Risk Adjustment and Healthcare Reform: Documentation & Coding

Why Coding Accuracy Matters...
It’s Bigger than Risk Adjustment

Introduction

With healthcare reform and system changes underway, accurate medical documentation and coding is critical to the financial health of your practice and to the health of your patients—our members.
Agenda:

- Healthcare Reform
  - The Marketplace
  - Subsidies
  - Grace Periods
  - ID Cards
  - Grace Periods
- Risk Adjustment
  - Objectives
  - Overview
  - What is Commercial Risk Adjustment?
  - How does the Commercial Risk Adjustment Program work?
  - What is Hierarchical Condition Category (HCC)?
  - Top Hierarchical Conditions Categories.
  - Why Coding Matters...
  - Risk Adjustment Guidelines.
  - Documentation Basics.
  - Coding and Medical Record Requirements.
  - Annual Evaluation.
  - Preparing for ICD-10.
  - Best Practices.
  - Questions?

The Marketplace

Platinum level. Targeted to individuals who use healthcare more often and the premium cost is worth the advantage of low-deductible and first-dollar coverage.

Gold level. Targeted to individuals willing to pay more for coverage that offers a lower deductible and rich benefits.

Silver level. Targeted to individuals eligible for cost-sharing reductions and those willing to pay slightly higher premiums to reduce out-of-pocket (OOP) costs.

Bronze level. Targeted to individuals looking for a low-cost product option with high deductibles and coinsurance.

The Silver level is the only level where qualifying members get the maximum subsidy benefits.

WHO CAN SHOP THE EXCHANGE?
- Individuals who do not already have coverage through an employer
- Small Business: Must have 50 or fewer full time employees

SHOPPING THE EXCHANGE...
- Apply for subsidies such as cost-sharing reductions and advanced premium tax credits
- The plans and programs the shopper is eligible for will be in a side-by-side comparable format

Open enrollment for 2015 starts on November 15, 2014 through February 15, 2015.
Subsidies

Those whose income is 100 to 400 percent of the federal poverty level (FPL) are eligible for these subsidies and only if they apply for or select them.

Cost-sharing reductions
- Built into the benefits of select policies that have lower deductible, coinsurance and copayment out-of-pocket costs
- Customers with incomes under 250 percent of FPL may be eligible to purchase cost-sharing reduction policies
- The level of savings is directly based on their income and family size
- Customer must buy the Silver Level reduction policy in order to get their eligible savings

APTC (advanced premium tax credit)
- A monthly premium assistance tax credit that is applied to the customer's premium amount to help lower their monthly premium out-of-pocket costs
- Subsidy-eligible customers may purchase a policy from a higher benefit tier plan (Gold or Platinum Level), but must pay the premium difference above the subsidy allowance out of their own pocket
- Operational impacts to provider for members who take advantage of APTC.

Premium Grace Period Scenario

Premium Grace Period Rules
- The APTC policy holder must have paid at least one month’s premium to be eligible for the grace period
- Blue Cross will pay claims for services rendered during month 1 of grace period
- Blue Cross will pend claims for services rendered during months 2 and 3 of the grace period
- Blue Cross will notify providers of Blue patients who are in the grace period and the possibility of denied claims for months 2 and 3

Sample grace period scenario

Payment Status: Current, 30 Days Delinquent, 60 Days Delinquent, 90 Days Delinquent

Claim Status: Pay Claims, Pay Claims, Denied Claims, Denied Claims

*Payments are made according to the member's benefits.
More on Premium Grace Periods

YOUR claims for services rendered during month 1 of the grace period for an APTC member will not be retroactively recouped by Blue Cross, even if the policy terms after month 3

APTC members in months 2 and 3 of the grace period will show a status in iLinkBLUE of “active pending premium payment.” YOU may collect payment UPFRONT (up to Blue Cross’ allowable) for future services.

To avoid risks of not collecting the proper payments from YOUR Blue patients upfront, please ensure YOUR business operations area verifies eligibility on iLinkBLUE prior to seeing a Blue member.

Should the APTC member pay all delinquent premiums and return to an active eligibility status, YOU contractually must refund, within 30 days, the member-collected amounts above their applied cost-share amounts.

Should the APTC member’s policy terminate for eligibility, YOU may follow the standard business operations YOU already have in place for non-insured patients for services rendered in months 2 and 3.

Members in months 2 and 3 of the grace period must pay the full allowed amount to the pharmacy for prescriptions. Prescribing generics can help lessen costs to members.

Newsletter is available online at www.bcbsla.com/providers >News

YOUR contract covers new HCR policies

We amended all network contracts to include updated language on changes we have implemented as a result of the new healthcare reform law.

Changes included language to address Risk Adjustment changes as they affect Blue Cross and our network providers.

This amendment has no change to our providers’ current reimbursement/allowable charges.

