Medicare Advantage

Risk Adjustment Coding
What we’ll cover today

• What is risk adjustment (RA) coding
• Why risk adjustment is done
• Defining Hierarchical Condition Categories (HCC) and Risk Adjustment Factor (RAF)
• How it affects you
• CMS audits
• Correct coding guidelines
• ICD-10-CM
What is risk adjustment?

A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee

Risk adjustment calculations consider:

- Diseases that have significant impact on patient cost of care
- Demographic information such as age and sex
- Information from current years to predict future year expenditures
Why risk adjustment is done

• To accurately reflect the health of our membership
• Risk adjustment scores are higher for a patient with a greater disease burden, less for a healthier patient
• The diagnosis codes reported on your claims determine a patient’s disease burden and risk score
• Chronic conditions must be reported once per year
• *Each January 1, the RA slate is wiped clean. All of your Medicare patients are considered completely healthy until diagnosis codes are reported on claims.*
What does HCC mean?

- In 2004 Medicare implemented an HCC (Hierarchical Condition Categories) model to adjust capitation payments to private healthcare plans for the health expenditure risk of their enrollees.
- The CMS risk adjustment model measures the disease burden that includes 70 HCC categories, which are correlated to diagnosis codes.
What is an HCC code?

The HCC model is made up of 3,300 ICD-9 codes that typically represent costly, chronic diseases such as:

- Diabetes
- Chronic kidney disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Malignant neoplasms
- Some acute conditions (MI, CVA, hip fx)
This risk score is also known as the Risk Adjustment Factor or RAF score. Each patient has a RAF score which includes baseline demographic elements (age/sex and dual eligibility status) as well as incremental increases based on HCC diagnosis's submitted on claims from face to face encounters with qualified practitioners during the calendar year.

- HCC coding is prospective in nature, the work you do in this year sets the RAF and subsequent funding for next year.
- All models include chronic conditions that do not change from year to year, i.e., diabetes, COPD, CHF, Atrial-Fib, MS, Parkinson’s, Chronic Hepatitis.
- Exchange model includes acute conditions pertinent to a younger demographics (pregnancy,) and congenital abnormalities.
### Risk adjustment coding example

<table>
<thead>
<tr>
<th>No conditions coded</th>
<th>Some conditions coded</th>
<th>All chronic conditions coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76-year-old female</td>
<td>0.442</td>
<td>0.442</td>
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<tr>
<td>Medicaid eligible</td>
<td>0.151</td>
<td>0.151</td>
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<tr>
<td>DM with complications</td>
<td>X</td>
<td>0.118</td>
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<tr>
<td>Vascular disease</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>CHF</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Disease interaction (DM +CHF)</td>
<td>X</td>
<td>x</td>
</tr>
<tr>
<td>Total RAF</td>
<td>0.593</td>
<td>0.711</td>
</tr>
</tbody>
</table>

**Medicare Advantage 2015**

**Premera Blue Cross**
Provider view of risk adjustment

- I just want to take care of my patients
- I care about CPT codes
- I can only report one diagnosis code per visit...
- I am paid to be a doctor - not a coder!
- This is busy work that only benefits the insurance company
- ICD10, Meaningful use, now what?

Medicare Advantage 2015
The current model

Reimbursement (and compensation) based on intensity of each individual service (CPT, HCPC codes)

Focus has been on documentation supporting level of service (99213 vs. 99214)

Less emphasis on diagnostic specificity
How does risk adjustment affect you?

Physicians will treat patients who are on plans that are funded through risk adjusted models.

These plans expect providers to document and code diagnoses correctly.

Physician documentation and coding establishes the complexity and workload of patient panels.

The documentation and diagnoses becomes the basis for funding and reimbursement.
Risk adjustment will be the future model

Healthcare is rapidly changing

More patients are affected than just Medicare patients

Risk adjustment is now used for ACA and Medicaid

Documentation and coding will increasingly drive reimbursement, quality measures, and medical home models
Premera’s goal

To encourage providers to report diagnosis codes as specifically and accurately as possible

*Diagnosis and procedure codes billed should accurately reflect the level of service supported by the patient’s medical records*
Premera enhanced annual wellness visits

- A typical visit will last between 45 and 60 minutes, presented as a no-cost service to the patient, including preventive labs.
- In addition to the traditional AWV CPT codes G0438 and G0439, Premera allows for an additional code of S0250 (3.0 RVU) to cover the extra time of assessing chronic conditions.
- The goal is to see every Medicare patient every year and for this service to be billed once per calendar year.
- The benefit refreshes January 1 of every year; no need to wait 365 days between visits.
- Visits need to be performed by a primary care physician, contracted nurse practitioner, or PA.
What happens during an enhanced wellness visit?

