Medicare Risk Adjustment
RAF 101

Presenter:
Renee White

Objectives

- Provide Overview of Medicare Risk Adjustment (MRA)
- Identify the role of Health Care Providers in the Medicare Risk Adjustment process
- Provide medical record documentation guidelines
Purpose

• MRA is intended to redirect money away from MAO that would cherry-pick the healthier enrollees

• MRA is a way to provide MAO that care for the sickest patients the resources to do so

Reimbursement Model RAF-HCC

• RAF-HCC is a predictive model CMS uses diagnosis data submitted from the previous year to establish capitation payments to the MA plan

• HCC’s are disease categories which are mapped to certain Diagnosis Codes for chronic conditions
  – 79 HCC’s and over 8830 ICD-10-CM diagnosis codes out of ~70,000
How it Works

• Each member is assigned a RAF
  – RAF is a numeric value assigned by CMS to identify the health status of a patient
  – RAF scores are made up of the following criteria for each member:
    • Demographic information e.g. age and sex
    • Medicaid status and if the patient was eligible for Medicare due to a disability
    • Chronic conditions and disease interactions

How it Works (cont.)

• Each diagnostic code falls into one Diagnosis Group and codes are grouped into Condition Categories

• The average Medicare FFS patient has the score of 1.00
Disease Interaction

• DM and CHF
• DM and CVD
• CHF and COPD
• COPD, CVD and CAD
• RF and CHF
• RF, CHF and DM

ICD-10-CM Official Guidelines for Coding & Reporting

• Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management.

• Do not code conditions that were previously treated and no longer exist.

• However, history codes (Z codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
Why is complete documentation important?

Hepatitis C generally presents as a chronic condition that is rarely fully eradicated.

- **B19.20** Hepatitis C, unspecified (No HCC)
- **B17.10** Hepatitis C, acute (No HCC)
- **B18.2** Hepatitis C, chronic (HCC-29)

Definition of M.E.A.T.

- **Monitor**—signs, symptoms, disease progression, disease regression
- **Evaluate**—test results, medication effectiveness, response to treatment
- **Assess/Address**—ordering tests, discussion, review records, counseling
- **Treat**—medications, therapies, other modalities
Example M.E.A.T.

• **Monitor**: B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits
• **Evaluate**: stump well healed, ostomy site w/o infection appears clean & dry
• **Address**: stable; controlled, worsening; unchanged, uncontrolled
• **Treatment**: taking Fosamax for osteoporosis; taking tamoxifen for breast cancer “treatment”, DM controlled on insulin

M.E.A.T.

• Providers are required to document all conditions evaluated during every face-to-face visit
• Each subjective, objective, assessment, and plan (i.e. SOAP note) must include key indicators:
  – history of present illness (HPI)
  – Physical exam (PE)
  – Medical decision-making (MDM)
Where’s the M.E.A.T

• Simply listing every diagnosis in the medical record does not support a reported HCC code and is unacceptable

• It will not stand up to validation in the event of a risk adjustment data validation (RADV) audit

The road to success starts and ends with M.E.A.T.

• A variety of downfalls beset providers and MA plans when confronted with a RADV audit

• Remember when the provider follows the M.E.A.T. guidelines the documentation is basically audit-proof
What Can You to Fail a RADV Audit?

• Failure to ensure the diagnosis codes being billed and the medical record documentation match
• Failure to document according to the M.E.A.T. principles (i.e. monitor, evaluate, addressed, and/or treatment
• Failure to link the causal relationship for manifestation codes
I’m Cured

CMS wipes the slate clean every January 1, so MA plans must recapture all chronic conditions in order to receive reimbursement.

Key to Success

• At the end of the day, providing timely and accurate documentation and submitting HCC codes allows proper reimbursement.

