Risk Adjustment Documentation Affects Payment/Forecasting
For Healthcare Professionals

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Insurance & Risk Adjustment

Course Objectives:
• Understand different how risk adjustment payments and forecasting are established
• Recognize how documentation can affect payment and forecasting efforts
• Understand the difference between ICD coding guidelines as they pertain to risk adjustment models
• Learn how risk adjustment models differ from Fee For Service and other traditional methods
**Risk Adjustment (RA)**

- Risk Adjustment is a method of analysis using diagnoses for financial forecasting that has been growing in popularity in healthcare.
- Medicaid plans began using Risk Adjustment modeling in 1996 and has continued to update that model.
- Medicare Advantage Plans have been using the HCC/Risk Adjustment model since 2004 and is expanding the program.
- Commercial Plans are now looking at Risk Adjustment as a valuable method to identify and plan for high risk patients.

**RA & Affordable Care Act (ACA)**

- “The Affordable Care Act calls for a risk adjustment program that aims to eliminate incentives for health insurance plans to avoid people with pre-existing conditions or those who are in poor health. Risk adjustment ensures that health insurance plans have additional money to provide services to the people who need them most by providing more funds to plans that provide care to people that are likely to have high health costs. Insurance plans then compete on the basis of quality and service, and not on the basis of whether they can attract healthy people” (Larsen, 2011)
Different Programs, Same Goals

- Whether Risk Adjustment is being utilized for Medicaid, Medicare, or Commercial patients, the main ingredients used are Diagnosis Codes (ICD codes)
- Diagnoses are collected and their specificity drives risk score or categorization
- The worse, or more serious a condition, or diagnosis, the higher the risk scoring
- Risk Scores either affect incoming payment or the future financial forecasting for each patient

Why It Matters

- For Medicare Advantage Plans
  1. Risk Adjustment (RA) identifies patients who may need disease management interventions and
  2. RA establishes the financial allotment allowed from CMS toward the annual care of each patient; with more dollars allocated for those with higher risk scores

- For Medicaid and Commercial Plans
  1. Risk Adjustment (RA) identifies patients who may need disease management interventions and
  2. RA establishes the “overall state of the population” by aggregating diagnoses; which assists in financial forecasting for future medical need
Risk Adjustment Payment

- Payments in risk adjustment models take the idea of an HMO PMPM, and apply the monthly value toward known current diagnoses being managed
- Payment can increase if all current diagnoses are submitted properly and can decrease if diagnoses are withheld
- Each diagnosis must be found as current in at least one face-to-face visit by an approved provider to be counted in the model

CMS HCC Payment Example

<table>
<thead>
<tr>
<th>No Conditions Coded (Demographics Only)</th>
<th>Some Conditions Coded (Claims Data Only)</th>
<th>All Conditions Coded (Chart Review by Certified Coder)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>76 year old female</td>
<td>76 year old female</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>Medicaid Eligible</td>
<td>Medicaid Eligible</td>
</tr>
<tr>
<td>DM Not Coded</td>
<td>DM (no manifestations)</td>
<td>DM with Vascular Manifestations</td>
</tr>
<tr>
<td>Vascular Disease not coded</td>
<td>Vascular Disease without complication</td>
<td>Vascular Disease with complication</td>
</tr>
<tr>
<td>CHF not coded</td>
<td>CHF not coded</td>
<td>CHF coded</td>
</tr>
<tr>
<td>No interaction</td>
<td>No interaction</td>
<td>+ Disease Interaction bonus RAF (DM + CHF)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Total RAF</th>
<th>Patient Total RAF</th>
<th>Patient Total RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>.645</td>
<td>1.062</td>
<td>1.973</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PMPM Payment for Care</th>
<th>PMPM Payment for Care</th>
<th>PMPM Payment for Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>$452</td>
<td>$743</td>
<td>$1,381</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yearly Reserve for Care</th>
<th>Yearly Reserve for Care</th>
<th>Yearly Reserve for Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,418</td>
<td>$8,921</td>
<td>$16,573</td>
</tr>
</tbody>
</table>
**Financial Forecasting**

- HHS and Medicaid models may not have an immediate “affected monthly payment”, however collection of diagnosis codes will affect forecasting.
- Plans attempt to estimate necessary recourses and plan accordingly for future years.
- The more that is known about patients diagnoses today, the more specific forecasting may become.
- If diagnoses are withheld, then there will not be enough money set aside to “earmarked” in anticipation to treat these illnesses and their possible complications.

