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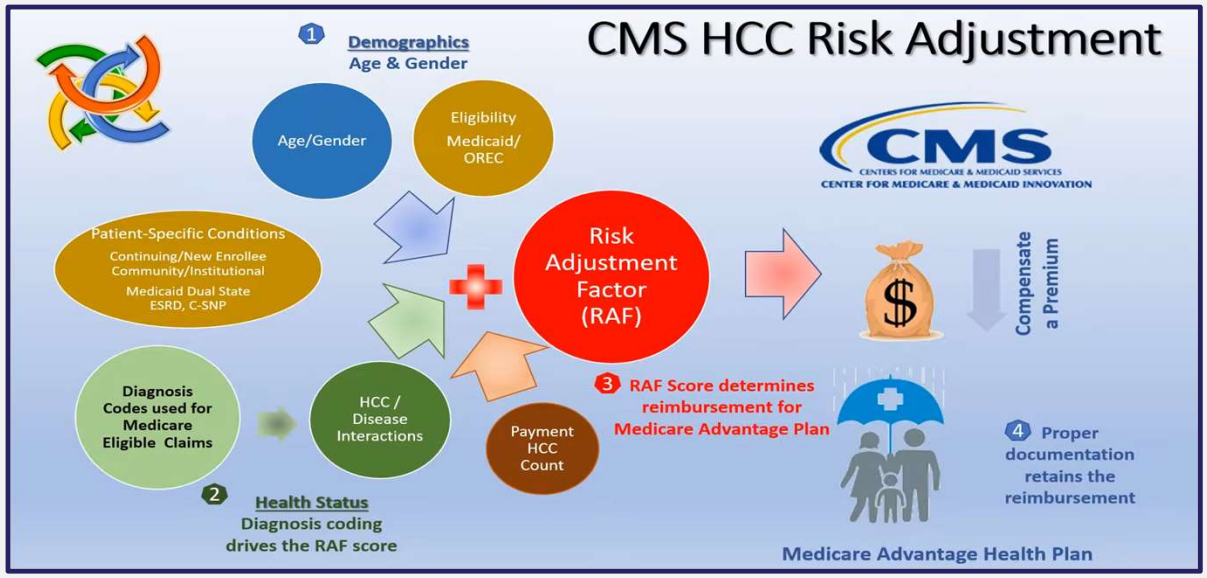
The Hidden Revenue In Your Notes: Closing Chronic Care Gaps

What is Risk Adjustment Methodology?

- A methodology used to calculate payments to healthcare providers based on patient's health status, expected use of healthcare services, and associated care costs

- Active conditions must be addressed and documented annually during (face-to-face or qualifying telemedicine) patient encounter



CMS-HCC Risk Adjustment Calculator http://hcc.medicareinformatics.com

What are Hierarchical Condition Categories (HCC) Codes?

- CMS and other payers use these codes to predict future healthcare costs for the members.
- HCCs group serious or chronic conditions (Diabetes Mellitus with complications, CHF, Cancer)
- Each HCC has a weight that contributes to the member's overall risk adjustment factor score (RAF) score
- "Hierarchical: means more severe conditions override less severe ones to avoid double-counting
- Accurate, specific documentation and coding are essential to capture the full picture of a member's health and ensure appropriate reimbursement

Listing of CMS - HCC

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC listed in this column
	CMS-HCC Hierarchical Condition Category Label	
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
20	Lung and Other Severe Cancers	21, 22, 23
21	Lymphoma and Other Cancers	22, 23
22	Bladder, Colorectal, and Other Cancers	23
35	Pancreas Transplant Status	36, 37, 38
36	Diabetes with Severe Acute Complications	37, 38
37	Diabetes with Chronic Complications	38
62	Liver Transplant Status/Complications	63, 64, 65, 68
63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
64	Cirrhosis of Liver	65, 68
77	Intestine Transplant Status/Complications	78, 80, 81

Example of HCC Hierarchy

Diabetes without Complications

HCC Weight: 0.1

Diabetes with Chronic Complications

HCC Weight: 0.3

Diabetes with Acute Complications

HCC Weight: 0.5

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Best Practice for Accurate Coding & Documentation

To ensure proper risk adjustment and reimbursement, providers should follow these key guidelines:

1. **Document all chronic and active conditions annually**—or during any visit where they impact care.
2. **Link each diagnosis to treatment plans or clinical decisions** to show medical necessity.
3. **Code to the highest level of specificity** following **ICD-10-CM guidelines**.
4. **Avoid vague or unsupported diagnoses** (e.g., “history of” without current relevance).
5. **Ensure documentation reflects the patient’s current health status**, not just past conditions.

