Thriving in a Value-Based Program

Appropriately capturing clinician's work. HCC, RAF and Quality.

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Key Words

- **Fee for Service** = Quantity (Old Model)
- **Value Based Program** = Quality (New Model)
- **RAF** – Risk Adjustment Factor. A score representing the payer risk associated with a patient's demographic and clinical data that has been captured this calendar year.
- **GAP** – a score of potential conditions/diagnosis' that have been billed in the previous 3 years, but not in the current year nor have they been dismissed as historical.
- **HCC** – Hierarchical Condition Categories (HCCs) are groupings of ICD-10 diagnosis codes for active and chronic conditions. Medicare and other payers use HCCs to calculate patient risk scores and predict costs, which inform provider organizations' reimbursement and performance benchmarks.
- **Patient Allotment** – Amount of money allocated for patients' treatment of medical expenses paid by insurance based on total RAF from previous year.
- **ACO – Accountable Care Organization**
  - ACO is a third party from Medicare. An ACO agree to work together with Medicare to give patients the best possible care.
  - An ACO is a group of health care providers who take responsibility for the total cost and quality of care for their patients, and in exchange they can receive a portion of the savings they achieve.
  - SCHC's ACO is **PEARL**

Goals

- January 1st of every year - patients RAF score starts at ZERO
- Our goal is to accurately diagnosis our patients as we *rebuild their RAF scores* to reflect how healthy the patient is
  - Utilize the most specified diagnosis
  - No More than **12** diagnoses are allowed on a claim
- Shorter more frequent touches with patients are vital to decrease in Hospitalization rate
- We bill off complexity which is the clinical documentation for MDM – Medical Decision Making
  - Excluding specialty providers like Psych, Social Workers and Dieticians
- All time outside of MDM (Medical Decision Making - listed in the A/P) should be captured as CCM time (this includes F2F and Nf2f activities)
- If patient does not qualify for CCM service, like commercial – please, stick to 15-minute visits at frequent touches
- Organize patients' problem list – Move specific clinical diagnoses to appropriate Categories
- After capturing RAF conditions – Complete Quality Measures and Screening (Quality and Support Team are assisting with these)

Overview of VBP

- Jan.1st 2023, provider see's a patient for the first time in the new year.
- 1. The provider would choose the most specific diagnosis.
- Ex: Which one is more specific and accurate to the patient? B
  - A. E11.9 Type 2 diabetes mellitus without complications (weight 0.105)
  - B. E11.22 - Type 2 diabetes mellitus with diabetic kidney disease (0.302)

***Note: Dual Diagnosis such as DM w/CKD needs to have both conditions addressed. Must add CKD, stage __ diagnosis as well. Are they on dialysis?

- 2. After the visit has been billed and processed through insurance, E11.22 will be captured stating that the patient has diabetes (HCC 85). The weight of that condition 0.302 will be added to patient's RAF score. GAP score will decrease for each condition captured and reviewed.
  - RAF should increase and GAP would decrease over the year

Overview cont.

- 3. Once the condition is captured, the quality measures and screenings will populate for the provider to complete throughout the year, proving adequate care is being provided.
  - Ex: Has the patient had the retinal exam? Is A1C checked every 3 weeks? Etc.
- If provider stays up to date with the patient with shorter and more frequent visits, the patient should not be hospitalized.
- If provider captures all the GAPs (diagnosis') to prove the patient's quality of health, RAF score, and treats the conditions appropriately by completing the quality measures → it will be a successful year in the ACO program

Reminder: Add additional codes describing conditions and capture Z codes (like dialysis or malnutrition)

Ex: Type 2 DM w/ Complications → what are the complications?

CKD, stage 5 → are they on dialysis? GFR?

Capture the Accurate Diagnosis

The provider must decide if the suggested condition is resolved, misdiagnosed, active, or historic:

- There may be inaccurate conditions listed from other physicians. If the patient has not had the stated condition, please properly dismiss the diagnosis with a note explaining why.
- If the condition is resolved, then please do not add it to the encounter or visit. Providers should not capture resolved issues like an acute UTI from a year ago that was resolved with a round of antibiotics.
  - If no longer active during the visit, please make this a ***Historic code*** → *'History of..'* or *'old'*
- Please verify if a condition is still active. If it is an ongoing active problem, provider will need to address, capture, treat, and bill for this diagnosis.
  - There will be some conditions that have *residual or sequalae effects* which have their own code. In these cases, please utilize the ***Subsequently code*** → '*Sequelae* of (late effects)..'

