READY. SET. GO.
We’ll get you to ICD-10 in record time.

Best Practices Roundtable on Risk Adjustment
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Publisher Notice

Although we have tried to include accurate and comprehensive information in this presentation, please remember it is not intended as legal or other professional advice.
Who are we?

• Sheri Poe Bernard, CPC, CPC-H, CPC-I
  – Consultant with this work history:
    • VP of Quality and Training, Outcomes Health Information Solutions
    • 15 years leading product development at Medicode/Ingenix/OptumHealth
    • 3 years VP of clinical content at AAPC

• Lynne Padilla, CPC, AHIMA-Approved ICD-10-CM/PCS Trainer
  – Coding professional with more than 25 years work history:
    • VP of Coding Operations and Quality, Peak Health Solutions
    • Director of Quality and Training (Coding and HEDIS), Outcomes Health Information Solutions
    • Director of Medical Course Development, Allied Medical Schools
Who are you?

• Raise your hand if:
  – You are a coder/manager in a provider office
  – You are a hospital coder/manager
  – You are an RA auditor/manager working for a consulting company
  – You are an RA auditor/manager working for a health plan
  – You are with the government
  – Who else is out there?

• Welcome!
Today’s Goals

• Discussions limited to Medicare Advantage and risk adjustment auditing
  – NOT an introduction to risk adjustment

• Start with an overview of one RADV and one mock RADV audit

• Open discussion on how to improve quality and protect your plan against negative audit results

• We hope you will share your audit stories!
Excerpt from OIG RADV Findings Report

• The Medicare Advantage Organization (MAO):
  – “did not have written policies and procedures for obtaining, processing and submitting diagnoses to CMS.”
  – “practices were not effective in ensuring that the diagnoses submitted to CMS complied with the requirements of the risk adjustment” manual.
  – officials stated that the providers were responsible for the accuracy of the diagnoses … submitted to CMS.

• Recommendations for this particular MAO:
  – Refund less than $200K in direct overpayments
  – Work with CMS to determine the correct adjustment for extrapolated overpayments of $115MM for the payment year of $827MM (14% of total)
  – Plan should implement written policies and procedures for obtaining, processing and submitting diagnoses and improve current practices
Excerpt from Same MAO’s RADV Findings Report

• “Significant” error rate in 100 samples
  – 57 valid
  – 43 invalid:
    • Documentation did not support the associated diagnosis
    • Diagnosis was unconfirmed (i.e., probable, suspected, questionable, rule out, working diagnosis as accepted in an inpatient setting)

Total value of overpayments for the sample: $183,247
Value of sample: $1,143,851
Percentage in overpayments: about 14.5%
Excerpt from OIG RADV Findings Report

- Error clusters, in order of frequency:
  - Vascular disease
  - Diabetes mellitus
  - Congestive heart failure
  - Ischemic or unspecified stroke
  - Major depressive, bipolar, or paranoid disorder
  - Chronic obstructive pulmonary disease
  - Malignant neoplasms
MAO's response to RADV

- **HCC** 92  **ICD-9** 426.0 Atrioventricular block, complete

  - “Final submission DOS 10/26/2006 documentation notes patient with complete heart block (426.0) treated with pacemaker; pacemaker evaluated during visit. Would offer as diagnosis per Coding Clinic that states although diagnosis of heart block not present still code as pacemaker was evaluated for functioning.”
**Coding Clinic**

**Coding Clinic Issue 5, 1993:**

- Although it can be argued that sick sinus syndrome (SSS) is an ongoing condition controlled by a pacemaker, no code assignment is required if no attention or treatment is provided to the condition or device. This differs from the ongoing medication administration provided for conditions such as congestive heart failure, hypertension or diabetes mellitus, and therefore, justifying code assignment. The use of V45.0, Cardiac pacemaker in situ is optional; some facilities will want to code the presence of the device for tracking purposes. Use of code V45.0 does not imply management of the pacemaker, only its presence.

