Managed Care
Enforcement and Compliance
Part 1

FDR enforcement in Medicare Advantage Plans

Kay Mesia
Principal/Chief Compliance Officer, *Two International*

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Today's Agenda

FDR enforcement in Medicare Advantage Plans
RADV expectations of a Medicare Advantage for claims data accuracy
Deficiencies remediation
Questions

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FDR enforcement in a Medicare Advantage Plan

Define

First-tier, Downstream, or Related entities (FDR)

FDRs delegates that are in a contractual relationship with a Medicare Advantage or Part D plan to provide healthcare or administrative functions

Vendors are third parties that provide products or services to the contract holder.

Enforcement is the process of ensuring **compliance** with laws, regulations, rules, standards.

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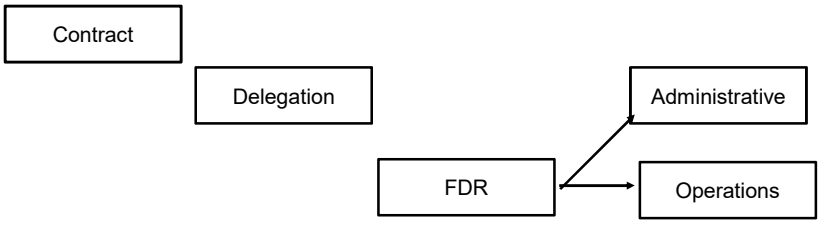
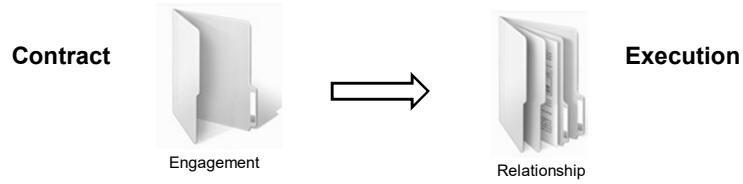
Nature of the Program

II. Purpose





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Who performs the oversight?

Everyone

FDR Monitoring - the ongoing oversight of delegated services or processes

- **The goal of Delegate Monitoring is to ensure an effective program focusing on compliance and conformity to delegated services or processes while controlling exposure to delegate-related risk.**

Function	Description
Foundation	Building blocks of a Vendor Oversight Program, Team, FDR identification and risk rating, Regulatory Impact.
Oversight and Monitoring	Process of ensuring federal, state, and contractual requirements are met. Compliance Committee, FDR (Vendor) Committee, Reporting Packages
Audit	Audit Readiness, FTE Universe, Corrective Action Plans, Audit, Regulatory impact
Reporting Results	Communicating performance - Reporting packages (Board, ERM, CAP), KPI/KRI,

Foundation | **Oversight** | **Monitoring** | **Audit** | **Reporting**

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Delegate Foundation

Federal
- HHS/CMS
- Compliance
- Federal Law
- Regulatory Changes

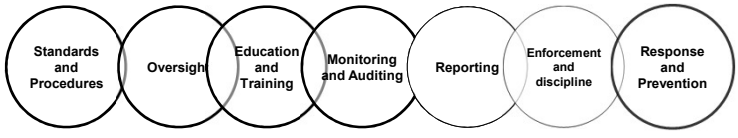
State
- Compliance
- State Law
- DOI
- Federal Component

Contract
- Federal
- State
- Benefits

Our Contracts are a Strategic Asset

Delegate Management is a Core Competence

Seven Components of an Effective Compliance Program



Oversight

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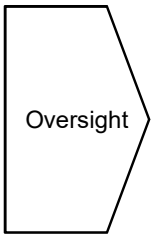
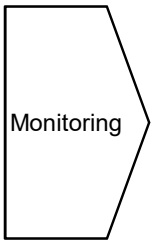
Oversight and Monitoring





Objective	Description
Operations	• Process
Compliance/legal	• Requirement
Contractual	• Specific contractual requirements and business requirements
Oversight Committees	• Existing programs
Financial	• Financial Results
Operational	• Departmental
Compliance	• Compliance Controls
Audit	• Audit activities and Corrective Action Plans

