



Clinical Risk Adjustment: Ensuring Compliance Through Complete and Accurate Documentation and Coding

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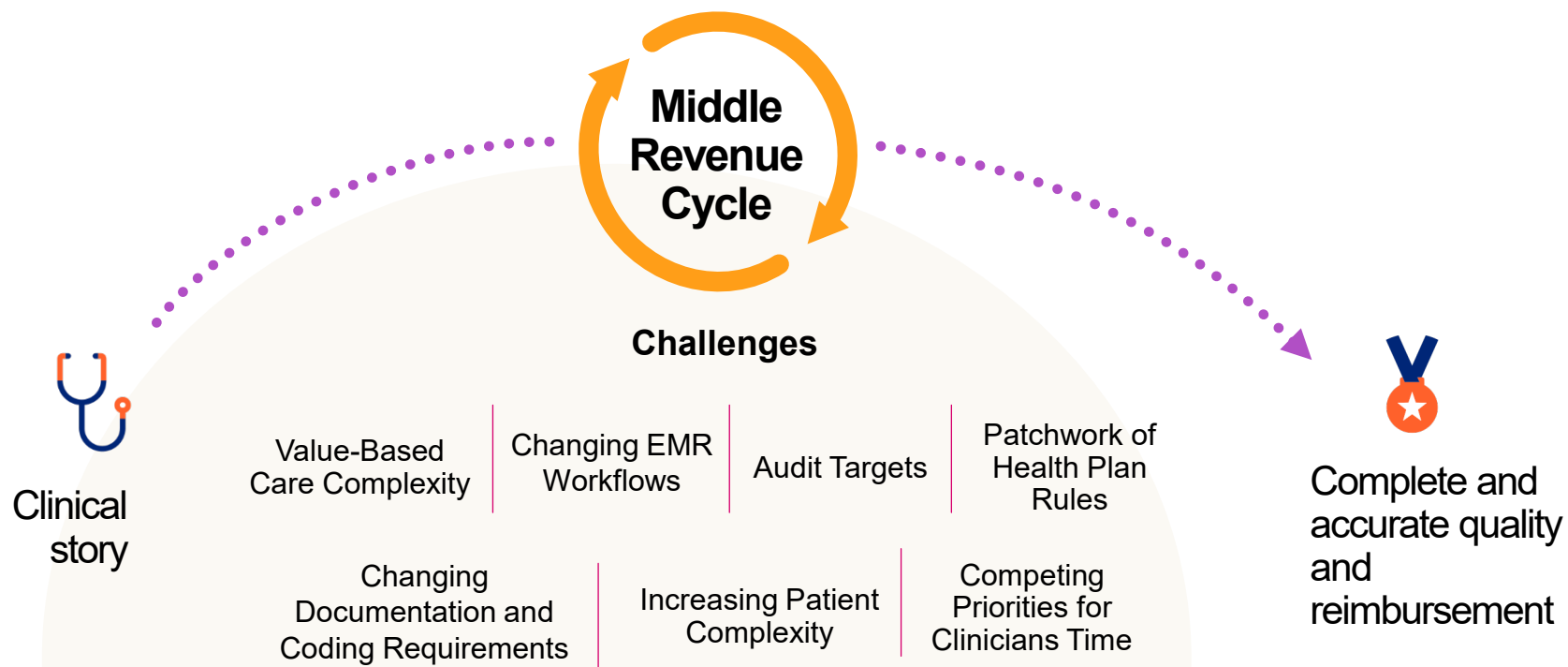


Reavis Eubanks, MD, is a medical director for Optum Advisory Services. He has 40 years of experience in private practice and four years in consulting including EMR implementation and optimization. Formerly he was a general and pediatric surgeon in private practice in North Carolina.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Identify critical success factors for Ambulatory Clinical Documentation Integrity programs
 - Recognize how ambulatory CDI and clinical risk adjustment efforts correlate to outpatient coding efforts in fee-for-service
 - Understand how data analytics can be used to identify high-risk and mis-keyed diagnoses appropriate for closer review

