# *Risk Adjustment Documentation & Coding*


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CHAPTER 1

# Risk Adjustment Basics


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# What Is Risk Adjustment?

- Risk adjustment is a process by which health insurers are compensated based on the underlying health status of their enrollees, thereby protecting the insurers against losses due to high-risk, high-cost patients.
- In 2017, 19 million of 58 million Medicare enrollees participated in risk-adjusted Medicare Advantage (MA) plans, and 10.3 million were enrolled in private risk-adjustment pools under the Affordable Care Act (ACA).
- In risk adjustment, the severity of illness, *as represented by the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes,* determines payment for insurance companies.
- This course focuses ***heavily*** on ICD-10-CM diagnoses that are linked to risk adjustment.


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# Coding and Payment Generalities

- Diagnoses are the cornerstone of medicine; however, the accuracy of ICD coding has not been a focus for coding, except when the codes affect hospital payment.
- For physicians, Current Procedural Terminology (CPT®) codes have traditionally been the focus of regulatory scrutiny, as these have been the “money codes,” and as long as ICD codes captured medical necessity, they weren’t scrutinized.
- Risk adjustment and quality incentives have changed this. Today, payments are also tied to the resources a patient may be expected to require based on the diagnoses associated with the patient.
    - These diagnoses include the reason for the current encounter ***and*** any underlying diseases the patient may have.


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# Two Patients, Same Diagnosis, Different Care

- **Patient A is newly diagnosed with influenza and pneumonia.**
  - **Patient age is 35**
  - **Patient has no chronic diseases**

- Patient B is newly diagnosed with influenza and pneumonia.
  - Patient age is 72
  - Patient comorbidities:
    - Diabetes, type 2
    - Chronic bronchitis
    - Emphysema

- **How would the resources required to care for Patient A and Patient B differ, even though they have the same presenting problem?**


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# Two Patients, Same Diagnosis, Different Care

- Patient A is newly diagnosed with influenza and pneumonia.
  - Patient age is 35
  - Patient has no chronic diseases
- Patient B is newly diagnosed with influenza and pneumonia.
  - Patient age is 72
  - Patient comorbidities:
    - Diabetes, type 2
    - Chronic bronchitis
    - Emphysema
- **Capturing the difference is called *risk adjustment.***
  - If the comorbidities are not documented and coded for Patient B, the true cost of the encounter is not captured.
  - Comorbidities bring extra risk, requiring extra utilization of resources. The risk results in an adjustment of payment.
  - Erroneously reporting a more complex diagnosis can lead to overpayment.


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# Risk Score Calculations

- **Several models exist for risk adjustment:**
  - **MS-DRGs** risk-adjust payment to **hospitals for medical hospitalizations** and for **surgical hospitalizations** in patients with coexisting chronic disease for Medicare and some private payers.
  - **CMS-HCCs** risk-adjust payments to **insurance companies** that offer Medicare Advantage insurance plans to Medicare-eligible enrollees.
  - **CDPS** risk-adjust payments **to insurance companies** that offer coverage for chronic illness or disability classification of Medicaid programs.
  - **ACA** risk-pools **reimburse insurance companies** that offer plans to uninsured citizens of any age.


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# Two-Pronged Goal of Diagnosis-Based Risk Adjustment

- Ensure conditions are diagnosed, documented, coded, and regularly monitored.
- Accurately track the care requirements of patients so that future demands on resources can be predicted.

**Note:** Previously, “risky” patients with pre-existing conditions would not be able to find insurers willing to cover them or face unaffordable premiums and deductibles. The Affordable Care Act aimed to make insurance available to more Americans.


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# What Does This Mean For Physicians and Coders?

- **Records must be:**
  - Specific
  - Accurate
  - Clinically valid
  - Unambiguous
- **Coding must be:**
  - According to guidelines
  - Accurate
  - To highest specificity
  - Complete


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# Why Isn't That Happening Now?

- Physician payment and audits have historically been based on CPT codes, so CPT code accuracy has been the focus of audits and internal documentation improvement programs.
- Most physicians are not well trained in diagnostic coding.
- ICD-10-CM coding is complex and time-consuming.


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# Example

- Physician offices may sometimes document or code with less detail or accuracy than is optimal.
- **Z00.00** Encounter for general adult medical examination without abnormal findings
  - This code captures medical necessity, but it does not capture comorbidities that may risk-adjust (eg, preexisting hypertension or diabetes).
- **K70.30** Alcoholic cirrhosis of liver without ascites
  - Guidance instructs coders to use an additional code to report alcohol abuse or dependence. Not doing so omits a valuable risk-adjustment payment.


