Cardiovascular Summit

A Practical Approach to HCC Capture and RAF Scoring

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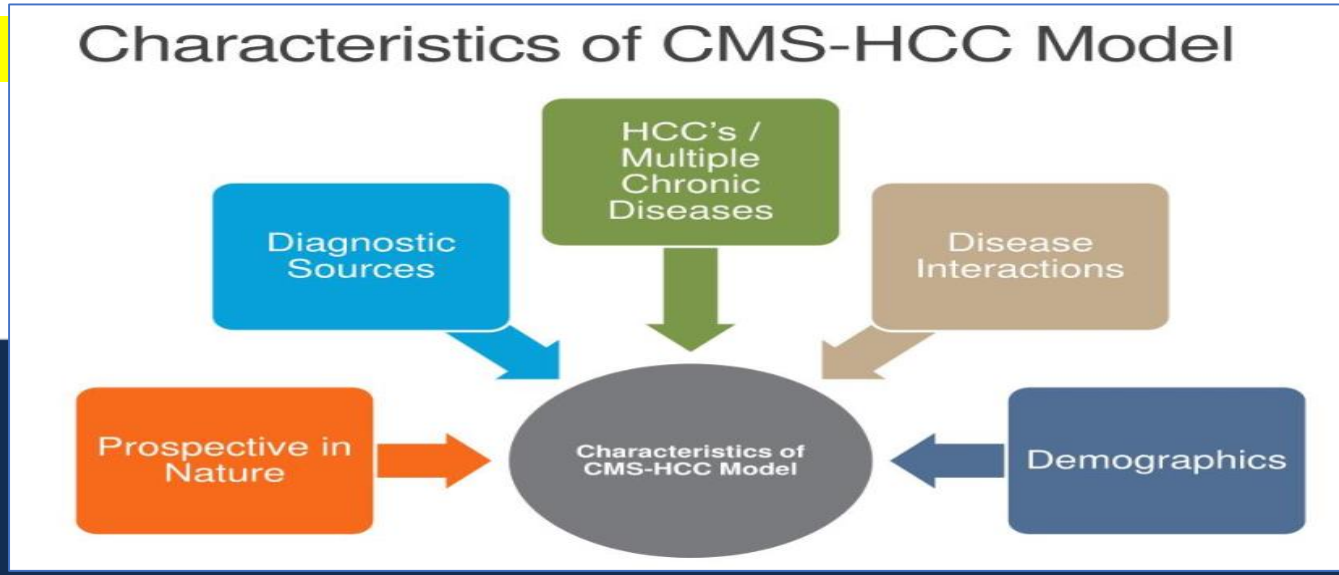
What Do We Mean By HCC and RAF?

What is HCC?

- Created by CMS in 1997, HCC or "**Hierarchical Condition Category**" is a risk adjustment model to calculate risk scores for Medicare beneficiaries.
- HCC scores reflect expected annual medical costs of a Medicare member. CMS uses HCC risk scores to **calculate its per-member/per-month fees** to payers.
- Individual diagnoses (70,000+) are classified using "ICD-10". Of these, ~9,500 ICD-10 codes are matched with the **85-90 HCC weighted codes**.
- HCCs — plus demographic factors — reflects the medical complexity of the patient. This is **captured numerically by the RAF score**.
- Many commercial payors also use this type of scoring.

What is RAF?

- RAF (**R**isk **A**djustment **F**actor) scores are "additive". Qualifying HCC diagnoses are summed for total RAF score. **Average risk patient = RAF score of 1.0**
- Health status is re-determined each year
  - **Codes must be submitted every year to be counted. RAF for each patient is "reset" every calendar year.**
- RAF scores are "predictive": they set cost benchmarks in value programs (e.g., MSSP)
  - **Scores are used to compare providers' effectiveness at controlling costs under value-based purchasing**.



HCC/RAF – Why Should I Care?

You and your organization are being “scored”.
You need to present an accurate picture

How Do Shared Savings Contracts Work?

We start with a defined population from the payer. Then we perform financially to fund the shared savings pool. Finally we must meet a “quality gate” to get to a final shared savings amount.

