

How to Champion OP CDI

Building a Risk-Adjustment Program for your Health System



Presenters:



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Learning Objectives

At the conclusion of this webinar, participants will be able to...



Apply

Understand and apply risk-adjustment concepts in current practice.



Evaluate

Begin to evaluate documentation and coding for risk-adjusted patients.



Build

Take initial steps to obtain support to build an outpatient CDI program for accurate risk-adjustment reporting.

Disclosure: The presenters declare they have no relevant relationship of a commercial interest to disclose. Neither presenter is receiving payment for the presentation and the presenters are not pitching a product.



Agenda

**Foundational Risk-
Adjustment Concepts**

Where to Begin

**Initial Steps to Build a Risk-
Adjustment Program**



RA Concepts

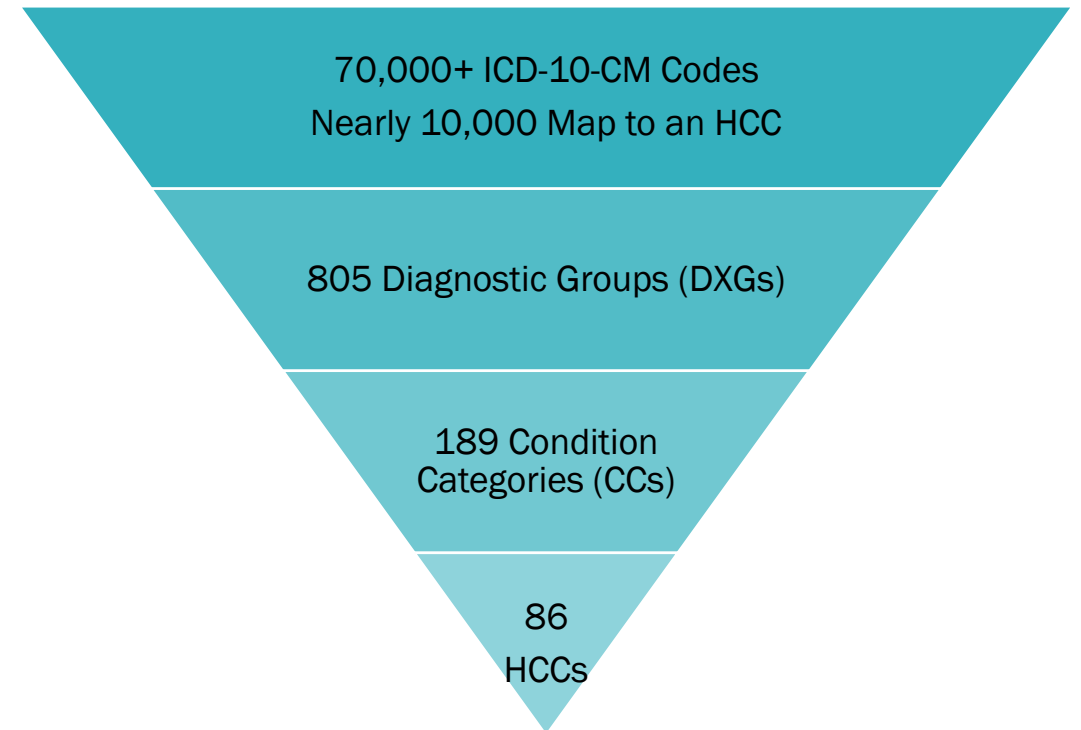
Introduction to risk-adjusted payment

Introduction to HCCs

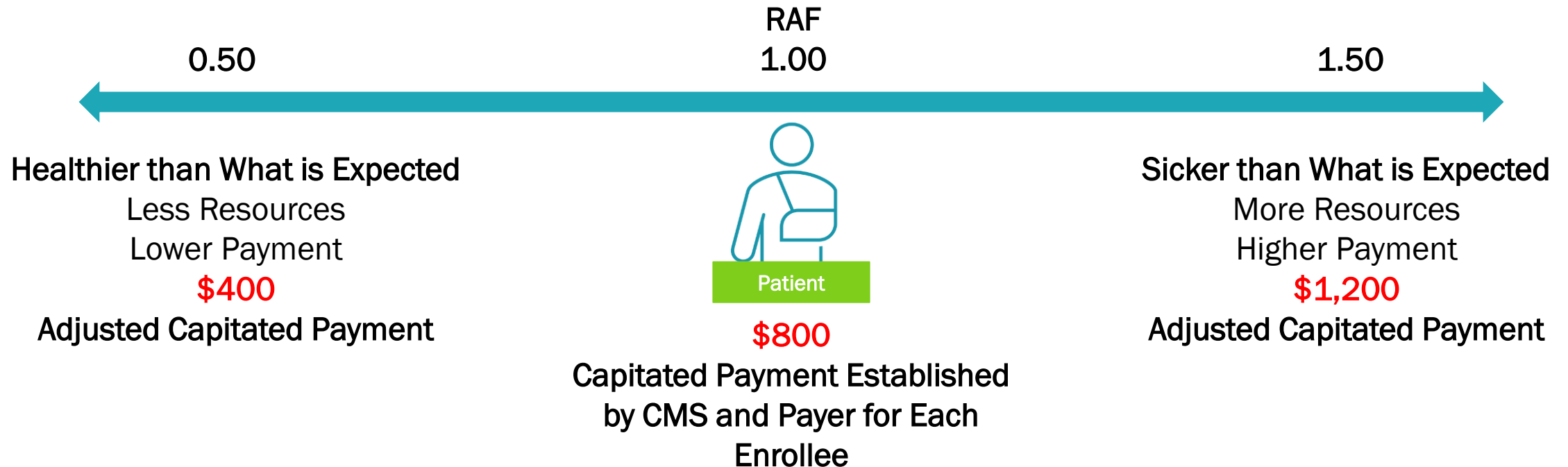
Correlation of HCCs with documentation
and reporting practices

