



Does Your Documentation Meet the M.E.A.T. Criteria

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- **Leigh Poland, RHIA, CCS**, and vice president coding service line - AGS Health, has over 24 years of coding experience and has worked in the coding and education realm over the last 20 years. Her true passion is coding education and making sure coders are equipped to do their job accurately and with excellence. Academically, Poland graduated from Louisiana Tech University with a Bachelor of Science. She has had the opportunity to present many times in the past at the AHIMA, ACDIS, and AAPC National Conventions. She has been a guest speaker on AHIMA webinars and has written several articles that were published in the AHIMA Journal. Poland has traveled the US and internationally providing coding education.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
 - Define CMS' chronic condition list
 - Identify three documentation challenges surrounding chronic conditions
 - Identify the M.E.A.T documentation criteria
 - Discuss how to apply M.E.A.T. documentation criteria
 - List the seven high-risk diagnoses that the OIG is targeting in recent Medicare Advantage audits



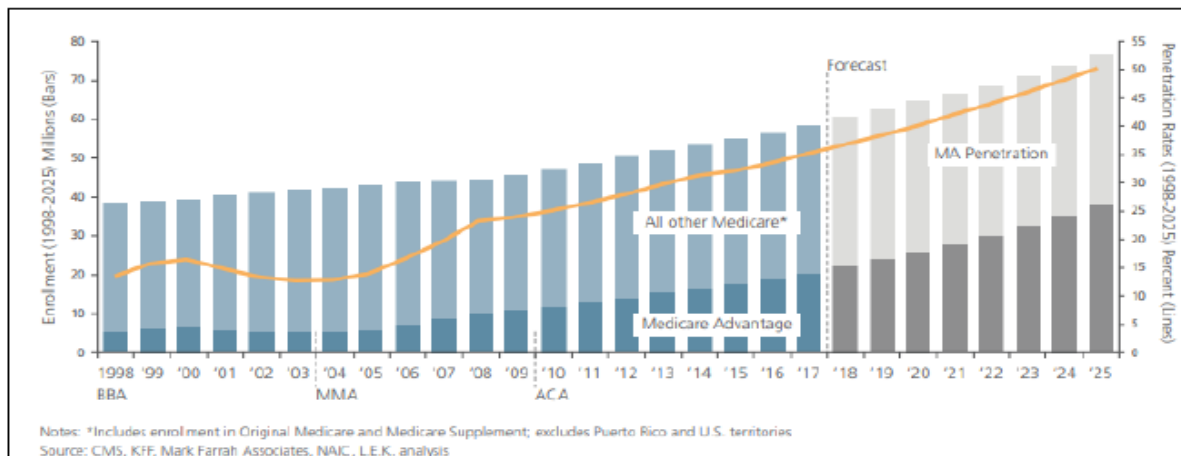
The Basics of HCC Coding

Pay for Performance Created Disruptive Changes

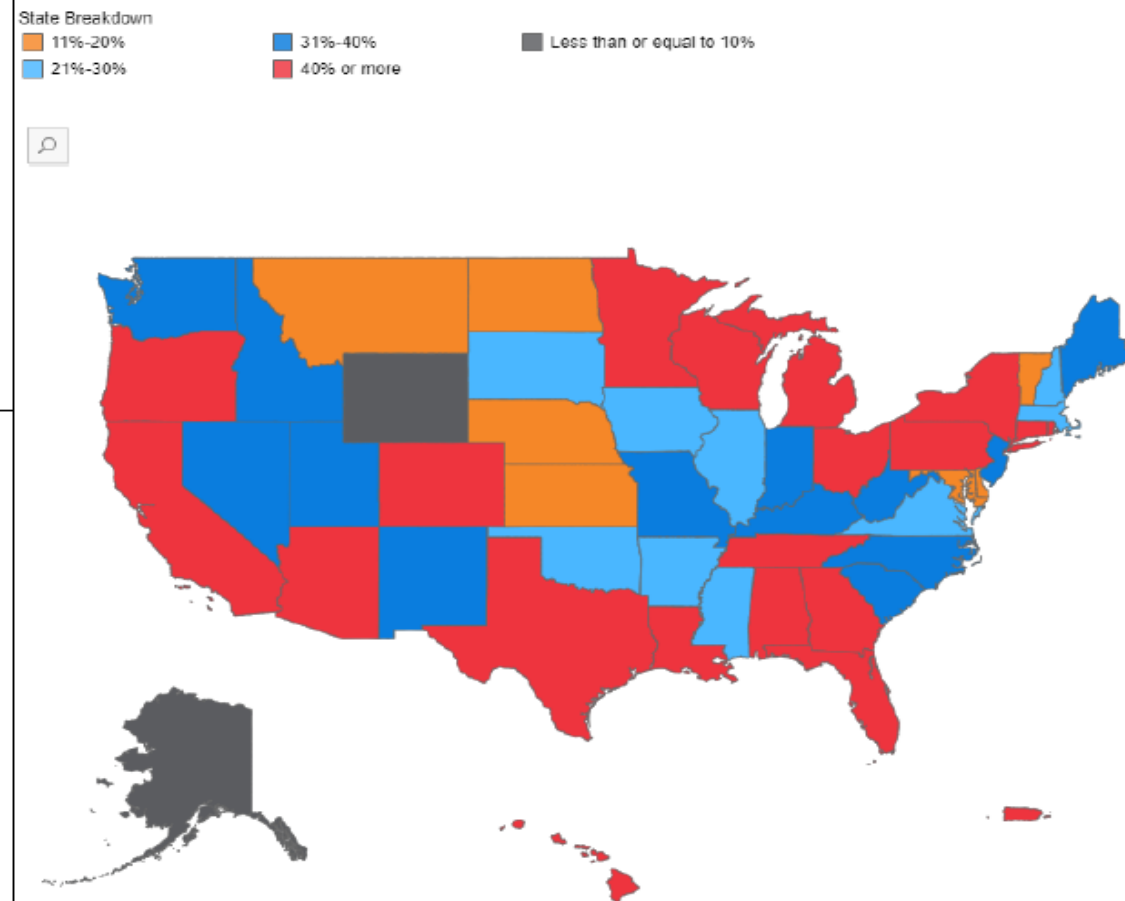
 Category 1 Fee-For-Service: No Link to Quality & Value		 Category 2 Fee-For-Service: Link to Quality & Value				 Category 3 APMs Build on Fee-For-Service Architecture		 Category 4 Population-Based Payment	
Fee-For Service	A	B	C	D	A	B	A	B	
	Foundational Payments for Infrastructure & Operations	Pay for Reporting	Rewards for Performance	Rewards & Penalties for Performance	APMs with Upside Gainsharing	APMs with Upside Gainsharing/ Downside Risk	Condition-Specific Population-Based Payment	Comprehensive Population-Based Payment	
Traditional FFS	Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT	Bonus payments for quality reporting	Bonus payments for quality performance	Bonus payments & penalties for quality performance	Bundled payment with upside risk only	Bundled payment with up- and downside risk	Population-based payments for speciality, condition, and facility- specific care (e.g., via an ACO, PCMH, or COE)	Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)	
DRGs not linked to quality		DRGs with rewards for quality reporting	DRGs with rewards for quality performance	DRGs with rewards & penalties for quality performance	Episode-based payments for procedure- based clinical episodes with shared savings only	Episode-based payments for procedure- based clinical episodes with shared savings & losses			
		FFS with rewards for quality reporting	FFS with rewards for quality performance	FFS with rewards & penalties for quality performance	Primary Care PCMHs with shared savings only	Primary Care PCMHs with shared savings & losses			Partial population-based payments for Primary Care
				Hospital P4P • HVBP • HACRP • HRRP	Oncology COEs with shared savings only	Oncology COEs with shared savings & losses	Episode-based, population payments for clinical conditions, such as diabetes	Population-based payments for comprehensive pediatric or geriatric care	
						EPMs • CJR • SHFFT • AMI • CABG		• ACO • MA • CPC+ • PCMH	
Financial and Outcome Accountability Population Focused									

