NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEDICAL RISK ADJUSTMENT

THIS MODULE COVERS

1 MEDICAL RISK ADJUSTMENT DEFINITION

Medical Risk Adjustment (MRA) is an actuarial tool used to predict health-care costs of a population. Patient demographics and disease burden, as indicated by ICD-10 diagnosis codes, are utilized to calculate a patient risk score.

2 WHY IS MEDICAL RISK ADJUSTMENT IMPORTANT?

MRA helps health insurance payers – including Medicare – understand how sick your patients really are, as indicated by their risk scores. MRA is used in value-based models to ensure that cost targets are adjusted to align with the illness burden of the population. This means providers are not penalized for taking care of sicker patients.

3 HOW DOES MEDICAL RISK ADJUSTMENT WORK?

The combination of demographic characteristics plus disease burden determines a patient's "risk score." The sicker the patient, the higher the risk score—and the higher the projected cost to treat that patient.

4 MEDICAL RISK ADJUSTMENT EXAMPLE

DEMOGRAPHIC-ONLY RISK SCORE

Mrs. Jones
Age: 78

- Lives at home
- Became eligible for Medicare at age 65 (+.466)

Total Risk Score = .466
Projected Cost = $4,475 to treat Mrs. Jones

DEMOGRAPHIC & DISEASE BURDEN RISK SCORE

Mrs. Jones
Age: 78

- Lives at home
- Became eligible for Medicare at age 65 (+.466)
- Morbid Obesity with a BMI > 40 (+.273)
- COPD (+.328)
- Stage 4 Chronic Kidney Disease secondary to uncontrolled hypertension (+.237)

Total Risk Score = 1.304
Projected Cost = $12,500 to treat Mrs. Jones

5 TIPS TO REMEMBER

- Higher risk scores represent patients with a higher disease burden and higher anticipated cost of care.
- Lower scores should represent a healthier population with a lower anticipated cost of care, but they may also indicate inadequate or incomplete documentation or incomplete or inaccurate diagnosis coding.
- From the insurance company's vantage point, if it's not coded, it doesn't exist.
- Risk coding for each patient is wiped clean on Jan. 1 of each year. Therefore, if your patient had an amputation last year, it will disappear with the dawn of a new year if the codes aren't captured again by you or your staff.

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6 DOCUMENTATION AND CODING BEST PRACTICES

- As a health-care provider, you play a critical role in helping to ensure the integrity of data used to calculate the health risk of your patients. Vital information needed from you includes:
  - A comprehensive health status for every patient
  - Accurate and complete ICD-10 diagnosis coding for every patient, every time
  - Medical record documentation sufficient to support ICD-10 diagnosis coding, and
  - Coding to the highest level of specificity for claim submission.
- A common acronym utilized by coders to identify documentation that supports coding accuracy is **M-E-A-T**. You can utilize this handy tool as you complete your documentation:
  - **M for MONITORED** - the patient for signs, symptoms, disease progression or disease regression
  - **E for EVALUATED** - evaluate test results, medication effectiveness, and response to treatment
  - **A for ASSESSED or ADDRESSED** by ordering tests, discussion, reviewing records o counseling
  - OR **T for TREATED** with medications, therapies and other evidence-based methods
- Remember to be specific include information as current status, dates and treatment, like some of these examples:
  - Instead of documenting "History of Diabetes" consider "Patient with diabetes since 2009."
  - Instead of "History of CHF, meds Lasix" consider "Compensated CHF, stable on Lasix."
  - Another example would be instead of "History of COPD, meds Advair utilize "COPD controlled with Advair."

7 ACCEPTABLE/UNACCEPTABLE DOCUMENTATION SOURCES

- Acceptable Documentation Sources:
  - An inpatient hospital encounter
  - Outpatient facility encounter or visits, or
  - A face-to-face office visit
- Unacceptable Documentation Sources:
  - Super bills
  - Referral forms
  - Encounter forms
  - Patient-only reported conditions
  - Non-face-to-face encounter notes
  - Stand-alone patient problem list
- Provider signatures and credential must accompany risk adjustment coding and documentation.
  - For hand-written signatures and credentials, legible signature or initials are required, along with credentials.
  - Electronic signatures must include credentials. And electronic signatures require authentication by the responsible provider. For example, "Finalized by," "Authenticated by," and "Electronically signed by" all are acceptable to accompany an electronic signature. The electronic signature must also be password protected and used exclusively by the individual physician.
  - Stamps are NOT acceptable as signatures, according to 2010 CMS guidelines.