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# New Incentives In Medicare

- Value-Based Payment Modifier Program and MIPS
  - Focus on quality and cost of care given based on diagnoses of the patient
    - Bonus payments or penalties based on estimated cost of care
    - Big difference in resource predictions for a patient with uncomplicated diabetes vs diabetes with complications

- **Clear, concise, and complete documentation, as well as accurate and complete coding, are more important than ever!**


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# Risk-Adjustment Models


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# Medicare

- **Medicare**
  - Available to US citizens who reach 65 years of age
  - **Part A** is free
  - **Part B** can be purchased at a relatively low rate
    - Administered by Medicare administrative contractors (MACs) under the guidance of the Centers for Medicare & Medicaid Services (CMS)
- **Traditional Medicare Parts A and B cover 80% of costs; enrollees are responsible for 20%**


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# Medicare *(continued)*

- **Medicare**
  - **Part C** is Medicare Advantage (MA), which covers Parts A and B
  - **Part D** is prescription drug coverage
    - Administered by private insurers that process claims and pay with federal dollars
    - Some programs merge Parts C and D for MA coverage
- **History**
  - **Medicare+ Choice**, developed under the Balanced Budget Act of 1997, was the first risk-adjusting plan
  - The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act [MMA]) replaced Medicare+ Choice with **Medicare Advantage**
    - The MMA also created Part D


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# Medicare Risk Adjustment

- **Medicare Advantage (MA)** is a type of Medicare health plan offered by private insurers that contract with Medicare. Participating insurers are called MA organizations (MAOs).
  - Enrollees must be eligible for Medicare
  - CMS Medicare coverage rules apply to MAO plans; however:
    - MAOs sweeten these plans by offering extras, including out-of-pocket maximums, health-club memberships, and prescription coverage. In exchange, MAOs charge a fee that is added to the normal monthly Medicare cost for Part B.


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# Medicare Example

- **Medicare hospitalization for coronary artery bypass graft (CABG)**
  - Cost for hospital, surgeon, and other costs associated with CABG in 2017[1]:
    - **$75,345**
    - Medicare pays $60,276
  - Patient pays $15,069, if the patient has traditional Medicare coverage and no supplemental (secondary) insurance
- **Many Medicare Advantage (MA) plans cap the out-of-pocket maximum.**
- **Today, one out of every three Medicare participants is enrolled in a MA plan.**


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# Medicare Advantage (MA)

- **Risk-adjustment factor (RAF)** is a score assigned to an enrollee in a risk-adjustment plan. For MA, the RAF score is based on ICD-10-CM codes associated with the patient during the previous calendar year.
  - Diagnoses from 2017 are used to create the patient's 2018 RAF score.
- The RAF score determines the monthly payment to the MA organization (MAO).
  - A patient with multiple comorbidities will generate higher payments than a patient with fewer comorbidities, as well as be associated with more office visits, hospitalizations, tests, and prescriptions.


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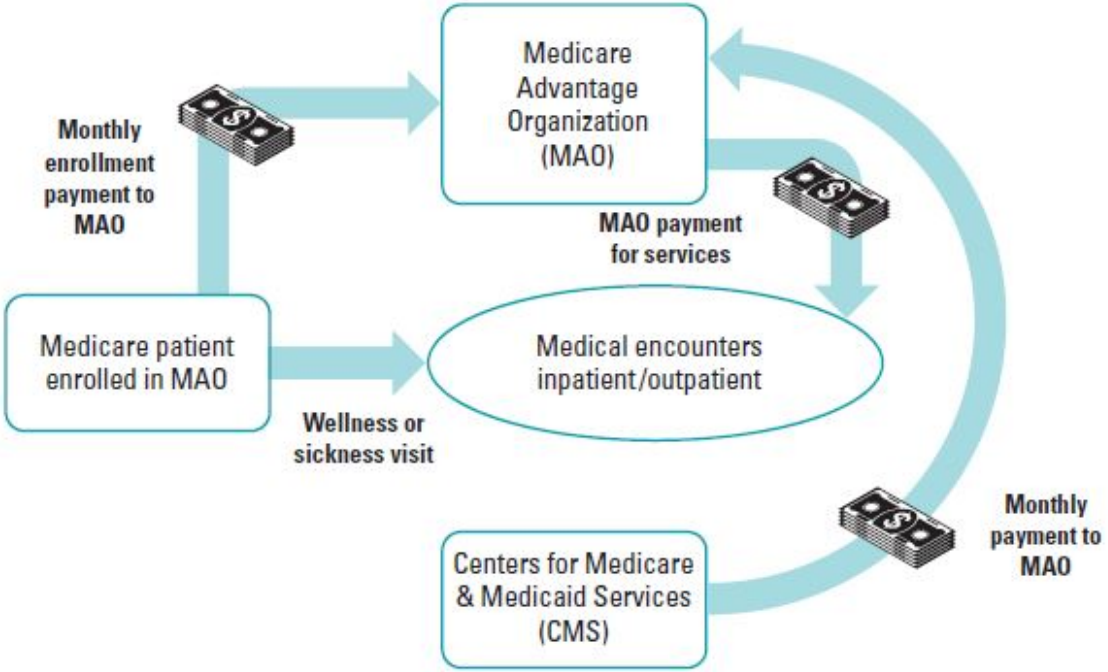
## FIGURE 1.1 How Medicare RA Works




