A Provider's Role in Risk Adjustment

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Medical record documentation — it's important

Identify overall health status

Providers play a key role in risk adjustment (RA) activities for Medicare Advantage plans. The Centers for Medicare & Medicaid Services (CMS) bases each member's overall health status on the conditions identified and supported in their medical record. Each health condition needs to be documented to the highest degree of specificity to be reported with the most accurate ICD-10-CM code. Specificity in documentation identifies severities, complexities, comorbidities, manifestations and other factors impacting the condition.

Along with specificity, be sure to document the condition in the appropriate tense avoiding terms such as "history of" or "past medical history" to describe current conditions. To prevent conflict, document details such as the condition's onset date with the current status. For example, "Patient with type II diabetes since 2009, well controlled with metformin."

All current health conditions, including those that coexist, need to be reported (at minimum) annually as they do not carry over each year for CMS. From an RA perspective, if chronic conditions (e.g., diabetes, congestive heart failure, atrial fibrillation) are not reported annually it indicates the condition has resolved and no longer exists. This can lead to an inaccurate depiction of the member's overall health status and a decrease in RA funds to provide medical care.

All current health conditions, including those that coexist, need to be documented:

- To highest degree of specificity.
- In the appropriate tense.
- At a minimum of annually.
- With impact to patient care treatment/management.

Identify care provided

Per *ICD-10-CM Official Coding Guidelines*[1], "Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. "

Each condition should have supportive documentation identifying impact to patient care treatment/management, such as (but not limited to):

- Monitor with ordering and reviewing of lab/test results.
- Evaluate pertinent exam findings.
- Assess condition's current status.
- Treatment with medication management, education, etc.
- Referral to specialists or other follow-up care.

Accurately documenting and reporting each health condition not only impacts RA, it helps improve the quality, access and outcomes of patient care. We use information on member health conditions to identify the need for health care services and/or case management. When the overall health status of patients are identified, we can positively impact the quality and affordability of health care provided.

1 Anita, Schmidt. "Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services J. Code all documented conditions that coexist." *ICD-10-CM Professional for Physicians*. Salt Lake: Optum360, 2016. 29. Print.

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