Medicare Risk Adjustment

RAF 101

Presenter:

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Disclaimer

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Abbreviations

- RAF: Risk Adjustment Factor
- MRA: Medicare Risk Adjustment
- CMS: Centers for Medicare & Medicaid Services
- RA: Risk Adjustment
- MA: Medicare Advantage
- HCC: Hierarchical Condition Categories
- MEAT: Monitor, Evaluate, Address, Treatment

Objectives

- Provide Overview of Medicare Risk Adjustment (MRA)

- Identify the role of Health Care Providers in the Medicare Risk Adjustment process

- Provide medical record documentation guidelines

Purpose

- MRA is intended to redirect money away from MAO that would cherry-pick the healthier enrollees

- MRA is a way to provide MAO that care for the sickest patients the resources to do so

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Reimbursement Model RAF-HCC

- RAF-HCC is a predictive model CMS uses diagnosis data submitted from the previous year to establish capitation payments to the MA plan
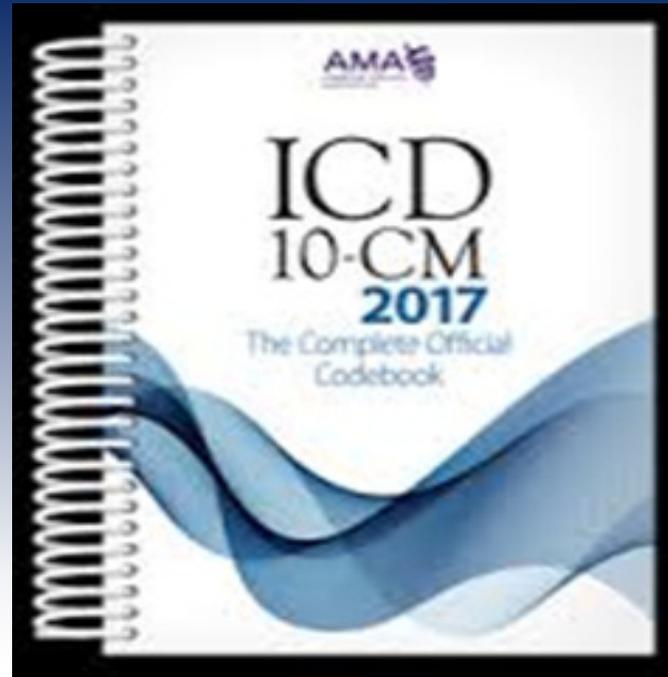
HCC's are disease categories which are mapped to certain Diagnosis Codes for chronic conditions:
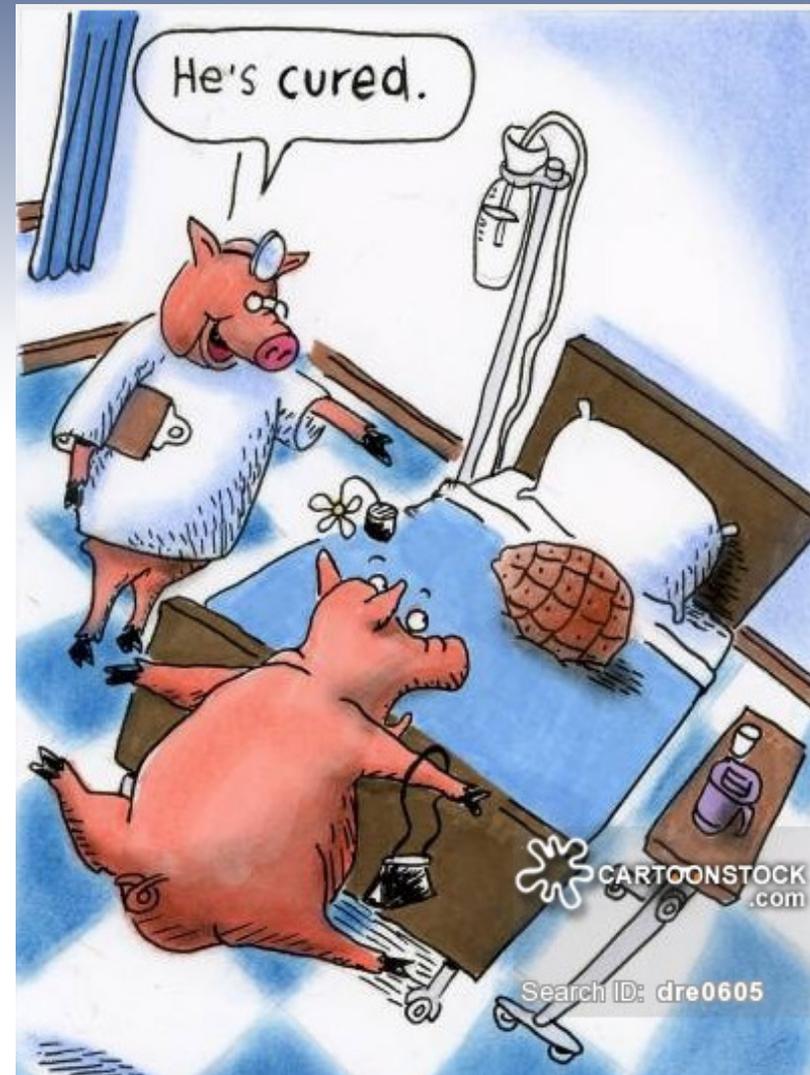- 79 HCC's and over 8830 ICD-10-CM diagnosis codes out of ~70,000