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Audits

Audit Readiness
- CMS
- State
- Internal Audit

First Tier Entity (FTE)
- First-Tier Entity Auditing and Monitoring (FTEAM)
- Employee and Compliance Team (ECT)
- Internal Auditing (IA)
- Internal Monitoring (IM)
- Fraud, Waste and Abuse Monitoring (FWAM)

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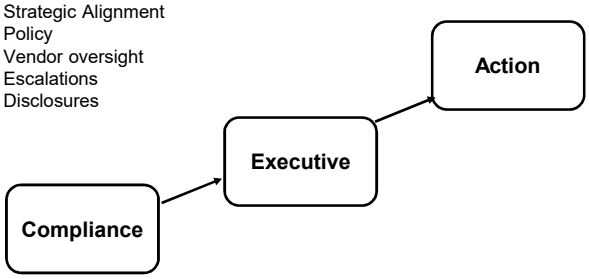
Reporting

- **Executive and Board engagement**
  - Defined roles and responsibility
  - Drive policy
  - Monitor vendor
- **Operations**
- **Financial**

Sets the tone…
- Strategic Alignment
- Policy
- Vendor oversight
- Escalations
- Disclosures



Drives Delegate….
- Performance
- Compliance
- Business
- Audits

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Best Practices

Ongoing Efforts FDR Partnership Performance Standards

Policies and Procedures Ownership

Organization
- Contractual
- Service Delivery
- Financial
- Business Continuity
- Regulatory
- Exit Strategy

FDR
- Internal processes
- Contractual obligations
- Constraints
- Best Practices

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Takeaways

✓ Define

✓ Understand

✓ Know your program

✓ Know your contract

✓ Communicate

✓ Regularly assess and monitor the program effectiveness

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MANAGED CARE ENFORCEMENT AND COMPLIANCE – PART 2

Prepared by Rose T. Dunn, MBA, RHIA, CPA, CHPS, FACHE, FHFMA
Chief Operating Officer, First Class Solutions, Inc.

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Disclaimer

- I have shared these comments for various national audioconferences sponsored by educational entities and with other professional associations including AHIMA state associations, Healthcare Financial Management Association, Health Care Compliance Association and National Association for Revenue Integrity.
- I have no ownership, investment, or other financial influences from any of the products I may mention.
- This is not to be construed as legal or billing advice. You should contract your attorney or billing advisor for guidance.
- That's it for the fine print!

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Focus – What to Monitor

- These payers
  - *Medicare Advantage (Part C)*
  - *Medicaid Managed Care*
  - *Affordable Care Act Plans*
- HCC compliance opportunities
- Other opportunities

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FDR Tenet-Monitoring for Part C

- Remediation or Preventative
  - *Remediation*
    - Damage done
  - *Preventative*
    - Avoiding damage in the first place

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What's the RADV Monitoring?

Contract-Level Risk Adjustment Data Validation

Medical Record Reviewer Guidance

In effect as of 03/20/2019

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/Medical-Record-Reviewer-Guidance.pdf

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What's the RADV Monitoring?

1. Attestation and Submission Issues
2. Signature and Credential Issues
3. Date Issues
4. Provider and Record Type Issues
5. Documentation Issues
6. Diagnosis Issues
7. Legibility/Readability/Missing Documentation/Distorted Images/Abbreviations, etc.

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Using your Health Information Management (HIM) Department to Do Some Heavy Lifting

- ➢ Credentialed health information professional: RHIA or RHIT
- ➢ Certified coding professionals: CCS, CPC, COC, CRC, specialty designations such as CIRCC
- ➢ Clinical documentation improvement professionals: CDIS or CDIP

- ❑ Analytics
- ❑ eForms design
- ❑ Routine auditing
- ❑ Concurrent assessments

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Medicare Advantage HIM Compliance Opportunities

- Record Retention:
  - *Maintain Records a minimum of 10 years*
    - Risk: Only maintaining them for 10 years
    - HIM Responsibility:
      - *Assessing state law*
      - *Assessing federal law*
      - *Maintaining and monitoring record retention (not just medical records)*
      - *Utilizing proper destruction methods*

