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CDI IN BLOOM | **acdis 2023**

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The 123s of HCCs

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Presented By



- **Purvi K. Shah, MD**, is a primary care internist and medical director, population health – complexity capture and post-acute care at NorthShore University Health System in Evanston, IL. Her focus is on improving complete and accurate documentation in the ambulatory setting and improving transitions across the continuum of patient care while ensuring appropriate use of post-acute services. She is passionate about improving quality without increasing clinician workload. She is a member of the ACPA CDI Committee and ACDIS Leadership Council. Dr. Shah attended Vanderbilt University School of Medicine and completed her internal medicine residency at Northwestern University prior to joining the professional staff at NorthShore University Health System in 2009.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Define Hierarchical Condition Categories (HCCs) and provide examples of common HCC diagnoses
 - Describe the role of HCCs and the risk adjustment factor (RAF) in risk-based contracting and value-based care as well as the impact of these on fee-for-service payers
 - Compliantly capture an HCC using M.E.A.T. (monitor, evaluate, assess, treat) criteria
 - Articulate the impact of complete and accurate HCC documentation on reimbursement
 - Describe key components of the NorthShore University Health System ambulatory CDI (aCDI) program

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A Brief History of HCCs

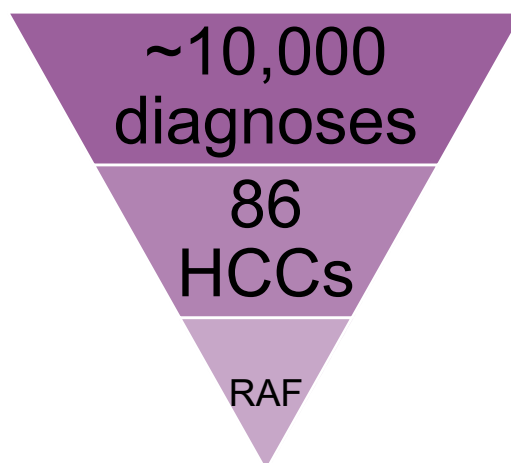
- HCCs are a way to track and report disease
 - Groups of diagnosis codes that communicate to risk-based payers how complex an attributed patient population is
 - Increased complexity within the same diagnosis moves the condition into a higher hierarchy
- Created by CMS in 1997 and implemented in 2004
 - Initially used in Medicare Advantage plans, which incorporated risk adjustment-based payment
- Affordable Care Act (2010)
 - Contained provisions and incentives to boost quality and curb costs, creating models tying quality to patient-related expenditures → the start of broader value-based care

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Why Do HCCs Matter?

- HCCs are used to assess the quality of care provided and determine the expected costs associated with that care by predicting healthcare resource consumption
- Under risk-based plans, reimbursement is based on the expected costs
- Completely and accurately capturing HCCs is good patient care and reflects the work that physicians are already doing to manage disease

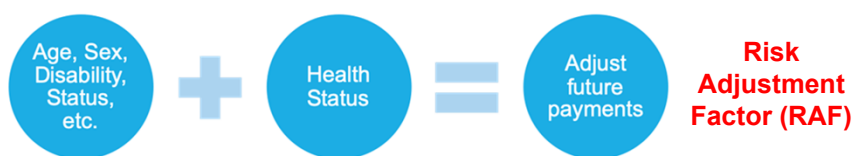


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HCCs → RAF (Risk Adjustment Factor)

- A coefficient or weight is assigned to each category of **chronic** complex diagnoses as well as severe **acute** conditions
- The weights associated with patient demographics are added to the weight of the HCC conditions for a patient to determine a RAF score



- Each unrelated HCC that applies to the patient is additive
 - Some HCCs join with others as “combination codes”
 - Some diagnoses interact with each other to raise the RAF score further

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RAF (Risk Adjustment Factor)

- RAF is applied to each eligible beneficiary, based on the patient’s predicted level of risk and the expected cost to maintain that patient’s health
 - The more severe, complex, or costly the diagnosis, the higher the RAF
- RAF values are calculated on a **calendar year basis** and must be reconfirmed every calendar year by capturing HCCs
 - HCCs have a 3 year “look back”—but we shouldn’t carry forward diagnoses that no longer apply
 - RAF scores reset to baseline on January 1
- RAF for average Medicare beneficiary = 1.0; higher if the patient is more complex

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HCCs in Population Health

- HCCs can be a data point for better care
- RAF scores allow for cost comparisons
- RAF allows for comparison of the quality of care across organizations
- Physician advisors can impact clinician experience