Risk Adjustment Concepts

- The Risk Adjustment Factor (RAF) is determined using a combination of demographic information with disease information to predict future healthcare costs for enrollees.
- RAF score is determined for each patient for a total year
 - Demographics: age, gender, community-based or institution based, Medicaid disability
 - Disease: Diagnoses correlate to an HCC, interactions between certain disease categories
- Hierarchical Condition Categories (HCCs)
- Multiple models (CMS-HCC, HHS-HCC, CDPS)
- Diagnoses accumulate over a year (any setting)
- Determines health expenditure risk
- Focus on long-term conditions (not acute)
- Learn more: https://bok.ahima.org/doc?oid=302516#.Yt2_kD3MJJaQ



RAF Score and Financial Impact



CMS-HCC Examples

HCC Category	Description	V24
17	Diabetes with Acute Complications	0.302
18	Diabetes with Chronic Complications	0.302
19	Diabetes without Complication	0.105
189	Amputation Status, Lower Limb/Amputation Complications	0.519

RAF Score and Financial Impact

Incomplete Documentation

67-year-old male patient with HTN and DM

Factors	ICD-10-CM	Score
Demographics	-	0.308
HTN (no HCC)	I10	0.000
DM (HCC 19)	E11.9	0.105
RAF Score		0.413

Cap Payment x RAF = Adjusted Cap Amount
\$800 x 0.413 = \$330.40

Complete Documentation

67-year-old male patient with HTN and heart failure, diabetic polyneuropathy, and morbid obesity

Factors	ICD-10-CM	RAF
Demographics	-	0.308
HTN + heart failure	I11.0/I50.9	0.331
DM complication	E11.42	0.302
Morbid obesity	E66.01	0.250
RAF Score		1.191

Cap Payment x RAF = Adjusted Cap Amount
\$800 x 1.191 = \$952.80

New Year, New Patient

- The RAF score is reset each calendar year
- HCC conditions have to be captured (or re-captured) each calendar year
- Providers need to report all active conditions and health status beginning with each new year
- Providers should evaluate, document, code, and bill all active coexisting conditions

BUT

- To report a condition, clinical documentation must demonstrate that the condition was actively monitored, evaluated, assessed, and/or treated

CMS HCC Category	Description	V24
189	Amputation Status, Lower Limb/Amputation Complications	0.519

The Documentation Challenge

M.E.A.T. is an acronym used to describe factors that help determine if there is supporting documentation to report the code for a chronic condition.

MEAT	Support	Disease Example	Documentation Example
Monitor	Signs, Symptoms, Disease progression/regression Ordering of tests Referencing labs/other tests	Diabetes Mellitus Type 2	Last A1c was 5.8, recheck in 4 months
Evaluate	Review of Test Results Medication effectiveness Response to treatment Physical exam findings	Major Depression	PHQ9 down to “X”, mild severity
Assess/Address	Discussion, review of records Counseling Acknowledging Documenting status/level of condition	COPD	FEV1=50, moderate COPD
Treat	Prescribing/continuation of medications Planned surgery Referral to specialist for treatment/consultation Plan for management of condition	Breast Cancer	Continue with Tamoxifen



