Risk Adjustment + HEDIS Transitions of Care (TRC)

Documentation Standards Across Payers August 4, 2021

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VNSNY CHOICE Medicare Star Rating

*2019 A Consumer's Guide to Managed Long-Term Care in New York City, New York State Department of Health

Agenda

- **2021 Initiatives: VNSNY CHOICE Total (HMO D-SNP)**
  - New Member Benefits and Member Quality Screening Initiative
- **Medicare Annual Risk Adjustment**
  - Documentation Standards
  - Claims and Coding Best Practices
- **Transitions of Care**
  - HEDIS Transitions of Care (TRC)
    - Quality Measures (Description)
  - Transitional Care Management (TCM) Services & Provider Visits (Description)
  - TRC & TCM
    - Suggested Workflows
    - Coding & Documentation Requirements
    - Workflow Checklist to Close Loop

2021
New Medicare Plan Benefits

New 2021 Member Incentive Program

Members can earn financial rewards for completing quality screenings in 2021:

- Breast cancer screening (BCS)
- Colorectal cancer screening (COL)
- Comprehensive diabetes care (CDC)
  - Retinal eye exam
  - HgA1c test
- Controlling blood pressure (CBP)
- Statin therapy for patients with cardiovascular disease - Received (SPC)
- Annual wellness visit (AWV) (all members eligible)
- Influenza vaccine (all members eligible)

THIS IS WHERE YOU BELONG

In the home you love.

In the community you know.

In the health plan designed for you.

If you need help to safely live at home, VNSNY CHOICE Total can make it easier to get the care you need. This two-in-one plan combines Medicare and Medicaid Long-Term Care plans for people who need ongoing help with daily activities, such as bathing, cooking, dressing and walking.

Benefits include:

- **$0 plan premiums**
- **$0 co-pays for medical care**
- **$0 for unlimited transportation to medical appointments**
- **$0 for skilled nursing, personal care services, rehabilitation therapy and more**
- **Consumer Directed Personal Assistance Services (CDPAS)**

You can also keep your doctors, specialists and home health aide!*

Total's New Benefits in 2021

Total has several new benefits to help you live safely in the comfort of your own home, where you belong.

Below are some benefits you can expect from VNSNY CHOICE Total

2021 Benefits Overview		
Monthly plan premium	$0	
Medicare Parts A & B services (including doctors, hospitals, clinics, labs)	$0	
Medicare Part D services (brand name and generic prescription drugs)	$0	
Over-the-counter (OTC) and grocery items	Up to $1,584/year ($132 per month)	NEW
Acupuncture	$0 for up to 30 visits/year & more**	NEW
Eye exam/Eyeglasses	$0 for routine eye exam, $300/year for eyeglasses (frames and lenses) or contacts	NEW
Telehealth service	$0	NEW
Dental	$0 for routine and preventative care	
Transportation	Unlimited to medical appointments (to plan-approved locations)	
Long-term services and supports (including Home Health Aide, nursing and social work)	$0	
Physical therapy	$0	
Social Day Care	$0	
Worldwide coverage	Up to $50,000/year for emergency services and urgent care	

*As long as the provider is in the network.
**Additional acupuncture visits for chronic low back pain covered by Medicare.

Documentation Standards: Annual Medicare Risk Adjustment

Risk Adjustment Diagnostic Sources

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage (MA) organizations collect and submit risk adjustment data from:

- Hospital inpatient facilities
- Hospital outpatient facilities
- Physicians
- Telehealth encounters*

From a risk adjustment perspective, treatment within the current year is evidence of diagnoses. Documentation support is evidence that service billed was provided.

*Diagnoses from telehealth claims are risk adjustment eligible only when both audio and visual components are used during the encounter.

Medical Documentation

Risk adjustment begins with the encounter visit and the medical documentation as a source of diagnoses.

- The documentation must support the codes selected and substantiate that proper coding guidelines were followed.
- It is the provider's responsibility to provide clear and legible documentation of a diagnosis, which is then translated to a code for external reporting purposes.

