Blue Advantage Risk Adjustment 101

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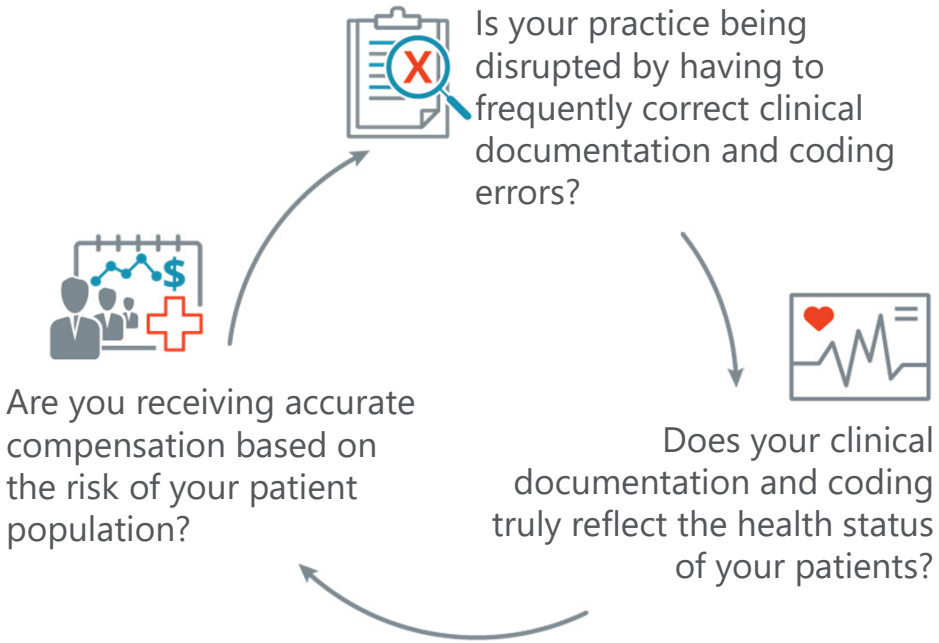
Agenda

- Introduction
- Risk Adjustment Programs
- Affects of Risk Adjustment
- Wellness Visits
- Coding and Documentation
- Medical Record Review and Audit
- Questions

Introduction

- In a time of continual regulatory reform and the evolution of payer/provider reimbursement models, are you potentially at risk?
- Today's discussion will focus on the importance of accurate clinical documentation and coding, and how this can translate to quality data that promotes the financial health of your practice and the health of your patients



Risk Adjustment Programs

- Provides tools to predict healthcare costs based on relative actuarial risk of enrollees in risk adjustment-covered plans
- Minimizes the incentive for health plans to select enrollees based on health status
- Encourages competition, based on quality improvements and efficiency, mitigating the impact of potential adverse selection[1], and stabilizing premiums

1. Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher-than-average costs are adversely selected. Source: HHS Risk Adjustment Model, May 7, 2012 (Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Department of Health & Human Services) http://cciio.cms.gov/resources/files/fm-1c-risk-adj-model.pdf

Medicare Advantage & Commercial Risk Adjustment Programs

MRA

- Administered by the Centers for Medicare and Medicaid Services (CMS)
- Risk adjustment payments are made to Medicare Advantage plans
- Medicare Advantage plans reimburse physician groups with whom they are in risk-sharing relationships according to contractual agreements

CRA

- Administered by the Department of Health and Human Services (HHS)
- Insurers pay in/out based on the risk associated with their individual and small group enrollees
- As a result, the risk adjustment model redistributes money from insurers with healthier patient populations to those with sicker patient populations

Why and How Risk Adjustment Affects Physicians?

Why will physicians be affected?

Risk adjustment relies on physicians to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient

How will physicians be affected?

Financial Health of Your Practice

Capturing diagnosis codes and encounter data accurately reduces the administrative burden of adjusting claims. For physicians involved in risk-sharing arrangements, it also ensures more accurate payments and reflection based on the severity of illness burden.

Opportunities to Improve Care Management Practices

Accurate risk capture improves high-risk patient identification, as well as the ability to reach out and engage patients in disease and care management programs and care prevention initiatives. It also helps in the endeavor to identify practice patterns and reduce variation when clinically appropriate.

