



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.

Risk Adjustment Information for Providers

HCC 131 – Chronic Kidney Disease (CKD) Guidelines and relationship with Diabetes mellitus

Chronic Kidney Disease affects at least 26 million American adults and is a major public health problem. Earlier stages of CKD can be detected through routine laboratory measurements: eGFR, serum creatinine and, urine albumin. Adverse CKD complications may be prevented or delayed through early detection and treatment of underlying disease. Chronic Kidney Disease is defined by the National Kidney Foundation (NKF) “according to the presence or absence of kidney damage and the level of kidney function (GFR) – irrespective of the type of kidney disease (diagnosis).

Definition of Chronic Kidney Disease - Criteria	Stages of Chronic Kidney Disease			
1. Kidney Damage for ≥ 3 months , as defined by structural or functional abnormalities, with or without decreased GFR, manifest by either:	Stage	Description	GFR	ICD-9 code
	<ul style="list-style-type: none"> Pathological abnormalities; or Markers of kidney damage, including abnormalities in the composition of the blood or urine, or abnormalities in imaging tests; OR 	1	Kidney damage w/ normal or ↑ GFR	≥ 90
2		Kidney damage with mild ↓ GFR	60 - 89	585.2
3		Moderate ↓ GFR	30 - 59	585.3
2. GFR <60 mL/min/1.73 m² for ≥3 months, with or without kidney damage.	4	Severe ↓ GFR	15 - 29	585.4
	5	Kidney Failure	< 15	585.5

Now that we have the diagnosing and staging (level of function) criteria established, let's now turn our attention to the relationship with CKD and diabetes. Individuals at high risk to develop CKD include those with diabetes, hypertension and family history of kidney disease. Diabetes is the leading cause of CKD per the National Kidney Foundation and diabetes accounts for 45 percent of kidney failure. The key documentation point to address is that Diabetes and any associated complication/manifestation like CKD must be **linked** with a cause and effect statement of either “Diabetic Chronic Kidney Disease” or “CKD due to Diabetes”.

The following table can be used as a reference for coding Diabetes with Renal Manifestations:

ICD-9 Codes (code both)	Clinical Diagnosis
250.40 [585.3]	“Type II Diabetic with chronic kidney disease, GFR 55” (codes to stage III)
250.40 [583.81]	“Diabetic Nephropathy – controlled”
250.41 [791.0]	“Type I Diabetic complicated by proteinuria less than 3 months”
250.42 [585.9]	“Chronic Renal Failure due to uncontrolled type II Diabetes”

What are physicians' and providers' responsibilities?

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

- In the specific case of diabetes with CKD, please submit the 5 digit diabetes code (see the Diabetes EZ Coder) and the CKD code together. Discuss both conditions and their current status and treatment plan in your note.
- For all FHCP members, but especially your Medicare members, providers should attempt to report ICD-9-CM 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 risk adjustment compliance. In simple terms this means that the Chief Complaint, History of Present Illness, Review of Systems, Physical, Diagnosis and Plan should all match and have consistent documentation and discussion for the condition.