Risk Adjustment Factor (RAF)

HCC Basics

July 6th 2016

Banner Health Network

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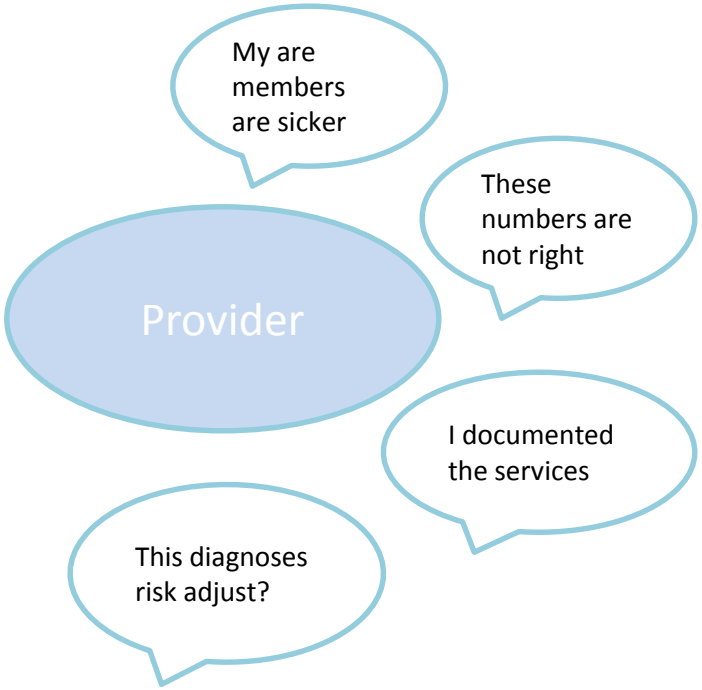
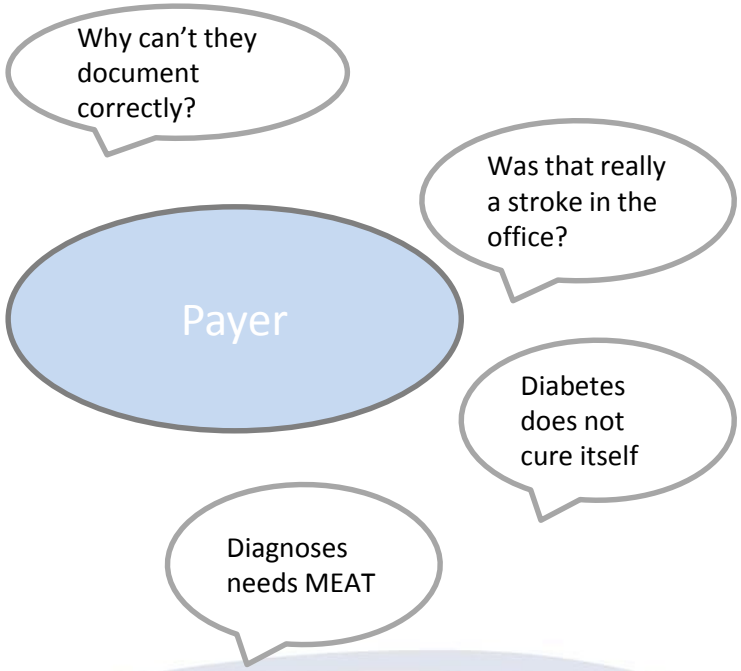
Objectives

- Provide an Overview of Medicare Risk Adjustment (MRA)
- Look at how payments are made for Medicare Risk Adjustment plans
- Review best practice Documentation Guidelines
- Tips

Background
MRA

View of Risk Adjustment





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Background - MRA

- The Centers for Medicare & Medicaid Services (CMS) Risk Adjustment Model ensures that there are adequate resources to care for our high-risk Medicare Advantage members

- The MRA Model utilizes a reimbursement method commonly referred to as Risk Adjustment Factor-Hierarchical Condition Categories (RAF-HCC) to adjust capitation payments to health plans

Background - MRA

What are Hierarchical Condition Categories (HCCs)

- HCCs are groups of similar diagnoses that consume similar resources.
- Each HCC is assigned a “weight” that impacts the patient’s risk score.
- Some HCCs are grouped into hierarchies while others are additive e.g. disease interaction

Purpose

- MRA is intended to redirect money away from MAO (Medicare Advantage Organizations) that would cherry-pick the healthier enrollees

- The ultimate purpose of the CMS-HCC payment model is to promote fair payments to MAOs that reward efficiency and encourage excellent care for the chronically ill.

