Health Plan of Nevada
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Quality Improvement – Clinical Quality Team

Monthly Jam Session and Tech Spec Series

Introduction

The QI Clinical Quality Team has interpreted and broken down the Measurement Year (MY) 2023 Technical Specifications.

They then organized them in a way to make them informative, interesting and in some cases, they even made learning HEDIS® and Risk **FUN**!!

This year we are excited to add two new sessions to our series!

- HEDIS 101 & Provider Resources
  - https://healthplanofnevada.com/Provider/HEDIS-Measures
- Risk Adjustment 101:
  - Risk Adjustment Factor (RAF)
  - Risk Adjustment Data Validation (RADV)

HEDIS® Lunch & Learn Series

2023 Monthly Jam Session and Tech Spec Series

- ~~June 14: HEDIS 101 & Provider Resources *(new offering)*~~
- ~~**July 12:** Coding and Closing Gaps in Care~~
- ~~**August 9:** Pregnancy and Pediatric Measures~~
- ~~**September 13:** Behavioral Health Measures~~
- ~~**October 11:** Adult Measures~~
- **November 8:** Risk Adjustment 101; RAF and RADV (*new offering*)

For more information or to receive the link to attend, email
Cheri.Levine@uhc.com

Intro and Bio

Cheri Levine, MS RN
cheri.levine@uhc.com

Western Background:

- Quality Improvement – HEDIS and RADV
- Quality Management
- Emergency & Trauma

Eastern Background:

- Licensed in Acupuncture and Herbal Medicine
- Certified Yoga Instructor; Vinyasa Flow and Yoga Sculpt

This presentation will be available on our website

HEDIS Measures - Doctor / Provider - Health Plan of Nevada

Agenda

- Myth Busters
- Acronyms and definitions
- Risk Adjustment Factor (RAF)
- Risk Adjustment Data Validation (RADV)
- How to prepare for RAF and RADV
- Documentation and Coding – Best Practices, Errors and Tips for Improvement
- Clinical Quality Nurse Visit Commercial

Myth Busters

- Myth Busters

- Risk Management comprises the clinical and administrative systems, processes, and reports employed to detect, monitor, assess, mitigate, and prevent risks.

- Risk Adjustment is a methodology that equates the health status of a person to a number, called a risk score, to predict healthcare costs.

Acronyms and Definitions

- RAF = Risk Adjustment Factor

Calculation of an individual's health status as a number, or risk score, that helps predict costs for healthcare services.

- RADV = Risk Adjustment Data Validation

Audit that occurs after the final risk adjustment data submission deadline for the contract year and after CMS recalculates the risk factors for affected individuals.

- BY = Benefit Year

- ICD-10 = International Statistical Classification of Diseases

Contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

Acronyms and Definitions (cont'd)

- Highest Level of Specificity

Is the most detailed or precise level of classification.

- HCC = Hierarchical Conditional Category

List of diagnoses that have been assigned a value for risk adjustment.

- M.E.A.T.
  - **M**onitoring
  - **E**valuation
  - **A**ssessment
  - **T**reatment

What is RADV?

What is RADV

- RADV = Risk Adjustment Data Validation.
- Process of verifying ICD-10 codes submitted for payment with the support of medical records.

What is the purpose of the RADV audit?

- RADV is an extension of the CMS Risk Adjustment Healthcare Reform program's calculation of the RA transfer payment.
- The audit is necessary in finalizing the transfer amounts by ensuring the submitted data is accurate to the medical charts.

When does the RADV project begin?

- The audit is an annual process beginning in June after benefit year (BY)
- If you are selected to participate in the HHS RADV Audit you will receive a letter from both CMS and UnitedHealthcare

Why is RADV important to our members?

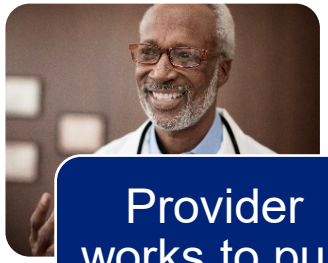
It is to ensure risk-adjusted payment integrity and accuracy, and it affects what plans are paid

It allows the health plans a balance to ensure they continue to provide quality health insurance at affordable rates

Current Dx's are collected each year to account for correct financial needs of members in the following year. Omitting factual Dx's harms the health plans and ultimately, their members

Why is RADV important to your patients?

