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CDI Week Webinar:

Risk Adjustment Documentation and Coding

PRESENTED ON SEPTEMBER 19, 2016

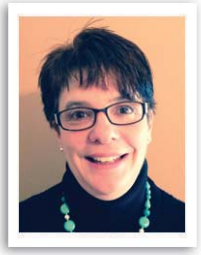
We will begin shortly!

CDI Week Webinar:

Risk Adjustment Documentation and Coding

PRESENTED ON SEPTEMBER 19, 2016

Presented By



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Presented By

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, is the director of HIM and coding for HCPro, a division of BLR. She oversees all of the Certified Coder Boot Camp programs. McCall developed the Certified Coder Boot Camp®—Inpatient Version, the Evaluation and Management Boot Camp™ and collaborated with the CDI team on the Risk Adjustment Documentation and Coding Boot Camp™. McCall works with hospitals, medical practices, and other healthcare providers on a wide range of coding-related custom education sessions.

Program Objectives

- Describe the purpose of risk adjustment as related to healthcare reimbursement & quality measures.
- Describe the basic organization of the CMS-HCC methodology.
- Discuss the documentation needed to assure accurate capture of CMS-HCC.
- Discuss the role of CDI in capturing accurate risk adjustment.

Risk Adjustment
Which Patient is Higher Risk?

- 85 years old
- Lives at home
- Participates in yoga and aerobic dance 2x a week
- History of osteoporosis
- Non smoker

- 87 years old
- Lives in SNF
- Hx includes CKD Stage 4
- COPD with history of smoking
- Diabetic – insulin dependent

Risk Adjustment

- The process of risk adjustment accounts for known health conditions, allowing for comparison of wellness amongst patients
- Utilizes diagnosis codes to determine potential risk
  - Variables pulled from documentation can identify those patients with higher medical needs than others
  - Used to predict both **costs** and **quality of care** measures

Risk Adjustment

- Can be used to evaluate and compare health plans or to adjust capitation payment to health plans based on the health status of the population covered
- Will assist in decreasing the incentives for health plans and providers to enroll those patients with a better-than-average health status
- Can be used to adjust observed differences in quality performance measures, resource utilization, and/or cost based on demonstrated differences related to the risk of illness/conditions

Risk Adjustment
Common Elements Considered

- Age
- Gender
- Socioeconomic Status
- Disability Status
- Functional Status
- **Insurance coverage**
  - Medicare
  - Medicaid
  - Dual eligible
  - Other

- **Claims Data**
  - Diagnosis Codes
  - Procedure Codes
  - Place of Service
  - Prescription Drugs
- **Patient Specific**
  - ESRD
  - Hospice
  - Other

Diagnosis-Based Risk Adjustment Models

- **Health and Human Services Hierarchical Condition Categories (HHS-HCCs)**
  - Commercial, Individual and Small Groups
- **Chronic Illness & Disability Payment Systems (CDPS)**
  - Medicaid
- **Adjusted Clinical Groups (ACG)**
  - Outpatient
- **Diagnostic Related Groups (DRG)**
  - Inpatient
- **Hierarchical Condition Category, Part C (CMS-HCCs)**
  - Medicare Part C

Hierarchical Condition Categories

- Payment for Medicare Advantage is based on the CMS-Hierarchical Condition Category (HCC) Model
  - The HCC model was originally developed by Health Economics Research, Inc.
- CMS adjusts Medicare Advantage healthcare payments for individual patients
  - Based on the patient's "risk score"
- Two patients within the same community can have a different payment based on several factors relating to their risk score, including level of risk, residence and disease interactions.

