COMMUNITY HEALTH PLAN
of Washington

Committed to your health.®

Provider Education Webinars

Course 3:
Hierarchical Condition Coding
(HCC Coding)

Housekeeping Items

Technical Difficulties

If you experience technical difficulties, please

- utilize the "Chat" feature of the GoToWebinar application to let us know what kind of problem you're having
- exit the application and try re-establishing your internet and phone connections
- call 1-888-206-2266 and enter Conferee pin number that came with your invitation/registration (if you cannot establish a webinar connection, this number will allow you to follow along with the conference using your handout). If you have to fall back on this method, please email us at the below email address and let us know what kind of problem you're having.

Webinar Questions

For questions concerning the content of this webinar, CHP has a dedicated email address: providereducation@chpw.org.

Questions about Specific Coding Scenarios

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at providereducation@chpw.org.

Questions about Claims

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn't set up to be the best forum to access claims information).

Continuing Education Credit

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: providereducation@chpw.org.

Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 3: Hierarchical Condition Coding.

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians
** American Academy of Professional Coders
*** American Health Information Management Association

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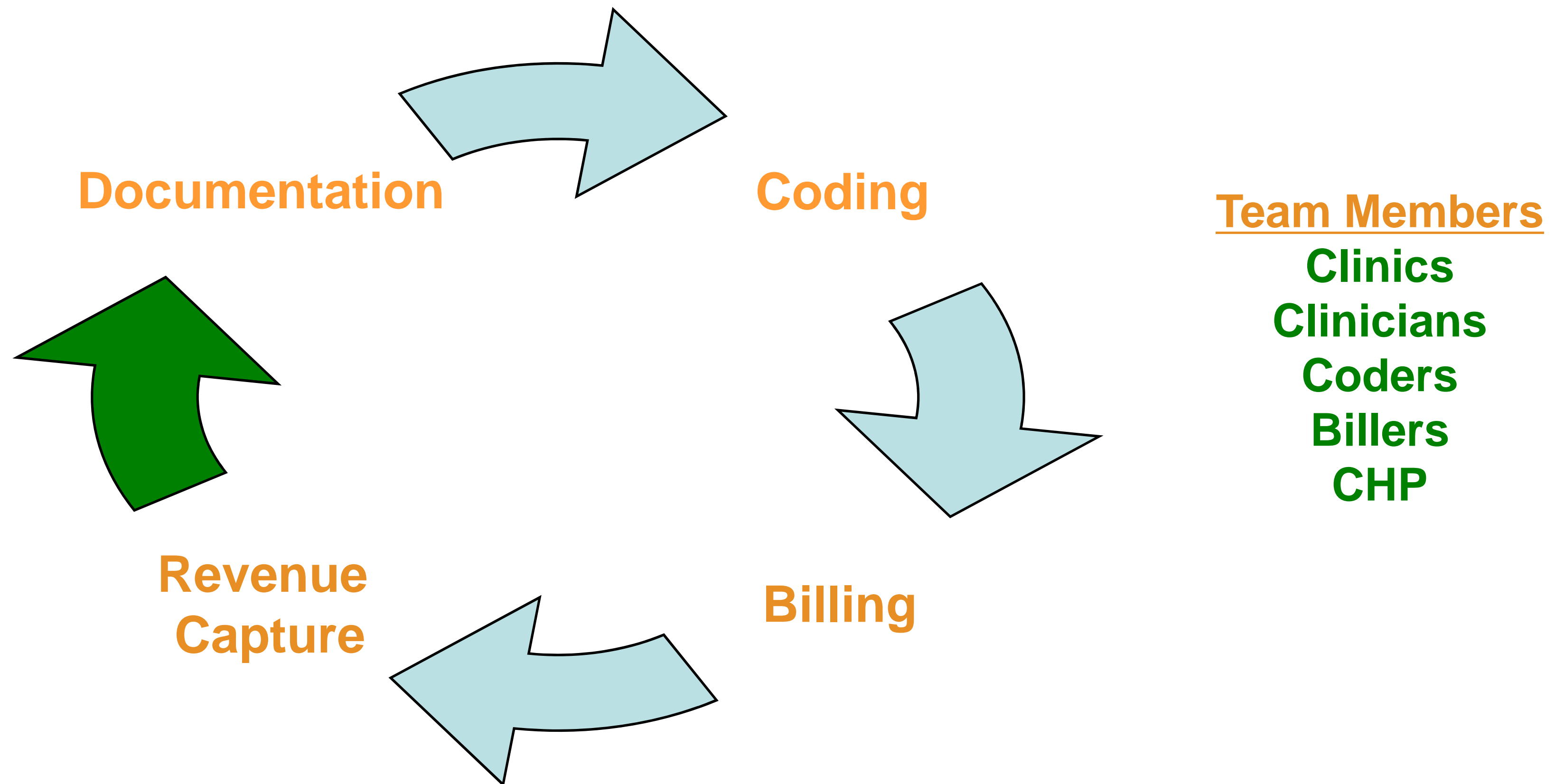
A Comprehensive Approach to Optimizing Documentation & Coding



