

# Acuity Documentation and Chronic Condition Recapture



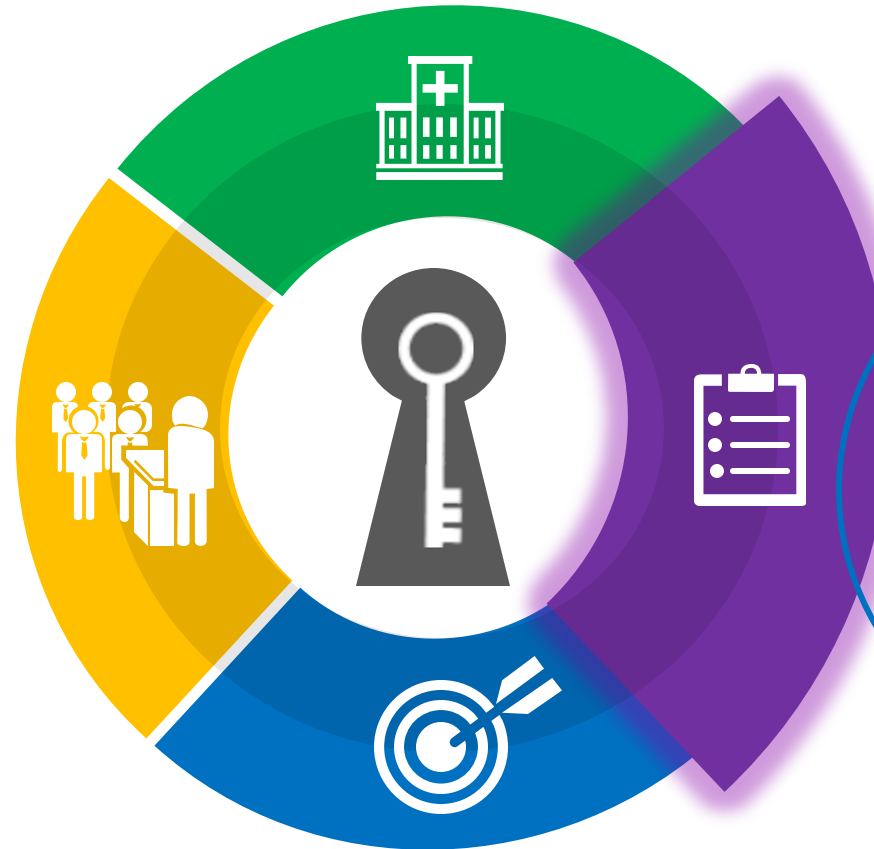
# Understanding the Basics



# Factors for Success in Alternative Payment Models (APMs)

*Cost and Utilization  
Management*

*APM Contract  
Terms*



**Complete and  
Accurate  
Clinical  
Condition  
Documentation**

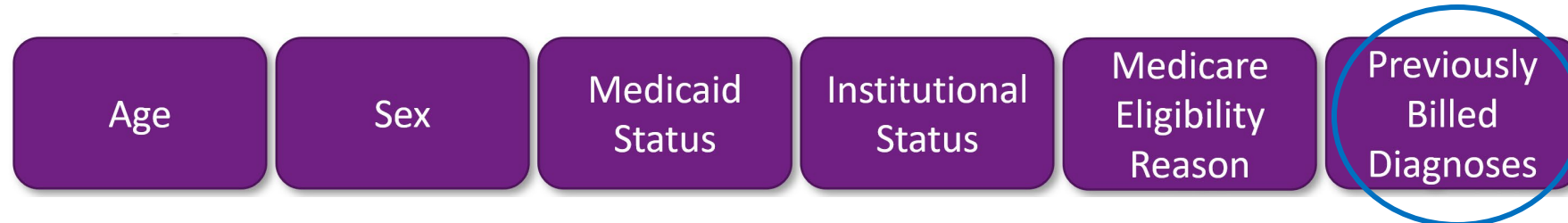
*Achieving  
Quality Targets*

# Reason for action – Why excellent Clinical Condition Documentation is critical:



# Acuity Documentation and Risk

- Diagnosis codes can only be billed with **proper documentation** in the medical records to support those conditions
- Those reported conditions are one of the contributing pieces in calculating the **Risk Adjustment Factor (RAF)** for the patient



- **Risk Adjustment** is used to predict future healthcare costs for patients and **sets our medical cost budgets**
  - Increased medical complexity, the payors expect increased medical costs
  - Lower risk, healthier populations, the payors expect lower medical costs

