Key Components of Prospective and Retrospective Audits

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Learning Outcomes

1. Describe prospective audit and coding activities
2. Describe retrospective audit and coding activities
3. Review oversight concerns for performing prospective and retrospective activities
4. Discuss best practices
Prospective and Retrospective Activities Impact on Risk Adjustment

Ensure the accuracy and integrity of RA data submitted to CMS

Identify coding and documentation barriers and opportunities to reporting the most accurate and precise ICD-10-CM codes to describe a patient’s condition(s)

Receive appropriate reimbursement for the management and treatment of these conditions
Prospective Audits and Coding Activities
Prospective Activities

“What’s the best defense? A good offense” ~ George Washington

Why do prospective projects?

- Ensure all chronic conditions (physical and emotional/behavioral) are addressed at least once per calendar year
- Promote best practices in coding and documentation
- Provide the patient an opportunity to see a clinician in the calendar year
- Improve patient outcomes and coordination of care
- Alignment with quality initiatives for more complete/consolidated care
Prospective Activities

- “On-site” Coding and Auditing Departments
- Provider Education Programs
- Embedded Coding Programs
- Annual Wellness Visit
- CDI Programs
- Health Risk Assessments
# Coding and Documentation Requirements

<table>
<thead>
<tr>
<th>Clinical documentation must support the presence of a condition</th>
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<tbody>
<tr>
<td><strong>Documentation elements</strong></td>
</tr>
<tr>
<td>Face to face, valid provider, signature, credentials, POS, two identifiers on each page, DOS, legibility</td>
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<tr>
<td><strong>Support</strong></td>
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<tr>
<td>MEAT, TAMPER</td>
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<tr>
<td>Medications</td>
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<tr>
<td>Co-existing conditions</td>
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<tr>
<td><strong>When in doubt ... Query when documentation is ambiguous or contradictory</strong></td>
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### In House Coding and Auditing Resources

#### In House, On Site
- Can perform general or targeted coding and documentation reviews
- Review criteria based on denials history, difficult to code scenarios, or regulatory areas of concern

#### Teams
- Coders
- Compliance Department or Auditors

#### Impact
- Build relationships between coding teams and clinicians
- Address issues with queries before charges are submitted
Provider Education Programs

Documentation Best Practices

- HCC Coding and Documentation Education
- ICD-10-CM Coding Guidelines Updates
- AHA Coding Clinic clarifications

Teams

- Typically, a designated person or team that specializes in creating content to train and education clinicians or others on best practices
- Provider Educator
- Physician Champions
Provider Education Programs

Educate and train stakeholders that have impact on the risk adjustment process

- Clinicians
- Practice Managers
- Billers
- Coders
- CDI teams

Hold educational events focused on industry best practices and updates

Impact

- Emphasis on patient outcomes and continuity of care
- Solicit buy in from Executive leadership and the clinicians
Embedded Coding Programs

Embedded Coding Programs place a coding and documentation professional within a clinician’s office to provide education and feedback in advance of claims submission.

- Real time training on best practices for coding and documentation
- Work directly with clinician and staff

Teams

- Coders
- Clinical Documentation Improvement Specialists

Impact

- Good for clinics that do not have dedicated coding staff
- Preempt potential coding or documentation concerns
- Less retrospective work down the road
<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Open vs. Closed</td>
<td>Suspect conditions, Code clearing</td>
</tr>
<tr>
<td>Source</td>
<td>Persistency, Rx claims, non-codable sources</td>
</tr>
<tr>
<td>Impact</td>
<td>Provider information sharing, Patient outreach</td>
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Health Risk Assessment (HRA)

Health Risk Assessment is a screening tool used to identify health risks and monitor patient health status over time.

- Questionnaire, Self reported
- Assessment of health status
- Personalized feedback to address risks, prevent disease, and maintain health
- Identify health risks to improve health outcomes
- Close HCC Gaps and Quality gaps
- Coordination of Care

Where are they performed?

- Primary care setting
- In-Home Assessments (IHAs)
- Mobile Clinics
Medicare’s yearly “wellness” visit

- Medicare benefit for beneficiaries with prescribed timelines
  - G0402 – Initial Preventative Physical Exam (IPPE)
  - G0438 – AWV, initial
  - G0439, AWV, subsequent

- Address all patient conditions
  - Physical Health
  - Emotional/Behavioral Health

The Annual Wellness Visit is the optimal opportunity for clinicians to address all chronic conditions.

