Workshop A:
Integrative Data & Technologies
Innovation Stations: Rotating Workshops Exploring Integrative Technologies for Successful Risk and Quality Programs

Panelists:
Mark Hillix, Director, Risk Adjustment and Star Ratings
BLUE CROSS BLUE SHIELD OF KANSAS CITY

Laura Boardman, Manager, Risk Adjustment Optimization
BLUE CROSS BLUE SHIELD OF NEBRASKA

Hiro Arai, FSA, MAAA – Staff Actuary
BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

Scott Stratton, Chief Data Scientist, Vice President, Product Analytics
PULSE8

Courtney Yeakel, MBA, Vice President, Customer Engagement
PULSE8

Mark Brooks, CPA, Vice President, Product
PULSE8
Mark Hillix is Director of Risk Adjustment and Stars at Blue Cross and Blue Shield of Kansas City (Blue KC), focusing on both the Commercial and Medicare Advantage segments. During his time at Blue KC he has worked in provider/facility payment and negotiation analysis, PCMH / value-based arrangements and implementation, cost of care initiatives to bend the medical cost trend, as well as product development. Mark currently serves on several Quality Councils, as well as the Analytics, Reporting, and Data Governance Council at Blue KC and has worked at the company since 2010. His educational background includes finance, economics, marketing, entrepreneurship, and business intelligence/analytics.
Laura Boardman is manager of the Risk Adjustment Optimization department for Blue Cross and Blue Shield of Nebraska. In this role, she is responsible for the development and oversight of Commercial Risk Adjustment initiatives, including retrospective and prospective review and provider education. She served as the RADV coordinator for the 2015 Risk Adjustment Data Validation audit and is accountable for reviewing CMS edits and reconciling data errors on the EDGE server.

Laura has taken on numerous roles during her 18 years at BCBSNE. Her career began in the Medical Support department, as a medical reviewer. She then transferred to medical underwriting, health analytics, and then risk adjustment. Laura has also served as a steward for enterprise data governance and a product owner on the IT team that is responsible for supporting the EDGE server submissions.

Laura is a Registered Nurse who earned her bachelor’s degree in nursing from the College of Saint Mary in Omaha, Nebraska and a master’s of nursing from Nebraska Wesleyan. She is also a Certified Risk Coder and a Certified Product Owner.
Scott Stratton is an industry leader in the design and development of products, technologies, business processes, and analytics. His focus is on collecting, integrating, organizing, mining, and modeling data to develop and optimize product development, sales, and profitability.

Scott has served as co-founder of CV-Sight, Vice President with Medco Health Solutions, Director at both Pfizer and Oxford Health Plans, and Assistant Vice President with GHI. Scott’s most significant design and development work includes Bayesian readmission analyses for one of the nation’s largest participants in CMS Innovation Center’s Bundled Payments for Care Initiative (BPCI); SAS70-compliant analytics to improve quality and costs of cardiac revascularizations; data models and processes supporting integrated pharmacy, hospital, medical, and ancillary claim data for >10 million lives, including episodes of care (ETGs) and ETG-based cost forecasting (ERGs); RightTrack™ Pfizer’s clinical trial management system still used after 13 years by the U.S. and 85 other countries for Phase II-IV trials; and co-founding Oxford’s global fees-oriented specialty management subsidiary.

Scott earned a Master’s Degree in Public Health from Yale’s School of Epidemiology and Public Health and a Bachelor of Arts in Philosophy from Carleton College. Additionally, Scott has been honored to serve on various state and national commissions, and was a founder of Yale’s John D. Thompson Fellowship Committee. CIO, American Demographics, and other periodicals have profiled him and he has published in the New England Journal of Medicine and most recently in the Journal of Clinical Oncology.
Courtney Yeakel is a results-driven leader with a progressive track record of technical and managerial successes with complex government risk-adjustment and payment programs. With nearly a decade of experience in government program’s health insurance, Courtney led enterprise-wide corporate initiatives focusing on the health plan’s risk adjustment strategy at both the federal and state levels. She was responsible for the execution and oversight of Medicare, Medicaid, and ACA encounter data submissions, intervention strategies, and financial reporting. Courtney has developed and led cross-functional operational teams to ensure both compliance and accurate revenue management. Prior to joining the Pulse8 team, in addition to risk adjustment, Courtney focused on the analysis of multiple data sets within government programs, including Medicare Secondary Payer, Prescription Drug Event data, federal & state payment reconciliations, cost share reduction, and data governance initiatives. Under her direction, the programs experienced significant process improvements that yielded substantial financial returns for the health plan by lowering administrative costs while increasing quality. Courtney is Lean Six Sigma-certified and a graduate of St. John Fisher College with a Bachelor of Arts in Economics, along with a Master of Business Administration degree from Penn State University.
Hiro Arai, ASA MAAA  
Staff Actuary, BCBSNC

Hiro Arai is an actuary at BCBSNC, managing the commercial risk adjustment process. He has developed tools and models to establish a successful commercial risk adjustment program, and worked on financial strategies for commercial risk adjustment.

He previously worked at Coventry Healthcare and Highmark Inc, in various roles spanning from Rating Tools to Medical Economics.

He is an associate of the Society of Actuaries and a member of the American Academy of Actuaries. He holds a bachelor’s degree in Mathematics and a bachelor’s degree in Computer Science from Dickinson College.

He is also the president and founder of the North Carolina Actuarial Club which serves over 120 members from students to professional actuaries.

He currently resides in Hillsborough, North Carolina and spends time with his wife and two children on his time off.
Mark Brooks  
Pulse8  
Vice President, Product Strategy

Mark is responsible for managing Pulse8’s distinguished team of data scientists, researchers, risk adjustment experts, and developers in deploying the most advanced analytics and data products, addressing customer demand for innovative technology and unique gap closure solutions. Mark brings a wealth of insight from the customer’s perspective that will help ensure our focus on products is driving positive outcomes.

Before joining Pulse8, Mark spent 11 years at Highmark Blue Cross Blue Shield, mostly in leadership roles over Risk Adjustment teams. For the two years prior to joining Pulse8, Mark served as the Revenue Program Management team’s Director of Program Strategy, focusing on intervention strategy and execution in support of Highmark’s Medicare Advantage and ACA Commercial programs. Mark’s experience also included 4 years as the Finance Director of Highmark’s Senior Markets business unit, during which he had responsibility for the financial analysis and projections of the Medicare Advantage and Part D products, development and management of the business unit operating budget, and oversight of the Revenue Program Management team.

Mark earned a Bachelor of Science in Accounting from Penn State University and a Master of Business Administration from the University of Pittsburgh.
Workshop B:
Risk Adjustment & Star Ratings Essentials
Mastering the Essentials: An Intro to Risk Adjustment and Star Ratings

Panelists:
David Meyer, Vice President, Risk Adjustment, Encounters, Coding and Audit
SCAN HEALTH PLAN

Ana Handshuh, Vice President, Managed Care Services
ULTIMATE HEALTH PLANS


Previously, Dave served as an independent consultant to healthplans, was Corporate VP, Operations (Revenue and Quality) at InnovaCare Health. He has also performed as Sr. Consultant, Risk Adjustment and Health Plan Operations for Dynamic Healthcare Systems, and in other roles with healthplans.
Ana Handshuh, Principal at CAT5 Strategies, is a government programs executive with expertise in creating and implementing corporate programs for the healthcare industry. Her background includes Quality, Core Measures, Care Management, Benefit Design and Bid Submission, Accreditation, Regulatory Compliance, Revenue Management, Communications, Community-based Care Management Programs and Technology Integration. Ms. Handshuh currently serves on the Board of the Resource Initiative and Society for Education (RISE), the preeminent national professional association dedicated to managed and accountable care financing and delivery. She is a sought after speaker on the national healthcare circuit in the areas of Quality, Star Ratings, Care Management, Member and Provider Engagement, and Revenue Management. Her recent consultancy roles have included assisting organizations create programs to address the unmet care management needs in the highest risk strata of membership, document their processes and procedures, achieve accreditation status, design and submit government program bids, institute corporate-wide programs and create communications strategies and materials. She possesses sophisticated business acumen with the ability to build consensus with cross-functional groups to accomplish corporate goals. Ms. Handshuh served as the Vice President of Managed Care Services at Central Florida Inpatient Medicine (CFIM). In this role, she provided leadership and strategy on CFIM projects and collaborations with physicians, risk entities, hospital health care systems, and health plans. CFIM is the largest Hospitalist group in Central Florida, with 70 providers discharging over 50,000 patients annually from multiple hospitals across two health care delivery systems and 24 skilled nursing facilities. At CFIM Ms. Handshuh previously served as the Vice President of Operations. Prior to those assignments, she worked with Precision Healthcare Systems as their Vice President of Quality Improvement. In that capacity, she led the IPA’s Quality efforts and collaborated with payers on implementing programs to move the needle on Quality and Star Rating initiatives. Ms. Handshuh also served as the Director of Corporate Program Development at Physicians United Plan. In this role, she led the Quality Management and Corporate Communications departments and spearheaded the development of innovative integrated technology solutions to drive business excellence and Star Rating achievement initiatives. For the past fifteen years Ms. Handshuh has taken an active role in redefining and implementing changes that have led to improvements and greater efficiency within Government programs and healthcare delivery. Prior to joining Physicians United Plan Ms. Handshuh was the founder of I-Six Creative. Under Ms. Handshuh’s vision and leadership, I-Six Creative provided expertise in the areas of managed Medicare benefit design, MSO/IPA operations, provider network strategy, new market launches, technology integration, corporate communications and quality improvement.
MASTERING THE ESSENTIALS: AN INTRO
STAR RATINGS

The Nuts and Bolts of Star Ratings

The 11th Annual RISE Summit
Nashville, TN
March 6-8, 2017

Ana Handshuh
Ultimate Health Plans / CAT 5 Strategies

About Ultimate Health Plans

- Boutique plan in Spring Hill Florida
- 6,000 members
- 3 counties
- NCQA Commendable Accreditation
- High performer in many areas: CAHPS patient experience, data validation, customer service, low disenrollment, HEDIS measures, drug adherence and safety, MTM – UHP does many things very well
- Tight network of providers = narrow network
- Risk based arrangements
- Focus on concierge service and earning member loyalty
- Recently out of CMS sanction
History of Star Ratings

2007:
Medicare Star Rating developed as informational tool.
• To aid consumers in plan selection through Medicare.gov

2011:
Medicare Star Rating attached to quality incentives.
• Affordable Care Act dictated payment incentives for performance on quality metrics

Why Star Ratings?

• Consistent with CMS’s Quality Strategy
• One of many levers CMS will pull to optimizing health outcomes
• Reflects CMS’s “Six Priorities” to improve:
  • Safety
  • Person- and caregiver-centered experience and outcomes
  • Care coordination
  • Clinical care
  • Population/community health
  • Efficiency and cost reduction
Health Care Reform Medicare Advantage: $ for Quality

Impact of Health Care Reform on Medicare Advantage Plans:

- **Standard Payment**
  (Age, Sex, Condition, County, Medicaid status, Disability status, Institutional status, FFS rate)

- **Health Plan Quality**
  (Quality Bonus Payment, Star Rating Rebate)

The movement towards paying for quality assists CMS in their goal of raising the quality of care for all members.

Stars Matter to Plan Premium

- CMS bases the Medicare payment on the relationship between the plan's bid and benchmark

<table>
<thead>
<tr>
<th>County name</th>
<th>Parts A&amp;B 5% Bonus 2017 Rate</th>
<th>Parts A&amp;B 3% Bonus 2017 Rate</th>
<th>Parts A&amp;B 0% Bonus 2017 Rate</th>
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</thead>
<tbody>
<tr>
<td>CITRUS</td>
<td>814.25</td>
<td>814.25</td>
<td>808.79</td>
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<tr>
<td>HERNANDO</td>
<td><strong>889.68</strong></td>
<td>876.66</td>
<td><strong>846.28</strong></td>
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<tr>
<td>PASCO</td>
<td>894.74</td>
<td>894.07</td>
<td>863.84</td>
</tr>
</tbody>
</table>

Source: CMS.gov – 2017 MA Rate Book
High and Low Performing Icons

Measures are in 5 Broad Categories

1. Outcome – improvements in beneficiary health
2. Intermediate outcomes – actions taken (i.e. controlling blood pressure)
3. Patient experience – patient perspective
4. Access – Issues that could create barriers
5. Process – services provided that assist in monitoring, maintaining or improving health status
The Star Ratings Framework

- Star Ratings based on performance measures for health and drug plans
- Score – numeric value or a “missing data” message
- Star – numeric value converted to a rating, 1 (lowest) to 5 (highest)
- Measures are further combined into groups
  - Domain
  - Summary
  - Overall (for MAPD)
- Half stars assigned in Summary and Overall groups

Levels of Star Ratings for Public Reporting

Based off 2017 Tech Specs
Sources of Star Rating Measure Data

In 2017, there are a total 47 measures – split into 9 domains
- MA-Only: 32 measures – split into 5 domains
- PDPs: 15 measures – split into 4 domains
- MAPDs: 47 measures – 9 domains (44 unique measures)
  - 3 measures appear in both Part C and Part D
  - Complaints, Members Choosing to Leave Plan, Beneficiary Access and Performance Problems

Part C Domains and Measures

Domain: 1 - Staying Healthy: Screenings, Tests and Vaccines......
  Measure: C01 - Breast Cancer Screening..........................
  Measure: C02 - Colorectal Cancer Screening.....................
  Measure: C03 - Annual Flu Vaccine...............................
  Measure: C04 - Improving or Maintaining Physical Health ....
  Measure: C05 - Improving or Maintaining Mental Health......
  Measure: C06 - Monitoring Physical Activity ..................
  Measure: C07 - Adult BMI Assessment..........................
Part C Domains and Measures

