Medicare Risk Adjustment Overview and Documentation Guidance

What is Risk Adjustment?

Risk adjustment is a method used by the Centers for Medicare & Medicaid Services (CMS) to account for the overall health and expected medical costs of each individual enrolled in a Medicare Advantage (MA) plan. CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into Hierarchical Condition Categories (HCCs). HCCs, together with demographic factors such as age and gender, are used to predict beneficiaries' total care costs. The CMS risk adjustment model is built on reviewing a previous year's health status to predict the following year's health expenses. That means physicians must report beneficiary diagnosis information every year. The best time to do this is during the beneficiary's Medicare Annual Wellness Visit.

Why should providers care about Risk Adjustment?

- Accurate identification of patient health status can improve the overall quality of care they receive
- Reduce the risk of a Medicare audit when coding on claims, orders, and referrals match the condition being treated
- Correct documentation in medical records can justify conditions reported on claim submissions
- Being compliant with CMS guidelines in claims submissions, with supporting documentation for visit and medical treatment
- Receiving accurate payments for services rendered

Tools to help with HCC documentation requirements:

MEAT	TAMPER	SOAP
• Monitor – signs, symptoms, disease progression/regression • Evaluate – test results, medication effectiveness, response to treatment • Assess – ordering tests, discussion, review of records, counseling, refer to another provider • Treat – medications, therapies, other modalities	• Treat – medications, therapies, other modalities • Assess – ordering tests, discussion, review of records, counseling • Monitor – signs, symptoms, disease progression/regression • Plan – what is being done about the patient's condition • Evaluate – test results, medication effectiveness, response to treatment • Refer – sending the patient to another provider for treatment of the condition	• Subjective - experiences, personal views or feelings of a patient • Objective - vital signs, physical exam findings, laboratory data, imaging results, other diagnostic data • Assessment - combination of "subjective" and "objective" evidence to arrive at a diagnosis • Plan - details the need for additional testing, consultation and any steps being taken to treat the patient.
(At least one element of MEAT/TAMPER/SOAP must be documented for each coded condition to qualify for HCCs)		

Guidance for the most commonly missed or incorrectly coded conditions:

Cancer/Malignant Neoplasm Disease – Active/Current vs. Personal History	• Active/Current Malignant Neoplasm - Assign the correct active neoplasm code for the primary malignancy until treatment is completed • Personal History Of - When a primary malignancy has been excised or eradicated and there is no further treatment of the malignancy directed to that site, and there is no evidence of any existing primary malignancy, a code from Category Z85
Congenital malformations, deformities and chromosomal abnormalities	• Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented anywhere within the note. Categories (Q00-Q99) ICD-10-CM Official Guidelines for Coding and Reporting may be used throughout the life of the patient
Diabetes Mellitus: E08–E13 – Report any DM manifestations, including Status Codes	• Diabetic neurological complications (neuropathy) • Other manifestations of diabetes mellitus (renal, ophthalmologic, oral, etc.) • Diabetic circulatory complications (Skin ulcers, gangrene, PVD) • Type 2 diabetic ketoacidosis • Ostomies/Artificial Openings – Colostomy, Gastrostomy, Ileostomy, etc. • Amputation status – Lower Extremities (AKA, BKA, Feet/Toes) • Long Term Insulin Use - Complications due to insulin pump malfunction
Disorders of psychological development: F01-F69	• F10-F69 Mental and Behavioral Disorders – Including Dementia, Substance Use/Abuse, Bipolar, Schizophrenia, MDD, Anxiety, and Other specified persistent mood disorders.
CVA, TIA, MI and Other Acute Vascular Conditions – Active/Current in an acute care setting versus Personal History and Subsequent Care	• CVA Initial Care - A CVA is an emergent event that requires treatment in an acute care setting. To report CVA, refer to code category: I63.xx Cerebral infarction *4th and 5th digits identify location and cause • Acute MI – A new myocardial infarction is considered acute from onset up to 4 weeks old. Acute myocardial infarction (AMI) may be reported in the acute care setting, following transfer to another acute setting, and in the post-acute setting • Subsequent Care and Personal History - Once a patient has completed initial treatment and is discharged from the acute care setting, report as personal history of and any sequelae residual effects