Agenda

Foundational Risk-
Adjustment Concepts

Where to Begin

Initial Steps to Build a Risk-
Adjustment Program



Begin at the Beginning

Obtain key information on the risk-
adjusted patient population

Explore ambulatory clinic documentation
and coding

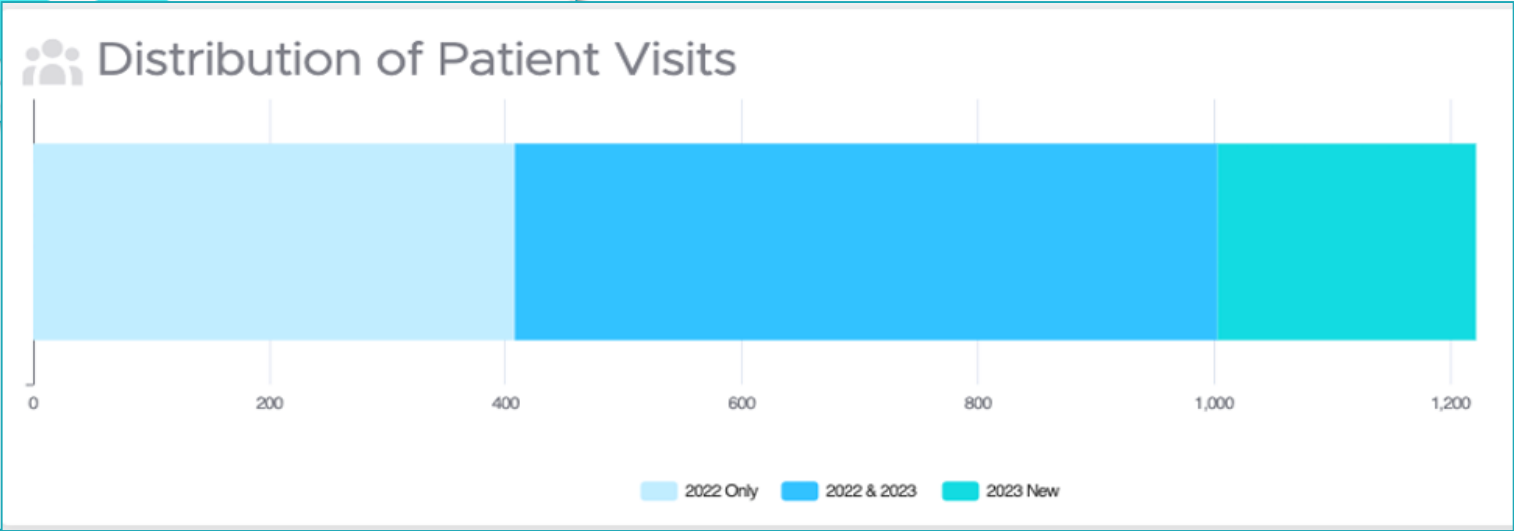
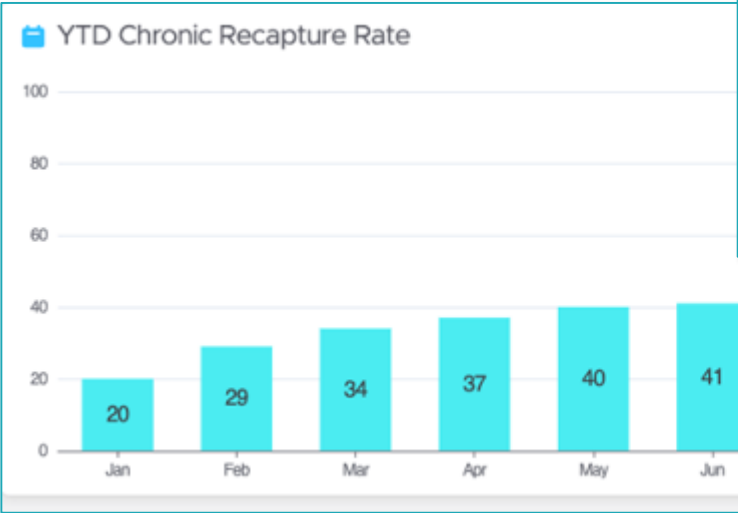
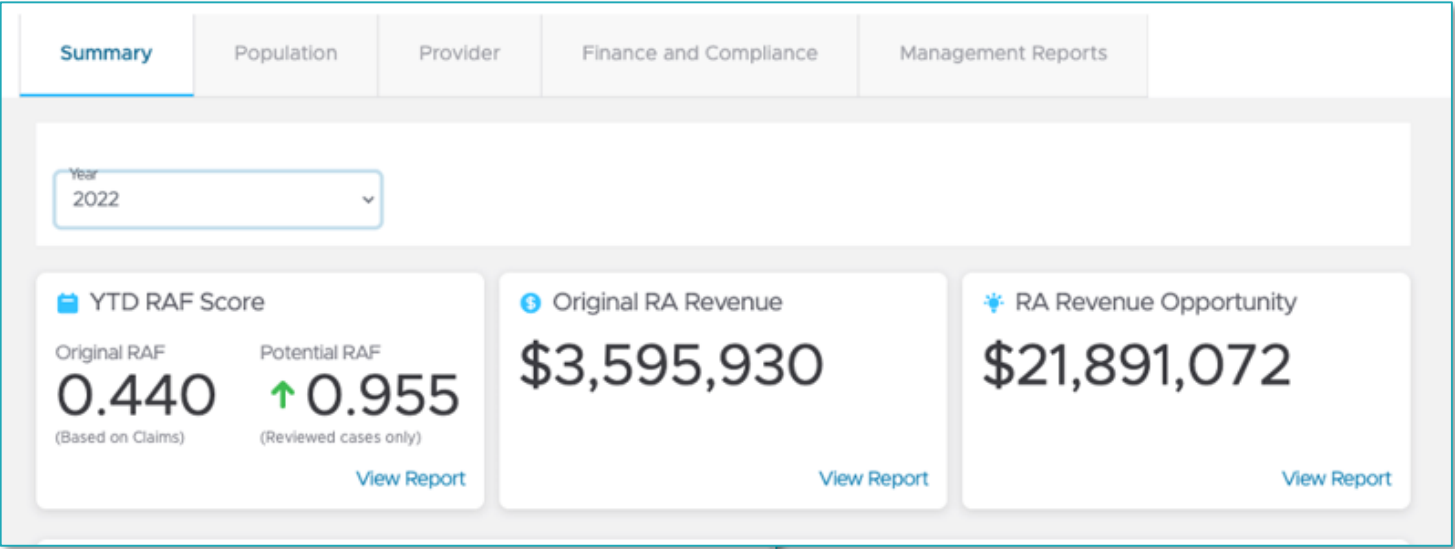
Share documentation findings to raise
awareness with key stakeholders within
your organization

