

GET READY TO SWITCH FROM RAPS TO EDPS

Provider's guide to a successful transition

Medicare Advantage organizations and providers will soon transition from the Risk Adjustment Payment System (RAPS) to the Encounter Data Processing System (EDPS). Now is the time to review the questions and answers that will help ensure a seamless transition. For more information on how risk adjustment impacts your practice, see reverse side.

Q. Why is CMS switching from RAPS to EDPS?

- A. EDPS is more comprehensive. It offers all the data of RAPS, plus additional information to help improve the overall quality of patient care.

DATA	RAPS	EDPS
Enrollment	✓	✓
Duplicates	✓	✓
Validity of diagnoses codes	✓	✓
Requires CPT codes to complete certain functions		✓
Must pass National Correct Coding Initiative edits		✓



Q. How are providers affected by the transition to EDPS?

- A. Providers are required to submit a complete, compliant claim that adheres to the Cigna billing guidelines for each face-to-face encounter. Submission of a noncompliant claim may result in a higher risk of claim rejection, which may impede reimbursement.

Q. What if a provider has a history of claim rejections?

- A. The time to resolve problems is before EDPS is fully implemented. Providers are encouraged to use a practice management system to track rejections by reason code. This helps identify common inaccuracies and prevent rejections.

Q. Where can providers get help with accurate diagnosis and coding before, during and after the EDPS transition?

- A. Cigna offers a range of resources to help providers improve coding accuracy and documentation. Take advantage of our educational tools, articles, best practice guides, webinars, tips, and more. It's all just a click away.

Clinicians, practice administrators, and health care information teams should consider transitioning from paper to electronic claim submissions to improve data accuracy.

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RISK ADJUSTMENT

Essentials all providers should know

The transition to value-based care requires that payers and providers work together to jointly manage risk, streamline risk adjustment and ensure data accuracy to improve compliance and reduce audit risk. With your help, we can avoid unnecessary and costly administrative revisions, premium changes and provide patients with quality care.

Why is risk adjustment important?

Specific and appropriate characterization of patient populations is a Centers for Medicare & Medicaid Services (CMS) requirement. Accurate risk categorization identifies patients for disease management interventions and assists in the financial forecasting of future medical need.

Where does risk-adjustment data come from?

Hospital and physician claims are the main source of data that drives the risk-adjustment model. Since 2008, Cigna has been required to submit patient data using both the Risk Adjustment Payment System (RAPS) and Encounter Data Processing System (EDPS) platforms. By 2020, Cigna will be required to solely submit all patient data through the EDPS platform and retire the RAPS legacy data submission process.

How does risk coding affect my practice?

- › Improved documentation and coding leads to better patient care, as they're the primary means of communicating the patient record for specialty care to health plans and CMS.
- › Accurate documentation also improves quality reporting and efficiency when responding to regulatory requirements, such as Health Care Effectiveness Data and Information Set (HEDIS) reviews and Risk Adjustment Data Validation (RADV) audits.
- › Financially, it helps achieve greater accuracy in the documentation of key quality metrics associated with payments by the Enhanced Primary Care (EPC) program.
- › If medical documentation lacks the accuracy and specificity needed to assign the most appropriate diagnosis code, providers face the possibility of reduced payment if they are part of a performance-based payment model.
- › Risk adjustment takes a close look at how medical record documentation can contribute to the complexity level of the encounter, medical decision making, and time spent with the patient.
- › Increased coding accuracy helps patients benefit from disease and medical management programs.

IT'S IMPORTANT TO KNOW.

- › No new skills are necessary for the partnering clinician in order to be EDPS-compliant. However clinicians need to submit a complete, compliant claim that adheres to the Cigna billing guidelines for each face-to-face encounter. Submission of a noncompliant claim may result in a higher risk of claim rejection, which may impede reimbursement.
- › Partnering clinicians are required to document specifically, and must submit a claim for service within the same year of encounter service delivery.
- › Clinician documentation should accurately align with a claim that is being submitted for payment, i.e., a patient seen for a diagnosis of diabetes, should have an appropriate ICD-10 code for diabetes.
- › Annual 360 exams, Health Management Reports (HMRs), and Enhanced Encounters (EEs) satisfy the annual necessity to report chronic diseases and the specific chronic disease treatment plan that support the risk adjustment program.
- › Reimbursement projections are based upon current year documentation dates of service for the next year payments, i.e., 2018 dates of service data is used to project/calculate for 2019 reimbursement.