ICD-9 Documentation and Coding – Impact on HCC

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• Agenda:
  ICD-9 general documentation guidelines
  What are HCC’s

• HCC Initiatives for Provider Groups
  How your EMR can help
YOU CAN’T BILL FOR WHAT IS DONE……..

YOU CAN ONLY BILL FOR WHAT IS DOCUMENTED!
Importance of Coding Accurately

Inaccurate coding can have the following negative results:

- Reduced revenues for risk based payment models
- Risk of audit for retrospective data capture
- Inaccurate profiling

- “Fallout” Diagnoses – A diagnosis that was reported on a claim one year, and “fell off” the following year
  - Chronic conditions that should follow a patient
  - Get on claim at least once per year (Annual Physical?)
  - CMS audits target these conditions
ICD-9 General Documentation Guidelines

Code to the highest level of specificity

• Be aware of 4th and 5th digit requirements!

  Example: Multiple sclerosis – 340
  Influenza - 487.1
  Pulmonary Embolism – 415.19

Only Code Confirmed Diagnoses

• If a confirmed diagnosis cannot be made, code the presenting signs/symptoms

• If a sign/symptom is routinely associated with a disease process, do not code separately

10/7/2014
ICD-9 General Documentation Guidelines

**Code all conditions managed on that visit**

- Co-morbid conditions should be captured on the billing sheet if managed on that day, or if they are documented in the medical record as having an impact on any other conditions that are managed on that day.
  - Considering medication interaction
  - Adjusting medications
  - Taking consideration of condition when treating presenting illness
  - It proves severity of illness and projects complete picture of work involved by provider
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**Etiology/Manifestation Codes**

Certain conditions have both an underlying etiology and body system manifestation due to the etiology

- The underlying condition is sequenced first on a claim
- The manifestation is sequenced second on a claim
- Notes in the coding book may state “use additional code”, “code first”, “in diseases classified elsewhere”

**Most Common is DIABETES**

- Diabetes – 250 category
- 4th digit indicates whether with complications
ETIOLOGY/MANIFESTATION - EXAMPLE

Examples:
- Diabetes Unspecified = 250.00
- Diabetic Nephropathy = 250.40
- Diabetic Retinopathy = 250.50
- Diabetic Neuropathy = 250.60
- Diabetic PVD = 250.70

• You may use more than one primary diabetes code if there is documentation to support the diagnosis.
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• In addition to coding the diabetes level of complexity, each complication should be coded separately if there is documentation to support the diagnosis.

Examples:  Diabetic PVD = 250.70
           PVD =               443.9

           Diabetic Retinopathy = 250.50
           Proliferative Retinopathy = 362.02

           Diabetic Neuropathy – 250.60
           Neuropathy in Diabetes – 357.2
ICD-9 General Documentation Guidelines

Status codes

Providers are often unaware that there are status codes to identify when a significant medical event occurred in the past that can impact current medical care.

<table>
<thead>
<tr>
<th>Status</th>
<th>Dx Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Limb Amputation</td>
<td>V49.70-V49.77</td>
</tr>
<tr>
<td>Status current “ostomy”</td>
<td>V44.1-V55.9</td>
</tr>
<tr>
<td>Transplant</td>
<td>V42.1-V43.2</td>
</tr>
<tr>
<td>Dialysis</td>
<td>V45.11</td>
</tr>
</tbody>
</table>
HCC Defined

• Hierarchical Condition Categories (HCC)

• 100% risk adjusted payment model for Medicare Advantage members

• Based on clinical conditions

• All conditions are placed into hierarchical categories and a final risk score is calculated for each member

• Accurate diagnosis documentation and reporting now determines reimbursement

• Higher reimbursement for less healthy members; lesser reimbursement for more healthy members
Why HCC?

- Mandated by the Balanced Budget Act of 1997
- Previous reimbursement methodology was based solely on demographic information
- CMS believes risk adjustment pays more accurately based on predicted health costs by adjusting payments based on health status
Data Sources for HCC

- Inpatient Data
- Hospital Outpatient Data
- Outpatient office data
  (Face-to-Face billable provider visit data)

Exclusions:
- Lab, Radiology, Ambulance, DME, Prosthetics, Orthotics, and AS
HCC Breakdown

- 79 disease categories (chronic)
- 3,200 diagnoses
- “Predictive Model”
  - 2014 payment based on CY2013 encounter data
- If no encounter data is submitted in 2013 = minimum payment for that member in 2014
## How much does it matter?

<table>
<thead>
<tr>
<th>HCC</th>
<th>Code</th>
<th>Description</th>
<th>2013 Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC 19</td>
<td>250.00</td>
<td>Diabetes with no complications</td>
<td>0.200</td>
</tr>
<tr>
<td>HCC 18</td>
<td>250.5X</td>
<td>D. w/ophthalmic manifestations</td>
<td>0.343</td>
</tr>
<tr>
<td>HCC 17</td>
<td>250.1X-3X</td>
<td>D. w/acute complications</td>
<td>0.391</td>
</tr>
<tr>
<td>HCC 16</td>
<td>250.6X</td>
<td>D. w/neurologic manifestations</td>
<td>0.552</td>
</tr>
<tr>
<td>HCC 15</td>
<td>250.4X</td>
<td>D. w/renal or peripheral circulatory manifestations</td>
<td>0.764</td>
</tr>
</tbody>
</table>

Note: Some categories have a hierarchy, (such as diabetes) in such categories, only the highest HCC would count.
HCC Initiatives for Provider Groups

• Properly reflect Medicare Advantage member’s health status

• Fully assess all chronic conditions at least annually

• Thoroughly document all conditions evaluated each visit in medical record

• Code to highest level of specificity and fully utilize the ICD-9 Diagnosis Coding System in claims submission
HCC Initiatives for Provider Groups

Areas of Focus:

• Fallout Diagnoses
• Status Codes
• Unspecified Diabetics
• Morbidly Obese patients
How Your EMR Can Help

Keep problem lists updated
• As new conditions arise or as problems are resolved, make sure the list is current to avoid discrepancies in documentation

Create pick lists and alerts
• Search terms such as “status code” can be created so all codes pop up when entered in search field
• Alerts can be created that prompt the provider to select a secondary code or more specific code choice before moving on to next screen/signing off

Example: “ALERT! Code 250.00 is a non-specific code choice! Use more specific diabetes code if complication or comorbidity exists.”
How Your EMR Can Help

Link the problem list with the Assessment and Plan

• Cause and effect relationships can be created
  If old MI in problem list, automatically assign code when CAD stated in assessment and plan

If status amputation leg in problem list, automatically assign code when PVD stated in assessment and plan

If status dialysis in problem list, automatically assign code when CKD stated in assessment and plan