Importance of Accuracy:

Risk Marker	Incremental Prediction (sample rate $1,000 * risk factor)	Relative Risk Factor
Scenario #1 (deficient documentation and coding)		
Female, age 75-79	$457	0.457
Diabetes Mellitus	$162	0.162
UTI	$0	0
Total	**$619**	**0.619**
Scenario #2 (same patient – accurate documentation and coding)		
Female, age 75-79	$457	0.457
Diabetes Mellitus w/ renal manifestations	$508	0.508
UTI	$0	0
Diabetic Nephropathy	$0 (only one HCC in same category)	0
CKD Stage 3	$368	0.368
Mild degree malnutrition	$856	0.856
Old MI	$244	0.244
BKA Status	$678	0.678
Total	**$3,111**	**3.111**
Difference	**$2,492**	**2.492**

Capture the Accurate Diagnosis

Example conditions to look closely at:

- MI (Myocardial Infarction - Heart Attack)
- CVA/TIA (Cerebrovascular Accident/Transient Ischemic Attack - Stroke)
- Cancer – Malignant Neoplasm
- Brain Injury
- DVT/PE (Deep Vein Thrombosis/Pulmonary Embolism)
- Wound Care

Active Condition – While some conditions develop slowly and exist over extended periods, others develop suddenly and last a short time, often only a few days or weeks. It is appropriate to report an acute condition when it is present and actively being treated.

Historical Condition – Once an acute illness has resolved, it should no longer be reported as active. ICD-10-CM (diagnosis codes) recognizes the need to report the occurrence of past conditions that no longer exist and has provided personal history codes for this purpose.

Active vs Historic

Examples	Do not use	Use
Patient seen in office, follow up for stroke	**I63.-** Cerebral infarction	**I69.-** Sequelae of cerebral infarction **Z86.73** Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
Patient seen and noted to have “history of XXX cancer” but no current evidence of disease or current treatment	Code indicating malignant neoplasm, starting with the letter C	Code from category **Z85.-,** Personal history of malignant neoplasm
Patient seen > 28 days after an acute MI	**I20.-, I21.-, I22.-** Current MI	**I25.2** Old myocardial infarction

Cost Containment

Good Examples:

Patient A:
On SCHC service: 54 months
Allotment: $469,878
Total cost: $64,432

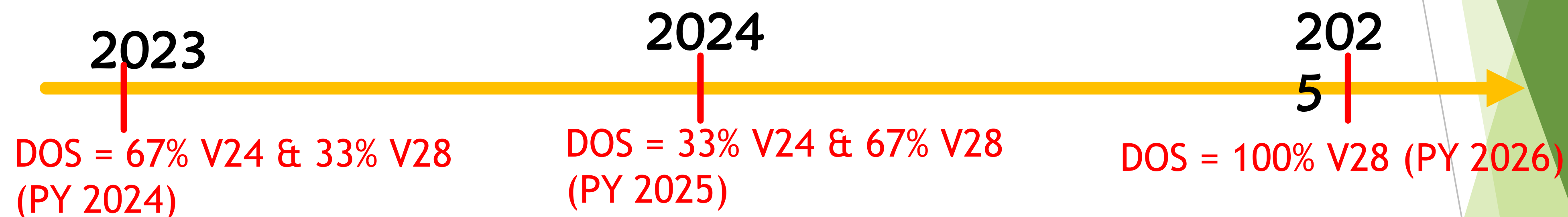
Patient B:
On SCHC service: 38 months
Allotment: $309,704
Total cost: $650

Bad Examples:

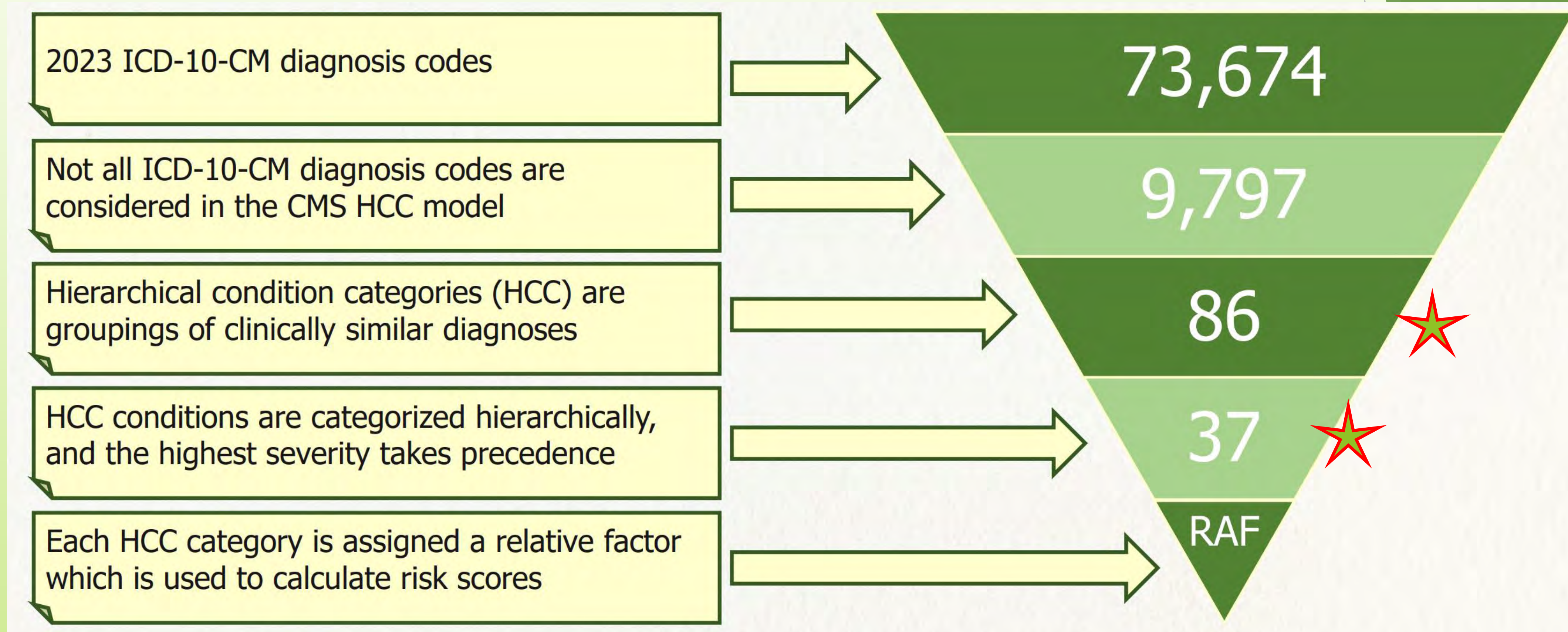
Patient C:
On SCHC service: 13 months
Allotment: $145,886
Total cost: $315,018

Patient D:
On SCHC service: 16 months
Allotment: $50482
Total cost: $215,475

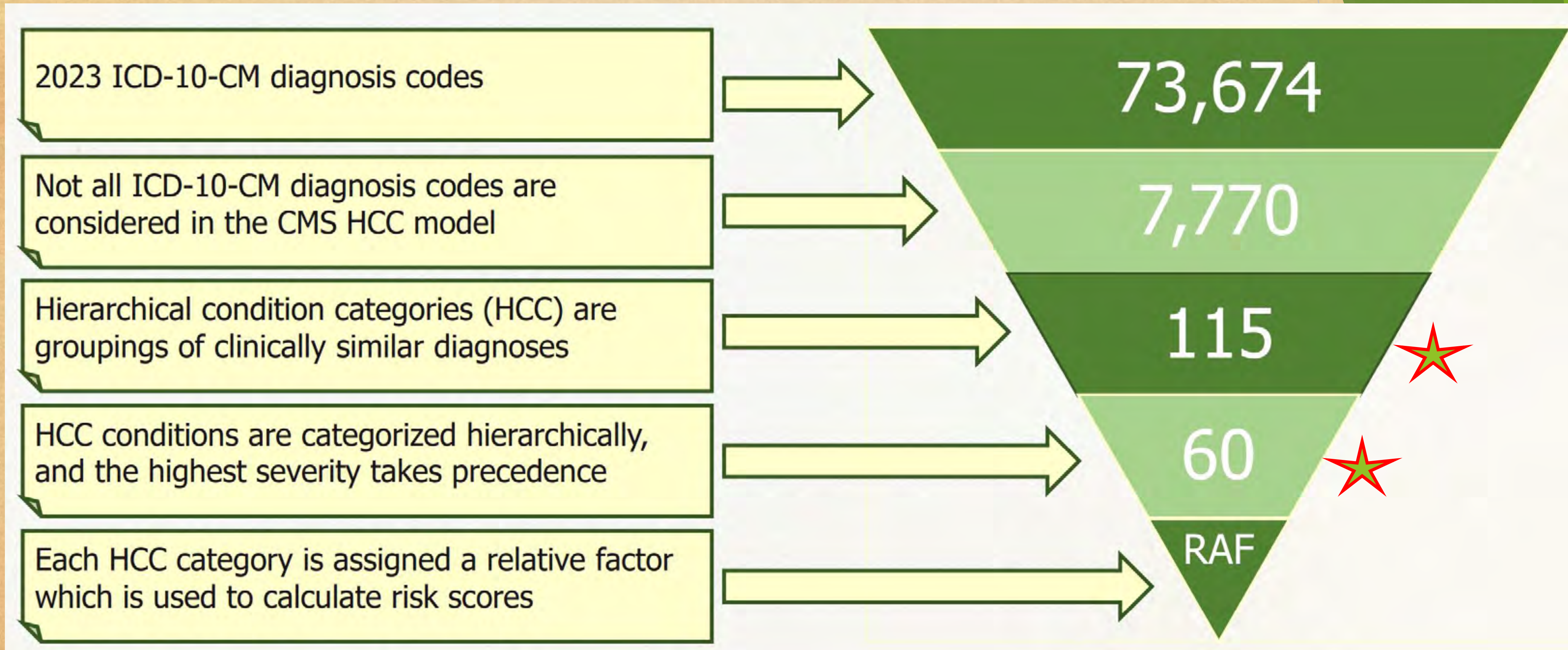
Migrating HCC model from V24 to V28 - **Understanding the 3-year Model Blending**