**Code For All Diagnoses**

- Some coders may confuse E&M guidelines for diagnosis reporting as it pertains to the selection of the E&M level of service codes.
- When choosing a level of service for E&M, diagnosis codes should only be counted toward the level of service when they are documented how they were evaluated or addressed.
- This is entirely related to selection of level of service for E&M purposes, and does not change the fact that ICD coding guidelines instruct coders to include all comorbidities for each encounter.
ICD-9 Guidelines

ICD-9-CM: Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services: H. ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. **List additional codes that describe any coexisting conditions.** In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician. (ICD-9-CM, 2013)

K. **Code all documented conditions that coexist**

**Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.** Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care.

ICD-10 Guidelines

ICD-10-CM: Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. **List additional codes that describe any coexisting conditions.** In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician. (ICD-10-CM, 2013 Draft)

J. **Code all documented conditions that coexist**

**Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.** Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
6.4.1 Co-Existing and Related Conditions: The instructions for risk adjustment implementation refer to the official coding guidelines for ICD-9-CM, published at www.cdc.gov/nchs/icd9.htm and in the Coding Clinic. Physicians should code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19 not in HCC model) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

- Co-existing conditions include chronic, ongoing conditions such as diabetes (250.XX, HCCs 15-19), congestive heart failure (428.0, HCC 80), atrial fibrillation (427.31, HCC 92), chronic obstructive and pulmonary disease (496, HCC 108). These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient’s health when treating co-existing conditions for all but the most minor of medical encounters.

- Co-existing conditions also include ongoing conditions such as multiple sclerosis (340, HCC 72), hemiplegia (342.9X, HCC 100), rheumatoid arthritis (714.0, HCC 38) and Parkinson’s disease (332.0, HCC 73). Although they may not impact every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.

- MA organizations must submit each required diagnosis at least once during a risk adjustment reporting period. Therefore, these co-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.

- The above excerpts give several examples on how to review diagnoses for Risk Adjustment purposes.

- CMS also acknowledges the common issue of diagnoses marked as “history of”
CMS Participant Guide Excerpts

• **Use of “history of.”** In ICD-9-CM, “history of” means the patient no longer has the condition and the diagnosis often indexes to a V code not in the HCC models. **A physician can make errors in one of two ways with respect to these codes. One error is to code a past condition as active. The opposite error is to code as “history of” a condition when that condition is still active. Both of these errors can impact risk adjustment.**

• Because the purpose is to code for all known diagnoses for each patient in risk adjustment models, diagnoses from any portion of the record should be valid, provided that they are accurately documented as current diagnoses

• This includes current diagnoses from the CC (Chief Complaint) or HPI (History of Present Illness); PMH (Past Medical History) when still current; Current, Ongoing, or Active Problem Lists; ROS (Review of Systems); Exam; and Assessment and Plan portions

General RA Guidelines

• These programs operate on similar rules and guidelines to include:
  
  – Specific diagnoses must be documented in a face-to-face visit by the treating licensed provider (showing credentials: MD, DO, PA, NP, OT, CRNA, MSW, and similar master’s level providers) and the documentation must be signed by the treating provider to be accepted

  – Diagnoses must be clearly stated on the DOS (Date Of Service) as a current problem if audited

  – Diagnoses must be documented each year, ongoing as each year is evaluated without historical context influence
Significance To Providers

• Providers have long attempted to establish the seriousness and severity of the patients they treat through the use of E&M CPT codes
• Higher level E&M codes identify serious encounters, utilizing more medical decision making, and are reimbursed at a higher rate
• In Risk Adjustment scenarios, these CPT codes have no significance
• Instead, specific diagnosis codes communicate the seriousness of medical decision making