Effective Jan. 1, 2015
4. Separate ID Card for each member on policy

Prior to January 1, 2014 – PPO members were issued ID cards in the policyholder’s name only

As of January 1, 2014 – Like HMOLA, PPO members now receive individualized (in their own names) ID cards for each member on the policy

We have simplified some aspects of our member ID cards to ensure they are accurate and consistent for all of our product options and member movement within the Marketplace.

iLinkBLUE Provider Suite

Blue Cross does not want YOU taking risks when it comes to APTC members. For this reason, we have enhanced multiple locations within iLinkBLUE where YOU can verify when a BCBSLA APTC member is in a "Premium Grace Period."

The ACA (Affordable Care Act) requires that health insurers give APTC members a 90-day grace period.

- Only applies to customers who receive premium subsidies (Advance Premium Tax Credits)
- Must provide a 90-day grace period for delinquent premiums before coverage is canceled

BCBSLA claims payment policy during premium grace period:

<table>
<thead>
<tr>
<th>Month 1:</th>
<th>Months 2 &amp; 3:</th>
<th>After Month 3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims will be paid to provider and no recoupment will occur if member becomes delinquent until premiums are paid or policy is termed.</td>
<td>Claims will be pended until premiums are paid or policy is termed.</td>
<td>Claims for months 2 &amp; 3 will reject for no eligibility once member’s coverage terminates.</td>
</tr>
</tbody>
</table>

Use iLinkBLUE to verify eligibility. Never go by the ID card alone.
# Premium Grace Period Scenario

## Premium Grace Period Rules

| The APTC policy holder must have paid at least one month's premium to be eligible for the grace period |
| Blue Cross will pay claims for services rendered during month 1 of grace period |
| Blue Cross will pay claims for services rendered during months 2 and 3 of the grace period |
| Blue Cross will notify providers of Blue patients who are in the grace period and the possibility of denied claims for months 2 and 3 |

## Sample Grace Period Scenario

<table>
<thead>
<tr>
<th>Payment Status</th>
<th>Claim Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>Pay Claims</td>
<td>Cancel</td>
</tr>
<tr>
<td>30 Days Delinquent</td>
<td>Pay Claims*</td>
<td>Send Claim Notice to member</td>
</tr>
<tr>
<td>60 Days Delinquent</td>
<td>Pend Claims</td>
<td>Send Claim Notice to member</td>
</tr>
<tr>
<td>90 Days Delinquent</td>
<td>Pend Claims</td>
<td>Send Claim Notice to member</td>
</tr>
</tbody>
</table>

**Payments are made according to the member’s benefits**

## Finding Grace Period Notices on iLinkBLUE

1. **Coverage Information > Coverage Summary**: An APTC premium status indicator will show on the Coverage Report(s) on the Coverage Summary page.

2. **Coverage Information > Eligibility**: A printable APTC premium status notice will be available on the Eligibility page based on the member’s status:
   - **ACTIVE COVERAGE**: when the APTC member is NOT delinquent OR within the first month of the delinquency period
   - **ACTIVE PENDING PREMIUM PAYMENT**: when the APTC member is within the second and third months of the delinquency period

3. **Coverage Information > APTC Grace Period Explanation**: This links to a printable PDF explanation guide on premium status information for APTC members.

4. **Claims Research > Claims Status**: Under the “Pended Claim Search Categories” there will be a new pended claim search category for “APTC Extended Grace Period.”

5. **Claims Research > Claims Status > Pended Claims > Pended Error Code Description**: Click the “Pended Error Code” link and a Pended Error Code Description box pops up. APTC members will show their premium status under the Blue Cross reason code SL16. The same printable PDF APTC premium status notice that is available on the Eligibility page is also available here when the coverage status shows “Active Pended Premium Payment.”
The Louisiana Healthcare Education Coalition (LHEC) was founded to help Louisianians better understand the Patient Protection and Affordable Care Act (PPACA).

As a civic organization committed to providing unbiased healthcare and wellness information, LHEC provides education on the major drivers of healthcare costs, the critical importance of personal wellness and the need for access to quality healthcare, by working with healthcare providers, small businesses, faith-based institutions, employers, community leaders, patient advocacy groups and the public.

LHEC exists solely as an educational resource.

It neither endorses nor seeks to create public policy.

Risk Adjustment Objectives

Upon the completion of this presentation, you will:

- Know what risk adjustment is and the impact it will have for your practice.
- Understand Hierarchical Condition Categories (HCCs).
- Be familiar with correct documentation guidelines.
- Understand the impact that incomplete coding can have on your practice.
Overview

- Risk adjustment is a process used by Centers for Medicare and Medicaid Services (CMS) to predict healthcare costs based on the relative risk of enrollees within a health plan to protect against potential effects of adverse selection.
- Risk adjustment is not a new concept. Medicaid began using risk adjustment modeling in 1996 and Medicare Advantage plans have been using the risk adjustment model since 2004.
- CMS is now looking to commercial plans to implement risk adjustment as a valuable method to identify and prepare for high-risk patients.

