Future Proofing Your Risk Adjustment Strategy by Optimizing your Claims Data – Upfront

Presented By:

Michelle Mitchell, MHA, CRC, *Director of Risk Adjustment* – **Moda Health**

Carrie Murphy, *Director Payerpath Solutions* – **Veradigm**

Lanae Smithers, *Payerpath Sales Manager* – **Veradigm**

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Meet the Team

Michelle Mitchell MHA, CRC
Moda Health, Director of Risk Adjustment

Carrie Murphy
Veradigm Payerpath, Sr. Solutions Manager

Lanae Smithers
Veradigm Payerpath, Sales Manager

A G E N D A

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Payer Challenges

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Challenges in Risk Adjustment

Claims are the largest and most important data source for risk adjustment

If a claim is accepted for payment without a required element, the encounter may reject downstream for risk adjustment:

- Platforms for facility claim pricing do not check for required EDPS elements

  Example:

  Revenue code 0360 (operating room services) billed during an inpatient hospital stay but the claim lacked a required procedure code to identify the specific associated surgical procedure performed.

Challenges in Risk Adjustment

- Format of elements may pass claim system but not meet EDPS requirements

  Example:

  Institutional ambulance claims require a 9-digit pick-up location ZIP code to be reported as a value code. Electronic claims are being submitted with incorrect ZIP code format causing encounter to fail.

  CMS Requirement: XXXXXXX.XX format

  9753699.98

  Claims System: XXXXX.00

  97536.00

Challenges in Risk Adjustment

- Finding a balance between requirements needed for timely claims processing and accurate encounter data submissions
  - Member and provider experience
    - If claim edits are too restrictive, payments may be denied causing frustration for members and providers
    - If claim edits do not consider encounter submission rules, claims may need to be reprocessed due to EDPS rejections for missing or invalid required elements
    - Providers may not understand root-cause of reprocessing or denial
  - Encounter data compliance and risk scores
    - Increasing focus on accurate encounter data submissions

Pending Legislation

H.R. 5854: "Medicare Advantage Consumer Protection and Transparency Act"

Requires MA organizations to report supplemental plan benefits and at least 90% of encounter data accuracy. Failure to comply may result in payment reduction of 5% of the monthly amount.

https://www.congress.gov/bill/118th-congress/house-bill/5854/text

S. 1002: "No Unreasonable Payments, Coding, Or Diagnoses for the Elderly Act" or the "No UPCODE Act"

Requires 2 years of diagnostic data for risk adjustment methodology and would exclude diagnoses collected from chart reviews and health risk assessments.

https://www.congress.gov/bill/118th-congress/senate-bill/1002/text

S. 3307: "Encounter Data Enhancement Act"

Requires identifiers indicating provision of at-home health risk assessments and/or other locations.

https://www.congress.gov/bill/118th-congress/senate-bill/3307/text

Challenges in Risk Adjustment

- Different encounter data requirements for various lines of business
  - Medicare Advantage
  - ACA
  - Traditional Medicare
  - Other insurance
- Communication of updates to EDPS edits and EDGE requirements
  - Responsibility for educating providers of ongoing changes to encounter data requirements

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Risk Adjustment + Claims + IT + Provider Relations

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Risk Adjustment Department Collaboration

POLL:

What departments do you interact with?

A. IT Department
B. Claims Department
C. Provider Relations
D. All of the above
E. NONE!

Risk Adjustment Department Collaboration

Collaborate with other departments to achieve desired outcomes:

- Claims Department
  - Inform of changes to EDPS edits and EDGE rules that have an impact on processing
  - Consider adding claim validation requirements prior to payment to prevent cycles of reprocessing
  - Share information about common errors

Risk Adjustment Department Collaboration

Collaborate with other departments to achieve desired outcomes:

- IT Department
  - Work as a team to ensure data is being translated correctly before it is submitted

Risk Adjustment Department Collaboration

Collaborate with other departments to achieve desired outcomes:

- Provider Relations
  - Communications to providers regarding claim submission requirements
  - Outreach and education to providers with billing practices causing errors
    - Diagnosis codes missing required characters
    - Professional claims exceeding billing limits for EDPS reporting

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Clean Claims = Clean Payments

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Poll: Clean Claims

In your organization, who is responsible for encounter data submissions and error resolution?

A. Claims Department
B. Encounter Data Team
C. IT
D. Risk Adjustment
E. Outsourced to 3rd Party
F. It's a combination of above

The Difference Clean Claims Makes

The term clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare. (CMS Medicare Managed Care Manual)

- Is it truly a "clean claim" if the encounter rejects at CMS for a missing required element?
  - Claims and Risk Adjustment teams must be aligned

Claim examples – Are they “clean?”

- Anesthesia claims missing required modifier in first position
- Hospital claim missing Occurrence Code 55 and Date of Death when discharge status indicates expired
- Professional claim billed charges exceeding $99,999.99
- Professional claims billed with over 50 lines
- Claim lines with unnecessary modifier

Reduce Reprocessing Claims

What happens when a paid claim rejects in encounter data submission?

- Risk Adjustment team researches root cause of issue: Technical vs. Claims Processing
- Claims team is asked to reprocess claim to deny if missing required element
- Provider receives recoupment request and must resubmit corrected claim
- Claim is reprocessed to correct element and payment sent to provider
- Encounter is submitted to CMS for risk adjustment

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The Provider Journey

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Provider Journey

- Clinical Documentation/Coding
- Claim form preparation/submission
- Regulatory Data Submissions
- Patient/Member Impact?

Clinical Documentation/Coding

- Healthcare providers, whether they are hospitals, clinics, or individual practitioners, face the challenge of accurately documenting and coding the services they provide.
- Inaccurate coding or incomplete documentation can lead to claim denials, delayed payments, or even allegations of fraud, impacting their financial stability and ability to deliver quality care.
- Lack of certified medical coding staff

Claim Preparation

- Administrative burden

  Managing the administrative tasks associated with claims processing, such as verifying insurance coverage, submitting claims, and following up on denials or rejections, can be time-consuming and resource-intensive

- Reimbursement delays

  Providers often face delays in receiving payments due to various reasons such as claim errors, incomplete documentation, or insurance company reviews. These delays can affect their cash flow and financial stability.

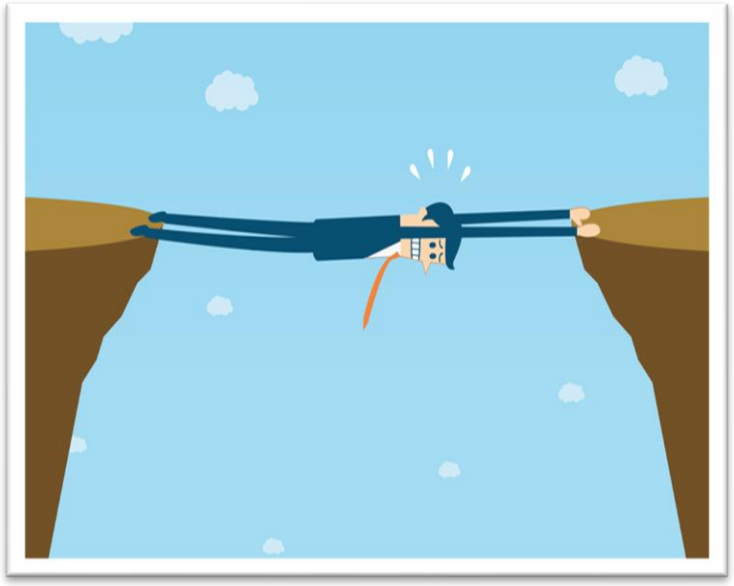
CMS Encounter Data Submissions

Claims paid by a health plan don't always mean they are clean enough to report.

A provider's claim is packaged up and sent on to the Submission Vendor. The vendor has data rules that are tailored and applicable for the regulatory program in which the member is enrolled.

During the data validation step, a provider's claim may be found to have an issue with the diagnosis code. The code is a valid diagnosis code, but not specific enough to pass all informational edits by CMS. According to CMS, the physician should have coded to the highest level of specificity.

The solution Bridges the Gap between Claims Payment and Submission Outcomes



- Many Payers can’t apply regulatory specific rules at the Program Level in their Claims Systems
- Veradigm believes the answer is to apply Regulatory Validation Rules between the Provider and the Payer

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What is an EDI Gateway?

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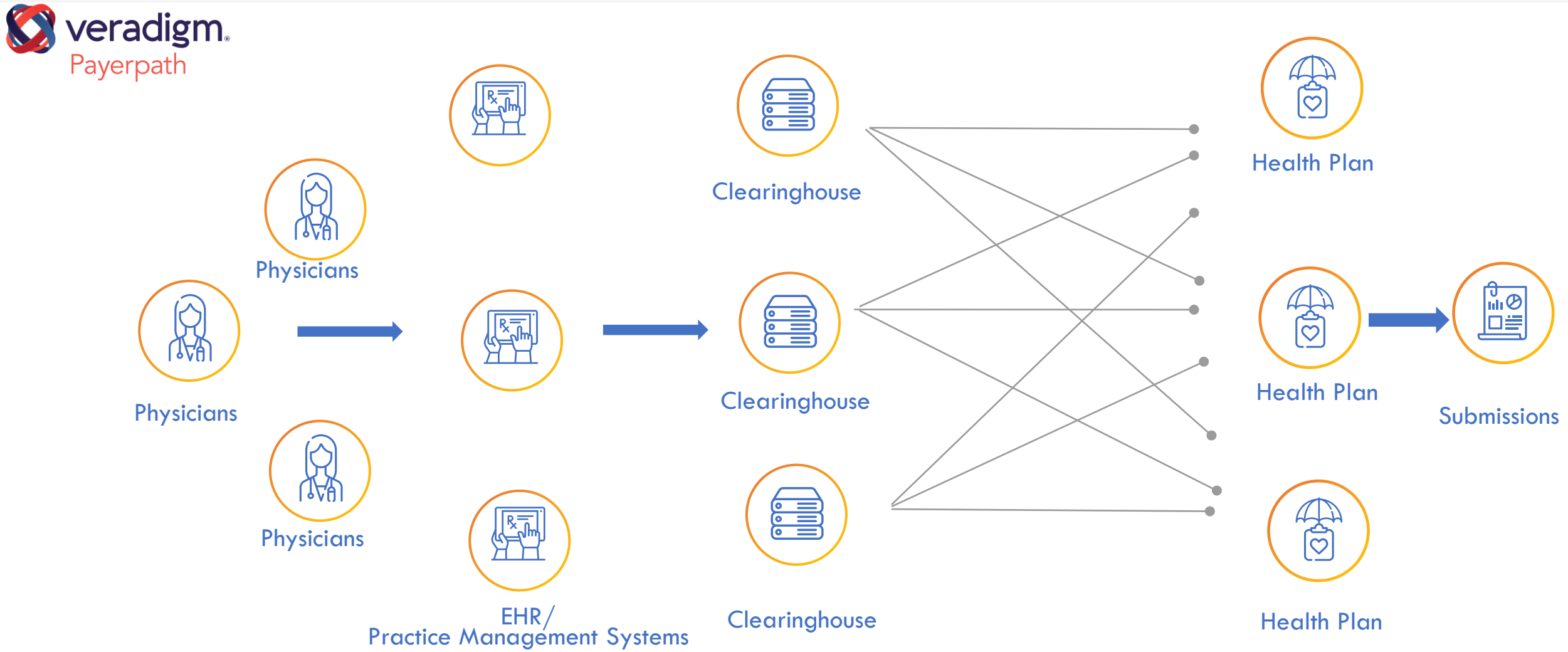
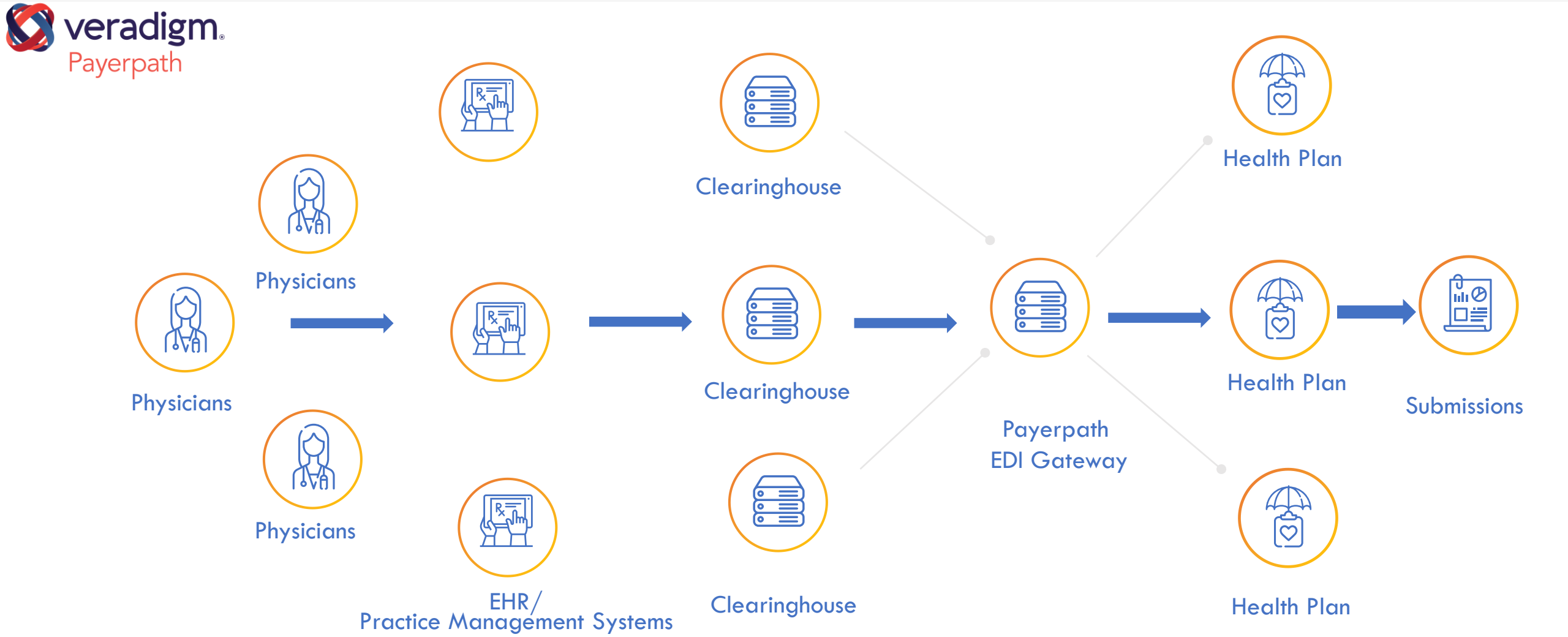
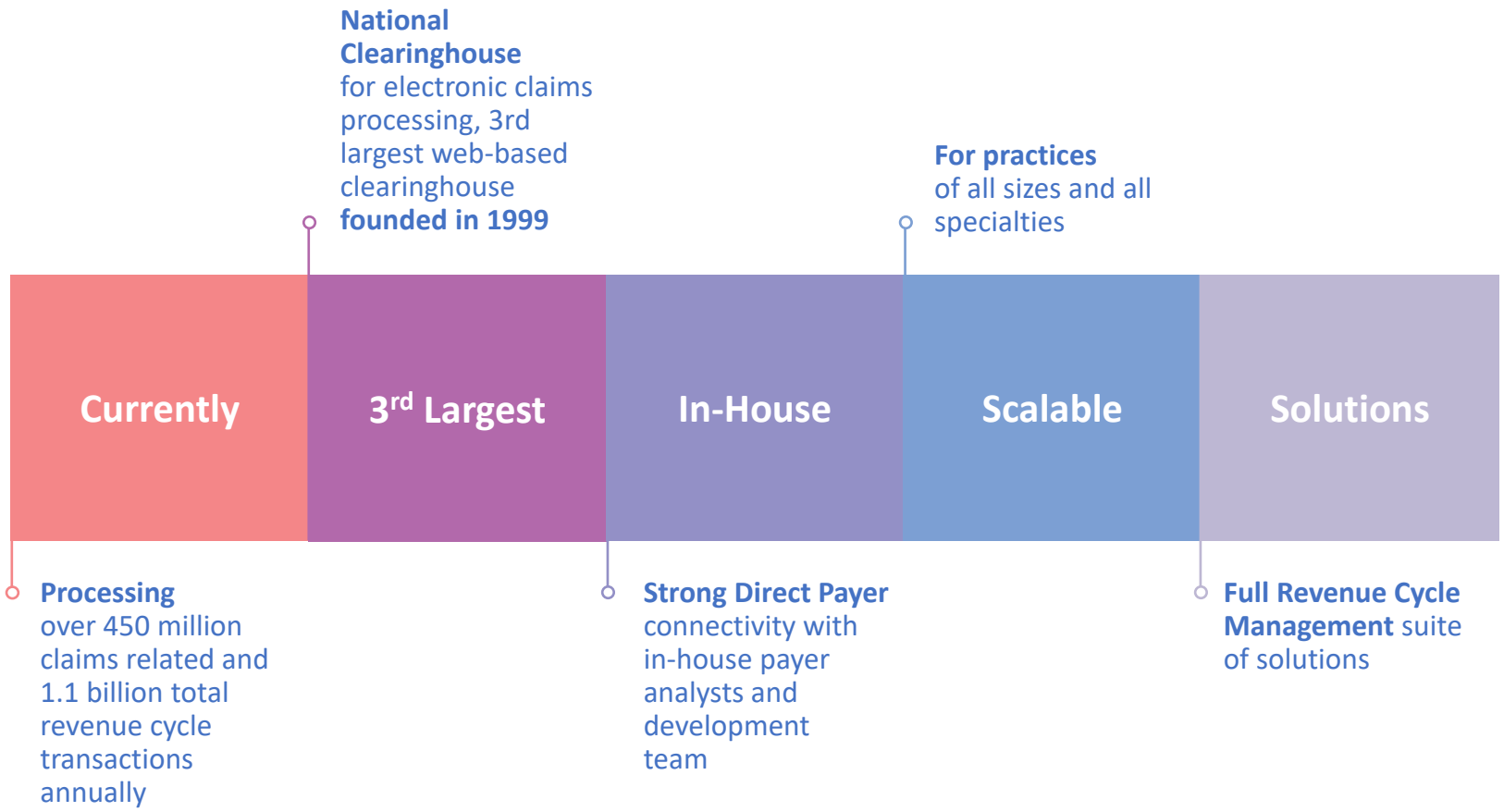
Managing Multiple Clearinghouses



EDI Gateway


Physicians
Physicians
Physicians
EHR/
Practice Management Systems
Clearinghouse
Clearinghouse
Clearinghouse
Payerpath
EDI Gateway
Health Plan
Health Plan
Health Plan
Submissions

What is Veradigm Payerpath?



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Payerpath Payer and Provider Solutions

#1 Black Book ranked revenue cycle solution and interoperability platform delivering financial, administrative and clinical workflows that connect providers, health plans and patients across the U.S.

SOLUTIONS

Patient Engagement

- Patient Appointment Reminders
- Outreach and Surveys

Practice Productivity

- Practice Performance Analytics
- EOB Scanning and Review

Claims Management

- Claims Management
- Workers' Comp
- Eligibility Benefits Inquiry
- Remittance Manager
- Direct EDI Connection
- EDI Exclusive Gateway
- Medical Claim Attachments

Patient Responsibility

- **Veradigm Intelligent Payments**
- Patient Statements
- Collection Letters
- Return Mail Manager
- eStatements with Online Bill Pay
- Patient Payment Lockbox
- Patient Check-In and Payment Collection

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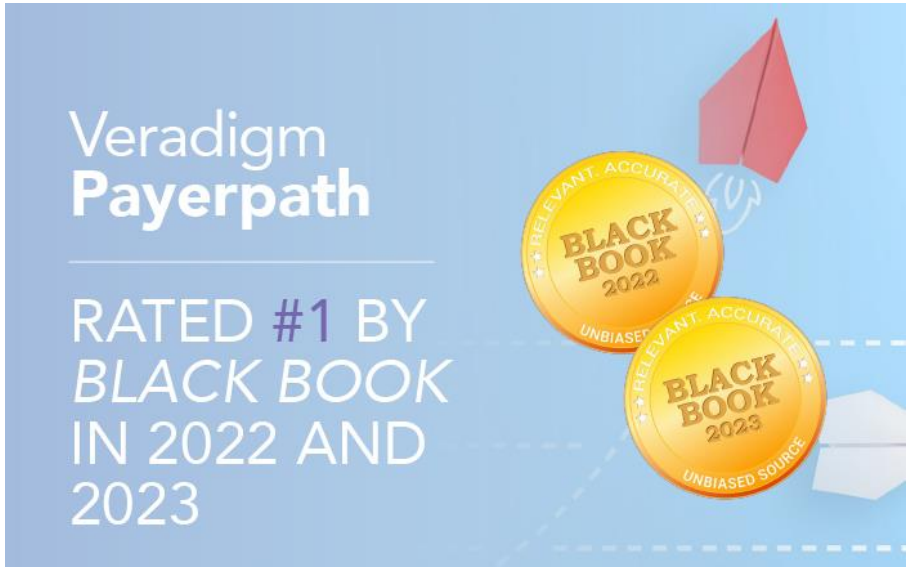
Veradigm Payerpath | Recognition



- Veradigm Payerpath™ Ranked #1 by Black Book™ for 2022 in its Ambulatory Claims Management and Clearinghouse Solutions category.
- Veradigm Payerpath Ranks #1 by Black Book for 2022 and 2023 in End-To-End Revenue Cycle Management (RCM) Software Technology.

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Q&A

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THANK YOU