Connection Between Patient Health & Cost of Care

Capturing risk accurately is important to ensure accurate payment for providers that are in a risk-sharing relationship

Example from the American Medical Association

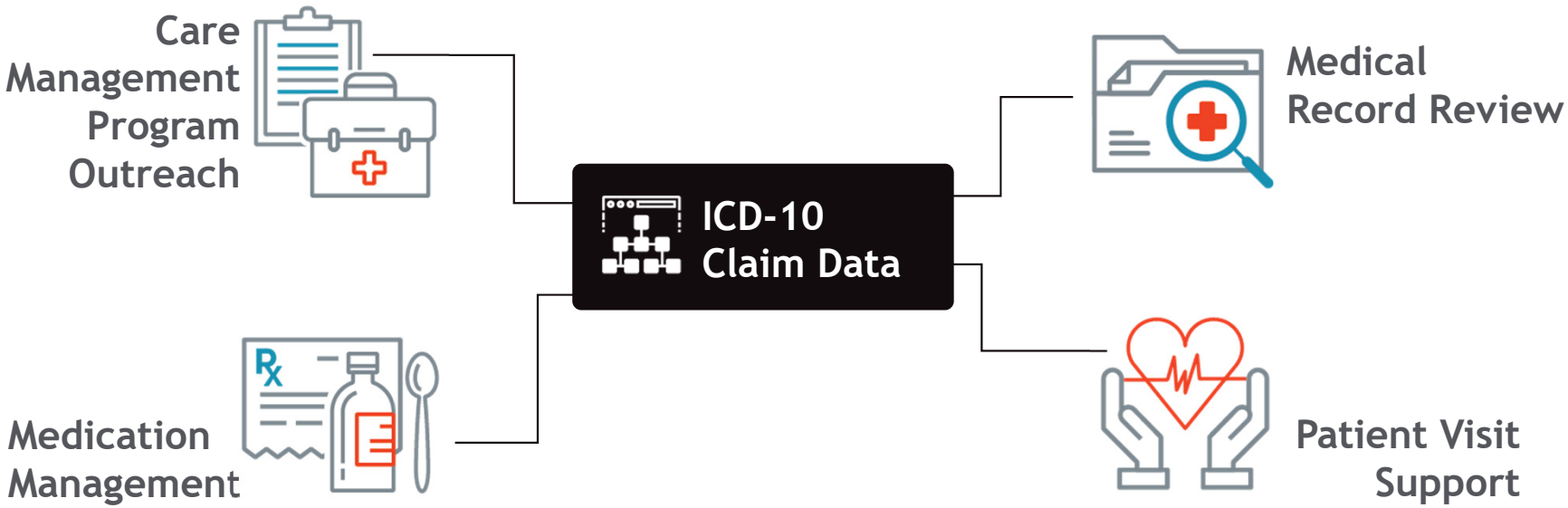
- The cost of diabetes treatment ranges from $28 – $5,111, with an average of $556
- If physicians treat lower-risk diabetic patients and receive the average payment, they would mostly likely be overcompensated
- By comparison, physicians who treat higher-risk diabetic patients would be left largely uncompensated for treating those patients if they receive the average amount

Risk adjustment is a method to fix this issue. Payment will accurately reflect the risk represented based on the severity of the patient's condition. Clinical documentation and accurate coding are critical to appropriately assess risk and ensure proper payment.

Source: American Medical Association, "Evaluating and Negotiating Emerging Payment Options," 2012

ICD-10 Coding & Analytics Intervention Strategies

Prospective risk analytics based on medical coding help decide which intervention strategy will work best on a patient-by-patient basis



Importance of Annual Wellness Visits

- Provides the ability to effectively assess your patients' chronic conditions, as well as close care and coding gaps for Medicare Advantage patients
- Covered at 100%, **once every 12 months**, for Medicare Advantage patients
- Quality
  - Assess and capture outstanding Star Rating Care Gaps for value-based contract performance and better patient outcomes
- Risk Adjustment
  - Greater appointment time allotment for comprehensive assessment and care planning for chronic conditions

Coding for Annual Wellness Visits

G0438: Annual Wellness Visit, Initial Annual Wellness Visit, including a personalized prevention plan of service (PPPS), *first visit*

G0439: Annual Wellness Visit, Subsequent (AWV) Annual Wellness Visit, including a personalized prevention plan of service (PPPS), *subsequent visit*

ICD-10: V70.0, routine general medical examination

Annual Wellness Visits can be for either new or established patients as the code does not differentiate

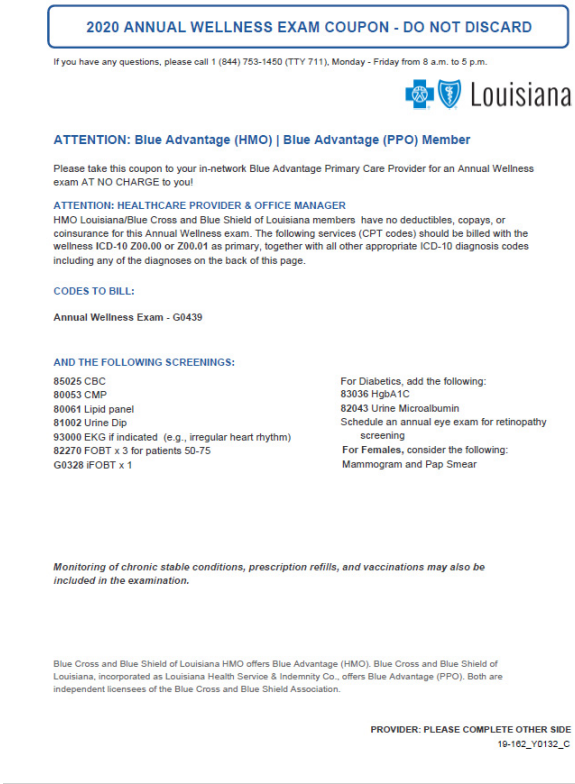
What is included in an initial AWV with PPPS?

