Medicare Risk Adjustment Documentation and Coding Guidance: Red Flag HCCs, Part 1
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Disclaimer

This training is based on coding guidance from the Official ICD-10-CM Coding Guidelines, American Hospital Association’s (AHA) Coding Clinic, and/or Centers for Medicare and Medicaid Services (CMS) guidance and guidelines. Documentation recommendations are based on the official requirements for correct code assignment per the aforementioned guidelines.

The ICD-10-CM code set is updated annually. Coding requirements and standards are subject to change, potentially impacting the accuracy of the content contained within this presentation. The practitioner supplying the medical documentation and the individual assigning codes are reminded to verify the accuracy, specificity, currency, and acceptability of such codes, coding methods, and supporting documentation by referencing official sources with up-to-date information.

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Providers are encouraged to listen to the recording of this presentation in order to achieve a greater understanding of the material.
Training Credit

Continuing Medical Education (CME)

This Live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from 01/23/2019 - 11/27/2019, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Approved for 1 AAFP Prescribed credit.
Agenda

Medicare Risk Adjustment Overview

Red Flag HCCs:

- Chronic Kidney Disease
- Cerebral Infarction (Stroke)
- Cerebral Hemorrhage
- Aspiration & Specified Bacterial Pneumonias
- Unstable Angina
- End Stage Liver Disease

Medical Record Documentation Best Practices and Case Studies
Section One

Medicare Risk Adjustment
Overview

Hierarchical Condition Categories (HCCs)

Red Flag HCCs
Medicare Risk Adjustment Overview

- Risk Adjustment models are actuarial tools used to predict health care costs
- CMS model uses risk adjustment to help predict the cost of medical care for Medicare Advantage (MA) members
- MA members each have a risk score which is determined by CMS based on their demographic information and their health status
- Health status information comes from providers, and is based on medical conditions that are documented during a patient encounter
- Conditions must be explicitly stated by the provider, who is responsible for establishing the diagnosis
Medicare Risk Adjustment Overview

It is important to ensure risk adjustment data is accurate and complete.

Higher risk scores represent members with a greater than average burden of illness.

Lower risk scores represent a healthier population.

Risk Scores do not follow a MA member from year to year.

Conditions must be reported annually in order to be included.
Medicare Risk Adjustment Overview

Hierarchical Condition Categories (HCCs) are a grouping of clinically related diagnoses with similar medical costs.

CMS-HCC Model has disease hierarchies.

Payment is only associated with the more serious condition when a less serious condition from the same hierarchy also exists.

71,932 ICD-10-CM Codes

9,621 Codes CMS-HCC V23

83 HCC Codes

End-Stage Liver Disease (HCC 27)

Chronic Hepatitis (HCC 29)

Cirrhosis of the Liver (HCC 28)
Medicare Risk Adjustment Overview

The Disease Hierarchy²

When a condition is reported with a higher HCC value...

<table>
<thead>
<tr>
<th>Hierarchical Condition Category (HCC)</th>
<th>If the Disease Group is Listed in this column...</th>
<th>Then drop the Disease Group(s) listed in this column</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>9, 10, 11, 12</td>
</tr>
<tr>
<td>9</td>
<td>Lung and Other Severe Cancers</td>
<td>10, 11, 12</td>
</tr>
<tr>
<td>10</td>
<td>Lymphoma and Other Cancers</td>
<td>11, 12</td>
</tr>
<tr>
<td>11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>12</td>
</tr>
<tr>
<td>17</td>
<td>Diabetes with Acute Complications</td>
<td>18, 19</td>
</tr>
<tr>
<td>18</td>
<td>Diabetes with Chronic Complications</td>
<td>19</td>
</tr>
<tr>
<td>27</td>
<td>End-Stage Liver Disease</td>
<td>28, 29, 80</td>
</tr>
<tr>
<td>28</td>
<td>Cirrhosis of Liver</td>
<td>29</td>
</tr>
<tr>
<td>29</td>
<td>Severe Hematological Disorders</td>
<td>48</td>
</tr>
<tr>
<td>54</td>
<td>Drug/Alcohol Psychosis</td>
<td>55, 56</td>
</tr>
<tr>
<td>55</td>
<td>Drug/Alcohol Dependence, or Abuse/Use with Complications</td>
<td>56</td>
</tr>
<tr>
<td>57</td>
<td>Schizophrenia</td>
<td>58, 59, 60</td>
</tr>
<tr>
<td>58</td>
<td>Reactive and Unspecified Psychosis</td>
<td>59, 60</td>
</tr>
<tr>
<td>59</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>60</td>
</tr>
</tbody>
</table>