- Documentation of patient’s current chronic conditions and ongoing treatment plans
- Preventative screenings for conditions such as high blood pressure, diabetes, depression, and heart disease
- Review of medications
- Scheduling of preventative treatments: colonoscopy, mammogram, blood work, etc.
- Lab work as necessary
- Provider can complete a pre-populated template from Premera
- Providers return chart notes to us at the end of the visit to receive payment, faxed to 855-574-8145
Benefits of an enhanced annual wellness visit

- Allows for accurate reporting/submission of patient’s chronic conditions to Medicare in the current year
- Maintains best practice of seeing your patients at least once a year
- Allows opportunity to identify care gaps and create a plan of care for the year
- Ensures acceptable medical record documentation in the case of a Risk Adjustment Data Validation (RADV) audit. Compliance with Star Measures is also required by CMS.
CMS measures outcomes in multiple domains, including measures focused on *your efforts to manage chronic conditions/issues* in the Medicare population:

- Osteoporosis
- Diabetes (retinopathy, nephropathy, HgbA1c, and cholesterol control)
- Hypertension
- Rheumatoid arthritis
- Bladder control
- Fall risk

The quality measures integral to the Enhanced Wellness Visit allows Premera to partner with providers in managing these patients.
Risk adjustment data validation (RADV)

- RADV audits *validate the accuracy of diagnoses* submitted by MA plans
- Medicare, Medicaid, and Dept. of Health and Human Services (Exchanges) will require annual RADV audits
- Providers who have treated a member whose name appears in a RADV audit provide the requested medical records
- **Success** = accurate chart notes to support every chronic condition you report
- **Average error rate nationally** is 20–30%
**Best practice: See your patient every year**

### Factors that can affect a patient’s diagnostic picture

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not seeing their PCP each year. This might be for many reasons, and through no fault of the PCP</td>
<td>Patient with chronic conditions not monitored = chronic conditions not treated</td>
</tr>
<tr>
<td>Patient seen infrequently for other problems, without updating and documenting chronic conditions</td>
<td></td>
</tr>
</tbody>
</table>

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Medicare Advantage 2015
Diagnostic coding guidelines

• ICD-9 and ICD-10 include Official Guidelines for Coding and Reporting. Adherence to these guidelines is required under HIPAA

• Documentation must show that condition was monitored, evaluated, assessed, or treated (MEAT)

• A diagnosis code may only be reported if it is explicitly spelled out in the medical record
  ▶ No coding from problem lists, super bills, or medical history
  ▶ Treatment is *prima facia* evidence of a diagnosis—if you are treating, it therefore exists
MEAT the chronic condition

Monitor
- Signs, symptoms, disease progression, disease regression

Evaluate
- Test results, medication effectiveness, response to treatment

Assess/Address
- Ordering tests, discussion, review records, counseling

Treatment
- Medications, therapies, other modalities

Examples:
- CHF: 428.0- symptoms well controlled with Lasix and ACE inhibitor. Will continue current medications
- Major depression: 296.20- Patient continues with feelings of hopelessness and anhedonia despite current regimen of Zoloft 50 mg daily. Will increase dose to 100 mg daily and monitor
Specificity counts

Coding guidelines state diagnosis codes are to be used at their highest level of detail. **Documentation is key to accomplishing this.**

<table>
<thead>
<tr>
<th>What condition does the patient actually have?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If your assessment says:</strong></td>
</tr>
<tr>
<td>&quot;Depression&quot;</td>
</tr>
<tr>
<td>&quot;Dysrhythmia&quot;</td>
</tr>
<tr>
<td>&quot;Bronchitis&quot;</td>
</tr>
</tbody>
</table>

If a condition is a specific disorder, or is chronic or recurrent, use that terminology.
Coding for diabetes: Document all manifestations