- Medical and family history
- List of current medical providers
- Height, weight, BMI, BP and other appropriate routine measurements
- Detection of cognitive impairment
- Review risk factors and functional ability
- Establish a written screening schedule for next 5-10 years
- Establish list of risk factors
- Provide advice and referrals to health education and preventative counseling services
- Other elements as determined by the Secretary of Health and Human Services

Blue Advantage Annual Wellness Coupon Program

- Blue Advantage members will receive a paper coupon in the mail as part of our Annual Wellness Coupon Program
- The coupons are for the patient's annual wellness exam, which should be provided by a primary care provider
- The current coupon program is limited to only Blue Advantage members

What will the coupon look like?



2020 ANNUAL WELLNESS EXAM COUPON - DO NOT DISCARD

If you have any questions, please call 1 (844) 753-1450 (TTY 711), Monday - Friday from 8 a.m. to 5 p.m.

Louisiana

ATTENTION: Blue Advantage (HMO) | Blue Advantage (PPO) Member

Please take this coupon to your in-network Blue Advantage Primary Care Provider for an Annual Wellness exam AT NO CHARGE to you!

ATTENTION: HEALTHCARE PROVIDER & OFFICE MANAGER

HMO Louisiana/Blue Cross and Blue Shield of Louisiana members have no deductibles, copays, or coinsurance for this Annual Wellness exam. The following services (CPT codes) should be billed with the wellness ICD-10 **Z00.00** or **Z00.01** as primary, together with all other appropriate ICD-10 diagnosis codes including any of the diagnoses on the back of this page.

CODES TO BILL:

Annual Wellness Exam - G0439

AND THE FOLLOWING SCREENINGS:

85025 CBC
80053 CMP
80061 Lipid panel
81002 Urine Dip
93000 EKG if indicated (e.g., irregular heart rhythm)
82270 FOBT x 3 for patients 50-75
G0328 iFOBT x 1

For Diabetics, add the following:
83036 HgbA1C
82043 Urine Microalbumin
Schedule an annual eye exam for retinopathy screening
For Females, consider the following:
Mammogram and Pap Smear

Monitoring of chronic stable conditions, prescription refills, and vaccinations may also be included in the examination.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

PROVIDER: PLEASE COMPLETE OTHER SIDE
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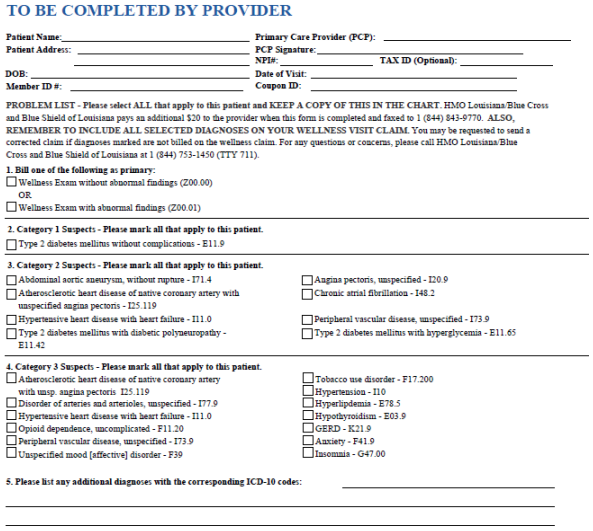
Front



TO BE COMPLETED BY PROVIDER

Patient Name: _____ **Primary Care Provider (PCP):** _____
Patient Address: _____ **PCP Signature:** _____
_____ **NPI#:** _____ **TAX ID (Optional):** _____
DOB: _____ **Date of Visit:** _____
Member ID #: _____ **Coupon ID:** _____

PROBLEM LIST - Please select ALL that apply to this patient and KEEP A COPY OF THIS IN THE CHART. HMO Louisiana/Blue Cross and Blue Shield of Louisiana pays an additional $20 to the provider when this form is completed and faxed to 1 (844) 843-9770. **ALSO, REMEMBER TO INCLUDE ALL SELECTED DIAGNOSES ON YOUR WELLNESS VISIT CLAIM.** You may be requested to send a corrected claim if diagnoses marked are not billed on the wellness claim. For any questions or concerns, please call HMO Louisiana/Blue Cross and Blue Shield of Louisiana at 1 (844) 753-1450 (TTY 711).

