AAPC

Medical Coding Training
CRC®

Certified Risk Adjustment

Certification Preparation

2023

2023

Official Study Guide
CRC® Certification

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Regarding HCPCS Level II

HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2022 code set for HCPCS Level II were unavailable when published.

About the Author

Brian Boyce has over 25 years of healthcare experience. He started his career in Aeromedical Evacuation (flight nursing) in the US Air Force. He has over 15 years of healthcare management experience and has spent the last 5 years with a focus on risk adjustment (diagnosis coding). He is regularly contacted by coders from virtually every big player in the risk adjustment market for his opinions, advice and expertise. He is a PMCC instructor and ICD-10-CM trainer. His company ionHealthcare offers PMCC courses, CEUs, and consulting specializing in coding operations, practice management and risk adjustment. Brian is trained in Six Sigma, and has many certifications to include a Certificate in Clinical Bioethics from Georgetown. Brian holds a Bachelors of Science in Health Sciences with a concentration in Health Administration from Old Dominion University.

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Coding as a Profession

Each time an individual receives healthcare, a record is maintained of the resulting observations, medical or surgical interventions, diagnostic test and studies, and treatment outcomes. Coding is the process of translating this written or dictated medical record into numeric and alphanumeric codes. There are separate code sets to describe diagnoses, medical and surgical services/procedures, and supplies. These code sets serve as a common language to ease data collection (for example, to track disease), to evaluate the quality of care, and to determine costs and reimbursements.

Proper code assignment is determined both by the content (documentation) in the medical record and by the unique rules that govern each code set in that particular instance. Coding rules also vary depending on who pays for the patient care (for example, self-pay versus health insurance).

Coding typically is performed by either the physician or a coder. When the physician performs the coding, the coder may act as an auditor to verify that the documentation supports the codes the physician selected. In some practices, the coder will receive the documentation and code the services based on what is documented in the medical record.

If the medical record is inaccurate or incomplete, it will not translate properly to the language of codes. The coder must evaluate the medical record for completeness and accuracy and communicate regularly with physicians and other healthcare professionals to clarify diagnoses or to obtain additional patient information.

Outpatient coding focuses on physician professional services and outpatient facility coding. Outpatient coders will focus on CPT®, HCPCS Level II, and ICD-10-CM codes. They will work in physician offices, outpatient clinics, and facility outpatient departments. Outpatient facility coders will also work with Ambulatory Payment Classifications (APCs).

Hospital inpatient coding focuses on a different subset of skills, where coders will work with ICD-10-CM and ICD-10-PCS. These coders also will assign medical severity diagnosis related groups (MS-DRGs).

Risk adjustment coding focuses on diagnosis coding using the ICD-10-CM code set. Risk adjustment diagnoses are reported from claims data and medical record documentation in all settings. Risk adjustment coders may work for health plans or provider, or may work in other healthcare entities.

Regardless of the setting, code updates and insurance payment policies may change as often as quarterly. Coders require continuing education to stay abreast of these changes.

The Role of a Risk Adjustment Coder

Risk adjustment coders work in various roles. The main role for a risk adjustment coder is in a health plan or for a vendor who is working with a health plan. Risk adjustment coders also work in provider offices when the providers have risk-based contracts.

Risk adjustment coders need to know the complexity of diseases associated with chronic conditions or comorbidities to ensure the documentation supports an accurate health status of the patient. Payment to the Medicare Advantage Organization (MAO) depends on the diagnoses reported by a provider; therefore, proper documentation and coding is pertinent to proper reimbursement.

Some risk adjustment coders will be tasked with educating providers on proper documentation and coding. As such, a risk adjustment coder should have a well-rounded, firm knowledge of medications, treatments, and diagnostic tests to identify areas for improvement. For example, an educational opportunity exists if a patient is taking insulin, but the provider has not documented diabetes.

The goal is to represent an accurate clinical picture and risk adjustment coders are often required to code for other purposes, in which you must be able to know and apply the ICD-10-CM guidelines. Throughout this curriculum, we will first teach the application of the ICD-10-CM guidelines, then will apply risk adjustment guidelines. Unless otherwise noted, all documented diagnoses are to be coded, regardless of whether it is a risk-adjusted code.

