Risk Adjustment Factor
(RAF)

RADV

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Health Network

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Objectives

- Risk Adjustment Data Validation (RADV) Audit
- Data Validation
- Top 10 Medicare Risk Adjustment Coding Errors
- Documentation Opportunities
- Tips

Risk Adjustment Data Validation

What is RADV?

- A RADV is an audit that CMS initiates to ensure the integrity and accuracy of risk-adjusted payments. It is the process of verifying that the diagnosis codes submitted by the Medicare Advantage health plans are supported by the medical record documentation for a member.

- Medicare Advantage health plans can be selected for RADV Audits annually. Health plans that are selected to participate in a RADV Audit are required to submit member medical records to validate diagnoses data previously reported to CMS.

RADV Audit Process

- Plan is notified of the RADV audit
- Roughly 600 Medicare contracts and 30 plans are selected annually
- CMS selects 201 members for the audit
- Plans are required to provide support for every HCC in the medical record submission to CMS
    - One best medical record

Why are RAF Reviews Important?

- Accurate risk adjusted payment relies on complete medical record documentation and diagnosis coding.

- CMS requires that all applicable diagnoses codes be reported, and reported to the highest level of specificity, and must be substantiated within the record.

- The CQA Team conducts medical record reviews to identify additional conditions not captured through claims and to verify the accuracy of coding.

  ✓ Reviews are performed to ensure all required ICD-10-CM codes are duly reported to CMS.

Data Validation

Every diagnosis billed on CMS-1500
Must be supported in the medical record

ICD-10-CM Coding Guidelines Section IV

H. Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

Example 1

H&P: Acute MI (I21.3, HCC 86) was billed, provider stated DDX is atypical chest pain rule out STEMI.

HISTORY AND PHYSICAL

PSYCHIATRIC: The patient is anxious.

ASSESSMENT AND PLAN:

1. Chest pain, rule out ST elevation myocardial infarction. We will admit the patient to ICU. We will continue aspirin 81 mg p.o. daily. We will check serial CPK and troponin q. 8 hours x3 sets. We will continue morphine p.r.n. for pain. We will consult cardiology. The patient is awaiting transfer to the cardiac cath lab.
2. Coronary artery disease status post 3-vessel coronary artery bypass graft, status post stent placement x7.
3. Hypertension. Continue metoprolol.
4. Hyperlipidemia. Continue Lipitor.

<CLAIM ICD10 DATA

Diag 1 .	R07.9
Diag 2 .	I21.3
Diag 3 .	
Diag 4 .	
Diag 5 .	
Diag 6 .	
Diag 7 .	
Diag 8 .	
Diag 9 .	
Diag 10 .	
Diag 11 .	
Diag 12 .	

Example 1 Rationale

When coding for physician's services provided during inpatient hospitalization, which set of coding guidelines is applicable, the inpatient or outpatient guidelines?

The Inpatient Coding Guidelines are for use by the facility only. Physicians use the Outpatient guidelines, no matter what the place of service is. **Coding Clinic, First Quarter ICD-10 2014** states in part: "When coding for physician services, whether provided in the hospital inpatient setting or in the physician office, coders should be guided by the Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital- Based and Physician Office). The inpatient guidelines are for hospital coding".

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Example 2

D/C Summary: CAD with unstable angina (I25.110, HCC 87) was billed, unstable angina is not documented.

ADMITTING DIAGNOSES:

1. Chest pain, rule out ST elevation myocardial infarction.
2. Coronary artery disease status post coronary artery bypass grafting.

DISCHARGE DIAGNOSES:

1. Atypical chest pain, status post cardiac catheterization with patent grafts. No cardiac intervention recommended.
2. Coronary artery disease status post coronary artery bypass grafting.
3. Hypertension.
4. Hyperlipidemia.
5. Type 2 diabetes.
6. Chronic pain syndrome.
7. Chronic smoker.

