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Health Insurance for New Yorkers

Documentation and Coding: **Risk Adjustment**

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At Healthfirst, we're committed to helping providers accurately document and code their patients' health records.

This tip sheet offers guidance on proper risk adjustment coding. Risk adjustment relies on correct ICD-10-CM diagnosis coding to represent the member's health status and to establish an accurate risk score.

Clinical Documentation Guidelines

Risk adjustment codes are reported once a year. Although chronic conditions are ongoing, providers must document a patient's chronic condition and capture the correct **ICD-10-CM** code.

- Ensure the documentation supports **MEAT**:

Monitoring	■ Signs, symptoms, progression/regression
Evaluating	■ Test results, response to treatment
Assessing	■ Condition of the patient, ordered test, referrals, reviewed records
Treatment	■ Medications, therapies

- Be sure to document accurate Dx, link conditions, and link complications within the encounter.
- Documentation of no evidence of disease (NED) reflects a "history of" status for coding if there is no active treatment, even if the patient is undergoing surveillance for reoccurrence. Document history under PMH.
  - Example: A patient with Chronic Heart Failure (CHF) requires a face-to-face encounter each year, at which time the provider can discuss and document the CHF. This encounter allows the appropriate ICD-10-CM code to be reported, and the HCC code to be captured, in the new base year.
- Be careful with "history of" statuses. Unless the condition is resolved, the provider cannot use "history of'' to describe a current condition. Documentation should indicate the condition is active and being addressed during the encounter.
  - Example: Mr. Brown is being seen today for diabetes, controlled with metformin and diet/exercise.
- Document medical necessity and specificity of diagnosis and conditions (e.g., active, acute, chronic, and "history of").
- A condition can be reported as many times as the patient receives treatment and management care.
- Ensure that the documentation has been updated by the provider during the current patient encounter and not "**cloned**" from a previous Date of Service (DOS)/encounter note.

Risk Adjustment Coding and Chart Components

Date of Service (DOS)	Documentation from a different DOS cannot be used to clarify documentation for a current DOS.
Problem List	Providers should update and address chronic illness annually.
Review of Systems (ROS)	Providers should document the specific systems with positive or pertinent negative responses. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, you must individually document at least 10 systems.
Radiology and Laboratory Findings	Providers should document relevant results in the medical record.
Medication List	Providers should update the medication list at each visit and notate in the documentation that the medication list is updated.
Assessment/Plan	Diagnosis should align with treatment plans.

General Principles of Risk Adjustment Documentation

- Risk adjustment documentation guidelines are applicable to **all types** of medical and surgical services. The services provided may occur in different settings (e.g., physician offices, inpatient hospitals, outpatient ambulatory services within a hospital).
- There are no standards as to how a record should look (e.g., header templates, location of dates), but there are elements which should be contained within the provider notes that support complete documentation of a **face-to-face visit** for coding and reporting.
- It is the provider's responsibility to provide clear, legible documentation. The medical record must include the following elements:

Patient name
Date of service
Provider signature
Provider credential

- If the provider credential or signature is missing at the time of an audit, CMS allows for submission of a completed CMS-Generated Attestation for the specific encounter date for an outpatient and inpatient record.

Documentation for Data Sources

- For physician and other acceptable provider type face-to-face encounters.
- Applicable to Hospital Outpatient Services, Emergency Department, Outpatient Surgery, Observation, Rehabilitation, Chemotherapy, Radiation Therapy, etc.
- Skilled Nursing Facilities encounter notes must be performed by an eligible provider and meet face-to-face and diagnosis documentation requirements. See the Acceptable and Unacceptable Data Sources below.

Acceptable Data Sources	Unacceptable Data Sources
Admission H&P	Ambulance
Consultation Reports	Diagnostic Radiology
Discharge Summaries	DME
Emergency Room Record	Freestanding Ambulatory Surgical Centers
Stress Test (Physician Supervised)	Laboratory Services
Surgical Procedures (Operative Notes)	National and State Registries
Pathology Reports *includes interpretation of the findings by a pathologist as an acceptable physician specialty and is an exception to face-to-face visit	Pharmacy Records
Physician Progress Notes	Physician's Signed Attestation of Diagnoses
	Prosthetic/Orthotic & Other Supply Orders
	Superbills/Charge Sheets
	Problem Lists *not part of the documentation of face-to-face visits