# Why does risk adjustment matter?

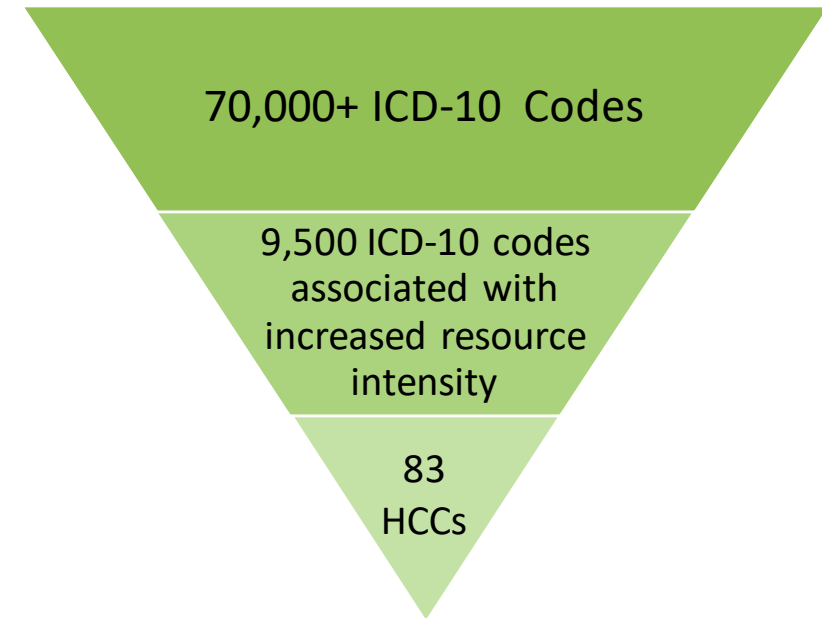
- Errors in risk adjustment will lead to errors in our medical cost budgets
  - Failure to code **all** conditions, or the **severity** of conditions, could make our patients *appear* healthier than they are, leading to lower budgets
- To be successful in our value-based contracts, the **actual total costs of care** must come in under the **medical cost budget**
  - This generates a **surplus** (shared savings) that is paid back to our network
  - That **added revenue** to practices can help fund office support, new technologies, or expansion

*See Appendix for an example of how shared savings are generated and the impact of risk coding*



# From ICD-10s to HCCs to RAF...

- Chronic conditions are grouped into Hierarchical Condition Categories (**HCCs**), each with a weight that contributes to a patient's RAF score
  - They are grouped by similar conditions that would require similar resource and cost needs
- Documenting the **highest specificity** is crucial to accurately capture the correct HCC and risk weight



ICD-10 Code	Code Description	HCC	Weight
E11.9	Type 2 diabetes mellitus without complications	19	.106
E11.65	Type 2 diabetes mellitus with hyperglycemia	18	.307

Improvement in documentation for a single diagnosis can lead to nearly triple the HCC weight for this condition

# Where does each patient stand?



*Important to note, CMS rebases what “1” is every year based on all Medicare beneficiaries and their risk scores*



# Capturing the full medical complexity:

In addition to capturing the highest specificity, providers need to document and bill all conditions each year. In this example, Member A's risk score is 5x greater when all conditions are captured compared to none.

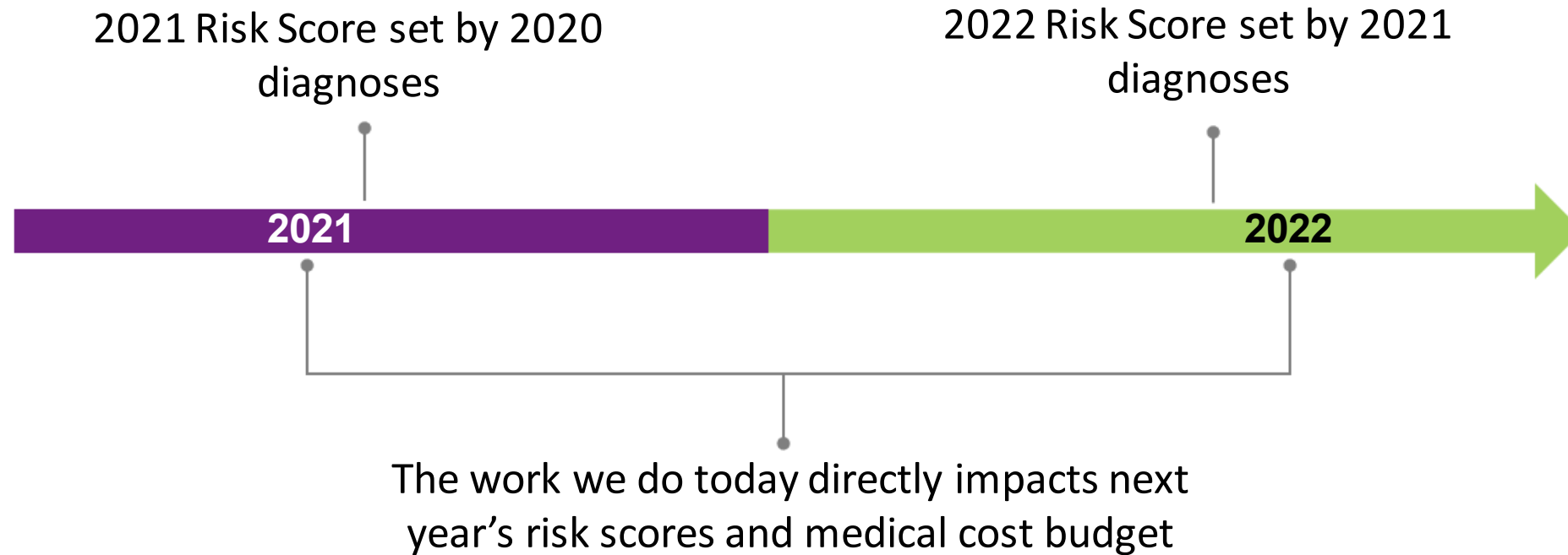
Member A		
Example 1 - All Conditions Coded	Example 2 - Some Conditions Coded	Example 3 - No Conditions Coded
<b>Demographics</b>	<b>Demographics</b>	<b>Demographics</b>
Female, 73 FB Dual, Aged 0.511	Female, 73 FB Dual, Aged 0.511	Female, 73 FB Dual, Aged 0.511
<b>HCCs</b>	<b>HCCs</b>	<b>HCCs</b>
HCC 17 - Diabetes w chronic complications 0.346	HCC 19 - Diabetes w/o complications 0.097	
HCC 85 - Congestive Heart Failure 0.355	HCC 22 - Morbid Obesity 0.41	
HCC 22 - Morbid Obesity 0.41		
HCC 189 - Amputation Status 0.787		
<b>Interactions</b>	<b>Interactions</b>	<b>Interactions</b>
CHF - Diabetes Group 0.205		
<b>RAF 2.614</b>	<b>RAF 1.018</b>	<b>RAF 0.511</b>

