

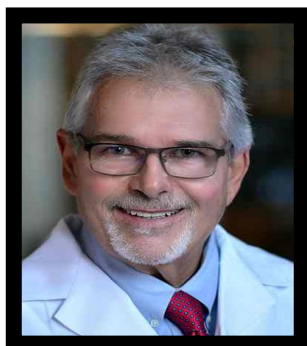
# ConnectCIN

[www.chitxcin.org](http://www.chitxcin.org)

August 16, 2018

## From the CMO

Jeff Steinbauer, MD



“Risk scoring” is a key part of network success. Getting these scores done correctly is the responsibility of our member physicians. Why is this important? Risk scores are used by insurers to establish the expected cost of care for a given patient. As these are totaled and averaged, our allowed cost goes up if the risk score has risen. Conversely, the allowable cost per member per year goes down as the risk score declines. Thus, it is important to have the risk score accurately reflect the actual diseases/conditions in every patient. In 2017, we missed shared savings in our ACO by 0.3%! It is possible that better risk scoring would have raised our cost threshold to a point that we would have had over \$3 million to share with our physicians.

### Special points of interest:

- FROM THE CMO
- MEDICAL CODING
- ASK THE CIN

How are risk scores calculated? Risk scoring is based on the diagnoses we submit to the payer during the contract year. This is why there has been an emphasis on “annual well visits” for Medicare patients and “checkups” for others. It’s assumed we would put in all the appropriate diagnoses during these visits. But sometimes we miss “updating” a diagnosis. It is best to assume the insurer has no memory of the patient’s problem list. Thus, diagnoses of amputation, CHF, renal disease, COPD and diabetes each year are important. Additionally, there are some diagnoses we may not put on the charge document. For example, diabetes with any complication (vascular, neurologic, or poorly controlled), significantly increases the risk score. Also, the diagnosis of morbid obesity (BMI>40) adds as much to the risk score as CHF! Many PCP’s, (like me) may forget to add this to an encounter diagnosis during the year. Thus, getting the right codes entered for the patient during the contract year is very important for the success of our CIN.

So how can we improve coding? In many organizations, including ours, the initial approach is to urge physicians to do annual well visits and document ALL diagnoses. This can raise the risk score. However, in the process of patient care, physicians often get distracted by the patient’s list of concerns and the list of quality metrics they must attend to. Adding one more thing to do can cause primary care providers to feel overwhelmed.

Thus, we are beginning a new approach. Under the guidance of our Quality Improvement and Network Performance Standards Committee, we are going to begin a new approach to help improve risk scoring. There are three elements:

1. Periodically (monthly to quarterly) we will send you a list of patients who have had important risk codes dropped from the database during the contract year. We ask that you attend specifically to these patients (rather than ‘all’ patients) and include those missing codes any time you see them. Some of you may decide to bring the patient in for a visit to be sure this gets done.
2. We will send a list of patients who have specific “gaps” in care. For example, chlamydia screening is a requirement for young women under our Cigna contract. But rather than looking at all 14,000 patients, we’ll send you information on the specific patients in your panel so that you can address these ‘gaps’ efficiently.
3. Lastly, we will analyze high cost but low risk score patients by looking at
  - a. Those who have high Charlson scores but low risk scores. These patients in particular would benefit from attention to coding.
  - b. Those who have high cost (ER use or hospitalizations) but low risk scores. Again, being sure these patients are appropriately coded will improve our network cost performance.

As a result of these focused reports, you’ll get a manageable list of patients where a few actions can make a big difference in our network performance. We welcome your questions and concerns as we begin this new initiative to improve our network performance. The CIN is growing; more contracts are on the horizon. We are ready to help you succeed!

## Medical Coding—Coding Improvement Tips

Tracy Maddox, JD, MSN, RN

### Coding Improvement Tips

#### I. Documentation must be supported with

### M E A T

#### MONITOR

Signs/Symptoms

Disease Progression

Disease Regression

#### EVALUATE

Test Results

Medication Effectiveness

Response to Treatment

#### ASSESS

Ordering Tests

Discussion

Review Records

Counseling

#### TREAT

Medications

Therapies

Other Modalities

#### II. Evaluate and Ensure

Evaluate and document all conditions during each encounter

Ensure a proper progress note with the HPI, physical exam and medical decision-making process

Document each diagnosis in an assessment and care plan

Ensure that each diagnosis provides evidence that the provider is monitoring, evaluating, assessing, and treating the condition

#### III. Remember

Code to the highest level of specificity

Maintain HCCs from a prior health plan if relevant Ensure comprehensive documentation

Perform chart reviews

Ensure consistent HCC capture Stay up-to-date on coding

#### IV. ICD-10 Coding Requirements

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management

Documentation must contain at least one of the elements of MEAT Any diagnosis used must be addressed during a face to face visit

## Medical Coding Continued

### V. Frequent Mistakes

1. Causal relationships not clearly documented  
Example: Type 2 diabetes with circulatory complications in the assessment and plan, but no mention as to what the circulatory complication is.
2. Diagnosis and documentation mismatch  
Example: Listing HCC diagnosis that may have physical manifestations such as pressure ulcer on the right ankle, but everything is normal in the physical exam.
3. Coding for conditions that are no longer present  
Example: Do not code for breast cancer if the patient has completed treatment and no longer has evidence of disease. History of breast cancer could be coded but there is no HCC value to it.

