Dx Gap Advisor ™ Resources

In December, we announced our partnership with Change Healthcare to implement Dx Gap Advisor. It's a solution designed to ensure complete and accurate claims and alert providers when diagnosis codes are potentially missing from a claim. It will be implemented on March 7, 2023.

Overview

Below is a high-level overview of the process.

- Automated messages are triggered on claims that may be incomplete or inaccurate for patients with historic claims data (e.g., evidence of an established diagnosis of a chronic condition missing on the current claim)
  - Messages are returned via the standard EDI 277CA transaction which fits into the existing claims workflow process
- Providers have three options to address the alert:
  - Ignore it and make no changes to the claim and then resubmit the claim using the original claim ID
  - Include additional supported diagnosis codes on the claim and then resubmit the claim using the original claim ID
  - Remove non-supported diagnosis codes on the claim and then resubmit the claim using the original claim ID

Resources

Attached are frequently asked questions about this solution. You can also find the FAQs, training video and more information when you log in at **hap.org**; select *Resources; Working with HAP; Dx Gap Advisor*.

We are confident this process will deliver complete and accurate claims the first time around. In addition, it could also result in fewer medical record requests in the future.

Dx (Diagnosis) Gap Advisor Frequently Asked Questions:

Q1 What is Dx Gap Advisor

Diagnosis (Dx) Gap Advisor is a provider based tool that works within the billing workflow to ensure complete and accurate diagnosis coding on claims before submission to health plans. It uses an analytics scoring engine to identify patients whose claims history shows diagnosis coding for chronic conditions. If the claim submitted does not include any of the chronic conditions documented in the patient's claims history, a real-time or next day Dx Gap Advisor claims status message ("Message") is sent to the individual or entity that submitted the claim ("Submitter"). The Message provides the two (2) most frequent chronic diagnoses codes located in the patient's claims history.

These chronic diagnoses may indicate that a diagnosis was overlooked in the initial chart review and that further review will confirm whether an ongoing or other condition should be reported. Having information about the patient's prior diagnoses may also make the chart review more efficient.

Messages are not intended to suggest what coding is or may be appropriate and the Messages must not be interpreted to do so.

Q2 Why is HAP implementing Dx Gap Advisor?

- Dx Gap Advisor improves completeness and accuracy in diagnosis reporting
- Complete capture of diagnosis codes allows HAP to:
  - Develop condition centric programs for members
  - Assist with data accuracy for risk adjustment calculations, including those required by government programs
- It allows the coder or other qualified Submitter to make any necessary changes to the claim before re-submission to the clearinghouse. Dx Gap Advisor Messages are delivered to the Submitter and intended for internal use only.
- Including historical chronic diagnoses in the Message likely indicates a diagnosis code was overlooked. This process allows providers to self-audit, which increases accuracy, supports efficient chart review, and reduces the need for burdensome external chart reviews.

- To the extent a chronic condition was unknown to the provider, the provider may explore the relevance of such condition with the patient in a future visit, if appropriate, potentially improving the quality of care and effectiveness of treatment.

Q3 Which claim types are subject to a Dx Gap Advisor Message?

Dx Gap Advisor applies to professional claims (also known as CMS 1500/837P). These are claims submitted by physicians and Advance Practice Providers (e.g., Physician Assistants and Nurse Practitioners).

Q4 What provider types are included?

Primary Care Physicians, Advance Practice Providers and Specialists. Please see the Dx Gap Advisor Approved Taxonomies. You can find them when you log in at hap.org; select Resources; Working with HAP; then Dx Gap Advisor.

Q5 What should I do when I receive a Message?

The Message indicates the claim needs to be reviewed. A qualified coder or other appropriate professional should review the medical records for the encounter being billed.

- If the coder finds that a diagnosis(es) was overlooked on the original claim:
    - Adjust the coding on the claim based on documentation in the chart to ensure complete and accurate diagnosis reporting
    - Resubmit the claim using the original claim ID
- If the coder determines that the diagnosis(es) coding on the original claim was complete and accurate:
    - Resubmit the claim without modification using the original claim ID

  Example. The patient visits the doctor for an eye issue. The claim is submitted with only unspecified retinopathy (ICD 10 H35.00). The Dx Gap Advisor Message is displayed for diabetes. The coder reviews the medical record and sees that diabetes is supported. Since the main reason for the visit was retinopathy due to the patient's diabetic condition, the claims should be resubmitted with the correct diagnosis code of Type I diabetes mellitus with unspecified diabetic retinopathy (E10.31).

