



Risk Adjustment

-Key points for providers-

Accurate risk categorization identifies members for disease management interventions and assists in the financial forecasting of future medical need.

In an effort to mitigate the effect of adverse risk selection in the individual and small group markets established by the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) uses a risk adjustment model to transfer funds from plans with a lower risk membership to plans with a higher risk.

The Hierarchical Condition Categories (HCC) system for assigning risk is used to make the risk adjustment. The HCC model primarily uses demographic and diagnosis data to determine an individual risk score which is then averaged across the entire population of patients that are assigned to any given provider or provider group.

Provider generated information in the form of accurate diagnosis and documentation in the medical record accounts for about 80% of the total score.

Risk adjustment takes a close look at how ICD-10 documentation and coding can contribute to the complexity level of the encounter, medical decision-making, and time spent with the patient. Good documentation around ICD-10 coding will paint the true clinical

picture of the patient and is reflective of the thought process of the provider. This helps control the cost of care and stabilize patient premium increases.

Accurate documentation also improves quality reporting and efficiency when responding to regulatory requirements, such as HEDIS reviews and risk-adjustment data validation (RADV) audits.

Improved documentation and coding leads to better patient care, as they are the primary means of communicating the patient record for specialty care to health plans and CMS.

If medical documentation lacks the accuracy and specificity needed to assign the most appropriate diagnosis code, providers face the possibility of reduced payment if they are part of a performance-based payment model, and they won't be compliant with CMS standards. There is also missed opportunity for patients to be identified for care management programs or disease intervention programs

Risk Adjustment Coding Tips to Improve Clinical Documentation:

- ▶ Identify patient name, date of service and date of birth on each page of the record
- ▶ Reported diagnoses must be supported with medical record documentation
- ▶ Document and report co-existing diagnoses
- ▶ Use only standard abbreviations
- ▶ CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented
- ▶ All dates of service must be signed and dated by the provider, stamps are not acceptable.
- ▶ 'History of' means that the patient no longer has the condition and cannot be coded as an active disease.

Chronic Conditions: See each patient at least once a year to evaluate chronic conditions; Evaluate and document all chronic conditions; Code all diagnoses.

Status Codes: HIV Status, Amputation Status, Renal Dialysis Status, Colostomy Status and Transplant Status should be included in the clinical documentation.

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