I'm Cured

CMS wipes the slate
clean every January 1,
so MA plans must
recapture all chronic
conditions in order to
receive reimbursement

How it Works

The average CMS FFS patient has the score of 1.00

- RAF is a numeric value assigned by CMS to identify the health status of a patient

- RAF scores are made up of the following criteria for each member:

  ➢ Demographic information e.g. age and sex

  ➢ Medicaid status and Medicare eligibility due to a disability

  ➢ Chronic conditions and disease interactions

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How it Works[2]

- RAF-HCC is a predictive model using diagnosis submitted from the previous year to establish capitation payments to the MA plan

- Each diagnostic code falls into one Diagnosis Group and codes are grouped into Condition Categories

Diabetic neuropathy
Diabetic nephropathy   > HCC 18 ———→ Risk Score ———→ Reimbursement
Diabetes with PVD
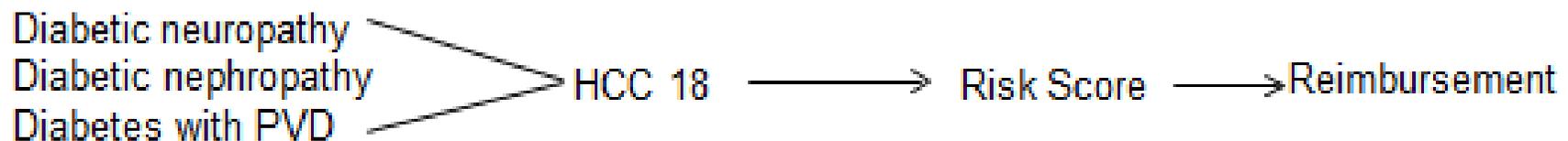
Disease Interaction

