What is Medicare risk adjustment?

Under the Medicare Advantage (MA) program, MA organizations are paid a set premium to cover the costs of healthcare services provided by their plans. The Centers for Medicare & Medicaid Services (CMS) uses demographic and disease data for each member to determine the individual premium. The amount of the premium does not vary based on actual use of healthcare services. This payment system, known as Medicare risk adjustment (MRA), allows CMS to adjust its premium payments to MA organizations based on the expected healthcare costs of its members.

The role of the MA plan, physicians and other healthcare providers

Diagnosis data from physicians and other healthcare providers is used to determine whether an individual member suffers from certain diseases that are expected to lead to higher healthcare costs for that member. CMS requires all health plans to submit Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 claims transactions to CMS for Medicare risk adjustment. All diagnoses submitted for risk-adjusted payment must meet the following criteria:

- Documented in a medical record based on a face-to-face encounter with an approved physician or other healthcare provider type (e.g., physician, hospital)
- Assigned based on dates of service within the relevant data collection period
- Coded in accordance with standard industry guidelines (International Classification of Diseases, Tenth Revision [ICD-10])
- Based not solely on laboratory or other diagnostic tests, such as radiology reports

MA plans must annually attest that, based on their best knowledge, information, and belief, all risk adjustment information submitted to CMS is accurate, complete and truthful. As part of the provider participation agreement, by submitting claims to CarePlus, physicians and other healthcare providers attest to the accuracy of the data, including diagnosis codes, submitted to CarePlus. Physicians and other healthcare providers are responsible for maintaining an accurate and complete medical record for each Medicare patient and must alert CarePlus to any erroneous data that has been submitted and follow the procedures for correcting such data. Physicians and healthcare providers are responsible for participating in any CarePlus medical record reviews or audits related to coding and documentation, such as the Provider Data Validation (PDV) coding and documentation review.

In addition to facilitating payment accuracy as well as good medical record documentation and coding practices, risk adjustment also helps ensure that MA plan members receive the care they need for their health conditions, and that they are able to take advantage of disease management and other programs available through their MA plans. To improve medical record documentation and coding practices, physicians and other healthcare providers should consider the following suggestions:

- Use an electronic medical records (EMR) system.
- Confirm that all diagnosis codes are included in the claim submission. For professional services, physicians and other healthcare providers should have the capacity to submit 12 diagnosis codes.
- Ensure procedure and diagnosis codes on the form are current when using a superbill, encounter sheet or checkout form.
- Provide full and accurate documentation–ascertain that diagnoses are supported.
- Purchase and use updated coding books or software each year. Make sure the practice management system is kept updated.
- Use a certified coder or health information management professional for coding and billing functions.

For more information, please contact your CarePlus risk adjustment representative.