Objectives

• Medicare Advantage - Overview

• Risk Adjustment 101

• Coding and Medical Record Documentation Requirements
Medicare Advantage - Overview

• Medicare is a federal health insurance program;

• Medicare consists of 4 parts:
  
  **Part A**
  
  - IP hospital, IP SNF, IP care in religious non-medical health care facility, home health, hospice;
  
  **Part B**
  
  - Doctor services, office visits, screenings, therapies, preventive services, OP hospital, emergency care, ambulance, medical/surgical supplies and durable medical equipment;
  
  **Part C (Medicare Advantage Plans)**
  
  - Part A & B services;
  - Additional services;
  
  **Part D**
  
  - Pharmacy benefits;
  - Includes plans with varying out-of-pocket requirements;
Part C (Medicare Advantage)

• Includes Part A & B services;
• Includes coverage for extra dental, vision, hearing and preventive services and some optional supplement services;
• Medicare Advantage plan receives payment for each member from CMS;
• Payment is based on member predicted health status and demographic characteristics;
• Medicare Advantage plans are regulated by CMS;
ADVANTAGE Medicare Solutions

About Us

• Indiana-based, provider-owned health plan and TPA;
• Offering healthcare benefits and innovative care management and wellness programs to employer groups of all sizes;

Our Mission

To provide managed care solutions that improve outcomes, keep costs affordable, and enhance the health and wellness of the communities we serve.
ADVANTAGE Medicare Solutions
Active Medicare Advantage Plans

Medicare Advantage Plans PPO (49 Counties)
• MAPD – Advantage Select, Advantage Choice, Advantage Enhanced;
• MA Only – Advantage Preferred;

Medicare Advantage Plans HMO (6 Counties)
• Networks; (St. Vincent, St. Francis, Community, Select, Eskenazi)
• Dual Eligible Special Needs Plan (SNP); for dual eligible (Medicaid & Medicare) members in 5 county area
  - Hamilton, Hancock, Marion, Johnson, Morgan;
Risk Adjustment 101

What is Risk Adjustment?

• the process by which CMS reimburses Medicare Advantage plans based on the health status of their members;

• Implemented to pay MA plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (e.g., age & gender) as well as health status;

• Risk-adjustment data is pulled from diagnosis data reported from claims data and medical record documentation from physician offices, hospital inpatient and outpatient settings;

• Hierarchical Condition Category (HCC) Model
Risk Adjustment 101 Importance
Significance for the Health Plan

• ADVANTAGE relies on complete reporting of medical diagnoses in order to build an accurate health risk profile for each individual patient;

• It is our goal for each patient to have an annual comprehensive assessment;

• It is our goal to capture each patient’s current and active diagnoses on an annual basis;
Risk Adjustment 101 Importance

Significance for Patients

• ADVANTAGE utilizes risk-adjustment data to determine care management programming resources for providing our members with patient-centric and collaborative support for those with complex care needs;

• Increased coding accuracy helps ADVANTAGE identify members who may benefit from disease and medical management programs;

• More accurate health status information can be used to match healthcare needs with the appropriate level of care;
Risk Adjustment 101 Importance
Significance for Providers

• Complete and accurate reporting allows for more meaningful data exchange between ADVANTAGE and providers to:
  – Identify potential new problems early;
  – Reinforce self-care and prevention strategies;
  – Coordinate care collaboratively;
  – Avoid potential drug-drug/disease interactions;
  – Improving the overall patient health care evaluation process;
  – Improving office practice patterns and communication among the patient’s health care team

• Commitment to risk adjustment will help providers meet their own CMS provider obligations which include the use of standard diagnosis coding standards in medical record documentation, reporting all conditions and diagnoses codes that exist on the date of an encounter, and participating in CMS Medicare Recovery Audit Contractor (RAC) and Risk Adjustment Data Validation (RADV) Audits.
Risk Adjustment 101

What are Hierarchical Condition Categories (HCC)?

