Merit Based Incentive Program (MIPS): Cost Category 2019 Overview

Defining Cost and Strategies to Reduce Cost

June 19, 2019

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Managing Advisor Quality Services

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Agenda

1) Overview of Quality Payment Program (QPP) Year 3 2019
2) Cost Performance Category Overview
3) Case Minimums, RAF, HCC
4) Scoring Cost Performance Category
5) Tips and Tools to Help Reduce Cost

Overview of Quality Payment Program (QPP)2019

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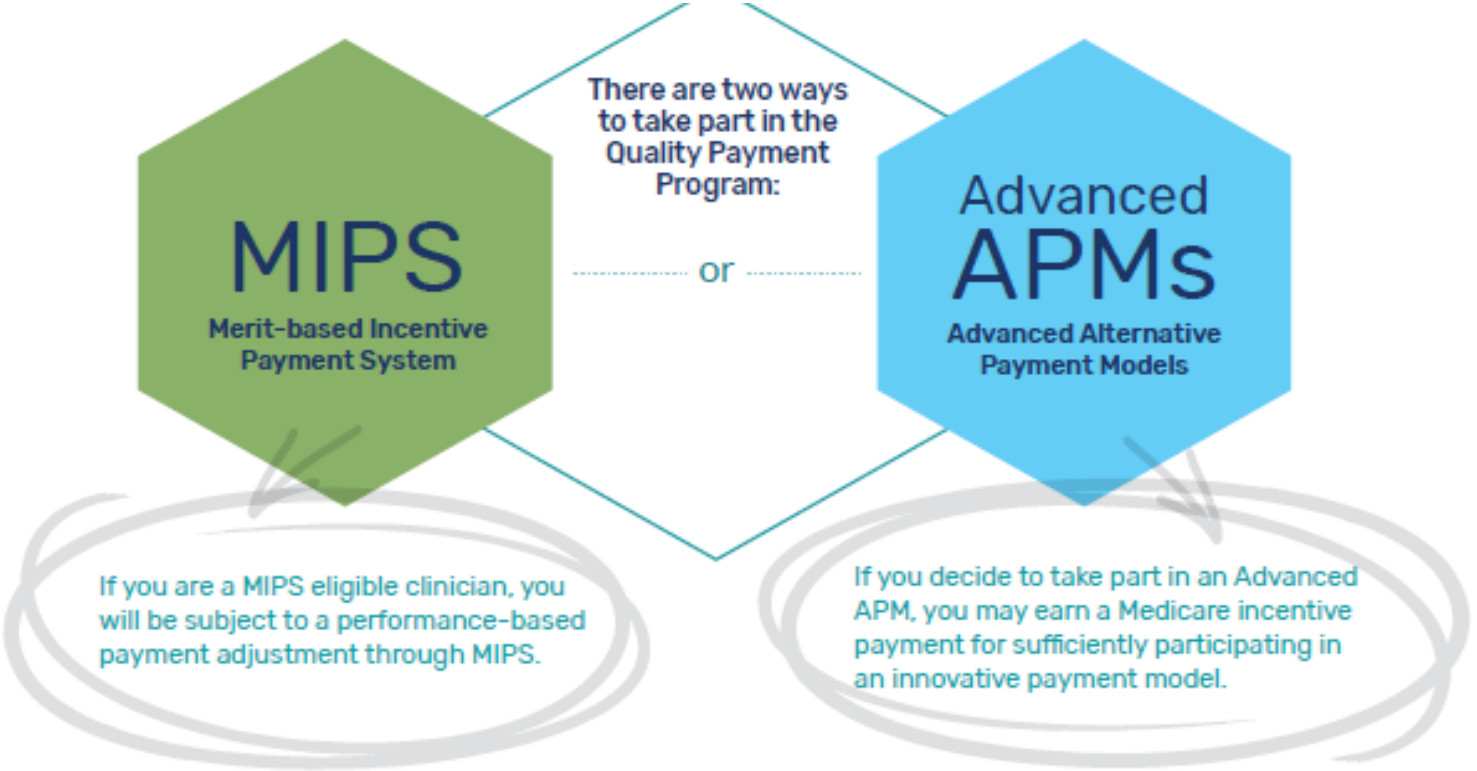
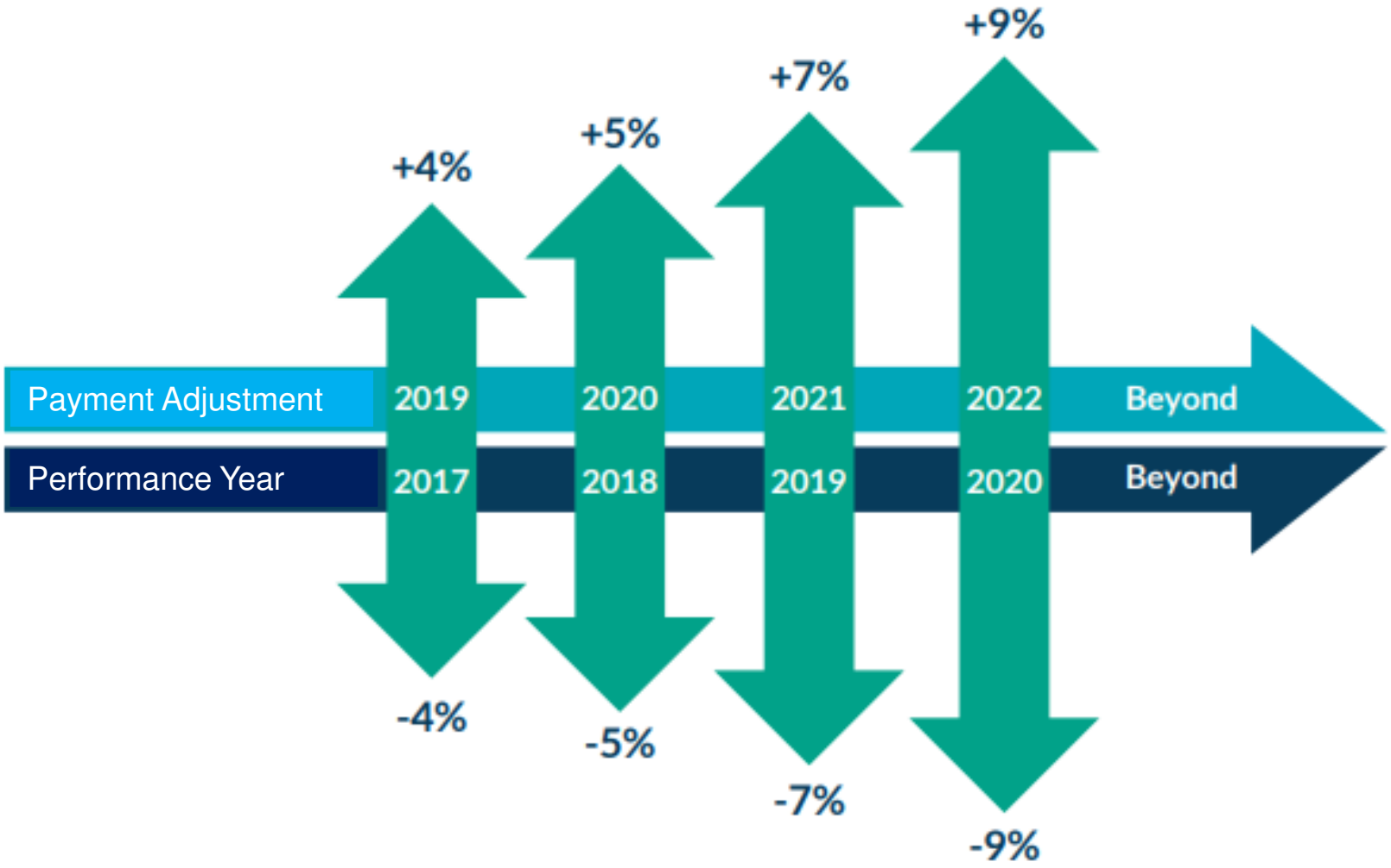
MIPS 2019 Promoting Interoperability

