CODING COMPLIANCE: WHAT YOU NEED TO KNOW TO BE AUDIT READY

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RISK ADJUSTMENT BASICS

Risk adjustment is designed to evaluate the risk of the members enrolled in a plan and accordingly compensate the issuer based on the amount of risk they carry for the health plan, utilizing the members’ demographics and diagnosis information.
RISK ADJUSTMENT BASICS

There are 3 types of risk adjustment programs that contain various models based on the line of business:

MEDICARE ADVANTAGE (MA)  COMMERCIAL  MEDICAID
RISK ADJUSTMENT BASICS

- By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs for MA and facilitate the appropriate transfer payments for Commercial.

- Risk adjustment is an important factor when completing MA bids and Commercial rate setting.

- Analytics are imperative to a successful risk adjustment program:
  - Understanding membership trends
  - Claim diligence
  - Identifying risk gaps
MEDICARE ADVANTAGE RISK ADJUSTMENT REQUIREMENTS

✅ Submit complete data to CMS based on the timing and methodology outlined in sub regulatory guidance.

✅ Submit accurate data to CMS based on the timing and methodology outlined in sub regulatory guidance.

✅ Comply with CMS audit
COMPONENTS OF RISK ADJUSTMENT

Medical Record Review

- Initiatives & Interventions
- Data Submission & Reconciliation
- CMS & Internal Auditing
- Financial Reporting
- Vendor Collaboration & Oversight
- Provider Engagement

STRATEGY
OPERATIONAL INFRASTRUCTURE
ANALYTICS
MEDICAL RECORD REVIEW AND AUDIT

TYPES OF RETROSPECTIVE AUDITS TYPICALLY CONDUCTED:

- ICD-10 Coding
- HCC
- RADV Readiness
- Targeted Audits
  - Coder Performance
  - Provider Performance
  - Vendor Performance
  - Condition Specific
- Billing

TYPES OF CMS AUDITS

- RADV Audit
- HHS-RADV Audit
- OIG Audit
IDENTIFYING AND EVALUATING LEVELS OF RISK

CODING COMPLIANCE

- Establishes identification, evaluation, and correction
- Coding Guidelines
- Ways to measure coding performance and oversight
- Policy & Procedures
- Onboarding training
- Annual training
- Provider education
Understanding your audit risk

- False claims act
- Whistleblower
- Fines
- Penalties
- Overpayment Takebacks
TYPES OF RISK MODELS

DIAGNOSIS BASED
- CMS-HCC - Medicare
- HHS-HCC - Commercial, Individual & Small Group
- Chronic Illness and Disability Payment System (CDPS)
- Adjusted Clinical Groups (ACG)
- Clinical Risk Group (CRG)
- Diagnosis Related Group (DRG)
- Episode Risk Groups (ERG)

PRESCRIPTION BASED
- MedicaidRx - HCC-D - Medicare
- RxGroups - Commercial
CHARACTERISTICS OF CMS-HCC MODEL

- Predictive Model
- Hierarchical Condition Category (HCC)
- Disease Interactions
- Demographics
WHAT IS HCC CODING?

- Risk Adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by the Centers for Medicare and Medicaid Services (CMS) in 1997.

- Implemented in 2003, this model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual’s health conditions and demographic details.

- The individual’s health conditions are identified via International Classification of Diseases – 10 (ICD –10) diagnoses that are submitted by providers on incoming claims.

- There are more than 9000 ICD-10 codes that map to 79 HCC codes in the risk adjustment model.
WHAT IS HCC CODING?

- HCC coding is the great equalizer.
- Prior to the rise of the risk adjustment model, reimbursement was based solely on demographic factors.
- Since costs can vary widely among patients, risk adjustment can now be used to evaluate patients on an equal scale.
- It opens up a world of new opportunities for coders and providers and may make reimbursements more efficient.
- And that’s good news for your revenue cycle performance.

Reality: HCC coding is nothing more than diagnosis coding according to the ICD-10-CM Coding Guidelines and AMA Coding Clinics.
CONFLICTING INFORMATION BETWEEN CMS AND CODING GUIDELINES

Inpatient Rule used for Outpatient coding – “MEAT”:
- M = Monitor
- E = Evaluate
- A = Assessment
- T = Treatment

Chronic Conditions “TAMPER™”:
- T = Treatment
- A = Assessment
- M = Monitor/Medicate
- P = Plan
- E = Evaluate
- R = Referral
- Did the clinician TAMPER with the diagnosis?
CONFLICTING INFORMATION BETWEEN CMS AND CODING GUIDELINES

Coding Guidelines: Section IV.G, IV.J, I.19

1. “...List additional codes that describe any coexisting conditions...”

2. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

3. Code assignment and Clinical Criteria *
   - The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
MEDICAL CODING OF PATIENT ENCOUNTERS IS ONLY AS GOOD AS THE UNDERLYING MEDICAL RECORD DOCUMENTATION

Accuracy    Specificity

Best practices in medical coding

Thoroughness    Consistency

Source: Asuris Northwest Health
TOP 5 DIAGNOSIS CODING ERRORS

- **Cancer Coding – Current versus History of**
  - Ongoing conversations amongst oncologist as to whether cancer is a chronic condition
  - Use of medications versus hormone therapy

- **Strokes (CVA) documented in an outpatient setting**
  - Very limited number of strokes/CVA/Intracranial Bleeds occur in the outpatient setting

- **MI (Heart Attacks) documented in an outpatient setting**
  - Clinicians continue to document current MI after the initial 4 week period
TOP 5 DIAGNOSIS CODING ERRORS
CONTINUED

↘ Diabetes with manifestations
   • ICD 10 Casual Relationship change – no longer needs to be linked

↘ History of conditions versus current conditions
   • Documentation error
   • Chronic condition
   • Supported within the documentation

Diabetes, diabetic (mellitus) (sugar) E11.9 with
  • amyotrophy E11.44
  • arthropathy NEC E11.618
  • autonomic (poly) neuropathy E11.43
  • cataract E11.36
  • Charcot’s joints E11.610
  • chronic kidney disease E11.22
  • circulatory complication NEC E11.59
  • complication E11.8
  • specified NEC E11.69
  • dermatitis E11.620
  • foot ulcer E11.621
  • gangrene E11.52
  • gastroparesis E11.43
  • glomerulonephrosis, intracapillary E11.21
  • glomerulosclerosis, intercapillary E11.21
  • hyperglycemia E11.65
  • hyperosmolality E11.00
  • with coma E11.01
  • hypoglycemia E11.649
  • with coma E11.641
  • kidney complications NEC E11.29

Not an all-inclusive list
RISK ADJUSTMENT MODELS
CMS – HCC (Hierarchical Condition Category) Model

15000+ICD10 Codes → Reduce 3100 ICD-10 Codes → Reduce 79 CMS HCC Disease Groups

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1159</td>
<td>Type 2 diabetes mellitus with other circulatory complications</td>
</tr>
<tr>
<td>E11610</td>
<td>Type 2 diabetes mellitus with diabetic neuropathic arthropathy</td>
</tr>
<tr>
<td>E11618</td>
<td>Type 2 diabetes mellitus with other diabetic arthropathy</td>
</tr>
<tr>
<td>E11620</td>
<td>Type 2 diabetes mellitus with diabetic dermatitis</td>
</tr>
<tr>
<td>E11621</td>
<td>Type 2 diabetes mellitus with foot ulcer</td>
</tr>
<tr>
<td>E11622</td>
<td>Type 2 diabetes mellitus with other skin ulcer</td>
</tr>
<tr>
<td>E11628</td>
<td>Type 2 diabetes mellitus with other skin complications</td>
</tr>
<tr>
<td>E11630</td>
<td>Type 2 diabetes mellitus with periodontal disease</td>
</tr>
<tr>
<td>E11638</td>
<td>Type 2 diabetes mellitus with other oral complications</td>
</tr>
</tbody>
</table>

200 Diabetes ICD -10 Codes = 3 HCC

Each “HCC” Group has an associated numeric factor that is used in the formula.
- Some related HCC’s trump each other.
- Diabetes HCC, #18 has 3 HCCs values.
- Most severe HCC trumps the lesser HCC
TOP 10 HCC DOCUMENTATION ERRORS

The record does not contain a legible signature with credential.

- The electronic health record (EHR) was unauthenticated (not electronically signed).

- The highest degree of specificity was not assigned the most precise ICD-10-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.

- A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record.
TOP 10 HCC DOCUMENTATION ERRORS

Continued

- Chronic conditions do not have supporting documentation.
- Records contain nonstandard abbreviations (arrows).
- Conflicting information within one DOS.
- Second patient identifiers is missing.
- Non approved clinicians
- Incorrect diagnosis coding by clinicians.
BEST PRACTICE APPROACH TO ESTABLISHING CODING COMPLIANCE

Know your company’s “level of risk”
- Grey areas of coding
- Unsigned documentation
- CMS confusion
- RADV audit process

Policies and Procedures (P&Ps)
- Update on an annual basis
- Refer back to Coding Guidelines, CMS Risk Adjustment Documentation and Coding Clinics
- Include the “look both ways” rule in P&Ps
Patient
Joseph Paul    DOS 1/1/2018

History of Present Illness
Patient words: Transition of care: XXX discharge 12/18/2016 for Sepsis.

