Risk Adjustment Best Practices

Patient clinical information is accessible in Member Viewer via the Provider Portal at www.providers.peopleshealth.com using your assigned login ID and password.

Authorized Administrative Staff

Prepare information about patient conditions that have not been evaluated, assessed and documented this year so the provider may address during the visit.

» Use the orange **Member Viewer Profile Summary** button to print a summary page of important health information about the patient. The conditions requiring review will be marked as such in the Disease Management and Clinical Indicators sections. Alert the provider to evaluate and document the conditions during the patient's visit.

» Use the Provider Portal Star Measure tool in Member Viewer to review star measures for the patient. From the main page, select your physician team from the Choose Team drop-down menu, then select **Provider Portal Star Measure** from the Criteria drop-down menu. Select your name from the PCP menu, and click Star Measures. A report is generated with a list of your patients, the star measures for each, and notes on compliance and noncompliance. The report also provides other PCP panel information, such as patient highlights on time-sensitive measures.

- PCP panel
- PCP highlights (time-sensitive measures)
- Individual patient
- Compliance by measure

» If you meet with the patient to obtain a summary of the reason for the visit before the provider sees the patient, document the reason and any other conditions in the patient's medical record.

TOOLS

- If you do not have access to Member Viewer, contact your provider relations representative.
- The **Diseases and Conditions Associated With HCCs** pocket card can help you verify that you have assessed all conditions and health statuses that may impact the patient's risk score.

Coding Staff

- Code to the highest level of specificity using ICD-10-CM codes.
- Only code for diseases or diagnoses that are explicitly documented. A disease or diagnosis should not be coded if the medical record notes only signs, symptoms or findings related to it without explicit documentation of the disease or diagnosis itself.
- Only code for confirmed diagnoses. As such, diagnoses that are "probable," "suspected," "questionable," "working" or "rule-out" should not be coded.
- If documentation is insufficient to support accurate coding, notify the provider that additional documentation is needed (assessment, plan of care, etc.). A list of medications or radiology reports in the medical record are insufficient documentation. The medical record should specify which medications pertain to which conditions, the provider's interpretation of a test, and significance of any diagnosis(es) identified a test, as well as corresponding evaluations and plans of care.

Note: Documentation must occur annually because CMS redetermines a patient's risk score each year.

TOOLS

- Code changes are available via the CMS website (www.cms.gov/MedicareAdvtgSpecRateStats) and the Optum360 website (www.optumcoding. com/CodingCentral) on Oct. 1 of each year.

Risk Adjustment Best Practices

During Evaluation, Diagnosis and Assessment

Conduct a comprehensive physical to assess, document and code the patient's primary reason for the visit, as well as the documented conditions that exist at the time of the visit and affect the patient's care, treatment or care management.

Evaluate and diagnose all chronic conditions, acute conditions, comorbidities, and acute or pertinent past conditions that impact the patient's treatment and plan of care.

Use the patient's **Member Viewer Profile Summary** and the **Diseases and Conditions Associated With HCCs** pocket card to confirm that you have addressed all applicable conditions.

During Documentation

If not already done by your staff, indicate the reason for the visit, observations, diagnoses and assessment, as well as the plan of care for the visit reason and other conditions.

Document diagnoses to the highest level of specificity, including specifying acute or chronic status. Risk score values vary depending on specificity. Document should be legible.

TOOLS

The **Diseases and Conditions Associated With HCCs** pocket card can help you verify that you have assessed all conditions and health statuses that may impact the patient's risk score.

Ask your staff with authorized access to print the patient's **Member Viewer Profile Summary** prior to the visit. Conditions that previously impacted the patient's risk adjustment and that require review will be marked as such in the Disease Management and Clinical Indicators sections. You can also reference the patient's risk score from the last reporting period in the Risk Score field at the top of the page.

Documentation Tips to Support Accurate Coding

- **Explicitly state any causal relationships** you identify. For example, chart notes that document diabetes and neuropathy separately may not be coded as "diabetic neuropathy" or "neuropathy 2° to diabetes." You must explicitly document the relationship to code in this manner.
- **Explicitly state the clinical significance or interpretation of lab and other test results** included in the chart as they pertain to a specific diagnosis. The results report alone is not sufficient to support a code for a diagnosis. For example, a chart note reference to an abnormal random blood sugar level without a chart note stating the patient has diabetes does not support a diabetes code. Each chart note must contain all applicable diagnoses with a status.
- **Use only standard abbreviations based** on ICD-10-CM guidelines.
- **Do not document "history of" or "(h/o)"** for any active or chronic condition ("history of" means the patient no longer has the condition).
- **Do not use symbols to indicate a disease.** For example, "↑ lipids" means lipids are elevated; "↑ BP" means a blood pressure reading is high. These are not the same as hyperlipidemia or hypertension. Clearly document the assessment, diagnosis and plan of care to support correct coding.
- **State the clinical significance of any numerical measurement** that indicates a patient is outside the boundaries of good health. For example, if a patient is morbidly obese with a BMI of 41, documentation must state "morbid obesity" in the assessment, not simply the BMI score, to support a code for morbid obesity.
- **Document (at least yearly) the presence, assessment and plan of care for any of the following:**
  - Amputation status
  - Artificial opening status
  - Chronic neurological conditions, such as multiple sclerosis, amyotrophic lateral sclerosis, Huntington's disease and epilepsy
  - Chronic kidney disease
  - Cancer
  - Diabetes and manifestations of diabetes
  - Hemodialysis
  - Late effects from cerebrovascular incidents
  - Morbid obesity