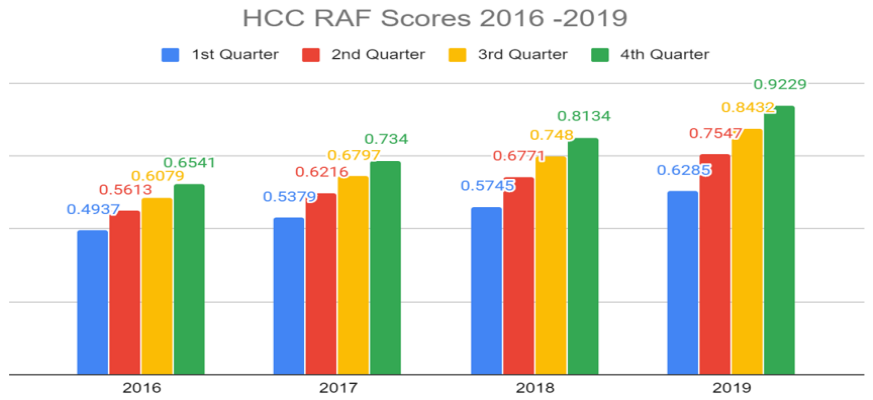
Key Concepts to Understand

- Benefit Design
- Attribution
- Risk Stratification
- Benchmark Spend
- Shared Savings Retention

HCC RAF Score Improvement 2016 - 2019

WHY SCORES MATTER

- More accurate representation of the patient’s total clinical picture
- Lower scores show a healthier population
- Higher scores show anticipated disease burden
- Scores at the end of each year impact the next year’s payment (or possibly longer)



How Do You Move The Dial?

- Run diagnosis reports and identify areas of opportunity for clinicians with lower scores
- Identify new approaches to improve – chart prep, Claim review, artificial intelligence, “risk tabs, Gap reports etc.

How Can You Impact Your RAF Score?

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

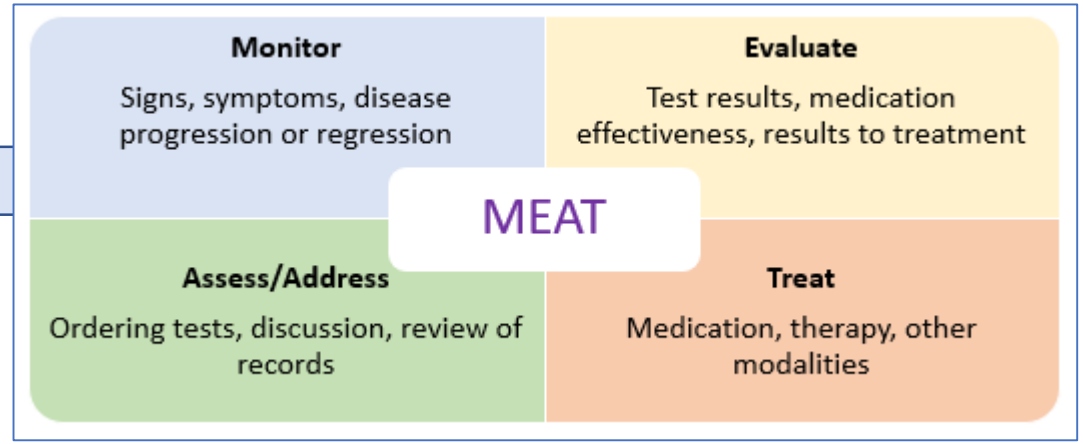
- J. Code all documented conditions that coexist. Code all documented conditions that **coexist at the time of the encounter/visit, and require or affect patient care treatment or management**. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80- Z87) may be used as secondary codes **if** the historical condition or family history has **an impact on current care or influences treatment**

Ex of Assessing/MEAT the Condition Statement:

"CHF symptoms well-controlled with Lasix and ACE, continue current doses."

- Avoid "history of" this indicates pt no longer has–state when diagnosed "Pt has had diabetes for 10 yrs"
- State causal relationship when appropriate – "hypertensive chronic kidney disease"

If it impacted your thought process, code it!
Document "MEAT".
AKA – "Think in ink".



Payors WANT you to assess, document and submit chronic conditions! Even if you aren't the treating provider – ensure the patient is following up

In reviewing clinicians with higher scores – the biggest difference comes down to coding specificity and comorbidities

When treating a patient for an illness or injury, their overall clinical condition is considered – how the current condition will impact their chronic conditions, will meds interact, will they need additional follow up or care?