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Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

Community Health Plan - Medicare Advantage
Member HCC Report

HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
Address: 1234 Main Street, Anytown, US 98765
Phone: (555) 555-5555

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning ______________ (mm/yyyy).

_____________________________ _____________________________ _____________

Printed Name & Credentials *Signature* *Date*

Community Health Plan of Washington Provider Education Webinar

Course 3: Hierarchical Condition Coding (HCC Coding)

Marvel Gray, CPC, CCS-P, MCS-P, PCS, CCP, CCO, CMPM
Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P
Cost Recovery Analyst

Learning Objectives

Webinar Learning Objective:

Community Health Plan's goal is that our Providers will apply this career training and best practices information across their care spectrum, regardless of Patients' ability to pay or insurance type.

Course 3 Learning Objective: CMS's HCC Coding Defined

Focus on proper use ICD-9-CM Official Guidelines for Coding and Reporting and CMS's HCC Risk Adjustment requirements.

Participants' learning objectives for Course 3 are:

- Understand the purpose of CMS's Hierarchical Condition Coding (HCC) Risk Adjustment Coding
- Learn that there are stipulations of the ICD-9-CM Official Guidelines for Coding and Reporting that affect proper documentation and diagnosis coding (and in turn, HCC coding accuracy).
- How proper use of the ICD-9 Official Guidelines will optimize both documentation & coding accuracy.

CMS's HCC Coding Defined

What is CMS's Hierarchical Condition Coding?

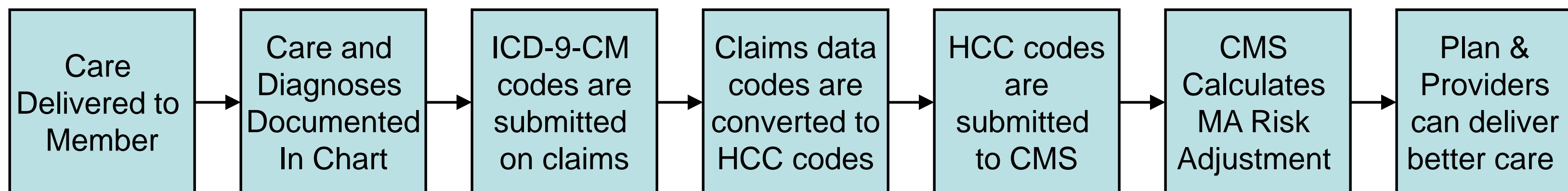
The goal of risk adjustment is to pay Medicare Advantage (MA) and Prescription Drug Plans (PDPs) accurately and fairly by adjusting payment for Enrollees based on their demographics *and* their health status. Previously, CMS paid MA and PDP premiums to Plans based on the populations' demographics alone. Severity of illness of the Plan's Medicare Advantage population is calculated using Risk Adjustment methodology which is done using HCC codes.

