Primer to Hierarchical Condition Coding

Transcript from Live Webinar

Thursday, April 11, 2019

Laurie Fink: Good afternoon and welcome to today's webinar, Primer to Hierarchical Condition Coding. My name is Laurie Fink and I'm a Communications Specialist with Quality Insights, and will serve as the host for today's session. We're so glad you were able to take time out of your day to join us live. For those of you who are joining us through the recorded webinar, welcome. Before we get started with the program, I'd like to go over just a few housekeeping items.

First, all participants entered today's webinar in a listen only mode. Should you have a question during the presentation, ask that you please type it into the Q&A box to the bottom right of your screen. There will be time to address your questions throughout the presentation. Today's webinar is being recorded. The recording, along with a slide deck and a transcript of the webinar, will be posted on the Quality Insights website, as well as the Quality Insight QPP support center website, as soon as possible. These resources can be found on archived events pages.

Joining us today as our guest speaker is Monica Wright from Medical Revenue Cycle Specialists. Monica has over 20 years of experience in medical coding, billing, and practice management, and she has taught medical coding and billing at the community college level and continues to teach physicians, managers, and staff of private medical practices and within hospital settings, and also holds multiple certifications. So, without further ado, I will now hand over the presentation to Monica.

Monica Wright: Thanks, Laurie. So, just a couple of housekeeping slides here before we get started, a little bit about me, which Laurie already told you, and then Kem Tolliver, who's the president of Medical Revenue Cycle Specialists. Okay. A couple of learning objectives that we're going to go through in this webinar today. First, we're going to talk about the history of risk adjustment and what it is and why it is, talk about the entities that have used it, and how it's now being used for scoring and reimbursement, talk about the HCC categories and how it relates to MIPS.

We'll talk about linking and trumping diagnoses, explain proper diagnosis selection, and how that translates into the correct HCC, review the necessity of ICD-10 specificity. I'll talk about proper documentation to capture complete conditions, we'll review the HCC's weighting and use, we'll review sample medical records, and analyze a problem in using the EMR to optimize

documentation. So, let's talk first a little bit about risk adjustment coding. I know this is something that has come up a lot recently, and a lot of you may think it's a new concept. But really, risk adjustment coding has been around for quite some time.

It was mandated by Medicaid in 1997 and first used in 2004. It's been used to predict annual costs per beneficiary for quite some time. So, who's using it? Where has it been in use? It's mainly been in use with insurance plans, and namely, a lot of the Medicare Advantage insurance plans. This is a system that's been used to determine how expensive it's going to be to provide insurance to a set of beneficiaries. So, this has been used by these insurance companies as a way to determine what they're going to bill Medicare for providing these programs. So, it's also used by the Affordable Care Act plans.

It's being used by accountable care organizations, if you're a member, to determine, again, how much money they need to pay members when they're negotiating with insurance companies. Commercial carriers are going there, and it's been used by Medicaid as well. So, what exactly is risk adjustment coding? It's a tool that estimates expected costs per beneficiary. It does this by using demographics, Medicaid eligibility, health status, and then it uses hierarchical condition categories, known as HCCs, to weigh each illness by severity to determine how much money each member is going to cost.

So, this is done by creating a risk adjustment factor for each patient. A factor of 1 is used to determine a patient that would use average resources. A patient that uses more than average resources would have a factor greater than 1 and a patient that uses less than average resources would have a factor of less than 1. So, what does that mean? How do they affect reimbursement? So, we have three examples here, all of an 82 year old male. For the age of the patient, there is a certain amount of risk factor that's built in. You'll see that's .561. So, just for being an 82 year old male, we're still at less than average use.

So, then we add the first condition that the patient's being seen for: low back pain. There's no HCC associated with low back pain, so our first patient total score stays at that .561 or a healthier level. Our second 82 year old male comes in with the same low back pain, but also has CHF, which does have an HCC score of .323. So, now this patient's total score is .884, which is still not quite average, but getting closer to that level. Our final 82 year old male continues to have the low back pain and the CHF, but also has chronic kidney disease, Stage 5. This member now has a total score of 1.21, which is more use or a higher risk factor than our average patient.