Risk Adjustment Data Validation

- Proper chart documentation helps ensure risk adjustment payment integrity and accuracy.
- 42 CFR § 422.310(e) requires MA organizations and their providers and practitioners to submit a sample of medical records for the validation of risk adjustment data, as required by CMS.
- CMS conducts medical record reviews to validate the accuracy and integrity of the risk adjustment data submitted by the MA organization for payments. CMS selects MA organizations to participate in the medical record review based on several criteria.
- For example, some organizations are randomly selected while others are targeted; thus, every MA organization has a chance of being selected for validation.

Risk Adjustment Data Validation Check List

Yes	No	
☐	☐	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 2013 payments, validating records should be from calendar year 2012)
☐	☐	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?

Medicare Signature Requirements

Documentation must meet Medicare's signature requirements. If Medicare claims reviewers cannot validate the signatures, Medicare Administrative Contractors (MACs) deny the claim, assess an error, and begin recouping overpayments.

A valid signature must be:

- For services you provided or ordered
- Handwritten or electronic
  - For electronic signatures, systems and software products must include protections against modification, and you should apply administrative safeguards that correspond to standards and laws.
  - CMS permits stamped signatures if you have a physical disability and can prove to a CMS contractor you are not able to sign due to that disability.
- Legible or can be validated by comparing to a signature log or attestation statement

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1419.pdf

Documentation Signature Examples

For risk adjustment data submission and validation purposes, the service provider's face-to-face encounter is identified on the medical record via his or her signature and credentials.

Name

- Printed or legible handwritten first and last name
- Printed or legible handwritten first initial and last name

Credentials

- Printed or legible handwritten CMS approved credentials
- The word "Provider" is not an acceptable credential
- It is acceptable to capture the following as credentials:
  - Physician
  - Attending
  - Resident

Note: Medical students are NOT medical doctors and require a co-signature from a physician.

Electronic Authentications and Provider Credentials

The following are examples of ACCEPTABLE Electronic Authentications (not all-inclusive):

Acceptable Authentication (Electronic)

Approved by	Digital Signed	Signed, but not meticulously reviewed
Authenticated by	Digitally Signed	Digitally reviewed and approved
Approved electronically	Signature	Electronic signature verified
Authorized by	Signed by	Electronically authenticated
Authorizing provider	Status signed	Electronically signed by
Automatic authentication	Verified by	Electronically verified
Finalized by	Validated by	Entered data sealed by
Closed by	Completed by	Confirmed by
Co-signed by	Manually signed by	

Missing and Illegible Signatures

- If your signature is missing from the medical record (other than an order), you may submit an attestation statement. Your contractor may offer specific guidance regarding signature attestation statements, including whether current laws or regulations allow attestation for missing signatures in certain situations.

- You may attest that a signature is yours through a signature attestation statement. A signature attestation statement must be signed and dated by the author of the medical record entry (that is, by you, the ordering physician or NPP) and must contain sufficient information to identify the patient.

- You or your organization may submit a signature log or attestation statement to support the identity of any illegible signatures. A printed signature below the illegible signature in the original record may be accepted.

EHR Copy and Paste Functionality

Copying clinical documentation can be a time-saver for busy clinicians. It also can pose a risk to document integrity.

Using the copy functionality in an EHR system poses risk to documentation integrity, including:

- Inaccurate or outdated information that may adversely impact patient care
- Inability to identify authors or what they thought
- Inability to identify when the documentation was created
- Inability to accurately support or defend E/M codes for professional or technical billing notes
- Propagation of false information
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes

EHR Copy and Paste Best Practices

Carrying existing information forward may be appropriate when the copied information is:

- Based on external and independently verifiable sources, such as basic demographic information that is stable over time
- Clearly and easily distinguished from original information, such as automatic summaries that populate data fields that are clearly identified as nonoriginal and cannot be mistaken for original information
- Not actually rendered as part of the record until after a re-authentication process and auditable for identifying actual origination

All imported documentation should be edited by the practitioner to ensure that only accurate and medically necessary imported documentation remains in the documentation of the patient encounter.

