Medical Record Documentation Guide

Risk Adjustment Overview

Risk Adjustment is a model used by most insurance payers to capture and recapture patients' health conditions and calculate the budget needed to provide quality care. This model assigns a risk adjustment factor (RAF) to chronic conditions and severe acute diagnoses. The total RAF of all a patient's conditions is added together to give each patient an overall RAF score.

- A RAF score of 1.0 is considered an average, generally healthy individual.
- A RAF score above 1.0 means the patient is expected to need more care than the average patient, increasing their budget allocation.

Risk adjustment helps ensure that there is enough funding to care for patients with more complex health problems. This allows providers to care for patients with a range of health conditions, not just healthier, less costly patients.

The Key to Good Documentation

Complete but concise documentation in the medical record is key for appropriate code selection! Specificity in documentation is extremely important in hierarchical condition category (HCC) coding. Some conditions do not carry a RAF if they are documented as unspecified or uncomplicated. To document a condition effectively, a provider should thoroughly record the patient's active conditions **to the highest specificity** during an office visit. This includes describing how comorbidities affect the patient's health, what medications they are taking, if the condition is stable, and outlining the treatment plan. The level of complexity or presence of comorbidities can determine if the diagnosis is considered an HCC and impacts the RAF score.

Think of M.E.A.T as you chart!

Monitor—	**E**valuate—	**A**ssess/ **A**ddress—	**T**reat—
signs, symptoms, disease progression, disease regression	**test results, medication effectiveness, response to treatment**	**ordering tests, discussion, review records, counseling**	**medications, therapies, other modalities**
e.g., B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits.	e.g., current hypertension regimen is working well with BP today at target.	e.g., stable; controlled, worsening; unchanged, uncontrolled.	e.g., taking Fosamax for osteoporosis; taking tamoxifen for breast cancer "treatment", DM controlled on insulin.

carina HEALTH NETWORK

M.E.A.T. Examples by Disease Category

Disease	Monitor	Evaluate	Assess/Address	Treat
Diabetes	"Patient has been newly diagnosed with T2DM with CKD stage 3a."	"A1c today 5.9. Last A1c was 6.2. Doing well with current medication regimen."	"Patient expressed difficulty maintaining blood sugar levels. Placing a referral for nutritional counseling. Advised to avoid sugary sodas and teas."	"Patient expresses elevated glucose levels of 220 after mealtimes. Increasing insulin to 100 units after meals."
HTN	"BP 160/95. Patient reported headaches and dizziness upon evaluation today."	"Pt BP is stable today with pt experiencing no negative symptoms after starting Zestril."	"Pt and has pre-existing HTN and has newly diagnosed AFIB. Reviewed cardiology consult notes and findings."	"Patients BP is stable and is taking Lisinopril as directed. No med changes needed today. Continue meds as directed."
CKD	"Hypertensive ESRD, on dialysis 3 times a week. Bleeding around the fistula site at last dialysis treatment."	"EGFR today was 43. Progression in severity from stage 3a at beginning of year to 3b."	"Pt EGFR levels were at 72. Referral placed to Nephrology for further evaluation of potential CKD."	"CKD stable on atorvastatin. Following up with Nephrology in 2 weeks. Recommended increasing daily exercise."
Cancer	"Patient is experiencing nausea, fatigue, weakness as part of current treatment for breast cancer."	"Leukemia in remission being monitored; CBC shows elevated white blood cell count. "	"Leukemia in remission being monitored by oncology. Reviewed oncology notes. Ordering repeat CBC."	"Stage 3 breast cancer of the upper outer left breast. Following with oncology. No issues with current meds. Continue taking Tamoxifen as directed for hormone therapy."
Heart Failure	"Left and Right Heart failure s/p stent placement 4 weeks ago. Chest pain is resolved."	"Echo shows ejection fraction is 37%. Pt reports no negative symptoms from new metoprolol Rx".	"Discharged from the hospital with acute HF. Reviewed consult notes from hospital. Discussed heart healthy diet and exercise regimens"	"Pt presented with HF and edema in bilateral lower extremities. Increase Lasix to 40 mg."

