VirginiaPremier™
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Medicare Advantage

Risk Adjustment Program

Provider Overview

6/29/18

Contents

What is Risk Adjustment?

Risk Adjustment was created in order to appropriately pay Medicare Advantage Organizations (MAOs) for care provided to members based on the health status of the members. Diagnosis (ICD) codes are collected and tracked by their specificity in risk adjustment models to create a patient profile of severity by illnesses. Each member receives a risk score from the Centers for Medicare and Medicaid Services (CMS) based on diagnosis identified through submitted claims and encounter data.

Risk adjustment is used to pay MAOs more accurately for the predicted health cost / expenditures of members by adjusting payments based on demographic factors and presence of disease conditions. Risk adjustment also helps Health Plans to identify patients for disease management programs, and to become more proactive in healthcare delivery. Therefore, reporting all diagnosis codes to their highest specificity is very important.

What are the Data Submission Requirements?

There are specific rules that govern MAO plan submission of data which are used in Risk Adjustment Scoring. Important considerations include:

- All diagnoses codes submitted must be documented during a “face to face” encounter and be clearly documented in the medical record
- MAOs may only use data from hospital inpatient facilities, hospital outpatient facilities, and physicians
- MAOs must follow ICD-10 coding guidelines
- MAOs must submit diagnosis at least once for each member during the plan year and must ensure data is accurate
    - If after submission it is discovered that submitted data does not meet CMS requirements, the MAO must delete the previously submitted data
- CMS sends reports back after submission which must be reconciled and changes tracked

How is Risk Score Calculated?

CMS calculates risk scores based on multiple criteria including demographic factors, enrollee status, and disease variables. CMS is transitioning from a Risk Adjustment Processing System (RAPS) based model to an Encounter Data System (EDS) model. During this transition, CMS will blend the two models to generate a combined Risk Score. After the transition, only the EDS model will apply. CMS believes the EDS model will supply more accurate and complete data. CMS will also use the encounter data for assessing quality, complexity, and effectiveness of care provide

For example in payment year (PY) 2018, CMS will **blend the two risk scores** to produce a final score.

- 85% of the score comes from the RAPS model
- 15% of the score comes from the EDS model

How does this affect me?

Many providers have expressed concerns about FFS (Fee-For-Service) rules when reporting E/M codes. Under those guidelines, a provider cannot count a diagnosis toward the E/M leveling selection unless the diagnosis was monitored, evaluated, assessed, or treated in some way. Meanwhile, ICD-10 guidelines have always instructed providers to code for all coexisting conditions at the time of the visit or encounter, but most providers have only reported ICD-10 codes that support the CPT® being billed. Coding for all current diagnose allows providers to illustrate how sick their patients are while also showing how much MDM (medical decision making) is involved when

treating patients with multiple comorbidities. Code for all active diagnoses, but only count those treated when choosing an E/M code.

For example, a patient who has Diabetes with nephropathy and uncontrolled hypertension is seen today. Patient also has a history of stroke and history of cancer. When the provider documents the encounter, all the active conditions that were evaluated, assessed and treated should be addressed in the MDM and coded to the highest degree of specificity. In this case cancer and stroke are documented as History of, and diabetes with nephropathy and uncontrolled hypertension coded to highest specificity.

Physician Role

Physician data is critical for accurate risk adjustment. Physicians are the primary source of data for the risk adjustment score. Ensuring that the members have an **annual wellness exam and/or comprehensive preventive exam** is a crucial component in the risk adjustment process. This visit provides the opportunity to discuss current issues with the member and accurately document the complexity of current disease states. Think about using the **TAMPER™** acronym for documentation during each visit. This will help ensure the documentation will be adequate to meet the parameters of the CMS Risk Adjustment Data Validation (RADV) audit.

- **T**reatment – What treatment is new or ongoing for a condition? Is the treatment effective?
- **A**ssess / Address – what conditions or complications are being assessed or addressed?
- **M**onitor – what conditions does the member have that require monitoring?
- **P**lan – what is the plan of care for the member? What conditions are the treatment plans addressing?
- **E**valuate – what conditions are being evaluated? What complications are being evaluated?
- **R**eferral – was a referral made for the condition?

Virginia Premier would like all new members to have their wellness exam within three months of becoming a member. This enables earlier management and documentation of conditions for the case and disease management, as well as, risk adjustment scoring.

There are some best practices and guidelines that will help with medical record documentation, and coding. Here are some that will help you stay compliant:

- Every visit within the medical record needs to contain a legible credentialed signature and date
    - Sign the documentation and include the patient's name, date of birth, and date of service on every page of the medical record form
- Make sure your electronic health record (EHR) is authenticated or electronically signed
- The highest degree of specificity needs to be documented so the most precise ICD-10 codes may be assigned
- Make sure that the diagnosis codes being applied to the claim, have supportive documentation provided within the medical record
- Status Codes and Chronic conditions need to be documented at minimum of once per year
    - Visits are required to be face to face
- Remember the TAMPER™ acronym during a patient exam if diagnoses are being treated assessed / addressed, monitored, planned, evaluated, or referred they can be coded and billed on the claim
- Conditions need to be in an assessment, and plan of action for follow up. Avoid using Past Medical History (PMH) for conditions that are still active or current.
- When writing medications, connect them to the diagnoses they treat
- Remember to always link casual relationships of diseases and their manifestations
    - Example: Diabetes with neuropathy, retinopathy, nephropathy

- Make sure the current conditions stay current, by using these words, stable, exacerbated, or referring the patient for the diagnosis
- Make sure history is historical by using healed, old, removed, or no longer being treated
- Arrows (←↑→↓) and or abbreviations are not an approved form of documentation for chart reviewers to use, please write out any abnormal labs that could be captured as diagnosis
    - Example: ↑ cholesterol should be documented as elevated cholesterol or LDL value
- Super Bills are not a good practice for billing, codes circled or written cannot be used
    - Coding requires a written diagnosis
- Remember to chart pressure ulcers along with the location and stage of the ulcer
- Drug and/or alcohol use instead of dependence is an important differentiating diagnosis for coding
- Outpatient Providers: If the following words / phrases are used with any diagnosis, that diagnosis will not be permitted to be coded and billed
    - Probable, Possible, Presumed, Likely, Suspect, Rule-out, Questionable, or any other uncertainty of the condition

The diagnoses tell a story about your patient from beginning to end. Clear, concise, consistent, and complete documentation can only bring success to you as a part of our Risk Adjustment Program at Virginia Premier. See the example below for impact on risk score for incomplete coding.

