# Medicare Advantage Plans:

## Coding Challenges and Best Practices

Understand the existing coding challenges for Medicare Advantage plans and some best practices for ensuring better compliance.

**In the ever-evolving medical landscape,** Medicare Advantage (MA) plans are becoming increasingly popular. MA plans, offered by private insurers that are approved by Medicare, provide an alternative to conventional Medicare by clustering Part A, B, and often Part D, as well. This means beneficiaries get comprehensive coverage that goes beyond what traditional Medicare offers.

However, for healthcare providers, MA plans present some unique challenges, especially in the domain of medical coding and relevant documentation. Circumventing these challenges holds the key in ensuring precise reimbursements, compliance, and ultimately, enhanced patient care. This article explores Medicare Advantage plans, the associated coding challenges, and some best practices healthcare providers can adopt to overcome them.

**Medicare Advantage – Plans and Benefits**

Medicare Advantage, commonly known as Part C, includes the benefits of Parts A and B, and often includes additional coverage. MA plans include private fee-for-service plans, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Special Needs Plans (SNPs). Each plan comes with its own coverage rules and healthcare network, allowing beneficiaries to choose from a wide range of options.

Medicare Advantage plans often provide benefits that aren't covered in standard Medicare. These can include dental care, vision exams, wellness programs, and even home-delivered meals and transportation services for those who need it. For chronically ill patients, most plans provide resources for care coordination to manage the patient's overall condition in a better way. The integration of all these benefits makes MA plans an excellent choice for the beneficiaries who are seeking something better than traditional Medicare.

**Medicare Advantage Payment Model and the Significance of Risk Scores**

The key differentiator between Medicare Advantage and Medicare is the payment model. MA plans are paid a capitated amount to cover care for the patient, which are adjusted based on the patient's risk score. This payment model is different from Medicare's Fee-for-Service (FFS) model, where the providers are compensated for the service they provide.

The decisive factor in determining the amount paid to the MA plans is the risk adjustment factor. The payment model changes based on the health status and demographic characteristics of the beneficiaries. The risk score decides the estimated medical cost of a beneficiary based on parameters such as age, gender, disability status, and the presence of certain chronic conditions.

Accurate coding is essential to ensure appropriate risk scores. The coding process involves precisely categorizing the health conditions of patients through the ICD codes. It is vital to accurately capture the beneficiary's health conditions through the most specific codes. If not, it can lead to underpayment to the plan. Conversely, if coding is exaggerated, it can result in overpayment or upcoding, which can lead to serious legal repercussions.

**Medicare Advantage vs Fee-for-Service Coding Practices**

The coding practices under Medicare Advantage are entirely different from that of traditional Fee-for-Service (FFS) Medicare. Under FFS Medicare, providers get paid for the specific services rendered to patients. Therefore, coding under FFS is primarily centered on documenting the specific services rendered during an encounter with a patient. However, in Medicare Advantage, coding is centered on capturing a patient's overall health status to determine the risk score that influences payments made to the insurance plan.

This focus on health status in Medicare Advantage coding has led to the implementation of the coding intensity adjustment. To account for the greater differences in coding intensity between MA plans and FFS Medicare, CMS adjusts payments to MA plans to account for differences in coding intensity between MA plans and FFS Medicare. This adjustment is intended to prevent overpayment to MA plans that code more aggressively than FFS.

One of the challenges with the coding intensity adjustment is ensuring transparency in the reflection of differences in the health status of beneficiaries. Adjustments should take into consideration that MA plans are often held by more vulnerable populations that have more complex health needs. Meanwhile, concerns about upcoding – where providers purposefully code conditions that are more severe than what they actually are to increase payments – have led to a tighter scrutiny of MA's coding plans.

**Implications of Upcoding**

Upcoding happens when providers assign a code that reflects a more serious or complex condition than what the patient actually experiences, for the sole purpose of increasing payments from MA plans. While a few of the incidents may be unintentional due to the intricacies of the ever-evolving coding system, deliberate upcoding can attract significant financial penalties. While CMS scrutinizes to prevent and detect upcoding, RADV audits identify scenarios that do not accurately capture the patient's health status.

**Coding Challenges With Medicare Advantage**

Precise coding in MA has been a force to reckon with – since its inception in the healthcare system. The main coding challenges Medicare Advantage plans face include CMS Risk Adjustment Data Validation (RADV) audits, social determinants of health (SDOH), and telehealth and remote care services.

***Risk Adjustment Factor (RAF) Scoring***

The foremost challenge plaguing the healthcare sector in terms of MA plans is accurately capturing the patient's clinical conditions and demographics, so that the CMS can determine how much to pay to the patient's particular health plan each year. CMS does this by using Hierarchical Condition Categories (CMS-HCCs) to calculate risk scores that directly affect the reimbursement rate.

Ensuring providers accurately capture and code chronic conditions is a challenge. Lack of clarity in the documentation or upcoding/undercoding can lead to overpayments or underpayments and attract penalties.