Underscoring the Importance and Complexity of Documentation



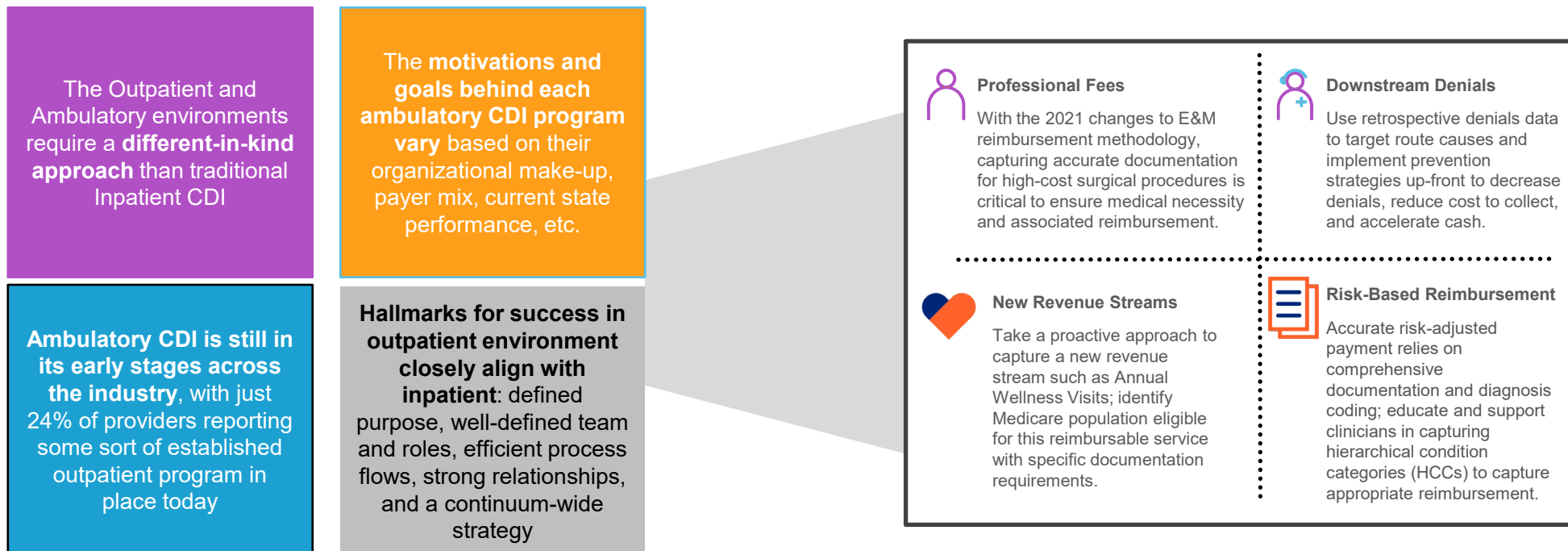
Documentation Is at the Core

The driving force for clinical risk adjustment is to accurately reflect care provided and appropriately support the disease burden of the population served during each visit



so your patients can live
their fullest lives.

Point of View on Ambulatory Documentation



We believe speaking a common language is important, and thus we offer the following possible delineations/definitions for outpatient versus ambulatory documentation and coding integrity:

Acute Care Outpatient

- Focus on key areas within the hospital facility that deliver outpatient services (e.g., Emergency Department, observations, etc.)
- Is not inclusive of the professional office setting

Outpatient




- Inclusive of both acute care outpatient and ambulatory settings
- Provides robust focus on increasing quality of documentation
- Addresses both fee-for-service and risk-based populations and opportunities

Ambulatory Care

- Focus on professional setting (office visits, in office procedures, ambulatory surgical centers, etc.)
- HCC, Risk Adjusted Factor (RAF), Risk, etc.
- Not inclusive of the acute care outpatient setting

CDI Program Considerations By Setting

Aside from the label, ambulatory CDI is challenging because it cannot simply replicate inpatient-oriented CDI processes. The differences between inpatient and physician practices need to be considered in establishing an ambulatory clinical documentation integrity program.