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Importance of the RAF Score: Risk-Based Payer

- The payer can only “see” how healthy or complex a patient is by the HCC diagnoses submitted on a claim
 - If we don’t capture all of a patient’s HCC diagnoses, it will appear that the patient is healthier than they are
 - Since payment under risk-based plans is based on RAF score, underreporting patient complexity leads to lower yearly payments that don’t cover the cost of care

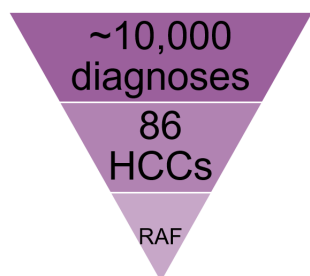


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Common HCCs

- These are conditions that your patients have—but they need to be documented appropriately!
- Capturing HCCs is good patient care



- Diabetes Without Complication (HCC 19)
- Breast, Prostate, Other Cancers (HCC 12)
- Diabetes With Complications (HCC 18)
- Seizure Disorders and Convulsions (HCC 79)
- Specified Heart Arrhythmias (HCC 96)
- Congestive Heart Failure (HCC 85)
- Other Significant Endocrine/Metabolic Disorders (HCC 23)
- COPD (HCC 111)
- MDD, Bipolar, Paranoid Disorders (HCC 59)
- Morbid Obesity (HCC 22)

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Easy-to-Capture HCCs

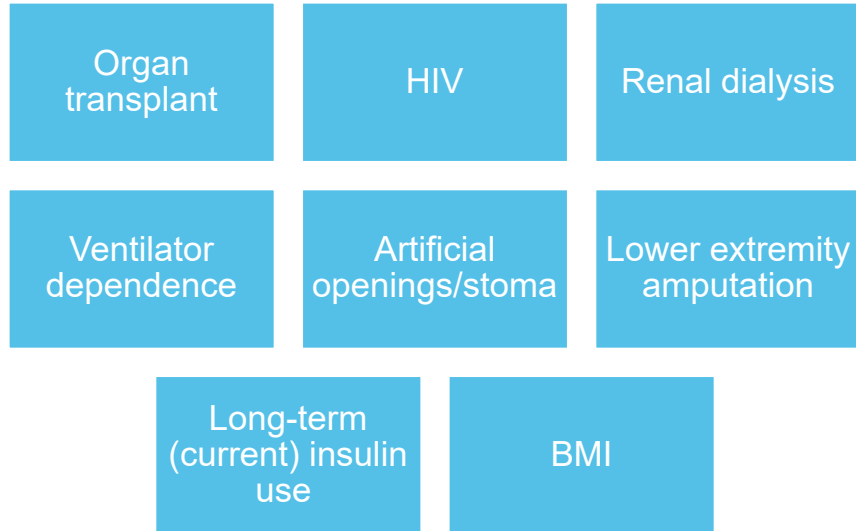
- Morbid Obesity BMI > 40 (RAF = 0.250)
- Severe Obesity BMI 35-39.9 With Comorbidities (RAF = 0.250)
- Aortic Atherosclerosis (RAF = 0.288)
- Senile Purpura (RAF = 0.192)
- Major Depressive Disorder, Mild (RAF = 0.309)
- Diabetes With Hyperglycemia (A1C >7) (RAF = 0.302 vs. 0.105 for DM Without Complication)
- Smoker's Cough, Chronic Bronchitis (RAF 0.335)

❖ Keep in mind that there will be changes with 2024 CMS-HCC model V28

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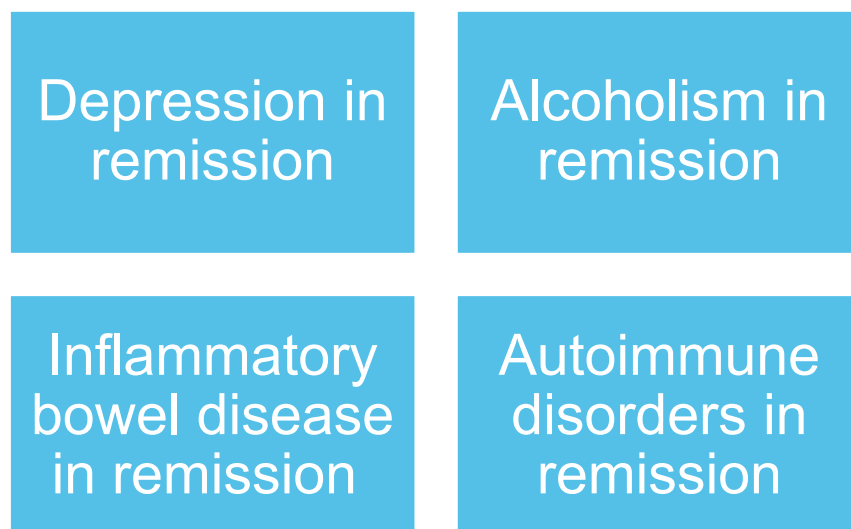
Status Codes