***CMS Risk Adjustment Data Validation (RADV) Audits***

CMS performs RADV audits on Medicare Advantage plans to ensure that the diagnosis codes submitted are accurate and adequately documented. The purpose of the RADV audits is to recover overpayments associated with erroneous coding, and ensure all overpayments identified during these audits are to be repaid by MA plans. Preparing for and responding to RADV audits is labor-intensive and time-consuming for plans, as they must be required to provide adequate documentation for every diagnosis code submitted.

The biggest challenge associated with RADV audits is the retrospective application process involved. A diagnosis that was appropriate during the time of coding could be brought into question later, requiring the plan to go back and redo the clinical situation with adequate documentation. If the said documentation is found incomplete or missing, the plan could be penalized.

***SDOH Coding***

As healthcare systems incorporate the impact of social determinants of health on patient outcomes, the necessity of accurate coding for SDOH has become critical. SDOH includes conditions such as housing instability, food insecurity, lack of transportation, and many other socioeconomic conditions that affect a patient's health. Medicare Advantage plans involving vulnerable populations are usually the ones in the forefront of addressing these issues.

Due to its infancy, many providers are not sure how to document and code these risk factors. The ICD-10 has developed a set of codes for SDOH, but providers may not always gather the necessary data to assign these codes.

***Coding for Telehealth and Remote Care***

The COVID-19 pandemic encouraged telehealth as a key area in healthcare provision. Telehealth services have been rapidly covered by MA plans, but coding of telehealth and remote care presents its own set of complexities. Often, providers are unfamiliar with the specific and relevant codes to assign for telehealth services. Another aspect is regarding the kind of documentation done for telehealth visits, which is different from other in-person visits.

As CMS refines the rules regarding telehealth reimbursement, providers offering MA plans need to stay up to date to code and bill their services accurately. This can be especially challenging as telehealth emerges as a permanent fixture within the U.S. healthcare system.

**Best Practices in Managing MA Plan Challenges**

**Providers can opt for the following best practices to overcome the challenges and ensure compliance:**

1. **Addressing the Social Determinants of Health (SDOH):** Accurately capturing and coding of SDOH should take place in collaboration with providers. This may entail upgrading the data collection process and educating the providers on the significance of the documentation of SDOH.
2. **Comprehensive Documentation Procedure:** A standardized documentation guideline should be implemented by the providers, ensuring all significant data relevant to the patient's conditions are captured during his/her visit. The documentation must be clear and complete, with every diagnosis marked and adequately justified.
3. **Staff Training:** Imparting regular, updated training to coders and providers alike is crucial to reduce errors in the process. Providers need to be trained in documenting patient conditions accurately, especially in high-risk areas, prescribed under the HCC (Hierarchical Condition Category). On the other hand, coders should be proficient in rules on both CMS and MA plans which would ensure the transparency of clinical documentation.
4. **Regular Chart Audits:** Auditing patient charts on a time-to-time basis can mitigate errors related to diagnosis and procedure coding. Audits can help identify documentation/diagnosis mistakes and coding errors. The subsequent feedback from these audits can help coders and providers understand their mistakes and reduce risks of any consequences in the future.
5. **Adoption of Advanced Tools and Software:** Investing in Electronic Health Record (EHR) systems with Artificial Intelligence (AI) can not only automate repetitive tasks and accelerate the coding process but can also help detect errors in documentation and suggest feedback on how to improve accuracy.
6. **Patient Health Assessments:** Patient Health Assessments (PHAs) usually serve as an information gathering tool that MA plans often rely on for beneficiaries' health status. Involving patients in PHAs can help providers capture a broader view of the patient's health conditions, thus ensuring proper coding and more effective management of patient care.

**Conclusion**

According to the article, "Quality, Health, and Spending in Medicare Advantage and Traditional Medicare" published in The American Journal of Managed Care (AJMC), 52% of the analyses favored Medicare Advantage as opposed to the 13% favoring traditional Medicare. The systemic review also revealed that the MA beneficiaries experienced better quality of care, better health outcomes, and lower costs compared with traditional Medicare.

Medicare Advantage offers great welfare for the patients but at the same time presents a unique set of challenges for providers and coders that can negatively impact coding accuracy and compliance. By focusing on producing comprehensive documentation, regular staff training and auditing, and staying up to date with the current guidelines, healthcare providers can reduce claim denials, thereby optimizing reimbursements and maintaining compliance. By adopting these best practices, providers can bypass roadblocks related to the ever-evolving landscape of MA plans, ensuring steady financial outcomes and enhanced patient care.

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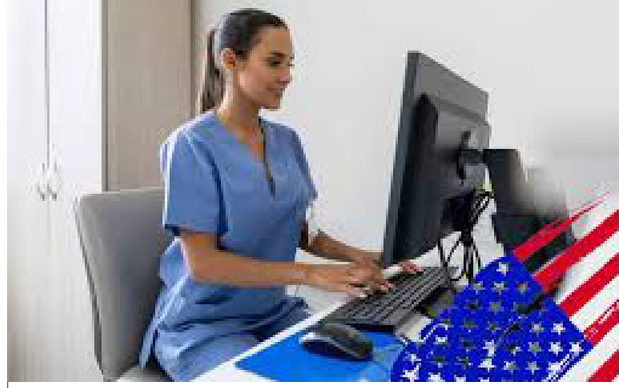

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