Demographic Variables

- The HCC Model includes the following five demographic factors to determine a patient's risk score:
  - Age, as of Feb 1st of the payment year
  - Gender
  - Disability status
    - Disabled beneficiaries living in the community who are under the age of 65
  - Original reason for entitlement
    - Those over age 65 who were qualified for Medicare due to disability before the age of 65
  - Medicaid or low income status
    - Medicaid eligible for one month or more in the data collection year

Demographic Variables

- Documentation will likely not impact these demographic variables, because these are usually collected during the registration and/or enrollment period
- The provider should include in the patient's history what disability (chronic condition) qualified the person for Medicare, when applicable, as it will likely be a condition requiring ongoing monitoring

Medicare Advantage (MA) Program

- Risk adjustment using diagnoses provides more accurate payments for MA organizations
  - Higher payments for enrollees at risk for being sicker
  - Lower payments for enrollees predicted to be healthier
- Risk adjustment allows CMS to pay plans based on the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries
  - However, the plan must submit the qualifying diagnoses, which are subject to verification

CMS-HCC Model

- Risk adjustment is used to modify payment based on the health status and demographic characteristics of an enrollee
- Risk scores measure individual beneficiaries' relative risk, allowing payment adjustments for each beneficiary's expected expenditures

CMS-HCC Model

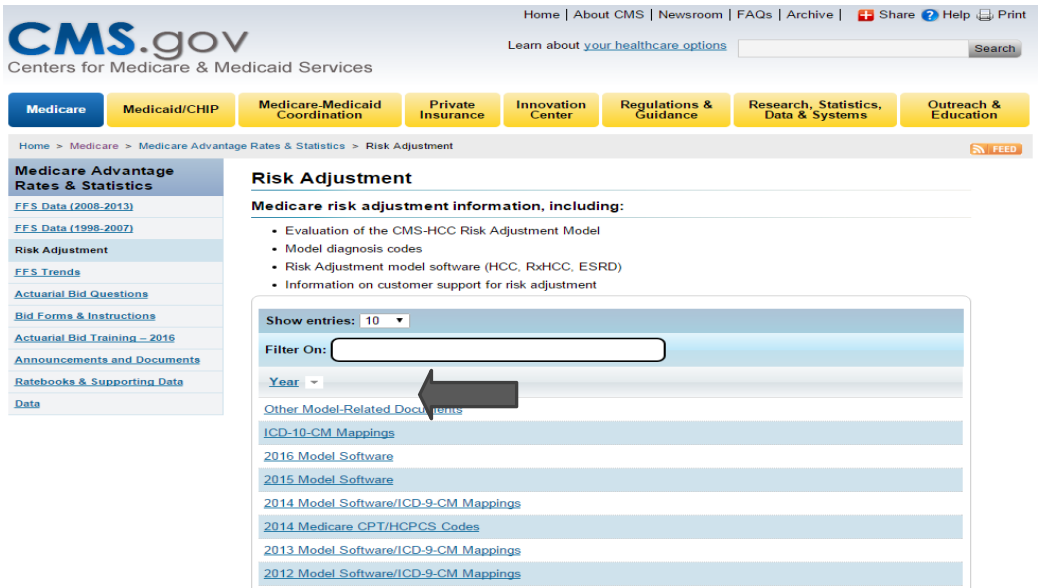
- The CMS-HCC models are organized by categorizing ICD-10-CM codes into disease groups called Hierarchical Condition Categories (HCCs)
- Each HCC includes diagnosis codes that are
  - Related clinically
  - Have similar cost implications
- The most recent version has 79 HCCs

ICD-10-CM Mapped into HCCs

Diagnosis Code	Description	CMS-HCC Model Category V22
A0103	Typhoid pneumonia	115
A0104	Typhoid arthritis	39
A0105	Typhoid osteomyelitis	39
A021	Salmonella sepsis	2
A0222	Salmonella pneumonia	115
A0223	Salmonella arthritis	39
A0224	Salmonella osteomyelitis	39
A065	Amebic lung abscess	115

Source: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/IDC10Mappings.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

ICD-10-CM Mapped into HCCs



Health Status Methodology

- Health Status is determined by:
  - Diagnosis codes
  - The ICD diagnoses codes relate to HCC Model categories (one to many relationship)
  - Each HCC Model Category relates to a *relative factor* or health risk score

The Hierarchical Conditions Categories

The basic HCCs categories include:

- Infection
- Neoplasm
- Diabetes
- Metabolic
- Liver
- Gastrointestinal
- Musculoskeletal
- Openings
- Amputations
- Blood
- Substance abuse
- Psychiatric
- Spinal
- Neurological
- Arrest
- Heart
- Cerebrovascular Disease
- Vascular
- Lung
- Eye
- Kidney
- Skin
- Injury
- Complications
- Transplants

