Appropriate coding helps provide a comprehensive picture of members' health

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We appreciate the role you play in managing the health of our members. As the physician of a member who has coverage compliant with the Affordable Care Act (ACA), you play a vital role in accurately documenting the health of the member to help ensure compliance with ACA program reporting requirements. *When members visit your practice, we encourage you to document ALL of their health conditions, especially chronic diseases. Ensuring that the coding on the claim submission is to the greatest level of specificity can help reduce the number of medical record requests from us in the future.*

Please ensure that all codes captured in your electronic medical record (EMR) system are also included on the claim(s), and are not being truncated by your claims software management system. For example, some EMR systems may capture up to 12 diagnosis codes, but the claim system may only have the ability of capturing four. If your claim system is truncating some of your codes, please work with your vendor/clearing house to ensure all codes are being submitted.

Reminder about ICD-10 coding

The ICD-10 coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, we use ICD-10 codes submitted on claims to monitor health care trends, cost, and disease management. Furthermore, the Centers for Medicare & Medicaid Services (CMS) uses ICD-10 as part of the risk adjustment program created under the ACA to determine the risk score associated with a member's health.

Using specific ICD-10 diagnosis codes will help convey the true complexity of the conditions being addressed in each visit.

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure.
- Include any secondary diagnosis codes that are actively being managed.

- Include all chronic historical codes, as they must be documented each year pursuant to the ACA. (Such as an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. ICD-10 coding guidelines still apply, so please ensure coding on a telehealth visit claim is to the highest specificity with all diagnosis codes. Previous Anthem *Provider News* editions provide telehealth reimbursement guidance to follow for claims submission.

If you are interested in a coding training session specific to risk adjustable conditions, please contact Alicia Estrada, the Commercial Risk Adjustment Network Education Representative at Alicia.Estrada@anthem.com.

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