Two Participation Tracks



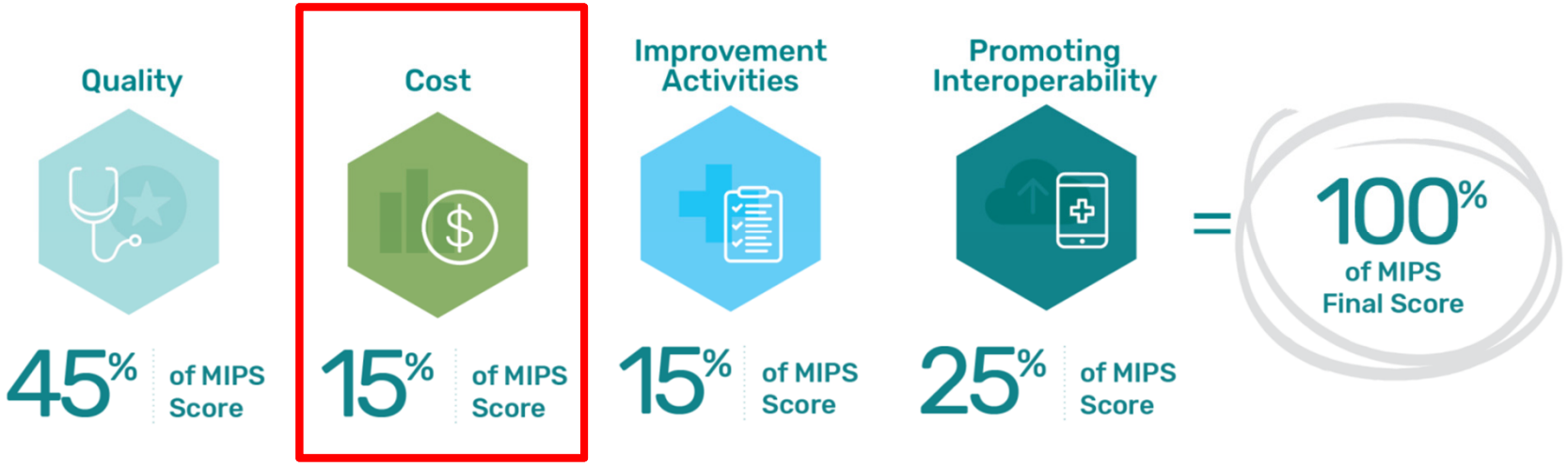
Merit Based Incentive Payment System

Payment Adjustment Schedule Based on Performance Year



Merit Based Incentive Payment System

MIPS Performance Categories



- Comprised of Four performance categories in 2019
- Points from each performance category are added together to give you a MIPS Final Score.
- MIPS Final Score is compared to MIPS performance threshold to determine if a **positive, negative**, or **neutral** payment adjustment is received.

MIPS Year 3 - 2019

Types of Clinicians Eligible to Participate 2018/ 2019

- Physicians
- Physicians Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- **Clinical Psychologists**
- **Physical Therapists**
- **Occupational Therapists**
- **Speech Language Pathologists**
- **Audiologists**
- **Registered Dieticians or Nutrition Professionals.**

Bolded *are NEW for 2019.*

MIPS Year 3 - 2019

Types of Clinicians Eligible - 2018/2019

*__Physicians include__:

- Doctors of Medicine
- Doctors of Osteopathy (including Osteopathic Practitioners)
- Doctors of Dental Surgery
- Doctors of Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors-*legally authorized to practice by a State he/she performs this function*.

MIPS Year 3 - 2019

Low Volume Threshold Criteria (LVT)

New for 2019

$90,000 a year Medicare Part B allowed charges **and** **200 Medicare Beneficiaries** **and** **200 Covered Professional Services under PFS**

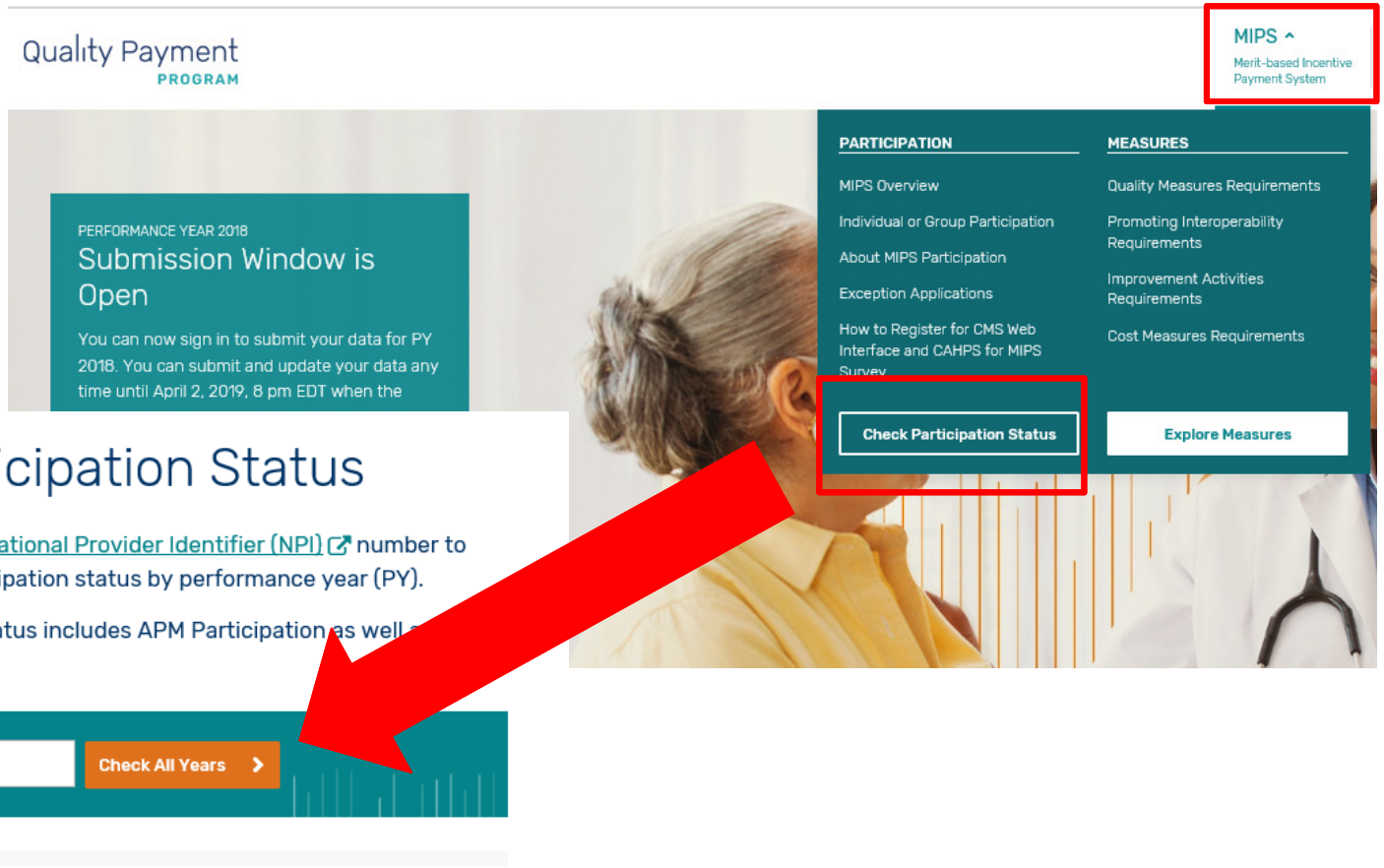
- Bill >$90,000 a year in allowed charges AND
- Provide care >200 Medicare beneficiaries AND
- Provide > 200 covered professional services under PFS.

Note: Must meet **ALL 3** to be eligible for MIPS 2019.

MIPS Year 3 - 2019

Check Your Eligibility

Go to www.qpp.cms.gov



MIPS Year 3 - 2019

If excluded, and still want to participate in MIPS?

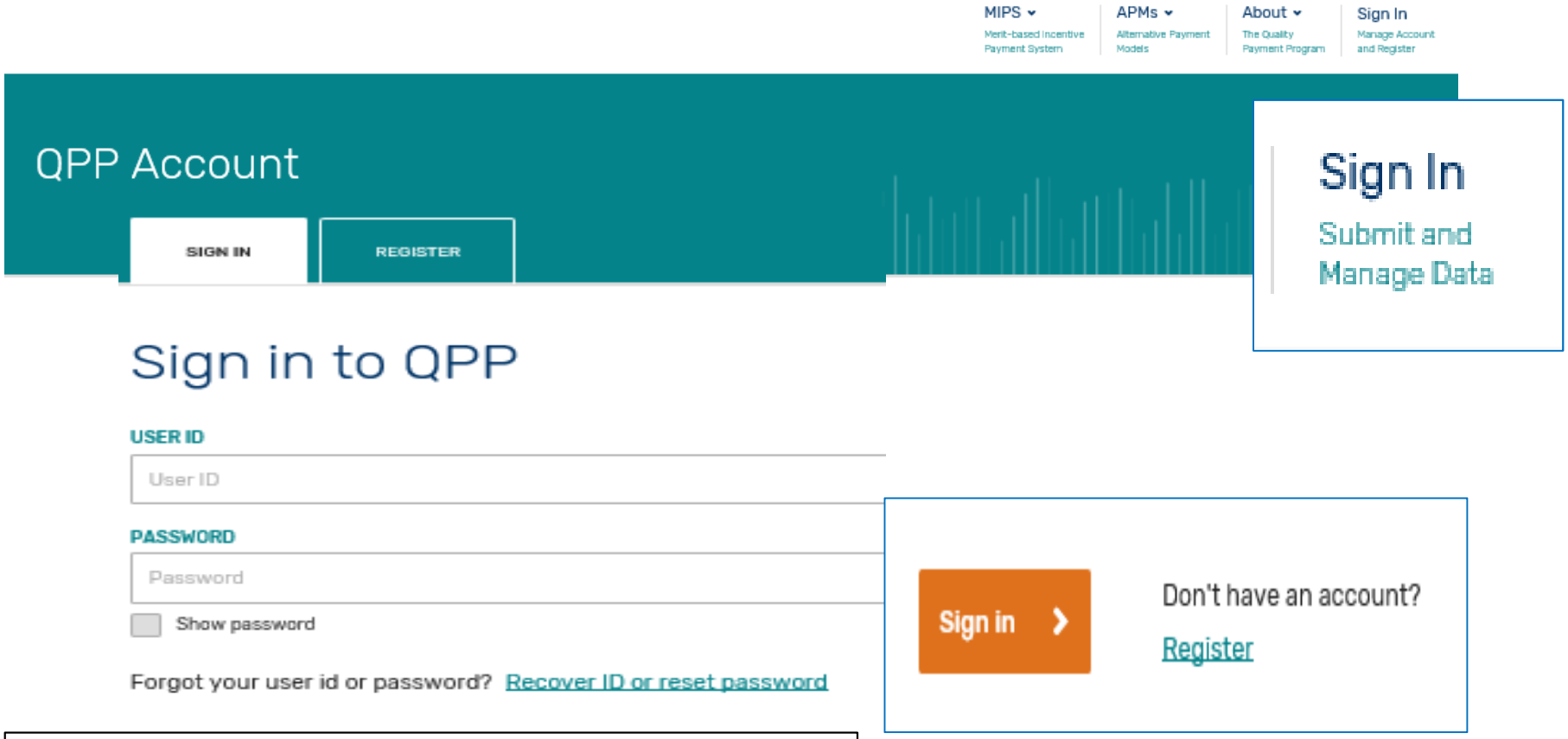
Two options:

1. **Voluntary**
   - Submit data to CMS and receive performance feedback.
2. **Opt-in** *(**New** for 2019)*
   - Available to EC's excluded from MIPS based on LVT.
   - Meet or exceed **at least one**, but not all of LVT criteria.
   - IF opt-in, subject to MIPS performance requirements, MIPS payment adjustment.

MIPS Year 3 - 2019

Submitting Your Data 2019*

Go to www.qpp.cms.gov



*Data Submission Deadline **March 31, 2020**

What Do I need to Understand about the Cost Category?

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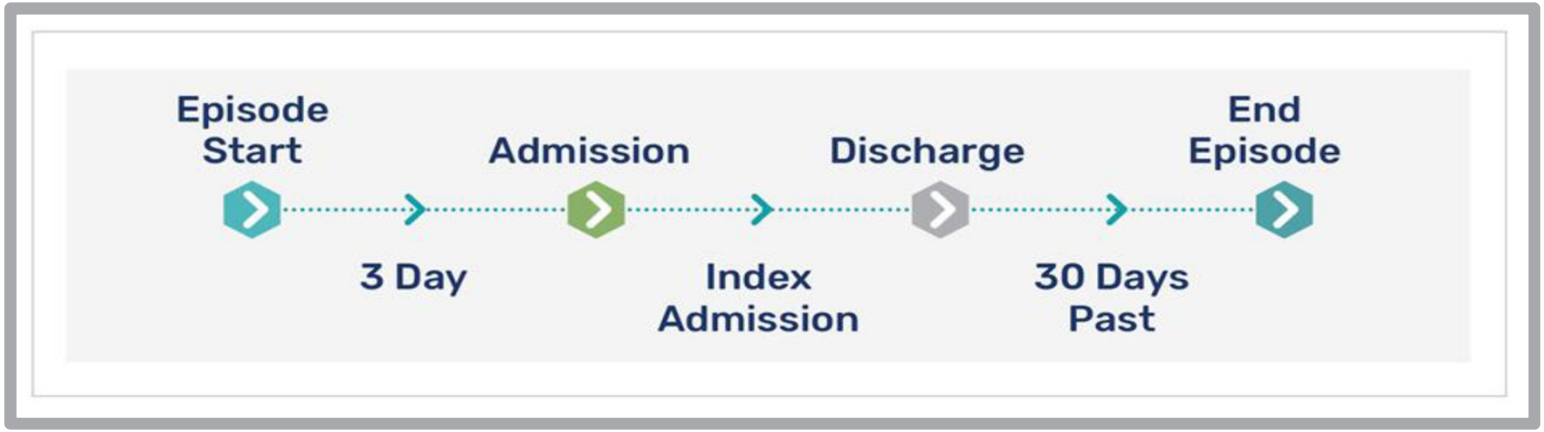
Cost Performance Category 2019

- **15%** of Final Score in 2019
- No reporting requirement-data pulled and calculated from administrative claims for entire calendar year.
- 10 Measures:
  - Medicare Spending per Beneficiary (MSPB)
  - Total Per Capita Cost (TPCC)
  - Eight episode based measures.
- Cost data analyzed by individual NPI/TIN combo.

Medicare Spending Per Beneficiary

MSPB Measure

- The total Medicare Part A and Part B costs incurred by a single beneficiary during an “episode” and compares observed costs to expected costs.
- MSPB episode includes all Medicare Part A and B claims with start dates within episode window- 3 days before an index admission through 30 days after hospital discharge.



Index Admission: admission with principle diagnosis of a specified condition meeting inclusion and exclusion criteria.

Medicare Spending per Beneficiary MSPB

What is included in an MSPB episode?

Data source for Medicare Part A and B claim types for items and services included during the episode "window" are:

- Inpatient Hospital
- Outpatient
- Skilled Nursing Facility
- Home Health Hospice
- Durable Medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Non-institutional physician/supplier claims (M'care Part B carrier claims)

Prescription drug costs Part D are **NOT included in calculation of MSPB measure.*

Medicare Spending per Beneficiary MSPB

MSPB Attribution

- Each Episode is “attributed” to a MIPS EC (NPI/TIN) providing the plurality or most Part B physician/supplier services measured by the dollar amount of M’care allowed charges-during the period between the index admission date and discharge date.
- Groups of clinicians participating as a “group”, a single measure score is calculated and assigned to group based on combined data.

Medicare Spending per Beneficiary MSPB

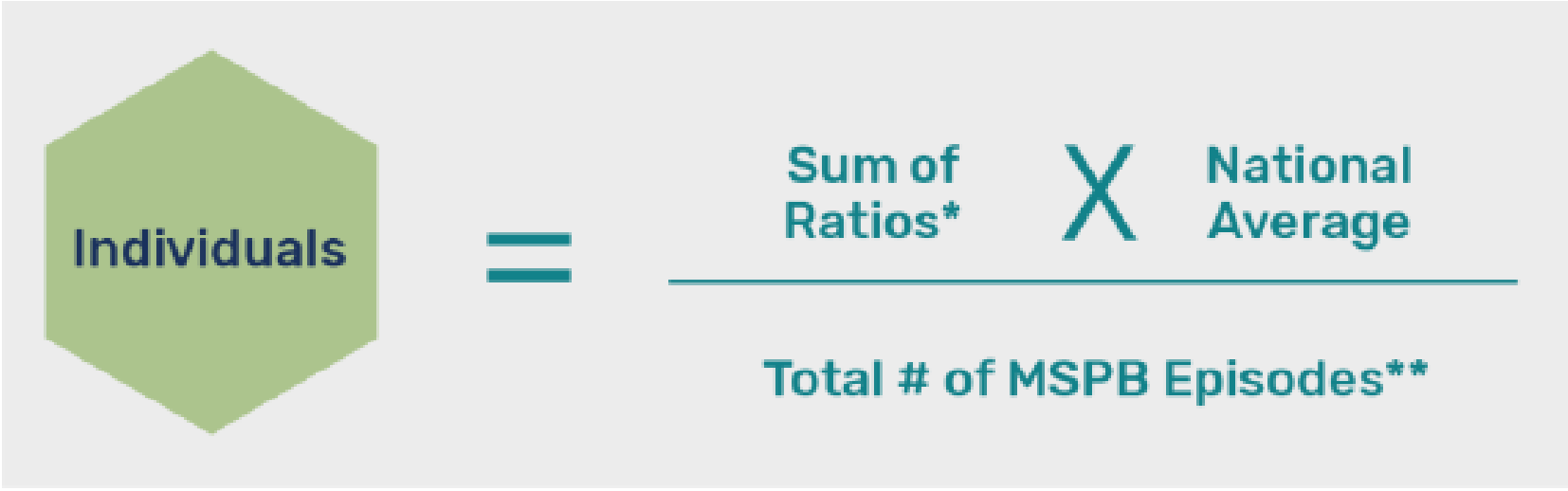
MSPB Attribution-*continued*

Attribution is determined on Part B services provided:

- Admission date and hospital setting with POS:
  - 21 (Inpatient)
  - 22 or 19 (Outpatient)
  - 23 (Emergency Department)
- During index hospital stay, regardless of POS
- Discharge date with POS restricted to Inpatient

Medicare Spending per Beneficiary MSPB

MSPB Calculation



*The sum of the ratios of payment-standardized observed to expected MSPB episode costs for all MSPB episodes attributed to an individual clinician's TIN-NPI

**Total number of MSPB episodes attributed to an individual MIPS eligible clinician's TIN-NPI

Medicare Spending per Beneficiary MSPB

Increasing your MSPB Score

- Know which clinicians your patients are seeing.
- Communicate with other clinicians about your patients.
- Focus on Quality measures and improvement activities that have a high impact on Cost measures.

Example: Quality measures related to All patient readmissions and Improvement Activities focused on improving this area, such as improving transitions of care and the associated Summary of Care exchange.