- Pacemaker, **not heart block**, was evaluated during the encounter.
MAO’s Response to RADV

• HCC 15 ICD-9 250.40 Type 2 diabetes mellitus with renal manifestations

• “Final submission DOS 5/30/2006 Page 2 documentation supports that the patient presented to the hospital with shortness of breath and weakness. On Page 7 under the impression, acute renal failure likely clearing off secondary to diuresis is listed as number one along with the following comment: ‘Would also need to consider component of diabetic neuropathy.’ It is suspected that neuropathy is a typo and should be nephropathy as diabetic neuropathy is also documented in list under impression. Additionally, DOS 3/6/2006 Page 2 supports that the patient was in for a visit for consult on labs and states DM type 2 with nephropathy and Chronic Renal Failure. It also states CHF stable, hypertensive heart disease stable, and old MI. Discussion included diet and weight loss with Avandia added to control DM. Therefore, would offer DM Type 2 with nephropathy as a valid diagnosis.”
MAO’s Response to RADV

- **HCC 10**  
  **ICD-9 174.9** Malignant neoplasm of breast

- “Final submission DOS 2/28/2006 Page 3 states breast cancer (174.9) treated with lumpectomy. Tomoxifen and patient is currently on Evista. Breast exam performed and mammogram requested. Per documentation, patient was evaluated with a mammogram and treated with Evista which is used to prevent further breast cancer.”
Coordination and Maintenance Committee Meeting

Tamoxifen

Agenda, Sept 27-28, 2007:

The ICD-9-CM distinguishes between current cases of cancer and personal history of cancer. The use of long term prophylactic agents to prevent recurrence of disease raises questions as to when treatment is actually complete. This issue was raised with Gynecologists at ACOG. These agents are used to prevent recurrence and metastasis, so classifying their use as prophylactic is valid, regardless of whether a cancer code or a V code for history of cancer is used.
MAO’s Response to RADV

• **HCC 149**  **ICD-9** 707.15 Ulcers of other part of foot

• “Final submission DOS 10/18/2006 Page 2 documentation supports that the office visit was at Podiatrist’s office and the main problem was an ulcer. Location of the ulcer is documented as R/L; therefore, unable to determine where on body the ulcer was located. Correct ICD-9 code for chronic ulcer of unspecified site is 707.9 which is within the original HCC of 149.”
Guidelines for Coding and Reporting

IV.C.
For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.”

Quoted in 7.2.2. of the 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide
MAO’s Response to RADV

- **HCC  9   ICD-9  171.2**  Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder

  - “ICD-9 code 171.2 was submitted on 12/07/2006. The OIG has noted that there is no evidence of an evaluation, clinical findings and/or treatment related to the ICD-9 code.

  “Upon review of the medical records, the patient was seen on 12/21/2006 by XXX, notes a left forearm lesion that was not healed and that appears to be squamous cell carcinoma. This lesion was present on the previous visit of 12/7/2006 and XXX referred the patient to XXX. The patient was seen on 12/28/2006 by XXX who noted a 1 cm ulcerated lesion of the left forearm. Local excision was planned. The clinical picture of a non-healing ulcer of several weeks duration is consistent with a malignancy.

  “Per our coding experts, reference to the shoulder in the ICD-9 description is permissible, not mandatory. That is, the description of the code is for the upper limb to include the shoulder if involved.”
Guidelines for Coding and Reporting

IV.C.

• “Probable,” “suspected,” “questionable,” “rule out” or “working” diagnoses cannot be reported to CMS as valid diagnoses by a physician.