CMS pays Medicare Advantage (MA) plans using Hierarchical Condition Categories (HCCs) and the HCC model is used by many private payers and ACOs for risk adjustment. Briefly, Medicare pays MA plans more for patients with a higher disease burden, as measured by their risk score – (Risk scores also include demographics and geographic location). In recent years, based on OIG audits, CMS has come to believe there is ***upcoding*** being done by MA plans. And, naturally, they have implemented changes for 2024.



V24: Risk Adjustment ICD-10 Codes



V28: Risk Adjustment ICD-10 Codes

Best practice

High-quality patient-provider connections

Accurate medical documentation and coding

Complete and accurate claim submissions

Required Documentation

- DOCUMENT **(DSP)**
  - Diagnosis – specificity; check labs, medical records
  - Status – Worsening, Chronic, New, At goal
  - Plan – Providers treatment plan

List comorbidities and helping codes. Specific documentation needs to be noted, not volume.

Patient Care

- Document all diagnoses that receive management and care during the encounter
- Include all active diagnoses that contributed to the medical decision-making
- Note all cause-and-effect relationships with managed conditions
- The medical necessity and clinical relevance of the visit should be established
- Document "history of" or "past medical history" only when a condition no longer exists

‘Dirty Dozen’ – OIG Red Flag List

Conditions:	Error Rate:
1. Acute Stroke	94%
2. Acute Heart Attack	94%
3. Acute Stroke + Acute Heart Attack Combined	97%
4. Embolism	75%
5. Vascular Claudication	23%
6. Major Depressive Disorder	20%
7. Lung Cancer	92%
8. Breast Cancer	98%
9. Colon Cancer	94%
10. Prostate Cancer	93%
11. Miskeyed Diagnoses	77%

If the patient has these? PROVE IT.

Don’t Miss…

- **Diabetes & Diabetic Complications**
  Document diabetes type (type 1 or type 2. Explicitly document causal relationships between diabetes and the diabetic complication/manifestation using words like diabetic, due to, secondary to, related to, etc.
- **Chronic Kidney Disease**
  Include eGFR value.
- **Morbid Obesity**
  Morbid obesity includes BMI 40+ with comorbidities.
- **COPD**
  A patient's COPD may be controlled and remain stable, but should still be assessed and reported annually, at minimum.
- **Smoker's Cough**
  In the coding world, smoker's cough is synonymous with mild chronic bronchitis.
- **Transplant Status**
  Can be any duration from surgery.
- **Congestive Heart Failure**
  A patient's CHF may be controlled and remain stable with medications or surgical interventions but should still be assessed and reported at least annually at minimum.
- **Substance Use Disorders**
  If a patient becomes sober after substance use dependence (whether days or decades), they still carry a diagnosis of substance dependence, in remission.
- **Artificial Openings**
  Physical presence of stoma must be documented.
- **Amputations**
  Specify site and any complications, phantom limb syndrome, or pain.
- **Late Effects of Stroke**
  Document the cause-and-effect relationship of CVA and specific related deficits.