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“Forever” Codes

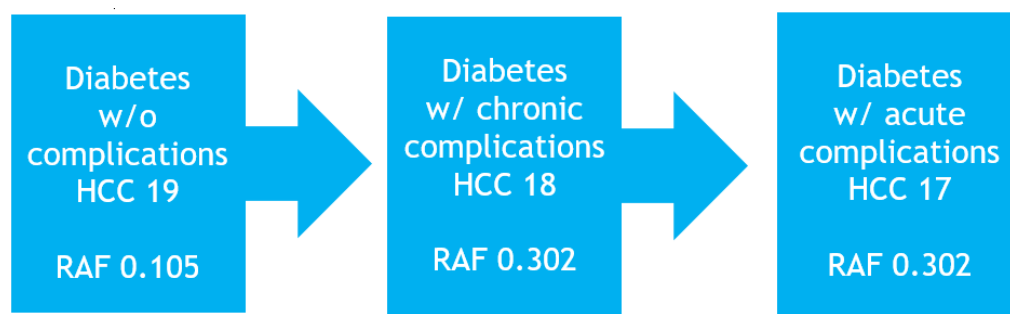


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Why “Hierarchical”?

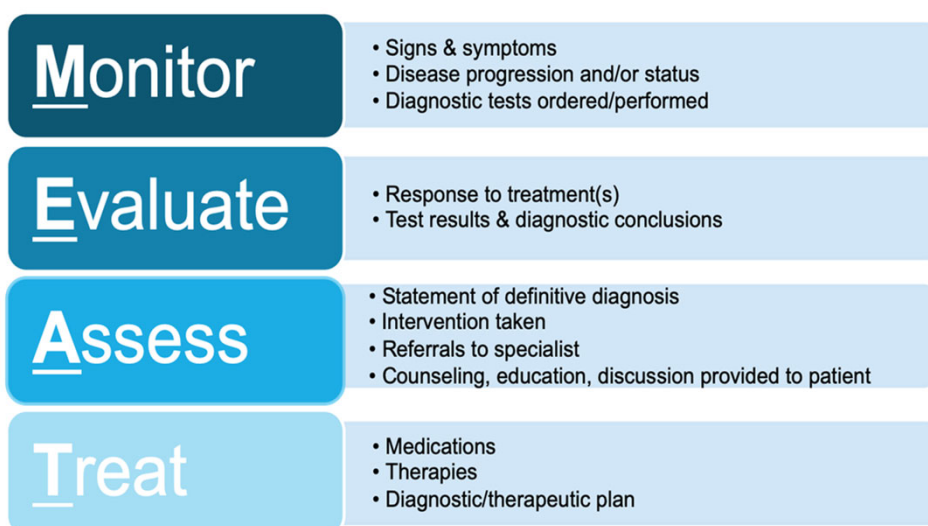
- As a disease process becomes more complex, it moves into a higher category (lower numbered HCC)
- This may be associated with an increase in RAF
- DM, dementia, substance abuse, vascular disease, CKD, ulcers, head injury



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M.E.A.T. = Documentation Compliance



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Rotten M.E.A.T.

- Remember **HCC** = **H**appening **C**urrently or **C**hronically
- Beware of coding conditions that are no longer active!
 - Cancer
 - Stroke
 - MI
 - Sepsis
 - AKI
 - DVT/PE

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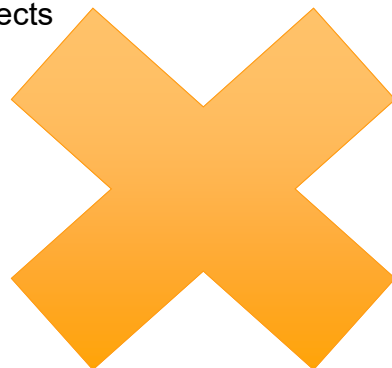
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Cancer Documentation

(C50.211, Z17.0) Malignant neoplasm of upper-inner quadrant of right breast in female, estrogen receptor positive (CMS-HCC) (primary encounter diagnosis)

