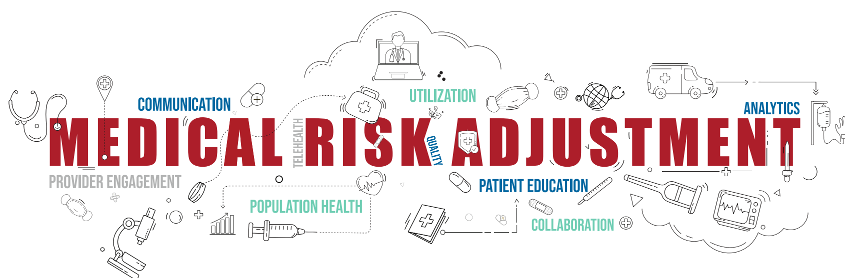
NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

MEDICAL RISK ADJUSTMENT

THIS MODULE FOCUSES ON:

1. What is Medical Risk Adjustment?
2. Why is it important?
3. How to accurately code for your patients



1 WHAT IS MEDICAL RISK ADJUSTMENT?

MRA is an actuarial tool used to predict health-care costs of a population. This ensures that cost targets are adjusted to align with illness burden of the population. Providers are not penalized for taking care of sicker patients.

2 WHAT ARE RISK SCORES?

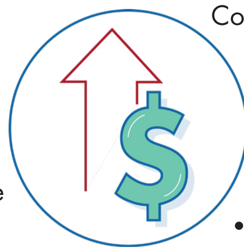
A patient's risk score is determined by a combination of demographics like age, gender, living situation and disease burden. These assist health insurance payers in understanding how sick their patients are.

3 HOW DOES MRA WORK?

When an ACO succeeds, both in delivering high-quality care and spending health-care dollars wisely they share in the savings they achieve in a value-based contract. MRA is key to making that happen. MRA ensures that providers are not penalized for caring for more sicker patients that may require more time and management.

KEY HIGHLIGHTS

- The sicker the patient, the higher the risk score and projected cost to treat that patient.
- MRA ensures that cost targets are adjusted to align with illness burden of the population.
- In a value-based contract, like the ones held by our ACO, payers evaluate the average risk of our entire patient population to determine our cost benchmarks.
- Lower risk scores should represent a healthier population and lower cost of care. It may also indicate inadequate or incomplete documentation or diagnosis coding.
- If a condition isn't coded, it doesn't exist.
- Z Codes are used in conjunction with other ICD-10 codes to document factors influencing health status or the reason the patient is being seen



BEST PRACTICES

Capture the following information:

- A comprehensive health status for every patient
- Accurate and complete ICD-10 diagnosis coding and Z Codes for every patient at every visit
  - Medical record documentation that is sufficient to support ICD-10 diagnosis coding, and
  - Coding to the highest level of specificity for claim submission and avoiding "unspecified" codes whenever possible
- Documentation for all current health conditions

KEYS TO SUCCESS

- All codes are wiped clean each calendar year (must document each patient as if it is the only one that year) – capture any new conditions
- Be as specific as possible (document to highest level of specificity)
- Be intentional with your documentation (avoid using acronyms to assist with proper coding)

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