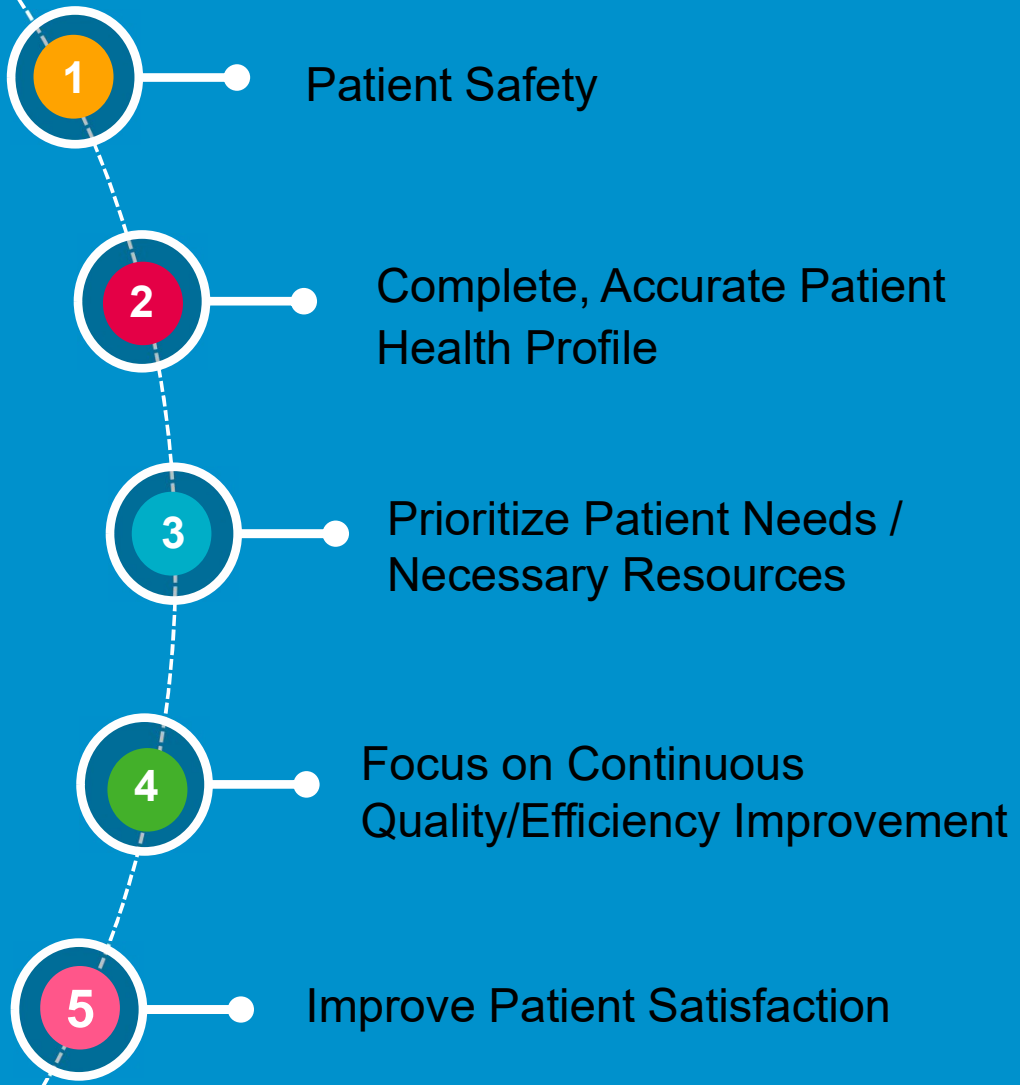
Rev 2023

Five Benefits of Risk Adjustment



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Commercial Risk Adjustment Brief Overview

1

The Center for Medicare & Medicaid Services (CMS) risk adjustment models predict medical care cost for Affordable Cares Act (ACA) patients.

Note: Risk Adjustment applies to both Medicare and Commercial (ACA), this presentation focuses on the uniqueness of ACA Risk Adjustment.

2

CMS assigns a risk score to each ACA member annually. This risk score is influenced by the member's demographic and health information.

