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REPORT

HCC CODES MOST TARGETED BY DOJ AND STRATEGIES TO REMAIN COMPLIANT

While it is not possible to avoid an audit, there are a few things you can do to prepare.

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HCC audits are growing. Physician group scrutiny is next. Are you prepared?

The compliance audit pressure on provider groups is mounting, and the landscape is not easy to navigate. Some of this may seem unfair and biased, and some are clearly warranted. For example, October saw the DOJ announce a new suit against Cigna while the Supreme Court refused to step in on behalf of Molina Healthcare, letting a whistle-blower case proceed unchecked. We know you are doing your best, and your clinicians are doing their best. But that is no defense in an audit - the only thing that matters is facts, documentation, accuracy, and pure compliance. Practicing healthcare is an art, but documenting is a strict science, and anything less than accurate documentation vigorously maintained will likely result in negative audit outcomes and your group's name landing in next month's headlines.

CMS and DOJ have been increasingly scrutinizing payor strategies and billing patterns as it pertains to Hierarchical Condition Categories (HCCs). As more and more physician groups take on risk in the VBC models, it is imperative that physician groups do not make the same mistakes as their payor partners (intentionally or not).

The following 3 strategies will help reduce your risk of overcoding resulting in significant fines. Further, when proactively implemented, it will propel you forward as a company committed to accurate documentation.

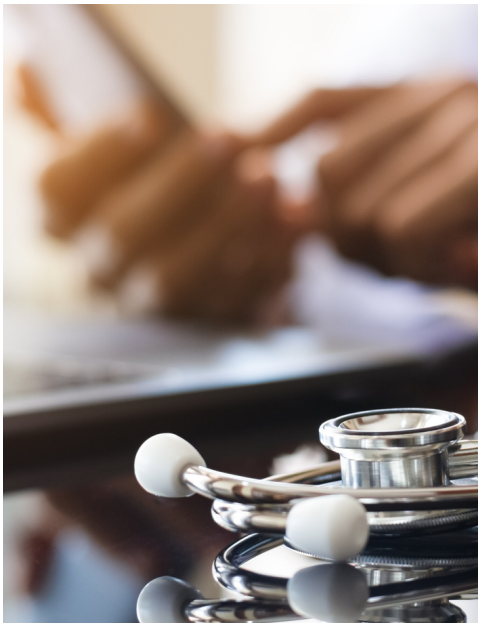
1 Using Acute Codes

As a rule of thumb, they should not repeat 2 years in a row for a specific patient. Acute heart attack is one of the most common errors penalized by CMS and the DOJ. One reason for this is misunderstanding how to document "history of heart attack" vs "heart attack." Another version is chronic conditions that have been mis-coded as acute. There is a very short distance between inaccurate documentation and upcoding and practicing good medicine. You should build out a process to look for these, year over year. Without it, they will get you into audit trouble.

Process recommendation:

- Pull a report each quarter from your EMR with acute HCCs documented two years in a row on the same patient**
- Manually audit each chart quarterly to ensure the patient did have a recurrence of an acute code.
- For all diagnoses that were inaccurate, notify payor partners immediately so those codes do not get submitted to CMS.

***If your EMR does not have these reports readily available, DoctusTech can help.*



Quick tips on the most commonly overcoded acute codes:

1. **Acute Stroke (I63.0-I63.9):** code history of stroke. Let the ER doctor code acute stroke unless the patient is currently having a stroke in the office.

2. **Acute Heart Attack (I21.0-I21.A9):** Can be coded only within 4 weeks of the event. After that, it must be "history of" (I25.2)

4. **Vascular Claudication:** This is often considered necessary to diagnose PVD, but it is not. It only regularly occurs in less than half of patients who have PVD. Rather than looking for claudication, screen with a yearly ABI to make sure you are accurately capturing all cases of PVD

5. **Lung, Breast, Colon Cancers:** code as active only when it is currently active or being treated - prophylactic chemo, adjuvant therapy, etc; code history of when it is in remission and no longer being treated. To often doctors carry the problem over from their problem list as they are still asking questions about the disease for early detection. This is still overcoding.

It is sometimes appropriate to use these within the year where the acute event occurred, but the following year you must diagnose and document a different code. *The third most common acute condition dinged by CMS is the combination of #1 & #2 - Acute Stroke and Acute Heart Attack.*

2 Lack of clinical accuracy or supporting documentation

Medical diagnoses are complex and sometimes exist in the gray area between possibilities - but coding and compliance are hard rules. While RADV audits are routinely looking for MEAT criteria, they are less focused on the actual clinical criteria or proving the accuracy of the diagnosis. So focus on documentation, your doctors are already deeply committed to accurately diagnosing.

What is the MEAT Criteria?

M = Monitoring by ordering or referencing labs, imaging studies or other tests
E = Evaluation with a targeted part of the physical examination specific to a certain diagnosis
A = Assessment of the status, progression or severity of the diagnosis
T = Treatment with medication, surgical intervention or lifestyle modification. Treatment also includes referral to a specialist for consultation or management.

Commonly misrepresented diagnoses:

The exact criteria can be confusing even though the treatment can be the same for mild, moderate, and severe forms of the following diseases. Misrepresentation of the severity can result in $$ in overpayment from CMS.