Domain: 2 - Managing Chronic (Long Term) Conditions
Measure: C08 - Special Needs Plan (SNP) Care Management
Measure: C09 - Care for Older Adults – Medication Review
Measure: C10 - Care for Older Adults – Functional Status Assessment
Measure: C11 - Care for Older Adults – Pain Assessment
Measure: C12 - Osteoporosis Management in Women who had a Fracture
Measure: C13 - Diabetes Care – Eye Exam
Measure: C14 - Diabetes Care – Kidney Disease Monitoring
Measure: C15 - Diabetes Care – Blood Sugar Controlled
Measure: C16 - Controlling Blood Pressure
Measure: C17 - Rheumatoid Arthritis Management
Measure: C18 - Reducing the Risk of Falling
Measure: C19 - Plan All-Cause Readmissions

Part C Domains and Measures

Domain: 3 - Member Experience with Health Plan
Measure: C20 - Getting Needed Care
Measure: C21 - Getting Appointments and Care Quickly
Measure: C22 - Customer Service
Measure: C23 - Rating of Health Care Quality
Measure: C24 - Rating of Health Plan
Measure: C25 - Care Coordination
Part C Domains and Measures

Domain: 4 - Member Complaints and Changes in the Health Plan’s Performance
  Measure: C26 - Complaints about the Health Plan
  Measure: C27 - Members Choosing to Leave the Plan
  Measure: C28 - Beneficiary Access and Performance Problems
  Measure: C29 - Health Plan Quality Improvement

Domain: 5 - Health Plan Customer Service
  Measure: C30 - Plan Makes Timely Decisions about Appeals
  Measure: C31 - Reviewing Appeals Decisions
  Measure: C32 - Call Center – Foreign Language Interpreter and TTY

Part D Domains and Measures

Domain: 1 - Drug Plan Customer Service
  Measure: D01 - Call Center – Foreign Language Interpreter and TTY Availability
  Measure: D02 - Appeals Auto-Forward
  Measure: D03 - Appeals Upheld

Domain: 2 - Member Complaints and Changes in the Drug Plan’s Performance
  Measure: D04 - Complaints about the Drug Plan
  Measure: D05 - Members Choosing to Leave the Plan
  Measure: D06 - Beneficiary Access and Performance Problems
  Measure: D07 - Drug Plan Quality Improvement
Part D Domains and Measures

Domain: 3 - Member Experience with the Drug Plan
Measure: D08 - Rating of Drug Plan
Measure: D09 - Getting Needed Prescription Drugs

Domain: 4 - Drug Safety and Accuracy of Drug Pricing
Measure: D10 - MPF Price Accuracy
Measure: D11 - High Risk Medication
Measure: D12 - Medication Adherence for Diabetes Medications
Measure: D13 - Medication Adherence for Hypertension (RAS antagonists)
Measure: D14 - Medication Adherence for Cholesterol (Statins)
Measure: D15 - MTM Program Completion Rate for CMR

4 Categories of Data Sources

- Health and Drug Plans
- Data Collected by CMS Contractors
- Survey of Enrollees
- CMS Administrative Data
Data Sources – An Overview

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>Health Effectiveness Data and Information Set</td>
</tr>
<tr>
<td>PDE</td>
<td>Prescription Drug Event data</td>
</tr>
<tr>
<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
</tr>
<tr>
<td>HOS Survey</td>
<td>Medicare Health Outcomes Survey questionnaire</td>
</tr>
<tr>
<td>Administrative Data</td>
<td>CMS Administrative Data: Complaint Tracking Module (CTM), Independent Review Entity (IRE), Call Centers, drug plan &amp; beneficiary databases</td>
</tr>
</tbody>
</table>

Star Rating Measure Weights

Each measure has a weight
- Member’s Health is in Control 3 x
- Member Experience with Plan 1.5 x
- Member’s Getting the Right Care 1 x

Additional Measures that reflect significant improvements across most other part C &D measures
- Quality Improvement (C) 5x
- Quality Improvement (D) 5x
Measure Scoring Details

Star cut points assigned for each measure based national performance using clustering and relative distribution (fixed cut points for beneficiary access and performance problems)

CAHPS measures must pass statistical significance testing for 1 or 5 star assignment

Plans receive a score based on a weighted average of the points received and points possible to the plan

Additional reward available with the Improvement Measure (5x)

Your Bible

Medicare
2017 Part C & D
Star Rating
Technical Notes
Dissecting a Measure

Measure: C13 - Diabetes Care – Eye Exam

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Label for Stars</td>
<td>Eye Exam to Check for Damage from Diabetes</td>
</tr>
<tr>
<td>Label for Data</td>
<td>Eye Exam to Check for Damage from Diabetes</td>
</tr>
<tr>
<td>Description</td>
<td>Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.</td>
</tr>
<tr>
<td>HEDIS Label</td>
<td>Comprehensive Diabetes Care (CDC) – Eye Exam (Retinal) Performed</td>
</tr>
<tr>
<td>Measure Reference</td>
<td>NQODA HEDIS 2016 Technical Specifications Volume 2, page 132</td>
</tr>
<tr>
<td>Metric</td>
<td>The percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had an eye exam (retinal) performed during the measurement year (numerator).</td>
</tr>
<tr>
<td>Primary Data Source</td>
<td>HEDIS</td>
</tr>
</tbody>
</table>

Dissecting a Measure

Data Source Category: Health and Drug Plans

Exclusions: (optional) Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the HbA1c Control (<7.0%) for a Selected Population denominator.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Contracts whose enrollment was at least 500 but less than 1,000 as of the July 2015 enrollment report and having measure score reliability less than 0.7 are excluded.

Contracts whose enrollment was less than 500 as of the July 2015 enrollment report are excluded from this measure.
Dissecting a Measure

Data Time Frame: 01/01/2015 - 12/31/2015
General Trend: Higher is better
Statistical Method: Clustering
Improvement Measure: Included
CAI Usage: Not Included
Case-mix adjusted: No
Weighting Category: Process Measure
Weighting Value: 1
CMS Framework Area: Clinical care
NQF #: 0055
Data Display: Percentage with no decimal point

Dissecting a Measure

Reporting Requirements:

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<thead>
<tr>
<th>Reporting Requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Local CCP, E-CCP, R-CCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Local CCP &amp; Regional CCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Local CCP &amp; Regional CCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cost &amp; Regional CCP w/o SNP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Local CCP &amp; Regional CCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cost &amp; Regional CCP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>MSA &amp; PDP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E-PDP &amp; PDP</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E-PFFS &amp; PFFS &amp; R-PFFS</td>
<td>Yes</td>
<td>No</td>
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Cut Points:

<table>
<thead>
<tr>
<th>Cut Points</th>
<th>1 Star</th>
<th>2 Stars</th>
<th>3 Stars</th>
<th>4 Stars</th>
<th>5 Stars</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 46%</td>
<td>≥ 46% to &lt; 61%</td>
<td>≥ 61% to &lt; 73%</td>
<td>≥ 73% to &lt; 81%</td>
<td>≥ 81%</td>
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</table>
Cut Points for Part D Measure

<table>
<thead>
<tr>
<th>Type</th>
<th>1 Star</th>
<th>2 Stars</th>
<th>3 Stars</th>
<th>4 Stars</th>
<th>5 Stars</th>
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<tbody>
<tr>
<td>MA-PD</td>
<td>&gt; 23.9</td>
<td>&gt; 12.1 to ≤ 23.9</td>
<td>&gt; 8.9 to ≤ 12.1</td>
<td>&gt; 2.7 to ≤ 8.9</td>
<td>≤ 2.7</td>
</tr>
<tr>
<td>PDP</td>
<td>NA</td>
<td>NA</td>
<td>&gt; 8.6</td>
<td>&gt; 4.3 to ≤ 8.6</td>
<td>≤ 4.3</td>
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</table>

Where is Your Score?

<table>
<thead>
<tr>
<th>Contract Type</th>
<th>Offers Part C or 1876 Cost</th>
<th>Offers Part D</th>
<th>Highest Rating</th>
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<tbody>
<tr>
<td>MA-Only</td>
<td>Yes</td>
<td>No</td>
<td>Part C rating</td>
</tr>
<tr>
<td>MA-PD</td>
<td>Yes</td>
<td>Yes</td>
<td>Overall rating</td>
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<tr>
<td>PDP</td>
<td>No</td>
<td>Yes</td>
<td>Part D rating</td>
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Rounding Rules for Summary and Overall Ratings

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<thead>
<tr>
<th>Raw Summary / Overall Score</th>
<th>Final Summary / Overall Rating</th>
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<tbody>
<tr>
<td>≥ 0.000 and &lt; 0.250</td>
<td>0</td>
</tr>
<tr>
<td>≥ 0.250 and &lt; 0.750</td>
<td>0.5</td>
</tr>
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<td>≥ 0.750 and &lt; 1.250</td>
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<tr>
<td>≥ 1.250 and &lt; 1.750</td>
<td>1.5</td>
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<tr>
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<td>4.5</td>
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<tr>
<td>≥ 4.750</td>
<td>5.0</td>
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</table>

CMS Makes Adjustments to Summary and Overall Scores

- Reward Factor (i-Factor): for plans that have BOTH high and stable relative performance – Added

- Categorical Index Adjustment (CAI): Adjusts for the average within-contract disparity in performance associated with plan’s percentages of beneficiaries with Low Income Subsidy/Dual Eligible (LIS/DE) and disability status.
The i-factor

CMS uses an i-factor that utilizes the means and the variance of individual performance ratings to differentiate contracts for the summary score.

• The i-factor is added to the mean score for rewarding contracts if they have both high and stable relative performance.

<table>
<thead>
<tr>
<th>Variability</th>
<th>High Performance</th>
<th>Relatively High Performance</th>
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<tbody>
<tr>
<td>Low Variability</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Medium Variability</td>
<td>0.3</td>
<td>0.1</td>
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Star Rating Timeline

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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 Stars</td>
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</table>
## Star Rating Timeline

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Data</td>
<td></td>
<td></td>
<td></td>
<td>-CAHPS</td>
<td>-Call Ctr</td>
<td>5 Stars</td>
<td></td>
<td></td>
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- CAHPS
- Call Ctr

## Star Rating Timeline

<table>
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<tr>
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<tbody>
<tr>
<td>Data</td>
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<td></td>
<td></td>
<td>-Care</td>
<td>-HOS</td>
<td>-Op Data</td>
<td>-CAHPS</td>
<td>-Call Ctr</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 Stars</td>
<td></td>
<td></td>
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### Star Rating Timeline

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<tr>
<td>HOS</td>
<td>-Plan Design</td>
<td>-Care</td>
<td>-HOS</td>
<td>-Op Data</td>
<td>-CAHPS</td>
<td>-Call Ctr</td>
<td>5 Stars</td>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HOS</td>
<td>-Plan Design</td>
<td>-Care HOS -Op Data</td>
<td>-CAHPS -Call Ctr</td>
<td>Stars</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
</tr>
<tr>
<td>HOS</td>
<td>-Plan Design</td>
<td>-Care HOS -Op Data</td>
<td>-CAHPS -Call Ctr</td>
<td>Stars</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
</tr>
<tr>
<td>HOS</td>
<td>-Plan Design</td>
<td>-Care HOS -Op Data</td>
<td>-CAHPS -Call Ctr</td>
<td>Stars</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
</tr>
<tr>
<td>HOS</td>
<td>-Plan Design</td>
<td>-Care HOS -Op Data</td>
<td>-CAHPS -Call Ctr</td>
<td>Stars</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
<td>Bonus</td>
</tr>
</tbody>
</table>

Adjusting to a Changing Landscape

- Improving National Performance
- Changes to Measures
- Changes to Rules
Setting Goal for a Changing Landscape

- **Start with Current Cut Points:** Use the most up to date star cut points are a foundation for goal setting.

- **Factor In Expected Improvement:** Understand how performance has changed and apply the degree of improvement to model next year’s cut points.

- **Set Projected Ratings and Targets for Display Measures:** Base target cut points off of percentile distribution or model using a clustering methodology.

Keeping Track of It All

Tracking how are we doing today and projecting where will we land
Track Throughout the Year

Each quality measure tracked needs monthly targets to track progress.

Understand Where to Take Action

<table>
<thead>
<tr>
<th>Measure</th>
<th>2016 YTD</th>
<th>2016 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Eye Exam</td>
<td>73%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Example:

Of the 27% of Members with a gap, only 9% need intervention

• 13% closed the gap in three previous years
• 3% we’ve found to receive care at the VA
• 2% have hits in the admin gap database
Creating Alignment in Our Organization

Knowledge and data are not enough…

• Senior leadership buy-in
• Common goals across organization
• Alignment of resources
• Continuous analysis for refinement

Promoting the QI Culture

“Thirty percent of driving performance is science: Identify the right thing to do. Seventy percent is sociology: Make the right thing happen and make the right thing easy to do.”