What are Z codes?

Z00-Z13 Persons encountering health services for examinations	Z14-Z15 Genetic carrier and genetic susceptibility to disease
Z16-Z16 Resistance to antimicrobial drugs	Z17-Z17 Estrogen receptor status
Z18-Z18 Retained foreign body fragments	Z19-Z19 Hormone sensitivity malignancy status
Z20-Z29 Persons with potential health hazards related to communicable diseases	Z30-Z39 Persons encountering health services in circumstances related to reproduction
Z40-Z53 Encounters for other specific health care	Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z66-Z66 Do not resuscitate status	Z67-Z67 Blood type
Z68-Z68 Body mass index (BMI)	Z69-Z76 Persons encountering health services in other circumstances
Z77-Z99 Persons with potential health hazards related to family and personal history and certain conditions influencing health status	

Preventative codes, specific therapy (dialysis), behavioral health/mental, identify non-medical factors that may influence health status like socioeconomic, education, housing etc.

- Categories Z00 - Z99 can arise in two main ways:
  - (a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is not a disease or injury.
  - (b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. **SDoH.**

SDoH Must be Captured

Many of the **social determinants of health (SDOH) Z codes** are in code block **Z55-Z65.** Code block Z55-Z65 is further broken down into ten categories.

- Z55, Problems related to education and literacy
- Z56, Problems related to employment and unemployment
- Z57, Occupational exposure to risk factors
- Z58, Problems related to physical environment
- Z59, Problems related to housing and economic circumstances
- Z60, Problems related to social environment
- Z62, Problems related to upbringing
- Z63, Other problems related to primary support group, including family circumstances
- Z64, Problems related to certain psychosocial circumstances
- Z65, Problems related to other psychosocial circumstances

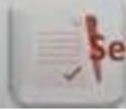
Category II codes are clinical quality codes that facilitate data collection in the ambulatory setting.

CPT Category II Codes Describe:

Clinical Components

Laboratory or Radiology Test Results

Processes that reflect patient safety practices


Services in compliance with state or federal law

CPT II

- Athena will **automatically** populate the code or codes on the Billing tab captured by billing.
- Please choose 'Reason for Visit' within Athena encounter to populate specific CPT II captures.
  - Example: 'A1C > 9'

DATA MANAGEMENT

Coding accuracy and documentation

Leveraging data to make coding operation decisions

The CMS Mandate Requires you to get it Right

- **ICD-10-CM guidelines state, “Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment”.**

- • The goal of complete and accurate documentation in progress notes is to help CMS evaluate the costs of taking care of the patient and pay Medicare Advantage plans accordingly.
- • You are going to pay now or later.
- • If not accurate now, then it will come up in an audit = Civil Monetary Penalty (CMP)
- • Thorough documentation promotes Continuity of Care!

CMS Guidance for Medicare Risk Adjustment

RAPS Participant Guide, section 6.4:

“Standard ICD-10-CM coding practices support the HCC model. In all cases, the documentation must support the code selected and substantiate that the proper coding guidelines were followed…. Up-coding or changing diagnoses to obtain higher reimbursement is fraudulent.”

CMS Guidance for Medicare Risk Adjustment

RAPS Participant Guide, section 6.4:

“Physicians should code all documented conditions that co-exist at the time of the encounter/visit and require or affect patient care treatment or management. [sic]

“Do not code conditions that were previously treated and no longer exist.”

Coding Accuracy and Quality Assurance are the Foundations of Risk Adjustment

- • Does the plan have a system that proactively checks that diagnoses codes submitted are
- consistent with the medical record?
- • Coding education and oversight should be the #1 priority
- • Policies & Procedures should be developed, approved, disseminated, and followed
- • Monitor coders on a regular basis and track results
- • Internal auditors
- • Spend the extra money with outside vendor/coder and do blind coding
- • Trends
- • Develop internal coding guidelines to address grey areas
- • Decide where your plan falls on the Over Cautious – Overzealous spectrum
- • Cautious approach sacrifices some dollars now to avoid penalties later
- • Zealous (not fraudulent) approach accepts more of the grey areas for dollars now