Any reported condition within the same disease hierarchy with a lower value will be dropped.

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HCC Mapping

9,621 ICD-10-CM codes map to 83 HCCs

One HCC may map to multiple diagnosis codes

Ex. HCC 1 maps to 3 ICD-10-CM codes

One diagnosis code can map to two distinct HCCs

Ex. E11.52 - Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene maps to HCC 18 and HCC 108

As the error report is based upon HCC information, the specific ICD-10-CM codes were not identified
Red Flag HCCs

Annual supplemental measure analyzes top CMS Hierarchical Condition Categories (CMS-HCCs) that have the highest rates of error

The resulting list of HCCs is based upon two separate payment models and includes:

- Chronic Kidney Disease (Stage 5) (HCC 135)
- Ischemic or Unspecified Stroke (HCC 100)
- Cerebral Hemorrhage (HCC 99)
- Aspiration and Specified Bacterial Pneumonias (HCC 114)
- Unstable Angina and Other Acute Ischemic Heart Disease (HCC 87)
- End-Stage Liver Disease (HCC 27)
- Atherosclerosis of the Extremities with Ulceration or Gangrene (HCC 106)
- Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome (HCC 75)
- Drug/Alcohol Psychosis (HCC 54)
- Lung and Other Severe Cancers (HCC 9)
- Diabetes with Ophthalmologic or Unspecified Manifestation (HCC 18)
Red Flag HCCs

Fiscal Year (FY) 2017 Medicare Advantage payment error estimate is based on Calendar Year 2015 payments

Two year lag is due to the final risk score reconciliation

Upon conclusion of this reconciliation, HHS can begin implementation of the risk adjustment data validation

Total payments = $172.8 Billion Improper payments = $14.4 Billion (8.31%)

Multiple causes of improper payments which include:

• Program Design or Structural Issue
• Failure to authenticate/verify data (death, financial)
• Administrative or Process Errors
• Insufficient Documentation to Determine

The vast majority of improper payments are due to unintentional errors
Section Two

Red Flag HCCs:

• Chronic Kidney Disease
• Cerebral Infarction (Stroke)
• Cerebral Hemorrhage
• Aspiration and Specified Bacterial Pneumonias
• Unstable Angina
• End Stage Liver Disease
Kidney Disease

Acute Kidney Injury (AKI)\(^4\)
- Also called acute renal failure
- Usually caused by an event that leads to kidney malfunction such as blood loss, dehydration or reaction to medicine
- More commonly reversible than chronic kidney disease

Chronic Kidney Disease (CKD)\(^4\)
- Usually caused by long term illness such as diabetes or high blood pressure
- Kidneys are slowly damaged and function decreases over time
- Several stages of progression from stage one to end stage renal disease (ESRD)
## Chronic Kidney Disease

### GFR Categories in CKD

<table>
<thead>
<tr>
<th>Category</th>
<th>GFR ml/min/1.73 m²</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>≥90</td>
<td>Normal or high</td>
</tr>
<tr>
<td>G2</td>
<td>60-89</td>
<td>Mildly decreased*</td>
</tr>
<tr>
<td>G3a</td>
<td>45-59</td>
<td>Mildly to moderately decreased</td>
</tr>
<tr>
<td>G3b</td>
<td>30-44</td>
<td>Moderately to severely decreased</td>
</tr>
<tr>
<td>G4</td>
<td>15-29</td>
<td>Severely decreased</td>
</tr>
<tr>
<td>G5</td>
<td>&lt;15</td>
<td>Kidney failure</td>
</tr>
</tbody>
</table>

Glomerular filtration rate (GFR) is a blood test which measures kidney function. It is calculated using the blood creatinine level, age, race, and gender.