These numbers are then taken and they're multiplied by a factor of 10,000. It's $10,000 per year for a risk factor of one. So, for an insurance company covering these three patients, their risk factor would be 2.566, or roughly an expectation of $25,660 of benefits to be paid out for these three patients for the year. Okay. So, why is this now affecting us in the physician realm? Obviously, this is something that's been used by the insurances and it's a way for them to get

payment. But all of a sudden now, as we are moving to value payment models, quality over quantity, these things are now coming into play in the physician world.

The first place that we're really seeing the HCC coding being used is MIPS. MIPS has a cost of care percentage, which is one of the categories that is being calculated now under MIPS. Cost of care, in order to determine that cost, is using HCCs or risk adjustment coding. So, how you affect your cost of care scores, or actually, the cost of care scores for every provider in the system is by reporting these HCC conditions, which we'll get into in more detail when you're doing your billing to the insurance companies, because these costs of care are determined by looking at what's been reported for these insurance companies, for the patients to the insurance companies.

So, they're getting their risk factor per patient. So, they're saying this particular patient was reported all these diagnoses this year, so this is where their risk factor should be. So, that's what they are basing what care's being provided on and whether or not you provide at high or low risk. So, if you have a patient that has conditions that code to an HCC and you are not reporting them, then you are indicating to the insurance company that the patient is healthier than they are and you look like you're a high risk provider, whereas if you are reporting all of these diagnoses appropriately, then the costs will be accounted for when Medicare's doing these calculations. In those instances, then you shouldn't be high risk because you'll be reporting what would be expected based on what they're looking at for that beneficiary.

So, MIPS is looking at two things in the cost category. First, they're looking at the Medicare spending per beneficiary, which is done in an episode arrangement. They're looking at the period immediately prior to, during, and following the patient's hospital stay. So, they're looking at every provider that saw a patient in that time period and they're looked, based again, they're creating this risk factor based on the diagnoses. Then they're looking at how much the provider billed and whether or not it's in line with what they think should be for how severe that patient's illness is.

The second is the total per capita costs, which means that they're looking at the total year. It's a risk adjusted, specialty adjusted measure that looks at the overall efficiency of care provided by both solo practitioners and groups by tax ID. So, there are two ways that this information's coming into play. As you know, the MIPS financial impact continues to go up. This year, everything that we're reporting for MIPS will have a 7% either win or lose scenario based on the score that you get. The cost factor is 10% of the score. Or it was 10% in 2018. I believe it's 15% this year. Again, it continues to go up.

So, this is something that is going to impact you financially if it hasn't already. So, this is really important that we understand what this does and why it's going to be important. Okay. Any questions about just the basics of how we got here before we move into some more detail? I promise more detail is coming.

Laurie Fink: Yes. There was one question here and it asks, “I code for PM&R doctors. I therefore bill with physical medicine ICD-10 codes, not medical disease codes. Should I be?"

Monica Wright: No. You're only going to bill for what is pertinent to the visit for the patients on that day. So, if that is the only realm that you're in and there isn't a comorbidity that's affecting what you're doing, then you would not add that to your bill. Every physician that bills for this patient is included in this yearly look-back. So, if they're seeing specialists for other things, it should be picked up somewhere along the line. We're going to get into in a minute what goes on your bills and when. But if you are treating a comorbidity or the comorbidity is determining what you're doing for the condition you are treating, then you do want to be sure that you get it on your bill.

So, let's look at the hierarchical condition categories and where they come from and what they mean. Okay. So, the categories are a case mix. It's not unlike the DRG in the acute hospital setting. They group patients that are both similar clinically and by class patterns, they focus on chronic and severe illnesses, and they use ICD-10 codes and demographic information to make these determinations. So, there are two types of HCC categories. There's the CMS HCCs, which are used, of course, for Medicare Advantage. They focus on diagnoses that are in the population that are over 65, and there's 79 of them total. The Health and Human Services also has a list of HCCs that are used for all ages, which are also used in commercial Medicaid ACA plans, and there's 127 HCCs in those categories.

