Introduction to Medicare Advantage risk adjustment

Medicare Advantage

Medicare Advantage (Medicare Part C) is an alternative form of Medicare where some beneficiaries choose to have their Medicare coverage through a private health plan. Medicare Advantage plans cover all of the services that Original Medicare covers; however, Medicare Advantage plans can include additional supplemental benefits such as vision, hearing or dental, as well as annual wellness programs that are not offered under Original Medicare.[1,2,3]

Definition[3]

Risk adjustment employs a payment methodology used to adjust payment to Medicare Advantage health plans based on the demographics and health status of a plan's enrollees.

Purpose[3]

Risk adjustment allows CMS to make appropriate and accurate payment to Medicare Advantage plans for enrollees with differences in expected costs based on accurate, specific and complete diagnosis coding.

Process[3]

Risk adjustment utilizes the CMS-HCC classification system that identifies high risk conditions, which places members into the appropriate risk category for expected medical resource utilization.

Risk adjustment methodology[4,5,6]

Risk adjustment (RA) is an essential mechanism used in many different health insurance programs to account for the overall health and expected medical costs by means of resource utilization and allocation of services for each individual enrollee. The RA process is a value-based program designed to help align MA funding with the health status of the covered population by adjusting the capitation payment for individual plan members based on the number and severity of reported diagnoses.

Focus on chronic conditions

- Identify, address and treat early stages of chronic conditions.
- Focus on preventive care and early intervention to promote improved quality of care to keep beneficiaries healthy.
- Minimize disease progression.

Accurate, specific and complete documentation and coding of diagnoses by clinicians is a critical component of the risk adjustment process. This ensures that beneficiaries receive the appropriate care management and related services they need based on the severity of each condition.

Why accurate, specific and complete documentation is important[3,4,6]

Detailed documentation → Accurate, specific and complete ICD-10-CM coding → Accurate program funding

→
- Supports the complexity of the services
- Validates medical necessity
- Demonstrates quality of care provided

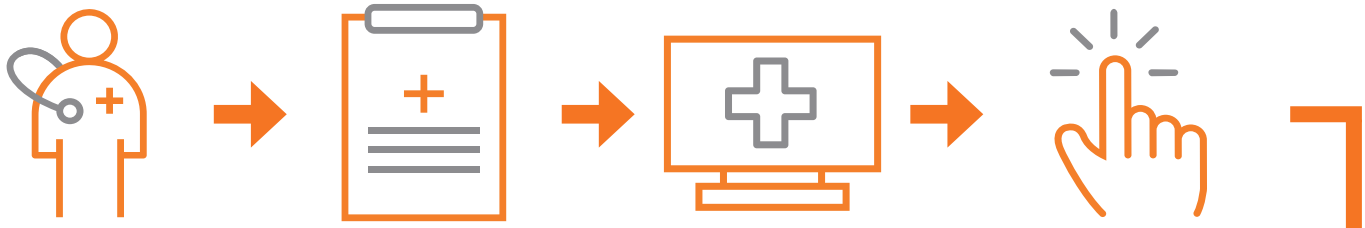
CMS-HCC risk adjustment model

The Medicare Advantage RA model uses beneficiary diagnoses from the current year to calculate funding for the following year. The goal is to promote clinical attentiveness to identify and treat all condition(s) for each member on a regular basis to:

- Reduce hospital admissions and readmissions
- Improve use of preventive and primary care services
- Achieve higher rates of screening and quality of care outcome metrics for chronic conditions

Clinicians are encouraged to identify condition(s), and document and code to the highest level of specificity each year to promote early interventions and control and/or slow disease progression. Documentation should capture a plan of care with evidence of monitoring, evaluation, assessment or treatment of each member's conditions.

Potential gaps in data submission: the data submission process



1 Provider

- Assess or address patient health status on at least one face-to-face visit each year to report disease progression and co-morbidities, and status of permanent condition(s)
- Diagnoses from a prior year do not carry over in the CMS-HCC Risk Adjustment model.

2 Medical record

- Evaluate and document all conditions that constitute the "composite health picture" of the patient.
- Documentation must be concise, consistent, complete, logical and legible in the progress note. This is not limited to what brought the patient to the doctor.

3 EMR/Superbill

- Electronic medical record (EMR) documentation must support current diagnosis codes for each condition and the patient status with a plan of care, in addition to efficiently utilizing coding software available in your EMR to assist with populating the ICD-10-CM code(s).
- Keep superbills up to date, utilizing a wide variety of ICD-10-CM codes to allow specificity of condition(s) to be accurately coded.