Coders cannot assign a CKD diagnosis based on GFR results alone. CKD and the stage must be expressly stated by the provider.

An estimated 20 million American adults have CKD.
Acute and Chronic Kidney Disease in ICD-10-CM

HCC 134
Z99.2  Dependence on renal dialysis

HCC 135
N17.0  Acute kidney failure with tubular necrosis
N17.1  Acute kidney failure with acute cortical necrosis
N17.2  Acute kidney failure with medullary necrosis
N17.8  Other acute kidney failure
N17.9  Acute kidney failure, unspecified

HCC 136
N18.5  Chronic kidney disease, stage 5
N18.6  End stage renal disease

HCC 137
N18.4  Chronic kidney disease, stage 4 (severe)

HCC 138
N18.3  Chronic kidney disease, stage 3 (moderate)
Cerebral Infarction (HCC 100)

ICD-10-CM Code Category I63* (CVA or Stroke). Additional characters indicate cause and anatomical site detail, including laterality.

Potentially life threatening and requires emergency medical intervention.

Testing is required to confirm diagnosis (CT, MRI, Angiography, etc.).

When suspected but not confirmed, should be documented as such (probable, suspected).

Once initial treatment is completed, code category I69* may be used for any residual conditions caused by the infarction.

*Note: additional characters are required; reference the official ICD-10-CM for complete code sets and descriptions.
Cerebral Infarction (HCC 100)

I69.3*
- Sequela of Cerebral Infarction
- Use when the patient has continued deficits as a result of stroke
- Record should detail specific residual (i.e. hemiplegia, right dominant side)

Z86.73
- Personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits
- Medical record should accurately reflect that the patient has a history of stroke

Incorrect reporting of cerebral infarction is a common error. Correct documentation should indicate when a stroke is suspected based on signs and symptoms, but has not yet been confirmed with appropriate testing or when the stroke is historical in nature as well as detailing any residual deficits.

*Note: additional characters are required; reference the official ICD-10-CM for complete code sets and descriptions.
All bleeding within the skull is referred to as intracranial hemorrhage. Bleeding around or within the brain itself is known as a cerebral hemorrhage (or intracerebral hemorrhage).

Bleeding caused by a blood vessel in the brain that has leaked or ruptured is called a hemorrhagic stroke.

Any type of bleeding inside the skull or brain is a medical emergency.

Stroke is the leading cause of disability and the fifth-leading cause of death in the United States.

Intracranial hemorrhage accounts for approximately 10% of all strokes in the U.S.
Cerebral Hemorrhage (HCC 99)

I60* - Nontraumatic Subarachnoid Hemorrhage
• Fourth and/or fifth characters are required which provide details regarding the location of the hemorrhage, including laterality of affected artery
  Example: I60.12 – Nontraumatic subarachnoid hemorrhage from left middle cerebral artery

I61* - Nontraumatic Intracerebral Hemorrhage
• Fourth character is required to provide detail regarding the affected area of the brain
  Example: I61.2 – Nontraumatic intracerebral hemorrhage in hemisphere, unspecified

I62* - Other and Unspecified Nontraumatic Intracranial Hemorrhage
• Forth and/or fifth characters are required which provide details regarding location and acuity
  Example: I62.03 – Nontraumatic chronic subdural hemorrhage
Pneumonia is an infection that causes inflammation in the air sacs in one or both lungs.

Purulent material causes cough, fever and difficulty breathing.

Variety of organisms can cause pneumonia such as bacteria, viruses and fungi.

The most common cause of bacterial pneumonia in the U.S. is Streptococcus pneumoniae (HCC 115).

According to the CDC, ~544,000 ER visits annually due to pneumonia.