Each 0.1 in RAF score equates to about \$800 per year added to the patient's medical cost budget. In Example 1, we would expect a budget of about \$20,000 compared to Example 3 where they would have a budget of about \$4,000.

Trying to provide necessary care for this patient within that smaller budget becomes nearly impossible, and when multiplied across an entire population, it becomes more difficult to stay under budget and earn any shared savings.



# HCCs must be captured on an annual basis!



Every year, the payors reset patients' risk scores – recapturing full acuity of the patient must be done each year.

*Incentivized metric for PCPs – target 80% HCC revalidation, see next slide for definitions*



# HCC Revalidation as an Incentivized Metric

**HCC Revalidation** – if a patient has a chronic condition that falls within an HCC that was billed within the previous two reporting years, and the same or similar code within the same HCC is billed in the current year, it will be considered as being revalidated

**Eligible population:** Any Medicare and MA covered life in the current reporting year (2021)

**Denominator:** All chronic HCCs that were billed in 2019 and 2020 for your current covered lives

**Numerator:** All chronic HCCs billed in 2019 and 2020 on your current covered lives that were re-billed during the current year

- Many ICD-10 codes fall into the same HCC category – any code within that category will “close” the HCC gap
- Erroneous codes from prior years that are clinically irrelevant or inaccurate shouldn’t be revalidated, but they will remain ‘open’ until next calendar year

## MSSP/MA Only

### PCP Metrics - Adults

AWVs – 75%

HCC Revalidation – 80%

## Commercial Only

### PCP Metrics – Peds

Well-Child Visits – 75%

Child & Adolescent Visits – 75%



# Best Practices for Documentation



# Best Practice: Document with M.E.A.T.

M.E.A.T. is an easy acronym for remembering what is needed for adequate documentation.

Only one of the M.E.A.T. elements needs to be present to bill that condition.

## Monitor

- Review signs and symptoms
- Review logs (blood sugar, BP)
- Disease progression/regression noted

## Evaluate

- Reviewing exam findings
- Review of diagnostic tests
- Medication/treatment effectiveness

## Assess or Address

- Stable, improving, worsening, etc.
- Exacerbation of condition
- Relevant record review

## Treat

- Referral to specialist
- Adjusting, refilling, prescribing medication
- Surgical procedures
- Education/counseling provided



**SOHO**  
HEALTH

# Putting M.E.A.T. in your Documentation

## Examples of documenting with M.E.A.T.:

### Monitor

- ✓ Diabetes Mellitus – hemoglobin A1c ordered
- ✓ CAD – echocardiogram ordered

### Evaluate

- ✓ Diabetes – foot exam normal, shoes and socks appropriate for diabetes
- ✓ COPD – new inhaler has improved SOB, renew inhaler

### Assess/Address

- ✓ Diabetes stable
- ✓ Hyperlipidemia improving

### Treat

- ✓ Diabetes – increase Neurontin for polyneuropathy
- ✓ Depression – no improvement, referral to psychiatrist



# What are acceptable locations for M.E.A.T.?

YES		NO	
√	History of present illness	X	Past medical history
√	Review of symptoms	X	Surgical history
√	Physical exam	X	Problem list
√	Assessment	X	Medication list
√	Plan		
√	Treatment		