- Includes Health Risk Assessment
- Focus is on chronic conditions treatment and management
- Longer visit with a clinician
- Touchpoints with several members of the care team

Impact

- Close HCC and Quality Gaps
- Educate on and initiate use of resources
- Determine if Care Coordination is needed
An In-Home Assessment is a healthcare encounter performed in the patient's home by a clinician, usually a Nurse Practitioner or Physician Assistant.

Reflects the same standards as an Annual Wellness Visit:
- Health Risk Assessments
- Point of Care testing is available
- Added benefit of home observations

Impact:
- Addresses scenarios when a patient is unable or unwilling to see a clinician in traditional settings
- Close HCC and quality gaps
CDI Programs

Successful clinical documentation improvement (CDI) programs facilitate the accurate representation of a patient’s clinical status that translates into coded data. Coded data is then translated into quality reporting, physician report cards, reimbursement, public health data, disease tracking and trending, and medical research.

- CDI Specialist scrubs the patient health record in advance of presenting on a date of service
- Provides the clinician a listing of open and suspect conditions (HCC Gaps) to address during the face-to-face encounter

Team

- Clinicians, CDI Specialists, Certified Documentation Experts, Coders, Auditors

Impact

- Closes HCC and quality gaps
- Promotes coordination of care
Impact of Telehealth

- New to Medicare Advantage risk adjustment
  - For the duration to the Public Health Emergency (PHE), CMS has advised that effective 3/30/2020 dates of service, encounters performed by a valid clinician type utilizing an interactive audio and video telecommunication system will meet the face-to-face requirement for risk adjustment purposes
  - 4/10/20 Applicability of diagnoses from telehealth services for risk adjustment memo
  - 1/15/21 Applicability of diagnoses from telehealth services for risk adjustment memo - Updated

- HHS operated risk adjustment programs
  - Telehealth visits are considered equivalent to face-to-face interactions, but they are still subject to the same requirements regarding provider type and diagnostic value.
  - 4/27/20 Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQs
Impact of Telehealth

**GAME CHANGER**

- Provides access to a health care provider when being seen in person is not an option, not recommended, or not desired by the patient
- More access to health care providers
- More opportunity to be seen, treated, and managed
- Not all chronic conditions can be assessed thoroughly via telehealth
  - Example: diabetes, cancer
OIG Health Risk Assessments

Findings

• Diagnoses that MAOs reported only on HRAs, and on no other encounter records, resulted in an estimated $2.6 billion in risk-adjusted payments for 2017

• In-home HRAs generated 80 percent of these estimated payments. Most in-home HRAs were conducted by companies that partner with or are hired by MAOs to conduct these assessments—and therefore are not likely conducted by the beneficiary’s own primary care provider

• Twenty MAOs generated millions in payments from in-home HRAs for beneficiaries for whom there was not a single record of any other service being provided in 2016

Concerns

• Data integrity concern that MAOs are not submitting all service records as required

• Care coordination concern that beneficiaries are not receiving follow-up care to address diagnoses identified during HRAs

• Payment integrity concern that if diagnoses are inaccurate or unsupported, the associated risk-adjusted payments would then be inappropriate
Retrospective Audits and Coding Activities
Retrospective Projects

“Hindsight is 20/20” ~Billy Wilder, Richard Armour

Why do retrospective projects?

- Validate the data being submitted to CMS is supported in the medical record
- Identify opportunities to address coding and documentation deficiencies
- Ensure all chronic conditions evaluated in a CY make it to CMS for risk score calculation
- Collaborate with quality initiatives for more accurate and complete care insights
Retrospective Projects

- Provider Education Programs
- Medical Record Retrievals
- Encounters Supplemental Submissions
- Technology Solutions
- Risk Adjustment Data Validation (RADV)
Provider Education Programs

Retrospective coding review of encounters already reported to the health plan for submission to CMS

- General reviews to assess coding and documentation quality and accuracy
- Targeted reviews based on provider or group performance (risk scores, HCC gaps)
- Identify under coding, over coding

Teams

- Coding educators, auditors, CDI specialist, data analysts

Impact

- Share findings with providers and healthcare leadership, make recommendations based on metrics
- Customize coding education and feedback based on review findings
- Improved coding and documentation accuracy and completeness
- Identify issues with data submission

RISK ADJUSTMENT 2021
Medical Record Retrievals

Medical record retrievals are the collection of patient health records for the purpose of validating that all documented conditions are accounted for. Medical record retrievals are performed for variety of purposes including chart reviews and RADV.

