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Risk Adjustment in Cal MediConnect Webinar

Jayson Bautista, Medicare HCC Coder II
Jennifer Calma, Medicare HCC Coder II
Misty McConnell, Supervisor HCC Outreach
Meredith Diep, Senior Manager, Enterprise Risk Adjustment

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PL0958 11/20

Agenda

1. 2021 Annual Wellness Exam (AWE) Physician Incentive Program
2. Hierarchical Condition Categories (HCC) & Documentation
3. Telehealth
4. RADV
5. Leveraging risk data
6. Q&A

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Annual Wellness Exam Physician Incentive Program

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AWE Program Overview

Why Participate?

- L.A. Care values ensuring that our CMC members receive an annual wellness exam (AWE).
- We offer an *annual incentive payment of $350* for each completed AWE form.
- Remember, the AWE is an important opportunity to:
  - Conduct a comprehensive health assessment for each L.A. Care CMC member.
  - Determine each member's health risk status and appropriate care plan.
  - Promote members' involvement in their own care.
  - Assist you in proper documentation for Healthcare Effectiveness Data Information Set (HEDIS).
  - Star Ratings and Hierarchical Condition Categories (HCC).
  - Maintain compliance with CMC Model of Care.

How it Works

Complete one (1) form per member to receive the maximum incentive payment of $350

1.

L.A. Care provides you with pre-populated Annual Wellness Exam Forms for members that qualify for the AWE Physician Incentive Program.

2.

You schedule and conduct the member's AWE via in-person visit or telehealth visit.

3.

After the visit, complete all sections in the AWE Form with the required PHQ-9 section and submit the form to L.A. Care.

4.

If you have an EMR tool, or would like training on how to complete the form, contact your HCC Outreach Rep.

Acceptable Methods of Submission

1. **Fax** – Fax completed forms to 213.438.4874

2. **Email** - Emailed submissions will be accepted only if sent via a secured transmission.
   - Submissions received via non-encrypted email will be deleted and rejected. Violations will be reported to the Centers for Medicare and Medicaid Services (CMS).

- For more information, please contact:
  - L.A. Care Health Plan Enterprise Risk Adjustment
  - For inquires only, RiskAdjustment@lacare.org or 213.694.1250
  - L.A. Care Health Plan Outreach Specialists:
    - Beatriz Soto De Quinonez, Ext. 4664
    - Betty Garcia, Ext. 4935
    - Misty McConnell, Ext. 5119

Impact of COVID-19 on the AWE Program

- Telehealth visits will be accepted for AWE incentive payment.
- Required criteria:
  - The provider must conduct the visit via **audio and visual**.
    - If conducted via audio only, we will still accept the data, however it *will not get risk adjusted*.
  - The provider must state the following on page 1 of the AWE form or in their EMR: ***"Visit conducted via telehealth, and was HIPAA compliant."***
    - If handwritten on the AWE form, provider must initial this statement.
  - Due to the limitations of telehealth, we understand that some of the components of the AWE cannot be completed. The following sections of the AWE may be left blank if the provider cannot capture the data:

Section 1- Vital Signs	Section 15 – Other Preventative Services/Tests
Section 9 – Physical Exam	Section 20 – Mini Cognitive Instructions
Section 12 – Cognitive Functioning	Section 21 – The Mini Cognitive Test
Section 14 – Annual Prevention Tests and Services for Diabetics	Section 22 – Orders for Medical Star Screening Tests

Impact of COVID-19 on the AWE Program (cont.)

- All other areas of the AWE must be completed to the highest specificity, signed, dated, and have the credentials marked on every page.
- Our members' health is most important. L.A. Care is not encouraging providers to bring members in for a face-to-face Annual Wellness Visit.
- COVID-19 regulation changes have impacted the efforts of the L.A. Care Risk Adjustment Outreach Team.
  - The team has stopped in-person deliveries of AWE packets and incentive checks.
  - The AWEs have been sent to our providers either by secure/encrypted email or via fax.
  - The incentive checks have been mailed out monthly by our Finance Department. This process will continue in 2021.