Sharon Levine, MD
Associate Executive Director
The Permanente Medical Group
Be Member Centric – not measure centric

- Start with the prospective member – proselytize in marketing
- Communicate in detail with member about Stars, why the measurement and what’s in it for them
- Create an army of members seeking their:
  - Eye exam
  - Colorectal cancer screening
  - Breast cancer screening
  - Flu shots
  - Conversations about falls and bladder control
- Enlist members in root cause analysis
  - Help identify special populations and appropriate approach
  - Help identify barriers
  - Help identify best communication methods
  - Help identify bad actors (from staff to providers)

Some Important Cross Functional Team Players and their Role in Quality

- It’s not something the “Quality Department” does any more
- Member Service – Customer Service
- Enrollment
- Network and Provider Relations
- Credentialing
- Claims
- IT
- Sales!
- Compliance
- Health Services
- Marketing – Corporate Communications
Other Best Practices for Cross Functional Team – Sub Groups

- Complaints workgroup – trend analysis, root cause
- Pharmacy workgroup – address barriers, patient safety, adherence, medication reviews, ENGAGE THE PBM
- Rejected claims workgroup – identify any system issues
- Preventive care workgroup – timelines, checklists, coordination of outreach efforts with other units
- Provider “Tactical” workgroup

Provider Best Practices

- Involve providers in planning
- Set agreed-upon goals and strategies
- Share data early and often
- Involve provider staff, not just the provider
  - Keep daily processes in mind
  - Include staff in incentive programs
- Tools, tools, tools
  - Checklists – preventive care
  - Reports – gaps in care
  - Rankings - Comparison to peer group
- Quality incentive programs
- Differentiate in Provider Directory and Website
- Drive unassigned members to quality providers
- Publicize successful performance – ads, awards, etc.
Best Practices in Sharing Data

- The right message for the right audience
- Executive team – graphs, charts, and tables let them “see” the progress on a “dashboard” – exclude minutia
  - % completed
  - Improvement over last year
  - Identify trouble spots
  - Show big picture Star Rating or HEDIS score
  - Show progress over time
- Operational areas need all the details to take action
  - Patient level data
  - Data integrity
  - How many more to get to next star?
- Timely, Predictable and Accurate for providers (explain limitations and timeframes)
  - Format for action
  - Format for quality incentive monitoring and tracking for groups
  - Provide details AND big picture
EXAMPLE: Tool for Part D Forecasting

<table>
<thead>
<tr>
<th>STAR 'D' Measures</th>
<th>In Measure</th>
<th>Met Criteria</th>
<th>Lost</th>
<th>Current Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk Meds:</td>
<td>4,388</td>
<td></td>
<td>70</td>
<td>98.1%</td>
</tr>
<tr>
<td>Diabetes/Hypertension:</td>
<td>597</td>
<td>499</td>
<td></td>
<td>83.6%</td>
</tr>
<tr>
<td>Adherence: Oral Diabetes:</td>
<td>275</td>
<td>258</td>
<td>0</td>
<td>93.8%</td>
</tr>
<tr>
<td>Adherence: ACE/ARB:</td>
<td>500</td>
<td>469</td>
<td>3</td>
<td>93.9%</td>
</tr>
<tr>
<td>Adherence: Statin:</td>
<td>377</td>
<td>344</td>
<td>1</td>
<td>91.4%</td>
</tr>
</tbody>
</table>

Analysis and Predictive Analytics

- Many vendors – typical method is “gap analysis”
- Beware, “NCQA Certified Measures” – Old
- Know the limitations of your own data (collection methods, what sources are missing, does it pass the “smell test”)
- Check out CMS sources for averages
- Check, double check and triple check your vendor’s info
- Do your own tests
- References
Does Not Pass Smell Test

<table>
<thead>
<tr>
<th>STARS Measure</th>
<th>Rating</th>
<th>Members Total</th>
<th>Members Met</th>
<th>Members Not Met</th>
<th>Members To 1 Star</th>
<th>Members To 2 Star</th>
<th>Members To 3 Star</th>
<th>Members To 4 Star</th>
<th>Members To 5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>C18 - Adult BMI Assessment</td>
<td></td>
<td>81</td>
<td>59</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>C19 - Cholesterol Management in Women with a Previous Heart Attack</td>
<td></td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C21 - Diabetes Care - Eye Exam</td>
<td></td>
<td>314</td>
<td>314</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C25 - Diabetes Care - Kidney Disease Monitoring</td>
<td></td>
<td>314</td>
<td>314</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C26 - Diabetes Care - Blood Sugar Controlled</td>
<td></td>
<td>314</td>
<td>133</td>
<td>181</td>
<td>187</td>
<td>113</td>
<td>133</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C28 - Controlling Blood Pressure</td>
<td></td>
<td>685</td>
<td>0</td>
<td>685</td>
<td>184</td>
<td>424</td>
<td>314</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C29 - Rheumatoid Arthritis Management</td>
<td></td>
<td>24</td>
<td>22</td>
<td>24</td>
<td>5</td>
<td>9</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Best Practices for Incentives

- Quality incentive programs
- Include key functional staff not just the group (physicians, care managers, front office, billing)
- Differentiate in Provider Directory and website
- Drive unassigned members to quality providers
- Publicize successful performance – ads, awards, etc.
Provider Directory Recognition

Vennamaneni, Manjusri, MD*
5362 Spring Hill Drive
Spring Hill, FL 34606
(352) 688-3379
NCQA Recognized Practice
Patient Centered Medical Home

Provider Directory Recognition

Vennamaneni, Manjusri, MD*
5362 Spring Hill Drive
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NCQA Recognized Practice
Patient Centered Medical Home
Coordinate, Coordinate, Coordinate

- Kill many birds with one stone by consolidating interventions
  - QIP
  - CCIP
  - Stars
  - Risk Adjustment
  - D-SNP Assessments
- Each member interaction should be leveraged
- Don’t overload providers with multiple burdens.

Leverage Provider-Member Trust

- Provider and staff already have a relationship with member
- They’ve already gotten to the “Yes”
- Coordinate member engagement campaigns with providers
- Live person calls better than IVR – Can we leverage provider office familiarity?
- Letters and materials from PROVIDER
- Preventive care checklists, signage and education
Preventive Care Checklists and Education
Signage and Member Education

At Your Appointment Today, Ask Me About:

• Whether the flu vaccine is right for you
• Whether we should schedule a test for osteoporosis screening

And While We’re At It… Let’s Talk About:

• Concerns about urine leakage. We can manage it!
• Your level of physical activity
• Could you be at risk for falling?

Get Your Priorities Straight

• What measures?
• What Members?
• Which Providers?
• Which Interventions?
Changing Your Dialogue…

STAR Ratings Impact Your…

<table>
<thead>
<tr>
<th>Finances (Finance and Medical Management)</th>
<th>Membership/Growth (Sales and Enrollment)</th>
<th>Your Relationships (Contracting and Network Mgmt)</th>
<th>Your Brand (Marketing and Communication)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 5 STAR Rating means…</td>
<td>The Impact is…</td>
<td>Who Cares?</td>
<td></td>
</tr>
<tr>
<td>Quality Bonus Payments $40 Million in 2016</td>
<td>Chief Financial Officer</td>
<td>$2 Million payable</td>
<td>Network Management</td>
</tr>
<tr>
<td>More PCP Incentive Payments</td>
<td></td>
<td>$17k saved per avoidance</td>
<td>Medical Management</td>
</tr>
<tr>
<td>A low readmission rate</td>
<td></td>
<td>125 members saved</td>
<td>Everyone</td>
</tr>
<tr>
<td>High Colorectal Cancer Screening Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Know Your Numbers

Communication

• **Internal**
  - **Key Takeaway: Know your numbers**
    - What are your top priorities and why?
  - **Prepare your “data driven elevator speeches”**
    - Go ahead…try it at your table…
      “For 2016 we are focusing on _____.
      This is a priority because ____. Our success means ____ for the organization.”
Craft Your Elevator Speech

1. Executive Team (i.e. CEO / CFO)
2. Operational Areas (i.e. Member Services, Claims)
3. Network Providers
4. Members and Community

What Can we Do While We Wait for 2018 Tech Specs

- Evaluate against national benchmarks
- Get Plugged In: Review Call Letters, Tech Specs, HPMS Memos, RFCs, NCQA Upcoming Measures, Attend Conferences
- Review work plan (what tactics worked, what didn’t)
- Plan to take advantage of new leeway CMS has provided (incentives)
- Leverage cross functional teams
- Educate and Activate
  - Executive team
  - Staff
  - Members
  - Providers

*When we catch fish, we bait the hook with what the fish like, not what the fisherman likes.*
Thanks for joining us today.

Ana Handshuh
CAT 5 Strategies
407-619-3016
anahandshuh@gmail.com
Workshop C:
Coding Fundamentals
A Primer: Navigating the Nuts and Bolts of Coding

Panelists:
Samantha Caplan, Risk Adjustment and Coding Analyst
PROVIDENCE HEALTH PLANS

Susan Wyatt
CODING EDUCATOR
Samantha Caplan a Risk Adjustment Educator with Providence Health Plan. Before joining the Coding Compliance team at Providence Health Plan in 2014, Samantha spent many years as a coder, auditor, physician educator, and reimbursement specialist in several large specialty groups. Samantha is credentialed as a certified professional coder (CPC) and certified risk adjustment coder (CRC), and has served as president of the Seattle First Hill Chapter of the American Academy of Professional Coders (AAPC). Samantha also carries a Bachelor’s degree in Public Health.
Susan Wyatt

I have been in the medical field 40 years. I have worked in doctor’s offices starting as a receptionist and working my way up to Office Manager and Administrator for Primary Care as well as a few different specialties. I have been coding since the 80’s but became a CPC (Certified Professional Coder) in 2003. I also am a CPC-I (Certified Professional Coding Instructor), CPMA (Certified Professional Medical Auditor) and CHCCS (Certified HCC Specialist). I am also an ICD-10 certified trainer. I have been in management for 25 years and the last 13 years have been working for Medicare Advantage Health plans as Director Risk Adjustment Audit and Education. I now have my own consulting business, Susan Wyatt HealthCare Consulting Inc. My specialty is educating clinicians, coders etc. on the Medicare Risk Adjustment HCC model. I focus on the clinicians to educate them on proper documentation and coding for ICD-10 diagnoses as it relates to HCC. I also do focus chart audits for Risk Adjustment HCC with analysis and educational feedback to the clinician. I have experience with RADV’s as well. ICD-10 tools is a specialty of mine as well.
The Science of Medicare Risk Adjustment
HCC Documentation and Coding

"I hear there's a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system."
**Medicare Risk Adjustment (MRA)**

**Before 2003**
- Managed Care ‘HMO’
  - Not influenced by Health Status
  - Based on Demographics
  - “Capitated” Flat rate/member/year

**MRA payment methodology was started in 2003 – mandated by the Balance Budget Act of 1997**

**After 2003**
- Managed Care HMO (CMS-HCC)
  - Risk Adjusted for Health Status
  - Based partially on Demographics
  - Predictive Model

**Medicare Fee for Service**
- Predetermined Fee for Service
- Payment based on CPT

**Hierarchical Condition Category (HCC)**

- 69,823 ICD-10 Diagnosis Codes
  - All Codes ICD-10

- 10,761 Risk Adjusted ICD-10 Codes
  - Map to 1 of 79 Categories
  - Each Code = an “HCC”

- 79 Categories of Codes
  - Clinically related Conditions
  - Each Category is technically an HCC
  - Each Category has a RAF (Risk Adjustment Factor)
  - Most Categories (RAFs) are Additive and some can Hierarch others
Why is Risk Adjustment Important?

For accurate RAF reimbursement for the patient’s health status, specific documentation and coding of the conditions is necessary!

RAF Score reflects disease burden of the patient

Average RAF of Patient = 1.00

Requirements for Documentation & Coding

- All Chronic Conditions must be documented at least once every year!
- Think about diagnostic documentation as a form of nomenclature!
- Thorough documentation promotes Continuity of Care!

Encounter must be a face-to-face visit

Legible signature and provider credentials

Manage, Evaluate, Assess, Treat – MEAT!

Patient Name; DOB; DOS on every page (backside, too!)
**Behavioral Health**

**Major Depression**

*5 of 9 DSMV SIGECAPS (sleep, interest, guilt, energy, concentration, appetite, psychomotor changes, suicidal ideation, plus depressed mood)

- 1 of the 5 must be either a depressed mood or loss of interest and must be present for at least 2 weeks
- Clinically significant distress or impairment in social, occupational or other areas of functioning
- The episode is not attributable to the physiological effects of a substance or to another medical condition

PHQ9 score >10

**Full Remission**: there must be a period of 2 or more months with no symptoms

**Partial Remission**: symptoms are present, but full criteria are not met, or there are no significant symptoms for a period of less than 2 months

**Recurrent Episode**: to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode.

"The clinical criteria above are used by providers to establish a diagnosis of Major Depression. The coder should only code for the condition if the provider documents "Major Depression".

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---

**Behavioral Health**

**“Depression”, unspecified = Major Depression, single episode, unspecified NOT an HCC!**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In/ Comm Dual PAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression Single Episode:</td>
<td>F32.0-8</td>
<td>58</td>
<td>0.395 / 0.444</td>
</tr>
<tr>
<td>Mild, Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severe w/o Psychotic Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severe w/ Psychotic Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Remission, Full Remission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Depression Recurrent Episode</td>
<td>F33.*</td>
<td>58</td>
<td>0.395 / 0.444</td>
</tr>
<tr>
<td>Unspecified, Mild, Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severe w/o Psychotic Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Severe w/Psychotic Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial Remission, Full Remission</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

"Major Depression", "Depression", Depressive Disorder (F32.9), Anxiety (F41.9), GAD (F41.1), Dysthymia (F34.1) ARE NOT HCCs!

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**HCC Quiz – Behavioral Health**

**Scenario**

HPI: Mr. H is here to follow up on his hypertension and Major Depression. He's teary, and stated “my whole world is falling apart”.

**Medications:**
Atenolol 25 mg, Prozac 10 mg

**Assessment:**
Hypertension – Continue monitoring. Blood pressure stable today. Major Depression – Prozac 20mg daily to see if symptoms improve. Referral for psychological counseling given.

**Select the best answer:**

What is missing in the documentation in order to code “Major Depression” to the highest specificity?