CMS' monthly payment to MAO is risk-adjusted based on the comorbidities of the enrollee rather than on the services provided. The base rate is capitated and risk-adjusted to reflect the chronic conditions of the patient.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# Medicare Advantage: Unintended Consequences

- **Poor outpatient diagnostic coding due to few ICD-10-CM audits in past**
  - Upcoding of conditions (eg, coding from past medical history)
  - Downcoding of conditions (eg, failing to code documented causal links)
  - Underdocumenting conditions that led to nonspecific codes being reported
  - Not coding all diagnoses because comorbidities were not the reason for the encounter
- **MAOs are held accountable for codes submitted by physicians within their plans, but don't control documentation or coding**
  - MAOs are offering clinical documentation improvement initiatives for diagnoses
  - MAOs are hiring auditors to review chart documentation


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# Focusing on “The Money Codes”

- CMS created hierarchical condition categories (HCCs) to report risks associated with required medical resources and prescription (Rx) HCCs (RxHCCs) for risks associated with prescription drug costs.
  - About 9,000 diagnoses map to 80 HCCs
  - About 4,000 diagnoses map to 75 RxHCCs
- Some ICD-10-CM codes have only HCCs or RxHCCs, and some have both.
- Most represent chronic conditions, although some acute conditions (eg, pneumonia, hip fracture) also risk-adjust.


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# Refer to Appendix A in Your Book

- The tables beginning on pages 316-332 identify the condition categories that are linked to HCCs and RxHCCs, with the HCC tables appearing first.
  - **What might you conclude from the HCC values assigned to age and sex factors associate in Table VI-1 on page 316?**
  - **The HCC disease coefficients begin on page 316 and continue to page 321. What is the highest paying HCC for community/nondual/aged?**
  - **Why might HCC 173 for traumatic amputation be valued at less than half of HCC 189 for amputation status, lower extremity?**


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# Refer to Appendix A in Your Book *(continued)*

- RxHCCs begin on page 325.
  - **What is the highest paying RxHCC for community/nondual/aged? What is the lowest?**
  - **What reason could there be for the HCC for HIV/AIDS to be significantly lower than the RxHCC for HIV/AIDS?**


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# Refer to Appendix A in Your Book *(continued)*

- Look at the HCC table on page 324 and the RxHCC table on page 332.
  - When two related conditions are diagnosed in the same year, CMS requires that only one of the conditions be “counted” toward a RAF score.
    - Coders still abstract all conditions, but CMS may drop some from the RAF tally.
  - These tables are used by CMS to determine which code is valued for the RAF.
  - In coding language, this is sometimes called “trumping,” as in “diabetes with acute complications is trumping diabetes without complications.”


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# Example of "Trumping" in Disease Hierarchies

**Which HCC and RxHCC should be reported for lung cancer with metastases to the brain?**

TABLE VI-4 Disease Hierarchies for the 2017 CMS-HCC Model

| Hierarchical Condition Category (HCC) | If the Disease Group is Listed in this column . . . | . . . Then drop the Disease Group(s) listed in this column |
|---|---|---|
| | **Hierarchical Condition Category (HCC) LABEL** | |
| 8 | Metastatic Cancer and Acute Leukemia | 9, 10, 11, 12 |
| 9 | Lung and Other Severe Cancers | 10, 11, 12 |

TABLE VII-5 2018 List of Disease Hierarchies for RxHCC Model

| Rx Hierarchical Condition Category (RxHCC) | If the Disease Group is listed in this column . . . | . . . Then drop the RxHCC(s) listed in this column |
|---|---|---|
| | **Rx Hierarchical Condition Category (RxHCC) LABEL** | |
| 15 | Chronic Myeloid Leukemia | 16, 17, 18, 19, 96, 98 |
| 16 | Multiple Myeloma and Other Neoplastic Disorders | 17, 18, 19, 96, 98 |
| 17 | Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer | 18, 19 |
| 18 | Lung, Kidney, and Other Cancers | 19 |