- Health plans, groups, or hired vendors will work with clinical sites to retrieve copies of medical records. The records are coded and any missed (adds) or invalid (deletes) are reported to CMS for risk score calculation via the **supplemental submission** process.

- **Teams**
  - Coding educators, auditors, CDI specialist, data analysts, vendors

- **Coding**
  - 1<sup>st</sup> Pass – Abstract ICD-10-CM codes from retrieved documentation
  - 2<sup>nd</sup> Pass – QA of work of the 1<sup>st</sup> pass coding process
  - Artificial Intelligence (AI), Natural Language Processing (NLP), Machine Learning, Computer Assisted Coding (CAC)
Using Risk Adjustment Processing System (RAPS) and Encounter Data Processing System (EDPS), a health plan will report new diagnoses and remove unsupported diagnosis codes.

The submission process alerts CMS of the method the encounter was performed, including encounter data and chart reviews.
Medical Record Retrievals

Impact

- Allows health plan, group, or hired vendor to add or delete diagnosis codes based on what is supported in documentation, resulting in accurate, appropriate risk scores
- Share findings with providers and healthcare leadership, make recommendations based on metrics
- Customize coding education and feedback based on review findings
- Identify issues with data submission

Challenges

- Clinician abrasion, participation
- Locating records
- ACA diagnoses must match to a claim
- Medicare Advantage diagnoses do not have to match to a claim
OIG Chart Reviews

Findings

• MAOs almost always used chart reviews as a tool to add, rather than to delete, diagnoses—over 99 percent of chart reviews in our review added diagnoses.

• Diagnoses that MAOs reported only on chart reviews—and not on any service records—resulted in an estimated $6.7 billion in risk-adjusted payments for 2017.

• CMS based an estimated $2.7 billion in risk-adjusted payments on chart review diagnoses that MAOs did not link to a specific service provided to the beneficiary—much less a face-to-face visit.

• Although limited to a small number of beneficiaries, almost half of MAOs reviewed had payments from unlinked chart reviews where there was not a single record of a service being provided to the beneficiary in all of 2016.

Concerns

• Data integrity concern that MAOs are not submitting all service records as required.

• Payment integrity concern if diagnoses are inaccurate or unsupported—making the associated risk-adjusted payments inappropriate.

• Quality-of-care concern that beneficiaries are not receiving needed services for potentially serious diagnoses listed on chart reviews, but with no service records.

RISK ADJUSTMENT 2021
Risk Adjustment Data Validation (RADV)

Retrospective Audits used by CMS to validate that medical record documentation supports diagnoses submitted by a health plan to CMS for risk adjustment purposes

- Medicare Advantage RADV
  - Improper Payments Measure Program (National RADV)
  - Contract Level

- HHS RADV
  - ACA Marketplace
Improper Payments Measure Program RADV

NAT RADV → Improper Payments Measure Program (IPM) for reporting year 2021 (CY2019)

CMS is required to annually calculate and report improper payment measures for the Medicare Part C and Part D programs. The Part C IPM activities verify that diagnosis codes submitted for payment by an MA organization are supported by medical record documentation for an enrollee:

- All payers that have Medicare Advantage contracts participate
- Medical record retrievals are performed to obtain records for submission to the Central Data Abstraction Tool (CDAT), the records are used to substantiate reported HCC’s
- Data driven, no repayments
- Determines the error payment reporting
The goal of Contract-Level RADV is to identify discrepancies in payments by comparing RA diagnosis data submitted by a Medicare Advantage Organization (MAO) for payment against medical record documentation provided by MAOs during Contract-Level RADV audits.