Bringing it All Together

Example: "Patient presented for follow-up on type II diabetes with **hyperglycemia** and **comorbid chronic kidney disease (CKD)**. Patient states they have been taking **Metformin and insulin** as prescribed, with **no adverse side effects**. Patients' **glucose has been elevated** in the mornings after breakfast. Advised to **increase morning Insulin** after mealtimes and to **avoid sugary juices in the morning**. **Ordered A1c** to be completed before our next 3-month follow-up appointment."

Documentation Elements for Chronic Conditions

When capturing ICD-10 codes for a patient, accurate documentation and code selection should not result in an additional charge to the patient for simply identifying or reporting a diagnosis. The purpose of assigning an ICD-10 code is to communicate to the insurer that the patient has a particular condition, which in turn helps determine the appropriate budget needed to manage that condition. To properly document a condition so that it may be billed out on a claim, providers should address relevant details from the categories below. Including just a **few (typically 2-4) elements** in each category can provide enough M.E.A.T to support the coding of each condition.

Note: Not all of the recommendations below need to be documented for a code to go out on a claim.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Amputations/ Transplants	• Document what was amputated/transplanted:
	  ○ **Site** and/or organ, **location,** and **laterality** (unilateral, bilateral, left, right, upper, lower, etc.
	• Document when the amputation or transplant took place (needs to be recoded annually).
	• Observe the amputation or transplant site:
	  ○ For amputations, note if the stump is well healed, stable, or is experiencing complications.
	  ○ For transplants, if the transplant was recent, make sure the site of the incision is well healed or is experiencing complications.
	• Note if the patient needs any mobility assisting devices or utilizes any prosthesis or other aids.
	• Document ways the amputation or transplant causes morbidity or quality of life issues.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Document any complications of the amputation or transplant, if applicable:
		  ○ Infection, injury, pain, phantom pain, irritation, etc.
		• Note any new or changed medications being used to treat the complication, if applicable.
		• Document any counseling or recommendations being made to prevent or relieve the complications' symptoms.
		• Document any referrals and orders placed to specialists or DME providers.
		• Document any follow-up or treatment plans.

Atrial Fibrillation (Afib)	• Notate the type of Afib (paroxysmal, persistent, permanent, chronic, etc.) with the status (stable, worsening, improved, in remission, etc.).
	• Link medication regimen, dosage changes, and any side effects.
	• Review outside consult notes and document new or changed findings/diagnoses (if applicable) and document changes or results.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
	• Document and code for pacemaker implantation yearly if present.
		• Link comorbidities (e.g., hypertension), risk factors, or behavioral factors that could complicate the condition:
		  ○ Hypertension, heart disease, heart failure, abnormalities of the heart, emphysema and COPD, sleep apnea, etc.
		• Note new signs or symptoms of heart disease:
		  ○ Palpitations decreased blood pressure, weakness and fatigue, lightheadedness, chest pain, shortness of breath.
		• Update any treatment plans or medication lists to reflect complications.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Cancer	• Review outside consult notes and document that the cancer is being treated by an outside provider (if applicable):
	  ○ Even if the PCP is not the overseeing provider treating the cancer, it is still appropriate to document and code for cancer as the diagnosis does affect your treatment plans of all other conditions.
	• Note the type of cancer the patient has:
	  ○ Carcinoma, Sarcoma, Leukemia, Lymphoma, Multiple Myeloma, Melanoma, etc.
	• Notate the anatomic site and laterality of cancer (unilateral vs. bilateral).
	• Notate if the cancer is primary or secondary:
	  ○ If the patient has secondary cancer, list the primary cancer associated with the metastasis.
	• Notate the stage (0-4) and behavior of cancer (if known):
	  ○ Primary Malignant, Secondary Malignant, In Situ, Benign, Uncertain Behavior, Unspecified Behavior.
	• Current medication management or treatment regimen (if applicable):
	  ○ If a patient is receiving active treatment or medications for cancer, the condition is considered an active cancer and should not be considered PMH.
	  ○ If a cancer is resected, or is not receiving any treatment or medications, the cancer should be labeled as historical/PMH. Notate any surgical history or resection of cancer.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Review outside consult notes and document new or changes findings/diagnoses (if applicable) and/or results. Make a note that the cancer is being actively treated.
		• Document any signs or symptoms of worsening severity, stage, or metastasis.
		• Update the treatment plan and document any labs or orders if applicable.
		• Link any comorbidities or complications that are affecting the treatment plan, especially as the PCP who manages all the patient's conditions, not just the cancer.

