# How to Stand Up an ACO Compliance Program with Auditing Metrics

HFMA/NEHIA Joint: 2023 Compliance & Internal Audit Conference

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# Presented by:

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- Stony Brook Medicine's first ACO Compliance Manager and Risk Adjustment Compliance Manager

# Disclaimer/Disclosure

The panelists have no relevant financial interests or conflicts to disclose. The information, statements, opinions, examples, and scenarios provided are exclusively those of the panelists and are not intended to describe any position of or at the entity or organization which they are affiliated with.

# Objectives

Appreciate How an Organization's Growth Can Result in a New Compliance Segment

Understand the Foundational Elements Needed to Implement New Workplan Items and Goals

Identify Key Stakeholders to Synthesize Engagement Across the Enterprise to Gain Buy-in and Support

Using Audit Results to Create KPIs and Performance Metrics

# Objective 1

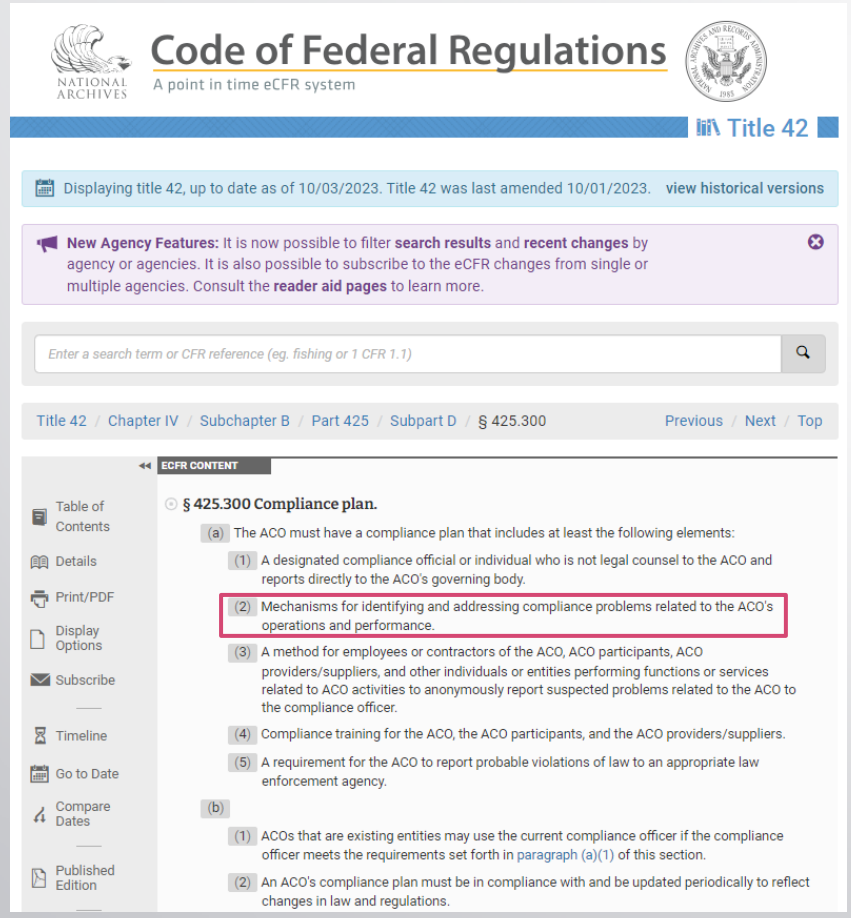
Appreciate How an Organization's Growth Can Result in a New Compliance Segment

# Stony Book Medicine's Accountable Care Organization

Stony Brook Medicine became a clinically integrated network (CIN) and an accountable care organization (ACO) on January 1st, 2020.

- Development began in 2018 spanning over two years to determine need, strategic and financial considerations, structure, operating model, and sustainability.
- Operationalization of network (i.e., governance, leadership, and operations), as well as engagement and education began in 2020.

# ACOs Require Their Own Compliance Program



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Title 42

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**§ 425.300 Compliance plan.**

(a) The ACO must have a compliance plan that includes at least the following elements:

(1) A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body.

(2) Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance.

(3) A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the compliance officer.

(4) Compliance training for the ACO, the ACO participants, and the ACO providers/suppliers.

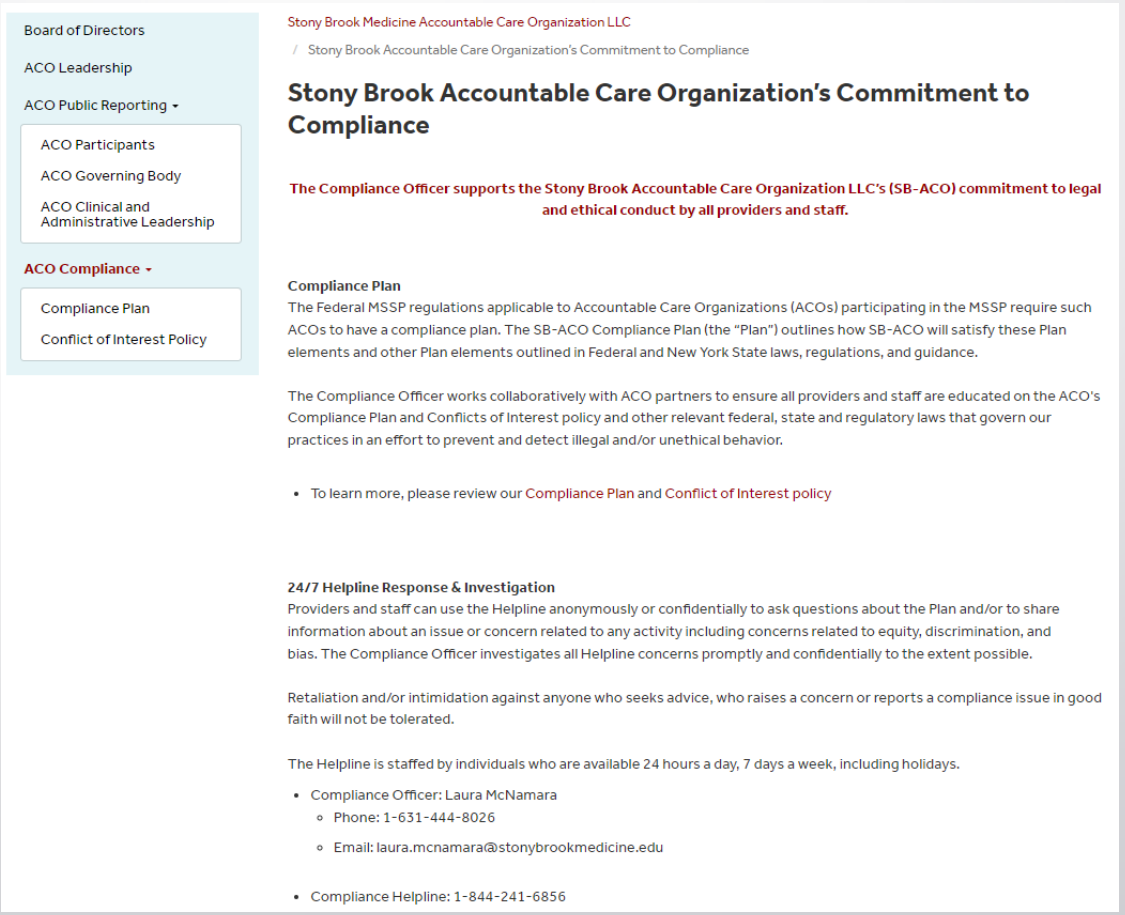
(5) A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

(b)

(1) ACOs that are existing entities may use the current compliance officer if the compliance officer meets the requirements set forth in paragraph (a)(1) of this section.

(2) An ACO's compliance plan must be in compliance with and be updated periodically to reflect changes in law and regulations.

Source: 42 CFR 425.300



Board of Directors
ACO Leadership
ACO Public Reporting
ACO Participants
ACO Governing Body
ACO Clinical and Administrative Leadership
ACO Compliance
Compliance Plan
Conflict of Interest Policy

Stony Brook Medicine Accountable Care Organization LLC

Stony Brook Accountable Care Organization's Commitment to Compliance

## Stony Brook Accountable Care Organization's Commitment to Compliance

**The Compliance Officer supports the Stony Brook Accountable Care Organization LLC's (SB-ACO) commitment to legal and ethical conduct by all providers and staff.**

**Compliance Plan**

The Federal MSSP regulations applicable to Accountable Care Organizations (ACOs) participating in the MSSP require such ACOs to have a compliance plan. The SB-ACO Compliance Plan (the "Plan") outlines how SB-ACO will satisfy these Plan elements and other Plan elements outlined in Federal and New York State laws, regulations, and guidance.

