



CPAs & ADVISORS

experience access //

TAHFA - HFMA LONE STAR LUBBOCK ROAD SHOW – FEBRUARY 17, 2017

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RISK ADJUSTMENT METHODOLOGY OVERVIEW



OBJECTIVES

- // Know what rick adjustment is and the impact it will have for your hospital and practice(s)
- // Understand Hierarchical Condition Categories (HCCs)
- // Be familiar with correct documentation guidelines
- // Understand the impact the incomplete coding can have on your hospital and practice(s)



GENERAL INFORMATION – RISK ADJUSTMENT

- // Effective 01/01/2014, a permanent Department of Health and Human Services (HHS) risk adjustment program was established under section 1343 of the Affordable Care Act (ACA) for non-grandfathered individual and small group plans
- // Risk adjustment identifies patients who require more resources and disease intervention as determined each year by the diagnosis codes billed for that patient in the previous review period
- // Medicare risk adjustment utilizes HCC grouping logic in its risk adjustment model. HCC conditions require more resources

GENERAL INFORMATION – RISK ADJUSTMENT

- // **What:** Transfers funds from lower risk plans to higher risk plans
- // **Goals:** Encourages health plan competition based on quality improvements and efficiency, mitigating the impact of adverse selection and stabilizing premiums
- // **Data Collection:** HHS runs risk adjustment software on enrollee data that resides on issuer's server and provides enrollee level risk scores to the issuer. HHS calculates enrollee level risk scores

GENERAL INFORMATION – RISK ADJUSTMENT

// **Issuers** – Health plans. Must use third party vendor for audits. Cannot have financial interest in IVA entity and vice versa. Directors and officers cannot serve on board of directors of IVA entity and vice versa

- All issuers will be audited annually
- 200 member sample for > 1,000 members
- 100 member sample for 100-999 members

Guidance pending for < 100



GENERAL INFORMATION – RISK ADJUSTMENT

// **IVA Entity** – Capable of performing audit and ensuring accuracy of risk adjustments according to HHS standards. Is selected by the issuer who submits notification of IVA entity to HHS by Spring 2017

- Must be free of conflicts
- Must use coders certified through either the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA)

GENERAL INFORMATION

// IVA Entity -

- ✓ Validates demographic and enrollment data – performed by financial insurance auditors
- ✓ Health status review – performed by certified coders
- ✓ Must have primary intake coder and senior intake coder
- ✓ Senior intake coder reviews all errors identified by primary coder and performs an inter-rater reliability (IRR) on a sample of diagnoses for all coders for an accuracy rate



MEDICAL RECORD REVIEW AND DIAGNOSIS ABSTRACTION

- ✓ Medical record source must be hospital inpatient, outpatient treatment, or professional medical treatment to identify reported HCCs
- ✓ Face-to face encounters only will satisfy the IVA medical record review
- ✓ Follows the “MEAT” documentation criteria – **M**onitored, **E**valuated, **A**ssessed or **T**reated
- ✓ Approved provider types – MD, DO, PA, APRN, Clinical Psychologist, PT, OT, Audiologist, DPM, etc.



HIERARCHICAL CONDITION CATEGORIES

// CMS requires documentation that supports the presence of the condition and indicate the provider's assessment and/or plan for management of the condition. This must occur at least once each calendar year in order for CMS to recognize the individual continues to have the condition.



HIERARCHICAL CONDITION CATEGORIES

- Hierarchy logic is imposed on certain disease groups
- The HCC model is cumulative – a patient can have more than one HCC and those are factored into the member’s risk profile
- Disease groups are clinically related diagnoses that have similar Medicare cost implications
- Each disease group relates to a specific ICD-9-CM or ICD-10-CM medical condition. A crosswalk is provided by CMS from I-9 to I-10
- Some HCCs are age-related – for example, some breast cancers



HIERARCHICAL CONDITION CATEGORIES

// COMMON HCCs

- COPD
- Congestive heart failure
- Acute or chronic renal failure
- Malignancies
- Diabetes with manifestations
- Newborns with problems
- Complicated deliveries



DOCUMENTATION REQUIREMENTS

// The Basics

Each page of a note must include:

- ✓ The patient's full name
- ✓ Date of birth or other unique identifier (on the first page)
- ✓ Date of service (including year)



DOCUMENTATION REQUIREMENTS

// The Basics, continued

The Provider's signature must be legible –

- ✓ Must also include provider's credentials
- ✓ Electronic signatures should include the date and time of authentication, the service provider's name and credentials and include a statement such as "electronically signed by...." or "authenticated by...."