Source: Recreated from Alternative Payment Model Framework, HCP/LAN, 2016

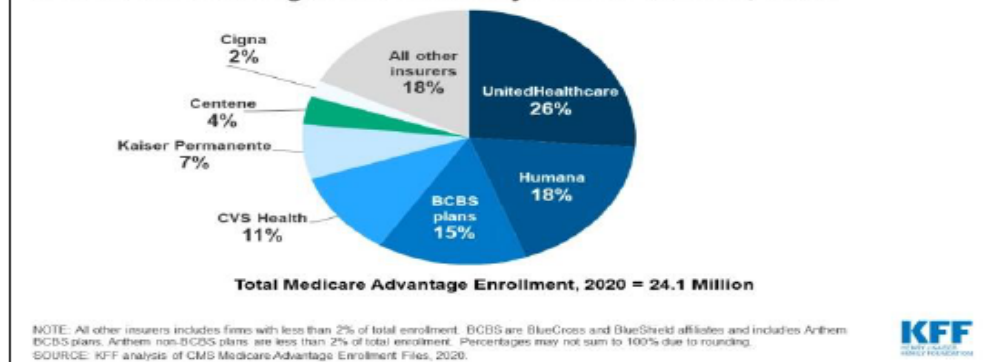
Medicare Advantage Marches Toward 70% Penetration



Medicare Advantage Penetration, by State, 2020



Medicare Advantage Enrollment by Firm or Affiliate, 2020



What Are Hierarchical Condition Categories (HCCs)?

- HCCs were introduced by the Centers for Medicare and Medicaid Services (CMS) to determine payment under Medicare Part C (Medicare Advantage)
 - Introduced under the Balanced Budget Act of 1997
- Under the Medicare Advantage Program CMS makes advance monthly payments for each enrollee to cover Medicare Part A and Part B benefits
 - Uses ICD-10-CM diagnosis information from a base year to **predict costs for the next year**
- Adopted by CMS (CMS-HCC) as the risk adjustment methodology that measures relative risk due to health status for payment determination under Medicare Advantage

What Are Hierarchical Condition Categories (HCCs)?

- CMS-HCCs are largely driven by:
 - The costs associated with **chronic diseases**
 - The systematic risk (costs) associated with Medicare populations
 - Demographic factors (ages, gender, etc.)
- Various medical conditions are broken into various categories
 - Codes within a category are roughly similar in resources needed to manage the condition across patients
- Becoming more of a focus with the shift to a value-based payment model
- The basic premise of this is that a patient with several chronic conditions will require more care/resources/expense than a patient with no chronic conditions

Two Models: CMS and HHS

CMS-HCC Characteristics	HHS-HCC Characteristics
Primarily use for Medicare Advantage (Part C) reimbursement	Primary use in commercial payer managed care plans (Health Exchange plans under the Affordable Care Act)
Intended for patients over 65 and/or disabled patients	Intended for patients of all ages
Risk-adjusted attributes include age, gender, demographics, medical conditions, and institutional status	Risk-adjusted attributes include age, gender, demographics, medical conditions, and financial status
Data capture included in regular Medicare processes	Requires additional data capture for demographics
Predicts future medical spending	Predicts future medical and drug spending
Prospective: Uses diagnostic information from a base year to predict costs for the following year	Concurrent: Uses data from the current benefit year to predict costs for that same year
Includes a special needs plan for individuals with severe or disabling chronic conditions	Includes an adult model (age 21+), child model (age 2-20), and infant model (age 0-1)
Provides frailty adjustment to predict expenditures for the community-residing frail elderly	Contributing elements vary by age (e.g., child model does not include disease severity interactions and categories in the infant model are defined by birth maturity)

HCC Coding Documentation

- CMS requires Medicare Advantage plans to collect **hospital inpatient, hospital outpatient, and physician risk adjustment data** and submit the data to CMS at least quarterly for calculation of the risk score for use in the payment calculation and payment reconciliation.



Why Is HCC Coding Important?

- Communicates patient complexity
- Gives a better idea of the patient as a whole, rather than just pieces
- RAF scores are used to risk adjust quality and cost metrics

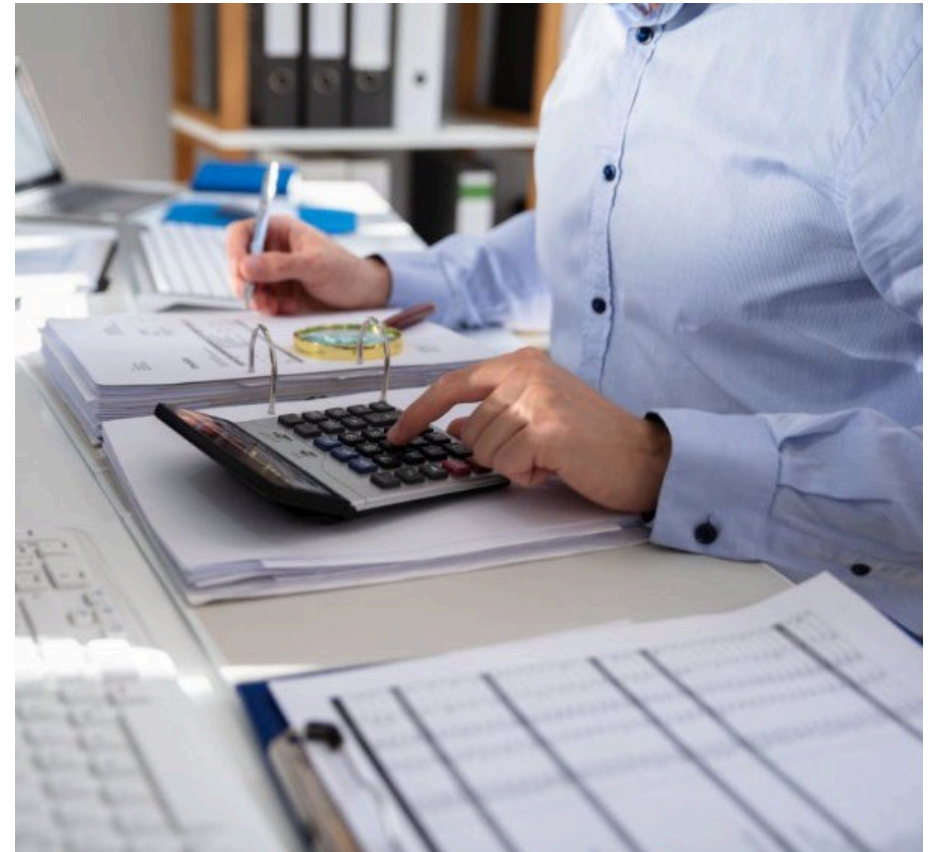




How Do HCC Categories Impact Reimbursement?