1. Bill one of the following as primary:
☐ Wellness Exam without abnormal findings (Z00.00)
OR
☐ Wellness Exam with abnormal findings (Z00.01)

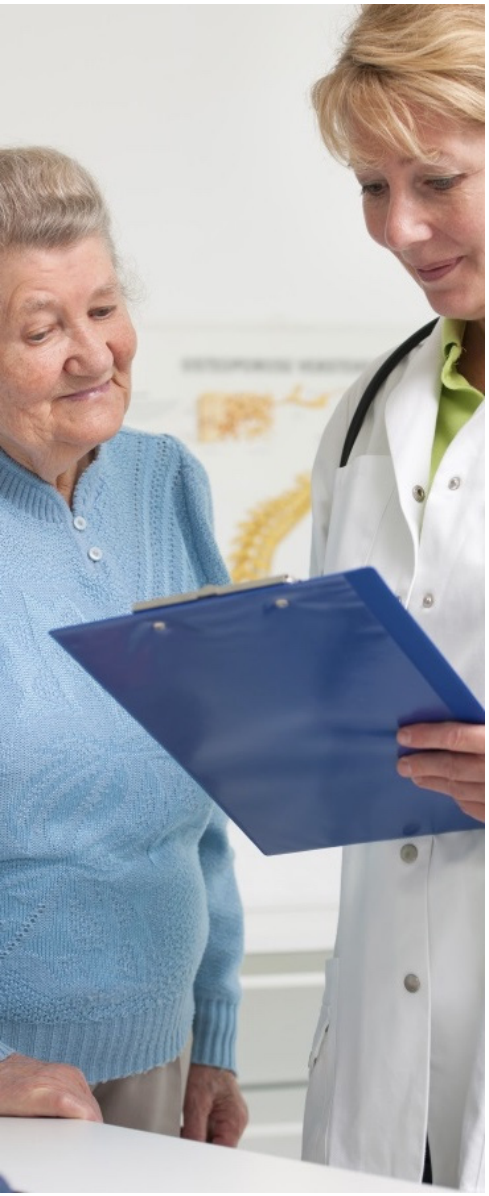
2. Category 1 Suspects - Please mark all that apply to this patient.
☐ Type 2 diabetes mellitus without complications - E11.9

3. Category 2 Suspects - Please mark all that apply to this patient.
☐ Abdominal aortic aneurysm, without rupture - I71.4
☐ Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris - I25.119
☐ Hypertensive heart disease with heart failure - I11.0
☐ Type 2 diabetes mellitus with diabetic polyneuropathy - E11.42
☐ Angina pectoris, unspecified - I20.9
☐ Chronic atrial fibrillation - I48.2
☐ Peripheral vascular disease, unspecified - I73.9
☐ Type 2 diabetes mellitus with hyperglycemia - E11.65

4. Category 3 Suspects - Please mark all that apply to this patient.
☐ Atherosclerotic heart disease of native coronary artery with unsp. angina pectoris I25.119
☐ Disorder of arteries and arterioles, unspecified - I77.9
☐ Hypertensive heart disease with heart failure - I11.0
☐ Opioid dependence, uncomplicated - F11.20
☐ Peripheral vascular disease, unspecified - I73.9
☐ Unspecified mood [affective] disorder - F39
☐ Tobacco use disorder - F17.200
☐ Hypertension - I10
☐ Hyperlipidemia - E78.5
☐ Hypothyroidism - E03.9
☐ GERD - K21.9
☐ Anxiety - F41.9
☐ Insomnia - G47.00

5. Please list any additional diagnoses with the corresponding ICD-10 codes: _____

Back



What are the goals of the program?

To help facilitate wellness visits by providing the patient's primary care provider with:

- Pertinent details about the patient's previously documented chronic conditions/current diagnoses
- Relevant clinical tests for the patient
- Commonly overlooked conditions/diagnoses that may be applicable to the patient
- Suspected conditions based on claims history

What are Diagnosis Categories?

Diagnosis categories are provided to allow easy reference and visibility during the wellness visit. The categories are listed below:

Category 1

Includes diagnoses that have been previously submitted on claims

Category 2

Includes diagnoses that are possible, given the patient's claims history

Category 3

Includes commonly overlooked diagnoses

What should providers do when they receive a coupon?

- Review and complete the back of the coupon at the visit, marking appropriate diagnoses and adding notes as applicable. As with a standard claim, the diagnoses and clinical values should also be documented on the claim and on the provider's electronic medical record.
- Sign the coupon to attest to the accuracy of the notes and diagnoses, then fax the completed coupon to **1-844-843-9770**

Providers will be compensated $20 per coupon for the additional administrative work associated with documentation and billing

What if the Patient loses their coupon or needs an extra copy?

