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.

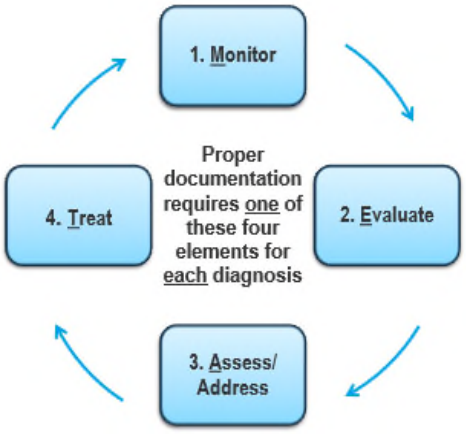
Documentation Standard = M-E-A-T

M- MONITOR
Signs, symptoms, disease progression, disease regression

E- EVAULATE
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 vd secondary
- Congential 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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NOTE: This tool is intended to assist with documentation only and not intended to take the place of clinical analysis. Information regarding any law or regulation does not constitute legal or tax advice and is subject to change based upon the issuance of new guidance and/or change in laws or regulations. Reference Official ICD-10-CM coding guidelines and manuals or electronic medical coding software for accurate ICD-10-CM codes and specificity.