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Provider documentation is a major contributor to HCC capture:

BASIC	D.S.P.
STANDARD	M.E.A.T.
BEST PRACTICE	T.A.M.P.E.R.

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Basic: D.S.P.

D	S	P
Diagnosis	**Status**	**Plan**
Clearly stated by the provider (e.g., “Patient has congestive heart failure”).	Describes the current state of the patient’s condition: stable, uncontrolled, worsening, or improving, or remission (e.g., “Patient is stable”).	Addressed through treatment, monitoring, medication, referrals, or follow-up (e.g., “Patient will follow up with Cardiology”).

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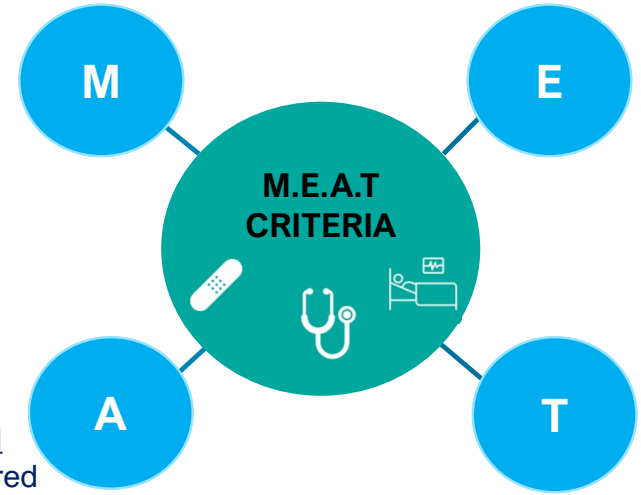
Standard: M.E.A.T Criteria

A problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service which includes consideration of further testing or treatment.

Monitoring
Monitoring signs, symptoms, disease progression, disease regression



Evaluating
Evaluating test results, medication effectiveness, response to treatment

Assessing/Addressing
Assessing or Addressing ordered tests, discussion, review records, counseling

Treating
Treating medications, therapies, other modalities

What Does not qualify:
Pulling in problem list without additional assessment or care coordination documented

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Best Practice: T.A.M.P.E.R.

Capturing the full story of every patient

Treat

The condition is being treated (medications, therapy, surgery, etc.).

Assess

The provider is evaluating the condition through history, exam, or data review

Monitor

The condition is being followed over time with labs, symptoms, or vitals.

Plan

The provider documents a plan of care (follow-up, medication changes, etc.).

Evaluate

Labs, tests, or diagnostics related to the condition are being interpreted.

Refer

The provider refers the patient to a specialist or additional services.

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From Notes to Numbers:

How Documentation Shapes RAF Scores

No Conditions Coded Low Level of Specificity		Some Conditions Coded Moderate Level of Specificity		All Conditions Coded High Level of Specificity	
75 y/o male	**0.502**	75 y/o male	**0.502**	75 y/o male	**0.465**
No DM coded	**X**	Diabetes w/o complications (E11.9 – HCC 38)	**0.166**	Diabetes w/ CKD3A (E11.22– HCC 37)	**0.166**
No CKD coded	**X**	CKD unspecified (N18.9 –No HCC)	**x**	CKD3A (N18.31 – HCC 329)	**0.202**
No CHF coded	**X**	CHF not coded	**x**	Chronic diastolic (congestive) heart failure (i50.32 – HCC 226)	**0.360**
No COPD coded	**X**	COPD (J44.9 – HCC 280)	**0.319**	COPD (J44.9, HCC 280)	**0.317**
No disease interaction	**X**	No disease interaction	**X**	1. Disease interaction (DM +CHF) 2. Disease interaction (CHF + COPD) 3. Disease interaction (CHF + CKD)	**0.112** **0.078** **0.176**
No HCC counts	**X**	3 or more HCC counts	**X**	5 HCC payment counts	**0.050**
Total RAF	**0.502**	Total RAF	**0.987**	Total RAF	**1.84**
	X $800		X $800		X $800
Total Funding PMPM	**$401.60**		**$789.60**		**$1,472**