Reimbursement Model

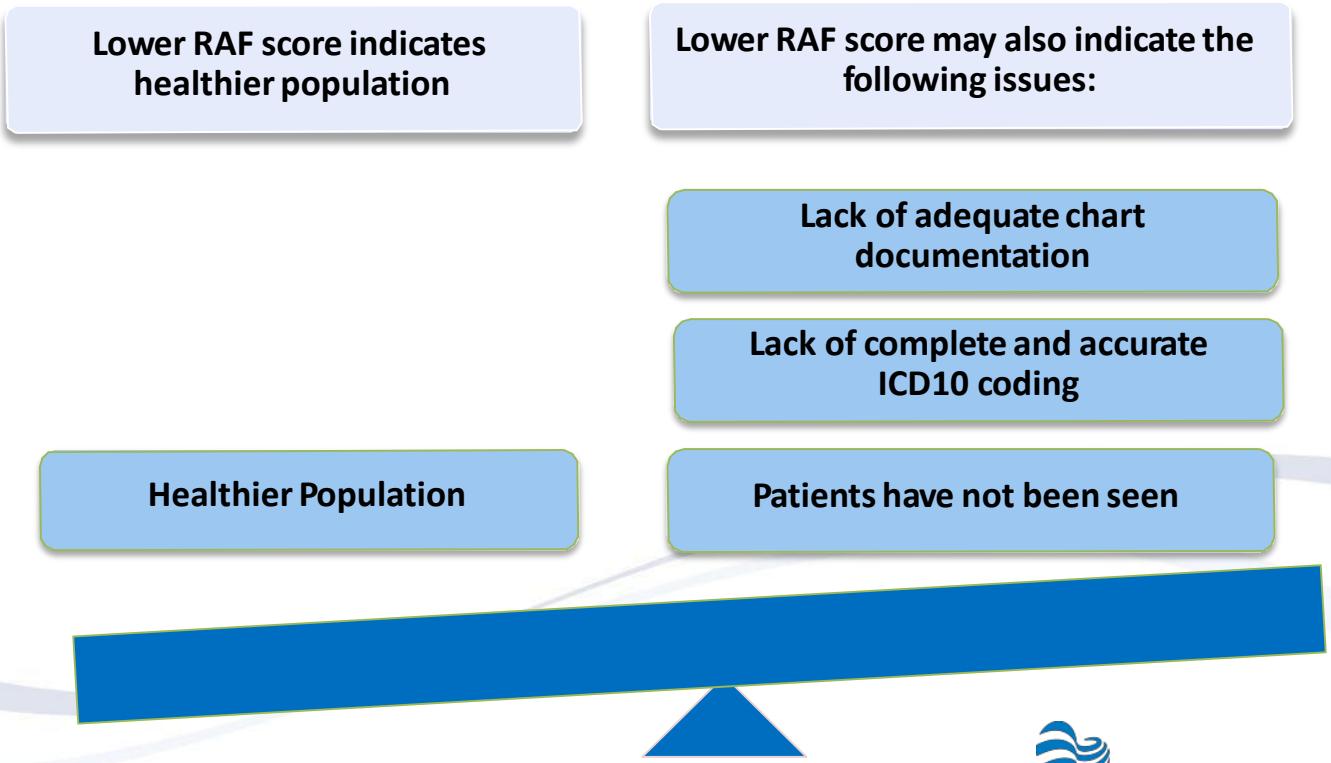
Payment Methodology: HCC's

- Prospective
  - Uses historical diagnosis as a measure of health status to predict future expense. Data from 2016 will be used to predict cost in 2017

- Two components
  - Demographic component
  - Disease burden component

Reimbursement Model RAF-HCC

The RAF score identifies the members health status and drives reimbursement.