Prospective in Nature

- The CMS-HCC model is prospective in the sense that it uses diagnosis information from a base year to predict costs or risks for the next year
- It is largely driven by:
  - The costs associated with chronic diseases
  - The systematic risk (costs) associated with Medicare populations

The CMS-HCC Model

- Diagnosis codes for a particular beneficiary are included in the model to produce a risk score
  - The risk score reflects demographic characteristics and combinations of HCCs associated with the beneficiary for the data collection year. The beneficiary's risk score for a year is a measure of expected health status

Impact of Diagnosis Codes

- The diagnosis codes assigned to a patient can have a huge impact on the payment a Medicare Advantage plan receives to provide care for the beneficiary during the plan year
- There is a validation process associated with the submitted diagnosis codes to ensure they are accurately reported
  - Although providers often have the best of intentions, they often assign diagnosis codes independent of their documentation, as few employ coders for the purpose of verifying diagnosis codes

Documentation Focus

- HCCs are based on the Selected Significant Disease (SSD) Model
  - This model considers serious manifestations of a condition rather than all levels of severity of a condition
- Documentation should clearly distinguish:
  - Acute from chronic conditions
  - Chronic conditions in exacerbation from baseline

Documentation Focus

- Documentation should reflect specificity within the code set to accurately capture a condition rather than relying on “unspecified” codes
  - The “default” code is often unspecified, which can result from insufficient documentation or imprecise documentation
  - Example: Use of the term pneumonia will default to an unspecified code (J18.9) which will not account for the severity of illness associated with a specific organism such as pneumonia due to MRSA (J15.212)

Foster Collaboration

- The growing importance of diagnosis coding in the office setting is an opportunity for improved collaboration between the community provider and healthcare organizations since the hospital (outpatient/inpatient setting) can also be a source of diagnoses to support HCC assignment
  - The hospital often has more resources dedicated to accurate diagnosis coding compared to the professional setting
- Accurate documentation not only demonstrates complexity under HCC methodology, but can also:
  - Positively affect inpatient MS-DRG payments
  - Support medical necessity of setting

Foster Collaboration

- Targeting those providers who accept Medicare Advantage beneficiaries could also be a way to engage providers in documentation improvement education, especially those related to increased specificity associated with ICD-10-CM
- Providers must also understand that the HCC model is used to risk adjust patients in some CMS quality programs (especially those with metrics associated with outcomes like 30-day mortality), so this collaboration could positively affect quality reporting and patient care

HCC Specific Characteristics

- Models are additive
  - Individual risk scores are calculated by adding the coefficients associated with each beneficiary's demographic and disease factors
  - Providers should document any and all diagnoses related to a condition
    - What is the impact of the poorly controlled diabetes on renal function? Neurological function? Circulatory status? Skin integrity? etc.
- Diagnoses or conditions can't be assumed—they must be specifically and accurately documented by the treating provider

HCC Documentation Sources

- Models recognize diagnoses from:
  - Hospital inpatient settings
    - Skilled Nursing Facilities and Hospice facilities are considered non-covered facilities so their diagnoses cannot influence HCC calculations
  - Hospital outpatient settings
    - Free standing surgery centers (ACS), home health and free standing dialysis centers are not acceptable sources for diagnoses
  - Physician settings
    - This includes data collected from non-network as well as network physicians obtained in a face-to-face visit
    - Exception: Pathology services (professional component only)

Approved Providers

- General Practice
- General Surgery
- Cardiology
- Neurology
- Family Practice
- Ophthalmology
- Optometrist
- Pathology
- Psychiatry
- Pulmonology
- Nephrology
- CRNA
- Audiology
- Physical Medicine & Rehab
- Physical Therapy
- Occupational Therapy
- Licensed Clinical Social Worker
- Pain Management
- Hematology
- Optometrist
- Medical Oncology
- Emergency Medicine
- Interventional Radiology
- Certified Nurse Midwife
- Nuclear Medicine