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# Synergistic Disease

- **Disease interactions**, page 320
  - Sometimes the interaction of two diseases is worse than the sum of each disease separately. For example, both congestive heart failure and chronic obstructive pulmonary disease compromise lung function. The two together, however, have worse outcomes.
  - A table on page 321 shows interactions specific to disabled patients.
  - These interactions are another reason all diagnoses documented during an encounter should be reported.
- **According to the table on page 320, which disorders interact with psychiatric disorders? Which disorders interact with pressure ulcers?**


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## EXAMPLE

Martin McNally is an MA patient whose comorbidities are tallied into a RAF score for HCCs. He does not subscribe to Part D (prescription coverage).

| RISK/PAYMENT FACTOR | HCC | RAF |
|---|---|---|
| 66-year-old male | (community, nondual, aged) | 0.300 |
| Congestive heart failure (CHF) | 85 | 0.323 |
| Prostate cancer | 12 | 0.146 |
| Diabetes mellitus (DM), complicated | 18 | 0.318 |
| Peripheral vascular disease | 108 | 0.298 |
| Below-knee amputation | 189 | 0.588 |
| Morbid obesity | 22 | 0.273 |
| Interaction CHF & DM | NA | 0.154 |
| **Total RAF** | | **2.400** |

**Nondual**
A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

If we assume a CMS capitated rate for McNally's locality of $800 per month, the MAO would receive a payment of $9,600 per year for an enrollee without risk diagnoses. Multiply the capitated rate ($9,600) by 2.400 (McNally's RAF) to determine the CMS payment to the MAO to cover McNally's care. The total is $23,040 annually. RxHCCs would be calculated separately and added to payment, if the patient subscribed to Part D.

A patient with McNally's comorbidities would be at higher risk for resource-intensive care, including hospitalization. The MAO would pay for such care.


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# Example

## Part C Risk Factors

Demographics contribute to RA calculations. In this example, we compare rates for a married couple with the same chronic illnesses: chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The husband, who is significantly older than his wife, is also disabled and living in an assisted-care center. Because his condition is more complex, it carries more risk and risk-adjusts at nearly twice the rate of his wife's condition.

| PATIENT | AGE FACTOR | COPD HCC 111 | CHF HCC 85 | DISABLED, CHF, IN INSTITUTION | TOTAL RAF* |
|---|---|---|---|---|---|
| Martha Jones, 69, who lives at home | 0.312 | 0.328 | 0.323 | – | 0.963 |
| Matthew Jones, 92, disabled and lives in assisted living | 0.964 | 0.305 | 0.191 | 0.321 | 1.781 |


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# Submission to CMS

- **A risk-adjustment processing system (RAPS)** is a data center for CMS, and MAOs are permitted to submit diagnostic updates to the system. These updates are corrections.
  - MAOs review claims data and determine if diagnoses are missing from the claims of patients with long-standing chronic conditions.
  - MAOs may commission risk-adjustment auditors to review physician or hospital coding to determine whether ICD-10-CM diagnostic coding was correct and complete.
  - The claims are updated during certain time periods called “sweeps.”
  - Remember, MAOs are held accountable for the contents of physician and hospital claims.


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# Data Validation

- **Risk-adjustment data validation (RADV)** is a CMS audit of claims documentation this is performed to determine whether submitted diagnoses are present.
  - During a RADV audit, the MAO will be asked to submit a copy of documentation to validate a diagnosis.
  - RADV audits are time-intensive.
  - Patient demographics and administrative issues, such as signatures are a consideration in RADV audits.
- CMS extrapolates repayment across all claims to determine the payment-error rate when a diagnosis is not validated, so stakes are high.


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# Five-Star Quality Rating System

- Star ratings are incentives to MAOs to promote quality of care and services within their provider groups by tracking prevention metrics and patient satisfaction.
- Star ratings translate into bonus payments or penalties for MAOs.
- Star ratings are made public and can be used by consumers in their health insurance decision-making.


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# Health Insurance Marketplace Risk Pools

- Risk pools are health exchanges created by the Affordable Care Act.
- Diagnoses risk-adjust according to the HHS-HCC model.
  - HHS-HCCs are similar to CMS-HCCs, but include perinatal and obstetric diagnoses.
- Documentation and coding is validated through **initial validation audits (IVAs)** performed by auditors selected by the risk-pool insurance company, and **secondary validation audits (SVAs)** performed by auditors selected by HHS. This ensures the integrity of the system.


