Documenting and Coding HCCs

Annual Documentation

Annual documentation of chronic conditions is required, even when stable with treatment.

- CMS considers the condition resolved if not evaluated and coded at least once per calendar year, in which case the risk factor score for the member is lowered.
- If chronic conditions (e.g., asthma, ADHD, diabetes, epilepsy, and developmental disabilities) are not reported annually it indicates the condition has resolved and no longer exists.

Always Document if conditions are...

- Acute or Chronic
- Active or Resolved

M.E.A.T. the Criteria

Only required to document ONE (1) of the below

Any disease or disorder listed in the Assessment and reported for a patient encounter should be linked with supporting documentation showing that the condition was monitored, evaluated, assessed or treated (MEAT) during the visit. Evidence of MEAT can include:

- Monitored:
  - Monitoring for symptoms, disease progression/regression
  - Ordering of ordering labs/ x-rays and diagnostic tests
- Evaluated:
  - Relevant Physical Exam
  - Review/interpretation of test results
- Assessed:
  - Assessing disease status, effectiveness of treatment
  - Addressing key risk factors
  - Counseling re: exercise and lifestyle modifications
- Treated:
  - Prescribing/managing medications
  - Surgical or other therapeutic interventions
  - Referrals to specialists for treatment/consultation

A complete diagnostic statement is specific.

When applicable, document:

- Underlying cause (e.g., trauma, disease process) of condition being treated
- Complications caused by or associated with the condition being treated
- Use specifiers where applicable, such as:
  - Acuity
  - Stage
  - Anatomic site/Laterality
  - Episode of care

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Remember to Note...

- If a chronic condition is acute or exacerbated.
- The severity/episode of conditions (ex: Bipolar disorder, current episode mixed, unspecified).
- If there have been any contributing factors (ex: Epileptic seizures related to external causes, not intractable, without status epilepticus).

Do not...

- Avoid ambiguity and avoid using the phrase "history of" when describing a chronic condition. "History of" implies a condition is no longer present.
- Avoid referring to problem list to identify a diagnosis.
  - Diagnosis listed on the progress note without an evaluation or assessment cannot be captured as an HCC.
- Do not report conditions that are
  - Probable
  - Suspected
  - Questionable
  - Rule Out
  - Working
  - Likely
  - Document what is known, which may be signs and/or symptoms, until a diagnosis is confirmed.

Level of Detail in Coding

- **Always code to the highest level of specificity known.**
- Code all conditions present at the visit that affect care or management. For example, A diabetic patient seen for an asthma exacerbation - steroid treatment may impact blood sugar control.
- A condition can be coded and reported as many times as patient receives care and treatment for the condition.
- Document and code all chronic, congenital and status conditions (such as artificial openings, BMI, organ transplant) at least once a year.

Commonly Pediatric Diagnoses:

- Most commonly overlooked diagnoses:
  - Asthma
  - Diabetes
  - Malnutrition
  - Epilepsy/Seizures
  - Behavioral Disorders
  - Psychiatric
  - Developmental Disorders
  - Congenital Conditions
  - Other Specified Mood
  - Autistic Disorders
  - Gastro-Esophageal Reflux Disease (GERD)