Significance To Providers

• Using specific ICD Diagnosis Codes will help convey the true seriousness of the conditions being addressed in each visit
• Documenting these carefully involves two main focal points:
  ① Identifying the Diagnosis as a current or ongoing problem as opposed to a PMH (Past Medical History) or previous condition
  ② Choosing the most specific Diagnosis Code while also being sure documentation supports it
General Diagnosis Coding Rules

• Code all current diagnoses that were a part of the medical decision making of the visit
• Signs and symptoms should never be coded when the reasons for the symptoms are identified. For example, one would not code “shortness of breath” when a diagnosis of asthma is known, nor “heartburn” when a diagnosis of GERD is known
• Old diagnoses which have been treated an no longer exist should not be coded unless there is a “history of” code that communicates the old condition (most of these do not risk adjust, but may be valuable to disease management and suspect logic)
• Persistent diagnoses such as amputations, Old MI, ostomy, quadriplegia, etc. should be re-documented at least yearly

Diagnosis Specificity

• Documentation of diagnoses must be specific
• This is paramount not only for Risk Adjustment programs, but also for ICD-10 implementation efforts
• Comorbidities; Cause and effect relationships of diagnoses; Location; and Other modifying factors should be clearly documented
• Examples of commonly under-diagnosed conditions are diabetes and hypertension
The Word “Chronic”

- Diagnosis specificity is of paramount importance and in many diagnoses, use of the word “chronic” can change the chosen diagnosis code (and its subsequent risk value)
- Examples include (but are not limited to):
  - Chronic Renal Insufficiency vs. Renal insufficiency
  - Chronic Hepatitis B vs. Hepatitis B
  - Chronic Bronchitis vs. Bronchitis
  - Chronic cor pulmonale vs. cor pulmonale

Coding Clinic

Department within AHA that makes authoritative determinations on ICD code use (fresh start on ICD-10 determinations)

- Cannot code diagnoses described as “consistent with” (includes: “suspect”, “likely”, “may be”, “rule out”, etc.) as current or active
- Cannot code hypo or hyper conditions when documented with up and down arrows ↑ or ↓, must be written out
- Cannot code “hemiparesis” for “weakness on one side of the body”, provider must document “hemiparesis”
- Should code 414.01 (native artery) CAD when no CABG Hx
Past Medical History (PMH)

- The different ways providers document PMH or historical diagnoses is challenging for coders and auditors reviewing medical records.
- Some providers use PMH as a true list of old diagnoses, while others use this as a combined list of historical and current problems.
- This documentation disparity is also often seen in the chief complaint or HPI (History of Present Illness).

PMH Examples in CC/HPI

**Current vs. Hx of is not clear:**

**CC/HPI:** Mr. Jones is here today for follow up of his **history of diabetes, CHF, and PVD.**

**PMH:**
- MI in 2002
- CHF
- PVD

**A/P:**
1. Diabetes

**Current vs. Hx is clear:**

**CC/HPI:** Mr. Jones is here today for his diabetes, he has a known **history of** CHF, and PVD.

**PMH:**
- MI in 2002
- CHF
- PVD

**A/P:**
1. Diabetes
PMH Examples in Lists

<table>
<thead>
<tr>
<th>Current vs. Hx of <strong>is not clear:</strong></th>
<th>Current vs. Hx <strong>is clear:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CC/HPI: ...........</td>
<td>CC/HPI: ...........</td>
</tr>
<tr>
<td><strong>PMH:</strong></td>
<td><strong>PMH:</strong></td>
</tr>
<tr>
<td>MI in 2002</td>
<td>MI in 2002</td>
</tr>
<tr>
<td>CHF</td>
<td>CHF</td>
</tr>
<tr>
<td>PVD</td>
<td>PVD</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Allergies</td>
<td>Allergies</td>
</tr>
<tr>
<td><strong>A/P:</strong></td>
<td><strong>A/P:</strong></td>
</tr>
<tr>
<td>1. Diabetes</td>
<td>1. Diabetes</td>
</tr>
</tbody>
</table>