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Reimbursement Model RAF-HCC

- Clinical encounter data is submitted to CMS by Health Plans or their Business Associates (BA) throughout the year

  - Final submission for 2015 Dates of Service (DOS) due by January 31, 2017.

How it works

Each member is assigned a Risk Adjustment Factor (RAF)

- RAF is a numeric value assigned by CMS to identify the health status of a patient

Sample of CMS-HCC Model

CMS-HCC Model Relative Factors for Community and Institutional Beneficiaries

Variable	Description Label	Community, NonDual, Aged	Community, NonDual, Disabled	Community, FBDual, Aged	Community, FBDual, Disabled	Community, PBDual, Aged	Community, PBDual, Disabled	Institutional
90-94 Years		0.857	-	1.186	-	0.822	-	0.964
95 Years or Over		0.976	-	1.268	-	1.038	-	0.781
Medicaid and Originally Disabled								
Medicaid		-	-	-	-	-	-	0.062
Originally Disabled, Female		0.244	-	0.172	-	0.126	-	-
Originally Disabled, Male		0.152	-	0.192	-	0.105	-	-
Disease Coefficients	**Description Label**							
HCC1	HIV/AIDS	0.312	0.288	0.585	0.500	0.550	0.232	1.747
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.455	0.532	0.596	0.811	0.409	0.417	0.346
HCC6	Opportunistic Infections	0.435	0.704	0.548	0.919	0.482	0.765	0.580
HCC8	Metastatic Cancer and Acute Leukemia	2.625	2.644	2.542	2.767	2.442	2.582	1.143
HCC9	Lung and Other Severe Cancers	0.970	0.927	0.973	1.025	0.955	0.879	0.727
HCC10	Lymphoma and Other Cancers	0.677	0.656	0.713	0.761	0.667	0.577	0.401
HCC11	Colorectal, Bladder, and Other Cancers	0.301	0.352	0.332	0.361	0.325	0.400	0.293
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.146	0.202	0.159	0.190	0.152	0.182	0.199
HCC17	Diabetes with Acute Complications	0.318	0.371	0.346	0.431	0.354	0.423	0.441
HCC18	Diabetes with Chronic Complications	0.318	0.371	0.346	0.431	0.354	0.423	0.441
HCC19	Diabetes without Complication	0.104	0.128	0.097	0.160	0.098	0.136	0.160

How it works

RAF scores are made up of the following criteria for each member:

- Demographic information including age and sex
- Medicaid status and if the patient was eligible for Medicare due to a disability
- Chronic conditions and a number of disease interactions

How it works

- If two or more ICD-10-CM conditions are mapped to the same HCC category, it will result in a payment for only one code and will be to the highest specificity code.

Examples of Diagnosis to HCC Mapping

Diagnosis	ICD-10-CM	HCC	Risk Score	Reimbursement
Diabetes with Ophthalmologic Manifestation	E11.39	18	.318	$
Diabetes with Neurological Manifestation		18	.318	
Diabetes with Circulatory Manifestation		18	.318	

Diagnosis	ICD-10-CM	HCC	Risk Score	Reimbursement
Alcoholism	F10.20	55	.383	$
Drug Dependence				

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
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
54	Drug/Alcohol Psychosis	55
57	Schizophrenia	58
70	Quadriplegia	71,72,103,104,169
71	Paraplegia	72,104,169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83,84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87,88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Cerebral Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107,108,161,189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135,136,137
135	Acute Renal Failure	136,137
136	Chronic Kidney Disease, Stage 5	137
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158,161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	161
166	Severe Head Injury	80,167

How it works

Disease Interaction 2017 Model Community Examples:

- Cancer and Immune Disorders
- Congestive Heart Failure and COPD
- Congestive Heart Failure and Renal Disease
- COPD and Cardiorespiratory Failure
- Sepsis and Cardiorespiratory Failure
- Artificial Openings and Pressure Ulcer
  - The risk scores for these disease interactions are all factored in behind the scene by CMS

Documentation

Documentation Guidelines

Per the ICD-10-CM Official Guidelines for Coding & Reporting:

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management.
- Diagnoses must be supported with MEAT.