Payer Perspective

Impact of risk adjustment

The Patient Protection and Affordable Care Act (ACA or "Obamacare") introduced risk adjustment to the mainstream. Although risk adjustment programs are subject to change every year, two factors remain the same:

1. These programs protect health plans from the risk of attracting a disproportionate number of unhealthy enrollees, while discouraging health plans from marketing to only healthier, less costly potential members.

2. Although some premium stabilization programs, such as reinsurance and risk corridor, were temporary, risk adjustment is a permanent program in all lines of business.

Beneficiaries of Medicare Part B may enroll in any Medicare Advantage plan that is offered for the county in which they live. Medicare Advantage plans are administered by Medicare Advantage Organizations. Plans must accept all enrollees. Plans submit "bids" to CMS, annually, to outline their additional benefits, cost-sharing rules, provider networks, and premiums. They are specific to each plan and are estimates of the expected cost of offering a benefits package to the average member. Plans remain competitive by offering additional benefits, lower premiums or both.

MANAGED CARE ORGANIZATIONS

Managed Care Organizations (MAOs) are private organizations that contract with Medicare to provide Medicare Advantage Plans that include all the Part A and Part B benefits. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Special Needs Plans
- Medicare Medical Savings Account Plans

Risk adjustment for the commercial population is a permanent program created by the ACA to transfer funds from lower-risk plans to higher-risk plans in the individual and small markets. Members' risk adjustment factors are considered when determining if a plan will receive funds, or if it will be required to pay funds.

Risk adjustment for the Medicaid population varies state-by-state. Although it has some similarities to the Medicare and Commercial programs, there are many differences that plans must consider as the Medicaid program expands.

Opportunities

The increased focus on diagnosis coding coincided with the implementation of ICD-10. Provider education became paramount to ensure the true severity of illness of members is reflected in claims data. The need for teams of certified professional coders grew during this time. The volume of charts that needed to be reviewed meant hiring vendor partners to assist with record retrieval, record review, and data submission. When a plan is able to collect the most accurate diagnosis codes for its members, it is empowered to use the information not only to cover claims cost, but to implement a robust care management plan. That plan will ensure its members are being

provided with the tools, education, and resources to ensure that diseases are prevented, controlled, and forestalled prior to manifestations or complications.

Challenges

A challenge for payers are the short timelines to gather and submit the data to cover claims costs. The timelines for different lines of business overlap. Careful planning and execution necessary to ensure all records are retrieved and coded, and data is submitted, accurately.

Some members do not seek preventive care services as recommended, or may self-refer to specialists, urgent care centers, and emergency rooms only "as needed." This creates an incomplete diagnostic profile of the member. Plans must continue to engage their members to find and visit a primary care physician to oversee their medical needs and provide a comprehensive review of their health.

Ongoing provider education is needed to capture the full diagnostic picture of the member. In addition, risk adjusted codes are required to be accurately submitted by providers, at least once annually, to CMS. The challenge is both getting the accurate code at the time of diagnosis and ensuring that the patient seeks care for the diagnosis. Some EMRs are taking note of the importance of these risk-adjusted diagnosis codes and are providing tools that highlight HCC codes for easy identification.

Role of the professional coder

Numerous risk adjustment roles are available on the payer side. The need for certified coders educated in risk adjustment has grown in recent years. Certified professional coders can accurately extract the most specific diagnosis codes from the medical documentation provided and help to recover appropriate funds to the health plan. They also are able to identify whether a chart may be over coded and help to mitigate a plan's Risk Adjustment Data Validation (RADV) audit (discussed in a later chapter). Risk mitigation is important to a plan's risk adjustment efforts: the threat of a RADV audit failure and the associated extrapolation of any errors found pose a serious threat to a plan's financial success.

Highly audited areas for risk adjustment are cancer, strokes, fractures, and acute myocardial infarctions. A certified coder on the payer's team can identify these codes so that they can be submitted as a deletion file to CMS. This will result in the diagnosis being deleted from the member's and plan's risk profile, as needed. This is invaluable to mitigate the risk of RADV extrapolation.

A certified coder can assist the risk adjustment department's management team with devising department policies and procedures that comply with accepted guidelines and are in line with the goals of the health plan.

Medical Terminology and Anatomy Review

Introduction

This chapter will review medical vocabulary and terminology and introduce the basic elements of human anatomy. You may encounter terms not covered here within subsequent chapters. Objectives for this chapter include:

- Understand the language of medicine
- Review word elements such as combining forms, prefixes, and suffixes
- Acquire an understanding of procedural and diagnostic terms
- Understand anatomy as it relates to coding

Medical Terminology

The best way to learn medical terminology is to understand the word parts and elements of medical language—root words, prefixes, and suffixes—that serve as the foundation of the medical vocabulary.