Comment: **NED**, diagnostic mammogram yearly

Plan: Continue tamoxifen—well-tolerated and no side effects



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Cancer Documentation

(C50.211, Z17.0) Malignant neoplasm of upper-inner quadrant of right breast in female, estrogen receptor positive (CMS-HCC) (primary encounter diagnosis)

Plan: See oncology yearly with diagnostic mammogram before appointments; continue tamoxifen **as adjuvant therapy given concern for untreated disease**—well-tolerated and no side effects



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The 123s of HCCs

1. You need to document an HCC diagnosis in order to capture it

- Your patients have these
- HCCs can be captured in hospital settings, office visits, and video visits by physicians and clinically trained providers
- The diagnosis needs to be on the claim
- The more specific the diagnosis, the better
- HCCs need to be captured yearly

2. You need to include M.E.A.T. for compliant documentation

- But really just one, and you have likely done the work to reflect this
- Make sure that your documentation supports that the condition is Happening Currently or Chronically

3. You need a complete and accurate picture of your patient's health

- Because it's good patient care, and it also impacts reimbursement

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Putting It All Together

History: 78 YO male with COPD presents with productive cough yellow sputum, audible wheezes, malaise, anorexia of 7 days. He is mildly short of breath and is using Albuterol every 6 hours. He has noted his sugars have been a bit lower than normal levels. Three days ago, felt shaky and dizzy. This was relieved by a teaspoon of honey.

Exam: Frail elderly male, appears ill. Vital signs - Temp 99.7, R 26, BP 105/66, P 82 irregular; Lung - increased AP diameter, diffuse wheezes, few rales in RLL; CV - no JVD, S1 S2 irregular, 1+ pretibial edema

Labs: WBC 11.9, 74% leukocytes

CXR: increased emphysematous changes, RLL infiltrate

A/P:

1. COPD exacerbation, RLL pneumonia – antibiotics, Prednisone 20 mg for 5 days, Albuterol PRN. To ER for increased dyspnea. Call tomorrow and follow-up in clinic in 3 days.
2. NIDDM – same meds, check sugars 3 times a day. Steroids should increase sugars. Report numbers at phone call tomorrow

	ICD-10	HCC	Total Risk Score
78 year old male			0.473
COPD exacerbation	J44.1	111	0.335
DM2 without complications	E11.9	19	0.105
Pneumonia	J18.9	X	-
Lobar Pneumonia	J18.1	115	0.130
Total Risk Score			1.043

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The Impact of Complete Documentation!

3. CHF, atrial fib – stable, same meds, evaluated by cardiology 10 days ago

	ICD-10	HCC	Total Risk Score
78 year old male			0.473
COPD exacerbation	J44.1	111	0.335
DM2 without complications	E11.9	19	0.105
Pneumonia	J18.9	X	-
Lobar Pneumonia	J18.1	115	0.130
CHF	I50.9	85	0.331
Atrial fib	I48.91	96	0.268
Disease Interaction (CHF + DM)			0.121
Disease Interaction (CHF + AFib)			0.085
Disease Interaction (CHF + COPD)			0.155
Total Risk Score			2.003

With 12 words, RAF goes from 1.043 to 2.003
Yearly reimbursement goes from ~\$10,000 to ~\$19,000!

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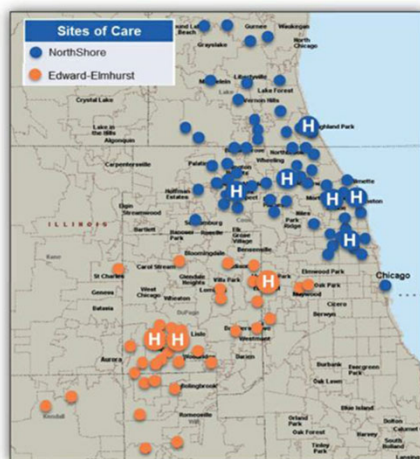
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Putting Knowledge Into Action

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About NorthShore-Edward Elmhurst Health



FORWARD TOGETHER.

