

24th Annual Charleston
APRN Conference

**Understanding
Medical Decision
Making and Risk of
Problems to Capture
Value**

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Objectives

- Show insight on how to get the correct code/level of service and match it to the medical decision making of a visit
- Know how to capture "risk" in a diagnosis and align it with the clinical severity of the condition

**Evaluation and Management
Components**

- Key Components
 - History
 - Exam
 - Medical Decision Making
- Contributory Components
 - Counseling
 - Time

Basic Coding 101

- o **All three** of the basic key components (Hx, Ex, MDM) are **needed to be equal** "weight"
 - o New patients
 - o Consults
 - o Hospital admits
 - o ED visits
 - o NH yearly physicals

Hx of 99202

Ex 99202

MDM 99202

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 - o ED visits
 - o NH yearly physicals
- o Only **two of the three** key components are needed to be equal
 - o Established patients not in those clinical situations above

Basic Coding 101

- o Only **two of the three** key components are needed to be equal
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Hx 99214

MDM 99214

Basic Coding 101

- Only **two of the three** key components are needed to be equal
 - Established patients not in those clinical situations above
- Note: Established patients who have not received any profession services from the physician/NPP (or another provider of the same specialty in the same group) in the last 3 years can be billed as a NEW PATIENT. Need "3 of 3" documentation

The Third Key Component



- History
- Examination
- Medical Decision Making
 - Diagnoses managed (number and type)
 - Data reviewed to manage diagnoses of visit
 - Risk associated with the management plan

For MDM calculation on diagnosis

- Maximum point total is "4"
 - If 4 is maximum, then the maximum MDM is being met ("High")
 - If 3 is achieved, then "moderate"
 - If 2 is achieved, then "low"
 - If 1 is achieved, then "minimal"

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For MDM calculation on diagnosis

- Maximum point total is "4"
 - If 4 is maximum, then the maximum MDM is being met ("99205/99215")
 - If 3 is achieved, then "99204/99214"
 - If 2 is achieved, then "low"
 - If 1 is achieved, then "minimal"

Number of Diagnoses or Treatment Options			
Types of Problems	Number x points = subtotal		
Self limited, minor	(max = 2)	1	
Est. problem, stable or improved		1	
Est. problem, medical adjustment needed		2	
New problem*, no work-up planned		3	
New problem*, further work-up planned		4	
Total			

TABULATION OF DECISION MAKING ELEMENTS					
A	Diagnoses/Management Options	Minimal (0-1)	Low (2)	Moderate (3) X	High (4) X
B	Amount/Complexity of Data	Min./Low (0-1)	Low (2)	Moderate (3)	High (4)
C	Highest Risk (from any category in table)	Minimal	Low	Moderate	High
Medical Decision Making <small>(Choose the column with at least 2 elements. Otherwise, pick the middle column of the three columns with 1 element)</small>		Straight-forward	Low	Moderate 99204/99215 X	High 9205/99215 X

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MDM for Diagnosis

- Lots of MDM "credit"
 - Often get "99214" and "99215" for this
 - Especially when we manage chronic diseases or see new multi-system problems
- Recall it is "2 of 3 parts with 2 being equal"
 - Still have Data and Risk to assess

For MDM calculation on data

- o Maximum point total is “4”
- o If **4** is maximum, then the maximum MDM is being met (“99205/99215”)
- o If **3** is achieved, then “99204/99214”
- o If 2 is achieved, then “low”
- o If 1 is achieved, then “minimal”

Amount and Complexity of Data Reviewed	
Categories of Data Reviewed	Points
Order and/or review clinical lab tests (CPT 8xxxx series)	1
Order and/or review tests from radiology section (nuclear med., Xray—not echo/cath) (CPT 7xxxx series)	1
Order and/or review tests from medicine section (EKG,EMG,echo,dopplers,cath,PFT,audiometry,etc.) (CPT 9xxxx series)	1
Decision to obtain old records or decide to obtain history from other caregivers/family, or discuss tests with performing physician	1
Review and summarize old records by updating chart or taking history from someone other than patient (nurse at NH, interpreter, children)	2
Independent visualization of image, tracing, or specimen	2
Total	