Root words are terms that can stand alone as the main portion of a medical term. The root word is the word part that holds the fundamental meaning of the medical term. A word can have more than one root.

Combining vowels are attached to root words to link the root word with the suffix or one root word to another root word. Combining vowels also make medical terms easier to pronounce. The most common combining vowels are O and I. Occasionally, these vowels are dropped altogether, such as when the suffix begins with a vowel; however, the combining vowel is always placed between two root words, even when the second root word begins with a vowel.

EXAMPLE

Combining vowel between root word and suffix:

Cystoscopy (cyst/o/scopy)

Combining vowel between multiple root words:

Uvulopalatopharyngoplasty (uvul/o/palat/o/pharyng/o/plasty)

Combining vowel between two root words with second root word starting with a vowel:

Gastroenterology (gastr/o/enter/o/logy).

Combining forms are root words with a combining vowel.

Common root words and their combining forms associated with the body systems include:

Root word	Definition
Blephar/o	eyelid
Bucc/o	cheek
Cholecyst/o	gallbladder
Colp/o	vagina
Cyst/o	a fluid sac or pouch, urinary bladder
Derm/o	skin
Encephal/o	brain
Enter/o	intestine
Hem/o, hemat/o	blood
My/o	muscle
Myel/o	spinal cord, bone marrow
Onych/o	nail
Oste/o	bone
Phleb/o	vein
Pulm/o, pulmon/o	lungs
Synov/i	synovial fluid, joint, or membrane

A prefix typically is attached to the beginning of a word to modify or alter its meaning. Prefixes often indicate location, time, or number. Common prefixes include:

Prefix	Definition
Ab-	away from
Ad-	toward, near
Ante-	before
Ec-, ecto-	out, outside
End/o-	in, within
Mon/o-	one
Poly-	many, much
Post-	after, behind

A suffix is attached to the end of a word to modify or alter its meaning. In medical terms, suffixes frequently indicate the procedure, condition, disorder, or disease. Common suffixes include:

Suffix	Definition
-centesis	puncture, tap
-desis	binding, fusion
-ectomy	excision, surgical removal
-graphy	act of recording data
-pexy	surgical fixation
-plasty	plastic repair, plastic surgery, reconstruction
-tripsy	crushing

Due to Greek and Latin origins of medical terms, the conventions for changing from singular to plural endings are dictated by a specific set of guidelines, as demonstrated below.

Plural Endings:

Word Ending	Plural Ending	Singular Example	Plural Example
a	ae	vertebra	vertebrae
en	ina	lumen	lumina
ex (ix, yx)	ices	index	indices
is	es	prognosis	prognoses
ma	mata	stigma	stigmata
nx (anx, inx, ynx)	nges	phalanx	phalanges
on	a	phenomenon	phenomena
um	a	serum	sera
us	i	thrombus	thrombi

Using the word parts for translation, you will find the approximate meaning of the complete medical term.

EXAMPLE

The word "cardiomyopathy" can be broken down to find its meaning:

cardi/o—heart

my/o—muscle

pathy—disease

Cardiomyopathy is a diseased heart muscle.

Anatomic Positions and Planes

The standard body position is considered the anatomic position. The anatomic position is an upright, face-forward position with the arms by the side and palms facing forward. The feet are parallel and slightly apart.

Anatomical Planes and Directions
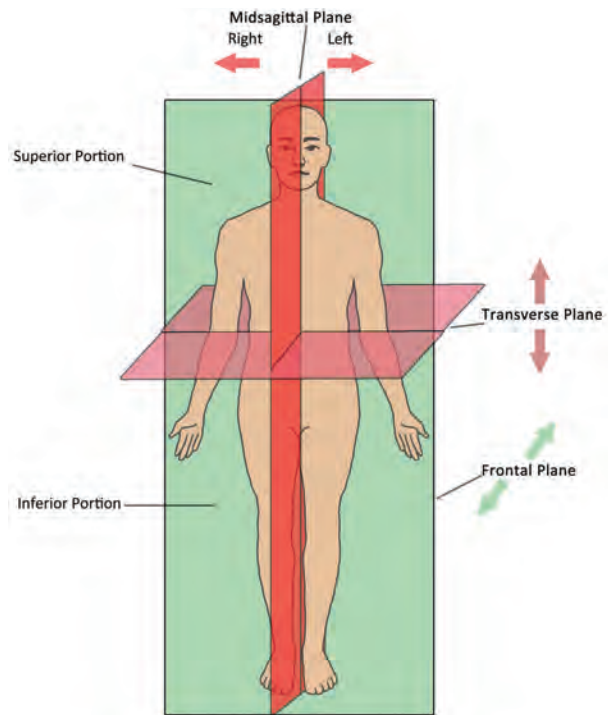
Source: AAPC