1. **Major Depressive Disorder:** Sometimes diagnosed where a severe depression NOT major depression would be more appropriate. Focus on education of DSM-V criteria to your clinicians.

2. **Substance use disorder:** Often diagnosed based on the volume a patient drinks alone or off of a screening tool like the AUDIT-C. To make this diagnosis, the DSM-V criteria needs to be followed.

3. **CKD:** This diagnosis requires 2 measurements 3 months apart to rule out AKI. This should not be diagnosed off of one measurement.

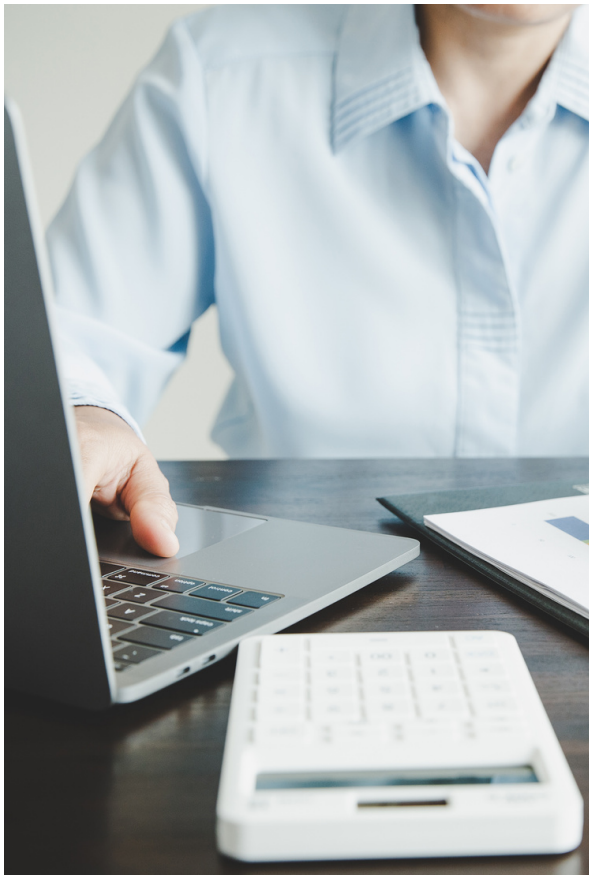
3 Diagnosing without care

Now that you've diagnosed it, what are you doing about the disease? A diagnosis that does not demonstrate a direct and deliberate impact on the plan of care is almost always incorrect at best, and in an audit, illegal. Diagnosing and documenting should function as a mechanism of providing care; documenting to document is never correct. So be on the lookout for conditions diagnosed and codes submitted that do not impact the plan of care. These are often targeted by CMS, both in OIG compliance audits and RADV audits.

Examples to look for:

- Embolism code documented without anticoagulant medication prescribed
- Secondary hyperparathyroidism documented without monitoring calcium or vitamin D.

Build a culture that connects patient care to diagnostic specificity and accuracy in coding and documentation. No doctor wants the business managers coming down from their offices, clipboard in hand, scolding about how code capture and RAF scores impact revenue. But every clinician understands the need to improve care and decrease costs. So start there - in VBC, practicing good medicine and providing better care starts with accurate diagnosis right through to rigorous documentation.



Documentation enables treatment, funds resources to provide care, ensures better health outcomes for patients, and actually lessens clinician workload - when done correctly.

Chart audits do not have to be brutal, they can be helpful, asking clinicians how a particular diagnosis changes the care trajectory and helping document for maximum patient benefit. Internal meetings should focus on coding as care. And manual chart reviews should be performed by medical doctors to give timely 1-to-1 feedback. If this is done, the last error on the OIG's list of usual suspects will go down:

- Potentially Mis-keyed Diagnosis Codes - these are much harder to find in the EMR, but overall not incredibly difficult to prevent.

If you encounter *any of these* **most common audit offenders** in your EMR or in chart reviews, you are not alone. Even the most compliant orgs have errors, submit undocumented codes, and get dinged on audits. The key is to demonstrate in good faith that you are doing all that can be done to rigorously maintain the highest possible standards of compliance, documentation, and care through specific and accurate documentation.

Often, compliance audits specifically reference a lack of compliance efforts and imply bad motives. One recourse to that is to demonstrate that you are doing all that can reasonably be done to maintain the highest possible standards of compliance in documentation and coding. In so doing, you will demonstrate good faith, and when it is your turn to be audited, all they will find is a few errors - no up-coding, over-coding, unlinked chart reviews, or obvious efforts to defraud CMS.

DoctusTech Helps

Master HCC coding fast, plus 25 hours CME per year in our Education App.
Find and manage HCC codes in your EMR, with our Patient Data Analytics Platform.

Schedule a consult today at www.doctustech.com.

Additional Resources:

Further details on the ten most common compliance issues identified in OIG audits:
https://www.doctustech.com/blog/hhs-oig-medicare-advantage-compliance-audits/

Dig deeper into this data in our RADV Audits White Paper featuring findings from 400+ RADV audits over 10 years. *https://www.doctustech.com/whitepaper/*