Risk adjustment and coding accuracy leads to more accurate and timely payments

Risk adjustment is a payment model used by the Center for Medicare & Medicaid Services (CMS) to predict the cost of care for health plan members. The model determines the capitated payment from CMS to Security Health Plan based on:

- Patient demographics – Age, sex, Medicaid status
- Patient health status – determined from the diagnoses on claims submitted to Security Health Plan by providers.

Approximately 9500 ICD-10 diagnosis codes (out of > 70,000) map to 86 Hierarchical Condition Category (HCC) categories. Hierarchies are built into the HCC model and Security Health Plan is paid based on the highest HCC supported in the hierarchy. Complete and specific documentation and diagnosis coding is essential to accurate risk score assignment for Security Health Plan members.

The submitted patient diagnoses:

- Must meet ICD-10 CM coding guidelines
- Result from a face to face visit with an acceptable provider type
  - Physicians, Nurse Practitioners, Physician Assistants as well as some other therapists and clinicians
- Be documented and coded once per calendar year, January 1st to December 31st.

Documentation should include the **specific** diagnosis that describes the patient's condition.

- For example, "chronic kidney disease stage 4" (is an HCC) is more specific than "unspecified chronic kidney disease" (not an HCC).

Diagnosis specificity could include any/all of the following about the patient's condition:

- Acute/chronic/acute on chronic
- Stable/unstable/worsening/resolved
- Type
- Stage or severity of condition
- Location – left/right/bilateral, upper/lower, proximal/distal
- Affecting dominant or non-dominant side
- Active, in remission, cured or "history of"
- If one condition is causing another

Additionally, documentation should indicate that the provider "TAMPERed" with the diagnosis

T = Treated the condition
A = Assess/Addressed the condition
M = Managed the condition
P = Planned for the condition
E = Evaluated the condition
R = Referred the patient for additional evaluation of the condition

A diagnosis can be coded when documentation includes both the diagnosis and evidence the provider TAMPERed with the condition.

Risk adjustment revenue is essential for the following:

- Payment of member claims
- Payment for any SHP contract provisions with affiliated providers
- Maintaining stable member insurance premiums
- Enhancing member benefits – hearing, vision or dental benefits, for example
- Identifying members who are eligible for SHP-provided Wellness, Case or Disease management programs
- Leveling the playing field between payers by stabilizing premiums.

Providers are encouraged to bring their patients in for annual physicals, preventive services and chronic disease management as recommended in clinical practice guidelines. Security Health Plan's goal is to encourage optimum health and management of SHP members and their chronic conditions.

Additional information about HCC coding is available on Security Health Plan's Provider webpage at: https://www.securityhealth.org/providers/hcc