Where's The M.E.A.T.?
Insights into How Recent Coding Clinics© Affect Risk Adjustment

Presented By:

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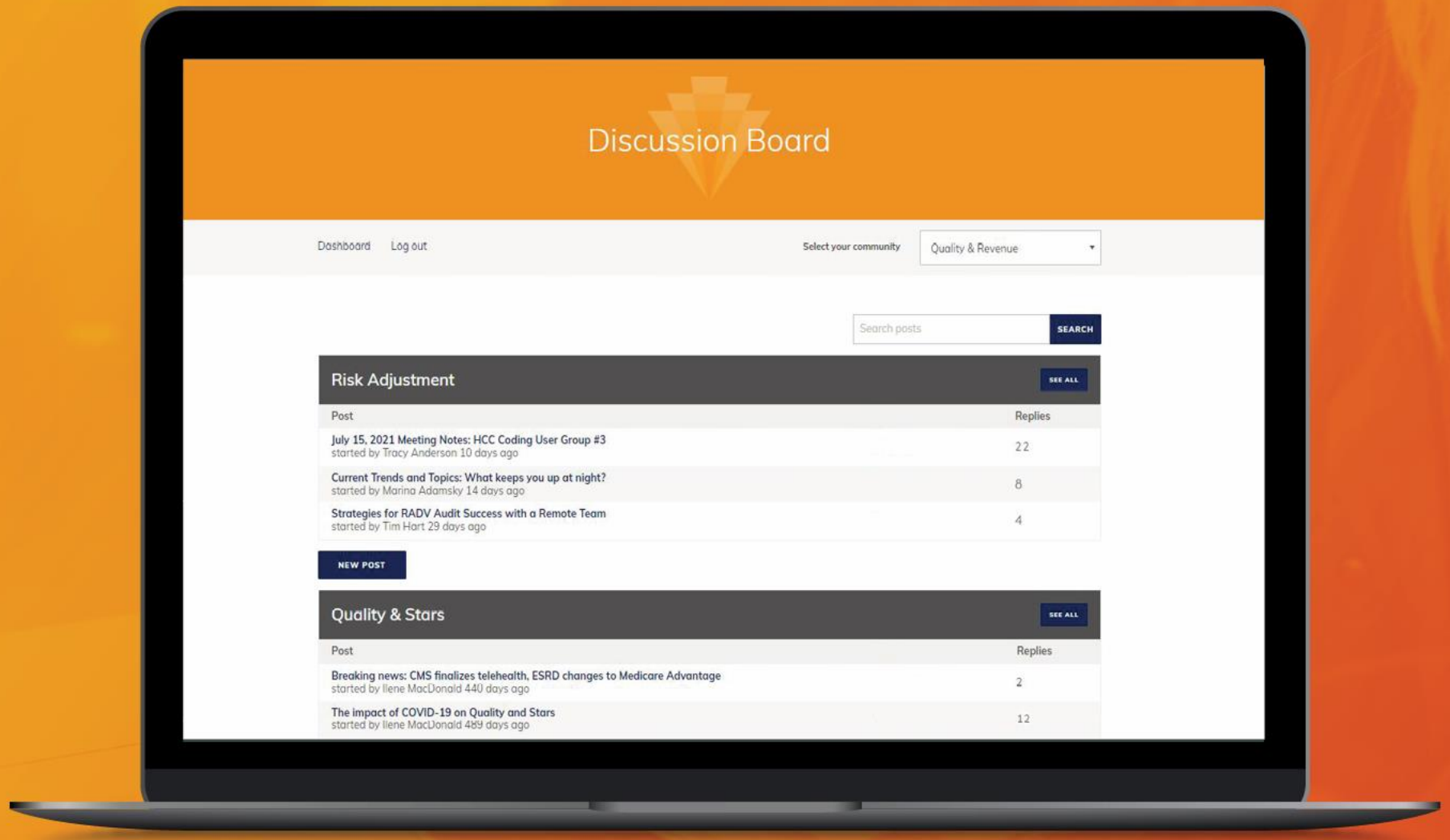

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About Ronni Knight

Ronni has more than 30 years in coding field and her experience includes HCC and CDI management and training as well as working with provider's, coders, and health plans in all aspects of the revenue cycle. She is a frequent AAPC chapter speaker and has presented over a thousand hours of instruction to coders and physician's regarding documentation and coding compliance.

She is currently the Director of Coding for Centauri Health Solutions, and her team has a 100% agreement rate over the past 3 years with HHS for their work as an IVA coding entity. Her team has also conducted Medicaid RADV for the state of WA and participated in numerous CMS RADV's.

Today’s discussion is on the origin of M.E.A.T. and how its evolved since the inception of Risk Adjustment.