Document and report any and all complications or manifestations associated with diabetes mellitus (DM)

- 250.0x - DM without mention of complication
- 250.4x - DM with renal manifestations (e.g., CKD, diabetic nephropathy)
- 250.5x - DM with ophthalmic manifestations (e.g., diabetic retinopathy)
- 250.6x - DM w/neurological manifestations (e.g., diabetic polyneuropathy)
- 250.7x - DM w/peripheral circulatory disorders (e.g., diabetic peripheral angiopathy)
- 250.8x - DM w/other specified manifestation (includes hypoglycemia in diabetes)

Use additional code(s) to identify complications, manifestations
# Coding for DM manifestations in ICD-9

Coding diabetic manifestations is frequently overlooked

## Documentation needs to support causal effect

<table>
<thead>
<tr>
<th>Documentation</th>
<th>It codes to both of these</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM code AND DM manifestation</td>
<td></td>
</tr>
<tr>
<td>Diabetes with CKD, stage 4</td>
<td>250.40, Diabetes with renal manifestations + 585.4, Chronic kidney disease, Stage IV (severe)</td>
</tr>
<tr>
<td>Diabetes w/(peripheral) angiopathy</td>
<td>250.70, Diabetes w/peripheral circulatory disorders + 443.81, Peripheral angiopathy in diseases classified elsewhere</td>
</tr>
<tr>
<td>Diabetic angiopathy</td>
<td></td>
</tr>
<tr>
<td>Diabetes w/neuropathy</td>
<td>250.60, Diabetes w/neurological manifestations + 357.2, Polyneuropathy in diabetes</td>
</tr>
<tr>
<td>Diabetic neuropathy</td>
<td></td>
</tr>
<tr>
<td>Diabetes w/proliferative retinopathy</td>
<td>250.50, Diabetes w/ophthalmic manifestations + 362.02, Proliferative diabetic retinopathy</td>
</tr>
<tr>
<td>Proliferative diabetic neuropathy</td>
<td></td>
</tr>
</tbody>
</table>
### Document patient’s status conditions

Status codes indicate factors that influence health status and affect treatment or outcomes—often complicating a patient’s care.

<table>
<thead>
<tr>
<th>Status codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>Asymptomatic HIV infection status</td>
<td></td>
</tr>
<tr>
<td>Organ or tissue transplant status</td>
<td></td>
</tr>
<tr>
<td>Artificial opening status</td>
<td>(tracheostomy, gastrostomy, cystostomy)</td>
</tr>
<tr>
<td>Amputation status</td>
<td></td>
</tr>
<tr>
<td>Renal dialysis status</td>
<td>(or noncompliance)</td>
</tr>
<tr>
<td>Morbid obesity (278.0x)</td>
<td>BMI &gt; 40 (V85.4x)</td>
</tr>
<tr>
<td>Paraplegia; paralysis, both lower limbs</td>
<td>(344.1)</td>
</tr>
<tr>
<td>Diplegia; paralysis, both upper limbs</td>
<td>(344.2)</td>
</tr>
<tr>
<td>Hemiplegia, late effect of CVA</td>
<td>(438.2x)</td>
</tr>
<tr>
<td>Hemiplegia, unspecified</td>
<td>(342.9x)</td>
</tr>
</tbody>
</table>

*In ICD-9, many are V codes; in ICD-10 many will be Z codes*
Coding guidelines specify that diagnoses for malignancies may be reported only until the patient has completed definitive treatment. Definitive treatment means surgical excision or eradication, chemotherapy, or radiation therapy directed at the malignancy.

Certain adjuvant cancer medications are considered treatment.

When a primary malignancy has been previously excised/eradicated, and there is no further treatment and no evidence of any existing primary malignancy, a code from V10.xx, Personal history of malignant neoplasm, should be used to indicate the former site of malignancy.

Use a personal history code for patients who have completed treatment, even if they are being monitored for a recurrence.
Coding for neoplasms: Capture all as appropriate

For malignancies still under definitive treatment, use codes to distinguish primary from secondary (metastatic) malignancies.