- DM and CHF

- DM and CVD

- CHF and COPD

- COPD, CVD and CAD

- RF and CHF

- RF, CHF and DM

Low level of specificity		Moderate level of specificity		High level of specificity	
76 year old female	0.426	76 year old female	0.426	76 year old female	0.426
Medicaid eligible (aged female 65+)	0.202	Medicaid eligible (aged female 65+)	0.202	Medicaid eligible (aged female 65+)	0.202
No Type 2 diabetes coded	X	Type 2Diabetes w/o complications E11.9 (HCC 19)	0.118	Type 2 Diabetes with diabetic peripheral angiopathy w/o gangrene E11.51 (HCC 18)	0.368
No vascular disease coded	X	Vascular disease w/o complications PVD, unspecifiedI73.9 (HCC 108)	0.299	Vascular disease w/ Atherosclerosis of native arteries of left leg with ulceration of ankle I70.243(HCC 106)	1.143
Chronic diastolic (congestive) heart failure not coded	X	Chronic diastolic (congestive) heart failure not coded	X	Chronic diastolic (congestive) heart failure I50.32 (HCC 85)	0.368
No Disease Interaction	X	No Disease Interaction	X	Disease Interaction (DM + CHF)	0.182
Total RAF	0.628	Total RAF	1.057	Total RAF	2.089
Total RAF, With FFS Normalization[1] & Coding Intensity Adj[2]	0.590	Total RAF, With FFS Normalization[1] & Coding Intensity Adj[2]	0.993	Total RAF, With FFS Normalization[1] & Coding Intensity Adj[2]	1.963
Estimated Average County Rate	$821	Estimated Average County Rate	$821	Estimated Average County Rate	$821
Estimated Dollars PMPM	$484	Estimated Dollars PMPM	$815	Estimated Dollars PM	$1,611
Estimated Dollars PMPY	**$5,812**	**Estimated Dollars PMPY**	**$9,782**	**Estimated Dollars PMPY**	**$19,333**

ICD-10-CM Official Guidelines for Coding & Reporting

- 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 (Z codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment

Why is complete documentation important?

- **B19.20** Hepatitis C, unspecified (No HCC)

- **B17.10** Hepatitis C, acute (No HCC)

- **B18.2** Hepatitis C, chronic (HCC-29)

Why is complete documentation important?

- If the patient is actively receiving medication for cancer treatment (AHA Coding Clinic 10/2008). Assign the following codes:

    ➢ Active cancer code e.g. breast cancer C50.919
    ➢ Long-term (current) use of medications Z79.81

- History of code should only be assigned if the drug is being used prophylactically.

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Where's the M.E.A.T

A diagnosis will not pass a RADV audit without the M.E.A.T

The Road to Success Starts and Ends with M.E.A.T.

- A variety of downfalls beset Providers and MA plans when confronted with a RADV audit

- Simply listing a diagnosis in the medical record without M.E.A.T. will not support a reportable HCC code and is unacceptable

- Remember when the Provider follows the M.E.A.T. guidelines the documentation is basically audit-proof

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Definition of M.E.A.T.

- Monitor—signs, symptoms, disease progression, disease regression

- Evaluate—test results, medication effectiveness, response to treatment

- Assess/Address—ordering tests, discussion, review records, counseling

- Treat—medications, therapies, other modalities

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Example M.E.A.T.

- **Monitor:** B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits

- **Evaluate:** stump well healed, ostomy site w/o infection appears clean & dry

- **Address:** stable; controlled, worsening; unchanged, uncontrolled

- **Treatment:** taking Fosamax for osteoporosis; taking tamoxifen for breast cancer "treatment", DM controlled on insulin

Why Would You Fail a RADV Audit?

- Failure to ensure the diagnosis codes being billed and the medical record documentation match

- Failure to document according to the M.E.A.T. principles (i.e. monitor, evaluate, addressed, and/or treatment

- Failure to link the causal relationship for manifestation codes

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Key to Success

- At the end of the day, providing timely and accurate documentation and submitting HCC codes allows proper reimbursement

- Accurate documentation and coding allows the plans to provide better benefits to members and improve premiums per member per month (PMPM)

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Conclusion

MRA supports achievement of "Triple Aim"

- Cost effective Care

- Quality Outcomes

- Patient Satisfaction

Resources

- http://www.hcpro.com/content.cfm?content_id=302031
- https://www.cartoonstock.com/directory/c/cured_ham.asp

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Evaluation & Management Services (E&M)

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What are E & M Services

- A section of codes in the AMA CPT Manual that are used to report the *professional fee* services performed by physicians and other qualified healthcare providers.

The "bread and butter" of many professional fee services

Why Is Documentation So Important?