• Accurate documentation and coding allows the plans to provide better benefits to members and improve premiums per member per month (PMPM).
Conclusion

MRA supports achievement of “Triple Aim”

• Cost effective Care
• Quality Outcomes
• Patient Satisfaction

Resources

• http://www.hcpro.com/content.cfm?content_id=302031
• https://www.cartoonstock.com/directory/c/cured_ham.asp
Evaluation & Management Services
Presenter Thomasina L Young

Medical Necessity

- Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code

- The volume of documentation should not be the primary influence upon which a specific level of service is billed
Evaluation & Management (E/M)
E/M services recognize 7 components which are used in defining the levels of E/M services

**Key Components**
- History
- Examination
- Medical Decision Making

**Contributory Components**
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

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Chief Complaint (CC)

- The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter
- Is required for every E&M service
- If there is no chief complaint, the service can be deemed not billable.
Chief Complaint Not Supported

- Subjective: pt seen and examined, no acute issues overnight
- Reason for Visit: follow up- 2/19 F/U since 12/30/15 appt – doing better
- Subjective: CC feels good
- Subjective: 92 year f pt no new complaints
- Subjective: Continuing slowly to feel better. Very limited in her ability to tolerate any kind of exertion at this point but she is supposedly heading for SNF today for working

History of Present illness (HPI)

A chronological description of the development of the patient's present illness with elements of:

<table>
<thead>
<tr>
<th>Two types of HPI:</th>
<th>Brief – 1-3 elements</th>
<th>Extended – 4 elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR the Status of 3 chronic conditions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity- pain scale (peds 0-4; adults 8-10)</td>
<td>Duration</td>
</tr>
<tr>
<td>Timing</td>
<td>Context</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Associated signs and symptoms</td>
</tr>
</tbody>
</table>
Past Medical, Family, Social History

- **Past Medical history** (the patient’s past experiences with illnesses, operations, injuries and treatments). For **Infants/newborns** may include mother’s pregnancy and the birth of the child.

- **Family history** - a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk.

- **Social history** - an age appropriate review of past and current activities, i.e., Military Status, living arrangements and education.

Review of Systems (ROS)

14 Systems Are Recognized

**Three types of ROS:**

1. **Brief** – inquires about organ system directly related to the presenting problem
2. **Extended** – inquires about 2-9 organ systems
3. **Complete** – Requires documentation of at least 10 organs systems individually OR some pertinent +/- of some organs systems with a statement “all other systems were reviewed and are negative”
## History Elements

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, family/ or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused (99201, 99212; 99241; 99251; 99231)</td>
<td>Required</td>
<td>Brief (1-3)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused (99202, 99213; 99242; 99252; 99232)</td>
<td>Required</td>
<td>Brief (1-3)</td>
<td>Problem Pertinent (1)</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed (99203, 99214; 99221; 99243; 99253)</td>
<td>Required</td>
<td>Extended (4+)</td>
<td>Extended (2-9)</td>
<td>Pertinent -1</td>
</tr>
<tr>
<td>Comprehensive (99204, 99205, 99215; 99222; 99223; 99244; 99245; 99254; 99255)</td>
<td>Required</td>
<td>Extended (4+)</td>
<td>Complete (10+)</td>
<td>Complete 2/ Established 3/New patient</td>
</tr>
</tbody>
</table>

## Examination Guidelines

<table>
<thead>
<tr>
<th>Exam level</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1995 &amp; 1997 Exam Guidelines</strong></td>
<td>99201; 99212; 99241; 99251; 99231</td>
<td>99202; 99213; 99242; 99252; 99232</td>
<td>99203; 99214; 99243; 99253; 99221</td>
<td>99204-99205; 99215; 99244-99245; 99254; 99255; 99222-99223</td>
</tr>
<tr>
<td>1995 Body Areas/Organ Systems</td>
<td>Affected area</td>
<td>2 – 4 body area/organ systems</td>
<td>5 - 7 body areas/organ systems</td>
<td>8+ organ systems</td>
</tr>
<tr>
<td>1997</td>
<td>1 - 5 bullets in 1+ systems/areas</td>
<td>6 - 11 bullets in 1+ system/areas</td>
<td>12+ bullets in 2+ systems/areas</td>
<td>2+ bullets for each of 9+ systems/areas</td>
</tr>
</tbody>
</table>
Medical Decision Making (MDM)

There are 4 levels of MDM:
1. Straightforward
2. Low
3. Moderate
4. High

MDM is:
A. The number of diagnoses or management options
B. Amount and/or complexity of data to be reviewed
C. Risk of complications and/or morbidity or mortality

The provider’s independent review and interpretation of an image, tracing, or specimen MUST be documented.