Medicare Managed Care Manual, Chapter 11, §100.4

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Hierarchical Condition Categories (HCCs)

- Categories of conditions that are predictive of future spending and severity of illness
- A method to distinguish the complexity and severity of an enrollee's condition(s).
- Driven primarily by chronic conditions.
- Drives a component of the MIPs (Merit-based Incentive Payment System) payment.
- Based on ICD-10CM

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Not All Diagnoses Considered a Payment HCC

➢ 10,258 ICD-10-CM codes map to the 83 PAYMENT HCC categories

➢ There are 71,932 CM codes

➢ Don't care about the 77,559 PCS codes

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FDR Tenet – Monitoring: Coding Compliance Audits

- *In the News*
  - DaVita: The DaVita settlement cites improper medical coding by HealthCare Partners from early 2007 through the end of 2014. The company, according to the settlement agreement, submitted **"unsupported" diagnostic codes** that allowed the health plans to receive higher payments than they were due. Officials did not identify the health plans that overcharged as a result. One such "unsupported" code was for **a spinal condition known as spinal enthesopathy** that was improperly diagnosed in patients in Florida, Nevada and California from Nov. 1, 2011, to Dec. 31, 2014, according to the settlement. **$270 mil**.
    - *DaVita self-disclosed*

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FDR Tenet – Monitoring: Coding Compliance Audits

- *In the News*
  - Beaver Medical Group L.P. (Beaver) and Dr. Sherif Khalil: In this case, several MAOs in California contracted with Beaver to provide health care to Medicare beneficiaries enrolled in their plans. The MAOs often **compensated Beaver with a share of the payments that the MAOs received** from Medicare for the beneficiaries under Beaver's care. Thus, Beaver had a financial incentive to submit additional diagnosis codes to the MAOs in order to increase the payments that the MAOs received from Medicare. The settlement resolves allegations that Beaver and **Dr. Khalil knowingly submitted diagnoses that were not supported by the beneficiaries' medical records in order to inflate the payments that the MAO received from Medicare. $5 mil**.

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FDR Tenet – Monitoring: Coding Compliance Audits

- *In the News*
  - Essence, Inc.: In the Essence audit of 218 cases, HHS found dozens of instances in which the health plan reported patients had **an acute stroke — meaning the patients had strokes that year — when they actually had suffered strokes only in past years.**

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FDR Tenet – Monitoring: Coding Compliance Audits

- **South Florida physician added chronic condition……. To every patient**
  - *Isaac K. A**. Thompson** (Delray Beach, South Florida) plus 3 other Palm Beach County doctors, two medical clinics, and a practice group*
  - *Thompson was indicted in 2015 (fraudulent coding 1/2006 to 6/2013)*
    - Facing up to **10 years in prison**
  - *Upcoded cases and applied false diagnoses*
    - **Thompson falsely diagnosed 387 Medicare Advantage beneficiaries with ankylosing spondylitis.**
    - The diagnoses resulted in Medicare paying approximately $2.1 million in excess fees, with about 80 percent going to Thompson under his fee arrangement with Humana.

Source: http://www.palmbeachpost.com/news/news/crime-law/delray-doctor-accused-of-medicare-fraud-falsely-di/nqdxK/; and www.publicintegrity.org/print/19397

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Avoiding the Damage

- Concurrent documentation reviews
  - *Face-to-face*
  - *Valid source of documentation*
  - *Legibility*
  - *Authenticated properly*
  - *Patient identity – 2*
  - *Does documentation support MEAT*
- Focus on common chronic conditions:
  - *Diabetes, Angina, Pneumonia, Renal Failure, CKD, Pressure Ulcer*

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Tip

- **Time allocations for office visits**
  - *Add an extra 2 minutes for those over 65 or in one of the HCC model health plans*
    - Probe and document all chronic conditions (at least once annually)
      - Review problem lists
  - *Use mid-levels (some using scribes or CMAs) to capture conditions to facilitate the provider's face-to-face encounter*

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TIP

- Teach clinicians how to avoid "History of" when the condition is still active:

Instead of Documenting…	Document This…
History of Diabetes	Patient with DM since 2009
History of CHF, meds Lasix	Compensated CHF, stable on Lasix
History of COPD, meds Advair	COPD controlled with Advair

Can't code from problem list: Diagnosis listed on the progress note without an evaluation or assessment is considered a "problem list."