PMH In Practice

- Remember to be very clear on what diagnoses or conditions are current or ongoing vs. those that are no longer present or historical.
- Diagnoses which are not being treated but are still current, to include ongoing monitoring should be documented as current.
- Every current diagnosis being taken into consideration for medical decision making should be documented in each visit as current and not documented as “historical.”
Documenting Diabetes

- Many providers have memorized the ICD-9-CM code of 250.00 for diabetes, yet this is often NOT the correct code for many patients
- Diabetes codes in both ICD-9 and ICD-10 have specific codes to identify diabetes-related manifestations
- In both: The 4th digit tells manifestation and 5th digit tells if controlled or uncontrolled
- Only diabetics with no manifestations should utilize the generic diabetes ICD code

Diabetes In ICD-9-CM

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Manifestation by 4th digit; Stated as: “Due to, with, etc.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.0x</td>
<td>DM, no mention of complication</td>
</tr>
<tr>
<td>250.1x</td>
<td>DM, with Ketoacidosis</td>
</tr>
<tr>
<td>250.2x</td>
<td>DM, with hyperosmolarity</td>
</tr>
<tr>
<td>250.3x</td>
<td>DM, with coma/insulin coma</td>
</tr>
<tr>
<td>250.4x</td>
<td>DM, with renal manifestations</td>
</tr>
<tr>
<td>250.5x</td>
<td>DM, with ophthalmic manifestations</td>
</tr>
<tr>
<td>250.6x</td>
<td>DM, with neurological manifestations</td>
</tr>
<tr>
<td>250.7x</td>
<td>DM, with peripheral circulatory disorders</td>
</tr>
</tbody>
</table>

Cause & Effect relationships must be documented by the provider when DM is the reason for any manifestation. (Only exception is gangrene in DM may be assumed related.)
### Diabetes In ICD-10-CM

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Type 2 (DM NOS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E10.1x-[Check 5th] with ketoacidosis</td>
<td>E11.0x-[Check 5th] with hyperosmolarity</td>
</tr>
<tr>
<td>E10.2x-[Check 5th] w/ kidney complications</td>
<td>E11.2x-[Check 5th] w/ kidney complications</td>
</tr>
<tr>
<td>E10.3x-[Check 5-6th] w/ ophthalmic complications</td>
<td>E11.3x-[Check 5-6th] w/ ophthalmic complications</td>
</tr>
<tr>
<td>E10.4x-[Check 5th] w/ neuro. complications</td>
<td>E11.4x-[Check 5th] w/ neuro. complications</td>
</tr>
<tr>
<td>E10.5x-[Check 5th] w/ circulatory comp.</td>
<td>E11.5x-[Check 5th] w/ circulatory complications</td>
</tr>
<tr>
<td>E10.6x-[Check 5-6th] w/ other specified complications</td>
<td>E11.6x-[Check 5-6th] w/ other specified complications</td>
</tr>
<tr>
<td>E10.8 w/ unspecified complications</td>
<td>E11.8 w/ unspecified complications</td>
</tr>
<tr>
<td>E10.9 without complications</td>
<td>E11.9 without complications</td>
</tr>
</tbody>
</table>

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### Documenting & Coding Diabetes

- Under-documenting DM communicates a less serious DM case, which affects value of care
- Any manifestations must be documented as a cause and effect relationship, for example:
  1. **Assessment:** 1. DM  2. Polyneuropathy
     - Can only code: 250.00 and 356.9 (ICD-9-CM)
     - E11.9 and G62.9 (ICD-10-CM) [Lower Value DM]
  2. **Assessment:** 1. DM **with** Polyneuropathy
     - Can code: 250.60 and 357.2
     - E11.42 and (ICD-10-CM) [Higher Value DM]
Documenting & Coding HTN

- Under-documenting HTN communicates a less serious HTN case, which affects value of care
- Any manifestations must be documented as a cause and effect relationship (CKD is an exception)