# Keeping Compliant Documentation

- Completeness and accuracy is always our goal!
- Never document or bill diagnoses that are not present or currently being treated
- Never “inflate” diagnoses to achieve a higher risk score
- Do not document a resolved or historical medical condition as current if it is no longer being treated
- Correct any errors in diagnoses previously reported or that no longer apply
- Keep accurate, specific problem lists to easily pull the most appropriate codes into encounter notes





# Clinical Condition Review



# Priority Conditions for Medicare HCC & Commercial

Diabetes with  
Complications  
(HCC)

Congestive Heart  
Failure (HCC)

Chronic  
Obstructive  
Pulmonary Disease  
(HCC)

Major Depression  
(HCC)

Vascular Disease  
(HCC)

Obesity (HCC and  
Commercial)

Chronic Kidney  
Disease (HCC and  
Commercial)

Hypertension  
(Commercial)

Housing Insecurity  
(Commercial and  
Medicaid)



# Diabetes Mellitus

**Diabetes codes are now combination codes which include:**

- Type of diabetes (type 1 or 2)
- Body system affected (eyes, neuro, kidney)
- Complications affecting that body system (gangrene, CKD)

**What they do not include is the control status:**

- For inadequately controlled, out of control or poorly controlled, use an additional code for diabetes, by type, with hyperglycemia:
- **E10.65** Type 1 diabetes mellitus with hyperglycemia
- **E11.65** Type 2 diabetes mellitus with hyperglycemia

➤ **Use additional code for long term insulin use (Z79.4)**

## Type of Diabetes

- Type 2 Diabetes with hyperglycemia **E11.65**
- Type 1 Diabetes with hyperglycemia **E10.65**

## Body System

- Type 2 Diabetic with Neuropathy **E11.40**
- Type 2 Diabetic with Nephropathy **E11.41**
- Type 2 Diabetes with other Ophthalmic complication **E11.39**
- Type 2 Diabetes with Circulatory complication **E11.59**

## Complication of Body System

- Type 2 Diabetes with retinopathy (**E11.31-E11.35**)
- Type 2 Diabetes with peripheral angiopathy with gangrene (**E11.52**)
- Chronic Kidney Disease **N18.1-N18.6** (add'l codes)

# Congestive Heart Failure

## Type of HF

- Diastolic I50.32
- Systolic I50.22
- Both Diastolic and Systolic I50.42

## Acuity

- Acute CHF
- Chronic CHF
- Acute on Chronic CHF

## Etiology of HF

- Etiologic
- Anatomic
- Physiologic

### Etiologic Diagnoses:

Atherosclerotic, Hypertensive, Coronary, and Restrictive Heart Disease Angina

### Anatomic Diagnoses:

LAD stenosis, valvular stenosis, etc.

### Physiological Diagnoses:

Conduction abnormalities, valve regurgitation, CHF, arrhythmias

## Commonly Used Congestive Heart Failure Codes

### Acute

I50.21	Acute systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

### Chronic

I11.0	Hypertensive heart disease with heart failure
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I42.0	Dilated cardiomyopathy
I43	Cardiomyopathy in diseases classified elsewhere
I50.1	Left ventricular failure
I50.22	Chronic systolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure

CHF should be thoroughly documented and coded in *every* encounter where it factored into the decision-making during the visit

Follow the MEAT guidelines:

**M: monitored/measured**

“No increase in SOB, weight increased 2 lbs”

**E: evaluated**

“PE: No JVD present, RRR. Noticeable ankle edema bilaterally”

**A: assessed/addressed**

“Mildly increased systolic CHF”

**T: treated**

“ACE dosage maintained and increase Lasix to BID x 1wk”

# Chronic Obstructive Pulmonary Disease

## Common COPD Codes

<b>J41.0</b>	Simple chronic bronchitis
<b>J41.1</b>	Mucopurulent chronic bronchitis
<b>J42</b>	Unspecified chronic bronchitis
<b>J43.9</b>	Emphysema, unspecified
<b>J44.0</b>	<b>Chronic obstructive pulmonary disease with acute lower respiratory infection</b>
<b>J44.1</b>	<b>Chronic obstructive pulmonary disease with (acute) exacerbation</b>
<b>J44.9</b>	<b>Chronic obstructive pulmonary disease, unspecified</b>

## Additional Relevant Codes

<b>Z99.81</b>	Dependence on supplemental oxygen
<b>Z87.891</b>	History of tobacco use
<b>F17.218</b>	Nicotine dependence, cigarettes, with other nicotine-induced disorders
<b>Z72.0</b>	Tobacco use (if no dependence exists)

