Preparing For & Managing a RADV Audit

Session 607

Dennis P.H. Mihale, MD, MBA

Scott Weiner, CMA, CFM, MBA

Agenda

- Assessing Your Risk
- CMS RADV Process
- Health Plan Process
  - Preparation
  - Execution
- Mock Audit
- Lessons Learned
- Q & A
- Contacts
Assessing Your Risk

What is Your Risk for a RADV Audit?

- Changes in Coding Intensity
  - How does your annual change compare to the rate announcement (coding pattern adjustment – 3.41% and normalization – 5.9%)

- Other Part C/D Violations
- Increased Probability of “Up-Coding”
  - High percentage of capitated providers
  - Incentives paid for “proper coding” with no oversight

- Stable Membership?
CMS Means Business

- False Claim Act Settlement - America’s Health Choice - $22.6M fine
  - “DOJ and HHS OIG are getting impatient with the process of RADV audits and are taking things into their own hands”
  - Low threshold; "Reckless" vs. "Negligent"
- Whistleblowers get a percentage of settlements

What is Your Exposure: Financial Impact

- For one of our 180K Member Plan clients, a 10% RADV Audit finding → approximately $230 million revenue impact
- And then there is extrapolation…
  - CMS will extrapolate to determine reimbursement and regulatory compliance
  - Representative audit findings extrapolated across the entire plan
  - $10 million in HCC reimbursement with a 20% error rate equals a $2 million penalty
  - Plans could be subject to adjustments to their risk scores if the audit shows overpayment based on discrepancies in HCC coding data submitted and documentation in medical records
The Tax Man Cometh

- Government will audit plans to fund healthcare reform:
  - Expected savings of $2-3B over next 10 years\(^1\)
- Conversion from RAPS to EDPS will lead to errors
- ICD-9 to ICD-10 will also cause errors

"We will determine whether CMS properly adjusted payments to MA plans based on the results of its calendar year (CY) 2007 data validation reviews. Risk adjustment data validation is an annual process of verifying diagnosis codes. (42 CFR §§ 422.308(c) and 422.310(e).)"\(^2\)

\(^1\) – 2011 Washington Healthcare Update – Focus on the Joint Select Committee on Deficit Reduction
CMS RADV Process

- Health Plan Selection
- Member Selection
- Medical Record Request
- Medical Record Review
- Plan-Level Findings
- Payment Adjustment
- Appeals
- Correct Payment

CMS Selection Criteria - Plans

- 110 Plans Per Year Selection
  - Targeted (plans with greatest increase in 4 year period prior to audit)
  - Pilot plans (were included in 2007 may not be in 2008)
  - Random selection
  - Anyone can be selected – even those recently audited
  - Unknown receipt date
CMS Process: Choosing Members

- CMS chooses 201 members
  - Each member could have 5 to 10 doctors
  - Resulting in reviewing as many as 10,000 encounters
  - CMS selects the members
    - 67 high RAR scores
    - 67 medium risk scores
    - 67 low risk scores
  - Must be continuously enrolled in measurement year and at least one month eligibility in payment year
  - No ESRD, hospice members

Health Plan Process
Health Plan RADV Process

How plans view the process
- Notify Providers
- Request Records
- Find the Medical Record
- Submit the Record
- Simple? Absolutely NOT

What is the process really like?
- Lets find out

Preparation
- What can be done now?
- What must be done when you receive notification?
- What should be done during implementation?
Initiation

- Identify key stakeholders in the process
- Choose your Rapid Response Team with a business owner and project manager
- Develop the project plan
- Assess organizational expertise
- Decide if a third party vendor is needed

Planning

- Understand the challenges
- Identify IT resources and software
  - load PDF reader/professional on machines
- Confirm staff HCC expertise
- Ensure all data sources are identified
- Create the workflow
Challenge 1: Get the Paper Record

- Automate record retrieval
- FAX, Email, Scan
- Ensure HIPPA compliance
- Create Image Data Base

Challenge 2: Get the EMR Record

- Validate getting records electronically
- Review data format for readability
- Validate EMR includes diagnoses
- Ensure all patient data is included
- Review for misuse of templates or "canned" documentation
Challenge 3: Find The Best Record

- **Prioritize Possible Sources**
  - Claims – including labs and pharmacy
  - Retrospective and prospective reviews
  - Hospital in-patient charts
  - Providers issuing ICD-9 codes
  - Specialty / HCC associations

- **Avoid Unacceptable**
  - **Source**: SNF, ACS, DME, Physician Extenders
  - **Documentation**: Super Bills, Attestations, Condition Lists, dates outside of service date
  - **Diagnoses**: Probable, Suspected, Questionable

---

Challenge 4: Prove the Rating

**Common Problems**

- **Invalid Medical Records**
  - Unacceptable source or date
  - Missing provider signature

- **Missing Medical Records**
  - Insufficient or incomplete documentation
  - No medical record to support the HCC

- **Coding Discrepancies that change HCC code**
  - ICD-9-CM code assigned changes a beneficiary HCC
Manage the Workflow

1. Identify Providers
2. Request Records
3. Acquire Records
4. Call & Send Letters
5. Image and Index
6. Review Records
7. 2nd & 3rd Wave of Record Requests
8. Best Record?
9. Link Record/ CMS Forms/ Submit

Automate the Workflow
(Retrieval and Review)

- Facilitate tracking requests and responses
- Link beneficiary information to records
- Allow review workloads to be distributed
- Make activity reporting easier
  NOTE: CMS pays for record retrieval based on state guidelines
- FTP submission to CMS is a **Must**
Create Document & Audit Databases

- They help to automate the workflow
- References for reporting under-reported scores
- They provide data for analysis:
  - Post audit review
  - Provider coding education
  - Areas for improvement/revenue enhancement

Execution
“The Paper Chase” – Start Fast

- Once CMS sample is received match the member/provider/HCC association file
  - Identify provider records with highest probability of containing diagnostic code
  - Launch multi-faceted outreach to providers
  - **Start calling on Day 1**
  - Deliver waves of customized letters
  - Ready scheduling team for follow-up
  - Ready field staff for possible office visits

Follow-up

- Incentivize providers to fax/mail in charts early in the process
- If unable to get provider to fax/mail chart, work with provider to retrieve copy on-site
  
- If unable to substantiate HCC
  - contact members to see if other provider chases may exist
- Capture Attestations with chart retrieval to avoid contacting provider a second time
Clinical Abstraction

- Assign Senior Clinical Reviewers to review all charts
- Review records currently in-house for CMS selected members to determine quality of records containing HCC
- Score each date of service for each HCC to make “best medical record” determination easier
- Over-read each chart reviewed by an independent senior quality analyst to validate the HCC

Substantiate

- Once charts have been coded and pass Quality Assurance, compare to the CMS provided HCC
- HCC Coding Manager examines charts with an HCC that substantiates the CMS HCC and determines the “Best Medical Record” for each Member/HCC
- If no charts substantiate the CMS HCC, alternate chart chases or other HCC within the Hierarchy should be examined
Additional Information

- If other HCC exist that were not previously captured at CMS, they should be included as well.
- It never hurts to send in a medical record that best substantiates a higher or lower code in the hierarchy.
- All chart reviews should be completed by the end of week 10 so the best medical record can be determined.

Validate and Confirm

- Confirm the appropriate diagnosis codes and level of specificity were used and clearly documented.
- Verify the date of service is within the data collection period.
- Ensure the provider’s signature and credentials are legible and present (or attestation is received).
Submit the Record

- Ensure assessments are clear and properly documented
- Proper diagnostic test results are incorporated into the progress notes (*avoid rule out diagnoses at all cost*)
- Any additional diagnosis found since the net will be applied to the weighting factor
- Allow time to reconcile and review documents submitted

Conducting a Mock Audit
Assemble the Team

- RADV Rapid Response Team includes:
  - Medical Directors to call doctors
  - Executives to call office managers
  - Project Manager(s)
  - Review / Audit staff
  - Other Team Members

Build Processes

- Build the outreach process
  - Match CMS target members with all providers
  - Prioritize most likely source of diagnosis
    - Providers, hospitals, specialists
  - Manage provider outreach
    - Outbound calls and letters
    - Match CMS forms
  - Track responses and results
Test and Review

- Test current methods of retrieving records
  - Paper, electronic, combinations
  - HIPAA-compliant fax/email and FTP sites
  - Field resources to visit offices

- Records review
  - Coders/auditors with ICD-9 and HCC knowledge
  - Education for HCC and rapid record review
  - Capacity and volume measurement

Packaging and Plan B

- Packaging for CMS submission
  - Match CMS forms to provider and medical records
  - Test FTP to CMS for submission

- Plan B
  - Other methods of record retrieval
  - Additional internal staff
  - Outsource alternatives
Evaluation

- How well did the mock audit work?
- What went wrong?
- Identify errors
- Gap analysis
- Correct problems
- Improve process
- Gain confidence

Lessons Learned
Case Study: Health Plan Experience

- What worked well
  - Planning Ahead
    - Engaged a vendor to help
    - Chase list was created before the sample selection was received
  - Motivated Staff

- What needed improvement
  - Data cleaning and prep prior to audit
  - Analytics and baseline modeling prior to audit due to data set availability
  - Better tracking for final decision making of chart
  - Additional dedicated resources

Q & A
Thank you

Dennis P.H. Mihale, MD MBA  
CEO & CMO  
Sunera-Parses LLC  
813.936.1090 x110  
dmihale@parses.com

Scott Weiner, CMA, CFM, MBA  
Managing Partner  
Strategic Health Consulting  
757.467.8179  
sweiner@strategichealthconsulting.com