DOCTUS TECH

White Paper

Planning Ahead For Strict HCC Compliance Protocols

Key Findings From 400 RADV Audits, 2011-2021

Learn what 400 RADV audits can tell you about your physician practice.

Contract-level RADV began as a corrective action plan to help cut significant errors within Medicare Part C coding as part of the Improper Payment Elimination and Recovery Act (IPERA) 2010. The goal of this audit is to identify incorrect coding patterns submitted to CMS from a Medicare Advantage Organization (MAO) through claims data and supplemental data.

Submission must follow strict guidelines adhering to the correct place of service, provider type, and specialty type, among others. MAOs receive prospective revenue at a risk-adjusted rate per member per month based on diagnosis codes, demographic data, and origin of eligibility. If selected for a contract-level RADV, up to 201 members can be chosen for the specific year for audit.

Example of Revenue

Mrs. Anne Smith is a 66-year-old and has been eligible for Medicare for several years due to a disability allowing for both Medicaid and Medicare. Mrs. Smith's health plan submitted three conditions to CMS showing CHF, COPD, Morbid Obesity, and Diabetes without complications.

FACTORS

- 66-year-old female
- Medicaid
- Originally Disabled

COEFFICIENTS

- 2018 Submission year for the Payment Year 2019
- HCC18 (.423), HCC22 (.297), HCC85 (.486) HCC111 (.331), Interaction
- HCC85+HCC111 (.154)
- (BASE PAYMENT RATE*ENROLLEE RISK SCORE) – ($903*1.671)
- $1,508.91 Per Member Per Month

RADV FINDINGS

- After records are submitted to support Mrs. Smith's diagnosis
- HCC22 and HCC85 could not be validated in the audit.
- HCC18 and HCC111 were validated in the audit.

RE-CALCULATION

- HCC18 (.423), HCC85 (.486)
- (BASE PAYMENT RATE*ENROLLEE RISK SCORE) – ($903*.909)
- $820.83 Per Member Per Month
- Overpayment of $688.08 Per Member Per Month or $8,256.96 total

Once RADV is concluded, it is the recommendation of CMS to then extrapolate specific error rates that fall into question across all demographic and condition codes to recoup an exceptionally large dollar amount from the health plan and at-risk providers. Several institutes have lobbied against this method unsuccessfully thus far, as they feel this is an actuarially incorrect method to recover full membership recoupments. Below are three historical case studies where CMS applied this method.

01-Case Study

Bravo Health Pennsylvania, Inc. Contract H3949

Membership size for contract year - 13,755 beneficiaries

Annual Revenue - $194 Million

AUDIT

35 of the 100 beneficiaries were valid. 65 were invalid due to not supporting one or more diagnosis for the following reasons:

- **The documentation did not support the associated diagnosis.**
- **The documentation did not include the provider's signature or credentials.**
- **Bravo did not provide any documentation to support the associated diagnosis.**

OVERPAYMENT

Bravo received an overpayment of **$422,409** in the sample review. Extrapolated to their patient population, they received an overpayment of **$22,108,905**.

02-Case Study

PacifiCare of Texas, Contract H4590

Membership size for contract year - 118,000 beneficiaries

Annual Revenue - $1.3 Billion

AUDIT

57 of the 100 beneficiaries were valid. 43 were invalid due to not supporting one or more diagnosis for the following reasons:

- **The documentation did not support the associated diagnosis.**
- **The diagnosis was unconfirmed.**

OVERPAYMENT

PacifiCare received an overpayment of **$183,247** in the sample review. Extrapolated to their patient population, they received an overpayment of **$115,422,084**.

03-Case Study

Excellus Health Plan, Inc. Contract H3351

Membership size for contract year - 48,000 beneficiaries

Annual Revenue - $488 Million

AUDIT

53 of the 98 beneficiaries were valid. 45 were invalid due to not supporting one or more diagnosis for the following reasons:

- **The documentation did not support the associated diagnosis.**
- **The diagnosis was unconfirmed.**
- **Excellus did not provide any documentation to support the associated diagnosis.**

OVERPAYMENT

PacifiCare received an overpayment of **$157,777** in the sample review. Extrapolated to their patient population, they received a projected overpayment of **$41,588,811**.