	Type of Encounter	Timing	Technology Platform	Coding Framework	Oversight Responsibilities	Provider Clarification
 Inpatient	Lower volume, higher payment per case	Multi-day stay	Unified	ICD-10 CM/PCS DRGs	Hospital and system management	Reactive
 Ambulatory Network	Higher volume, lower payment per case	~20-minute encounter	Disparate	ICD-10 CM, HCCs CPT, HCPCS	Physician enterprise	Proactive
 Key Differences Preventing Scale	Need to prioritize subset of cases	Need to get information during shorter visit	Must capture data from multiple sources	Need unique coding knowledge	Greater physician involvement required	Inpatient and ambulatory documentation and coding guidelines

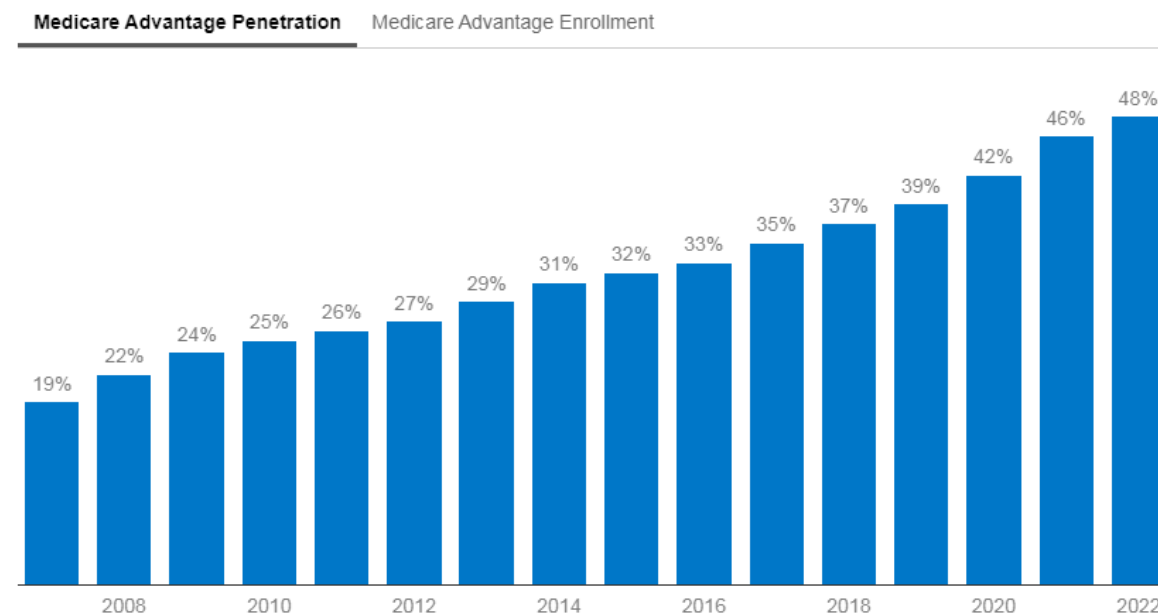


While inpatient care allows time for concurrent CDI, outpatient care is better suited to CDI activities done before (prospective) and after (retrospective) the patient visit.

Medicare Advantage Has More Than Doubled Since 2007

CMS risk-adjusts the capitated payments to Medicare Advantage plans based on an enrollee's "risk score" – a measure of the expected costs associated with a person's care. Risk adjustment aims to accurately predict expected health care costs, encouraging plans to compete for beneficiaries based on price and quality, not health status. To ensure these capitated payments accurately reflect the expected cost of providing health care to each beneficiary, CMS uses a process called "risk adjustment" to adjust payments based on the health status of enrollees. An accurate, stable risk adjustment model is a critical tool for ensuring adequate resources to care for enrollees in the Medicare Advantage program.

Total Medicare Advantage Enrollment, 2007-2022



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.

