Improving Medicare Reimbursement through Modernization

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“Revenue Cycle Management” is often used these days as a catch-all term to describe the financial processes healthcare organizations use to manage their service-related administrative and clinical functions.

Health Plans, Medical Service Organizations (MSOs), Accountable Care Organizations (ACOs), and other entities paid on risk must properly document and code all conditions for each patient. Over- or undercoding can trigger severe recoveries and penalties from the government; undercoding can also leave money on the table.

Success depends on providing all — and only — services that are clinically indicated and coding them correctly. At Exafluence, we built the RevAssurant online portal to enable coders to code only for services that are sufficiently documented, while also ensuring that all sufficiently documented services are coded for. It’s a doctor- and plan-tested tool that’s shown to improve both risk scores and patient care.

This paper outlines the challenges coders and documenters face; the impact of differing risk incentives on diagnosis, treatment, and coding, along with step-by-step guides to accurately performing each; and, finally, an in-depth look at the industry’s technology issues and how RevAssurant addresses them.

The Challenges

At an individual practice, the end coder (staff) and documenter (the physician) may not have the same risk incentives as the at-risk entity — in fact, they may have no risk at all. So it’s imperative that at-risk entities find a proper, accurate balance.

To do that, they’ll have to overcome these four challenges:

1. **Addressing all of the patient’s conditions and/or illnesses.** How can a provider who sees dozens of patients per day ensure that each patient gets all relevant conditions addressed, especially if they require multiple visits?

2. **Ensuring the code is justified.** Did the management, evaluation assessment, and treatment meet the appropriate criteria?
3. **Documenting properly.** Unfortunately, many electronic medical records (EMR) were built when current procedural terminology (CPT) coding and evaluation and management (E&M) procedures dominated the reimbursement landscape. Today, at-risk entities rely on ICD-10 coding. How can we bridge that gap?

4. **Catching and correcting inaccurate documentation.** When should the doctor be queried about services that were provided but not properly documented?
How RevAssurant Helps Plans and Providers

*Plans* can use RevAssurant to improve patient care, track and help their providers, and ensure accurate, compliant Centers for Medicare and Medicaid Services (CMS) submissions.

*Providers* can use RevAssurant in two ways:

- **To instantly, easily view existing conditions and identify follow up items.** RevAssurant puts the most relevant information for every patient visit directly into overworked doctors’ hands.

- **To identify potential new conditions.** Over a dozen proprietary algorithms give providers the information and insight to inquire about any new patient symptoms or conditions based on Rx data, lab tests, OTC reimbursements, etc.

### Diagnosing Conditions

In CMS terms, risk is the sum of mutually exclusive hierarchical condition categories (HCC) consisting of one or more diagnoses or ICD-10 codes. The CMS has determined which ICD-10 codes bear risk and to which HCC they are assigned. The first step is to properly diagnose the patients’ condition(s) and assign the proper ICD-10 codes.

**Establishing all diagnoses requires multiple strategies:**

- Diagnosis review from the prior calendar year.

- Medications review to ensure that the patients’ medications are consistent with those
diagnoses, and to identify possible additional diagnoses.

- Laboratory data review to identify abnormal values which would suggest a possible diagnosis.

- Imaging and testing to identify abnormal results that suggest possible diagnoses.

- Chart review by calendar year to identify diagnoses that might have been documented, but not coded.

- Chart review to look for orders, including medications, labs, and testing, that might suggest diagnoses. Since many medications, labs, and tests are never completed by patients, reviewing the orders is a critical process.

Assuming all appropriate diagnoses are identified, the next step is to address and treat them. This is true for all diagnoses, but it’s especially important for risk-adjusted diagnoses in order to prevent audit issues.
To be coded correctly, interventions and services must completely address a specific illness or condition during a specific visit. Providers need to perform these fundamental services each time they see a patient:

- **Monitor.** Speak to the patient about signs and symptoms of the disease since their last visit. Ask how they feel and inquiring about any new, increased, or decreased symptoms. Successful monitoring often combines a history of present illness (HPI) and the review of systems (ROS), which are subjective measures.

- **Evaluate.** Perform a traditional physical exam and combine with lab and test results to get an objective measure of the disease.

- **Assess.** Use monitoring and evaluation results to assess the disease and determine its trajectory. Is it improving? Remaining stable? Worsening, or subject to new or unusual signs or symptoms? Merely stating the diagnosis is insufficient. By itself, “diabetes” is not an assessment; “diabetes, stable on meds,” is.

- **Treat.** Create a clear, specific, detailed treatment record. “Continue medications” is inadequate. “Continue Metformin 500 mg BID” is appropriate.

The diagnosis is often the only documentation in the chart even when other services are provided, but a diagnosis alone is insufficient to address the disease.
Documenting Services

Each of the fundamental services requires a specific approach to documentation.

**Monitoring:** Documentation starts with a history of present illness (HPI) — the patient’s explanation of their illness or condition. It’s not a chronology, but rather a patient’s perspective on how they’re doing, elicited by a physician’s questions. It should include symptoms and patient observations related to the chief complaint as well as a review of systems (ROS); follow up of the chief complaint should include follow up on these as well.

**Evaluation:** A physical exam, including the most prominent systems corresponding to the patient’s chief complaint(s) and any other necessary systems. It’s important to document pertinent positives and negatives related to the chief complaint or the reason for follow up; simply listing examinations with little or no comment isn’t sufficient basis for coding.

**Assessment:** Assessment can only be documented after a physician has performed and documented the monitoring and evaluation steps, and must go beyond a simple diagnosis to include the trajectory or pattern of the patient’s condition.

**Treatment:** Lastly, treatment must reflect the documentation above. Physicians often document worsening conditions without adjusting treatment. A worsening condition clearly requires an updated treatment regimen.

When all four steps are complete and documented, the medical record should withstand scrutiny and audit. If documented only reflects three steps, the record will likely pass an audit, but remains incomplete. Showing only two steps risks rejection; and one alone is simply inadequate.

**Coding for Diagnoses and Risk**

Poor or incomplete documentation forces coders to either guess if a diagnosis exists or omit it entirely. Complete, appropriate documentation makes coding for diagnoses simple.

The purpose of a risk adjustment solution is to ensure that coded diagnoses have the proper documentation.
Technology Issues — and How We Help

EMR technology simply hasn’t achieved a level of ICD-10 documentation and coding necessary to prevent overcoding and undercoding. Even more troubling, EMR technology doesn’t focus on education and training for overcoding and undercoding and is unable to identify ubiquitous documentation and coding problems.

EXF built a microservices-driven architecture which improves interoperability with providers, payers, and clinical research organizations (CRO).

![FHIR Processing Architecture for HealthCare Applications](image)

Our solution provides:
- Machine learning patterns that understand patient and provider data and interpret outliers

- Real-time data streaming from different sources to create a single source of truth for each member or patient

- A patient portal with a longitudinal view of claims, eligibility, EMR records, and related underlying information, enabling accurate risk assessment

- GraphDB, a tool which visualizes the impact of the events from a patient perspective

- Lightweight master data management tool to create a “golden copy” for members and providers

- Geocoding of members and providers, enabling location-based demographic analysis

- MongoDB’s data management platform, enabling record keeping and data exchange across formats

- Reporting and analytics portal

- The ability to optimize MongoDB via operations or cloud manager

- HIPAA-compliant data security

- Private network to securely house data in the cloud

Using the totality of this data, the RevAssurant online portal helps all providers to provide the best care for their patients while helping the plan to accurately bill CMS for the services they have already provided.
READY TO GET STARTED?
See how our technology solves your pain points.
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