- COPD should be thoroughly documented and coded in *every* encounter where it factored into the decision-making during the visit
- Follow the MEAT guidelines- the coders' shorthand for proper documentation:
  - **M: monitored/measured**
    - ✓ "peak flow testing shows COPD is stable compared with 6 months ago"
  - **E: evaluated**
    - ✓ "patient has acute bronchitis in context of long-term emphysema"
  - **A: assessed/addressed**
    - ✓ "discussed need for quitting smoking immediately d/t COPD dx"
  - **T: treated**
    - ✓ "submitted refill for Spiriva for COPD"

# Major Depression

By Type	
ICD-10	Description
<i>Mild</i>	
<b>F32.0</b>	<b>Major depressive disorder, single episode, mild</b>
F33.0	Major depressive disorder, recurrent, mild
<i>Moderate</i>	
<b>F32.1</b>	<b>Major depressive disorder, single episode, moderate</b>
F33.1	Major depressive disorder, recurrent, moderate
<i>Severe</i>	
<b>F32.2</b>	<b>Major depressive disorder, single episode, severe without psychotic features</b>
<b>F32.3</b>	<b>Major depressive disorder, single episode, severe with psychotic features</b>
<b>F33.2</b>	<b>Major depressive disorder, recurrent severe without psychotic features</b>
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
<i>Other Severity</i>	
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.89	Other persistent mood [affective] disorders
F34.9	Persistent mood [affective] disorder, unspecified
F39	Unspecified mood [affective] disorder

- Document the episode status, severity, and any associated manic/psychotic symptoms
  - Single or recurrent episode
  - Mild, moderate, severe, with or without psychotic features
  - In partial or full remission
  
- Some frequently used but unspecified codes do not carry risk adjustment weights because they lack specificity:
  - F32.9 MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED
  - F32.8 OTHER DEPRESSIVE EPISODES



# Morbid Obesity

- A BMI of 40 or above is categorized as morbidly obese, however you must document the condition by name to bill E66.01
- BMI diagnosis should be reported in conjunction with obesity code (Z68.1-Z68.45 for BMI ≤19 to BMI ≥70)
- A BMI between 35-40 with a comorbidity is also considered morbidly obese and should be reported as such

## Example of MEAT Documentation:

Patient is morbidly obese. We discussed cutting back on processed foods and increasing exercise as the patient also has OSA currently using a CPAP.

**DX: E66.01, G47.33 & Z99.89**

## Common ICD 10 Codes

Morbid Obesity	
E66.01	Morbid Obesity due to excess calories
E66.2	Morbid obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.9	Obesity, unspecified
Z68.2X	BMI 20 – 29, adult (5 <sup>th</sup> digit required, which corresponds to current BMI, I.E. Z68.28 for BMI of 28.0 - 28.9)
Z68.3X	BMI 30-39, adult (5 <sup>th</sup> digit required, which corresponds to current BMI, I.E. Z68.34 for BMI of 34.0 - 34.9)
Z68.41	BMI 40.0 - 44.9, adult
Z68.42	BMI 45.0 – 49.9, adult

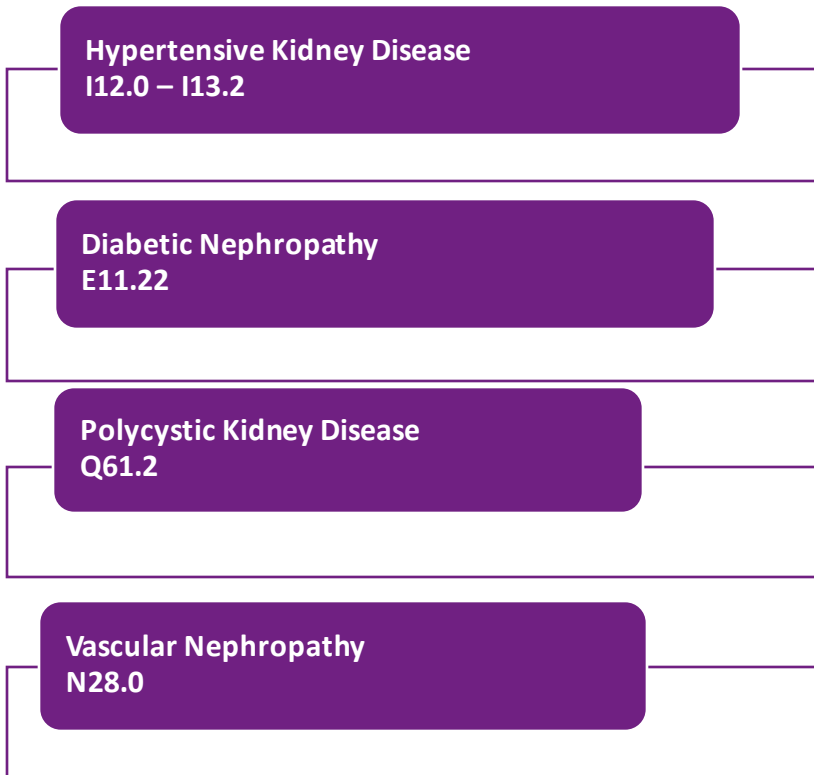
## Comorbidities, if documented, that can allow for Morbid Obesity to be billed in patients with BMI 35-40:

- Old MI
- Angina (stable or unstable)
- CAD procedures/ surgeries (angioplasty)
- PVD/ PAD
- Abdominal aortic aneurysm
- Type 2 Diabetes Mellitus
- Sleep apnea/respiratory problems
- Impaired fasting glucose
- Cigarette smoking
- Lipid disorders (High LDL/ low HDL/ high triglycerides)
- Hypertension
- Osteoarthritis or gout
- Physical inactivity



# Chronic Kidney Disease

Chronic Kidney Disease Stage		Calculated GFR	ICD-10 Code
Stage 1	Normal	>90 mL/min	N18.1
Stage 2	Mild	60-89 mL/min	N18.2
Stage 3A	Moderate	45-59 mL/min	N18.3
Stage 3B	Moderate	30-44 mL/min	
Stage 4	Severe	15-29 mL/min	N18.4
Stage 5	End Stage	< 15 mL/min	N18.5
Additional Diagnoses with CKD to code		Diabetic Nephropathy CKD and CHF	E11.21 Type 2 diabetes with diabetic nephropathy I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 CKD, or ESRD



Complication	ICD-10 Code
Anemia in CKD	D63.1
Hyperkalemia	E87.5
Metabolic Acidosis	E87.2
Secondary Hyperparathyroidism	E21.1

Assess, Document, Code & Stage of CKD Based on GFR

Assess, document and Code Etiology of Kidney Disease

Assess, document and Code complication of CKD



# Top 10 Most Common Documentation Errors

1. Not restating the diagnosis each time it is addressed
2. Not documenting causal relationships
3. Using ICD CM titles without supporting documentation
4. Using “unofficial” symbols/abbreviations
5. Documenting “history of” versus “active” diagnosis
6. Lack of specificity to support appropriate code
7. Incorrectly documenting “qualifying language”
8. Overlooking documentation of permanent diagnosis
9. Not documenting health “status conditions”
10. Lack of supporting documentation for diagnosis



# Appendix



# How do value-based agreements work?

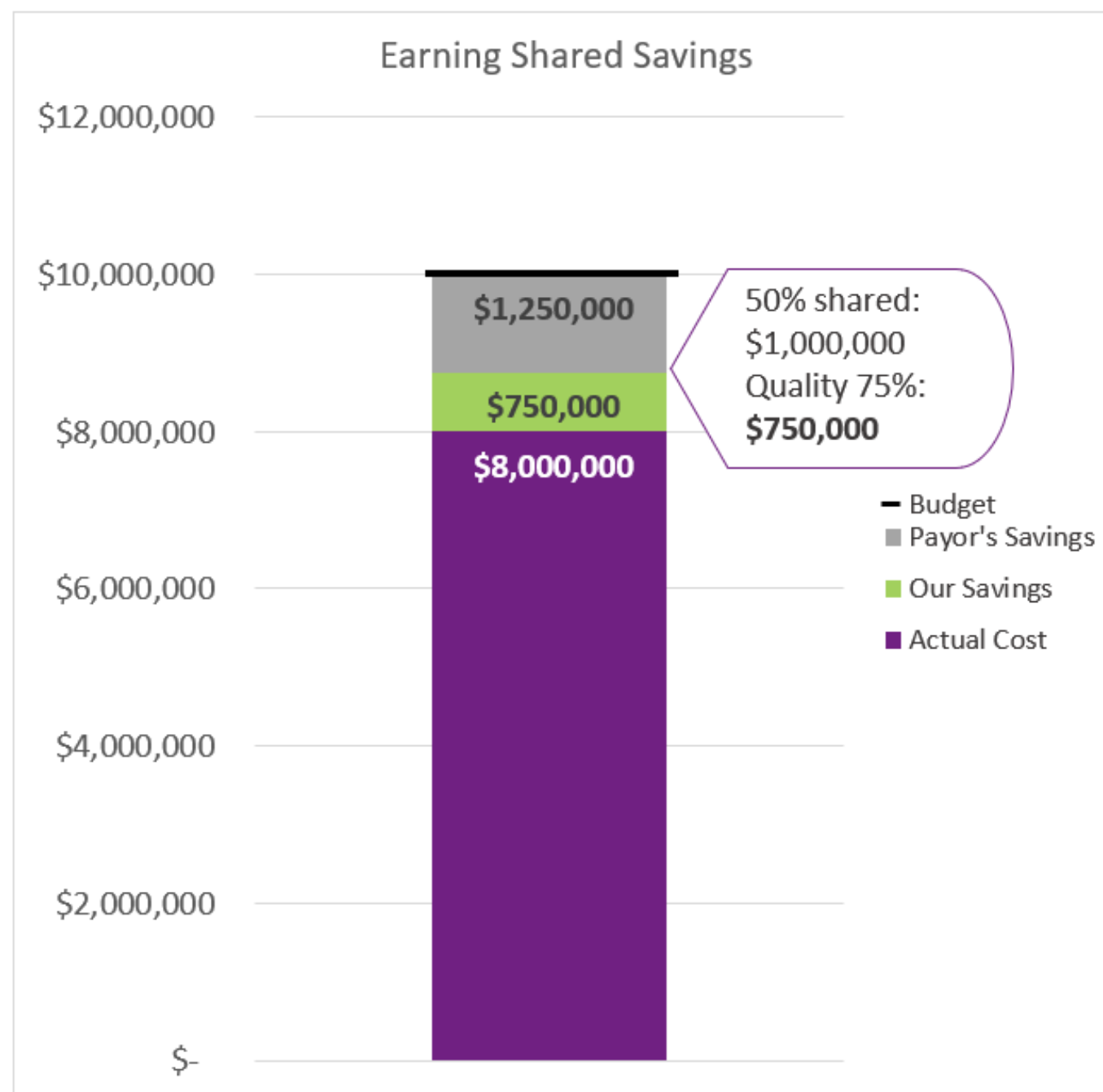
- Payor sets **total medical cost budget** based on estimated costs
  - Risk adjustment (how complex the patients are) is applied to a historical cost trend to establish budget
- Year-end reconciliation compares **actual medical costs** to the budget
  - Under budget = **surplus** = shared savings
  - Over budget = **loss** = payback in down-sided risk agreements
- Earning **shared savings**
  - Negotiated shared rate per the contract (e.g., 50/50 split)
  - Quality scores applied or minimum gate must be met to earn savings



