



**Florida
Health Care
Plans**



An Independent Licensee of the Blue Cross and Blue Shield Association

TO: All FHCP Providers

FROM: Linda L. Schoenwetter, CPC, CPMA
Benefit Plans and Coding Manager

CC: Wendy Myers, M.D., President/CEO
Sherrie Hutchinson, MHSA, Contract Services Administrator

DATE: March 7, 2011

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.

Clarification of Active Conditions versus “History of” Conditions

ICD-9-CM offers many coding ideas and conventions that guide code selection based upon language used in the diagnostic statement. These guidelines sometimes do not line up with the clinical mindset of the physician. A major example of this is documenting a diagnosis as “History of”, like a diagnosis of “history of CHF”. The first thing to consider here is if the patient has active CHF compensated with medication, or does the patient have a personal history of CHF that has resolved? ‘History of’ should only be used for something like a cancer that is resolved.

If the patient has active, compensated CHF (ICD-9 code 428.0), then please state in your note “CHF, compensated on medications. When dealing with long-term chronic systemic illnesses, please do not utilize the term “history of” since these diseases will not go away. If a patient has RA, or other similar chronic illness and they do not show any symptoms at the time of visit but are being treated for the condition, do not use “history of” language, please state the condition as active. Medical record auditors are trained to follow the guidelines when assigning medical diagnoses, so it is imperative to word your diagnosis appropriately to alleviate any question of clarity. If a patient is taking a medication for a condition, code it as active.

The following table highlights some documenting scenarios involving **Active Conditions:**

Don’t Say: “Patient has History of…” that is active	ICD-9 Code	Do Say: “Patient has Active Condition... currently being treated”	ICD-9 Code(s)
H/O of Atrial Fibrillation, on Coumadin	V12.59	Stable Atrial Fibrillation on anti-coagulant and anti-arrhythmic therapy. Check PT/INR in 2 weeks.	427.31
H/O Rheumatoid Arthritis since 1999	V13.59	Rheumatoid Arthritis since 1999, continue steroid therapy. Follow up with Rheumatologist.	714.0
H/O NIDDM with neuropathy	V12.2	Diabetic Neuropathy, good symptom control with Neurontin; continue meds and A1c in 3 months	250.60 357.2
H/O Congestive Heart Failure	V12.59	Congestive Heart Failure, compensated. Continue ACE, beta blocker and Lasix follow up in 4 months.	428.0
H/O Crohn’s Disease,	V12.79	Crohn’s Disease stable, continue Asacol & see GI.	555.9
History of Renal Insufficiency for last 12 months	V13.09	Chronic Renal Insufficiency. Avoid NSAID use to reduce further decline in kidney function.	585.9
History of PVD, on Trental	V12.59	Peripheral Vascular Disease. Continue Pletal as claudication symptoms have diminished.	443.9

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, Assessment, Plan and Discussion/Summary must all match and have consistent documentation and discussion for the condition.