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Aspiration and Specified Bacterial Pneumonias (HCC 114)

A48.1 Legionnaires' disease
J15.0 Pneumonia due to Klebsiella pneumoniae
J15.1 Pneumonia due to Pseudomonas
J15.20 Pneumonia due to staphylococcus, unspecified
J15.211 Pneumonia due to Methicillin susceptible Staphylococcus aureus
J15.212 Pneumonia due to Methicillin resistant Staphylococcus aureus
J15.29 Pneumonia due to other staphylococcus
J15.5 Pneumonia due to Escherichia coli
J15.6 Pneumonia due to other Gram-negative bacteria
J15.8 Pneumonia due to other specified bacteria

Code first associated influenza, if applicable (J09.X1, J10.0-, J11.0-)
Code also associated abscess, if applicable (J85.1)

Note: J18.9 Pneumonia, unspecified organism has no HCC value
Unstable Angina (HCC 87)

Sometimes referred to as acute coronary syndrome
Commonly caused by reduced blood flow to the heart muscle
Should be treated as an emergency

I20.0       Unstable angina
I25.110     Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.700     Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
I25.710     Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
I25.720     Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
I25.730     Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris
I25.750     Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.760     Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.790     Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
There are four stages of liver disease\textsuperscript{10}

1. Inflammation
2. Fibrosis
3. Cirrhosis
4. End Stage Liver Disease

End stage liver disease occurs when cirrhosis is so severe that the decompensation is generally irreversible with medical management other than transplant.

Decompensation may include hepatic encephalopathy, variceal bleed, kidney impairment, ascites and lung issues.

4.9 million U.S. adults have liver disease\textsuperscript{11}
End Stage Liver Disease (HCC 27)

- I85.00 Esophageal varices without bleeding
- I85.01 Esophageal varices with bleeding
- I85.10 Secondary esophageal varices without bleeding
- I85.11 Secondary esophageal varices with bleeding
- K70.41 Alcoholic hepatic failure with coma
- K71.11 Toxic liver disease with hepatic necrosis, with coma
- K72.01 Acute and subacute hepatic failure with coma
- K72.10 Chronic hepatic failure without coma
- K72.11 Chronic hepatic failure with coma
- K72.90 Hepatic failure, unspecified without coma
- K72.91 Hepatic failure, unspecified with coma
- K76.6 Portal hypertension
- K76.7 Hepatorenal syndrome
- K76.81 Hepatopulmonary syndrome
Section 3
Medical Record Documentation Best Practices
Case Studies and Coding Examples
Medicare Risk Adjustment Best Practices: Documentation Recommendations

- Patient name and date of service on each page and unique identifier such as date of birth
- Provider signature and credentials, with date
- All the patient’s medical conditions, including chronic and status conditions
- Specific details regarding acuity and laterality
- Treatment for each condition, including medications
Detailed, Concise and Accurate

<table>
<thead>
<tr>
<th>Provider’s Diagnostic Statement</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has pneumonia</td>
<td>J18.9</td>
<td>None</td>
</tr>
<tr>
<td>Patient has pneumonia due to <em>Streptococcus pneumoniae</em></td>
<td>J13</td>
<td>115</td>
</tr>
<tr>
<td>Patient has pneumonia due to methicillin-susceptible</td>
<td>J15.211</td>
<td>114</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Concise, detailed documentation and accurate diagnosis coding are essential elements to ensure accurate risk adjustment.
Fictional Case Study Example 1

DOS: 01/12/2019
Name: Patient One DOB: 05/01/1953

Chief Complaint & HPI
65 year old female accompanied by her husband, here for routine visit, lab results

Past Medical History
Diabetes, CKD, Hyperlipidemia, HTN

ROS
Constitutional – patient notes fatigue
GU – positive for urinary frequency
MS – mild swelling in the hands and feet
other systems negative

Vitals
Ht. 69 in, Wt. 275 lbs.
BP 124/82
Temp 97.6 Pulse 78

Exam
General Appearance: Well groomed, pleasant, obese female ENMT: Normal CV: RRR; Lungs: clear, good breath sounds bilaterally