Proper Documentation

Proper documentation ensures patients get items or services that are reasonable and necessary.

Proper documentation ensures proper claims payments.

Proper documentation supports favorable medical review decisions.

Proper documentation meets the requirements for CMS data validation.

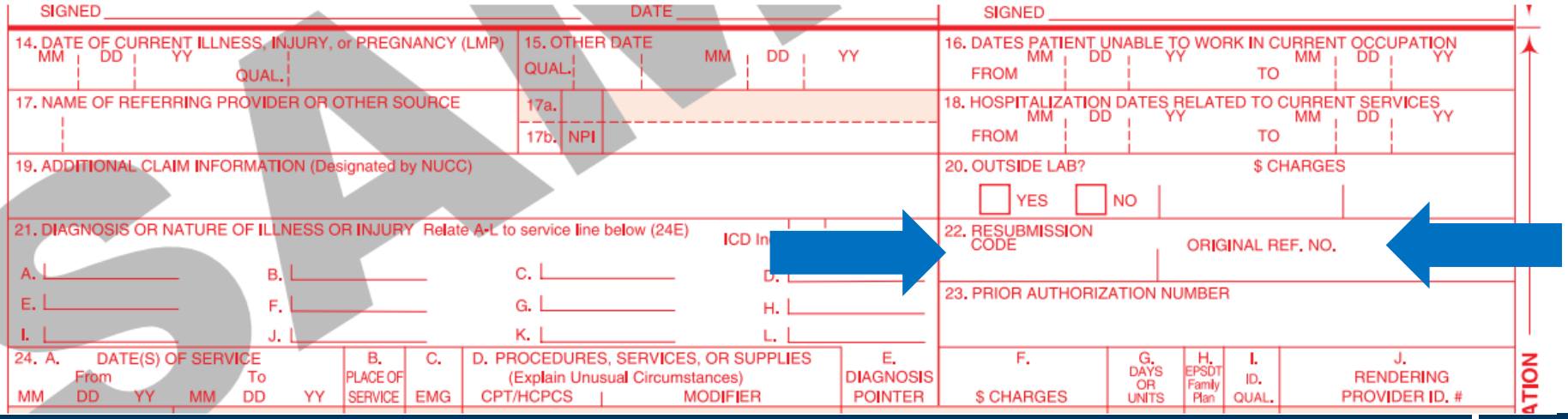
Risk Adjustment
Claims and Coding Best Practices

Professional Claim – Replacement Submissions

- When a professional claim is denied, or an adjustment needs to be made to a paid claim, the best practice is to resubmit the claim.
  - Diagnoses code denials, or any clinical edit denial that you would correct what was billed on the claim is appropriate for replacement claim/resubmission.
  - Not all denials require a corrected claim, (for example a denial for no authorization)

- In CMS 1500 or EDI claim ***Complete field 22 (Resubmission Code) to include a 7 (the "Replace" billing code)*** and include in the ***Original Ref No. field***, the original 12-digit claim number for appropriate processing.

- To meet the timely filing guidelines, the resubmission must be received within 90 days of the adjudication date of the original claim.



Claims and Payment Information and Resources - VNSNY CHOICE

As of 2/22/2021, **Availity** is the preferred Electronic Data Interchange (EDI) and Portal vendor for VNSNY CHOICE Health Plans transactions: **availity.com/vns**

- **270/271 Eligibility and Benefits**: Check coverage for a patient.
- **837 I, P Claim Submission**: Submit an institutional or professional claim.
- **276/277 Claim Status**: Check the status of a claim.
- **835 Remittance Advice**: Availity can support VNSNY CHOICE remittances in addition to your other ERAs managed through Availity.

For information about VNSNY CHOICE claims, payments and other billing processes visit the CHOICE website: **vnsnychoice.org/for-health-professionals-overview**

Q: Do you know the Documentation Standards for Medicare Medical Records?