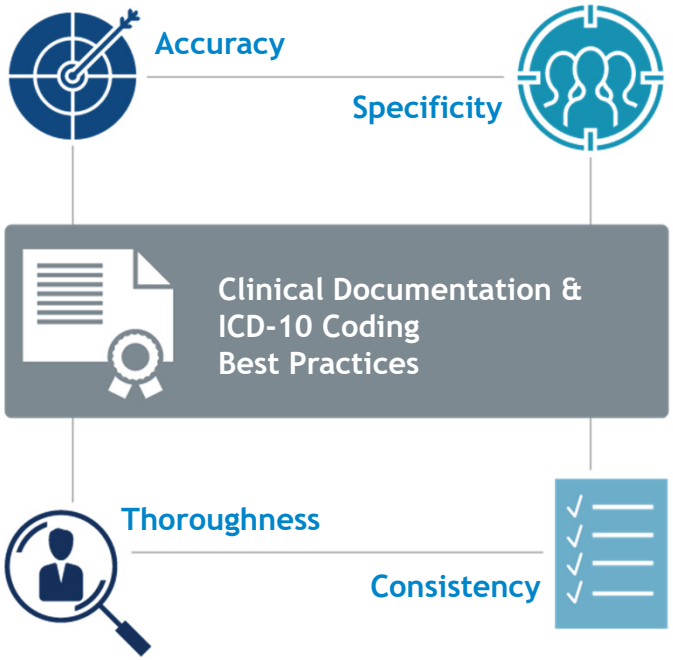
- Coupons are personalized and unique to each patient. Only the customized coupons that are received by patients will be processed (not photocopied coupons). Duplicated coupons will not be accepted.
- Copies may be requested by calling **1-844-753-1450**

Diving Into Risk Coding and Documentation

Complete and Accurate Clinical Documentation & ICD-10 Coding

Best Practices in Medical Record Documentation

- Documentation needs to be sufficient to support and substantiate coding for claims or encounter data
- Diagnoses cannot be inferred from physician orders, nursing notes or lab/diagnostic test results; diagnoses need to be in the medical record
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., leg amputation and/or transplant status must be reported each year)
- Include condition specificity where required to explain severity of illness, stage or progression (e.g., staging of chronic kidney disease)
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented



Documenting Past Medical History (PMH)

- Historically, clinical documentation stating “history of” and notation of a current chronic condition/treatment was standard practice for providers whether there was current treatment or not
- Complexities in risk adjustment documentation, coding and ICD-10 validation audits have begun to require new best practices in clinical documentation
- Conditions documented as “history of” or listed under “PMH” should be reserved for resolved conditions that are under no active treatment
- Some examples include a history of a myocardial infarction (MI) or history of a cerebrovascular accident (CVA)

MEAT vs TAMPER

A well-documented progress note would include the HPI, ROS, and physical exam, as well as show the medical decision-making process. Each diagnosis must be documented in an assessment and care plan, showing that the provider is **M**onitoring, **E**valuating, **A**ssessing/addressing or **T**reating the condition:

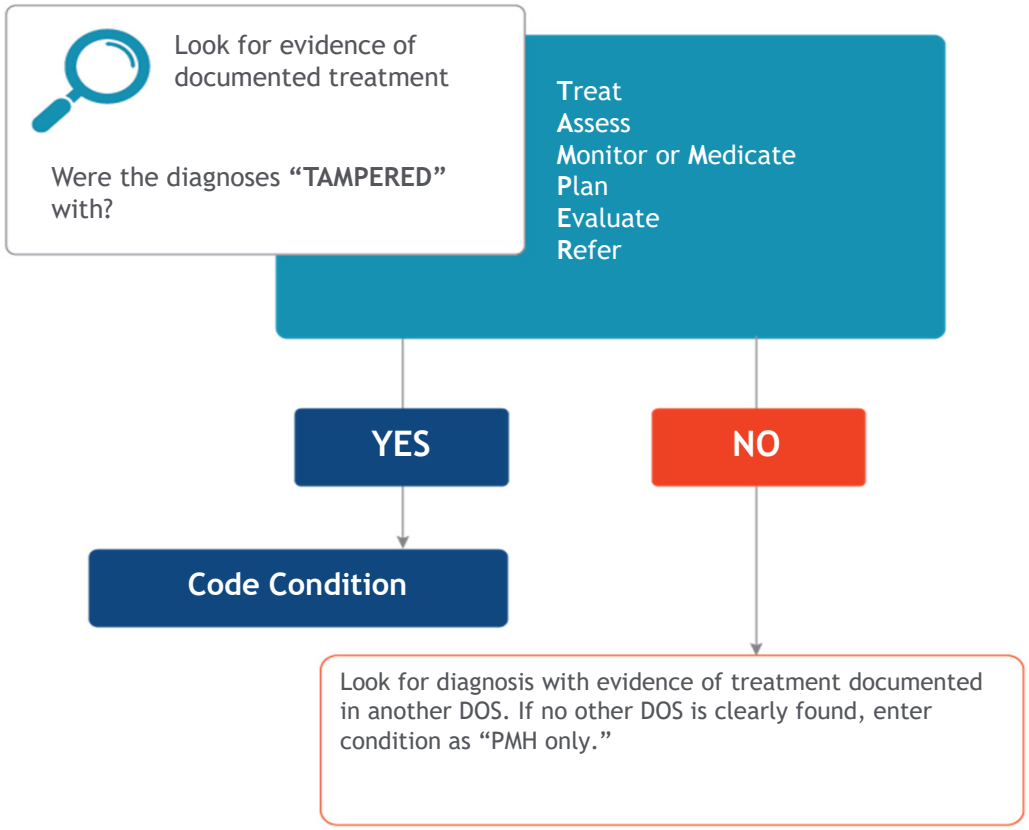
MEAT is an acronym for:

M: Monitor—signs, symptoms, disease progression, disease regression
E: Evaluate—test results, medication effectiveness, response to treatment
A: Assess/Address—ordering tests, discussion, review records, counseling
T: Treat—medications, therapies, other modalities

These four factors help providers establish the presence of a diagnosis during an encounter and ensure proper documentation

An assessment and care plan for each diagnosis must be documented and show support that the provider is treating, assessing, monitoring or medicating, establishing a plan, evaluating the condition and/or referring the patient (TAMPER™). A simple list of diagnoses are not acceptable or valid per official coding guidelines, nor does a simple list meet the definition of an assessment or plan.

MEAT vs TAMPER



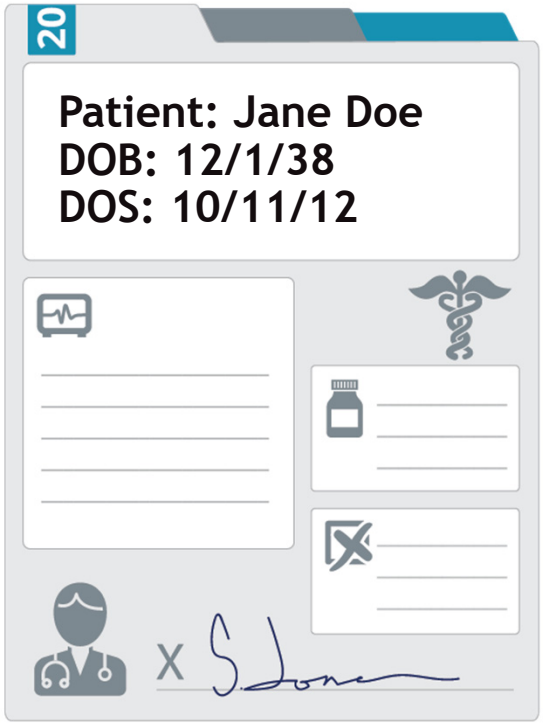
Top 10 Risk Adjustment Clinical Documentation & Coding Errors

1. **The medical record does not contain a legible signature with credentials.** Sign documentation and include the patient's name, date of birth and date of service on every page of the assessment form.
2. **The electronic health record (EHR) was unauthenticated** (not electronically signed)
3. **The highest degree of specificity was not assigned the most precise ICD-10 code** to fully explain the narrative description of the symptom or diagnosis in the medical chart
4. **A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record.** If the record indicates depression, NOS (F32.9 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter claim is major depression (F32.0-F32.5 major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.

Top 10 Risk Adjustment Clinical Documentation & Coding Errors

5. **Documentation does not indicate** the diagnoses are being **treated, assessed, monitored or medicated, planned, evaluated or referred (TAMPER™)**
6. **Chronic conditions,** such as hepatitis or renal insufficiency, are not documented as chronic
7. **Lack of** specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia)
8. **Chronic conditions or status codes aren't documented** in the medical record at least once per year
9. **Status of cancer is unclear.** Treatment is not documented.
10. **A link or cause relationship is missing,** or there is a failure to report a mandatory manifestation code

Medicare Advantage Risk Adjustment Case Example



Patient is a 72-year-old female with Urinary Tract Infection symptoms. Patient complains of fatigue, low energy and poor appetite. Patient status is Post-Myocardial Infarction, 18 months ago. Patient appears frail and with mild malnutrition. Has lost 23 pounds in the last four months. Patient has been complaining of pain with urination, weakness, and has had dry, itchy skin for the past several months. Urinanalysis done today shows white blood cells, leukocyte esterase, and microalbuminuria. Serum creatinine is 1.5.