Objectives

- History of RA
- What is M.E.A.T.?
- What do coding guidelines say?
- CMS and the DOJ stance on coding and risk adjustment
- OP CDI Programs and Opportunities

Introduction

- What is Risk Adjustment?

- It is a methodology of predictive modeling to assess and calculate expected expenditures and resource utilization over a fixed time based on the diagnosis and demographics of a patient (dependent on the model (MA, ACA, or Medicaid). For our purposes today we are speaking to Medicare Advantage guidance which was the first guidance published.

Introduction

- When did it all start?

- RA was first introduced in 1997 with Balanced Budget Act(BBA) where CMS first implemented risk adjustment in the inpatient setting for diagnosis collection to determine payment to MAO's. The Benefits Improvement and Protection Act of 2000 (BIPA) mandated ambulatory data also be collected and was fully implemented in 2007 with 100% RA payments (phased in incrementally prior to 2007). Then in 2006 via the Medicare Prescription Drug Improvement and Modernization Act(MMA) the Part D methodology was introduced for RxHCC's.

Introduction

- The data is collected for covered facilities and OP services provided to the plan's covered population. For an MAO this data translates into a "RAF" score for the individual which determines the plans per member per month payment from CMS. Failure to capture all a member's HCC's can result in thousands of dollars in reduced payments each month for uncaptured HCC's during the calendar year. Therefore, gap closure and a good CDI program is important.

The M.E.A.T. Acronym

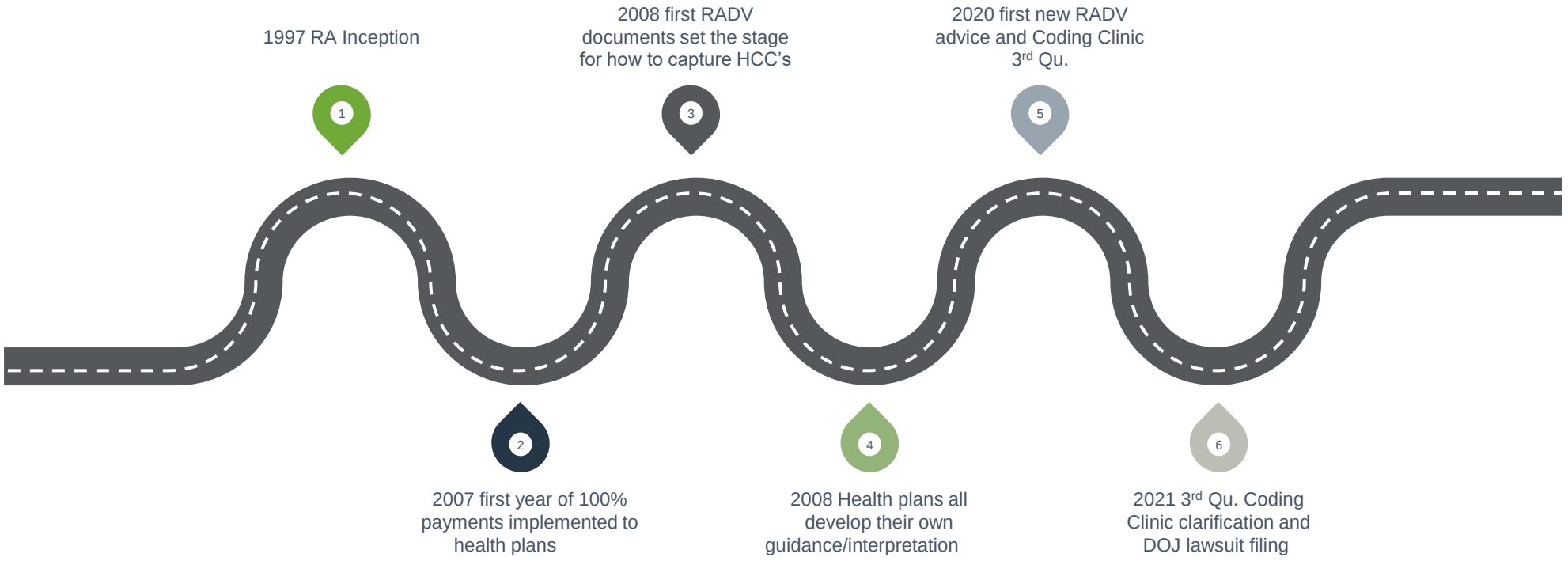
- Monitor,
- Evaluate/Examine
- Address/Assess
- Treat

M.E.A.T.

- CMS does not recognize the acronym. When asked they said they do not recognize this term.

- Wait, What?? That's correct, what you have been told or learned did not come from CMS. It was an industry term that took fire and became the gospel over time.

M.E.A.T. Roadmap



CMS vs. M.E.A.T. 2008

CMS

CMS frequently uses the term "support" for the diagnosis assigned to an encounter based on documentation and coding guidelines. This dates to the 2008 risk adjustment data technical assistance for MA organizations participant guide.