Example of earning shared savings in a value-based contract –

### Baseline performance

- \$10million budget
- \$8million actual costs
  - \$2 million surplus: split 50/50 with a 75% quality factor earns \$750k



Example and numerical figures are for illustrative purposes only



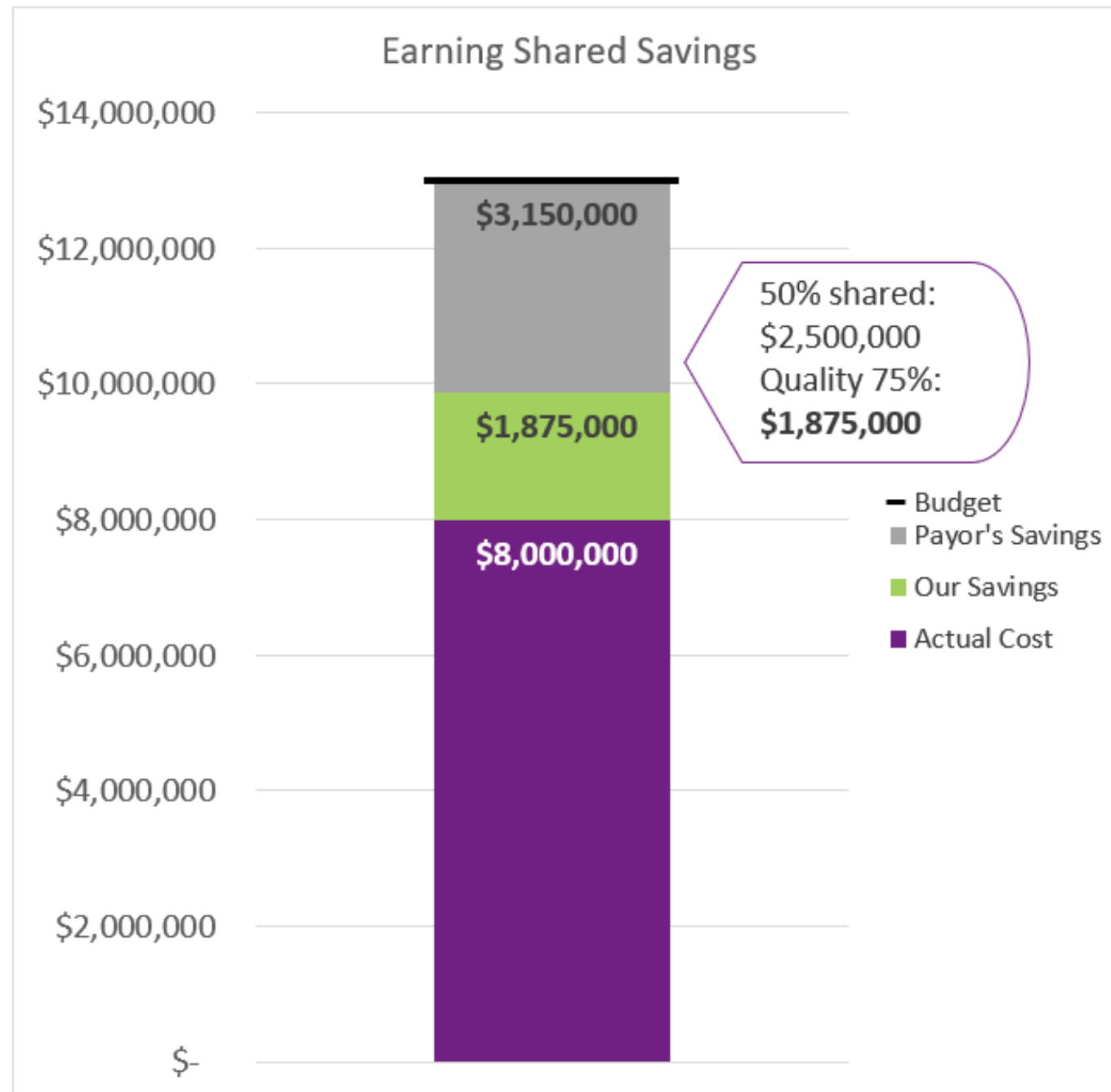
Accurate and complete HCC documentation increases risk scores