So, let's take a look at what they are, starting with the Health and Human Services HCCs. These are the conditions that aren't included in the CMS HCCs, and these are the provisions that can apply to obviously children to younger adults to people under that age 65 population. Things like autistic disorder, cleft palate, but you can see the severity and, in some cases, the chronic nature of these illnesses. Okay. Now, these are some more of the HCCs, but these are the 79 HCCs that are captured by CMS. I've gone ahead and listed all of them so that you can see. We'll go into a little bit more detail about a couple of them in a minute.

But just to give you an idea of the type of illnesses that are included when they're looking at these risk categories. So, you've got things like diabetes and arthritis, in some cases, major depression, spinal cord disorders, muscular dystrophy, congestive heart failure, myocardial infarction, a lot of the cardiology based, cerebral hemorrhage, vascular disease, COPD, renal failure. Okay. Some burns and some organ transplant, things of that nature. So, these are all of the HCCs that are out there for CMS.

So, what does that look like? Okay. So, we say CMS has an HCC for chronic obstructive pulmonary disease. How do you get a patient there? Well, each one of these HCCs has a list of diagnoses that's associated with it. This is a diagnosis list that goes with that HCC to COPD. So, when you report one of these

diagnosis codes on your claim, then that notifies the insurance, okay, this patient has a diagnosis that's connected to an HCC and that's how it's reported and captured.

Then the insurance companies, and how this has been done in the risk adjustment world for the insurances, will take those bills, and then some of you may have seen letters from some of your HMOs or your Medicare Advantage plans that are asking for records. They'll ask for records on these patients so that they can read the documentation and confirm that the HCC is there so that they can count it. That's why documentation is so important, and we'll talk about that in a few minutes. Here's another example: diabetes with acute complications. These are some of the diagnosis codes that will be associated with that HCC.

Vascular disease. Again, some more example of some of the diagnosis codes that code to that HCC. We'll look at specific examples of those with documentation in a little bit. Now, more than one HCC can be captured per encounter, but when they're related, there is a process with HCCs known as trumping conditions. What that means is when you have multiple related conditions reported on the same claim, you're only going to get credit for the highest HCC. So, in this case, acute renal failure is considered higher than chronic kidney disease, Stage 5, which is considered higher than kidney disease, Stage 4.

So, if you reported acute on chronic kidney disease and acute on chronic renal failure, you're only going to get credit for the HCC risk factor that goes with the acute renal failure for that day. This is the list that's given that tells you if a disease is in this column, then you're going to drop a disease in this column because you can only get one or the other for these related conditions on that day. So, any questions about what an HCC is before we get into the documentation?

Laurie Fink: Yes, we did have a few questions, Monica. The first one is, "Why don't all codes have HCCs?"

Monica Wright: It's really, it's about trying to determine, over the course of the year, how much medical care a patient is going to need. So, what they've looked at are the chronic and severe illnesses that require more visits. Your chronic diseases, now we know, are going to be seen every three to six months, that have the complications with them that could land people in the hospital more. So, it's really a way of tracking of the outliers of a sicker patient. It's a way to put in an overall setting to say, okay, if we're looking at 10,000 lives, we know that these illnesses are going to cost us more money.

So, it's really about the illnesses that tend to be more expensive, the patients that tend to cost more to use more medical benefits. So, that's why it's not everything, because patients, the common cold, they see a visit every now and

then, obviously that's a healthier patient, so isn't going to require the same usage as someone with COPD or chronic renal or chronic respiratory failure.

Laurie Fink: All right. The next question is, "Beyond putting us at 'higher risk' if we don't document well, does this specifically affect our MIPS score? If so, how?"