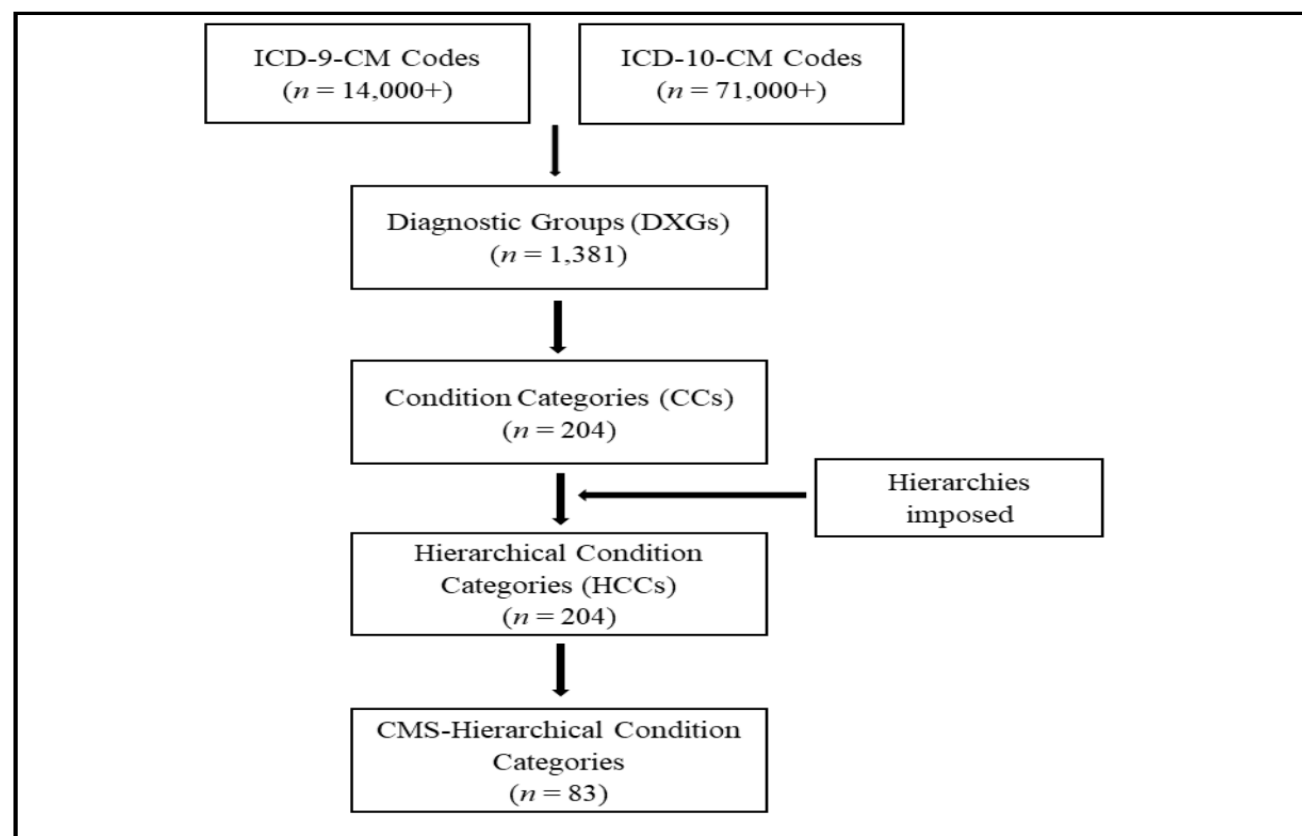
Documentation is Key

- Risk adjustment using diagnoses provides more accurate payments for Medicare Advantage organizations
 - Higher payments for enrollees at risk for being sicker
 - Lower payments for enrollees predicted to be healthier
- Risk adjustment allows CMS to pay Medicare Advantage plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries
- HCCs have become the preferred method of risk adjustment for the Medicare population



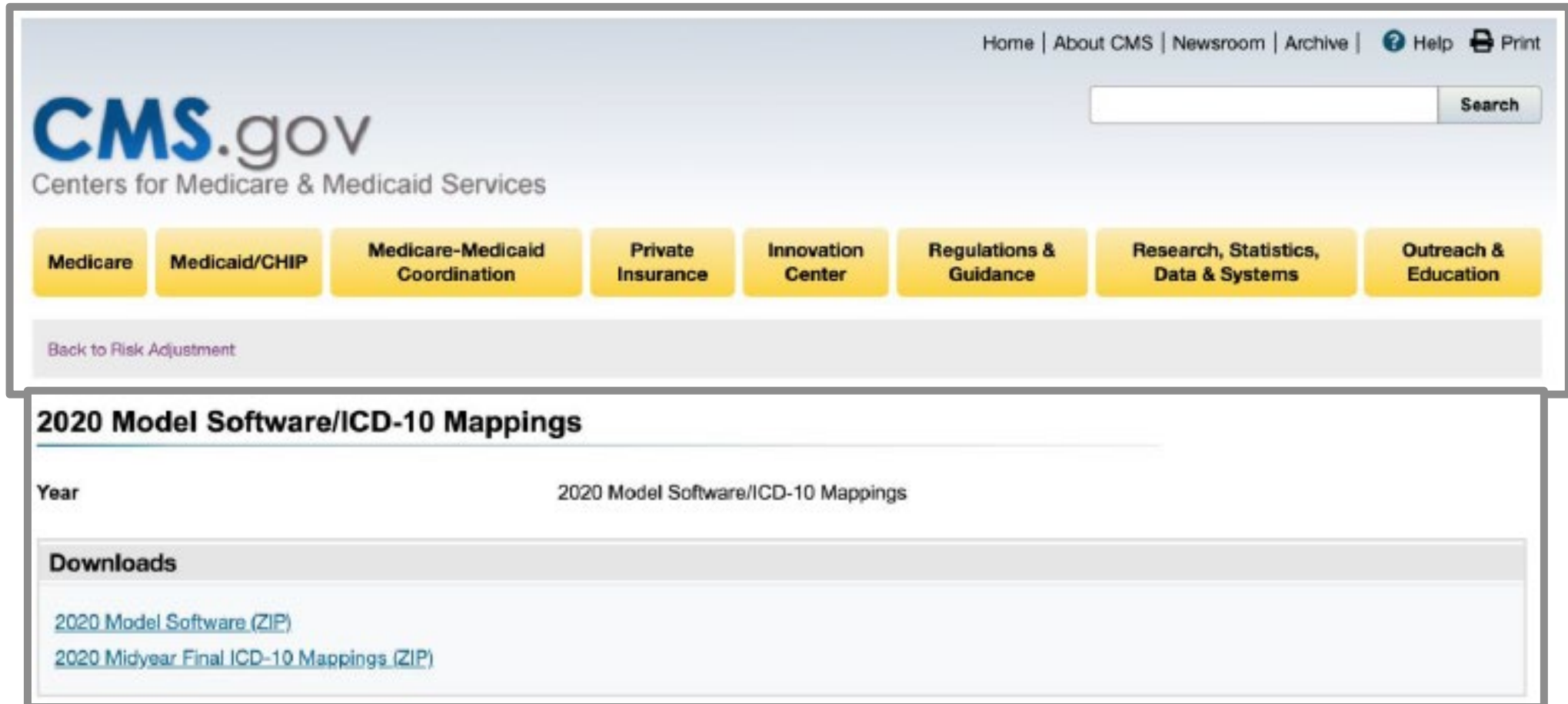
Translating ICD-10-CM Codes into HCCs

- Over 9,700 ICD-10-CM Codes are included in the CMS-HCC risk adjustment model equating to about 14% of all possible ICD-10-CM codes.