"History of" means its resolved

Source: Triangle Medical Group, Robert Resnik, MD, MBA

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Documentation that drives an HCC

- During the encounter conditions must support **MEAT**:
  - ***M**onitor: Signs, symptoms, disease progression, disease regression*
    - HgbA1c 5.9
  - ***E**valuate: Test results, medication effectiveness, response to treatment*
    - Ostomy site pink, painful to touch, not relieved with medications
  - ***A**ssess/**A**ddress: Ordering tests, discussion, review records, counseling*
    - Diabetes controlled with diet
  - ***T**reat: Medications, therapies, other modalities*
    - Taking Lipitor for hypercholesterolemia

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Concurrent Data Analysis - Outliers

- CMI by physician
  - compared to specialty
  - compared to group
- Frequency of diagnosis by physician
- Monitor unspecifieds

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Routine Coding Auditing

- Regardless of whether coding is done by physician or a coder
- At least 15 encounters per quarter per coder or physician
- Set expectation for 95% accuracy rate
- Initiate remedial education when indicated
- Get the Docs out of the coding business and into the documentation business

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Provide Tools to Assist the Provider

- Required fields in EHR templates for those ICD-10 Attributes
  - *Laterality*
  - *Chronicity*
  - *Degree*
  - *Stage*
  - *Manifestations*
  - *Specific Site*
  - *Injury Details*
  - *Complications*
  - *Episode of Care*
- Clinical documentation improvement initiatives – use the coding team

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HCCs and ICD-10

- Thrive on ICD-10 because of ICD-10's specificity
- Built on **DIAGNOSES**
- **14% of ICD-10 diagnosis (CM) codes are Payment HCCs**

  More than 50% of the HCCs are MCCs or CCs.

  - Model typically **excludes:**
    - ***SYMPTOMS*** *and conditions that are past or resolved*
    - *"**UNSPECIFIEDS**" (e.g. lacking laterality, episode of care, severity, manifestation linkage, etc.)*
  - Continue to query!

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Clinical Specificity

- **Clinical specificity involves having a diagnosis fully documented in the source medical record instead of routinely defaulting to a general term or an unspecified diagnosis.[1]**
  - *Supports need for Concurrent and Retrospective Reviews!*

1. Source: CMS, "2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide." Sec. 6.4.3.

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Clinical Specificity

- *The practice of specific documentation and coding of diagnoses can have an impact on E&M and procedural reimbursement due to "**medical necessity**."*
- *The following examples are commonly used by physicians for all forms of a disease or condition.*
  - Chronic Kidney Disease (N18.9) – No payment HCC
  - Hepatitis C (B17.1-B17.9) – No payment HCC
  - Anemia (D64.9) – No payment HCC
  - Congestive Heart Failure (I50.9)
  - Diabetes (E11.9) (low weight)
  - Pneumonia (J18.9) – No payment HCC

Can you afford to lose 66% of your reimbursement?

1. Source: CMS, "2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide." Sec. 6.4.3.

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Risk Adjustment Coding Example: The Value of Accurate Coding & Documentation

No conditions coded	Coefficient	Some conditions coded	Coefficient	All chronic conditions coded	Coefficient
76-year old female	0.442	76-year old female	0.442	76-year old female	0.442
Medicaid eligible	0.151	Medicaid eligible	0.151	Medicaid eligible	0.151
DM with complications	Not documented	DM w/o complications	0.118 Incorrectly coded	DM with complications	0.368
Vascular disease	Not Specified	Vascular disease, peripheral, unspecified	0.299	Vascular disease, peripheral with complications (query)	0.401
CHF	Not documented	CHF	Not coded	CHF, acute systolic	0.368
Disease interaction (DM+CHF)	Does not qualify	Disease interaction (DM+CHF)	Does not qualify	Disease interaction (DM+CHF)	0.182
Total RAF	**0.593**	**Total RAF**	**1.01**	**Total RAF**	**1.912**