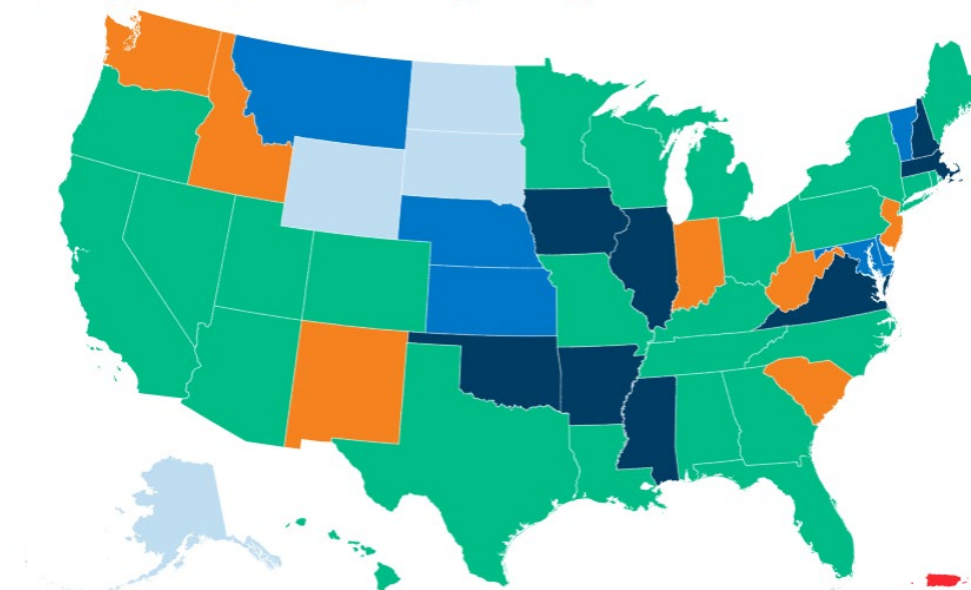
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022. • PNG

KFF

Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State

< 20% 20%–30% 30%–40% 40%–50% 50%–60% ≥ 60%



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022 • PNG

KFF

Source: Kaiser Family Foundation

<https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/> ;
https://bettermedicarealliance.org/wpcontent/uploads/2020/03/BMA_RiskAdjustment_WhitePaper_2018_02_27_v2a.pdf

Urgency to Set an Appropriate Baseline

All programs should be focused on completeness and accuracy to improve member outcomes.

An 85-year-old MA patient comes in for a visit ...

Date of Service: June 29, 2020

Symptoms

- Symptoms of UTI, reports mild claudication
- Tired, less energy, poor appetite, mild malnutrition weight loss 25lbs. in 6 months
- Urinalysis performed shows white cells, leukocyte esterase and microalbuminuria

Medical history

- Stable diabetes mellitus (DM)
- Chronic kidney disease (CKD) stage 4 exacerbated by diabetes with serum GFR 29
- Stable left great toe amputation due to non-healing ulcer
- BMI of 22
- UA (+) Nitrites

Care plan set

- Glipizide 5 mg b.i.d. for DM
- Cipro for UTI
- Ensure supplements for malnutrition
- Return to clinic (RTC) in 3 months
- Referral to nephrologist for CKD4
- Walking program for claudication

ONE PATIENT, THREE SCENARIOS

1 Capture basic demographics and primary reason for visit

85-year-old female
• UTI

Total RAF	0.664
PMPM care funding	\$531
Annual care funding	\$6,372

2 Capture additional condition

85-year-old female
• Diabetes mellitus
• UTI

Total RAF	0.769
PMPM care funding	\$615
Annual care funding	\$7,382

3 Capture complete clinical information

85-year-old female
• Diabetes mellitus
• UTI
• CKD stage 4 due to diabetes
• Mild degree malnutrition
• H/O toe amputation

