

HCC RISK MANAGEMENT PROSPECTIVE CHART AUDIT: THE PROSPECTIVE MEDICAL RECORD REVIEW

WHAT IS A “PROSPECTIVE MEDICAL RECORD REVIEW” AND WHY IS IT IMPORTANT TO OUR PLAN ?

At Peak Health Solutions our **HCC Risk Management Prospective Medical Record Audit** is a powerful device for identifying and deterring substandard documentation and coding, and for building an optimal but appropriate HCC Plan profile. Specifically, the Prospective Medical Record Review process allows the Plan to examine preselected claims before they are reported to CMS via the RAPS file submission. As the majority of the Plan's RAPS data is collected from provider claims, it makes sense on numerous levels to analyze the information prior to officially reporting it to CMS for the purposes of:

- Ensuring correct federal reimbursement and risk adjustment factor rate setting.
- Adhering to federal coding and documentation compliance standards.
- Affording opportunities to monitor and strengthen provider documentation.
- Lowering administrative costs (less corrective steps) as a result of cleaner RAPS file submissions.

In the current RAPS submission process, the standard is to submit unaudited claims through the RAPS file data, wait up to a year to retrospectively review the information by performing after-the-fact Medical Record Reviews, involve providers who must produce the filed-away documentation, and then analyze the results for remediation. Why is it the industry standard to wait to correct your Plan's data? Peak doesn't think you should, and we offer the necessary solutions to get the correct information 'out the door' the first time.

WHAT EXACTLY IS THE “PROSPECTIVE MEDICAL RECORD REVIEW” ?

Peak has devised an innovative way to avoid the gap in time between reviews, catch potential errors before they are officially reported, and shore-up provider documentation and coding to accurately improve the Plan's HCC profile. By using Peak's ground-breaking workflow system you will be able to review claims data that you determine should be assessed prior to reporting it to CMS.

So how does this all operate? Peak works with your Plan to determine which claims to review. Some Plans may decide they want to look at all claims destined to be reported to CMS; others may only want to preview claims from specifically targeted providers (e.g., with high documentation errors), or claims generated via members with specific HCC classifications. Before this process begins Peak assists you in analyzing the information at hand and deciding what is the most appropriate option(s) for your Plan.

Once the member claims list has been generated, the process is fast-tracked into Peak's HCC Risk Management workflow system. Peak will contact the providers, collect the data for all pre-identified dates of service, examine the supporting documentation and determine correct HCC profiling. The final analyses are then provided back to the Plan in real-time through our state-of-the-art workflow technology.

Your Plan can utilize this data to:

- Optimize the Plan's Risk Score.
- Identify ICD-9-CM code errors and enhance current and future coding accuracy.
- Recognize provider documentation weaknesses and identify opportunities for clinical documentation improvement (CDI).
- Act proactively by capturing potentially missed HCC/RxHCC classification opportunities in the current calendar year.

WHAT ARE THE CONTINUING LONG-TERM BENEFITS OF A PROSPECTIVE MEDICAL RECORD REVIEW?

1. Appropriate Patient Care: First, the Plan can establish the appropriate diagnoses for each patient's profile, which in turn establishes the level of care each patient requires. Also, by reviewing the data concurrently, the Plan is actively capturing appropriate risk scores for all members - not waiting until the next RAPS cycle. ***This allows for immediate and appropriate risk score optimization.***

2. Improved physician documentation and decreased errors to CMS: Provider documentation forms the basis of the Plan's HCC risk score. By concurrently reviewing claims you can simultaneously decrease errors reported to CMS and strengthen provider documentation. Following Peak's documentation analysis, the Plan can target providers in need of documentation education and continue to monitor them to ensure each time a patient presents for care those providers are properly documenting all germane diagnoses and conditions. ***This CDI process lets you optimize your patients' risk scores concurrently instead of retrospectively correcting the data, leading to fewer errors reported to CMS.***

3. Be better prepared for impending RADV Audits: Another advantage of a Prospective Medical Record Review lies in the fact that the Plan is, in essence, preparing for the inevitable RADV audit carried out by CMS. By having Peak collect and review chart documentation in a concurrent fashion, the Plan will have all documentation "images" on hand and ready for the CMS RADV audit team. ***Preparation for the RADV audit will be less burdensome and the Plan can rest assured the information is as accurate as possible, thereby minimizing audit liability.***

4. HCC Profile Management: By far, the main advantage of this process is ***it allows the Plan to take charge of the HCC profiling and reporting process,*** enabling the Plan to:

- Lower administrative costs by ensuring the RAPS data is correct during initial submissions.
- Strengthen provider documentation and identify providers for ongoing CDI purposes.
- Monitor and pre-audit providers with continuing documentation errors.
- Analyze and identify ICD-9-CM coding patterns and opportunities for coding improvement.
- Identify missed HCCs and ascertain HCC suspects for potential HCC/RxHCC classification.
- Mitigate and manage audit liability as a result of the CMS-led RADV audits.



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