PMH: Type II diabetes, chronic kidney disease secondary to diabetes, history of below knee amputation, skin intact at stump, no erythema, history of Myocardial Infarction. Previous Urinary Tract Infection four months ago with a serum creatinine of 1.6. Lab results at that time revealed stage two chronic kidney disease.

A/P: Diabetes-Metformin 500 mg twice a day, Bactrim for Urinary Tract Infection. Malnutrition- Ensure twice a day. and nutrition consult. Return to clinic in six weeks. Referral made to Dr. Navar (Nephrologist) for Chronic Kidney Disease.

Note: Electronically signed by Steven Jones, MD 10/11/2012 0814

Medicare Advantage Risk Adjustment Case Example (Cont.)

ICD-10 CM Code	Condition	HCC
E11.9	Type II DM W/O Complication	19 (HCC-C)
N39.0	Urinary Tract Infection	Does not risk adjust

Coding Example 1: Typically submitted ICD-10 codes for the office visit

ICD-10 CM Code	Condition	HCC
E11.22	Type II DM with Chronic Kidney Disease	18 (HCC)
N18.2	CKD Stage II	Does not risk adjust
E44.1	Malnutrition of Mild Degree	21 (HCC)
N39.0	Urinary Tract Infection	Does not risk adjust
I25.2	Old MI/History of MI	Does not risk adjust
Z89.519	Amputation, Below Knee (BKA)	189 (HCC)

Coding Example 2: Opportunities for additional risk adjustment based on clinical documentation

Clinical Documentation & Coding: Cancer

Clinical provider training may not always align to ICD-10 coding guidelines

- Cancer is an example of conflicting clinical training and ICD-10 coding guidelines

Current Cancer

- Receiving treatment for symptoms
- Document any treatment such as chemotherapy, radiation or adjunct therapy
- Patient elects no treatment
- Code the malignant neoplasm including the affected site

History of Cancer

- Report “personal history of malignant neoplasm”
- If a patient’s presenting problem, signs or symptoms may be related to the cancer history or if the cancer history impacts the plan of care, report history of malignant neoplasm

Clinical Documentation & Coding: Cancer

Clinical Documentation	Current or History of?	ICD-10
82-year-old woman S/P mastectomy for breast cancer, on Tamoxifen	Current	C50.919
Prostate cancer on Lupron	Current	C61
History of Dukes A colon cancer, no recurrence, no current treatment	History of	Z85.038
Personal history of malignant neoplasm, kidney	History of	Z85.528

Clinical Documentation & Coding: Major Depression (MDD)

- Marked persistent depressed mood lasting at least two weeks
- Symptoms must cause the patient significant impairment and not be due to substance abuse, other medical conditions, recent death/grieving or another more appropriate condition (i.e., schizophrenia)
- Additionally, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) lists several criteria that must be met:
  - Loss of interest in everyday activities
  - Depressed mood
  - Significant weight loss or weight gain
  - Psychomotor agitation
  - Insomnia or hypersomnia
  - Fatigue or loss of energy
  - Feelings of worthlessness or guilt
  - Inability to think or concentrate
  - Thoughts of death or suicide

Incorporating the Patient Health Questionnaire (PHQ-9) into your patient depression screening activities will bring ease to scoring the severity of depression

Clinical Documentation & Coding: Major Depression (MDD) (Cont.)

Coding for Major Depression (MDD)

- In ICD-10, codes to indicate major depressive disorder, single episode, are found in category F32
- ICD-10 code category F33 (HCC 59) indicates major depressive disorder, recurrent
- Both of these codes require fourth digits to indicate the severity or provide remission status
- Sub-category F33.4- requires a fifth digit to provide additional detail regarding full or partial remission status

Complete and accurate clinical documentation is critical to code to the highest degree of specificity for depression

Clinical Documentation & Coding: Morbid Obesity and Malnutrition

Clinical documentation of the BMI value **in addition to** the provider documenting that the patient is morbidly obese or malnourished is required to code for these conditions

The medical record must **ALSO** include a treatment plan for the conditions to support the ICD-10 code submission

Morbid Obesity BMI Value Requirements

- BMI value must be 40% or greater
- Patient is 100 pounds or more above their ideal body weight
- The patient has a BMI of 35% or greater **AND** one or more comorbidity

Morbid Obesity

- For correct coding, documentation should include:
  - Severity: Overweight, obese or morbidly obese
  - Contributing Factors: Excessive calories or drug induced
  - Association: Pregnancy
  - Symptoms/Findings/Manifestations: BMI or alveolar hypoventilation
  - Treatment plan: Increase exercise, reduce caloric intake, walk every day, referral to nutritionist, etc.