Chest pain codes to R07.9

<CLAIM ICD10 DATA <PROF>

Diag 1 .	R07.9
Diag 2 .	I25.110
Diag 3 .	E11.9
Diag 4 .	E78.5
Diag 5 .	I10
Diag 6 .	F17.210
Diag 7 .	
Diag 8 .	
Diag 9 .	
Diag 10 .	
Diag 11 .	
Diag 12 .	

The patient is a 67-year-old female with past medical history as mentioned above, who came in with a chief complaint of chest pain. She was found to have a normal troponin. There was a concern for anterior STEMI on the EKG. The patient was seen by cardiology and was taken for an immediate cardiac cath. The cardiac cath showed that all her grafts from prior CABG are patent. No cardiac intervention was done, and she was recommended to continue her home medications of aspirin, Plavix, statin. She was seen and examined at bedside today. She is chest pain free currently and has been cleared for discharge by cardiology.

Example 3

Cerner EMR

A/P intracerebral hemorrhage (I61.9, HCC 99).

Chief Complaint

No qualifying data available.

History of Present Illness

Hx of non traumatic cerebral hemorrhage July 2014, then had cerebral infarct while off coumadin
posterior ICA stenting 11/2014
on statin and back on coumadin

Assessment/Plan

1. Intracerebral hemorrhage

2. Status post CVA
   on statin and coumadin
   blood pressure excellent
   continue to follow with Dr Bandi
   ok to do trial off fluoxetine. take one every other
   let me know if this is not successful.
   labs ordered to follow statin.

Coded Diagnoses

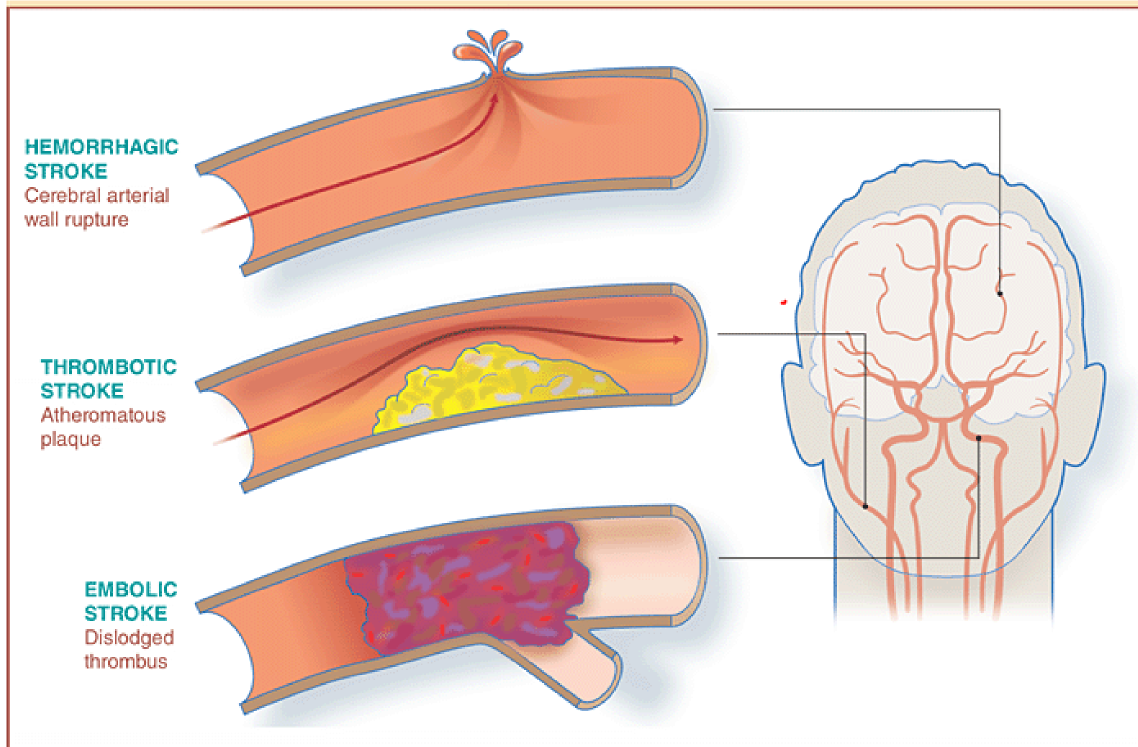
Idiopathic peripheral neuropathy (Chronic inflammatory demyelinating polyneuritis, G61.81)
Hypertension (Essential (primary) hypertension, I10)
GERD (gastroesophageal reflux disease) (Gastro-esophageal reflux disease without esophagitis, K21.9)
Gout (Gout, unspecified, M10.9)
Intracerebral hemorrhage (Nontraumatic intracerebral hemorrhage, unspecified, I61.9)
Status post CVA (Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, Z86.73)
Atrial fibrillation (Unspecified atrial fibrillation, I48.91)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. I61 9	B. Z86 73	C. K21 9	D. I10
E. G61 81	F. M10 9	G. I48 91	H.
I.	J.	K.	L.