Documentation Guidelines

- Patient's name
- DOS
- A face-to-face visit
- Patient's condition(s) must be documented
- Monitor, Evaluate, Address, Treatment (MEAT)
- Acceptable provider signature with credentials and date of authentication

Sources of Data

CMS only accepts diagnosis codes submitted from specific sources and specific documentation

Acceptable	Excluded
Inpatient hospitalization	SNF
Outpatient hospital services	Nursing Homes
Physician office visits	Hospice
*Note: all visits must be Face-to-Face with a CMS approved clinician	Lab
	Diagnostic Radiology
	Ambulance
	Durable Medical Equipment (DME)
	Ambulatory Surgery Centers (ASC)
	Outpatient pathology
	A list of patient conditions
	Superbill
	A diagnostic report that has not been interpreted
	Alternative data sources (e.g., pharmacy)
Acceptable clinicians	**Excluded clinicians**
Medical Doctor (MD)	Registered Nurse (RN)
Specialists	Registered Dietitian (RD)
Nurse Practioners (NP)	Medical Assistant (MA)
Physician Assistant (PA)	

Documentation Guidelines

- Do not code conditions that were previously treated and no longer exist.

- However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment

Why is complete documentation important?

- ICD10 Hepatitis C, unspecified (No HCC)
- ICD10 Hepatitis C, acute (No HCC)
- ICD10 Hepatitis C, chronic (HCC-29)

Why is complete documentation important?

- When a primary malignancy has been previously excised or eradicated from its site and/or there is no further treatment directed to that site and there is no evidence of any existing recurrence, a code from Personal history of malignant neoplasm should be used to indicate the former site of the malignancy.

Why is complete documentation important?

Impression/plan

82-year-old male with CLL stage 0, clinically remains stable, Small cell bladder cancer as well as prostate cancer, stable, received 2 cycles carboplatin,VP16, but developed complications of urosepsis, admitted to Del Webb ICU as he was hypotensive as well. He continues on Eligaard (given by Urology, Dr Hansen). Will consider consolidation XRT after PET/CT to assess response to chemotherapy. Coronary artery disease status post CABG and stenting, clinically stable. Hypertension, clinically stable, continues on blood pressure medication regimen. History of squamous cell skin cancer, no evidence of disease recurrence.

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Why is complete documentation important?

HPI: The patient is here for follow-up of multiple problems. She believes that she needs her Tegretol level checked. She takes Tegretol for her trigeminal neuralgia. She continues to have back pain. She wonders if her bone cancer has progressed. She does not see an oncologist anymore because of her decision to avoid chemotherapy. She had been on hospice but was discharged for prolonged treatment. She reports that her 94-year-old sister recently died.

Physical exam
Gen. appearance alert and oriented well-dressed and groomed acute distress
Lungs clear to auscultation bilaterally with good air movement
Heart regular rate S1 and S2 without murmur or gallops
Extremities no cyanosis no clubbing no edema

Assessment and plan

Metastatic breast cancer–the patient has bone pain. She wants to know if her cancer has progressed. She wants to know how long she has LEFT. I explained I could not predict that. She will have a total body bone scan. She denies needing analgesics.

Why is complete documentation important?

History of CA vs. Current CA

- History codes should NOT be assigned if a prophylactic drug is given as part of current cancer treatment.
- In this case, the current cancer code should be assigned.

