Moving into 2022 – Chronic Condition Capture Supporting Risk Adjustment Coding

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Wednesday, December 15th, 2021

Agenda

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- ICD-10 CM Codes Reset January 1st, 2022
- Risk Adjustment Coding Supports Patient Care
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- Documentation Best Practice Supporting Risk Adjustment Coding Capture
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Chronic Condition Capture Review

- Report everything from the office visit that affects the plan of care for the chronic condition.
- Chronic conditions must be coded annually with the highest level of specificity.
- All chronic conditions should be discussed and documented when meeting with a new patient. If the condition does not affect the patient's care six months from the initial visit, there is no need to report it again.
- Document only confirmed diagnoses, not suspected conditions.
- Providers must link the chronic condition with the care plan by evaluating, assessing, monitoring, or treating the condition in some way, documenting care they provided or plan to provide.
- If chronic conditions are not linked to the care plan and a data validation audit occurs, the code will be removed and not counted as part of the patient's risk adjustment factor.

Risk Adjustment Factor (RAF) Overview

- Patients with chronic conditions are assigned a risk score based on their overall health status, relative risk that the condition will worsen, and various demographic characteristics.
- The risk adjustment factor (RAF) is a statistical tool that predicts speculated healthcare cost by reported ICD-10 diagnosis codes that identify future risk.
- Risk could include hospital admissions for a chronic condition exacerbation, costly treatments, or ongoing medications that may require consistent funding.
- Providers should annually report all chronic conditions and co-morbidities to the highest level of specificity.
- The more chronic conditions a patient has, the more care may be required, so yearly reporting is crucial to ensure quality of care as well as proper funding.
- If providers do not report all conditions, money funded for a certain patient could be put into a negative balance, creating difficulties for the provider, payer, and patient.

Risk Adjustment Coding Overview

- Chronic Condition Coding provides the necessary information in the patients' records to make sure physicians are proactively monitoring and managing all ongoing chronic conditions.
- It helps reduce costly hospital admissions and emergency room visits, it also provides the framework necessary to ensure that providers are following quality measures that must be reported for value-based payment.
- Detailed documentation and coding encourage more patient engagement, an important part of value-based care. When patient records contain an accurate recap of all ongoing conditions, physicians can more easily discuss these concerns with patients, educating and encouraging them to make lifestyle changes and take a more active role in their care.
- Proper documentation and coding validate and substantiate the cost of care, a critical component of value-based care.

Overview of Medical Necessity

- **Medical Necessity Overview:**
  - American College of Medical Quality:
    - Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
  - American Medical Association (AMA):
    - In accordance with the generally accepted standard of medical practice.
    - Clinically appropriate in terms of frequency, type, extent, site and duration.
    - Not intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

Tips to Document Medical Necessity

- Identify a specific medical reason or focus for the visit (e.g., worsening or new symptoms).
- Document the rationale for ordering tests or referrals.
- Describe how the patient/caregiver has managed chronic conditions from the previous visit to present or explain acute symptoms; status of three chronic conditions may be used for History of Present Illness (HPI) credit.
- Include within the assessment and plan the provider's clinical impression, condition status, and treatment plan for each diagnosis assessed that day.
- Summarize the patient's health (e.g., improved, worsening, not responding as expected) and document services performed, treatments recommended, medication management, education/counseling, and goals of care conversations.
- Represent the patient complexity, overall patient risk level, and any aggregating factors or psychosocial challenges.
- Document initiation of, or changes in, treatment.
- Include patient and nursing instructions, therapies, and medications.

Documentation Supporting Chronic Conditions

- A condition can be coded when documentation states that the condition affects the care, treatment, or management of the patient. This must be documented and cannot be assumed.
  - **Example**: Sugar free cough syrup prescribed due to Type 2 DM
- Medication changes and the condition being treated need to be documented
  - **Example**: Major Depressive Disorder (MDD)-increase Paxil to 50 mg/day
- Conditions can be coded when documentation states condition is being monitored and treated by a specialist.
  - **Example**: Patient on Coumadin for A-fib followed by Cardiology

Diagnosis Capture Supports Accurate Health Status

Select not only the diagnosis codes that describe why the patient was seen but also codes for any chronic conditions that affected treatment choices.

Examples:

- A patient with diabetes presents with severe poison ivy. The physician discusses the diabetes with the patient in deciding whether to use prednisone and documents it in the assessment. The physician should report poison ivy first and diabetes second.
- A patient followed by nephrology for chronic kidney disease (CKD) is seen by his family physician for hypertension, which is not well controlled. The physician considers and documents the CKD when selecting hypertension treatment, and should report hypertension first and CKD second.
- A patient with multiple chronic diseases presents for an annual exam. The physician reviews and documents the status of chronic diseases treated within the practice and by other providers.

If a patient has a serious chronic condition with a manifestation or complication that has its own code, use that code rather than an unspecified code.

Example:

- Code “Type 2 diabetes with retinopathy” instead of “Type 2 diabetes, uncomplicated” or “Varicose veins with inflammation or ulcer” rather than “Varicose veins, unspecified.”