Outpatient E/M Services

<table>
<thead>
<tr>
<th>CPT Code New</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
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</table>

<table>
<thead>
<tr>
<th>CPT Code Established</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>
### Inpatient Hospital E/M Services

<table>
<thead>
<tr>
<th>CPT Code Initial</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>30</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward/Low</td>
</tr>
<tr>
<td>99222</td>
<td>50</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99223</td>
<td>70</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
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</table>

**Subsequent**

<table>
<thead>
<tr>
<th>CPT Code Initial</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>15</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99232</td>
<td>25</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Moderate</td>
</tr>
<tr>
<td>99233</td>
<td>35</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
</tr>
</tbody>
</table>

### Time Documentation Guideline

- The total face-to-face time must be documented; and greater than 50% of the visit was spent in counseling/coordination of care. This does not include obtaining history, performing the examination, or the medical decision making.

- Inpatient services include floor time along with bedside/face-to-face time.
OBSERVATION SERVICES (OBS)

- There must be a physician’s order specifying “Placement for Observation” or simply “Observation” including the reason and medical necessity for OBS care.

- A physician order for observation services should NOT read “Admit to (or for) Observation”.

- All OBS services must be ordered by a physician.

- OBS starts at the documented time that observation care is initiated.

- All other physicians who furnish evaluations or services while the patient is receiving OBS must bill the appropriate outpatient service codes.

**Physicians at Teaching Hospitals P.A.T.H**

Services furnished in teaching settings are paid through the Medicare Physician Fee Schedule if:

- Personally furnished by a physician who is not a resident;

- Furnished by a resident when a teaching physician is physically present during the critical or key portions of the service; or

- Furnished by a resident under a primary care exception within an approved Graduate Medical Education (GME) Program.
Medical Students

• TP can only use the ROS and PFSH from a Medical Students documentation

• TP MUST re-document the HPI, Exam and MDM

• TP MUST be present during the entire encounter

Incident To Requirements:

• Services are furnished in the clinic/office setting or the patient’s home

• There must be an initial plan of care in place by the physician and documentation of the physician’s ongoing management of the patient

• There must be a valid employment arrangement

• Must be an established patient

• Physician must be physically present in the office suite and immediately available to help if needed
Split/Shared Services Documentation Requirements

In order to report the service under the physician’s NPI number, the physician must meet the documentation requirements:

- Must provide a *face to face* encounter with the patient
- Must document at least *one element* of the history, exam *and/or* MDM.
- There must be a *legible* signature by *both* providers

Copy/Paste/Cloning/Carry Forward

The documentation may be worded:
- Exactly the same as another DOS
- Similar to a previous DOS
- The same for all patients

Cloned documentation methods include:
- Templates
- Handwritten
- EHR
## Scribe

### Role of a Scribe

- A scribes role is to capture accurate and detailed documentation for the provider.
- **Documentation** must clearly indicate who performed the services, recorded the service credentials of each person, electronically **signed** and **dated** by both the **physician** and **scribe** in real time entry.
- Note: Provider must perform the medical services.

### Prohibited Duties

- Participate in **patient care** activities.
- **Fulfill hospital duties** including answering phones, calling patients from waiting rooms or calling physicians.
- Dictate reports.
- Enter orders or prescriptions.
- **Utilize** Provider log-in or password, but may **document** in the record once the **Provider** has logged into the record.

