HCC Coding Educational Update and PPR Meeting
CMS Model Changes V24 to V28

Presented by

Beth St. Laurent, LPN, CPC, CRC, CPMA - Team Coordinator Risk Adjustment Coders
&
Stephanie Zeiber, MPA, PA-C – Manager Risk Adjustment Programs, SASD

Guest Speakers

Dean Ratzlaff - Director – Actuary/Revenue Management
&
Lisa Garrett, RN, MSHA, CPC, CPC-I, CPC-P, CRC - Director, Revenue Management Sentara Health Plans

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October 17, 2023

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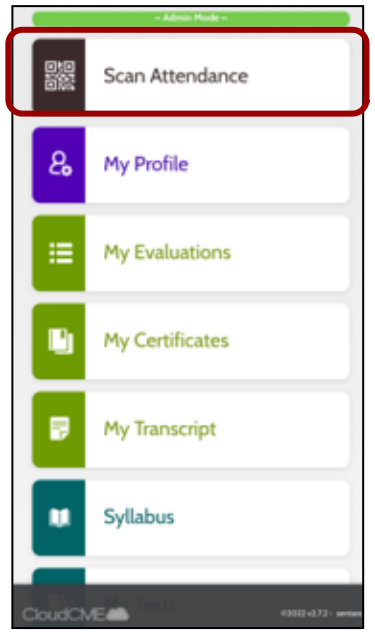
Instructions for tracking Attendance in CloudCME platform

QR Code Via Mobile App – specific to each month's presentation

Text code – specific to each month's presentation



1. **Via mobile app** – in your browser search CloudCME® check in or CloudCME® mobile app and download to your Apple or Android device(s) to access the Check-in menu and scan a QR code.

Link to CloudCME website

Sentara Healthcare Continuing Medical Education Continuing Education (cloud-cme.com)

Each month a code will be given at the start of the meeting so you can text your attendance to CloudCME

Text 12618 to

(844) 626-0992

2. **Via text message** – A distinct code will be provided for each Live activity. ***If this is the first time you are texting your attendance, you must first pair your mobile number to your account.** Text your email address to: **(844) 626-0992**. You will receive a text notification indicating your phone number has been updated. Once your account is paired to your mobile number and you have obtained the event code, send the code via text to 1-844-626-0992

Please note, attendance can only be recorded 60 mins. prior to the activity start time, during the activity, and up to 120 minutes after the activity closes – you will have 2 weeks to complete the evaluation and claim CME credit.

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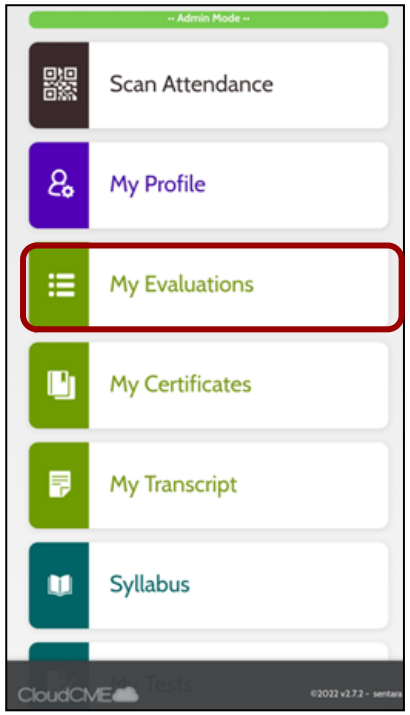
Instructions for Claiming CME certificate in CloudCME platform

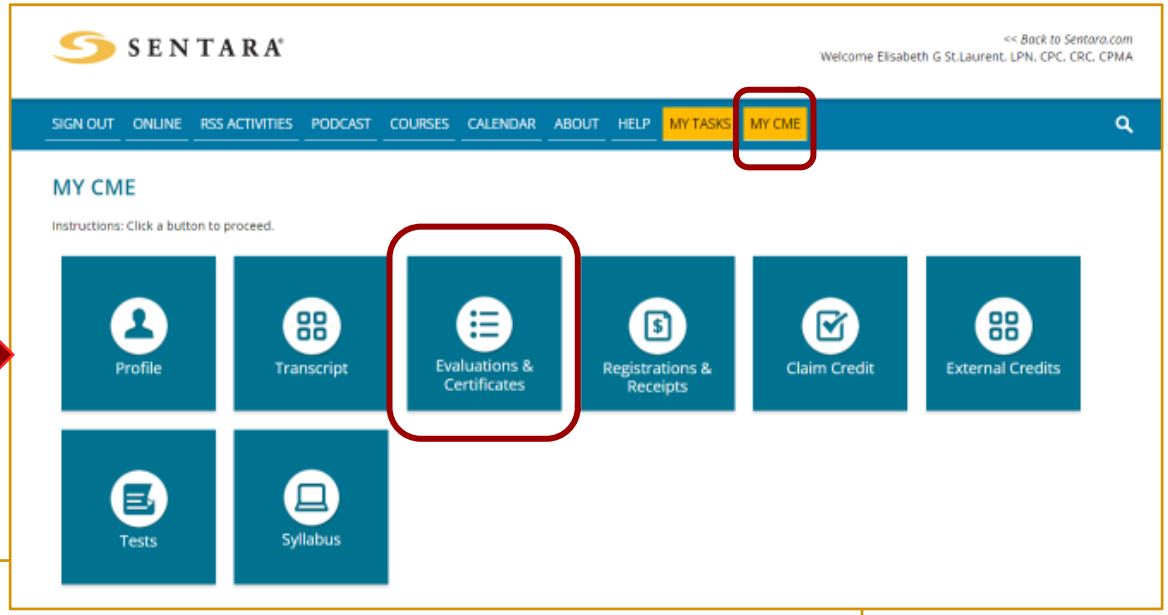
Via Mobile App

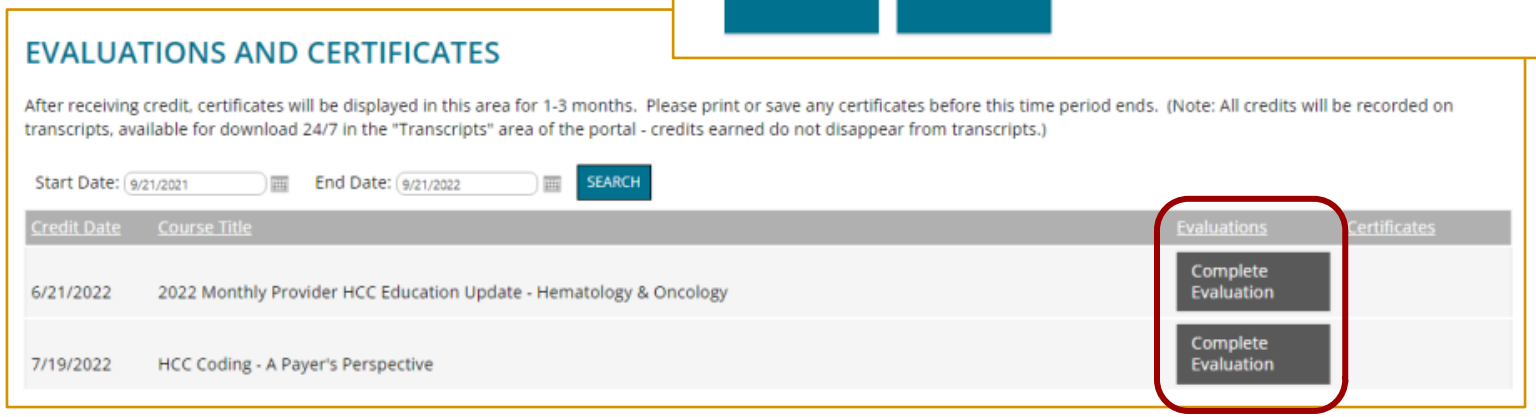


Not all Boards accept internal transcripts for CME credit

You MUST complete the evaluation in order to receive your CME Certificate!!!