Medicare Spending per Beneficiary MSPB

Increasing your MSPB Score

- Care Coordination.
- Follow up and talk with your patients if admitted into ER.
- Educate patients on appropriate levels of care.
- When reviewing your data, keep in mind what the biggest drivers of cost.
  - Hospitalizations
  - ED Use
  - Readmissions
  - Use of post acute care services

Total Per Capita Cost Measure

Total Per Capita Costs-TPCC

- Risk and Specialty Adjusted
- Case Minimum 20

- Total Medicare Part A and B costs for beneficiaries attributed to the clinician with the **most allowed primary care services,** other than inpatient hospital, ER, and SNF during the reporting period.
- Payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure.

Total Per Capita Costs-TPCC

Calculating TPCC

Sum of the annualized, risk-adjusted, specialty-adjusted Medicare Part A and Part B costs across all Medicare beneficiaries attributed to a TIN-NPI, within a TIN or TIN-NPI*

# of all Medicare beneficiaries who received Medicare-covered services and are attributed to a TIN-NPI, within a TIN or TIN-NPI* during the performance period

Total Per Capita Cost Measure

Measure Calculation Factors

TPCC Measure is calculated through the following steps:

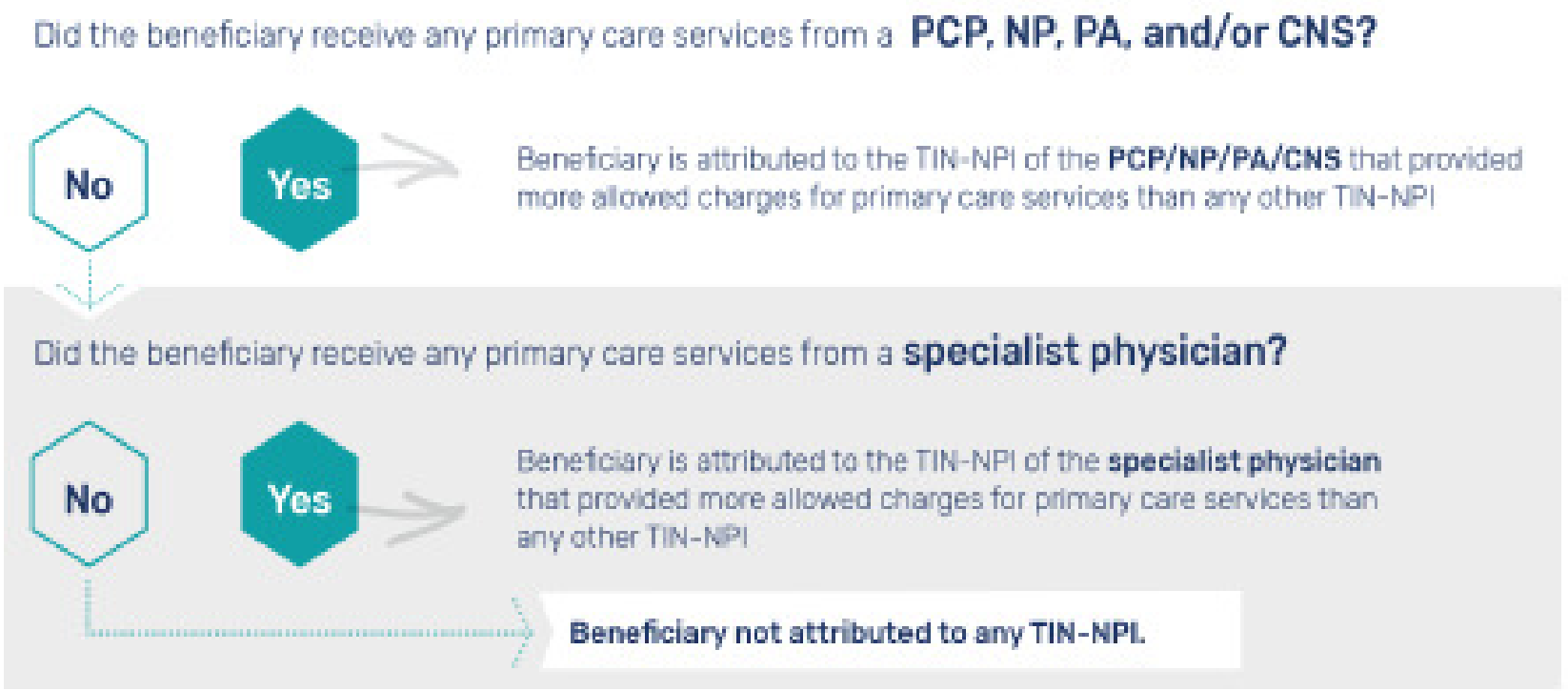
- **Attribute** beneficiaries to individual TIN/NPIs.
- Calculate **payment standardized** per capita costs.
- **Annualize** costs for partial year enrolled Medicare beneficiaries included in measure.
- **Risk adjust** costs.
- **Specialty adjust** costs.

Note: IF a beneficiary is attributed to an FQHC or RHC CCN (CMS Certification Number), then that beneficiary is NOT included in the TPCC, and excluded from risk adjustment.

Total Per Capita Cost Measure

TPCC Attribution

Two step Attribution process:



Total Per Capita Cost-TPCC

Increasing your TPCC Score

- Review your data at the patient level.
- Know which patients are attributed to you.
- Continue to monitor internal costs for beneficiaries who may be attributed to your TIN/NPI.
- Bill services correctly.
- Are you a specialist? Make sure your patients see their PCP.
- If you are a PCP, make sure you schedule annual wellness appointments.
- Be aware of your patient population and their needs.

NEW 8 Episode Based Cost Measures

Overview

Episode Based Measures-

- Only include items and services that are related to the *episode of care* of a **clinical condition** or **procedure** (defined by procedure and diagnosis codes)
- Assess cost of the care that's clinically related to initial treatment of a patient and provided during an episode's time frame.
- Same as MSPB and TPCC, Episode Based measures are calculated using Medicare Parts A & B fee-for-service (FFS) claims data.

8 Episode Based Cost Measures

Cost Measure	Episode Group Type
Elective Outpatient Percutaneous Coronary Intervention (PCI)	Procedural
Intracranial Hemorrhage or Cerebral Infarction	Acute Inpatient Medical Condition
Knee Arthroplasty	Procedural
Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Procedural
Routine Cataract Removal with Intraocular Lens (IOL) Implantation	Procedural
Screening/Surveillance Colonoscopy	Procedural
Simple Pneumonia with Hospitalization	Acute Inpatient Medical Condition
ST-Elevation Myocardial Infarction (STEMI) with PCI	Acute Inpatient Medical Condition

NEW 8 Episode Based Cost Measures

Episode Groups

- Represent a clinically cohesive set of medical services rendered to treat a given medical condition, **and**
- Aggregate all items and service provided for a defined patient cohort to assess the total cost of care.

Episode Groups consist of the following components:

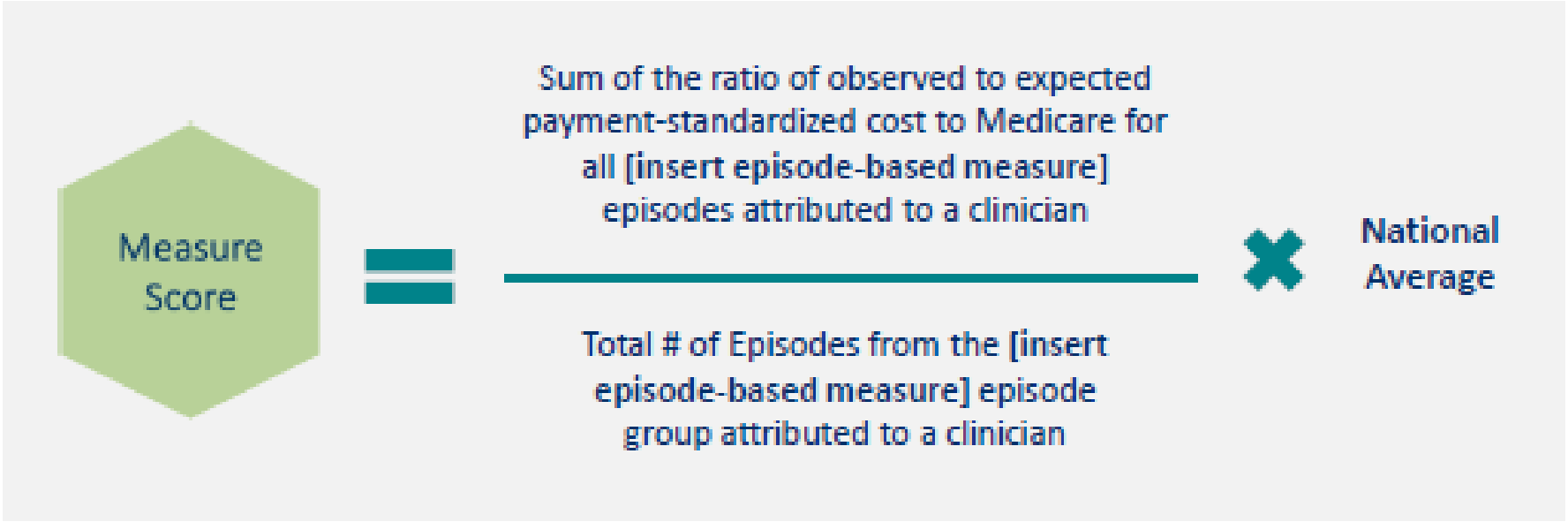
- Episode triggers and windows
- Item and Service assignment
- Exclusions
- Attribution methodology
- Risk Adjustment variable

Detailed Methodology documents for each Episode Based Cost Measure can be found in a zip file in **QPP Resource Library.*

NEW 8 Episode Based Cost Measures

Measure Calculation

Example of the numerator and denominator for Episode Based Measure.