- Supports the medical necessity of the service

- Reduces risk to audit exposure

- Supports billing services to payers

- Demonstrates the quality of care rendered

- Serves as a legal document in malpractice cases

- Provides continuity of care across disciplines

Outpatient E/M Services

CPT Code New	Time	History	Exam	MDM
99201	10	Problem Focused	Problem Focused	Straightforward
99202	20	Expanded Problem Focused	Expanded Problem Focused	Straightforward
99203	30	Detailed	Detailed	Low
99204	45	Comprehensive	Comprehensive	Moderate
99205	60	Comprehensive	Comprehensive	High

CPT Code Established	Time	History	Exam	MDM
99212	10	Problem Focused	Problem Focused	Straightforward
99213	15	Expanded Problem Focused	Expanded Problem Focused	Low
99214	25	Detailed	Detailed	Moderate
99215	40	Comprehensive	Comprehensive	High

Inpatient Hospital E/M Services

CPT Code Initial	Time	History	Exam	MDM
99221	30	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward/ Low
99222	50	Comprehensive	Comprehensive	Moderate
99223	70	Comprehensive	Comprehensive	High
Subsequent				
99231	15	Problem Focused	Problem Focused	Low
99232	25	Expanded Problem Focused	Expanded Problem Focused	Moderate
99233	35	Detailed	Detailed	High

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Observation E/M Services

CPT Code Initial	Time	History	Exam	MDM
99218	30	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward/ Low
99219	50	Comprehensive	Comprehensive	Moderate
99220	70	Comprehensive	Comprehensive	High
Subsequent		**History**	**Exam**	**MDM**
99224	15	Problem Focused	Problem Focused	Low
99225	25	Expanded Problem Focused	Expanded Problem Focused	Moderate
99226	35	Detailed	Detailed	High

Consultations

Medical Record Documentation requirements:

- Request for consultation

- Rendering of consultant's opinion

- Report sent back to the requesting physician

Example: I saw this patient in consultation at the request of Dr.___

Inpatient	Time	Outpatient	Time
99251	20 min	99241	15 min
99252	40 min	99242	30 min
99253	55 min	99243	40 min
99254	80 min	99244	60 min
99255	110 min	99245	80 min

CMS Preventive Visits

There are **3 types** of "wellness visits/preventive visits", each has **different** reporting requirements.

➢Initial Preventive Physical Examination (IPPE)

➢Initial Medicare Annual Wellness Visit (AWV)

➢Subsequent AWV

Care Management Services

99487: Complex chronic care management 60 minutes of clinical staff time

99489: Complex chronic care management EACH additional 30 minutes of clinical staff time

99490: Chronic care management service at least 20 minutes of clinical staff time

99495: Transitional care management (TCM) moderate complexity; face-to-face within 14 days

99496: Transitional care management high complexity; face-to-face within 7 days

Medical Necessity

- Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code

Components of Medical Necessity

Medical necessity cannot be quantified using a points system. Determining the medically necessary LOS is multi-factorial and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why patient needs to be seen (chief complaint)
- Any acute exacerbations/onsets of medical conditions or injuries
- Stability/acuity of patient
- Multiple medical co-morbidities
- Management of patient for that specific DOS

Medical Necessity Criteria

- Consistent with the symptoms and diagnoses or treatment of the patient's condition, illness, disease or injury

- In accordance with accepted professional medical standards

- Not primarily for the convenience of the patient or provider

- Furnished at the most appropriate level that can be safely provided to the patient

Evaluation & Management (E/M)

E/M services recognize 7 components which are used in defining the levels of E/M services

Key Components
- History
- Examination
- Medical Decision Making

Contributory Components
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Chief Complaint (CC)

- The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter

- Is required for every E&M service

- If there is no chief complaint, the service can be deemed not billable.

History of Present illness (HPI)

A chronological description of the development of the patient's present illness with elements of:

Two types of HPI: Brief – 1-3 elements Extended – 4 elements OR the Status of 3 chronic conditions	
Location	Quality
Severity- pain scale (peds 0-4; adults 8-10)	Duration
Timing	Context
Modifying factors	Associated signs and symptoms

Past Medical, Family, Social History

- Past Medical history (the patient's past experiences with illnesses, operations, injuries and treatments). For Infants/newborns may include mother's pregnancy and the birth of the child

- Family history - a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)

- Social history - an age appropriate review of past and current activities, i.e., Military Status, living arrangements and education

Review of Systems (ROS)
14 Systems Are Recognized

Three types of ROS:

1. Problem Pertinent – inquires about organ system directly related to the presenting problem

2. Extended – inquires about 2-9 organ systems

3. Complete – Requires documentation of at least 10 organs systems individually *OR* some pertinent +/- of some organs systems with a statement "all other systems were reviewed and are negative"

Examination Guidelines

Exam level	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1995 & 1997 Exam Guidelines	99201;99212; 99241;99251; 99231	99202;99213; 99242;99252; 99232	99203;99214; 99243;99253; 99221	99204-99205; 99215; 99244-99245; 99254-99255; 99222-99223
1995 Body Areas/Organ Systems	Affected area	2 – 4 body area/organ systems	5 - 7 body areas/organ systems	8+ organ systems
1997	1 - 5 bullets in 1+ systems/areas	6 - 11 bullets in 1+ system/areas	12+ bullets in 2+ systems/areas	2+ bullets for each of 9+ systems/areas

Medical Decision Making (MDM)

There are 4 levels of MDM:

1. Straightforward
2. Low

3. Moderate
4. High

MDM is:

A. The number of diagnoses or management options

B. Amount and/or complexity of data to be reviewed

C. Risk of complications and/or morbidity or mortality

OBSERVATION SERVICES (OBS)

- There must be a physician's order specifying "Placement for Observation" or simply "Observation" including the reason and medical necessity for OBS care

- A physician order for observation services should NOT read "Admit to (or for) Observation"

- All OBS services must be ordered by a physician

- OBS starts at the documented time that observation care is initiated

- All other physicians who furnish evaluations or services while the patient is receiving OBS must bill the appropriate outpatient service codes

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Teaching Physician (TP) Guidelines

The Teaching Physician must personally document:

That they performed the service or were physically present during the critical or key portions of the service furnished by the resident; and

His or her participation in the management of the patient

Documentation by the resident of the presence and participation of the TP is NOT sufficient

Medical Students

- TP can only use the ROS and PFSH from a Medical Students documentation

- TP MUST re-document the HPI, Exam and MDM

- TP MUST be present during the entire encounter

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Medicare Administrative Contractors (MACs)

Banner Health is located in seven states:

Arizona – Corporate Headquarters

Alaska

California

Colorado

Wyoming

Nebraska

Nevada

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Variances Encountered

MAC's

- Noridian

- Novitas

- WPS

Areas

- Review of Systems

- Exam

- PFSH

- Medical decision making (MDM)

Copy/Paste/Cloning/Carry Forward

The documentation may be worded:
- Exactly the same as another DOS
- Similar to a previous DOS
- The same for all patients

Cloned documentation methods include:
- Templates
- Handwritten
- EHR

Medical Record Cloning

- Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter

- Cloned documentation does not meet medical necessity requirements for coverage of services.

- Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made

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Common Errors

- Insufficient Documentation
- Incorrect Coding
- Medical Necessity Not Supported
- Documentation Doesn't Support Level Billed
- Prolonged Services
- Time-based Services
- Duplicate submissions
- Other Issues

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Documentation Doesn't Support Level Billed

- Each encounter must tell a complete story

- Prior encounters cannot be considered unless referenced by date in the encounter being audited

- All three components (history, exam and medical decision making) must be present when billing initial/new patient visits

Documentation Doesn't Support Level Billed

- Should be able to find a correlation between chief complaint/HPI/exam findings and what is documented for medical decision making

- It would not be medically necessary or appropriate to bill a higher level E/M when a lower level of service is warranted

CERT Findings Improper Payments

Part B Service	$ Amounts	No Doc	Insufficient Doc	Medical Necessity	Incorrect coding
Office visits - new	$490,841,942	0.7%	18.2%	0.9%	77.1%
Office visits - established	$1,141,913,178	4.8%	4.8%	0.0%	59.7%
Hospital visit - initial	$888,882,432	3.7%	29.1%	0.0%	66.2%
Hospital visit - subsequent	1,048,419,405	4.3%	55.9%	0.4%	38.3%
Emergency room visit	$292,397,866	0.0%	9.7%	0.6%	89.7%
Nursing home visit	$362,260,716	9.9%	40.8%	0.0%	49.3%