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Hierarchical Condition Categories (HCC) & Documentation

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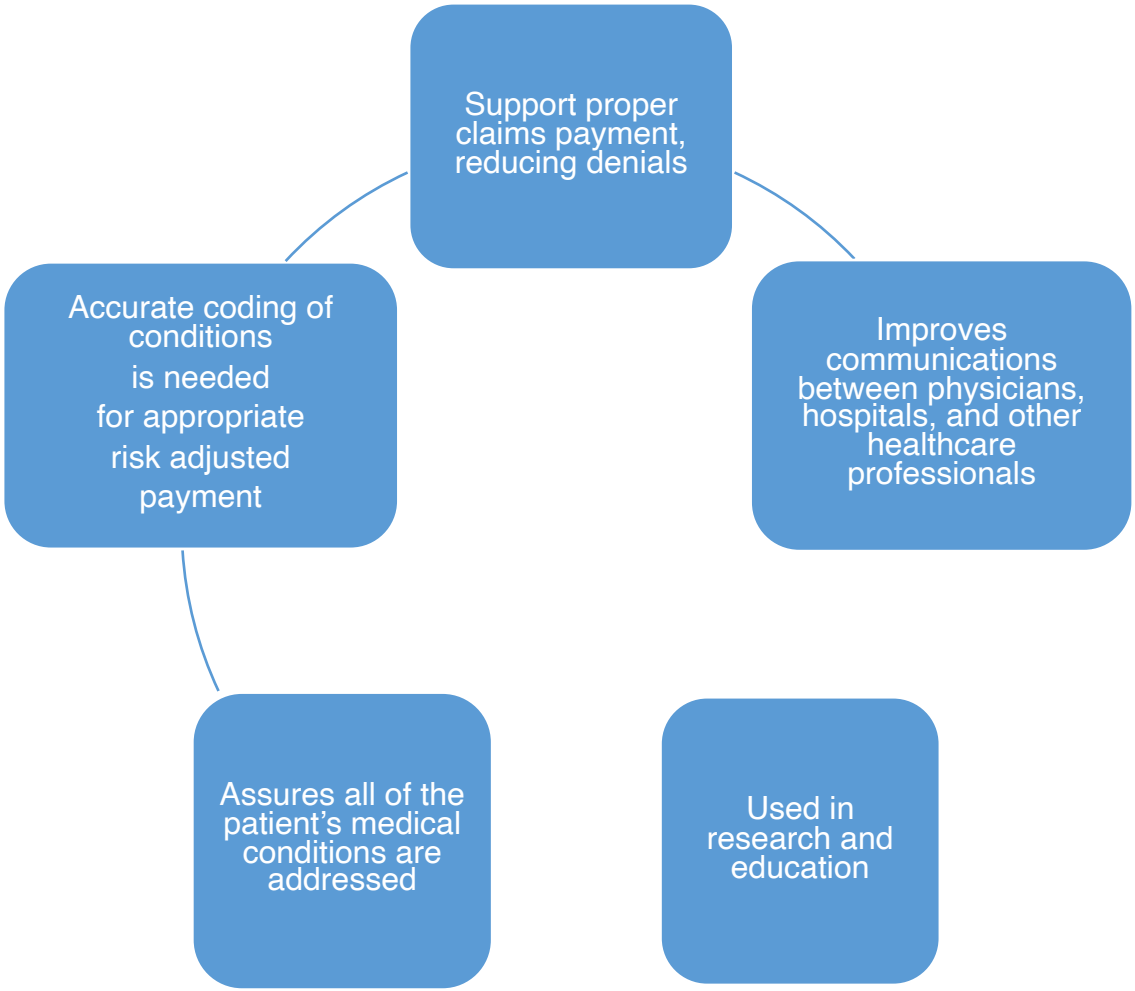
Risk Adjustment and Factors Impacting Risk Scores

- Higher Risk Scores
  - Represent members with greater than average burden of illness and appropriately documented

- Lower Risk Scores
  - Represent a healthier population, but it may also falsely indicate a healthier population due to:
    - Inadequate or incomplete chart documentation
    - Incomplete or inaccurate diagnosis coding
    - Incomplete Encounter data submission

Importance of Documentation

Documentation is key: *"If not documented, it cannot be coded!"*



Critical Role of Providers & IPAs

- **Providers and provider groups play a critical role in helping to ensure the integrity of the data used in calculating the overall health risk of member**

