Documentation and Addressing Gaps

2024

1. You can address gaps earlier in the year with Health Alliance Plan (program runs year-round)

2. AWV- Annual wellness visit (incentive for member of $40)

3. Gap reports are updated in June or July, but it is important for providers to understand:
    a. These are conditions that were captured in the past. Possibly in the hospital, urgent care or by a specialist. If you do not agree or the condition is resolved, say so.
    b. Logic tells us that Medicare Advantage gaps are mostly chronic. Keep in mind that if a condition that is acute shows up on the gap list, it may have been acute in the past but is no longer acute. For example, a CVA. Once that condition occurs (usually seen in the hospital) a provider would use documentation to describe it as a history or sequela of a CVA at follow up appointments. The biller should then use the appropriate ICD-10-CM code.
    c. Documentation is important! Do not just agree with a code. Somebody could have chosen an improper code to describe the condition.
    d. Sometimes documentation is clear, but a biller uses an acute code instead of chronic or historical. It is important that you have someone you can rely on to address your billing.

Examples of poor documentation in 2023:

- Patient had a follow up in the office after experiencing a possible TIA/CVA at the hospital. The code that was submitted from the provider office was an acute CVA. The provider cannot capture a possible or probable condition in the outpatient setting, only confirmed diagnosis. In this case the provider would need to refer to signs and symptoms. Also, an acute CVA can only be reported once and it was at the hospital so if it were a confirmed condition, the provider office would use a history code or a sequala.

- Follow up visit occurred for multiple conditions. Colon cancer also appeared with a history of hemicolectomy. Cancer dx was originally reported years ago. No mention of chemotherapy or radiation. No mention of any adjuvant therapies. Provider office billed acute colon cancer which would not be appropriate because there is no proof that the condition is still current. Documentation was a past medical history.

- Diagnosis and assessment both describe a history of a chronic pulmonary embolism. Nothing monitored, evaluated, addressed, or treated to show that the condition still exists. Billing should have used a history code.

- Patient diagnosed with prostate cancer in 2015. PSA documented as 2.4 and recheck PSA in 6 months. Though we see a follow up, we cannot capture acute cancer as we do not see documentation to support current treatment. Providers would need to state adjuvant or some sort of ongoing treatments.