Assessment/Plan
1. Diabetes – currently well controlled, a1c at 5.2
2. Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. CKD – currently no change, GFR at 51
4. HTN, hyperlipidemia – both currently well controlled. Repeat labs and schedule follow up in 3 months

Electronically signed by: A. Medical Doctor, MD on 01/12/19
**Fictional Case Study Example 1**

First Coding Scenario:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/ CKD</td>
<td>E11.22</td>
<td>18</td>
</tr>
<tr>
<td>CKD</td>
<td>N18.9</td>
<td>none</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.0</td>
<td>none</td>
</tr>
<tr>
<td>Hypertensive CKD, unspecified</td>
<td>I12.9</td>
<td>none</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
<td>none</td>
</tr>
</tbody>
</table>
Fictional Case Study Example 1 with Improved Documentation

**DOS:** 01/12/2019
**Name:** Patient One **DOB:** 05/01/1953

**Chief Complaint & HPI**
65 year old female accompanied by her husband, here for routine visit, lab results

**Past Medical History**
Diabetes, CKD, Hyperlipidemia, HTN

**ROS**
Constitutional – patient notes fatigue
GU – positive for urinary frequency
MS – mild swelling in the hands and feet
other systems negative

**Vitals**
Ht. 69 in, Wt. 275 lbs. BMI 40.6
BP 124/82
Temp 97.6 Pulse 78

**Exam**
**General Appearance:** Well groomed, pleasant, **morbidly** obese female **ENMT:** Normal **CV:** RRR;
**Lungs:** clear, good breath sounds bilaterally

**Assessment/Plan**
1. Diabetes – currently well controlled, a1c at 5.2
2. **Morbid** Obesity – counselled regarding weight loss and maintaining low calorie, low fat diet
3. **CKD, Stage 3, secondary to diabetes** – currently no change, GFR at 51
4. **HTN, hyperlipidemia** – both currently well controlled. Repeat labs and schedule follow up in 3 months

Electronically signed by: A. Medical Doctor, MD on 01/12/19

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### Fictional Case Study Example 1

**First Coding Scenario:**

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<thead>
<tr>
<th>Diagnosis</th>
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</tr>
<tr>
<td>CKD</td>
<td>N18.9</td>
<td>none</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.0</td>
<td>none</td>
</tr>
<tr>
<td>Hypertensive CKD, unspecified</td>
<td>I12.9</td>
<td>none</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
<td>none</td>
</tr>
</tbody>
</table>

**Second Coding Scenario**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes w/ Stage 3 CKD</td>
<td>E11.22</td>
<td>18</td>
</tr>
<tr>
<td>Stage 3 CKD</td>
<td>N18.3</td>
<td>138</td>
</tr>
<tr>
<td>Morbid Obesity BMI 44.0-44.9</td>
<td>E66.01</td>
<td>Z68.41</td>
</tr>
<tr>
<td>Hypertensive CKD, stage 3</td>
<td>I12.9</td>
<td>none</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>E78.5</td>
<td>none</td>
</tr>
</tbody>
</table>

Detailed documentation is key for accurate risk score reporting.
Fictional Case Study Example 2

DOS: 10/28/2018
Name: Patient Two DOB: 07/22/1947

Chief Complaint & HPI
71 year old male patient here for follow up, recently hospitalized with pneumonia

Past Medical History
Hypercholesterolemia, Afib

ROS
Pt admits generalized body aches, cough, sore throat, fatigue; all other systems negative

Vitals
Ht. 68 in, Wt. 176 lbs.
BP 130/82
Temp 99.0 Pulse 68

Exam
General Appearance: Ill appearing, pale
Lungs: rales, wheezing and percussion dullness noted
CV: RRR Abdomen: soft, non-tender

Assessment/Plan
1. Pneumonia – repeat chest x-ray shows moderate improvement. Advised continued fluids and rest, aspirin or acetaminophen as needed. Continue antibiotics even if symptoms clear. Follow up in one week or less if needed.
2. All other conditions stable