- Comprehensive health status for each member
- Accurate and complete ICD-10-CM coding for every member, every time
- Medical record documentation sufficient to support ICD-10-CM coding
- Coding to the highest level of specificity

— Ensure encounter data submissions are timely, accurate, and **ROBUST** (i.e. reflecting the level of diagnostic specificity found in the medical chart)

Documentation Recommendations

- Document must be **complete** and **legible**
- All chart notes must contain:
  - **Patient name, DOB,** and **DOS** on every page
  - **Provider printed name** and **signature,** including credential
    - Credential after signature and after printed name
- Encounter must be documented in the medical record
- Condition(s) must be documented in the medical record
- Documentation MUST show that condition was monitored, evaluated, assessed, or treated (MEAT).
  - Each condition requires a status, such as *stable*, *worsening*, or *improving condition,* and a *plan of action,* such as medication prescribed, tests ordered, followed by specialist.
- Conditions coded must be stated in the medical record using text format.
  - i.e. conditions documented using only numerical codes (E11.9) are not acceptable for risk adjustment, per CMS.
- If both numerical code (ICD-10) and the description are present, we assign a diagnosis code based on the code description, *not the ICD-10 code provided.*

Documentation Summary

- For the purposes of Risk Adjustment Coding, a valid medical record should:

1. Include documentation of a face-to-face encounter (or telehealth encounter) with an acceptable provider type for Risk Adjustment.
2. Clearly identify the patient name, date of birth and date of service.
3. Providers are required to maintain a medical records for all members.
4. Encounters documented using an EMR are considered to be one single document, meaning that continuation is assumed for all encounters, regardless of the number of pages. And must have an authentication (electronic signature) from the rendering provider.

If is not documented/coded…
…the member doesn't have it!

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Telehealth

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COVID-19 and Telehealth

- Beginning in March 2020, routine medical services were either canceled or postponed due to COVID-19. Health plans and providers must work effectively to ensure patient care.

- Estimated $125 to $200 billion in incremental US health system cost from ongoing impact of COVID-19[1]

- Boom in Telehealth[2]
  - In the five years preceding 2019, telemedicine had **grown by 44%**[2]
  - Post-COVID-19 = potentially **$250 billion** in care could be virtualized[3]
  - **New regulations** for Medicare and Medicaid

[1]McKinsey & Company, "Understanding the hidden costs of COVID-19's potential impact on US healthcare", Sept. 4,2020; [2]GlobalMed, "Why Telemedicine, Why now?", Sept. 3,2019; [3]McKinsey & Company, "Telehealth: A quarter-trillion-dollar post-COVID-19 reality?", May 2020

Telehealth Guidelines

- Telehealth visits:
  - A visit with a provider that uses telecommunication systems between a provider and a patient;
  - Visits are considered the same as an in-person or face-to-face visit;
  - Providers are encouraged to use a HIPAA compliant platform that uses an interactive audio and video telecommunication with the patient;
  - Audio only visits are not acceptable by CMS
  - Conduct and document a thorough history and assessment of both past and current patients conditions
  - Document start/stop time, visit site/location, type of visit (audio and video)

Telehealth Platforms

- HIPAA-compliant video communication applications[1]:
  - Skype for Business/Microsoft Teams
  - Updox
  - Vsee
  - Zoom for Healthcare
  - Doxy.me
  - Google G Suite Hangouts Meet
  - Cisco Webex Meetings/Webex Teams
  - Amazon Chime
  - GotoMeeting
  - Spruce Healthcare messenger

