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RISK-BASED DOCUMENTATION AND CODING

Why Are These High-Stakes Healthcare Topics Today? And What Is It That Providers Need To Be Doing?

Most people who work in and around health care already understand, at least at a high level, the concepts of documentation and coding in a fee-for-service context. Physicians have to document every service so that they and their organizations can be properly paid for the work they do.

But move coding and documentation into a ***risk*** context, and many key nuances change in ways that even savvy, experienced health care professionals may need a bit of help getting up to speed with – and it is critical that they do so because in the realm of value-based care, these topics carry a significant new load. They're politically sensitive, make-or-break for strategy and provider/payer finances, and carry high regulatory and legal stakes.

This FAQ directly addresses healthcare stakeholders who need a quick conceptual boost or refresher on the overall topic terrain of documentation and coding, specifically in the context of risk or value-based care. It answers questions such as:

- Why is there so much intensity around these topics?
- What ***is*** the problem? Under-coding? Over-coding?
- In order to hit the universal goals – correct, thorough, and compliant risk-based documentation and coding, what should providers be doing?

The issues of risk-based documentation and coding

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Risk and value-based care contracts were designed to move health care AWAY from per-click service economics, which would seem to make exact documentation in every patient visit LESS of a big issue. **Why is there so much intensity around the issues of risk-based documentation and coding?**

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Correct and thorough documentation and coding are both crucial in risk contracts for three big-picture reasons:

1 In any form of modern health care risk economics, having a correct **severity adjustment (aka risk adjustment) for a given patient/population will make or break the organization's financial performance under the terms of the contract.**

All contracts that revolve around reducing total costs must include some mechanisms to prevent adverse patient selection – providers or plans 'cherry picking' the healthiest, least-costly patients and avoiding the highest-cost patients. **Severity adjustment** (higher payment for higher-cost/complexity patients and populations) **is that mechanism.** It ensures that the organization is **fully paid for caring for patients whose conditions are more complex,** making them more costly to treat. **Clinical documentation and coding, together, are the keys to severity adjustment.**

The key to documenting and coding accurately for the correct severity adjustment is capturing and properly supporting not only all diagnoses, but the specific, and relatively small subset of patient diagnoses that qualify as Hierarchical Condition Category (HCC). HCC refers to **conditions that trigger higher reimbursement to reflect the assumed higher cost of caring for that patient under the value-based contract.**

2 All risk contracts come with **quality and cost-related performance metrics.** A provider is much more likely to be able to hit both types of goals – keeping chronic conditions managed, closing care gaps, and preventing avoidable admissions, if the information in the clinical record makes it obvious to the care team what conditions patients have that need addressing, gaps that need closing, etc.

3 Given the financial incentives for capturing patient complexity through documentation and coding, **policymakers and regulators are keenly focused on making sure that no entity is 'over-coding'** – submitting codes for conditions that increase the risk adjustment factor **without the patient record reflecting proper documented support for those (higher-intensity) codes.** This makes it even more important for clinicians to ensure they are documenting and coding conditions in a way that is accurate, thorough, and compliant with regulations. (See further discussion below.)

The risk adjustment mechanism in Medicare value-based contracts is known as the **"RISK ADJUSTMENT FACTOR"**, which goes by "RAF". More thorough documentation and coding often results in a "RAF lift".

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When talking about risk-based documentation/coding, what contract types are we probably talking about?

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Commercial and Medicaid risk contracts exist and require severity adjustment, but the majority of risk dollars and energy today are focused on one of two types of Medicare risk contracts – the Medicare Shared Savings Program (MSSP, now known as Pathways) or a Medicare Advantage contract.

The HCC system is specific to Medicare risk contracts, so by using the term **'HCC'** in a discussion of risk documentation and coding, one is rhetorically excluding risk contracts that are commercial, or Medicaid. However, in non-Medicare value-based contracts, risk-adjustment methods will tend to be based on similar concepts and rules.

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If we're talking about risk-based documentation and coding, what PROVIDERS/SITES OF CARE are we most likely referring to?

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Ambulatory sites, and most likely primary care/multi-specialty medical group clinics. Participating PCP/multi-specialty groups may be independent, part of a health system or part of a national chain.

These providers/sites of care are the focus because provider-patient interaction at these sites is considered a powerful opportunity for the active and ongoing management of longer-term, chronic conditions (and therefore inflection point for driving down overall avoidable cost). As a result, this part of the care continuum is where the most risk-based contracting activity is concentrated. These are also the providers with the biggest lift in front of them when it comes to learning how to do risk-based documentation and coding correctly.

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Is there a big national problem with providers systematically over-coding?

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'High code intensity' is one of a series of drivers that industry experts have flagged as a cause of over-payments by CMS to the Medicare Advantage program as a whole. And CMS is definitely cracking down on this form of potential fraud, waste and/or abuse. Audits have been triggered, payments have been clawed back, and false claims act suits have been brought.

The core issue here is that without strong systems to
That said, most providers are not systematically adding inappropriate codes to the patient record for financial gain. When providers add diagnoses without merit, very often the cause is not malfeasance, but

There is a specific kind of audit that plans and providers are concerned about in this terrain. It's called a **risk adjustment data validation (RADV) audit (pronounced "rad-v").**

"rad-v"

human error. Or, more constructively – weak systems. Few provider organizations have achieved a practice environment in which it is easy for physicians to do risk-based documentation correctly and thoroughly.

To improve at risk-based documentation and coding, healthcare as an industry must look back at its hard-won lessons when it comes to systems thinking – engaging in systems thinking, and looking for ways in which systems are failing physicians who are doing their best to care for patients, and who generally have not been fully trained or supported when it comes to risk-based documentation and coding, and conventional metrics of safety/quality.

