Risk Adjustment Frequently Asked Questions

1. **What is risk adjustment?**
   Risk adjustment is a form of predictive modeling introduced by the Medicare Modernization Act of 2003. It gauges the risk that a member will incur medical expenses above or below an overall average over a defined period of time. Risk adjustment assists in the financial forecasting of future medical need. The more severe or complex a diagnosis, the higher the risk value that is assigned. The concept was introduced to minimize the incentive to choose enrollees based on their health status. It is designed to encourage competition among health plans based on quality, efficiency, and premium stabilization.

2. **How does risk adjustment work?**
   A risk-adjustment value is assigned to each diagnosis code that falls into the payment model. The ICD-9/ICD-10 codes are then grouped into an HCC, or hierarchical condition category. HCC categories are related both clinically and financially. Unlike hospital DRGs, HCCs are cumulative: Each additional HCC in an unrelated disease category is factored into the risk profile.

3. **Why is risk adjustment important?**
   Accurate risk categorization identifies members for disease management interventions and assists in the financial forecasting of future medical need.

4. **Where does risk-adjustment data come from?**

   Hospital and physician claims are the main source of data that drives the risk-adjustment model. Accuracy and specificity in ICD-9/ICD-10 coding and medical documentation is critical for risk adjustment. ICD-9-CM/ICD-10 diagnosis coding is used to represent the member's health status and establish an accurate risk score. As in all coding, diagnoses cannot be inferred from physician orders, nurse notes, or lab or diagnostic tests—they need to come from the medical record documentation.

5. **How does risk coding affect my practice?**
   Risk coding affects many areas of your practice. Improved documentation and coding leads to better patient care, as they're the primary means of communicating the patient record for specialty care to health plans and CMS. Accurate documentation also improves quality reporting and efficiency when responding to

regulatory requirements, such as HEDIS/QARR reviews and risk-adjusted data validation (RADV) audits. Financially, it helps achieve greater accuracy in the documentation of key quality metrics associated with payments by the Enhanced Primary Care (EPC) program.

6. **What impact does unspecific diagnosis coding have on providers and patients?**
   If medical documentation lacks the accuracy and specificity needed to assign the most appropriate diagnosis code, providers face the possibility of reduced payment if they are part of a performance-based payment model, and they won't be compliant with CMS standards. There is also missed opportunity for patients to be identified for care-management programs or disease intervention programs. As health care continues to change, high-quality documentation continues to be a cornerstone of accurately reflecting the work of the provider and the condition of the patient. Risk adjustment takes a close look at how ICD documentation and coding can contribute to the complexity level of the encounter, medical decision-making, and time spent with the patient. Good documentation around ICD coding will paint the true clinical picture of the patient and is reflective of the thought process of the provider. This helps control the cost of care and stabilize patient premium increases.

7. **How do I know if my clinical documentation and coding are as accurate as possible?**
   CDPHP offers complimentary medical record coding consultations. This education will enable you to achieve greater accuracy in the documentation of key quality metrics, identify and eliminate clinical documentation concerns that could pose a compliance risk for your medical practice, and reduce the need for retrospective chart retrieval and review.

To schedule a complimentary consultation, email riskcoding@cdphp.com.