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Provider Alerts

Important information for our providers

January 21, 2026

Exchange Risk Adjustment Overview and Documentation Guidance

What is Risk Adjustment?

Risk adjustment is a method used by the Centers for Medicare & Medicaid Services (CMS) to account for the overall health and expected medical costs of each individual enrolled in an Exchange plan. CMS uses a disease model to determine a risk "score" for each member. The model takes individual diagnosis codes and combines them into broader diagnosis groups, which are then refined into Hierarchical Condition Categories (HCCs). HCCs, together with demographic factors such as age and gender, are used to predict consumers' total care costs. **That means providers must report consumers diagnosis information every year. The best time to do this is during the consumer's annual physical. During this examination, each diagnosis should be evaluated and documented.**

Tools to help with HCC documentation requirements:

MEAT	TAMPER	SOAP
• Monitor – signs, symptoms, disease progression/regression • Evaluate – test results, medication effectiveness, response to treatment • Assess – ordering tests, discussion, review of records, counseling, refer to another provider • Treat – medications, therapies, other modalities	• Treat – medications, therapies, other modalities • Assess – ordering tests, discussion, review of records, counseling • Monitor – signs, symptoms, disease progression/regression • Plan – what is being done about the patient's condition • Evaluate – test results, medication effectiveness, response to treatment • Refer – sending the patient to another provider for treatment of the condition	• Subjective - experiences, personal views or feelings of a patient • Objective - vital signs, physical exam findings, laboratory data, imaging results, other diagnostic data • Assessment - combination of "subjective" and "objective" evidence to arrive at a diagnosis • Plan - details the need for additional testing, consultation and any steps being taken to treat the patient.
(At least <u>one</u> element of MEAT/TAMPER/SOAP must be documented for each coded condition to qualify for HCCs)		

Guidance for the most commonly missed or incorrectly coded conditions:

Cancer/Malignant Neoplasm Disease – Active/Current vs. Personal History	• Active/Current Malignant Neoplasm - Assign the correct **active** neoplasm code for the primary malignancy until treatment is completed • Personal History Of - When a primary malignancy has been excised or eradicated and there is **no further treatment of the malignancy directed to that site**, and there is **no evidence of any existing primary malignancy**, a

	code from Category Z85
Congenital malformations, deformities and chromosomal abnormalities	• **Assign an appropriate code(s) from categories Q00-Q99**, Congenital malformations, deformations and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented **anywhere** within the note • Codes from Chapter 17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) of the **ICD-10-CM Official Guidelines for Coding and Reporting may be used throughout the life of the patient.**
Diabetes Mellitus: E08–E13 – Report any DM manifestations, including Status Codes	• Diabetic neurological complications (neuropathy) • Other manifestations of diabetes mellitus (renal, ophthalmologic, oral, etc.) • Diabetic circulatory complications (Skin ulcers, gangrene, PVD) • Type 2 diabetic ketoacidosis • Ostomies/Artificial Openings – Colostomy, Gastrostomy, Ileostomy, etc. • Amputation status – Lower Extremities (AKA, BKA, Feet/Toes) • Long Term Insulin Use - Complications due to insulin pump malfunction

Disorders of psychological development: F01-F69	• F10-F09 Mental disorders due to known physiological conditions • F10-F19 Mental and Behavioral disorders due to psychoactive substance use • F20-F29 Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders • F30-F39 Mood (affective) disorders (Bipolar, MDD, Manic Episode, etc.) • F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders • F50-F59 Behavior syndromes associated with psychological disturbances and physical factors • F60-F69 Disorders of adult personality and behavior
CVA, TIA, MI and Other Acute Vascular Conditions – Active/Current in an acute care setting vs. Personal History and Subsequent Care	• **CVA Initial Care -** A CVA is an emergent event that requires treatment in an **acute care setting**. To report CVA, refer to code category: I63.xx Cerebral infarction *4th and 5th digits identify location and cause • **Acute MI** – A new myocardial infarction is considered **acute from onset up to 4 weeks old**. Acute myocardial infarction (AMI) may be reported in the **acute care setting**, following transfer to another acute setting, and in the post-acute setting • **Subsequent Care and Personal History -** Once a patient has completed initial treatment and is discharged from the acute care setting, report as personal history of and any sequelae residual effects

Questions:

Thank you for your participation in our network and your continued commitment to the care of our members. If you have questions about this communication, please contact your Provider Network Account Executive or the Provider Services Department for your state.