A Clinical Example

HISTORY OF THE PRESENT ILLNESS:
84-yo woman reports shortness of breath on minimal activity. Recent BNP 1065. Her HbA1c is 8.2. Activity limited due to dyspnea. Sleeps in the recliner with head elevated. Since starting a diuretic, she's lost ~10 pounds and feels better. She denies chest pain but reports increasing palpitations.

PHYSICAL EXAMINATION:
Pulse: 80, irregularly irregular. BP: 132/70. BMI is 41.
JVP is normal; Carotids: no bruit. Heart: S1, S2, IRR IRR ,no murmur. Lungs: clear Extremities: No edema; ulcer L great toe

ECG: Atrial fibrillation, rate 96 BPM; nonspecific ST and T-wave abnormalities.

IMPRESSION:
1. Congestive heart failure; diastolic dysfunction: discussed with the patient in detail.
2. Atrial fibrillation, tolerating well. No need for cardioversion.
   -Anticoagulant therapy, discussed need to reduce CVA risk from Afib.
3. Decreased activity with dyspnea on exertion and abnormal ECG: see below
4. Abnormal ECG. Intermediate risk of CAD. Ischemia burden needs evaluation
5. Toe ulceration: newly recognized. See below

RECOMMENDATIONS:
1. Switch metoprolol tartrate to metoprolol succinate at 50 mg daily; Continue Lasix as prescribed.
2. Pharmacologic MPI stress test.
3. Obtain ABIs w/ TBIs. Refer to Wound Care team.
4. Connect with primary care team regarding advancing DM management: SGLT2i treatment?.

A Clinical Example

Partial Reporting		Accurate/Complete	
84 YR old female		84 YR old female	
Dual Eligible		Dual Eligible	
Type II, circulatory compl	**0.346**	Type II, with ulcer	**0.853**
CHF, unspecified	No RAF	CHF chronic diastolic	**0.355**
		DM + CHF interaction	0.205
Obesity unspecified	No RAF	Morbid Obesity BMI>40	**0.41**
Palpitations	No RAF	Atrial Fibrillation, chronic	**0.369**
		CHF + arrythmia interaction	0.2
Demo Score	Demo 0.739	Demo Score	Demo 0.739
RAF	**0.346**	**RAF**	**1.723**
Total	**1,085**	**Total**	**3.381**
Annual pymt	**$9,765**	**Annual pymt**	**$30,429**

HCCs Present*

1. Atrial fibrillation
2. PVD with ulcer
3. Morbid obesity
   - Qualifies at BMI 35 w/ DM
4. Type 2 DM
   - Complicated by cardiomyopathy
5. Diastolic HF

*supported by documentation

PMPY Payment

$9,765 → $30,429

HCCs Common in CV Practice

1. Diabetes w/ circulatory complication
2. Atherosclerosis of the aorta (HCC 108: PAD)
3. Thoracic aortic ectasia (HCC 108: PAD)
4. Morbid Obesity
   - BMI 35+ with obesity-related DM or HTN
5. CKD 3
6. Chronic stable angina (HCC 88)
   - Can be pain-free, if (+) CAD and on medication
7. Thrombocytopenia (platelets <150K)
8. COPD

9. Major Depression, in remission
10. Alzheimer Dementia

HCC	Descriptor	Weight
18	Diabetes mellitus with circulatory complication	0.305
19	Diabetes mellitus with no complication	0.105
21	Protein-calorie malnutrition	0.455
22	Morbid obesity	0.244
48	Coagulation defects (thrombocytopenia)	0.191
84	COPD	0.335
85	CHF	0.331
137	CKD 4	0.288
138	CKD 3	0.069
88	Chronic stable angina pectoris	0.135
89	CAD	0
96	Specified heart arrhythmias	0.268
186	Major organ transplant status	0.823
106	PAD with ulcer or gangrene	1.488
107	PAD with complications	0.384
108	PAD (includes thoracic aortic ectasia, atherosclerosis of aorta)	0.288
189	Amputation status (includes toes)	0.519
103	Hemiplegia after CVA	0.437
58	Major Depression	0.393
55	Drug/Alcohol Dependence	0.329
52	Alzheimer Dementia	0.346
78	Parkinson disease	0.606