The Compliance Officer works collaboratively with ACO partners to ensure all providers and staff are educated on the ACO's Compliance Plan and Conflicts of Interest policy and other relevant federal, state and regulatory laws that govern our practices in an effort to prevent and detect illegal and/or unethical behavior.

- To learn more, please review our Compliance Plan and Conflict of Interest policy

**24/7 Helpline Response & Investigation**

Providers and staff can use the Helpline anonymously or confidentially to ask questions about the Plan and/or to share information about an issue or concern related to any activity including concerns related to equity, discrimination, and bias. The Compliance Officer investigates all Helpline concerns promptly and confidentially to the extent possible.

Retaliation and/or intimidation against anyone who seeks advice, who raises a concern or reports a compliance issue in good faith will not be tolerated.

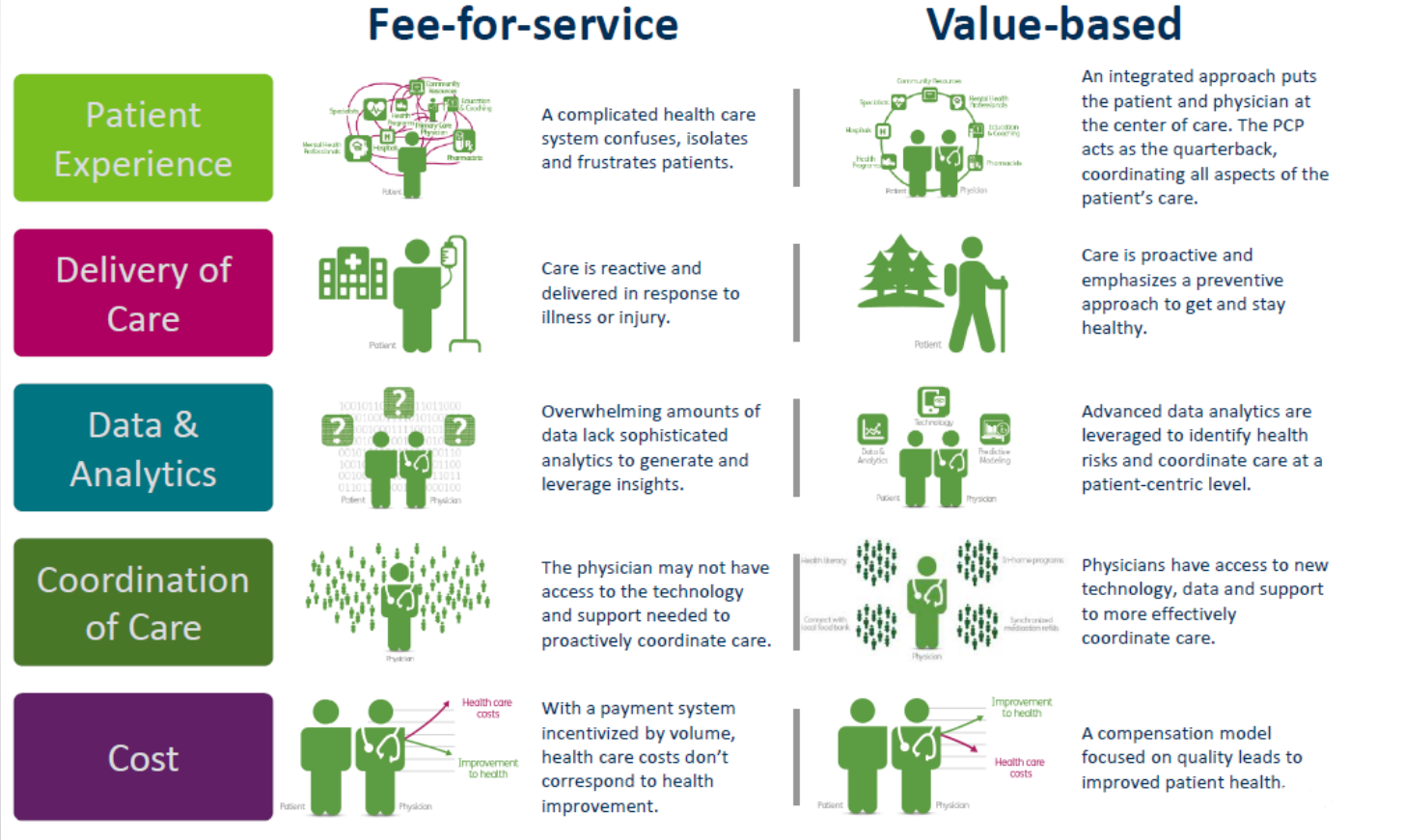
The Helpline is staffed by individuals who are available 24 hours a day, 7 days a week, including holidays.

- Compliance Officer: Laura McNamara
  - Phone: 1-631-444-8026
  - Email: laura.mcnamara@stonybrookmedicine.edu
- Compliance Helpline: 1-844-241-6856

Source: Stony Brook Accountable Care Organization, LLC

# A Primer: Value Based Care, Risk Adjustment Factor Scoring, and Hierarchical Condition Categories

- Historically, U.S. healthcare providers have been reimbursed on a fee-for-service (FFS) basis. However, the health care payment system is rapidly evolving.
- We are seeing a shift towards value-based care (VBC), an alternative form of reimbursement that ties payments to quality with rewards for effectiveness and efficiency.
- Value-based care aims to provide better care for individuals, improve population health, and reduce healthcare costs.




Field, C. & Riley, C. (2021, September 13-14). *Value-Based Care* [Conference session]. AAPC RISKCON 2021, United States.

# Accountable Care Organizations

As defined by the Centers for Medicare and Medicaid Services (CMS),
**"ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients."**

- Originally designed by CMS to help providers ensure patients get the right care at the right time, prevent duplicative, unnecessary services, and reduce medical errors.
- In 2012, the Affordable Care Act (ACA) established the Medicare Shared Savings Program (MSSP) to further encourage the development of ACOs.
- The MSSP offers providers and suppliers an opportunity to create an ACO and, in doing so, agree to be held accountable for the quality, cost, and experience of care of an assigned Medicare FFS beneficiary population.
- Shared savings vs. shared loss:
    - If an ACO can meet quality benchmarks and keep spending for their attributed patients below budget, they share in the resulting savings. However, there is also a shared risk of being penalized if they are unable to.

# Risk Adjustment

As part of the ACA, effective January 1st, 2014, insurers were no longer able to deny coverage or charge higher premiums based on preexisting conditions.

To avoid negative effects and adverse selection, three provisions were instated: risk adjustment, reinsurance, and risk corridors.


**Risk adjustment (RA)** is an annual process in which health plans are compensated for the costs associated with taking on members with chronic health conditions, thereby protecting the insurer against losses due to patients who are high-risk, high-cost.

Funds are transferred from plans with lower-risk enrollees to plans with higher-risk enrollees.