Quality of Record & Risk Adjustment

- Industry billing has yet to fully evolve from an FFS (fee for service) model to a diagnosis model, typically provider payment is based on Procedure Codes, not Diagnostic Codes
- Medical chart documentation often does not meet CMS

  requirements, which are more rigorous than standard practice
- Requirements for ICD codes to count for risk adjustment:
  - Face-to-face encounter
  - Only certain claim types/sources are allowable
  - Only certain provider types are acceptable
  - Documentation in the medical record must meet coding standards
  - Co-morbidities and finance impact

BPA#1: DELETING codes is NOT OPTIONAL

- • Accurate coding entails both ADDING and DELETING when appropriate
- • CMS MA uses delete “clusters”

Each of the clusters would be unique diagnosis clusters because they have different dates of service. (Duplicate diagnosis clusters are those that have the same MBI, from and through dates of service, diagnosis code, provider type, and risk assessment code). Therefore, they will appear on the report in the counts for total stored. The diagnosis would be stored, but later de-duped when the model was run.

BPA #2: Analytics & Reporting

- Critical Information to analyze & develop useful reporting
  - What HCCs did each member have in previous years but have not been submitted in the current year (dropped HCCs)
  - Is there a group or practice that has HCC outliers?
    - 60% of Plan's diabetic population has complications but Group A's is only 20%
- A typical well-run program will actively monitor and use reports to:
  - Reconcile payments
  - Reconcile EDS submissions
  - Project future revenue (recall that diagnoses accepted in the current year drive next year's revenue)
  - Core data source for analytics and external reporting (provider groups)

Your Numbers in Action

1. The “value” of HCCs vary widely. Some have a weight of 2.546 and others have a weight of 0.046. This difference represents ~$22,000 per year.
2. 2. Aside from Dropped HCCs, where there is prior evidence, targeting new member-conditions have varying probabilities. • A member taking a drug that is only associated with diabetes has a high probability of having that condition. • A member taking a drug that is used for many different conditions, including diabetes, has a lower probability of having diabetes
3. 3. Using information from 1 & 2 can be very helpful in selecting targets for retrospective reviews. Note that the probabilities in 2 are mostly anecdotal so while useful, it should be one of many factors in target selection.

Developing your Target List for Interventions

WHO? What Members Need Intervention

- Members that are otherwise unlikely to have a complete and accurate disease profile

WHY? What is the likelihood the member's disease profile is not accurately and completely captured?

- Probability of a condition gap existing Impact of that gap for quality and risk

HOW? What type of intervention is best for a given member?

- IHA/Prospective/Retrospective Provider Engagement Member Engagement

Build Internally, or use Vendor

- Unless you have an expert in house, use a vendor that has proprietary analytics to build your target lists

Coding and Choosing your Fighters

- Experienced coders
- Experienced HCC Coders
- Newly Credentialed
- Temp to Hire
- Nurse Coders

Coders & Productivity

Determine appropriate productivity levels for your internal coding team:

- Time Study with two or more reliable coders with review over an hour/half day/full day:
  - ✓ Coders complete the chart type you are targeting (MA, ACA) without interruption to determine valid productivity expectations
  - ✓ Keep in mind, Medicare charts may take significantly longer to code than ACA charts, so productivity for different projects will change based on project type
- Industry Standard - Network with other health plans to determine productivity standards across the industry:
  - ✓ BSW requires a minimum productivity of 30 charts per day for Medicare Advantage;
  - ✓ ACA projects have a minimum productivity standard of 40 charts per day

Coders & Quality

It is important to target an acceptable level of quality for your internal coding team. The goal is always 100%!

- New coder encounters are audited at 100% until they achieve a score of between 90- 95% accuracy; then 50% until they are consistently above 95%
- Once the 95% accuracy is proven, all coder completed encounters are audited at 30%
- If trends arise during audit, the coder is provided education and the percentage of encounters is increased until back on track
- Our quality standard is 97% - 100%; goals are leveled at “Meets” “Exceeds” and “Far Exceeds”

Productivity & Quality - Tracking

Vendor software can be a real help with tracking coder productivity and quality:

- Make certain that your risk adjustment software provides for tracking these important goals
- Risk Adjustment coding tools should be able to funnel the coder oversight audit percentage into a separate queue for a supervisor or senior peer coder to review

If you are tracking internally, be sure you are consistently tracking in spreadsheet, database, or another system in order avoid the guesswork during employee reviews. Productivity Tracking will help you gauge timing of coding projects!

