Documenting for risk adjustment

Risk adjustment coding and documentation

Samaritan Health Plans

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

Less specific

Code	Condition
R25.1	Tremor
I10	HTN unspecified
I125.10	CAD

More specific

Code	Condition
G20	**Parkinson's**
I11.0 & I50.-	**HTN heart disease with HF**
I25.119	**CAD with stable angina pectoris**

- **Add qualitative words to diagnosis**
  - Chronic/acute; stable/improved/worsening.
  - Resolved; in remission; active.
  - 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/**A**ddress	• 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.