ICD-9-CM codes which describe Members' health status are converted electronically to HCC codes and submitted to CMS in a Risk Adjustment data file, communicating the health risk (severity) of the Plan's MA population.

The HCC Coding Classification: Why CMS Requires It, and How It Benefits the Members, Providers, and Plan

CMS feels that it better serves the Medicare population to base the premium payment to the Plan on both factors: the Member's demographics and the *documented* severity of the Member's health conditions.

The Process:



Document, Document, Document
No Documentation = No Justification For Services Billed*

Fact:

A Patient's chronic conditions affect the management of the Patient, even when the Patient is presenting with a straightforward illness that would appear unrelated to the chronic condition.

Fact:

If the chronic condition isn't documented
To have affected the patient's care (and how so)
It is not to be coded or reported on the claim as an active condition.**
("History Of" codes may be used, but are informational unless it's documented how the patient's care was impacted by that history.)

Fact:

Coding and reporting chronic conditions that aren't documented to have affected the patient's treatment and management on that particular encounter constitutes billing for conditions that are not supported by the documentation.

How to Proceed:

Deliver timely comprehensive care
Document the care you deliver
Code the care you document
Capture the codes you document

* Medicare B News Issue 236 April 17 2007, Heading: Reminder, Title: Documentation Guidelines for Amended Records - Revised

** Diagnostic Coding and Reporting Guidelines for Outpatient Services, Section IV, Chapter K:

Example 1A: Olga Jones Has Influenza with an Acute URI

Jones, Olga J. DOB: 07/04/1932 DOS: 09-10-2008

Allergies: NKDA Meds: See updated medication list
VS: R: 28, P: 80, T:99.2

S: Patient is here today with fatigue and chest congestion, S/P MI 3 yrs ago, homebound, takes insulin for DM2, & wonders if she has Pneumonia.

O: Pt appears alert, oriented, NAD. Wears glasses, is due for eye exam, ear canals patent w/no wax present. Nasal mucosa inflamed, pharynx slightly red, thyroid not enlarged. Chest wheezy w/rales. There is no extremity edema.

A: Acute upper respiratory infection with Flu 487.1

P: Chest x-ray performed, no pneumonia, counseled patient to force fluids, bed rest, and return to clinic if not improved.

Electronically signed by Joe Smith Date 09-10-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: 487.1	487.1	Yes
Secondary ICD-9-CM code: S/P MI is not coded:	No: Isn't *documented* as having affected the Patient's care at this visit.	Not reportable to as HCC to CMS: Lost opportunity to illustrate how the chronic condition affected the care.
Tertiary ICD-9-CM code: DM: Same as above	Same as above	Same as above
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? No	-	Not reportable to CMS without the Provider's credential.

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Example 1B: Olga Jones Has Influenza with an Acute URI and Diabetes

Jones, Olga J DOB: 07/04/1932 DOS: 09-10-2008

Allergies: NKDA Meds: See updated medication list
VS: R: 28, P: 80, T:99.2

S: Patient is here today with fatigue and chest congestion, she is S/P MI 3 yrs ago, homebound, takes insulin for her DMII, & wonders if she has pneumonia.

O: Pt appears alert, oriented, no acute distress. Wears glasses, due for eye exam, ear canals patent w/no wax present. Nasal mucosa inflamed, pharynx slightly red, thyroid not enlarged. Chest wheezy w/rales. There is no extremity edema, and her glucose reading done today is 15.

A: Acute upper respiratory infection with Flu 487.1
DM Type II or unspecified type, not stated as uncontrolled 250.00

P: Chest x-ray performed, counseled patient to force fluids, monitor glucose readings for changes due to illness, bed rest, and return to clinic if not improved.