Miscellaneous Coding Comments

DM with Circulatory Compromise

- When the patient also has any other symptoms such as PVD, ischemic ulcers, etc. absolutely. These are listed in the ICD-10 as examples. Absent those conditions it is less clear, and requires a closer review of the documentation.
- AHA Coding Clinic in first quarter 2016 ruled that we can assume a "cause and effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system." This is often given as a reason to support CAD and DM as a circulatory complication.
- This same statement goes on to state that "if physician documentation specifies DM is Not the underlying cause of the other condition, the condition should not be coded as a diabetic complication".
- Coding Clinic also says there is a presumed causal relationship between two conditions when they are linked with the term "with". The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the alpha index, or an instructional note in the tabular list.
- I believe the answer comes down to does the provider document an association or connection of the CAD to the circulatory complication and or vice versa.
- If so you have a clear yes and or no response. Absent that linkage by the provider you would either code both conditions, and or rely on your interp of the AHA coding clinic guidance - coders do not all agree with that interp

Obesity versus Morbid Obesity

Obesity and Morbid Obesity

Obesity: Is measured based on BMI and is considered those who have a **BMI of 30 to 39.9.**

Morbid Obesity: Is defined as someone who is 100 pounds over their ideal weight, has a **BMI of 40 or higher** or has a **BMI of 35 or more and is experiencing obesity-related health conditions such as DM or HTN.**

ICD-10	Body mass index [BMI]	ICD-10	Obesity and Morbid Obesity
Z68.30 - Z68.34	Body mass index (BMI) 30.0-34.9 (adult)	E66.0	Obesity due to excess calories
		E66.09	Other obesity due to excess calories
		E66.1	Drug-induced obesity
		E66.8	Other obesity
		E66.9	Obesity, unspecified
Z68.35 - Z68.39	Body mass index (BMI) 35.0-39.9 (adult) *with comorbidities		Select Obesity code Select Morbid Obesity code
Z68.41 - Z68.45	Body mass index (BMI) 40.0-or greater (adult)	E66.01	Morbid (severe) obesity due to excess calories
		E66.2	Morbid (severe) obesity with alveolar hypoventilation

★ It is required to document and code not only the BMI (numeric value) but also the patient's diagnosed condition of Obesity or Morbid Obesity.

Coding Opportunities/Common Misses

Diabetes Mellitus – This is a big one!

- "Pre-Diabetes" – for years, on meds (0.000)
- Diabetes with:
  - **Neuropathy**: Diabetes with foot numbness, tingling (believed to be neuropathy) (0.368)
  - **Chronic Renal Disease**: (Code also the Renal Disease with Stage) (0.368)
  - **Circulatory Complication**: Diabetes with peripheral vascular issues (ulcers, etc.) (0.368)
  - **Retinopathy**: Diabetes with diagnosed diabetic retinopathy with or without macular edema (0.368)
  - **Other possibilities**: DM with Arthropathy, Hyperglycemia, Hypoglycemia, Skin Condition, Oral Condition (0.368)
- Long-Term Insulin Use – Z79.4 (0.118)

Coding Opportunities/Common Misses

- Morbid Obesity (0.365)
  - Also code patient's BMI (BMI of ≥ 40 is 0.365) and/or more than 100 lbs overweight
- Heart Failure (0.368)
  - Consider if due to hypertension - I11.0 or if with chronic kidney disease -I13.0 (0.368) – Code also HF
  - Be as specific as possible: congestive, chronic, systolic, diastolic
- COPD (0.346)
- Drug/Alcohol Abuse or Dependence (0.420)
  - Note type of dependence-alcohol or drug/opioid, cannabis, etc., Dependence with Withdrawal, Dependence, in Remission

Coding Opportunities/Common Misses

- Bipolar Disorder, Major Depressive Disorder (0.284) – specify type, status
- Epilepsy, Seizures, Convulsions –be as specific as possible (0.284)
- Rheumatoid Arthritis, Polymyalgia Rheumatica, Rheumatoid Psoriasis – (0.374)
- Peripheral Vascular Disease – consider cause, if known, i.e. atherosclerosis (0.299)
- Acquired Amputations (0.779)

Coding Opportunities/Common Misses

- Status Post Ileostomy, colostomy, gastrostomy, ostomy of urinary tract (0.651)
- Status Post Transplant – Heart, Lung, Intestine, Liver, Pancreas, Bone Marrow, Stem Cell (0.891)
- Sequelae (late effects) of Stroke:
  - Hemiplegia or hemiparesis (0.581) – Note right or left, dominant vs non-dominant
  - If no sequelae after stroke, do not code as current, code as personal hx of stroke, no residual -Z86.73

What are the changes you can make tomorrow?

