TO: **All FHCP Providers**

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SUBJECT **FHCP Risk Adjustment Newsletter**

In October 2000, CMS started collecting physician encounter data from Florida Health Care Plans as part of transition to comprehensive risk adjustment payments for Medicare Advantage Organizations. The transition period has been completed. As a result, all Medicare Advantage (MA) plans and Prescription Drug (MAPD and PD) plans like FHCP are financially dependent upon the specific documentation of each individual patient's diagnoses and co morbid conditions as classified within the highly specific CMS Hierarchical Condition Category (HCC) system. With this, accurately assessing and representing the diagnostic, procedural, and pharmaceutical characteristics of enrollees has become paramount to FHCP to assure that we receive appropriate premium reimbursement from CMS for our Medicare members. The requirement of accurate assessment, improvement, and reporting of factors that drive risk score calculation is critical. Failure to do so has both significant quality of care implications and critical financial ramifications for FHCP.

To help with understanding and also to better communicate Medicare Risk Adjustment information to our providers, periodically FHCP will be sending out bulletins such as the one attached to our network of providers.

If you have any questions about Medicare Risk Adjustment or the attached bulletin, please contact me at lschoen@fhcp.com or you may call me at the Holly Hill facility (386-615-4024 or 800-352-9824 x 4024.) Thank you.

HCC 71 - Polyneuropathy

There are many types of neuropathies that affect patients; some are mild and others are more severe requiring medication management if the underlying cause cannot be found. For informational purposes we will focus on the more typical polyneuropathies that fall under HCC 71. The majority of management of these diseases in the outpatient setting will be regularly scheduled visits with re-evaluation of condition on examination and reassessment of medication effectiveness.

Often, physicians will document “Neuropathy” in the medical record which is a very generic term and usually should not be used. It would be advantageous to use a more specific neuropathy diagnosis since the patient’s treatments and plans of care can vary depending upon their individual case. The more typical neuropathies that patients have would be: Peripheral neuropathy, Diabetic polyneuropathies, Myasthenia gravis, Charcot-Marie-Tooth disease and, Chronic inflammatory demyelinating polyneuritis (CIDP).

Special consideration should be taken for diabetic patients that have associated neuropathy. A cause and effect relationship must be stated by the physician to correctly identify these comorbid conditions either as “Diabetic neuropathy” or “Neuropathy due to diabetes”. Please be sure to note any planned workup or testing since they are vital to the treatment of the patient’s given condition, as well a level of stability associated with the medication(s) the patient takes. This will help you tell the story of a patient’s illness for proper coding/billing.

The following table can be used as a reference for coding HCC 71:

ICD-9 Code	Descriptor
356.9	Unspecified Hereditary and Idiopathic **Peripheral Neuropathy**
250.6x; [*357.2*]	Diabetes with neurological manifestations; *Polyneuropathy in diabetes*
250.6x; [*337.1*]	Diabetes with neurological manifestations; *Peripheral **autonomic** neuropathy in disorders classified elsewhere*
358.00	Myasthenia gravis **without** (acute) exacerbation
358.01	Myasthenia gravis **with** (acute) exacerbation
356.1	Peroneal Muscle Atrophy (Charcot–Marie-Tooth disease)
357.81	Chronic Inflammatory Demyelinating Polyneuritis (CIDP)

What are physicians' and providers' responsibilities?

For all FHCP members, but especially your Medicare members, providers and physicians must:

- Report all diagnoses that impact the patient's care and ensure these diagnoses are accurately documented in the medical record. This includes the main reason for the visit and all co-existing, acute or chronic conditions, and pertinent past conditions that impact clinical evaluation and therapeutic treatment. Symptoms that are common to the main reportable diagnosis should not be coded. If you have a problem or diagnosis, code that. If you only have a symptom but do not yet know the diagnosis, then you may code the symptom.

- Report ICD-9-CM diagnosis codes to the highest level of specificity and report these codes accurately. Coding to the highest degree of specificity provides the most accurate coding and ensures appropriate grouping in the risk adjustment model.

- Complete, legible and logical Medical record documentation is important for risk adjustment because quality documentation leads to correct code specificity and accurate risk adjustment payment. In simple terms this means that the Chief Complaint, History of Present Illness, Review of Systems, Physical, Diagnosis and Plan must all match and have consistent documentation and discussion for the condition.