A. Episode – single or recurrent
B. Severity – mild, moderate, or severe
C. There is enough MEAT to properly code the condition
D. A and B are correct

**Answer:**

D. A and B are correct

---

**Behavioral Health**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In/Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder, Unspecified (Bipolar Disorder, Manic-depressive Reaction, Manic-depressive Psychosis)</td>
<td>F31.9</td>
<td>58</td>
<td>0.395 / 0.444</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>F22</td>
<td>58</td>
<td>0.395 / 0.444</td>
</tr>
<tr>
<td>Schizophrenia, Unspecified</td>
<td>F20.9</td>
<td>57</td>
<td>0.608 / 0.612</td>
</tr>
<tr>
<td>Schizoaffective Disorder, Unspecified</td>
<td>F25.9</td>
<td>57</td>
<td>0.608 / 0.612</td>
</tr>
<tr>
<td>Schizoaffective Disorder, Bipolar Type</td>
<td>F25.0</td>
<td>57</td>
<td>0.608 / 0.612</td>
</tr>
<tr>
<td>Schizoaffective Disorder, Depressive Type</td>
<td>F25.1</td>
<td>57</td>
<td>0.608 / 0.612</td>
</tr>
</tbody>
</table>
**Pathological Fracture**

**Documented Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis (age related) with current Path Fracture, Vertebrae (Initial Encounter)</td>
<td>M80.08XA</td>
<td>169</td>
<td>0.495 / 0.552</td>
</tr>
</tbody>
</table>

7th Character:
- A: Initial Diagnosis
- D: Subsequent encounter for Fx with Routine Healing (for use after the patient has completed active treatment)
- G: Subsequent encounter for Fx with Delayed Healing
- K: Subsequent encounter for Fx with Nonunion
- P: Subsequent encounter for Fx with Malunion
- S: Sequela

---

**Pathological Fracture**

**Documented Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathological Fracture of Femur due to Osteoporosis</td>
<td>M80.051*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Right Femur, Initial Encounter</td>
<td>M80.052*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Left Femur, Initial Encounter</td>
<td>M80.059*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Unspecified Femur, Initial Encounter</td>
<td>M80.551*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Pathological Fracture of Femur due to Cancer</td>
<td>M84.551*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Left Femur, Initial Encounter</td>
<td>M84.552*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
<tr>
<td>Left Femur, Initial Encounter</td>
<td>M84.553*</td>
<td>170</td>
<td>0.418 / 0.520</td>
</tr>
</tbody>
</table>

7th character “A” is for use as long as the patient is receiving active treatment for the fracture:

Example of active treatment are:
- Surgical Treatment, Emergency Department Encounter, Evaluation and continuing treatment by the same or a different provider.
- While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

---

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**Rheumatoid Arthritis & Connective Tissue Disease**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In/Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflammatory Polyarthritis</td>
<td>M06.4</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>M06.9</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Psoriatic Arthritis</td>
<td>L40.50</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Ankylosing Spondylitis</td>
<td>M45.9</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
</tbody>
</table>

- If the patient has RA, please document if they are on a DMARD
- If DMARD is contraindicated, please document current treatment
- Please do not document RA if it has not been confirmed by a Rheumatologist.

If you know the patient has Inflammatory Arthritis but are not sure which type, you can document “Inflammatory Arthritis” and it is in the same HCC category as RA.

Osteoarthritis or DJD, Arthritis (M19.90); Polyarthritis M13.0; Fibromyalgia (M79.7); Gout (M10.9) ARE NOT HCCs!

---

**HCC Quiz - Rheumatoid Arthritis & Connective Tissue Disease**

**Scenario**

Assessment and Plan:
Rheumatoid arthritis

**Select the best answer:**

What does the provider need to document in order to code the rheumatoid arthritis to the highest specificity?

A. Type
B. Anatomical site
C. Laterality
D. Rheumatoid factor with or without organ involvement
E. All of the above

Answer: E. All of the above
### Rheumatoid Arthritis & Connective Tissue Disease

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polymyalgia Rheumatica (PMR)</td>
<td>M35.3</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Sacroiliitis</td>
<td>M46.1</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Lupus (SLE)</td>
<td>M32.9</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Systemic Sclerosis</td>
<td>M34.9</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Sicca Syndrome</td>
<td>M35.00</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Polymyositis</td>
<td>M33.20</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
<tr>
<td>Diffuse Connective tissue Disease</td>
<td>M35.9</td>
<td>40</td>
<td>0.423 / 0.370</td>
</tr>
</tbody>
</table>

Osteoarthritis or DJD (M19.90); Arthritis (M19.90); Fibromyalgia (M79.7); Gout (M10.9) ARE NOT HCCs!

### Diseases of Blood Forming Organs & Blood

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpura, Thrombocytopenic</td>
<td>D69.49</td>
<td>48</td>
<td>0.221 / 0.268</td>
</tr>
</tbody>
</table>

Purpura (Senile, NOS, Non-thrombocytopenic)  
Causes:  
- Connective tissues weaken and skin becomes thinner due to aging or sun exposure  
- Blood leaks under the skin, dark purplish-red splotches occur that fade gradually  
- May occur without trauma or injury

Petechiae (R23.3); Ecchymosis (R58); Skin Lesion (L98.9); Contusion, Hematoma (T14.8) ARE NOT HCC's!
### Diseases of Blood Forming Organs & Blood

#### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Hypercoagulable State</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Venous stasis (caused by immobility, obesity, CHF)</td>
<td>D68.59</td>
<td>48</td>
<td>0.221 / 0.268</td>
</tr>
<tr>
<td>• Coagulation factor activation (caused by malignant disease, Nephrotic Syndrome)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Platelet activation (caused by Myeloproliferative Disorder, Thrombotic Thrombocytopenic Purpura)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquired Coagulopathy (Liver Disease, Vitamin K Deficiency)</td>
<td>D68.4</td>
<td>48</td>
<td>0.221 / 0.268</td>
</tr>
<tr>
<td>Coagulation Defect (Coagulopathy)</td>
<td>D68.9</td>
<td>48</td>
<td>0.221 / 0.268</td>
</tr>
</tbody>
</table>

#### Anemia (D64.9), Anemia in CKD (D63.1), Anemia in Neoplastic Disease (D63.0), Anemia in Other Chronic Diseases (D63.8), Iron Deficiency Anemia (D50.9) ARE NOT HCCs!
New ICD-10-CM “With” Coding Rule

- 2017 ICD-10 CM Coding Guidelines state the following regarding “With”:
  The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetic order.

- The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. The conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

How the “with” rule applies to Diabetes

- Any condition listed under “with” is assumed to be a complication of Diabetes.

- The provider does not need to state the cause and effect relationship between the Diabetes and the condition as long as the condition is under “with” following Diabetes.

- Exception to the new rule – when a condition is not listed under “with” the provider must link them by using words or phrases such as “Diabetic”, “due to”, “secondary to”, “associated with”, “related to”, etc.
**Educating Clinicians on the New Diabetes Assumed Rule**

- “Make the causal link” and similar statements have been impressed upon providers by risk coding educators for many years.

- Providers should be informed of this new rule to ensure they code completely and to the highest specificity. Whether they are documenting on a hand-written or electronic note — without knowledge of this new rule they may choose the incorrect code on a hard-copy superbill/encounter form or search incorrectly in their EMR for a combination code.

- The most difficult aspect of educating providers will be helping them remember that when the condition is not listed under “with” they will still need to link it to the Diabetes. Many providers, particularly those who document in an EMR, do not have an ICD-10 CM code book readily available for reference.

- Exception to the new rule – A causal relationship should *not* be inferred if the documentation clearly states the conditions are unrelated.

**Common Diabetic Complications Listed Under “With”**

- Arthropathy
- CKD
- Cataract
- Nephropathy
- Retinopathy
- Dermatitis
- Gangrene
- Gastroparesis
- Foot Ulcer and Skin Ulcer
- PVD
- Neuropathy
- Hyperglycemia
- Osteomyelitis
- Periodontal Disease
- Hypoglycemia
Some Conditions that Need Linkage

Providers would need to establish the cause-and-effect relationship with statements such as:
- Hypertension due to Diabetes
- Hyperlipidemia associated with Diabetes
- Angina related to Diabetes

Diabetes Mellitus Type 2

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM Type 2 without a Complication</td>
<td>E11.9</td>
<td>19</td>
<td>0.104 / 0.097</td>
</tr>
<tr>
<td>Diabetes with Hyperglycemia</td>
<td>E11.65</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM Type 2 with Kidney Complications</td>
<td>E11.2*</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM Type 2 with Ophthalmological Complication</td>
<td>E11.3**</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM Type 2 with Neurological Complication</td>
<td>E11.4*</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM Type 2 with Peripheral Circulatory Complication</td>
<td>E11.5*</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM Type 2 with Other Specified Complications</td>
<td>E11.6**</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
</tbody>
</table>

Glucose Intolerance, Pre-Diabetes, Borderline Diabetes, Abnormal Glucose (R73.09), Elevated Glucose A

ARE NOT HCCS
### Diabetes with Kidney Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic CKD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD Stage 4-5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM</td>
<td>E11.22</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>CKD</td>
<td>N18.*</td>
<td>136</td>
<td>0.237 / 0.244</td>
</tr>
<tr>
<td>Diabetic ESRD on Dialysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESRD (CKD Stage 6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM</td>
<td>E11.22</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>CKD</td>
<td>N18.6</td>
<td>136</td>
<td>0.217 / 0.223</td>
</tr>
</tbody>
</table>

ESRD requires an additional code “buddy code”

ESRD (CKD Stage 6)

Diabetes with a Kidney complication requires a “buddy code”.

CKD Stage 1-3 & Unspecified (N18.1-3, 9), Renal Insufficiency (N28.9), Kidney Failure (N19), Proteinuria/Microalbuminuria (R80.9) ARE NOT HCCs!

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### Diabetes with Ophthalmic Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified Diabetic Retinopathy (Background) with or without Macular Edema</td>
<td>E11.31*</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Proliferative Diabetic Retinopathy</td>
<td>E11.35*</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Right Eye with or without Macular Edema</td>
<td></td>
<td>122</td>
<td>0.217 / 0.223</td>
</tr>
<tr>
<td>Diabetic Cataract</td>
<td>E11.36</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>DM with Other Diabetic Ophthalmic Complications</td>
<td>E11.39</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Wet (Exudative) Macular Degeneration</td>
<td>H35.32</td>
<td>124</td>
<td>0.499 / 0.278</td>
</tr>
</tbody>
</table>

DM with Other Diabetic Ophthalmic Complications

Diabetes with the above complications are combination codes; both the Diabetes and the particular Ophthalmic manifestation are represented by a single code.

This Diabetes code would need an additional code for the complication but cause and effect is stated in the code description.

Glaucoma (H40.9); Blindness (H54.0); Macular Degeneration (H35.30); Dry Macular Degeneration (H35.31) ARE NOT HCCs!

These conditions can be due to Diabetes and can be used as “Buddy Codes”

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**Diabetes with Neurological Complications**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Neuropathy, Unspecified</td>
<td>E11.40</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetic Peripheral Neuropathy (Diabetic Neuralgia)</td>
<td>E11.42</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetic Mononeuropathy</td>
<td>E11.41</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
</tbody>
</table>

Diabetes with Neuropathy complications are combination codes. One code describes both the Diabetes and the complication ("buddy").

- Diabetic Autonomic Neuropathy (Diabetic Gastroparesis) | E11.43 | 18  | 0.318 / 0.346 |
- Gastroparesis (K31.84) - Code also the "buddy code" |
- Diabetic Neurological Complication | E11.49 | 18  | 0.318 / 0.346 |

Also code the Complication – "Buddy Code"

Gastroparesis (K31.84), Peripheral Autonomic Neuropathy (G90.9) ARE NOT HCCs! These conditions can be “due to Diabetes” and can be used as “Buddy Codes”

---

**HCC Quiz - Diabetes with Neurological Complications**

**Scenario**

Mr. J came in for follow-up visit with his PCP

Assessment:
1. DM with neurological manifestations

**Select the best answer:**

Should the code for DM with neurological manifestations be selected if the manifestation isn’t documented?

A. Yes
B. No

**Answer:** B. No
Diabetes with Circulatory Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic PVD w/o Gangrene</td>
<td>E11.51</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td></td>
<td></td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.616 / 0.670</td>
</tr>
<tr>
<td>Diabetic PVD w/Gangrene</td>
<td>E11.52</td>
<td>18</td>
<td>0.368 / 0.346</td>
</tr>
<tr>
<td></td>
<td></td>
<td>106</td>
<td>1.416 / 1.744</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.779 / 2.090</td>
</tr>
<tr>
<td>Diabetes with Other Circulatory complication</td>
<td>E11.59</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Also code the complication — “Buddy Code”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Limb Amputation</td>
<td>Z89.***</td>
<td>189</td>
<td>0.588 / 0.787</td>
</tr>
</tbody>
</table>

Diabetes with Other Specified Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes with Diabetic Arthropathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Neuropathic Arthropathy (Charcot’s)</td>
<td>E11.610</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetes with other Diabetic Arthropathy</td>
<td>E11.618</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
</tbody>
</table>

Diabetic Arthropathy is a combination code. One code describes both the Diabetes and the complication (“buddy”).

Neuropathic Arthropathy (M14.60) is NOT an HCC!
### Diabetes with Other Specified Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Skin Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes with Foot Ulcer</td>
<td>E11.621</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Code also the &quot;buddy code&quot;</td>
<td></td>
<td></td>
<td>0.853/1.103</td>
</tr>
<tr>
<td>Foot Ulcer</td>
<td>L97.4**-5**</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
<tr>
<td>Diabetes with Other Skin Ulcer</td>
<td>E11.622</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Code also the &quot;buddy code&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Ulcer</td>
<td>L97.1**-L97.9**</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
</tbody>
</table>

Ulc = Site + Laterality + Severity  

### Diabetes with Other Specified Complications

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Oral Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes w/Periodontal Disease</td>
<td>E11.630</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetes with Other Oral Complications</td>
<td>E11.638</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetes with Hypoglycemia</td>
<td></td>
<td></td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetes with Hypoglycemia with Coma</td>
<td>E11.641</td>
<td>17</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Diabetes with Hypoglycemia without Coma</td>
<td>E11.649</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
</tbody>
</table>

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**Diabetes with Other Specified Complications**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/other specified complication</td>
<td>E11.69</td>
<td>18</td>
<td>0.318 / 0.346</td>
</tr>
<tr>
<td>Osteomyelitis (due to DM)</td>
<td>M86.9</td>
<td>39</td>
<td>0.425 / 0.522</td>
</tr>
</tbody>
</table>

The causal relationship between diabetes and osteomyelitis can now be assumed in the absence of a documented causal link!