<table>
<thead>
<tr>
<th>Hypertension Type</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTN (primary, benign, essential, malignant)</td>
<td>401.x</td>
<td>I10</td>
</tr>
<tr>
<td>“with” Heart Disease *Must Document Cause &amp; Effect</td>
<td>402.xx</td>
<td>I11.x</td>
</tr>
<tr>
<td>“with” CKD [Cause &amp; Effect are Assumed]</td>
<td>403.xx</td>
<td>I12.x</td>
</tr>
<tr>
<td>“with” Heart &amp; Kidney Disease *Must Document Cause &amp; Effect for Heart Dz</td>
<td>404.xx</td>
<td>I13.x</td>
</tr>
<tr>
<td>Hypertension, secondary</td>
<td>405.xx</td>
<td>I15.x</td>
</tr>
</tbody>
</table>

Documenting & Coding Cancers

- Per guidelines, cancers are coded by their location and may only be coded as active when current treatment is being directed to the cancer, or if the cancer is active and treatment was refused
- Radiation, Chemotherapy, and Hormonal treatments used specifically for a given cancer qualify as current treatment
- Without current treatment, the patient only has a personal history of cancer (V code) and these typically do not risk adjust
- Helpful to know if cancer is primary, metastatic, and what treatments are ongoing in order to code
Documenting & Coding Depression

• Patients who are on anti-depressant therapy are considered to have “major depression” clinically
• Providers rarely document it this way, often only noting “depression”
• Coders can only code what is documented and “depression” alone defaults to “situational depression” such as bereavement or job loss or other temporary depression
• Depression assessment tools are often used to validate or support moderate to severe or “major depression” but when patients are receiving therapy these scores may not reflect the diagnosis and this should be noted

Documentation Tips

• Avoid homegrown abbreviations
• Document all cause and effect relationships
• Include all current diagnoses as part of the current medical decision making and carry them to the final assessment of the encounter
• Each note needs a date, signature, & credential (MD, DO, NP, PA, etc.)
• Document history of heart attack, any amputations, hypoxia, status codes, ostomy, etc., when factual
• Only document diagnoses as “history of” or “PMH” when they no longer exist or are a current condition
3 Small Steps to Take Now

1. Begin to document laterality, specifying “left” or “right” whenever applicable
2. Begin to document manifestations clearly
   I. Things which are “clinically intuitive” are not allowed to be assumed by coders
   II. Complications & manifestations need to be documented
3. Begin to separate diagnoses which are truly historical as opposed to those which are current
   I. Current diagnoses carry value as part of Medical Decision Making
   II. PMH (Past Medical History) Lists should only contain diagnoses which have been treated and no longer exist

Documentation for RA & ICD-10

• Many documentation efforts for risk adjustment simultaneously assist for coding in ICD-10-CM
• Making strides to improve documentation through specificity and clarity helps identify valuable time spent by providers and
• Identifies patients in need of disease management programs
Documentation Matters

- Lack of documentation may leave diagnosis codes which are current to me missed from the risk adjustment equation
- These missed diagnosis codes are not reimbursed or forecasted
- The missed diagnoses also affect patient care by potentially leaving patients out of disease management programs offered by the health plans when they are not aware of the diagnoses

Changes in Models

- Models change yearly and the universal supporting factor will be provider documentation
- Pressure ulcers will only carry value in 2014 if they are stage 3 or higher, where they previously always counted - thus documentation of staging of these ulcers becomes paramount
- Old MI will be dropped as a Part C and carry Part D value only
Changes in Models

- Many lung disease (494-508) that previously had no C value will now carry Part C value
- Many nephritis codes (580.0-583.9) that had Part C value will drop to Part D value only
- CKD codes correlating to Stages 4, 5, and 6 (ESRD) will carry Part C value & Part D value, but all other CKD (Stages 1-3) will only carry part D value.
- Hypoxemia and asphyxia are being dropped altogether with no C or D value
- Chronic pancreatitis will continue to carry C value, but many other pancreatitis codes 577.2-579.9 will only carry Part D value

Questions/Feedback
Risk Adjustment Documentation Affects Payment/Forecasting

Contact

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Medical Record Audit and Review - Physician Practice Optimization - Leadership Mentoring Healthcare Education and Networking for Patients and Professionals - Risk Adjustment