NEW 8 Episode Based Cost Measures

Tips To Maximize Your Score

- Do the episode based measures align with your specialty?
- Understand how these measures differ from MSPB.
  i.e. simple pneumonia
- Evaluate your processes related to the cost associated with these episode based measures. Review related quality measures and improvement activities to reduce costs in conjunction with quality improvement efforts.
- Specialists-take advantage of these measures to earn a high cost score.

Note*:* *episode based measures may be added in future that could align with your specialty.*

Case Minimums, Risk Adjustment Factor, and Hierarchical Condition Category

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Scoring Cost Performance Category

Must Meet or Exceed Case Minimum

Measure	Case Minimum
Total Per Capita Cost (TPCC)	20
Medicare Spending Per Beneficiary (MSPB)	35
Procedural Episodes	10
Acute Medical Condition Episodes	20

- TPCC < 20 not scored.
- MSPB <35 not scored OR did not bill Part B services in hospital stays during performance period.
- Procedural Episodes<10 not scored.
- Acute Medical Condition Episodes .<20 not scored.

2019 Cost Performance Scoring

Case Minimum and Reweighting

- If you don't meet the case minimums to be scored on any of the cost measures, your performance on Cost will count toward **0%** of your MIPS Final Score

- The weight of your Quality score will increase from **45% to 60%** of your MIPS Final Score

- **Pay attention**: Are you meeting the case minimum? If not, this will have an impact on your quality score!

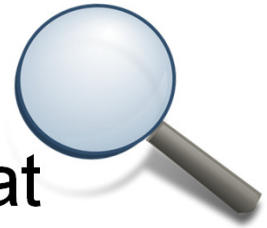
Risk Adjustment Factor (RAF)

Define RAF

- Tool used to estimate expected costs per beneficiary.
- Uses demographics, age, severity or “disease burden”, and ICD-10 codes.
- Medicare Advantage Plans and many commercial payors utilize RAF scores for reimbursement purposes.
- Uses Hierarchical Condition Categories (HCC) provides a snapshot into a patients illness by severity.

Hierarchical Condition Category-HCC

Coding to Specificity



- Sorting mechanism for chronic conditions that assigns a value on care for a patient.
- Provides “snapshot” into a patients disease complexity providing insurers valuable info to assess outcomes, determine payment rates, and gauge overall hospital performance..
- ICD codes are mapped to exactly one HCC.
- Factor into the risk adjustment scores to predict future costs.
- HCCs must be captured once every 12 months.

HCC-RAF Example

Source	Description	RAF
HCC 1	HIV/AIDS	0.470
HCC 2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.535
HCC 6	Opportunistic Infections	0.440
HCC 8	Metastatic Cancer and Acute Leukemia	2.484
HCC 9	Lung and Other Severe Cancers	0.973
HCC 10	Lymphoma and Other Cancers	0.672
HCC 11	Colorectal, Bladder, and Other Cancers	0.317
HCC 12	Breast, Prostate, and Other Cancers and Tumors	0.154
HCC 17	Diabetes with Acute Complications	0.368
HCC 18	Diabetes with Chronic Complications	0.368
HCC 19	Diabetes without Complication	0.118
HCC 21	Protein-Calorie Malnutrition	0.713
HCC 22	Morbid Obesity	0.365
HCC 23	Other Significant Endocrine and Metabolic Disorders	0.245
HCC 27	End-Stage Liver Disease	0.923

Source	Description	RAF
HCC 55	Drug/Alcohol Dependence	0.420
HCC 57	Schizophrenia	0.490
HCC 58	Major Depressive, Bipolar, and Paranoid Disorders	0.330
HCC 70	Quadriplegia	1.234
HCC 71	Paraplegia	1.052
HCC 72	Spinal Cord Disorders/Injuries	0.509
HCC 73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.958
HCC 74	Cerebral Palsy	0.045
HCC 75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barr Syndrome/Inflammatory and Toxic Neuropathy	0.408
HCC 76	Muscular Dystrophy	0.565
HCC 77	Multiple Sclerosis	0.556
HCC 78	Parkinson's and Huntington's Diseases	0.691
HCC 79	Seizure Disorders and Convulsions	0.284
HCC 80	Coma, Brain Compression/Anoxic Damage	0.570
HCC 82	Respirator Dependence/Tracheostomy Status	1.520

Hierarchical Condition Category

Example of ICD-10 code-HCC Group RAF

ICD-10-CM Code	Description	HCC Group	Risk Adjusted Factor
F32.9	Major depressive disorder, single episode, unspecified	0	0.00
F32.0	Major depressive disorder, single episode, mild	58	0.395

How is Cost Calculated?

How is Cost Calculated?

Individual EC's must have enough attributed cases to meet or exceed case minimum for that cost measure.

- If **only one** measure can be scored, that will be the Cost Performance category score.
- If **multiple** cost measures are scored, score is equally weighted average of all the scored measures.
  - *Example: if 7 out of 10 cost measures are scored, the cost performance score is the equally weighted avg. of the 7 scored measures.*
- IF **none** of the 10 cost measures can be scored, cost performance score will be 0%, and Cost will be reweighted to Quality, which is 45% + 15% = 60%.

Cost Scoring Example

Measure	Measure Achievement Points Earned by the Group	Total Possible Measure Achievement Points Available
TPCC Measure	8.2	10
MSPB Measure	6.4	10
Elective Outpatient PCI Measure	Not scored	N/A-not scored
Knee Arthroplasty Measure	7	10
Revascularization for Lower Extremity Chronic Critical Limb Ischemia Measure	5.5	10
Routine Cataract Removal with IOL Implantation Measure	9	10
Screening/Surveillance Colonoscopy Measure	Not scored	N/A-not scored
Intracranial Hemorrhage or Cerebral Infarction Measure	4.8	10
Simple Pneumonia with Hospitalization Measure	6.7	10
STEMI with PCI Measure	Not scored	N/A-not scored
TOTAL	47.6	70

Cost performance category score is (47.6/70=0.68), which is equal to a Cost performance category percent score of 68%. Cost performance category =15 points, group would earn 10.2 points towards their final score (68 x .15=10.2)

Tips and Tools to Help Reduce Cost

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Tools to Help with Cost

Cost Makes a Difference

- Hardest to change and least understood.
- Look at your data.
- Plan your transitions of care.
- Choose referring providers.
- Careful documentation.
- Category weight is increasing and will have a greater impact year to year.