Via Desktop Site





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Link to CloudCME website

Sentara Healthcare Continuing Medical Education Continuing Education (cloud-cme.com)

Objectives

1. Understand the importance of HCC coding in value-based care models.
2. Review updated HCC performance data
3. Discuss CMS upcoming HCC Model Changes
4. Understand the Importance of specificity in the New V28 model with coding and documentation examples
5. Recognize Compliance regulations for appropriate coding and documentation.
6. Apply knowledge in supporting applicable HCC codes within case scenarios/Questions.

Hampton Roads Region

ALL patients 18+

Practice	Avg Coded RAF MEDICARE	% Coded RAF MEDICARE	Avg Coded RAF OTHER	% Coded RAF OTHER
APS Family & Internal Medicine Physicians – Edenton	0.64	96%	0.35	91%
SMG Comprehensive Care - Fort Norfolk	1.44	96%	0.95	97%
SFMP-WAKEFIELD	0.77	94%	0.31	73%
DEDICATED CARE CENTER	0.82	94%	0.43	87%
SFMP-CHIMNEY HILL	0.78	92%	0.34	85%
SIMP-FORT NORFOLK	0.71	92%	0.35	86%
Senior Health Services	1.71	91%	1.24	72%
SMG FM GREENBRIER	0.88	91%	0.37	85%
SIMP-WARDS CORNER	0.97	91%	0.45	83%
SFMP-THOROUGHGOOD	0.76	91%	0.28	80%
APS Family Medicine Physicians - N. Road	0.65	90%	0.28	80%
SFMP-FORT NORFOLK	0.77	90%	0.31	80%
SFMP- SUFFOLK	0.77	90%	0.32	78%
SFIMP-YORKTOWN	0.76	90%	0.28	78%
SFMP-NEW TOWN	0.64	90%	0.26	79%
SFMP-OLD HAMPTON	0.93	88%	0.37	78%
SFMP-LITTLE NECK	0.76	88%	0.27	72%
SFMPP EDINBURGH	0.79	88%	0.22	67%
SFMP-BELLE HARBOUR	0.73	87%	0.29	77%
SIMP- DOWNTOWN SUFFOLK	1.05	87%	0.55	78%
SFMP-FIRST COLONIAL	0.67	87%	0.25	75%
SFMP-DUMFRIES	0.61	86%	0.21	73%
SFMP-1950 PRINCESS ANNE	0.73	86%	0.21	71%
SIMP-NEW TOWN	0.69	85%	0.39	82%
SIMP-WOODBRIDGE	0.63	85%	0.23	79%

Practice	Avg Coded RAF MEDICARE	% Coded RAF MEDICARE	Avg Coded RAF OTHER	% Coded RAF OTHER
SIMP-CHESAPEAKE SQUARE	0.72	85%	0.30	78%
SIMP-KINGSMILL	0.68	85%	0.28	76%
SIMP-PORT WARWICK	0.76	85%	0.33	72%
SFMP-GLOUCESTER	0.63	84%	0.27	68%
SFMP-APS ELIZABETH CITY	0.76	84%	0.34	74%
SFMP-INDEPENDENCE	0.71	84%	0.23	67%
SFMP-PORT WARWICK	0.77	83%	0.29	72%
SFMP-NIMMO	0.63	83%	0.20	72%
SFIMP-WOODBRIDGE	0.64	83%	0.20	74%
SENTARA HOSP MED PHYS-SPAH	1.27	82%	0.10	45%
SFMP-WESLEYAN	0.69	82%	0.26	72%
SFIMP - SOUTH NORFOLK	0.63	82%	0.11	46%
SFMP-PROVIDENCE ROAD	0.76	82%	0.28	71%
SFMP-ST LUKES	0.76	82%	0.33	74%
SFMP-OCEANFRONT	0.66	81%	0.19	59%
SIMP-KEMPSVILLE	0.73	81%	0.34	72%
SFIMP-COLISEUM	0.77	81%	0.37	75%
SFMP-1080 BLDG	0.67	80%	0.29	74%
SFMP-RIVERWALK	0.75	78%	0.27	67%
SFMP-PENINSULA TOWNE	0.67	78%	0.31	68%
APS Family & Internal Medicine Physicians – Moyock	0.70	77%	0.26	68%
SFIMP - LAKE RIDGE	0.55	77%	0.19	67%
SFIMP-WILLIAMSBURG	0.61	76%	0.27	72%
Sentara Family Internal Medicine Physician - Stafford	0.41	73%	0.19	81%
SFIMP-PRINCESS ANNE	0.69	67%	0.27	63%

SMG Avg Medicare – 85%
SMG Avg Other – 74%

SASD Avg Medicare – 85%
SASD Avg Other – 75%

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Blue Ridge Region

ALL patients 18+

Halifax

Practice	Avg Coded RAF MEDICARE	% Coded RAF MEDICARE	Avg Coded RAF OTHER	% Coded RAF OTHER
SHMG FMP HALIFAX	0.77	89%	0.44	81%
SHMG FMP VOLENS	0.75	88%	0.39	73%
SHMG FMP CLARKSVILLE	0.69	83%	0.36	78%
SHMG FMP CHASE CITY	0.64	82%	0.32	71%

Martha Jefferson

Practice	Avg Coded RAF MEDICARE	% Coded RAF MEDICARE	Avg Coded RAF OTHER	% Coded RAF OTHER
SMJMG PALMYRA MED ASSOC	0.61	90%	0.22	78%
SMJMG FAMILY MEDICINE	0.62	90%	0.21	82%
SMJMG WAYNESBORO IM	0.54	88%	0.25	76%
SMJMG AFTON FAM MED	0.57	87%	0.22	75%
SMJMG FAM MED-ALBEMARLE SQ	0.63	86%	0.23	76%
SMJMG INTERNAL MED	0.67	85%	0.23	74%
SMJMG GREENE FAM MED	0.64	83%	0.27	75%
SMJMG BLUE RIDGE IM	0.52	83%	0.16	66%
SMJMG SPRING CREEK FAM MED	0.57	80%	0.22	70%
SMJMG FOREST LAKES FAM MED	0.53	78%	0.17	69%
SMJMG CROZET FAM MED	0.53	74%	0.14	57%

Rockingham

Practice	Avg Coded RAF MEDICARE	% Coded RAF MEDICARE	Avg Coded RAF OTHER	% Coded RAF OTHER
SRMG Timber Way Health Center	0.82	90%	0.31	81%
SRMG Integrative Medicine	0.48	90%	0.20	88%
SRMG East Market Street Health Ct	0.80	88%	0.29	77%
SRMG Mt Jackson Health Center	0.66	86%	0.28	74%
SRMG South Main Health Center	0.74	83%	0.28	78%
SRMG East Rockingham Hlth Ctr	0.72	81%	0.27	69%
SRMG Primary Care Staunton	0.59	75%	0.15	57%

Medicare

SMJMG Avg – 84% ↓

SRMG Avg – 85% =

SHRH Avg - 86% ↑

Other

SMJMG Avg – 72% ↓

SRMG Avg – 76% ↑

SHRH Avg - 77% ↑

SASD Avg Medicare – 85%
SASD Avg Other – 75%

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Specialty Performance

Neurology	% Coded	HCCs Available
080_Coma_Anoxic_Damage	100.0%	56
099_Intracraial_Hemorrhage	100.0%	79
100_Ischemic_Stroke	100.0%	744
166_Severe_Head_Injury	100.0%	1
078_Parkinson_Huntington	91.8%	1152
073_ALS	84.8%	46
079_Seizure_Disorders	83.1%	2749
077_Multiple_Sclerosis	81.6%	580
052_Dementia_without_Compl	76.3%	859
051_Dementia_with_Complications	65.9%	499
074_Cerebral_Palsy	53.3%	105
075_Myasthenia_Gravis	51.4%	362
076_Muscular_Dystrophy	47.5%	40
103_Hemiplegia	40.1%	401
072_Spinal_Cord_Disorder	35.9%	674
070_Quadriplegia	28.8%	52
071_Paraplegia	28.6%	56
167_Major_Head_Injury	28.0%	483
104_Monoplegia	22.0%	59
018_Diabetes_Chronic_Complications	20.3%	883
012_BRST_PRST_CANCER	14.5%	881
108_Vascular_Disease	13.1%	1444
107_Vascular_Disease_Complications	5.7%	436
022_Morbid_Obesity	3.3%	1403
021_Malnutrition	1.0%	482
Grand Total	49.1%	14526