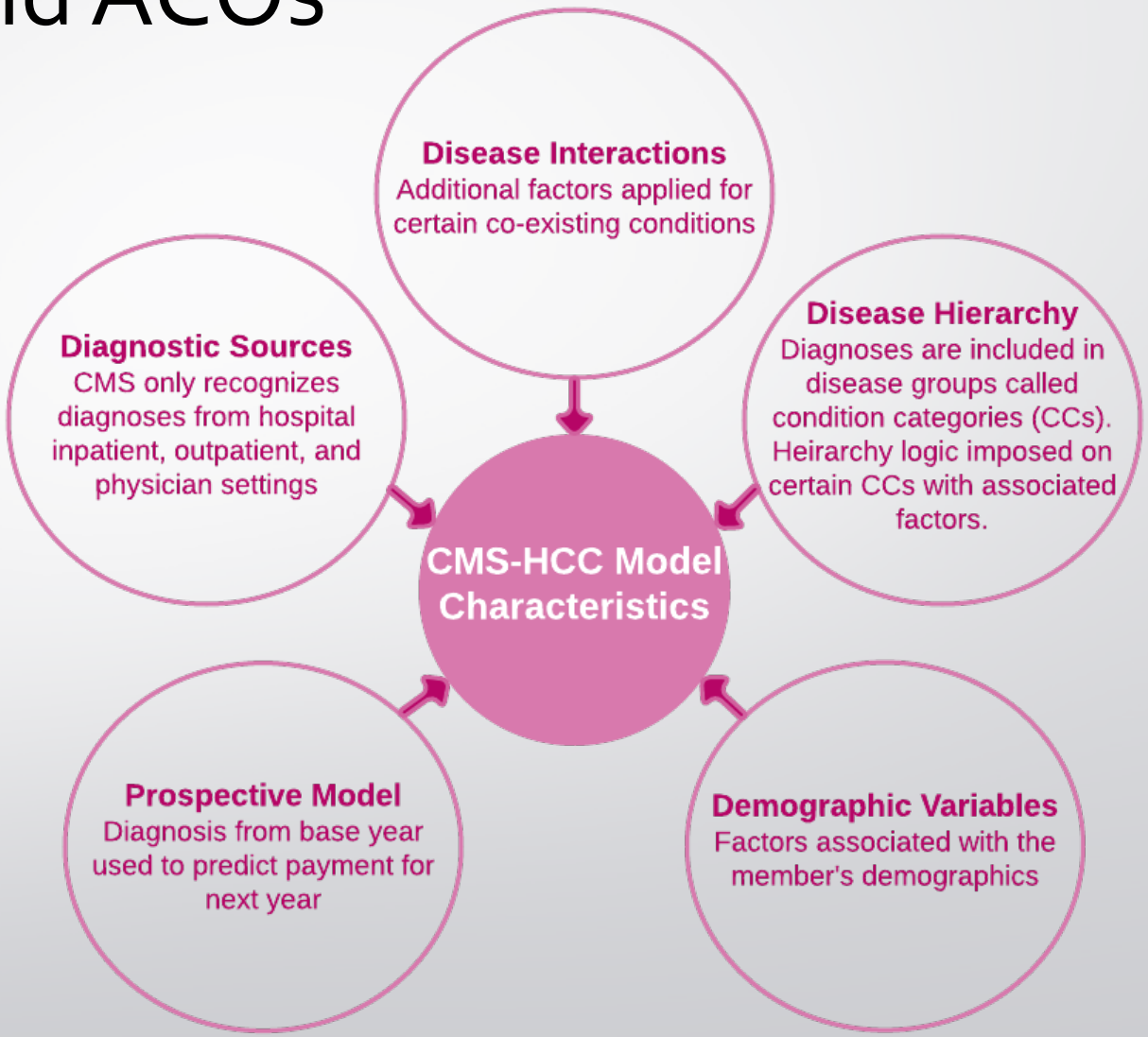
# RA and ACOs

**How is this applicable to ACOs?**

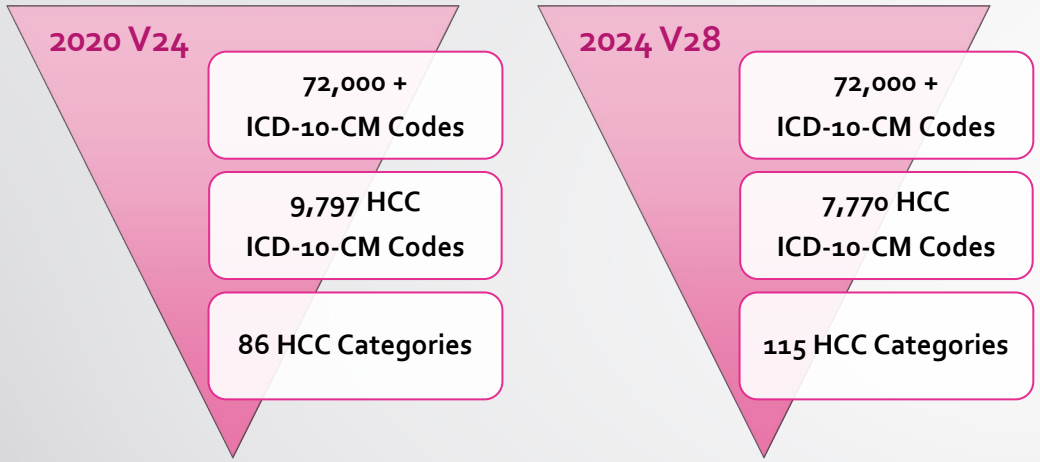
- Shared savings (through the MSSP) are based on the severity of illness and expenditures.
- Severity and expenditures are captured through the use of hierarchical condition category (HCC) codes that factor into a risk adjustment factor (RAF) score.

The CMS-HCC model is a prospective risk-adjustment tool implemented by CMS to estimate future expenditures for Medicare beneficiaries.

The model calculates expenditure benchmarks for MSSP ACOs.



# Hierarchical Condition Categories




**Hierarchical condition categories (HCCs) are groups of diagnosis codes that are categorized into a disease hierarchy.**

These groups of diagnoses consume similar resources, known as a clinical disease burden, which are grouped into the disease hierarchies.

**Not all diagnoses have HCC categories!**

- That doesn't mean, though, that you're not going to put them on your claims, only that they don't factor into patients' RAF scores.
- Diagnoses that don't get included in mapping are those that don't predict future cost.

**Example:** Long-term conditions such as diabetes, along with others will "risk adjust", or fall within an HCC; whereas acute illnesses and injuries will not because acute conditions are not likely predictive of ongoing healthcare costs.

# Documenting HCCs

**Physicians must provide a robust health status for every patient. Document accurately, thoroughly, and to the highest level of specificity.**

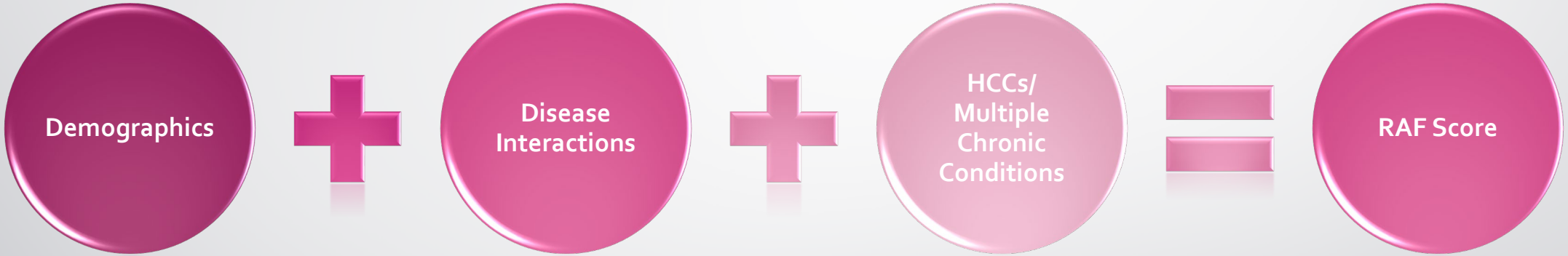
**According to the ICD-10 guidelines,** a diagnosis must be based on a clinical medical record documentation from a face-to-face encounter, documented at least once per year, and coded to be factored into the risk adjustment.

| Common HCCs |
| --- |
| • Major Depressive and Bipolar Disorders |
| • Morbid Obesity |
| • Asthma and Pulmonary Disease |
| • Diabetes |
| • Specified Heart Arrhythmias |
| • Congestive Heart Failure |
| • Hip Fracture |

- Lookout for chronic and acute conditions that predict high future costs (i.e., cancer, heart disease, HIV, etc.)
- It's important to map chronic conditions like COPD, CHF, amputation, and diabetic neuropathy as these require long-term care and could complicate routine illnesses.
- Data mining is used to determine the top HCCs captured. This information can be benchmarked to identify common HCC trends.