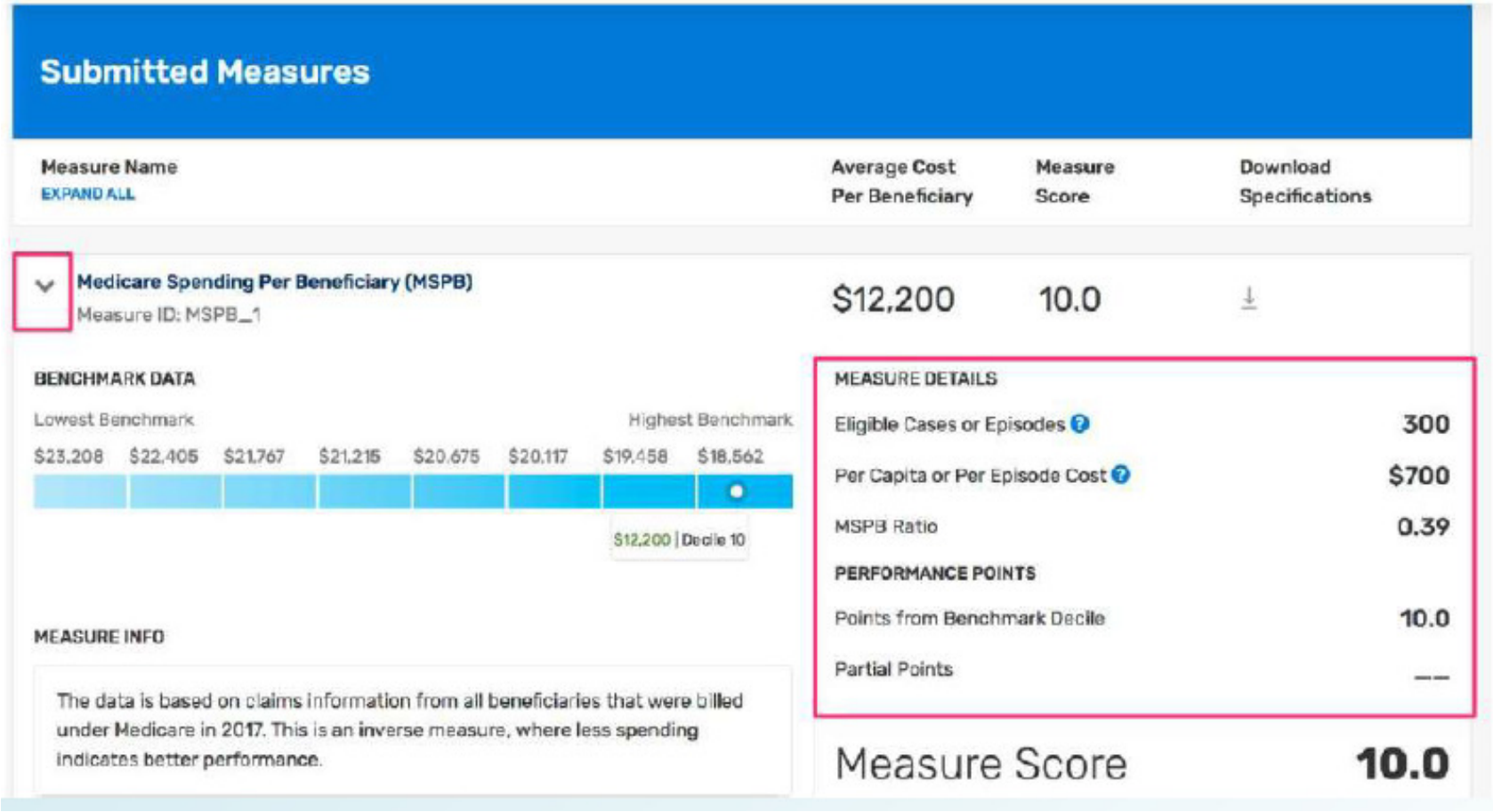
Tips For Success in Cost Category

- Review Performance Feedback Reports. Did you meet case minimum? 2018 Feedback Reports available July 2019!
- Look at your incoming Summary of Care info from specialties in your area and see where patients have been.
- Partner with local hospitals to receive daily reports of your patients that have gone to the ER or hospitalized.
- Commitment to continuous performance improvement.
- Coding to specificity. (HCC coding and ICD-10)
- AWV, CCM, TCM

START NOW! DO NOT WAIT!

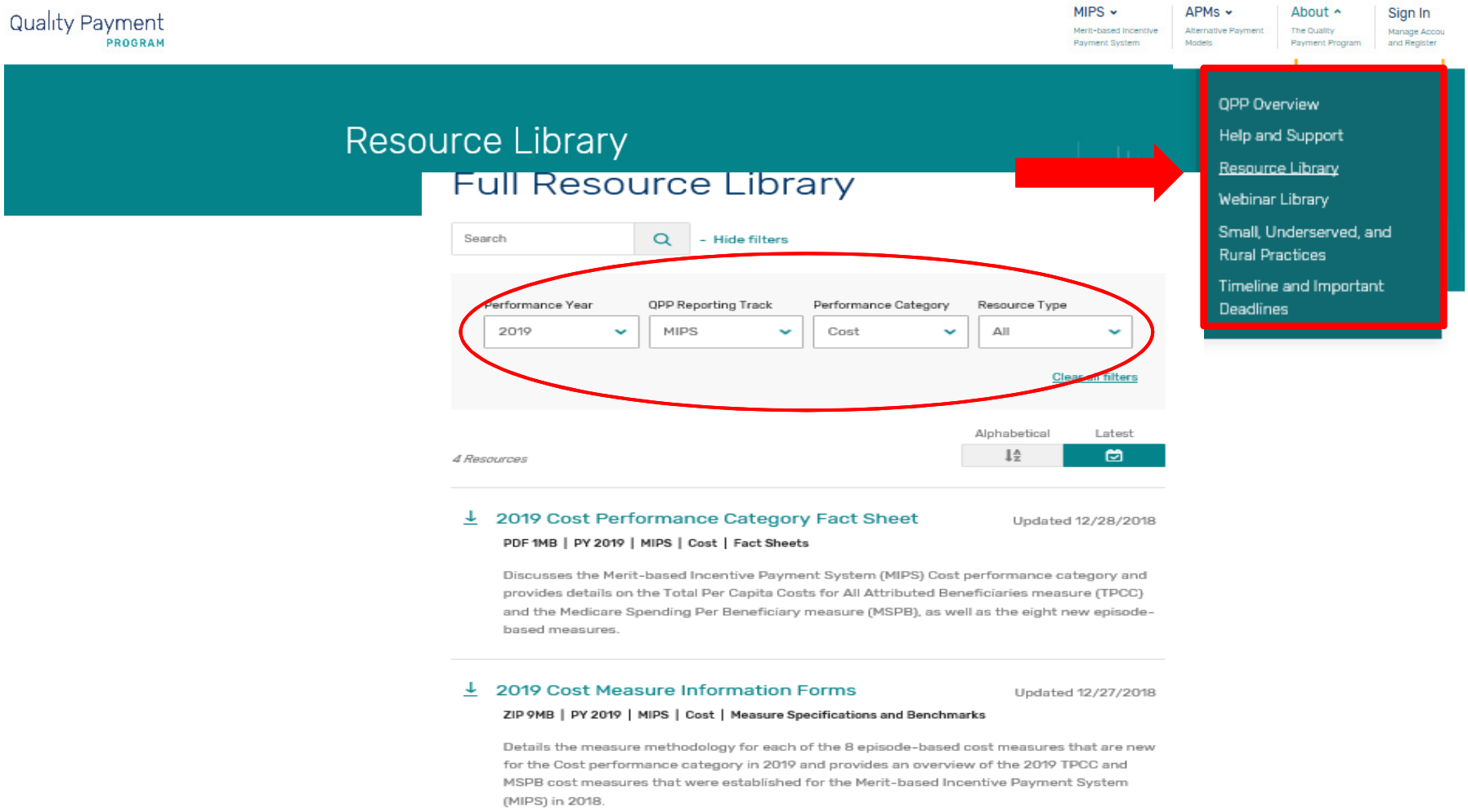
MIPS 2017 Performance Feedback Report

Cost: MSPB



Quality Payment Program Resources

www.qpp.cms.gov



Resources

- MIPS 2019 Cost Performance Category Fact Sheet
- MIPS 2019 Summary of Cost Measures
- Medicare Spending Per Beneficiary Measure Information Form
- Total Per Capita Cost Measure Information Form
- 2019 Cost Measure Information Forms (Episode Based zip files)
- 2019 Cost Measure Code Lists (Episode Based zip files)
- 2019 MIPS Opt-In and Voluntary Reporting Policy Fact Sheet
- Chronic Care Management Toolkit
- Annual Wellness Visit
- Transitional Care Management

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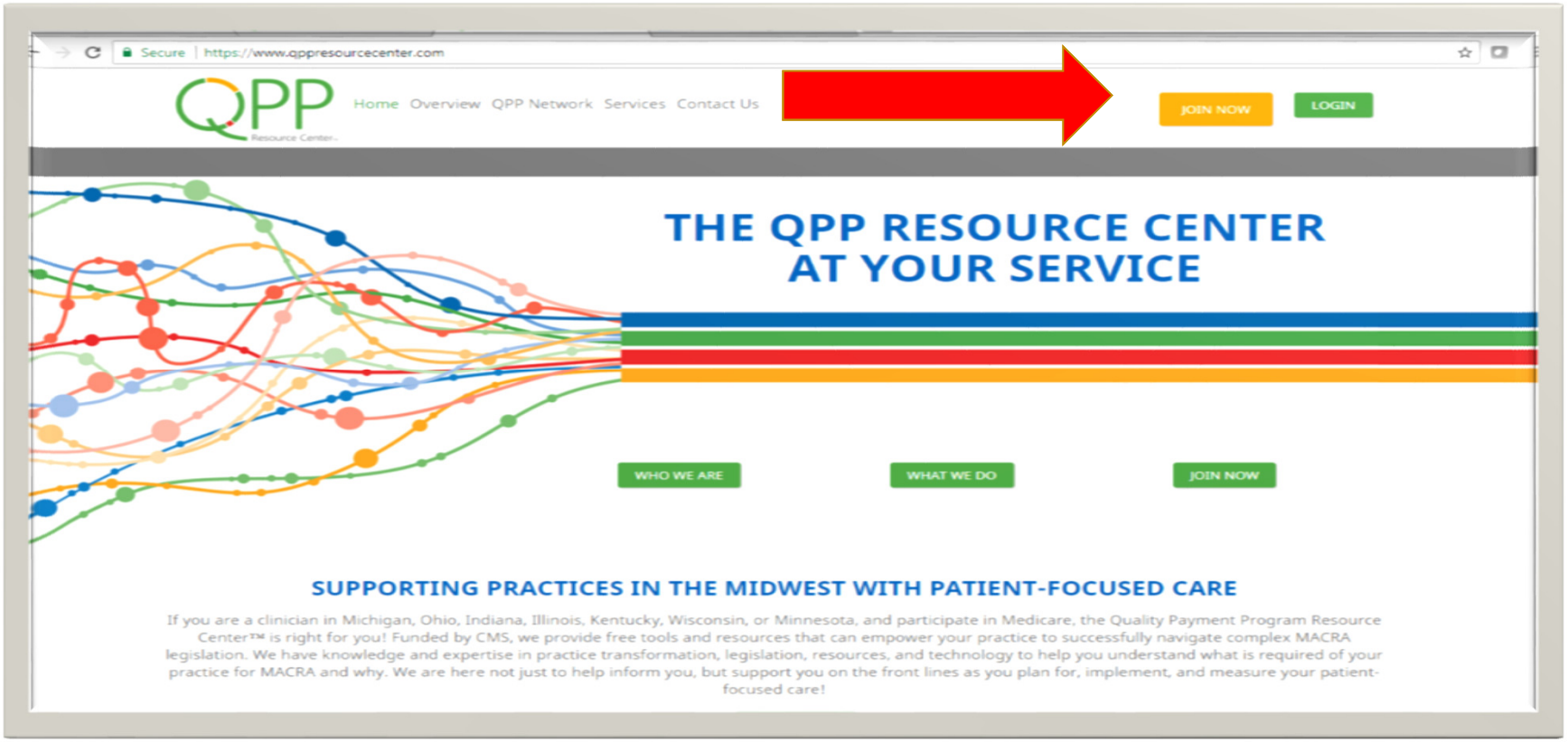
NO COST Support Available - Start by clicking JOIN NOW!

https://www.qppresourcecenter.com/



Questions?