Conditions Supported by Documentation

Diagnosis:	Documentation Example:
Congestive Heart Failure (CHF)	Will continue same dose of Lasix and ACE inhibitor
Abdominal Aortic Aneurysm (AAA)	Abdominal ultrasound ordered
Major Depression Disorder (MDD)	Feelings of hopelessness despite increase in Zoloft. Will Refer to psychiatrist for further evaluation and management
Diabetes Type II w/hyperglycemia	Patient has uncontrolled Type II diabetes. They take insulin on a daily basis.
Morbid Obesity	Advised patient to monitor calorie intake and increase physical activity
Ulcerative Colitis	Discussed diet and foods to avoid and to help reduce flare up during holiday season

Be Sensitive Documenting Patient Conditions

- Patients must feel that a provider is empathetic and does not judge them. This is key not only to discussing weight, but to any subject that comes up. Providers should always try to give honest, straightforward answers and make patients feel at ease.
- A providers should build a relationship based on trust with their patient as this will help support honest conversations that will capture a patient's true health status.
- Sensitivity will help drive positive patient experience and health outcomes.
- Speak honestly and link conditions to overall health status. This will improve health outcomes and improve patient healthcare compliance.
  - **Example:** Patient is morbidly obese with BMI >40. The patient has hypertension and diabetes. The weight does affect their other conditions. Discussing treatment to reduce weight will help improve their hypertension and diabetes. An overall treatment plan will improve all areas of health.
- Document in a non-judgmental way to better support management of care.
- Documenting accurate health status of patient will support continuity of care.

If It Isn't Documented It Didn't Happen

- **"If you didn't document it, it didn't happen."** This statement is often used in medical training as a method to strive for better documentation. This also helps to guard against malpractice suits.
- **"If you didn't document it, you're not getting paid."** This statement should be used more to support accurate reimbursement and patient management of care.
- Items to document during a patient encounter:
  - Plan of Service
  - What services are needed
  - Changes in the plan
  - Past & present treatment of physical and psychological conditions
  - Progress Notes
  - Health Information
  - Illnesses
  - Doctor's Orders
  - Medication
  - Unusual Incidents

Top HCC Categories

- A patient's risk score is captured accurately by coding their disease and conditions to the highest specificity. HCCs are diseases and conditions that are organized into body systems or similar disease processes. The top HCC categories include:
  - Major depressive and bipolar disorders
  - Asthma and pulmonary disease
  - Diabetes
  - Specified heart arrhythmias
  - Congestive Heart Failure
  - Breast and prostate cancer
  - Rheumatoid arthritis
  - Cancer: Colorectal, breast, kidney (examples)

Risk Adjustment Documentation

- NEPHO has some very specific coding and documentation practices in place to help support provider HCC performance. The following examples provide guidance to practices that are working to improve risk adjustment coding capture:
  - **Document and code all chronic conditions discussed and documented during a patient encounter:** Chronic and/or permanent diagnoses should be documented as often as they are assessed or treated.
  - **Clarify whether a diagnosis is current or "history of":** Anything that is listed as "repaired" or "resolved" should not be coded as current. Providers should be made aware of Z codes that are appropriate for these scenarios.
    - **Example:** Neoplasms that are current code to ICD-10 codes in Chapter 2: Neoplasms.
    - **Example:** Neoplasms that are no longer present should be coded to Chapter 18: Factors Influencing Health Status and Contact with Health Services
  - **Update the patient's problem list regularly:** Make sure all problems listed as active are appropriate and haven't been brought forward (copied and pasted) in error.

Importance of Diagnosis Capture

- **Providers should document conditions they monitor and treat:** Diagnosis codes are not limited to what brought the patient to the office today. Any condition the provider monitors, evaluates, assesses, or treats should be included in the documentation.
- **Avoid using generic or unspecified codes:** Code to the highest level of specificity. Use of generic or unspecified codes does not fully support medical necessity and the management of care for the patient. Payers need to have an accurate picture of the patient's health status.
  - **Example:** Congestive heart failure should be coded by type and acuity. The term congestive heart failure is considered nonspecific, outdated, and inadequate to fully describe the condition. Documentation should be present in the record of systolic and/or diastolic failure or dysfunction and acuity.
- **It is important to link manifestations and complications.** Providers need to make the link between a manifestation and complication. Some terms that can be used to link conditions are "because of," "related to," "due to," or "associated with."

Risk Adjustment Coding Capture Best Practice

- **Educate Providers**: Physicians should be educated on how risk-based contracts work and the importance of HCC coding and the need for proper documentation for patients with chronic conditions. Clinical staff should also be educated about the tools and workflows for patient management and reporting.
- **Identify most Frequently Encountered Patient Conditions**: Practices should be familiar with the most prevalent HCCs, identify the codes most relevant to them, and ask physicians to focus on these conditions.
- **Prepare for each Patient Visit**: When seeing complex HCC patients, physicians should prepare in advance of the appointment. This will help them document and address chronic conditions more accurately and document their findings in the medical record. (Pre-Visit Coding Review)
- **Prepare an Accurate Problem List**: Optimize the EMR and ensure an accurate problem list by removing duplicative and inactive diagnoses, and using a diagnosis preference list to include HCC gaps will help with annual capture. (Epic has this functionality to highlight HCC gaps)
- **Document Chronic Conditions even if not Treating them**: Even if the physician is not seeing a patient for a chronic condition, it should be documented. For instance, if an orthopedist is treating a patient for a knee condition and the patient has diabetes, the physician should document diabetes in the medical record as it will affect the patient's care plan.