Source: Adapted from 3M 2019 and Premera Blue Cross, Based on Version Unknown Circa 2014

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Risk Adjustment Coding Example: The Value of Accurate Coding & Documentation

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Disease interaction (DM+CHF)	Does not qualify	Disease interaction (DM+CHF)	Does not qualify	Disease interaction (DM+CHF)	0.182
Total RAF	0.593	Total RAF	1.01	Total RAF	1.912
Using the $9,367.51 Base Payment Model 23		**$5,554.93**		**$9,461.19**	**$17,910.68**

Source: Adapted from 3M 2019 and Premera Blue Cross, Based on Version Unknown Circa 2014

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Risk Adjustment Factors

Higher RAFs represent patients with a greater than average burden of illness

Lower RAFs represent healthier patients or may not accurately represent the population served due to:

- In adequate or incomplete chart documentation
- Inaccurate or incomplete diagnosis coding

Source: Resnik; http://www.trianglemedicalgroup.com/raf2017.pdf

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CMS-HCC Reimbursement Model is Anti-Gaming

- The more conditions managed…the more challenging the patient's care is to manage (more time)…higher risk…higher cost … higher reimbursement for the provider or the plan
- **Coding adjustment:**
  - *CMS anticipates that upcoding will be more likely in MA programs than in FFS programs*
  - *CMS applies an annual coding adjustment*

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Top 10 Most **Over-Documented** HCCs

1. Conditions that have been **surgically corrected** (e.g., abdominal aortic aneurysm- no longer active, now resolved)
2. **Diabetes** with complications
3. **Malnutrition**
4. **Nephritis**
5. **Pathological fractures** (e.g., old pathological fractures reported as current)
6. **Pneumococcal pneumonia** (e.g., unspecified pneumonia reported as pneumococcal)
7. **Polyneuropathy** (e.g., reported as current when no treatment, evaluation, or monitoring is documented)
8. **Primary site cancers** (e.g., indicating historical conditions as current)
9. **Strokes** (e.g., indicating acute stroke instead of late effect of stroke)
10. **Vascular disease** (e.g., reported as current when no treatment, evaluation, or monitoring is documented.

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Documentation Guidelines for HCCs

- Medical Decision Making:
  - ***Patient-specific*** *assessment that* ***documents the diagnosis****, its status and any causal relationships (e.g., psoriasis, due to arthritis; CHF, due to hypertension).* [3,4]
  - *Assessment that documents not only conditions being treated, but any chronic conditions that affect the care and treatment of the patient.* [3,4] *(Use terms such as: Stable, Improved, Tolerating Meds, Deteriorating, Uncontrolled)*
  - ***Plan that specifies treatment for each condition*** *listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.* [3]
  - ***Use terms*** *such as: Monitor, D/C meds, Continue current meds, Refuses treatment (Z Codes), Referred to AND* * * * *

Kill cloning And autofill applications

3. CMS. "1995 Documentation Guidelines for E/M Services. " 1999. Medicare Learning Network.
4. National Center for Health Statistics 2011 1-107. www.cdc.gov/nchs/icd/icd9cm_addenda_gudlines.htm

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Let's Talk about Problem Lists

- Do your problem lists populate your claims?
  - *Do you know?*
- When was the last time the problem list was updated?
- Who is authorized to update your problem lists?
  - *HCPro's 2018-2019 Coding Productivity Survey reported that ~14% of the survey respondents* ***involve the coders to some degree in updating the problem list.***