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Risk Adjustment Coding

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Indiana Rural Heath Association
June 19, 2019

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Agenda

- Risk Adjustment
- Hierarchical Condition Categories
- Documentation for Risk Adjustment
- Shift to Value-based Care

What is Risk Adjustment?

What is Risk Adjustment?

- Provides clearer understanding of the health status of a member population
- Ensures resources are available to treat high-cost patients
- Increased access to health insurance for high-cost patients
- Close quality care gaps

What is Risk Adjustment?

"Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries."

"Risk scores measure individual beneficiaries' relative risk and risk scores are used to adjust payments for each beneficiary's expected expenditures."

From CMS Pub. 100-16 Chapter 7, Risk Adjustment
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

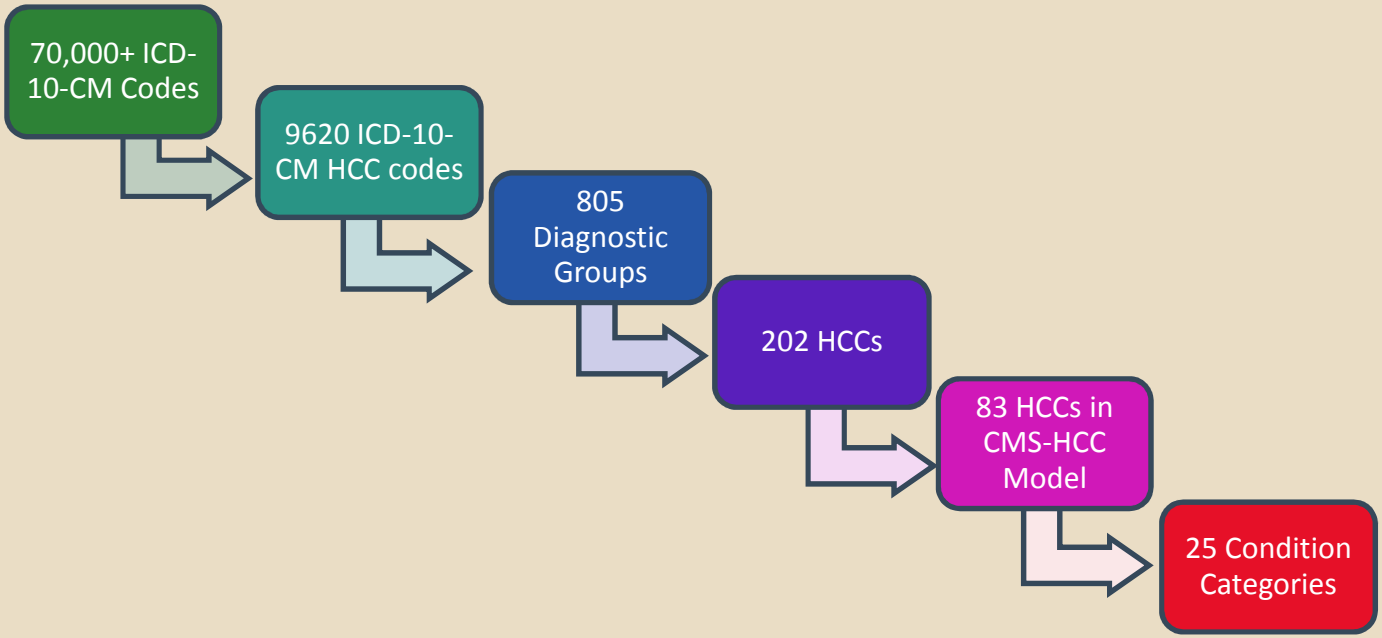
What is Risk Adjustment?

- Codes should be captured each year
- Chronic conditions are assigned a value used in calculating the numeric score (RAF Score)
- Diagnostic codes drive CMS's payments to Medicare Advantage plans
- Codes reported this year determine cost of care for next year

What is Risk Adjustment?

What are Hierarchical Condition Categories?

What are Hierarchical Condition Categories?



What are Hierarchical Condition Categories?

83 HCCs Included in the CMS-HCC Model

HCC1 = HIV/AIDS
HCC2 = Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
HCC6 = Opportunistic Infections
HCC8 = Metastatic Cancer and Acute Leukemia
HCC9 = Lung and Other Severe Cancers
HCC10 = Lymphoma and Other Cancers
HCC11 = Colorectal, Bladder, and Other Cancers
HCC12 = Breast, Prostate, and Other Cancers and Tumors
HCC17 = Diabetes with Acute Complications
HCC18 = Diabetes with Chronic Complications
HCC19 = Diabetes without Complication
HCC21 = Protein-Calorie Malnutrition
HCC22 = Morbid Obesity
HCC23 = Other Significant Endocrine and Metabolic Disorders
HCC27 = End-Stage Liver Disease
HCC28 = Cirrhosis of Liver
HCC29 = Chronic Hepatitis
HCC33 = Intestinal Obstruction/Perforation
HCC34 = Chronic Pancreatitis
HCC35 = Inflammatory Bowel Disease
HCC39 = Bone/Joint/Muscle Infections/Necrosis
HCC40 = Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
HCC46 = Severe Hematological Disorders
HCC47 = Disorders of Immunity
HCC48 = Coagulation Defects and Other Specified Hematological Disorders
HCC54 = Substance Use with Psychotic Complications
HCC55 = Substance Use Disorder, Moderate/Severe, or with complications
HCC56 = Substance Use Disorder, Mild, Except Alcohol and Cannabis
HCC57 = Schizophrenia
HCC58 = Reactive and Unspecified Psychosis
HCC59 = Major Depressive, Bipolar, and Paranoid Disorders
HCC60 = Personality Disorders
HCC70 = Quadriplegia
HCC71 = Paraplegia
HCC72 = Spinal Cord Disorders/Injuries
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HCC76 = Muscular Dystrophy
HCC77 = Multiple Sclerosis
HCC78 = Parkinson's and Huntington's Diseases
HCC79 = Seizure Disorders and Convulsions
HCC80 = Coma, Brain Compression/Anoxic Damage
HCC82 = Respirator Dependence/Tracheostomy Status
HCC83 = Respiratory Arrest
HCC84 = Cardio-Respiratory Failure and Shock
HCC85 = Congestive Heart Failure
HCC86 = Acute Myocardial Infarction
HCC87 = Unstable Angina and Other Acute Ischemic Heart Disease

What are Hierarchical Condition Categories?

HCC88 = Angina Pectoris
HCC96 = Specified Heart Arrhythmias
HCC99 = Cerebral Hemorrhage
HCC100 = Ischemic or Unspecified Stroke
HCC103 = Hemiplegia/Hemiparesis
HCC104 = Monoplegia, Other Paralytic Syndromes
HCC106 = Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC107 = Vascular Disease with Complications
HCC108 = Vascular Disease
HCC110 = Cystic Fibrosis
HCC111 = Chronic Obstructive Pulmonary Disease
HCC112 = Fibrosis of Lung and Other Chronic Lung Disorders
HCC114 = Aspiration and Specified Bacterial Pneumonias
HCC115 = Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC122 = Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC124 = Exudative Macular Degeneration
HCC134 = Dialysis Status
HCC135 = Acute Renal Failure
HCC136 = Chronic Kidney Disease, Stage 5
HCC137 = Chronic Kidney Disease, Severe (Stage 4)
HCC138 = Chronic Kidney Disease, Moderate (Stage 3)
HCC157 = Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC158 = Pressure Ulcer of Skin with Full Thickness Skin Loss

HCC161 = Chronic Ulcer of Skin, Except Pressure
HCC162 = Severe Skin Burn or Condition
HCC166 = Severe Head Injury
HCC167 = Major Head Injury
HCC169 = Vertebral Fractures without Spinal Cord Injury
HCC170 = Hip Fracture/Dislocation
HCC173 = Traumatic Amputations and Complications
HCC176 = Complications of Specified Implanted Device or Graft
HCC186 = Major Organ Transplant or Replacement Status
HCC188 = Artificial Openings for Feeding or Elimination
HCC189 = Amputation Status, Lower Limb/Amputation Complications

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

What are Hierarchical Condition Categories?