Based on the anatomic position, the following directional terms are pertinent to understanding medical documentation:

Anterior (ventral)—Toward the front of the body.

Posterior (dorsal)—Toward the back of the body.

Medial—Toward the midline of the body.

Lateral—Toward the side of the body.

Proximal—Nearer to the point of attachment or to a given reference point.

Distal—Farther from the point of attachment or from a given reference point.

Superior (cranial)—Above; toward the head.

Inferior (caudal)—Below; toward the lower end of the spine.

Vessels–Venous Circulation

Sigmoid signus
External jugular vein
Internal jugular vein
Inferior thyroid vein

Subclavian vein
Internal thoracic vein
Axillary vein
Cephalic vein
Brachial veins
Intercostal veins
Basilic vein
Median cubital vein
thoracoepigastric vein

Cephalic vein
Ulnar vein
Median antebranchial vein
Inferior epigastric vein
Deep palmar arch
Superficial palmar arch
Palmar digital veins

Pulmonary arteries
Heart
Inferior vena cava
Hepatic veins

Renal veins
Abdominal vena cava
Testicularis vein
Common iliac vein
Perforating branches
External iliac vein
Internal iliac vein
External pudendal vein

Deep Femoral vein
Great saphenous vein
Femoral vein
Accessory saphenous vein
Superior genicular veins
Popliteal vein
Inferior genicular veins

Great saphenous vein
Small saphenous vein
Anterior/posterior tibial veins

Deep plantar veins
Dorsal venous arch
Dorsal digital vein

Source: By LadyofHats, Mariana Ruiz Villarreal [Public domain], via Wikimedia Commons

Plasma is a pale yellow mixture of water, proteins, and salts, and acts as a carrier for blood cells, nutrients, enzymes, and hormones.

Components of the Blood

Plasma
(55% of total blood)

Buffy Coat
leukocytes & platelets
(<1% of total blood)

Erythrocytes
(45% of total blood)
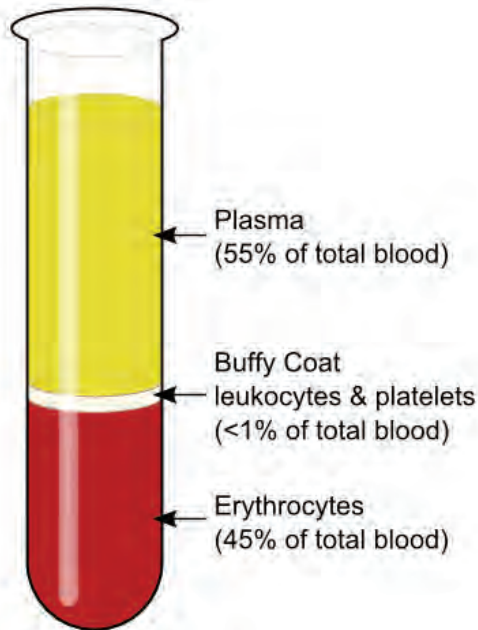
Source: KnuteKnudsen at English Wikipedia [CC BY 3.0 (http:// creativecommons.org/licenses/by/3.0)], via Wikimedia Commons

Immune System

Most immune cells have their origins in the hematologic system. In medicine, the study of the immune system (immunology) and the study of allergies often go together because an allergic response is an immune response. The human immune system is the body's final line of defense against invading microorganisms, harmful chemicals, and foreign bodies. There are two kinds of immune cells: B-cells and T-cells. Several types of cells protect the body from infection (e.g., neutrophils, lymphocytes, monocytes, eosinophils, and basophils). Neutrophils are the body's main defense against infection and antigens. High levels may indicate an active infection; a low count may indicate a compromised immune system or depressed bone marrow (low neutrophil production).