Total RAF	2.168
PMPM care funding	\$1,734
Annual care funding	\$20,808

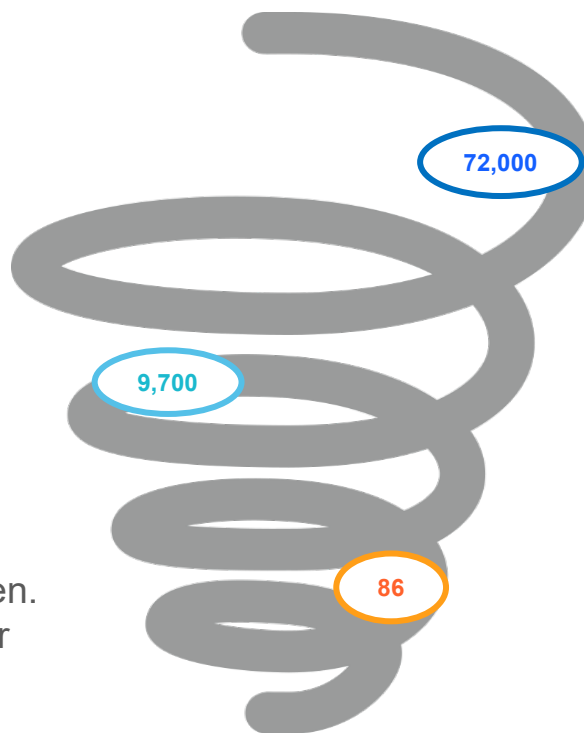
HCC Risk Adjustment Capture

Clinicians must thoroughly report on each patient's risk adjustment diagnosis based on clinical medical record documentation from a face-to-face encounter (includes video visits per CMS.) Specific chronic conditions determine the RAF score which is used to calculate payer reimbursement and predict potential future costs associated with each patient.

Hierarchical Condition Category (HCC) is a risk adjustment model that is used to calculate risk scores to predict future healthcare costs.

CMS-HCC V24 Diagnosis Codes

- Diagnosis codes or disease classifications that identify a patient's risk or disease burden.
- Identifies the cost of caring for that patient.
- Conditions are grouped into categories.



ICD-10-CM Diagnosis Codes

- Number of ICD-10-CM diagnosis codes available to support patient severity.
- A subset of these diagnosis codes are classified in groups for risk adjustment methodologies.
- Type of risk adjustment include CMS-HCC (Medicare Beneficiaries); HHS-HCC (Children/adults in ACA exchange plans) and Inpatient MS-DRGs.

HCC Categories

- Each category contains multiple ICD-10 codes.
- Each category carries a risk adjustment value or "weight".
- Used for risk adjustment of quality and outcome measures.

Annual Risk Adjustment Factor Score Calculation

Undocumented conditions are not managed and may impact patient outcomes.



On **January 1st**, the patient's chronic conditions are **reset** to "zero"



- It is not enough to correctly code the patient's diagnosis.
- The assessment and plan must support each visit diagnosis.
- All chronic conditions ***must be reestablished annually***.



Demographics include age, sex, original Medicare entitlement, disability, and Medicaid status.



Visit diagnoses and conditions from base year are used to predict payment for the following year.



Conditions addressed are obtained ***from outpatient visit diagnosis codes*** and inpatient hospital codes.



Base payment for each member is based on HCCs documented; there is an additional risk factor credit for certain disease interactions.

What Conditions Should Be Reported?

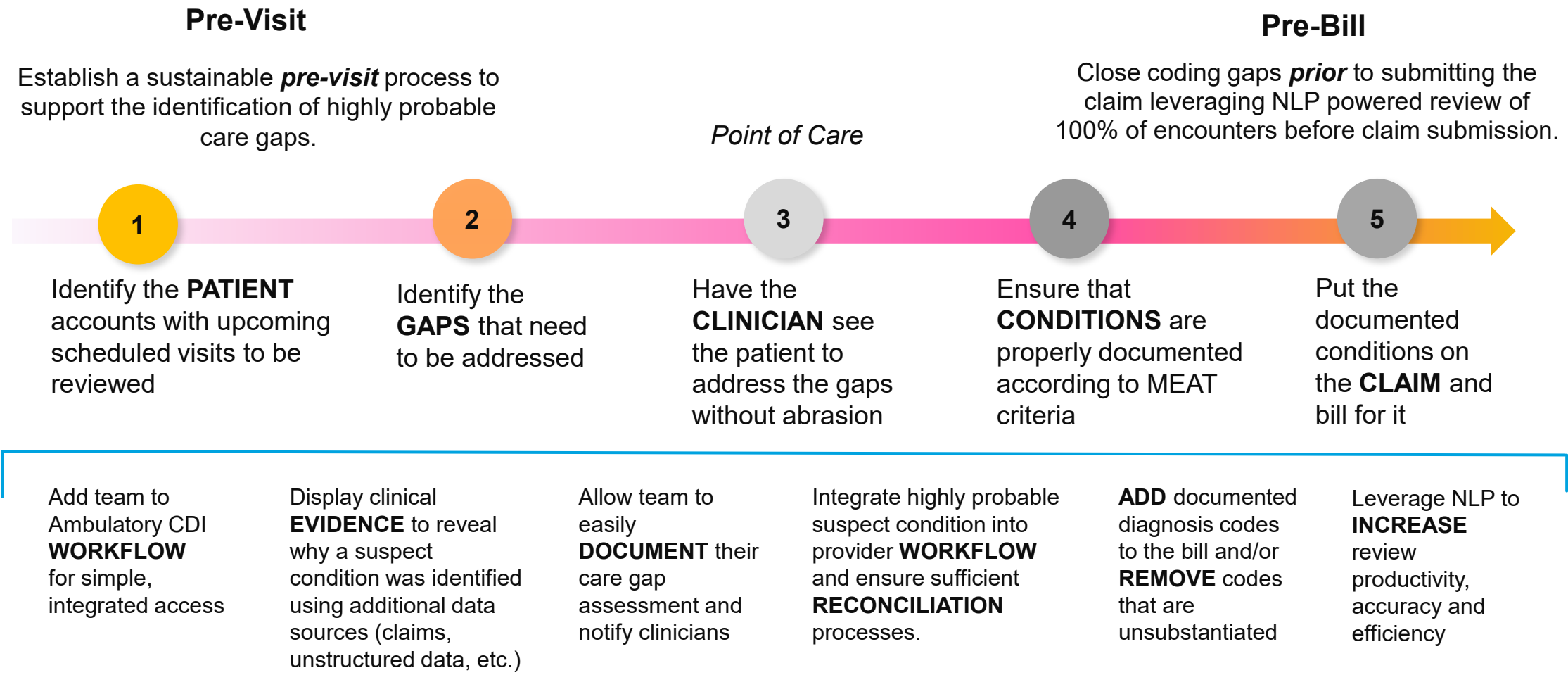
MEAT is an acronym used in HCC to ensure that the most accurate and complete information is being documented. Each condition or diagnosis must include at least, one of the following criteria to be appropriate for reporting (coding).