**This list is not all-inclusive*

HCC Specific Characteristics

- Multiple chronic diseases affect risk adjustment
  - Risk adjusted payment is based on assignment of diagnoses to disease groups
    - Condition Categories (CCs)
    - Not all diagnoses/disease groups have the same risk value
  - The model is most heavily influenced by Medicare costs associated with chronic disease
    - Most chronic conditions are managed in the outpatient or physician setting

Hierarchies

- Condition Categories (CC) are placed into hierarchies reflecting severity and cost dominance
- Beneficiaries get credit for the disease with the highest severity or that includes the costs of other diseases
- Hierarchies allow for payment based on the most serious conditions when less serious conditions also exist
  - A serious chronic condition can make treatment of a less serious condition more complex

The Impact of Diagnosis Codes

- While all ICD-10-CM codes are mapped to a condition category, not all condition categories are included in the model for payment
- The decision to include a condition category (CC) in the model is based on each category's ability to predict costs for Medicare Parts A and B
  - Those that don't predict costs well aren't included
- Hierarchies are imposed on the condition categories, ensuring that more advanced and costly forms of a condition are reflected in the risk score

Diseases Hierarchies

- Disease hierarchies address situations where there are multiple levels of severity for a disease, with varying levels of associated costs
- The hierarchies prioritize the inclusion of conditions in a risk score of multiple HCCs where diagnoses are clinically related and ranked by cost
- In the case of a disease hierarchy, Part C payment is based only on the most severe and costly manifestation of the disease

How the Hierarchies Function

Category	Included HCCs	Community Factor
Diabetes	HCC17 Diabetes w/acute complications	0.312
	HCC18 Diabetes w/chronic complications	0.312
	HCC19 Diabetes w/o complication	0.102

How the Hierarchies Function

Diagnosis Code	Description	CMS-HCC Model Category V22
E1010	Type 1 diabetes mellitus with ketoacidosis without coma	17
E1011	Type 1 diabetes mellitus with ketoacidosis with coma	17
E1021	Type 1 diabetes mellitus with diabetic nephropathy	18
E1022	Type 1 diabetes mellitus with diabetic chronic kidney disease	18
E1029	Type 1 diabetes mellitus with other diabetic kidney complication	18

ICD Code

HCC

How the Hierarchies Function

Table 3. Disease Hierarchies for the Revised CMS-HCC Model

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the Disease Group(s) listed in this column
	Hierarchical Condition Category (HCC) LABEL	
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19

If the beneficiary progresses from diabetes w/o complication (HCC 19) into HCC 18 because they now have a chronic condition associated with their diabetes, then the patient is paid under HCC 18 and HCC 19 is dropped from the calculation

Hierarchy Example

- The beneficiary has diagnoses within the following disease groups:
  - 135 - Acute Renal Failure
  - 136 - Chronic Kidney Disease (Stage 5)

Hierarchical Condition Category	If the HCC label is listed in this column…	…then drop the HCCs listed in this column
	Hierarchical Condition Category (HCC) Label	
135	Acute Renal Failure	136,137

Hierarchy Example

- The beneficiary has diagnoses within the following disease groups:
  - 110 - Cystic Fibrosis with intestinal manifestations
  - 111- Simple Chronic Bronchitis

Hierarchical Condition Category	If the HCC label is listed in this column…	…then drop the HCCs listed in this column
	Hierarchical Condition Category (HCC) Label	
110	**Cystic Fibrosis**	**111, 112**

  - According to the table, disease group 110 supersedes disease group 111, so payment would be based on the HCC of 110

Diseases and Disabled Interactions

- The CMS-HCC methodology also recognizes:
  - Certain combinations of diseases
  - Impact of disease process by setting
    - Community vs. Institutional
  - Impact of disability on some disease processes
- The CMS-HCC methodology includes formulas that can capture the interactions between a variety of disease processes that have an exponential impact on a person's health, rather than just an additive impact

Aged/Disabled Stratification by Residency

- Separate models represent significant cost differences between community-based Medicare beneficiaries and long-term institutionalized beneficiaries with the same disease profile
  - Long-term institutionalized enrollees are individuals residing in an institution for more than 90 days as identified using 90-day assessments in the Minimum Data Set (MDS)
    - Institutional status is recognized in the payment year itself rather than the preceding year
  - Short term institutionalized beneficiaries are included in the community population

Diseases and Disabled Interactions: Add Up!