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina (due to DM)</td>
<td>I20.9</td>
<td>88</td>
<td>0.140 / 0.068</td>
</tr>
<tr>
<td>CAD with Angina (Due to DM)</td>
<td>I25.119</td>
<td>88</td>
<td>0.140 / 0.068</td>
</tr>
<tr>
<td>MI (Acute and up to 4 weeks) (Due to DM)</td>
<td>I21.3</td>
<td>86</td>
<td>0.233 / 0.473</td>
</tr>
</tbody>
</table>

Angina, CAD with Angina, and Acute MI cannot be assumed to be a result of Diabetes unless the provider documents the causal relationship between the condition and the DM.

Hypertension (I10), Hyperlipidemia (E78.5), Erectile Dysfunction (N52.9) ARE NOT HCCs!

These conditions can be “Due to DM” and can be used as “Buddy Codes”

**Malnutrition**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cachexia (Wasting Disease)</td>
<td>R64</td>
<td>21</td>
<td>0.545 / 0.752</td>
</tr>
<tr>
<td>Protein Calorie Malnutrition</td>
<td>E46</td>
<td>21</td>
<td>0.545 / 0.752</td>
</tr>
<tr>
<td>Mild, Moderate or Unspecified</td>
<td>E46</td>
<td>21</td>
<td>0.545 / 0.752</td>
</tr>
<tr>
<td>Severe PCM (under-coded in the elderly)</td>
<td>E43</td>
<td>21</td>
<td>0.545 / 0.752</td>
</tr>
</tbody>
</table>

Commonly used indicators:
- Albumin < 3.5
- 10% Unintentional weight loss in 6-12 months
- BMI < 18.5 especially with comorbidity
- Marked reduction in physical capacity
- Wasting appearance or muscle wasting or fat loss
- Poor nutrition, loss of appetite
- Seriously curtailed food intake
- Persistent, daily gastro symptoms in last 2 wks.

Failure to thrive (R62.7) and Weight loss (R63.4) ARE NOT HCCs!
### Morbid Obesity

#### Documented Diagnosis

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td>E66.01</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td>With Obesity Hypoventilation (Pickwickian) Syndrome</td>
<td>E66.2</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td><strong>BMI (Body Mass Index)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ 40.0 – 44.9</td>
<td>Z68.41</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td>▪ 45.0 – 49.9</td>
<td>Z68.42</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td>▪ 50.0 – 59.9</td>
<td>Z68.43</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td>▪ 60.0 – 69.9</td>
<td>Z68.44</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
<tr>
<td>▪ 70 and over</td>
<td>Z68.45</td>
<td>22</td>
<td>0.273 / 0.410</td>
</tr>
</tbody>
</table>

Need to document the BMI at least once a year as it is a STARS measure!

Loss of Weight (R63.4), Underweight (R63.6), Obesity (BMI 30-39.9) (E66.9), Sleep Apnea (G47.30) ARE NOT HCCs!

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### HCC Quiz – Morbid Obesity

#### Scenario

Vitals: BMI 40.3

Assessment and Plan:
BMI of 40.0-44.9, adult – patient counseled and diet and exercise.

#### Select the best answer:

Should the code for the BMI be captured without the assessment of an associated condition (overweight, obese, morbidly obese)?

A. Yes
B. No

Answer: A. Yes
### Nephrology

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD Stage IV (Severe) (GFR 15-29)</td>
<td>N18.4</td>
<td>136</td>
<td>0.237 / 0.244</td>
</tr>
<tr>
<td>CKD Stage V (ESRD, no Dialysis) (GFR &lt;15)</td>
<td>N18.5</td>
<td>136</td>
<td>0.237 / 0.244</td>
</tr>
<tr>
<td>CKD Stage VI (ESRD on Dialysis)</td>
<td>N18.6</td>
<td>136</td>
<td>0.237 / 0.244</td>
</tr>
</tbody>
</table>

**Code also the “buddy code”**

<table>
<thead>
<tr>
<th>Dialysis Status</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Compliant w/Dialysis</td>
<td>Z91.15</td>
<td>134</td>
<td>0.422 / 0.672</td>
</tr>
<tr>
<td>Presence of surgically created A/V Shunt for Dialysis – Z99.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Acute Renal Failure                       | N17.9  | 135  | 0.422 / 0.672               |
| Secondary Hyperparathyroidism (renal origin) | N25.81 | 23   | 0.228 / 0.228               |
| Hypertensive CKD (Stage 5 or ESRD)        | I12.0  | 136  | 0.237 / 0.244               |

**HTN + CKD = Hypertensive CKD (assumed relationship)**

| Two ICD-10 codes required: I12.* and N18.* |

**Code also, if applicable**

| CKD Stage 1-3 & Unspecified Stage (N18.1-3, 9), Kidney Disease, Acute Renal Insufficiency, Nephropathy (N28.9); Chronic Renal Insufficiency (N18.9); Hypertensive CKD Stages 1-3 (I12.9 + N18.1-3,9) ARE NOT HCCs! |

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### Neurology

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson’s</td>
<td>G20</td>
<td>78</td>
<td>0.674 / 0.751</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>G35</td>
<td>77</td>
<td>0.441 / 0.687</td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td>G80.9</td>
<td>74</td>
<td>0.280 / 0</td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td>G40.909</td>
<td>79</td>
<td>0.309 / 0.357</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>G82.50</td>
<td>70</td>
<td>1.314 / 1.098</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>G82.20</td>
<td>71</td>
<td>1.007 / 0.920</td>
</tr>
<tr>
<td>Alcoholic Neuropathy</td>
<td>G62.1</td>
<td>75</td>
<td>0.457 / 0.436</td>
</tr>
</tbody>
</table>

**Code also, if applicable**

| Alcohol Dep or Dep in Remission            | F10.2* | 55   | 0.383 / 0.522              |

**Peripheral Neuropathy (G62.9), Mononeuropathy (G56.9), Myelopathy (G62.9), Neuropathy of lower extremity (G57.90), Peripheral Autonomic Neuropathy (G90.90), Myopathy (G72.0) ARE NOT HCCs!**
# HCC Quiz - Neurology

## Scenario

**HPI:** History of seizure. None since original. Tapered off seizure medications under Dr. M’s direction. EEG normal. No problems. Has started to drive again. The report from the patient’s most recent visit was reviewed.

**Active Problem List:**
- Seizure

**Assessment:**
- Convulsions, unspecified convulsion type

## Select the best answer:

Based on the documentation, can convulsions be coded?

- A. Yes
- B. No

**Answer:** B. No

---

## Neurology

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute CVA</td>
<td>I63.9</td>
<td>100</td>
<td>0.263 / 0.474</td>
</tr>
<tr>
<td>Carotid Stenosis with Infarction</td>
<td>I63.20</td>
<td>100</td>
<td>0.263 / 0.474</td>
</tr>
<tr>
<td>CVA with Hemiparesis/Hemiplegia, right dominant side</td>
<td>I69.351</td>
<td>103</td>
<td>0.538 / 0.548</td>
</tr>
<tr>
<td>CVA with Monoplegia Upper or Lower Limb</td>
<td>I69.3**</td>
<td>104</td>
<td>0.395 / 0.374</td>
</tr>
</tbody>
</table>

When the provider documents “weakness” due to a cerebral infarction it can be coded as hemiparesis/hemiplegia. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia.

**AHA Coding Clinic® 1st Quarter 2015/Vol. 2, No. 1.**
### Non-Pressure Chronic Ulcers

**“WOUND” IS NOT SYNONYMOUS WITH “ULCER”!**

Wounds are not HCC codes!

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Pressure (Chronic) Ulcer</td>
<td>L97.***</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-pressure Chronic Ulcer of Right Heel and Midfoot, limited to Breakdown of Skin</td>
<td>L97.411</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
<tr>
<td>Non-pressure Chronic Ulcer of Other Part of Left Foot, with Necrosis of Muscle</td>
<td>L97.523</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
</tbody>
</table>

- **Site** identifies the location of the ulcer
- **Laterality** specifies left, right or unspecified side of the body
- **Severity** is designated by 5 levels:
  - limited to breakdown of skin,
  - fat layer exposed,
  - necrosis of muscle exposed,
  - necrosis of bone exposed and
  - unspecified severity

### Pressure Ulcers

Pressure Ulcers use Combination Codes
(1 code = Site + Laterality + Stage)

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer (Decubitus)</td>
<td>L89.90*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcer of Right Hip, Stage 3</td>
<td>L89.213</td>
<td>158</td>
<td>1.204 / 1.576</td>
</tr>
<tr>
<td>Pressure Ulcer of Left Heel, Stage 4</td>
<td>L89.624</td>
<td>157</td>
<td>2.163 / 2.879</td>
</tr>
<tr>
<td>Pressure Ulcer, Sacrum, Unstageable</td>
<td>L89.150</td>
<td>158</td>
<td>1.204 / 1.576</td>
</tr>
</tbody>
</table>

Pressure Ulcer Site & Stages I, II and Unspecified Stage (L89.9* - L89.92*) ARE NOT HCCs!
# Vascular Disease

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVD (PAD, Intermittent Claudication)</td>
<td>I73.9</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Atherosclerosis of the Extremities</td>
<td>I70.2**</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Venous Stasis Ulcer (w/varicose veins)</td>
<td>I83.0**</td>
<td>107</td>
<td>0.400 / 0.540</td>
</tr>
<tr>
<td>Stasis Dermatitis w/Ulcer (w/varicose Veins)</td>
<td>I83.2**</td>
<td>107</td>
<td>0.400 / 0.540</td>
</tr>
<tr>
<td>Stasis Edema w/Ulcer (Chronic Venous HTN w/ulcer)</td>
<td>I87.31*</td>
<td>107</td>
<td>0.400 / 0.540</td>
</tr>
<tr>
<td>Pain in the legs (M79.606), Atherosclerosis (I70.90), Venous Insufficiency (I87.2), Stasis Dermatitis (I83.10), Stasis Edema (I87.309), Carotid Stenosis (I65.29), Aortic Stenosis (I35.9) ARE NOT HCCs!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in the legs (M79.606), Atherosclerosis (I70.90), Venous Insufficiency (I87.2), Stasis Dermatitis (I83.10), Stasis Edema (I87.309), Carotid Stenosis (I65.29), Aortic Stenosis (I35.9) ARE NOT HCCs!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in the legs (M79.606), Atherosclerosis (I70.90), Venous Insufficiency (I87.2), Stasis Dermatitis (I83.10), Stasis Edema (I87.309), Carotid Stenosis (I65.29), Aortic Stenosis (I35.9) ARE NOT HCCs!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code also Site, Laterality &amp; Severity of Ulcer</td>
<td>L97.***</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
<tr>
<td>Code also Site, Laterality &amp; Severity of Ulcer</td>
<td>L97.***</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
<tr>
<td>Code also Site, Laterality &amp; Severity of Ulcer</td>
<td>L97.***</td>
<td>161</td>
<td>0.535 / 0.757</td>
</tr>
</tbody>
</table>

Pain in the legs (M79.606), Atherosclerosis (I70.90), Venous Insufficiency (I87.2), Stasis Dermatitis (I83.10), Stasis Edema (I87.309), Carotid Stenosis (I65.29), Aortic Stenosis (I35.9) ARE NOT HCCs!

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aortic Calcification (Atherosclerosis of the Aorta)</td>
<td>I70.0</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Aortic Ectasia</td>
<td>177.81*</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Stricture of/ Tortuous Aorta</td>
<td>I77.1</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Aneurysm (w/o repair)</td>
<td>I72.9</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Acute DVT (Unspecified vessel, Initial episode of care)</td>
<td>I82.40*</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Chronic DVT (on an anticoagulant)</td>
<td>I82.50*</td>
<td>108</td>
<td>0.298 / 0.324</td>
</tr>
<tr>
<td>Acute Pulmonary Embolism (Initial episode of care)</td>
<td>I26.99</td>
<td>107</td>
<td>0.400 / 0.540</td>
</tr>
<tr>
<td>Chronic Pulmonary Embolism (on anticoagulant)</td>
<td>I27.82</td>
<td>107</td>
<td>0.400 / 0.540</td>
</tr>
</tbody>
</table>

(*) = Right, Left, Bilateral, Unspecified

Further specificity available for actual vessel & side involved

H/O DVT (prophylaxis use or not on anti-coagulant) (286.718); H/O PE (prophylaxis use or not on anti-coagulant) (286.711) ARE NOT HCCs!

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**HCC Quiz - Vascular**

**Scenario**

HPI: Ms. F is here for follow-up of right lower leg pain.

Medications: Coumadin

PMH: Compartmental syndrome status post surgery 2 years ago

Assessment: Right leg pain – Duplex Doppler report of lower extremities from radiologist shows findings of “consistent with DVT”.

**Select the best answer:**

Can the DVT diagnosis code be assigned in this case?