Assuming an average bid rate of $800 PMPM

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High-Risk Diagnosis Groups for Audit

Office of Inspector General (OIG)

Figure: Errors in High-Risk Groups as of November 2023

High-Risk Group	Total	Errors	Error %
Acute stroke	945	908	96%
Acute heart attack	791	751	95%
Embolism	754	593	79%
Lung cancer	391	345	88%
Breast cancer	390	373	96%
Colon cancer	390	368	94%
Prostate cancer	360	322	89%
Potentially mis-keyed diagnosis codes	522	421	81%
Totals	**4,543**	**4,081**	**90%**

The table on the right represents, identified high risks diagnosis from OIG resulting in Risk Adjustment Validation (RADV) audits.

TOOLKIT

To Help Decrease Improper Payments in Medicare Advantage Through the Identification of High-Risk Diagnosis Codes

December 2023|A-07-23-01213

Toolkit To Help Decrease Improper Payments in Medicare Advantage

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Focus on High-Impact Condition Categories

Chronic Condition Opportunities (Persistent & Suspected)	Quantity
Heart Disease	102
Lung Disease	57
Diabetes	47
Metabolic Disease	45
Kidney Disease	43
Psychiatric Disease	30
Neoplasm	29
Vascular Disease	19
Musculoskeletal Disease	19
Neurological Disease	17
Grand Total	**408**

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Congestive Heart Failure

1. Specify the Diagnosis Clearly

Avoid vague terms like “history of CHF” or “CHF” without type or acuity.

2. Use precise ICD-10 Codes:

I50.2X – Systolic CHF
I50.3X – Diastolic CHF
I50.4X – Combined Systolic & Diastolic CHF
I50.84 - End-Stage CHF
I11.0 – Hypertensive Heart Disease w/CHF

3. Include Stages/ NYHA Class of Heart Failure

Stages of Heart Failure	NYHA Classification System
Stage A: At Risk for Heart Failure	**Class I:** No limitation of physical activity
Stage B: Pre-Heart Failure	**Class II:** Slight limitation of physical activity
Stage C: Symptomatic Heart Failure	**Class III:** Marked limitation of physical activity
Stage D: Advance Heart Failure	**Class IV:** Symptoms occur even at rest; discomfort with any physical activity

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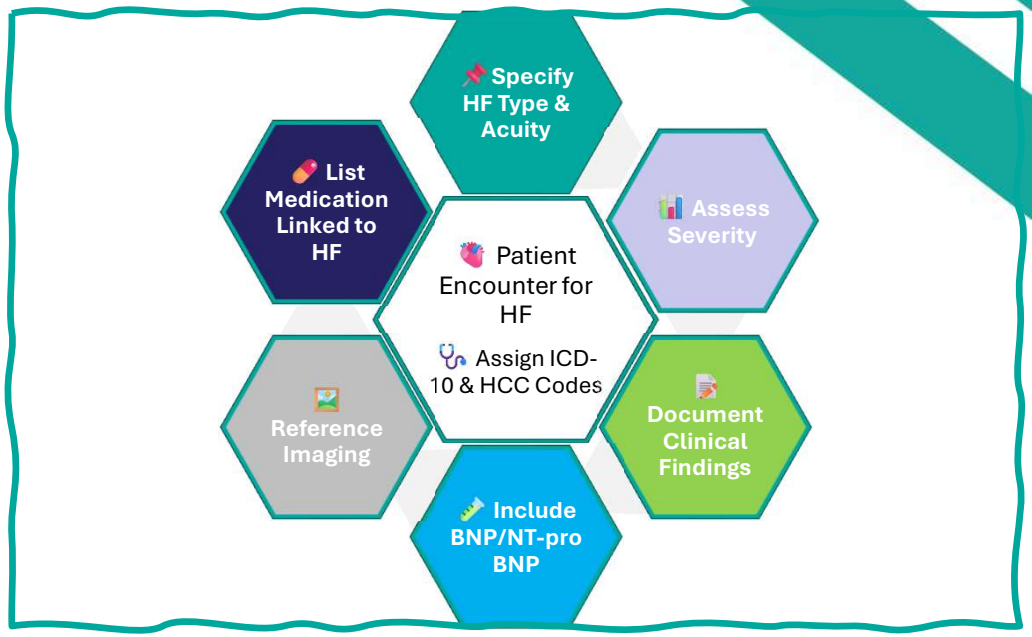
Congestive Heart Failure

