Medicare Advantage Risk Adjustment:
Training for Providers

January 2022

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Objectives

At the end of this presentation, you will understand:

1. The basics Medicare Advantage risk adjustment;
2. The importance of accurately documenting a member's health status;
3. How telehealth affects risk adjustment;
4. Why coding matters;
5. Tips to keep the medical documentation robust;
6. That all documentation is subject to audit; and,
7. Key take-aways.

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Risk Adjustment Overview

- **Risk adjustment is a process** that the Centers for Medicare & Medicaid Services (CMS) uses **to reimburse Medicare Advantage (MA) plans** such as Denver Health Medical Plan (DHMP).

- Risk scores are based on **member demographics** (e.g. age and gender) as well as **health status**, and help to predict more accurately the health cost expenditures of a plan's member population. This allows CMS to reimburse a plan for its specific population.

- Risk scores are higher for a patient with greater disease burden, and lower for a healthier patient.

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Health Status and Risk

- **The ICD-10 diagnosis codes reported on your claims determine a member's health status, and ultimately their risk score.**

- These diagnosis codes are submitted to CMS, and linked to specific Hierarchical Condition Categories (HCCs). These HCCs are then used to calculate a member's risk score.

- The number of HCCs and affected ICD-10 codes can change from year to year.

- Chronic conditions must be reported at least once per year.

  Each January 1, the Risk Adjustment slate is wiped clean!
  All Medicare members are considered completely healthy until diagnosis codes are reported on claims.

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The Telehealth Factor

- All diagnosis codes documented as the result of a *face-to-face visit* count for risk adjustment.
  - **Telehealth visits** that include both **audio *and video*** count as face-to-face for risk adjustment.
  - Telehealth visits that are *audio-only do not*.

- For audio-only encounters, please consider using a **procedure code that signifies audio-only**, such as the appropriate telephone E/M codes (99441-99443).
  - This will tell CMS that the encounter did not include video, and therefore does not qualify for risk adjustment payment.

- To capture a Medicare member's true health status for risk adjustment, please make every effort to **see Medicare members *in person* or *via video* at least once each year!**

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Why Coding Matters

- **Complete and accurate diagnosis coding, supported by complete and accurate medical documentation**:
  1. Allows for better medical decision-making, better health management, and member inclusion in any quality and/or care management program offered by DHMP.
  2. Increases the member's risk score, ensuring that DHMP has the needed resources to provide quality care to members.
  3. Reduces the need for DHMP to request medical records or audit a provider's claim.

- It is DHMP's goal to have a **comprehensive annual assessment** for each member, capturing **all** of a member's **current, active diagnoses**.

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Documentation Tips

- ***Document every condition.***
  - All chronic conditions
  - All conditions that are relevant to a member's current care

- Review all relevant conditions annually.
  - Chronic conditions (diabetes, heart failure, COPD)
  - Active status conditions (amputations, ostomy)
  - Pertinent past conditions (previous cancers, previous stroke)
  - All conditions being treated with medication

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Documentation Tips (con't)

- Be as specific as possible.
  - chronic bronchitis v bronchitis
  - morbid obesity v obesity
  - chronic kidney disease should be staged
- Code multiple conditions when applicable.
  - diabetes *with retinopathy/nephropathy/neuropathy*
  - cirrhosis *due to alcohol dependence*
- Include Psychosocial Diagnoses.
  - major depression
  - lifetime illnesses (schizophrenia, bipolar disorder)

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MEAT in the Documentation

- Use the MEAT acronym to ensure that the most complete and accurate information is being documented:
  - **Monitor:** must indicate that you asked about the current status of the condition; signs and symptoms; disease progression or regression.
  - **Evaluate:** exam results; lab/imaging findings; medication effectiveness; patient response to treatment.
  - **Assess/Address:** note the current medical status of the member's condition; order tests; give patient education; review records; counsel patient and family members.
  - **Treat:** record the treatment plans; medications, therapies, procedures, modalities.

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Audits

- **All claims and/or encounters submitted to DHMP are subject to audit.**
  - Audits may come from CMS or DHMP, and used to determine if the documentation and coding are complete and accurate.
  - Please provide all medical records quickly, and provide all available medical documentation for the services rendered to the member.

- Medical records must support all conditions coded on the claims and/or encounters you submit using clear, complete and specific language.
  - Ensure that the record includes the member's name and date of service.
  - Ensure that the diagnosis codes align with the member's gender.
  - Ensure that the record is signed by the provider, with credentials.

- Notify DHMP ***immediately*** about any diagnostic data you have submitted that you later determine may be erroneous.

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Key Take-Aways

- Completely and accurately documenting a **member's health status** is crucial to Medicare risk adjustment calculations.

- All **current, active diagnoses** must be captured. For chronic conditions, these diagnoses must be **captured on an annual basis**.

- All medical documentation that support submitted diagnoses codes must be **complete, accurate, and robust enough to withstand audit.**

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Any Questions?

- If you have any questions, reach out to Denver Health Medical Plan.

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