What is Commercial Risk Adjustment?

- Commercial Risk Adjustment (CRA) is one of three new premium stabilization programs, established by the Affordable Care Act (ACA), for the individual and small group commercial markets for products sold on and off the exchange.
- CRA encourages health plans to focus on quality improvements, efficiency and the stabilizing of premiums designed to prevent adverse selection.
How does the Commercial Risk Adjustment Program Work?

- CMS is responsible for operating the risk-adjustment programs.
- CMS reviews each health plan’s claims’ data for the calendar year to establish an overall “risk factor” for the health plan.
- The “risk factor” is determined based on diagnosis coding supported by medical record documentation.
- CMS will validate the health plan’s risk factor through medical record chart audits. Risk scores for the health plan will be adjusted as necessary.

* Claims—individual and small group, on and off the Federally Facilitated Marketplace

What is Hierarchical Condition Category (HCC)?

- Disease groups, organized into body systems or similar disease processes, are referred to as HCCs.
- CMS and The Department of Health and Human Services-HCC model (HHS-HCC) includes both diseases and demographic factors, called coefficients.
- The models are cumulative; therefore, a patient may be assigned to more than one category.
- CRA uses a hierarchical system in which some HCCs will override other related conditions (only one HCC in a category may be assigned).
- The implementation of ICD-10 will significantly impact the number of HCCs and number of diagnosis codes currently in effect.
Top Hierarchical Condition Categories

- Major Depressive and Bipolar Disorders
- Asthma and Pulmonary Disease
- Diabetes
- Specified Heart Arrhythmias
- Congestive Heart Failures
- Breast (Age 50 plus) and Prostate Cancer
- Drug Psychosis/Dependence
- Rheumatoid Arthritis
- Colorectal, Breast (Age < 50), Kidney
- Coagulation Defects

What are our HEALTH SCORES?

Risk Adjustment Reporting

BCBSLA Commercial Risk Adjustment Provider Outreach Report-Sample Report
As of 7/31/2014

This report may contain Protected Health Information (PHI) subject to federal law. Use discretion in disseminating and sharing it.
Why Coding Matters...

Three Key Areas of Impact:

1. Inclusion of chronic conditions considered in the medical decision making for the Evaluation and Management (E&M) will allow for better health management.

2. Complete patient diagnosis coding allows the member to be included in any number of quality management programs offered by Blue Cross and Blue Shield of Louisiana.

3. Complete and accurate coding practices can minimize your administrative burden of additional paperwork later (i.e.- no need for health insurance company to request medical records).

Importance of Risk Adjustment Coding

- CMS requires health plans to report complete and accurate diagnostic information on their members.

- Health plans must verify through medical records, that the reported diagnostic information is correct and accurate.

- Appropriate diagnosis code reporting and complete clinical documentation by the provider increases the accuracy of a member’s risk score while reducing the need to request medical records and/or audit our provider’s claims.
Risk Adjustment Guidelines

• All diagnosis taken into consideration in the medical decision making for the visit should be included on the claim and in the medical record.
  - This is much different than historical guidelines and will require re-education to physicians and coders.
• Specific diagnoses must be documented in a face-to-face visit by the treating licensed provider and the documentation must be signed by the treating provider to be accepted.

Documentation Basics

• Each page of the patient’s medical records should include the following:
  - The patient’s name
  - Date of birth or other unique identifier (on the first page)
  - Date of service including the year
• The provider’s signature must be legible and include credentials
  - Legibility issues can be solved with a preprinted signature/credential block and a handwritten signature above.
  - Electronic signatures should include the date and time of authentication, the servicing provider’s name and credentials and include a statement such as “Electronically signed by” or “Authenticated by.”
Documentation Basics

• Remember to be very clear on what diagnoses or conditions are current or ongoing instead of those that are no longer present or historical.

• Diagnoses that are not being treated but are current and ongoing for monitoring should be documented as current. All monitoring efforts should be included in medical documentation.

• Every current diagnosis being taken into consideration toward a medical decision should be documented in each visit as current and not documented as “historical.”

Coding & Documentation: Diagnosis Specificity

• Documentation of diagnoses must be specific. This is important not only for Risk Adjustment programs, but also for ICD-10 implementation efforts.

• Comorbidities and other modifying factors should be clearly documented.

• Examples of commonly under-diagnosed conditions are diabetes and hypertension.
Coding & Documentation: Common Errors

- Chronic or coexisting conditions are not documented or are left out of the clinical documentation for an office visit.
- Discrepancies exist between the medical records and the reported diagnosis codes.
- The historical status of a diagnosis is unclear.
- The electronic health record was not authenticated.
- The record contains nonstandard abbreviations or up and down arrows to indicate diagnoses.