E66.01: Morbid (severe) obesity due to excess calories

E66.2: Morbid (severe) obesity with alveolar hypoventilation

Clinical Documentation & Coding: Morbid Obesity & Malnutrition (Cont.)

Malnutrition BMI Value Requirements

- BMI must be 19% or less
- Low body weight: less than 80% of ideal weight
- Significant weight loss from baseline
- 2% decrease in one month
- 5% decrease in three months
- 10% decrease in six months
- Calf circumference of less than 31 cm

Malnutrition Documentation Requirements

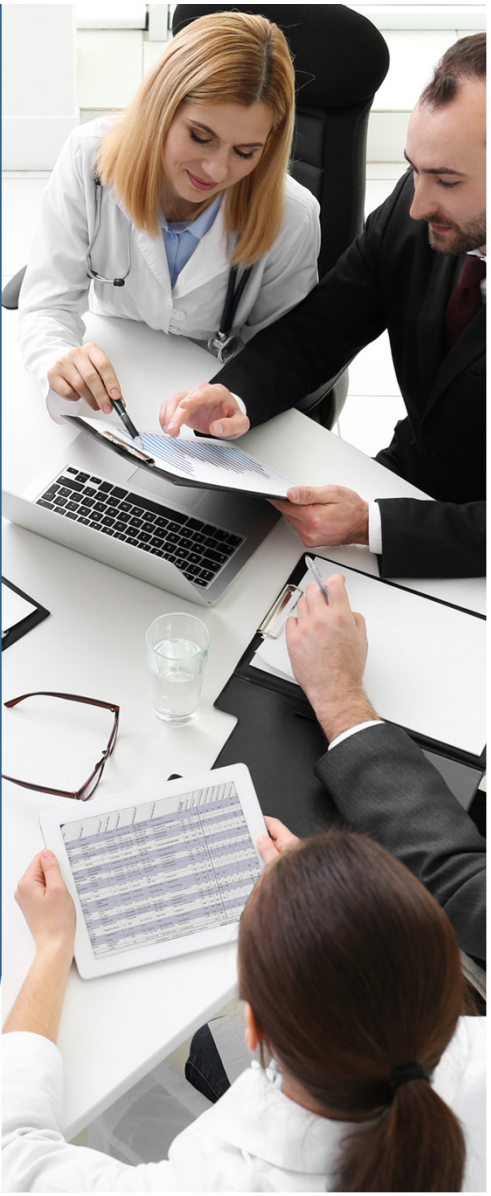
- Clinical manifestations of asthenia, anorexia, early satiety, nausea, significant loss of body fat, muscle and other components
- Notation of sunken temporal fossae, cheeks and loose-fitting dentures due to gum atrophy
- Treatment Plan: Increase caloric intake, high calorie shakes incorporated into diet, referral to nutritionist, etc.

Clinical Documentation & Coding: Morbid Obesity & Malnutrition (Cont.)

Malnutrition ICD-10 Coding Options

Diagnosis / Documentation / Terms	Code
Kwashiorkor	E40
Emaciation (due to malnutrition) – unspecified (codes to nutritional marasmus)	E41
Malnutrition – severe pro-cal intermediate form (codes to marasmic kwashiorkor)	E42
Marasmic kwashiorkor	E42
Malnutrition – severe protein-calorie / protein-energy	E43
Starvation edema	E43
Malnutrition – moderate protein-calorie	E44
Malnutrition – moderate protein-energy	E44
Malnutrition – mild protein-calorie	E44.1

Diagnosis / Documentation / Terms	Code
Malnutrition – mild protein-energy	E44.1
Malnutrition – unspecified	E46
Malnutrition – protein-calorie, unspecified	E46
Protein-calorie or protein-energy imbalance	E46
Weight loss	R63.4
Underweight with BMI 19 or less	R63.8
Failure to thrive (child)	R62.51
Failure to thrive (adult)	R62.7



Medical Record Review and Audit

- Retrospective and value-based provider audits are performed to review provider coding practices and proactively identify both deficiencies and opportunities where Blue Cross and Blue Shield of Louisiana can provide effective feedback and education to the provider group
- The goal of these audits is to validate that all risk conditions applicable to the patient are captured within the progress notes along with assessment and treatment options for each
- This review and audit process ensures compliance with the Centers for Medicare and Medicaid (CMS) and the U.S. Department of Health and Human Services (HHS) Risk Adjustment Data Validation (RADV) requirements by verifying diagnosis codes previously submitted to CMS and/or HHS via claims data
- If diagnosis codes previously submitted are not supported in the medical record, the required corrections must be submitted to CMS and/or HHS accordingly

Questions?

If you have additional questions about Risk Adjustment after this webinar, please email Mia Bell at mia.bell@bcbsla.com or Taylor Lawrence at taylor.lawrence2@bcbsla.com. Include "BA Risk Adjustment" in the subject line.