Letter requests for RADV are sent



Provider works to pull and return charts

Charts are received

Charts are coded

UHC identifies member's chronic condition

A UHC clinician outreaches to member

Member enrollment in chronic support programs

Member is more likely to have healthier outcomes

RADV Letters – CMS and UHC

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: May 20, 2022

To: Hospitals, Physicians, and Practitioner Health Care Providers

From: [redacted]
Director, Payment Policy & Financial Management Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services

Re: Support for Medical Record Requests for the HHS Risk Adjustment Data Validation Program (HHS-RADV)

SPECIAL NOTE: DO NOT SEND MEDICAL RECORDS TO CMS. Please follow the instructions provided by the requestor.

On behalf of the Secretary of the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) is responsible for annually validating the accuracy of risk adjustment data submitted by a health insurance company with risk adjustment covered plans in the individual and small group health insurance markets through the validation of medical records for States where HHS operates the risk adjustment program.[1] This process is known as the HHS-operated Risk Adjustment Data Validation (HHS-RADV) program.

As part of the HHS-RADV program, please find attached a medical record request from a health insurance company, or its delegated entity. Please respond to this request as soon as possible.

The current HHS-RADV audit pertains to services provided during the 2021 benefit year. The entity sending this request has determined that one or more of your patients is part of an HHS-RADV random sample. Because the 2021 benefit year HHS-RADV medical record review process begins in May 2022, **your immediate attention to these requests is appreciated**.

These requests are applicable to all providers, whether or not the provider has a contractual agreement with the health insurance company.

Thank you in advance for your prompt cooperation. Any questions regarding the HHS-RADV audit, requested patient information, or where to send the required medical record should be directed to the entity sending the request (insurance company or designated retrieval company) and not CMS.

Please provide the medical record(s) to the requesting entity. In accordance with CMS policies, do not forward any medical records to CMS or its contractors. Medical records received by CMS will be destroyed.

[1] Section 1343 of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148) established a permanent risk adjustment program. Consistent with Section 1321(c) (1) of the PPACA, the Secretary is responsible for operating the program on behalf of any State that elected not to do so. For the 2021 benefit year, HHS operated the risk adjustment program in all 50 States and the District of Columbia.

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WE NEED YOUR ASSISTANCE PLEASE

Date: June, 2023

To: Hospitals, Physicians, and Other Health Care Practitioners

From: Medical Record Review Nurse, Phone: (XXX) XXX-XXXX, **Fax: (XXX) XXX-XXXX**

Re: Fax request for Medical Records for the HHS Risk Adjustment Data Validation Program (HHS-RADV) Due Date

We appreciate your support during our annual HEDIS® audit, as it is vital to meeting federal requirements. Now that the HEDIS activities are wrapped up, the team has been tapped to obtain additional medical records as part of a CMS requirement.

On behalf of the Secretary of the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS) is responsible for annually validating the accuracy of risk adjustment data (claims) submitted by health insurance companies. Regulatory bodies (CMS and HHS) require any health plans with Exchange or small business plans to participate in the Risk Adjustment Data Validation (HHS-RADV) program.

The current HHS-RADV audit pertains to services provided during the **2022** benefit year. HPN/SHL has determined that one or more of your patients is part of an HHS-RADV random sample. Because the 2022 benefit year HHS-RADV medical record review process begins in May 2023, **your immediate attention to these requests is appreciated**.

WE NEED YOUR HELP. The current HHS-RADV audit pertains to all providers, *whether or not there is a contractual agreement with HPN/SHL.*

Thank you in advance for your prompt cooperation. If there are any questions regarding the HHS-RADV audit, requested patient information, or where to fax the required medical record(s) please feel free to contact the nurse listed above.

Thank you

1 Section 1343 of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148) established a permanent risk adjustment program. Consistent with Section 1321(c) (1) of the PPACA, the Secretary is responsible for operating the program on behalf of any State that elected not to do so. For the 2020 benefit year, HHS operated the risk adjustment program in all 50 States and the District of Columbia

Preparation for RAF and RADV

- Make sure the correct contact information is available
- Centralized department, EMR vendor, etc
- Prioritize and retrieve the requested charts
- Match target members with providers
- Know the coding guidelines
- Follow submission guidelines

If you're a physician or other health care professional, please submit:	If you're from a hospital, inpatient or outpatient facility, please submit:
• Progress notes from face-to-face office/ Virtual/Telehealth visits • History and Physical • Consult notes • Demographics sheet • Problem list • Medication list • Radiology reports	• Progress notes • Consultation reports • Operative and procedure notes • Radiology and pathology reports • Prescription for laboratory services • History and physical exam • Discharge summary • Emergency room records
Please submit signed authenticated copy of the medical record.	

You don't need to send us the following: physician orders, nurse notes, medication administration records (MARs), flow sheets, discharge instructions, lab reports or EKG strips.