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For MDM calculation on risk

- o “Highest box wins”
- o Moderate or High is our focus

RISK FACTORS—SELECT HIGHEST IN CATEGORY			
LEVEL OF RISK	PRESENTING PROBLEM	PROCEDURES ORDERED	MANAGEMENT OPTIONS CHOSEN
Minimal	One self-limited or minor prob.	Labr, X-rays, EKG, EEG	Rest, superficial dressings
Low	Many self-limited or minor 1 chronic stable illness Acute, uncomplicated illness/injury	Physiologic test w/o stress Imaging studies w/ contrast Superficial needle biopsy Skin biopsy Arterial blood draw	OTC meds Minor surgery w/o risk factors Physical/Occupation Therapy IVF w/o additive
Moderate	One or more chronic illnesses with exacerbation, progression, or treatment of side effects 2 or more chronic stable illnesses New prob w/ uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	Stress test Endoscopies w/o risk factors CV imaging w/o risk factors Deep needle biopsy Centesis of body cavity	Minor surgery w/ risk factors Elective major surgery w/o risk factors Prescription drug management IVF w/ additives Closed Rx of skeletal injury
High	1 or more chronic illness with SEVERE exacerbation, progression, or treatment side effects Acute/chronic illness that may pose threat to life or body (ix) Sudden neurologic change	CV imaging studies with risk factors Cardiac EPS tests Endoscopy with risk factors Discography	Elective major surgery with risk factors Emergency major surgery IV controlled drug Drug therapy requiring intensive monitoring DNR status

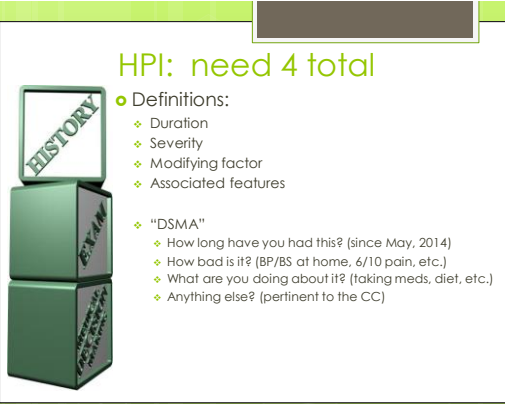
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Using Medical Decision Making to Bill the Visit: Supporting Documentation

The History Key Component

History of Present Illness

- Definitions:
 1. Location- place, whereabouts
 2. Quality- description, characteristic to define chief complaint (CC)
 3. Severity- degree, intensity, ability to endure, 1-10 scale
 4. Duration- length of time ongoing
 5. Timing- regulation of occurrence, when CC occurs
 6. Context- a circumstance or cause, outside factors
 7. Modifying factor- what makes it better/effects it, treatment plan adherence
 8. Associated features- other things that accompany or relate to the CC (ROS)

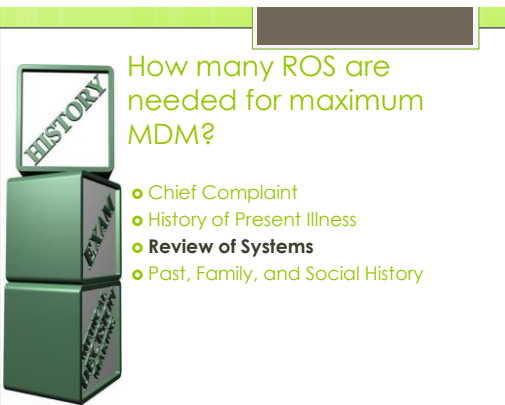


HPI: need 4 total

- Definitions:
 - Duration
 - Severity
 - Modifying factor
 - Associated features
- "DSMA"
 - How long have you had this? (since May, 2014)
 - How bad is it? (BP/BS at home, 6/10 pain, etc.)
 - What are you doing about it? (taking meds, diet, etc.)
 - Anything else? (pertinent to the CC)


History Types

<p>Problem Focused (PF) 99212</p> <ul style="list-style-type: none"> ✓ HPI 1-3 Elements <p>Expanded Problem Focused (EPF) 99213</p> <ul style="list-style-type: none"> ✓ HPI 1-3 Elements ✓ ROS 1 Element ✓ (HPI/ROS inclusive) 	<p>Detailed (D) 99214</p> <ul style="list-style-type: none"> ✓ HPI 4 or more, 3 chronic prob. ✓ ROS 2-9 systems/body areas ✓ PFSH 1 element <p>Comprehensive (C) 99215</p> <ul style="list-style-type: none"> ✓ HPI 4 or more, 3 chronic prob. ✓ ROS 10 or more ✓ PFSH 2 or 3 elements
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How many ROS are needed for maximum MDM?