Monica Wright: So, it can affect the MIPS score, only in the cost category. Right now, we're looking at this strictly at MIPS costs because the HCCs are being used to determine how much these patients should cost. So, when they're determining you to be a high cost or lost provider, that's based on these HCCs and how much money they're determining this patient should be costing for the year. The other place where this can come to affect you when you're being rated as high cost or low cost is when you to go try to enroll in an APM or an ACO because these are things where they're going to be looking at that for the providers that they're trying to get to join because obviously, those organizations want the low cost providers if at all possible because it saves them money and has a chance of making a profit.

Laurie Fink: All right, and one more questions is, "Is there a user-friendly website to see all HCC values for all codes? The CMS website is not helpful."

Monica Wright: Most of the information, where I've gotten them, is there are spreadsheets on the CMS website, but you have to dig for them. I know the CMS website doesn't really, it doesn't point it out. But if you do a search every year, they do put out Excel spreadsheets that give all of that information. I haven't really seen a site more in detail than that. It's not like the QPP site because they really haven't put this out there per se yet. This is still something that I think on the physician side, as physicians, we're still learning that this is something that's affecting us. So, maybe soon. But right now, if you go to CMS and search HCCs, you got to dig, but it is there.

Laurie Fink: All right, and one more question. "Is the value of the HCC probably purely based on dollars spent by CMS? It would seem this is a specific population. For instance, migraine does not have an HCC value, despite its medical and societal cost."

Monica Wright: Well, it's not all CMS. This is done, like I said, across the board. The Health and Human Services has the other HCCs as well. The general overall factor right now is a factor of one equals $10,000 spent per year. That's done on a basis of a lot of research and years of using these codes in the Medicaid and the Medicare Advantage worlds. So, I don't think it's all coming from CMS. I just know that this is the system that they are using to make these determinations. It's been that way for a little while. This has experience with this because these programs have been out there for a number of years with some of these risk insurances.

Laurie Fink: All right. That's all the questions for now, Monica.

Monica Wright: Okay. So, let's move into documentation. What documentation is required? What needs to be in the notes so that when your chart is requested because you used the diagnosis, the insurance company can say yes, there's an HCC here? First, the information must come from a face to face encounter. Second, the encounter must be properly signed. Any note that's not properly signed, the insurance company has to throw out and can't count. Patient name needs to be on all pages of the note. The diagnoses must be clearly documented. Coders are not allowed to interpret. Just because there's a lab result there doesn't mean they can say, "Oh, this patient has this condition." They cannot do that.

It should be coded to the highest level of specificity because some of the codes require, if it has specific complications associated with it to even be an HCC, and others, the points for the HCC are more if there are complications involved. You may assign more than one HCC per encounter. You can assign up to five. So, how do you document to get this information there to justify the HCC? Well, they're looking for what's been called M.E.A.T.: monitor, evaluate, assess, and treat. The information that they need is going to come from signs and symptoms. It's going to come from test results, current medications, response to treatment. It's going to come from orders, counseling, and records reviews, and it's going to come from medications, therapies, and procedures that indicate that this condition was assessed and treated on this day.

Words in the documentation that convey M.E.A.T.: stable, improving, weaning, decompensating, persistent, asystematic, progression, uncontrolled. These are things that indicate that, again, you looked at the condition today. So, any format of note is acceptable, as long as the M.E.A.T. is clearly documented. You need to be careful of the abbreviations, so be sure that any abbreviations you're using have a standardized meaning so that there can't be multiple interpretations of what you're trying to say. Each documented diagnosis should have an assessment and plan. Just listing a diagnosis in the problem list does not count. In order to count that condition today, it must be clearly assessed today.

Now, in order to count towards and HCC, each condition must be reported once per year. So, December 31st, the conditions no longer exist. If they're not reported again in the new year, then they're not attributed to the patient. So, it's really important that chronic conditions get reported every year. But that being said, they only have to be reported once per year. So, if you have a patient with a chronic condition and they're coming back there in a course of the year and you don't treat that chronic condition every time, then you're not going to report it every time. That's fine. You'll still get credit for it, because you will report it when you do see them for that condition, which should be at least once, if not more than once in the course of that year.