Change Healthcare will not process or submit the claim to the payer until it is resubmitted. Whether changes to the coding are made or not, claims must be resubmitted, or they will not be processed and adjudicated. Once resubmitted, the claim will not be stopped by Dx Gap Advisor again.

Q6 Where do I find Change Healthcare Dx Gap Advisor Messages?

- If you are a Change Healthcare Office (Vision) user, Dx Gap Advisor Messages will be found under My Alerts on the Home page
- If you are a Change Healthcare Claim Master user, Dx Gap Advisor Alert claim status Messages will be available in the Claim Log, Payer RPT 10 report, and Change Healthcare Report
- If you are a batch Submitter, Dx Gap Advisor Messages will be found in RPT-5 and RPT-11 reports

- If you do not submit your claims through Change Healthcare, you will not receive Messages.

Q7 How does the Dx Gap Advisor identify and select potentially missing chronic condition diagnosis codes for inclusion in the Message?

Change Healthcare searches up to three (3) years of patients' claims histories for chronic diagnoses that are not reported on submitted claims. Diagnoses are selected based on the most frequent in the patient's history first. If there is a tie, then they are selected on the most recent diagnosis code. If the provider submitting the claim is a specialist, only the chronic diagnoses codes relevant to the specialty are selected.

Q8 If Change Healthcare does not locate historical diagnosis information or no Message is sent to the provider, does that mean the patient had no history of chronic conditions?

No. Sometimes patients have coverage through a health plan that either did not utilize Change Healthcare services or is not participating in Dx Gap Advisor such that Change Healthcare and/or patients' current plans may not have three (3) years of diagnostic information. Additionally, a data input error by a prior provider, the health plan, or others may render a search ineffective. An error also could conceivably occur in the electronic search. This is one reason the provider's independent medical record review is so important.

Q9 What types of conditions are identified by the Messages?

The tool only identifies reportable chronic conditions.

Q10 When should I respond to the Message?

When the Message is received, providers should determine as soon as possible whether the diagnosis(es) referenced in the Message are supported in the medical record for the associated medical encounter, per applicable coding guidelines. Until the claim is resubmitted, Change Healthcare will not process or submit it to the health plan for adjudication. **The medical record review and resubmission should occur as soon as possible. Providers, not Change Healthcare, are responsible for meeting all timely filing deadlines.**

Q11 How does the Dx Gap Advisor process impact timely filing of claims from provider to the Health Plan?

Dx Gap Advisor clearinghouse Messages occur within a same-day or next day process that initiates at the point of claims submission. Providers can resubmit the claim immediately upon medical record review for adjudication by the Health Plan. Providers should ensure claims are submitted well within applicable time limits. The medical record review and resubmission should occur as soon as possible. Providers, not Change Healthcare, are responsible for meeting all timely filing deadlines.

Q12 When resubmitting a claim, should we fill in item 22 on the CMS 1500?

No. A Dx Gap Advisor Messaged claim has not been submitted to the health plan. According to Nation Uniform Claim Committee (NUCC) reference manual for 2017, page 33, Item Number 22 is not intended for use for original claims submissions. http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v5.pdf.

Q13 Are there other items on the claim we should modify before resubmission?

See item 24.E. on the CMS 1500/837p. Upon review of the medical record, the coder may need to re-assess and change which diagnosis code (item 21) applies to which procedure code in item 24 D.

Q14 If a patient's current office visit is for a condition or problem not related to the Messages, how should the Message be handled?

Upon confirming the original claim diagnoses were complete and accurate, providers will not make any changes and should resubmit the claim for adjudication in its original form.

> **Example**. The Dx Gap Advisor Message is displayed for diabetes. The patient visits the doctor for a right elbow injury. The provider should resubmit the claim in its original form unless the medical record documentation indicates otherwise.

Q15 How can we ensure the Dx Gap Advisor Messages will not lead to "up-coding"?

Providers are obligated by law to submit accurate and complete diagnosis information on claims. The Message, provider letters, training and marketing materials, provider webinar and other materials referring to DX Gap Advisor specifically reiterate providers' sole responsibility to ensure that coders and others who submit the claims are properly trained, agree at all times never to modify a diagnosis code based on the Chronic Condition Message alone and to diligently comply with all applicable coding manuals, standards, and guidelines, including reviewing the underlying medical record to ensure that any change to the diagnosis coding is supported for the encounter. Additionally, Health Plans should have Program Integrity programs or tools in place to detect potential instances of up-coding. Finally, Dx Gap Advisor monitors changes and may audit both unedited and edited claims for compliance and/or may provide information to health plans about which claims they should audit.