Risk Adjustment Support Fee For Service

- Risk adjustment in payment models refers to the practice of accounting for the differences in the underlying risk (i.e., expected costs) of patient populations.
- It would be unfair to compare the costs incurred of a healthy member to that of a sick member without properly adjusting for the expected cost of each person based on his/her health status.
- However, risk adjustment is not just a payment model mechanism. Successful capture of risk enables obtaining a complete and accurate picture of your patients' acuity, which is critical to ensuring proper reimbursements, effectively managing costs of your high-risk members, and delivering high quality care.
- Developing a risk adjustment coding program is critical for any risk-bearing provider and requires establishing end-to-end processes that engage both physicians and patients.

NEPHO Coding Opportunity In 2021

- NEPHO focused education efforts this year on Diabetes Coding to the Highest Specificity and Depression/Substance Disorders.
- Diabetes with Complications captured to the highest specificity:
  - **Example:** Patient has a 3 month follow-up visit and has the following chronic conditions: Diabetes II (E11.9), CKD 3 stage 3a (N18.31), Morbid Obesity (E66.01) with BMI >40 (Z68.41), hyperthyroidism (E03.9).
    - Accurate coding: Diabetes with CKD stage 3a: E11.22, N18.31, Diabetes with complications: E11.69, E66.01, E03.9.
- Capturing chronic conditions during Telehealth visits:
  - **Example:** Patient is having 3 month check in call with provider. Could not have face-to-face visit due to flu like symptoms. Patient is being managed by provider for depression (F33.8), Anxiety (F41.1), Hypertension (I10), and Rheumatoid Arthritis (RA) (M06.9). The provider has a check in call with the patient via Video/Audio and captures/documents Depression & Anxiety only. Accurate coding and documentation should have included:
    - Depression, Anxiety, Hypertension, RA

Highlights of the new 2022 CPT code Updates

- The American Medical Association (AMA) has made 405 editorial changes, including 249 new codes, 63 deletions and 93 revisions
- Updates are effective on January 1, 2022
- The CPT code set incorporates a series of 15 vaccine-specific codes to efficiently report and track immunizations and administrative services against COVID-19
- Almost half of the editorial changes are tied to new technology services described in Category III CPT codes and the continued expansion of the Proprietary Laboratory Analyses (PLA) section of the CPT code set
- In response to the fast pace of innovation in digital medicine services, the AMA created 5 new CPT codes (98975, 98976, 98977, 98980, 98981) to report therapeutic remote monitoring.
- The AMA also created new codes for principal care management (99424, 99425, 99426, 99427), which allow physicians and qualified health care professionals to report care management services for patients with one complex chronic condition.

Social Determinants of Health (SDOH) Overview

- The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:
  - Income and social protection
  - Education
  - Unemployment and job insecurity
  - Working life conditions
  - Food insecurity
  - Housing, basic amenities and the environment
  - Early childhood development
  - Social inclusion and non-discrimination
  - Structural conflict
  - Access to affordable health services of decent quality

SDOH Overview (continued)

- Inequities in health are socially determined, preventing poorer populations from moving up in society and making the most of their potential.
- Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
- Action requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development.
- ***"Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically".***

SDOH Z Codes

- Z55.5 Less than a high school diploma
- Z58 Problems related to physical environment
- Z58.6 Inadequate drinking-water supply
- Z59.00 Homelessness unspecified
- Z59.01 Sheltered homelessness
- Z59.02 Unsheltered homelessness
- Z59.4 was revised from “Lack of adequate food and safe drinking water” to
  - Z559.4 “Lack of adequate food”
- Z59.41 Food insecurity
- Z59.48 Other specific lack of adequate food
- Z59.81 Housing instability, housed
- Z59.811 Housing instability, housed with risk of homelessness
- Z59.812 Housing instability, housed, homelessness in past 12 months
- X59.819 Housing instability, housed unspecified
- Z59.89 Other problems related to housing and economic circumstances

Resources

- **Shawn.m.bromley@lahey.org & Jessica.m.bryan@lahey.org**
- https://www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat
- https://www.amazon.com/Adjustment-Documentation-Coding-Sheri-Bernard/dp/1622027337
- https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf
- https://www.cms.gov/fy-2022-ipps-final-rule-home-page#Reg
- https://www.icd10monitor.com/exploring-icd-10-cm-s-chapter-19-injury-poisoning-certain-other-consequences-of-external-causes
- https://rtwelter.com/blog/2021/05/06/2022-icd10cm-updates-are-just-around-the-corner/
- https://yes-himconsulting.com/everything-you-need-to-know-about-the-hcc-risk-adjustment-models/