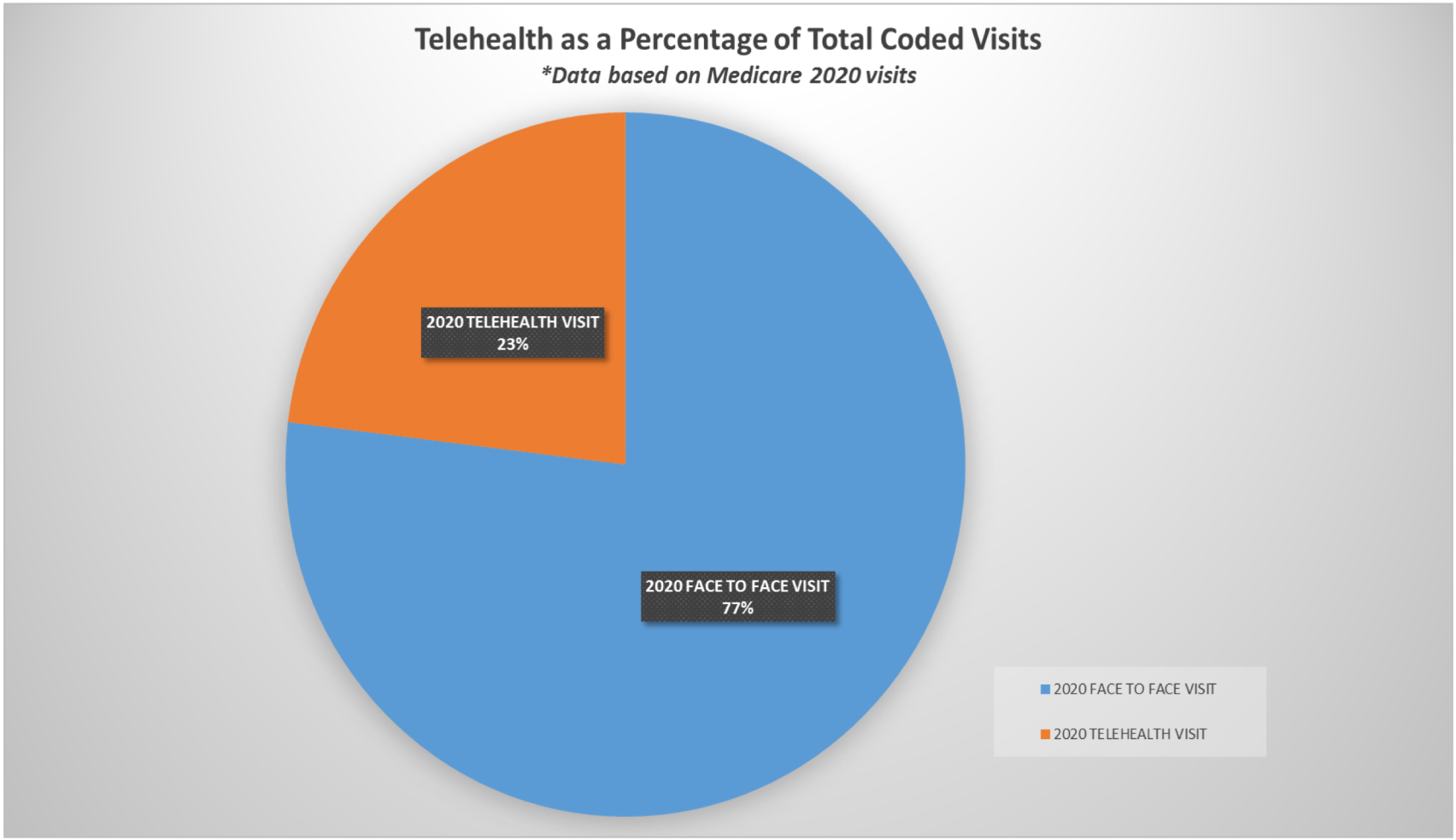
*Facebook Live, Twitch, TikTok, and similar video applications are not to be used for Telehealth

Top Diagnoses Missed During a Telehealth Visit

- Diabetes with chronic complications
- Major depressive, bipolar, and paranoid disorders
- Morbid obesity
- COPD
- Specified Heart Arrhythmias
- Vascular Disease
- Congestive Heart Failure
- Angina Pectoris
- Rheumatoid Arthritis
- Malnutrition
- Chronic ulcer of skin, except pressure

** Usually happens when there is a new diagnosis that requires an additional work up to confirm the diagnosis*

L.A. Care Coded Telehealth Charts Since March 2020



Medicare Telehealth Services for the COVID-19 Pandemic

Service	HCPCS/CPT Code	
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS)First visit and subsequent visit	G0438	G0439
Medicare Telehealth Visits	99201-99215 (office or other outpatient visits)	G0425-G0427(Telehealth consultations, emergency department or initial inpatient)
Virtual Check-in (established patients)	G2012	G2010
Interactive Complexity Psychiatry Services and Procedures	90785	
Health Risk Assessment	96160,	96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506	
Psychotherapy for crisis	90839	90840
Prolonged preventive services	G0513	G0514

for a more expanded list of codes visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telehealth Services Billing & Payment