• **Primary**
  - 153.9 – Malignant neoplasm of colon, unspecified
  - 162.9 – Malignant neoplasm of bronchus and lung, unspecified
  - 174.9 – Malignant neoplasm of breast (female), unspecified
    (Use additional code V86.0 or V86.1 to identify estrogen receptor status)
  - 185 – Malignant neoplasm of prostate

• **Secondary (metastatic)**
  - 196.x – Secondary malignant neoplasm of lymph nodes
  - 197.0 – Secondary malignant neoplasm of lung
  - 197.7 – Secondary malignant neoplasm of liver
  - 198.5 – Secondary malignant neoplasm of bone or marrow
Circulatory system diseases: Be specific

• **Nonspecific: Hypertension, High blood pressure**
  - 401.9 Essential hypertension, unspecified

• **Specific: Hypertensive heart disease with heart failure**
  - 402.91 Hypertensive heart disease, unspecified, with heart failure
  - 402.11 Benign hypertensive heart disease w/heart failure
    (use additional code for type of heart failure, if known)

• **Specific: Hypertensive chronic kidney disease**
  - 403.91 Hypertensive (unspecified) CKD, stage I-IV or unspecified
  - 403.11 Benign hypertensive CKD, stage V or ESRD
    (use additional code for CKD stage)
Heart Disease: Be specific

- **Nonspecific: Coronary artery disease**
  - 414.00  Coronary atherosclerosis of unspecified type of vessel, native, or graft

- **Specific:**
  - 412  Old MI
  - 427.31  Atrial fibrillation
  - 427.31  Atrial flutter
  - 413.9  Angina, other and unspecified
  - 411.1  Intermediate coronary syndrome (Unstable angina)
  - 425.x  Cardiomyopathy
  - 425.5  Alcoholic cardiomyopathy
    (use additional code 303.9x for alcohol dependence, if present)
Coding for aortic aneurysm: Be specific

- 441.2 - Thoracic aneurysm without mention of rupture
- 441.4 - Abdominal aneurysm without mention of rupture
- 441.7 - Thoracoabdominal aneurysm without mention of rupture
- 441.9 - Aortic aneurysm, unspecified site w/out mention of rupture

If the patient’s aortic aneurysm was previously repaired, report **V12.59, Personal history of other disease of circulatory system**
Respiratory Disease: Acute or chronic

• **Nonspecific:**
  - 490 Bronchitis
  - 466.0 Acute bronchitis
  - 493.9 Asthma
  - 486 Pneumonia

• **Specific:**
  - 491.9 Chronic bronchitis
  - 491.20 Obstructive chronic bronchitis
  - 491.22 Acute bronchitis with COPD
  - 493.20 Chronic obstructive asthma (asthma with COPD)
  - 496 Chronic obstructive pulmonary disease (COPD)
  - 481 Pneumococcal pneumonia (*Streptococcus pneumoniae*)
Digestive system diseases: Be specific

Nonspecific:
- 558.9  Colitis, enteritis, gastroenteritis
- 577.0  Pancreatitis

Specific:
- 556.9  Ulcerative colitis; ulcerative enteritis
- 555.9  Regional enteritis; Crohn’s disease
- 577.1  Chronic pancreatitis
- 560.9  Intestinal obstruction, unspecified
- 560.1  Paralytic ileus
- 560.30 Intestinal impaction, unspecified
- 560.32 Fecal impaction (excludes constipation, incomplete defecation)
Personal history of CVA is often miscoded as acute CVA. Do not report code 436 for history of stroke

- **Personal history of CVA with no late effects**
  - V12.54 – Transient ischemic attack, and cerebral infarction w/out residual deficits

- **Personal history of CVA with late effects**
  - 438.xx – Late effects of cerebrovascular disease
    - 438.2x – Hemiplegia/hemiparesis
    - 438.3x – Monoplegia of upper limb
    - 438.4x – Monoplegia of lower limb
    - 438.5x – Other paralytic syndrome
Mental and behavioral health: Be specific

- **Nonspecific:**
  - 311 Depression, depressive disorder

- **Specific:**
  - 296.2x **Major** depressive disorder, single episode
  - 296.3x **Major** depressive disorder, recurrent episode

Key elements for coding **major** depression:
PHQ-9 with an appropriate severity score, or documentation that qualifies the depression

- **Specific:**
  - 295.xx Schizophrenic disorders
  - 296.8x Bipolar disorder, manic depression
Under ICD-9 guidelines, “Personal history (of)” means a past medical condition that no longer exists.