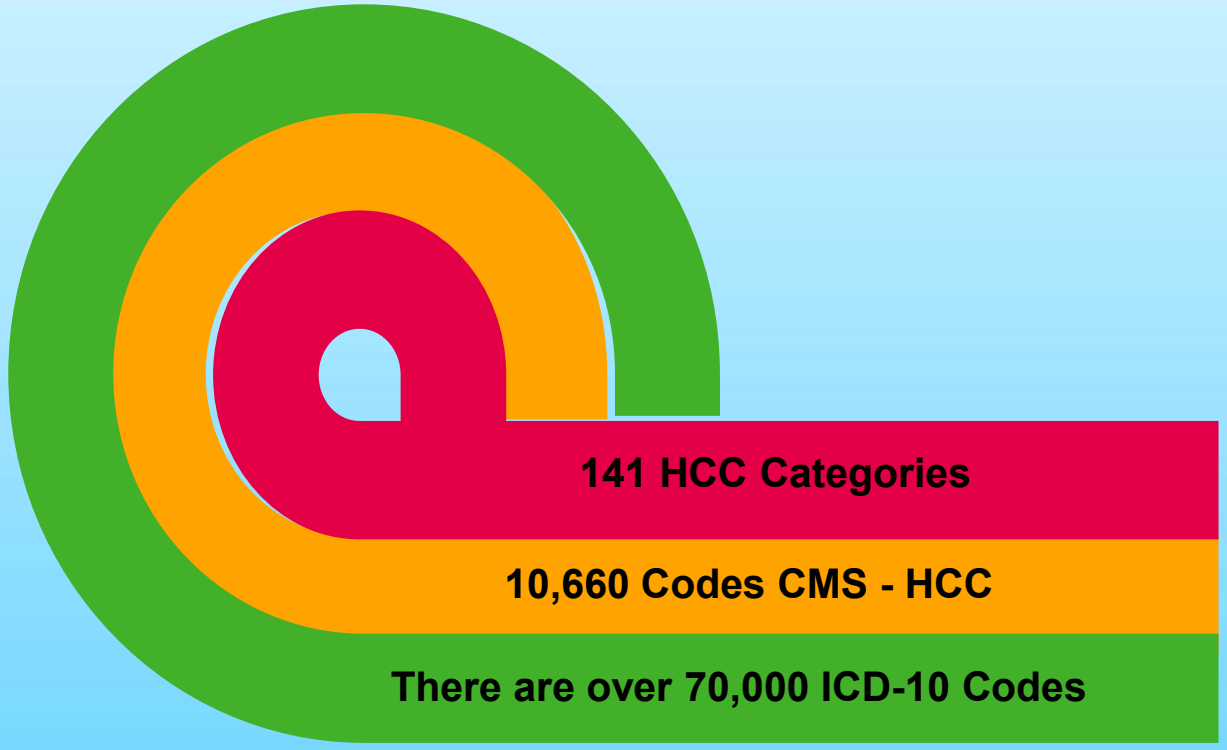
3

Physician documentation of member visits must be concise and capture all diagnosis.

Commercial Risk Adjustment (ACA) Overview

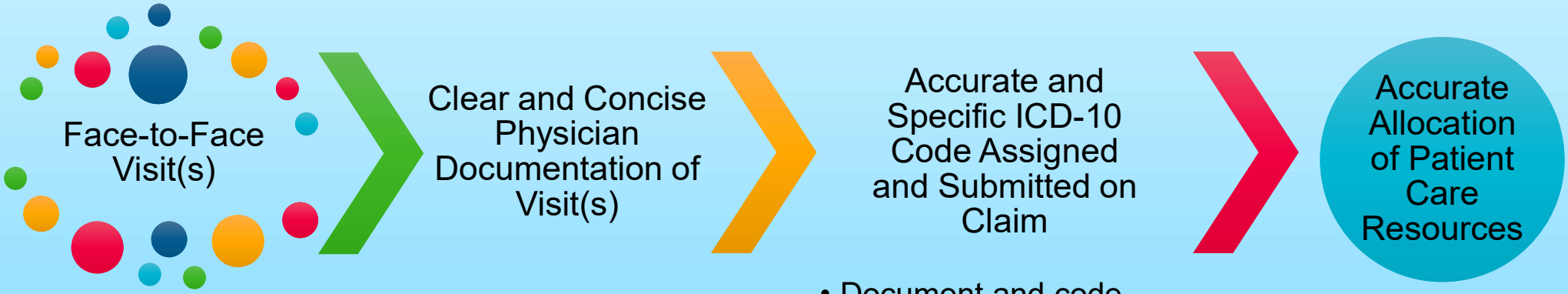
1. Patient's risk score resets every January 1
2. Member's risk score formulated based on Health Assessment captured between January 1 and December 31 each year
3. 141 hierarchical condition categories (HCCs) – Each HCC category value reported and counted annually
4. 10,660 + diagnosis codes fall in 141 HCCs