Obtain Key Data and Information

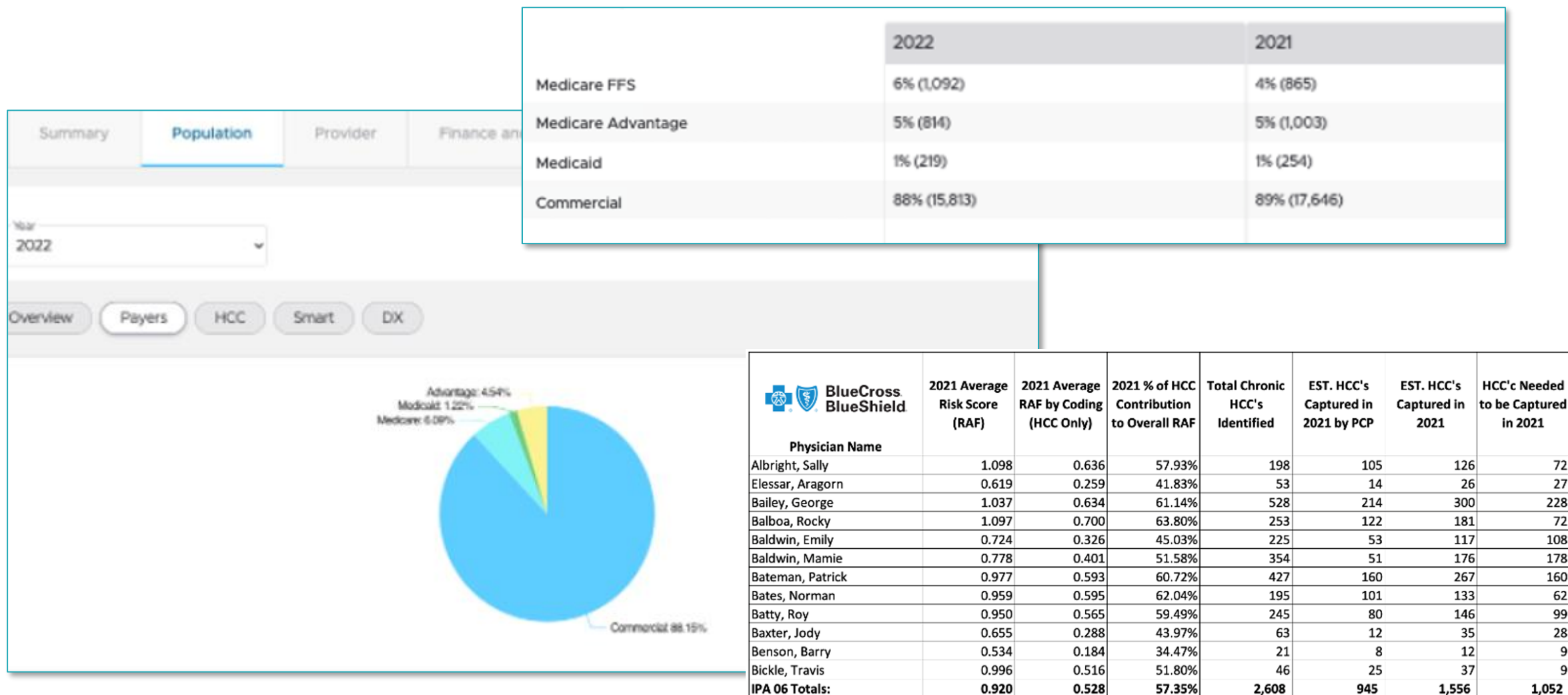
- Who are your risk-adjusted payers?
- What health plans are capitated or shared risk?
- Do you have risk-adjusted data from these health plans?
- Who are your risk-adjusted patients?
- How many risk-adjusted lives are your responsible for?
- What are your RAF scores?
- How do your RAF scores compare to benchmarks (regionally or by specialty)?
- How well does your RAF data represent your patient population?
- What is your prevalence of top chronic conditions compared to your region?
- Who assigns diagnosis codes in the ambulatory care clinics?
- Who is responsible for the specificity, accuracy, sequencing of Diagnosis codes submitted on ambulatory claims?

A distinctive characteristic of OP CDI is that it requires population level and individual level patient data views across the calendar year.

Examples of Population Data



Examples of Population Data



Top Ten CMS HCCs Reported

1. Diabetes Mellitus without Complication (HCC 19)
2. Breast, Prostate, and Other Cancers and Tumors (HCC 12)
3. Diabetes Mellitus with Chronic Complications (HCC 18)
4. Seizure Disorders and Convulsions (HCC 79)
5. Specified Heart Arrhythmias (HCC 96)
6. CHF (HCC 85)
7. Other Significant Endocrine and Metabolic Disorders (HCC 23)
8. COPD (HCC 111)
9. Major Depressive, Bipolar, and Paranoid Disorders (HCC 59)
10. Morbid Obesity (HCC 22)

Diabetes Diagnosis

- Diabetes Types
 - Type 1, 2, secondary to another condition or external cause
- Status
 - Controlled, poorly controlled
 - If the term “uncontrolled” is used, the documentation must include whether it is related to hypoglycemia or hyperglycemia
- Treatment
 - Lifestyle modifications, oral hypoglycemic drugs, non-insulin injectables, or insulin
- Linking terms between the DM and its complications to correctly report combination codes is important
 - “Due to,” “diabetic,” “secondary to”

Codes Submitted	Codes Supported
E11.9 Type 2 DM without complications; & I73.9 Peripheral vascular disease, unspecified	E11.51, T2DM w diabetic peripheral angiopathy without gangrene
HCC 19 & 108 (0.393 wt)	HCC 18 & 108 (0.590 wt)

Cancer Diagnoses

- | | | | |
|--|---|--|--------|
| 1. Active Cancer | | | |
| C34.10, Malignant neoplasm of upper lobe, unspecified bronchus or lung | → | | HCC 9 |
| 2. Metastatic Active Cancer | | | |
| C78.00, Secondary malignant neoplasm of unspecified lung | | | |
| When documenting metastatic cancers, include both the primary site and the secondary site(s) | → | | HCC 8 |
| 3. History of Cancer | | | |
| Z85.118, Personal history of other malignant neoplasm of bronchus and lung | → | | No HCC |

Cancer Example

“History of” Cancer or Active Cancer

malignant neoplasm of uterus

She is due for CT scan in the near future. She will forward these results.