I know a lot of your medical records have problem lists. Problem lists are great. But just because the diagnosis is listed in that problem list, it's not going to give you credit for seeing the patient for that diagnosis. That has to be some M.E.A.T.s associated with it. So, we're looking for assessment and plan, assessing treatment of that condition. Now, the history of the condition does

not count either. So, it has to be actively treated. So, it's very important with some of these chronic conditions, the patient still has the condition. It's not a history of scenario. But if anything's listed as history of, it will not count.

Again, we're looking for documentation to support that the condition affected the management of the patient during that particular encounter. So, in this case, comorbidities, diabetes being a big one, could be something that did affect, although they were here from something else, it affected how you were able to manage what they came in for because you need to be aware of the medications, etc., that you can prescribe because that patient also has diabetes. The other thing you want to be sure to document is causal relationships. We talked about complications. When you document complications, the HCC points go up. But in order to get credit for the complications, the diagnoses must be linked.

Looking for words like due to, associated with, secondary to, diabetic, hypertensive. For example, a patient with diabetes and neuropathy, you're not going to get a diabetic complication for that neuropathy. It doesn't say they go together. A patient with diabetic neuropathy, now you'll get the complication because the two conditions are linked, the way it's worded. Hypertension is not an HCC by itself. So, that linking with hypertension is very important because hypertension and kidney failure doesn't have to be linked. There's a causal relationship between hypertension and kidney failure, so it can be applied or implied if you document both.

But for example, hypertensive heart disease, you must show the causal relationship for it to count. So, just listing hypertension and then listing heart disease would not give you the HCC credit for hypertensive heart disease because both are in your encounter. The encounter would have to state hypertensive heart disease to get credit. Questions about documentation before we look at some medical record samples and how this works in practice?

Laurie Fink: I'm not seeing any at this time.

Monica Wright: Okay. So, let's start with the HCC for diabetes. Diabetes has three HCC values, one just for diabetes, one for diabetes with chronic complications, and diabetes with acute complications. So, again, when we're documenting, we're looking to link those complications because .318 is a lot higher than .104, document if there's insulin dependence, and document if it's controlled, uncontrolled. So, here's our first documentation example. So, let's take a look at this patient.

So, with this patient, we have an assessment that starts with the ICD-10 codes. Then we have a prescription, and then we have a plan. So, in a second, we're going to put up a polling question that I want you to look at this before we do and decide by looking at this, do we get to the HCC for diabetic neuropathy with this documentation? April, can you put up that polling question? Let's wait about 30 more seconds here. So, let's give people a chance to answer. Okay. So,

do we have the results? Let's see. So, it's close. We had about 50% say yes and 50% say no.

The answer for this one is actually no. Even though the Type 2 diabetes with diabetic neuropathy is listed as the diagnosis code, when we go down into the M.E.A.T. of the documentation, it doesn't really give us that much information. It mentions the medication, but then it just doesn't say anything in the plan that would indicate that that's what was treated today. Now, if we look at this next documentation, we can see how this is just a little bit better than the last one. Notice the ICD-10 codes are still there. That hasn't changed. They still have medications, but in the plan, we're specifically mentioning the diabetic neuropathy and the medication that's being used for it. Then the HA1C is also mentioned.

So, this example has a little bit more M.E.A.T. than that first example when we're looking at trying to get to the specificity needed to get to that complication for the HCC. Okay. Our next example is kidney disease. Chronic kidney disease, Stage 4, is rated at .237, as is Stage 5. Then dialysis status is .422. So, it's very important to specify by the type of failure, cause of the stage is very important, the GCR, if you know it, and of course, document temporary or permanent dialysis, because that dialysis is what's going to go to the higher HCC.

So, let's take a look at this documentation, looking for the kidney disease. Again, I'm going to give you a minute to look at this. In a minute, we'll put up another polling question for this one. On this one, we're looking for whether or not the HCC was met for any of the kidney disease HCCs that we just looked at. So, April, can you put up the next poll? About another 30 seconds for everyone to answer. Okay. The poll has ended. Just a minute before we have those results. In the case, the majority said no, which is the correct answer, because the first HCC started at Stage 4 and this documentation only documents Stage 3.

