Policy:	MA.9110
Title:	**Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 06/05/2024*
Effective Date:	01/01/2010
Revised Date:	06/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a Hierarchical Condition Categories (HCC) auditing and monitoring process to ensure CalOptima Health Providers' compliance with proper documentation and coding guidelines defined by the Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG).

II. POLICY

A. CalOptima Health shall monitor and evaluate a Provider's compliance with proper diagnosis coding and documentation practices to ensure:

1. Medical Record Documentation for each Encounter includes:

   a. Reason for Encounter;

   b. Relevant history;

   c. Prior diagnostic test results;

   d. Assessment/diagnosis to the highest level of specificity, acuity, severity, and complexity (if known at the time of encounter);

   e. Clinical impression/problem story/History of Present Illness (HPI)/treatment responses, goals, compliance or noncompliance to medication and/or other medical regimen with reason;

   f. Medical plan of care;

   g. Date of service;

   h. Date of birth (patient identifier on each document page); and

   i. Legible identity of rendering Provider for each date of service entry.

j. Provider's full name, credential, electronic or legible handwritten signature with date signed on encounter note.

2. Providers are reporting current International Classification of Diseases (ICD) codes on the health insurance claim form or billing statement supported by documentation in the Medical Record, in accordance with International Classification of Diseases, Clinical Modification (ICD-10-CM) Office Guidelines for Coding and Reporting, and CMS Risk Adjustment Coding Methodologies.

3. Diagnosis Coding as follows:

   a. Code describes the Member's diagnosis, system, complaint, or problem;

   b. Code listed is applicable for the item or service provided;

   c. Code assigned is to the highest level of specificity (sixth and seventh digit, as applicable) based on documentation of Encounter;

   d. A chronic condition documented during a face-to-face encounter and coded as often as applicable to the Member's treatment; and

   e. All documented conditions that coexist during a visit and require or affect a Member's care or treatment are coded.

4. Providers shall not code conditions that no longer exist.

5. Providers shall not code uncertain diagnoses or rule out diagnoses.

6. All Medical Record documentation is appropriately authenticated, legible, and dated by the rendering Provider with credentials, which must be within one hundred eighty (180) calendar days of the encounter, in accordance with CalOptima Health Policies GG.1603: Medical Records Maintenance and PA.6001: Medical Records Maintenance.

III. PROCEDURE

A. The CalOptima Health Financial Analysis Department or Designee shall:

1. Assess the existence and effectiveness of CalOptima Health policies and procedures to audit Provider compliance in accordance with this policy.

2. Revise and update CalOptima Health policies and procedures, as appropriate, according to applicable rules and regulations.

3. Develop and implement a schedule for conducting audits of affiliated Providers.

4. Use audit methodologies consistent with methods used by CMS, OIG, and other federal and state regulatory agencies charged with oversight of Medicare Plans.

5. Assign a qualified individual or group of qualified individuals to conduct audits.

6. Identify and select Providers for audit. Providers shall be selected based on the following criteria:

a. Volume of Members assigned;

b. Overall risk score of Members (very high or very low); and

c. Frequency of Provider audits in the past for chart audits and the subsequent results of the audits.

7. Identify and select a random sample of charts per Provider to audit compliance with applicable coding and documentation rules and regulations.

8. Require a Corrective Action Plan (CAP) for the Health Network(s), PACE, or CalOptima Health contracted Provider to address deficiencies identified during the Provider audit, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

9. Report the results of the audit to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GG.1603: Medical Records Maintenance
B. CalOptima Health Policy HH.2005: Corrective Action Plan
C. CalOptima Health Policy PA.6001: Medical Records Maintenance
D. Centers for Medicare & Medicaid Services (CMS) Contract-Level Risk Adjustment Data Validation - Medical Record Reviewer Guidance
E. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) FY2024 Official Coding and Reporting Guidelines
F. Title 42, Code of Federal Regulations (CFR), §§ 422.308 and 422.310

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare
Revised	01/01/2013	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare
Revised	12/01/2015	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2016	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	09/01/2017	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	08/01/2018	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	07/01/2019	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	07/01/2020	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	07/01/2021	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	05/01/2022	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare OneCare Connect PACE
Revised	12/31/2023	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare PACE
Revised	06/01/2024	MA.9110	Auditing and Monitoring of Hierarchical Condition Categories (HCC) Coding	OneCare PACE

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Encounter	Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.
Medical Record	OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.