Chronic Kidney Disease (CKD)	• Document the **stage** of CKD (1, 2,3 unspecified, 3a, 3b, 4, 5 or ESRD).
	• Review and document the most recent EGFR reading or relevant lab results.
	• Current medication management (if applicable)
	• Notate if the patient is currently undergoing dialysis, and update on changes and complications as the patient undergoes dialysis (bleeding around AV fistula)
	• Review outside consult notes and document new or changed findings/diagnoses (if applicable).
	• Link medication regimen, dosage changes, and any side effects.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Notate any changes in stage/severity.
		• Document and link complications associated with CKD:
		  ○ Diabetes, hypertension.
		• Note signs, symptoms, or complications
		  ○ Abnormal laboratory values (creatinine, electrolytes), High blood pressure, Changes in urine output, Swelling due to fluid buildup in the tissues (edema), Fatigue and weakness, Loss of appetite, Weight loss, Nausea and/or vomiting, Excessive sleepiness or inability to sleep, Headaches, Decreased mental sharpness, trouble concentrating, Dry, itchy skin.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:
COPD/ Emphysema	• Notate the type of obstructive lung disease, like COPD or Emphysema (emphysema is more complicated than COPD, so when the patient has both, code Emphysema). • Link medication regimen, dosage changes, and any side effects. • Review outside consult notes and document new or changed findings/diagnoses (if applicable) and document changes or results. • Screen and document smoking history if applicable. • Outline counseling and guidance given to the patient. • Treatment plan and follow-up recommendations. • Orders associated with the condition.	• Link comorbidities, risk factors, or behavioral factors that could complicate the condition: ○ Asthma, bronchitis, bronchiectasis, upper respiratory infection • Notate exacerbations (signs, symptoms, or complications) that the patient presents with: ○ Chronic cough or cough with mucus, shortness of breath (with or w/o exertion), Wheezing and chest tightness, Fatigue, Low oxygen blood saturation
Dementia	• Document the type and stage of dementia (**mild, moderate, and severe**) • Identify if the dementia is linked to any known etiology (**code also the underlying condition**): ○ Alzheimer's, Creutzfeldt- Jakob disease, epilepsy, Huntington's disease, multiple sclerosis, Parkinson's Disease, Pick's disease, lupus, traumatic brain injuries, etc. • Score and record all cognitive and behavioral screenings performed in the medical record with their results, and link results to the diagnosis in A&P. • Note any challenges or issues the patient or caregivers are experiencing, including mobility, ADLs, IADLs, etc. • List the caregiver if applicable and note home safety and any advance directives in AWV. • Link medication regimen, dosage changes, and any side effects. • Review and document lab results and diagnostic findings. • Review outside consult notes and document new or changed findings/diagnoses (if applicable). • Outline counseling and guidance given to the patient or caregivers. • Treatment plan and follow-up recommendations. • Orders associated with the condition.	• Note if the patient is experiencing behavioral disturbances accompanying their condition. ○ Anxiety, angry outbursts, agitation, mood changes, psychotic episodes, sleep disturbances, social disinhibition, violence, combativeness, apathy, depression, anhedonia, sexual disinhibition, paranoia, delusion, etc. ○ Rocking, pacing, exit-seeking, or other aberrant motor behavior.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Diabetes	• Type of diabetes (gestational, secondary, Type 1, Type 2, etc.).
	• Document the current status of diabetes (stable, worsening, improved, etc.).
	• Disease management method (diet, exercise, medication management).
	• Name of medication taken (with additional Z code for the type of medication), including changes in medications or doses.
	• Counseling recommendations on lifestyle and nutrition.
	• A1c lab values, urine labs, and any other associated lab values.
	• Glucose values or glucose home logs (if applicable).
	• Treatment plan and follow-up recommendations.
	• Associated orders and preventative screening recommendations.
		• Link between comorbidities and diabetes using terms," with", "and", "due to", "complicated by"...
		  ○ Hypertension, retinopathy, neuropathy, polyneuropathy, PVD, CKD, coma, pressure ulcers, hyperglycemia, cataracts, hyperlipidemia, etc.
		• Signs or symptoms, if experiencing complications:
		  ○ Frequent urination, excessive thirst, excessive hunger, fatigue, irritability, blurry vision, lightheadedness, ulcers or slow healing wounds, etc.
		• Treatment plan and follow-up recommendations for both diabetes and its comorbidities.
		• Current status of diabetes control – In ICD-10-CM, "uncontrolled" is considered a diabetic complication.