Electronically signed by Joe Smith, MD Date 09-10-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: 487.1	487.1	Yes
Secondary ICD-9-CM code: 250.00	250.00	Yes
Tertiary ICD-9-CM code: S/P MI is not coded:	No: Isn't *documented* as having affected the Patient's care at this visit.	Not reportable to as HCC to CMS: Lost opportunity to illustrate how the chronic condition affected the care.
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? Yes	-	Yes

Example 1C: Olga Jones Has Influenza with an Acute URI, Diabetes, Ulcer, Congestive Heart Failure, and Vascular Disease

Jones, Olga J DOB: 07/04/1932 DOS: 09-10-2008

Allergies: NKDA Meds: See updated medication list
VS: R: 28, P: 80, T:99.2

S: Patient is here today with fatigue and chest congestion, S/P MI 3 yrs ago, homebound, takes insulin for DMII, & wonders if she has pneumonia

O: Pt appears alert, oriented, no acute distress. Wears glasses, due for eye exam, ear canals patent w/no wax present. Nasal mucosa inflamed, pharynx slightly red, thyroid not enlarged. Chest wheezy w/rales. There is +2 bilateral lower extremity edema due to vascular disease, and L ankle decubitus ulceration due to DM.

A: Acute upper respiratory infection with Flu 487.1
Diabetes mellitus with peripheral circulatory disorders type ii or unspecified type not stated as uncontrolled 250.70
Ulcer 707.06
CHF 428.0
ASCVD 414.00

P: Chest x-ray performed, counseled patient to force fluids, bed rest, and return to clinic if not improved. DM, ulcer, edema: stable, no Changes to meds. CHF and ASCVD: stable: no changes to meds.

Electronically signed by Joe Smith, MD Date 09-10-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: 487.1 Acute URI w/Flu	487.1	Yes
Secondary ICD-9-CM code: 250.70 DM2 w/manifestation	250.70	Yes
Tertiary #3 ICD-9-CM code: 707.06 Ulcer	707.06	Yes
Tertiary #4 ICD-9-CM code: 428.0 CHF	428.0	Yes
Tertiary #5 ICD-9-CM code: 414.00 ASCVD	414.00	Yes
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? Yes	-	Yes

Increase Your ICD-9-CM Accuracy

Medicaid's adoption of risk adjustment is on the near horizon, so starting now to increase diagnosis documentation and coding accuracy will create an easier path to tread when Medicaid implements risk adjustment.

Implementation, Best Practices, and Efficiency Tools

Implementation

Choose Physician Champions to Lead other Physicians in the Pursuit of Continuous Documentation and Coding Quality

Designate a Documentation and Improvement Team to Actively Coordinate Efforts

Coordinate with CHP to use the reports to increase ICD-9-CM accuracy

Best Practices (for more Best Practices regarding Documentation and Coding, contact providereducation@chpw.org)

Supply billers and coders with the most up-to-date reference books and software to increase coding knowledge and therefore decrease denials.

Provide clarification to billers in writing (in answer to a Physician Query Form, for instance) when more specificity is needed to code.

Adopt and utilize an approved abbreviations list for all handwritten notations, and include support staff in the education (staff that don't dictate or use EMR to enter information in the record). Make a binder with the approved abbreviations list available to all employees, including Coders, in a centralized location. Using abbreviations is faster only if everyone understands them.

Efficiency

Learn the ICD-9-CM Official Guidelines for Coding and Reporting (the outpatient section, Section IV) is not very long. This is the best way to increase efficiency and is better than any clever shortcut. For most Providers, the basic intent of the Guidelines becomes clear fairly quickly: improve the documentation in the medical record to increase the coding accuracy.

Perspectives on HCC Coding

Accuracy: If ICD-9-CM Codes Are Accurate, HCC Codes Will Be Accurate

Accountability: Do Your Own ICD-9-CM Mini-Review, and take appropriate steps to address issues to decrease documentation-to-code errors

Quality: Quality and Continuity of Care Goals Directly Benefit When ICD-9-CM Coding Excellence is Achieved

Integrity: Medical Record Documentation Integrity is a Sacred Trust Between Provider and Patient

Example 2A: Mr. Smythe Has Untreated Hypertension

Smythe, Donald K.