- Add the GQ and/or 95 modifier with the professional service CPT or HCPCS code
- Use Place of Service (POS) 02-Telehealth, 11-Office Visit, and other POS are also acceptable for telehealth

- Resources:
  - List of Telehealth Services
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing
  - For information on the COVID-19 waivers and guidance, and the Interim Final Rules, go to the CMS COVID-19 flexibilities webpage

CMS.gov
Centers for Medicare & Medicaid Services

Key Takeaways

- Telehealth care can be challenging.
- Some patients have limited access to technology.
- It will be difficult to assess new diagnoses through telehealth because some require a person-to-person touch for assessment (COPD, DVT).
- Educate members to engage virtually with providers.
- Do your best to document chronic conditions, manifestations, and treatment plans.
- Document! CMS loves a well documented medical record. A well documented record means a well cared patient.
- Remain compliant.

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RADV

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RADV - Background

- Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment are supported by medical record documentation. The purpose is to ensure risk adjustment payment integrity and accuracy with the intent of increased auditing activity and emphasis on reducing payment errors.
- There are two main types of RADV for CMS:
  - **Random** CMS RADV uses a selection process in which a Medicare Advantage (MA) plan is randomly selected for an audit.
  - **Targeted** CMS RADV is applied to MA plans who have raised red flags, such as a large increase in risk scores, etc.
- Purpose is to substantiate its Risk Adjustment Factors (RAFS)
  - CMS
  - HHS
- RADV detects over-coding and mis-coding
- RADV audits affect the following organizations:
  - Medicare Advantage Plans
  - Fully Integrated Dual Medicare-Medicaid Plans
  - Medicare Accountable Care Organizations
  - Health Insurance Exchanges

RADV Checklist

This checklist was provided to plans involved in national RADV audits. This list may help to determine a record's suitability for Risk Adjustment Data Validation (RADV). Any items checked "no" may indicate that the record will not support a CMS-HCC.

- Is the record for the correct enrollee?
- Is the record from the correct calendar year for the payment year being audited (i.e., for audits of 2011 payments, validating records should be from calendar year 2010)
- Is the date of service present for the face to face visit?
- Is the record legible?
- Is the record from a valid provider type? (Hospital inpatient, hospital outpatient/ physician)
- 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?

Information contained in this document is intended to provide general guidelines for representatives of Medicare Advantage (MA) contracts selected for Risk Adjustment Data Validation (RADV). The guidance provided here does not guarantee that the documentation that you submit for review will validate the HCC under review. The Centers for Medicare & Medicaid Services (CMS) may determine the validity of medical record documentation based on criteria other than those described herein. Submission of medical record documentation for RADV must comply with all CMS instructions.

Considerations

When submitting a record for RADV, consider the following:

- If the condition warrants an inpatient hospitalization, the HCC may be supported by an inpatient record.
  - Examples of such conditions may include septicemia, cerebral hemorrhage, cardio respiratory failure, and shock. For these conditions, an inpatient record, a stand-alone inpatient consultation record, or a stand-alone discharge summary may be appropriate for submission.
- When possible, obtain a record from the specialist treating the condition, e.g. an oncologist for a cancer diagnosis. These records may be more likely to sufficiently document the condition.
- Pay special attention to cancer diagnoses. A notation indicating “history of cancer,” without an indication of current cancer treatment, may not be sufficient documentation for validation.
  - For example, if in an attempt to validate HCC 10 (Breast, Prostate, Colorectal and Other Cancers and Tumors) a Medicare Advantage contract submits a record that indicates a patient has a history of cancer that was last treated outside the data collection year, the HCC may be not be validated.
- Any problem list in submitted documentation should be included and not just referenced

Considerations (cont.)