So, here's an example of documentation that would meet the requirement for the highest level for kidney disease for the dialysis. So, this case, we have the plan that indicates the end stage renal disease, they're going to continue dialysis, and then in the HPI, it talks about the dialysis and they're taking off fluid. So, there's enough in this documentation to get credit for that HCC. Okay. Obesity. Morbid obesity does qualify for an HCC. The BMI may be used as documentation as long as the physician documents it.

Now, what that means is it's in the physician's notes. That doesn't mean that you can't have it documented by an MA or have it done earlier in the office. But it can't just go on a list in front of the chart. It physically has to be in today's documentation. Most EMRs, you can pull that in, and that's absolutely fine, and the credit can be given there. But it has to physically be in the note that the provider would be signing. Now, you also want to identify any findings that are consistent with comorbidities because it's very possible that those

comorbidities will go towards another HCC in addition to the morbid obesity. Again, you want to capture as many HCCs as you can in each visit.

If you're using a BMI screening tool, then this would be acceptable documentation. Obviously, we're looking for that BMI to be over 40 in order to qualify for the morbid obesity. This gives a little bit of information that it was discussed. So, it's the combination. It's in the documentation that it was reviewed that day. Liver disease, another HCC. End stage liver disease, .0962. Cirrhosis, .390. Chronic hepatitis, .165. So, this case, it's important to document acuity, because that's the chronic hepatitis level there, not acute. Document the etiology and document complications, because you want to be sure, again, you're getting to the highest level of HCC under the liver disease and you're also capturing any comorbidities that may be there as well.

Here's an example of documentation. This case, it was the cirrhosis under number one, under liver mass. We're talking about the longstanding liver cirrhosis. So, there's certainly enough here to get to the HCC for cirrhosis. In this case, there's also enough for an additional HCC because under number four, the diabetes is mentioned. Now, diabetes is not linked to anything and the code given even under it is without complications. So, this would be the lowest diabetes HCC just for diabetes without complications. But it would be a second HCC in addition to the cirrhosis. So, there will be two given for this visit.

Stroke. An ischemic or unspecified stroke has an HCC of .263. That's very important to document acuity, document any residuals from a prior stroke, and document with or without infarction. The most important thing to recognize, though, with the stroke is that an acute stroke only counts if you're within the first 24 hours. So, anything beyond that first 24 hours, you will not get this HCC. The visit has to occur within that first 24 hours. Now, that doesn't mean there aren't HCCs for older strokes because there are HCCs for residuals. Hemiplegia, there are a couple of others because of the chronic nature of those complications after the stroke have their own HCCs. But in this particular case, we're looking at the HCC for acute stroke, and that requires the patient to be seen within that first 24 hours.

So, here's an example of a patient. The duration is today, sudden onset at 11:00 a.m., and gone now. So, this would be an HCC that counted because the MRI showed the acute CBA, and it all occurred today. So, this would count for that acute CBA. Now, granted this might not be a patient you're seeing in the office because based on symptoms, you might be sending him to the hospital. But HCC will be picked up from the hospital chart. But if a situation does occur, you will get the HCC for this type of visit.

Skin ulcers. A pressure ulcer of the skin with necrosis through the muscle, tendon, and bone is 2.16, a pressure ulcer with full thickness skin loss is 1.20, and a chronic ulcer of the skin that's not a pressure ulcer is .54. So, when you're dealing with ulcers, it's really important to document the location, the stage, and the severity to determine which of these categories it would fall into, if it

even falls into at all, because if it's unspecified stage, then you're not getting enough information to determine if it's full thickness skin loss or if it's skin necrosis.

So, here is a skin ulcer example, and we're going to do our lost poll here with this one. So, take a minute to look at this documentation. Does this qualify for an HCC for the ulcer? April, can you put up the poll? About another 20 seconds or so to let people answer.