Key Points to Remember
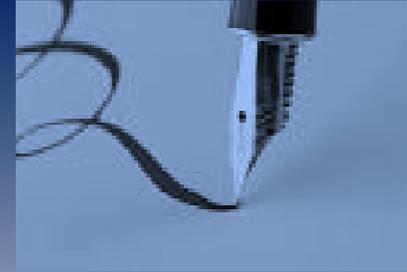
- Professional fee service and facility fee services are reported differently but support the **total care** rendered to patients

- Providers should have ongoing CDI education and taught how to **"think in ink"**

- Coders should have ongoing education and given the tools necessary to ensure their success

WHAT'S NEW FOR 2017

UPCOMING UPDATES

Global periods:

- Instituting GXXX global period codes for data gathering; time based 10 min; based on complexity of the visit; by setting inpt/outpt

New Codes for Telehealth:

- Critical Care – G Codes; 1 per day;

Complex Chronic Care Management Services 99497/99498

- Payable 1/12017

BHI CoCOM –Psychiatric Collaborative Care Model

- G codes for initial and subsequent; all are time based

SPECIFICITY

Each health care encounter should be coded to the level of certainty known for that encounter

NOTE: Check with commercial payers regarding reporting unspecified ICD-10-CM

The End of Grace Period

October 1st, 2016 will mark the end of a 1-year grace period that Centers for Medicare and Medicaid Services (CMS) established for the ICD-10-CM diagnosis codes. CMS will no longer accept unspecified ICD-10-CM codes on Medicare fee-for-service (FFS) claims when a specific one is warranted by the medical record.

- Avoid unspecified ICD-10-CM codes whenever documentation supports a more detailed code. Check the coding on each claim to make sure that it aligns with the clinical documentation.

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Unspecified Codes

- Rheumatoid Arthritis
  - Juvenile, seronegative, seropositive, site
- Crohn's disease
  - Enteritis, regional: colon, duodenum, ileum, jejunum, large bowel, intestine
- Ulcerative Colitis
  - Enterocolitis, ileocolitis, proctitis, pseudopolyposis, psychogenic, rectosigmoiditis, complications
- Asthma
  - Intermittent (mild)
    - Exacerbation or status asthmaticus
  - Persistent: mild, moderate, severe
    - Exacerbation or status asthmaticus

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Unspecified Codes

- Osteoporosis
  - Age related, disuse, drug-induced, idiopathic, involutional , localized, postmenopausal, post-traumatic, senile, etc
- Osteopenia
  - Site: ankle, foot, forearm, hand, leg, rib, shoulder, etc
- Lung CA
  - Type: primary, secondary, benign, in-situ, malignant,
  - Laterality: right, left, bilateral, upper, lower, middle lobe
- Breast CA
  - Type: primary, secondary, benign, in-situ, malignant,
  - Laterality: right, left, bilateral, lower, upper, inner, outer

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References

CMS Claims Processing Manual; Chapter 12; sec 30.6.1; pgs. 40-41

CMS 1995 & 1997 Examination Guidelines

BH Pol 12411;Incident To

BH Position Statement: Review of Systems; Formal P&P upcoming

BH Position Statement "Physician Practices/Clinics: Assistant at Surgery, Co-Surgery, Team Surgery."

BH Policy #678

BMG Compliance Newsletter June 2012 "Cloning of Medical Notes"

CMS IOM 100-04, Chp.12, Section 30.6.13-H,

http://www.cms.gov.Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c12.pdf

Novitas Web Article, "Split/Shared E/M's

 https://www.novitas-solutions.com/em/split-shared-em.html

WPS Web Article, "Inpatient Split/Shared/E./M Services"

http://www.wpsmedicare.com/partb/department/medicalreview/20091116em.shtml

- AMA CPT Manual 2016

- Federal Register:

https://www.federalregister.gov/articles/2015/07/15/2015-16875/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions#h-8

https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-28005.pdf

https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched/

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf

http://www.icd10watch.com/blog/cms-clarifies-what-end-icd-10-flexibilities-means

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