History of Present Illness

67-year-old Hispanic female who was found to have dipstick trace blood on urinalysis recently. In 2011 she was diagnosed with aggressive uterine cancer when she presented with blood on the toilet tissue after wiping. She underwent radical hysterectomy at that time followed by chemotherapy. In 2013 she had blood on the toilet tissue after wiping again and was diagnosed with a local recurrence in the vaginal cuff that was adherent to the bladder and bowel. She received chemotherapy and then underwent resection of the local recurrence including an intentional cystotomy to take the tumor off the bladder wall. Stents were placed by the urologist at that time. She then had another round of chemotherapy and is clinically NED for going on 8 years. Today she has dipstick trace blood on urinalysis. She denies any flank or abdominal pain. She has no gross hematuria.

Code Submitted	Code Supported
C54.1 Malignant neoplasm of endometrium HCC 12	Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm <u>Or</u> R82.91 Other Chromoabnormalities of urine <u>And</u> Z85.42 Personal history of malignant neoplasm of other parts of uterus No HCC

Depression Diagnoses – HCC 59

Documentation must include:

Severity; mild, moderate, severe

Status and episodes; single episode, recurrent or in remission

Major depressive disorder (MDD)

F32.0, MDD single episode, mild

F33.0, MDD recurrent, mild

F33.40, MDD recurrent, in remission

F32.9, MDD, single episode, unspecified

F32.A , Depression, unspecified

}



HCC 59

}



No HCC

Depression Example

HCC Opportunities

In order to support code F32.0, documentation must include terms “mild,” “major,” and “single episode.”

depressive disorder

At this time patient is symptomatic: PHQ9 = 15 today; symptoms are stable. Patient denies suicidal or homicidal ideation. Plan to add medication; BUPROPION . Plan to re-evaluate patient at follow up; patient also referred to counseling services and community resources. Patient was advised to call or come in if symptoms worsen. Patient verbalized understanding.

Renew Cymbalta 60 mg capsule,delayed release

Start buPROPion HCL SR 150 mg tablet,12 hr sustained-release 1 tablet 2 times a day in the morning

Code submitted	Code supported
F32.0, Major depressive disorder, single episode, mild HCC 59	F32.A Depression, unspecified No HCC

The Financial Impact is Significant

Morbid Obesity (HCC 22) Population Example

Patients with potential missed HCCs		RAF weight for HCC 22		CMS annual base rate		
1000	X	0.250	X	\$9366	=	\$2,341,500

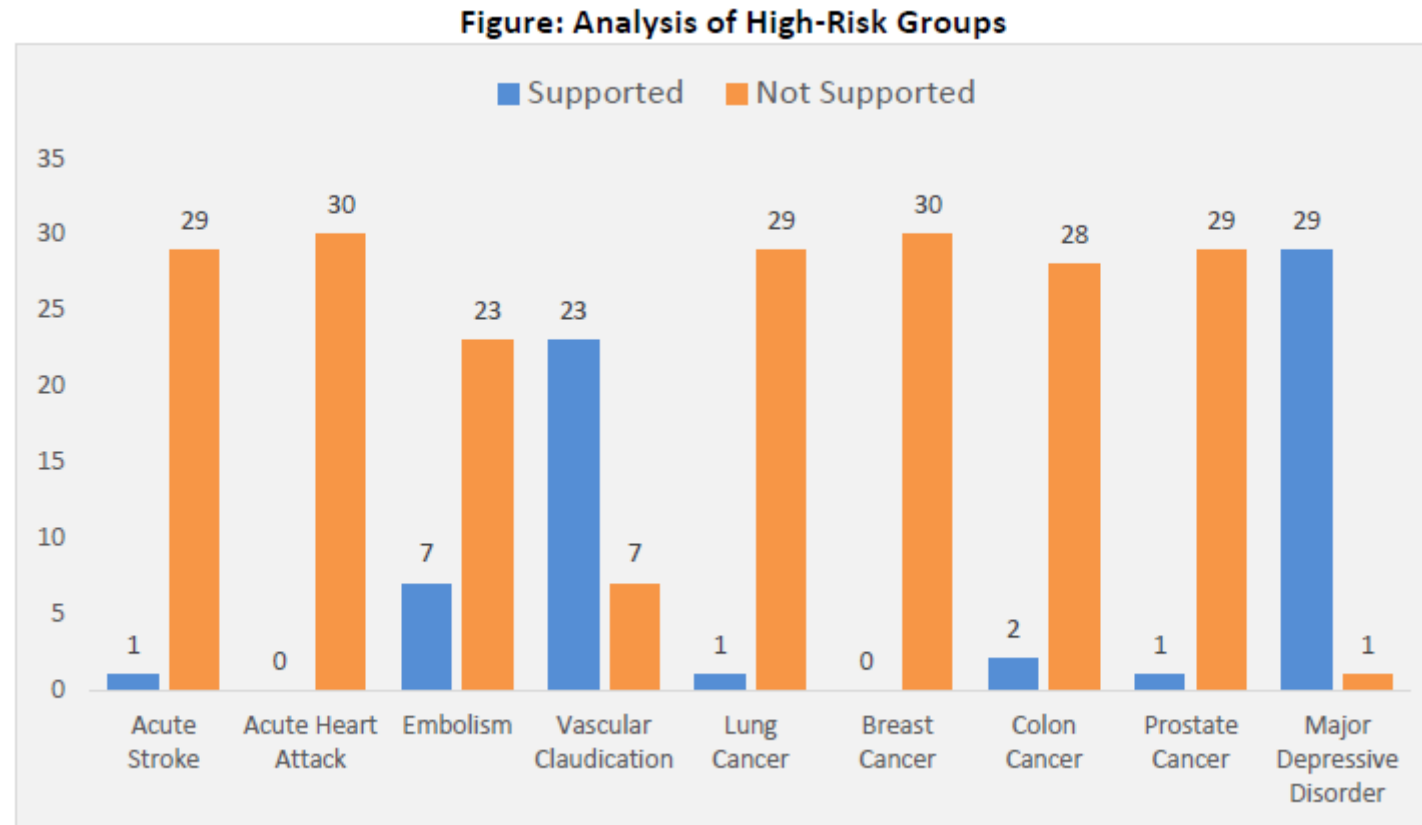
*Sampling of 1,000 patients for one condition only