M.E.A.T.

This became equivalent to the CMS "support" statement for a diagnosis for conditions other than the "CMS8" chronic conditions listed as always reportable (always impacting care except in the most minor of encounters) as per the 2008 guidance noted.

CMS vs. M.E.A.T. 2008-2019

CMS

Nothing changed in their verbiage regarding support however they did become more aggressive in chasing recoupment of monies paid for some diagnosis they felt were over coded. Plans were targeted for RADV audit if they had what CMS felt was as over abundance in their population of specific diagnosis that were likely to be frequently miscoded.

M.E.A.T.

Health Plans developed their own guidelines and chronic lists based on their interpretation of the CMS guidance. There has been much disparity with some more aggressive and others more conservative in their approach.

CMS vs. M.E.A.T. 2020

CMS

CMS changed the chronic conditions list in the RADV technical assistance guide to a broader statement regarding systemic conditions always impacting care. Also, due to the pandemic, rules for telehealth were introduced for the capture of RA diagnosis as long as they used both audio and visual for the encounters with the patient (for MAOs).

M.E.A.T.

Some Health Plans again changed their guidance based on their interpretation of this RADV guidance and became more aggressive in capture of these diagnosis.

Coding Rules Hierarchy

Recent Coding Clinics

2020 3rd Qtr. Advice

A question was posed asking about capturing a patients mental health condition for an ER encounter for strep throat.

The answer was that a provide must indicate the condition or any other condition affected the management of the patient during the encounter for the diagnosis to be reported.

Recent Coding Clinics

2020 3rd Qtr. Advice

A follow up question was sent in stating they felt the prior advice given in 3rd Qtr. 2019 that a provider statement of a pt. being treated for Crohn's should be reported even if it did not occur during the encounter and the new advice that it must state a condition impacts care are contradictory. The 2020 3rd Qtr. advice that the patient was on medication for mental health condition and ongoing use of the antipsychotic meds would seem to constitute affecting management of the patient.

Recent Coding Clinics

2020 3rd Qtr. Advice

Answer: The two are not the same. In the 2019 advice, the provider specifically states the patient is receiving treatment of Crohn's and thus affects care. In the 2020 advice, the provider does not state an impact on care for the medication and history of the mental condition therefore did not demonstrate an impact on care.

Coding clinic further stated “coding professionals should not assign codes solely based on diagnosis noted in the history, problem list, and/or medication list. It is the provider’s responsibility to document that the chronic condition affected care and management of the patient for that encounter.”

CMS

As I mentioned, CMS frequently uses the term “support” and under RADV warns about such things as coding from unreviewed “lists” or other elements in an EMR that may be carried over from visit to visit without being updated.

Often these are unreviewed or contradictory to other documentation in the encounter note itself. They also warn about capturing from IP problem lists that are not supported. If you were coding from a “**discharge problem list**” the list may be supported elsewhere in the stay but not necessarily within the discharge itself.

When RAPS goes away, this may become problematic. Under IP rules a secondary dx is reportable if it impacts care in any way regarding resource utilization (nursing care, treatment, procedures, etc.) It will be harder using only the fee for service claim to justify some of those conditions.

Possible Coding Pitfalls As Result of 100% EDPS submissions

- Reconciliation of HCC's and gap closure when using only a fee for service claim could be difficult if you don't have a CDI program in place after RAPS use disappears.

- If the provider said so, do I code it even if conflicts with other documentation? For standard audits, a fee for service claim is reviewed under OP rules even if its an IP provider claim (except for consults and discharge) and the claim stands alone. This has yet to be tested under RADV since up to now they have been able to use hospital claims under RAPS submissions.

- Will this advice change? Only time will tell. But one should be prepared in the event it does.

Possible Coding Pitfalls As Result of 100% EDPS submissions

- Coding Guidelines: “the assignment of a diagnosis code is based solely on the provider’s diagnostic statement the condition exists. The provider’s statement that a patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

- Does this statement ring true for HCC code capture?

For Heath Plans

- Have your guidelines and policies been shared with your coding vendor?
- Have a conversation before you start.
- Make sure you are on the same page for capture and reporting.

Poll Question #1

What best describes your role with your organization?

- A) coder/auditor
- B) CDI Professional
- C) Health Plan Risk Adjustment Manager
- D) Other

For Coding Vendors

- Have your guidelines and policies been shared with the health plans you code for?

- Inform them and go over any changes as they are made. The last thing you want is to have to rereview records already completed because you didn't talk through and agree on any changes. If you are audit entity you also need to provide your clients with a manner of appealing coding decisions leaving the possibility of discussions open if you should not come to an agreement though you are under no obligation to change the outcome if guidelines/protocols were followed. You can work together for understanding of outcomes.