Electronically signed by: I.B. Adoc, MD on 11/01/18
Fictional Case Study Example 2

First Coding Scenario:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia, unspecified organism</td>
<td>J18.9</td>
<td>none</td>
</tr>
</tbody>
</table>
Fictional Case Study Example 2 with improved documentation

DOS: 10/28/2018
Name: Patient Two DOB: 07/22/1947

Chief Complaint & HPI
71 year old male patient here for follow up, recently hospitalized with methicillin-susceptible Staphylococcus aureus pneumonia

Past Medical History
Hypercholesterolemia, Afib

ROS
Pt admits generalized body aches, cough, sore throat, fatigue; all other systems negative

Vitals
Ht. 68 in, Wt. 176 lbs.
BP 130/82
Temp 99.0 Pulse 68

Exam
General Appearance: Ill appearing, pale
Lungs: rales, wheezing and percussion dullness noted
CV: RRR Abdomen: soft, non-tender

Assessment/Plan
1. MSSA Pneumonia – repeat chest x-ray shows improvement. Advised continued fluids and rest, aspirin or acetaminophen as needed. Finish all antibiotics even if symptoms clear. Follow up in one week or less if needed.
2. Persistent atrial fibrillation – followed by cardiology, currently well controlled
3. Hypercholesterolemia – refill Atorvastatin

Electronically signed by: I.B. Adoc, MD on 11/01/18
# Fictional Case Study Example 2

## First Coding Scenario:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia, unspecified organism</td>
<td>J18.9</td>
<td>none</td>
</tr>
</tbody>
</table>

## Second Coding Scenario:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10-CM</th>
<th>HCC Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia due to Methicillin susceptible Staphylococcus aureus</td>
<td>J15.211</td>
<td>114</td>
</tr>
<tr>
<td>Persistent atrial fibrillation</td>
<td>I48.1</td>
<td>96</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>E78.00</td>
<td>none</td>
</tr>
</tbody>
</table>
Red Flag HCCs

- Insufficient detail to support reporting of conditions
- Acute and emergent conditions reported in error
- ICD-10-CM Diagnosis Codes require greater detail in the documentation
- Conditions must be expressly stated and documented as coders cannot assume
- Improved, detailed documentation and accurate diagnosis coding are key
- Correct and accurate risk score reporting leads to improved patient care

Conditions reported in error have resulted in over $14 billion in improper payments
The Medicare Risk Adjustment Regulatory Compliance (MRARC) unit has multiple resources and tools available, including the Coding Focus.

- **Coding Focus**, a useful and concise one page publication focusing on specific condition(s) with details regarding the clinical definition, diagnostic criteria, and relevant ICD-10 coding guidance with impact to HCC code(s) assignment.

Recent and upcoming topics include:

- Diabetes with Neurological Complications
- Diabetes with Ophthalmic Complications
- Rheumatoid Arthritis
- Unstable Angina

The Coding Focus, along with other coding training material, is available on Anthem’s Provider Webpage(s)
Provider Training Materials

Medicare Advantage resources are available under “Medical Record Documentation and Coding Tips” on the following provider web pages:

Anthem Blue Cross Blue Shield:
• https://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f2/s2/t4/pw_e180931.htm&label=Medical%20Record%20Documentation%20and%20Coding%20Tips&state=oh&rootLevel=0

Amerigroup:
• https://providers.amerigroup.com/Pages/medicare-record-doc-coding-tips.aspx

Anthem BlueCross (California):

Empire Blue Cross/Empire BlueCross BlueShield

Blue Cross Blue Shield of Georgia
Questions?

Thank you for attending. If you have any questions, please contact the MRARC team at MedicareRiskAdjustmentCompliance@anthem.com
References

7 Cleveland Clinic (2017). Intracranial Hemorrhage, Cerebral Hemorrhage and Hemorrhagic Stroke. Accessed December 11, 2018 from my.clevelandclinic.org