Imagine the impact of 2k, 5k, or 10k patients across multiple chronic conditions

The Compliance Risk is Real – Documentation is key!

The OIG identified these high-risk groups of HCC Diagnoses in recent reports.

<https://oig.hhs.gov/oas/reports/region2/22001009.asp>





Agenda

Foundational Risk-
Adjustment Concepts

Where to Begin

Initial Steps to Build a Risk-
Adjustment Program

Initial Steps

Accurately interpret your risk-adjusted
patient data

Anticipate and plan to overcome common
challenges

Engage the right expertise and leverage
internal people, processes and tools



Interpreting Population Data

County Prevalence

Anywhere, US Code (00001)

Show 10 entries


Search:

Category	Count
Hypertension	65.78%
Hyperlipidemia	47.67%
	39.42%
	36.38%
	31.09%
	23.65%
	20.60%
	19.25%
	16.88%

HCC	Count	Dollar Value	Previous year	Percentage	Recapture
(18) - Diabetes with Chronic Complications	466	\$1,351,027.20	549	85	83
(59) - Major Depressive, Bipolar, and Paranoid Disorders	302	\$895,852.80	382	79	80
(108) - Vascular Disease	244	\$674,611.20	369	66	125
(138) - Chronic Kidney Disease, Moderate (Stage 3)	242	\$160,300.80	281	86	39
(19) - Diabetes without Complication	239	\$240,912.00	292	82	53
(111) - Chronic Obstructive Pulmonary Disease	235	\$755,760.00	314	75	79
(22) - Morbid Obesity	198	\$475,200.00	292	68	94

Interpreting Your Data

UASI

 **Mary Stanfill**
Demo Care

Home

REPORTS

- HCC Reports

CASE SELECTION

- Case Management**
- My Cases

FOLLOW-UP ACTIONS

- Audit Coordination
- AWV Coordination

TOOLS

- Patient Search

CARESITE SETUP

- Payers
- Assessments

Assessment
Retrospective test

Payer
Filter By Payer

Provider
Filter By Provider

Specialty
Filter By Specialty

Smart Search
Filter By Smart Search

HCC Codes
Filter By HCC

Annual Wellness
None

☐ Show open cases ☐ Show selected cases

812 entries found

Display 10

<input type="checkbox"/>	Name	2022 RAF	2022 Visits	2022 Cost	HCC Count	Recapture Opportunities	RAF Variance	Search Count	Most Recent DOS	Most Recent AWV
<input type="checkbox"/>	SPINKA, GUDRUN	0.7	1	\$146	1	1	-2.352	0	08/19/2022	
<input type="checkbox"/>	KOHLER, YAZMIN	0.69	2	\$286	1	6	-1.62	0	02/09/2022	
<input type="checkbox"/>	REICHEL, TRUDIE	0.46	6	\$920	0	5	-1.507	0	08/05/2022	

Useful Data Elements:

- RAF Score YTD
- Most Recent AWV Date
- HCC Count
- HCC Recapture Rate
- Recapture Opportunities
- Number of Visits (CY-PY)

Sort/Filter by:

- Payer
- Provider
- Specialty
- Region/Location

Interpreting Patient Level Data

EMMERICH, JACQUELYN

Age 76 Sex M DOB 01/02/1947 PID xv1e3dts1 Insurance Type WPS TRICARE FOR LIFE SECONDARY TO MEDICARE Member ID xv1e3dts1

2022	Visits 11	Cost \$1304	RAF 0.872	RAF Potential 0.200	RAF Change 0
2021	Visits 4	Cost \$987	RAF 1.072	RAF Potential 0	RAF Change 0