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If most providers have considerable room to improve on risk-based documentation and coding accuracy, and we don't have a problem with rampant over-coding, is the problem then rampant under-coding?

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The core issue here is that without strong systems to support physicians in risk-based documentation and coding, it is difficult to code thoroughly and correctly in either direction. In other words, because mistakes are common, both over-coding and under-coding are also common. That means ANY GIVEN provider organization is probably at risk of inadvertently, across its many individual providers and care teams, doing both.

- Some individuals in the organization are adding codes without fully thinking through whether the clinical documentation evidence base is there.
- Some individuals are overlooking or hesitating to add codes even when warranted.

Unfortunately, these diametrically different types of error **do not cancel each other out.** Provider organizations with weak risk-based documentation and coding systems are BOTH leaving money on the table under the terms of the risk contract, AND leaving themselves open to the risk of an audit, claw-back and/or adverse judgment in a lawsuit.

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Coding and documentation improvement efforts, technology, whole departments, and a massive services/technology support sector have been around forever. What exactly is making documentation/coding so hard to do correctly under VBC?

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Physicians are consistently juggling too many different tasks. Risk-based documentation and coding rules are very complicated, vary from condition to condition, and are substantially different from fee-for-service coding rules.

Even when insurers, provider organizations, or vendors have tried to help by way of tools such as pre-visit lists of potential care gaps and diagnoses for a given patient, those supports do not help unless they are well designed and executed – which many are not. Many of these tools include too many overall items, with low- and high-merit items mixed together. That overwhelms the physician and any other member of the care team tasked with identifying clinical gaps that need closing.

What to do about it

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Provider organizations need to fix both under-coding and over-coding across all physicians, sites and teams. GENERALLY, what's in the playbook?

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How much time do you have? This document will never hold all the strategic and tactical keys to correct and thorough documentation and coding for risk contracts, but here are some essential building blocks to start with:

1. **A robust data management process within the clinical process.** This kind of data doesn't thoroughly gather and rigorously process itself. It requires dedicated teams, technology, and a new multi-step process that surrounds the patient visit. It will be necessary to invest resources, time and energy into performance analysis/monitoring across this new process continually eliminating blind spots, spotlighting performance shortfalls, and remediating problems at every step along the way.
2. **Prioritized provider-facing lists of potential care gaps/diagnoses for each patient.** Today not all physicians are receiving these kinds of lists. Among those who are, many are receiving lists that are not streamlined enough to be actionable. The two key requirements are a very wide funnel for all the relevant data and a powerful winnowing mechanism of some kind such as, but not limited to, AI solutions.

   By the way, it's not only the physicians you need to avoid overwhelming; it's also the other staff (care managers, coding and documentation improvement (CDI) professionals). When they are overwhelmed, both over-coding and under-coding can result.

   Narrowing down to only the most-founded items has another benefit; it communicates to everyone in the organization that pre-visit support processes are both clinically sophisticated and principled.
3. **Effective physician learning.** Most providers are going to need a new, pretty major capability around risk-based education and continuing improvement. At this point, most providers with VBC contracts should be at least doing the basics – a kickoff educational session on core concepts, and meeting a defined standard to be considered complete – documenting how the condition is being Monitored, Evaluated, Assessed, and Treated (M.E.A.T.)

Where most providers may be falling short is on additional educational features beyond the initial introduction:

- Make sure each physician who joined after the official dedicated kickoff is also getting that same content.

- Make this education ongoing/iterative. Backsliding is guaranteed, but risk documentation and coding needs to be a hefty part of one or more ongoing meeting series.
- Close the coder feedback loop. Showing physicians where, for what populations, and in what ways the group's documentation tends to be correct (don't forget to celebrate the wins!), and where it is tending to miss the mark.
- Make practical, risk-condition-specific lessons about the conditions that are both contract-relevant and common. Show physicians what an accurate representation of that condition tends to look like versus where inaccuracies tend to creep in. Put documentation opportunities in the context of the standard workflow for that specific patient type.

4 **Make 'Deletions' an essential part of new systems, processes, and everyone's coding integrity mindset.** When plans or providers have experienced adverse judgements and penalties for value-based care over-coding, the red flag is often that activities and systems that purport to ensure 'documentation and coding integrity' all seem to add diagnoses to the bill and never remove any.

When plans or providers have experienced adverse judgements and penalties for value-based care over-coding, the red flag is often that activities and systems that purport to ensure 'documentation and coding integrity' all seem to add diagnoses to the bill and never remove any.

BOTH to avoid being on the wrong side of this issue, AND to ensure the whole team is looking at a streamlined, well-prioritized opportunity list (which will yield better quality and financial results), organizations must excel at building processes and staff education that explicitly teaches how to remove unfounded (or resolved) diagnoses from the patient record.

At the executive level, check to see if everyone has the right mentality by taking a look at what's happening when the organization does risk contract financial planning related to coding and documentation. For example, when the team is considering investing in a resource (tech, internal teams, campaigns, or outside services) to support risk-based documentation and they're trying to forecast the ROI of all this, are they building in assumptions that reflect needed subtractions as well as additions of diagnoses? If yes, that team has a balanced, accuracy-focused mindset and is in a good position to reap benefits – including financial, reputational, and increased clinical 'street cred' with physicians.

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If a provider organization does all this, will it succeed under value-based care?

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It's time to take a large step back. This whole discussion has taken place within the rabbit hole of **risk-based documentation and coding**, which is a critical piece, but only one piece of the larger puzzle that is success under value-based care.

WIth that in mind, investing in an organization-wide transformation around risk-based documentation and coding is necessary, but not sufficient, for overall success under value-based care.

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