A. Yes
B. No

Answer: B) No

**Cardiology**

**Documented Diagnosis**

<table>
<thead>
<tr>
<th></th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEMI/Unspecified, Initial</td>
<td>I21.3</td>
<td>86</td>
<td>0.233 / 0.473</td>
</tr>
<tr>
<td>NSTEMI, Initial</td>
<td>I21.4</td>
<td>86</td>
<td>0.233 / 0.473</td>
</tr>
<tr>
<td>Acute MI, Initial (within 4 wks.)</td>
<td>I21.3</td>
<td>86</td>
<td>0.233 / 0.473</td>
</tr>
</tbody>
</table>

Acute MI can be coded with the Acute Code for 4 weeks only if the 4 week time frame is documented!

Example:

“Patient released from hospital 3 weeks ago for Initial MI” I21.3 86 0.233 / 0.473

“Patient had recent MI” (Not HCC) I25.2 - -

Old MI (I25.2) is NOT AN HCC!
Table: Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF (Heart Failure, unspecified)</td>
<td>I50.9</td>
<td>85</td>
<td>0.323 / 0.355</td>
</tr>
<tr>
<td>HTN + HF = Hypertensive HF is now an assumed relationship. Two codes I11.0 &amp; I50.9 for Heart Failure</td>
<td>I11.0</td>
<td>85</td>
<td>0.323 / 0.355</td>
</tr>
<tr>
<td>Primary Cardiomyopathy or Cardiomyopathy</td>
<td>I42.9</td>
<td>85</td>
<td>0.323 / 0.355</td>
</tr>
<tr>
<td>Alcoholic Cardiomyopathy</td>
<td>I42.6</td>
<td>85</td>
<td>0.323 / 0.355</td>
</tr>
<tr>
<td>Code also, if applicable Alcohol Dep or Dep in Remission</td>
<td>F10.2*</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>Unstable Angina</td>
<td>I20.0</td>
<td>87</td>
<td>0.218 / 0.336</td>
</tr>
<tr>
<td>CAD with Unstable Angina</td>
<td>I25.110</td>
<td>87</td>
<td>0.218 / 0.336</td>
</tr>
<tr>
<td>Stable Angina</td>
<td>I20.8</td>
<td>88</td>
<td>0.140 / 0.068</td>
</tr>
<tr>
<td>CAD with Stable Angina</td>
<td>I25.119</td>
<td>88</td>
<td>0.140 / 0.068</td>
</tr>
</tbody>
</table>

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**HCC Quiz - Cardiology**

**Scenario**

Patient has a history of congestive heart failure that has been clinically stable without recurrence for the past year.

Current Meds:
- Toprol-XL 100 mg tablet
- Lopid 600 mg tablet
- Lipitor 40 mg

Assessment and Plan:

**Select the best answer:**

- A. Personal history of other diseases of the circulatory system
- B. Heart failure, unspecified

**Answer:**

B. Heart failure, unspecified
### Cardiology

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick Sinus Syndrome (Sinoatrial Node Dysfunction), Tachy-Brady Syndrome</td>
<td>I49.5</td>
<td>96</td>
<td>0.268 / 0.369</td>
</tr>
<tr>
<td>A-fib</td>
<td>I48.91</td>
<td>96</td>
<td>0.268 / 0.369</td>
</tr>
<tr>
<td>A-flutter</td>
<td>I48.92</td>
<td>96</td>
<td>0.268 / 0.369</td>
</tr>
<tr>
<td>Complete AV or 3rd degree block</td>
<td>I44.2</td>
<td>96</td>
<td>0.268 / 0.369</td>
</tr>
</tbody>
</table>

Sinus Bradycardia (I49.8), Cardiac Dysrhythmia (I49.9), Tachycardia (R00.0) ARE NOT HCCs!

If the patient has a pacemaker for either SSS or Complete or 3rd degree AV Block, do not code the SSS or the Complete or 3rd degree AV Block

"Sick Sinus Syndrome s/p pacemaker" (non-HCC) Z95.0
"Complete or 3rd degree block s/p pacemaker" (non-HCC) Z95.0

If the rhythm is being treated with a medication in addition to the pacemaker or if the pacemaker is being implanted for the first time, the code for SSS or Complete or 3rd AV Block may be reported.

AHA Coding Clinic®, 3rd Quarter 2010, Page 9

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### Pulmonology

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>J44.9</td>
<td>111</td>
<td>0.328 / 0.422</td>
</tr>
<tr>
<td>Chronic Bronchitis</td>
<td>J42</td>
<td>111</td>
<td>0.328 / 0.422</td>
</tr>
<tr>
<td>Simple Chronic Bronchitis (Smoker’s Cough)</td>
<td>J41.0</td>
<td>111</td>
<td>0.328 / 0.422</td>
</tr>
<tr>
<td>Emphysema</td>
<td>J43.9</td>
<td>111</td>
<td>0.328 / 0.422</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>J47.9</td>
<td>112</td>
<td>0.209 / 0.134</td>
</tr>
<tr>
<td>Pulmonary Fibrosis</td>
<td>J84.10</td>
<td>112</td>
<td>0.209 / 0.134</td>
</tr>
</tbody>
</table>

Use Additional Code to Identify (if applicable):
- Nicotine Dependence, Cigarettes (F17.210) (non-HCC)
- Nicotine Dependence, Cigarettes "in remission" (F17.211) (non-HCC)

Cough (R05); Asthma (unspecified), Chronic Asthma, Asthmatic Bronchitis, RAD (J45.909); Bronchitis (unspecified) (J40); and Acute Bronchitis (J20.9)

***ARE NOT HCCs!***
### Pulmonology

#### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Respiratory Failure</td>
<td>J96.00</td>
<td>84</td>
<td>0.302 / 0.471</td>
</tr>
<tr>
<td>Acute Respiratory Distress</td>
<td>J80</td>
<td>84</td>
<td>0.302 / 0.471</td>
</tr>
<tr>
<td>Respiratory Failure</td>
<td>J96.90</td>
<td>84</td>
<td>0.302 / 0.471</td>
</tr>
<tr>
<td>Chronic Respiratory Failure</td>
<td>J96.10</td>
<td>84</td>
<td>0.302 / 0.471</td>
</tr>
</tbody>
</table>

\[
\text{COPD + O}_2 \text{ Dependence} = \text{Chronic Respiratory Failure} \\
0.329 + 0.346 = 0.675
\]

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respirator Dependence</td>
<td>Z99.11</td>
<td>82</td>
<td>1.055 / 2.304</td>
</tr>
<tr>
<td>Tracheostomy</td>
<td>Z93.0</td>
<td>82</td>
<td>1.055 / 2.304</td>
</tr>
</tbody>
</table>

**Respiratory Insufficiency (R06.89), Dyspnea (R06.00), SOB (R06.02), Dependence on Oxygen (Z99.81)** ARE NOT HCCs!

---

#### Pulmonology

#### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration Pneumonia</td>
<td>J69.0</td>
<td>114</td>
<td>0.599 / 0.707</td>
</tr>
<tr>
<td>Pneumococcal Pneumonia (Streptococcus Pneumoniae)</td>
<td>J13</td>
<td>115</td>
<td>0.221 / 0.162</td>
</tr>
</tbody>
</table>

**Bacterial Pneumonia**

- **Type of Bacteria must be documented!**
  - Bacterial Pseudomonas Pneumonia     | J15.1  | 114 | 0.599 / 0.707               |
  - Bacterial Streptococcal Pneumonia  | J15.4  | 115 | 0.221 / 0.162               |
  - Bacterial Staphylococcal Pneumonia | J15.20 | 114 | 0.599 / 0.707               |

**Pneumonia (CAP, HAP) (J18.9); Bacterial Pneumonia, unspecified (J15.9)** ARE NOT HCCs!

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### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
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</thead>
<tbody>
<tr>
<td>Ulcerative colitis</td>
<td>K51.90</td>
<td>35</td>
<td>0.294 / 0.334</td>
</tr>
<tr>
<td>Crohn's</td>
<td>K50.90</td>
<td>35</td>
<td>0.294 / 0.334</td>
</tr>
<tr>
<td>Chronic Pancreatitis</td>
<td>K86.1</td>
<td>34</td>
<td>0.276 / 0.333</td>
</tr>
<tr>
<td>Paralytic Ileus</td>
<td>K56.0</td>
<td>33</td>
<td>0.246 / 0.369</td>
</tr>
<tr>
<td>Fecal Impaction</td>
<td>K56.41</td>
<td>33</td>
<td>0.246 / 0.369</td>
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<tr>
<td>Intestinal Obstruction</td>
<td>K56.60</td>
<td>33</td>
<td>0.246 / 0.369</td>
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<tr>
<td>Intestinal Impaction</td>
<td>K56.49</td>
<td>33</td>
<td>0.246 / 0.369</td>
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<tr>
<td>Alcoholic Gastritis (non-HCC)</td>
<td>K29.2*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alcohol-Induced Chronic Pancreatitis</td>
<td>K86.0</td>
<td>34</td>
<td>0.276 / 0.333</td>
</tr>
<tr>
<td>Alcohol-Induced Acute Pancreatitis</td>
<td>K85.2</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Code also, if applicable**

### Documented Diagnosis

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<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
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</thead>
<tbody>
<tr>
<td>Chronic Hepatitis</td>
<td>K73.9</td>
<td>29</td>
<td>0.165 / 0.038</td>
</tr>
<tr>
<td>Chronic Hepatitis C</td>
<td>B18.2</td>
<td>29</td>
<td>0.165 / 0.038</td>
</tr>
<tr>
<td>Chronic Hepatitis B</td>
<td>B18.1</td>
<td>29</td>
<td>0.165 / 0.038</td>
</tr>
<tr>
<td>Autoimmune Hepatitis</td>
<td>K75.4</td>
<td>29</td>
<td>0.165 / 0.038</td>
</tr>
<tr>
<td>Alcoholic Hepatitis (non-HCC)</td>
<td>K70.1*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alcohol Dep or Dep in Remission</td>
<td>F10.2*</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
</tbody>
</table>

**Code also, if applicable**

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Gastroenterology

### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis of the Liver</td>
<td>K74.60</td>
<td>28</td>
<td>0.390 / 0.342</td>
</tr>
<tr>
<td>Biliary Cirrhosis</td>
<td>K74.5</td>
<td>28</td>
<td>0.390 / 0.342</td>
</tr>
<tr>
<td>Alcoholic Cirrhosis</td>
<td>K70.3*</td>
<td>28</td>
<td>0.390 / 0.342</td>
</tr>
<tr>
<td>Alcoholic Liver Damage</td>
<td>K70.9</td>
<td>28</td>
<td>0.390 / 0.342</td>
</tr>
<tr>
<td>Alcoholic Fatty Liver (non-HCC)</td>
<td>K70.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Code also, if applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol or Dep in Remission</td>
<td>F10.2*</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>Esophageal Varices w/o bleeding</td>
<td>I85.00</td>
<td>27</td>
<td>0.962 / 1.242</td>
</tr>
<tr>
<td>Esophageal Varices w/ bleeding</td>
<td>I85.01</td>
<td>27</td>
<td>0.962 / 1.242</td>
</tr>
<tr>
<td>Portal Hypertension</td>
<td>K76.6</td>
<td>27</td>
<td>0.962 / 1.242</td>
</tr>
<tr>
<td>Hepatic Encephalopathy</td>
<td>K72.9*</td>
<td>27</td>
<td>0.962 / 1.242</td>
</tr>
<tr>
<td>End Stage Liver Disease</td>
<td>K72.9*</td>
<td>27</td>
<td>0.962 / 1.242</td>
</tr>
</tbody>
</table>

Fatty Liver (K76.0), Alcoholic Fatty Liver (K70.0) ARE NOT HCCs!

---

Alcohol Dependence

### Documented Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Dependence</td>
<td>F10.20</td>
<td>55</td>
<td>0.383 / 0.525</td>
</tr>
<tr>
<td>• Chronic Alcoholism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Alcoholism</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

"Chronic use", "requires", "long term use" are not synonymous with Dependence!

| Alcohol Dependence in remission                | F10.21 | 55  | 0.383 / 0.522               |
| • Alcoholism in remission                      |        |     |                             |
| • History of Alcohol Dependence                |        |     |                             |

Alcohol Use With:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Other Alcohol-induced Disorder</td>
<td>F10.98*</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>(Anxiety, sexual, sleep, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• With Unspecified Alcohol-induced Disorder</td>
<td>F10.99</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
</tbody>
</table>

There isn’t an ICD-10 code for History of Abuse or Use. Please consider if it is History of Dependence (F10.21)

Alcohol Abuse (F10.10) IS NOT an HCC
**Drug Dependence**

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Dependence</td>
<td>F11.20</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>In Remission</td>
<td>F11.21</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>Methadone use (F11.20) due to Opiate dependence (HCC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone use for Pain Control (279.891) (non-HCC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedative, Hypnotic, or Anxiolytic-related Dependence</td>
<td>F13.20</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>In Remission</td>
<td>F13.21</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>Other Drug Dependence</td>
<td>F19.20</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
<tr>
<td>In Remission</td>
<td>F19.21</td>
<td>55</td>
<td>0.383 / 0.522</td>
</tr>
</tbody>
</table>

Symptoms of tolerance and withdrawal during appropriate medical treatment with prescribed medications (e.g., opioid analgesics, sedatives, stimulants) are not considered drug dependence!

Exception is when there are other symptoms of compulsive, drug-seeking behavior.

There isn’t an ICD-10 code for History of Abuse or Use. Please consider it is History of Dependence (F**.21).

Drug abuse (F19.10); H/O Methadone use for pain control (279.891) ARE NOT HCCs!