NorthShore
University HealthSystem

6 HOSPITALS
1,630 BEDS
77,000 ADMISSIONS
17,000 TEAM MEMBERS
3,720 PHYSICIANS
~ 1350 Employed Physicians
\$205M CHARITABLE CARE & SERVICES

Healthy Driven
Edward-Elmhurst
HEALTH

3 HOSPITALS
2 - Adult Services
1 - Behavioral Health
737 BEDS
44,000 ADMISSIONS
7,700 TEAM MEMBERS
1,900 PHYSICIANS
~ 350 Employed Physicians
\$123 M COMMUNITY BENEFIT (2020)

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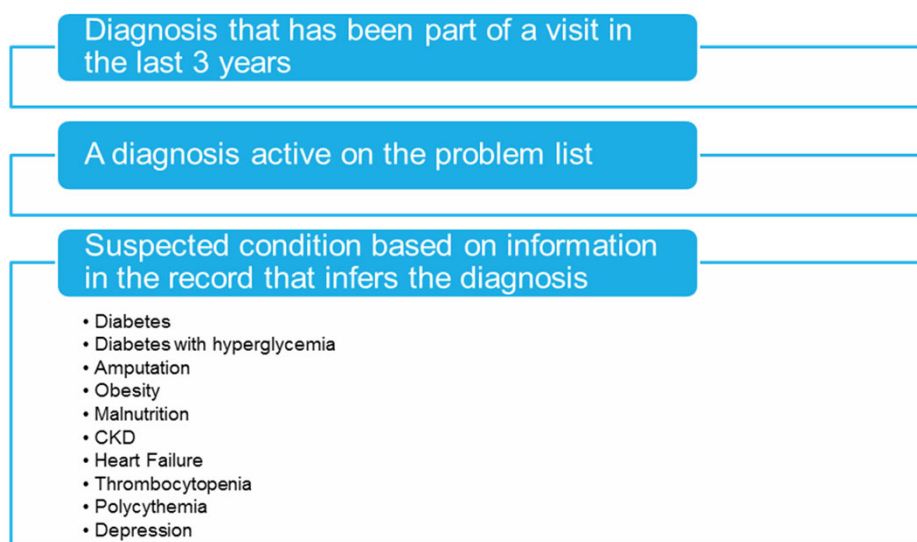
NorthShore's HCC Journey—Phase 1

- **FY2017: The Introduction**
 - ✓ First presentation on HCCs mid-2017
 - ✓ Created monthly HCC provider scorecard
 - ✓ Implemented Epic **historic** BPA and BPA use dashboard
- **FY2018: The Basics**
 - ✓ Continued orientation to HCCs; documentation + coding education
 - ✓ Presentations to PCP and specialty leaders
- **FY2019: Adding Tools and Increasing Visibility**
 - ✓ Hired a physician advisor dedicated to this work: continued education to PCP and specialty leaders and practice-based education
 - ✓ Created new **suspected** HCC BPA framework in Epic
 - ✓ Began a coder chart review program, billing coding stops for missing combination codes
 - ✓ Added HCC capture as a metric on corporate + medical group scorecards; refined HCC-specific reports

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HCC BPA (Best Practice Alert)



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HCC BPA (Best Practice Alert)

Snapshot w/Hx

Confirm HCCs (circled in red)

Demographics

HCC1 Zztesting
67 year old
EVANSTON, IL

Mark as Reviewed

Allergies, Problem List, Medications, History

Room (circled in red)

Plan (circled in red)

Verify Rx Benefits	Care Everywhere	Medications	Reconcile Dispense	History
Filed Documents	Outside Information	Data Center	Best Practice	Quality Measures
HCC (circled in red)				

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HCC BPA (Best Practice Alert)

Below are helpful tips regarding the HCC refresh choices provided:

- Add Visit Diagnosis** - this will add the HCC to the current visit diagnosis list. This requires documentation indicating the medical decision making of this diagnosis in the visit progress note.
- Add to Problem List** - add this HCC to the patient's problem list.
- Do Not Add** - this indicates the HCC will not be addressed during the current visit but will be available for review at subsequent visits.
- Resolve Problem** - this will remove the HCC from the patient's current problem list and BPA **permanently** unless new data is filed indicating that the HCC applies. **Use this option if the diagnosis is erroneous or no longer requires monitoring, evaluation, or treatment.**

Add Visit Diagnosis **Do Not Add** **Resolve Problem**

Chronic kidney disease, stage IV (CMS-HCC)

Chronic kidney disease, stage IV (CMS-HCC) is already on the problem list

Last addressed by Purvi K. Shah, MD on 4/11/22

[Search](#)

Add Visit Diagnosis **Do Not Add** **Resolve Problem**

Keratoconjunctivitis sicca (CMS-HCC)

Keratoconjunctivitis sicca (CMS-HCC) is already on the problem list

Last addressed by Purvi K. Shah, MD on 4/11/22

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Add Visit Diagnosis **Do Not Add** **Resolve Problem**