DOB: 07/04/1931
DOS: 09-30-2008

Allergies: NKDA
Meds: none
Vitals: BP 180/90, HR 78, RR 20, WT 260, T: 99.0

S: Patient here because his BP at the drug store booth was elevated several times over the last year, and has had headaches, chest tightness and congestion. Pt wonders if he has a bad case of flu. Pt states he has not been to a physician for 5 years, but both his mother and father had hypertension. Reports his weight is up 28 lbs. in 1 year.

O: Pt appears nervous, conversant, looks stated age. Repeated VS: B/P 190/90, HR 82, RR 22. Neck: No JVD or carotid bruits. Skin: Unremarkable Eyes: PERRLA, denies blurry vision. Extremities: mild bilateral calf edema. Lungs Clear. C/V: RRR.

A: HTN 401.9, previously untreated.
Obesity 278.01
Family History of Hypertensive Disease V17.49

P: Start Lisinopril 40 mg PO QD. Labs: CBC, Creatinine, Lipids, ECG, UA. Lifestyle modification counseling brochures provided for hypertension and obesity. RTC 4 weeks, sooner if not improved.

Electronically signed by Joe Smith, MD Date 09-30-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: HTN 401.9	401.9	Yes
Secondary ICD-9-CM code: Obesity 278.00	278.01	Yes
Tertiary ICD-9-CM code: Fam Hx HTN V17.49	V17.49	Yes
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? Yes	-	Yes

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Example 2B: Mr. Smythe Has Malignant Hypertension w/Renal Failure

Smythe, Donald K.

DOB: 07/04/1931
DOS: 10-21-2008

Allergies: NKDA
Meds: none
Vitals: BP 180/90, HR 78, RR 20, WT 248, T: 99.0

S: Patient here for follow up of HTN. Continues to have headaches, and reports tinnitus, some occasional confusion, and is frequently nauseous. Has lost 12 lbs in 3 weeks, is not dieting: bad taste in mouth causing decreased appetite.

O: NAD, looks older than stated age. Repeated VS: B/P 190/90, HR 82, RR 22. Neck: No JVD or carotid bruits. Skin: Slightly yellow-brown. Eyes: PERRLA, denies blurry vision. Extremities: mild bilateral calf edema. Lungs Clear. C/V: RRR.

A: Malignant hypertensive renal disease with renal failure 403.01
Decrease in existing body weight 783.21

P: Increase Lisinopril 60 mg PO QD, add Losartan 50 mg PO BID . Labs: Electrolytes, BUN, creatinine, phosphate, Ca, CBC, urinalysis (incl. urinary sediment exam), ordered renal U/S. restriction of dietary protein, phosphate, and K, RTC 1 week. If serum Na concentration is < 135 mmol/L, will restrict fluids.

Electronically signed by Joe Smith, MD Date 10-21-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: 403.01	403.01	Yes
Secondary ICD-9-CM code: 783.21	783.21	Yes
Tertiary ICD-9-CM code:	-	-
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? Yes	-	Yes

Ms. White diagnosed with Diabetes Mellitus Type 2

White, Sarah A. DOB: 07/04/1940 DOS: 09-30-2008
Allergies: NKDA Meds: Seroquel 200 mg BID, Lipitor 20mg QD, Multivitamin
Vitals: BP 120/80, HR 78, RR 20, WT 220, T: 98.0, Ht. 62"

S: Pt presents to the office early this AM C/O excessive thirst, has had a 50 pound weight gain since beginning Serquel 3 months ago, and increased urination at night. She wonders if her symptoms could be side effects of her antidepressant medications. Pt. monitors her bipolar disorder well and states her mood diary demonstrates her medications are effective.

O: Patient hasn't eaten today, glucometer reading done here is 198. Lungs: CTA, Cardio: RRR, Skin: unremarkable, Extremities: no edema, Cap refill good, Abdomen: soft, non-tender, ENT: negative.

