The Power Of Quality Review:
How Auditing Programs Can Enhance Accuracy & Program Outcomes

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RISE

Agenda

01 Background & Introductions

02 Industry Landscape

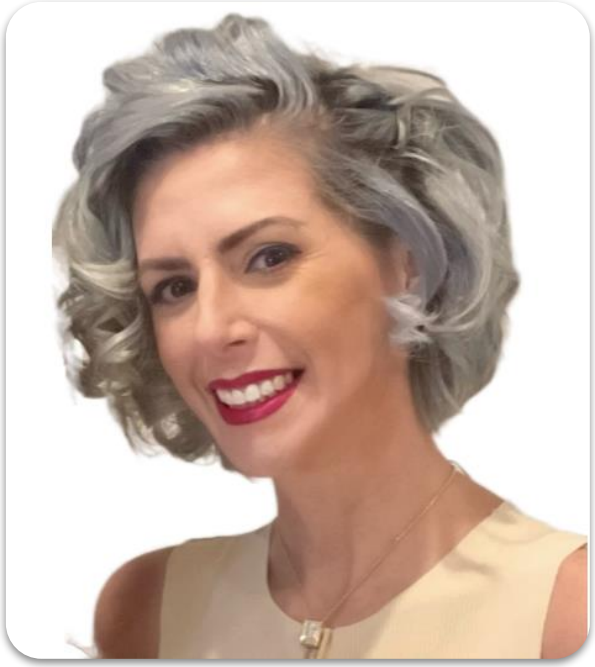
03 QA Importance/Process

04 Metrics to Monitor

05 Case Study Results

06 Next Steps/Pointers/Questions

Speaker Introductions



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The Power of Quality Review

Areas of discussion:

- Risk adjustment industry and leadership oversight focus on the quality of submissions for reimbursement
- Types of quality assurance policies/programs that allow for risk reduction when working with a vendor
- Key quality metrics of retrospective coding programs

At the end of this session, you will be able to:

- Understand impact of current industry/governmental audits
- Recognize how structure, content, and delivery together create impact and strengthen your program
- Examine the importance and use of coding quality metrics to support minimizing future financial impact