Laurie Fink: Monica, while that calculates, I thought maybe I'd read one of the questions that came in during this part of the presentation.

Monica Wright: Sure.

Laurie Fink: The first question asks, "Many diseases like hypertension still require medications, visits, and counseling to prevent future diseases. While it may not be costly, couldn't it still be valued at a low HCC? Otherwise, it would seem that providers are demotivated financially from seeing these patients."

Monica Wright: For the purposes of how much a patient's going to cost per year, which is what we're looking at with an HCC, hypertension by itself is considered something that's an average cost. Your visits for seeing the patient for hypertension, the medications, in and of itself, that's going to end up being a patient that gets a 1 risk factor or under. So, it's just a matter of putting the patients in the categories to determine an overall population cost of how much things are going to cost. Seeing that patient's not going to hurt you in any way because that patient will calculate into your overall risk scores just fine because you're not going to be over utilizing resources for that patient because you'll be using them appropriately because what's expected for that type of patient.

So, this is just really about for that population that, it's the population that ends up being the outliers, the population that really ends up causing all the readmissions that pulls everybody down. It's allowing for that population and not penalizing you because you're seeing the sicker patients vs. penalizing you for seeing the ones that aren't as sick, if that makes sense. Okay. Our poll results are in and I've got a few more people saying yes than no. This one was a little bit tricky because we do have the Stage 4 clearly documented again with the diagnosis. But then the plan is kind of general. It just says buttock ulcer and continue wound care consult.

So, we don't have a lot of M.E.A.T. in this example. There aren't a lot of details of what's going on with the ulcer. Because the list of the diagnosis could be considered a problem list, some insurance companies that are looking at this documentation might not give you credit for it. So, what would be better than what's here is just a little bit more documentation, noting in the plan that it was Stage 4, and then indicating the size of the ulcer, even though it's improving, and look, there's muscle involvement. It's still there. So, this would definitely get

you credit for it because it just provides a little more detail into the patient's condition.

Depression. Major depressive, bipolar, and paranoid disorders have an HCC. Major depression requires a documentation of five symptoms, based on the American Psychiatric Associations algorithm. This list here lists the possible symptoms that can be considered for major depression. If you're using a depression screening tool in your practice and the total score indicates that the patient falls into that severe depression category, then this would be enough for the M.E.A.T. to show that you've met that diagnosis in your documentation. One thing to be aware of on this particular screening, at the bottom, you'll see it was done in 2015. You're not going to get credit for this every year. This would have been given credit once when it was done, but when you get into the next year, you're going to have to assess, treat something with that condition to get continuing credit for that HCC.

The heart disease HCCs, congestive heart failure, unstable angina, angina pectoris all have HCC amounts. Again, it's important to link the complications. Heart failure is considered a chronic condition. So, you do want to report it every year, even if the patient's asymptomatic or doing well. Here's an example of documentation with the angina. So, we've got the list again, but it indicates that there is an acute exacerbation and hypertensive cardiovascular disease is listed linked. Then we have the plan. So, this would meet a couple HCCs based on the congestive heart failure or the hypertensive cardiovascular disease. But we may hit a trumping condition on that when we go to bill it.

Atherosclerosis and vascular disease. If you look at the difference between vascular disease and vascular disease with complications, we jump from .298 to .400. Another important reason to be sure that the complications are documented. Atherosclerosis must be specifically documented in order to be coded. If it's aortic, it needs to be clearly specified. You have to link diabetes and peripheral artery disease to get that complication credit. Don't say history of arterial disease. Again, it's a progressive disease. It does not go way. If you say history of, you don't get credit.

DVT cannot be counted as chronic unless it's clearly documented that it's a chronic DVT. Here's another documentation example, indicates the symptoms of the PAD. We have a diagnosis of severe claudication. So, this would qualify for the vascular disease. Okay. So, one thing to think about when you are looking at this and ways to improve your documentation so that you are documenting the ICD-10 codes to the best specificity to be sure that you're getting credit for HCCs and just moving to value based coding in general, it may be a good idea to review your problem lists that are already set up in your EMRs. Compare the problem list to the assessments.