Lymphocytes are involved in protection of the body from viral infections such as measles, rubella, chicken pox, or infectious mononucleosis. Elevated levels may indicate an active viral infection and a depressed level may indicate an exhausted immune system; or, if the neutrophils are also elevated, an active infection.

Monocytes fight severe infections and are considered the body's second line of defense against infection. Elevated levels are seen in tissue breakdown, chronic infections, carcinomas, leukemia (monocytic), or lymphomas. Low levels indicate a good state of health.

The body uses eosinophils to protect against allergic reactions and parasites; elevated levels may indicate an allergic response. A low count is normal. Basophilic activity is not understood fully, but it is known to carry histamine, heparin, and serotonin. High levels are found in allergic reactions; low levels are normal.

Antibodies are immune system-related proteins called immunoglobulins. Some antibodies destroy antigens directly; others indirectly by making it easier for white blood cells to destroy the antigen.

Chapter 2 Questions

1. Which organ is in the thoracic cavity?

    A. Gallbladder

    B. Kidneys

    C. Spleen

    D. Lungs

2. What does the term distal indicate?

    A. Front or toward the front

    B. Farther from the point of attachment

    C. Nearer to the point of attachment

    D. Posterior or toward the back

3. Blood is received back into the left atrium of the heart through _____.

    A. pulmonary veins

    B. pulmonary arteries

    C. the aorta

    D. the right atrium

4. The root of the nail is also known as what?

    A. Nail bed

    B. Perionychium

    C. Hyponychium

    D. Germinal matrix

5. The documentation states: PAST SURGICAL HISTORY: She had a lumpectomy of the breast for DCIS 12 years ago which successfully eradicated the CA.

    How would this be reported?

    A. Breast cancer, in situ

    B. Skin cancer

    C. Personal history of breast cancer

    D. Personal history of skin cancer

6. The documentation states: Soft drusen, some calcified

    What system would have this documentation?

    A. Integumentary

    B. Breast

    C. Cardiovascular

    D. Ocular

AAPC

This chapter will discuss common documentation barriers in risk adjustment coding. A professional coder working in the field of risk adjustment must be vigilant about updates to the ICD-10-CM guidelines and code sets, as well as the AHA Coding Clinic®. These two references are the accepted defense and support for a RADV audit.

Signature or Credential Issues

Providers' signatures and credentials are of the utmost importance in all documentation efforts. The signature is an attestation from the treating and documenting provider that certifies the written document as reflecting the treating provider's intentions and thought processes regarding what was performed in the encounter, and for what reason(s). Absence of a signature leaves the medical record as an incomplete draft.

CMS requires the treating provider to sign the medical record in a timely basis. Timely basis is not defined; however, note that a signature is an expected element for payment under the U.S. Code of Federal Regulations. Some organizations have policies outlining how long a signature may take place from the treatment date, and these can vary from 30, 60, 90, or even 365 days.

Adding a missing signature or credential later, to validate or clarify the treating provider credentials, is different from adding an addendum to a record. An addendum, to include information about what was done to the patient, or any test results, should be added within a reasonable time frame, usually capped at a maximum of 60 days after the encounter. Some organizations enforce shorter limits of 30 days, 14 days, seven days, etc. Any changes to a medical record beyond this time is difficult to justify, and it is unreasonable to assume the provider could recall specific details about the encounter beyond this time.

Medicare requires a legible identity of the treating provider for services provided or ordered. The method used (for example, handwritten, electronic signature) to sign an order or other medical record documentation for medical review purposes is not relevant. Rather, an indication of a signature, in some form, needs to be present. The provider's name must be either legible by his or her signature, or the printed name of the provider must be present somewhere on the document. The name of the provider may appear as a header or footer, such as on practice letterhead, or at the end of the medical record entry.

The U.S. Code of Federal Regulations cites the signature requirement as a condition for Medicare payment: "If the plan of treatment is established by a physician (MD, DO), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA, PA-C), the certification must be signed by that treating physician or non-physician practitioner." (Federal Register, 2013)

A signature or credential missing from a DOS does not negate the factual diagnoses identified. But if the record were to be used in an audit (such as a RADV or HRADV), an attestation for signature or credential would be necessary. When possible, flag such DOS as needing an attestation (for signature or credential) so that this may be expedited in an audit situation.

Attestations are commonly accepted for RADV or other audit purposes when clarifying signatures and or credential issues. Attestations cannot be used to validate diagnoses. Those must be clearly documented in the record and cannot be later attested to by the provider.