Palliative Care	% Coc	HCCs Availa
189_Amputation_Lower_Limb	100.0%	1
188_Artificial_Openings	77.8%	27
009_Lung_Cancer	72.2%	18
051_Dementia_with_Complications	70.0%	10
011_COLORECTAL_CANCER	63.6%	11
008_Metastatic_Cancer	60.6%	104
021_Malnutrition	45.9%	85
010_Lymphoma	45.5%	11
012_BRST_PRST_CANCER	33.3%	9
047_Disorders_of_Immunity	25.3%	87
052_Dementia_without_Compl	25.0%	8
Grand Total	49.3%	371

Behavioral Health	% Coc	HCCs Availa
059_Major_Depress_Bipol_Paran_Dis	93.1%	3,092
060_Personality_Disorders	91.5%	153
057_Schizophrenia	82.9%	222
055_Substance_Use_Disorder_with_Compl	66.6%	634
056_Substance_Use_Disorder	52.5%	99
052_Dementia_without_Compl	50.0%	26
051_Dementia_with_Complications	47.4%	19
058_Reactive_and_Unspec_Psychosis	47.0%	83
054_Substance_Use_With_Psyc_Compl	45.5%	33
021_Malnutrition	11.9%	59
022_Morbid_Obesity	4.2%	406
Grand Total	78.3%	4,826

Vascular	% Coded	HCCs Available
106_Atherosclerosis	100.0%	173
173_Traumatic_Amputations	100.0%	52
108_Vascular_Disease	79.2%	5,411
189_Amputation_Lower_Limb	66.5%	553
134_Dialysis_Status	60.5%	395
136_Chronic_Kidney_Disease_Stg5	42.0%	112
107_Vascular_Disease_Complications	39.6%	1,685
161_Chronic_Ulcer_Skin	36.8%	1,063
018_Diabetes_Chronic_Complications	27.0%	1,897
022_Morbid_Obesity	22.2%	1,511
021_Malnutrition	1.8%	1,085
Grand Total	50.9%	13,937

Primary Care BPA Utilization

Percentage of Population and Number of BestPractice Advisories by Action Taken

Between 1/1/2023 and 10/1/2023

	Percentage of Population	Number of BestPractice Advisories	All
Jan 1 – Oct 1, 2023	**100 %**	**396,512**	
Reviewed Hyperlinks	0.527 %	2,090	
Add Visit Diagnosis	26.1 %	103,321	
Inaccurate/Resolved	10.9 %	43,320	
Added to Problem List	9.3 %	36,834	
BPA Ignored - No Action Taken	66.1 %	262,237	

ICD-10 Updates and Epic HCC designation discrepancies

- **ICD-10 Updates for 2024 occurred on October 1, 2023**
- **Recent ICD-10 changes to Dx codes for greater specificity took place**
  - ***Parkinson's***
  - Certain COPD codes *(especially when combined with asthma and chronic bronchitis)*
  - SVT
  - Certain Osteoporotic Fractures
  - Stable Anginas
  - Certain Sepsis codes
- **HCC updates do not take place until Jan 1, 2024**
- **HCC designation in Epic usually happens within the 1st qtr. of the new year**

Because of the gap between the updates to ICD-10 and the Updates to the new HCC model Epic may not show the HCC designation on some codes that previously held that designation, Even though they most likely will remain HCCs.

This happens quite frequently when code changes are made, or disease groups are expanded for greater specificity (like AFIB and Aneurysms in the past)

HCC Timing: Acute Vs. Chronic

Condition	When is it Acute or Active?	When is it Chronic or Historical?	
Congestive Heart Failure (CHF)	Acute during time of exacerbation: based on symptoms, elevated BNP, and/or imaging findings	"History of" when acute exacerbation resolves IF it was not previously chronic, or Chronic if CHF was previously diagnosed and still exists.	Sometimes acute CHF will occur secondary to infection, AKI, or other cause but not remain chronic.
Respiratory Failure	Acute during initial episode of care, based on ABGs, O2 sat, and symptoms. Could be considered active **up to 3 months** if remaining newly O2-dependent.	"History of" when ABGs/O2 sat normalized and symptoms resolved or revert to Chronic if ABGs remain abnormal and/or O2 need remains 3 months after acute hospitalization or event, and it does not resolve.	Various criteria for this exist; justify reasoning within documentation. Medicare requires recertification of O2 after 3 months.
Deep Vein Thrombosis (DVT)	Acute x 6 months after initial event	"History of" after 6 months from acute event, or **Chronic if Chronic DVT shown on repeat imaging > 6 months from acute event**	**Chronic anticoagulation status doesn't justify dx of acute nor chronic DVT .**
Pulmonary Embolism (PE)	Acute at time of event, episode of care, and when symptomatic	"History of" once acute symptoms have resolved and after treatment of initial episode (i.e. in hospital), or can become **Chronic if later confirmed after repeat imaging**	**Chronic anticoagulation status doesn't justify dx of acute nor chronic PE.**
Cancer	Active when there is evidence of malignancy and/or on treatment (including adjuvant)	"History of" once resolved and no longer on treatment, ***except* blood cancers (leukemia, lymphoma, multiple myeloma) will become in remission**	Blood cancers: Leukemia, Lymphoma and Multiple Myeloma. Code as active cancer if "in remission" code does not exist (i.e. Merkel cell lymphoma)
Sepsis	Acute when sepsis criteria are actively met, during hospitalization	"History of" when resolved, post-hospitalization	Causative agent of sepsis MAY hold risk (i.e. specified pneumonias)
CVA	Acute during hospitalization and post-hospitalization SNF admission	"History of" after hospitalization/SNF stay (**resolved at hospital f/u appt**)	Code for hemiparesis as sequelae of CVA if applicable
MI	Acute x 28 days from initial event	"History of" after 28 days from occurrence	Following acute event, code for coronary artery disease (w/ specified angina type as applicable)

For all acute and resolved conditions, remove from PL or change to "history of" or "chronic" as applicable

SHP

Compliance Considerations

The skinny on Risk Adjustment Compliance

- Federal government is increasing oversight of MA Insurers
- As a result, MA Insurers may increase oversight of Providers

This is all because nationally, evidence continues to mount that taxpayers are paying billions of dollars to MA Insurers for Risk Adjustable ICD-10's not supported in medical documentation

Federal oversight of MA Insurers - 3 angles

OIG

Anthem
BCBS RI
BCBS TN
BCBS MI
BCBS OR (Regence)
CA Physicians' Service
Cariten
Cigna HealthSpring TN
Coventry
Essence
Excellus
Geisinger
HealthFirst
Highmark (BCBS)
Humana
Keystone
Peoples Health
SCAN
Tufts
UPMC
WellCare of FL

$415M

False Claims Act

More than a dozen settlements

Recently: $90M from Sutter Health & $22.4M from Martin's Point

Ongoing Cases

1. *U.S. ex rel. Osinek v. Kaiser,* No. 3:13-CV-03891 (N.D. Cal.)
2. *U.S. ex rel. Poehling v. UnitedHealth,* No. 2:16-CV-8697 (C.D. Cal.)
3. *U.S. v. Anthem,* No. 1:20-CV-02593 (S.D.N.Y.)
4. *U.S. ex rel. Ross v. Indpt. Health Assoc.,* No. 12-CV-0299 (W.D.N.Y.)
5. *U.S. ex rel. Cutler v. Cigna Corp.,* No. 17-CV-7515 (S.D.N.Y.)