The patient is a 73 year old male who presents to the practice today for a transition into care.

The patient is transitioning into care from a hospital (XXX discharge 12/18/2016 for Sepsis) admitted overnight and treated with Zosyn and Augmentin. had shaking chills several hours after getting cleaned, felt much better day after onset and felt normal after 3d.

Allergies (12/23/2016 8:44 AM)
Lisinopril *ANTIHYPERTENSIVES* THROAT TIGHTNESS, SEE HOSPITAL REPORT FROM ST. JOSEPH

Social History 12/23/2016 8:44 AM
Assessment of health literacy: Yes

Living Situation: spends 3m in Alabama for winter

Tobacco Use: Former smoker. quit age 36

Exercise History: Walking. Anytime Fitness, stair stepper//trailer camping grew up in Flint

Marital status: Married. 3 sons (1 son-suicide), 13 grandkids

Current Work/Study Status: Retired. Trucker

Alcohol Use: Occasional alcohol use. Rare
Medication History (12/23/2016 8:47 AM)

- Amoxicillin-Pot Clavulanate (875-125MG Tablet, 1 (one) Tablet Oral two times daily (x 10 days), Taken starting 12/19/2016) Active. (hospital)
- Levothyroxine Sodium (112MCG Tablet, 1 (one) Oral daily, Taken starting 08/29/2016) Active.
- Digoxin (250MCG Tablet, 1 (one) Oral daily, Taken starting 08/29/2016) Active.
- Omeprazole (20MG Capsule DR, 1 (one) Oral two times daily, Taken starting 07/27/2016) Active.
- MetFORMIN HCl (1000MG Tablet, 1 (one) Oral AM, 1/2 tab (500 mg.) PM, Taken starting 07/22/2016) Active.
- NovoLOG FlexPen (100UNIT/ML Soln Pen-inj, 4-8 units Subcutaneous with meals, Taken starting 04/15/2016) Active. (1 unspecified= 1 month supply) Pen Needles 5/16" (31G X 8 MM Misc, 1 (one) needle four times daily, Taken starting 02/05/2016) Active.
- Ventolin HFA (108 (90 Base)MCG/ACT Aerosol Soln, 2 (two) Puff Inhalation every 4 hours as needed, Taken starting 11/12/2013) Active.
- Adult Low Dose Aspirin (81MG Tablet, 1 Oral daily) Active.

Medications Reconciled
REVIEW OF SYSTEMS (MD: 12/23/2016 9:14 AM)

- General Not Present - Fever.
- Respiratory Not Present - Difficulty Breathing.
- Gastrointestinal Not Present - Diarrhea.
- Hematology Not Present - Abnormal Bleeding.

VITALS (12/23/2016 8:55 AM)

- 12/23/2016 8:55 AM
- BP: 140/80 (Sitting, Left Arm, Large)
- Weight: 261.8 lb  Height: 67.5 in
- Body Surface Area: 2.28 m²
- Body Mass Index: 40.4 kg/m²
- Temp.: 97.6° F (Tympanic)
- Pulse: 64 (Irregular)
- Resp.: 20 (Unlabored)
- BP: 145/79 (Sitting, Left Arm, Large)
- Mental Status - Alert.
- General Appearance - Cooperative, Not in acute distress.
Build & Nutrition: Well nourished and Well developed.

Hydration: Well hydrated.

Chest and Lung Exam

Accessory muscles: No use of accessory muscles in breathing.

Auscultation

Breath sounds: Normal. Adventitious sounds:

No Adventitious sounds.

Cardiovascular

Auscultation


Assessment & Plan (MD; 12/23/2016 9:15 AM)

ATRIAL FIBRILLATION, PERMANENT (I48.2) <HCC96>

DENTAL INFECTION (K04.7)

SEPSIS (A41.9) <HCC2>

BMI 40.0-44.9 IN ADULT (Z68.41) <HCC22>

Signed by Thomas G Smith, MD (12/23/2016 9:16 AM)
“She has no rigors or shaking chills, but her husband states she was very hot in bed last night.”

“Patient has two teenage children but no other abnormalities.”

She stated that she had been constipated for most of her life until 1989 when she got a divorce.

“History of sick as hell disease” (sickle cell disease).
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