A: Finding, other abnormal glucose 790.29, possible DM2
Obesity, most likely due to antidepressants 278.00
Bipolar disorder 296.80
Hyperlipidemia 272.4

P: No changes to current meds. Labs ordered: FBS, A1c, lipids panel, CBC, urinalysis. I counseled Sarah in a 1500 calorie ADA diet, gave glucometer, and provided instructions on monitoring her glucose readings, and she will start a diet log. Sarah will increase her exercise by going to the community pool for water aerobics.

Electronically signed by Joe Smith, MD Date 09-30-08

Addendum: Lab results received: A1c and FBS elevated, DX is DM2 250.00, advised Pt. by phone: start Metformin 1000 mg QD, called RX to pharmacy. RTC fasting 2 weeks, bring glucometer, diet, and mood logs.

Signed by Joe Smith, MD Date 10-01-08

Documented in Medical Record:	Reported on Claim:	Required for Risk Adjustment:
Primary ICD-9-CM code: 790.29 Abnormal Glucose	790.29	Yes
Secondary ICD-9-CM code: 278.00 Obesity	278.00	Yes
Tertiary #3 ICD-9-CM code: 296.80 Bipolar	296.80	Yes
Tertiary #4 ICD-9-CM code: 272.4 Hyperlipidemia	272.4	Yes
Addendum meets CMS criteria? Yes	-	Yes
Chief Complaint (Reason for Visit) Documented? Yes	-	Yes
Date and Physician Signature? Yes Valid Electronic: Yes	-	Yes
Credential Documented? Yes	-	Yes

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Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar,
- are counted as present,
- complete a brief Self-Assessment and Quality Survey at the end of the webinar, and
- request the continuing, education credit in the manner described in the steps in the next slide.

Obtaining Continuing Education Credits

1. Send an email to providereducation@chpw.org with "Continuing Education Credit Request" in the subject line.

2. Be sure to let us know which organization/s you're requesting continuing education credit from, and

3. Include your contact information in the body of the email.

4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and

5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.

6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).

7. As always, it's the responsibility of the Participant to submit and/or make available proof of continuing education
   credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn't submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS's website: http://www.cms.hhs.gov/MLNGenInfo/ and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 3 Webinar: Hierarchical Condition Coding.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.

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References

- Slide 8 (and throughout)

ICD-9-CM Official Guidelines for Coding and Reporting, Outpatient Services, Section IV, Chapter K: "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment."

- Slide 11

Medicare B News Issue 236 April 17 2007, Heading: Reminder, Title: Documentation Guidelines for Amended Records - Revised

CMS RAPS Participant Guide 2008, Section 7.2.4.2: Physician Signatures, Physician Credentials, and Dates of Service

- Slide 17

Requirements for Addendums to the Medical Record (Must be timely, bear the signature of person making the addition/change, date of the new/revised entry, and reason for the addendum)

Medicare B News, Issue 196, dated April 15 2002: "Documentation Guidelines for Medicare Services"

Medicare B News Issue 236 April 17 2007, Heading: Reminder, Title: Documentation Guidelines for Amended Records - Revised

1833(e) Title XVIII of the Social Security Act (No Documentation)

1842(a)(1)(c) of the Social Security Act (Carrier Audits)

1862(a)(1)(A) of Title XVIII of the Social Security Act (Medical Necessity)

Schott, Sharon. "How Poor Documentation Does Damage in the Court Room." Journal of AHIMA 74, no. 4 (April 2003): 20-24.

Dougherty, Michelle. "Maintaining a Legally Sound Health Record." Journal of AHIMA 73, no. 8 (April 2003): 64A-G.

*Just a reminder that per CMS, deliberate falsification of the medical record is a felony offense.

1995 and 1997 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES, Section II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

CMS (RAPS Participant Guide 2006 and 2008), the Washington Administrative Code, ICD-9-CM Official Guidelines for Coding and Reporting, and National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Documentation.