High and Low Performers

- **Cost of not dealing with low performers**
  - Toxic environment
  - Dragging other team members with them
- **Level set with leadership to keep high performers**
  - Salaries are higher
  - How to tell if someone is worth the investment
- **Make sure you are efficiently staffed**
  - Coder burnout
- **Are you working at Industry Standards?**
  - Review salaries
  - Benefits
  - PTO
  - Reward programs (Motivosity)

Keeping the Coders Happy

- Onsite vs remote work
- Connect with your team
- Encourage a spirit of cooperation
- Treat everyone with respect
- Continuing Education Offerings
- Perks

Retrospective Coding

- Traditional way that health plans work
- Know your retrospective review time frames (LOB have different timing)
- Most do not have resources to look at all charts
  - Targeted analytics
    - Previous HCCs not re-captured
    - Members with high utilization but no HCCs reported • Provider diagnosis counts on claims
    - Low prevalence rate of chronic disease states compared to average population
    - Acute codes submitted in outpatient setting (ALL OF THESE SHOULD BE DELETED)

Prospective Coding

Allows plan to get a full picture of “New Enrollees” for following year payment

Provides early identification for case and disease management programs

Fairly costly to vend – Some plans will pay providers directly for a comprehensive review early in the year

CMS has tried to eliminate these over the past few years. They feel that it is used to gather HCC diagnoses only; no real health value. **They are allowing it to continue provided that the results are sent to the member’s PCP.**

Can use staff to audit charts *before the visit occurs*. Can look at coding, quality and HEDIS measures at the same time. This allows us to educate providers on CDI based on their own charts. EX: provider documents renal insufficiency, but lab values show eGFR’s of 25 for the past 9 months correlating to CKD Stage 4

What Can be Done to Ensure that All HCC Diagnoses are Captured Each Year?

Provider education and engagement: CMS allows plans to collect data from alternate sources which can be looked at as being either Prospective or Retrospective.

Prospective:

- Initiatives taken prior to an encounter to ensure valid diagnosis codes are documented at the time of the encounter
- These include Patient Assessment Forms (PAFS) and Comprehensive Health Assessments (CHAs)
- Pros: Aids in capturing complete and accurate diagnoses at the time of the encounter
- Cons: Slow adoption, not in the provider workflow

Retrospective:

- Actions taken after the encounter has already taken place in order to ensure complete data collection
- These include Chart Reviews
- Pros: Charts relatively easy to access
- Cons: Incomplete diagnostic profile; might not be an encounter tied to the chart

Concurrent Coding

Pros:

- Ensures proper documentation by providers
- Ensures all codes are properly submitted on claim
- Accurate RAF scores and payments
- Quality and HEDIS codes are submitted
- Reduces audit risk, submitting of incorrect codes

Cons:

- Can be difficult without remote access to EMRs
    - Delay of faxing in records
    - Delay of soliciting feedback from office
    - Must have enough staff so claim submission is not delayed
    - Staff needs are different – would want some regional versus remote for provider education

Submission Management
CMS MEDICARE REIMBURSEMENT

- PMPM (based on member enrollment, monthly rate from CMS)
- LOW-INCOME SUBSIDY adjustment
- ESRD
- Long-term INSTITUTIONAL
- STARS (HEDIS)
- RISK ADJUSTMENT PAYMENTS

    * MONIES PAID DIRECTLY BY CMS documented in MARx (portal)

VENDOR Management
Vendor Partners – How they Can Help Us

➔Prospective & Retrospective programs

➔Dashboards and reporting

➔Chart retrieval

➔Coding

➔Submissions

➔Auditing

Do more with less

Increase efficiency

Respond to labor shortages

Integrate technologies into provider and health plan workflows

Managing the FUTURE
Summary of Stars Changes

CMS continues improvements to the Star Ratings program by finalizing new methodological enhancements to further drive quality improvement for all enrollees. In this rule, CMS finalizes a health equity index (HEI) reward, beginning with the 2027 Star Ratings, to further encourage MA and Part D plans to improve care for enrollees with certain social risk factors. CMS also reduces the weight of patient experience/complaints and access measures to further align with other CMS quality programs and the current CMS Quality Strategy. In addition, CMS includes an additional rule for the removal of Star Ratings measures and removes the 60 percent rule that is part of the adjustment for extreme and uncontrollable circumstances. The changes will further drive quality improvement and health equity in MA and Part D.

