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ICD-9-CM CODING & MEDICARE HIERARCHICAL CONDITION CATEGORIES...

Did you know that approximately 11 percent of Medicare beneficiaries are enrolled in private managed care health care plans, with the rest in the traditional FFS (Fee for Service) programs? Did you also know that Medicare Advantage payment methodology is driven a lot by documentation and ICD-9-CM diagnosis codes? Like most aspects of our healthcare system, there are great complexities. In this article I want to share with you some basics about Medicare Advantage Hierarchical Condition Categories (HCCs) and the ICD-9-CM codes behind them.

Medicare Advantage (MA), Medicare Risk or Medicare C are all the same program. MA allows Medicare beneficiaries to receive their Medicare benefits from private insurance plans rather than from the traditional fee-for-service (FFS)

program. Under the Medicare Advantage program, which can be chosen by the Medicare beneficiary, certain clinical data elements are key and vital to accurate payment. When a beneficiary signs up for MA it is with a managed care organization and then providers also contract to be apart of the MA program to provide care.

Each beneficiary or patient has specific demographics and clinical data (health risk characteristics) about themselves that help to establish a MA "risk score" for that patient. Medicare uses these beneficiaries' characteristics, such as age and prior health conditions, and a risk-adjustment model—the CMS-hierarchical condition category (CMS-HCC)—to develop a measure of their

expected relative risk for covered Medicare spending. The risk score in turn will help in determining the reimbursement the provider and managed care organization will receive. The risk score is similar to a relative weight seen with Medicare-Severity DRGs. The base payment for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's risk measure, known as the CMS-HCC weight.

This payment structure which is on an **annual** basis was summed up best in an article from Medical Care in 2005, "CMS-HCC model uses

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QUOTE OF THE MONTH...

" Progress always involves risk; you can't steal second base and keep your foot on first."

Frederick Wilcox

COMMENTARY REGARDING RAC, MIC & INPATIENT AUDITS

The RAC and MIC audits are not going to be kind to the overall picture of 'healthcare fraud' if organizations, clinical leaders and providers do not get on the same page rapidly. In completing RAC readiness assessments for over 2+ years - with hospitals as well as employed providers - a common theme emerges : **there is a disconnect between what is required to be present in the**

medical record to support the billable services with ownership for completeness and the accountability for these billable services.

The same issue is found in every part of the country. There were no 'uniqueeeee' issues in the west that were not seen in the east, mid-west, south, etc. What that says to us: We have a profound challenge to

'change the message' that the accountability for accuracy of 'billed services' is strictly a revenue cycle/PFS issue. Creating bills and coding the bill is the easy part. ACCURACY of the pt status and charges to match the claim/UB against the medical record is much more difficult. OWNERSHIP is a collaboration between the care **Continued on pg. 2— Commentary..**

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givers who chart the service and the reimbursement staff in educating on billable rules. Who owns this in your facility? Huge void in most organizations -possibly not purposeful but still creates of vacuum of accountability .

Collaboration: Disconnects are prevalent between the providers and the story in the hospital's medical record. Unfortunately, the current environment is not equitable as CMS has stated (June 2009 website) that they will NOT automatically recoup the physician payment when the hospital loses their payment. If the physician did a poor job of documenting the 'severity of the illness that contributed to the decision to admit to an acute care level of care' - the facility is at risk to lose the inpatient status. Nursing must chart to the 'unique/intensity of' care that was driven by the severity of

illness as identified by the provider.

1 day inpatient findings: With over 2 years of data, we have found the following % of variance. This means: the record was billed as an inpatient, but the severity of illness /physician and intensity of services/nursing is poorly documented. EMRs do not help identify the 'unique' care that is being provided if they 'look like a carbon copy of the previous patient." Additionally, CMS does not mandate nor endorse any clinical guidelines. (Feb 25, 2009 - "Evidence based care guidelines will be used to combat waste.)

Therefore, it is critical that all caregivers understand what is an inpatient? Medicare defined it in Medicare Benefit Policy Manual, Chapter 1... It has been around for a while. However, if the provider does not provide an excellent order with supporting H&P, there is no

alternative but to go to the resource/fall back position of using Interqual. BUT remember, it is all about what the physician ACTUALLY says in the record -with or without Interqual or Millman.

Audit results: 40 % variance (60% accuracy rate to support the billable service that was documented in the medical record).



GOOD NEWS! Implementing concurrent review of all inpatients and OBS with midnight reconciliation of patient status are HUGE wins in teaching these concepts. Additionally, growing the clinical documentation specialists to add 'patient status/billable services' into the provider educational outline is a great way to 'kill 2 birds with 1 teaching stone.'

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UNDERSTANDING STREE...

There is no doubt that at some point in our life we have experienced stress. We may know we have stress when we experience it, but what is it exactly?

Stress is defined as a response to a demand that is placed upon you. Without some stress, people would not get a lot done. That extra burst of adrenaline that helps you finish your final paper, perform well in sports, or meet any challenge is positive stress. It is a short-term physiological tension and added

mental alertness that subsides when the challenge has been met, enabling you to relax and carry on.