Risk Adjustment

ICD-10 Guidelines	Impact of Risk Adjustment to Providers	Common Pitfalls
Physicians and other qualified providers are accountable for their patient's diagnosis. ■ Code all documented conditions that coexist. ■ A **combination code** is a single code used to classify two diagnoses, or a diagnosis with an associated secondary process (manifestation) and a diagnosis with an associated complication. ■ The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title. ■ Document and code **status of conditions** at least once a year (e.g., amputation, dialysis status, transplant status, chemotherapy status). ■ Select unspecified ICD-10-CM codes as a last option.	■ Inaccurate HEDIS scores, time, infrastructure, and resources. ■ Incorrect identification in care gap measures. ■ Missed opportunity for patient to be identified for care management programs or disease intervention programs. ■ Possibility of reduced payment (if part of a performance-based payment model). ■ Diagnoses cannot be inferred from physician orders, nurse notes, lab, or diagnostic tests. They need to come from the medical record. **NOTE:** before Diagnoses, delete bullets on last two paragraphs, and justify copy left, since these are notes about the impacts listed above. ■ Risk adjustment relies on correct ICD-10-CM diagnosis coding to represent the member's health status and to establish an accurate risk score.	■ Using rule out diagnosis codes. ■ Coding "history of" as current. ■ Reporting only the primary diagnosis. ■ Coding generic or unspecified codes. ■ Overlooking chronic conditions related to health status. ■ Using signs and symptoms when a definitive diagnosis has been made by the provider. ■ Cloning (cut/copy and paste).

Questions?

Contact us at **#Risk_Adjustments_and_clinical_Documentation@healthfirst.org**.

References: **AAPC.com**, 2020 CRC Study Guide, **AHIMA.org**, **CMS.gov**, refer to appendix A for provider specialty and credentials.

Appendix A

Acceptable Provider Specialty Types and Credentials for Risk Adjustment Data Submission

Acceptable Credentials	Acceptable Provider Specialty Types
ACNP	Acute Care Nurse Practitioner
APN	Advanced Practice Nurse
APRN	Advanced Practice Registered Nurse
AUD	Doctor of Audiology
CCC-A	Certificate of Clinical Competence in Audiology
CCC-SLP	Certificate of Clinical Competence in Speech Language Pathology
CNM	Certified Nurse Midwife (A Specialized APN)
CNP	Certified Nurse Practitioner
CCNS	Certified Clinical Nurse Specialist
CRNA	Certified Registered Nurse Anesthetist
CRNP	Certified Registered Nurse Practitioner
DC	Doctor of Chiropractic
DDS	Doctor of Dental Science/Doctor of Dental Surgery
DMD	Doctor of Dental Medicine
DO	Doctor of Osteopathy/Doctor of Ophthalmology/Doctor of Optometry
DPM	Doctor of Preventative Medicine, Podiatric Medicine, Psychiatric Medicine, Physical Medicine
DPT	Doctor of Physical Therapy
FNP	Family Nurse Practitioner
LCP	Licensed Clinical Psychologist
LCSW	Licensed Clinical Social Worker
LP	Licensed Psychologist
LPCC	Licensed Professional Clinical Counselor
LICSW	Licensed Independent Clinical Social Worker
MBBS	Md Degree Conferred by Medical Schools in United Kingdom, as well as Other English-Speaking Countries

Acceptable Credentials	Acceptable Provider Specialty Types
MBChb	Bachelor of Medicine and Bachelor of Surgery Degree
MD	Medical Doctor/Doctor of Medicine
MPT	Master of Physical Therapy
MSPT	Master of Science in Physical Therapy
NP	Nurse Practitioner
OD	Doctor of Optometry
OT	Occupational Therapist
PA	Physician Assistant
PA-C	Physician Assistant Certified
PSY-D	Doctor of Psychology
PT	Physical Therapist
RNCS	Registered Nurse Clinical Specialist
ST	Speech Therapist

Acceptable Provider Signature/Attestation

The authentication statements below are acceptable according to CMS. Any statement not found on this list will not be considered a valid authentication statement.

Acceptable Provider Signature		
Accepted by	Digitally Signed by	Read by
Acknowledged by	Digitally Signed	Released by
Approved by	Electronically Approved by	Reviewed by
Authenticated by	Electronically Authored by	Sealed by
Charted by	Electronically Signed by	Signature on file (with date and time signed)
Closed by	Entered by	
Completed by	Entered Data Sealed by	Signed by
Confirmed by	Finalized by	Validated by
Created by	Generated by	Verified by
Digitally Signed by	Performed by	Written by