Risk Adjustment 101: ABCs

A. **Say what you did**
   Document to the highest level of specificity with clarity and (M.E.A.T.)

B. **Do what you say**
   Code to the highest level of specificity and support with documentation

C. **Sign chart**
   Signature in timely manner; within 90d, no more than 120d

Tell A Story

Examples for Provider

Impact of accurate documentation on a RAF score

All conditions coded to Highest specificity		Some conditions coded to Moderate specificity		Minimal conditions coded to Lowest specificity	
76 Year old female, full-benefit dual, aged	0.611	76 Year old female, full-benefit dual, aged	0.611	76 Year old female, full-benefit dual, aged	0.611
Diabetes w/diabetic peripheral angiopathy (HCC 18 & 108)	0.346	Diabetes w/o complications (HCC 19)	0.097	No diabetes coded	X
Atherosclerosis, L-extr w/ulcers (HCC 106)	1.744	Vascular disease w/o complications (HCC 108)	0.324	No vascular disease coded	X
Chronic ulcer, Lt. L-extr, unsp site (HCC 161)	Not additive to HCC 106	Chronic ulcer, Lt, L-ext (except pressure), unsp site. (HCC 161)	0.757	Wound, open, L-extr, multiple, NOS complicated	X
Chronic systolic HF (HCC 85)	0.355	No chronic systolic HF coded	X	No chronic systolic HF coded	X
Disease interaction	0.205	No disease interaction	X	No disease interaction	X
Amputation of great toe	0.779	No great toe amputation	X	No great toe amputation	X
Total RAF	4.040	Total RAF	1.789	Total RAF	0.611

Examples for Coding Professional

Coding Example A: Outpatient

- The orthopedic provider documents a “non-displaced right talus fracture.”
- The right ankle X-ray documents a “non-displaced avulsion fracture of the right talus.”
- The code S92.101A, Unspecified fracture of right talus, was initially assigned.
- After a final review, the code S92.154A, Nondisplaced avulsion fracture of right talus, is assigned based on the greater specificity found in the imaging report.

Coding Example B: Inpatient

- The H&P and D/C Summary document that the patient suffered an “embolic cerebral infarction with residuals.”
- The brain CT scan report documents a “large embolus in the right middle cerebral artery (MCA) territory.”
- The code I63.40, Embolic cerebral infarction of unspecified artery, was initially assigned.
- After a final review, I63.411, Cerebral infarction due to embolism of right middle cerebral artery, should be assigned based on greater specificity found in the brain CT report.

Documentation

- Accurate and thorough documentation is critical
- Diagnosis codes must be addressed during encounter and/or documented in the note
- The Annual Health Assessment is very important
  - List chronic conditions annually, even if primary management is by a consultant or specialist
  - Document:
    - **M**onitoring- signs, symptoms, disease progression, disease regression
    - **E**valuation- test results, medication effectiveness, response to treatment
    - **A**ssessing- ordered tests, discussion, record review, counseling
    - **T**reatment- medications, therapies, other modalities

Documentation (cont'd)

- Link medications in the Medication List to condition in the note
  - Example: Prednisone 5 mg PO daily for asthma
- Notes reflect test results
  - Example: Chest x-ray confirms pneumonia
- RADV Audit assures the chart and claim match:
  - Accurate and specific diagnosis coding
  - Complete medical record documentation

Non-Compliant Examples

- No documentation to support diagnosis billed

Past Medical History

Condition	Answer
Asthma	N

Time On Scene with Patient: 00:28:57
1. Upper gastrointestinal bleeding
acute-resolved
K92.89: Other specified diseases of the digestive system
2. Ascites
acute-resolved
R18.8: Other ascites
3. Post-discharge follow-up
acute
Z09: Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Common Coding and Diagnosis Errors

- No documentation to support diagnosis billed
- Codes not properly sequenced
- Not enough specificity of disease
  - Patient is diabetic and on insulin –documentation does not indicate patient has Type 1 or 2
- Cause and effect coding not present
  - “Due to”, “associated with”, “manifested by”, “secondary to”, “R/O”
- Use of “history of” when current condition exists
- Active health status missing
  - CABG, amputation, congenital diseases, transplant status
- Chronic conditions not coded or assessed
  - Diagnosis listed on problem list but not noted in the note

Non-Compliant Examples

- No documentation to support diagnosis billed

1. **Appointment:** Individual Appointment on March 21, 2022
   12:00 pm - 1:00 pm, 60 min
   Billing code: 90837 - Psychotherapy, 60 min

   Progress Note

   Late CXL

2. **Plan**
   Admit to MedSurg
   Ortho consulted recs
   Hold metformin, mild sliding scale insulin
   Pain control per ortho
   DVT prophylaxis per ortho
   Monitor labs
   Resume home meds as appropriate
   PT/OT