- Chief Complaint
- History of Present Illness
- Review of Systems**
- Past, Family, and Social History



**ROS: 2=Detailed
10=Comprehensive (1/syst)**

- Constitutional
- Eyes
- ENT, mouth
- CV
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin and/or breast
- Neurologic
- Psychiatric
- Endocrine
- Hematologic/lymph.
- Allergy/Immunologic


History Types

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**PFSH: 1=Detailed;
2=Comprehensive (3, if new pt)**

- Past History
 - Major illnesses, operations, medications, allergies, immunization status
- Family History
 - Health status of relatives, diseases related to the problems addressed in the CC, hereditary risk factors
- Social History
 - Use of tobacco, alcohol, drugs; marital status, employment, living arrangements, education



**Clinically Correct Coding (C³) Concept:
Detailed History Mnemonic = 4 + 2 + 1**

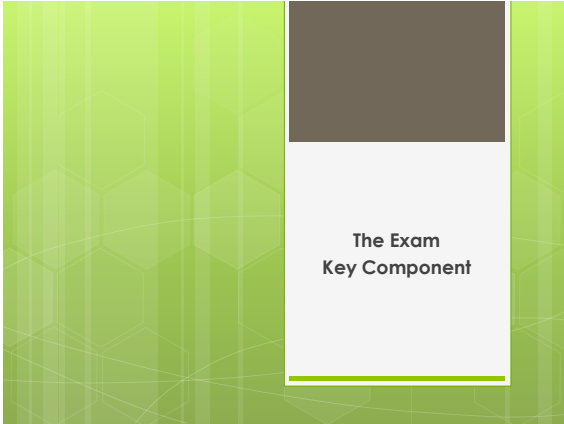
- From the History of Present Illness (HPI)
 - obtain **4 elements (DSMA)**
- From the Review of Systems (ROS)
 - obtain **2 pertinent elements**
- From the PFSH
 - Obtain **1 element** of the PFSH
 - Can be done by nursing
 - Remember: nonsmoker and medication list → count as **two** elements
- Equate to a **Detailed History (4 + 2 + 1)**
 - 99214, 99203, 99283, 99221, 99218, 99243, and the 99253 encounter
- C³ Concept:** *The 4 + 2 + 1 history should be the initial building block for histories taken at every encounter.*


History Types

<p>Problem Focused (PF)</p> <ul style="list-style-type: none"> ✓ HPI 1-3 Elements 	<p>Detailed (D)</p> <ul style="list-style-type: none"> ✓ HPI 4 or more, 3 chronic prob. ✓ ROS 2-9 systems/body areas ✓ PFSH 1 element
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The detailed (4 + 2 + 1) history

- 65 yo for f/u HTN. Diagnosed in 4/2001. Checking BP at home with ranges 120-135/75-85, never over 140/90. Checks 2x/wk by daughter (RN). Following diet and exercise and is med compliant. No CP, visual probs, SOB, DOE, or LE edema. No rash or HA.
- Meds: Lisinopril 10mg/d, ECASA 81mg/d, HCTZ 12.5 mg/d.





How do the exam's compare?

<ul style="list-style-type: none"> ● 1995 ● PE: 1 area examined ● EPE: limited of affected area and a related area ● Detailed: extended exam of one system and another related (2-7 systems) ● Comprehensive: 8+ systems examined 	<ul style="list-style-type: none"> ● 1997 ● PE: 1 bullet ● EPE: 6 bullets ● Detailed: 12 bullets from two or more systems ● Comprehensive: Complete exam, document 18 bullets from 9 systems
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General Multi-system Exam
Handout

C³ Concept Summary: Hx and Ex

- o For ALL histories
 - o **4 + 2 + 1 = Detailed** (99203, 99214, 99221, 99283...)
 - o DSMA for the 4 HPI
 - o Duration – Severity – Modifying Factors – Associated Features
 - o Associated Symptoms is bridge to ROS, so make it varied in its content to cover associated organ systems
 - o 2 ROS pertinent to CC
 - o 1 PFSH = Medication list OR allergies OR smoking status
 - o **4 + 10 + 2 / (3 for new pt) = Comprehensive** (99204/99205, 99215)
- o For examination
 - o 1997 rules ("bullet points") more defensible in audits
 - o 12 from 2 systems is Detailed, "touch everything" for Comp.
 - o 1995 rules 2 well documented organ systems/areas (Detailed)
 - o Be "clinically correct" in the examination content and avoid "include all" buttons
- o The Detailed history and exam often correlates with the level of medical decision making of primary care chronic disease management encounters