Disease Interactions:

CHF + DM = 0.121
CHF + COPD = 0.155
CHF + Renal Disease = 0.156
CHF + Heart Arrhythmia = 0.085



Monitor	Track symptoms, disease progression, or stability
Evaluate	Review test results, labs trends & functional status, or medication effectiveness
Assess	Identify HF type, document acuity, or physical exam findings
Treatment	Prescribe or adjust medications, lifestyle modification, refer to cardiology

Documentation Example:

- **Assessment:** Chronic Systolic HF, NYHA Class III, currently decompensated. Lower extremity edema & dyspnea on exertion. Echo: 30% EF.
- **Plan:** Increase furosemide & continue carvedilol. Reinforce sodium and fluid restriction. Follow up in 2 weeks or sooner if worsening symptoms.

Chronic Heart Failure & Home Oxygen

HCC 213 – Cardio-Respiratory Failure and Shock

- Patient with **CHF (I50.22),** and/or **COPD (J44.9)** on **home oxygen** supports coding for **J96.10 (Chronic Respiratory Failure).**
- Link CHF/COPD to oxygen use to validate coding for J96.10.
- **Z99.81 (Dependence on Oxygen)** can also support J96.10 when clinically appropriate.

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HCC 280: Chronic Obstructive Pulmonary Disease

1. Specify the Diagnosis Clearly

Avoid vague terms like “chronic lung disease” or “ reactive airway disease.”

2. Use precise ICD-10 Codes:

J44.9 – COPD, unspecified
J44.1 – COPD with acute exacerbation
J44.0 – COPD with lower respiratory infection
J43.* - Emphysema
J41 – J42 – Chronic bronchitis (if not part of COPD)

3. Include Spirometry Results

GOLD Staging Based on FEV_1% Predicted:

GOLD 1: Mild (>80%)
GOLD 2: Moderate (50-79%)
GOLD 3: Severe (30-49%)
GOLD 4: Very Severe (<30%)
* A GOLD Stage 4 supports the diagnosis of chronic respiratory failure.

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Chronic Obstructive Pulmonary Disease

4. Document Tobacco Use History

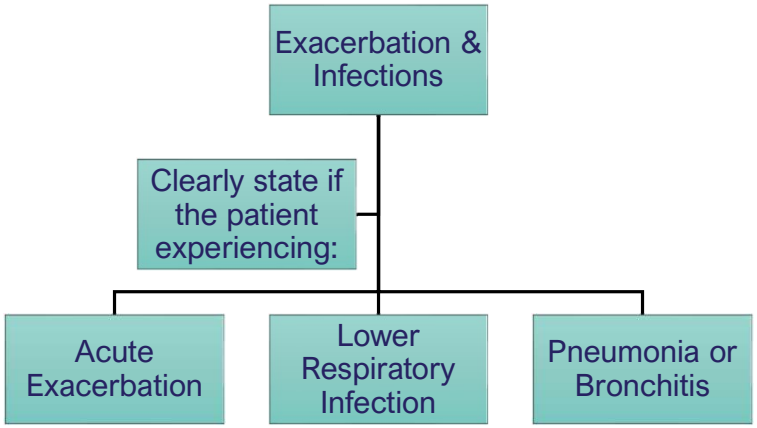
Include: current or former smoker, pack-years, quit date (if applicable)

Use code Z87.891 to report personal history of nicotine dependence

5. Describe Symptoms and Functional Impact

Dyspnea, Cough, Sputum Production

Activity Limitations (e.g., “SOB with walking 1 block)