Quoted in 7.2.2. of the 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide
Guidance within the OIG Report

• “For a second beneficiary, (the MCO) submitted the diagnosis code for ‘peripheral vascular disease (PVD).’ CMS used the HCC associated with PVD in calculating the beneficiary’s risk score. However, the documentation that (the MCO) provided indicated that the patient’s chief complaint on the date of service was pain in her right foot, which was caused by a heavy can that fell on her foot. The documentation did not mention PVD or indicate that PVD had affected the care, treatment, or management provided during the encounter.”
Guidance within the OIG Report

• “For a third beneficiary, (the MCO) submitted the diagnosis code for ‘malignant neoplasm of the brain, cerebrum, except for lobes and ventricles.’ CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. However, the documentation that (the MCO) provided referenced benign prostatic hypertrophy. The documentation did not mention brain cancer or indicate that brain cancer had affected the care, treatment, or management provided during the encounter.”
Guidance within the OIG Report

• “One beneficiary, (the MCO) submitted a diagnosis code for ‘chronic airway obstruction, not elsewhere classified.’ CMS used the HCC associated with this diagnosis in calculating the beneficiary’s risk score. The documentation that (the MCO) submitted noted a ‘history of smoking with possible mild chronic obstructive pulmonary disease.’ Diagnoses that are ‘probable,’ ‘suspected,’ ‘questionable,’ or ‘working’ should not have been coded.”
Excerpts from a Mock RADV Audit Report

• The Health Plan
  – Chart collection and retrieval posed a significant challenge
    • 20% of dates of service were not present in the MRs collected
    • AIDS/HIV (042, V08) and mental disorders (290-319) accounted for the largest amount of DOS not present
  – Conditions reported were not adequately supported in documentation
    • 25% of codes not supported or were overcoded (RISK)
  – Only 1/3 of all conditions were confirmed as an exact code match
    • Codes were often reported incorrectly at the 4th and 5th characters
  – Signature deficiencies will require CMS-generated attestations
    • 16% of records had a signature deficiency
  – Undercoding was low (1.3%)
    • Most commonly missed codes were old myocardial infarction (412) and long-term use of insulin (V58.67)
Excerpts from Same Mock RADV Audit Report

- **Recommendations for the Health Plan**
  - Develop a collection tool to increase DOS /chart retrieval
    - Include the actual disease /condition requested in the medical record documentation, DOS, ICD-9-CM code, HCC, and reason for the audit
    - Include language on “Meaningful USE” and how the record will be utilized and by whom
    - Increase sample size for those groups with the highest rate of DOS not present. Determine if at risk for fraud
  - Identify the top codes/HCCs unsupported or overcoded
    - Targeted education by group/provider based on results. Limit to 5 error trends
  - Develop P4P program to reduce risk and improve documentation
  - Conduct additional confirmation audits based on new RADV methodology
    - Stratify members as low, moderate, high risk. Increase sample size
Excerpts from Same Mock RADV Audit Report

• 15 groups (providers) were responsible for 25% of the errors
  – State 1
    • 5 providers (Internal medicine, multispecialty and endocrinology)
    • Highest error rates in office and outpatient settings
    • 1 provider **32 of 32 DOS not present**
    • 2 providers identified with higher than Health Plan average of undercoding
  – State 2
    • 10 providers (General clinic services, general hospital subspecialty)
    • 100% of errors limited to OP hospital and ED
    • 1 provider **35/37 DOS not present**
Excerpts from Same Mock RADV Audit Report

• Findings for unsupported or overcoding
  – 24% lacked (MEAT). Documentation did not support the condition
  – Acute conditions coded in the outpatient setting that were resolved or a history
  – Conditions stated on a problem list not brought to the assessment/plan. Not addressed during the face-to-face encounter
  – PMH versus active chronic conditions
  – Manifestations not clearly linked to underlying disease
    • Diabetes and comorbidities
Guidelines for Coding and Reporting

Guidance for problem lists

• “For CMS’s risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service, and it must be signed and dated by the physician or physician extender.”
  – Be sure the problem list is incorporated into a face-to-face visit by an acceptable provider and the chronic conditions have been addressed.
  – Quoted in 7.2.4.3 of the 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide
Guidelines for Coding and Reporting

Guidance for problem lists

• “When reviewing medical records, pay special attention to the problem list on electronic medical records. Often, in certain systems, a diagnosis never drops off the list, even if the patient is no longer suffering from the condition. Conversely, the problem list may not document the HCC your MA contract submitted for payment.”