RADV

Currently on pause while CMS takes care of backlog

CMS will resume in '24 or '25, validating data as far back as 2018

CMS estimates recouping $479M in 2025, and a similar amount each year thereafter

OIG audits target codes most likely to be not supported

High-Risk Group	ICD-10 Codes	Other criteria	Error Rates
Acute Stroke	I63*, I9781*, I9782*, P9182*	Diagnosis present on professional claim with place of service 11 but no claim with place of service 21 (inpatient)	94%
Acute Heart Attack	I2101-I249, I25700, I25710, I25720	Diagnosis present on professional claim with place of service 11 but no claim with place of service 21 (inpatient)	94%
Embolism	I26*, I2782, I74*, I75*, I76, I822*, I823*, I824*, I825*	Member does not have a pharmacy claim for an anticoagulant (GPI 83*) during the service year	75%
Vascular Claudication	I7021*, I7031*, I7041*, I7051*, I7061*, I7071*	Member has a pharmacy claim for an opioid, corticosteroid, or musculoskeletal therapy agent (GPI 65*, 22*, 75*) during the service year	23%
Major Depression	F32*, F33*	Member does not have a pharmacy claim for an antidepressant (GPI 58*) during the service year	20%
Lung Cancer	C34*	Member does not have a pharmacy claim for an antineoplastic (GPI 21*), a medical claim with CPT code 772*, 773*, 774*, 775*, 776*, 777*, or G60* for radiation therapy, or a medical claim with CPT code 3244*, 3248*, or 32503-32505 for surgery within six months before or after the diagnosis	92%
Breast Cancer	C50*	Member does not have a pharmacy claim for an antineoplastic (GPI 21*), a medical claim with CPT code 772*, 773*, 774*, 775*, 776*, 777*, or G60* for radiation therapy, or a medical claim with CPT code 19300 -19307 for surgery within six months before or after the diagnosis	98%
Colon Cancer	C18*, C19	Member does not have a pharmacy claim for an antineoplastic (GPI 21*), a medical claim with CPT code 772*, 773*, 774*, 775*, 776*, 777*, or G60* for radiation therapy, or a medical claim with CPT code 44140 -44160 or 44204-44212 for surgery within six months before or after the diagnosis	94%
Prostate Cancer	C61	Member does not have a pharmacy claim for an antineoplastic (GPI 21*), a medical claim with CPT code 772*, 773*, 774*, 775*, 776*, 777*, or G60* for radiation therapy, or a medical claim with CPT code 55801 -55865, 53850-53854, or 0655T for surgery within six months before or after the diagnosis	93%

MA Insurers may increase Provider oversight

MA insurers must monitor data received from providers and submitted to CMS. They must establish and implement an effective system for routine monitoring and identification of compliance risks

-42 CFR § 422.503(b)(4)(vi)

MA organizations may include in their contracts with providers, physicians, and other practitioners, provisions that require submission of complete and accurate risk adjustment data. These provisions may include financial penalties for failure to submit complete data.

- 42 CFR §§ 422.310.d.4

Sentara Health Plan does not currently apply either of these tools

Sentara

Risk Adjustment Compliance at Sentara

Both Sentara Health Plan and SASD are taking steps to develop risk adjustment compliance programs.

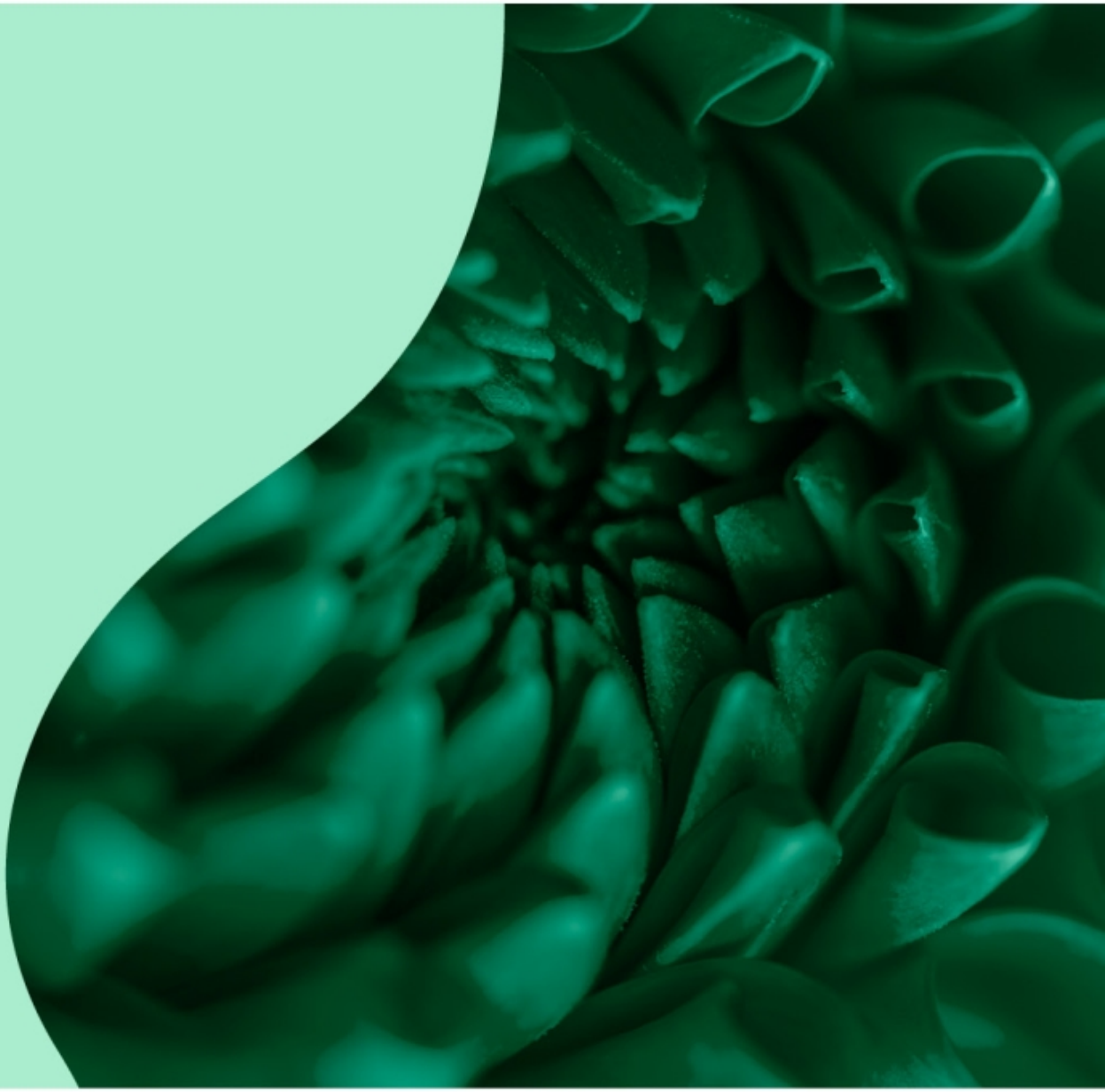
Each entity has its own OneSentara initiative to do this.

Current focus is on auditing those same diagnostic codes that the OIG is auditing (listed on prior slide)

Other plans and providers across the country are doing the same

SHP

CMS's new Risk Adjustment Model – Version 28



Basics of CMS's model change

- 9,800 ICD-10 codes in current model
  - 2,200 ICD-10 codes removed
  + 200 ICD-10 codes added
  =7,800 ICD-10 codes in new model

- 86 HCCs in current model → 115 HCCs in new model

- Current model is V24 → new model is V28

- 2025 – Encounter year in which new model will take hold 100%

Specifics of CMS's model change

	Number of HCCs - V24	Number of HCCs - V28	Change in HCCs	Number of ICDs - V24	Number of ICDs - V28	Change in ICDs	% Change in ICDs
Infectious Disease Group	3	3	0	92	91	-1	-1%
Neoplasm Disease Group	5	7	2	1,128	1,175	47	4%
Diabetes Disease Group	3	4	1	429	344	-85	-20%
Metabolic Disease Group	3	4	1	246	59	-187	-76%
Liver Disease Group	3	5	2	36	51	15	42%
Gastrointestinal Disease Group	3	5	2	135	161	26	19%
Musculoskeletal Disease Group	2	3	1	1,300	1,187	-113	-9%
Blood Disease Group	3	7	4	225	132	-93	-41%
Cognitive Disease Group	2	3	1	123	103	-20	-16%
Substance Use Disorder Disease Group	3	5	2	458	464	6	1%
Psychiatric Disease Group	4	5	1	859	438	-421	-49%
Spinal Disease Group	3	3	0	403	302	-101	-25%
Neurological Disease Group	8	12	4	216	200	-16	-7%
Arrest Disese Group	3	0	-3	40	-	-40	-100%
Heart Disease Group	5	10	5	157	138	-19	-12%
Cerebrovascular Disease Group	4	4	0	296	312	16	5%
Vascular Disease Group	3	3	0	603	365	-238	-39%
Lung Disease Group	5	7	2	147	123	-24	-16%
Eye Disease Group	2	2	0	140	192	52	37%
Kidney Disease Group	5	4	-1	64	9	-55	-86%
Skin Disease Group	5	7	2	488	552	64	13%
Injury Disease Group	5	6	1	1,785	1,498	-287	-16%
Complication Disease Group	1	0	-1	325	-	-325	-100%
Amputation Disease Group	1	1	0	291	44	-247	-85%
Transplant Disease Group	1	1	0	48	14	-34	-71%
Openings Disease Group	1	1	0	41	41	0	0%
Arrest Disease Group	0	3	3	-	51	51	NA
NA				268	2,297	2029	

