CODING COUNTS

Understanding and avoiding the common pitfalls of coding

Coding begins with you!

The Center for Medicare and Medicaid (CMS) uses Risk Adjustment, a system of payments that are reimbursed based on a provider's documentation and coding that explain how complex a beneficiary's conditions may be. This coding then results in a risk score assigned to each payment. To ensure the most accurate risk score and reimbursements, providers are asked to take the following three steps:

1. See all of your beneficiaries at least once per year.
2. Improve continuity of care for your beneficiaries by documenting and coding all chronic conditions every year.
3. Confirm documentation of other existing conditions such as amputation every year.

JUST BECAUSE IT EXISTS DOES NOT MEAN IT HAS BEEN DOCUMENTED

Why does coding count?

1. CODING ACCURACY

HIPAA defines the requirements to follow ICD-10-CM diagnosis coding guidelines. This includes compliant code selection and documentation to support codes reported. The health care system and the beneficiaries count on the providers to assist with showing medical necessity.

2. RAF

Risk Adjustment Factor scores are assigned by CMS to each beneficiary based on demographic and disease-related factors such as location, age, gender, disability, Medicaid and health status.

3. HCC

Hierarchical Condition Categories is a system created by CMS for risk-related ICD-10 codes. CMS uses HCC's to assess, adjust and pay for the costs of taking care of the disease burden among beneficiaries. HCC codes are based on a face-to-face encounter note and must be reported annually.

What are the impacts of incorrect coding?

1. Dropped HCCs-missed diagnosis codes are those identified in previous years but not reported in the current calendar year review.
2. Results in misrepresentation of the disease burden of the NWMHP beneficiary.
3. Benchmarks are not calculated appropriately for conditions and associated services which can result in the inability to collect shared savings.

Frequently asked coding questions

WHAT IS THE DIFFERENCE BETWEEN ACTIVE CANCER AND HISTORY OF CANCER?

Cancer is considered "active" when:

1. The beneficiary is currently receiving treatment or adjuvant therapy.
2. The beneficiary is not receiving treatment but cancer is present.

Cancer is considered "history of" when:

1. All active treatments have ceased.
2. The provider surgically or medically cleared the beneficiary from needing current treatment.
3. Supporting documentation contains descriptive statements such as: "under surveillance," "no active disease" or "history of."

HOW DO I MOST ACCURATELY CODE AND DOCUMENT DEPRESSION?

Document episode:

1. Single.
2. Recurrent.

Document severity:

1. Mild.
2. Moderate.
3. Severe with psychotic features.
4. Severe without psychotic features.
5. In partial or full remission (if applicable).
6. Document any associated diagnoses/conditions.

RAF SCORES:

GOOD TO KNOW

>1.0 = SICKER BENEFICIARY

<1.0 = HEALTHIER BENEFICIARY

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TOP 25 DX CODES

NO.	DX ICD-10	DESCRIPTION	HCC	WEIGHT
1	C50.919	Malignant neoplasm of unspecified site of unspecified female breast	12	0.158
2	E11.40	Type 2 diabetes mellitus with neuropathy, unspecified	18	0.34
3	E11.9	Type 2 diabetes mellitus without complications	19	0.107
4	E46	Protein-calorie malnutrition, unspecified	21	0.693
5	E66.01	Morbid (severe) obesity due to excess calories	22	0.383
6	Z68.41	Body mass index (BMI) 40.0-44.9, adult	22	0.383
7	M06.9	Rheumatoid arthritis, unspecified	40	0.371
8	M35.3	Polymyalgia rheumatica	40	0.371
9	F31.9	Bipolar disorder, unspecified	59	0.299
10	G40.89	Other seizures	79	0.237
11	I50.9	Heart failure, unspecified	85	0.371
12	I42.9	Cardiomyopathy, unspecified	85	0.371
13	I20.9	Angina pectoris, unspecified	88	0.034
14	I48.91	Atrial fibrillation, unspecified	96	0.384
15	I48.92	Atrial flutter, unspecified	96	0.384
16	I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side	103	0.487
17	I71.4	Abdominal aortic aneurysm, without rupture	108	0.294
18	I73.9	Peripheral vascular disease, unspecified	108	0.294
19	I79.8	Other disorders of arteries, arterioles and capillaries in diseases classified elsewhere	108	0.294
20	I82.509	Chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity	108	0.294
21	J44.9	Chronic obstructive pulmonary disease, unspecfied	111	0.43
22	L97.909	Non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity	161	0.723
23	Z93.2	Ileostomy status	188	0.742
24	Z93.3	Colostomy status	188	0.742
25	Z89.519	Amputation or Acquired Absence of unspecified leg below knee	189	0.795

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***Per the 2022 CMS Call Letter, 2020-10 CMS V24 HCC Model Codes and The Community, FB Dual, Aged are the default weights used for this flyer**