Hierarchical Condition Categories (HCC)



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

Commercial Risk Adjustment Process and the Physician's Role



- Physician sees patient yearly for scheduled appointment

- Reason for visit, services rendered, conclusions, screenings, and follow-up face-to-face visits

- Document and code diagnoses to greatest degree of specificity
- Provider should document and substantiate all medical conditions assessed of the member during that visit

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Why is accurate documentation and coding important?

REASONS:

1. Improves Medical Record Documentation
2. Places patients into appropriate risk category for expected resource utilization
3. Improves Quality (HEDIS and STARS)
4. Early interventions slows progression of disease
5. Ensures monitoring of complex conditions reducing need for emergency care

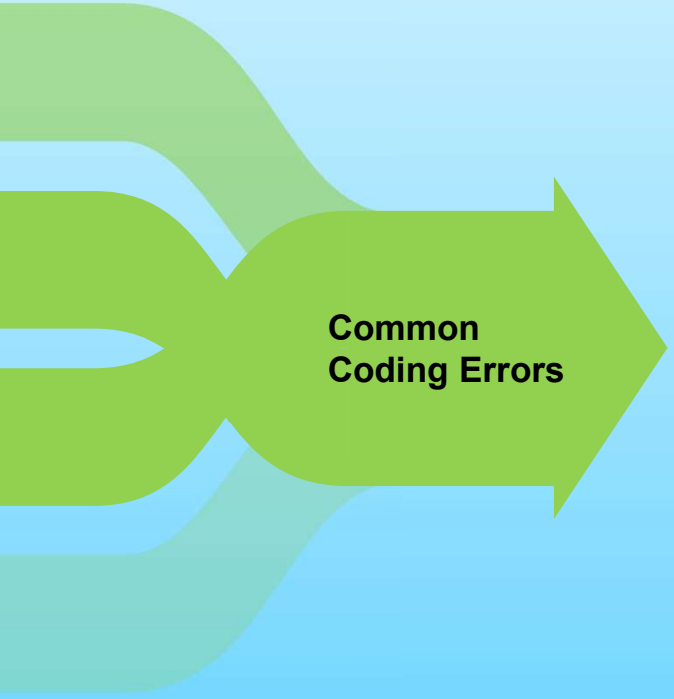
M.E.A.T. CRITERIA FOR DOCUMENTATION

Accurate, complete MEAT documentation of Chronic Condition diagnoses by clinicians is an essential component of the risk adjustment and HCC process. Most chronic conditions match to an HCC. To support an HCC, documentation must support the presence of the disease/condition. Additionally, it must also include the clinical provider's assessment and/or plan for management of the disease/condition. Most organizations use the "M.E.A.T." criteria – **Monitoring**, **Evaluation**, **Assessment, and Treatment** for their documentation practices. As well as ICD-10-CM diagnosis coding and HCC assignments.