Reasons for CMS's model change

- Remove ICD Crosswalk - Current model was calibrated on ICD-9 data and crosswalked to ICD-10. New model calibrates on ICD-10
- More recent data - Current model calibrated on 2014 encounters, new on 2018 encounters
- Clinical Review – CMS met with panel of physicians to assess Diag's against 10 principles. Reasons for removing diagnoses:
  - 6% Subsequent encounter… less intensive follow-up treatment
  - 40% Sequela … late effects of a condition
  - 24% Side effect of treatment … complication and/or drug
  - 30% Diagnosis deemed not clinically meaningful, over predict tx cost, or not specific

Risk Adjustment – Tell the Story About Your Patient

Specific diagnosis codes reported by providers drive the amount of RA revenue

Patients' conditions and treatment plans are a UNIQUE story told by the:

- specific documentation

and

- specific diagnosis codes

Sentara Health Plans

Patients' SPECIFC documentation and diagnosis codes support:

- improved care/ healthcare outcomes

and

- risk adjustment (RA) revenue

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V24 to V28 CMS-HCC Model Transition Keys to success

Specificity is Key!

Laterality & Position

- Left vs right
- Upper vs lower extremity

Severity

- Mild > moderate > severe MDD
- PVD w/ claudication > rest pain > ulceration > gangrene
- CAD w/o angina > w/ stable angina > w/ unstable angina

Acute vs chronic

- CHF
- Respiratory failure
- DVT/PE

Timing

- Initial > subsequent > sequelae

Active vs resolved vs in remission

- Malignancy
- Major Depression

Many unspecified diagnoses hold little to no risk score

i.e. Depression, PVD, angina

*Just as important as it is to make sure we are getting credit for the appropriate severity of a condition, it's also important we are not mislabeling conditions we should NOT be receiving HCC credit for too - **FRAUD**

*See tip sheet on Acute vs Chronic and appropriate time intervals for use of diagnosis codes

Major Depressive Disorder

PHQ-9 Scoring (DSM-V criteria)	Severity Level
1 to 4	Only meets MDD criteria if in 'remission' or 'partial remission'
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27 *or any SI/psychotic symptom regardless of PHQ9*	Severe

Specify Severity level with PHQ-9 → **Mild, Moderate, Severe** → **"Unspecified" – try to avoid, NO HCC**

Specify Episode → **'Single'** – First episode → **'Recurrent'-** Symptomatic relapse (now or previous)

Stability → **"In Partial Remission"** – Sustained symptomatic recovery with **PHQ9 < 5** for **< 2 months**, stable on treatment → **"In Complete Remission"** – Sustained symptomatic recovery with **PHQ9 < 5** for **≥2 months**, stable on treatment → **"Active" – PHQ9 ≥ 5**, remains symptomatic

"History of" (no HCC) → **Resolved** (no meds, no symptoms)

Complications present? → Specify presence or absence of psychotic features

PHQ9 must be < 5 for greater than 2 months to be classified as "in remission"
(For CMS/HEDIS, type of remission - partial vs full - is less relevant)

Mild major depressive disorder and Major depressive disorders, in remission will NOT HOLD HCC VALUE IN V28 model

Major Depressive Disorder

PHQ9 must be < 5 over a 2-month period of time to be classified as "in complete remission"
AKA - you will need 2 PHQ9 readings with a score of < 5 over 2 months
If you have a PHQ9 score < 5 on 2 occasions over less than a 2-month time period, then it would be considered "partial remission"

For coding purposes, you would need **PHQ9 w/ related coding basically three times in a calendar year to fully screen and evaluate remission of depression**

Example:

First HCC code eval = When the **PHQ9 is initially above 5** and the provider thinks the person has depression (and its not from, say hypothyroidism, i.e., they still need a clinical diagnosis)

Second HCC code eval = **between months 4-8** (to check on remission, *if they have a score <5 they may still be considered not in remission if the score has been less than 2 months, so severe would still be severe*)

Third HCC code eval = **at month 12** (*would still need 2 months of PHQ9 <5* to be considered in remission).

Vascular Disease / Atherosclerosis

Avoid "unspecified" or "other" PVD

Utilize → Atherosclerosis of arteries of extremities **with**…

Code & document **highest level of vascular disease**:

Claudication → **Rest pain → Ulcer → Gangrene (HCC)**

Code Thrombus/Embolism if Applicable:

Acute: First 6 months after symptom onset

Chronic: > 6 months after symptom onset ***AND***

-**Repeat imaging verifies chronic DVT**

-***Chronic anticoagulation does not justify diagnosis of chronic DVT***

Remember SPECIFICITY:

- **Location**
  - Thigh
  - Ankle
  - Calf
  - Heel
  - Etc.
- **Laterality**
  - Left
  - Right
  - Bilateral
- **Native artery vs bypass graft**
  - If graft:
    - Autologous
    - Nonautologous biological
    - Nonautologous

Angina

*The most common cardiology diagnosis utilized is CAD

- ***Documentation – Be Specific:***
  - Specify **vessel** *(native artery or bypass graft)* ***and*** presence of **angina**

- Coronary artery disease with stable angina
  - **Symptoms not required to be present, but they may be**
  - **Patient has been prescribed an anti-angina medication**
    - Nitrates (i.e. prn NTG, isosorbide mononitrate)
    - Ranolazine
    - Beta blockers

V24 only

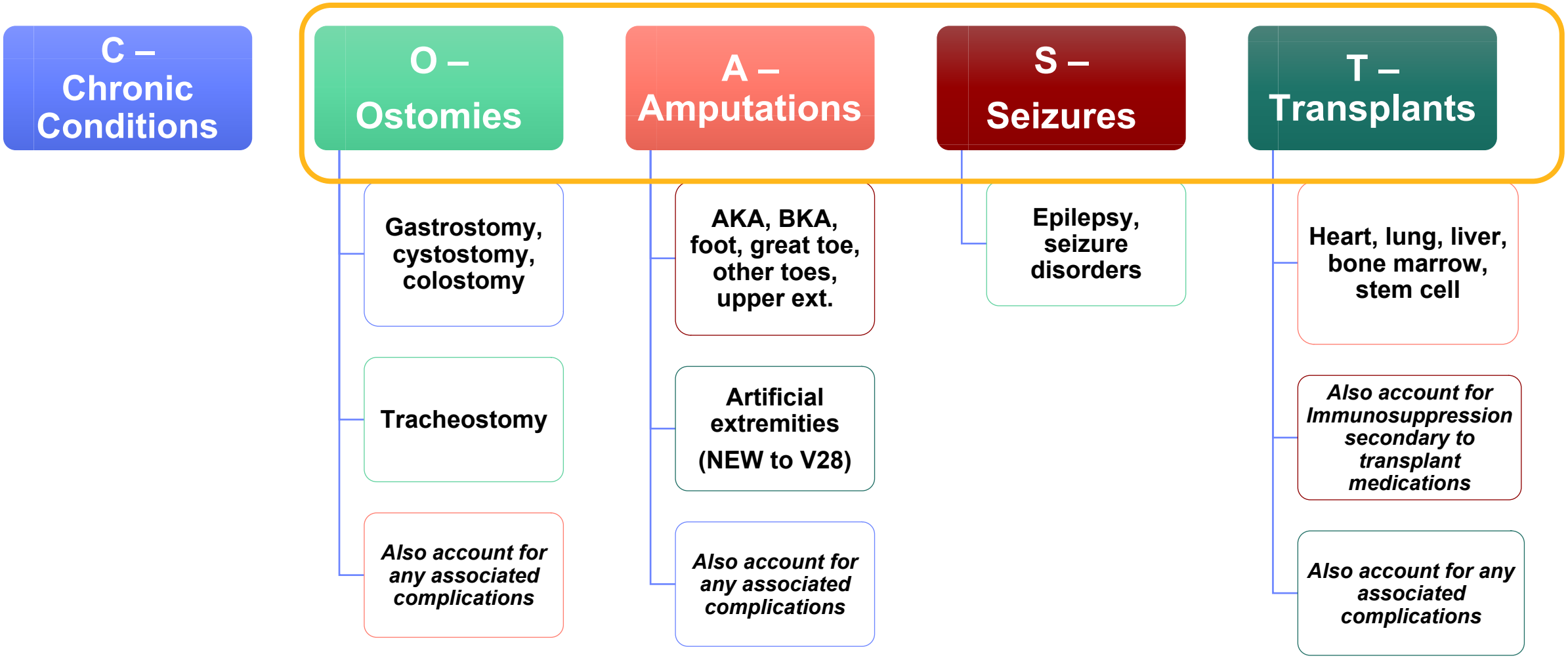
- Coronary artery disease with unstable angina
  - Dependent upon symptoms, diagnostic indicators (EKG, enzymes)