- Records submitted to validate HCCs that encompass additional manifestations or complications related to the disease (e.g. HCC 15, Diabetes with Renal Manifestations or Diabetes with Peripheral Circulatory Manifestations) should include language from an acceptable physician specialist which establishes a causal link between the disease and the complication.
  - An acceptable record that clearly defines the complication or manifestation and expressly relates it to the disease may validate the HCC. A record that does not define and link this relationship may not validate the HCC.
- If a physician or outpatient record is missing a provider's signature and/or credentials, consider using the CMS-Generated Attestation that was provided with your data. CMS will only consider CMS-Generated Attestations for RADV.
- Minimum requirements for inpatient records state that these must contain an admission and discharge date. In addition:
  - inpatient records must include the signed discharge summary,
  - stand-alone consultations must contain the consultation date, and
  - stand-alone discharge summaries submitted as physician provider type must contain the discharge date

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Additional Statistics on Telehealth Data

- There are about 3 times more telehealth visits in 2020
- Telehealth impacts on risk adjustment reimbursement final payment year 2021
- Diagnoses from telehealth services applies both to data submissions to Risk Adjustment Processing System (RAPS) and Encounter Data System (EDS)
- Review telehealth claims/encounters
  - Charts acquisition critical to validate risk adjustment
  - LA Care identified 94% of the medical records for telehealth claims/encounters are audio only
- Establish audit readiness for telehealth risk adjustment at all levels to ensure data integrity
  - Starts with provider documentation; complete and accurate data submission to PPG/MSO and to LA Care

Maximize Value with Risk Adjustment Data for Quality Measures

- Risk Adjustment initiatives drive quality improvement, as the diagnoses captured have impact on HEDIS and Star Rating
- L.A. Care Risk Adjustment supplemental data collection and integration
  - Data sources include Annual Wellness Exams, In-Home Assessments, Alternative Submission Method (ASM), and Retrospective Medical Records/Charts.
  - 30-40% members match with HEDIS population samples
  - Utilize the Risk Adjustment HCC Prevalence to identify data available for Star Rating Measures
  - 37% of Star Rating Measures can be identified in HCC conditions for Part C
    - 17 out of 46 measures

Samples of 2021 Star Ratings Improvement Measures

Part C or D	Measure	Measure Type	Weight	Improvement Measure
C	Breast Cancer Screening	Process Measure	1	Yes
C	Colorectal Cancer Screening	Process Measure	1	Yes
C	Annual Flu Vaccine	Process Measure	1	Yes
C	Improving or Maintaining Physical Health	Outcome Measure	3	No
C	Improving or Maintaining Mental Health	Outcome Measure	3	No
C	Monitoring Physical Activity	Process Measure	1	Yes
C	Adult BMI Assessment	Process Measure	1	Yes
C	Special Needs Plan (SNP) Care Management	Process Measure	1	Yes
C	Care for Older Adults – Medication Review	Process Measure	1	Yes
C	Care for Older Adults – Functional Status Assessment	Process Measure	1	Yes
C	Care for Older Adults – Pain Assessment	Process Measure	1	Yes
C	Osteoporosis Management in Women who had a Fracture	Process Measure	1	Yes
C	Diabetes Care – Eye Exam	Process Measure	1	Yes
C	Diabetes Care – Kidney Disease Monitoring	Process Measure	1	Yes
C	Diabetes Care – Blood Sugar Controlled	Intermediate Outcome Measure	3	Yes
C	Rheumatoid Arthritis Management	Process Measure	1	Yes
C	Reducing the Risk of Falling	Process Measure	1	Yes