Translating ICD-10-CM Codes Into HCCS

You can obtain the most recent crosswalk of ICD-10-CM codes to CMS-HCCs at CMS.GOV



The screenshot displays the CMS.gov homepage. At the top right, there are links for Home, About CMS, Newsroom, Archive, Help, and Print. A search bar is located below these links. The CMS.gov logo and the text 'Centers for Medicare & Medicaid Services' are on the left. A row of yellow buttons provides navigation to various CMS services: Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. Below this row is a link for 'Back to Risk Adjustment'. The main content area is titled '2020 Model Software/ICD-10 Mappings'. Under this title, there is a 'Downloads' section with two links: '2020 Model Software (ZIP)' and '2020 Midyear Final ICD-10 Mappings (ZIP)'.

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2020 Model Software/ICD-10 Mappings

Year 2020 Model Software/ICD-10 Mappings

Downloads

[2020 Model Software \(ZIP\)](#)
[2020 Midyear Final ICD-10 Mappings \(ZIP\)](#)

HCC Condition Categories Example

CMS publishes ICD-10-CM mappings as a Microsoft Excel Spreadsheet

ICD-10-CM Codes, CMS-HCC and RxHCC Models
Includes ICD-10 codes valid in FY2018 or FY2019.

Diagnosis Code	Description	CMS-HCC PACE/ESRD Model Category V2	CMS-HCC Model Category V22	CMS-HCC Model Category V23	RxHCC Model Category V05	CMS-HCC PACE/ESRD Model for 2019 Payment Year	CMS-HCC Model Category V22 for 2019 Payment Year	CMS-HCC Model Category V23 for 2019 Payment Year	RxHCC Model for 2019 Payment Year
J9602	Acute respiratory failure with hypercapnia	84	84	84		Yes	Yes	Yes	No
J9610	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia	84	84	84		Yes	Yes	Yes	No
J9611	Chronic respiratory failure with hypoxia	84	84	84		Yes	Yes	Yes	No
J9612	Chronic respiratory failure with hypercapnia	84	84	84		Yes	Yes	Yes	No
J9620	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia	84	84	84		Yes	Yes	Yes	No
J9621	Acute and chronic respiratory failure with hypoxia	84	84	84		Yes	Yes	Yes	No
J9622	Acute and chronic respiratory failure with hypercapnia	84	84	84		Yes	Yes	Yes	No
J9690	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia	84	84	84		Yes	Yes	Yes	No
J9691	Respiratory failure, unspecified with hypoxia	84	84	84		Yes	Yes	Yes	No
J9692	Respiratory failure, unspecified with hypercapnia	84	84	84		Yes	Yes	Yes	No
J982	Interstitial emphysema	111	111	111	226	Yes	Yes	Yes	Yes
J983	Compensatory emphysema	111	111	111	226	Yes	Yes	Yes	Yes
J99	Respiratory disorders in diseases classified elsewhere	112	112	112	227	Yes	Yes	Yes	Yes
K200	Eosinophilic esophagitis				58	No	No	No	Yes
K208	Other esophagitis				58	No	No	No	Yes
K209	Esophagitis, unspecified				58	No	No	No	Yes
K210	Gastro-esophageal reflux disease with esophagitis				58	No	No	No	Yes
K219	Gastro-esophageal reflux disease without esophagitis				58	No	No	No	Yes

HCC Hierarchy

- Payments associated with most severe manifestation of a disease for the same calendar year
- If a patient has multiple HCCs in the same hierarchy reported in same calendar year, the lower severity HCC will be dropped from payment consideration

E08.0-, E08.1-, E08.641, E09.0-, E09.1-, E09.641, E10.1-, E10.641, E11.0-, E11.1-, E11.641, E13.0-, E13.1-, E13.641	Diabetes with acute complications	17	18, 19
E08.21-E08.638, E08.649-E08.8, E09.21-E09.638, E09.649-E09.8, E10.21-E10.638, E10.649-E10.8, E11.21-E11.638, E11.649-E11.8, E13.21-E13.638, E13.649-E13.8	Diabetes with chronic complications	18	19
E08.9, E09.9, E10.9, E11.9, E13.9, Z79.4	Diabetes without complication	19	

G82.5-, R53.2, S14.11-(A)(D)(S)	Quadriplegia	70	71, 72, 103, 104, 169
G82.20-G82.22, S24.11-(A)(D)(S)	Paraplegia	71	72, 104
B00.82, B01.12, B02.24, G04.1, G04.89, G04.91, G05.4, G11.-, G12.0, G12.1, G12.8, G12.9, G32.0, G32.81, G37.3, G37.4, G83.4, G90.1, G95.-, G99.2, Q00.-, Q01.-, Q02, Q03.-, Q04.-, Q05.-, Q06.-, Q07.-, S14.0-(A)(D)(S), S14.10-(A)(D)(S), S14.12-(A)(D)(S), S14.13-(A)(D)(S), S14.14-(A)(D)(S), S14.15-(A)(D)(S), S24.0-(A)(D)(S), S24.10-(A)(D)(S), S24.13-(A)(D)(S), S24.14-(A)(D)(S), S24.15-(A)(D)(S), S34.0-(A)(D)(S), S34.1-(A)(D)(S), S34.3XX(A)	Spinal cord disorders/injuries	72	169

Risk Adjustment Factor (RAF)

- Value assigned to each HCC category
- Value also assigned for gender, ages, living situation, and Medicaid eligibility
- Value also assigned for specific disease interactions
- Total value determine patient's risk score
 - Average is 1.000
 - Healthier people are below 1.000
 - Less healthy people are above 1.000
- Paid based on capitation

HCC	HCC Description	Weight
1	HIV/AIDS	0.470
2	Septicemia, Sepsis, SIRS/Shock	0.535
6	Opportunistic Infections	0.440
17	Diabetes with Acute Complications	0.368
18	Diabetes with Chronic Complications	0.368
19	Diabetes without Complication	0.118
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	2.488
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.338
161	Chronic Ulcer of Skin, Except Pressure	0.536
188	Artificial Openings for Feeding or Elimination	0.651
189	Amputation Status, Lower Limb/Amputation Complications	0.779

RAF Basic Example

A 68-year-old patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 37.2



ICD-10	Description	RAF
E11.9	T2 DM with no complications	0.105
I10	Hypertension	0.00
Z68.37	BMI of 37.2	0.00
Total		0.105