Example 3 Rationale

Acute organic (nontraumatic) conditions affecting the cerebral arteries include hemorrhage, infarction, occlusion, and thrombosis and are coded in the I60-I68 series. Category I63, Cerebral infarction, is used to describe occlusion and stenosis of cerebral and precerebral arteries resulting in cerebral infarction



Treatment usually starts in the ambulance and continues in the hospital.

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Top 10 Medicare Risk Adjustment Coding Errors

Top 10 Medicare Risk Adjustment Coding Errors

1. The record does not contain a legible signature with credentials.

2. The electronic health record (EHR) was unauthenticated (not electronically signed).

3. The highest degree of specificity was not assigned the most precise ICD-10 code to fully explain the narrative description of the symptom or diagnosis in the medical chart.

4. A discrepancy was found between the diagnosis code billed vs. the actual written description in the medical record.

5. Documentation does not indicate that diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).

Top 10 Medicare Risk Adjustment Coding Errors

6. Status of cancer is unclear. Treatment is not documented.
7. Chronic conditions such as hepatitis or bronchitis are not documented as chronic.
8. Lack of specificity (e.g. an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
9. Chronic conditions or status codes aren't documented in the medical record at least once per year.
10. A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code, or diabetes uncomplicated is coded with complications.

Top Error #1 Signature

Example 4

- "Signing physician" when provider's name is typed

  Example: Signing physician: ______________________
  John Smith, M.D.

- "Dictated by" when provider's name is typed

  Example: Dictated by: ______________________
  John Smith, M.D.

Top Error # 3 Specificity

Example 5

IMPRESSION:
The patient has been diagnosed with adenocarcinoma of the cecum. I am hopeful that this will be an early stage lesion, this was explained to the patient and his wife. I suspect this may be the case because deep invasion is not seen on the biopsies, plus the tumor is well differentiated. However, the patient still needs to be treated for this colon cancer.

<CLAIM ICD10 DATA <PROF>

Diag 1 .	C18.9
Diag 2 .	
Diag 3 .	
Diag 4 .	
Diag 5 .	
Diag 6 .	
Diag 7 .	
Diag 8 .	
Diag 9 .	
Diag 10 .	
Diag 11 .	
Diag 12 .	

C18.9, Malignant neoplasm of colon, unspecified is coded.

C18.0, Malignant neoplasm of cecum is a more appropriate and codes to the higher specificity.

Top Error #5 No MEAT

Example 6

Chief Complaint
Annual Exam

History of Present Illness
1. Preventative exam

Reports she is feeling "different"
She notes shaking of hands at times especially in the morning when she is getting coffee.
She feels her handwriting is a bit shaky sometimes but other times she is quite steady.
She feels it is related to her anxiety attack she had a few months ago.

