

Risk Adjustment Information for Providers

What is Risk Adjustment?

The method used by CMS for determining premium payment rates paid to Medicare Advantage Organizations such as FHCP. CMS uses the CMS-Hierarchical Condition Category (CMS-HCC) payment model to calculate member premium adjustments. This model incorporates inpatient hospital, outpatient hospital and physician encounters in predicting costs of care. Risk Adjustment uses diagnosis information from a base year to predict costs and adjust payments for the next year. Largely driven by costs associated with chronic diseases, Risk Adjustment determines the systematic risk of cost associated with Medicare populations. In order for FHCP to provide benefits and services to our Medicare members it is important that we receive accurate premium reimbursement from CMS. Accurate premium reimbursement depends on our providers reporting the diagnosis codes in a complete, accurate and timely manner which are supported by the patient's medical record.

CMS-HCC Model Characteristics

The CMS-HCC model uses approximated 3,300 ICD-9-CM diagnosis codes, which are combined into a reduced code set of approximately 800 codes. These are mapped to approximate 64 disease groups called Hierarchical Condition Categories (HCCs).

The HCCs are disease groups broadly organized into body systems. The diagnoses within each disease group are related clinically in terms of cost.

Why is Risk Adjustment important to providers and physicians?

While procedure codes remain important for calculating your reimbursement of services, the Risk Adjustment Payment Model relies on ICD-9-CM diagnosis code specificity. Therefore it is important that you report to FHCP, via claims or encounter records, appropriate and specific diagnosis codes to the highest level of specificity and for all applicable diagnoses.

What are physicians' and providers' responsibilities?

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

- 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.
- Report claims and encounter data in a timely manner, generally within 30 days of the date of service (or discharge from hospital inpatient facilities).
- 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.
- Report all diagnoses that impact the patient's care and ensure these diagnoses are accurately documented in a medical record. This includes the main reason for the episode of care 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.