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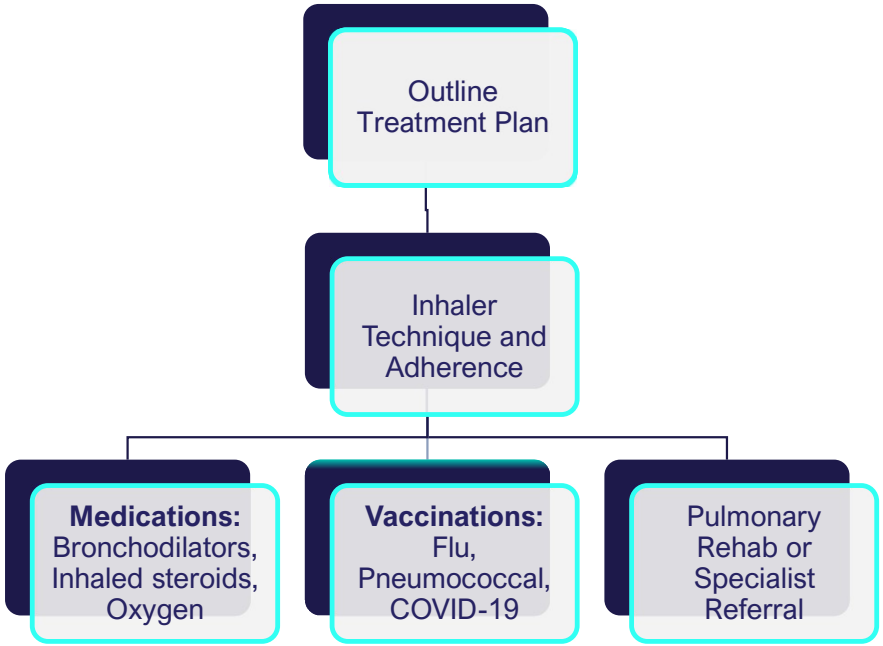
Chronic Obstructive Pulmonary Disease



Monitor	Track symptoms, disease progression, or stability
Evaluate	Review test results, medication effectiveness, or physical exam finding
Assess	Discuss condition, review records, counsel patient
Treatment	Prescribe or adjust medications, refer, initiate therapy

Documentation Example:

Assessment: COPD, GOLD 2, stable. FEV1 65% predicted. Former smoker, 30 pack-years, quit 2015. No recent exacerbations.

Plan: Continue Albuterol daily. Reinforce inhaler technique. Flu and COVID vaccines up to date. Recheck in 3 months.

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Diabetes Mellitus

1. Specify the Type of Diabetes

with or without complication

2. Use precise ICD-10 Codes:

E08 – Diabetes Mellitus due to underlying condition
E09 – Drug or Chemical Induced Diabetes Mellitus
E10 – Type 1 Diabetes Mellitus
E11 – Type 2 Diabetes Mellitus
E11.A - Diabetes in remission *
E13 – Other Specified Diabetes Mellitus

3. Document Complication Clearly:

- **Always link complications to diabetes when applicable**

Kidney: Diabetic Nephropathy, CKD (also code CKD stage: N18.*)
Eye: Retinopathy (nonproliferative, proliferative), macular edema
Neuropathy: Peripheral, Autonomic
Circulatory: Peripheral Angiopathy, Gangrene
Skin: Ulcers, Infections
Hypo-/Hyperglycemia: with or without coma

***If using DM with chronic complication - the complication needs to be noted and addressed**

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Diabetes Mellitus

4. Include Control Status:

- Controlled vs. Uncontrolled – **must state** Hyperglycemia or Hypoglycemia
- Use HbA_1C values to support the control status (e.g., HbA_1C 8.7% - uncontrolled")
- Document if the patient is in remission (e.g., s/p bariatric surgery)

5. Address Preventive and Supportive Care

Annual eye and foot exams

Nephropathy screening

DSMES (Diabetes Self-Management Education and Support)

Nutrition and exercise counseling

Medication adherence and side effects

Monitor	Labs (HbA_1C, Lipids, Microalbumin, Foot Exam)
Evaluate	Symptoms & Complication
Assess	Control, Adherence, Barriers
Treatment	Medications, Lifestyle, Referrals

Documentation Example:

Assessment: Type 2 Diabetes with non-proliferative diabetic retinopathy without macular edema, uncontrolled. HbA_1C 9.2%.
Plan: Continue Metformin, add GLP-1 agonist. Referral to Ophthalmologist. Recheck HbA_1C in 6 months.