4 Coder/Data entry clerk

- Consider using a professional coder to capture all diagnoses that have been properly documented and to communicate coding conundrums with the provider when appropriate.
- Your administrative staff must have access to current ICD-10-CM manuals for assigning highest level of specificity to accurately report the level of disease severity.

5 Practice management system

- Make sure all data is captured and the provider is aware of the limitations of their practice management system.
- Be cognizant of the number of diagnosis codes your EMR system allows, and if there are any diagnosis codes that are being dropped or not captured.
- Properly sequence the diagnosis codes and periodically conduct random chart reviews to ensure all information is captured.

6 Clearinghouse

- If using a clearinghouse or submission vendor, verify they can send and receive all recorded codes, and number of valid diagnosis codes their system (and the providers') is capable of supporting for data submission.
- Consider enhancements to your claims system and practice management system to capture more data due to HIPAA data requirements.

7 Health plan

- Be certain that your claim (or encounter format or form) contains all data needed to be extracted for processing.
- Test your system to be sure all diagnosis codes are being extracted and sent to the health plan, and not limiting or reducing the number of diagnosis codes processed.
- Avoid only sending one or two diagnosis codes to support procedure codes reported on claims.

8 CMS

- Verify that health plans can send and receive all recorded diagnosis codes, and total number of codes your payer can accept.
- Seek an alternative submission method (ASM) of submitting codes if your payer does have limitations beyond the accepted number.

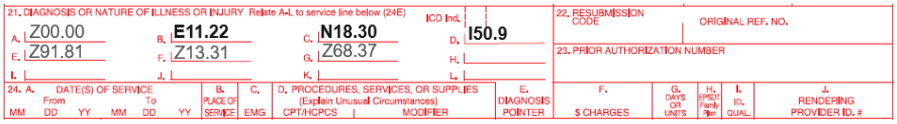
Accurately and appropriately reporting diagnosis codes

Placing each Medicare Advantage beneficiary into the appropriate risk adjustment category for expected medical and financial forecasting purposes requires entering all problem-pertinent diagnoses for each episode of care in the appropriate fields within the billing forms. Providers, coders and others in the health care industry frequently ask about the number of diagnosis codes allowed on the paper forms and electronic formats when billing for services.

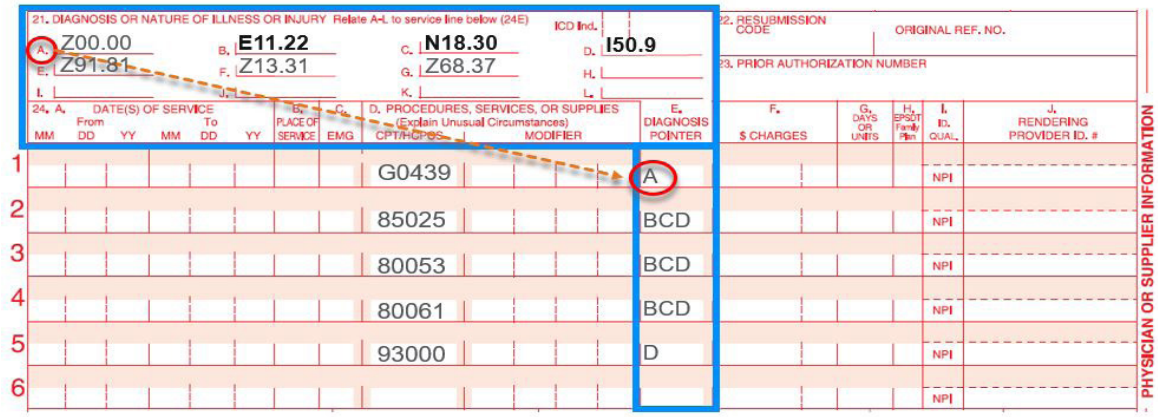
Medicare billing forms CMS-1500 and 837P [6, 7, 8, 9]

CMS-1500 claim

Accommodates up to 12 ICD-10-CM diagnosis codes in Item No. 21 (block) for patient cases that will require multiple codes to delineate the true illness burden characteristic of each beneficiary's specific and unique heath care needs.



Pointers are used to link the diagnosis codes (as listed in the illustration above) to a CPT (Current Procedural Terminology) or Healthcare Common Procedure Coding System (HCPCS) procedure code relative to the most significant diagnoses in order to request payment. A maximum of four pointers (Column E as illustrated below) are used to describe relationships between submitted diagnosis codes entered in Block 21 (pointers A–L) and service or treatment code information described in lines 1–6 on the health claim.



A properly coded claim, utilizing up to the maximum of 12 diagnosis codes, often will include diagnoses that are not pointed to any one specific service or treatment code. Using pointers means that no diagnosis code entered in Block 21 will ever need to be listed more than once to keep data transmission lean and reduce error.

