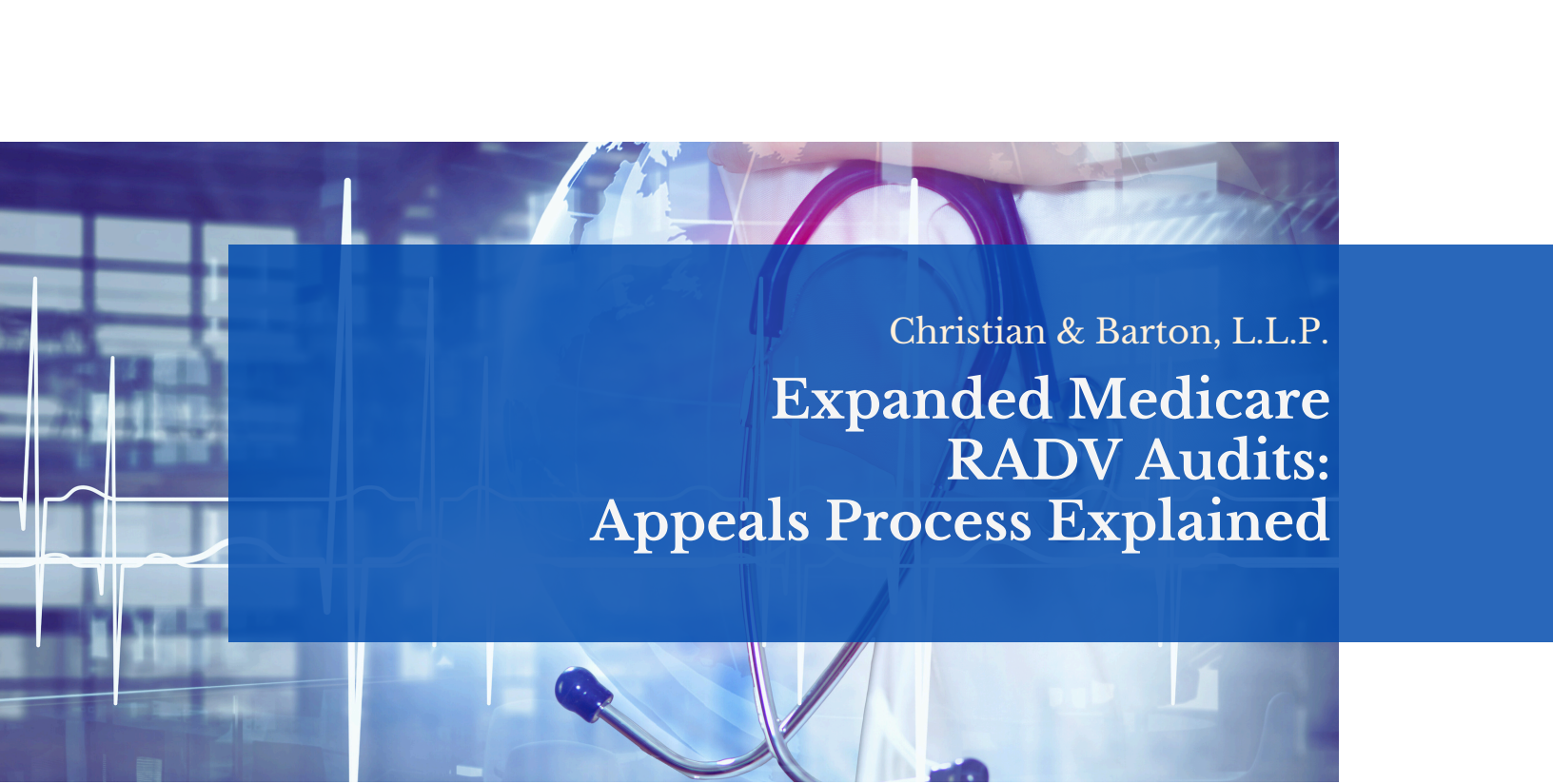




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Expanded Medicare RADV Audits: Appeals Process Explained

The Centers for Medicare & Medicaid Services (CMS) has announced it will now conduct Risk Adjustment Data Validation (RADV) audits of all Medicare Advantage (MA) plans annually, a major shift from its previous strategy of auditing only a fraction of contracts each year. This increased scrutiny is likely to impact providers, who play a crucial role in documenting the care that drives risk-adjusted payments.