### VI. Patient Planning Checklist for Coding Accuracy

1. What are the insurer/payer requirements for this patient?
2. Persistent Condition validation (PCV): Have you reported on each chronic condition for this patient this year?
3. i.e. Metastatic Cancer, Pressure Ulcer, Quadriplegia, Amputation, Morbid obesity, COPD, must be documented every year
4. Have you appropriately assessed this patient for next year's baseline payment through proper use of HCC Coding?
5. Have you properly coded this patient's diagnoses using appropriate ICD-10?

## Medical Coding Continued

### HCCs included in the CMS-HCC risk-adjustment model

HCC number and brief description of disease/condition	
HCC1 = HIV/AIDS	HCC82 = Respirator Dependence/Tracheostomy Status
HCC2 = Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	HCC83 = Respiratory Arrest
HCC6 = Opportunistic Infections	HCC84 = Cardio-Respiratory Failure and Shock
HCC8 = Metastatic Cancer and Acute Leukemia	HCC85 = Congestive Heart Failure
HCC9 = Lung and Other Severe Cancers	HCC86 = Acute Myocardial Infarction
HCC10 = Lymphoma and Other Cancers	HCC87 = Unstable Angina and Other Acute Ischemic Heart Disease
HCC11 = Colorectal, Bladder, and Other Cancers	HCC88 = Angina Pectoris
HCC12 = Breast, Prostate, and Other Cancers and Tumors	HCC96 = Specified Heart Arrhythmias
HCC17 = Diabetes with Acute Complications	HCC99 = Cerebral Hemorrhage
HCC18 = Diabetes with Chronic Complications	HCC100 = Ischemic or Unspecified Stroke
HCC19 = Diabetes without Complication	HCC103 = Hemiplegia/Hemiparesis
HCC21 = Protein-Calorie Malnutrition	HCC104 = Monoplegia, Other Paralytic Syndromes
HCC22 = Morbid Obesity	HCC106 = Atherosclerosis of the Extremities with Ulceration or Gangrene
HCC23 = Other Significant Endocrine and Metabolic Disorders	HCC107 = Vascular Disease with Complications
HCC27 = End-Stage Liver Disease	HCC108 = Vascular Disease
HCC28 = Cirrhosis of Liver	HCC110 = Cystic Fibrosis
HCC29 = Chronic Hepatitis	HCC111 = Chronic Obstructive Pulmonary Disease
HCC33 = Intestinal Obstruction/Perforation	HCC112 = Fibrosis of Lung and Other Chronic Lung Disorders
HCC34 = Chronic Pancreatitis	HCC114 = Aspiration and Specified Bacterial Pneumonias
HCC35 = Inflammatory Bowel Disease	HCC115 = Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC39 = Bone/Joint/Muscle Infections/Necrosis	HCC122 = Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
HCC40 = Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	HCC124 = Exudative Macular Degeneration
HCC46 = Severe Hematological Disorders	HCC134 = Dialysis Status
HCC47 = Disorders of Immunity	HCC135 = Acute Renal Failure
HCC48 = Coagulation Defects and Other Specified Hematological Disorders	HCC136 = Chronic Kidney Disease, Stage 5
HCC54 = Drug/Alcohol Psychosis	HCC137 = Chronic Kidney Disease, Severe (Stage 4)
HCC55 = Drug/Alcohol Dependence	HCC157 = Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
HCC57 = Schizophrenia	HCC158 = Pressure Ulcer of Skin with Full Thickness Skin Loss
HCC58 = Major Depressive, Bipolar, and Paranoid Disorders	HCC161 = Chronic Ulcer of Skin, Except Pressure
HCC70 = Quadriplegia	HCC162 = Severe Skin Burn or Condition
HCC71 = Paraplegia	HCC166 = Severe Head Injury
HCC72 = Spinal Cord Disorders/Injuries	HCC167 = Major Head Injury
HCC73 = Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	HCC169 = Vertebral Fractures without Spinal Cord Injury
HCC74 = Cerebral Palsy	HCC170 = Hip Fracture/Dislocation
HCC75 = Myasthenia Gravis/Myoneural Disorders, Inflammatory and Toxic Neuropathy	HCC173 = Traumatic Amputations and Complications
HCC76 = Muscular Dystrophy	HCC176 = Complications of Specified Implanted Device or Graft
HCC77 = Multiple Sclerosis	HCC186 = Major Organ Transplant or Replacement Status
HCC78 = Parkinson's and Huntington's Diseases	HCC188 = Artificial Openings for Feeding or Elimination
HCC79 = Seizure Disorders and Convulsions	HCC189 = Amputation Status, Lower Limb/Amputation Complications
HCC80 = Coma, Brain Compression/Anoxic Damage	

6 This information can be found by navigating to: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2014.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>.

