Documentation Improvement for Risk Adjustment Questions Log

Purpose

The purpose of this document is to outline questions asked during the presentation and document the answers that were given by the presenters.

This webinar was launched live at 12pm on January 14, 2020.

Questions

1. If a patient has a condition that is an HCC and the condition has resolved, and I state in the medical record that they no longer have the condition, should I still code for the condition in the medical record?

   Answer: No, if the condition has resolved and no longer exists, this should be stated in the medical record, and not coded for. Some exceptions to this include conditions that have personal history codes. Common examples of these conditions include personal history of neoplasms, personal history of stroke, or Old MI.

2. Does the supporting documentation for the HCC have to be in the Assessment/Plan?

   Answer: No, although this is the best location for the supporting documentation. It can also be in the review of systems, history of present illness, physical exam, or treatment plan. It should not be in the problem list or past medical history.

3. If a patient has developed complications from a disease that didn't have complications in the past, what would be the appropriate documentation/coding for this situation?

   Answer: It would be appropriate to document the condition as specific as possible. This should include the new complications, and the condition should be coded using the more specific ICD-10 code. If there is an assumed relationship between the complication and the condition (ex: diabetes, hypertension with CKD/CHF), the combination code should be used.