EMR Problem List Evaluation

Select

HCC 18 (0.302) Description

2021

2022

> E1140 ⚠ Type 2 diabetes mellitus with diabetic neuropathy, unspecified

11

0

> E1142 Type 2 diabetes mellitus with diabetic polyneuropathy

11

0

HCC 19 (0.105) Description

2021

2022

> E119 Type 2 diabetes mellitus without complications

0

4

HCC 108 (0.288) Description

2021

2022

> I739 ⚠ Peripheral vascular disease; unspecified

2

2

DX Codes Description

2021

2022

> B351 Tinea unguium

3

4

EMMERICH, JACQUELYN

Age 76 Sex F DOB 2/26/1948

PID xv1e13dts1

Insurance Type MEDICARE BFL FIRST COAST SERVICE OPTIONS

2021

Visits 11 Cost \$1,304 RAF 1.072

HCCs

E1140 HCC 18 RAF 0.305

E1142 HCC 18 RAF 0.305

I739 HCC 108 RAF 0.288

2022

Visits 4 Cost \$987

HCCs

E119 HCC 19

I739 HCC 108 RAF 0.288

Interpreting Provider Data

Mary Stanfill
Demo Care

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AWV Coordination

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Patient Search

CARESITE SETUP

Payers

Assessments

HCC REVIEW SETUP

Reasons

Client Actions

Problems

Smart Search

Category

Users

SummaryPopulationProviderFinance and ComplianceManagement Reports

Year: 2022Specialty: AllAssessments: All

OverviewRAF AnalysisQuery Analysis

Export Report

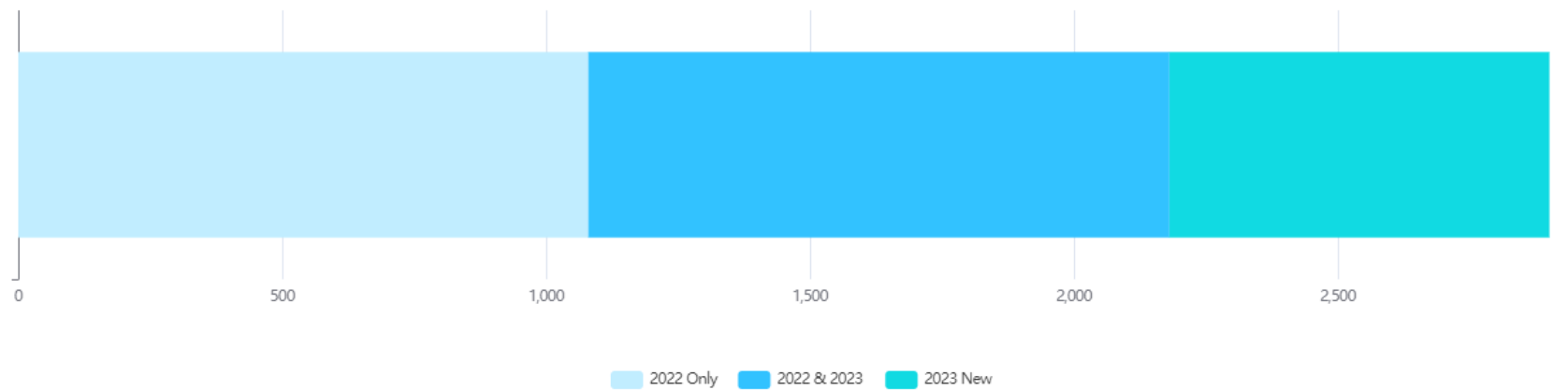
Display 10

Provider	Specialty	Patient Audited Count	Avg RAF Score	Potential Avg RAF Score	% Change	Query Count	Accepted	Not Accepted	In Process	Not Started	Closed or Lost
CASSIN, ZACHERY	Gastroenterology	25	1.53	2.29	76%	12	4	2	4	2	1
POUROS, MIREYA	Family Medicine	32	0.39	1.27	88%	3	1	1	0	1	0
PFEFFER, KENDALL	Internal Medicine	62	2.66	3.30	64%	9	3	2	3	1	1
CUMMINGS, ERIK	Internal Medicine	58	1.59	1.77	78%	33	11	5	16	1	1
CONROY, HEIDI	Endocrinology	14	1.22	1.59	68%	27	9	5	12	1	0
BOEHM, HUDSON	OBGYN	35	0.59	1.19	59%	39	13	5	20	1	0
ABBOTT, KENNY	Nurse Practitioner	26	2.66	2.70	64%	9	3	2	3	1	0
ORN, STAN	Nurse Practitioner	11	1.97	2.30	64%	9	3	2	3	1	2
YOST, LISA	Internal Medicine	19	1.53	2.29	76%	12	4	2	4	2	1
STEHR, MAUDIE	Geriatric Medicine	24	1.87	2.22	35%	6	2	1	3	0	2
MOORE, HAILEE	Psychiatry	62	0.77	1.22	35%	6	2	1	3	0	3
KUHLMAN, DELORES	Internal Medicine	28	0.39	1.27	88%	3	1	1	0	1	1
ROWE, MADISON	Internal Medicine	36	1.59	2.19	78%	30	10	5	14	1	2
BOGISICH, SONNY	Orthopedic Surgery	30	1.87	2.22	35%	6	2	1	3	0	0
MORALES, CARMEN	Internal Medicine	15	2.66	2.77	64%	9	3	2	3	1	2

Interpreting Provider Data



Distribution of Patient Visits



WINDLER, RUPERT

Identification: 8s2941887a

2021

	Caresite AVG	WINDLER, R	Caresite AVG	WINDLER, R
Total Patients	44	53	62	118
Total Visits	1,211	1,355	1,452	1,625
Provider Queries				
Total	28	35	33	42
Not Started	9	12	11	14
In Progress	10	13	12	15
Responded	22	28	26	33
Queries	28	35	33	42
Total Patients Reviewed	117	147	141	176
Without Issues/Audited	144	2	1	2
HCC Analysis				
Reported	282	353	338	423
Chronic Recaptured	175	219	210	262
New	10	13	12	15
RAF Analysis				
RAF Score AVG.	0.66	0.83	0.80	1.00
Potential RAF AVG.	0.77	0.96	0.92	1.15