Examples of MEAT

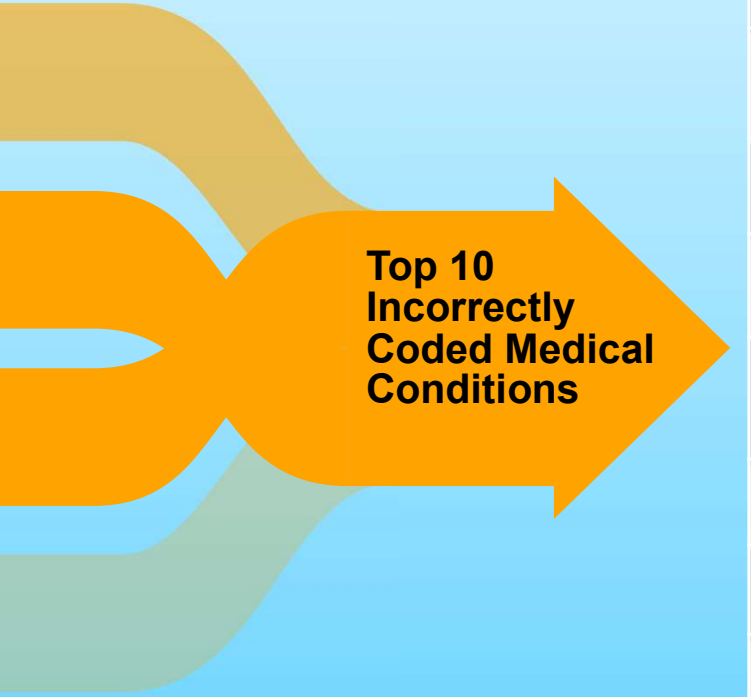
MEAT	Support	Disease Example	Documentation Examples
Monitor	• Symptoms • Disease progression/regression • Ordering of tests • Referencing labs/other tests	CHF DJD, hip Hyperlipidemia	Stable. Will continue same dose of Lasix and ACE inhibitor Pain Controlled with current medication Lipid Profile ordered
Evaluate	• 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

Common Coding Errors



Medical record does not contain a legible signature.
Electronic medical record (EMR) was unauthenticated (not electronically signed).
Coding a condition as current when it is “History Of”
Highest degree of specificity was not assigned the most precise ICD-10 to fully explain the narrative description of the symptom or diagnosis in the medical chart.
Documentation does not indicate the diagnosis is being monitored, evaluated, assessed/addressed, or treated (MEAT).
Status of cancer is unclear. Treatment is not documented.
Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
Chronic conditions or status codes are not documented in the medical record at least once per year.
A link or causal relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

Top 10 Incorrectly Coded Medical Conditions Found in Florida Blue Provider Quality Audits



Diabetes (with/without complications)
Asthma
Congestive Heart Failure
Respiratory
Autoimmune Disorders (RA, LUPUS, etc.)
HIV/AIDS
Cancer
Heart Arrhythmias
Major Depressive/Bipolar Disorder
Seizure Disorders and Convulsions

Medical Record Documentation Helpful Tips

All chronic conditions must be documented yearly as diagnoses do not carry over 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.
If condition is being monitored and treated by a specialist, code condition and status. ex: Patient on Coumadin for atrial fibrillation; followed by **Dr.** Hill".
Document and code status conditions at least once a year. i.e…Transplant status, amputation status, dialysis status, chemotherapy status, artificial opening status/maintenance.
Do not code unconfirmed diagnoses such as: probable, possible, suspected, working diagnosis.
Be sure diagnosis codes billed are consistent with medical record documentation. Ex…you cannot just state I10 only with no description, you must document the word hypertension.

Commercial Risk Adjustment Case Example

Mr. Johns presents today with a known history of HIV dementia and urinary incontinence. According to his brother, Mr. Johns had a nap around 4 p.m. and stated that he witnessed the patient shaking shortly after he woke up. He developed loss of consciousness approximately lasting 3 minutes. There is no previous history of seizure documented. He denies any prior episodes similar to this. The patient was somewhat confused but is now trying to improve back to baseline. Mr. Johns also has a previous history of a CVA and is dependent on his brother for routine activities of daily living. He uses a motorized wheelchair and persists on smoking 1 pack of cigarettes a day.

