CASE STUDY

Medical Group

The Client

Medical Group with 3,000 Medicare Advantage members located in California. Contracts with multiple Health Plans; no one plan with majority of members.

Client's Challenges

- Client's objective is to have risk adjustment scores match the acuity level of their membership to ensure proper reimbursement. Client continually reconciles internal systems data to diagnosis information forwarded to their Health Plan Payers
- Although there are few discrepancies noted, the risk scores are failing to rise to the appropriate levels. Medical Group had grave concerns as the final deadline for data submission which was 120 days away. Without proper reimbursement for resources expended, Medical Group will have to reconsider its contracts for Medicare Advantage Organizations
- The Medical Group was looking for assistance in determining what, if any, changes are needed to ensure correct payment for services rendered
- Medical Group currently has verified that their diagnosis data has been forwarded to Health Plan for risk adjustment reimbursement. Medical Group receives sporadic error reports from Health Plans data rejected. While other Health Plans had not provided any reporting at all
- Further complicating the situation, each Health Plan that provided feedback information was in disparate formats and it required large amounts of manual effort to correlate the data into actionable information
- Since the Providers are actually seeing the members for their health conditions, they are the only ones that can speak to the completeness of data that CMS has received for risk adjustment reimbursement. However, the Physicians in this Medical Group have never been provided access to this type of information and had the Plans provided it, there is still the issue of dissimilar systems and data integration

SCIO's Solutions

- SCIO designed a web-based SaaS solution, SCIORevMaxPro, for use by the Provider and Health Plan community that integrates information from disparate sources and provides actionable intelligence at a detailed (member) and summary level. The application displays what diagnoses have actually been accepted by CMS for risk adjustment reimbursement to Health Plans, which in turn, is used to reimburse the Providers. Implementation for client use was completed within 30 days
- This is the first time Providers and Plans were able to 'read from the same page'; both having first hand access to what was reality for CMS, which is the basis for all payments. Once the Physicians were able to collectively view all the information from all their Plans that had been sent and accepted by CMS, they could clearly see that much of the data was not present in the CMS data set. Within 90 days they identified and resubmitted the missing clinical information prior to the deadline

RESULTS

The Medical Group was able to quickly and efficiently identify services provided for which CMS had no knowledge.

Identification of this missing information resulted in an additional $10 Million of CMS reimbursement to the Health Plan which the group received a portion

SCIO health analytics®

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