moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM050
Policy Title:	Risk Adjustment/HCC Coding and Documentation		
Section:	Administrative	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2013	Initially Published:	6/8/2016
Last Updated:	8/9/2024	Last Reviewed:	8/14/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		8/14/2024	

Reimbursement Guidelines

A. HCC Risk Adjustment Requirements

1. We are required by the federal government to report risk adjustment data to CMS and HHS and to validate that risk adjustment data for our member claims. Therefore, we routinely conduct HCC diagnosis coding and documentation reviews to ensure accurate HCC data reporting. These HCC reviews are part of our quality review program.
2. CMS and HHS reserve the right to audit any risk adjustment findings through a process known as Risk Adjustment Data Validation (RADV). In the event a member is chosen for RADV, we are required to participate and retrieve all claim and encounter data for that member.
3. HCC reviews apply standard diagnosis coding and documentation guidelines (e.g., ICD-10-CM guidelines, Coding Clinic guidelines, CMS guidelines).
4. Medical records will be requested for HCC reviews and federally mandated RADV reviews.
   a. Providers are required to cooperate with medical records requests.
   b. Records/copying fees:
      i. For member plans originating in the state of Texas, reimbursement will be made for providing copies of medical records, not to exceed the amount required by current Texas state law.
      ii. For all other plans no separate payment will be made for records/copying fees. [A]

B. Medical Record Documentation is Important for Risk Adjustment

1. Physician documentation and diagnosis coding data is critical for accurate risk adjustment.
2. CMS-HCC and HHS-HCC models rely on ICD-CM coding specificity. Appropriate coding requires use of the most specific code available.
   a. ICD-CM diagnosis coding is substantiated by the medical record.
   b. Physicians are the largest source of data for the risk adjustment model.
3. Medical record documentation for the encounter dictates what code is assigned. Coders are not permitted to assume any diagnosis.
4. Providers are expected to fully document and accurately code the evaluation and ongoing management of all severe and chronic conditions, to ensure an accurate clinical record of the patient's condition. Thorough medical record documentation and coding will provide a full and complete picture of the practitioner's work and care of the patient, particularly of those with complex and challenging health concerns.

C. Supporting a Diagnosis in the Medical Record

1. Documentation is the only way a diagnosis can be supported for an encounter.
2. Documentation for a valid diagnosis must indicate how the condition is **managed, evaluated, assessed, or treated (MEAT)** for it to be captured for risk adjustment.
   a. The diagnosis must be documented, and it should be very clear how the provider is managing the condition.
   b. The Problem List, Active Condition List, Past Medical History List, etc., are not suitable examples of documentation of MEAT.
   c. If there is no MEAT documented to substantiate the diagnosis, the diagnosis will be rejected by CMS due to the lack of evidence by provider.
3. Diagnoses may not be captured from cloned encounters.
   a. Do not copy and paste encounters.
   b. Each encounter must be unique and should reflect the visit as it occurred.
4. See also "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039. [B]

D. Records Copying Fees

1. For member plans originating in the state of Texas, reimbursement will be made for providing copies of medical records, not to exceed the amount required by current Texas state law.
2. For all other plans, separate reimbursement is not provided for records fees, copying fees, etc. for these HCC reviews. Any costs associated with copying and providing needed records for purposes of quality reporting reviews are also considered a normal part of providing the services to our members which are being reviewed for quality, and records copying fees are not eligible for separate reimbursement. [A]

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
ACA	Affordable Care Act
AHA	American Hospital Association
AHIMA	American Health Information Management Association
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HHS	U. S. Department of Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
MA	Medicare Advantage
MEAT	Managed, evaluated, assessed, or treated
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
NCHS	National Center for Health Statistics
RADV	Risk Adjustment Data Validation
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	Uniform Bill

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible task." [5]

Cross References

A. "Records Fees, Copying Fees." Moda Health Reimbursement Policy Manual, RPM005.

B. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

References & Resources

1. CMS, DHS, CCIIO. "Risk Adjustment Methodology Overview." Centers for Medicare and Medicaid Service (CMS). May 21-23, 2012: June 2, 2016.

https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-risk-adjustment-methodology.pdf