The Third Key Component




- o History
- o Examination
- o Medical Decision Making
 - o Diagnoses managed (number and type)
 - o Data reviewed to manage diagnoses of visit
 - o Risk associated with the management plan

Moderate (Detailed) Medical Decision Making (MDM)



- o IF you manage a prescription (risk), **AND**
- o There are three chronic, stable problems (3 points) **OR**
- o There are two chronic problems, 1 in need of medical management **OR**
- o There is one new problem, with no further work-up planned

THEN, there is **MODERATE** MDM



High (Comprehensive) Medical Decision Making (MDM)

- IF you manage a patient with three medical conditions and one is out of control

OR

- You manage two medical conditions and both are out of control

OR

- You manage a new problem and other diagnostics (CT, MRI, etc.) are needed to fully care for the patient

AND

- The illness(s) are such as severe respiratory distress, progressive severe RA, acute kidney injury, suicidal gesture/threats, seizure, TIA, sudden weakness, or acute MS change

THEN
That decision making falls in line with **HIGH** MDM

Risk: Practical Applications

Why is "risk stratification" important?

- VP of Clinical Integration:
 - "Dr. X, I sent you a copy of your latest report card and wanted to make sure you didn't have any questions about the summary."
- Dr. X:
 - "I got the report, but don't pay much attention to it because my patients are sicker than those of these other guys, so I expected worse than what that report says. So, I think I'm good, thanks."
- Is Dr. X right or is perception here not reality? Applying a clinical "risk score" may help clarify...

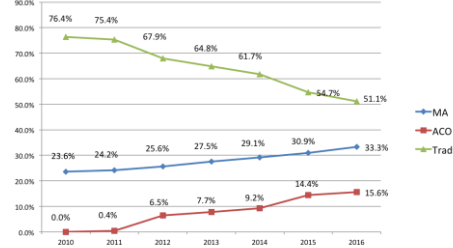
Why is "risk stratification" important?

- o Medical Director of health plan:
 - o "Dr. X, I sent you a copy of your latest report card and wanted to make sure you didn't have any questions about the summary. Your cost of care this quarter is far out of line and for your population of patients with Plan X, the severity of their chronic conditions does not seem to be present as we see it in other physicians of your specialty within the plan."
- o Dr. X:
 - o "I have no idea what you are talking about."

Why is "risk stratification" important?

- o In the world of "population health management", the practice of medicine is being defined as
 1. Best quality
 2. Most optimal cost (cheapest)
 3. Satisfied patients
 4. Satisfied providers (physicians, NPPs, facilities)
- o ...with a realization that sicker patients will cost more to care for and thus, a "weight" or "risk score" is needed to apply that cost credit to be fair to those who have this population.

Trend: Fee for service Population management



Risk Adjustment

- Risk adjustment accounts for patient differences that can affect their medical costs, regardless of the care provided
- Risk adjustment is a method of adjusting payments to health plans or individual providers, either higher or lower, to account for the differences in expected health costs of individuals
- The process accounts for known health conditions which then allow for comparison of "wellness" amongst patients
 - Diagnosis codes are used to determine potential risk
 - Used to predict cost of care and quality of care

Risk Adjustment

- Used to evaluate and compare health plans or to adjust payment to health plans based on the health status of the population the plan is managing
 - Higher payments for enrollees at risk for being sicker
 - Lower payments for enrollees predicted to be healthier
 - CMS is able to pay more appropriately for the beneficiaries being covered in MA plan instead of the average amount for all Medicare patients
 - MA plan must submit proof each year of quality, risk—much of which is garnered from our diagnosis codes
 - BMI, DM w chronic complication, Stage IV CKD, etc.

A risky "game" ...?

- Some call this "playing the game"...*but, this is no game*. This is the business of medical economics.
- This is the clinically correct application of a disease state to show the severity of the patient's condition with an eye to predicting how much they will cost to be cared for during the year.
- But, some health plans are accused of "gaming the system"
 - US Senator Chuck Grassley (R-Iowa) challenged Seema Verma (new CMS Admin) on answers to charges that CMS has improperly paid MA plans due to unsupported risk score calculations (§70 B 2008-13)

Risk Adjustment and YOU

- Used to evaluate and compare YOU to evaluate the cost of care and the quality measure attainment of the patients attributed to YOU compared to your peers.
- Higher risk score translates into higher premiums paid by CMS for the patient's care. If care is appropriately managed, then there are monies left over (profit) for the plan (or bonus opportunities for the provider)
- Lower risk scores associated with high cost is indicative of a provider of poor clinical management or poor abilities to appropriately document the clinical picture
- "Panel size shrunk"