CMS Latest Findings – OIG Audit

The Office of Inspector General (OIG) released findings in a brief dated December 2019 relating to supplemental diagnosis codes that were not linked to an encounter. This practice is used when submitting retrospective codes via a CMS submission in either Risk-Adjusted Processing System (RAPS) or an unlinked chart-review through Encounter Data Processing System (EDPS). Of the submissions, it was found that $1.7 Billion of the total $6.7 Billion risk-adjusted payments were retrospective chart reviews. OIG also found that within all chart review submissions, only 1% accounted for deletions for previous erroneous codes submitted. Regarding the supplemental unlinked chart reviews submitted, half were linked to only 10 HCCs:

HCC	HCC Description	Number of HCCs Added by Unlinked Chart Reviews	Estimated Payments From Unlinked Chart Reviews	Percentage of Unlinked Payments
HCC108	Vascular Disease	105,607	$269,536,256	10%
HCC18	Diabetes With Chronic Complications	74,221	$208,226,576	8%
HCC111	Chronic Obstructive Pulmonary Disease	67,703	$189,101,725	7%
HCC85	Congestive Heart Failure	63,568	$178,715,593	7%
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	58,059	$173,294,795	6%
HCC22	Morbid Obesity	71,924	$169,677,377	6%
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	35,260	$119,265,820	4%
HCC55	Drug/Alcohol Dependence	24,629	$75,094,794	3%
HCC8	Metastatic Cancer and Acute Leukemia	3,237	$71,051,426	3%
HCC96	Specified Heart Arrhythmias	28,674	$67,609,601	2%
	Total	532,882	$1,521,573,963	56%

Source: OIG estimation of 2017 payment amounts using 2016 MA encounter data from CMS's IDR.

OIG concluded in its findings specific recommendations regarding the practice of retrospective chart review:

- **Provide targeted oversight of MAOs that had risk-adjusted payments resulting from unlinked chart reviews for beneficiaries who had no service records in the encounter data.**
- **Conduct audits that validate diagnosis reported on chart reviews in the MA encounter data.**
- **Reassess the risks and benefits of allowing chart reviews that are not linked to service records to be used as sources of diagnosis for risk adjustment.**

When a health plan and provider has not set up a robust prospective process to capture diagnosis at the point of care, they rely heavily on retrospective audits to capture any lost revenue. If the documentation supports, many codes can be submitted up to a year and a half after the encounter. This process is flawed in many ways, and CMS, with the help of OIG, is beginning to realize the massive compliance implications. The RADV process has been expanded to include more health plans every year and to conduct analysis based on high volume compliance-driven codes.

RADV findings can occur for many different reasons, such as:

- Missing components of MEAT documentation
- Chronic diagnosis recaptured but never clinically present.
- The company may have lost the claim, and it expired.
- The claim being sent to the wrong managing company.
- The provider is not paneled with the insurance company.
- Services were rendered at the wrong location.
- The service may have already been rendered.
- The patient has an out-of-state insurance plan.

Payers and value-based provider groups share in the risk of an RADV audit. There are practices and processes that align all parties involved to assure that the relevant, compliant codes are being captured year over year for purposes of revenue integrity. These include:

- **Provider Education:** Physicians are not trained on any of this during medical school. Spend the time and money early to professionally train your clinicians on CMS sanctioned documentation and clinical diagnosis.
- **Internal Audits:** Create a quality assurance process to audit coding and documentation to help highlight trends, behaviors, and mistakes within the coded encounters before an RADV audit occurs.
- **Claims Adjudication:** Ensure claims accuracy, so all conditions that were addressed by providers make it to the superbill.
- **Data Analytics and Reporting:** Utilize an analytical reporting suite to track, monitor, and report on the patient level diagnosis, trends in patient encounters, coordination, and scheduling.
- **Point of care clinical support:** All relevant and up-to-date information collected from historical diagnosis, payer data, demographics, and suspecting must be fully integrated into clinical workflow to allow for compliant capture at the point of care.

Key Takeaways

For too long, documentation compliance has fallen on payors and large provider groups. As more and more physician practices take on down-side risk in value-based care arrangements, they also need to be prepared to ensure strict compliance protocols. Learn more about the 5 Strategies For An Effective HCC Coding Program (https://www.doctustech.com/5-strategies-for-a-highly-effective-hcc-coding-program/).

- **Avoid overcoding:** Ignorance is expensive. Put a process in place NOW to prevent inaccurate billing/overcoding. CMS is expanding its audits. Physician groups, not just payors, can be held liable based on recent RADV audits.

- **Top overcoding reasons for physicians include:** Misrepresentation of diagnoses clinically, recapturing diagnoses erroneously that were never present, and lack of MEAT criteria.

- **Must get clinician participation:** Accurate representation of your patient population's RAF begins and ends with your clinicians. Change is difficult. Clinicians are not taught this in medical school. So the process of education and change management falls on all physician practices.

Resources

https://oig.hhs.gov/oas/reports/region6/60900012.pdf

https://oig.hhs.gov/oas/reports/region3/30900003.pdf

https://oig.hhs.gov/oas/reports/region2/20901014.pdf

https://oig.hhs.gov/oei/reports/oei-03-17-00470.pdf

DoctusTech HCC Coding Tools