Advancing Health Equity

CMS is committed to advancing health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality

CMS is clarifying current rules, expanding the example list of populations that MA organizations must provide services in a culturally competent manner. These include people:

1. With limited English proficiency or reading skills
2. Of ethnic, cultural, racial, or religious minorities
3. With disabilities
4. Who identify as lesbian, gay, bisexual, or other diverse sexual orientations
5. Who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex
6. Who live in rural areas and other areas with high levels or deprivation
7. Otherwise adversely affected by persistent poverty or inequality

RADV Audits to Intensify / OIG

- CMS reported that it plans to begin audits that would include chart

reviews for validity of diagnoses in 2020 after a recent study by the

Office of Inspector General (OIG). The study found potential issues

with the extent to which chart reviews are leveraged by Medicare

Advantage Organizations (MAOs) and overseen by CMS.

- OIG conducted the study due to concerns that MAOs used chart

reviews to increase risk adjusted payments inappropriately, saying

“unsupported risk adjusted payments are a major driver of improper payments in the Medicare Advantage (MA) program.”

Office of Inspector General Audits

- The OIG is actively auditing Medicare Advantage plans for diagnosis codes that they determine are at high risk of being miscoded
- Between 2/2021 and 5/2023, the OIG audited 25 health plans (audits are continuing)
    - Audits covered DOS in 2016 and 2017
    - Overpayments = $8.3M covering 3,435 members
    - Extrapolated estimate greater than $427M

Risk Adjustment Industry has been put on NOTICE – DOJ

On March 26, 2020, the DOJ filed a False Claims Act suit against Anthem for failure to conduct two-way medical chart reviews

Anthem allegedly used chart reviews to identify and submit additional diagnosis codes but failed to delete previously submitted codes that were not supported by the review causing overpayments from CMS

https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf

DOJ Filing: Kaiser

In the 10/25/2021 court filing against Kaiser, the DOJ made clear and concise statements on what is considered supportive documentation for HCC conditions

For an outpatient visit (sometimes called an encounter), the ICD Guidelines only allow the coding of documented conditions that both exist at the visit and that "require or affect patient care treatment or management."

In other words, it is not enough that a condition merely exists; the condition must have specifically mattered to patient care, treatment, or management

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Future Direction: Risk Adjustment Industry

OIG Audits

- Are you auditing 100% of IHA net new HCCs?
- Be proactive with targeting audits on the “watchlist”

Shift toward Clinical Validation

- Lack of evidence of diagnostic criteria or treatment plan is missing
- Do you have a clinical champion?

Building a Successful Program

Study and follow all CMS and OIG guidance (and court interpretations of the same)

- HCC coders and auditors should be fluent in CMS program guidance and RADV audit preparedness

Build a two-way review process for ALL coding activities

- Do all your process documents include a section on what steps to take when inappropriate codes are found?
- Who is monitoring that the deletes are going out the door?

Internal Audit Strategies

- Plan should perform quarterly
  - Internal/External medical records reviews
  - Prospective home assessments partners
  - Quality Audits/RAVDs and HHS-RADV Preparation or mock audits
- Members who had an acute, "hospital type" treatment condition reported on a professional (physician office) claim one time or greater in (prior 24 months of CMS Payment year)
- Definite coding error examples when billed and if accurate would have been captured in hospital bill:
  - Acute Myocardial Infarction
  - Acute Myocardial Infarction
  - Cerebral Hemorrhage
  - Stroke
  - Embolism
  - Aneurysm
- Partnering with STARS/HEIDIS teams to audit medical records

Future of MA Risk

- Less reimbursement (closer to ACA model)
- Targeting continues to increase (greater use of suspecting & integrated, actionable data); concurrent coding
- Patient Experience continues to be important
- Longer revenue cycles to manage
- SDoH weights
- Flexibility with MLR
- DE-Professionalization of medicine, less restrictions on license
- Growth in patients, decrease in clinicians
    - Uptick in Duals

Fun Facts We Need to Understand

- Adult population 60 and older is projected to be 2B in 2060 vs. 900M in 2020 (WHO).
- There are more people over 60 than there are under 5.
- People are living longer…but not necessarily healthier…
- 40% of the US population have at least one chronic disease (~157M) & 81M have two or more.

Stay Healthy and Safe. Thank you for all you do.

Questions?

Contact:

Dr. Kenneth Becker or Kayce Cleary – Dir of Coding Operations