Acceptable and Unacceptable Signatures for Risk Adjustment

Unacceptable Signature/Authentication	Acceptable Signature/Authentication
"Signed but not read"	Handwritten signature or initials of treating provider
"Dictated but not signed/read", etc.	Electronic signature/authentication (e.g. "authenticated by," "completed by," "finalized by," "validated by," "attested by," "sealed by," etc.
Signed by someone other than the treating provider (nurse, transcriptionist, etc.) on provider's behalf	
Signature stamps were phased out effective 12/31/2008. (Note that some EMR systems affix a JPEG that may look like a signature stamp and these are approved)	

Signatures in Risk Adjustment Data Validation (RADV or HRADV)

CMS conducts Risk Adjustment Data Validation (RADV) audits to verify the accuracy of the diagnosis codes submitted for payment by the Medicare Advantage organization; HHS conducts RADV audits for commercial risk adjustment verification. The medical record must support the diagnosis codes submitted. The provider signature and credentials are required on the record submitted to support the diagnosis code(s) and HCC.

The CMS guidance in the RADV training states that CMS expects all DOS to include the treating provider's signature/attestation for each visit. The provider's printed name isn't required if the signature or attestation is legible. If the signature or attestation is illegible, or there is more than one provider listed on the record stationery, you must identify which provider the patient saw, and there must be appropriate credentials (MD, DO, PA, NP, LCSW, OT, PT, etc.) for each DOS. "Dr." is not an acceptable credential.

During an official CMS RADV audit, carriers may obtain an attestation from the treating provider for any signature, printed name, or credential issues during the specific timeline of the RADV audit only, and only for outpatient encounters. Due to this ruling, many carriers and vendors will submit retrospective chart review diagnoses that may have printed name, signature, or credential issues on the original medical record. Some carriers and vendors will go a step farther and obtain a fresh copy of any DOS used to support active diagnoses, with all needed corrections from the provider (such as the missing signature or credential) as part of the chart review. CMS will not allow submission of signature logs for RADV. CMS will allow their specific attestation form to be used only in cases where signature or credentials are missing, to attest treatment during the RADV process.

Although CMS has been clear that any needed attestations related to signature, printed name, or credential may be obtained during the RADV process, it could be advantageous to obtain an attestation outside of that process. Even if pre-RADV attestations may not be accepted by CMS, this still helps to validate the DOS in question. Both options of reaching out to the provider offices assist in educating them on the requirements, which can be an advantage, going forward. The exercise to obtain attestations helps to re-educate providers about these types of issues and can help avoid future problems.

Past Medical History

It is common for providers to list both past and current diagnoses in a statement of "history of." A professional coder working in the field of risk adjustment must closely examine the entire record to confirm if a condition is current, despite being listed in the summary statement of "history of." A certified risk coder can add value by educating their providers on this disparity and offering documentation improvement tips to documented more clearly that these conditions are current (e.g., linking a diagnosis to all medications that are actively being managed).

Lab and test Results

Coders working in risk adjustment cannot code from lab and radiology reports, nor can they infer a diagnosis code from lab values listed in the record. Providers should be reminded to document any findings in these types of records in the face-to-face encounter if they are relevant to the patient's care and treatment.

Status Conditions

Permanent or long-term conditions such as amputations, transplant status, and current ostomies factor into the clinical and financial resource needs for the patient. Because of this, it is crucial that these diagnoses be captured at least once every year. Providers often overlook documenting these conditions, which creates an incomplete clinical picture of the patient.

Signs and Symptoms

Coding guidelines instruct coders when it is appropriate to report signs and symptoms. Report codes for signs and symptoms when the treating provider has not yet established a diagnosis or cause for those signs and symptoms.

ICD-10-CM GUIDELINE EXCERPTS

Selecting diagnosis code(s) for signs and symptoms

ICD-10-CM:
Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

D. Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of the ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (Codes R00 – R99) contain many, but not all codes for symptoms.

Uncertain Diagnosis

The coding guidelines to select an uncertain diagnosis code differ, depending on whether the service is outpatient or inpatient. In an outpatient setting, uncertain diagnoses cannot be coded. Instead, report signs and symptoms. You may report

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Chapter 1

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1. **Answer:** C

   Rationale: Medicare Advantage (Medicare Part C) plans are reimbursed by CMS using risk adjustment models based on the health status of their members.