Medical cost budget increases to \$13million

All else equal, earned shared savings increases by over \$1million

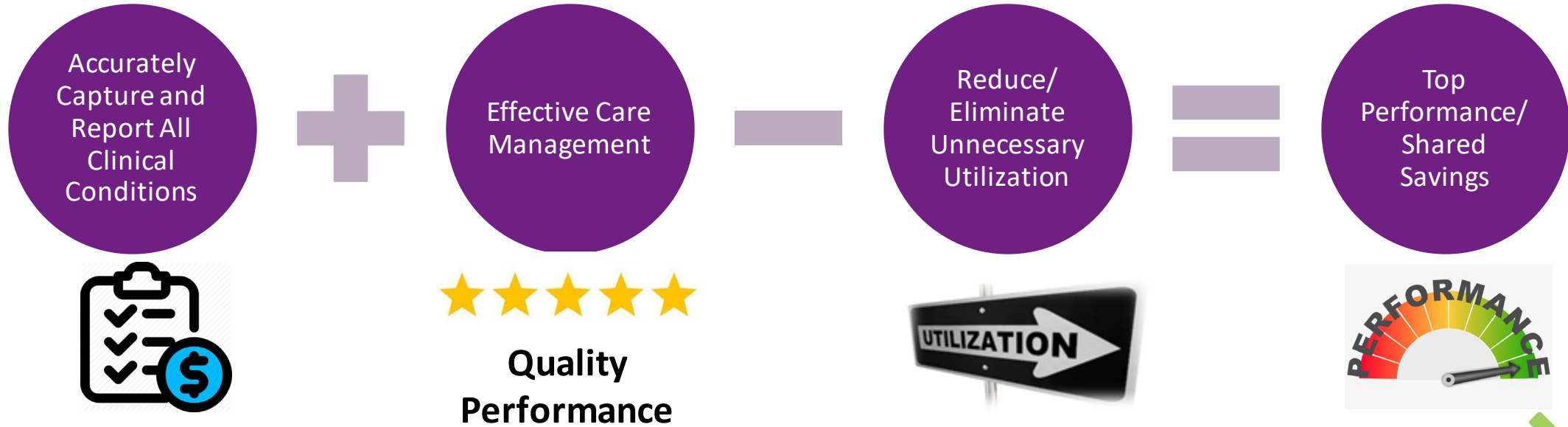
- Costs stay at \$8million
- \$5 million surplus: same 50/50 split and 75% quality now earns \$1.875million



Example and numerical figures are for illustrative purposes only



# Equation for Success in Value-Based Agreements



# M E A T

## MONITOR

- Review signs and symptoms
- Review logs (blood sugar, B/P)
- Disease progression/regression noted

Example: “Major Depressive Disorder, mild – patient reports worsening fatigue and insomnia.”

Code: F33.0: Major Depressive Disorder Recurrent Mild

# M E A T

## EVALUATE

- Review lab/test results
- Review of diagnostic tests
- Medication/treatment effectiveness
- Relevant physical examination

**Example:** “Chronic Obstructive Pulmonary Disease – New inhaler has improved shortness of breath. Renew inhaler”

**Code:** J44.9: Chronic Obstructive Pulmonary Disease, unspecified



# M E A T

## ASSESS

- **Stable, improving, worsening, etc.**
- **Discussion/counseling, ordering tests**
- **Exacerbation of condition**
- **Relevant record review**

**Example:** “Congestive Diastolic Heart Failure –  
Weights have been stable, order renal panel.”

**Code:** I50.32: Chronic diastolic (congestive) heart  
failure

# M E A T

## TREAT

- Referral to/mention of specialist
- Adjusting, refilling, prescribing medication
- Surgical procedures
- Education given to patient

Example: “Type 2 Diabetes Mellitus – refill metformin and monitor blood sugars.”

Code: E11.9: Type 2 diabetes mellitus without complications