RAF Example with Payments

- **Suppose the starting capitated rate the provider receives from CMS is \$900 per member per month.**
(This rate is adjusted based on the HCC scores)
- **If the patient has diabetes with complications that is not coded, the payment impact is pronounced**

Scenario 1			Scenario 2			Scenario 3		
	HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor
72-Year-Old Female		0.386	72-Year-Old Female		0.386	72-Year-Old Female		0.386
Diabetes not coded		--	E11.9 Type 2 diabetes mellitus w/o complications	HCC19 Diabetes w/o Complication	0.105	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302
Total RAF		0.386	Total RAF		0.491	Total RAF		0.688
Payment per month		\$ 347.40	Payment per month		\$ 441.90	Payment per month		\$ 619.20
Payment per year		\$ 4,168.80	Payment per year		\$ 5,302.80	Payment per year		\$ 7,430.40

RAF Example with Payments (CONTD)

The same patient may have multiple conditions that contribute to the HCC score.
Missing documentation carries a cost

Scenario 4			Scenario 5			Scenario 6		
	HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor
72-Year-Old Female		0.386	72-Year-Old Female		0.386	72-Year-Old Female		0.386
E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302
K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308	K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308	K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308
			M05.60 Rheumatoid arthritis of unspec site w/involvement of other organs/systems	HCC40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.421	M05.60 Rheumatoid arthritis of unspec site w/involvement of other organs/systems	HCC40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.421
						F33.1 Major Depressive Disorder, Recurrent	HCC59 Major Depressive, Bipolar, and Paranoid Disorders	0.309
						Bonus for 4 Chronic Conditions		0.006
Total RAF		0.996	Total RAF		1.417	Total RAF		1.732
Payment per month		\$ 896.40	Payment per month		\$ 1,275.30	Payment per month		\$ 1,558.80
Payment per year		\$ 10,756.80	Payment per year		\$ 15,303.60	Payment per year		\$ 18,705.60

Transition to Fee for Value

- Annually providers should be assessing all chronic conditions of their patients to ensure that Medicare has record of them
- This will ensure that the prospective payment made for the following calendar year is more accurately represented for the member





HCC Chronic Conditions

Definition of a Chronic Condition

Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as **heart disease, cancer** and **diabetes** are the leading causes of death and disability in the United States. They are also leading drivers of the nation's **\$3.8 trillion** in annual **health care costs**.



Chronic Conditions CMS list

Alcohol Abuse	Drug Abuse/Substance Abuse
Alzheimer's Disease and Related Dementia	Heart Failure
Arthritis (Osteoarthritis and Rheumatoid)	Hepatitis (Chronic Viral B & C)
Asthma	HIV/AIDS
Atrial Fibrillation	Hyperlipidemia (High cholesterol)
Autism Spectrum Disorders	Hypertension (High blood pressure)
Cancer (Breast, Colorectal, Lung, and Prostate)	Ischemic Heart Disease
Chronic Kidney Disease	Osteoporosis
Chronic Obstructive Pulmonary Disease	Schizophrenia and Other Psychotic Disorders
Depression	Stroke
Diabetes	

Health Risk Behaviors Causing Chronic Diseases

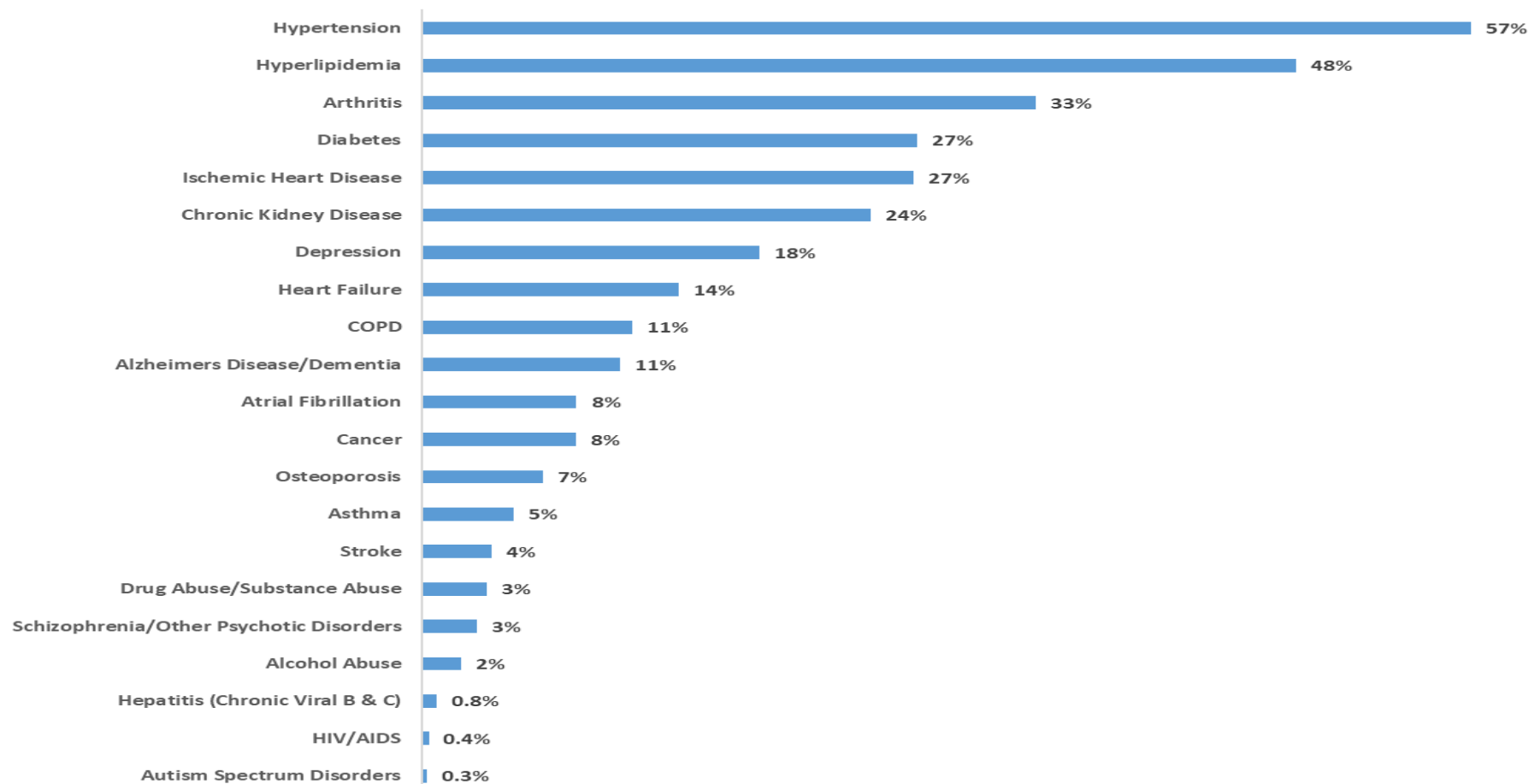
- Many chronic diseases are caused by a short list of risk behaviors
- Tobacco use and exposure to second-hand smoke
- Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats
- Lack of physical activity
- Excessive alcohol use



The Most Common Chronic Conditions Among Medicare

Percentage of Medicare FFS Beneficiaries with the 21 Selected Chronic Conditions: 2018

Figure 1: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries: 2018





What Is M.E.A.T.?

