

HCC RISK MANAGEMENT SOLUTIONS:

RETROSPECTIVE HCC AUDIT SERVICES

With CMS tightening risk adjustment payments to plans and now performing RADV Audits, what's a reasonable approach to preparing for these audits while at the same time ensuring our Medicare Advantage Plan is receiving "optimal yet appropriate" CMS payments?

Medicare Advantage Organizations and Plans have been alerted that for 2011, CMS will expand the Hierarchical Condition Categories (HCCs) from the current 70 HCC groups to 87 groups; likewise, the current RxHCC groups for 2011 have been expanded in some areas and collapsed in others ... this broadens possibilities for correct diagnosis code classification into these groups and enhances your Plan's chances of being paid appropriately by CMS. No matter which year is under review, your Plan must ensure providers are documenting all services and clinical information in complete fashion, and must verify that providers have accurately and thoroughly abstracted and assigned all relevant ICD-9-CM diagnosis codes. How can your Plan be certain these activities are ongoing and correct? Further, how can your Plan be certain it is receiving (or recovering in the instance of Medicare Part D drug/pharmaceutical expenditures) optimal and appropriate reimbursement for its reported HCCs and RxHCCs?

The "**Retrospective HCC Audit**", performed by highly skilled and seasoned Peak Health Solutions' Medicare experts, is one of the tools necessary for your Plan to accomplish several things at once: (a) assess the accuracy of prior HCC and related RAPS data file submissions, (b) make revisions where necessary to correct patient chronic condition profile errors, (c) begin receiving the appropriate reimbursement for the current year by making such corrections, and, (d) help your Plan stay on track in the critical areas of provider documentation, ICD-9-CM coding, and related RAPS file reporting for the coming years. It's a multi-faceted and extremely beneficial approach.

Not only do the **Retrospective HCC Audits** zero-in on prior errors, but they also highlight ongoing provider-based problems - e.g., *missing, illegible or incomplete medical record documentation* - errors that must be corrected immediately for your Plan to succeed under the Medicare Advantage program. Through Peak Health Solutions' robust workflow system, you are given the information and feedback you need to successfully utilize all information captured by Peak to continue to provide real feedback to your providers to ensure the best results in your continuing education efforts. Another benefit of Peak's **Retrospective HCC Audits** is that they proactively contribute to your Plan's preparation for more aggressive CMS audit activities, such as RADV Audits which are currently being carried out on Medicare Advantage Plans and for which your Plan should be preparing ... now!

The **Retrospective HCC Audit** can help support your Plan in gauging its potential stance in terms of CMS's RADV audits and let you know where your Plan's potential risk areas may surface during such federal audit processes. Peak's process allows for every record that we collect and review to be returned to the plan in HIPAA-secure format to store and use for both continued education and to have on hand for future RADV audits.

WHAT ARE THE SERVICES PEAK PROVIDES DURING A RETROSPECTIVE HCC AUDIT?

Peak's Retrospective HCC Audit can be managed to accommodate any particular prior RAPS data submissions that your Plan wishes to review. Aside from validating and comparing the ICD-9-CM data officially reported to CMS via the RAPS file submission(s), Peak's audit team will provide the following action-ready feedback on your Plan's information:

- All documented ICD-9-CM diagnosis codes for each member
- An assessment of provider documentation for appropriateness, regulatory standards and HCC eligibility
- Identification of coding errors including incorrect or invalid ICD-9-CM codes
- Identification of the potential fiscal impact to the Plan's reimbursement profile by identifying HCC/RxHCC opportunities missed or incorrect in the original RAPS file submission(s).
- Review and validation of all clinical documentation relevant to diagnoses:
 - Documented diagnoses supporting HCCs
 - Documented diagnoses supporting RxHCCs
 - Ambiguous documentation in support of potential ICD-9-CM code assignment
 - Missed or undocumented diagnoses for (potentially) current year HCC/RxHCC group assignment

Peak Health Solutions' HCC Risk Management Solutions contain customizable and scalable Retrospective HCC Audit Solutions that allow for timely, effective and valuable post-RAPS file submission audit services to assist your Plan.

WHAT ARE THE GENERAL PROTOCOLS PEAK WILL FOLLOW DURING THE RETROSPECTIVE AUDIT PROCESS?

Peak has developed a fast-track system using state-of-the-art programming to guide and support your Plan through these processes. Once the prior year or years have been selected for the **Retrospective HCC Audit**, Peak will work with your Plan to determine which RAPS file data or claims, i.e., dates-of-service for specific patients (depending on the approach) within those target years should be audited. Certain Plans have had Peak review their own pre-selected RAPS file data containing the patient-specific data; other Plans have opted to target high risk/high dollar HCCs to be audited by Peak's team. Some Plans prefer that specific providers be audited during this process. Whichever the choice, Peak can work with your Plan in arriving at these decisions.

Once the RAPS file and/or claims member list has been generated, the process is fast-tracked into Peak's **Retrospective HCC Audit** workflow system. Peak will contact the providers, collect the data for all pre-identified DOS, 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 immediately utilize this retrospective data to:

- Strengthen the Plan's risk adjustment profile by correcting all relevant ICD-9-CM coding errors for current and future coding accuracy.
- Assess medical record documentation integrity for errors, inconsistencies and/or ambiguities:
 - Identify HCC cases ineligible for CMS reporting due to documentation deficiencies, e.g., provider identifier errors and invalid medical records per CMS guidelines.
 - Identify which of these providers will require CMS-generated attestations if selected for a CMS RADV Audit due to documentation deficiencies (lack of signature).
- Identify potential problems with the intrinsic provider query process (as related to your Plan's current MR request process or medical necessity process). Prepare your Plan to be "RADV Audit-ready" for the impending CMS-led RADV Audits.
- Identify opportunities for provider education (CDI, coding, etc.), identifying providers requiring monitoring because of continuing documentation errors, identifying physician practices with high claims error rates (i.e., incorrect ICD-9-CM codes), etc.

... and importantly ...

Peak Health Solutions' HCC Retrospective HCC Audit Services optimizes your Plan's Risk Adjustment Factor (RAF) Score while ensuring accurate and compliant coding of your medical records at all times.



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