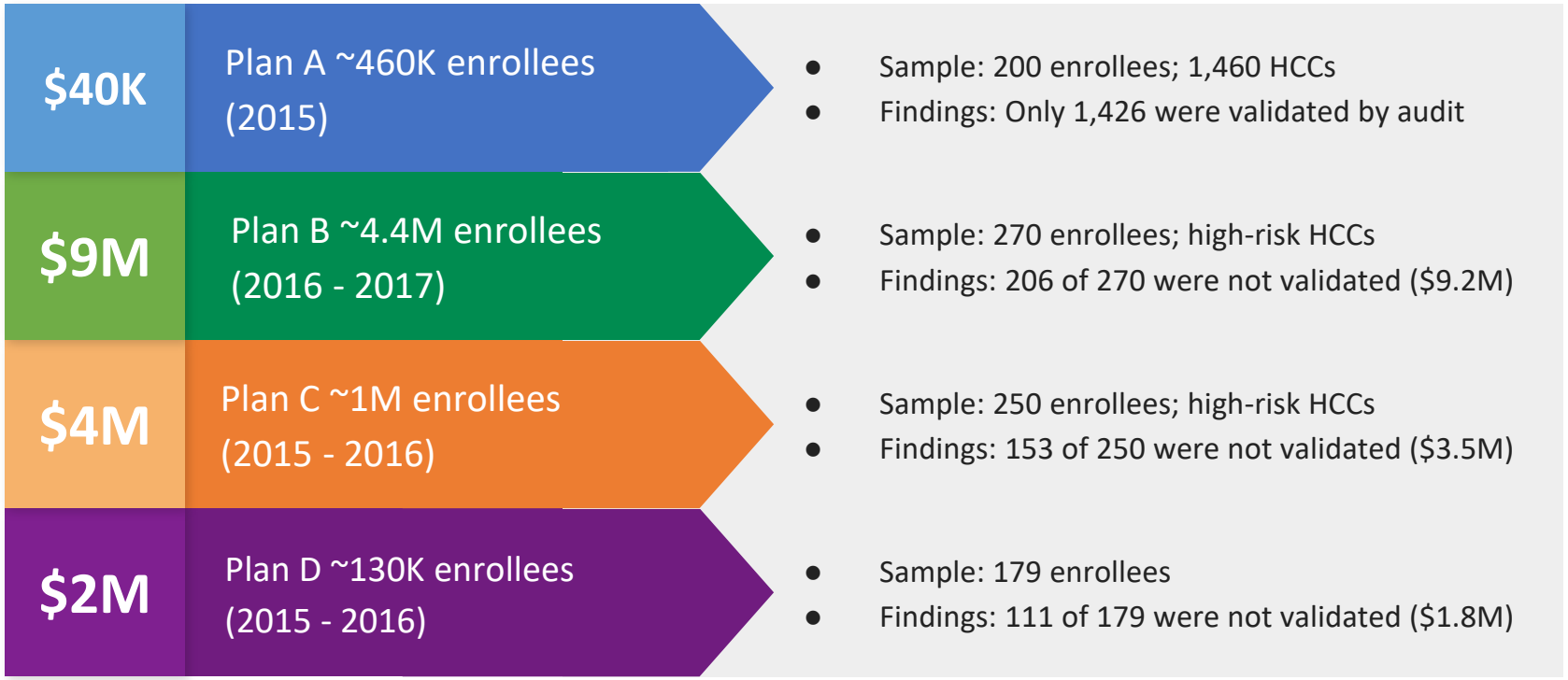
Risk Adjustment Industry

Industry Audits on the Rise

"Eight of the 10 biggest Medicare Advantage insurers — representing more than two-thirds of the market — have submitted inflated bills, according to the federal audits. And four of the five largest players have faced federal lawsuits alleging that efforts to overdiagnose their customers crossed the line into fraud." [1]

"...Examine its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements and take the necessary steps to enhance those procedures."

— **OIG**



360 Degrees of Risk Adjustment

How to Address Rising Audits: Quality Assurance Program

- **Sustainable member/provider connections:** Enables members and providers to connect in meaningful ways to document and promote the health and care of beneficiaries
- **Complete/accurate medical records:** Ensures members are correctly assessed and the diagnoses captured and charted effectively
- **Complete encounter submissions:** Ensures that submissions to CMS are accurate, compliant with regulatory guidelines, thorough, and comprehensive

Medical Coding Process

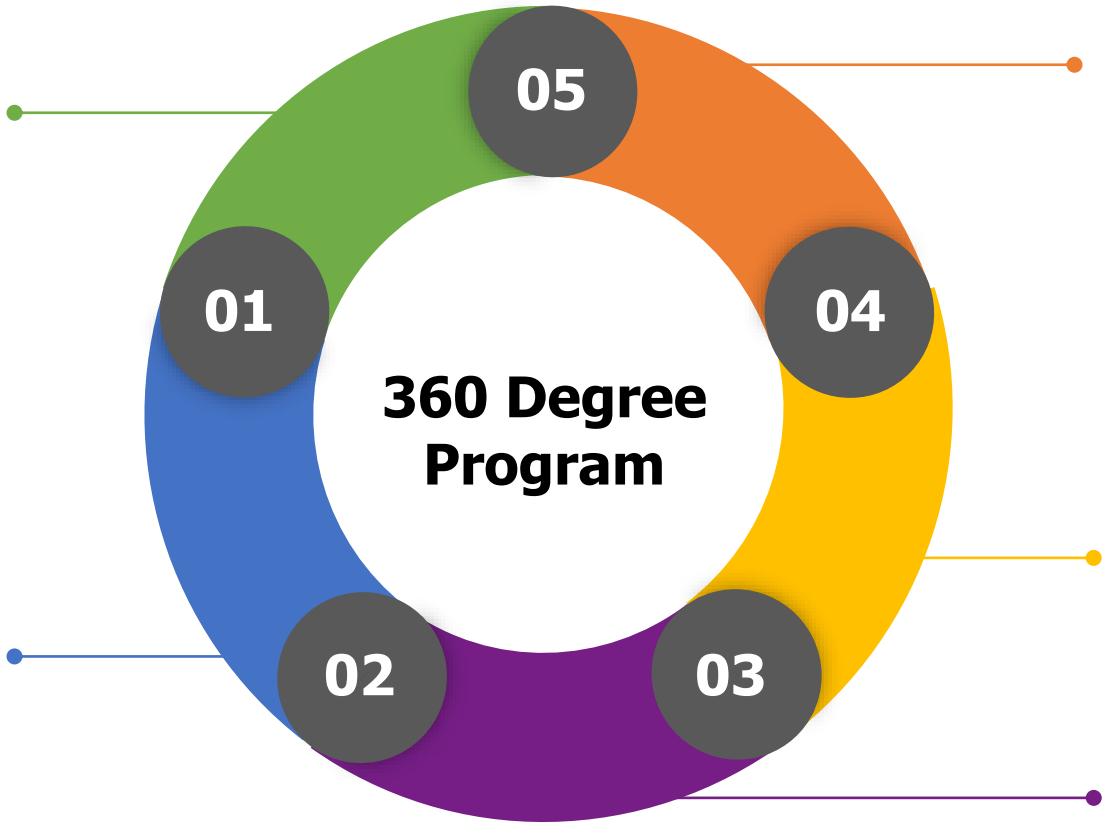
Coding Program Does Not Stop at Submissions!