Assessment/Plan
1. Routine medical exam
   Doing well overall although she has had tremor and unsteady gait. Does have intention tremor on exam but reports possible resting symptoms at times. I would like assistance with further evaluation with neurology to see if something other than benign essential tremor is the cause.
   --Recommend neurology evaluation.
   --Reviewed labs.
   --Ear lavage today.
2. Tremor
3. History of unsteady gait
4. Other pulmonary embolism without acute cor pulmonale
5. Cerumen impaction

Hypertensive disorder

Top Error #10 DM complicated with uncomplicated

Example 7

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Type 2 diabetes mellitus without complication (E11.9).
	Impression	Increase lantus to 67 units twice a day. Continue Novolog 30 units prior to meals Continue metformin 1000mg twice a day Referral has been placed to see our pharmacist to help you with adjusting the insulin to better cover you sugars Continue to try to focus on a healthy diet Try to exercise for 20-30 minutes most days of the week. You eye exam looked great in 1/2016 It is recommended that you take a baby aspirin once a day (81mg) unless you have a reason that your are not supposed to..
	Plan Orders	Hemoglobin A1c, Lipid Panel 3 Months, Microalb/Creat Ratio, Randm Ur 3 Months and CMP to be performed in 3 Months. Referrals: Internal Medicine: General. Tricia Patterson PHARMD. Location: BH Employed. Evaluate and treat
2.	Assessment	Essential (primary) hypertension (I10).
	Impression	Your blood pressure was too high in the office Check your blood pressure at home 2-3 times a week and write numbers down. Call with these numbers in 2 weeks to let me know results. Goal is <140/90. Continue amlodipine 10mg daily and losartan-hctz 100-12.5mg daily.
3.	Assessment	Type 2 diabetes mellitus with hyperlipidemia (E11.69).
	Impression	I will check your cholesterol with the next labs in 3 months Make sure you are fasting..

Documentation Opportunity

Historical vs. Current

- Do not use the descriptor "history of" to describe a current or chronic condition that is still present, active or ongoing.

- Do not use the descriptor "history of" to describe a current condition that is in remission. Describe the condition as "in remission."

- Do not document a condition as current if it is historical only.
  - For example: A patient with a history of prostate cancer that has been eradicated in the past presents to the office for an evaluation, examination and PSA (prostate specific antigen) lab test to monitor for recurrence.
  - The assessment section should not state "prostate cancer," but rather "history of prostate cancer." The related plan should state, "Will continue to monitor PSA every six months to check for prostate cancer recurrence."

Example 8

CC: **I have prostate cancer.**

HPI: JAMES MASSEY is a 80 year-old male patient who was referred by SCOTT HAFERKAMP, M.D. who is here **evaluation for treatment of prostate cancer.**

His prostate cancer was **diagnosed 10 years ago.** His cancer was **diagnosed at Scottsdale.**

He does have **urinary incontinence.** He does have problems with **erectile dysfunction.** He has not recently had unwanted weight loss. He is not having pain in new locations. He does not have a good appetite.

He was diagnosed with prostate cancer in 2006 which was treated with brachytherapy. He has severe urinary incontinence. He has tried Oxybutynin which he finished about a week ago with no good response. His PSA has slightly increased from 0.1 to 0.3.

PSA: 0.3

ASSESSMENT:

		ICD-9	ICD-10	Details
1	GU:	Prostate Cancer - 185	Malignant neoplasm of prostate - C61	
2		Overactive Bladder - 596.51	Overactive bladder - N32.81	
3		Incontinence, Urge - 788.31	Urge incontinence - N39.41	

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Example 9

CC: Follow-up multiple problems

HPI: Patient is here for follow-up of multiple medical problems. He has a history of hyperlipidemia, area. He has benign prostatic hypertrophy and takes Flomax. He stopped taking it because he had an episode of reduced energy. He has a history of colon polyps and had a colonoscopy. He has muscle spasms and headaches cyclobenzaprine as needed. He had foot pain so he saw a podiatrist.