## Patient Satisfaction Survey

*Congratulations to the following providers for being mentioned by name in the surveys! Keep up the good work! We hope to see more names in the future!*

***Bonnie Lokey, NP***

***Anne Moser, MD (May and October)***

***Mark Riley, MD***

***Weslei Rice, MD***

***Thomas Stasicha, MD***

## Need to find a CIN Provider? Update Your Information?



Do you need to find a CIN participating provider, update your location, phone number, email or other important details on file with the Texas Health Network? Please visit <http://www.chitxcin.org> and click on "FIND A DOCTOR."

## Ask the CIN

Questions? Comments? Concerns?

Please refer to the staff directory below and send us your feedback. We look forward to hearing from you and assisting in any way we can. General questions can be sent through the website at [www.chitxcin.org](http://www.chitxcin.org) or via email to [texasdivisionclinical@stlukeshealth.org](mailto:texasdivisionclinical@stlukeshealth.org).

### CIN Leaders:

Mike Camacho, Division VP, CIN, [mcamacho@stlukeshealth.org](mailto:mcamacho@stlukeshealth.org)

Jeffrey Steinbauer, MD, Chief Medical Officer, [Jeffrey@bcm.edu](mailto:Jeffrey@bcm.edu)

Lisa Cochran, Division Director, Network Development, [lcochran@stlukeshealth.org](mailto:lcochran@stlukeshealth.org)

Royd Hernandez, Division Director, Data and System Integration, [rhernandez@stlukeshealth.org](mailto:rhernandez@stlukeshealth.org)

Tracy Maddox, Division Director, Quality, [tmaddox@stlukeshealth.org](mailto:tmaddox@stlukeshealth.org)

Pamela Fails, Sr. Administrative Assistant, [pfails@stlukeshealth.org](mailto:pfails@stlukeshealth.org)

### CIN Network Staff:

Janel Greig, Provider Relations, [jgreig@stlukeshealth.org](mailto:jgreig@stlukeshealth.org)

Lecey Rosen, Manager, Credentialing and Operations, [rosen@stlukeshealth.org](mailto:rosen@stlukeshealth.org)

Marilyn Sweet, Credentialing Specialist, [msweet@stlukeshealth.org](mailto:msweet@stlukeshealth.org)

Loretta Tarwater, Credentialing Specialist, [ltarwater@stlukeshealth.org](mailto:ltarwater@stlukeshealth.org)

Jodi Vella, Provider Relations, [jvella@stlukeshealth.org](mailto:jvella@stlukeshealth.org)

### CIN Data Analytics Staff:

Sohail Alam, Data Analyst, [salam3@stlukeshealth.org](mailto:salam3@stlukeshealth.org)

Jacob Hoyt, Data Analyst, [jhoyt@stlukeshealth.org](mailto:jhoyt@stlukeshealth.org)

### CIN Quality Staff—Houston/Lufkin Market:

Deborah Dornes, MSN, BSN, RN, Population Health Coach, [ddornes@stlukeshealth.org](mailto:ddornes@stlukeshealth.org)

Alexandria Jackson, BSN, RN, Population Health Coach, [ajackson7@stlukeshealth.org](mailto:ajackson7@stlukeshealth.org)

Meshel Stewart, BSN, RN, Population Health Coach, [mstewart@stlukeshealth.org](mailto:mstewart@stlukeshealth.org)

Myriam Valdez-Saker, BSN, RN, Population Health Coach, [mvaldezsaker@stlukeshealth.org](mailto:mvaldezsaker@stlukeshealth.org)

Bertha Brown, Medical Assistant, [bbrown2@stlukeshealth.org](mailto:bbrown2@stlukeshealth.org)

Jennifer Martir, Medical Assistant, [jmartir@stlukeshealth.org](mailto:jmartir@stlukeshealth.org)

### CIN Quality Staff—Bryan Market:

Candace Dotson, Care Coordinator Associate, [cdotson@st-joseph.org](mailto:cdotson@st-joseph.org)

Shelly Hearn, BSN, RN, Care Coordinator RN, [shearn@st-joseph.org](mailto:shearn@st-joseph.org)

Sarah Hilton, Project Manager, [shilton@st-joseph.org](mailto:shilton@st-joseph.org)

Heather Rutledge, RN, Care Coordinator RN, [hrutledge@st-joseph.org](mailto:hrutledge@st-joseph.org)