Documenting for risk adjustment

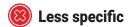
Risk adjustment coding and documentation



"Any condition that is taken into account or affects patient care, treatment or management should be documented and ultimately coded." — CMS mandate

Best documentation practices

- Document and code for any patient condition that is:
 - o Present but stable.
 - Acute or chronic.
 - o Managed on therapy.
 - o Requires observation.
 - o Requires referral to another provider for management.
 - o Influences your decision making in care of the patient.
- Do not use "history of" to document a current condition.
 - o In ICD-10-CM the term "history of" means the patient no longer has the condition.
 - o Avoid using "history of" for a condition that is chronic but currently stable.
 - o Do not say "history of CHF" to indicate compensated CHF. You should use CHF.
- Document all complications/manifestations including the causal language.
 - o Clearly link complications or manifestations of a disease process.
 - o Use linking verbiage such as "due to", "associated with", "secondary to", etc.
- Document severity/stage of condition.
 - o Include condition specificity where required to explain severity of illness, stage or progression (i.e., **stage IV chronic** kidney disease or **major** depression).





More specific

Code	Condition	Code	Condition
R25.1	Tremor	G20	Parkinson's
110	HTN unspecified	I11.0 & I50	HTN heart disease with HF
1125.10	CAD	125.119	CAD with stable angina pectoris

Add qualitative words to diagnosis

- o Chronic/acute; stable/improved/worsening.
- o Resolved; in remission; active.
- o Specific site; laterality; complication.

Documentation tool

M-E-A-T is a common industry-accepted acronym to identify documentation that supports coding accuracy.

Monitor	Symptoms.Disease progression/regression.Ordering of tests.Referencing labs/other tests.		
Evaluate	 Test results. Medication effectiveness. Response to treatment. Physical exam findings. 		
Assess/Address	Discussion, review records.Counseling.Acknowledging.Documenting status/level of condition.		
Treat	 Prescribing/continuation of medications. Surgical/other therapeutic interventions. Referral to specialist for treatment/consultation. Plan for management of condition. 		

RADV audits

- Conducted by CMS to determine whether the diagnosis codes submitted can be validated by supporting medical record documentation.
- Having at least one element of MEAT documented in the medical record for each diagnosis will suffice CMS's requirements for supporting and validating diagnoses.
- Listing medications and problem lists in a medical record does not meet documentation requirements to indicate that an evaluation for a condition was performed.
- Assessments/plans must be connected to a diagnosis. Coders are not allowed to make any assumptions.
- CMS will penalize plans that have submitted Hierarchical Condition Categories (HCC) codes for which there is insufficient documentation or support.

Assessment and Plan examples

- CHF: stable-no notable edema or dyspnea. Continue lasix, lisinopril and bisoprolol.
- **GERD:** no complaints. Symptoms controlled by meds.
- AAA: abdominal ultrasound ordered.
- **Major depression**: continued feelings of hopelessness. Will refer to psychiatrist.