Physical exam

Gen. appearance alert and oriented well-dressed and groomed no acute distress
Lungs clear to auscultation bilaterally with good air movement
Heart regular rate S1, S2, without murmur, gallops
Extremities no cyanosis no clubbing no edema

Assessment and plan

Prostate cancer–prostate-specific antigen will be checked
Erectile dysfunction–she was given a prescription of Viagra to get from Canada
hyperlipidemia–low-cholesterol diet was advised

Example 10

HPI: Patient is a pleasant 82-year-old gentleman with a complex medical history including chronic kidney disease stage IV, hypertension, radiation cystitis and proctitis secondary to prostate cancer treatment, hypertriglyceridemia and chronic urinary tract infection who is here with complaints of fevers and chills and foul smelling urine.
Patient has a history of recurrent urinary tract infection/pyelonephritis secondary to cystoprostatectomy with bilateral ureterostomy. Patient had his bladder removed after he had radiation therapy for prostate cancer. He has had recurrence hospitalizations for urinary tract infection. He is followed by Dr. Roberts for urology and patient has his ureteral stents replaced every 3 months.
Continues to have his ileostomy
He has chronic kidney disease stage IV and is followed closely by his nephrologist. Discussed nephrotoxins to be avoided because of chronic kidney disease including NSAIDS, sulfa-containing drugs, IV contrast and aminoglycosides.
Also advised to drink adequate amounts of fluid to prevent dehydration.
Patient has mild chronic obstructive pulmonary disease and has been evaluated by Dr. Rundbakken. He is not on any bronchodilator therapy.
He also has sleep apnea.

Tips!

Provider's Role

Provider's must document all pertinent, applicable diagnoses and how they impact the care of the patient

- **Monitor:** signs, symptoms, disease progression, disease regression
- **Evaluate:** test results, medication effectiveness, response to treatment
- **Assess/Address:** ordering tests, discussion, review records, counseling
- **Treat:** medications, therapies, other modalities

Examples:
CHF: symptoms well controlled with Lasix, continue medication.

Major depression, recurrent mild: patient continues to feel depressed, will increase dose of Zoloft to 100 mg daily.

Provider's Role

Medical Record Documentation

- Documentation should be clear, concise, consistent, complete and legible
- Document coexisting HCC conditions at least annually
- Use standard abbreviations
- Identify patient and date on each page of the record
- Authenticate the record with signature and credential

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Documentation Specificity

Clinical Term Documented	Diagnostic Terms Needed
Severe asthma	Chronic obstructive asthma or COPD
Cardiac arrhythmia	Atrial fibrillation/SVT
Chest pain	Angina
Diabetes and CKD	Diabetic nephropathy
DVT/PE	Acute, chronic, or history of DVT/PE
High blood pressure/LVH	Hypertensive cardiomyopathy
Elevated Hgb A1c	Uncontrolled DM
Open wound	Skin ulcer
Wasting/weight loss	Protein calorie malnutrition
Metastatic lung cancer	Lung cancer with metastasis to _______

Common HCC's

- DM and complications
- Angina/CAD
- A-fib, SVT (arrhythmias)
- PVD, claudication
- AAA, aortic atherosclerosis
- CHF (specificity)
- Amputations (status)
- Ostomies (PEG, trach)
- Chronic respiratory failure and oxygen use
- Seizures
- Malnutrition/morbid obesity
- Anemia including sickle cell
- Metastatic cancer (site specified)
- Complications of a device or graft
- Cirrhosis/ESLD
- Paraplegia, hemiplegia
- CKD stage/ESRD
- COPD, obstructive asthma
- Major Depression Disorder, bipolar
- Alcohol/drug remission/continuous use

More Tools

For additional learning tools and resources visit the BMG Physician Coding RAF SharePoint and the Banner Health Network site.

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References

- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organization Participant Guide”. Centers for Medicare & Medicaid Services.

  http://www.csscoperations.com/Internet/Cssc3.Nsf/files/participant-guide-publish_052909.pdf/$File/participant-guide-publish_052909.pdf

- ICD-10-CM Official Guidelines for Coding and Reporting

  http://www.cdc.gov/nchs/icd/icd10cm.htm

- HCC model mappings

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/IDC10Mappings.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Questions or Comments

Contact us!

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