Responses to stress can be physical, such as a headache; emotional, such as fear or sadness; and mental, such as increased anxiety. If you cannot return to a relaxed state, then the stress becomes negative. The changes in your body (increased heart rate, higher blood pressure and muscle tension) start to take their

toll, often leading to mental and physical exhaustion and illness. Too much stress can cause problems and affect our health, productivity and relationships.

If you frequently find yourself feeling frazzled and overwhelmed, it's time to take action to bring your nervous system back into balance. You can protect yourself by learning how to recognize the signs and symptoms of stress and taking steps to reduce its harmful effects.



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demographics and a diagnosis-based medical profile captured during all clinician encounters—both inpatient and outpatient—to produce a health-based measure of future medical need.”

Here are some of the HCCs, keep in mind there are some 3400 ICD-9-CM diagnosis codes behind the HCCs:

- HCC 2: Septicemia, shock
- HCC 5: Opportunistic Infections
- HCC 17: Acute complications of Diabetes, such as DKA
- HCC 21: Protein-Calorie Malnutrition (could be long term)
- HCC 31: Intestinal Obstruction
- HCC 37: Bone/Joint/Muscle Infections
- HCC 51: Drug/Alcohol Psychosis
- HCC 78: Respiratory Arrest
- HCC 79: Cardio Respiratory Failure and Shock
- HCC 81: Acute Myocardial Infarction

Most of the diseases that have been mapped to Hierarchical Condition Categories (HCCs) represent chronic conditions that will persist from one data period to the next, or one year to another. However, as you see above there are also acute or subacute conditions included in the HCC methodology. The emphasis is on diagnoses alone and not on procedures or surgeries performed. Disease categories are **accumulated** — that is, reimbursements are based on the sum of all chronic conditions diagnosed in different hierarchical categories.

MA managed care reimbursement depends on accurate and complete diagnostic documentation for the physician, inpatient and outpatient settings. So with MA the ICD-9-CM coding also must be accurate and complete so the accurate HCC can be captured. Sometimes providers don't take the time to document accurately and if coding staff don't code completely you could lose out on justified HCC reimbursement. Yes, this is a similar challenge faced each and everyday in dealing with MS-DRGs too.

The hierarchies are established so that each patient is only paid for the most severe manifestation among related diseases. For instance, ischemic heart disease diagnoses are organized in the Coronary Artery Disease (CAD) in the hierarchical category. The CAD hierarchy consists of three Hierarchical Condition Categories (HCCs) arranged in descending order by clinical severity and cost. HCC 81 for Acute Myocardial Infarction (AMI) through HCC 83 for Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease.

A patient with a diagnosis code in HCC 81 is excluded from the payment grouping in HCCs 82 and 83, even if these ICD-9-CM codes are present, as the hierarchy is applied.

ICD-9-CM Code	ICD9 Description	Diagnosis Code Effective Date	CMS-HCC Model Category	CMS-HCC Model Calendar Year 2009 Payment	CMS-HCC Model Calendar Year 2010 Payment
41072	Subendo Infarct, Subseq	1/1/1991	82	Yes	Yes
41080	Ami Nec, Unspecified	1/1/1991	82	Yes	Yes
41081	Ami Nec, Initial	1/1/1991	81	Yes	Yes
41082	Ami Nec, Subsequent	1/1/1991	82	Yes	Yes
41090	Ami Nos, Unspecified	1/1/1991	82	Yes	Yes
41091	Ami Nos, Initial	1/1/1991	81	Yes	Yes
41092	Ami Nos, Subsequent	1/1/1991	82	Yes	Yes
4110	Post Mi Syndrome	1/1/1991	82	Yes	Yes
4111	Intermed Coronary Synd	1/1/1991	82	Yes	Yes
4118	Ac Ischemic Hrt Dis Nec*	1/1/1991	82	No	No
41181	Acute Cor Occlsn W/O Mi	1/1/1991	82	Yes	Yes
41189	Ac Ischemic Hrt Dis Nec	1/1/1991	82	Yes	Yes
412	Old Myocardial Infarct	1/1/1991	83	Yes	Yes
4130	Angina Decubitus	1/1/1991	83	Yes	Yes

Performing HCC audits similar to other inpatient coding audits should be performed to identify opportunities and gaps. Providers have also found that having a concurrent documentation improvement (CDI) program in place can also capture -

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MAKING A DIFFERENCE WHERE IT COUNTS...

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improve documentation, coding and HCCs. Even expanding the physician query (clarification) process to include the ICD-9-CM diagnosis for HCCs can yield additional clinical data resulting in a positive financial impact. Providers and MA healthcare plans should be proactive and conduct audits or even conduct data mining to identify opportunities. CMS does perform audits also to validate the HCCs reported.

A good next step to take would be to ask for a data report that would show the volume of patient encounters or discharges by payer and ask for Medicare Advantage to be separated out. See if you need to include MA in your documentation and coding audits. And if you want to learn more about Medicare Advantage, simply do a "Google" search on Medicare HCCs, there are thousands of hits on this topic.

Happy surfing and reading about the world of Medicare Advantage and HCCs.,

Resources: *Medical Care*, Vol 43, Number 1, January 2005, pg. 34.; *Medicare HCC Coding is Mission Critical for HMOs*, Sep 1, 2007, Al Lewis; *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*, Healthcare Financing Review, September 2004;

www.cms.hhs.gov/MMCAG/04_PartCRecon.asp

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