What Is M.E.A.T.? An Introduction

- The Official ICD-10-CM Coding Guidelines state that a condition must be present at the time of the encounter, affect patient care or management and be clearly documented in order to be coded as a diagnosis.
- Physicians must accurately document each patient diagnosis and the diagnosis **MUST** be based on clinical medical record documentation from a face-to-face encounter.
- This simply means that diagnoses cannot be wholly determined from test results and a patient's past medical history.



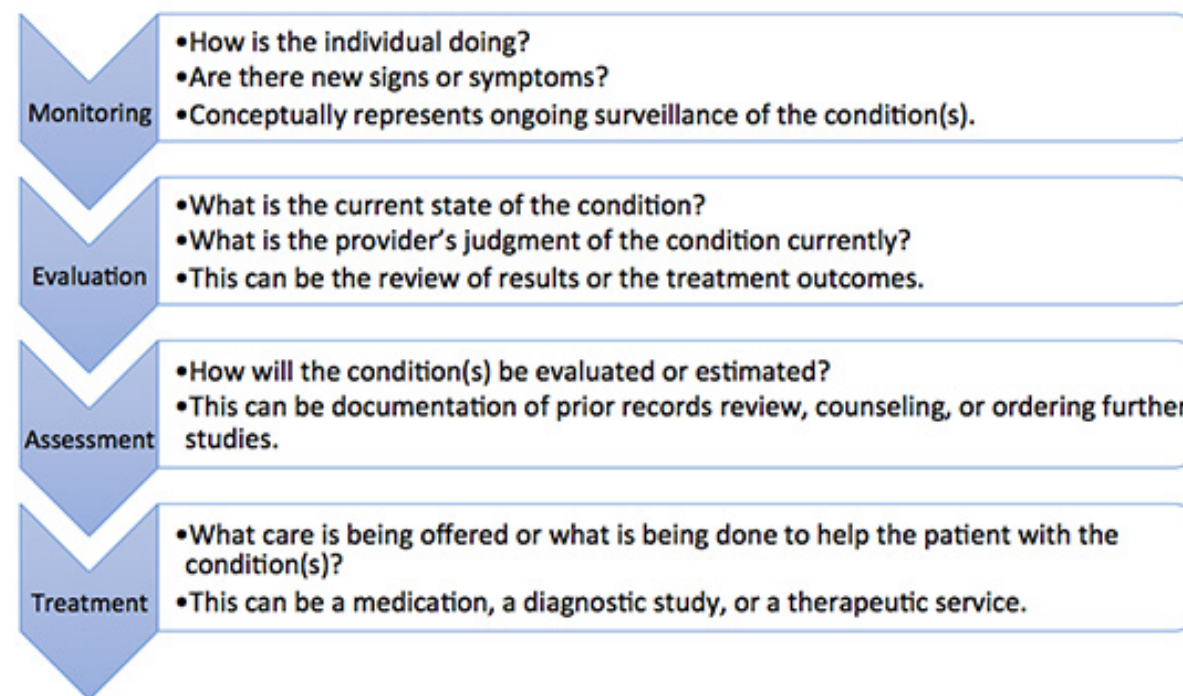
What Is M.E.A.T.? An Introduction

- A well-documented progress note would include the HPI, ROS, physical exam and show the medical decision-making process.
- Each diagnosis must be documented in an assessment and care plan and each diagnosis must show that the provider is Monitoring, Evaluating, Assessing/Addressing, or Treating the condition:
- **M.E.A.T is an acronym for:**



What Is M.E.A.T.? An Introduction

- These four factors help providers establish the presence of a diagnosis during an encounter and ensure proper documentation.
- Simply listing every diagnosis in the medical record does not support a reported HCC code and is unacceptable according to CMS. An acceptable problem list must show evaluation and treatment for each condition that relates to an ICD code.
- Including one or more of the M-E-A-T details at a face-to-face visit for each condition that requires or affects patient care treatment or management will put you on the path to success in capturing risk!



What Is M.E.A.T.? An Introduction

BEST PRACTICES FOR CODING CHRONIC CONDITIONS

One way to document chronic conditions is by utilizing the acronym M.E.A.T.

Monitor **Evaluate** **Assess/address** **Treat**

Examples of M.E.A.T.	
Monitor	<ul style="list-style-type: none"> • Symptoms • Disease progression/regression • Ordering of tests • Referencing labs/other tests
Evaluate	<ul style="list-style-type: none"> • Test results • Medication Effectiveness • Response to treatment • Physical exam findings
Assess / Address	<ul style="list-style-type: none"> • Discussion, review records • Counseling • Acknowledging • Documenting status/level of condition
Treat	<ul style="list-style-type: none"> • Prescribing/continuation of medications • Surgical/other therapeutic interventions • Referral to specialist for treatment/consultation • Plan for management of condition



Medicare Advantage OIG Focus: Recent Investigations

Medicare Advantage Compliance Audit of Specific Diagnosis Codes

January 2022

- The OIG published a review of whether select diagnosis codes that Healthfirst Health Plan, Inc., a Medicare Advantage organization, submitted to CMS for use in the risk adjustment program complied with federal requirements. The OIG conducted the audit by selecting 240 unique enrollee-years with high-risk diagnosis codes for which Healthfirst received higher payments in 2015-2016. The OIG found that the diagnosis codes Healthfirst submitted for 155 of the 240 enrollee-years did not comply with federal requirements as they were not supported by the medical records. Healthfirst received an estimated \$5.2 million in net overpayments from 2015-2016 because of these errors.
- The OIG recommended that, in addition to refunding the federal government for the \$5.2 million in net overpayments and identifying and returning any similar overpayments, Healthfirst investigate existing compliance procedures to identify areas where improvements could be made to ensure that these diagnosis codes comply with federal coding requirements. The diagnosis codes did not meet the coding guidelines for reportable diagnosis.

Medicare Advantage Compliance Audit of Specific Diagnosis Codes

- The seven High-Risk diagnosis groups for this audit:
 1. Acute stroke
 2. Acute heart attack
 3. Acute stroke and acute heart attack combination
 4. Embolism
 5. Vascular claudication
 6. Major depressive disorder
 7. Potentially mis-keyed diagnosis codes

REF: <https://oig.hhs.gov/oas/reports/region2/21801029.pdf>

OIG Audit Says Tufts Received \$3.7 Million in Overpayments for High-Risk Diagnosis Codes

February 2022

- **Tufts is an MA organization based in Watertown, Massachusetts.** As of December 31, 2016, Tufts provided coverage under contract number H2256 to approximately 107,000 enrollees. For the 2015 through 2016 payment years (audit period), CMS paid Tufts approximately \$2.3 billion to provide coverage to its enrollees.
- An [audit performed by the Office of Inspector General \(OIG\) of Tufts Health Plan, Inc.](#) sampled 212 unique Medicare Advantage enrollee-years with high-risk diagnosis codes for the years 2015 through 2016. Only 54 of the 212 sampled validated HCCs, while the remaining 154 had diagnosis codes that were unsupported in the medical record. Based on the sample result, the OIG estimates that Tufts received at least \$3.7 million in net overpayments for high-risk diagnosis codes in 2015 and 2016.
- The OIG recommends that Tufts repay the \$3.7 million, as well as identify similar instances of noncompliance for the high-risk diagnoses included in the audit and repay that amount as well