• The checklist and guidance are available on CMS’s web site at http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/RADVIndustryTrainingSlides.pdf
Error clusters, in order of frequency:

- Diabetes mellitus and diabetes mellitus with associated manifestation
  - Accounted for 25% of all codes not supported
  - Targeted by CMS in RADV
- Cystic fibrosis
  - Not confirmed in 12 of 12 encounters. Misinterpretation of abbreviation in MR
- Ischemic or unspecified stroke
  - Coded acute episodes in OP setting/not supported. History
- Major depressive, bipolar, or paranoid disorder
- Chronic obstructive pulmonary disease
- Peripheral vascular disease
- Malignant neoplasms
  - Reported as current when documentation clearly supports a history
  - Targeted by CMS in RADV
Auditor’s Response to Health Plan

• **HCC** 15 and 105
• **ICD-9** Diabetes complicated by peripheral vascular disease 250.70 and 443.81

• Patient has DM noted in history on insulin. PVD stated in ROS; however, not pulled to assessment or linked to DM as a complication. No other support.
Guidelines for Coding and Reporting

• “Records submitted to validate HCCs that encompass additional manifestations or complications related to the disease (e.g. HCC 15, Diabetes with Renal Manifestations or Diabetes with Peripheral Circulatory Manifestations) should include language from an acceptable physician specialist which establishes a causal link between the disease and the complication. An acceptable record that clearly defines the complication or manifestation and expressly relates it to the disease may validate the HCC. A record that does not define and link this relationship may not validate the HCC.”

Auditors Response to Health Plan

- **HCC 107 ICD-9** Cystic fibrosis 277.00

  - “We were unable to confirm 12 of 12 encounters submitted for cystic fibrosis. There is no medical record documentation to support this condition in the measurement year (MY).”

  - 12 coding errors based on $0.385 \times 800 \times 12 = $3,696 per member. This does not include extrapolation of these errors (along with others) to the entire MA contract.

**Health Plan RISK!**
2013 OIG Work Plan

• What does this mean for you?
  – Provision of Services—Compliance with Medicare Requirements
    • We will review MA organizations’ oversight of contractors that provide enrollee benefits, such as prescription drugs and mental health services. We will determine the extent to which MA organizations oversee and monitor their contractors’ compliance with regulations and examine the processes they use to ensure that contractors fulfill their obligations.
    • MA organizations are **accountable** for the performance of the entities with which they contract. MA organizations that delegate responsibilities under their contracts with CMS to other entities must specify in their contracts with those entities provisions that the entities must comply with all applicable Medicare laws, regulations, and CMS instructions. *(42 CFR § 422.504(i)(4)). (OEI; 00-00-00000; expected issue date: FY 2014, new*
2013 OIG Work Plan

- What does this mean for you?
  - **Encounter Data—CMS Oversight of Data Integrity (New)**
    - We will review the extent to which MA encounter data reflecting the items and services provided to MA plan enrollees are complete, consistent, and verified for accuracy by CMS.
    - In 2012, MA encounter data reporting requirements will expand from an abbreviated set of primarily diagnosis data to a more comprehensive set of data. (One Time Notification, Pub. 100-20, CR 7562.)
    - Prior CMS and OIG audits have indicated **vulnerabilities in the accuracy of risk adjustment data reporting by MA organizations**. (OEI; 00-00-00000; expected issue date: FY 2014, new)
2013 OIG Work Plan

What does this mean for you?

Risk Adjustment Data—Sufficiency of Documentation Supporting Diagnoses

We will determine whether the diagnoses that MA organizations submitted to CMS for use in CMS’s risk-score calculations complied with Federal requirements. We will review the medical record documentation to ensure that the documentation supports the diagnoses submitted to CMS. Payments to MA organizations are adjusted on the basis of the health status of each beneficiary. (Social Security Act, §§ 1853(a)(1)(C) and (a)(3).) MA organizations submit risk adjustment data to CMS in accordance with CMS instructions. (42 CFR § 422.310(b).) (OAS; W-00-09-35078; W-00-10-35078; various reviews; expected issue date: FY 2013; work in progress)
Open the Floor for Discussion
Thank You!

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