“History of” is an often misused descriptor. Never use this term to describe a condition that the patient still has.

Frequently seen examples:
• “History of CHF” misused to indicate compensated CHF
• “History of Afib” misused to indicate atrial fibrillation controlled by medication or pacemaker
Coming October 2015: ICD-10-CM

- Conversion to ICD-10 is a HIPAA code set requirement
- Code set expands from ~13,600 ICD-9 codes to ~69,000 ICD-10 codes.
- New features in ICD-10 allow for greater level of specificity and clinical detail and reflect current medical knowledge
- Key to correct coding in ICD-10: Thorough, accurate, specific documentation

Don’t fret about the new code set; do focus on your documentation
Medicare Advantage Provider Website
PCP Roster—select a provider or tax ID

PCP Member Roster Report: Medicare

This tool will allow you to search for PHP Medicare and Medicaid members assigned to individual providers as a PCP within your clinic.

Select an individual provider from the drop down menu and click SEARCH.

Thank you for using ProvLink.

Select Providers:

Select by Tax ID:
- ABANO, JOHN B.
- ACUNA-EATON, INGRID L.
- ALEXANDER, WENDI D.
- ANDERSON, CLINTON W.
- ANDREONI, MICHAEL J.
- ARGUE, LEE R.
- BLUE, SUSAN M.
- BOYD, RAE
- BUMSTEAD, KATHERINE D.
- BURSON, SEAN M.
- CADENA-FORNEY, GINA A.
- CHISHOLM, JOHN D.
- CHOI, ROBERT Y.
- CLARKSON, THOMAS A.
- CLOSS-BREWER, MELISSA L.
- CLYNE, VICTORIA E.
- COFFMAN, WENDY J.
- CULVER, JOLENE A.
- DASTVAN, CELIA M.
- DAVIS, KARINE J.
- DE CASTRO, GARRET G.
- DECHADENEDES, NICHOLAS B.
- DHANKI, CATHERINE J.
- DIAZ, GEORGE A.
PCP roster—results

PCP Member Roster Report: Medicare

This tool will allow you to search for PHP Medicare and Medicaid members assigned to individual providers as a PCP within your clinic.

Select an individual provider from the drop-down menu and click **Search**.

Thank you for using ProvLink.

Select Providers: CHISHOLM, JOHN D. – Search – Cancel

Select by Tax ID: – Search – Cancel

Export to Excel

Search returned 10 records.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Member Name</th>
<th>DOB</th>
<th>Sex</th>
<th>Effective Date</th>
<th>Address</th>
<th>Phone #</th>
<th>Term Date</th>
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<tbody>
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</tbody>
</table>

Export to Excel
Annual Wellness Visit Reports

To ensure appropriate reimbursement for services rendered to Medicare members an annual wellness visit is required to document the existing conditions of the Medicare members assigned to your clinic’s PCPs, indicates the current risk score, documented conditions and when the last Wellness Visit occurred for each member or export a partial report to excel. If you need a guide for your annual visit, please utilize the Annual Wellness Visit Blank Template for required to be submitted to the Health Plan.

By PCP: 

By Clinic: 

By Member ID: 

By New To Clinic: 

DISCLAIMER: All information contained within reports is generated from claims data with no actual medical record review. It is possible you will find another treating provider. This is especially true for "Conditions" which is meant as a guide for the treating physician but should never be used as
Select the patients you want more information on, including last wellness visit date and conditions. Once selected, you can generate a report.
## Annual Wellness Visit Reports

<table>
<thead>
<tr>
<th>PCP Group</th>
<th>PCP ID</th>
<th>PCP Name</th>
<th>Member ID</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>HICN ID</th>
<th>Last Wellness Visit</th>
<th>Last Matrix Visit</th>
<th>Risk</th>
<th>Silver Sneakers?</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>No</td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
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<td>3</td>
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<td>Major Complications of Medical Care and Trauma</td>
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<td>Vascular Disease w/ Complications</td>
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Essential takeaways for today and tomorrow

- Risk adjustment will become a more prevalent part of a provider’s patient care
- The importance of consistent, accurate, and complete documentation in the medical record cannot be overemphasized
- Documentation and specificity are the keys to success
Questions