# Risk Adjustment Factor

**The Risk Adjustment Factor (RAF) is a relative measure of probable costs to meet the healthcare needs of the individual beneficiary.**




| How RAF Affects Providers |
| --- |
| Providers will treat patients on plans funded through RAF models |
| Plans expect providers to document and code diagnoses correctly |
| Provider documentation and coding establishes the complexity and workload of patient panels |
| Documentation and diagnoses become the basis for funding and reimbursement |

# How Diagnosis Documentation Affects Scoring

**CMS suggests that a RAF score of 1.00 is a reflection of the average senior who is generally healthy.** RAF scores above 1.00 suggest a patient has a chronic condition. Lower RAF scores indicate a healthier population.

| No Conditions Coded | |
|---|---|
| Female, 73, FB Dual, aged | **0.519** |
| HCCs | |
| | |
| | |
| Note: Full benefit dial (FB Dual) eligible are those who are eligible for full Medicaid benefits under title XIX of the SSA | |
| **RAF = 0.519** | |

| Some Conditions Coded | |
|---|---|
| Female, 73, FB Dual, aged | **0.519** |
| HCCs | |
| HCC 19 – Diabetes w/o Complication | **0.107** |
| HCC 22 – Morbid Obesity | **0.383** |
| | |
| | |
| | |
| **RAF = 1.009** | |

| All Conditions Coded | |
|---|---|
| Female, 73, FB Dual, aged | **0.519** |
| HCCs | |
| HCC 18 – Diabetes w/ Chronic Complication | **0.340** |
| HCC 85 – Congestive Heart Failure | **0.371** |
| HCC 22 – Morbid Obesity | **0.383** |
| HCC 189 – Amputation Status | **0.795** |
| | |
| **RAF = 2.408** | |

*Source: 2nd Edition Risk Adjustment Documentation & Coding Publisher: American Medical Association - For illustrative purposes only*

**Lower RAF scores may be a reflection of incomplete or inaccurate coding!**

# Master Documentation Basics with M.E.A.T.

| M.E.A.T. |
| --- |
| **Monitored or Managed** signs/symptoms, disease progression/regression |
| **Evaluated** test review, response to treatment |
| **Assessed** tests ordered, record review, counseling, discussing |
| **Treated** medications, therapies, other modalities |

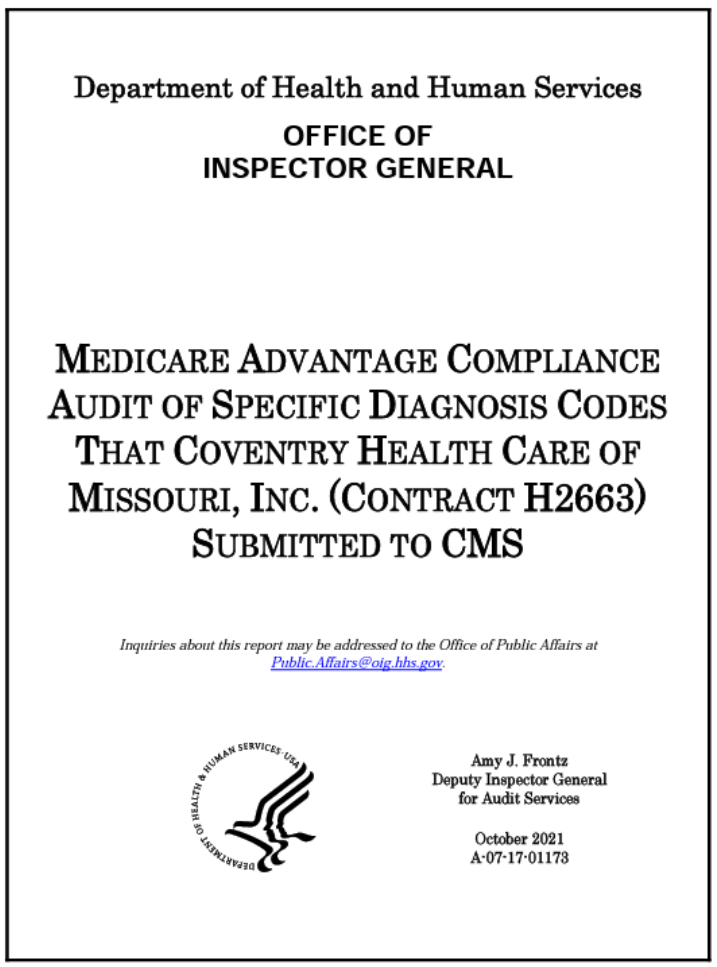
**M.E.A.T. is a mnemonic device designed to help providers and coders capture accurate documentation.**

Providers must capture all of the items specified in M.E.A.T. to document accurately and thoroughly.

**Tips:**

1. Document chronic conditions at least once annually
2. Such conditions should involve aspects of M.E.A.T.
3. Note the severity or stage of the condition and document any complications or associated conditions
4. Document all conditions, including co-existing conditions that affect treatment or management of a patient

# OIG Activity



Department of Health and Human Services

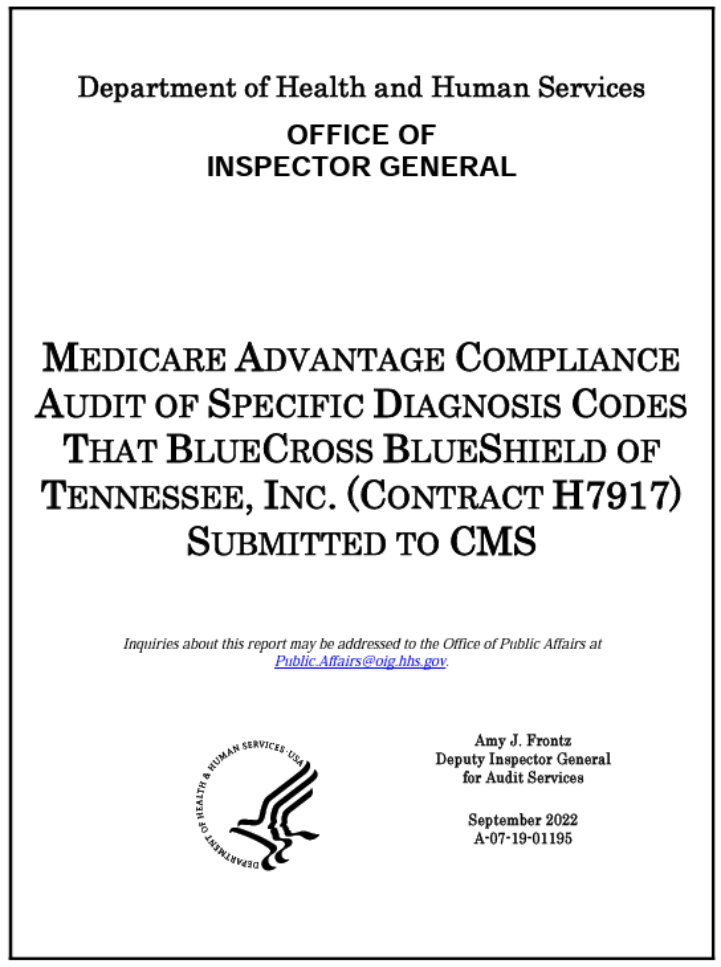
OFFICE OF
INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT COVENTRY HEALTH CARE OF MISSOURI, INC. (CONTRACT H2663) SUBMITTED TO CMS

*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Amy J. Frontz
Deputy Inspector General
for Audit Services

October 2021
A-07-17-01173



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

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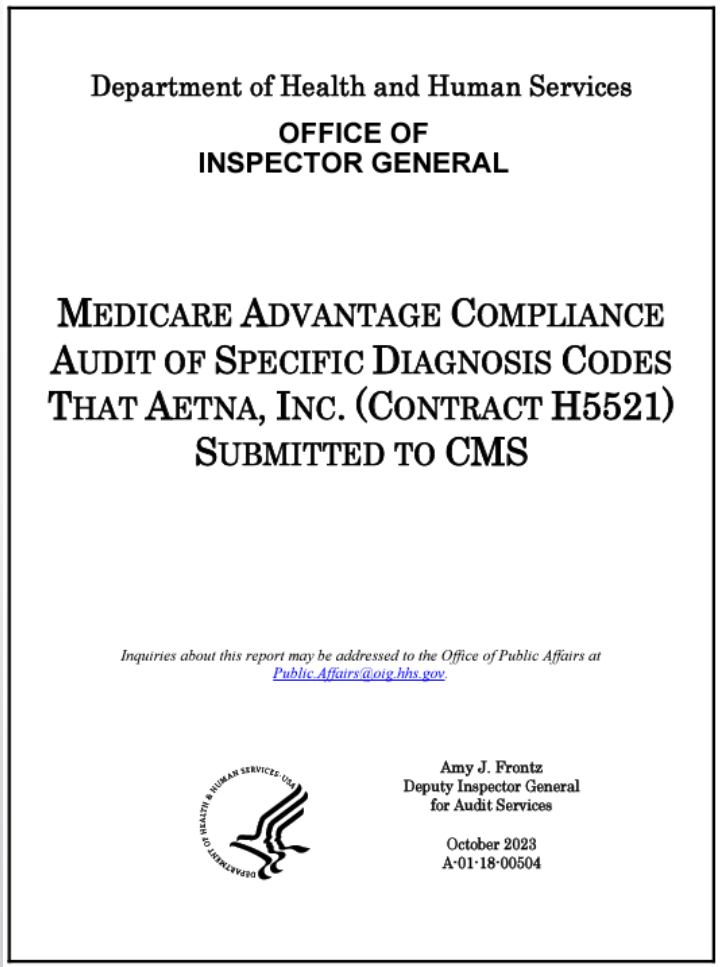
*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

Amy J. Frontz
Deputy Inspector General
for Audit Services

September 2022
A-07-19-01195



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*Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.*

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Deputy Inspector General
for Audit Services

October 2023
A-01-18-00504

# Objective 2

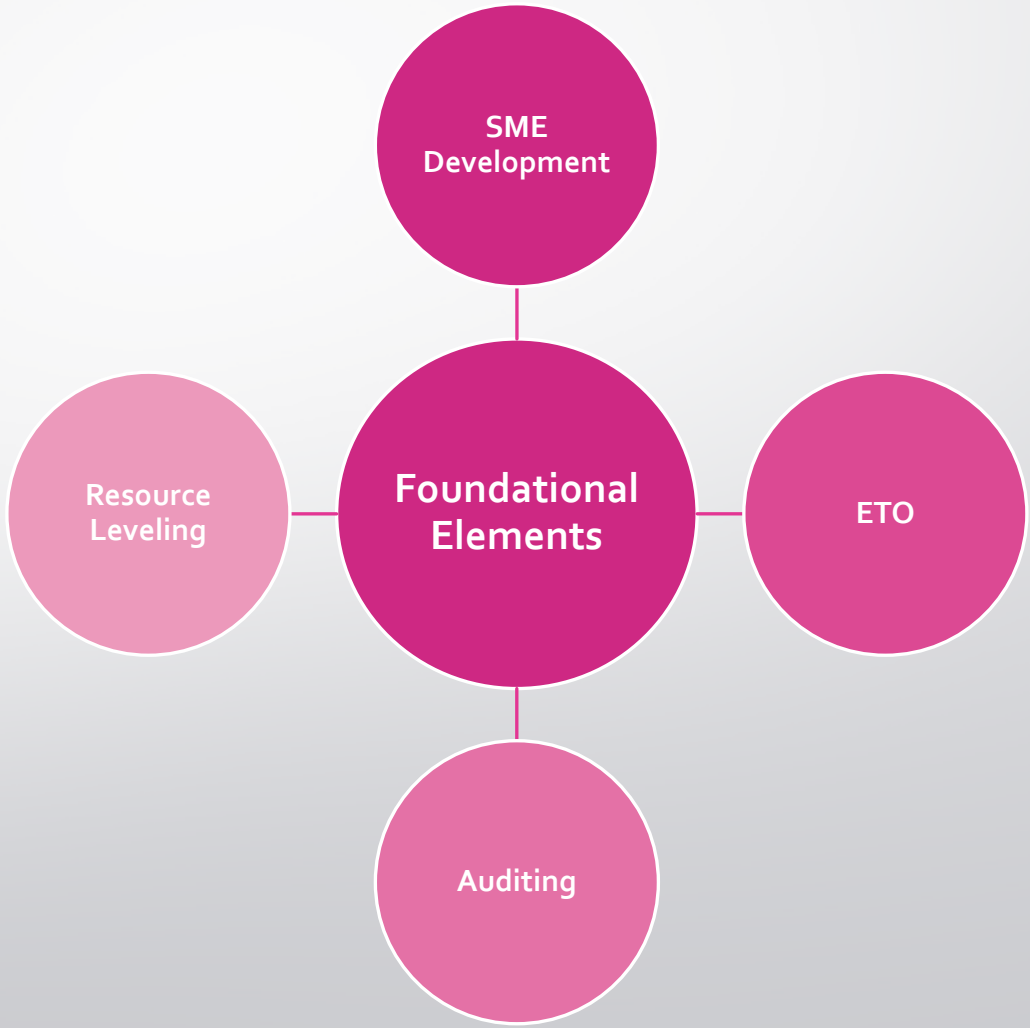
Understand the Foundational Elements Needed to Implement

New Workplan Items and Goals

# Incorporating Risk Adjustment Into an Existing Program

Needed to determine:

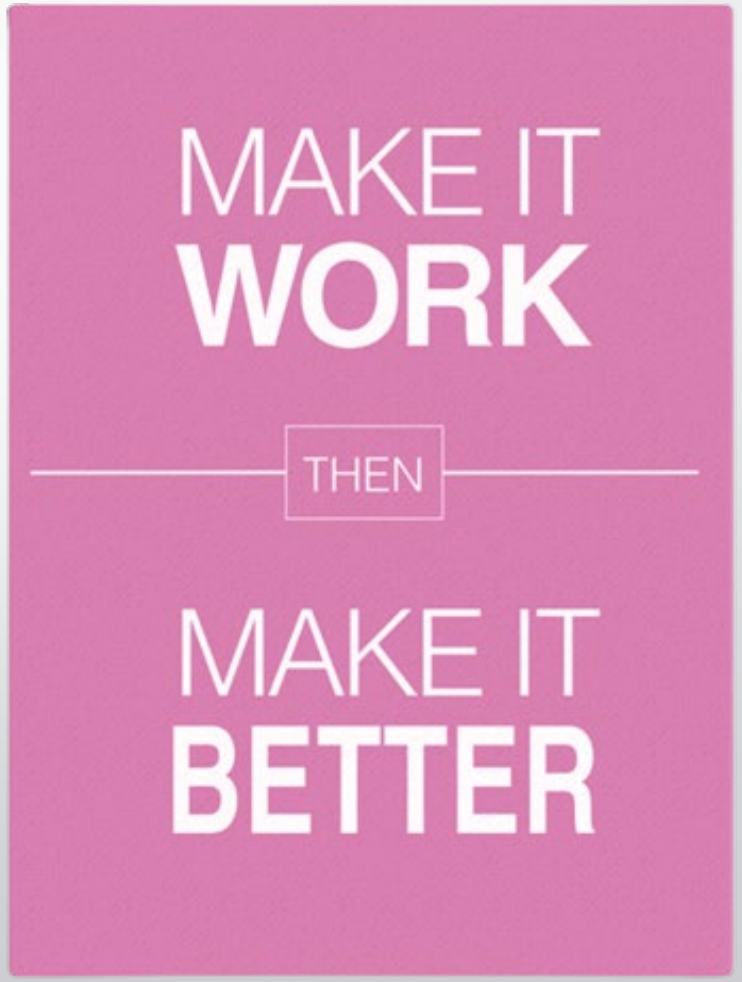
- How to quickly train staff to become HCC subject matter experts (SMEs)
- Identify programmatic areas where RA could be introduced
- If adding RA to our workplan would cause a reduction or elimination of work in other risk areas



# Years 1-3

## We were able to:

- Create a Risk Adjustment Compliance Manager (RACM) position to oversee ACO compliance operations
- Send employees to RA coding boot camps provided by the AAPC
- Provide resources to the RACM to perform a HCC review project for ACO leadership
- Incorporate RAF/HCC content into a mandatory billing compliance training initiative
- Revise New Provider Training to include RAF/HCC content
- Incorporate ACO-specific items into FY22-23 and FY 23-24 work plans



# CPMP Compliance Department's ACO-Related Workplan Items FY 23-24

**SB Clinical Practice Management Plan**
**Compliance Workplan Fiscal Year 2023/2024**

## Auditing

| | Title/Topic | Description with Reference | Schedule |
|---|---|---|---|
| 1 | New Provider Billing Compliance | Ten (10) encounter prospective review of all billable services within 60 days of New Provider Billing Compliance Training to ensure that the billing/claims being submitted are proper and that appropriate and correct payments are being received. Review to also include notation of any Diagnosis (Dx) coding that links to a Hierarchical Condition Category (HCC), impacting patient Risk Adjustment Factor (RAF) scoring to ensure documentation to the highest level of specificity for certain newly hired providers. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |
| 2 | Routine Provider E/M Billing Compliance | Ten (10) encounter prospective review of all billable services of certain established providers to ensure that the billing/claims being submitted are proper and that appropriate and correct payments are being received. Review to also include notation of any Diagnosis (Dx) coding that links to a Hierarchical Condition Category (HCC), impacting patient Risk Adjustment Factor (RAF) scoring to ensure documentation to the highest level of specificity for certain established providers. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |

## Monitoring

| | Title/Topic | Description | Schedule |
|---|---|---|---|
| 3 | Risk Adjustment Factor (RAF) Scoring, Hierarchical Condition Category (HCC) Coding, and Risk Adjustment Data Validation (RADV) | Continue monitoring OIG, MA, and other RADV activity to ensure effective RAF/HCC education and audit methodology. Additionally, under the guidance of the CIN's Medical Director, all RAF/HCC ETO is to be monitored and reported to CIN leadership when requested to ensure clinician attention and engagement to SB-ACO RAF/HCC initiatives. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |
| 6 | On-site Signage Checks | Ensure Compliance Helpline Posters are posted in breakrooms. Identify ACO Beneficiary notices appropriately placed in certain patient waiting areas. Project partnership with HIPAA/Privacy PHI audit (see Auditing #6). **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Q1 |

## Education,Training and Outreach

| | Title/Topic | Description | Schedule |
|---|---|---|---|
| 1 | New Provider Billing Compliance and HIPAA/Privacy Training | An important part of our Compliance Program is compliance training and education. Providers who bill for Evaluation and Management (E/M) services are given this training within 30 days of hire. Curriculum is curated and assigned by services provided. It will also include the importance of Diagnosis (Dx) coding and Hierarchical Condition Category (HCC) codes which impact patient Risk Adjustment Factor (RAF) scoring. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |
| 2 | Existing Provider E/M Billing Compliance Refresher Training | Our goal is for all billing providers to receive Evaluation and Management (E/M) services billing compliance refresher training every three (3) years in order to ensure that the billing/claims being submitted are proper and that appropriate and correct payments are being received. Curriculum is curated and assigned by services provided. It will also include the importance of Diagnosis (Dx) coding and Hierarchical Condition Category (HCC) codes which impact patient Risk Adjustment Factor (RAF) scoring. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |
| 5 | Specialized/Periodic Training to Include but is not Limited to:<br>* Compliance and Ethics Week<br>* Quarterly compliance e-brief<br>* RAF/HCC<br>*HIPAA/Privacy<br>* Ad-hocfrequested ETO | Training and education programs may consist of oral presentations, PowerPoint presentations, written policies and procedures, informational handouts, newsletters, mailings, training seminars, individual meetings, or other appropriate means. **Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Quartlery / Ongoing |

## Standards, Policies and Procedures

| | Title/Topic | Description | Schedule |
|---|---|---|---|
| 1 | Annual review and assessment of the Code of Conduct, Compliance Structure and Guidelines, Program Polices and Procedeures, SB-ACO Compliance Plan, and SB-ACO Policies and Procedures | The Code of Conduct and SB-ACO Compliance Plan sets forth the general standards of conduct to which all Personnel employed by or associated with the Practice Plan and ACO must adhere. The Compliance Program Structure and Guidelines set forth the structure of the Practice Plan's Compliance Program and describes its day-to-day operation. **Reference:** CPMP Compliance Manual: Reporting Requirements, Code of Conduct, Compliance Program Structure and Guidelines | Q2-Q3 |

# Objective 3

Identify Key Stakeholders to Synthesize Engagement Across the Enterprise to Gain Buy-in and Support

# Analysis and Assessment

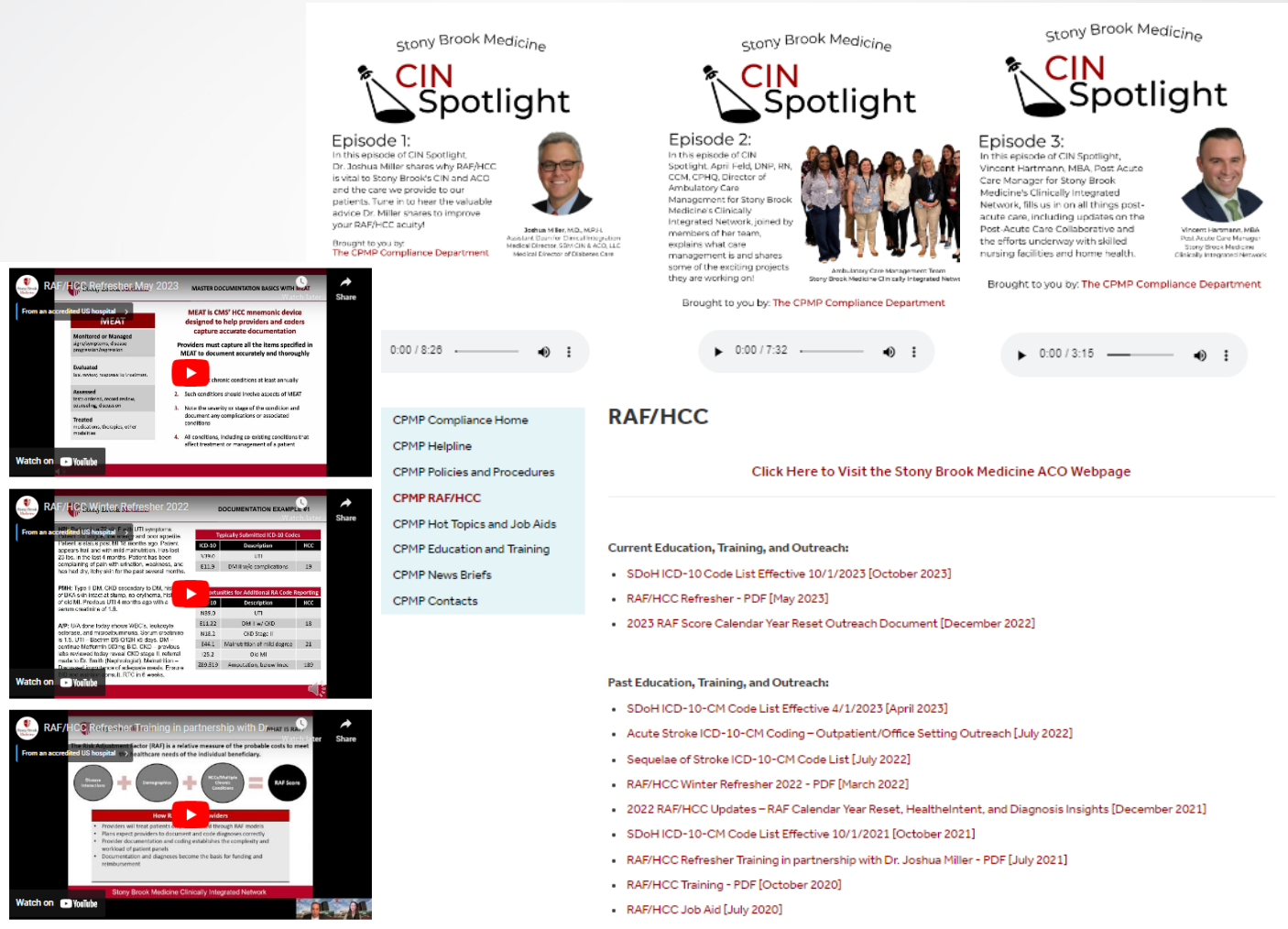
Needed to understand:

- Key organizational groups/leaders and how they can support our work
- The overall RAF/HCC mission and strategy for SBM's CIN/ACO
- Clinicians adoption of best documentation and coding practices
- Risk Adjustment regulatory scrutiny

# Years 1-3

## We were able to:

- Develop multiple job aids to introduce clinicians to RAF/HCC
- Perform HCC review project for ACO leadership
- Perform "road show" training and incorporate an abbreviated version as part of the mandatory billing compliance training initiative
- Record educational videos including one with the CIN's Medical Director
- Create a podcast to bring attention to and support the CIN and ACO
- Deploy outreach documents such as correct ICD-10-CM coding of acute strokes (I11.9) in the outpatient setting to mitigate risk



# ACO Performance Results

## First Agreement Period

### Performance Year 2020

**Shared Savings: $4,046,851.00**

- Proportion invested in infrastructure: 50%
- Proportion invested in redesigned care processes/resources: 0%
- Proportion of distribution to ACO participants: 50%

### Performance Year 2021

**Shared Savings: $0**

- Proportion invested in infrastructure: N/A
- Proportion invested in redesigned care processes/resources: N/A
- Proportion of distribution to ACO participants: N/A

### Performance Year 2022

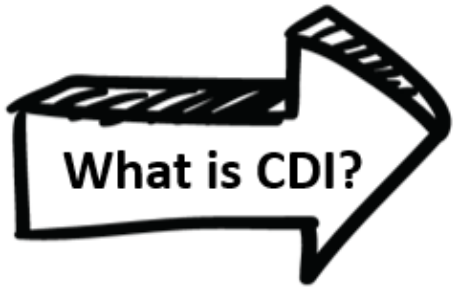
**Shared Savings: $5,206,292.81**

- Proportion invested in infrastructure: 50%
- Proportion invested in redesigned care processes/resources: 50%
- Proportion of distribution to ACO participants: N/A

# Our Push for Outpatient CDI

Stony Brook Medicine

**OUTPATIENT CDI PILOT PROGRAM RECOMMENDATION**

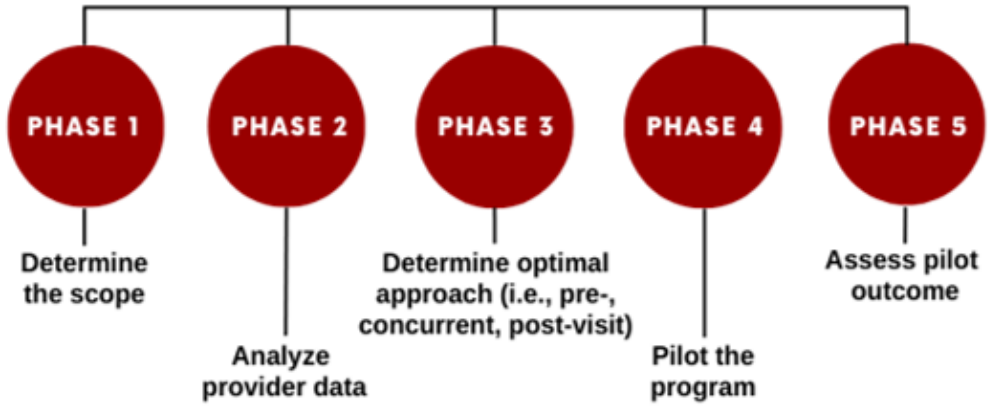



**Clinical Documentation Improvement**

- ✓ CDI programs ensure documentation completeness to reduce unsupported diagnoses, identify missed diagnoses, and capture appropriate HCCs through documentation review and provider queries
- ✓ Improves quality of care for patients, reduces denials, and reduces clinician burden

**Recommendation:**

Pilot outpatient CDI program with the Department of Medicine



# Objective 4

Using Audit Results to Create KPIs and Performance Metrics

# Audit Approach: Phase 1

## FY 2021-2022 Audit of Diagnoses That Map to a High-Risk HCC Category

**Purpose:** The CPMP Compliance Department will conduct Hierarch[illegible]ondition Category (HCC) audits, in line with recent Department of Health and Human Ser[illegible]ces Office of In[illegible]l (HHS-OIG) Compliance Audits of specific diagnosis codes submitted to CMS [illegible]sure the acc[illegible]l to CMS for the purpose of reimbursement as participants i[illegible]icare Sh[illegible](MSSP). Audits will validate whether diagnoses submitted for the[illegible] adju[illegible]d by medical record documentation to identify potential overpaymen[illegible]or educational purposes.

**Rationale:** Stony Brook Medicine Accountab[illegible]O), as participants in the MSSP, relies on risk adjustment to account for the sever[illegible]dicare Part B beneficiaries over a period of time and to set and track targets for performance[illegible]are Part B beneficiaries are assigned risk adjustment factor (RAF) scores, a numerical value base[illegible]s, diagnoses (HCCs), and disease interactions, which depict the predicted health costs compa[illegible]hy individual. CMS utilizes RAF scores when setting MSSP cost targets and savings rates.

To risk adjust, HCCs must b[illegible]ter annually through accurate, thorough, and specific documentation a[illegible]ician. Improperly, undocumented, or unsupported HCCs ma[illegible]over[illegible]

**Scope:** For FY 2021-2022, 250 HCC[illegible]sional cl[illegible]or new and established inpatient and outpatient CPT codes (i.e., 99221-99223, 99231-992[illegible]2-99205, a[illegible]99212-99215) will be audited for SB-ACO assigned Medicare Part B beneficiaries with a diagnos[illegible]hat maps to one of the following top five high-risk groups:

| High-Risk Group | HCC Mapping |
|---|---|
| 1. Acute Stroke | 100 |
| 2. Acute Heart Attack | 86, 87 |
| 3. Embolism | 107, 108 |
| 4. Vascular Claudication | 108 |
| 5. Major Depressive Disorder | 59 |

**Approach:** For FY 2021-2022, a retrospective audit report of University Faculty Practice Corporation (UFPC), Stony Brook Community Medical (SBCM), and Meeting House Lane Medical Practice (MHLMP) outpatient new/established (CPTs 99202-99205, 99212-99215) and inpatient initial/subsequent (CPTs 99221-99223, 99231-99233) claims for each of the top five high-risk groups will be created and then compared against the list of SB-ACO assigned Medicare Part B beneficiaries. Diagnoses that map to an HCC must be properly supported within the documentation, indicating the condition was either monitored/managed, assessed, evaluated, or treated. In order to meet timely filing requirements, if applicable, billing error correction (BEC) reports will be sent to the CPMP Revenue Cycle Department on a weekly basis. Upon completion, results will be reported to SB-ACO leadership for review and to determine and operationalize the dissemination of results and/or necessary follow-up.

# Audit Approach: Phase 2

## Audit of Diagnosis Codes from Medicare Annual Wellness Visits (AWVs) Performed by University Faculty Practice Corporation (UFPC) and Stony Brook Community Medical Community Medical (SBCM) Providers

**Purpose**: Medicare Annual Wellness Visits (AWVs) are an opportune time for clinicians to assess patients' conditions and capture all appropriate diagnoses, incl[illegible] responding t[illegible]rchical Condition Categories (HCCs). As part of our FY 2022-2023 workpla[illegible] MP Compli[illegible]e[illegible]ent will audit diagnosis codes submitted with Medicare AWVs. Audits will va[illegible] whether the medical [illegible] documentation supports the diagnoses submitted and/or whether diagnoses w[illegible]issing from the claim [illegible]o[illegible] have been captured. Audit findings will be used to identify gaps in medical r[illegible]rd documentation, co[illegible]illing[illegible]d educational purposes.

**Rationale**: Stony Brook Medicine Acc[illegible]tal[illegible]e Organizat[illegible]B-ACO), a[illegible] participant in the Medicare Shared Savings Program (MSSP), relies on [illegible]a[illegible] to acc[illegible]or the seve[illegible] of conditions of its attributed Medicare Part B beneficiaries over a perio[illegible]f ti[illegible]ack targets f[illegible]erformance. Attributed Medicare Part B beneficiaries are assigned ri[illegible]djustmen[illegible]F) scores, a[illegible]herical value based on demographics, diagnoses (HCCs), and diseas[illegible]eractions, w[illegible]epict the p[illegible]cted health costs compared to a generally healthy individual. Medicare ut[illegible] RAF scores w[illegible]en setti[illegible]SSP cost targets and savings rates.

To risk adjust, HCCs must be captured [illegible]e encounter annually through accurate, thorough, and specific documentation and diagnosis coding from a qualified clinician. Improper, undocumented, or unsupported HCCs may result in potential overpayments.

**Scope**: One hundred professional claims from providers who performed ten or more Medicare Annual Wellness Visits (AWVs) (G0438/G0439), excluding claims with an Evaluation and Management (E/M) service (modifier 25) on the claim for the date of service, within July and August 2022 with at least four or more diagnoses attached to the claim.

**Approach**: CPMP Compliance will work with the Revenue Cycle Department to generate a list of providers who billed Medicare AWVs during July and August of 2022 with the associated claim information. A randomized sample of one hundred (100) claims will be selected be sent to Pinnacle Enterprise Risk Consulting Services (PERCS), who will code each claim with the appropriate ICD-10-CM codes, identifying ICD-10-CM codes that map to an HCC. CPMP Compliance will then analyze against the billed diagnoses to identify discrepancies. Upon conclusion, a summary of findings will be reported to SB-ACO leadership.

# Audit Approach: Phase 3

## Audit of Diagnosis Codes from Medicare Annual Wellness Visits (AWVs) Performed by Meeting House Lane Medical Practice, PC, Clinicians

**Purpose:** Medicare Annual Wellness Visits (AWVs) are an opportune time for clinicians to assess patients' conditions and capture all appropriate diagnoses, including the corresponding Hierarchical Condition Categories (HCCs). As part of our FY 2022-2023 workplan, the MP Compliance Department will audit diagnosis codes submitted with Medicare AWVs. Audits will validate whether the medical record documentation supports the diagnoses submitted and/or whether diagnoses were missing from the claim that could have been captured. Audit findings will be used to identify gaps in medical record documentation, coding, billing and educational purposes.