Past Medical History: HIV diagnosed 20 years ago, HIV dementia, urinary incontinence, NIDDM, PVD, hypertension, and CVA w/ hemiparesis (right-sided)

Medication: Stribild, Losartan, Detrol, Metoprolol, Aricept, Actos, Cilostazol

Surgical History: Cervical fusion, L BKA

Allergies: NKDA

Social History: Currently smokes 1ppd, cigarettes

Review of Systems: A detailed 14-point review of systems ascertained but is negative other than described above.

Vital Signs: BP-180/90, HR-80, R-18, Temp-98.6°

Physical Examination: There is no aphasia. There is paucity of verbal output. He blinks to visual threat bilaterally. Facial sensation intact. Muscle facial expression intact. Hearing intact. Palate and uvula are midline and elevated symmetrically. Tongue is strong without weakness or wasting. Diminished pulse in RLE. Motor, strength is 2/5 in the RU & RLE and 5/5 in the LUE. L BKA. Right side hemiparesis 2/2 CVA. He does not ambulate at this time.

Assessment
1. R/o seizure d/o
2. HIV dementia, mild-continue Stribild and Aricept
3. Htn-continue Losartan and Metoprolol
4. Urinary incontinence, continue Detrol

Plan:
At this time, we will order carotid Doppler studies and check orthostatic vitals. For now, I will wait before starting him on any anticonvulsant unless his EEG is abnormal, or his imaging studies show evidence of underlying involvement. Follow up w/ endo for DM and w/ the cardiologist for PVD, continue with Cilostazol.

Electronically Signed by: John K. Smith, MD

Commercial Risk Adjustment Case Example (continued)

Typically submitted ICD-10-CM codes for the office visit

ICD-10-CM Code	Condition	HCC
B20	Human Immunodeficiency Virus (HIV)	HCC 1
I10	Hypertension	Does not risk adjust
R32	Urinary Incontinence	Does not risk adjust

Opportunities for additional risk adjustment code reporting

ICD-10-CM Code	Condition	HCC
F02.A0	Dementia, mild, in other diseases classified elsewhere	Does not risk adjust
E11.51	Diabetes w/ Peripheral Vascular Disease	HCC 20
I69.351	CVA w/ right-sided hemiparesis	HCC 150
Z89.512	Left below the knee amputation (L BKA)	HCC 254
F17.210	Smoker, cigarettes	Does not risk adjust
Z99.3	Dependence on wheelchair	Does not risk adjust
Z79.02	Current use of antithrombotic/antiplatelets (Cilostazol)	Does not risk adjust

Submitting Supplemental / Additional Diagnoses: 99080

1

Submit a second, original claim, and use procedure code 99080

2

Use a zero (0) charge or penny charge on the supplemental line.

If the claim is electronic, use frequency code "0"

3

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

When your practice management system will not allow you to bill all the diagnosis codes on an original claim you will need to submit a supplemental claim to include the additional diagnoses.

Key Points to Remember

- Diagnoses must be coded according to ICD-10-CM guidelines
- Support for diagnoses must be documented according to the CMS guidelines
- CMS-HCCs are derived from ICD-10 codes
- Acceptable data sources – hospital inpatient/out-patient facilities, and physicians
- Slate is wiped clean every January 1
- Diagnoses must be documented from a face-to-face visit
- Code all conditions affecting patient care

Florida Blue Commercial Risk Adjustment Activities

1. Retrospective Review Audit
2. Coding Opportunities (Provider Vista)
3. Chart Procurement

Retrospective Review Audit

1

Provider groups undergo random audits throughout the year, via statistically valid samples of submitted claims and member charts

Coding Opportunities (ProviderVista)

2

This indicates opportunities for providers. Shows conditions they may need to assess or treat or may have previously assessed/treated for a patient, but recent documentation may not have captured. Coding Opportunities will be updated once monthly, based on analysis of claims and other supplemental data sources. This application will consist of all members with suspect, dropped or captured conditions, inclusive of pharmacy.

Chart Procurement

3

- 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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Connect with us…

- **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 CRAproviderEducationTeam@bcbsfl.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

Please send any questions to:
Commercial Risk Adjustment Provider Educator Team:
CRAproviderEducationTeam@bcbsfl.com

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TS0 Update ICD-10 official guideline link--> https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines.pdf
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