Commercial risk adjustment (CRA) reporting update

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In a continuation of our CRA reporting update in March 2019, we request your assistance with respect to our commercial risk adjustment (CRA) reporting processes. There are two approaches that we take (retrospective and prospective) that work to improve risk adjustment reporting accuracy. We are focusing on performing appropriate interventions and chart reviews for patients with undocumented hierarchical condition categories (HCC), to close the documentation and coding gaps that we are seeing with our members enrolled in our Affordable Care Act (ACA) compliant plans.

With both our prospective and retrospective approaches, accurate documentation and coding are what we are encouraging physicians to achieve. As a physician for our members with ACA compliant plans, you play a vital role in the success of our CRA reporting processes and ACA compliance. When members visit your office, we encourage you to document ALL of the members' health conditions, especially chronic diseases on the claim. As a result, there will be ongoing documentation that indicates these conditions are being properly assessed and managed. Additional benefits of accurate coding include:

- Reduced volume in medical chart requests in the future due to the increased level of specificity in documentation and coding, as part of our retrospective approach; and
- Reduced volume of health assessment requests by ensuring your patients with our ACA compliant plans are seen for their annual exams each and every year, as part of our Prospective approach.

Please note: It's important to ensure that all diagnosis codes captured in your EMR system are included on the claims, and are not being truncated by your claims software management system. For example, some EMR systems may capture up to 12 diagnosis codes, but a claim system may only have the ability of capturing four (4). If your claim system is truncating some of the listed diagnosis codes, please work with your vendor/clearing house to ensure all codes are being captured.

Reminder about ICD-10 CM coding

As you may be aware, the ICD-10 CM 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 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.
- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider's overall management or treatment of that patient in the remaining positions.
- Include all chronic historical codes, as they must be documented each year under the ACA. (E.g. an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

URL: https://providernews.anthem.com/connecticut/article/commercial-risk-adjustment-cra-reporting-update-accurate-coding-helps-provide-a-comprehensive-picture-of-patients-health-and-services-provided

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