Samples of HCC Conditions Translate to Star Ratings

HCC	HCC Description	Sample HCC Prevalence Calculated Rate	HEDIS measures for Stars Rating	MOST common ICD10 CODES
17	Diabetes with Acute Complications	0.48%	by Annual preventive Services and Tests for Diabetics	E10.10, E10.11, E11.00, E11.01
18	Diabetes with Chronic Complications	22.36%	by Annual preventive Services and Tests for Diabetics	E11.22, E11.51, E11.52, E11.59, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.311-E11.39, E11.610-E11.69
19	Diabetes without Complication	7.41%	by Annual preventive Services and Tests for Diabetics	E11.9, E10.9
122	Prolif Diabetic Retinopathy & Vitreous Hemorrhage	0.92%	by Annual preventive Services and Tests for Diabetics	E11.3511- E11.3599
107	Vascular Disease with Complications	1.96%	by Annual preventive Services and Tests for Diabetics	I79.0, I79.1, I79.8
108	Vascular Disease	22.13%	by Annual preventive Services and Tests for Diabetics	I73.01, I73.1, I73.81, I73.89, I73.9
111	COPD	16.32%	by Tobacco use	J44.0, J44.1, J44.9
59	Major Depressive, Bipolar, and Paranoid Disorders	15.71%	by completing PHQ9 Depression Screening	F32 (F32.0-F32.9), F33 (F33.1-3, F33.41, F33.42, F33.9)
134	Dialysis Status	0.24%	by Annual preventive Services and Tests for Diabetics	Z99.2
135	Acute Renal Failure	4.80%	by taking blood pressure	N17.0, N17.1, N17.2, N17.8, N17.9
136	CKD, Stage 5	0.21%	by Annual preventive Services and Tests for Diabetics	N18.5
137	CKD, Severe (Stage 4)	1.00%	by Annual preventive Services and Tests for Diabetics	N18.4
138	CKD, Moderate (Stage 3)	9.24%	by Annual preventive Services and Tests for Diabetics	N18.3
21	Protein-Calorie Malnutrition	2.40%	by taking/ recording the BMI	E46, E44.0, E44.1, E43
22	Morbid Obesity	11.19%	by taking/ recording the BMI	E66.01, E66.2
40	RA and Inflammatory Connective Tissue Disease	7.91%	by pain assessment	M05.00-M05.9, M06.00-M06.9, M32.0-M32.9
12	Breast, Prostate, and Other Cancers and Tumors	5.73%	by: Colorectal CA Screening/ Mammogram Screening	C18.9, (C18.0-C18.9), C50 (C50.011-C50.911)(C50.012-C50.912)
51	Dementia with complications	1.61%	by: cognitive function assessment	F0280, F0281
52	Dementia without complications	4.88%	by: cognitive function assessment	F0390, F0391
8	Metastatic Cancer and Acute Leukemia	1.27%	by: Colorectal CA Screening/ Mammogram Screening	C18.9, (C18.0-C18.9), C50 (C50.011-C50.911)(C50.012-C50.912)
9	Lung and Other Severe Cancers	1.09%	by: Colorectal CA Screening/ Mammogram Screening	C18.9, (C18.0-C18.9), C50 (C50.011-C50.911)(C50.012-C50.912)
10	Lymphoma and Other Cancers	1.37%	by: Colorectal CA Screening/ Mammogram Screening	C18.9, (C18.0-C18.9), C50 (C50.011-C50.911)(C50.012-C50.912)
11	Colorectal, Bladder, and Other Cancers	1.76%	by: Colorectal CA Screening/ Mammogram Screening	C18.9, (C18.0-C18.9), C50 (C50.011-C50.911)(C50.012-C50.912)
33	Intestinal Obstruction/Perforation	1.25%	by: Colorectal CA Screening	K56.0-K56.699, K56.7
35	Inflammatory BowelDisease	1.12%	by: Colorectal CA Screening	K51.00-K51.919
54	Substance Use with Psychotic Complications	0.16%	by medication reviewed	F11, F12, F13, F14, F15, F16, F18, F19
55	Substance Use Dsrdr, Mod/Sev, or Subst Use w/Compl	4.86%	by medication reviewed	
56	Substance Use Dsrdr, Mild, Except Alcohol and Cannabis	0.31%	by medication reviewed	
58	Reactive and Unspecified Psychosis	0.28%	by completing PHQ9 Depression Screening	F32 (F32.0-F32.9), F33 (F33.1-3, F33.41, F33.42, F33.9)
100	Ischemic or Unspecified Stroke	2.87%	by taking blood pressure/ cholesterol level	I60-I62, I63.0-I63.9, I67.0-I67.9, I68.0, I68.0, I68.2, I68.8
115	Pneumococcal Pneumonia, Empysema, Lung Abscess	1.26%	by Tobacco use	J43.0, J43.1, J43.2, J43.8, J43.9

Questions

Meredith Diep
213.694.1250 ext. 4933
Mdiep@lacare.org

Misty McConnell
213.694.1250 ext. 5119
Mmcconnell@lacare.org

Jayson Bautista
213.694.1250 ext 5927
Jbautista@lacare.org

Jennifer Calma
213.694.1250 ext 4540
Jcalma@lacare.org