OIG Audit Says Tufts Received \$3.7 Million in Overpayments for High-Risk Diagnosis Codes

Using data mining techniques and discussions with medical professionals, OIG identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, they focused on seven high-risk groups:

- **Vascular Claudication:** An enrollee received one diagnosis related to vascular claudication (which maps to the HCC for Vascular Disease) but had medication dispensed on his or her behalf that is frequently dispensed for a diagnosis of neurogenic claudication. In these instances, the vascular claudication diagnoses may not be supported in the medical records.
- **Major Depressive Disorder:** An enrollee received a major depressive disorder diagnosis (which maps to the HCC entitled Major Depressive, Bipolar, and Paranoid Disorders) on one claim during the service year but did not have an antidepressant medication dispensed on his or her behalf. In these instances, the major depressive disorder diagnoses may not be supported in the medical records.
- **Potentially Mis-keyed Diagnosis codes:** An enrollee received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-9 diagnosis code 250.00 (which maps to the HCC for Diabetes Without Complication) could be transposed as diagnosis code 205.00 (which maps to the HCC for Metastatic Cancer and Acute Leukemia and in this example would be unvalidated). Using an analytical tool that we developed, we identified 811 scenarios in which diagnosis codes mis-keyed because of data transposition or other data entry errors could have resulted in the assignment of an unvalidated HCC.

OIG Audit Says Tufts Received \$3.7 Million in Overpayments for High-Risk Diagnosis Codes

Using data mining techniques and discussions with medical professionals, OIG identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, they focused on seven high-risk groups:

- **Acute Stroke:** An enrollee received one acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. A diagnosis of history of stroke (which does not map to an HCC) typically should have been used.
- **Acute Heart Attack:** An enrollee received one diagnosis that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on only one physician claim but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician's claim). A diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.
- **Acute Stroke and Acute Heart Attack Combination:** An enrollee met the conditions of both the acute stroke and acute heart attack high-risk groups in the same year.¹⁰
- **Embolism:** An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease with Complications (Embolism HCCs) but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. A diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.

SCAN Refund to the Federal Government \$54.3 Million of Net Overpayments

February 2022 -- Medicare Advantage Compliance Audit of Diagnosis Codes that SCAN Health Plan Submitted to CMS

The OIG published a Review of whether select diagnosis codes that SCAN Health Plan, a Medicare Advantage organization, submitted to CMS for use in the risk adjustment program complied with federal requirements. The OIG conducted the audit by selecting 200 enrollees with at least one diagnosis code that mapped to an HCC for 2015 and looking at the 1,577 HCCs associated with those enrollees to see whether the medical records supported the use of those diagnosis codes. The OIG found that 164 of the 1,577 sampled HCCs were not validated by the medical records. Risk scores therefore should have been based on a lower number of HCCs, and the OIG estimated that SCAN received at least \$54.3 million in net overpayments due to these incorrect HCCs and their effect on risk scores.

The OIG recommended that SCAN refund the federal government for the \$54.3 million in net overpayments and improve its policies and procedures to prevent, detect, and correct noncompliance with federal requirements for diagnosis codes that are used to calculate risk-adjusted payments. SCAN disagreed with the OIG's findings and stated that the medical reviewer erred in determinations by not validating certain HCCs and used flawed methods to identify samples of enrollees for audit and for extrapolation. After reviewing SCAN's comments, the OIG revised its determination for the number of non-validated HCCs, reduced the estimated overpayments down from \$66.9 million to \$54.3 million, and revised the wording of one of its recommendations.

SCAN, an MA organization with headquarters in Long Beach, California, has several geographically based Medicare Part C contracts with CMS. As of December 31, 2015, SCAN provided coverage under contract number H5425 to approximately 179,000 enrollees in California. For our audit period (the 2015 payment year), CMS paid SCAN approximately \$1.9 billion to provide this coverage.

Incorrect diagnosis codes can lead to improper payments. An improper payment is any payment that should not have been made or that was made in an incorrect amount (either an overpayment or an underpayment). An estimated 7.87 percent of payments to MA organizations for calendar year 2017 were improper, mainly due to MA organizations submitting unsupported diagnosis codes to CMS. This audit is part of a series of audits in which OIG is reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.

CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented because of a face-to-face encounter. The diagnosis must be coded according to the International Classification of Diseases (ICD), Clinical Modification, Official Guidelines for Coding and Reporting. Further, the MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians.

SCAN Refund to the Federal Government \$54.3 million of Net Overpayments

What OIG Found

- SCAN did not submit some diagnosis codes to CMS for use in the risk adjustment program in accordance with Federal requirements. First, although most of the diagnosis codes that SCAN submitted were supported in the medical records and therefore validated 1,413 of the 1,577 sampled enrollees' HCCs, the remaining 164 HCCs were not validated and resulted in overpayments. These 164 unvalidated HCCs included 20 HCCs for which we identified 20 other HCCs for more and less severe manifestations of the diseases. Second, there were an additional 21 HCCs for which the medical records supported diagnosis codes that SCAN should have submitted to CMS but did not.
- Thus, the risk scores for the 200 sampled enrollees should not have been based on the 1,577 HCCs. Rather, the risk scores should have been based on 1,454 HCCs (1,413 validated HCCs plus 20 other HCCs plus 21 additional HCCs). As a result, we estimated that SCAN received at least \$54.3 million in net overpayments for 2015. As demonstrated by the errors found in our sample, SCAN's policies and procedures to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved.



Why Is M.E.A.T. So Important?

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The importance of documentation

- Documentation should be clear, concise, and legible.
- CMS requires submission of risk adjusting diagnosis codes:
 - From a face-to-face or audio-visual telehealth visit with physician or another approved provider.
 - Within the reporting period each calendar year.
- Document conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment and/or management.
- Diagnoses cannot be coded from diagnostic reports alone. The review and pertinent findings of the diagnostic reports should be documented in the progress note.

Why Is M.E.A.T. So Important?

DOCUMENTATION TIPS

A condition can be coded when documentation states that the condition affects the care, treatment, or management of the patient. This must be documented and cannot be assumed.

Example: Sugar free cough syrup prescribed due to Type 2 DM

Medication/medication changes and the condition being treated need to be documented.

Example: MDD-increase Paxil to 50 mg/day

Conditions can be coded when documentation states condition is being monitored and treated by a specialist.

Example: patient on Coumadin for a-fib followed by Dr. X

Why Is M.E.A.T. So Important?

Additional Tips

Document each patient encounter as if it is the only encounter

Codes should be assigned for every condition documented in the chart note that has evidence of M.E.A.T., not just the condition for which the patient came in.

All chronic and complex conditions need to be coded annually.

Review and document conditions managed by a specialist.

- This counts as M.E.A.T. and can be coded on the claim

When seeing a patient who comes in infrequently, ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.

When refills are made outside of a visit, encourage patient to schedule a check-up so that the condition can be reviewed and managed at least once a year.

Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "history of"

Specify the basis for ordering additional testing/treatment.

Show patient's progress or lack of progress.

Avoid using the words "history of" for a condition that is chronic but currently stable, such as COPD, DM, or atrial fibrillation.