A: Medical Records from providers should contain:

- Enrollee name and date of birth for every record received; All pages of every record are for the correct enrollee
- Date of service is clearly documented; The provider type, specialty, and face to face requirement is clearly documented
- Acceptable physician/practitioner authentication comes in the form of handwritten signatures and electronic signatures. Stamped signatures are not acceptable.

Transitions of Care

HEDIS TRANSITIONS OF CARE (TRC) MEASURES

HEDIS TRC Quality Measures

Description: *The percentage of members ages 18 and older who had each of **four TRC measures reported** for an inpatient discharge (hospital, rehab, SNF) to the **community/home** between 1/1/21 and 12/1/21*

- Discharges 12/2-12/31 of calendar year are not reported to provide 30 days for post-discharge interventions.
- Members in hospice are excluded.
- Measures are based on discharges, i.e., member can fall into the measures again with readmission after 30 days.

HEDIS TRC Measures Description

Notification of Inpatient Admission

Medical record documentation of receipt of notification of inpatient admission on the date of admission or within the 2 following calendar days. (Not a claims-based measure.) Includes:

- ADT (automated data transfer) from HIE to PCP and Communication to the PCP from member health plan

Receipt of Discharge Information

Medical record documentation of receipt of discharge information on the day of discharge or within the following 2 calendar days. (Not a claims-based measure.)

HEDIS TRC Measures Description

Patient Engagement After Inpatient Discharge	**Medical record documentation**, as well as a **claim**, for patient engagement (e.g., office, telehealth or in-home visits) provided within 30 days after discharge.
Medication Reconciliation Post-Discharge (MRP) CPT II Code 1111F	**Medical record documentation**, as well as a **claim**, for medication reconciliation comparing the current record medication list to discharge medications; can be conducted by prescribing practitioner, RN, or pharmacist, on the date of discharge through 30 days after discharge.

TRANSITIONAL CARE MANAGEMENT (TCM) SERVICES & PROVIDER VISITS

TCM Services & Visits Description

TCM Visit Within 7 Days Post-Discharge: CPT Code 99496

Medical record documentation must include:

- Communication (direct contact, telephone, electronic/email) with the patient and/or caregiver within **two business** days of discharge
- Medical decision making of **high complexity** during the service period
- Face-to-face visit (in-office or **video telehealth**) within seven calendar days of discharge:
  - Includes medication reconciliation and discharge summary review
  - Assistance in scheduling referrals, tests, and follow-up care