**Oncology**

All cancers (except skin) are HCCs if they are under active treatment! (C00 – D49)

Melanoma (C43.9) is the only skin cancer that is an HCC – after excision it is “history of” Z85.820

Cancers can be coded as active when:

1. There is current treatment directed to the site
   - Chemotherapy
   - Radiation
   - Adjunct Therapy
     - Examples are use of Tamoxifen for Breast cancer or
     - Lupron for Prostate cancer
2. Newly diagnosed and treatment hasn’t started yet
3. Patient elects not to have any treatment

Cancer not under active treatment is coded as history of cancer (Z85.4)

History of Cancer (Z85.4)
IS NOT an HCC but appropriate documentation when there isn’t active treatment!
HCC Quiz - Oncology

Scenario

HPI: Mr. C is here to follow up on his COPD, DM, and HTN. He has a history of prostate cancer.

Current Medications:
Singulair, Albuterol inhaler, Actos, Insulin, Atenolol, Lupron

Assessment:

Select the best answer:

Based on the documentation the prostate cancer can be coded as:

A. Malignant neoplasm of the prostate
B. Personal history of malignant neoplasm of the prostate

Answer:

A. Malignant neoplasm of the prostate

Oncoogy

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Myeloma</td>
<td>C90.0*</td>
<td>9</td>
<td>0.970 / 0.973</td>
</tr>
<tr>
<td>Chronic Leukemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chronic Lymphoid Leukemia</td>
<td>C91.9*</td>
<td>10</td>
<td>0.677 / 0.713</td>
</tr>
<tr>
<td>• Chronic Myeloid Leukemia</td>
<td>C92.9*</td>
<td>9</td>
<td>0.970 / 0.973</td>
</tr>
<tr>
<td>• Chronic Monocytic Leukemia</td>
<td>C93.9*</td>
<td>9</td>
<td>0.970 / 0.973</td>
</tr>
<tr>
<td>Acute Lymphoid Leukemia</td>
<td>C91.0*</td>
<td>8</td>
<td>2.625 / 2.542</td>
</tr>
<tr>
<td>Acute Myeloid Leukemia</td>
<td>C92.0*</td>
<td>8</td>
<td>2.625 / 2.542</td>
</tr>
<tr>
<td>Acute Monocytic Leukemia</td>
<td>C93.0*</td>
<td>8</td>
<td>2.625 / 2.542</td>
</tr>
</tbody>
</table>

If there is a chance of the condition coming back then “H/O” is not used. Correct documentation would be “in remission” or “in relapse”.

"Multiple Myeloma in remission" C90.01 9 0.970 / 0.973
"Leukemia in relapse" C95.92 10 0.677 / 0.713
"History of Leukemia" Z85.6 - -
"History of Multiple Myeloma" Z85.79 - -
Oncology

“History of Lymphoma” is only used if the Lymphoma is completely cured. Otherwise, it is considered “in remission” and coded with the current active code.

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Lymphoma in remission”</td>
<td>C85.90</td>
<td>10</td>
<td>0.677 / 0.713</td>
</tr>
<tr>
<td>“Hodgkin’s in remission”</td>
<td>C81.9*</td>
<td>10</td>
<td>0.677 / 0.713</td>
</tr>
</tbody>
</table>

History of Hodgkin’s (Z85.71), History of Lymphoma (Z85.72) are NOT HCCs!

Metastatic Cancer

The spread of a cancer from one organ or part to another not directly connected with it.

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Breast Cancer on Arimidex w/ mets to the lung”</td>
<td>C50.919 &amp; C78.00</td>
<td>8</td>
<td>2.625 / 2.542</td>
</tr>
<tr>
<td>“Prostate cancer on Lupron w/mets to the bone”</td>
<td>C61 &amp; C79.51</td>
<td>8</td>
<td>2.265 / 2.542</td>
</tr>
<tr>
<td>“H/O Colon cancer w/ Liver mets”</td>
<td>Z85.038 &amp; C78.7</td>
<td>8</td>
<td>2.625 / 2.542</td>
</tr>
<tr>
<td>&quot;Breast ca on Femara with positive lymph nodes&quot;</td>
<td>C50.919 &amp; C77.9</td>
<td>10</td>
<td>0.677 / 0.713</td>
</tr>
</tbody>
</table>

Positive lymph nodes are considered metastatic!
### Complications and Malfunctions

**Problems of Internal Devices, Implants and Grafts**
- Neuro, Cardiac, Genitourinary, Orthopedic, Vascular, Peritoneal dialysis catheter.

**Mechanical Complications**
- Breakdown, Displacement, Loosening, Dislocation, Broken, etc.
- Vascular, Nervous, Genitourinary, Internal Orthopedic

**Infection and Inflammatory Reaction**
- Cardiac Device, Vascular Device, Nervous Sys Device, Indwelling Urinary Cath Device, Internal Joint Prosthesis

**Other Complications**
- Pain, Bleeding, Occlusion, Embolism due to...
  - Vascular, Nervous, Genitourinary, Internal joint prosthesis

---

### Documented Diagnosis

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-9</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Urinary catheter, clogged – Mechanical
  - T83.09XA
  - 176
  - 0.597 / 0.721

- Urinary catheter infection – Infection
  - T83.51XA
  - 176
  - 0.597 / 0.721

- Failed Hip replacement – Mechanical
  - T84.098A
  - 176
  - 0.597 / 0.721

- Pain due to Knee replacement – Other (pain)
  - T84.84XA
  - 176
  - 0.597 / 0.721
  - Use additional code to identify Joint Prosthesis: 296.6**
  - Use additional code to identify Knee Pain: M25.56*

- Insulin Pump malfunction – Mechanical
  - T85.694A
  - 176
  - 0.597 / 0.721

- Stenosis A/V Fistula or Shunt – Other
  - T82.858A
  - 176
  - 0.597 / 0.721

- Infected Internal Fixation Device – Infection
  - T84.60XA
  - 176
  - 0.597 / 0.721

---
## Documented Diagnosis

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Knee (BKA)</td>
<td>Z89.51*</td>
<td>189</td>
</tr>
<tr>
<td>Above Knee (AKA)</td>
<td>Z89.61*</td>
<td>189</td>
</tr>
<tr>
<td>Foot</td>
<td>Z89.43*</td>
<td>189</td>
</tr>
<tr>
<td>Ankle</td>
<td>Z89.44*</td>
<td>189</td>
</tr>
<tr>
<td>Great Toe</td>
<td>Z89.41*</td>
<td>189</td>
</tr>
<tr>
<td>Other Toe</td>
<td>Z89.42*</td>
<td>189</td>
</tr>
</tbody>
</table>

* = Right, Left and Unspecified

### Amputation Status

Upper Limb Amputations (Z89.2**) ARE NOT HCCs!

### Artificial Openings

An artificial opening (ostomy) is used for elimination or feeding.

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrostomy</td>
<td>Z93.1</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>Colostomy</td>
<td>Z93.3</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>Ileostomy</td>
<td>Z93.2</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>Jejunostomy</td>
<td>Z93.4</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>Cystostomy (Supra-pubic Catheter)</td>
<td>Z93.50</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>Other specified Ostomies</td>
<td>Z93.6</td>
<td>188</td>
<td>0.571 / 0.775</td>
</tr>
<tr>
<td>• Nephrostomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ureterostomy</td>
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</table>
Transplant Status

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>ICD-10</th>
<th>HCC</th>
<th>Comm Age In / Comm Dual RAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>Z94.1</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Lung</td>
<td>Z94.2</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Liver</td>
<td>Z94.4</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Bone Marrow</td>
<td>Z94.81</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Stem Cell</td>
<td>Z94.84</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Z94.83</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Intestines</td>
<td>Z94.82</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
<tr>
<td>Complications are the same HCC</td>
<td>T86.***</td>
<td>186</td>
<td>1.000 / 0.816</td>
</tr>
</tbody>
</table>

Kidney transplant (Z94.0), Unspecified complication of kidney transplant (T86.10) ARE NOT HCCS!

Medical Record Documentation and Coding Requirements

- Be Specific
  - Chronic Bronchitis vs. Bronchitis
  - CKD vs. Renal Insufficiency
  - Acute; Chronic; Acute on Chronic
  - R/O, Likely, Versus, Possibly – Code signs and symptoms instead

- Include
  - MEAT: Manage or Monitor, Evaluate, Assess, Treat or
  - TAMPER: Treat, Assess, Monitor/Medicate, Plan, Evaluate, Refer
  - Every Page:
    - Provider Name, Credentials, DOS
    - Patient Name; Patient Identifier

- Link
  - Medications/Labs to Specific Problem: (HgA1C for DM)
  - Treatment plan to Diagnosis
  - Causal Relationships: Diabetic Ulcer; Hypertensive HF

- H/O
  - Only use "H/O" when documenting some status conditions
  - "H/O" in ICD-9 terms means the patient no long has the condition
  - "Compensated CHF"; “Stable Angina"
### How to Calculate Risk Score!

<table>
<thead>
<tr>
<th>All Conditions Coded with High Specificity</th>
<th>Some conditions coded with Poor Specificity</th>
<th>No conditions Coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>0.448</td>
<td>76 year old female 0.448</td>
</tr>
<tr>
<td>DM w/vascular CC (HCC 18)</td>
<td>0.318</td>
<td>DM not coded 0.0</td>
</tr>
<tr>
<td>Vascular Disease w/CC (HCC 107)</td>
<td>0.400</td>
<td>Vascular Disease not coded 0.0</td>
</tr>
<tr>
<td>CHF (HCC 85)</td>
<td>0.323</td>
<td>CHF not coded 0.0</td>
</tr>
<tr>
<td>Disease Interaction* DM &amp; CHF</td>
<td>0.154</td>
<td>No Disease Interaction 0.0</td>
</tr>
<tr>
<td>Total RAF</td>
<td>1.643</td>
<td>Total RAF 0.890</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total RAF 0.488</td>
</tr>
</tbody>
</table>

*Additional risk score added automatically when certain diseases are coded together

*Coefficients represent community model

CC – chronic conditions; RAF – risk adjustment factor

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Workshop D:
Foundations of Integration
Next Level Integration of Risk Adjustment for Quality and Care Management

Panelists:
Suresh Ramakrishnan, President, Health Plan Services
EMSI HEALTH

Michelle Storto, Vice President, Client Services
EMSI HEALTH

Crystal Callaway, Manager, Clinical Quality and Documentation
EMSI HEALTH

Donna Malone, CPC, CRC Senior Manager, Risk Adjustment Coding, Quality Assurance & Provider Education
TUFTS HEALTH PLAN
Risk Adjustment for Quality and Care Management

RISE NASHVILLE SUMMIT
Pre-Conference Session
Omni Nashville Hotel, TN
Monday, March 6, 2017

Introductions

Suresh Ramakrishnan
President
Health Plan Services

Suresh has extensive expertise in risk adjustment programs, call center operations and medical coding services. As President of Health Plan Services at EMSI Health, he leads strategic growth initiatives for the business unit. He previously served as senior vice president of Operations for UnitedHealth Group’s HouseCalls operations.

Michelle Storto
Vice President
Client Services

Michelle heads Client Services and Credentialing in Health Plan Services at EMSI Health. Previously, Michelle was Director of Payor Operations for Landmark Health where she oversaw health plan client implementations and provider credentialing. Her experience in the industry ranges from network management, including quality and risk adjustment initiatives in value-based models, to private practice operations.

Crystal Callaway
Director,
Healthy House Calls
Clinical and Coding

Crystal oversees the Clinical Quality Team in Health Plan Services at EMSI Health. Crystal is a registered nurse with 10 years of experience in coding and over eight years of experience in HCC risk adjustment coding. Her past experience includes serving as Director of Nursing for one of the largest Home Health Agencies in Texas, Director of Hospice, Medicaid oversight, Clinical Trial Research, and has several years of hospital experience.

Donna Malone
Sr Manager,
RA Coding, QA,
Provider Education

Donna is responsible for Tuft’s Risk Adjustment Coding, Quality Assurance, and Provider Education enterprise wide. She also is Chair of the RISE Risk Adjustment Academy HCC Coding Faculty Advisory Group.

Donna continues to be responsible for audit and coding review management, development and implementation of department policies. She has a mastery of HCC coding and is CPC, CRC and ICD-10 trained.
Agenda

1. Welcome
2. HCC Coding Supports Multiple Programs
   - Risk Adjustment (RA) • HEDIS • Star Ratings • Disease and Care management
3. Quality Rating System (QRS)
   - Overview • Implementation via new or existing programs
4. Aligning Internal Processes
   - Data and Analytics • HCC management and medical Management • HCC Management and Quality Management

How HCC Coding Supports Multiple Programs
Risk Adjustment (RA)

- Premium payment based on member severity
- Select ICD 10 diagnosis codes used in most models
- Very few models take some Rx information
- Generally time period restricted to one calendar year

Why Chart Retrieval and Abstraction?

- Claims system is payment system, not health information system
- Not all information from chart makes it to claims
- Health information in multiple codified sources: ICD9/10, NDC, CPT, DRG and more
  + Most RA models use only small subset of this information
  + Time window of information generally restricted to one year
- Audits like RADV lag by years, potential lag for getting the right chart expands
- Plans have claims verification obligation when chart is touched for capturing additional codes
Why In-Home Assessments?