2. **Answer:** D

   Rationale: Risk adjustment coders typically work for health plans.

3. **Answer:** A

   Rationale: Health plans are considered a covered entity under HIPAA. A key provision under HIPAA is the Minimum Necessary requirement. This requirement applies to all covered entities.

4. **Answer:** A

   Rationale: The definition of fraud is to purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service provided.

5. **Answer:** C

   Rationale: Medicare Part C, also called Medicare Advantage, combines the benefits of Medicare Part A, Part B, and—sometimes—Part D.

6. **Answer:** B

   Rationale: Medicaid is a health insurance assistance program for some low-income people (especially children and pregnant women) sponsored by federal and state governments. It is administered on a state-by-state basis, but state programs must adhere to certain federal guidelines.

7. **Answer:** D

   Rationale: Twice a year, the OIG releases a work plan outlining its priorities for the fiscal year ahead. Of special interest to healthcare, the work plan announces potential problem areas with claims submissions that it will target for special scrutiny.

8. **Answer:** B

   Rationale: Risk adjustment coding focuses on diagnosis coding using the ICD-10-CM code set.

9. **Answer:** C

   Rationale: Portions of HITECH strengthen HIPAA rules by addressing privacy and security concerns associated with the electronic transmission of health information.

10. **Answer:** B

    Rationale: Coding is the process of translating this written or dictated medical record into a series of numeric and alphanumeric codes.

Compliance

1. Which record would cause concern during a RADV audit?

    a. A legible record by a family practice provider.

    b. A record without a valid signature sent with a completed CMS-Generated Attestation for the date of service provided.

    c. A record with the targeted diagnosis but, also several other chronic diagnoses.

    d. A record from a dietician that did not see the patient.

2. Medicare recognizes that certain conditions are chronic and ongoing conditions usually treated by ongoing medication management. These conditions have the potential for acute exacerbation if not treated properly. Which of the options below are examples of these types of conditions?

    I.   COPD

    II.   Chronic heart failure

    III.   Pneumonia

    IV.   Urinary tract infections

    a. I and II

    b. II and III

    c. III and IV

    d. I, II, and III

3. What is a RADV audit?

    a. A DOJ audit of CMS to verify the diagnoses in the risk scores are supported by the documentation.

    b. A CMS audit of Part C HCCs to verify the diagnoses in the risk scores are supported by the documentation.

    c. A CMS audit to verify that every diagnosis maps to an HCC.

    d. An HCC audit of providers to determine if the documentation supports the diagnoses submitted.

4. What does the acronym IVA stand for?

    a. Intermediary Validation Auditor

    b. Internal Validation Assessment

    c. Initial Validation Auditor

    d. Internal Vacation Authentication

Compliance

1. **Answer:** d.

   Rationale: Review the CMS RADV checklist. The record should be legible with a signature or attestations from a valid provider type. A record may have multiple diagnoses in addition to the diagnosis targeted by the RADV audit. The record must be from a face-to-face visit.

2. **Answer:** a.

   Rationale: Risk adjustment has created the need to ensure providers document care of chronic conditions at least once per year. As a result, it is important for a documentation specialist to be able to identify chronic conditions and determine when a provider has documented treatment of any existing chronic conditions. To qualify for risk adjustment, chronic conditions must be documented in a way that is reasonable to determine that a physician is managing the patient and treating the chronic condition within the year.

   CMS considers the following conditions as chronic conditions:

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	

3. **Answer:** b.

   Rationale: In a CMS Risk Adjustment Data Validation (RADV), CMS identifies a random stratified sample of patients to audit. The sample is ⅓ of patients with a high-risk factor, ⅓ of patients with a medium risk factor, and ⅓ of patients with a low risk factor. Only Part C HCCs are audited in a RADV. The health plans must submit up to five best records from an acceptable treating provider, demonstrating those diagnoses as current in the year being audited that support the HCC values that were paid. Supplemental diagnoses (those that were not originally submitted via claims) may be approved if they are documented as current diagnoses in the record. The submission of all diagnoses (with HCCs) are cumulative; therefore, there may be a negative or positive financial outcome in such an audit. The purpose of the audit is to evaluate the appropriateness of risk scores of patients.

4. **Answer:** c.

   Rationale: In an HRADV, there is an Initial Validation Auditor (IVA) that reviews the sample to identify DOS that support HCCs (through diagnosis codes) for the chosen patients in the sample.

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