



Risk Adjustment

Risk adjustment is a process used by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Advantage and Marketplace programs and by state Medicaid agencies to account for expected differences in cost of treatment of members who have varying health status. Risk adjustment programs rely on complete and accurate diagnosis coding and reporting according to the ICD-9-CM coding guidelines.

In order to better assess the health acuity of our members and ensure the accuracy of our risk adjustment reporting, we ask our provider partners to correctly and completely report the conditions affecting our members every time they are addressed or affect the patient's care by documenting these in the medical record and reporting the appropriate diagnosis code on the claim. The Official ICD-9-CM Guidelines for Coding and Reporting, Section IV.K, indicates for outpatient services providers should "code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."

All conditions, even status conditions such as a patient requiring intermittent renal dialysis or a patient who has previously undergone amputation of a limb, often play into the medical decision making during an office encounter. These "status" conditions are generally reported with V-codes. While it is true that in some cases it is inappropriate to use a V-code as a primary diagnosis based on the Official ICD-9-CM Guidelines for Coding and Reporting, when correct and complete coding requires the use of V-codes, they should be reported on the claim. Diagnosis codes which are not appropriate to report as a primary diagnosis may be appropriate to report as a secondary or tertiary diagnosis.

Performing, documenting and coding a head-to-toe exam on every patient at least once every year can be another strategy to both improve patient health and make sure all relevant conditions are being reported. In some cases, historical conditions (history of myocardial infarction, previous below knee amputation), are important to the current and future health of our patients. Receiving correct and complete diagnosis information on claims provides better insight into the health issues facing our members, so we can better serve their needs. Our goals are mutual - to help our patients achieve and maintain better health.

We appreciate your commitment to thorough documentation of each and every encounter to reflect the conditions present and services provided, and to following all official documentation and coding guidelines provided by the CMS and other regulatory agencies. Thank you for being part of the Sunshine Health network and providing excellent care to our members.