CMS uses RADV audits to confirm the accuracy of payments, identify overpayments and verify that MA plans are paid accurately based on the health conditions of their members. The regulations that govern RADV audits do not require a specific type of audit. As a result, new audits may be more focused on specific diagnosis codes or Hierarchical Condition Categories (HCCs) rather than the broader audits that CMS had previously conducted. Based on information available from CMS, it is unclear if only potentially unsupported codes will be identified, or if potentially supported but unbilled codes will also be targeted.

While MA plans are the direct subject of RADV audits, provider documentation is often the evidence to validate diagnoses. If documentation is incomplete with missing notes or unclear links between services and diagnosed conditions, MA plans could be forced to repay funds to CMS. Specifically, once the MA plan exhausts its appeal rights, the Secretary of Health & Human Services recalculates the MA plan's payment error and issues a revised audit report with the new calculation.

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CARE
DOCUMENTATION
DRIVES RISK-ADJUSTED
PAYMENTS
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Contract-level RADV Process

The purpose of a contract-level RADV is to note payment discrepancies by comparing diagnosis data that a MA plan has submitted for payment against enrollees' medical records. To start the process, CMS sends an Audit Notice to the MA plan's chief executive officer and Medicare compliance officer. This letter outlines essential information about the audit, establishes points of contacts and contains links to important documents.

Designated MA plan contacts must register with the CMS' secure RADV system portal, which also includes enrollee data lists and selected HCCs. Typically, MA plans have 25 weeks to obtain medical records that best represent the requested HCCs and prepare the files according to RADV instructions.

These submission rules should be followed carefully to avoid unnecessary denials. For example, medical records must note the correct beneficiary as provided on the RADV cover sheet; acceptable risk adjustment provider type, source and physician specialty that provided the face-to-face encounter must be included; the date of service must be within the data collection period under review; and the record must contain valid signatures and credentials.

Each submitted record may undergo up to three rounds of review, with the first two conducted by certified medical record coders. A physician review is the last step in the abstraction process and occurs when there is disagreement between the first and second rounds. MA plans receive an Audit Report Package when the audit is complete.

Navigating the RADV Appeals Process

When CMS completes the contract-specific RADV audit, an Audit Report Package is posted in the MA plan's secure portal, and the plan's designated contacts are notified via email. The Audit Report Package includes audit results with detailed feedback of each sampled enrollee and audited HCC.

MA plans that disagree with RADV audit findings have the right to appeal medical record review determinations (MRRDs) and payment error calculations (PECs) through three levels of administrative appeal: reconsideration, hearing and CMS administrator review. MA plans bear the burden of proof by a preponderance of the evidence that the MRRD determination and/or PEC calculation were incorrect.

Requests for a Level One Reconsideration must be submitted within 60 days of issuance of the revised audit report following the completion of the MRRD appeal process. Only HCCs determined to be "discrepant" or "discrepant lower" are eligible for reconsideration. Medical records deemed invalid during the intake review process are ineligible for review.

MRRD appeals must include the disputed HCC-enrollee combination, the supporting medical record, justification of how the record supports the audited HCC with the specific page noted, and an attestation.

PEC appeals may not challenge the accuracy of non-health related data factors that may affect enrollee risk scores. Supplied documentation must include the MA plan's payment error calculation plus note where the audit's PEC was erroneous.

If dissatisfied with the reconsideration decision, MA plans may file an appeal with a CMS Hearing Officer. These Level Two appeals must be submitted within 60 days of the reconsideration decision. The Level Three appeal is made to the CMS Administrator.

Preparation and Compliance Strategies

As CMS ramps up its audits, compliance expectations will increase across the board. MA plans should take proactive steps to ensure provider documentation is clear and detailed.

This includes making sure such documentation specifies dates and times, and links to services to diagnosed conditions when applicable. Also, MA plans should ensure providers are equipped with resources to understand what is needed to support certain diagnoses.

In addition, MA plans should promptly review RADV reports and determine which issues in each report are appealable so as to not miss appeal deadlines.

Finally, it is helpful to retain legal counsel experienced with the CMS process regarding deadlines, guidelines, and audit submissions to ensure regulatory conditions are addressed.



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