► Best healthcare infrastructure, highest spend, poor health quality
► Healthcare system still more reactive than proactive
► Typical office visit is 6-8 minutes
► Current problems mindset
► Lack of time for questions, education and proper understanding
► Members and caregivers still bridge between various providers
► Understanding home factors paramount to overall management
  + Socio-economic
  + Environment – fall risk, food in refrigerator
  + Caregivers and support structure

Program Integration

► Members do not think in programs
  + They look at plan and provider as all part of system
  + Expect information shared in one side is shared across the plan
  + Member abrasion due to multiple touchpoints
  + Effective use of resources and administrative costs
► Providers don’t, either
  + Chart requests multiple times in multiple slices becoming a hassle
  + Expect plan to be coordinated
  + Request same member be seen for different purposes not practical and conducive to member satisfaction
**CMS Star Rating - Program Overview**

- **Program objectives**
  - Improve quality of service and care for plan members
  - Side-by-side comparison for consumer review
- **Annual score** 1 (LOW) to 5 (HIGH) by H-plan
- **Star score**
  - 33% Healthcare Effectiveness Data and Information Set (HEDIS) measures
  - 29% Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes (HOS) surveys
  - 24% Administrative data measures
  - 14% Part D measures
- **Rating types**
  - MA only – 5 domains Part C Rating
  - PDP plans – 4 domains Part D Rating
  - MA-PD – all 9 domains Overall Star Rating

---

**CMS Star Health Plan Performance**

- **Pay for performance:**
  - 4+ Star plans = BONUS PAYMENT
  - Plan rebate
  - Plan growth
- **High-performing plans:**
  - Members receive annual wellness visit
  - Members have easy access to providers
  - Leverage technology, data to close gaps
  - Providers incented to meet quality goals
  - Necessary member screenings, tests

---

*Supported by In-Home Assessments*

- High Touch
- Convenient
- POS Testing
- Leverages Analytics and Targeting
**MAPD Star Ratings over Time**

- Individual Star scores for most measures improved over time
- Increase in highly rated plans since 2014
- Is quality and service improving?

**CMS Star and HCC Coding**

- Stars increasingly outcomes-focused
  - Plan feedback to CMS: health risk factors influence outcomes and thus Stars
    - Chronic disease and high-needs members pose adherence risks
    - Aligns with CMS expectations that plans focus on Quality Improvement (QI)
    - Higher weights applied to outcomes-centered measures
  - Early identification and intervention via coding critical to positive outcomes
    - Health status and risk factors used to analyze and target members for intervention
- Categorical Adjustment Index (CAI) Factor for members with socioeconomic and disability qualifiers
  - MAPD plans Dual Eligible (DE) and Low Income Subsidy (LIS) members
  - Factor added to Star Rating based on percentage of LIS + DE to support plans with a disproportionate share of members in these statuses.
  - Enrollment and Data Accuracy important
Introduction to HEDIS®

- Standardized measurement of performance in care and service
- Used by 90% of U.S. health plans
- Started 1980s, then published by National Committee for Quality Assurance (NCQA) since 1993
- NCQA Committee on Performance Measurement updates annually
- Informs CMS STAR and Quality Rating System (QRS) scores
- HCC Coding
  + Diagnosis capture and timing drives HEDIS measure eligibility
  + Opportunity for early identification and intervention

HEDIS® Data Drivers

1. Analytics-driven targeting
2. Comprehensive health risk assessment visits
   + Member convenience and satisfaction
   + Encouragement of member clinical adherence
   + Screenings and tests
3. Data Collection
   1. Administrative ✓ Appropriate Coding
   2. Hybrid ✓ Provider Documentation
   3. Surveys ✓ Patient Education & Satisfaction
4. Submission
   + Accurate, precise data capture to close identified gaps
   + Supplemental data
HEDIS® Management: A Team Approach

Program Administration
- Holistic Patient View
- Efficiency
- Reduced Member Abrasion & Contacts
- Outcomes-Driven
- Actionable, Prospective Planning
- Incorporate into Quality Improvement

In-Home Assessments
- Patient Education
- Patient Satisfaction
- Enhance Adherence
- Flag Issues & Risks
- POS Testing
- Assess Patient in Home Setting
- Medication List

Primary Care Team
- Ordering & Referring
- Ongoing Treatment & Management
- Assess Patient Over Time
- Prescribe & Adjust Medications
- Time-Sensitive Interventions

In-Home Assessments
- Body Mass Index (BMI)
- Testing:
  - Annual Monitoring for Patients on Persistent Medications
  - Blood Sugar (HbA1C)
  - Osteoporosis Management in Women with a Fracture – BMD Test
  - Colon Cancer Screening - FOBT
  - Nephropathy Screening
  - Retinopathy Screening
- Care for Older Adults Measures
  - Medication Review
  - Functional Status Assessment
  - Pain Assessment
- Referral to Medication Management (MTM, prescription changes, etc.)
- HOS & CAHPS Surveys
  - Tobacco Use
  - Recommend Flu Shots, Pneumonia Shots
Primary Care Team

- Controlling Blood Pressure
- Controlling Blood Sugar (HbA1C) for members with Diabetes
- Order Screenings:
  + Breast Cancer
  + Cervical Cancer
  + Colorectal Cancer
  + Diabetic Eye Exam
- CAHPS Survey
  + Access to and receiving care from personal doctor and specialists
  + Access to prescription drugs
- Medication Management:
  + DMARD for Rheumatoid Arthritis
  + Pharmacotherapy Management of COPD Exacerbation
  + Medication Management for People with Asthma
  + Reduction of High Risk Medication prescriptions (BEERS list)
  + Osteoporosis Management in Women with a Fracture – Prescription for treatment of osteoporosis
- Health Outcomes Survey (HOS)
  + Improving or Maintaining Physical and Mental Health over 2 years

Retrospective Chart Reviews

<table>
<thead>
<tr>
<th>Code</th>
<th>HEDIS Hybrid Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td>Adult BMI Assessment</td>
</tr>
<tr>
<td>WCC</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</td>
</tr>
<tr>
<td>CIS</td>
<td>Childhood Immunization Status</td>
</tr>
<tr>
<td>JMA</td>
<td>Immunizations for Adolescents</td>
</tr>
<tr>
<td>LSC</td>
<td>Lead Screening in Children</td>
</tr>
<tr>
<td>CCS</td>
<td>Cervical Cancer Screening</td>
</tr>
<tr>
<td>COL</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>COA</td>
<td>Care for Older Adults</td>
</tr>
<tr>
<td>CBP</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>CDC</td>
<td>Comprehensive Diabetes Care</td>
</tr>
<tr>
<td>MRP</td>
<td>Medication Reconciliation Post-Discharge</td>
</tr>
<tr>
<td>PPC</td>
<td>Prenatal and Postpartum Care</td>
</tr>
<tr>
<td>FPC</td>
<td>Frequency of Ongoing Prenatal Care</td>
</tr>
<tr>
<td>W15</td>
<td>Well-Child Visits in the First 15 Months of Life</td>
</tr>
<tr>
<td>W34</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
</tr>
<tr>
<td>AWC</td>
<td>Adolescent Well-Care Visits</td>
</tr>
<tr>
<td>WOP</td>
<td>Weeks of Pregnancy at Time of Enrollment</td>
</tr>
</tbody>
</table>
Disease Management and Risk Adjustment

► Reasons to integrate disease management
  + Increase member satisfaction
    ▪ Member involvement
    ▪ Healthier members
  + Improved outcomes

► Benefit to the health plan
  + Decreased exacerbations
  + Reduced hospitalizations
  + Lower health care cost

"44% of Americans who live at home have chronic conditions and they account for 78% of the health care expenditures in the United States"
—Health Institute, Georgetown University,

Care Management and Risk Adjustment

► Reasons to integrate care management
  ► Promotes optimal health and member involvement
    ► Involves members in their everyday care
    ► Lifestyle integration is key to maintaining healthy life
    ► Facilitates disease management thru self-management
      ► Increased member satisfaction
      ► Improves outcomes

► Benefits of care management
  + Individualize care management to member's needs
  + Reduce unnecessary healthcare cost

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.
Integration of Disease and Care Management within Risk Adjustment

+ Identifying members with chronic conditions
  - Chart Retrieval
    - Coordination of all records
  - Retrospective Reviews
    - Comprehensive and wholistic view of the member
    - Identification of all chronic conditions and disease management
  - In-home assessments
    - Identification and closure of high-risk members as well as care gaps
      - Real life look at the member’s home environment, current conditions, and understanding of treatment

+ Multidisciplinary coordination of care
  - Development and implementation of programs that meet members’ needs
    - Right program for the right population
  - Care management programs that promote disease management and optimal health
  - Utilization of in-home assessments
    - Improved management for members who are homebound or challenged
    - Members identified by the health plan for intervention
      - Closure of care gaps
      - Decreased re-hospitalizations following discharge

+ Measuring outcomes and success
  - Hospitalizations and program expenses
  - Member outcomes

Quality Rating System (QRS)
QRS Overview

- Role and responsibilities
  - Provide consumers with information on quality of health care services and membership
  - Make quality rating information more understandable to consumers
  - Improve quality, performance and reporting standards oversight per ACA
  - QHP issuers to submit data for 42 eligible reporting units in the QRS measure set
    - 30 clinical quality measures and 12 survey measures
- 2016 and 2017 QRS requirements comparison
  - QRS and QHP Enrollee Survey, reporting units must have more than 500 enrollees as of July 2016 and 2017
  - 2017 QRS measure set will include all measures except:
    - Relative Resource Use for People with Diabetes (Inpatient Facility Index) measure
    - Immunization for Adolescents (DxA) measure combined with the Human Papillomavirus Vaccination for Female Adolescents (HPV); this measure not used in scoring for 2017 QRS
  - CMS to publish 2017 QRS global rating and three summary indicators for each eligible QHP during 2018 OE period

2017 QRS Requirements and Responsibilities for QHP Issuers

- Comply with quality reporting per QHP certification to offer coverage through a Marketplace during Plan Year (PY) 2017
- Submit data to CMS from QHP Enrollee Survey and QRS clinical measures
  - Survey data submitted to CMS via QHP Enrollee Survey website by May 25, 2017
  - Validated clinical measure data submitted via NCQA Interactive Data Submission System (IDSS) by June 15, 2017
- Oversee QHP certification and compliance with certification standards for issuers
  - CMS coordinates with State-Based Marketplaces (SBMs) on oversight, enforces compliance of QRS and QHP Enrollee Survey requirements
- Provide SBMs with:
  - QHP issuers with eligible reporting units and are required to submit QRS clinical measure and QHP Enrollee Survey response data
  - Status update following data submission deadline with list of issuers that submitted data for issuers’ eligible reporting units
Asthma: Potential Focus Area for QRS

- Asthma is leading cause of morbidity, mortality
  + Lower quality of life, lost productivity, missed school and work
  + 24 million Americans have asthma*
    - 7.4% of adults and 8.6% of children
    - Two million emergency room visits, four million doctor visits, 439,000 hospital stays
    - Half of children and one-third of adults missed school or work
    - 10 Americans die daily from asthma, avoidable with proper treatment

- HEDIS measures
  + Use of Appropriate Medications
  + Medication Management
  + Asthma Medication Ratio

*CDC

COPD: Potential Focus Area for QRS

- COPD third leading cause of death in U.S. for 2014
  + 15.7 million Americans (6.4%) diagnosed with COPD
  + 50% of adults with low pulmonary function unaware they had COPD
  + COPD cost U.S. $49.9 billion in 2010*
    - $29.5 billion of that spent on direct healthcare costs
    - $8 billion from indirect morbidity costs
    - $12.4 of indirect mortality costs from misdiagnosis or late diagnosis

- HEDIS Measures related to COPD
  + Spirometry Testing in Assessment and Diagnosis
  + Pharmacotherapy Management of COPD Exacerbation

*American Lung Association
Preview of the 2017 Quality Rating Information Process

► August 2017
  + QHP issuers preview issuers’ respective 2017 QRS ratings and submit inquiries to CMS during a preview period
  + QHP issuers receive issuers’ complete 2017 QHP Enrollee Survey results, including results for survey measures not used for QRS
  + Marketplace administrators receive 2017 QRS ratings QHP Enrollee Survey results for QHP issuers operating in issuers’ Marketplaces

Integration into Risk Adjustment

► Value-based healthcare improves patient risk management
  + Improves both clinical and quality end results
  + Reporting of clinical results closes HEDIS quality gaps
  + Identifying and closing clinical gaps often improves risk scores

► Quality-related clinical data analysis
  + Equips clinical personnel with historical knowledge of patient medical conditions and potential quality gaps in care
  + Provides insight into patient historical lab results and other factors relating to overall wellness and health plan risk mitigation
  + Medication adherence, in home safety factors, disease progression analysis relate to quality and clinical aspects of wellness care

► Resultant outcomes of quality programs related to health and risk management support both patient and MAO
Aligning Internal Processes

Operational Departments

Risk Adjustment
Management
Data source
Applications

HEDIS/Stars
Management
Data source
Applications

Care Management
Management
Data source
Applications

Integrated Data Exchange
Member data
Provider data
Risk score
Pharmacy data
Lab data
Claims
Diagnosis
Data Analytics Framework

Source: Health Plan Data
- Claim Data
- Member Data
- Provider Data
- Pharmacy Data
- Plan Specific Data
- Lab Data
- Regulation Data
- Enrollment

Analytics: Proprietary Algorithms and Systems
- Data Quality Checks
- Processing
  - Traditional Reporting
  - Data Mining
  - Business Intelligence
- Predictive Analytics

Output: Integrated Services
- Meaningful Output
  - Risk Scores
  - Quality Data
  - HEDIS
  - Care Management

Data: Key to a Successful Program

- Data quality key to analytics
  - Member and provider demographics
  - Medical claim data, including lab and pharmacy
  - Enrollment information
  - CMS reports: RAPS Return, MMR, MOR, EDPS, MAO

- Risk score calculations
  - Inputs
    - Member data and attributes
    - CMS Risk Model: coefficients and rules
  - Outputs:
    - Risk score uplift tracking
    - Revenue/ROI calculations
Strategic Alignment

- Seamless integration of risk and medical management
  - Single reporting structure through medical management
  - Enhanced communication and collaboration
  - Efficiency addressing overlapping issues

Outcomes

- Improving clinical outcomes
  - High-risk member identification
    - Targeted member outreach
  - Care gap identification and closure
    - Apply appropriate interventions, reduce exacerbation and cost
  - Care management
    - Assigned case manager
    - Targeted member outreach
    - Coordinate cost-effective care
    - Member takes active role improving health
  - Integrated medical management
    - Coordinate overall care across all plan programs