Where are your biggest opportunities?

Coding Opportunities/Common Misses

- Malignancies: Current vs Personal History
  - When primary has been excised but further tx (more surgery, radiation, chemotherapy) – ***Code as Current***
  - When primary has been excised and there is no further treatment being done and no evidence of cancer – use ***Personal History*** code from Z85- specifying site

HCC/RAF Program Goals

1. Achieve optimal RAF scores for your population → RAF scores most accurately reflecting the complexity/severity of illness of your patients.

2. Design efficient and effective workflows around HCC and RAF score capture.

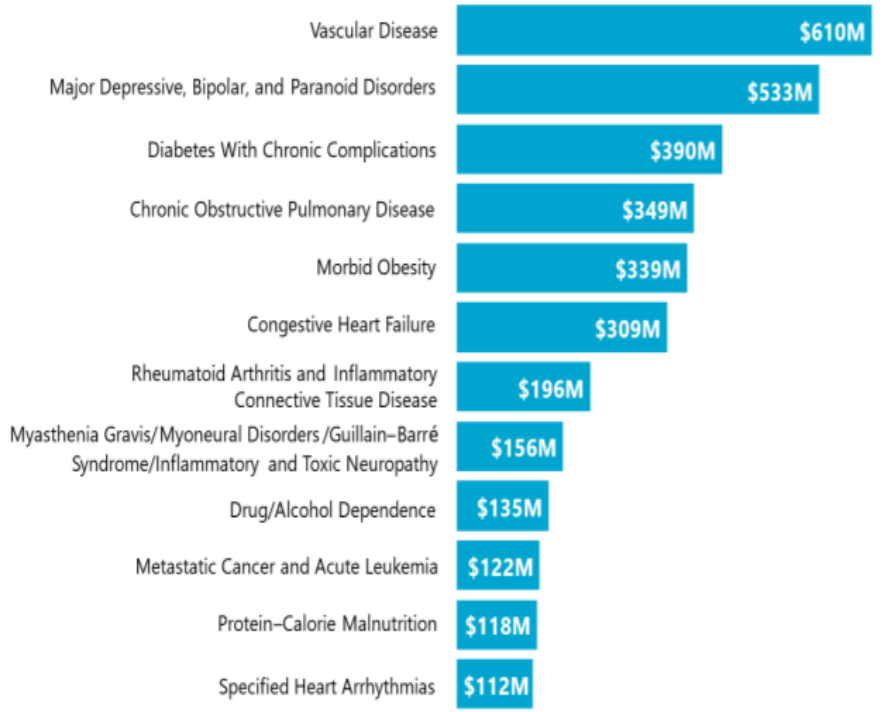
3. Audit your HCC/RAF capture processes. How do you benchmark against your peers?

Making National Headlines

U.S. Department of Health and Human Services
Office of Inspector General

Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments

Exhibit 4: For 20 MA companies, 12 health conditions drove billions in risk-adjusted payments from chart reviews and HRAs.



Source: OIG estimation of 2017 payment amounts using 2016 MA encounter data from CMS's IDR.

OIG calls for more oversight as MA insurers bank $9.2B on the back of chart reviews, risk assessments

Justice Department Targets Data Mining in Medicare Advantage Fraud Case

HCC and RAF Scoring: Key Take-Aways

1. Your completeness in reporting of the extent and complexity of your patients' medical conditions through **HCC reporting drives the external assessment of quality and value** of the care you provide.

2. **Be familiar with "never miss" HCCs** you encounter in everyday cardiovascular practice that influence RAF scoring.

3. Work with your local coding/documentation teams to **ensure your clinical notes support the HCCs** associated with your care.