**Rationale:** Stony Brook Medicine Accountable Care Organization (SB-ACO), as a participant in the Medicare Shared Savings Program (MSSP), relies on risk adjustment factors for the severity of conditions of its attributed Medicare Part B beneficiaries over a period of time and to track targets for performance. Attributed Medicare Part B beneficiaries are assigned risk adjustment factors (RAF) scores, a numerical value based on demographics, diagnoses (HCCs), and disease interactions, which depict the predicted health costs compared to a generally healthy individual. Medicare utilizes these scores when calculating MSSP cost targets and savings rates.

To risk adjust, HCCs must be captured from a face-to-face encounter annually through accurate, thorough, and specific documentation and diagnosis coding from a qualified clinician. Improper, undocumented, or unsupported HCCs may result in potential overpayments.

**Scope:** The scope is restricted to Medicare Annual Wellness Visits (AWVs, G0438/G0439) from the twenty-four (24) Meeting House Lane Medical Practice, PC (MHLMP) clinicians that have billed such services.

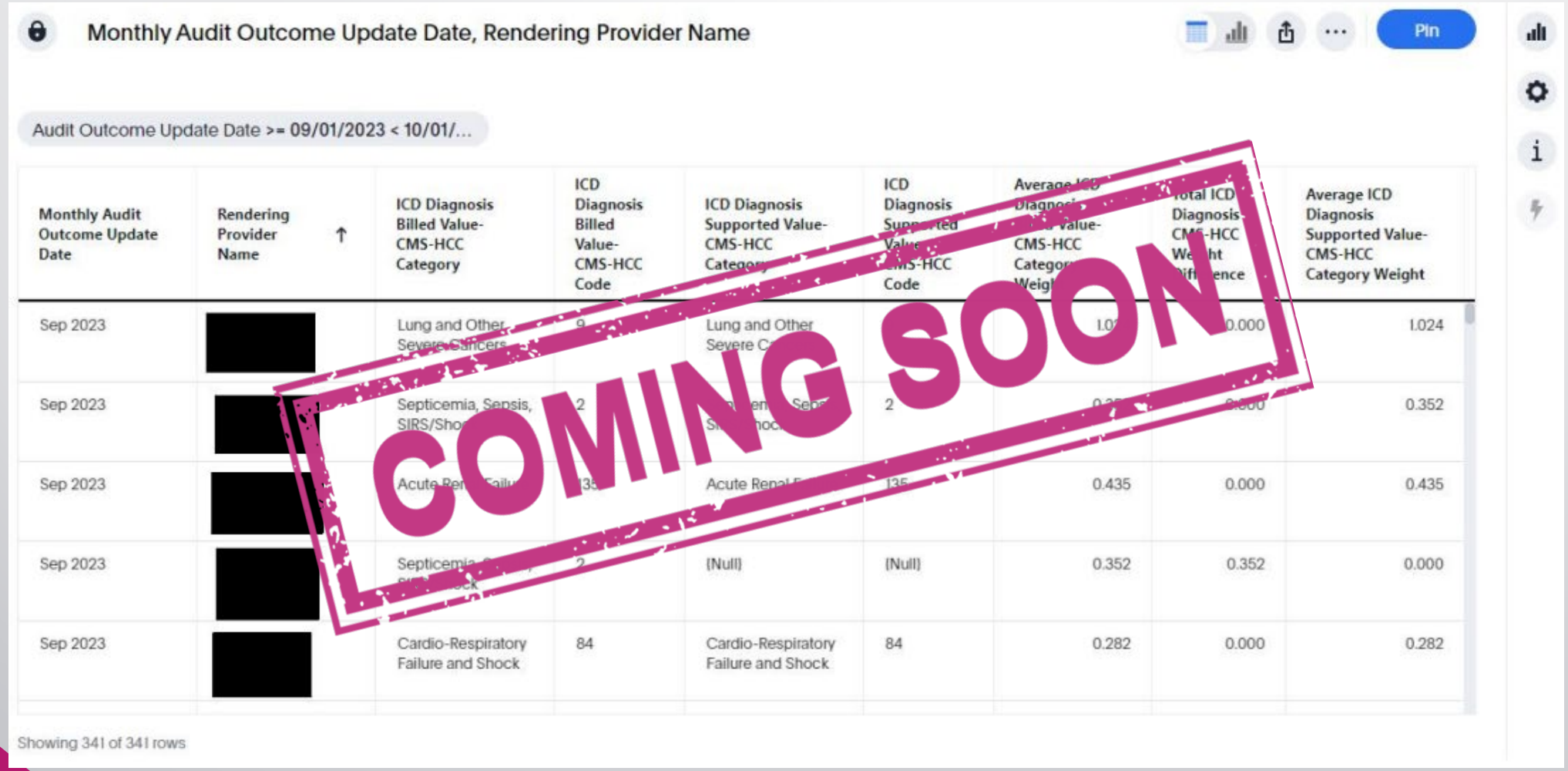
**Approach:** The CPMP Compliance Department will work with Dawn O'Sullivan, Charge Post Master with MHLMP, to generate a list of all clinicians who billed Medicare AWVs within the last six (6) months and the associated claim information. Five (5) encounters for each clinician will be selected for auditing purposes. The billed ICD-10-CM codes for each encounter will be audited against the medical record documentation for accuracy, with an emphasis on ICD-10-CM codes that map to an HCC. Upon conclusion, a summary of findings will be reported to SB-ACO leadership.

# Audit Approach: Current Phase

| SB Clinical Practice Management Plan<br>Compliance Workplan Fiscal Year 2023/2024 | | | |
|---|---|---|---|
| **Auditing** | | | |
| | **Title/Topic** | **Description with Reference** | **Schedule** |
| **1** | New Provider Billing Compliance | Ten (10) encounter prospective review of all billable services within 60 days of New Provider Billing Compliance Training to ensure that the billing/claims being submitted are proper and that appropriate and correct payments are being received. Review to also include notation of any Diagnosis (Dx) coding that links to a Hierarchical Condition Category (HCC), impacting patient Risk Adjustment Factor (RAF) scoring to ensure documentation to the highest level of specificity for certain newly hired providers. | Ongoing |
| **2** | Routine Provider E/M Billing Compliance | Ten (10) encounter prospective review of all billable services of certain established providers to ensure that the billing/claims being submitted are proper and that appropriate and correct payments are being received. Review to also include notation of any Diagnosis (Dx) coding that links to a Hierarchical Condition Category (HCC), impacting patient Risk Adjustment Factor (RAF) scoring to ensure documentation to the highest level of specificity for certain established providers.<br>**Reference:** SB-CPMP Policy: Compliance Monitoring, Risk Assessment and Training | Ongoing |

MDaudit

# MDaudit HCC Metrics




| Monthly Audit Outcome Update Date | Rendering Provider Name | ICD Diagnosis Billed Value-CMS-HCC Category | ICD Diagnosis Billed Value-CMS-HCC Code | ICD Diagnosis Supported Value-CMS-HCC Category | ICD Diagnosis Supported Value-CMS-HCC Code | Average ICD Diagnosis Billed Value-CMS-HCC Category Weight | Total ICD Diagnosis CMS-HCC Weight Difference | Average ICD Diagnosis Supported Value-CMS-HCC Category Weight |
|---|---|---|---|---|---|---|---|---|
| Sep 2023 | [redacted] | Lung and Other Severe Cancers | 9 | Lung and Other Severe C | | 1.0 | 0.000 | 1.024 |
| Sep 2023 | [redacted] | Septicemia, Sepsis, SIRS/Sho | 2 | Sep Sho | 2 | | | 0.352 |
| Sep 2023 | [redacted] | Acute Re Failu | 135 | Acute Renal F | 135 | 0.435 | 0.000 | 0.435 |
| Sep 2023 | [redacted] | Septicemia Sock | 2 | (Null) | (Null) | 0.352 | 0.352 | 0.000 |
| Sep 2023 | [redacted] | Cardio-Respiratory Failure and Shock | 84 | Cardio-Respiratory Failure and Shock | 84 | 0.282 | 0.000 | 0.282 |

# Key Takeaways and Wrap-up

- Organizations grow, and with that can come new compliance areas.
- Adoption and execution is a team effort.
- Education and engagement are essential.
- Implement new workplan items and goals using the same formula as the previous one.
- Socialize and champion to key stakeholders to help boost your culture of compliance.
- The proof is in the data!

Questions?

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