CODING AND DOCUMENTATION

- // All relevant diagnosis codes should be reported at least once per year for each member (preferably every six months)
- On January 1 each year, the member's diagnosis information is reset in preparation for a new year of diagnosis encounter data
- 2015 initial validation audits completed and will be starting the 2016 audits this spring 2017
- 2015 was a pilot year. Penalties will begin in 2017 based on results of 2016 audits



CODING AND DOCUMENTATION

// Hospitals and Practices should perform an annual evaluation, documentation and submission of all relevant diagnoses and corresponding diagnosis codes which is imperative for:

- Data validation
- Promoting quality patient care
- Accurate patient risk score calculation
- Ensuring appropriate screening tests are received
- Ongoing assessment of the patient's chronic conditions



LESSONS LEARNED FROM AN ISSUER'S PERSPECTIVE

- // Needs better communication with IVA entity
- // Requested volumes of unnecessary documentation
- // Paid enormous copy expenses to vendor for record retrieval
- // Additional documentation requests when correct documentation was not provided from hospitals or practices
- // Requested physician attestations when signatures were unacceptable
- // Do not have certified coders that understand HCC coding
- // Time involved during the whole process – June to January



LESSONS LEARNED FROM AN ENTITY'S PERSPECTIVE

- // Needs better communication with Issuer
- // Lack of documentation to support the MEAT criteria for correctly capturing the HCCs
- // Illegible provider signatures
- // Stamped signatures
- // No birth date on progress note
- // Voluminous documentation that had to be sifted through to identify a HCC



LESSONS LEARNED FROM AN ENTITY'S PERSPECTIVE

- // Time involved during the whole process – June to January
- // Failure to capture HCCs once every 12 months – 18 to 20% error rates
- // Copy and pasted “problem lists” from one encounter to another that could not be used to support the HCC due to not meeting the MEAT criteria
- // Newly identified HCCs - an error but has potential result in a positive impact to the Issuer



LESSONS LEARNED FROM AN ENTITY'S PERSPECTIVE

- // Use of quantifying language in the outpatient setting, such as “consistent with, probable, possible....”
- // Historical status of a diagnosis unclear, especially with malignancies
- // Chronic or coexisting conditions are not documented or are left out of the clinical documentation of an office visit
- // Records contained nonstandard abbreviations or up and down arrows to indicate diagnoses



MOST AUDITED ENCOUNTER TYPES

- // Hospital Anesthesiologist Pre-Evaluations
- // Hospital outpatient department records – provider documentation
- // Hospital emergency room records – physician documentation
- // Physician practice office visits – most often
- // Oncology and urology office visits worst



PROVIDER PRACTICE IMPLICATIONS

- Document each patient's demographic information and clinical information in the medical record
- Ensure complete medical record documentation and submission of all appropriate diagnosis codes, using the highest level of specificity
- If coding is accurate and complete, provider practices are minimally disrupted, allowing greater focus on patient care and other practice business operations
- If coding is incomplete, higher likelihood of more medical record requests by an Issuer, or Plan with practice disruption and cost



NEXT STEPS

- // Secondary Validation Audit (SVA)
- // Works with HHS to validate a sub-sample of the IVA sample (oversight audit) with IVA's ability to appeal
- // Waiting for results from HHS
- // Working with Issuers NOW to improve communication, documentation requests and education to provider regarding accurate documentation and coding (MEAT)
- // Certified Risk Coder through AAPC



FINAL THOUGHTS

// **Copy and Paste in the EHR - Risks**

- // Inaccurate or outdated information that may adversely impact patient care
- // Inability to identify authors or what they thought
- // Inability to identify when the documentation was created
- // Inability to accurately support or defend E/M codes for professional billing notes
- // Internally inconsistent progress notes
- // Unnecessarily lengthy progress notes
- // Redundant information



DISCLOSURE

// Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.

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