- M** *Monitor*
 Condition status (mild, moderate, severe, hypo or hyper).
- E** *Evaluate*
 Signs and/or symptoms, laboratory or radiology results, response to treatment.
- A** *Assess*
 Review of specialist's notes, counselling, complications of care.
- T** *Treat*
 Medication reconciliation and adjustment or initiation, referral to specialists, order diagnostic studies.



Complete Documentation of Patient Complexity

Pre-Visit, Point of Care, and Pre-Bill teams working in tandem to fully capture complexity of care.



Do Resources Utilized and Disease Burden Align?

The patients below each present for a follow-up visit.

Do these patients *look the same* when you read their chart?
Will they take the *same amount of resource expenditure*?



Joseph

- 66 years old
- No chronic illnesses
- No current meds
- Active lifestyle, exercises



Barbara

- 73 years old
- Diabetes
- COPD
- Renal Insufficiency
- Home Oxygen
- Lives in assisted living



Accurate capture of the ***visit diagnoses for all conditions treated*** ensures credit for the quality of care provided through the clinical risk adjustment process.

This supports the time, effort and provides appropriate resources to care for your patients.

Let's Review Barbara's Story



HPI: 73-year-old presents for follow-up on diabetes. Recently completed annual eye exam and was found to have an age-related cataract in right eye with plan for surgery next month. Patient reports monitoring blood glucose 1 x per day with results between 90-120. Compliant with meds without side effects. Problem List: DM, CKD, COPD on Home Oxygen
 VS: T 98.5, P, 76, R 22, BP 136/82, O2 Sat 93% on 2 LPM
 Relevant Exam Findings: “Lungs diminished in bases” “Uses 2 LPM Nasal Cannula, continuously.”