HCC Financial Difference in Coding and Documentation Improvement

No Coded Conditions (Demographics only)		Conditions Coded with Poor and Incomplete Specificity		Everything Coded Appropriately (Reviewed for Risk Adjustment)	
Criteria	**Factor**	**Criteria**	**Factor**	**Criteria**	**Factor**
82 Year-old	.557	82 Year-old Female	.557	82 Year-old Female	.557
Medicaid Eligible	.179	Medicaid Eligible	.179	Medicaid Eligible	.179
		DM (no Manifestations)	.118	DM with Vascular Manifestations	.368
		Vascular Disease (no complication)	.299	Vascular Disease with complication	.410
		No CHF Coded		CHF Coded	.368
		No Interaction		+ Disease Interaction = Bonus Factor (DM & CHF)	.182
Patient Total Risk Score	**.736**	**Patient Total RAF**	**1.153**	**Patient Total RAF**	**2.064**

Chart Audit Processes

Accurate documentation is critical in the delivery of high quality clinical care. Data validation ensures the integrity of you the provider, your place of employment, and the profession. Through the Virginia Premier audit process we will help you and your staff gain more knowledge of correct coding and documentation, which will in turn, bring more accurate financial revenue for your practice, and most importantly provide continuity of care to our patients so they receive the care they deserve. In addition to the official CMS RADV audit, Virginia Premier will conduct annual audits for a multitude of different members including those who are high risk and/or have complex conditions.

Starting in late February, Virginia Premier will be requesting access to records for members who

have had their annual wellness visit during the previous month. It will be important to appoint a contact person in your office for communication. We will provide a record review list to your contact person which will include the member names, identification numbers, dates of birth, and known dates of service.

The purpose of the audit is multipurpose:

- To validate that all items were covered in the annual wellness visit
- To evaluate that the medical record documentation supports submitted diagnoses codes on claims present and past
- To determine if the member's chronic conditions documented last year are addressed in the assessment and care plan for the current year

Virginia Premier contracts with ionHealthcare, LLC who will be reviewing the medical records. Records may be securely faxed to the Virginia Premier office or the auditor may acquire the record via an electronic health record. If you prefer the auditor acquire health records electronically, access will need to be granted in order to complete the audit. If you need any information from our staff to have temporary access granted, please feel free to reach out. Our contact information is listed below. Take into consideration the time frame it takes if access is needed, so that you can stay within the receipt of request days. We request that records be made available within 15 days of receipt of the request. Virginia Premier and ionHealthcare, LLC will maintain confidentiality and follow all rules related to protecting private information.

Important note:

During the CMS Risk Adjustment Data Validation (RADV) audits, participation is mandatory and on a time sensitive schedule. Provider offices failing to meet the CMS requirements may be subject to Virginia Premier administrative actions including corrective action plans and possible termination from the network.

Provider Office Reports and Dashboards

Virginia Premier will provide a quarterly report in a dashboard format to each provider and group. The report will contain the following:

- Projected risk score by member for those assigned to the practice based on currently submitted claims and encounter data
- A list of members that may have risk gaps

Access to a Certified Risk Adjustment Coding Auditor

Virginia Premier provides access to a Certified Risk Adjustment Coding Auditor for questions, education, and assistance. Please use the contact information below for assistance.

Quality Connection

Risk adjustment isn't just about finances. It has strong connections to quality and continuity of care for patients. Issuers are keenly focused on identifying chronic life-long illnesses and tending to these in a proactive approach to avoid ER visits and hospitalizations. Many diagnoses that are life-long have previously been unidentified in Fee-For-Service coding methods.

Concurrent STARS Measures Data Collection

In addition to conducting chart audits for risk adjustment, the auditor will also collect data for the Virginia Premier Stars Management Program. By completing both audits at the same time, we feel the process will be more efficient for both the office and Virginia Premier.

Here is the list of **STARS Measures** that may be reviewed during the audit:

- Date of breast cancer screening / mammogram
- Date and type of colorectal cancer screening
- Vaccination status for both influenza and pneumonia
- BMI assessment
- Diagnosis of Diabetes and care inclusive of each of these:
    - Most recent A1c level
    - Evidence of kidney disease monitoring
    - Dilated eye exam
    - Medications to include statin therapy
    - Most recent blood pressure
- Diagnosis of Rheumatoid Arthritis and review of medications for treatment
- Listing of all current acute conditions
- Listing of chronic conditions from the member history
- List of all conditions coded at the annual wellness visit and/or any other visits within the year (HCC coding purposes, matching to the member history)
- Listing of all medications including any documentation of barriers to medication adherence

Questions or Comments?

Please feel free to contact Virginia Premier with any questions or comments regarding our efforts to ensure safe, quality care for our members.

To schedule Risk Adjustment Coding Education
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Questions on Provider relationships, value based or performance contracting
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Brian Boyce- CEO Ion Healthcare

https://www.ionhealthcare.com/about