Chronic systolic heart failure (CMS-HCC)

Chronic systolic heart failure (CMS-HCC) is already on the problem list

Last addressed by Purvi K. Shah, MD on 4/11/22

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NorthShore's HCC Journey—Phase 2

- **FY2020: Expanding our Focus**
 - ✓ HCC gap closure becomes a component of primary care incentive model
 - ✓ Physician education on HCCs in every primary care and specialty practice
 - ✓ Distribution of monthly provider-level scorecards and HCC tip of the month to all providers
 - ✓ Hired additional physician advisor, HCC manager, coding analyst
- **FY2021: Translating Teaching Into Action**
 - ✓ Targeted physician and practice education based on volume and opportunity
 - ✓ New reporting to better identify patients with missed opportunities or no visits
 - ✓ More user-friendly HCC page on Intranet with updated materials for physicians
 - ✓ Regional collaborative for information sharing (RAF calculation, Epic tools, outpatient CDI)
 - ✓ Coordination with broader value-based care strategy
 - ✓ Exploration of models for office-based CDI and created implementation plan
 - ★ **Surpassed internally calculated RAF > 1.0 for the first time since measurement began**

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NorthShore's HCC Journey—Phase 3

- **FY2022: Building on Success**
 - ✓ Moved HCC work from revenue cycle to ambulatory risk adjustment and clinical documentation integrity department (director, manager, CDS, analysts, coders) under our population health work
 - ✓ Regional collaborative with new focus on standardizing education and engagement for physicians, leaders, and patients (including patient outreach)
 - ✓ Continued coordination with value-based care strategy
 - ✓ Created new regional physician organization with primary goal of establishing an integrated structure across entities to align and optimize performance in risk-based contracting and payment models
 - ✓ Created medical director role and hired 3 additional physician advisors focused on HCC work
 - ✓ Ongoing physician education to improve documentation
 - ✓ Pilot office-based CDI
 - ✓ Engaging specialists: Education, goal-setting, reporting

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Today: A Comprehensive Ambulatory CDI (aCDI) Program

- Tips of the month
- Using audits to drive improvement
- Engaging specialists and creating reports
- Creating documentation tools
- Ambulatory CDI process

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Tips of the Month

- Topics decided at system level
- Co-developed with Physician Advisors and ambulatory CDI (aCDI) team
- Sent out system-wide
- Paired with live monthly session

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HCC 134, 135, 136, 137, & 138 CKD Stage 3 to ESRD, AKI & Dialysis Status

Relevant Clinical Data:

Diagnosis	GFR	ICD10 Code
CKD stage 3, unspecified	30-59	N18.30
CKD stage 3a	45-59	N18.31
CKD stage 3b	30-44	N18.32
CKD stage 4	12-29	N18.4
CKD stage 5	<15	N18.5
ESRD (CKD stage 5 requiring Dialysis)	<15	N18.6
Acute Kidney failure/injury unspecified	Abrupt decrease in kidney function – do not continue to capture once GFR is at baseline	N17.9
Dialysis Status	Must be captured every year that patient is on HD or PD	Z99.2

**** TIP:** If there is a sudden drop in GFR without 3 months of sustained decrease: Instead of changing CKD staging, consider documenting and coding AKI until the GFR returns to baseline or there are 3 months of sustained decrease for new CKD staging.**

Documentation MEAT Criteria:

Staging

Documentation should always specify CKD staging. Without staging, no HCC can be captured.

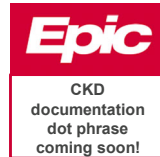
Staging CKD requires 3 months of sustained decreased GFR. For patients with varying GFR, use CKD stage that corresponds with most recent GFR.

Etiology of CKD

- Endocrine
- Renal
- Cardiac/Hypertension
- Autoimmune
- Oncologic
- Medication induced
- Multifactorial

Plan/Management

- Refer to Nephrology
- Avoid NSAIDs
- Control Hypertension/Diabetes



Examples of Documentation:

N18.32 Stage 3b chronic kidney disease

GFR has been decreased consistently in last 9 months. Most recent GFR 39. Will give referral to nephrology. Instructed to avoid NSAIDs and monitor BP. Will schedule f/u visit after nephrology consult.

N18.6 + Z99.2 ESRD on dialysis

Managed by nephrology. Continues hemodialysis 3x weekly (M/W/F schedule). No issues with fistula. Compliant with diet and medications.