But don't continue to code for this once resolved

- Coronary artery disease **without angina (NOT HCC in V24 or V28)**

Status Conditions

*These are **often permanent** conditions that must be redocumented and coded once per year.*



NEW to V28: Asthma

1. **Obtain PFTs / spirometry**
   - **FEV1 < 80% predicted**

NEW HCC

1. **Classify SEVERITY level:**

Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms < 2x/week	Symptoms > 2x/week but not daily; may affect activity	Daily symptoms; daily use of SABA; affect activities and may last days	Continual symptoms; limited activity
Nocturnal symptoms < 2x/month	Nocturnal symptoms > 2x/month	Nocturnal symptoms > 2x/week	Frequent nocturnal symptoms

3. Classify status

- Uncomplicated, acute exacerbation, status asthmaticus

NEW to V28: Central / Tributary Branch Retinal Vein Occlusion

- Approximately 400 patients had this dx reported between May and July 2023
- **Treatment** can be very **costly** → why it's important to appropriately capture
- How to verify this diagnosis? **Review ophthalmology consult notes** to see if condition is active and under treatment.

Be SPECIFIC in the documentation:

- Right, left, or bilateral
- Stable vs macular edema vs retinal neovascularization

Similar to Retinopathy - **Be SPECIFIC:**

- Proliferative vs non-proliferative
- With or without macular edema

Diabetic complication that holds HCC value in two categories: DM w/ Complication + Retinopathy

Key Takeaways:

- BE SPECIFIC!
  - Especially for conditions such as ***depression, vascular disease, angina, and asthma – these will hold the most impact in V28***
- Account for all status conditions annually
- Code & document for central & tributary branch retinal vein occlusions as applicable

How Will These Changes Impact Epic & Analytics?

- For 2024, we are **keeping the old v24 model in place in Epic**, although we have the option to integrate either or both models in a blended manner. In 2025, we will 100% transition to v28 when v24 is completely phased out.

- Blending would provide the most accurate risk scores but would create duplicate BPAs of many diagnoses that are changing HCC categories from v24 to v28.

- For Analytics/QPI reporting, YOY comparisons would not be apples-to-apples given the amount of variability between the models.

- There are still **more opportunities for risk capture in v24** than in v28.

- Payers are using blended models in their reporting and business modeling.


ANY
Questions
?

SHP Risk Adjustment Contacts

Dean Ratzlaff
Director, Actuary - Revenue Management
Sentara Health Plans

Email : daratzla@sentara.com

Kwame Appiah-Yeboah
Director, Risk Adjustment & Revenue Management
Sentara Health Plans
Email : kxappiah@sentara.com

Lisa Garrett, RN, MSHA, CPC, CPC-I, CPC-P, CRC
Director, Revenue Management
Sentara Health Plans
Email : ljgarre1@sentara.com

SASD Risk Adjustment Contacts

Stephanie Zeiber, MPA, PA-C
Manager, Risk Adjustment, SASD
E-mail: snzeibe2@sentara.com
Office Phone: 757-252-3228

Beth St. Laurent, LPN, CPC, CRC, CPMA
Team Coordinator Risk Adjustment Coders
E-mail: egstlaur@sentara.com
Office Phone: 757-252-2905

HCC Coders – Hampton Roads

Diana Dlubala, CPC, CRC
HCC Coder
E-mail: dvdlubal@sentara.com
Office Phone: 757-252-2759

Janelle Coleman, CPC, CRC, CPCO, CFPC
HCC Coder
E-mail: jegrandi@sentara.com
Office Phone: 757-252-2815

HCC Coder – Blue Ridge

Patricia Taylor, CPC
HCC Coder
E-mail: pataylo2@sentara.com
Office Phone: 434-654-7734

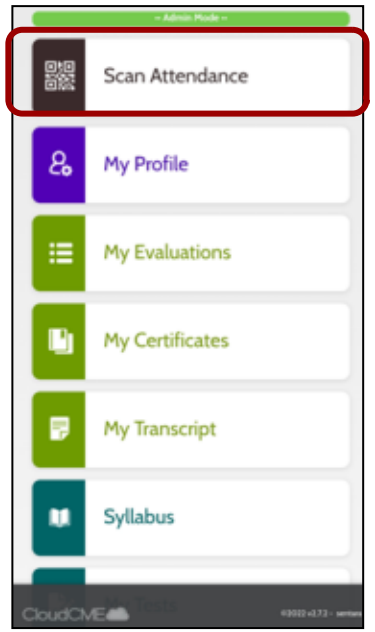
HCC Coding Educator

Beth Allen, CPC, CRC
HCC Coding Educator
E-mail: erallen3@sentara.com
Office Phone: 757-469-1393

Instructions for tracking Attendance in CloudCME platform

QR Code Via Mobile App – specific to each month's presentation

Text code – specific to each month's presentation



1. **Via mobile app** – in your browser search CloudCME® check in or CloudCME® mobile app and download to your Apple or Android device(s) to access the Check-in menu and scan a QR code.

Link to CloudCME website

Sentara Healthcare Continuing Medical Education Continuing Education (cloud-cme.com)

Each month a code will be given at the start of the meeting so you can text your attendance to CloudCME

Text 12618 to

(844) 626-0992

2. **Via text message** – A distinct code will be provided for each Live activity. ***If this is the first time you are texting your attendance, you must first pair your mobile number to your account.** Text your email address to: **(844) 626-0992**. You will receive a text notification indicating your phone number has been updated. Once your account is paired to your mobile number and you have obtained the event code, send the code via text to 1-844-626-0992

Please note, attendance can only be recorded 60 mins. prior to the activity start time, during the activity, and up to 120 minutes after the activity closes – you will have 2 weeks to complete the evaluation and claim CME credit.

