Accurate coding and documentation help your patients and your practice

Vatica Health™

You want to spend your day delivering high-quality patient care, not bogged down with paperwork. While diagnostic coding can feel arduous, accurate coding and documentation are critical to risk adjustment, giving you valuable resources for improving practice performance and patient care. Providers with successful risk adjustment strategies use the funds to hire care managers, pharmacists, social workers and behavioral health providers, adding useful resources for their physicians and expanding patient services. Here's how it works for your Medicare Advantage patients.

Medicare Advantage (MA)

- Is an alternative way for patients to receive their Medicare benefits through private insurance plans
- Provides patients with a broader range of benefits and resources than Original Medicare
- Provides Medicare protections and standards
- Covers more diverse, medically complex and socially at-risk patients than Original Medicare

How risk adjustment works in MA

Beneficiaries receive their Medicare benefits via private health plans.

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The Centers for Medicare and Medicaid Services (CMS) pays these health plans based on the health status of each member.

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Health status is based on demographic and disease factors. Disease factors are based on provider coding.

Risk adjustment

- Promotes fairness and equity in the MA program
- Ensures the appropriate funding is available so health plans can cover the cost of patient care and providers have the resources they need to execute care plans
- Discourages health plans from not enrolling patients with complex medical needs

Accurate coding matters

Hierarchical Condition Category (HCC) Coding is distinct from office visit coding, grouping similar diagnoses into categories for risk adjustment payment models. It plays a critical role in risk adjustment by providing more accurate and comprehensive information about the health status of individuals. Inaccurate coding can have significant impacts.

Financial implications
Under/overpayments or under/overbilling

Compliance issues
Legal liabilities, fines and reputational damage

Compromised care
Incorrect treatment decisions, delays or unnecessary procedures

Healthcare system inefficiencies
Claim denials and payment delays

Better MA risk adjustment benefits everyone

Patients

MA plans offer additional benefits not covered by Original Medicare

97% offer vision benefits

91% offer dental benefits

94% offer hearing benefits

94% offer wellness or fitness benefits

More efficient care than Original Medicare

49% lower rate of long-term acute care hospital stays

13% lower in-patient hospitalization costs

43% lower rate of potentially avoidable hospitalizations

$1,965 less in total annual out-of-pocket spending

Highly satisfied patients

98% of MA beneficiaries stay with MA plans due in part to long-term relationships with their providers

Providers

Identify and close care gaps

Better coding improves the accuracy and completeness of health records, enabling proactive identification of patient needs and targeted interventions

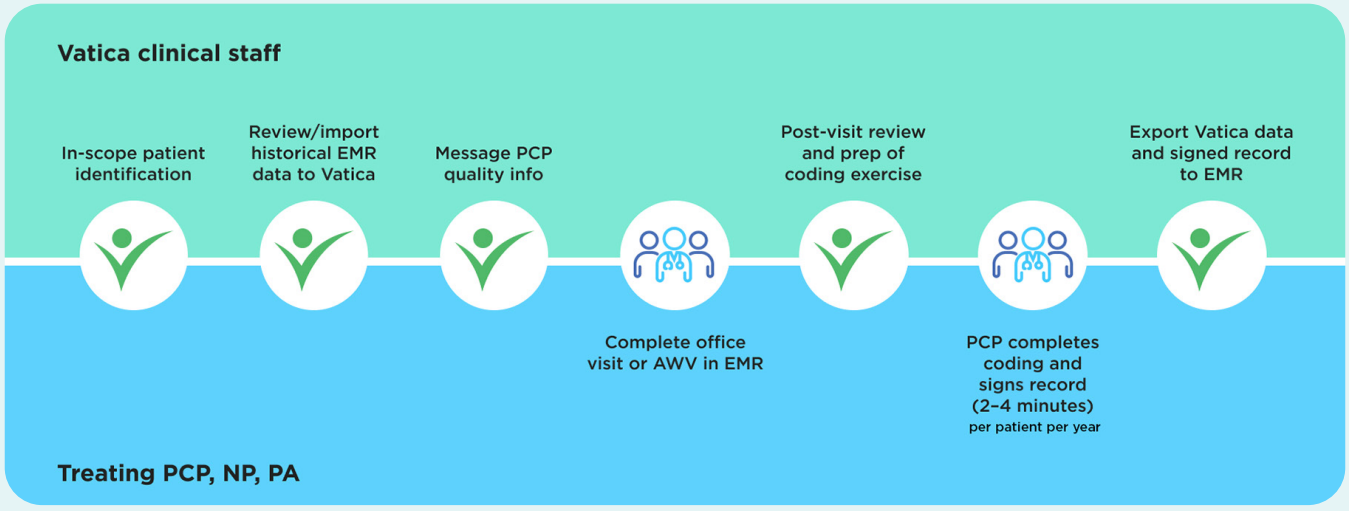
Offer programs not covered by Original Medicare

Care management programs like disease and medication management, lifestyle coaching and preventive screenings give providers an extra hand in caring for patients with complex conditions

Vatica makes coding and documentation easier

Vatica provides clinical teams plus user-friendly technology at the point of care to help providers capture more accurate and complete diagnostic codes that lead to accurate reimbursement from CMS. Working with Vatica, providers receive an incentive payment for each completed visit. Providers often use this funding to hire staff and provide services such as care management, behavioral health and enhanced pharmacy services.

Our dedicated clinical staff supports PCPs



For additional information, contact your Vatica representative.

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