- Medicare beneficiary:
  - Disabled
    - Disabled * Heart Failure, HCC 85 = 0.315
  - Resides in the SNF
  - Has the following diagnoses:
    - Rheumatoid arthritis HCC 40 = 0.323
    - Heart Failure HCC 85 = 0.187
- Risk Score =
  - (demographics) + 0.315 + 0.323 + 0.187

Documentation Focus

- Coach providers to use terminology that accurately reflects conditions that require:
  - Treatment
  - Evaluation
  - Monitoring
  - Diagnostic testing
  - Increases in nursing care
  - Prolonged lengths of stay

Risk Adjustment and Quality

- Risk adjustment allows those patients with multiple comorbidities who are more apt to experience complications to contribute less to quality measures
- They will provide a different weight or impact within a measure

2016 CMS-HCC Model

- For more information about Medicare Advantage:
  - Please refer to the Medicare Managed Care Manual
  - Or the following link

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html

Clinical Example: What is the MS-DRG?

- Discharge summary describes an admission for Mrs. Moody, 79 year old, living at home. She was admitted with chest pain later diagnosed with an acute MI, angina pectoris. History of COPD and renal failure and a right ankle sprain.
- Principal Diagnosis:
  - Acute Myocardial Infarction- I21.3
- Secondary Diagnoses:
  - COPD- J44.9
  - Renal Failure- N19
  - Right Ankle Sprain- S93.401A

DRG 282 Acute Myocardial Infarction, Discharged Alive without CC/MCC
GMLOS 2.1 AMLOS 2.5 RW 0.7551 T

Clinical Example: What are the CMS-HCCs?

- Principal Diagnosis:
  - Acute Myocardial Infarction- I21.3 → HCC 86
- Secondary Diagnoses:
  - COPD- J44.9 → HCC 111
  - Renal Failure- N19
  - Right Ankle Sprain- S93.401A
- Demographics:
  - 79 yr, female*
  - Lives at home

Risk Score

.229
.322
+ .440
0.991

Clinical Example: Query Opportunities?

- Discharge summary describes an admission for Mrs. Moody, 79 year old, living at home. She was admitted with chest pain later diagnosed with an acute MI, angina pectoris. History of COPD and renal failure and a right ankle sprain.
  - Type/location of myocardial Infarction?
  - Is the angina post infarction angina?
  - Further clarification of the renal failure?
- Principal Diagnosis:
  - Acute Myocardial Infarction- I21.3
- Secondary Diagnoses:
  - COPD- J44.9
  - Renal Failure- N19
  - Right Ankle Sprain- S93.401A

Clinical Example: Query Response MS-DRG

The provider documents acute non-ST elevation myocardial infarction with post infarction angina. Chronic kidney disease stage 3.

- Principal Diagnosis:
  - Acute NSTEMI- I21.4
- Secondary Diagnoses:
  - Post-Infarctional Angina Pectoris- I23.7
  - COPD- J44.9
  - Chronic Renal Failure- Stage 4- N18.4
  - Right Ankle Sprain- S93.401A

DRG 281 **Acute Myocardial Infarction, Discharged Alive with CC**
GMLOS 3.1 AMLOS 3.8 RW 1.0568

Clinical Example: Query Response CMS-HCC

- The provider documents acute non-ST elevation myocardial infarction with unstable angina pectoris. Chronic kidney disease stage 3.
- Principal Diagnosis:
  - Acute NSTEMI- I21.4 → HCC 86*
- Secondary Diagnoses:
  - Post infarction Angina - I23.7 → HCC 87*
  - COPD- J44.9 → HCC 111*
  - Chronic Renal Failure- Stage 3- N18.4 → HCC 137*
  - Ankle Sprain- S93.409A

Risk Score
.229
.322
.233
+ .440
1.224

Clinical Example: What is the MS-DRG?

- Mrs. Moody's husband is a patient at Rolling Hills Nursing Facility, he is 85 years old with diabetes, chronic kidney disease, and a chronic wound of his left great toe. He has left hemiparesis, a late effect of CVA. He became a bit agitated upon learning of his wife's health issues, he aspirated his afternoon milkshake and developed an aspiration pneumonia and acute respiratory distress syndrome. He is now in the room next to his wife at the hospital.