- Repayments to CMS based on validation of HCC’s (payment recovery)
- “Random”, CMS determines what contracts are selected for contract RADV
  - At least one (1) CMS-HCC assigned resulting in a positive risk-adjustment payment amount for the payment year in question
  - Continuous enrollment in the contract for the entire data collection period and the first month of the payment year
  - No end-stage renal disease (ESRD) and hospice status
  - For selected enrollees, all audited CMS-HCCs that contributed to the risk-adjusted payments for the payment year in question will be reviewed

[Link to CMS website for further information](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/RADV-Industry-Slide-Deck.pdf)
Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance

Contract-Level 15 Risk Adjustment Data Validation
Medical Record Reviewer Guidance
In effect as of 01/10/2020*
Version 2.0

* This guidance will be used for audits commencing after 01/10/2020

01/01/2020

The general guidance in this document is nonexclusive. In addition to this guidance, all other rules, requirements, and instructions relating to medical record documentation, submission of diagnoses, and the coding of diagnoses apply, including, but not limited to, the supporting medical record be clear and unambiguous, the requirements set forth in Chapter 7 of the Medicare Managed Care Manual, the requirements of the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting (ICD-9-CM), and all requirements set forth in Medicare regulations, the Parts C and D contracts, and the Electronic Data Interchange Agreements.

Centers for Medicare & Medicaid Services
Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance

This checklist list has been provided to Medicare Advantage contracts involved in RADV audits. This list may help to determine a medical record's suitability for RADV. Any items checked “no” may indicate that the medical record will not support a CMS-HCC.

Yes  No
☐  ☐ Is the record for the correct enrollee?
☐  ☐ Is the record from the correct calendar year for the payment year being audited (i.e., for audits of 2013 payments, validating records should be from calendar year 2012)
☐  ☐ Is the date of service present for the face to face visit?
☐  ☐ Is the record legible?
☐  ☐ Is the record from a valid provider type? (Hospital inpatient, hospital outpatient/physician)
☐  ☐ Are there valid credentials and/or is there a valid physician specialty documented on the record?
☐  ☐ Does the record contain a signature from an acceptable type of physician specialist?
☐  ☐ If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-Generated Attestation for this date of service?
☐  ☐ Is there a diagnosis on the record?
☐  ☐ Does the diagnosis support an HCC?
☐  ☐ Does the diagnosis support the requested HCC?
Ensures the integrity of the HHS-operated risk adjustment program and to validate the accuracy of data submitted by issuers for use in transfer calculations, CMS performs risk adjustment data validation in states where the HHS-operated program applies (HHS-RADV).

- Annual retrospective audit
- Ensures that the issuers’ actual actuarial risk is reflected in transfers and that the HHS-operated program assesses charges to issuers with plans with lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk
- Sample is determined by CMS, 200 enrollees from each issuer
- Coding is performed to validate submitted diagnoses
- Medical Record Retrievals activities to submit records to CMS to substantiate reported HCC’s
- Records submitted via the External Data Gathering Environment (EDGE) server
HHS-RADV is a six (6) step process:

1. CMS selects a sample of an issuer’s enrollee records for audit.

2. Each issuer selects an IVA Entity to validate the demographic and enrollment (D&E) data, Prescription Drug Categories (RXC)s data, and health status data submitted on the issuer’s EDGE server for the selected sample enrollees.

3. A Second Validation Audit (SVA) is performed on a subsample of IVA Entity submission data to verify the accuracy of the IVA findings.

4. CMS performs Error Estimation and calculates issuer risk score error rates using the failure rate for each HCC across all issuers’ IVA samples (or SVA samples, as applicable).

5. CMS administers the SVA Findings Attestation and Discrepancy Reporting Process, the Error Rate Attestation and Discrepancy Reporting Process, and an Administrative Appeals Process.

6. Final results are used to adjust RA risk scores and the transfers

HHS RADV - Protocols

- Defines Protocols and guidance for the HHS-RADV process, outlines participant roles and responsibilities, and defines activity timelines.
- Protocols are dynamic
- Appendix C: Lifelong Permanent Conditions
Best Practices
Best Practices

“Start with why” ~ Simon Sinek

- Ensure the accuracy and integrity of the data being submitted to CMS for risk score calculation
- Address coding and documentation prospectively to reduce the need for retrospective interventions
- Ensure members have opportunity to engage with a health care provider in the calendar year
- Evaluate and audit the operational activities that support the transmission of data to CMS
How can we accomplish this?

- Quality versus quantity mindset
- Collaboration with clinicians and healthcare systems
- Rigorous controls to ensure reliability of data
- Working with vendors to achieve goals
- Bring value with efforts
What we want to avoid?

- Diminish clinician abrasion
- Reduce duplication of efforts
- Not providing value
- Not applying lessons learned
Perspective

- High Quality Coding and Documentation
- Accurate Risk Scores
- Improved Patient Outcomes
- Appropriate Reimbursement
Thank you!

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