25 Condition Categories

Infection	Blood	Cerebrovascular Disease	Complications	Neoplasm
Openings	Lung	Diabetes	Transplant	Vascular
Metabolic	Eye	Neurological	Gastrointestinal	Kidney
Spinal	Amputation	Liver	Skin	Arrest
Heart	Injury	Musculoskeletal	Substance Abuse	Psychiatric

What are Hierarchical Condition Categories?

Neurology Category

HCC	Description
HCC99	Cerebral Hemorrhage
HCC100	Ischemic or Unspecified Stroke
HCC103	Hemiplegia/Hemiparesis
HCC104	Monoplegia, Other Paralytic Syndromes

What are Hierarchical Condition Categories?

HCC Category	CMS-HCC Category	HCC Category Description	ICD-10-CM Codes	ICD-10-CM Descriptors
Neurology	#79	Seizure Disorders and Convulsions	G40.821	Epileptic spasms, not intractable, with status epilepticus
			G40.822	Epileptic spasms, not intractable, without status epilepticus
			G40.823	Epileptic spasms, intractable, with status epilepticus
			G40.824	Epileptic spasms, intractable, without status epilepticus
			G40.89	Other seizures
			G40.901	Epilepsy, unspecified, not intractable, with status epilepticus
			G40.909	Epilepsy, unspecified, not intractable, without status epilepticus

What are Hierarchical Condition Categories?

- HCC17: Diabetes with acute complications
- HCC18: Diabetes with chronic complications
- HCC19: Diabetes without complications

HCC	If the Disease is Listed in this Column…	…then drop the Disease Group listed in this column
17	Diabetes with acute complications	18, 19
18	Diabetes with chronic complications	19

Documentation is the Key!

Documentation is the Key!

ICD-10-CM Official Guidelines:

"The importance of consistent, complete documentation in the medical record cannot be over emphasized. Without such documentation, accurate coding cannot be achieved."

Documentation is the Key!

Good Documentation =

- Indicates the severity of the disease
- Shows the level of complexity of the visit
- Supports all diagnoses coded
- Includes assessment and plan for each condition addressed

Documentation is the Key!

Document the MEAT:

M = Monitor/Measure	Signs, symptoms, progression, regression,
E = Evaluate	Test results, response to treatment, status (ex. stable)
A = Addressed	Order tests, referrals, review records, counseling/discussions
T = Treat	Prescriptions, therapies

Documentation is the Key!

REMEMBER:

- Without proper documentation of the **MEAT**, HCC valued conditions will not be supported:
  - Could result in lower risk scores
  - Insufficient funds to provide the appropriate level of care
  - Lost revenue
- Proper documentation allows for more accurate identification of populations of high risk patients in need of the most healthcare resources.

Documentation is the Key!

Diagnosis	ICD-10-CM Code	HCC Category	HCC Value
Diabetes, type 2, w/o complication	E11.9	19	0.104
Major Depression	F32.9	N/A	N/A
Demographic Factor			0.379

Risk Score = 0.483

Documentation is the Key!

Diagnosis	ICD-10-CM Code	HCC Category	HCC Value
Diabetes, Type 2, w/Neuropathy	E11.40	18	0.318
Major Depression, Single, Mild	F32.0	58	0.395
CHF	I50.9	85	0.323
Morbid Obesity BMI 42.5	E66.01 Z68.41	22	0.273
Right Great Toe Amputation	Z89.411	189	0.588
Demographic Factor			0.379

Risk Score = 2.276

Documentation is the Key!

Average PMPM = $800

Risk Score = 0.483

PMPM = $387

Annual Payment to MA Plan = $4,637

Risk Score = 2.276

PMPM = $1821

Annual Payment to MA Plan = $21,850

The Shift to Value-Based Care

The Shift to Value-Based Care

- CMS shift from fee-for-service to value-based care
- Payment based on quality, not quantity
- Accountable Care Organizations (ACOs)

The Shift to Value-Based Care

ACOs:

"Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated, high quality care to their Medicare patients."

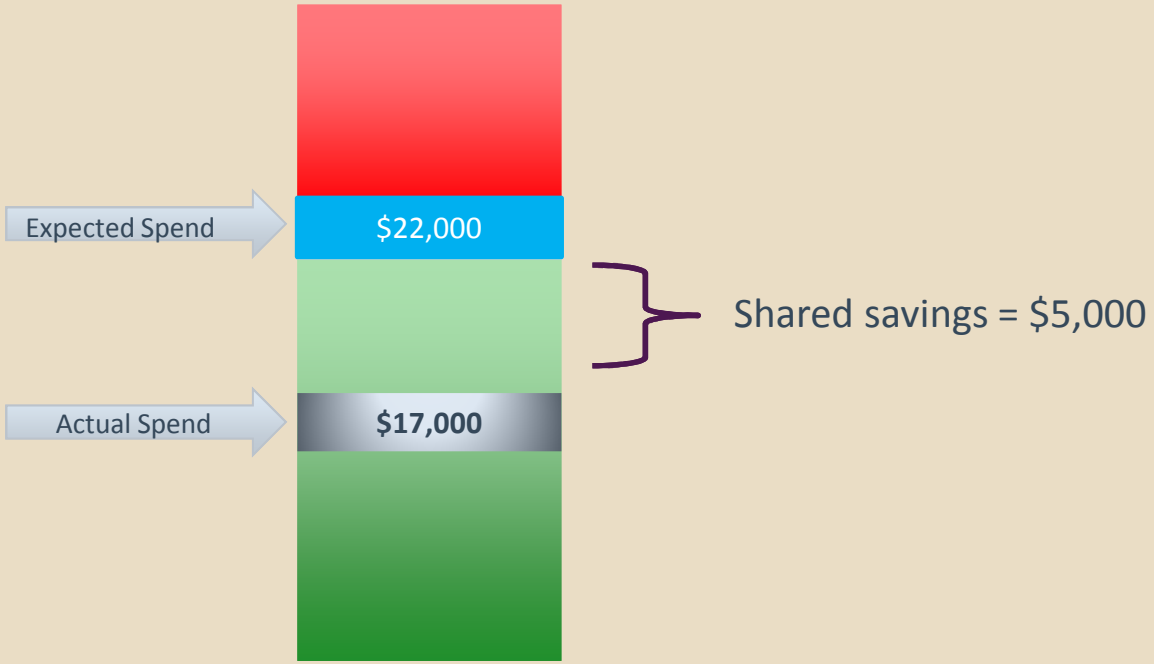
The Shift to Value-Based Care

Risk Score = 2.276

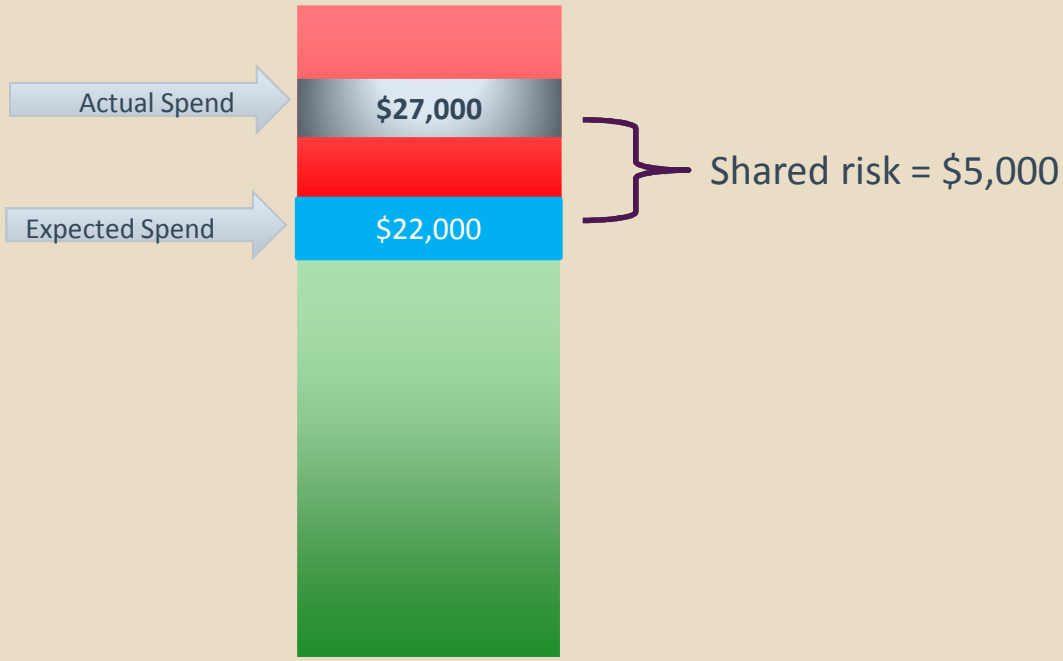
PMPM = $1821

Annual Payment to MA Plan = $21,850

The Shift to Value-Based Care



The Shift to Value-Based Care



Questions?

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