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. The tool uses Change Healthcare's Risk View™ 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 through the Intelligent Healthcare Network™ 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. Thus, Dx Gap Advisor improves completeness and accuracy in diagnosis reporting and 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.

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

Q2 Which claim types are subject to a Dx Gap Advisor Message?

Dx Gap Advisor applies to professional claims (also known as CMS 1500/837P).

Q3 If a client has both Coding Advisor and Dx Gap Advisor and the claim could be flagged for a Message for both, which Message will be presented?

When a health plan has both Coding Advisor and Dx Gap Advisor and the claim could be flagged for a Message for both, the clearinghouse will present the Dx Gap Advisor message and suppress the Coding Advisor Message.

Q4 What should I do when I receive a Message?

The Message indicates the claim was rejected to provide an opportunity for self-auditing and, if supported in the record, editing of the reported diagnoses on the claim. Therefore, when you receive a message, you should have a qualified coder or other appropriate professional re-review the medical records for the encounter being billed.

- If the coder finds that a diagnosis(es) was overlooked on the original claim, the provider should adjust the coding on the claim based on documentation in the chart to ensure complete and accurate diagnosis reporting, and resubmit the claim.
- If the coder determines that the diagnosis(es) coding on the original claim was complete and accurate, the provider should resubmit it without modification.

  Example. The patient visits the doctor for an eye issue and submits the bill, coding only unspecified retinopathy (ICD 10 H35.00) on the claim. The Dx Gap Advisor alert 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 provider should resubmit the claim 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 and unless the claim is resubmitted, as described below. Again, whether changes to the coding are made or not, claims must be resubmitted or they will not be processed and adjudicated.

Q5 Where do I find Change Healthcare Dx Gap Advisor alerts?

- If you are a Change Healthcare Office (Vision) user, Dx Gap Advisor alerts 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 alert claim status 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 alerts.

Q6 How does this new messaging system benefit contracted providers?

Dx Gap Advisor alert messaging benefits providers by helping to ensure complete and accurate submission of patient diagnosis(es) on claims. Additionally, the near real-time provision of historical information promotes review and correction, where appropriate, based on the medical record, prior to claim submission. Including historical chronic diagnoses in the Message likely indicates that 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. Moreover, 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.

Q7 How does this new messaging system benefit the Health Plan?

Dx Gap Advisor alert messaging helps to ensure complete and accurate diagnosis coding on submitted claims. Complete capture of diagnosis codes allows Health Plans the ability to develop condition centric programs for members and assists with data accuracy for risk adjustment calculations, including those required by government programs.

Q8 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 first on the most frequent in the patient's history and if there is a tie, then 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.

Q9 If Change Healthcare databases do 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.

Q10 What types of conditions are identified by the alerts?

The tool only identifies reportable chronic conditions.

Q11 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, in accordance with applicable coding guidelines. As indicated above, 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, remain responsible for meeting all timely filing deadlines.**

Q12 How does the Dx Gap Advisor process impact timely filing of claims from provider to the Health Plan?

Dx Gap Advisor clearinghouse rejections occur within a same-day or next day process that initiates at the point of claims submission. Providers have the ability to 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. As noted above, the medical record review and resubmission should occur as soon as possible. Providers, not Change Healthcare, remain responsible for meeting all timely filing deadlines.

Q13 In cases where billers submit claims, are they allowed and will they have access to the medical records for their patients?

Reviewing the medical record and determining whether it supports a change to any coding is a function that should be performed only by a coder or other qualified professional. While coders need not be certified, they must be knowledgeable and experienced. Billers may function as coders or review medical records only with the express permission of the physician(s) or group for whom they work. The providers should ensure that billers are qualified coders.

Q14 When resubmitting a claim, should we fill in item 22 on the CMS 1500?

No. Because a Dx Gap Advisor Messaged claim has not been submitted to the health plan, the "resubmission" after medical record review and consideration of the diagnosis coding history will lead to the original claim submission – not to a resubmission 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.

Q15 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.

Q16 If a patient's current office visit is for a condition or problem not related to the alert Messages, how should the alert Message be handled?

If the conditions listed in an alert are not relevant to the claim submitted for the patient's medical encounter, i.e., the patient did not have a condition listed on the alert or a listed condition was not the first listed diagnosis or primary diagnosis, the conditions on the alert should only be added in compliance with coding conventions defined in the ICD-10 manual and/or applicable standard and coding guidelines. In general, 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 alert 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.

Q17 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 alert, 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 Alert 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.

Q18 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.

Q19 Does the Dx Gap Advisor service look to correct an invalid diagnosis(es) on a claim that is flagged as part of the Dx Gap Advisor service?

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, including to determine whether diagnosis codes were inflated.

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.

Q20 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.

Q21 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.

Q22 Will Dx Gap Advisor reject "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 has the ability to resubmit the original claim in its original state.

Q23 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.

Q24 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 affected health plans, audit a sample set of claims and medical records, or take other action designed to remediate concerns.

Q25 How will the Health Plan 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 rejections, 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)