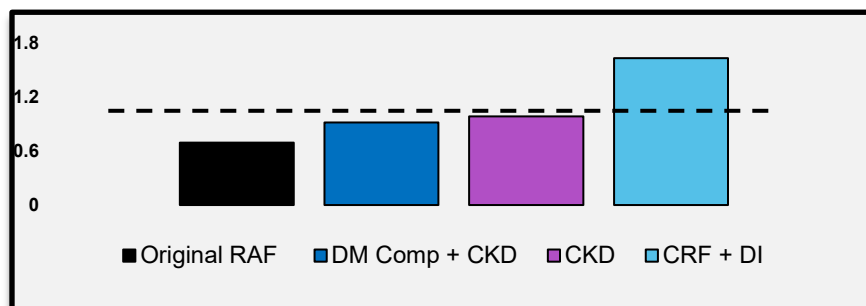
Original Visit Diagnoses	Additional Documentation Opportunities
<p>Assessment and Plan:</p> <ol style="list-style-type: none"> 1. Diabetes, stable: Continue current medications and testing 1 x per day. RTC 3 months. 2. CKD, GFR 58 and 56 respectively over last two visits, will recheck labs. 3. COPD on Home oxygen 4. Check A1c and BMP for renal status. 5. Age-related cataract, right OK for cataract surgery. Continue meds on day of surgery with a sip of water. 	<p>Assessment and Plan Considerations:</p> <ul style="list-style-type: none"> • Type 2 Diabetes with Ophthalmic Complications • Type 2 Diabetes with Kidney Complications • CKD, Stage 3a, recheck labs • COPD with Chronic Hypoxic Respiratory Failure with home oxygen use of 2 LPM nasal cannula, continuously

Rationale: There is an assumed relationship between diabetes and both the cataract and kidney disease. This should be captured as type of diabetes with ophthalmic complication and diabetes with kidney complications, with an additional code to capture the cataract and stage of CKD. CMS does not recognize renal insufficiency and some stages of CKD in its risk adjustment model. Chronic hypoxic respiratory failure is supported by the continuous use of home oxygen.

Clinical criteria and assessment/plan support additional diagnoses of **diabetes with complications** as noted above and **CKD stage 3a** per lab finding and **chronic hypoxic respiratory failure**. These conditions were not documented and coded to support the patient’s disease burden and the medical decision during the visit.

Patient Risk Burden Through Visit Diagnosis Capture

Original Visit Diagnoses	RAF	Accurate Diagnoses	RAF
Diabetes Type 2	0.105	<i>Type 2 Diabetes with Ophthalmic Complications</i>	<i>0.302</i>
Chronic Kidney Disease	No HCC	<i>Diabetes Type 2 with Kidney Complications</i>	
Age-Related Cataract	No HCC	<i>Cataract, Age-Related, Left Eye</i>	<i>No HCC</i>
COPD	0.335	No Change	0.335
Dependence on Oxygen	No HCC	<i>Chronic Kidney Disease, Stage 3a</i>	<i>0.069</i>
Baseline Demographics	0.386	Baseline Demographics	0.281
Original Visit RAF	0.695	<i>Chronic Hypoxic Respiratory Failure</i>	<i>0.282</i>
		<i>Disease Interaction COPD/Respiratory Failure</i>	<i>0.363</i>
		<i>Total Possible RAF</i>	<i>1.743</i>
- - - - Medicare Baseline 1.097 - - - -			



*Additional visit diagnoses
Impact RAF scores*

Preventing Healthcare's Top Four Documentation Disasters

Patient safety is just one of the many reasons for improved accuracy of clinical documentation. Education needs are driven by the increased specificity needed for ICD-10-CM/PCS, transition to pay-for-performance versus fee-for service methodologies. There is also increased scrutiny of claims data and health record documentation to ensure medical necessity is met and quality indicators are captured.

Mixed messages (dictation or legibility)

- Dictation programs and EHRs were thought to eliminate problems such as illegible handwriting or hard to understand dictation.

Common errors include:

- Documentation on the wrong chart
- “he” versus “she”
- “hyper” rather than “hypo”
- Unapproved abbreviations

Misuse of copy and paste or copy forward

- While this can save provider time; it’s a breeding ground for documentation errors.

Impacts:

- Ability to track progression of an illness (worsening or improvement)
- Perpetuates errors
- Adds pages and pages of documentation making it difficult to process the information
- Finding pertinent information is tedious

Incomplete or missing documentation

- Vague terminology is used
- Diagnoses lack specificity
- Lack of capture of secondary conditions that impact patient management

Misplaced documentation

- Data that is entered into the wrong fields
- Hybrid records
- Procedure notes as an encounter note
- Problem lists identifying conditions as “active” instead of “history of”



Any one of these errors may result in a patient safety event.

Mitigating Documentation Challenges in the Ambulatory Setting

In a perfect world, every patient encounter should be documented in a manner that will stand alone and tells the patient story.

► Coding

- Providers do more of their own coding which requires more training on coding guidelines to ensure accuracy in captured conditions.