Heart Failure	• Document the type of heart failure (Left, Right, Systolic, Diastolic, Combined, Biventricular, End-stage) if known.
	• Document the current status of heart failure (stable, worsening, improved, in remission, compensated, decompensated, etc.).
	• Link hypertension and heart failure with a combination code if applicable to the patient (I11.-).
	• Link medication regimen, dosage changes, and any side effects.
	• Review and document lab results and diagnostic findings.
	• ECG, EKG, chest x-ray, stress tests, etc.
	• Review outside consult notes and document new or changed findings/diagnoses (if applicable).
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Document if the change in severity is due to an acute instance of heart failure or if it is acute on chronic heart failure.
		• Link comorbidities (e.g., hypertension), risk factors, or behavioral factors that could complicate the condition:
		  ○ Smoking, hypertension, PMH myocardial infarction, diseases of the heart, obesity, diabetes, lung disease, heart arrhythmias, etc.
		• Notate new signs or symptoms of heart disease:
		  ○ Edema of extremities, palpitations, irregular heart rate/rhythm, shortness of breath, cough, fatigue, indigestion, etc.
		• Notate the treatment plan and any changes in medications or regimen for the patient.
		• List any counseling or guidance given on specific treatment plans or diet and exercise recommendations that may have changed due to the difference in severity.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Hypertension	• Blood Pressure reading (take multiple BP readings if the result is over 140/90).
	• Document the current status of hypertension (stable, worsening, improved).
	• Notation on how the patient is monitoring their BP at home, and any lifestyle or behavioral risk factors.
	• Medication regimen, dosage changes, and any side effects.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Link comorbidities using terms," with", "and", "due to", "complicated by"...
		  ○ Heart failure (I11.-), CKD (I12.-).
		• Medication regimen, dosage changes, and any side effects.
		• Outline counseling and guidance given to patients.
		• Signs, symptoms, or manifestations if the patient is presenting with complications:
		  ○ Dizziness, chest pain, headaches, shortness of breath, fatigue/weakness.
		• Link the primary condition/agent causing the secondary hypertension (if applicable).

Major Depression	• List the type of depression with (if known):
	  ○ **severity** -mild, moderate, severe
	  ○ **frequency of episodes**- single episode, recurrent, in remission.
	• Review outside consult notes and document new or changed findings/diagnoses (if applicable) and document changes or results.
	• Document and tally PHQ-2 or 9 scores, with a notation of positive or negative depression screening.
	• Link medication regimen, dosage changes, and any side effects to the depression diagnosis.
	  ○ Even if the patient is stable, if they are taking depression medications, it is not appropriate to list the depression as historical. It is an active condition as long as treatment is being provided.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Document any change in severity of depression and list the comorbidities or risk factors underlying the change in severity:
		  ○ Increased alcohol or substance abuse, weight loss or gain, disordered sleep, anxiety, social isolation, difficulties with interpersonal relationships, suicidal ideation or attempts, or other medical or psychological complications.
		• Update medication regimen, dosage changes, or interventions and recommendations made to the patient.
		• Link positive screening results to the diagnosis.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Malnutrition	• Patient's height, weight, and calculated BMI (below 18.5).
	• Weight classification (underweight, cachexia, malnourished, etc.).
	• Document the severity of the malnutrition:
	  ○ Mild, moderate, severe.
	• Link comorbidities or causes of malnutrition if another condition is causing weight loss.
	  ○ Cancer, alcohol or substance use, liver disease, CKD/ESRD, anemia, pancreatitis, etc.
	• Document patient-reported information, like loss of appetite or dysregulated eating habits.
	• Link medications used to aid in the weight change or treatment of the patient.
	• Document recommendations on lifestyle and exercise changes, and any other counseling provided to the patient.
	• Outline the treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		N/A

