Risk-Based Coding and Reimbursement
What is Risk-Based Coding?
Risk-Based Coding

Overview

- A diagnosis coding methodology utilized in risk adjustment models to “adjust” cost for all patients within a health plan or group

- Risk adjustment models take into consideration additional elements as well as diagnosis codes:
  - Demographic data (age, gender), insurance status, special patient-specific conditions (i.e., ESRD), etc. for one year are used to determine payment for the following year.
Risk-Based Coding

Overview

- Risk-based coding can help explain current trends in healthcare spending, forecasting of future needs of patients, and identifying resources necessary to deliver care.
- Risk-based coding not only affects payments to health plans but it can influence the quality of care provided to patient’s.
- Providers can combine risk-based coding data collection with quality of care measures.
Risk-Based Coding

Hierarchical Condition Category (HCC)

- HCCs are categories of health conditions, both acute and chronic, used to adjust payments to **Medicare Advantage (MA) (Part C) health plans** and project healthcare costs for MA beneficiaries for an upcoming coverage period.

- Diagnosis codes are mapped to HCCs for conditions such as diabetes, congestive heart failure, chronic kidney failure, etc.
Risk-Based Coding

Top 10 Risk Adjusted Categories

1. Chronic obstructive pulmonary disease (COPD)
2. Congestive heart failure (CHF)
3. Diabetes without complications
4. Vascular disease
5. Specified heart arrhythmias
6. Breast, prostate, colorectal, and other cancer tumors
7. Angina
8. Ischemic or unspecified stroke
9. Rheumatoid arthritis and inflammatory connective tissue disease
10. Ischemic heart disease

Source: Health Plan of San Mateo: Medicare Risk Adjustment and You
Risk-Based Coding

Common Missing or Incomplete Diagnoses

- Major depression (rather than depression)
- Old myocardial infarction (old MI)
- Renal failure (rather than chronic renal/kidney failure)
- Diabetes with complications
  - Missing linkage or causal relationship for diabetic complication/failure to report mandatory manifestation code.
- Angina pectoris
- Status of breast, prostate, colorectal or other cancers coded as “history of” rather than active and treatment not documented
- Protein calorie malnutrition
- Amputation status
- Drug or alcohol dependency
- Tracheostomy status or respirator dependence
- Chronic conditions such as hepatitis not documented as chronic
- Unspecified arrhythmia coded rather than the specific type of arrhythmia.

Source: HPSM Medicare Risk Adjustment
### Risk-Based Reimbursement

## Types of Risk Adjustment Models

There are several risk adjustment models utilized:

<table>
<thead>
<tr>
<th>Diagnosis Based Program Risk Adjustment Examples</th>
<th>Prescription Based Program Risk Adjustment Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hierarchical Co-Existing Conditions (HCC-C) – Medicare</td>
<td>MedicaidRx (UCSD)</td>
</tr>
<tr>
<td>Chronic Illness and Disability Payment Systems (CDPS) – Medicaid</td>
<td>RxGroups (DxCG)</td>
</tr>
<tr>
<td>Diagnosis Related Groups (DRG) – Inpatient</td>
<td>Hierarchical Co-Existing Conditions (HCC-D)</td>
</tr>
<tr>
<td>Adjusted Clinical Groups (ACG) – Outpatient</td>
<td></td>
</tr>
</tbody>
</table>
Risk-Based Models

CMS-HCC

- Medicare Advantage (MA) (Part C) health plans utilize ICD-10 coding submitted through claims data to map patients to HCCs for particular conditions.
- The risk score assigned is based on the patient condition and payment is assigned accordingly.
- Diagnoses for the current year are used to budget payments for the next year.
- Undercoding patient conditions will have a direct impact on available future reimbursement.
Risk-Based Models

HHS-HCC

- Under the Affordable Care Act, HHS utilizes ICD-10 coding submitted through claims data to map patients to HCCs for particular conditions.
- This data is used to determine if payers have insured a disproportionate share of higher risk patients.
- Money is shifted from payers with lower risk patients to payers with higher risk payments to maintain budget neutrality.
Risk-Based Models

Value-Based Reimbursement Models

- There is a strong shift away from fee for service payments towards payments based on fixed rates and effective management of patient conditions within budget.
- Where the primary focus for payment has traditionally been placed on CPT coding, ICD-10 coding is becoming more relevant.
Risk-Based Models

Bundled Payment and Shared Savings

- Bundled payments assign a fixed fee based on a patient’s condition. Accurate diagnosis coding will impact on the fixed rate assigned.

- Shared Savings Plans such as ACO (Track 1) models set a budget for managing patient conditions. If a group is able to manage care under budget, they are rewarded with a portion of the savings.