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Diabetes Mellitus

- **Diabetes in remission: E11.A**

🆕 E11.A – Type 2 Diabetes Mellitus Without Complications, In Remission

This code is used when a patient with a documented history of Type 2 diabetes mellitus is no longer taking antidiabetic medications and maintains normal or controlled glucose levels through lifestyle changes alone.

✅ Key Criteria for Using E11.A

Prior diagnosis of Type 2 diabetes mellitus (confirmed by standard diagnostic criteria).
No current use of diabetes medications (oral agents, insulin, or injectables).
Sustained glycemic control (e.g., HbA1c < 6.5%) for at least 6 months without pharmacologic therapy.
Clear provider documentation stating the diabetes is in remission.
No active diabetic complications (if present, they should be documented as sequelae).

Frequently Asked Questions About E11.A Code

Q: Can E11.A be used with diabetes complication codes?

A: Yes, if complications persist despite remission, code both E11.A and the appropriate complication codes (e.g., E11.A + E11.42 for diabetic polyneuropathy).

Q: What happens if a patient's A_1C rises above 6.5%?

A: Discontinue E11.A and return to appropriate active diabetes codes (E11.9, E11.65, etc.).

Q: Is E11.A applicable to Type 1 diabetes?

A: No, E11.A is exclusively for Type 2 diabetes in remission. Type 1 diabetes cannot achieve a true remission.

Q: How often should remission status be verified?

A: ADA guidelines recommend quarterly A_1C testing during the first year of remission, then semi-annually.

Case Scenario

Patient Name: John M.
Age: 72
Encounter Type: Follow-up visit

Provider Note Excerpt:

Patient returns for follow-up of chronic conditions. He has **chronic systolic heart failure** with NYHA Class III symptoms. He continues to use **home oxygen** for his **COPD,** which has had **frequent exacerbations** this year.

He also has **Type 2 diabetes mellitus** with **diabetic neuropathy**, and his glucose remains poorly controlled despite adjustments to insulin.

Recent labs show elevated BNP and HbA1c of 9.2%.

Plan: Continue diuretics for CHF, monitor oxygen saturation, adjust insulin dosage for DM2, and refer to pulmonology for evaluation of possible **pulmonary hypertension** due to RV strain noted on echo.

1. Which conditions in this case map to HCCs?

A. Chronic systolic heart failure
B. COPD with exacerbations
C. Diabetic neuropathy
D. Oxygen dependence
E. Pulmonary hypertension

3. What MEAT elements support the CHF diagnosis?

A. Monitoring: BNP levels
B. Evaluation: NYHA Class III
C. Assessment: Chronic systolic HF
D. Treatment: Diuretics

4. What documentation improvement would help support pulmonary hypertension coding?

A. Confirm diagnosis with echo results
B. Link RV strain to pulmonary hypertension
C. Include MEAT elements
D. All of the above

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APPENDIX

Definitions of Terms

Terms	Description
Hierarchical Condition Categories (HCC)	HCCs are **groups of related medical conditions** used by Medicare to estimate how sick a patient is. If a patient has several conditions in the same group, **only the most serious one counts**. These groups help Medicare figure out how much care someone might need and how much it might cost. **Each HCC is assigned a relative factor** that is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.
Risk Adjustment Factor (RAF)	A **RAF score** is a number that shows how sick a person is, based on their health problems and age or gender. Medicare uses this score to **predict future healthcare costs** for each patient and to adjust payments to health plans accordingly
Medicare Advantage (MA) Plan	Also called **Part C**, a Medicare Advantage Plan is a type of Medicare coverage run by **private insurance companies**. It includes everything from hospital and doctor coverage (Parts A & B) and often adds extras like **dental, vision, and prescriptions**. Medicare pays these plans based on how sick their members are (using the RAF score), so they are **financially responsible** if care costs more than expected. CMS pays MA plan a **monthly premium** that estimated using RAF scores for their population.
Medicare Accountable Care Organization (ACO)	An ACO is a **team of healthcare providers** (doctors, hospitals, etc.) that work together to take care of Medicare patients. They try to **improve care and lower costs**. If they save money while keeping patients healthy, they get to keep part of the savings. If they spend more than expected, they may have to **pay money back to Medicare**.

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Thank you for your time today.
For any questions, please feel free to reach out to:

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