Clinical Example: What is the MS-DRG?

- Principal Diagnosis:
  - Aspiration Pneumonia- J69.0
- Secondary Diagnoses:
  - Diabetes- E11.9
  - CKD- N18.9
  - Late Effect Hemiparesis- I69.354 CC
  - Chronic toe Wound- S91.101D
  - Acute Respiratory Distress Syndrome- J80 CC

DRG 178 **Respiratory Infections and Inflammations with CC**
GMLOS 5.1 AMLOS 6.1 RW 1.3955

Clinical Example: What are the CMS-HCCs?

- Principal Diagnosis:
  - Aspiration Pneumonia → HCC 114*
- Secondary Diagnoses:
- Diabetes → HCC 19*
- CKD
- Late effect hemiparesis → HCC 103*
- Stroke
- Chronic toe wound
- Acute Respiratory Distress syndrome → HCC 84*
- Demographics:
- 85 yo, male
- Skilled Nursing Facility

Risk Score
.066
.157
.031
.292
+1. 109
1.655

Clinical Example: Query Opportunities

- Mrs. Moody's husband is a patient at Rolling Hills Nursing Facility. he is 85 years old with diabetes, chronic kidney disease, and a chronic wound of his left great toe. He has left hemiparesis, a late effect of CVA. He became a bit agitated upon learning of his wife's health issues. he aspirated his afternoon milkshake and developed an aspiration pneumonia and ARDS. He is now in the room next to his wife at the hospital.
  - Do clinical indicators support query for acute respiratory failure?
  - Diabetic foot ulcer? Depth?
  - Stage of CKD?
- Principal Diagnosis:
  - Aspiration Pneumonia- J69.0
- Secondary Diagnoses:
  - Diabetes- E11.9
  - CKD- N18.9
  - Late Effect Hemiparesis- I69.354 CC
  - Chronic toe Wound- S91.101D
  - Acute Respiratory Distress Syndrome- J80 CC

Clinical Example: Query Response?

- The provider responds to queries with acute hypoxic respiratory failure, BiPap initiated. Diabetic ulcer of the left great toe, related to diabetic peripheral neuropathy and CKD stage 3.
- Principal Diagnosis:
  - Aspiration Pneumonia- J69.0
- Secondary Diagnoses:
  - Diabetic Ulcer, Left Great Toe - E11.621, L97.529
  - Diabetic Peripheral Neuropathy- E11.40
  - CKD stage 3- N18.3
  - Late Effect Hemiparesis- I69.354 CC
  - Acute Respiratory Failure- J96.01 MCC

DRG 177 **Respiratory Infections and Inflammations with MCC**
GMLOS 6.4 AMLOS 7.9 RW 1.9934

Clinical Example: What are the CMS HCCs?

- Principal Diagnosis:
  - Aspiration Pneumonia- J69.0 → HCC 114
- Secondary Diagnoses:
  - Diabetic Ulcer – E11.621 → HCC 18
  - Diabetic Peripheral Neuropathy- E11.40 → HCC 18
  - CKD stage 3- N18.3
  - Late Effect Hemiparesis- I69.354 CC → HCC 103*
  - Acute Respiratory Failure- J96.01 MCC

Risk Score
.066
.433
.031
.292
+1.109
1.931

Risk Adjustment Validation Audits

Medicare Advantage Fraud Investigations

- A top, privately-run Medicare Advantage plan faces a federal investigation into allegations that it overbilled the government by exaggerating how sick some of its patients were. It is thought that inappropriate diagnoses were added to records to allow for higher billing.
- A private health care plans in Las Vegas claimed more than $100 million in added Medicare charges after claiming patients within their plan exhibited a higher level of risk than was accurate.
- In New York, a Medicare plan was paid $41 million to treat people with serious diseases, but was unable to demonstrate the patients actually had those conditions.