Electronic medical record (EMR)

The provider will enter or select from a drop-down menu from the appropriate diagnoses to populate the assessment section of each progress note for each patient encounter as exemplified here. In most EMR systems, up to 12 diagnoses may be populated. This is often a setting within the EMR that can be changed based on user preference.

#	ICD-10	Description	Billed
A	Enter or select ICD-10 code form dropdown list	**Z00.00** Encounter for general adult medical examination without abnormal findings	☰
B	**E11.22**	Type 2 diabetes mellitus with diabetic chronic kidney disease	X
C	**N18.30**	Chronic kidney disease, stage 3 unspecified	X
D	**I50.9**	Heart failure unspecified	X

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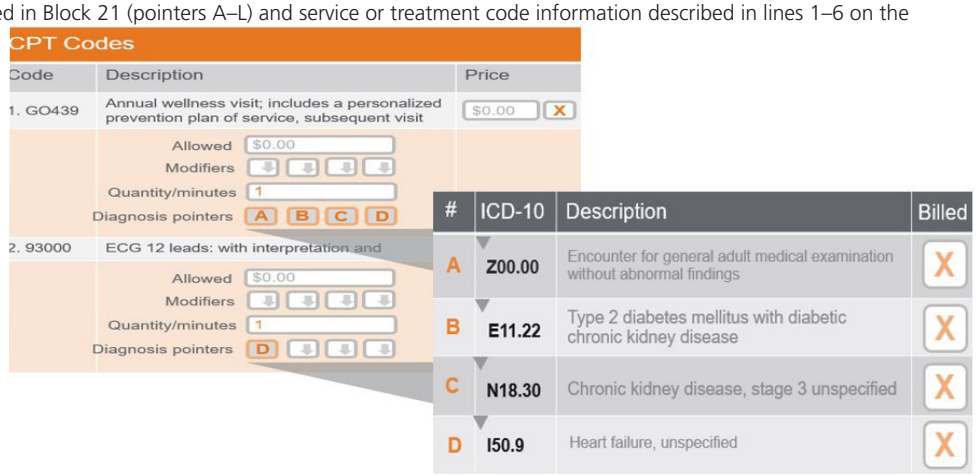
Enter your diagnosis code pointers for each CPT/HCPCS code billed as exemplified here. Diagnosis pointers are used to describe the relationship between the diagnoses and the specific service or procedure being billed, and a limit of four diagnosis codes can be populated from the assessment of a specific encounter in order to be linked to a specific service or procedure.

Example: Enter your diagnosis code pointers for each CPT/HCPCS code billed as exemplified here. Diagnosis pointers are used to describe the relationship between the specific service or procedure being billed and up to four diagnosis codes that are populated from the assessment of a specific encounter



The 837P (Professional)

The 837P is the standard claim format used by health care professionals and suppliers to transmit health care claims electronically. EMR billing system data field formats may vary among different software product lines; however, the information required is generally the same. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P Version 5010A1 is the current electronic claim version. For more information, please visit the ASC X12 website at: x12.org

Point-of-care data entry

In most instances, the EMR system initiates claims processing by auto-generating the fee sheet as line-item services with procedure codes, modifier options, pricing and other necessary data. However, an intrinsic pop-up feature reveals only four available spots to associate only four diagnosis pointers to each service or procedure (as illustrated above). In most EMR systems, an addition field is available to allow for 12 or 24 (or more) additional diagnoses to populate all problem-pertinent diagnoses for the encounter in order to finalize processing of the claim (work with your specific EMR vendor to troubleshoot or add additional diagnosis fields).

Concerns with EMR pointers

Some EMR systems may inadvertently auto-generate and process a claim by carrying over only diagnosis code pointers, thus omitting "nonpointed" diagnosis codes. The proper way to code an encounter is to submit all diagnoses for the visit and then, for each treatment, submit the most relevant related diagnosis — with up to four pointers.

- Do a "test" claim submissions to see if at least 12 diagnoses can be populated with line-item code pointers (four maximum) from the fee schedule to justify line-item procedures.
- Check with your clearinghouse to see if there is a way to populate all diagnoses instead of line-item code pointers (four maximum) to justify line-item procedures. Ask for screenshots to view code population for claims submission and to see if the clearinghouse software is capable of populating 12 diagnoses. Then integrate their results with the EMR claims submission test field to find out where the gap is that dropped the additional codes.
- Contemplate performing retrospective and prospective chart reviews and reporting additional diagnoses through a different portal.
- Check with your EMR vendor regarding current diagnosis submission settings. In many EMRs, there is a setting in which the system truncates the number of diagnosis codes that are populated and submitted on each claim form. This setting can often be changed based on user preference.

The following references were used in the creation of this document:
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