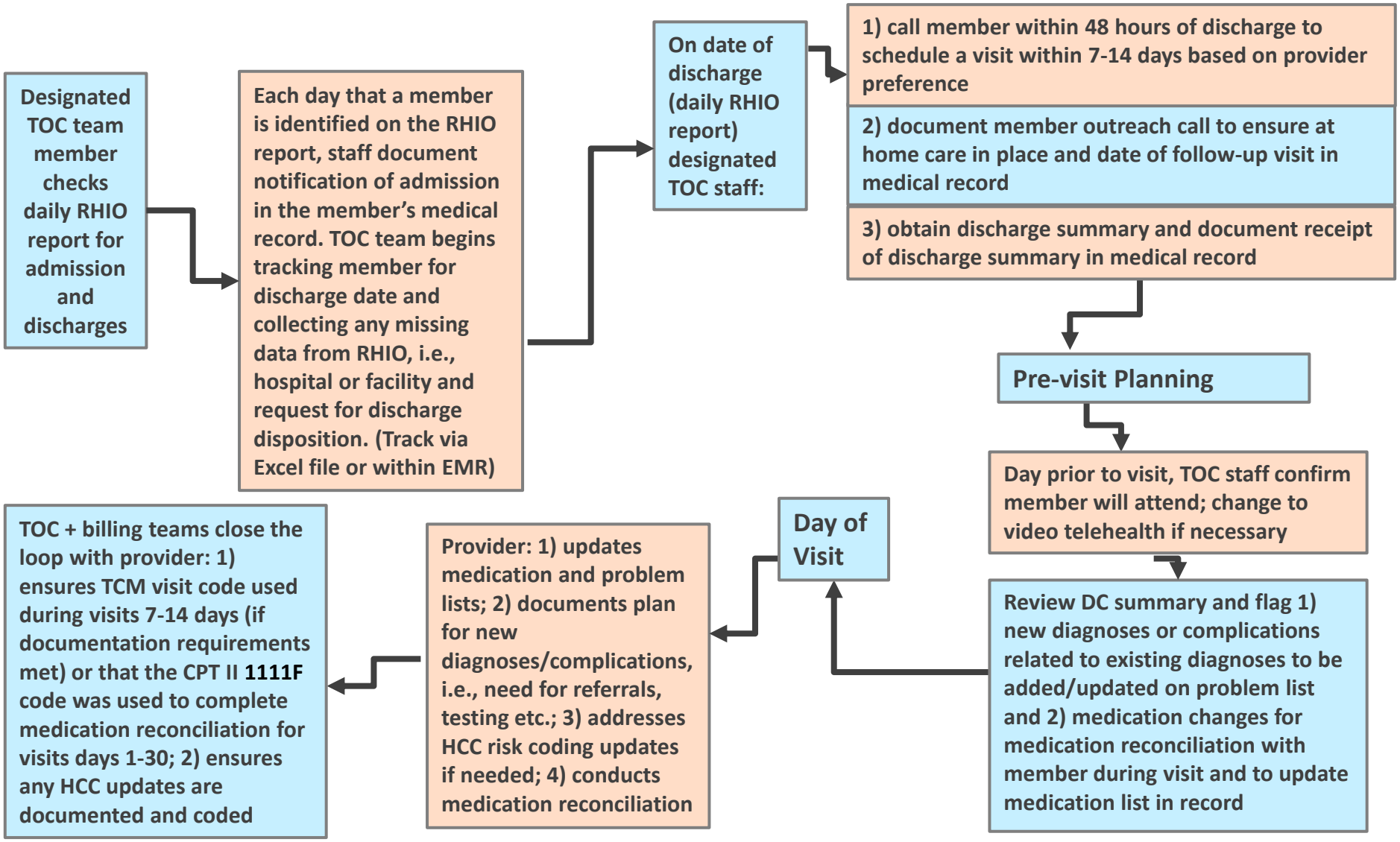
TCM Visit Within 14 Days Post-Discharge: CPT Code 99495

Medical record documentation must include:

- Communication (direct contact, telephone, electronic/email) with the patient and/or caregiver within **two business** days of discharge
- Medical decision making of **at least moderate complexity** during the service period
- Face-to-face visit (in-office or **video telehealth**) within 14 calendar days of discharge:
  - Includes medication reconciliation and discharge summary review
  - Assistance in scheduling referrals, tests, and follow-up care

TRC + TCM WORKFLOWS FOR SUCCESS

Transitions of Care Suggested Workflows



HEDIS TRC QM + TCM Services & Visits

Admission Notification and Discharge Receipt

Workflow Checklist:

- Who checks daily RHIO Report for admissions ***AND*** documents notification of admission?
  - How is the admission notification documented/captured in the EMR?
  - What are the other notification sources (i.e., ACO or MCO apps, faxes, emails)?

- Who checks the daily RHIO report/all discharge sources ***AND*** requests/obtains the discharge summary? How/where is DC summary receipt documented? (Is there a standard EMR storage site/folder for the DC summary?)

HEDIS TRC QM + TCM Services & Visits

Patient Engagement

Workflow Checklist

- Who notifies PCP and confirms PCP recommended **timing** and **site** (office, in-home, or telehealth) for follow-up visit?

- Who calls member to schedule post-discharge visit within 7-14 days per PCP recommendation **AND** documents call (***to meet TCM code requirements***)? Where is the call documented in the EMR?