Diagnosis Based Risk Adjustment Models

- Hierarchical Condition Category, Part C (CMS-HCC)
 - Medicare Part C (Medicare Advantage)
- Health and Human Services HCCs (HHS-HCC)
 - Some commercial, individual and small group plans, Some health exchange plans
- Chronic Illness and Disability Payment Systems (CPDS)
 - Medicaid
- Diagnosis Related Groups (DRGs)
 - Inpatient

Diagnosis Based Risk Adjustment Models

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Hierarchical Condition Category, Part C (CMS-HCC) for MA Plans

- Demographic variables come into play with HCCs
 - Age on 02-01 of the payment year
 - Gender
 - Disability status
 - Disabled beneficiaries < 65 living in community
 - Original reason for entitlement
 - Identifies those over 65 who "disabled into Medicare" before 65
 - Medicaid or low-income status
 - Medicaid eligible for one month or more in data collection year
- These variables usually collected at registration. We need to document chronic conditions that need ongoing monitoring
 - HCCs are ICD-10-CM disease codes that are related clinically and have similar cost implications
 - 79 HCCs in most recent version

ICD-10-CM Diagnoses: Basis

- All clinical conditions that affect the patient are to be assigned each year as CMS does an annual "clearing of the slate" for each patient
 - "The leg does not grow back"
- The diagnosis needs to be supported by the documentation
 - Multiple chronic conditions with resultant elevated HCC risk score, but only one 99213 office visit all year
- The diagnoses are additive to get the HCC score
 - So if it is clinically pertinent, make sure that the diagnosis is "active" (on the bill) at least once a year (MWV)
- CMS also uses HCCs to risk adjust patients in some quality programs (readmissions)
- But, not all diagnosis codes are linked to HCCs
 - The codes that help predict cost the most accurately are
 - The most serious manifestations of a condition is considered

HCCs: "Outpatient DRGs"

- Based on **inpatient and outpatient** documentation and coding of certain diagnosis codes within a calendar year
- Numerical value for each diagnosis is added to produce the risk adjusted factor (RAF)
 - Average patient of average health RAF = 1.0
 - Healthy patient RAF < 1.0
 - Patient with multiple illnesses RAF > 1.0
 - \$\$ assigned to these numbers, adjusted yearly
 - ~\$9,350/1.0 for most recent survey

● HCPro Risk Adjustment Boot Camp/RTI CMS data 2013-14. Accessed 03-2017

65 yoF, breast CA hx, tamoxifen, BMI 41

	No noted illnesses	H/O Br CA	Br CA, Rx or present	BMI 41, no "overwt"	
65 yo Female	.306				
H/O Br CA					
Br CA, Rx or present					
BMI 41 dx noted					
TOTAL RAF	.306				
Premium	2,861				

The BMI discussion

- More than just a number
- CMS Quality Metric
 - Note, assess and provide a treatment plan
- Need to reassess each year
- Put the right ICD-10 code down (use the BMI)
- Medicare Wellness Visit strategy

65 yoF, breast CA hx, tamoxifen, BMI 41

	No noted illnesses	H/O Br CA	Br CA, Rx or present	BMI 41, no "overwt"	
65 yo Female	.306	.306	.306	.306	
H/O Br CA		0			
Br CA, Rx or present			.143	.143	
BMI 41 dx noted				.268	
TOTAL RAF	.306	.306	.449	.717	
Premium	2,861	2,861	4,198	6,703	

Documentation is key

- Paint the picture with words to show the patient's condition (highest degree of clinical specificity) and associated conditions that are affecting this diagnosis - Diabetes *with neuropathy*
- Describe what you are doing, what is planned, why your are concerned
 - "Think in ink"
 - "Afib is stable on Cardizem."
- "History of" means the patient no longer has the condition. Be aware of conflicting verbiage
 - History of COPD, stable on Breo
- Update this at least once a year

Current vs Personal History of CA

- When a primary malignancy has been excised but **further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site**, the primary malignancy code should be used until treatment is completed
 - For liquid cancers, indicate whether the malignancy is active, in remission, or in relapse
 - History of a leukemia implies that it is cured.
 - For solid cancers, any patient receiving adjuvant treatment should be documented as being active, not a "history of malignancy"
- When a primary malignancy has been previously excised or eradicated from its site, **there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy**, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Disease state: Diabetes