(AHA Coding Clinic, Fourth Quarter 2008 Page: 156-160)

Provider's Role

- Documentation should demonstrate complete and concise picture of the patient's condition
- Treatment /Plan should link conditions to medications
- Document all conditions that co-exist at the time of the visit and how they impact current care and treatment

Provider's Role

- Providers must report the ICD-10 diagnosis codes to the highest level of specificity
- Excellent documentation is reflective of the "thought process" of provider when treating patients
- Accurate diagnosis code reporting and complete clinical documentation increases the accuracy of a patient's RAF score

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Tips

In order for CMS to make the payment, documentation submitted must indicate how the provider is treating, managing or addressing the chronic conditions

Language Samples:	
Assessment	Plan
Stable Improved Tolerating Meds Deteriorating Uncontrolled	Monitor D/C Meds Continue Current Meds Refuses Treatment Refer
Example of Acceptable Language	
Ex: Diabetes type 2, stable well controlled on meds Ex: COPD Stable on Advair	

M.E.A.T

All codes reported on the encounter claim must be supported by MEAT

Monitor: B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits
Evaluate: stump well healed, ostomy site w/o infection appears clean & dry
Address: stable; controlled, worsening; unchanged, uncontrolled
Treatment: taking Fosamax for osteoporosis; taking tamoxifen for breast cancer "treatment", DM controlled on insulin

Note: Some conditions require specific MEAT to confirm new or active status (e.g. cancer, CVA, pulmonary embolism, fracture, etc.)

Coder's Role

Codes may be assigned from the body of the note when **supported by the documentation (MEAT)** in the following areas:

- History of present illness (HPI)
- Physical examination (PE)
- Assessment
- Impression
- Plan

Codes will **not** be assigned from **list** such as:

- Active problems
- Current problem
- Problems

Codes will **not** be reported if diagnoses are documented as:

- Probable
- Suspected
- Questionable
- Rule out
- Working diagnosis

Or other similar terms indicating uncertainty as stated by ICD-10-CM guidelines.

Coder's Role

- When in doubt, query the provider, do not assume

- Know the ICD-10-CM Official Guidelines for Coding and Reporting results in accurate and complete coding

References

- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organization Participant Guide". Centers for Medicare & Medicaid Services.

  http://www.csscoperations.com/Internet/Cssc3.Nsf/files/participant-guide-publish_052909.pdf/$File/participant-guide-publish_052909.pdf

- ICD-10-CM Official Guidelines for Coding and Reporting

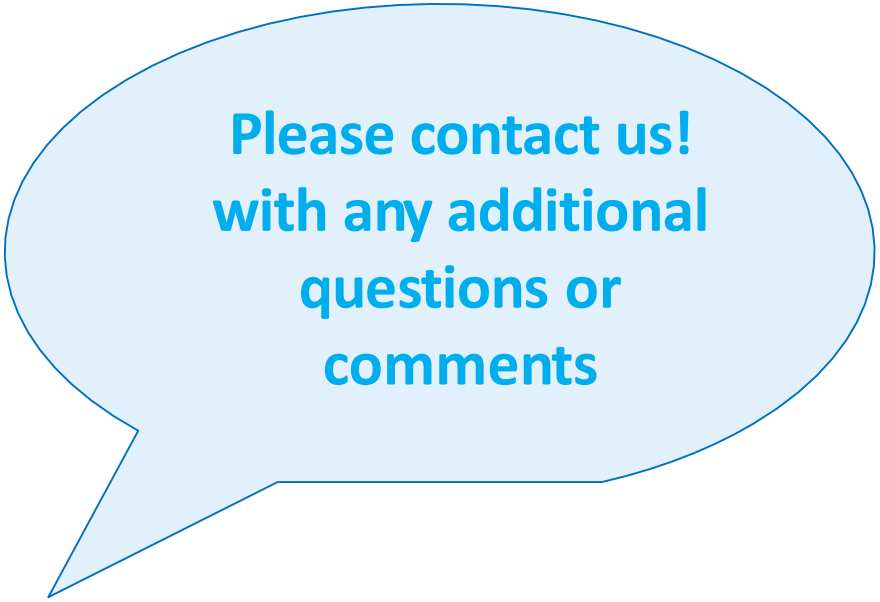
  http://www.cdc.gov/nchs/icd/icd10cm.htm

- HCC model mappings

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/IDC10Mappings.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Questions or Comments

We are happy to help you!



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Thank you!