Q16 Is there a process to address an erroneous Dx in the member claims history?

Dx Gap Advisor uses up to three years of claims history as provided by the health plan. Change Healthcare does not remove or alter a patient claims history.

Q17 Does the Dx Gap Advisor look to correct an invalid diagnosis(es) on a claim that is flagged as part of the Dx Gap Advisor?

Yes. The Dx Gap Advisor program is designed to ensure that providers review medical records at the point of billing to validate the diagnosis(es) on the claim are truthful, complete, and accurate and make any and all necessary corrections to the claim.

If research points to the possibility the patient may have a certain diagnosis, but documentation is unclear in the medical record, the rendering physician should be consulted. If the diagnosis is not in the medical record, do not add it to the claim.

Q18 Does the Message violate HIPAA?

No. HIPAA regulations allow the use and disclosure of PHI for Treatment, Payment, and Healthcare Operations. "Ready access to treatment and efficient payment for health care,

both of which require use and disclosure of protected health information, are essential to the effective operation of the health care system. In addition, certain health care operations—such as administrative, financial, legal, and quality improvement activities—conducted by or for health care providers and health plans, are essential to support treatment and payment. Many individuals expect that their health information will be used and disclosed as necessary to treat them, bill for treatment, and, to some extent, operate the covered entity's health care business. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities." 45 CFR 164.506.

Q19 How does the new process handle sensitive conditions such as behavioral health and STD related chronic conditions?

Dx Gap Advisor excludes sensitive diagnoses as required by state law.

Q20 Will providers receive Dx Gap Advisor Message on "clean claims"?

Possibly. Generally, a claim is not "clean" if elements are missing that are necessary to process for payment. However, the required elements must be complete, legible, and accurate. If a claim is submitted that is later changed to ensure the diagnosis coding is complete and accurate, the original claim cannot be considered a "clean claim." If the original claim submitted contains complete and accurate information, the provider can resubmit the original claim in its original state.

Q21 Has the Dx Gap Advisor process been vetted with CMS or HHS?

CMS and HHS do not provide advisory opinions on processes like Dx Gap Advisor. However, Dx Gap Advisor was designed to promote compliance with law, including applicable coding standards. Further, all components of the process were based on an extensive compliance assessment, and Change Healthcare implemented a framework to ensure ongoing legal and ethical conduct and communications, adopting the following statement:

> This statement affirms Change Healthcare's commitment to high ethical standards relating to Dx Gap Advisor services (the "Services"). Change Healthcare embraces the spirit and the letter of the law regarding the Services, including standards applicable to diagnosis coding. Accordingly, Change Healthcare expects all physician office and related users to act in compliance with such standards at all times, making their own independent judgments about appropriate diagnosis coding they report on claims submitted to Change Healthcare, based solely on documentation in the medical record for the date of service on the bill.

Q22 Does Dx Gap Advisor analyze provider responses?

Yes, Change Healthcare monitors the number and types of changes a provider makes, and other submission behaviors. Behaviors indicating that medical records are not being reviewed before claims are resubmitted may raise compliance concerns. When such behavior is suspected, Change Healthcare may report such behavior to HAP, audit a sample set of claims and medical records, or take other action designed to remediate concerns.

Q23 How will HAP use the additional information obtained through the new Message system process?

Change Healthcare provides monthly reports described below to help them understand the results of the program.

- General Report
  - Overview of Dx Gap Advisor metrics including claim messages, resubmissions, and resubmission / response behaviors
  - Transactional claim metrics
    - Claims aging
    - Top providers messaged
    - Claim and category transaction summary of changes to claims
  - Provider insights
    - Top responders by specialty
    - Top providers identified for education - ignored claims
    - Top providers identified for education – suspended claims (unresponded)
- Provider Reporting
  - Provider Details regarding messages, responses including nature of response
  - Claims aging report
  - Nature of response comparison to peers
    - Tier 1 (top tier) – Exact Diagnosis Code Added
    - Tier 2 – Same Disease Category Diagnosis Added
    - Tier 3 – Disease Category Added that was not Messaged
    - Tier 4 – Diagnosis Code Deleted from Original Claim
    - Tier 5 (Bottom Tier) – No Changes Made to Resubmitted Claims
- Changed Claim Detail
  - A listing of responded claims detail along with the specific changes
- Member Detail Report
  - A listing of members associated with Dx Gap Advisor messages and chronic diagnoses, message response statistics, documentation response rate
- Billing Invoice Detail
  - Detailed listing of all changed claims and nature of change
- Support Report
  - Claims Aging
  - Provider Group (when grouping data is provided) and Provider response metrics)