HEDIS TRC QM + TCM Services & Visits

Patient Engagement + Medication Reconciliation Post-Discharge (MRP)

Workflow Checklist

- Who conducts pre-visit planning and flags chart for the PCP to:
  - Conduct medication reconciliation?
  - Update medication and problem lists addressing new medications/diagnoses/complications from discharge summary?
  - Review and update HCC risk adjustment for new diagnoses or complications in DC summary?
  - Who closes the loop between provider and billing on all visit coding (***TCM, MRP and HCC),*** *i.e.,* ensures the correct TCM visit code or CPT II **1111F** code (for medication reconciliations days 1-30) are billed?

TRC QM Measures (4 rates reported) + TCM Services & Visits Workflows – Summary Details

HEDIS TRC Quality Measure	Documentation/Workflow	CPT TCM/CPT II Codes
Notification of Inpatient Admission	• TOC Staff check daily RHIO report • Document call to member within 48 hours post-discharge • Schedule visit (in-person or video telehealth) within 7-14 days • Document receipt of inpatient notification in medical record on the day of admission or within the 2 following calendar days	• NA (must be documented in the medical record) Incudes EDTs and shared EMRs
Receipt of Discharge Information	• Obtain and document receipt of the discharge summary report in the medical record on the day of discharge or within the 2 following calendar days; includes the "instructions for patient care post discharge"	• NA (must be documented in the medical record)
Patient Engagement after Inpatient Discharge	• Ensure that TCM documentation requirements are met • Do not include patient engagement on date of discharge	• Within 7 days post-DC: CPT 99496 (TCM) • Days 8-14 post-DC: CPT 99495 (TCM) • Days 15-30 post-DC: appropriate visit code
Medication Reconciliation Post-Discharge (MRP)	• Documentation must include reference to the discharge medications and the current medication list in the medical record; can be on the date of discharge through 30 days post discharge	• Within 7 days post-DC: CPT 99496 (TCM) • Days 8-14 post-DC: CPT 99495 (TCM) • Days 1-30 post-DC: CPT II 1111F (if TCM codes are not used)

Did you know all Medicare payers now report four HEDIS Transitions of Care Quality Measures?

1) **Notification of Inpatient Admission**: must be documented in medical record within 2 calendar days

2) **Receipt of Discharge Information**: must be documented in medical record within 2 calendar days

3) **Patient Engagement after Discharge**: claim or medical record documentation within 30 days

4) **Medication Reconciliation Post-discharge**: TCM claims (7-14 days post-discharge); CPT II code or medical record documentation (within 30 days post-discharge)

Thank you!

CHOICE Contacts

- Risk + Quality topics webinar registrations
- Individual practice education on your topic choice
- Information on individual practice gaps in care reports or EMR data sharing

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Visit the VNSNY CHOICE Provider Website!

vnsnychoice.org/for-health-professionals-overview

- Guideline and Policy Updates
- Provider Toolkit
- Claims, Billing, and Payments
- Credentialing

Link to telehealth coding guidance:
vnsnychoice.org/wp-content/uploads/2020/09/CHOICE-Quality-HEDIS-Telehealth-Updates.pdf

References and Resources

CMS References

Centers for Medicare & Medicaid Services (CMS) Risk Adjustment

- www.cms.gov/Medicare/Health-Plns/MedicareAdvtgSpecRateStats/Risk-Adjustors

Medicare Managed Care Manual 100-16, Chapter 7 – Risk Adjustment

- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf

Customer Service and Support Center (CSSC) Operations- Risk Adjustment Processing System

- www.csscoperations.com/internet/csscw3.nsf/T/Encounter%20and%20Risk%20Adjustment%20Program%20(Part%20C)

Risk Adjustment Resources

ICD-10-CM Official Guidelines for Coding and Reporting

- www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

ICD10 HCC Model Mappings

- www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsrisk-adjustors/2021-model-softwareicd-10-mappings