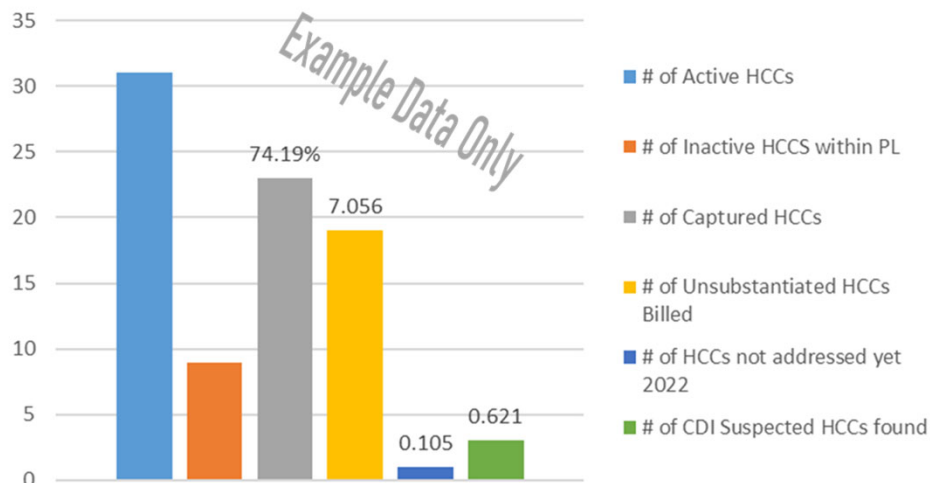
N17.9 AKI

Creatinine/GFR still not at baseline per recent labs but improving. Patient avoiding NSAIDs and has adequate fluid intake. Will repeat renal function labs in two weeks. Will f/u when results available.



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Audits Show Opportunities for Documentation Improvement



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Specialty Reporting and Education

- Focus the effort of specialists into **coding and documenting** on HCCs they manage in their daily practices
- In addition to specialty-specific HCCs, specialists are expected to address:
 - Group 22: Morbid Obesity
 - Group 21: Protein-Calorie Malnutrition
 - Group 18: Diabetes Without Complications
- Most large specialties have specific, targeted groups of HCCs that they are expected to address

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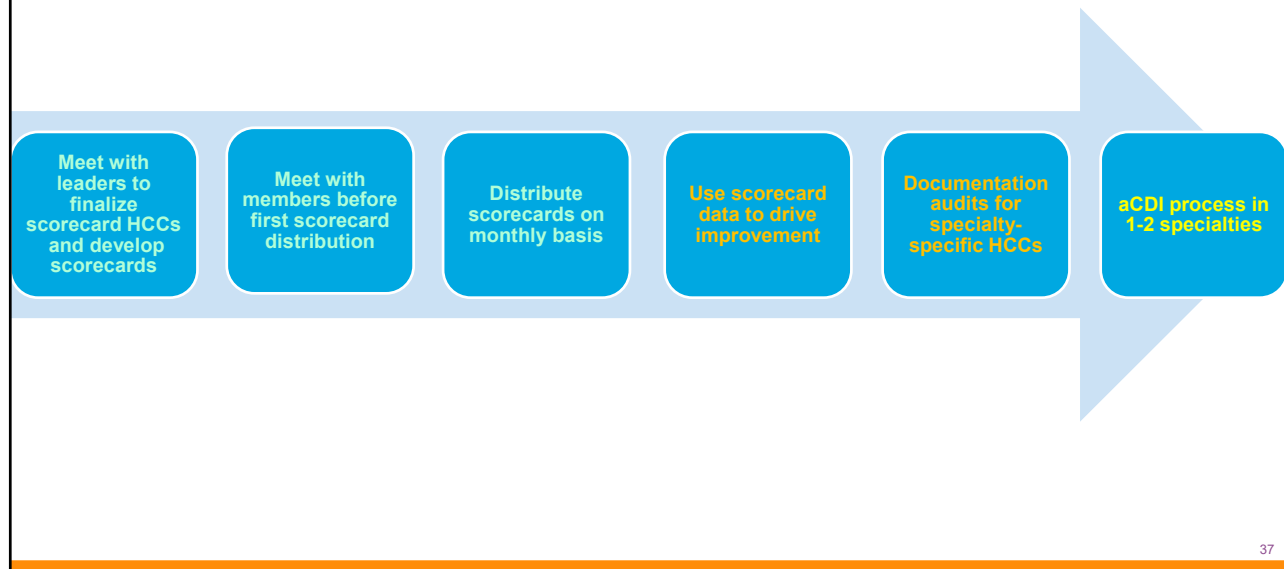
Specialty Reporting and Education