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## CMS Preventive Visits

There are 3 **types** of “wellness visits/preventive visits”, each has **different** reporting requirements.

- Initial Preventive Physical Examination (IPPE)
- Initial Medicare Annual Wellness Visit (AWV)
- Subsequent AWV
Care Management Services

99487: Complex chronic care management 60 minutes of clinical staff time
99489: Complex chronic care management EACH additional 30 minutes of clinical staff time
99490: Chronic care management service at least 20 minutes of clinical staff time (New for 2015)
99495: Transitional care management (TCM) moderate complexity; face-to-face within 14 days
99496: Transitional care management high complexity; face-to-face within 7 days

WHAT’S NEW FOR 2016
## 2016 New Removal of Impacted Cerumen

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<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>69209</td>
<td>Removal impacted cerumen using irrigation/lavage, unilateral</td>
<td>0.35</td>
<td>0.00</td>
<td>$12.85</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>69211</td>
<td>Nurse visit</td>
<td>0.37</td>
<td>0.18</td>
<td>$20.01</td>
<td>0.37</td>
<td>0.18</td>
<td>$20.08</td>
<td></td>
</tr>
<tr>
<td>69210</td>
<td>Removal impacted cerumen requiring instrumentation, unilateral</td>
<td>0.72</td>
<td>0.61</td>
<td>$49.82</td>
<td>0.72</td>
<td>0.61</td>
<td>$50.00</td>
<td></td>
</tr>
</tbody>
</table>

## Medicare’s Separate Payment for Advance Care Planning (ACP)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2016 WRVU</th>
<th>2016 $ Amount</th>
<th>Non Facility</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate</td>
<td>1.50</td>
<td>$85.49</td>
<td>$79.05</td>
<td></td>
</tr>
<tr>
<td>+99498</td>
<td>each additional 30 minutes (List separately in addition to 99497)</td>
<td>1.40</td>
<td>$74.39</td>
<td>$74.03</td>
<td></td>
</tr>
</tbody>
</table>
ACP As An Optional Element of the AWV - G0438 & G0439

Voluntary Advance Care Planning (ACP) means the face-to-face service between a physician or OQHP and the patient discussing advance directives, with or without completing relevant legal forms.

- Voluntary ACP can be an **optional** element of the Annual Wellness Visit (AWV)
- When **voluntary** ACP services are furnished as a part of an AWV, the coinsurance and deductible are waived
- Both services must be billed together on the **same** claim
- **Modifier 33** (Preventive services); 99497-33

Time for Reporting ACP

- Standards shall apply to time measurement, unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary.
- Time is the face-to-face time with the patient.
- **A unit of time is attained when the mid-point is passed.**
- When another service is performed concurrently with a time based service, the time associated with the concurrent service should **not** be included in the time used for reporting the time-based service.
## 2016 New E/M Prolonged Clinical Staff Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>2016 PE RVU</th>
<th>2016 $ Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 99415</td>
<td>Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour</td>
<td>0.24</td>
<td>$8.91 $8.91</td>
</tr>
<tr>
<td>+ 99416</td>
<td>Each additional 30 minutes (List separately in addition to code for prolonged)</td>
<td>0.13</td>
<td>$4.97 $4.97</td>
</tr>
</tbody>
</table>

**Tips**
- Time must be documented
- If the time spent is less than 45 minutes the service is not billable
- These are add-on codes and are not reported separately

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## Global Surgery- CY 2015 Final

- Transforming all 10- and 90-day globals into 0-day globals
  - 10-day in CY 2017
  - 90-day in CY 2018
References

- CMS Claims Processing Manual; Chapter 12; sec 30.6.1; pgs. 40-41
- CMS 1995 & 1997 Examination Guidelines
- BH Pol 12411; Incident To
- BH Position Statement: Review of Systems; Formal P&P upcoming
- BH Policy #678
- BMG Compliance Newsletter June 2012 "Cloning of Medical Notes"

- AMA CPT Manual 2016
- Federal Register:
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched/