

# Improving Medicare Reimbursement Seamlessly

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# Introduction

Revenue Cycle Management is a term often tossed around. This paper gets down to the details regarding: **Improving revenue and getting paid for the services you perform**, including the complexity of patients managed.

With the RevAssurant and Exafluence team, every party—from the Plan to individual providers—can improve patient care *and* increase revenue.

**Mission:** Health Plans, MSOs, ACOs, and many other entities paid on risk, must properly document and code each and all conditions of the patients seen. The documentation and code must match the risk. Over coding or under documentation can result in severe recoveries and penalties from the government. **Under coding can result in money left on the table.** The at-risk entity must be careful to avoid either of the above and find a proper and accurate balance.

**The Simple Truth:** The end coder and documenter, the physician practice, may not have the same risk incentives as the at-risk entity. In fact, sometimes the physician (documenter) and staff (coder) may have no risk at all.

**Challenge 1:** Address all the conditions and illnesses a patient has, not necessarily all in one visit, and not necessarily in each visit. How can the provider, with dozens of patients per day ensure that the patient gets all relevant conditions addressed?

**Challenge 2:** Ensure that the conditions addressed are done so in a fashion that justifies coding for them. Did the management, evaluation assessment, and treatment meet the appropriate criteria?

**Challenge 3:** Document properly: Unfortunately, many EMRs were built when CPT coding (E&M and procedures) dominated the reimbursement landscape. Today, at-risk entities rely in ICD-10 coding. How does one bridge that gap?

**Challenge 4:** Properly coding the documentation: **WHEN** should the doctor be queried about services that were provided but not properly documented?



# Overview

## Compliance and Care with the RevAssurant tool:

RevAssurant is the tool plans use in order to improve patient care, track and help their providers, and ensure both accurate and compliant CMS submissions. Utilizing RevAssurant, at-risk providers are reminded when to address existing conditions. In addition, providers are notified of potential conditions that may also be present, or co-morbidities.

**How do we help providers:** The RevAssurant tool helps providers twofold:

1. First, the RevAssurant tool provides an instant-access online tool where any doctor and all of their office staff can view previous conditions that may require a checkup or follow up at the patient's next appointment. Doctors are extremely overworked and the RevAssurant tool helps place the most relevant information in their hands for every patient visit.
2. Second, the RevAssurant tool uses over a dozen proprietary algorithms to identify potential new conditions that a patient may have. Providers may use this information to inquire about any new symptoms or conditions based on RX data, lab tests, OTC reimbursements, etc.

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.

The RevAssurant online tool is a doctor- and Plan-tested online portal shown to improve both risk scores and patient care.



## How to improve reimbursement through identification, intervention, documentation, and coding of risk conditions and illnesses. Methodology explained.

**Step 1: Identification of Risk/Diagnoses:** In CMS/Medicare terms, risk is the sum of mutually exclusive Hierarchical Condition Categories 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.** Before any intervention, documentation, or coding can occur, the at-risk diagnoses (ICD-10) codes must be identified. Multiple are strategies employed to establish all diagnoses for the patient.

- Review of diagnoses from the prior calendar year
- Review of medications to determine possible or differential diagnoses. Those diagnoses consistent with the medications taken by the patient.
- Laboratory data to identify abnormal values which would suggest a possible diagnosis.
- Imaging and testing identifying abnormal results suggesting possible diagnoses.
- Review of the chart, specific to the calendar year, to identify diagnoses that might have been documented but not coded.
- Review of the chart 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 the diagnoses. This is true for all diagnoses, not just risk-adjusted diagnoses, but it **especially important for risk adjusted diagnoses** to prevent audit issues.





**Step 2: Interventions/Services Performed for Risk/Diagnoses:** In the world of risk and coding, interventions and services require addressing the illness during the specific visit in question. To completely address the illness or condition requires four fundamental components (services):

- **Monitoring the disease:** Speaking to the patient about signs and symptoms of the disease since the last visit. Asking how the patient feels and inquiring about any new, increased or decreased symptoms. Often the History of Present Illness (HPI) and the Review of Systems (ROS) which are subjective measures, combine to form the monitoring of the disease.
- **Evaluating the disease:** The traditional physical exam combined with lab and test results for the evaluation or objective measure of the disease.
- **Assessing the disease:** The physician uses the above two components 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. Diabetes by itself is not an assessment. Diabetes, stable on meds, is an assessment.
- **Treating the disease:** clarify, specificity and details are important in the treatment of the disease. Continue medications is a poor record of treatment. Continue Metformin 500 mg BID is an appropriate record of treatment.

**All too often, the only documentation in the chart, regardless of services provided is the diagnosis.** There is no assessment as to the status of the disease (the assessment) just the specific diagnosis. Making the diagnosis and then documenting it, is insufficient for the purpose of addressing the disease and will result in the documentation not supporting the diagnosis submitted.



**Step 3: Documentation of Services Performed:** To make it easier on the reader, the documentation will be segregated by the four components listed above.

**Monitoring the disease:** The HPI (history of present illness) is the illness or condition explained from the patient perspective, with questions and interview from the physician. It is not a chronology of the diseases/conditions but a patient perspective on how they are doing. This should include symptoms and patient observations related to the chief complaint. When the chief is follow-up, it is recommended that it document the reason for follow up. What complaints, systems or disease processes are being followed up. This also includes the ROS.

**Evaluating the disease:** The physical exam, with emphasis on the pertinent systems. The patient is visiting for a reason, a chief complaint(s). While other conditions may be evaluated, the most prominent systems, from the patient perspective, should be examined. Often, the EMR lists a complete physical exam (including systems that are not normally examined) with little or no comment. Pertinent positives and negatives, related to the chief complaint or the reason for follow up, should be documented.

**Assessing the disease:** First and foremost, has the physician documented performing the two items above: Monitoring and Evaluating the disease. In the absence of this, how could any physician assess the status of the disease. All too often physicians document the diagnoses of the patient rather than the status. Second, the condition must be assessed, and its trajectory or pattern documented beyond a simple diagnosis.

**Treating the disease:** Lastly, does the treatment reflect the documentation above. All too often a physician will document worsening conditions followed by continue treatment. Even the lay person knows a worsening condition requires an alteration to the treatment regimen.

When all four components are documented, the medical record should withstand scrutiny and audit. If only three components are documented, the record will likely pass audit but is not as appropriate as possible. Only two components can often be rejected by reviewers and one component is grossly inadequate.

**Coding for Diagnoses/Risk:** Coding for diagnoses should be simple if the services were provided and the four components documented. In many cases the documentation is poor, leaving the coder to either guess if the diagnosis exists or omit the diagnosis. Neither choice is optimal.

**What the coder needs is a well-documented record that supports the diagnosis.** The purpose of a risk adjustment solution is to ensure that coded diagnoses have the proper documentation.



**Industry Issue:** Health plans, MSOs, at risk IPA and any other at-risk group face two opposing challenges. Over-coding and under-coding. Code too high and you face fines, penalties, recoveries and sanctions from CMS and Payors. **Code too low and you leave money on the table making fiscal viability a great challenge.** Each of these issues is solved in different but related approaches.

**Overcoding:** Only code for services that were sufficiently documented to support the code.

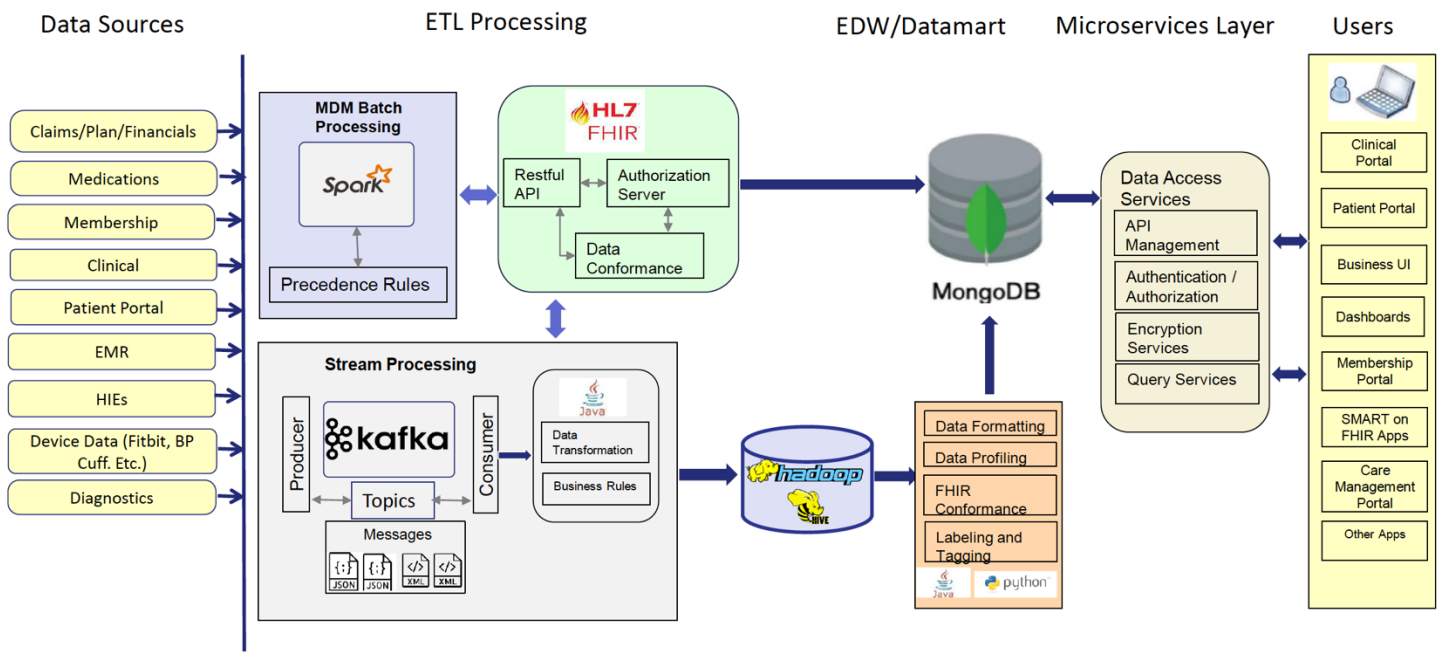
**Undercoding:** Code for all services properly documented in the medical record.

Both of these approaches imply only providing services that are clinically indicated and, most importantly, **properly documenting all services provided during the visit.** Hence, any solution must start with documenting all services provided during the visit, coding for all services documented and only coding for services documented during the visit.

**Technology:** EMR technology has not achieved a level of ICD-10 documentation and coding necessary to prevent overcoding and/or undercoding. Even more troubling, EMR technology does not focus on education and training for overcoding and/or undercoding. The ability to identify ubiquitous documentation and coding problems or a small group of physicians with coding and documentation challenges is absent from EMR technology. Revassurant was built to address these issues on an individual, group and entire provider population basis.

Exf has built microservices driven architecture improving interoperability with Providers, Payers and CRO's. Attached is the snapshot of the architecture

## FHIR Processing Architecture for HealthCare Applications



- ML/AI patterns interpreting outliers and understanding of patient / Provider data
- Real time streaming of data from different sources and creating a single version of truth for member/ patient
- A longitudinal view of patient available in-patient portal for understanding the risk and all underlying information from claims, eligibility and also from their EMR records
- AI/ML driven data quality/ data profiling
- GraphDB to visualize the impact of the events from a patient perspective
- Light weight Master data management construct to create golden copy for Member and Provider
- Geocoding of Member and provider to understand the demography
- Data management platform in MongoDB for record keeping and Data exchange format
- Portal for interpretation for reports and analytics
- Optimize MongoDB via Ops / Cloud manager



- Data security by encrypting and decrypting PHI /PII information adhering to HIPPA compliance
- Private network with trusted factor for cloud housing the data in data center





READY TO GET STARTED?  
See how our technology  
solves your pain points.

GET A DEMO