A lot of those problem lists, especially if they were transitioned from ICD-9 to ICD-10, probably have a lot of unspecified conditions in them. It's very possible that your providers are just continuing to use that because it's there. So, you

may want to update the problem list to the more specific conditions when you know the complications to make sure that it's being used appropriately for that patient. Look at the discrepancies and notice any obvious documentations discrepancies too, deficiencies based on the problem list, and what the providers are documenting. So, just a good double check to make sure that your documentation is at the best that it can be.

So, kind of is just a refresher. Specificity should be the new normal. We're trying to do everything as specific as possible for the patient. Comorbidities matter. Having all of this information helps. Again, we're trying to prevent readmissions. The QRUR went away at the end of 2017 because the cost measures were part of the PQRS program. So, those of you that reported under PQRS, you might still have some old QRUR reports. That will give you an idea of something to look it as to how the cost measures are going to play out under MIPS. It's basically the same system. So, if you do have that resource, it's something to look at. Might be something to help you forward with this. Consider internal auditing just to be sure that everything's getting documented the way it should be. Okay. Any other questions?

Laurie Fink: Yes. One question is in a context of an ICD-10 assessment, whereby the assessment is labeled as stable and the plan says no change in treatment. Would that qualify to get HCC credit?

Monica Wright: Assuming that the last visit indicated what the treatment was and it was also this year, then yes, you will probably have already gotten your credit for that diagnosis within the course of the year. Remember, we only have to report these once per year. So, as long as at least once, all the information is there to connect that diagnosis to that patient, then it should be fine. I know it's a lot of work to be specific and that documentation outside of HCC, just as a general rule, if you were to send that documentation back over to a specialist or to a PCP, they're not going to have any clue what's going on with that patient because the treatment's not listed. So, as a general rule, I would say that's not a best practice. But from a HCC standpoint, more than likely, you'll be okay.

Laurie Fink: Okay. Next question, "Why does an acute stroke have a lower HCC compared to pressure ulcer? It would seem the costs of a stroke and its debilitation is more severe than a pressure ulcer."

Monica Wright: Well, keep in mind the acute stroke is just within that first 24 hours. After that, if there's any debilitation, those debilitations can code to other HCCs that are going to be worth more. Hemiplegia, I believe, is worth more. So, some acute strokes, the patients are fine and there aren't any lasting effects that go on for months or years. It's now a comorbidity in that it's something that has to be a concern in the future, if it's going to happen again. But the costs of the actual stroke itself aren't necessarily the same. It's the costs of the late effects, the complications, the things that come out of it.

Laurie Fink: With respect to MIPS, is it accurate to say that our cost score will be based on the cost attributed to us divided by HCC score, and not compared to colleagues within our field?

Monica Wright: That is my understanding of it, yes. It's supposed to be looking at second ... The HCC is a piece of it. Now, there is some demographic info as well because obviously, the cost of care is different in different geographic regions. We even see that in our Medicare C schedules with the gypsy indexes. So, there is some demographic, location, age of the patient, and all of that are taken into account, as well as their HCC scores. But yes. It's going to be looked at at the patient's total cost, what they think the patient's total cost should be based on all of those factors against what you're reporting.

Laurie Fink: All right. I believe we've addressed all of the questions.

Monica Wright: Okay. Just a couple of final notes, just a little bit about Medical Revenue Cycle Specialists and who we are, having presented this presentation to you, and some of the supports that we do offer to medical practices, and I thank you very much for your time.

Laurie Fink: All right. Thanks so much, Monica, and thank you to everyone who was able to join us today. Just a quick reminder that when you close out of today's session, you will be automatically directed to a very brief evaluation. We ask that you please take just a moment to complete it. We greatly appreciate your feedback and all of your comments. So, thanks again for joining us today. Have a great rest of the day and this session is now concluded. Thank you.

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