How to Boost Your VBPM with ICD-10

written by Dave Halpert | August 26, 2015

With five weeks until ICD-10 becomes official, take note: Your transition strategy must include PQRS and the Value-Based Payment Modifier (VBPM). Neglecting VBPM in your short-term plan may lead to long-term penalties. That now goes for everybody, whether you helm an Academic Medical Center or run a small practice.

October 1, 2015, marks the starting date of the new coding set for diagnoses and inpatient procedures. ICD-10's increased specificity dovetails with how medicine is practiced today, versus the 36-year-old ICD-9 coding. Given a choice between implementation and lost revenues, practices will have no option but to make the transition.

As you make the change, remember that revenue and reimbursement can take different shapes. Understandably, most groups are focused on ensuring that they are compensated for the care they've delivered. For patients on Medicare, this is defined in the Medicare Physician Fee Schedule. However, that schedule also defines overarching adjustments, positive or negative, based on reporting and performance in Medicare's quality programs—namely PQRS and VBPM. And therein lies the rub.

Take heart. It is possible to transition to ICD-10 without forfeiting your quality reporting success. By embracing the specificity within the system, rather than running from it, you will be in a better place to optimize your Value-Based Payment Modifier. Here's how:

ICD-10 Can Create More Accurate Risk Adjustments

Yes, it's true that greater specificity means more codes. That has been one of the greatest challenges in implementing the program: practices are concerned that they will be paralyzed by the sheer number of options. Realistically, we all know that the entire code set won't be

used by each group; just as each practice doesn't use the entire library of ICD-9 codes, they will not need to know each ICD-10 code. Nevertheless, there is still concern that these additional options will end up hurting productivity, and people will begin to look for shortcuts, particularly the General Equivalence Mappings (GEMs).

Here's the risk of using GEMs as your lone tool for the ICD-10 transition: while GEMs will help ensure that you are using the correct family of codes, they will not help you to define your patients' conditions. You will deprive CMS of the ability to accurately risk-adjust your patients, and that may be detrimental to your VBPM. In other words, in an effort to make the transition less painful, you've actually put yourself at a disadvantage.

To understand why, consider how Medicare will calculate your VBPM. They create two composite scores, one for cost and one for quality. Those with high costs and low quality are penalized, and those with low costs and high quality are rewarded. However, before making its final calculations, CMS will account for your patients by adjusting their risk compared to others.

Risk Adjustment and the VBPM Quality Composite

Your quality composite is based on your performance on the measures you report for PQRS, along with three outcomes measures Medicare calculates from its claims, for your attributed patients:

> Ambulatory Care Sensitive Condition (ACSC) Admissions for Acute Conditions
> Ambulatory Care Sensitive Condition (ACSC) Admissions for Chronic Conditions
> All-Cause Re-Admissions

The claims-based outcome measures are where your risk adjustment becomes critical. CMS will look at each score and then adjust it according to, in the simplest terms, the overall health of your patients. When analyzing your coding, if CMS determines that your patients are at a higher risk than your peers, you will be graded more leniently. You may have had a raw average of 50 patients per 1,000 admitted for diabetes, but Medicare may assign you a score of 40, if they see that your patients have a higher "relative burden of illness." If you've used precise coding when diagnosing patients, CMS will be in a position to more scientifically score your patients' outcomes, relative to others.

Risk Adjustment and the VBPM Cost Composite

CMS also adjusts for risk when calculating cost composites. The cost composite is determined by looking at all of the costs your attributed patients incur, regardless of the setting. The cost composite is the aggregation of scores for patients in the following categories:

> Per Capita Costs for All Beneficiaries

Per Capita Costs for Patients with Chronic Conditions (scored individually, and then rolled up, for patients with diabetes, coronary artery disease, heart failure or COPD)
Medicare Spending Per Beneficiary (MSPB), where costs are tracked three days prior to admission through 30 days after discharge.

Like the quality composite, CMS risk-adjusts the cost composite to account for severity. Your per capita spending on a patient with diabetes may be $20,000, but if CMS has calculated that your patients are in a higher Hierarchical Condition Category (HCC), your composite could be based on a score of $15,000. This may put you in a more advantageous cost tier, and mean a better VBPM.

Risk Adjustment Fallout

Conversely, in both quality and cost composites, those who do not use ICD-10 to accurately define a patient's condition may find themselves at greater risk. For example, a provider may have a population at high risk, one that could legitimately qualify for a 25 percent reduction on the metrics for admission per 1,000 beneficiaries, or per capita costs. However, without precise coding, Medicare will not have the information to make this correction to its VBPM scoring, resulting in a provider's disadvantageous position because of grading on the wrong scale.

ICD-10 and Performance Improvement

There is no doubt that assembling the additional detail to code precisely will be challenging, particularly this year. However, utilizing the additional options under ICD-10 can actually save time down the road, particularly when it comes to improving performance. Those who are able to lower costs, reduce ACSC admissions, and improve performance on PQRS measures are raising the bar for everyone. With limited time to develop plans and facilitate improvement, it is critical to be able to know which patients need what type of support. A massive email campaign may be wonderful for informing patients that influenza immunizations have arrived, but are less helpful when dealing with the nuances of a particular condition. This is where ICD-10 can help.

Let's look at pressure ulcers, more commonly known as "bed sores." These can lead to serious complications, becoming so deep that they can damage patients' muscles and bones, and may result in infections that spread throughout the body. As damage occurs and infection spreads, the patient's quality of life plummets while health care costs surge. In ICD-9, there are 9 location codes for pressure ulcers, but nothing that defines the depth/stage of the ulcer. By contrast, in ICD-10, there are more options, giving you the ability to denote stage, as well as more detailed location.

With time at a premium, this information can help you and your Registry more quickly identify

which patients should be the focus in your quality improvement program. You will be able to spend more time delivering care and less time trying to determine which patients should be included in the program you and your Registry have developed.

Reporting More Detail Is a Competitive Advantage

Few expect the transition from ICD-9 to ICD-10 to be easy and without hiccups. Strictly speaking, PQRS should not change, although measure denominators will only include ICD-10 codes, and that's what you will be using, starting on October 1, 2015. PQRS measure specifications have already defined which ICD-10 codes should be used in each denominator, which will reflect how you are required to bill.

VBPM is tied to PQRS, but is a separate program, and the impact of ICD-10 on your VBPM is more variable. While you should not "up-code," or add artificial severity in your coding, additional detail available in ICD-10 can be beneficial, both for understanding your patients' current status, and identifying goals for improvement. It may be more work at first, but those who are able to embrace the nuances of ICD-10 will put themselves in a comparatively better position than those who do not. Improvement does not come from complacence, and it's time to move to the next level.

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