- There is a shift towards more risk-based models (ACO Track 2 and 3, MIPS) that places a portion of reimbursement at risk if the condition is not managed within budget.
How Does Risk-Based Coding Affect My Practice?
How Does Risk-Based Coding Affect My Practice?

Effective Patient Care

Accurately assessing a member’s health status enables you to:

♫ Monitor all of each member’s existing health conditions
♫ Avoid harmful drug interactions
♫ Identify potential new problems early
♫ Reinforce self-care and prevention strategies

Source: Health Plan of San Mateo: Medicare Risk Adjustment and You
How Does Risk-Based Coding Affect My Practice?

Risk-Based Contracts

- Failing to capture all documented diagnoses will skew a patient's healthcare profile and create a negative effect on the available funds to the health plan year to year needed to care for the patient.
- The negative effects can lead to:
  - Underpayments
  - Limited resources available for the patient’s care
  - Health plans being unprepared financially and unable to provide appropriate care when it comes time to treat conditions that occur later in a year or following years
- Inaccurate diagnosis coding can negatively affect a provider’s risk-based contract with a Medicare Advantage plan and narrowing commercial networks and lead to a loss of patient population

Source: Health Plan of San Mateo: Medicare Risk Adjustment and You
How Does Risk-Based Coding Affect My Practice?

Reimbursement

- Accurate coding is the primary means to ensure accurate payments for the health plan and participating providers
- **Remember:** Diagnoses reported in one year affect payments for the next year.

<table>
<thead>
<tr>
<th>No Conditions Coded (Demographics Only)</th>
<th>Some Conditions Coded (Claims Data Only)</th>
<th>All Conditions Coded (Chart Review by Certified Coder)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year-old female</td>
<td>.468</td>
<td>76 year-old female .468</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td>.177</td>
<td>Medicaid Eligible .177</td>
</tr>
<tr>
<td>DM Not Coded</td>
<td>DM (No Manifestations)</td>
<td>DM w/Vascular Manifestations .368</td>
</tr>
<tr>
<td>Vascular Disease Not Coded</td>
<td>Vascular Disease w/o Complication</td>
<td>Vascular Disease w/Complication .41</td>
</tr>
<tr>
<td>CHF Not Coded</td>
<td>CHF Not Coded</td>
<td>CHF Coded .368</td>
</tr>
<tr>
<td>No Interaction</td>
<td>No Interaction</td>
<td>+ Disease Interaction Bonus RAF (DM+CHF) .182</td>
</tr>
<tr>
<td>Patient Total RAF</td>
<td>.645</td>
<td>Patient Total RAF 1.062</td>
</tr>
<tr>
<td>PMPM Payment for Care</td>
<td>$452</td>
<td>PMPM Payment for Care $743</td>
</tr>
<tr>
<td>Yearly Reserve for Care</td>
<td>$5,418</td>
<td>Yearly Reserve for Care $8,921</td>
</tr>
</tbody>
</table>

Source: AAPC Risk Adjustment Predictive Modeling, Documentation and Capture of Diagnosis Codes
What Can My Practice Do to Improve Our Risk-Based Coding?
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Documentation

For both health plan and CMS acceptance, medical records should include:

- Patient name and date of service on each page
- Physician’s signature with legible provider name and credentials
- EMR records must be authenticated, such as “electronically signed by,” followed by the providers name and credential

Documentation should include whether condition is being

- Monitored, Evaluated, Assessed/Addressed, and/or Treated (MEAT) or;
- Treatment Assessment Monitoring/Medicated Plan Evaluate Referral (TAMPER)
What Can My Practice Do to Improve Our Risk-Based Coding?

Documentation

- Ensure diagnosis code and verbal description mirror one another.
- Existing acute conditions, chronic conditions, and status updates must be documented at least once per year.
- Document to the highest degree of specificity.
  - Approximately 10,100 diagnosis codes have been identified as appropriate for Medicare risk adjustment in the ICD-10 transition.
  - Practices are encouraged to provide proactive and ongoing ICD-10 education in an effort to receive appropriate reimbursement and promote coding accuracy.
What Can My Practice Do to Improve Our Risk-Based Coding?

Evaluate Current Processes

- Evaluate current access/appointment availability
- Proactively manage appointments- appointment reminders, missed appointment follow-up, etc
- Provide care plans and education to patient
- Evaluate self-management resources
What Can My Practice Do to Improve Our Risk-Based Coding?

Obtain Physician Buy-in

- Educate physicians on the importance of accurate coding.
- Discuss physician concerns/barriers to accurate coding.
- Promote communication between coders and physicians
- Continuously monitor progress and provide periodic feedback
Action Items
Action Items

- Educate providers on risk-based coding
- Provide coding and documentation training
- Assess Resources
- Monitor progress