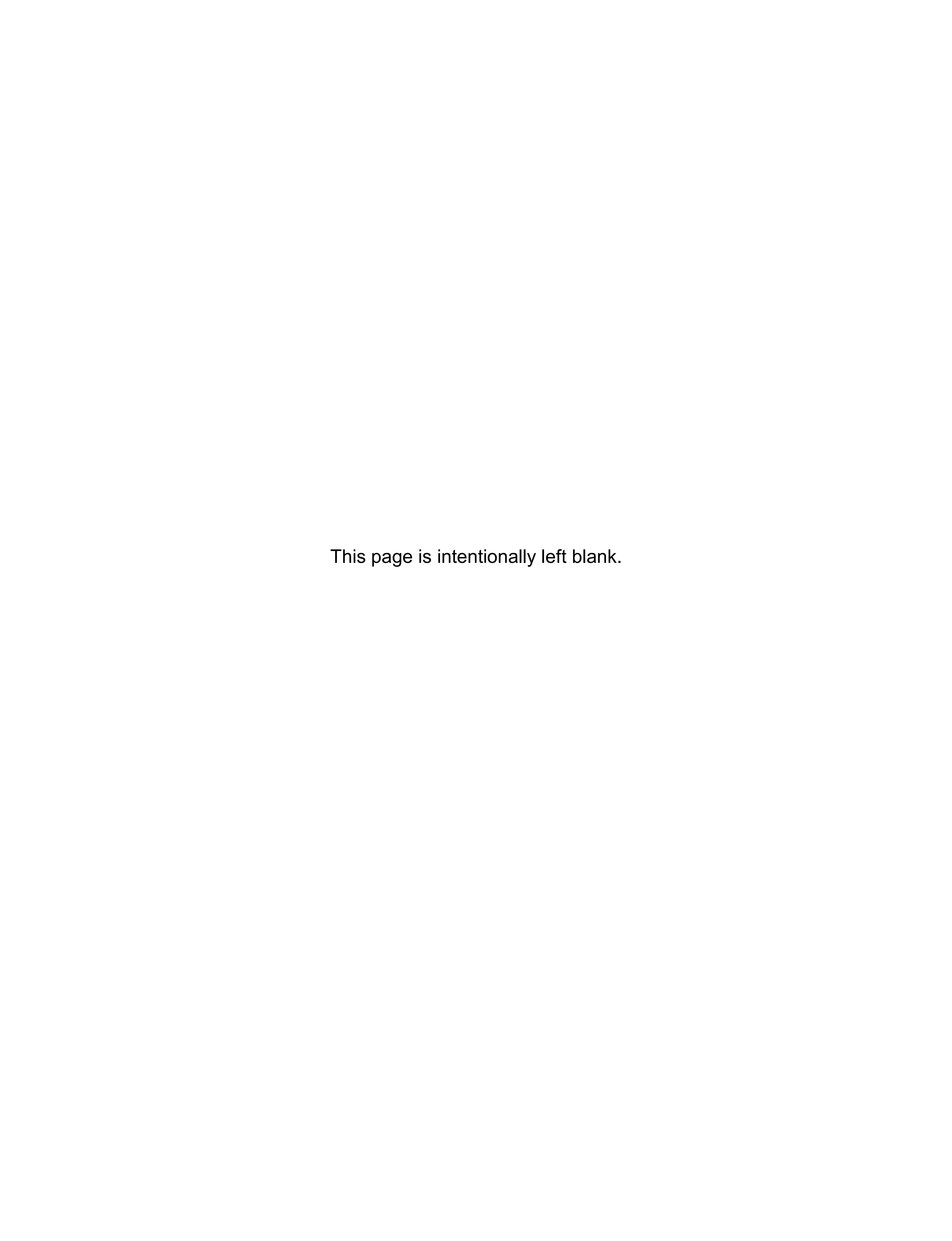
RISK ADJUSTMENT MODEL

FOR CAL MEDICONNECT PLAN MEMBERS

For more recent information or other questions,
contact Provider Network Operations at 1-408-874-1788
Monday through Friday, 8:30 a.m. to 5 p.m.,
by email at ProviderServices@scfhp.com,
or visit www.scfhp.com.

Updated on 01/01/2022
40622



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Section 1: Introduction: Provider Packet 2022: Documenting and coding for Cal MediConnect Plan members

Santa Clara Family Health Plan (SCFHP) must submit complete and accurate risk adjustment data to the Centers for Medicare and Medicaid Services (CMS). This data will come from services that you provide to SCFHP Cal MediConnect Plan members. To maintain compliance with CMS' regulations, SCFHP provides training via materials, electronic communication and telecommunication technology to our contracted providers and their staff.

Cal MediConnect members have both Medicare and Medicaid medical insurance. This packet will guide you through the essential documentation and coding practices required for Cal MediConnect members. All the practices you will learn will be from the ICD-10-CM Official Guidelines for Coding and Reporting and CMS guidance. The healthy practices you will learn will be beneficial for documenting and coding for all insurance types.

For any questions, please contact SCFHP Provider Network Operations at ProviderServices@scfhp.com or call 1-408-874-1788, Monday through Friday, 8:30 a.m. to 5:00 p.m.

Section 2: Provider’s role in documentation and coding for Cal MediConnect Plan members

Each year the Centers for Medicare and Medicaid Services (CMS) attribute a risk score to every Cal MediConnect member, based on the member’s diagnoses from the previous year. This is known as risk adjustment and the risk score is used to determine the payment that a Health Plan receives for that member. Therefore, it is vital that providers accurately and completely document their patients’ diagnoses in medical record and report the same information on the claim submission. When diagnosis codes are not accurately and completely documented or submitted on claims member’s costs of care can exceed the payments to the health plan.

In the following information you will review risk adjustment documentation and coding requirements and best practices as outlined by CMS and the official coding guidelines.

Proper risk adjustment coding, documenting all diagnoses and submitting them on claims, is essential. Every January 1st, Medicare will start with a blank slate on the diagnostic profile of a member. The profile will be built from diagnoses submitted by providers on claims in that Calendar Year. Therefore, when diagnosis codes such as amputations, transplant status, and old MIs are not reported yearly, Medicare assumes that the illness is resolved and no longer exists. Not reporting diagnosis codes and medical conditions annually leads to an inaccurate picture of the member’s health status and payments to the health plan.

How providers can contribute to the risk adjustment model

To ensure SCFHP is receives sufficient funding to cover the risk and level of care that our members need, please capture all acute and chronic diagnosis(es) by doing the following:

- See your patients at least once a year for a face-to-face visit
- When documenting, make sure each diagnosis has at least one element of “MEAT”
    - **M**anaged, **E**valuated, **A**ssessed or **T**reated
- Be specific when documenting. Use terms such as acute and chronic, link medications to diagnoses and code all conditions that are active and affect patient care.

The following materials will provide additional guidance on the abovementioned practices.

Welcome to the risk adjustment model!

Section 3: Compliance with audits

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage (MA) plans such as Santa Clara Family Health Plan (SCFHP) to participate in audits. To satisfy audit requirements SCFHP must submit medical records to CMS for specific Cal MediConnect members. Since it is unknown which Cal MediConnect members CMS will select beforehand, all provider documentation must be audit ready for CMS submission requests.

Purpose of CMS audits

CMS validates diagnosis codes submitted by MA plans to ensure payment integrity and accuracy. All risk adjustment diagnosis codes submitted by MA plans must be supported by medical record documentation.

SCFHP access to your medical records

SCFHP relies on the accuracy of information submitted by providers to ensure that patients receive the appropriate level of care and we receive the appropriate compensation. To ensure that the data submitted on claims is accurate and to capture all documented diagnoses, SCFHP and our contracted vendors will periodically request medical records from your office for official audits and SCFHP activities. The request is based on diagnosis data submitted to CMS as a result of services you provided. Note that Federal regulations require MA plans and their contracted providers to submit medical records for the validation of official risk adjustment data (42 CFR 422.310-Risk adjustment data). We ask that your office response in a timely manner to medical records request, thank you in advance.

Keep your documentation audit ready: use the following guidelines for complete medical record documentation

- Use ICD-10 official coding guidelines and document all conditions that coexist at the time of the encounter and affect patient care.
- Be specific. Use terms such as acute and chronic and stages such as CKD 3.
- Medical records must have support for all diagnoses submitted on claims. See below on how to use **MEAT** for diagnosis support.
- Link medications to diagnoses and submit all diagnoses captured during the encounter on a claim.
- Medical records must be legible and should clearly identity the provider.
- Services provided must be authenticated by a handwritten or electronic signature
    - **Acceptable electronic signature**
        - Signed by: Smith, John, MD 01/01/2021
    - **Not acceptable electronic signature**
        - Signed by: Smith, John, MD 01/01/2021 **pending sign-off status**

Per CMS an acceptable electronic signature must not be left in a pending status.

What is M.E.A.T.?

Use the acronym MEAT for your documentation to support illness that were submitted on claims. Each diagnosis should have at least one element of MEAT:

- **M**onitoring – Signs and symptoms, progression/regression, ordering or referencing test.
- **E**valuation – Test results, medication effectiveness, referrals, medical response to treatment and exam findings.
- **A**ssessment – Decision making, acknowledgements, and counseling.
- **T**reatment – Surgical/therapeutic interventions, referrals, medical plan or link medications to illness.

Section 4: Provider signature requirements

The Centers for Medicare and Medicaid Services (CMS) has specific requirements for provider signatures on medical record documentation. CMS requires documentation be authenticated for each date of service with a valid signature by the person responsible for the care of the member. CMS also requires the following signature practices.

What is required for a valid signature?

A valid signature must be:

- For services you provided or ordered
- Handwritten or electronic
- Legible or can be validated by a signature log

Electronic Signatures

There is no standard format for electronic signatures. Some examples of acceptable electronic signatures are: **"Electronically signed by," Authenticated by," Approved by," "Signed by," or "Validated by"** along with the provider's name, credentials and the date signed. For example, **Signed by: Smith, John, MD 01/01/2021.**

Electronic signature contradictions are not acceptable. Electronic signature contradictions happen when signatures are left in a pending status after they have been authenticated. For example, signed by: Smith, John, MD 01/01/2021 **pending sign-off status**.

Hand written signatures

Per CMS a handwritten signature is a mark or sign by a provider on medical documentation signifying knowledge, approval, acceptance or obligation. **Table 1** shows acceptable and unacceptable handwritten signature types. Signature requirements met equals an acceptable signature. Contact billing provider and ask a non-standardized follow up question equals an unacceptable signature type.

It is up to the discretion of Santa Clara Family Plan to reach out to providers that submit unacceptable signatures types (handwritten and electronic) and request them to complete an attestation statement. Accurately completing an attestation statement will make the signature compliant.

If the signature is illegible, a signature log can be used to determine the provider's identity. For information on handwritten signature requirements and signature logs, refer to section 3.3.2.4 - Signature Requirements in the Medicare Program Integrity Manual: [Medicare Program Integrity Manual (cms.gov)](cms.gov).

Table 1

#	Description	Signature Requirement met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature.	X	
2	Legible first initial and last name.	X	
3	Illegible signature over a typed or printed name. Example: John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement.	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is UNaccompanied by: a signature log, or an attestation statement. Example:		X
7	Initials over a typed or printed name.	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement.	X	
9	Initials NOT over a typed/printed name **Unaccompanied** by: a signature log, or an attestation statement.		X
10	Unsigned typed note with provider's typed name. Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name.		X
12	Unsigned handwritten note, the only entry on the page.		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"Signature on file."		X

Source: Medicare Program Integrity Manual 3.3.2.4-Signature Requirements

Signature attestation statement

Providers will sometimes use a signature attestation statement instead of an electronic or handwritten signature. There is no formal signature attestation format, however the attestation statement must be signed and dated by the person providing or ordering the service and contain sufficient information to identify the member.

Section 5: Clear concise and specific documentation and coding

The Centers for Medicare and Medicaid Services (CMS) requires Santa Clara Family Health Plan's (SCFHP) contracted providers follow CMS guidelines for proper documentation and diagnosis coding. The following are best practices for clear concise and specific documentation and coding.

Documentation and coding best practices

- Submit all active diagnoses assessed or addressed at the visit through claims.
- Each date of service should have documentation that supports the diagnosis assessed.
- Document that each diagnosis is being monitored, evaluated, assessed and/or treated (MEAT).
- Use the terms such as "acute" and "chronic when applicable and state causal relationships between diagnoses by using the term "due to."
- Document amputations, artificial openings, HIV, dialysis, transplants and osteoporosis as applicable. These are conditions that are typically not reported on claims.
- CMS requires that patient conditions be documented at least once each calendar year.
- Avoid using terms such as "PMH" and "history of" if the patient still has the condition. Instead, use active verbs and write in present tense, e.g. "76 Y female with CKD3, and DM2.
- When there is no evidence of any existing primary malignancy or no further treatment is directed to the primary malignancy, use a code from category Z85, personal history of malignant neoplasm.
- Use words when documenting the patient's condition. Using symbols such as -, +, ↑, ↓, and listing ICD-10 codes without support does not adhere to CMS guidelines.
- Assign and document illness to the highest level of specificity or manifestation e.g., DM2 with CKD 4.
- Link medications for the diagnosis or the symptoms being treated.

Cal MediConnect and the risk adjustment payment model

Under the risk adjustment payment model provider's accurate documentation and diagnosis submission results in funding for the patient's care and compensation for the health plan. Please submit all diagnosis codes on the claim that coexist at the time of the encounter and affect patient care.

Common diagnosis categories that are documented in the medical record but are not submit on claims:

Vascular disease, morbid obesity, BMI, pulmonary diseases, diabetes with chronic complication, congestive heart failure, mental health disorders, arthritis and inflammatory connective tissue disease, cancer and leukemia, drug and alcohol dependence, coagulations defects, chronic ulcers, and amputations

Section 6: Achieving high-quality documentation

The key to high-quality documentation is knowing what is relevant to document. Medical records are an important form of communication and should be complete, clear, concise and specific. There a several principles to keep in mind when creating high-quality documentation:

1. It's a form of communication

Medical records communicate diagnoses and treatment plans. Physicians and allied health professionals rely on documentation from previous encounters to guide their medical decision-making. Documentation must convey an accurate description of your patient's health status, including illness, co-morbidities, severity, and treatment. Note that more detail is not necessarily better. Your colleges will appreciate, clear, concise, and specific text.

2. It's a legal document

A medical record is a legal document that can serve as evidence of diagnosis, treatment and care provided in legal proceedings. Documenting prognosis and treatment completely and clearly is essential.

3. It's a document for reimbursement and government audits

Under Medicare's risk adjustment payment model funding for Santa Clara Family Health Plan's Cal MediConnect patients is based on their diagnosis(es) and severity of illness. Document and submit on claims all active acute and chronic illness present at the time of the encounter. Not reporting diagnosis codes and medical conditions yearly leads to an inaccurate picture of the member's health status and benchmark costs. Periodically the government will request validation on the diagnosis codes submitted on claims and medical records are used to validate these request. Make sure your documentation is always in an audit ready status by using the documentation tips you will learn in this packet.

Important documentation and coding practices

- Use at least one element of MEAT (**M**anaged, **E**valuated, **A**ssessed or **T**reated) to support each diagnosis code e.g., hypercholesterolemia- start 10 mg Ezetimibe daily.
- Code and document to the highest level of severity using the official coding guidelines e.g., DM2 w/ CKD3 continue metformin and low protein diet.
- Only use approved medical abbreviations and do not use symbols e.g., ↑ parathyroidism. Symbols are not an acceptable documentation practice.
- According to ICD-10 guidelines: when a primary malignancy has been previously excised or eradicated from its site, there is no further treatment directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal History of malignant neoplasm, should be used to indicate the former site of the malignancy.

- **It is not acceptable to list ICD-10 codes in the assessment and plan without support.** ICD-10 codes listed without support cannot be reported on claims.

Incorrect Assessment and Plan **without** support

Assessment and Plan
1. Hypercholesterolemia E78.0 2. Colostomy- Z93.3 3. Lung cancer- C34.90

Correct Assessment and Plan **with** support

Assessment and Plan
1. Hypercholesterolemia E78.0- start 10 mg Ezetimibe 2. Colostomy Z93.3- no mases or tenderness 3. Lung cancer C34.9- on chemo, f/u with oncology

Documentation examples

Diagnoses in bold have an element of MEAT for support

Case 1

Assessment: Pleasant 71 yr old female with **type 2 DM**, continue metformin. Patient is using OTC anti-itch cream with good results for **dermatitis** continue use.

- DM2 w/ complication of dermatitis E11.620

ICD-10 diabetes codes are combination codes that include the type of diabetes mellitus, the body system affected and the complication affecting that body system. Document the type of diabetes and all diabetes complications.

Case 2

Weight: 245lbs BMI: 40.77
S: Patient returns for scheduled follow up for depression and weight check
PMH: L breast mastectomy 10/2015
MEDS: Parpxetome
O: Hearing/Throat: NL. Heart-RRR. Lungs-CTA. BLE-pulses decreased, no lesion

Assessment and Plan

1. **Recurrent, mild MDD** F33.0: worsening; continue 50 mg Parpxetome daily; add Vilazodone 20 mg
2. **Morbid Obese** E66.01: low carb diet increase exercise
3. **BMI 40-44** Z68.14: weight 245lbs
4. **History of L breast cancer** Z85.3: stable

Documentation states “L breast mastectomy 10/2015” with no evidence of an active state. Code history of for L breast cancer Z85.3.

Case 3

63 yr old man here for follow up on **diabetes type 2** controlled by diet and exercise. **HTN** well controlled on med. He has **peripheral neuropathy from DM** and is on Duloxetine.
MED: Lisinopril for HTN, vit D

Assessment and Plan:

1. **COPD** J44.9- currently asymptomatic, uses inhaler as needed.
2. **Osteoporosis** M81.0- continue Alendronic acid

Diagnosis can be captured throughout the note not just the assessment and plan, as long as there is support for the diagnosis e.g., DM w/ peripheral neuropathy E11.40.

Case 4

Past Medical History: MI, CKD4, Depression, AKI
Medications: Citalopram
Assessment: Patient fully engaged in ADLs, and continue group therapy sessions. Continue Citalopram for **moderate MDD. History of non-Q wave MI** in 1998. **CKD4** followed by nephrology, currently on **dialysis**.

Link medications to diagnosis e.g., moderate MDD on Citalopram F33.1.

Submitting diagnosis on claims

Submit all diagnosis codes on a claim that have documentation support. For assistance with submitting more than 12 diagnoses on one claim contact Provider Network Operations at: phone: 1-408-874-1788, email: ProviderServices@scfhp.com.

Section 7: Medicare and Telehealth during the COVID-19 Public Health Emergency

What is telehealth

Telehealth services refers to the exchange of medical information performed through telecommunication technology between patients and providers who are not at the same location. In early 2020, the federal government declared a public health emergency (PHE) due to COVID-19 which resulted in the Centers for Medicare and Medicaid Services expansion of traditional Medicare coverage for telehealth services. Before the PHE telehealth services were limited to Medicare beneficiaries living in rural locations, with restrictions on where they could receive services.

Expanded Coverage for Medicare beneficiaries during the PHE

Today, Medicare beneficiaries may use telecommunication technology for office and hospital visits and other generally occurring in person services. For a complete list of covered telehealth services visit https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. Most telehealth services covered by Medicare will require the use of real-time, two-way interactive audio and video telecommunication systems.

Examples of acceptable two-way interactive audio and visual systems include: compliant EMR telehealth integration, Apple FaceTime, Google Hangouts, and Skype. Public-facing communications tools are not accepted, e.g., Facebook Live, Twitch and TikTok.

Evaluation and management visits, CPT codes 99202-99205 and 99211-99215, require two-way audio and video telecommunication

Billing for Medicare telehealth services during PHE

To bill for real-time two-way interactive audio and video visits, use the place of service (POS) codes that you would of billed if it were face-to-face and modifier 95 (real-time two-way interactive audio and video).

- For example, for office visits bill POS 11 (office) and modifier 95

To bill for telephone/audio –only visits bill POS 02 (telehealth).

SCFHP is a participant of Medicare's risk adjustment payment model. During the Public Health Emergency, diagnoses resulting from an interactive audio and video visit will be acceptable for risk adjustment.

Best practices for telehealth documentation

Telehealth documentation should be the same as your face-to-face visit documentation. Include pertinent information of the visit, the history, review of systems, assessment and

plan and information used for medical decision making. Telehealth documentation should also include:

- Documentation of the communication mode used: two-way interactive audio and video or audio only, and the tool used during the visit, e.g., Apple FaceTime.
- Verify that your documentation supports the diagnosis codes used. Each diagnosis must have one element of MEAT (**M**anaged, **E**valuated, **A**ssessed or **T**reated).
- Patient consent. Document the patient verbally agrees to receive telehealth services.

Section 8: Santa Clara Family Health Plan calendar year 2022 activities

Find out how to receive additional reimbursement of $150

On an annual basis, Santa Clara Family Health Plan (SCFHP) encourages providers to participate in chronic condition recapture activities. Doctors' offices and organizations who participate will be eligible to receive additional reimbursement of $150 for each Cali MediConnect member for completing a Health Care Quality Assessment form (HCQAF).

The $150 is separate from the claims reimbursement.

What is the HCQAF?

The HCQAF will be unique to each Cal MediConnect member. Each HCQAF will have the member's chronic conditions and gaps in care listed. During a Medicare Annual Wellness Visit (AWV) providers will use the HCQAF to review all the listed conditions and gaps in care. Document all active conditions and reviewed gaps in care in the clinic note.

Submitting the HCQAF:

- Have the patient complete the health risk assessment (HRA) component of the AWV. Use the HRA responses to identify risk factors, suggest preventive services and create a personalized prevention plan.
- Fax HCQAF, HRA and clinic note to SCFHP and submit the claim as usual.

All chronic conditions should be captured at least once a year. The AWV is a great time to assess all of your patient's chronic conditions e.g., amputations, morbid obesity, dialysis status, and hypertension and diabetes with manifestations or complications.

For more information and to get your office or organizations HCQAF contact:

Provider Network Operations, Phone: 1-408-874-1788
Email: ProviderServices@scfhp.com.

Santa Clara Family Health Plan

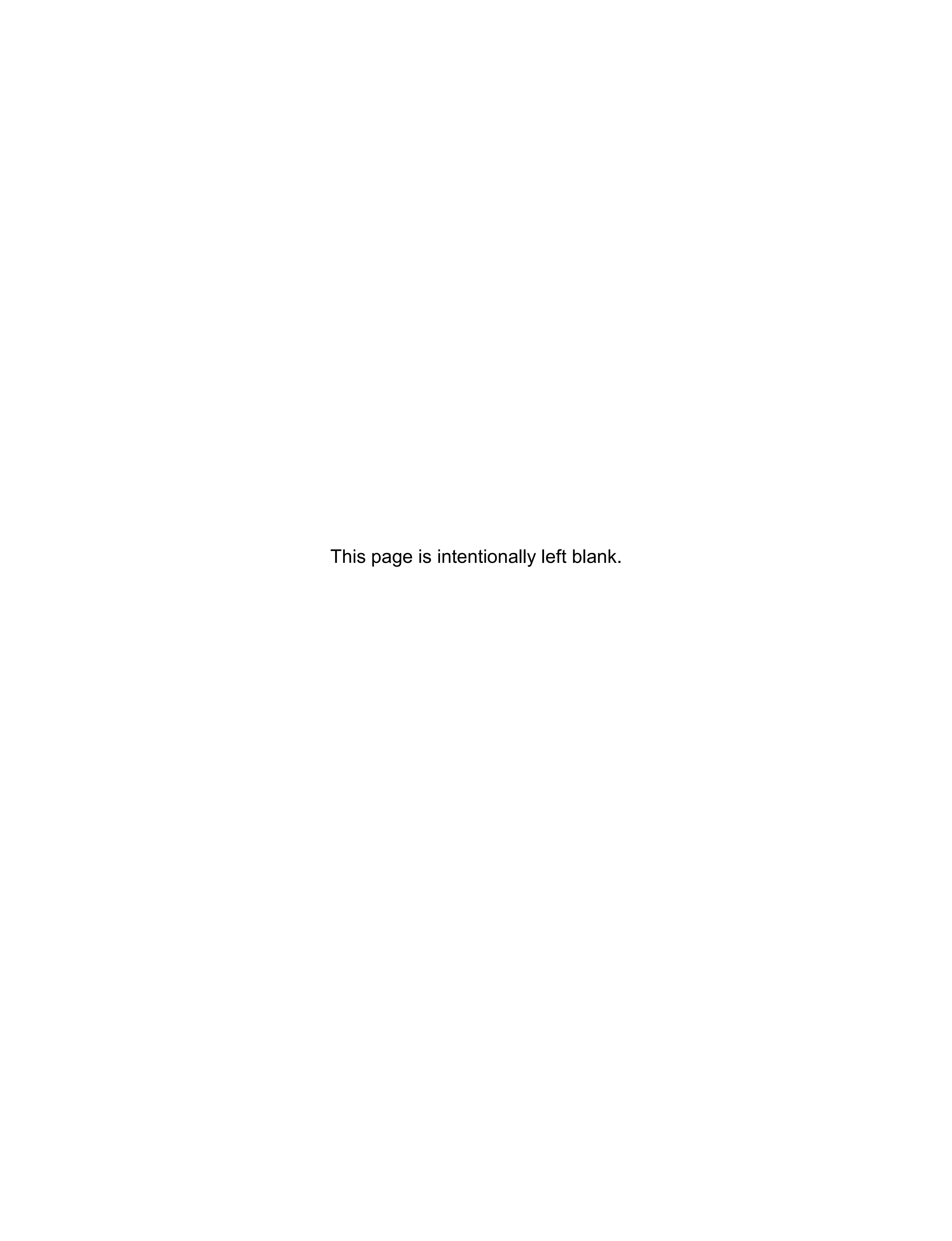
Health Care Quality Assessment Form

Finance
Phone: **1-510-468-9601**
Fax: **1-409-874-1924**
Email: MReynolds@scfhp.com

Diagnosis Code History		
Diagnosis Description	**Code**	**Reviewed**
Chronic viral hepatitis B without delta-agent	B181	
Malignant neoplasm of thyroid gland	C73	
Hyperparathyroidism, unspecified	E213	

Previously Coded Conditions	
Diagnosis Description	**Reviewed**
Cirrhosis of Liver	
Coagulation Defects and Other Specified Hematological Disorders	

Gaps in Care	
Diagnosis Description	**Reviewed/Performed**
Breast Cancer Screening	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Updated 01/2022

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