- Category of medical conditions that map to a corresponding group of ICD-9 diagnosis codes; (3,000 ICD-9 codes map to 1 of 87 HCCS)
- The number of HCCs and affected ICD-9 codes can change from year to year;
- Implementation of ICD-10 will significantly impact the number of HCCs and the number of diagnosis codes currently in effect;

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis Code</th>
<th>ICD-9 Description</th>
<th>CMS-HCC Model Category</th>
<th>CMS-HCC Model Calendar Year 2010 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>260</td>
<td>K washiorkor</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>261</td>
<td>Nutritional Marasmus</td>
<td>21</td>
<td>Yes</td>
</tr>
<tr>
<td>262</td>
<td>Oth Severe Malnutrition</td>
<td>21</td>
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<tr>
<td>2630</td>
<td>Malnutrition Mod Degree</td>
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<td>Yes</td>
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<td>2631</td>
<td>Malnutrition Mild Degree</td>
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<td>2632</td>
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<td>Yes</td>
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<td>2638</td>
<td>Protein-Cal Malnutr Nec</td>
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<tr>
<td>7994</td>
<td>Cachexia</td>
<td>21</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Patient Risk Scoring

• There are approximately 87 risk score categories which map to over 3,000 different ICD-9 codes.

• In order to accurately reflect a patient’s risk profile, it requires more than the standard ICD-9-CM codes commonly seen in current billing practices.

• ADVANTAGE desires to offer tools that assist providers in reporting all needed information.
Risk Adjustment 101
Characteristics of CMS-HCC Model

- **HCCs/Multiple Chronic Diseases**: Base payment for each member based on HCCs and influenced by Medicare Costs for Chronic Diseases
- **Disease Interactions**: Additional factors applied when hierarchy of more severe and less severe conditions co-exist
- **Demographics**: Final adjustment due to: age, sex, original Medicare entitlement, disability & Medicaid status
- **Prospective in Nature**: Diagnosis from base year used to predict payment for next year
- **Diagnostic Sources**: CMS will only consider diagnoses from IP & OP Hospital & Physician Data
- **New Enrollee vs Existing Enrollee**
Annual Wellness Exam

• ADVANTAGE has designed an assessment form to facilitate completion and reporting of the annual wellness exam

• We would like each patient enrolled in the health plan to have this comprehensive assessment every year

• For our new members, our goal is to have an annual assessment performed within the first three months of plan enrollment
Risk Adjustment 101

Why is Medical Record Documentation Important to Risk Adjustment?

• Critical role in risk adjustment;

• Accurate risk adjustment payment relies on complete medical record documentation and diagnosis coding;

• Ultimately impacts the services and benefits ADVANTAGE Medicare Solutions is able to provide to its membership;

• CMS requires that all applicable diagnosis codes be reported and that all diagnoses be reported to the highest level of specificity and this must be substantiated by the medical record;

• ADVANTAGE conducts medical record reviews to identify additional conditions not captured through claims or encounter data and to verify the accuracy of coding:
  
  Ø Reviews performed to help us make sure all required ICD-9 codes are duly reported to CMS;

  Ø CMS requires that the medical record validate the diagnoses codes that have previously been reported by the Physician;
Risk Adjustment 101

What are RADV Audits?

• CMS audit that ensures the integrity and accuracy of risk-adjusted payment;

• Verifying that the diagnosis codes submitted by the Medicare Advantage plans are supported by the medical record documentation for a member;

• MA plans can be selected for RADV Audits annually;

• If selected, MA plans are required to submit member medical records to validate diagnosis data previously reported to CMS;

• Providers should be aware of RADV Audits because providers are required to assist the MA plan by providing medical record documentation for members included in the audit;
Risk Adjustment 101

Top 10 Medicare Risk Adjustment Coding Errors

1. The medical record does not contain a legible signature with credentials;
   - Sign Documentation & Include patient’s name, date of birth, and date
     of service on every page of the assessment form;

2. The electronic health record (HER) was unauthenticated (not electronically
   signed).

3. The highest degree of specificity was not assigned the most precise ICD-9 codes
   to fully explain the narrative description of the symptom or diagnosis in the
   medical chart.

4. A discrepancy was found between the diagnosis codes being billed vs. the actual
   written description in the medical record. If the record indicates depression, NOS
   (311 Depressive disorder, not elsewhere classified), but the diagnosis code written
   on the encounter claim is major depression (296.20 Major depressive affective
   disorder, single episode, unspecified), these codes do not match; they map to a
   different HCC category. The diagnosis code and the description should mirror
   each other.
Risk Adjustment 101

Top 10 Medicare Risk Adjustment Coding Errors

5. Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT);

6. Status of cancer is unclear. Treatment is not documented;

7. Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic;

8. Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia);

9. Chronic conditions or status codes aren’t documented in the medical record at least once per year;

10. A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code;

Providers should consider ways to improve clinical documentation: Develop an internal compliance plan and implement prospective and retrospective, internal and external chart reviews with ongoing monitoring and feedback.
Medical Record Documentation
Helpful Tips