2. CMS, DHS, CCIIO. "Summary Report On Transitional Reinsurance Payments And Permanent Risk Adjustment Transfers For The 2014 Benefit Year." Centers for Medicare and Medicaid Service (CMS). June 30, 2015: June 2, 2016. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf
3. Klitgaard, Don, MD, FAAFP. "Risk Adjustment 101." Heartland Rural Physician Alliance. May 8, 2015: June 2, 2016. http://www.heartlandrpa.org/documents/cms/docs/Summit_IV/Risk_101_Presentation_Dr._Klitgaard_May_8_2015.pdf
4. CMS. "Risk Adjustment Data Submission Requirements." Medicare Managed Care Manual, Chapter 7 – Risk Adjustment, § 40. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf
5. HHS. "Selection of Principal Diagnosis." ICD-10-CM: Official Guidelines for Coding and Reporting. Section II., 2016. U. S. Department of Health and Human Services (HHS), American Health Information Management Association (AHIMA), National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA).
6. "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." Federal Register. March 23, 2012: June 2, 2016. https://www.federalregister.gov/articles/2012/03/23/2012-6594/patient-protection-and-affordable-care-act-standards-related-to-reinsurance-risk-corridors-and-risk#h-4
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8. CMS, DHS, CCIIO. "Reinsurance, Risk Corridors, and Risk Adjustment Final Rule." Centers for Medicare and Medicaid Service (CMS). March 2012: June 2, 2016. https://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf
9. Pope, et al. "Evaluation of the CMS-HCC Risk Adjustment Model – Final Report." *Medicare & Medicaid Research Review* 2014: Volume 4, Number 3. Centers for Medicare and Medicaid Service (CMS). March 2011: June 2, 2016. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf
10. CMS. "Risk Adjustment Fact Sheet." Centers for Medicare and Medicaid Service (CMS). April 2015: June 2, 2016. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Risk-Adjustment-Fact-Sheet.pdf
11. Kautter, J., Pope, G. C., Ingber, M., et al. "The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act." Centers for Medicare and Medicaid Service (CMS). April 2015: June 2, 2016.
12. "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors." The Henry J. Kaiser Family Foundation. January 22, 2014: June 2, 2016. http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/

Background Information

Effective 2006, Centers for Medicare & Medicaid Services (CMS) instituted the prospective risk adjustment model used to reimburse Medicare Advantage (MA) claims. Then effective 01/01/2014 a

permanent Department of Health & Human Services (HHS) risk adjustment program was established under section 1343 of the Affordable Care Act (ACA) for non-grandfathered individual and small group plans inside and outside Exchanges (Commercial carrier claims).[1]

Risk Adjustment is a process that identifies patients who require more resources and disease intervention as determined each year by the diagnosis codes billed for that patient in the previous review period. CMS has classified the costly chronic conditions of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) into Hierarchical Conditional Categories (HCCs). Patients with HCC conditions require more resources.

The CMS and HHS risk adjustment programs provide payments to health insurance issuers that cover higher-cost and higher-risk populations and evenly distribute financial risk amongst issuers and stabilize member premiums.[2] This risk adjustment program requires insurance carriers to verify that diagnoses are substantiated within the members' medical record and report diagnosis coding/HCC data to the federal government.[4]

Risk Adjustment relies on annual health information. Each enrollee is assigned an individual risk score based on the health status information obtained from the diagnosis codes of their claims. Each chronic condition must be addressed at least once a year for the patient's risk score to be impacted.

Provider Documentation & Risk Adjustment

Chronic conditions require long-time attention and management, but often due to high familiarity with the patient, documentation of diagnoses during a face-to-face visit tend to dwindle with time. Insufficient documentation impacts the assignment of diagnosis codes, and directly impacts the patient's risk score. All conditions affecting the treatment or management of the patient's health shall be documented at least once a year, as applicable to providing care, to accurately reflect the true complexity and severity of the patient's health.

If the diagnosis coding on the claim is not accurate or complete, the claim reflects that the provider did much less work (medical decision making, evaluation, and management) than they performed. [3]

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
8/14/2024	Formatting updates. No policy changes.
8/9/2023	Formatting updates. No policy changes.
7/13/2022	Added Texas information in case plans subject to HHS HCC requirements are offered in the future. None now so not subject to 28 TAC. No other policy changes. Updated Acronyms. Formatting updates.
6/8/2016	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2013	Original Effective Date (with or without formal documentation). Policy based on CMS and HHS risk adjustment programs, policies, and requirements.