Risk Adjustment Quick Reference

Progress Notes

- ☑ Must be legible
- ☑ The patient's name and date of service need to be on each page of the progress note
- ☑ Use only standard medical abbreviations

Coding and Reporting

- ☑ Submit all required ICD-10-CM diagnosis codes at least once during the risk adjustment data reporting period. All active conditions must be documented and reported at least once a year. On Jan. 1 each year, the patient's diagnosis information is reset in preparation for a new year of diagnosis encounter data.
- ☑ Accurate diagnosis codes are a result of clear, consistent and complete documentation.
- ☑ Health status conditions are typically identified by a code from Category Z in ICD-10-CM. Those that affect risk adjustment include asymptomatic HIV, organ transplants, artificial openings, hemodialysis, and amputations. These conditions should be evaluated, documented and assessed at least once a year.

Other

- ☑ Watch for inconsistencies in the progress note (i.e., physical exam indicates normal gait but in the assessment there is a diagnosis of right-sided hemiparesis).
- ☑ Have you updated your fee ticket/encounter form for the current year?
- ☑ Are you submitting all diagnosis codes? If not, please contact your vendor or clearinghouse. WellCare can accept up to 24 diagnosis codes per outpatient claim.

Signature Guidelines

CMS must be able to determine the rendering provider.

Electronic signatures must have:

- ☑ Authentication (i.e., approved by, electronically signed by, completed by, etc.)
- ☑ Provider name and credentials
- ☑ Date signed – verify that the date listed next to signature is date signed and not date printed

Acceptable handwritten signatures include:

- ☑ Handwritten signature or initials with pre-printed name and credentials on a progress note
- ☑ Legible handwritten signature with credentials
- ☑ If more than 2 names are listed on the progress note, the provider signing the chart must circle or otherwise indicate he/she was the rendering provider

Steven Smith, MD

- or -

Signature: S.S.

Steve Smith, MD
123 Main St.
Anytown, USA 12345

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Medicare Advantage

Risk Adjustment Program

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What is Risk Adjustment?

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburse Medicare Advantage Plans, such as WellCare Health Plans, Inc., based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage Plans more accurately for the predicted health expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

What are Hierarchical Conditions Categories (HCC's)?

HCCs are separate categories within the risk adjustment payment model that correspond to clusters of similar diseases/conditions. CMS determines which conditions qualify for inclusion in the model, assigns them to an HCC, and assigns a risk adjustment factor to each HCC. The risk adjustment model can vary from year to year, with changes to the conditions included in the model, the number of HCCs, and modifications to the risk adjustment factors.

Why is HCC Risk Adjustment So Important?

Accurate, complete medical record documentation and diagnosis coding keeps WellCare Health Plans updated on the health status of our members. This enables us to identify patients who may benefit from disease management programs, meet our reporting obligations to CMS, and plan appropriately for anticipated healthcare needs. Your assistance and commitment to risk adjustment affects the amount of resources available for our member population, thereby impacting patient care.

The Role of the Physician

- Document all conditions at least annually, and remember to address overlooked conditions such as amputations, stomas, renal dialysis status, organ transplant, paraplegia, and quadriplegia.
- Probable, suspected, questionable, ruled out or working diagnoses cannot be reported to CMS as valid diagnoses in an outpatient record.
- Documentation should clearly reflect how the reported condition was monitored, evaluated, assessed/addressed or treated.
- Use descriptors where appropriate to increase specificity in documentation.
- Use standard abbreviations.
- Documentation should be clear, concise, consistent, complete and legible.
- Authenticate each encounter in the record with signature and credentials.
- Identify the patient's full name and the date of service on each page of the medical record.
- Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact care.
- Incorporate and document laboratory results and diagnostic results into the progress note.

Best Practices in Medical Coding

Accuracy Consistency

Specificity Thoroughness

Medical coding is only as good as the underlying medical record documentation.