Coding & Documentation: Common Errors

- Non-specific diagnosis codes are used.
- Unlisted diagnosis codes (NEC/NOC).
- The use of quantifying language in the outpatient setting, (e.g. “Consistent with, probable, possible...”).
- Patient status conditions are not evaluated and/or documented at least once a year.
- A cause and effect relationship between diabetes and diabetic manifestation codes is not sufficiently documented and/or coded.
- The highest degree of diagnosis code specificity was not assigned or utilized.
Coding & Medical Record Requirements

• Encounter must be based on a face-to-face visit.
• Condition(s) must be documented in the medical record.
  - Diagnosis cannot be inferred from test results
• Diagnosis code can be assigned to each condition documented on the record.
• Documentation must show that condition was monitored, evaluated, assessed or treated (MEAT).

Coding & Medical Record Requirements

• Treatment and level of care must be justified.
• Health status assessed.
• All chronic conditions must be assessed and reported no less than once a year.
• Medical record must support codes reported on the claim or encounter form.
Coding & Medical Record Requirements

Providers must report all diagnoses (not just primary diagnosis) that impact the patient’s evaluation, care and treatment including:

- Main reason for visit
- Co-existing acute conditions
- Chronic conditions (such as CHF, CKD, RA, COPD/Asthma, Cardiomyopathy)
- Care rendered
- Conclusion and diagnosis

Coding & Medical Records

History Of

- **History of** means the patient no longer has the condition.
- Frequent documentation errors regarding use of **history of**:
  - Coding a past condition as active
  - Coding **history of** when condition was still active
- Exception: It is appropriate to document/code “history of” when documenting some status conditions (e.g. Amputation).
Examples:

<table>
<thead>
<tr>
<th>Incorrect Documentation</th>
<th>Correct Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF, meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>H/O angina, meds nitroquick</td>
<td>Angina, stable on nitro</td>
</tr>
<tr>
<td>H/O COPD, meds Advair</td>
<td>COPD controlled w/Advair</td>
</tr>
</tbody>
</table>

• Face-to-Face visit
• Documentation must show how chronic condition is being monitored, evaluated, assessed or treated (MEAT).
• Each diagnosis must have an assessment and a plan.

Sample Language

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable</td>
<td>Monitor</td>
</tr>
<tr>
<td>Improved</td>
<td>D/C Meds</td>
</tr>
<tr>
<td>Tolerating Meds</td>
<td>Continue Current Meds</td>
</tr>
<tr>
<td>Deteriorating</td>
<td>Refer</td>
</tr>
</tbody>
</table>
Coding & Medical Records: Incomplete Inpatient Records

- Discharge summary:
  - Valid inpatient record for coding if it has both the admit and discharge dates.
  - Use Inpatient Coding Guidelines to code.
- Admission history and physical not valid for inpatient record coding.
- Consults during the inpatient stay may be coded as physician records.
  - Use Inpatient Coding Guidelines to code.
- Emergency room visit on the same date as admission can be coded as an outpatient visit.
  - Use Inpatient Coding Guidelines to code.

Annual Evaluation

- All relevant diagnosis codes should be reported at least once a year for each patient.
- On January 1 of each year, the patient’s diagnosis code information is reset in preparation for a new year of diagnosis encounter data.
- Ensure all applicable diagnosis codes are submitted for each patient during the calendar year.
  - 12 diagnoses on CMS-1500 (4 per line item)
  - 26 diagnoses on UB-04 Claim Form
Annual Evaluation

- Annual evaluation, documentation and submission of all relevant diagnoses and corresponding diagnosis codes is important for:
  - Promoting quality patient care
  - Ensuring appropriate screening tests are received
  - Ongoing assessment of the patient’s chronic conditions
  - Accurate patient risk score calculation
  - Data validation audits

Preparing for ICD-10

- With the implementation of ICD-10, the number of codes and mapping will be more extensive and complex.
- With a more expansive code set and larger number of diagnosis codes, more efforts will be required for updating and maintaining the clinical classifications.
- Coding patterns may be more variable and will require frequent updates of the clinical classifications.
Best Practices- How Do You Get The Best Results?

- Medical coding of patient encounters is only as good as the underlying medical record documentation.
- Best practices in medical coding should include:
  - Accuracy
  - Specificity
  - Consistency
  - Thoroughness

Best Practices

- Engage clinicians to perform accurate capture of primary conditions and comorbidities, particularly in more complex cases.
- Engage coders and office staff to ensure the use of coding best practices. Consider taking classes or using concise reference cards.
- Standardize coding processes to minimize disruptions to practice flow.
- Adopt technologies such as electronic health records or other software to improve efficiency and accuracy.
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