

Medicare Advantage Risk Adjustment Program

Effective July 1, 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a *risk adjustment model* for Medicare reimbursement.

The CMS-HCC (Hierarchical Condition Category) model includes several changes that physicians' practices should become familiar with, so that Medicare encounter (visit) claims can be submitted accurately.

The CMS-HCC model uses "condition" categories to determine reimbursement. The model uses information drawn from diagnosis codes contained on claims submitted for physicians' services and hospital inpatient and outpatient claims.

While procedural codes – CPT and HCPCS codes - remain important for reimbursement of care provided to Medicare fee-for-service patients, the risk adjustment model relies on ICD-9-CM diagnosis codes and the specificity of diagnostic information imparted.

CMS explains in its training documentation that the responsibilities of physicians and other health care providers who treat Medicare patients include:

- Accurately reporting ICD-9-CM diagnosis codes, including secondary diagnoses, to the highest level of specificity.
- Maintaining accurate and complete medical record documentation; ICD-9-CM codes submitted must be justified with proper documentation.
- Alerting the Medicare Advantage organization to any erroneous data that has been submitted and following the procedures for correcting erroneous data.
- Reporting claims and encounter data in a timely manner, generally within 30 days of the date of service or discharge from a hospital's inpatient facilities.

Most diseases that have been "mapped" to Hierarchical Condition Categories (HCCs) are chronic conditions that will persist from one data period to the next, such as Diabetes, COPD, End-stage renal disease, etc. Funding and other program decisions made by CMS is dependent upon the accuracy of the diagnostic information that participating Medicare Advantage (formerly Medicare+Choice) organizations supply to CMS. In turn, those organizations are dependent upon the accuracy of information reported by physicians, hospitals and other care giving organizations.

What is Risk Adjustment?

Risk Adjustment is the process by which the CMS reimburses Medicare Advantage plans, based on the health status of their members. Risk Adjustment was implemented to pay Medicare Advantage organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

Risk Adjustment Implementation

CMS initially collected hospital inpatient diagnoses for determining payment to Medicare Advantage plans. In 2000, Congress mandated a change to include ambulatory data. This change took place gradually, with full implementation in 2007. CMS selected a payment model that included diagnostic data reported from hospital inpatient, physician, and hospital outpatient settings, the CMS-Hierarchical Condition Category (CMS-HCC) payment model.

Physicians' Role

- Physician data is critical for accurate risk adjustment
- Physicians are the largest source of ambulatory data for the risk adjustment model
- Risk adjustment uses ICD-9-CM diagnosis codes, not CPT procedure codes
- CMS-HCC model relies on ICD-9-CM coding specificity

Why is Medical Record Documentation Important for Risk Adjustment?

- Accurate risk adjusted payment relies on complete medical record documentation and diagnostic coding.
- CMS conducts risk adjustment data validation by reviewing medical records.
- Specificity of the ICD-9 diagnosis coding is substantiated by the medical record.

Data Process for Risk Adjustment

Physician documents the member's visit in the medical record; Physician and practice staff assign codes to the claim, drawn from the medical record



Medicare Advantage Plan submits diagnostic data from claims to CMS for risk adjustment calculation and payment



CMS conducts annual data validation audit on selected plans

Medical Record Documentation

- Documentation should be clear, concise, consistent, complete and legible.
- Document co-existing conditions at least annually
- Use standard abbreviations
- Develop a problem list
- Identify patient and date on each page of the record
- Authenticate the record with signature and credentials

Requests for Medical Records

Medicare Advantage Plans perform medical record reviews to identify additional conditions that are not captured through claims or encounter data, and to verify the accuracy of coding. Typically the requirement for participation in these reviews is dictated by the contract signed by physicians' practices.

Under CFR 164.502 - HIPAA implementation - practices are permitted to disclose the requested data for the purpose of health care operations, after you have obtained the "general consent" of the member. A general consent form should be an integral part of your medical record file.

Many practices receive requests for medical records reviews from Medicare Advantage plans and confuse these reviews with traditional health plan audits. It is important to understand the type of review so that you can respond appropriately.

Key Points

Medicare's reimbursement calculations and cost estimates are based on ICD-9-CM diagnostic codes, not CPT procedural codes.

Federal regulations require CMS and designated agents to review medical records in order to validate and avoid both underpayments and overpayments.

It is important for the physician's practice to fully code each encounter. The claim should report the ICD-9-CM code of every diagnosis that was addressed at the visit, but should only report codes of diagnoses that were actively addressed.

Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial.

It should be readily obvious in the medical record entry associated with the claim that all reported diagnoses were addressed, and that all diagnoses that were addressed were then reported.

CMS Data Validation

Data Validation is the process of verifying that the diagnosis codes submitted by the Medicare Advantage organization are supported by the medical record documentation for a member. This process ensures the integrity and accuracy of risk adjusted payment. Medicare Advantage plans are selected for data validation audits annually.

It is important for physicians and their practice staff to be aware of risk adjustment data validation activities because medical record documentation may be requested by the Medicare Advantage organization.

For more information on risk adjustment, visit the Centers for Medicare & Medicaid Services website at <http://csscooperations.com/>.

Handling Risk Adjustment Audits

The WSMA has received anecdotal reports that requests can be excessive in the number of records selected and the impact to the practice can be significant. These actions can help mitigate those effects.

- Review the health plan's request to determine which type of audit is intended. (e.g. Risk Adjustment or traditional audit).
- Review the provider contract with the health plan to be clear on your rights and obligations in complying with the audit request.
- Understand your rights to request additional time and compensation for complying with records requests.
- Understand how to respond to risk adjustment audit
 - Track requests by creating a Contact log including date, time, and notes for each call or request received.
 - Track the date for response and submission of charts to the requesting organization.
 - Review Contract to determine if payment for handling and copying of records apply to the request.
- Be prepared to receive a significant number of requests for records, especially if your practice has a high concentration of Medicare Advantage patients.

The WSMA Coding Hotline is available to assist members regarding Health Insurance, Coding, Medical Billing and other Practice Management issues at 206-441-9762, or 1-800-552-0612, or via email: mml@wsma.org.