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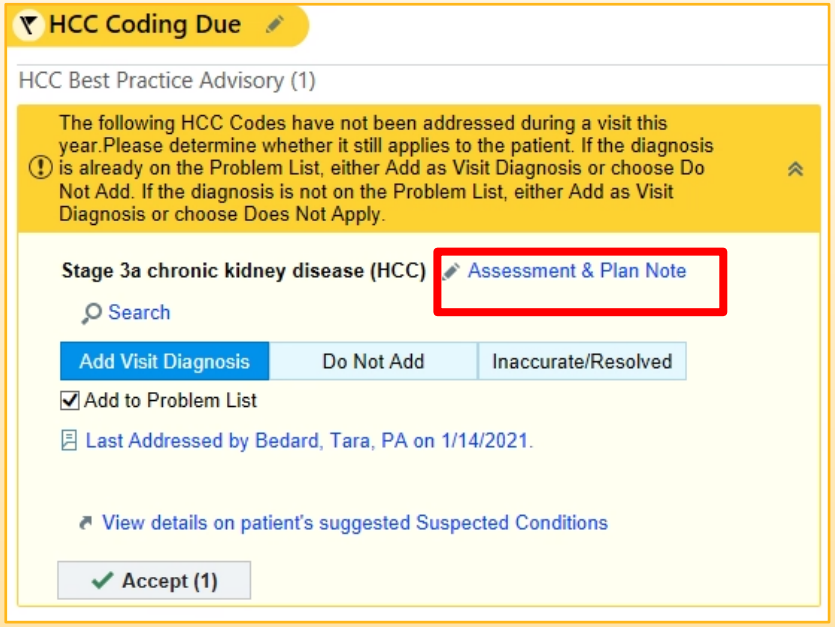
Appendix

Epic Tip – A&P Notes

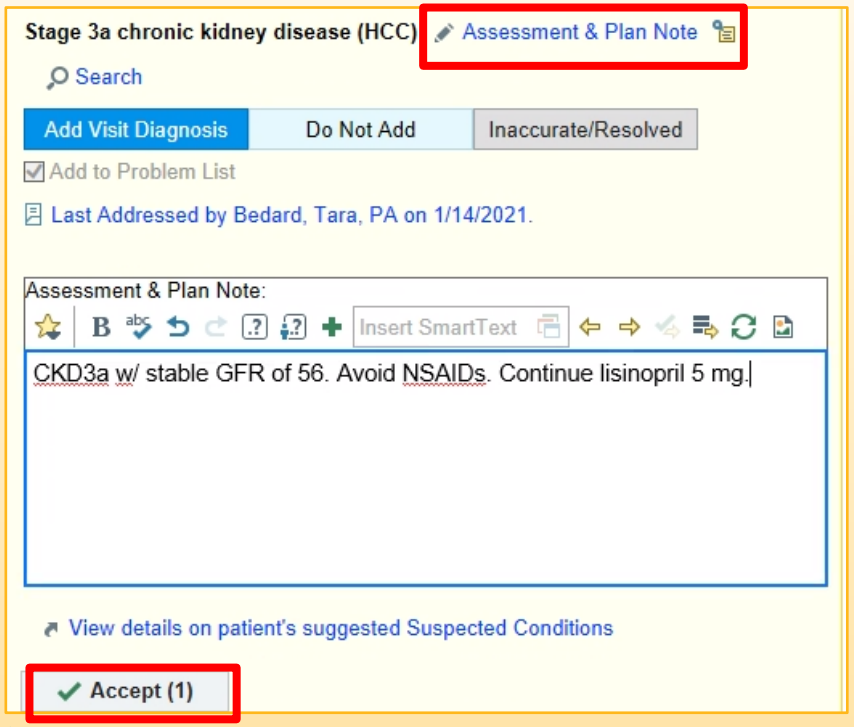
1. Optional to use the **Assessment & Plan Note** in BPAs to help meet HCC documentation requirements



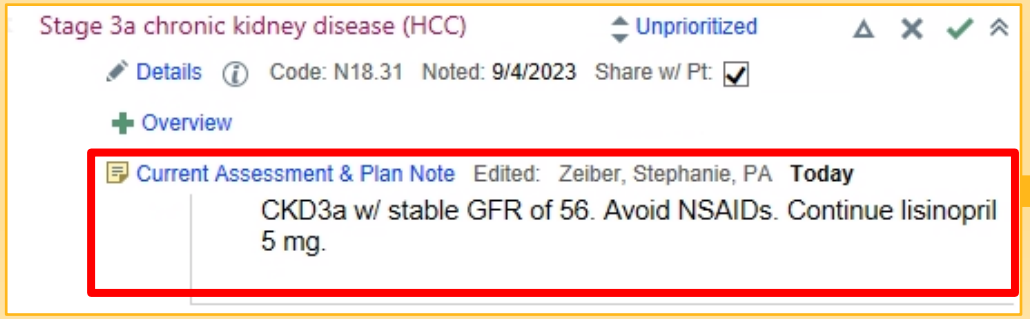
2. Type your note in the A&P Note box and click "Accept."

D-S-P:

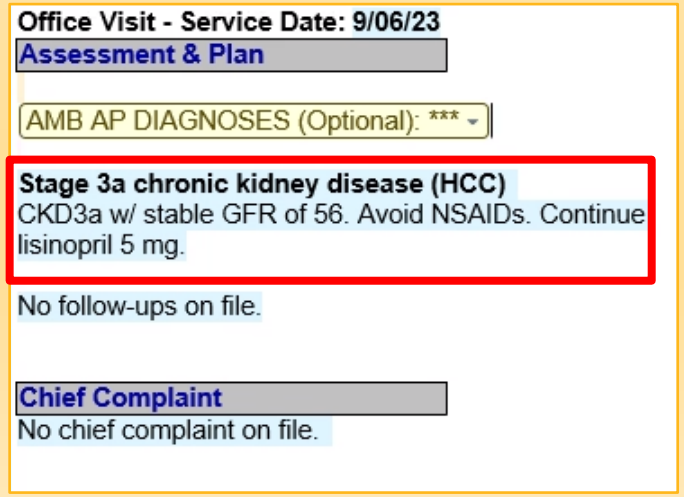
Diagnosis – Status – Plan



3. Your note will appear in the PL under "Current A&P Note" but *won't save to future encounters* A&P notes



4. It will also pull automatically into NoteWriter when you open note



Updated HCC Documentation Criteria

3 Key Elements

D – Diagnosis

S – Status

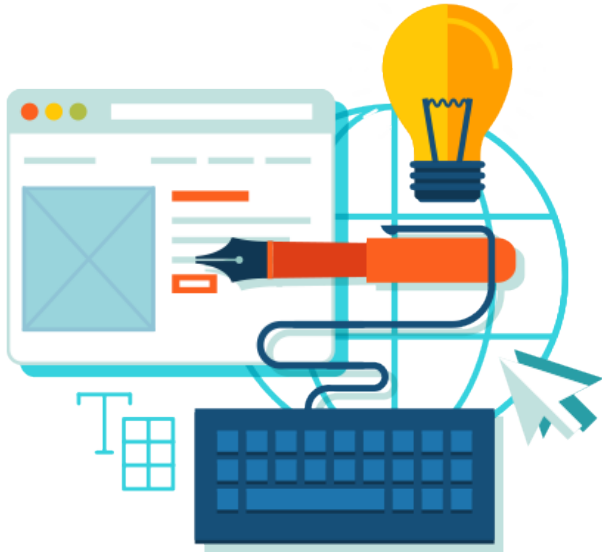
P - Plan

Pre-populated Epic Dx descriptions alone with associated orders are ***not acceptable*** as supporting documentation per RADV audit guidelines

- Providers diagnostic statement must be in their own words in the body of the note
  - (HPI most often)

Diagnosis, Status, Plan

Newest Documentation Guidance for Risk Adjustment (HCC) Coding



Valid HCC Documentation requires 3 Points

- ***Diagnosis*** – State the diagnosis within the body of your note *(in your own words)*
  - In a face-to-face visit, state the diagnosis to the highest specificity including complications/manifestations - utilizing linking verbiage (due to, with, related to)
- ***Status*** – State the status of the condition
  - Stable, worsening, exacerbation, newly diagnosed
- ***Plan*** – State how you are monitoring and plan to treat the patient's diagnosis
  - Labs ordered to monitor progression, meds adjusted for better control, plans for future diagnostic tests, follow up visits with PCP or follow up visits with specialists

Diagnosis

This is how OIG and CMS look at chart documentation for RADV audits

If no Epic Dxs were selected for the DOS and a coder reviewed your note to code it for you, would your documentation lead them to the correct Diagnosis?

The Diagnoses stated in your HPI (in the provider's own words) need to lead a coder to the correct diagnosis in the coding book, meaning **specificity is key**.