► Specificity

- Unconfirmed or presumed conditions cannot be captured.
- Signs and symptoms are used until there is a definitive diagnosis.
- Providers need to understand combination codes and when additional diagnoses are needed to fully describe the condition.

► Preparation

- Teach providers to document a good note, regardless of the setting or payer.
- Utilize tools and technologies to support efficiencies, ensuring each note stands alone.
- Utilize physician advisors, educators to support peer to peer documentation improvement.

Common Documentation and Coding Opportunities

The following are common examples of incomplete or inaccurate documentation that may result in lower quality of care and outcomes, but also impact our care funding to support quality patient care.

Complete and Accurate Documentation

- Supports outreach efforts (population health management) to ensure timely follow-up and preventive care management.
- Complete and accurate documentation related to outpatient (e.g., continuity of care).

Accurate and Specific Coding

- Ensures appropriate patient management (Permanent atrial fib – no further attempts to restore NSR).
- Supports Primary Care time for prescription refills.
Example: Prednisone refills for a patient without a supporting diagnosis such as PMR.

Diabetes with Ophthalmological Conditions

- Patients require more frequent eye examinations to prevent progression of the complication.
- Impacts Quality related outcomes.

Chronic Kidney Disease

- Ensures appropriate medication dosage to prevent acute kidney injury or other complications.
- Supports maximizing specific therapies (ACE) to prevent progression of disease.

Case Study



Chart Summary: A 76-year-old female comes in for a 6-month follow up visit for diabetes. Her diabetes is in control on oral medications. Patient has known peripheral artery disease related to her diabetes and an ejection fraction of 25% due to previous MI with heart failure.

Provider Documents: Assessment/Plan – all conditions stable, plan repeat A1c, LDL and urine micro-albumin in 6 months at next scheduled office visit. The only billed diagnosis is Z00.00 – general adult examination.

Less Specificity



Diabetes – Not Coded
RAF = 0

Vascular Disease – Not Coded
RAF = 0

Heart Failure – Not Coded
RAF = 0

Disease Interaction
RAF = 0

Some Specificity



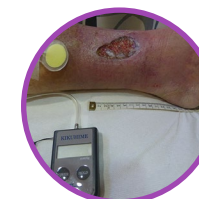
Diabetes without Complication
(E11.9 – HCC 19)
RAF = 0.105

Peripheral Artery Disease
(I71.9 – HCC 108)
RAF = 0.288

Heart Failure – Not Coded
RAF = 0

Disease Interaction
RAF = 0

Most Specificity



Type 2 Diabetes with PAD
(E11.51 – HCC 18 and HCC 108)
RAF = 0.393

Varicose Veins with Ulcer & Inflammation
(I83.201 – HCC 107)
RAF = 0.383

Congestive Heart Failure
(I50.9 – HCC 85)
RAF = 0.331

DM/CHF Disease Interaction
RAF = 0.121

Specificity is the key to appropriate risk score representation

OIG Focus Areas for Medicare Advantage in 2021



Risk-Adjusted Payments

- Target: High-risk diagnoses
 - Diagnoses on a physician claim without a corresponding inpatient claim (e.g., Acute stroke and acute heart attack)
 - Diagnoses that would typically be treated with medicine, but had no corresponding prescription (e.g., Major depressive disorder and embolism)
 - A cancer diagnosis that did not have surgical, radiation therapy, or chemotherapy within 6 months preceding or following the diagnosis (e.g., Lung cancer, breast cancer, colon cancer)
- RADV-like Audits



Health Risk Assessments & Chart Reviews

- Only source for diagnosis
- No indication of follow-up care



Provider Data

- NPIs for ordering providers missing
- DMEPOS, clinical laboratory services, imaging, and home health

Source: OIG Presentation at RISE National March 2022

Mis-keyed Diagnoses

Analytical tool developed by OIG to identify scenarios, usually related to data transposition or entry errors.

1 Enrollee Profile



- Multiple diagnosis codes for condition (ICD-9 250.00 – Diabetes)
- One diagnosis code for an unrelated condition (ICD-9 205.00 Cancer)

2 Error Rate



76% of scenarios identified errors



Adapting for ICD-10 diagnosis codes



Thank you.

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