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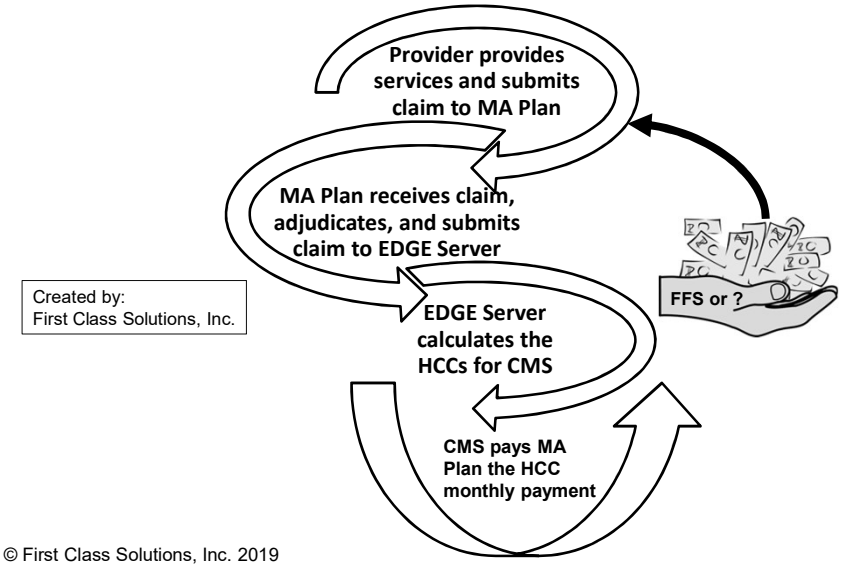
Where're the Bucks?



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Physicians Are Not "Feeling" the HCCs

- May be treating Medicare Advantage (MA) patients and it's just like treating any other type of patient
- Providers submit their claims to the MA Health Plan (just like any other payer)
- MA payers may be paying providers through a FFS schedule just like any other payer
  - *This means that they are paid on their E&M*
- Physician says: Why all the hoopla!?

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System Support

- Concurrently: Establish edit to kick back to coders any unspecified diagnoses selected by provider
- Denials for Medical Necessity
- Dashboards
  - *CMI by provider*
  - *Outlier RAFs*

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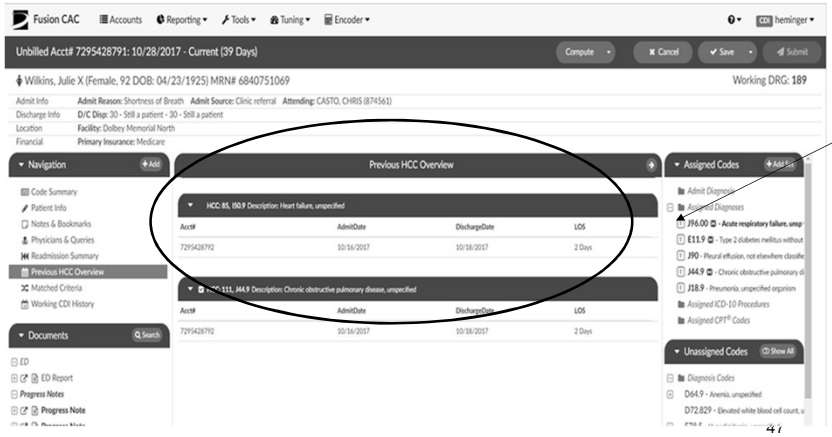
Technology Assist for Coding



Courtesy: Dolbey Systems

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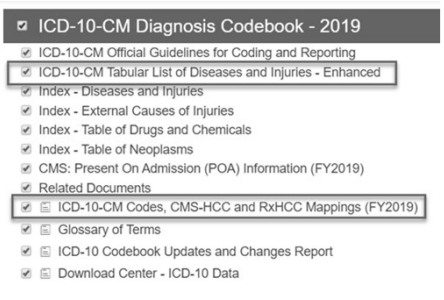
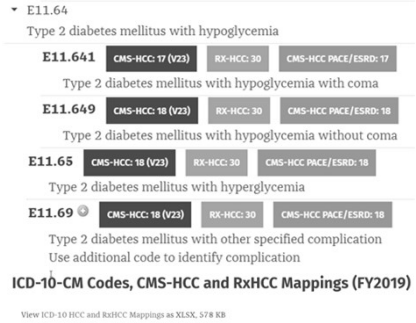
Courtesy of: MediRegs® Electronic ICD-10-CM CodeBook with HCC





