Risk adjustment & HCC documentation basics

Each page of the patient's medical record should include:

- ✓ The patient's name
- ✓ Date of birth or other unique identifier (on the first page)
- ✓ Date of Service including year

Requirements:

- ✓ Encounter must be a face to face visit
- ✓ Documented condition(s) in the medical record
- ✓ Diagnosis cannot be inferred test results
- ✓ You may assign code for each Documentation condition
- ✓ Documentation must show that condition was:
  - ✓ Monitored
  - ✓ Evaluated
  - ✓ Assessed
  - ✓ Treated
- ✓ Treatment and level of care must be justified
- ✓ Health status assessed
- ✓ Assess and report All chronic conditions at least once per year
- ✓ Medical Record must support codes reported on the claim or encounter form

Report all diagnoses (not just primary diagnosis) that impact the patient's evaluation, care and treatment including:

- ✓ Main reason for visit
- ✓ Co-existing acute conditions
- ✓ Chronic conditions (such as CHF, CKD, RA, COPD, Asthma, Cardiomyopathy)
- ✓ Care rendered
- ✓ Conclusion and diagnosis

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