- 57% of diabetics have systemic complications
 - 42% none
 - 33% one
 - 10% two
 - 14% three or more
- Document the Diabetes type
 - DM type I is **E10**
 - DM type II is **E11**
 - DM secondary to chemical (**E09**), underlying condition (**E08**), related to other condition (**E13**)
- The control status: hypo-/hyperglycemia
- Complications: nerve, eye, GI, renal, etc.
- Treatment, especially if with insulin

Diabetes HCC score

- Diabetes with acute complication 0.312
 - BS 322, A1c 10.1
- Diabetes with chronic complication 0.312
 - DM with B peripheral LE numbness mid-foot distally
- Diabetes with no complication 0.102
 - 47% of the time

- The difference annualized with the correct HCC is 0.210 or \$1,963 each patient that falls into this category
 - For 100 patients is \$196,350 over a year

How to code the visit...

- 67 yo DMII with FSBS 299. Bilateral peripheral diabetic neuropathy on Neurontin. Also with stage IV CKD from DM as well (ACEI). Has seen neurology and renal medicine.

- E11.42 Type 2 DM with Diabetic with Hyperglycemia
 E11.65 Type 2 DM with Diabetic Polyneuropathy
 E11.22 Type 2 DM with Diabetic chronic kidney disease
 N18.4 Chronic Kidney Disease, stage 4

Disease State: CKD

- Avoid Chronic Kidney Disease, unspecified if stage is known
- CKD is defined as either
 - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
 - GFR: At least 2 eGFRs < 60 cc/min/1.73m² for > 3 months
- Stage I normal, GFR > 90ml/min
- Stage II mild, GFR 60-89ml/min
- Stage III mod GFR 30-59 ml/min
- Stage IV severe GFR 15-29 ml/min
- Stage V kid. failure with < 15 ml/min

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Key areas to not miss (yearly)

- o Amputations (AKA, BKA, toes) and how it affects functional state
- o BMI, especially over 40, with a plan to address (med, RD session, lifestyle plan, etc.)
- o Malnutrition: documentation is key
- o Ostomy: urostomy, cystostomy, tracheostomy, ileostomy, gastrostomy with a status/condition
- o Transplanted organs: heart, liver, lung, pancreas, bone marrow, etc. with a status of the condition
- o Functional quadriplegia: complete inability to move due to disability (not neuro). Usu dementia. Lack mental function to move. "total care", "bedridden".
- o Co-morbid interaction of disease states

Combination condition and risk

- o Certain disease states have elevated risk because when seen together clinically added cost of care is realized
 - o CHF and COPD 0.186
 - o CHF and Renal disease 0.266
 - o CHF and cardiac arrhythmias 0.103
 - o CHF and DM 0.151

Case Discussion

- 65 yo F with a history of DCIS with microinvasion of R breast (neg LN). Stable x 5 years on Tamoxifen. The patient is a former smoker, none for 8 years, but carries a diagnosis of COPD, stable on steroid MDI, rare rescue MDI. Developed afib 3 years ago and is chronic afib, rate controlled with Cardizem and low dose Toprol. Could not manage the Coumadin nor afford other agents. On 325mg ASA. Losing weight past 3yr despite supplements and you have diagnosed her with malnutrition. DM on mefformin ACEI, and Micronase. A1c 6.1, but with RLS and paresthesias to toes bilaterally. Stable x 5 months.

Score the HCC

Risk factor	No chronic conditions	Cancer of Breast	COPD	Malnutrition	Chronic Afib	DM w complication (w/o)
65 y/o female Community-based	0.299	0.299	0.299	0.299	0.299	0.299
Hx of Breast CA	0.000					
Cancer breast present or Rx'd		0.158	0.158		0.158	0.158
Malnutrition				0.731	0.731	0.731
DM w Chronic Complication (w/o)						0.312 (0.102)
COPD			0.322	0.322	0.322	0.322
Chronic afib					0.264	0.264
Total RAF score	0.299	0.457	0.779	1.211	1.475	1.787(1.577)
Predicted Annual Cost	\$2,782	\$4,252	\$7,248	\$11,277	\$13,724	\$16,628/ (\$14,674)

Closing comments

- The risk score optimization...
 - Is set to garner the appropriate amount of monies into a health plan to manage the patient so profits may be realized when care is optimized
 - Can benefit the medical group/system when bonuses are tied to "savings"
 - Can be leverage for the medical group to use in contract negotiation with plans, especially if you have a track record
 - Can be a market strategy used against competitors... "our patients are sicker than the average, but our quality scores rank higher than most".

Thanks!

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