Medical Record Review

- Access record
- Validate completeness/member

Medical Record Coding

- NLP highlighting
- Coder confirmation of NLP
- Assign appropriate Dx based on demographics / model / LOB



Submission

- Submitting to CMS/HHS/State
- Compare accepts to coding results
- Incorporate results into training programs

Quality Audit

- Sample audit vendors
- Set time frame: monthly/annually
- Scorecard for vendor and internal
- Share results / action plan

Second-Level Review

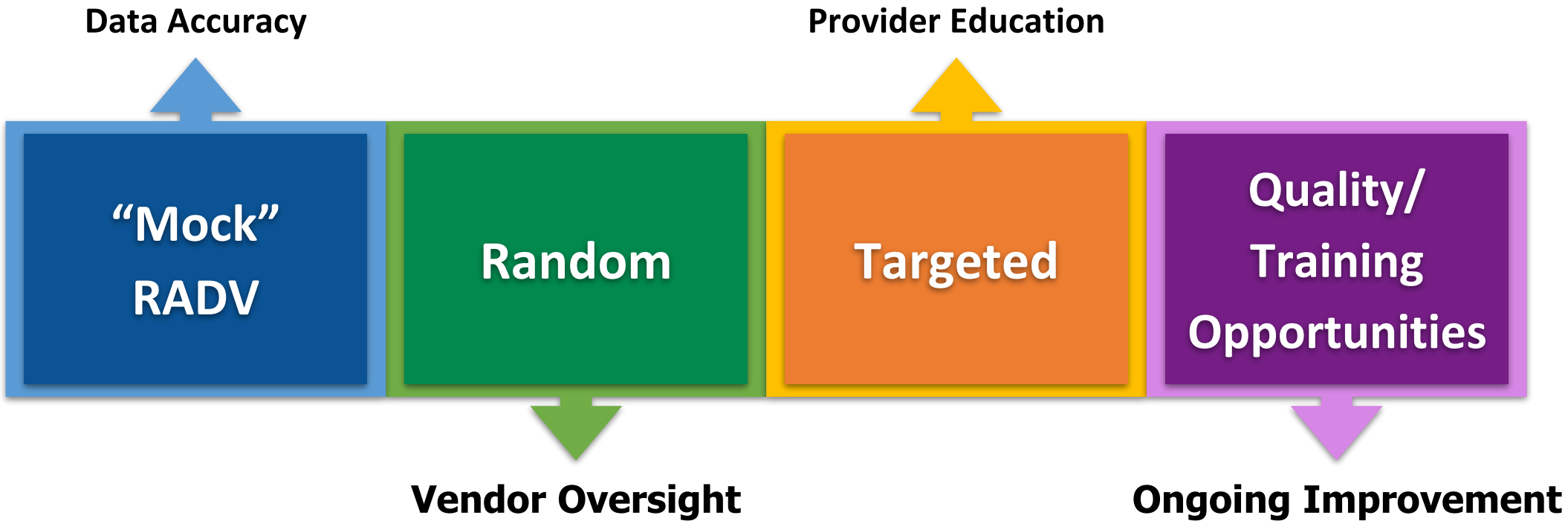
- Review incremental and newly identified conditions
- Review all possible deletes

Auditing for Quality Assurance

Planning & Preparing

Communication is KEY!

