

Risk Adjustment in Clinical Practice

CMS resets chronic condition status each year for every Medicare beneficiary. As part of **quality** care delivery, **validation** of all chronic conditions should occur at minimum, annually during a face to face evaluation. All reported diagnoses must have **support** in the medical record documentation and be a *specific* and *accurate* representation of current health status.

Documentation Standard = M-E-A-T

M- MONITOR

Signs, symptoms, disease progression, disease regression

E- EVALUATE

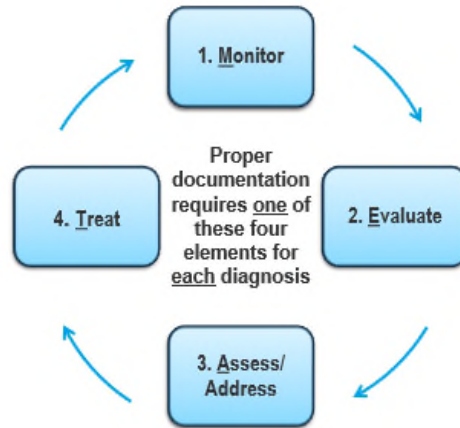
Test results, medication effectiveness, and response to treatment

A- ASSESS/ADDRESS

Ordering Test, discussion, review records, counseling

T- TREAT WITH A PLAN OF CARE

Medications, therapies, other modalities



Clear, Concise Documentation

Key terminology

- Improving
- Worsening
- Stable
- Unstable
- At goal
- No change
- Acute vs. chronic
- Primary vs secondary
- Congenital vs acquired
- Recurrent
- Due to ...
- Compensated
- Controlled
- Poorly controlled
- Asymptomatic



Capture specific diagnoses supported

- Diabetic complications
DM w/ CKD III
- Specific Cardiac Arrhythmia
A-fib, A-Flutter
PAF, VT, SVT
- Differentiate Anemia
Pancytopenia, Thalassemia
- Hepatitis vs. **Chronic** Hepatitis
- Abuse vs. Dependence
- Coagulopathy
- Avoid conflicting documentation
Impaired glucose vs. DM
Wound vs. ulcer



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