Useful Provider Data:

- Patient attribution (CY-PY)
- AWW gaps
- HCC Change Rate
- RAF Score Compared to Avg.
- HCC Recapture Rate
- Query Response Rate
- Query Agreement Rate

Interpreting CDI Program Data

Useful Program Data:

- Work Status
- HCC Change Rate
- RAF Impact
- HCC Recapture Rate (pre and post)
- Query Response
- Query Agreement

Audit Demographics

Selected Count	Total Assigned	Patients Removed	Provider Visits	Search Queries	Reported HCC's
221	74	2	424,157	1,546	759

Reviewers

Name	Role	Progress	Assigned	Assistance	Review	Completed
One, CDI	Auditor	65%	34	2	3	22
Manager, Manager	Manager	73%	11	0	0	8
Manager, Site	Manager	90%	29	5	2	26

HCC Analysis

New	Recaptured	Validated Lower	Validated Same	Validated Higher	Removed
13	78	13	235	43	12

Common Challenges, Solutions

Deciding where to start, consider a pilot at one clinic location

Resourcing the effort, start small (one person)

Deciding what to do, specific RA plan target 1 or 2 conditions

Demonstrating improvement, define success (specific goals)

Staff resources and continuity, temp staff or cross-train

Provider engagement, provide visibility and incentives

Provider burden and competing initiatives, integrate FFS & RA efforts

Member attribution and utilization, process to identify and maintain

EHR imbedded HCC tools presenting too many options, pre-visit review

Provider workflow variation, shadow providers

Provider pick list difficulties, review “favorites”

Tracking CDI program performance, buy/build database tool to track performance metrics

Provider engagement, provider champion and advisor partners

Demonstrating sustained improvement, Incremental HCC recapture rate

Commonly Missed HCCs:

- Diabetes Complications
- Morbid Obesity
- Depression Episode/Severity
- Drug/Alcohol Addiction
- Cancer (current vs. history)
- Transplant Status
- Amputation Status
- Ostomy Status

Best Practices

People

- Employ experienced OP CDS and HCC coders who are highly skilled and proficient in compliant risk-adjustment coding practices (CCDS-O, CRC credentials preferred)
- Train HCC coders side-by-side with clinical CDI staff to learn how to review charts for documentation to support MEAT criteria

Process

- Complete targeted previsit and post visit chart reviews to identify opportunities for HCC diagnosis capture
- Complete ICD-10-CM diagnosis coding on every encounter – including both acute conditions (to support medical necessity for services provided) and chronic conditions impacting care (to support severity of illness, accurate RAF score)
- OP CDI staff perform pre-visit chart reviews to validate clinical indicators for HCC capture/re-capture
- Intentional/accurate sequencing and linking of diagnosis codes on 1500 claim form (e.g., first code represents reason for the visit, next up to 11 codes could be conditions addressed during the patient encounter)
- Use of separate work queue to monitor pre and post visit risk-adjusted patient encounters to help ensure compliant diagnosis coding
- Implement an electronic deferral process for second level support prior to releasing to the provider previsit or to billing post visit
- Ensure chart reviews are compliant, addressing both diagnosis codes to add and/or delete based on supporting clinical documentation

Take Action now

- ☐ Increase your knowledge of HCCs
- ☐ Take some initial steps
- ☐ Define the problem and priorities
- ☐ Obtain stakeholder support
- ☐ Use Internal and Payer data
- ☐ Set incremental goals
- ☐ Invest in people
- ☐ Leverage EHR tools
- ☐ Engage providers
- ☐ Buy or build CDI program tools
- ☐ Use multi-disciplinary approach

Resources

Insert ACDIS introductory white paper (May 2016)

ACDIS CDI Blog “Introducing your outpatient departments to CDI” October 13, 2014. Volume 7, Issue 20 <https://acdis.org/articles/introducing-your-outpatient-departments-cdi>

ACDIS CDI Strategies “Q&A: How to get started in outpatient CDI” July 21, 2022. Volume 16, Issue 29. <https://acdis.org/articles/qa-how-get-started-outpatient-cdi>

ACDIS Podcast “Outpatient CDI: Prospective chart reviews” November 23, 2021 <https://acdis.org/acdis-podcast/outpatient-cdi-prospective-chart-reviews>

ACDIS CDI Strategies “Q&A: Updating the problem list” January 12, 2023. Volume 17, Issue 2. <https://acdis.org/articles/qa-updating-problem-list>

Watson Monica. Ann Casto, Julie Davis, Mary Stanfill. "Documentation and Coding Practices for Risk Adjustment and Hierarchical Condition Categories." *Journal of AHIMA* 89, no.6 (June 2018): extended online version https://bok.ahima.org/doc?oid=302516#.Yt2_kD3MJJaQ

Fee, James. Sonia Trepina, Jennifer Boles, Joel Sparks. “Focus on Population Health CDI Generates ACO Shared Savings.” *Journal of AHIMA* 90, no. 7 (Jul-Aug 2019): 14-17. <https://bok.ahima.org/doc?oid=302774>

Insert ACDIS white paper Oct 2022 on queries

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Thank you for joining us