Agenda

- ICD-10 Post Implementation
  - How Did We Do?
  - What Can We Expect in 2017
- Intersection of ICD-10 and Risk Adjusted Data Validation Audits
- Understanding the RADV Audit Process for Medicare Advantage Plans
  - 2007 Pilot Audit
  - Methodology
  - Appeals
  - Plans at Risk and Recommendations
- Early Management of ICD-10, RAC, and Other Government Oversight

ICD-10 POST IMPLEMENTATION
HOW DID WE DO?

LEGISLATIVE STEPS TO ICD-10 SYSTEM CONVERSION

- 2003: NCVHS voted to recommend ICD-10 under HIPAA
- 2008: Proposed implementation date of 10/01/11
- 2009: HHS publishes final rule to adopt ICD-10 on 10/01/13
- 2012: Final date for compliance
- 2013: Version 5010 required for all health plans
- 2014: HHS changed compliance date to 10/01/15
- 2015: ICD-10 Compliance Date
- 2016: End of grace period
- 2017: ?

ICD-10 POST IMPLEMENTATION
ICD-10 POST IMPLEMENTATION
HOW DID WE DO?

EARLY CONCERNS OVER THE TRANSITION FROM ICD-9 TO ICD-10

More Codes  
Lower Productivity

ICD-10

Higher Costs

Increased Denials

Reduced Accuracy

ICD-10 POST IMPLEMENTATION
 HOW DID WE DO?

REALITY OF THE TRANSITION – DIAGNOSIS CODING

Productivity
- 70% reported a decrease
- 26.3% reported no change
- Seasoned coders reported the highest decrease

Accuracy
- 61.5% reported no change
- 27% reported a decrease
- Seasoned coders reported the least decline

*Based on a June 2016 AHIMA survey

ICD-10 POST IMPLEMENTATION
 HOW DID WE DO?

REALITY OF THE TRANSITION – CLAIMS DENIALS AND COST

Final 2015 ICD-10 Claims Dashboard Medicare FFS Metrics

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Historical Baseline</th>
<th>Q4 CY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Submitted</td>
<td>4.6 Million per day</td>
<td>4.6 Million per day</td>
</tr>
<tr>
<td>Total Claims Rejected</td>
<td>2% of total claims submitted</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total ICD-10 Claims Rejected</td>
<td>0.17% of total claims submitted</td>
<td>0.07%</td>
</tr>
<tr>
<td>Total ICD-9 Claims Rejected</td>
<td>0.17% of total claims submitted</td>
<td>0.07%</td>
</tr>
<tr>
<td>Total Claims Denied</td>
<td>10% of total claims processed</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Source: CMS.gov
ICD-10 POST IMPLEMENTATION
HOW DID WE DO?

SUCCESSFUL TRANSITION... OR FALSE SENSE OF SECURITY?

- Extensive training and education
- Multiple delays (time)
- CDI programs
- CMS Strategies
  - Customer Focused
  - Highly Collaborative
  - Responsive and Accountable
  - Metrics Driven
- End of grace period 10/1/16
- CMS diagnosis coding audits
  - Family of code specificity is no longer permissible
- Focus on unspecified codes
- Increase in denials based on diagnosis coding
- Increase in ADR letters

ICD-10 POST IMPLEMENTATION
WHAT TO EXPECT IN 2017?

KEY PERFORMANCE INDICATORS TO WATCH IN 2017

1. Level of specificity: Grace period for inadequate level of specificity ended on 10/1/2016
2. Claims acceptance and rejection rates: Percentage of claims accepted/rejected during payer front-end edits
3. Claims denial rates: Percentage of claims accepted into the payer’s adjudication system that are denied
4. Payment amounts: Amounts provider receives for specific services
5. Coder productivity: Medical records coded per hour, per coder
6. Use of unspecified codes: Volume and frequency
7. Medical necessity pass rate: Acceptance of claims with medical necessity content

INTERSECTION OF ICD-10 & RADV

INTRODUCTION TO RADV AUDITS

- Required under the Affordable Care Act
- Purpose is to review payments based on risk scores
  - Determined by demographic information on the enrollee and diagnosis codes
  - Calculated each year to establish payment for the following year
  - Used to predict the cost to the health plan for accurate reimbursement
- CMS performs two types of RADV audits each year
  1. To establish the national MA improper payment rate
  2. To review medical record documentation to validate the diagnosis codes submitted for payment on a contract level
- RADV audits require specific coding criteria and documentation standards
RADV AUDITS AND ICD-10 DIAGNOSIS CODING

1. Be as specific as possible in documenting conditions

| Laterality | Left, right, dominant, non-dominant |
| Type       | 1, 2, obstructive, restrictive, dilated |
| Stage      | 1-4, end stage, single, recurrent |
| Abuse, dependence, or in remission | Tobacco, drugs |
| Occurrence | Paroxysmal, atypical, acute, chronic |
| Location   | Lower extremity, native vein |
| Severity   | Mild, moderate, severe |

2. Include documentation when etiology is known

Cardiomyopathy | Alcohol or drugs |
Heart failure | Due to hypertension |
Dementia | Alzheimer's, Parkinson's |
Secondary Diabetes | Pancreatitis, Cushing's, Drugs, Cancer |
Neuropathy | Diabetes |

VARIOUS TYPES OF ICD-10 DENIALS AND SOLUTIONS

| Technical Denials | Denials due to problems with claim processing |
| Solution: Perform end to end testing |

| Logic-based Denials | Denials for ICD-10 codes that do not correspond with CPT codes |
| Solution: Coder education, data mining and claim scrubbing software |

| Unspecified Codes | Coverage related denials due to lack of specificity |
| Solution: Mentor unspecified codes in LCDs and NCDs and ensure documentation is specific enough to avoid use of these codes |

| Invalid Codes | Denials due to insufficient characters or placeholders |
| Solution: Coder training |

ICD-10 DENIAL MANAGEMENT PROGRAM GUIDELINES

1. Identify trends
2. Utilize coders in unconventional departments, such as admissions
3. Maximize cash reserves
4. Automate the process for working denials
5. Understand the root causes of denials
6. Establish a denials manager
UNDERSTANDING RADV AUDITS

RADV 2007 PILOT AUDIT

- Conducted in 2008, findings issued in August of 2012
- The audits took 2 years to complete
- CMS potentially overpaid the 5 health plans up to $128 million, but settled the audits in 2012 for $3.4 million
- In all 5 audits, two sets of auditors performed an audit of 201 patients at each plan for 2007
- Refunds were requested for records without supporting documentation of diagnosis codes
- Auditors credited records that were underreported

UNDERSTANDING RADV AUDITS

RADV 2007 PILOT AUDIT RESULTS

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Payment Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna (New Jersey)</td>
<td>$27.6</td>
</tr>
<tr>
<td>Independence Blue (Philadelphia)</td>
<td>$34.0</td>
</tr>
<tr>
<td>Lovelace Health Plan (Albuquerque)</td>
<td>$33.5</td>
</tr>
<tr>
<td>Humana</td>
<td>$20.2</td>
</tr>
<tr>
<td>PacifiCare (Washington State)</td>
<td>$13.0</td>
</tr>
</tbody>
</table>

*In millions

UNDERSTANDING RADV AUDITS

RADV 2007 PILOT AUDIT

- Auditors concluded that risk scores were too high for more than 800 of the 1,005 patients, which in many cases, led to overpayments
- Medicare’s annual payment for more than 200 patients was at least $5,000 higher than merited
- Auditors could not confirm one-third of the 3,950 medical conditions the health plans reported, mostly because records lacked “sufficient documentation of a diagnosis”
  - The names of the medical conditions were redacted by officials
  - HCC coding uses the ICD-10-CM coding guidelines and the documentation must be supported in the medical record
  - In RADV audits, the facility must send supporting medical records of the diagnosis codes submitted
UNDERSTANDING RADV AUDITS

STAGES TO RISK ADJUSTED DATA VALIDATION AUDITS

1. Sample Selection
2. Initial Validation Audit
3. Second Validation Audit
4. Error Estimation
5. Appeals
6. Payment Adjustments

STEP 1: SAMPLE SELECTION

- Sample size and strata
  - CMS conducts RADV audits on 30 contracts per payment year
  - Enrollees are sampled from each selected Medicare Advantage contract
  - 201 eligible enrollees are included for a medical record review
  - The sample of beneficiaries is grouped into strata based on community risk score, ranking by lowest, middle and highest score

RADV Eligible Enrollees

- Enrolled in MA contract in January
- Non ESRD Status
- Non Hospice Status
- Enrolled in Part B for all 12 months
- At least 1 Risk Adjusted Diagnosis

STEP 2: INITIAL VALIDATION AUDIT (IVA)

- Medical records submitted for RADV first undergo an intake evaluation by an initial validation auditor (IVA Entity)
- The medical records are reviewed for accuracy and only valid records go forward for coding
- Components of a valid medical record include:
  - Documentation by an approved credentialed provider
  - Documentation from a face-to-face encounter
  - Approved provider’s signature which includes credentials, date, and time
  - Patient’s name and date of service on each page of the medical record
- CMS has created a Risk Adjustment Data Validation Medical Record Checklist and Guidance to assist in selecting the medical records
UNDERSTANDING RADV AUDITS

RADV Medical Record Checklist

- Is the record for the correct enrollee?
- Is the record from the correct calendar year for the payment year being audited?
- Is the date of service present for the face to face visit?
- Is the record legible?
- Is the record from a valid provider type?
- Are there valid credentials and/or is there a valid physician specialty documented on the record?
- Does the record contain a signature from an acceptable type of physician specialist?
- If the outpatient/physician record does not contain a valid credential, and/or signature, is there a completed CMS-Generated Attestation for this date of service?
- Is there a diagnosis on the record?
- Does the diagnosis support an HCC?
- Does the diagnosis support the requested HCC?


UNDERSTANDING RADV AUDITS

STEP 3: SECOND VALIDATION AUDIT (SVA)

- CMS will hire second validation audit (SVA) entities to review the IVA auditors findings
- A sub-sample of the IVA findings will be audited

STEP 4: ERROR ESTIMATION

- Payment Error Estimation
  - Based on the validation process from the medical review
  - If the diagnosis code is not supported in the medical record, the new RADV-corrected risk score is calculated
  - The payment error is calculated for each enrollee
  - A payment error extrapolation calculation is based on the enrollees sampling weight

UNDERSTANDING RADV AUDITS

STEP 4: ERROR ESTIMATION

- RADV Process Findings
  - At the conclusion of the initial medical record review process, results, called “Preliminary Audit Report Findings” (AROF), will be sent to the contracts
  - The report includes the detail of the validation outcome, error type, and eligibility for the medical record dispute
  - The AROF will detail the calculation of the corrected risk score and payment for each enrollee based on the initial medical record review
  - The payment error will be provided in a dollar amount
  - Contracts will receive information and instructions on medical record disputes (MRD) with the preliminary AROF
UNDERSTANDING RADV AUDITS

STEP 5: APPEALS

• Errors can be disputed and overturned through an appeal process

• Issuers have the opportunity to appeal both IVA and SVA findings

• Two types
  – Medical record review determination appeals
  – Payment error calculation appeals

• Stages of an Appeal
  – Medical Record Dispute (Reconsideration)
  – Hearing Officer Review
  – CMS Administrator Review

UNDERSTANDING RADV AUDITS

STEP 5: APPEALS

• Medical Record Dispute (MRD)
  – Conducted following the AROF
  – Opportunity for the MA contracts to appeal certain types of errors
  – MA has 60 days from the date of issuance of the RADV audit to file a written request with CMS for the appeal
  – The appeal must specify one of the following:
    • Medical record review determination appeal: The issues with which the MA contract disagrees and the reasons for the disagreements
    • Payment error calculation appeal: The issues with which the MA contract disagrees and the reasons for the disagreements
    • Both a medical record review determination appeal and payment error calculation appeal: The issues with which the MA contract disagrees and the reasons for the disagreements

UNDERSTANDING RADV AUDITS

STEP 5: APPEALS

• Hearing Stage
  – If the MA disagrees with the reconsideration, they must do so in writing within 60 days of the date the MA contracts receives the reconsideration officer’s written reconsideration decision
  – The written notice must include:
    • A copy of the written decision of the reconsideration official
    • The audited HCCs that are in error
    • A justification of why the MA contract disputes the determination
  – A hearing officer is designated and, once the hearing is conducted, the decision is final, unless reversed or modified by the CMS administrator
UNDERSTANDING RADV AUDITS

STEP 5: APPEALS

• CMS Administrator Review Stage
  – If the MA disagrees with the hearing officer, they must do so in writing within 60 days of the date the MA contract receives the hearing officer’s written reconsideration decision.
  – The CMS Administrator can decide to review the hearing officer’s decision or to decline the review.
  – If the CMS Administrator chooses to review the hearing decision, a written notice will be sent to both CMS and the MA contract of their right to submit comments within 15 days of the date of the notification.
  – The CMS Administrator must render the decision in writing within 60 days.
  – The decision of the hearing officer is final if the CMS Administrator declines to review the hearing officer’s decision or does not make a decision within 60 days.

UNDERSTANDING RADV AUDITS

STEP 6: PAYMENT ADJUSTMENTS

• In a prospective approach, the error rate from the prior year will be utilized to adjust the average risk score in the current year.
• CMS will recover net overpayments identified during the RADV audit process that result from diagnosis data not justified by the medical record documentation.

UNDERSTANDING RADV AUDITS

FINDINGS WITH THE CURRENT PROCESS OF RADV AUDITS

• CMS does not always select contracts based on evidence of the potential for improper payments.
• CMS lacks a timetable to complete the audits on an annual cycle.
• CMS web-based system (CDAT) has ongoing performance issues of transferring data and medical records.
• Disputes and appeals of contract level RADV audits have been ongoing for years and CMS has not incorporated measures to expedite the process.
• CMS’s lack of resources for conducting contract level audits and intends on using RACs in MA.
UNDERSTANDING RADV AUDITS

RADV BY THE NUMBERS

- In 2013, CMS estimated that it improperly paid $14.1 billion to MA organizations primarily due to unsupported diagnosis codes
- In 2014, Medicare paid about $160 billion to MA organizations for approximately 16 million beneficiaries
  - It is estimated that around 9.5% of its payments were improper
- The GAO conducted a study and determined CMS’s methodology of selecting contracts for auditing is not the best approach
- Concerns over the substantial delays in the process of recovering improper payments

UNDERSTANDING RADV AUDITS

GAO RECOMMENDATIONS

1. Select contracts based on 3 most recent pair years
2. Focus on contract selection on those most likely to have high rates of improper payments
3. Enhance the timeliness of CMS’s contract level RADV process
4. Require that reconsideration decisions be rendered within a specified number of days
5. Develop specific plans and a timetable for incorporating a RAC in the Medicare Advantage program as mandated by the Patient Protection and Affordable Care Act

UNDERSTANDING RADV AUDITS

MEDICARE ADVANTAGE PLANS AT RISK

- Increased risk scores
  - Review the risk scores from the previous contract years to see if there are any changes that appear inappropriate
  - CMS will possibly flag you for an audit if the scores are significantly higher than expected
- Previous reviews for other issues
  - Information could be noted from other audits and provide insight for another review
- Not deleting records based on accuracy of coding
  - Choosing the appropriate medical records to support the submitted diagnoses
UNDERSTANDING RADV AUDITS

TOP MEDICARE ADVANTAGE CODING ERRORS

• Medical record is not signed/authenticated correctly
• Documentation is not legible
• Highest degree of specificity was not assigned
• Diagnosis code submitted is not supported in the medical record
• Diagnosis code does not support the MEAT criteria
• Provider did not “link” conditions
• Documentation supports HCC conditions that are not captured
• Documentation is not from a face-to-face encounter
• Appropriate provider has not signed the medical record
• Patient’s demographic information/date is not on each page
• Note contains conflicting documentation

CMS EARLY MANAGEMENT

CMS PROGRAM OPERATIONS

HHS FY 2017 BUDGET – CMS PROGRAM MANAGEMENT

![Budget Pie Chart]

CMS EARLY MANAGEMENT

CMS FINALIZES REFORMS FOR MEDICARE ADVANTAGE PROCESS

• Effective Jan. 17, 2017, the Centers for Medicare & Medicaid Services (CMS) published a final rule titled Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, finalizing proposed changes made to the Medicare appeals process.

• This will become effective March 20, 2017

• It will reduce the workload on the ALJ level of appeal and improve efficiencies at all levels
EARLY MANAGEMENT

CMS FINALIZES REFORMS FOR MEDICARE ADVANTAGE PROCESS

- Permit certain decisions from the Departmental Appeals Board (DAB)/Medicare Appeals Council to be binding on all CMS components, HHS components that adjudicate matters in dispute, OMHA ALJs, and entities that render initial determinations, redeterminations, and reconsiderations
- Chair of the DAB should consider when determining whether to identify a decision as precedential which would be published in the Federal Register
- Implementation of attorney adjudicators at the ALJ level of appeal
- May submit evidence for the first time at the ALJ level of appeal if good cause exists

EARLY MANAGEMENT

OIG WORKPLAN 2017

Risk Adjustment and Encounter Data Sufficiency of Documentation Supporting Diagnoses

- In general, MA organizations receive higher payments for sicker patients
- CMS estimates that 9.5% of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations
- Prior OIG reviews have shown that medical record documentation does not always support the diagnosis submitted to CMS by MA organizations

Thank you!

QUESTIONS?