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Real Time Prompts

- Software that bolts onto the EHR
  - *Reads the digital documentation real time*
  - *Analyzes other data in the record real time*
  - *Provides guidance alerts to provider real time*
    - ICD-10 CM attributes
    - Potentially overlooked diagnosis

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Documentation Capture Strategies

✓ Use your Scribes/CMAs to capture documentation
- *Nearly 10% of the MIPS measures are "Assessments"*
- *Physician reviews during Face-to-Face encounter and assesses conditions*

✓ Reward providers for diagnosis and documentation specificity

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Error Prevention Strategies

✓ Data analytics

✓ *Know your payers' system limitations*

- How many diagnoses will be accepted?
- Confirm the Clearinghouse does not limit diagnoses

✓ *Monitor code rejection reports (this may be the 1 claim with an HCC)*

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Prospective Strategies

✓ **Future: Anticipate** Conversion by most payers to an HCC model

- *Ideal for ETGs……..finally since 1988*
- *Think PDPM/PDGM*

✓ **Always Think Profile:** Simply reporting the basic ICD-10 codes, such as a single unspecified principal diagnosis code, will portray their patients to be clinically less complex than they are, and thus in need of fewer resources.

- *Resulting in lower reimbursement*
- *Excluded from network participation*
- *Will not demonstrate SOI/ROM*

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HCC Capture Enhancement Strategies

- ✓ Use coding team to review encounters and identify annually those past conditions that are active based on physician documentation
  - *Alert providers of those from prior year that are not addressed*
- ✓ Audit regularly to capture conditions documented but not coded
  - *Submit corrected claims*

Adapted from McDermott Will & Emery & Central Massachusetts Independent Physician Association

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Thank you.

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About the Speaker

Ms. Dunn is a Past AHIMA President and recipient of AHIMA's 1997 Distinguished Member and 2008 Legacy Awards. She is Chief Operating Officer of St. Louis-based, First Class Solutions, Inc., a national health information management consulting firm providing coding compliance and coding support services and HIM operational consulting services for hospitals, physician practices, and SNFs. Rose is active in ACHE, AICPA, HFMA, and AHIMA. Ms. Dunn is the author of several texts and hundreds of published articles. Additionally, her HCC Fundamentals educational module is offered through Libman Education (https://libmaneducation.com).

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA
AHIMA Approved ICD-10CM/PCS Trainer
Rose.Dunn@FirstClassSolutions.com
800-274-1214

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Resources

- Society of Actuaries publish a number of articles on Risk Adjustment for Medicare Advantage and Affordable Care (ACA).
- March 31, 2016, HHS Operated Risk Adjustment Methodology meeting-Discussion Paper
  - *Https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Dowloads/RA-March-31-White-Paper-032416.pdf*
- March 31, 2016, HHS Operated Risk Adjustment Methodology meeting – Q&A
  - *Https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/RA-OnsiteQA-060816.pdf*
- http://kff.org/medicare/fact-sheet/medicare-advantage/ Medicare Advantage Fact Sheet (Kaiser Family Foundation)

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Resources

- Report to Congress: Risk Adjustment in Medicare Advantage. December 2018. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf
- Evaluation of the CMS HCC Risk Adjustment Model. CMS. 3/11 Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf
- Risk Adjustment Documentation, Coding & Quality Toolbook. Optum. 2013. Available at: http://www.stvincentipa.com/public/forms/Risk_Adjustment_Toolbook.pdf
- Documenting and Coding Chronic Conditions for Medicare Risk Adjustment. Optum. 9/2015. Available at: https://www.vanlangipa.com/static/docs/HCC-RAF-Coding/Documenting%20and%20Coding%20Chronic%20Conditions_Presentation_Sep2015.pdf

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