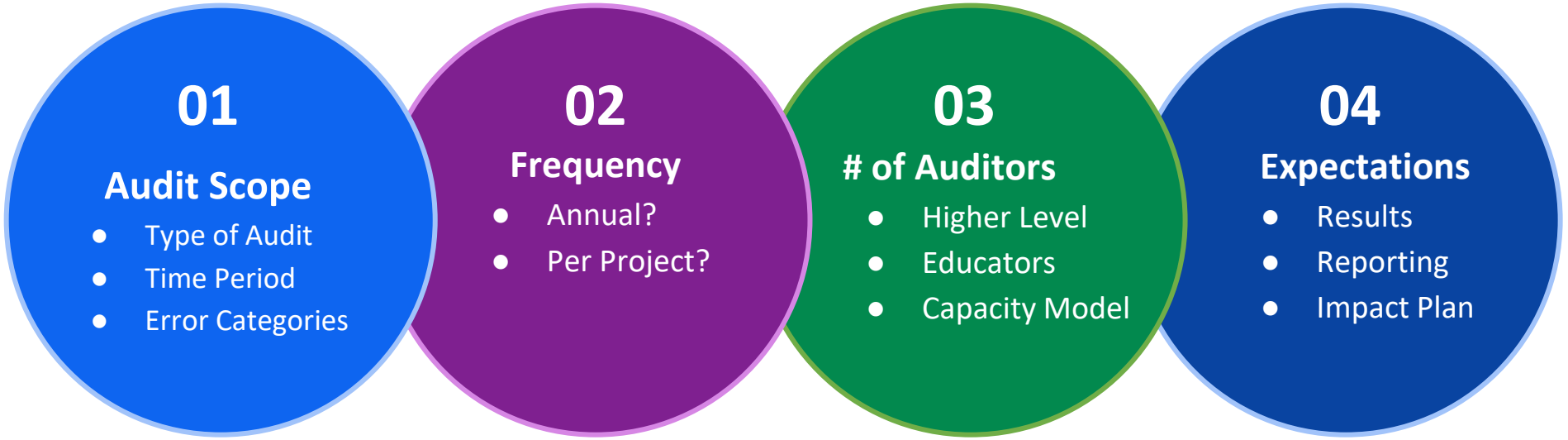
Before implementing ANY Quality Assurance Process, be sure to present and discuss proposed audits or reviews with key stakeholders.



Audit Planning

Audit Requirements

Four key required areas in audit planning include:



Tip: *Recommend having a dedicated auditing team to support any OIG/CMS related audits, but also internal mock audits for documentation improvement*

Trifecta of Quality Assurance

Internal Quality Assurance Program & Team Selection

Recruitment:

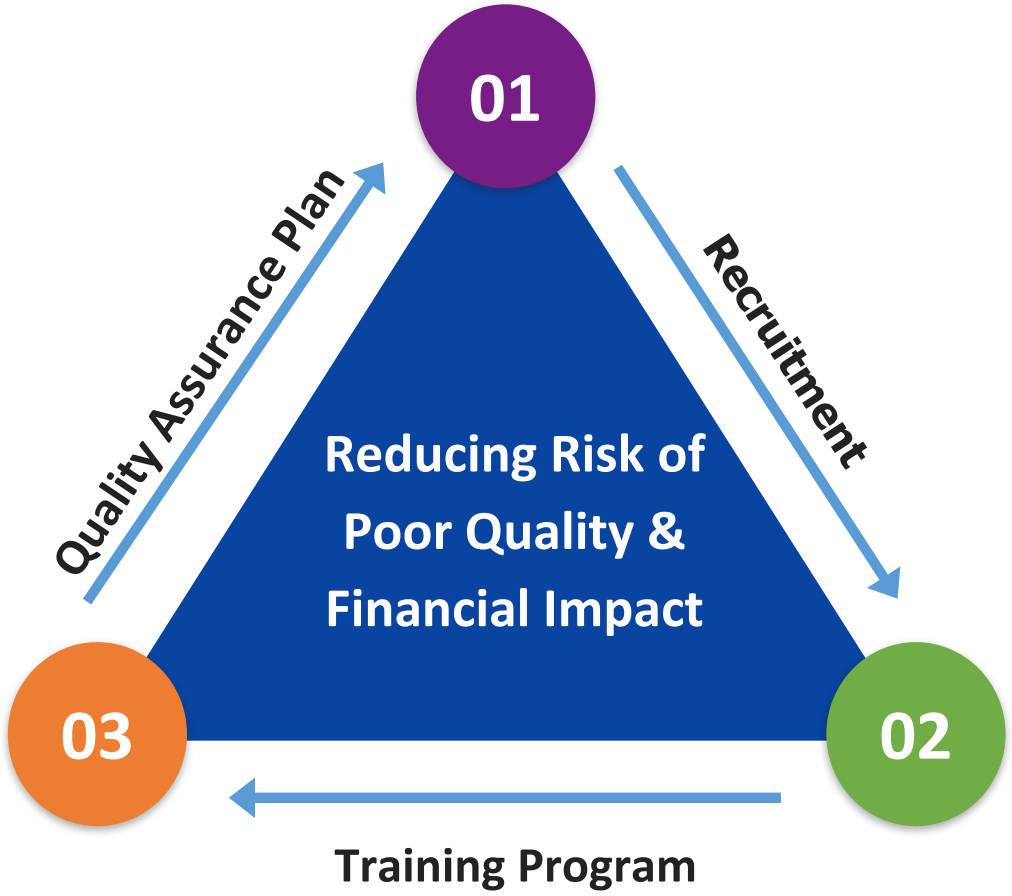
- Certifications: AHIMA or AAPC Certified?

Training Program:

- Annual/Quarterly?
- Coding clinic changes?

Quality Assurance Plan:

- How are they measured?
- How often?
- Set baseline? What happens if they drop under?



Metrics to Monitor

Categories	Importance
Coding Errors/Unsupported Conditions • "Drill down" to HCCs/RxHCCs	Continuous improvement by identifying trends & educating providers/coders on the proper coding documentation
Demographic Errors • Wrong member • Missing member identifier	Identify data quality issues sooner prior to submitting inaccurate data for submission
Encounter Errors • Incorrect DOS • Missed signature/credential flag • Incorrect provider	Good data is not only important in submissions, but to improve care coordination in a 360 degree program
Missed Conditions	Missed conditions can misrepresented member profiles for care coordination programs and create waste due to inaccuracies

Case Study: Compliance Retrospective

Sample Size: 15,165 Beneficiaries on 2021 Payment Year MA

207 Diagnoses

Match fact patterns for "Selected High-Risk Diagnosis Codes"

796 Diagnoses

Found only one time in claims

Findings of Case Study

Invalidated diagnoses surfaced for over 1% of beneficiaries through targeting of suspicious fact patterns, followed by NLP-assisted coder audit

- 64 replacements of invalid dx codes with incremental change
- $1K per code x 64 = Possible overpayment of $64K

Results

- 21 Validated
- 105 Required Chart Review
- 81 Invalidated Dx

Results

- 79 Validated
- 532 Required Chart Review
- 185 Invalidated Dx

23% of diagnoses found in claims only once were not supported by the medical record using OIG data and model inputs

Summary

Quality Assurance Process is Powerful!

01 Risk adjustment industry and leadership oversight has changed their focus on the quality of submissions and member profiles for reimbursement.

- **Takeaway:** Audits will continue and the financial impact can be large. Health plans should invest in quality assurance programs.

02 Quality assurance policies and programs allow for risk reduction for financial penalties and true financial estimates.

- **Takeaway:** Each health plan is different, but a repeatable documented process should be put in place to reduce financial penalties for the future.

03 Key metrics that should be tracked to indicate where to improve.

- **Takeaway:** Auditing is not just for financial reimbursement, they are part of the 360 program of continuous improvement

Questions?

THANK YOU