Common Coding and Diagnosis Errors (cont'd)

- Status of cancer is not clear, or no treatment is documented
- Acquired organs or amputations are not documented
  - Kidneys, toes, feet, etc….
- BMI status and level of obesity is missing
- Pertinent family and social elements
  - Family history of cancer, DM, HTN, MI, sudden cardiac death, congenital diseases
- Medication listed in Medication List but condition not mentioned or linked in the note
  - Lisinopril but HTN not documented or coded
  - Insulin but no diabetes diagnosis or treatment documented or coded
- Missing diagnosis codes
- Chart not signed by authorized/qualified provider or out of date range

Non-Compliant Examples

- Chart not signed by authorized/qualified provider or out of date range

1. Electronically Signed By [redacted] on 09/01/22 at 10:32 AM PDT

2. Referral electronically submitted by [redacted] MD 08/15/2023 08:47AM

3. [redacted], M.D.
   FES/mo/Job [redacted]

4. Chart reviewed, case discussed with the APRN, and agreed current management

5. ENCOUNTER
   Office Visit

NOTE TYPE	SOAP Note
SEEN BY	[redacted] MD
DATE	12/16/2022
AGE AT DOS	63 yrs

Not signed

Tips for Documentation Improvement

- Do not claim ICD-10 codes from the problem list and remember the acronym M.E.A.T.
  - Report conditions at least once a year
  - Document all current conditions evaluated
  - Code to highest level of specificity (morbid obesity vs obese or overweight)
  - Code all co-existing acute conditions (protein calorie malnutrition)
  - Avoid non-specific codes
    - Don’t use F32.9 – depression; use F32.0-mild, F32.1-moderate, F32.2-severe

- Electronic Medical Record is authenticated or signed appropriately
  - Medical record has legible signature and appropriate credentials
  - Signature signed at the time of documentation

Risk Adjustment 101: ABCs

A. **Say what you did**
   Document to the highest level of specificity with clarity and (M.E.A.T.)

B. **Do what you say**
   Code to the highest level of specificity and support with documentation

C. **Sign chart**
   Signature in timely manner; within 90d, no more than 120d

References

- CMS (Centers for Medicare and Medicaid Services)
- AAPC (American Academy of Professional Coders)
- OptumEducation
- RCX Rules Blog
- AHIMA HIM Body of Knowledge

Clinical Quality Nurse Visits

2023 Monthly Jam Session and Tech Spec Series

Recommendations

- When screenings or preventive modalities may be indicated:
  - Colonoscopy, Cologuard® and/or FOBT
  - Mammography
  - Pap Smear and/or HPV testing
  - Immunizations

Teaching/Coaching

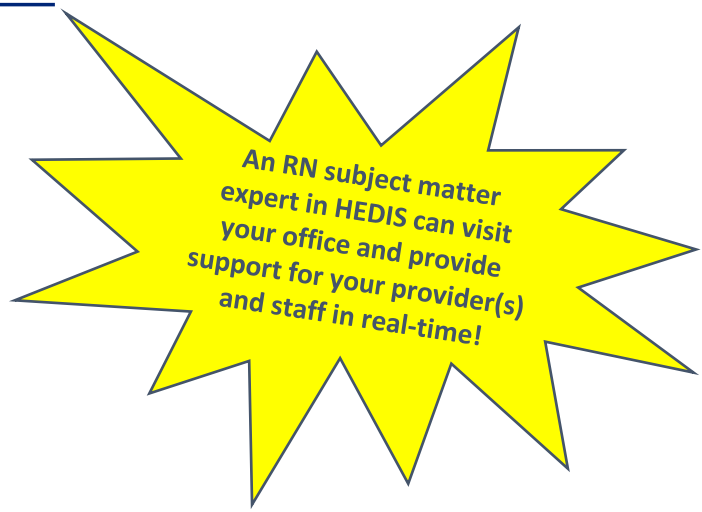
- How to perform an appropriate blood pressure screening and when to repeat if indicated
- What elements may be necessary to complete measure compliance
  - Point of care testing and/or recommendations for lab orders
  - Obtaining height or weight for BMI calculations

Advisement

- Documentation elements that may have been captured during visits
  - History taking and recording; medical, surgical
  - Problem list updating; current vs historical
  - Diagnosis/Assessment awareness
- Coding for capturing compliance

Specialty Visits

- Primary Care / Family Medicine
- Pediatrics
- Women's Health
- Cardiology
- Endocrinology
- Nephrology
- Urgent Care Clinics



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Thank you!
Questions?

If you have questions, please contact ClinicalQualityNV@uhc.com