Department of Justice (DOJ)

- The DOJ has recently filed suit against a health plan stating, “there is no such thing as a condition that is always coded.” https://www.scribd.com/document/535332957/DOJ-alleges-Kaiser-Permanente-upcoded

- How do we then reconcile the differences in all the advice?

- Answer: Very carefully. Remembering to follow coding indexing and guidelines first. Coding Clinic is a secondary advise meant to support the guidelines where there is ambiguity and not to contradict guidelines, but in a case where it does conflict with guidelines, default to the guidelines. I do not see this latest advice as conflicting with guidelines.

CDI Programs

- Accurate coding results in proper payments
- Inaccurate coding results in higher risk for audit and to the patient in resulting care gaps.
- How much focus is your program placing on the accurate and complete diagnosis reporting?
- Do you focus a single aspect such as HCC's? Or do you also consider HEDIS? Or MACRA?

CDI Programs

- If you don't have an OP CDI program, a health plan is likely to lose money over time and not close care gaps or HCC gaps which are a big part health plan initiatives. Often these HCC's tie into other quality programs such as HEDIS. The "support" or "MEAT" for a condition is often also the support for your HEDIS measures. Under MACRA, the merit-based incentive payment system they look at risk to determine morbidity of patients in an assessment of provider efficiency.
- Example for the DM HEDIS Measure of a recent A1c documented supports the diabetes for HCC reporting and depending on the A1c result can be captured for HEDIS with CAT II codes 3044F (A1c < 7%), 3045F(A1c 7-9%) and 3046F(A1c >9%).
- A single gap closure can effort more than one quality program in many instances. Don't rest your laurels on just one aspect of reporting.

CDI Programs

- A physician advisor for CDI programs is often one of its greatest assets along with well trained coders and CDI professionals who understand what and when to query a provider for clarity. Often these are tied to provider bonus or incentive programs.

- CDI will become even more important as CMS moves to do away with RAPS and goes solely to EDPS submissions. This means you no longer get those IP HCC's using RAPS. You will be forced to use the provider's fee for service claim to capture those HCC's and they will need to be supported within the encounter itself without the use of the entire hospital record.

- If you were to compare the IP claim with the individual provider claims, you would find more disparity than you should in the diagnosis reported on the claims. This is a gap everyone should be analyzing and working with their providers to bridge.

Poll Question #2

Does your organization have a CDI program?

- A) Yes
- B) No
- C) I am not sure

What Does It All Mean?

- Have a CDI plan in place to bridge gaps
- Have solid defined guidelines for coders to follow and review your compliance at regular intervals.
- Have a physician advisor in place for peer-to-peer reviews to help with provider buy-in to your program with someone that speaks their language with the same clinic knowledge base that can also help your CDI staff in understanding the documentation.
- Stay up to date with any code and regulation changes.

Submission Timeline for MAOs

Risk Score Run	Dates of Service	Deadline for Submission of Risk Adjustment Data
2020 Interim Final Run	01/01/2019 – 12/31/2019	Monday, 02/01/2021
2021 Mid-Year	01/01/2020 – 12/31/2020	Friday, 03/05/2021
2020 Final Run	01/01/2019 – 12/31/2019	Monday, 08/02/2021
2022 Initial	07/01/2020 – 06/30/2021	Friday, 09/03/2021
2021 Interim Final Run	01/01/2020 – 12/31/2020	Monday, 01/31/2022
2022 Mid-Year	01/01/2021 – 12/31/2021	Friday, 03/04/2022
2021 Final Run	01/01/2020 – 12/31/2020	Monday, 08/01/2022
2023 Initial	07/01/2021 – 06/30/2022	Friday, 09/02/2022
2022 Interim Final Run	01/01/2021– 12/31/2021	Tuesday, 01/31/2023
2023 Mid-Year	01/01/2022 – 12/31/2022	Friday, 03/03/2023
2022 Final Run	01/01/2021 – 12/31/2021	Monday, 07/31/2023

References

- 2022 Official Coding Guidelines
- AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS - 2021 Issue 3; Clarification-
- Reporting of Additional Diagnoses in Outpatient Setting
- AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS - 2020 Issue 3; Ask the Editor-
- Reporting Mental Disorders as Additional Diagnoses in the Outpatient Setting
- AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS - 2019 Issue 3; Ask the Editor-
- Coding Chronic Conditions for Outpatient Encounters
- 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide | Guidance Portal (hhs.gov)
- 2020 Risk Adjustment Technical Assistance Guide for Medicare Advantage
- The Federal Register (publishes the yearly Advance Notifications)
- 2022 AHA Coding Handbook with Answers

Questions?

- Please type your questions in the Q&A box and we will address as many as possible in the time remaining.

THANK YOU

Thank you for joining us today. We look forward to seeing everyone in person again this coming spring in Nashville!

Comments or questions may be directed to Ronni Knight at ronni.knight@centaurihs.com