Projected Improper Payments for Medicare Advantage

Fiscal Reporting Year	Improper Amount (in Billions)	Improper Rate
2013	$11.8	9.5%
2014	$12.2	9%
2015	$14.1	9.5%
2016	$18.7	9.1%
2017	$18	8.8%
2018	S17.7	8.8%

https://paymentaccuracy.gov/tabular-data/projected-by-program/237

Risk Adjustment Validation (RADV)

- CMS conducts Medicare Advantage (MA) risk adjustment data validation activities for the purpose of ensuring the accuracy and integrity of risk adjustment data and MA risk adjusted payments.
- Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by an MA organization are supported by medical record documentation for an enrollee.

Risk Adjustment Validation (RADV)

- CMS RADV audits:
  - Validate the accuracy of the HCC codes
  - Examine whether health plans obtain overpayments by exaggerating the severity of conditions or by reporting conditions that may not have any impact on medical care or health
  - Measure organization-level payment error rates related to risk adjustment data for payment recovery.

RADV is a corrective action that is expected to help reduce the Part C error rate.

Expansion of MCR RAC Program

- The Affordable Care Act required Medicare's RAC program to expand to Medicare Advantage and Part D plans.
- Under the new Medicare Advantage auditing system, RACs would be tasked with conducting risk adjustment data validation (RADV) reviews.
- In addition to general RADV audits, RACs would conduct “condition-specific” RADV audits. Those reviews would focus on specific medical codes or health conditions, such as diabetes, that have high rates of payment errors.
  - Currently, the CMS performs only 30 RADV audits a year, which covers 5% of all Medicare Advantage contracts.

Provider & Payer Team Up!

- MA plans can be selected for RADV Audits annually.
- If selected, MA plans are required to submit member medical records to validate diagnosis data previously reported to CMS.
- Providers should be aware of RADV Audits because providers are required to assist the MA plan by providing medical record documentation for members included in the audit.

RADV Medical Record Choose the Best Record

- The entire medical record should be reviewed and diagnoses should be coded based on the *Official Guidelines for Coding and Reporting*.

RADV Medical Record Choose the Best Record

- The documentation should clearly support the diagnoses documented including related clinical indicators and medical decision making.

Patient admitted with the diagnosis of diabetic foot ulcer with related gangrene. Ulcer located on left great toe, Wagner grade 2. Excisional debridement identified gangrenous, necrotic tissue invading the phalanx and the tip of the metatarsus. After consult with the patient, family and orthopedic surgeon it is felt that a partial amputation of the foot is required.

Self-Audit Reviews are Key

- Provides a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.
- Monitoring should include data analytics and personal review of claims and diagnoses reported in addition to an audit plan.
- Ensures that data is accurate, complete, properly formatted, and otherwise in compliance with HHS requirements.

Audit Reviews Provide Ongoing Feedback

Clinical Documentation Improvement Week

- Concurrent reviews
  - Performed pre-bill
- Retrospective reviews
  - Performed post-bill

- Internal reviews
  - Performed by internal staff
  - Peer reviews
  - Audit team reviews
- External reviews
  - Performed by outside audit team

Teach Complete Documentation

Clinical Documentation Improvement Week

1. Identify the Diagnosis

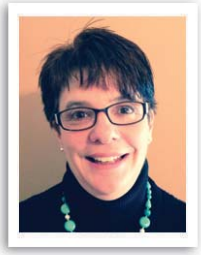
2. List the clinical indicators "…. *As demonstrated by…*"

3. Describe the plan. *"…. With a treatment plan of…."*

4. Document the patient's response & how the plan of care was altered if needed.

Progress notes must demonstrate progression

Questions & Answers



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Submit a question:
Go to the chat pod located in the lower left corner of your screen. Type your question in the text box then click on the "Send" button.

Thank you for attending!

Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at *http://hcproevents.hrhero.com/materials.cgi?64677:.mlsp.:YH091916A*

For more information about **CDI Week**, and to download our 2016 poster, industry survey, Q&As, and more, visit *www.acdis.org/cdi-week*.

This concludes today's program.

Please complete and submit the program evaluation, which has been sent to the person who registered for this event at your facility. *We kindly request that they forward it to everyone in your group.*

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HCPro

Certificate of Attendance

_____

attended

"Risk Adjustment Documentation and Coding"

a 60-minute webinar on
September 19, 2016

Elizabeth Petersen
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