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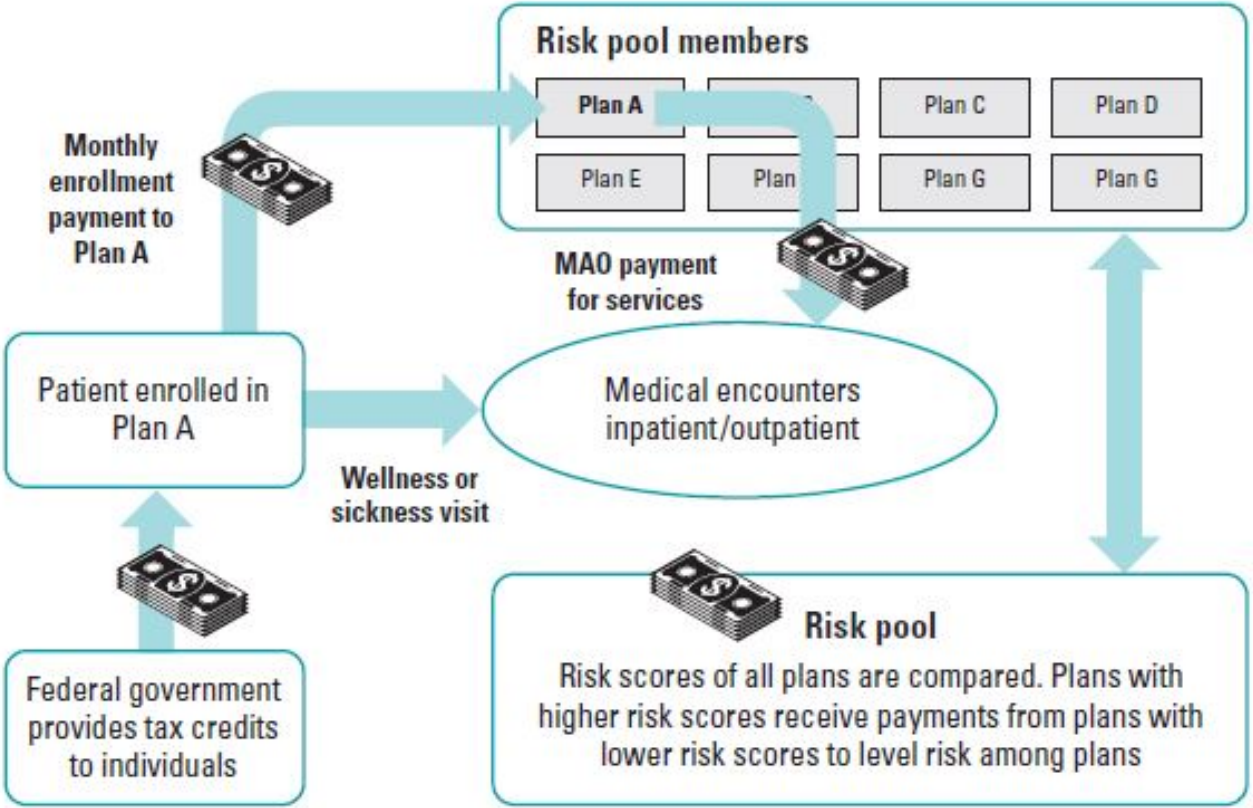
## FIGURE 1.2 How ACA Risk Pools Work





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# Alert

- Because this course focuses on documentation and coding, we will refer to CMS-HCCs simply as **HCCs**, and CMS-RxHCCs simply as **RxHCCs**.
    - Included in the appendixes are tables for CMS-HCCs and CMS-RxHCCs, but not for the HHS-HCCs.
- Documentation and coding in this course is applicable to **all** diagnostic coding scenarios because *risk-adjustment coding* is based on *correct coding principles*.


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# Do Not Fear!

- No one expects you to memorize HCCs or RxHCCs by number, title, RAF value, interactions, or hierarchies.
- Appendix B links ICD-10-CM codes to these HCCs and RxHCCs, but no one expects you to memorize these links, either.
- You will be expected in this course to understand “themes” that risk-adjust (eg, all diabetes codes risk-adjust and hypertension risk-adjusts).

**With proper documentation and coding, all risk-adjusting codes will be appropriately abstracted from the medical chart.**


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# Risk-Adjustment Goals

- Direct clinicians to focus on resource-intensive chronic conditions and preventive measures to drive down complications and costs.
- Improve the quality of documentation and coding of diagnoses, which are key to evidence-based medicine.
- Offer more choices in medical insurance.


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