The **Diagnoses stated in your HPI** need to match the diagnoses you have selected from Epic to code

– *CMS & OIG look for specificity and consistency in your documentation*

Best Practice

When utilizing abbreviations

- Make sure they are standard abbreviations
- Make sure that somewhere in your note the abbreviation is spelled out.
  - *This clarification may be contained in the Epic inserted diagnosis to confirm the diagnostic statement within your HPI*
- Utilize same abbreviation throughout note.

Status and Plan

This is how OIG and CMS look at chart documentation for RADV audits

Your supporting documentation *(status and plan)* can be located anywhere in your documentation – it can be linked to the Epic chosen Dx, in your HPI, or even in your ROS or physical exam findings.

The Status of your diagnoses need to be consistent throughout the documentation and not contradict your stated or the Epic chosen Diagnoses

If the Status of a diagnosis is not known because you are not the managing provider and have not received the consult notes, or the patient is noncompliant with diagnostic testing - state the reasons it is not known and your plan to follow up on the condition (i.e. – requesting consult note(s), referring to specialist, labs etc.)

The Plan needs to show medical necessity &/or clinical significance to patients' overall care – if not actively being treated/managed by you, then how it affects other chronic conditions or affects you MDM for the patient

Documentation Pearls

Diagnosis

'CKD3a'

Status

'GFR stable at 50'

Plan

'Avoid NSAIDs'

Avoid use of "History of…" if condition is chronic or ongoing. "History of" signifies to CMS that the condition is resolved and no longer active (ex: History of breast CA).

Clearly state that the condition is active - "Pt with current conditions being evaluated today as follows: COPD, Diastolic CHF, DM2 w HTN etc."

Use same verbiage in note as is in the codes you selected for submission:

DM w/ Neuropathy submitted on claim, but HPI states "DM uncomplicated, Leg pain- controlled on Neurontin."

DM w/ Neuropathy submitted on claim, HPI states DM w/neuropathy- both controlled, continue Metformin and Neurontin

Document 'status' conditions once yearly.

- Transplants
- Ostomies
- Amputations
- Dialysis

Be specific: 'Obesity' is not an HCC code, but 'Severe Class 2 Obesity (BMI 35+) with comorbidity' carries HCC weight. 'Depression' is not an HCC code but 'Mild Major Depression' or 'Major Depression in remission' are HCC codes. 'Alcohol dependence in remission' carries HCC weight.

The 2021 E&M guidelines and HCC Coding

The latest HCC documentation guidance has indicated that

CMS/OIG are trying to more closely align the HCC documentation requirements to the E&M guidelines for utilization of Comorbidities & underlying diseases.

Comorbidities/underlying diseases, *in and of themselves*, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management.

Problem addressed: A problem is addressed or managed when it is *evaluated or treated at the encounter* by the physician or other qualified health care professional reporting the service.
This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented by the encounter provider does not qualify as being 'addressed' or managed by the physician for MDM purposes - this also no longer satisfies the requirements for HCC coding.

HPI Documentation

History of Present Illness

57-year-old female presents today for follow-up.

Face rash
Dry
Sometime itch
No new products

She was admitted 11/28/2022 - 12/2/2022
Systolic CHF exacerbation
Lasix 20mg BID, Nitro, Aldactone, sacubitriL-valsartan
Hypoxic respiratory failure, hypertensive urgency

Plans for repeat echo scheduled 2/15/23 at 9:30 AM and cardiology appointment 3/1/2023
Has 2 appts for each. Advised her to cancelled ones that she does not need

Diagnosis - Status & Plan

PNA
Multi focal consolidative parenchymal opacities with remaining areas of groundglass opacity and diffuse septal thickening with small effusions.
multifocal pneumonia and pulmonary edema
D/c w/ doxycycline

Diagnosis – Should spell out as done in A&P i.e.. NICM (Nonischemic cardiomyopathy) don't just use abbreviations

CMO
Nuclear stress test 7/8/2022: EF 38%, global hypokinesis, no evidence of scar or ischemia
Seeing cardio
EF improved to 42% - > repeat echocardiogram 11/29/2022 with EF of 23%
Coreg 6.25mg BID

Cardio made a referral to cardiac rehab 12/29/22

Stress/depression
PHQ 9 - 11
Denies SI/HI
She was referred to social work for financial stress. She is working to appeal disability. She did get approval for assistance.

Started on Wellbutrin July 2022
Going well -> helping mood "a lot"

Diagnosis – Specify type & chronicity of depression as was listed in A&P

Diagnosis – be specific - list complication(s) also and utilize linking verbiage (due to, related to Diabetic etc.) address complication as well as underlying Dx

Diabetes Type II
The patient presents for evaluation of diabetes.
She is compliant with medications.
Patient denies hypoglycemic symptoms or foot complaints.
Home blood glucose readings are not being checked.
Patient is not on chronic insulin therapy. Was in the past
A1c 10.5% 7/16/20
Has supplies but has not been check BG
Reports she is taking her Metformin as prescribed
--
Seeing Endo - last seen 3/2021
Glipizide XL 10mg
Metformin 1000mg BID
A1c 9.6% -> 8.9%
Trulicity 0.5mg on Mondays
-
6.8%
Dapagliflozin added inpatient
A1c down 6.3%

HYPERTENSION
The patient presents for evaluation of essential hypertension.
She is compliant with medications.
Patient denies chest pain, shortness of breath or edema.
The patient reports blood pressures are: not taken.
Denies any stroke/MI symptoms
Elevated today - has not taken meds yet
Lisinopril 20 mg -> increased to 40 mg July 2022

DYSLIPIDEMIA
The patient presents for evaluation of dyslipidemia.
She is attempting to control her dyslipidemia with prescription medications; is not compliant.
The patient denies myalgia or flushing.
Interval comments: Atorvastatin 40mg
LDL up to 194

Tobacco use/COPD
40 years - few cig/day
Decreased to 5 cig/day
Quit tobacco since admission 1/2022
Started again but stopped during admission 10/2022

Office Visit - Service Date: 1/23/23

Assessment & Plan

A&P Documentation

1. Type 2 diabetes mellitus with hyperglycemia (HCC)
Trulicity, metformin, glipizide
Last A1c 6.8%; which is significantly improved for her
She was followed by endocrinology in the past
During her recent admission Dapagliflozin added
We gave her the phone number to her endocrinology office to schedule follow-up

Status & Plan

2. Tobacco use
Quit x 2 months

3. Moderate episode of recurrent major depressive disorder (HCC)
4. Anxiety
Currently well controlled on Wellbutrin

Status

5. Essential hypertension
well controlled with Coreg. While admitted Lasix, Entresto, Aldactone added
She has been controlled with this regimen. Elevated today due to being out of medication 1 week
Advised to please let us know in the future so we can refill prior to visit

6. Mixed hyperlipidemia
Crestor 20 mg

7. Chronic obstructive pulmonary disease, unspecified COPD type (HCC)
Not currently on any treatment. Currently not smoking
Consider pulmonary referral and PFTs in the future

Status & Plan

Status

8. NICM (nonischemic cardiomyopathy) (HCC)
Echo 11/29/2022: EF 23%, global hypokinesis, cLVH with severe enlargement of LV, mod MR, mild TR/PR, PAP 29 mmHg. Small echodensity seen in LV-could not rule out apical thrombus

9. Chronic systolic congestive heart failure (HCC)
- furosemide (LASIX) 20 mg PO TABS; Take 1 Tab by Mouth 2X Daily Diuretic. Dispense: 180 Tab; Refill: 3
- sacubitriL-valsartan (ENTRESTO) 24-26 mg PO TABS; Take 1 Tab by Mouth Twice Daily. Dispense: 180 Tab; Refill: 1
- dapagliflozin (FARXIGA) 10 mg PO TABS; Take 1 Tab by Mouth Once a Day. Dispense: 90 Tab; Refill: 1
- spironolactone (ALDACTONE) 25 mg PO TABS; Take 0.5 Tabs by Mouth Once a Day. Dispense: 45 Tab; Refill: 1
Managed by cardiology
Upcoming Echo and appt

Plan

10. Rash face
- hydrocortisone (CORTIZONE 5) 0.5 % Top OINT; Use 1 Application to affected area Twice Daily. Dispense: 28 g; Refill: 1'

Return in about 3 months (around 4/23/2023) for Follow up w/ labs 1 wk prior.