Why Is M.E.A.T. So Important?

Language of documentation

- Diagnosis codes reported must be supported by documentation in the medical record. It is recommended to identify evidence of monitoring, evaluating, assessing/addressing and/or treating (M.E.A.T.).
- Utilize adjectives to specify conditions documented & coded such as: severity, site, stage, laterality, episode, type, complications, comorbidities, insulin status or amputation status.
- In order to document accurately, and make this process easier, healthcare organizations can choose to adopt M.E.A.T. criteria standards. Checking all the boxes of M.E.A.T. criteria can help you be successful in RADV (Mandatory CMS and Health and Human Services Audits are called Risk Adjustment Data Validation) audits. In these audits, CMS requires codes be fully supported by documentation in the medical record and diagnosis codes (ICD-10) submitted follow the Official Coding Guidelines. It is key that medical record documentation supports diagnosis codes submitted on a claim. Complete documentation will also help in assisting providers to meet the requirements for other alternative payment methods such as Stars, HEDIS, MIPS and MACRA.



Understanding the Crux of the M.E.A.T.

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- HCCs are based on ICD-10 codes. To generate a risk adjustment factor (RAF) score, the HCC payment system uses demographics (age, sex, institutional status) and ICD-10 diagnosis codes. Therefore, being up to date on ICD-10 codes is crucial for success with risk adjustment HCC coding.
- People with chronic conditions need long-term attention and management. However, physicians may neglect to show evaluation and treatment for all conditions assessed at the time of the encounter due to high familiarity with the patient.
- Adherence to M.E.A.T. criteria – Monitor, Evaluate, Assess, Treat – is necessary to ensure proper documentation of diagnoses during a face-to-face visit. Insufficient documentation impacts the assignment of diagnosis codes, and directly impacts the patient’s risk score and physician reimbursement.

Manage	Evaluation	Assessment	Treatment
<ul style="list-style-type: none"> • Signs • Symptoms • Disease progression • Disease regression • Medications • Referrals to specialists or disease management programs 	<ul style="list-style-type: none"> • Medications • Therapies • Other modalities • Test results • Medication effectiveness • Response to treatment 	<ul style="list-style-type: none"> • Ordering tests, diagnostics, labs • Discussion • Reviewing records • Counseling 	<ul style="list-style-type: none"> • Medications • Therapies • Other modalities

Understanding the Crux of the M.E.A.T.

- **M.E.A.T. is at the crux of risk adjustment.** Documentation for a valid diagnosis must provide evidence of how the condition is monitored, evaluated, assessed, or treated (M.E.A.T.) for it to be captured for risk adjustment. To adhere to M.E.A.T., providers should:
 - Document all conditions evaluated during each encounter
 - Ensure a proper progress note with the HPI, physical exam and medical decision-making process
 - Document each diagnosis in an assessment and care plan
 - Ensure that each diagnosis provides evidence that the provider is Monitoring, Evaluating, Assessing/addressing and Treating the condition.
- Without M.E.A.T. documented to substantiate the diagnosis, CMS will reject the diagnosis due to the lack of evidence by provider. When using electronic medical records, providers should take care not to capture diagnoses from cloned encounters.



Application of M.E.A.T. Criteria

Scenario for M

MDM

- Number of Diagnoses or Management Options
- COVID-19
- Hematemesis
- Pharyngitis
- Diagnosis management comments: The patient is a 22-year-old male presents emergency department generalized malaise, pharyngitis and episode of hematemesis.
- Patient has a history of thrombocytopenia. Platelets are technically low but not critically so today.
- He is COVID positive which likely source of all of his symptoms. Patient will be discharged home. Understanding followed emergency department for any worsening concerns or shortness of breath.
- Amount and/or Complexity of Data Reviewed
- **Clinical lab tests:** ordered and reviewed

- **Rationale:** Provider noted that the patient has a past medical history of thrombocytopenia with low platelets upon review of lab data
- **Supports “M” of M.E.A.T. criteria as the platelets value is reviewed from the lab data**

Scenario for E

MDM

89-year-old female presents for evaluation of generalized weakness, fatigue, shortness of breath, fever, and decreased appetite for 4 days. Pt was recently exposed to someone with COVID. VS remarkable for elevated BP. PE remarkable for frail little lady with dry mucous membranes. Workup showed pt. was COVID +. She had a decreased WBC of 2.8 and anemia with Hgb of 9.9. CXR showed hazy pulmonary opacity likely caused by developing COVID pneumonia. Pt had ambulatory O2 saturation > 92%. Pt did appear to be slightly volume depleted, so she was given 1 L of LR as well as Zofran and Toradol for nausea and myalgias.

From a social standpoint, patient is an elderly female who is weak and frail and generally unable to care for herself and perform all ADLs independently at baseline. Now she has contracted COVID and is even weaker than usual and unable to take care of herself as her daughter who lives with her is hospitalized with COVID as well. We anticipate that if discharged, pt. would have ended up back at the ED in likely worse condition. So, after discussions with social work and MOD, pt. was admitted for observation with a plan to set up safe short-term rehab stay where she could be taken care of.

- **Rationale:** Provider has assessed the lab values of anemia and found that the patient already had history of chronic disease anemia
- **Supports “E” of M.E.A.T. criteria as the provider has reviewed and identified the history of anemia**

Scenario for A

MDM

Jasmine is a 17-year-old female with PMH of hearing loss in right ear who presents with foreign body in right ear. Vital signs within normal limits. Physical exam is remarkable for foreign body in right ear. Hearing aid ear cushion piece removed with alligator forceps. Patient tolerated procedure well.

Pt stable while observed in ED. Results and plan of care discussed with patient's caregiver- agreeable to discharge. Return precautions were given to patient and instructed to report back to the ED if symptoms worsen or any new concerning symptoms arise.

- **Rationale:** The hearing loss is a current condition as evidenced by the need for a hearing aid.
- **Supports “A” of M.E.A.T. criteria as the provider has assessed and confirmed the need of hearing aid device to manage her condition, hearing loss.**

Scenario for T

MDM

Patient is a 58-year-old female with PMHx above notable for previous liver cysts s/p resection, s/p IR drainage who presents for jaundice, abdominal pain, concerning for CBD compression. CT ab pelvis showed

- Increasing size of the multiseptated cystic lesion within the right hepatic lobe/operative bed, now measuring 8 cm in maximal dimension. This lesion causes extrinsic compression of the adjacent common bile duct.
- No other acute pathology identified within the abdomen or pelvis.
- Other postoperative and incidental findings as above.

CMP notable for T bili of 7.9, ALP 186, AST 108, ALT 171. Ammonia 36. Lipase wnl. INR 1.3.

Spoke with GI at 1:15 p.m. who will evaluate the patient. They ultimately recommended IP med admission due to biliary obstruction and need for IR drainage.

The patient accepted at 3:10 PM by IP med. Patient updated and verbalized understanding. BP elevated, patient reports not taking her BP meds this AM. Will give lisinopril here.

- **Rationale:** BP elevated, patient reports not taking her BP meds this AM. And the provider has mentioned that he will give lisinopril.
- **Supports “T” of M.E.A.T. criteria as the lisinopril was prescribed on this admission.**



Thank you.

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