Morbid Obesity	• Document the patient's height, weight, and calculated BMI.
	• Select a weight classification (overweight, obese, morbidly obese/class III obesity) to go along with the BMI code (it is not appropriate to just code the BMI without the weight classification code accompanying it).
	• Document patient's dietary and exercise habits if asked during visit.
	• Outline counseling and guidance given to the patient.
	• Link medications being used to aid in the weight reduction or treatment of the patient.
	• Document recommendations on lifestyle and exercise changes, and any other counseling provided to the patient.
	• Outline the treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Link the obesity to any comorbidities that can negatively affect the severity of the condition.
		  ○ Diabetes, hypertension, COPD, etc.
		  ○ If a patient has a BMI of 35.0+ with a comorbid condition, it can be appropriate for the patient to be documented as being morbidly obese (class III obesity) if formally diagnosed by the provider.
		• If the obesity is due to another underlying condition, code for “other” obesity/morbid obesity and link in the documentation the underlying condition.

Condition Category	Without Complications	With Complications Utilize the same information as uncomplicated, with additional information to document:

Stroke	• Notate the type and cause of the stroke:
	  ○ Type- nontraumatic subarachnoid, intracerebral, etc.
	  ○ Cause- embolism, thrombosis, occlusion, and stenosis.
	• Document what artery it took place in, if known (right/left/bilateral):
	  ○ Precerebral artery, vertebral artery, cerebral artery, posterior artery, basilar artery, carotid arteries, etc.
	• When the stroke occurred (active vs PMH)
	  ○ If the stroke does not have residual effects after the initial stroke period, **DO NOT code an active stroke code**.
	  ○ The active stroke code can only be applied while the patient is having a stroke. If it is resolved, code PMH stroke. If there are residual effects, code for **sequelae only**.
	• Review outside consults, labs, scans, and document pertinent findings or changes.
	• Link any medications being used to prevent further strokes from occurring.
	• Document recommendations on lifestyle and any other counseling provided to the patient.
	• Outline the treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Document any sequala or residual effects of the stroke:
		  ○ Monoplegia, hemiplegia, paralytic syndrome, apraxia, facial droop, memory deficit, attention/concentration deficit, visuospatial deficit, social or emotional deficit, executive function deficits, aphasia, dysphasia, etc.
		  ○ If the stroke recently occurred, only code an active stroke code if there are residual effects.
		• Document any DME or other assistive devices the patient uses to perform daily functions.
		  ○ Wheelchairs, walkers, Hoyer lifts, etc.
		• Document if they require any nursing assistance or other assistance.

Substance Use, Abuse, & Dependence	• List the type of substance being used/abused, and the frequency of use if known.
	• Document if the patient is **using, abusing, or dependent** on the substance:
	  ○ mild (abuse), moderate (dependence), or severe (dependence).
	  ○ If both use and abuse are documented, assign **only the code for abuse**.
	  ○ If both abuse and dependence are documented, assign **only the code for dependence**.
	  ○ If use, abuse, and dependence are all documented, assign **only the code for dependence**.
	  ○ If both use and dependence are documented, **assign only the code for dependence**.
	• Document if the substance use is active, in early remission, or in sustained remission.
	• Review outside consult notes and document new or changed findings/diagnoses (if applicable) and document changes or results.
	• Document any complications or outcomes that result from the patient's use of the substance.
	• Score and document any screening tools used to measure the patient's level of use.
	• Link medication regimen, dosage changes, and any side effects.
	• Outline counseling and guidance given to the patient.
	• Treatment plan and follow-up recommendations.
	• Orders associated with the condition.
		• Link the use, abuse, or dependence on any substance-induced complications:
		  ○ Delirium/delusions, intoxication, withdrawal, perceptual disturbances, mood disorders, bipolar disorder, depressive disorders, psychotic disorders, hallucinations, anxiety, sexual dysfunction, sleep disorders, etc.
		• Document the treatment plan and follow-up recommendations for both the main condition and the complications.
		• Associate any medications, referrals, or orders with complications.