• All chronic conditions must be assessed and reported annually;
  Ex: CHF, Diabetes, COPD

• Co-existing acute conditions
  Ex: protein calorie malnutrition

• Active status conditions
  Ex: amputations, HIV, dialysis

• Pertinent past conditions
  Ex: Old MI and other underlying medical problems

• Medications that may indicate other conditions
Medical Record Documentation
Helpful Tips

• Specific rather than general information
  Ex: major depression rather than depression, if applicable

• Causality
  Ex: diabetic neuropathy, not diabetes and neuropathy

• Highest level of specificity
  Ex: Diabetes w/ renal manifestations
  -Include Signs/Symptoms
  -Abnormal test results
  -Other reason for the visit

• Support documentation of conditions
  Ex: stable, controlled, uncontrolled, poorly controlled, improving, worsening, etc.
Medical Record Documentation
Helpful Tips

“History Of”

• “History Of” means the patient no longer has the condition;

• Frequent documentation errors regarding use of “History Of”:
  ➢ Coding a past condition as active;
  ➢ Coding “history of” when condition is still active;

• Exception: It is appropriate to document/code “history of” when documenting some status conditions (e.g. Amputation);

• Examples

<table>
<thead>
<tr>
<th>Incorrect Documentation</th>
<th>Correct Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF, Meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>H/O angina, meds nitroquick</td>
<td>Angina, stable on nitro</td>
</tr>
<tr>
<td>H/O COPD, meds Advair</td>
<td>COPD controlled w/Avair</td>
</tr>
</tbody>
</table>
Medical Record Documentation
Helpful Tips
Common Risk-Adjusted Categories

• Angina
• Cancer tumors (breast, prostate, colorectal, other)
• COPD
• CHF
• Diabetes, with any reported manifestations
• Ischemic heart disease
• Ischemic or unspecified stroke
• Rheumatoid arthritis & inflammatory connective tissue disease
• Specified heart arrhythmias
• Vascular disease
Medical Record Documentation
Helpful Tips
Chronic Conditions

• Over the years, several chronic conditions seem to fall off of claims submissions;

• For patients with chronic conditions, we recommend at least two office visits yearly to facilitate assessment and monitoring of complete information;

• All existing chronic illnesses should be documented in the medical record and have an assessment and a plan of care;

<table>
<thead>
<tr>
<th>Sample Language</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Plan of Care</td>
</tr>
<tr>
<td>Stable</td>
<td>Monitor</td>
</tr>
<tr>
<td>Improved</td>
<td>D/C Meds</td>
</tr>
<tr>
<td>Tolerating Meds</td>
<td>Continue Current Meds</td>
</tr>
<tr>
<td>Deteriorating</td>
<td>Refer</td>
</tr>
</tbody>
</table>
Medical Record Documentation
Helpful Tips

Common Missing or Incomplete Diagnoses

• Diabetes w/ manifestations
• Major depression versus depression
• Old myocardial infarction (Old MI)
• Renal failure
• Angina pectoris
• Cancers coded as “history of” rather than active
• Drug or alcohol dependency
Medical Record Documentation

Helpful Tips

Common Status Conditions

- Transplants
- Dialysis
- Old MI
- Paraplegia and Quadriplegia
- Amputations
- AIDS or HIV+ status
- Chronic or debilitating neurological conditions:
  - MS, ALS, Huntington’s Disease, myasthenia, epilepsy
- Ostomies (respiration, feeding, or elimination)
- Ventilators
Medical Record Documentation
Helpful Tips
Assess for Protein Calorie Malnutrition

- Involuntary weight loss > 10% in previous months
- Severely curtailed food intake
- Muscle wasting and fat loss
- Presence of edema or ascites
- Persistent GI symptoms
- Marked reduction in physical capacity
- Presence of metabolic stress due to trauma, inflammation, or infection
Medical Record Documentation
Helpful Tips

Inpatient Medical Record Documentation

Complete Inpatient Medical Record Documentation includes the following information:

• **Discharge Summary**
  - Valid IP record for coding if it has both the admit and discharge dates;
  - Use Inpatient Coding Guidelines to code;

- **Admission history and physical must be valid for IP record coding guidelines;**
- **Consults during the inpatient stay may be coded as physician records;**
  - Use Inpatient Coding Guidelines to code;

- **ER visit on the same date as admission date can be coded as an outpatient visit**
  - Use Inpatient Coding Guidelines to code;
Thank You!