- Phased roll-out of reports, based on impact on RAF score
- Divisions with specialty-specific reports:
 - Cardiology
 - Neurology
 - Hematology-Oncology
 - Gastroenterology
 - Orthopedics
 - Ophthalmology
 - Pulmonary
 - Endocrinology
 - Rheumatology
 - General surgery
 - Surgical oncology
 - Neurosurgery
 - Infectious disease
 - Dermatology
 - Cardiothoracic surgery
 - Vascular surgery

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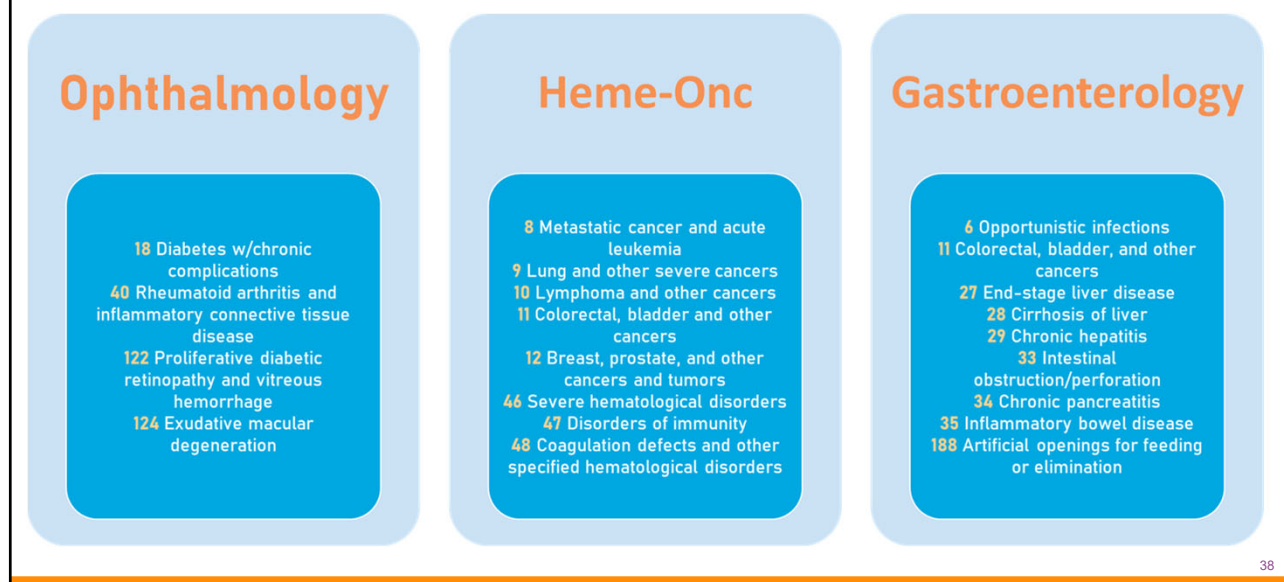
Process for Specialist Engagement



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Specialty-Specific HCCs



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Documentation Tools

- Dot phrases
 - Co-developed between physician advisor team and aCDI team
 - Makes it easy for clinicians to document on HCC diagnoses
 - Obesity With Comorbidities
 - Diabetes With Complications
 - Chronic Kidney Disease (CKD)
 - Malnutrition
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Depression

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aCDI Process

Pre-visit chart review by Clinical Documentation Specialist

- Problem list clean-up
- Review HCC BPA for accuracy
- 3 year comprehensive lookback to identify new HCCs + payer data review (pre-visit queries)
- **Requires clinician to review this information, include appropriate HCCs, and document at the visit**



Post visit chart review by Certified Risk Coder

- Add ICD10 codes if HCC is supported with documentation already in chart
- Query if additional documentation is needed to support HCCs billed or if HCC is felt to not apply to the patient
- **Requires clinician to addend the chart**



Closing the Loop

- Data collection
- Trend review
- Educational materials
- Clinic meeting attendance
- 1:1 education as needed
- EMR tool creation
- Query creation

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Summary

- Complete and accurate HCC capture and documentation is important for success in value-based contracts
- A close relationship between physician advisors and ambulatory CDI is key to improvement efforts
- Physician advisors can help improve clinician experience with HCC education, reporting, documentation tool development, and support for aCDI processes

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Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

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