Concurrent, Retrospective, or Prospective? An Expert's Take on HCC Coding

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Value-based care is complex, and medical groups have multiple ways to create value during the risk adjustment process.

THE THREE MAIN METHODS ARE:

Pre-visit Chart Prep

Concurrent Review

Retrospective Review

Each have pros and cons, which are covered in detail below.

CONCURRENT REVIEW

In a concurrent coding review process, coders review the EHR medical notes and HCC codes in real time before the claims are submitted to payers. A significant benefit of a concurrent review process is the speed of mark up. You can get feedback into the hands of a provider very quickly and drive behavior change through repeated stimulus and response.

Doctors went to school for a long time and excel at learning—when they're given the right information they're going to pick up on patterns really quickly and alter their behavior accordingly. This behavioral change aspect is unique to concurrent review. The ability to get feedback to a provider right away and improve documentation prior to filing is a game changer. You can't really achieve that feedback model with any other review process.

Another strong argument in favor of concurrent review is the accelerated accruals and leading indicators for risk score forecasting. Accurately forecasting risk adjustment scores is extremely difficult. Concurrent review gives you real-time data that can be leveraged immediately, as opposed to other workflows where the data lags behind and may be less useful a few months after the fact.

The concurrent review process also offers an early reduction of compliance risk. Including the correct HCC code on the initial claim is a safer option than adding or deleting an HCC after submission. By including all relevant information—and ensuring it's correct—the first time, you can reduce your audit risk.

As valuable as the real-time feedback process is, it can also become a negative if isn't handled in a way that's efficient for both coding staff and providers. It's important to avoid a situation where the learning and behavioral changes become a burden that doctors don't want to deal with. The key lies in creating as frictionless an experience as possible. The feedback element is also a qualitative process, which can make it difficult to translate into financial terms.

Another potential issue is the negative impact on fee-for-service A/R. If you tie up a claim for a week waiting for a provider to respond, you can complicate things. When there's fee-for-service and shared savings (with an ACO for example) holding up claims, it can delay fee-for-service revenue.

RETROSPECTIVE REVIEW

Retrospective coding review occurs after care has been delivered and claims have been submitted to the payer. In theory, retrospective review sounds like an efficient and cost-effective approach. It takes minimal effort to acquire suspect codes to pursue for the following year, and groups can leverage cheaper offshore coders for the associated manual tasks. So why do medical groups seem to be moving away from this approach?

In reality, as focus on point of care increases, the financial viability of a retrospective review decreases. With point of care being so important, groups need to find a way to work within the provider workflow. EHR access for offshore vendors can actually be quite difficult. Groups are increasingly finding these obstacles prohibitive and realizing the value in identifying larger issues and proactively working to address them.

PROSPECTIVE REVIEW/ PRE-VISIT PLANNING

Pre-visit planning is about getting ahead of the encounter, which in theory helps groups get ahead of potential problems. In reality, pre-visit planning works to prime providers for the visit and increase the chances of complete code capture. Doctors are busy, and realistically they're not going to read a complex pre-visit report in detail. But a concise, well-done prospective review can prime a provider with relevant information. When done right, pre-visit planning can give a provider enough relevant context to be clinically useful. It also works to establish accountability through prior clear knowledge.

Pre-visit planning requires a suspecting engine to be most effective. It's labor intensive if done manually and can't be easily outsourced. It can also be difficult to find the optimal workflow—teams need to understand exactly how the provider prepares for the visit.

Where pre-visit planning really becomes valuable is when it's used in conjunction with concurrent review. In this scenario, the pre-visit prompts set up a provider to follow up and capture relevant information, and the concurrent review process ensures nothing is missed.

Speed, effectiveness, and efficiency make a concurrent review process the best workflow option. With or without the addition of pre-visit planning, a concurrent review process adds value to the risk adjustment process. Even with a well-implemented concurrent review workflow, manually reviewing all risk contract charts is inefficient. By introducing automation into the workflow, groups can further improve the process and ensure risk adjustment accuracy.

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