CareSource PARTNER with Purpose

Risk Adjustment Coding Guidance
Chronic Conditions

Context

CareSource is required to submit accurate ICD-10-CM diagnosis codes on their members to regulatory agencies. These ICD-10-CM codes reported to the regulatory agencies are gathered from hospital and professional claims submitted for payment. Reviews of provider documentation are conducted to ensure the accuracy of diagnosis codes reported to us and subsequently to the regulatory agency.

Comprehensive coding requires the reason for the visit be assessed, evaluated, documented and coded. In addition to coding and documenting the reason for the visit, code all conditions that complete the picture of the members' illnesses. Chronic conditions affecting the care, treatment or management of the patient should be documented and coded. Chronic Conditions need to be evaluated and reported at least one time each year.

Scenario

A male, age 54 is seen by the provider on February 16, 2020. Documentation supports that an office visit was performed. The note documents that the patient was seen for a cough and abdominal pain, has a history of COPD, congestive heart failure and diabetes with chronic kidney disease (CKD). The documentation supports all the conditions as active illnesses. Some conditions were assessed, others were noted in the medical history with a medication listed to treat the illness.

- The claim submitted to the insurance carrier reports the CPT code for the office visit and the ICD-10-CM codes R05 (cough) and R10.9 (abdominal pain).
- Missing from the claim are the ICD-10-CM codes, J44.9 (COPD), I50.p (CHF), E11.22 (DM with CKD). These illness are chronic conditions that affect the patient's ongoing care.

Coding Guidance

It is important to report all conditions that exist at the time of the visit and that affect patient care.

- If the patient has chronic conditions documented within the body of the progress note and that affect the patient's care, report all chronic conditions with the appropriate ICD-10CM code on your claim.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting, 2020: Code all documented conditions that co-exist at the time of the face to face encounter/visit and require or affect patient care, treatment, or management.

Importance
Complete, specific and accurate coding helps to ensure CareSource is able to connect our members, your patients, to appropriate disease management and case management resources.

Questions
For questions about risk adjustment coding, please send your inquiries to:
raprovidereducation@caresource.com

Source
ICD-10-CM Official Guidelines for Coding and Reporting 2020

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