ICD-10-CM Documentation and Coding Best Practices for Medicare Advantage Risk Adjustment

What is Risk Adjustment?

CMS-HCC Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) adjusts payments to Medicare Advantage Plans, such as WellCare Health Plans, Inc., based on the perceived healthcare needs (i.e., anticipated healthcare expenditures) of their members. These needs are determined using member demographics (age, gender) and diagnoses that were reported for members the previous year.

What are Hierarchical Condition Categories (HCCs)?

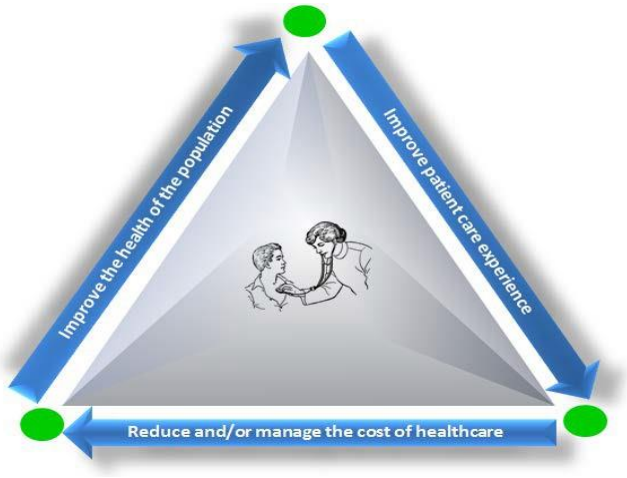
HCCs are a hierarchy of condition categories that link to corresponding diagnosis categories. CMS determines the qualifying codes and assigns risk adjustment factors to HCCs. The number of HCCs and affected ICD-10-CM codes can change from year to year. Each year, CMS determines which diagnosis codes qualify for inclusion in the model, sets the number of HCCs, and assigns a risk adjustment factor to each HCC category.

Why is HCC Risk Adjustment important?

The main role of diagnosis codes in the model is to increase diagnosis coding accuracy. This helps WellCare improve outcomes by identifying members who may benefit from Disease Management Programs and matching them with the appropriate level of care.

Why is medical record documentation so important for Risk Adjustment?

Medical record documentation plays a critical role in risk adjustment: accurate risk-adjusted payment relies on complete medical record documentation and diagnosis coding. CMS requires that all diagnosis codes reported for risk adjustment be based on clinical medical record documentation from a face-to-face encounter. This means the provider must document and report all diagnoses that affect the patient's evaluation, care, and treatment, including chronic or co-existing conditions. This ultimately affects the services and benefits WellCare Health Plans is able to provide to our members.



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ICD-10-CM Documentation and Coding Guidelines

Coding Must Mirror Medical Record

Under ICD-10 Official Coding Guidelines, a diagnosis can only be coded if it is stated explicitly in the documentation.

Coders cannot presume a given condition exists based on symptoms or lab results. For example, abnormal GFR levels cannot be interpreted to be CKD unless confirmed and documented by the provider. A clinician is the only one who can interpret results and assign a final diagnosis.

Documentation Must Be Specific

Documentation should be thorough and specific so that the appropriate diagnosis code can be assigned.

Include descriptors such as:

- Acuity
- Stage/Severity
- Underlying cause
- Complications/Associated conditions
- Anatomic site/Laterality
- Episode of care

Active Conditions

The CMS-HCC Risk Adjustment process requires the documentation and reporting of active conditions at least once per year.

In practice, co-existing conditions should be documented and reported each time they affect care, treatment decisions, etc.

Health Status Codes

Frequently overlooked, but significant, conditions may include:

- Ostomies
- Amputation status
- Renal dialysis status
- Asymptomatic HIV status

It is important to assess, document and code these conditions, when present, at least once annually.

"History of"

Under ICD-10 Official Coding Guidelines, the term "history of" indicates a historical condition that no longer exists.

If a condition is being managed, treated or monitored, it is considered active disease; therefore, the term "history of" should not be used for active conditions.

CVA/Stroke Coding Reminders

A CVA is a critical event that requires treatment in the acute care setting. Following discharge from the hospital or rehabilitation center, report any residual deficits (sequelae) related to the CVA:

- *I69.3xx – Sequelae of cerebral infarction*
  **5th and 6th digits identify nature of late effect*

In the absence of late effects, report:

- *Z86.73 – Personal history of TIA, and CVA without residual deficits*

Cancer Coding Reminders

- **Active Cancer** - Cancer should be documented and coded as active when:
  - The patient is undergoing treatment directed at the malignancy for curative or palliative purposes
  - The patient has failed all treatment options and no other options remain
  - Patient has elected to waive treatment
- **Personal history of cancer -** After cancer has been excised/eradicated, all active treatment has ceased, and there is no evidence of current disease, a "history of" Z code is appropriate.
- **Metastatic Cancer -** Clearly document the primary site and the metastatic site to avoid reporting multiple primary sites.

EMR Considerations

When using copy/paste feature in EMR, ensure any information brought forward is valid, current and applicable to the current visit.

Additional Tips

- Use standard medical abbreviations
- Incorporate and document lab and diagnostic results into progress note
- Link medications to the condition(s) they treat to show ongoing care/management
- Review/update medication and problem lists

Don't forget to sign the note!

CMS Signature Requirements:

- **Electronic** - Authentication, provider name, credential and date signed
- **Manual signature** - Legible signature with credential, or signature with provider name and credential preprinted on note
- **Stamped/Typed signatures** are not acceptable

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