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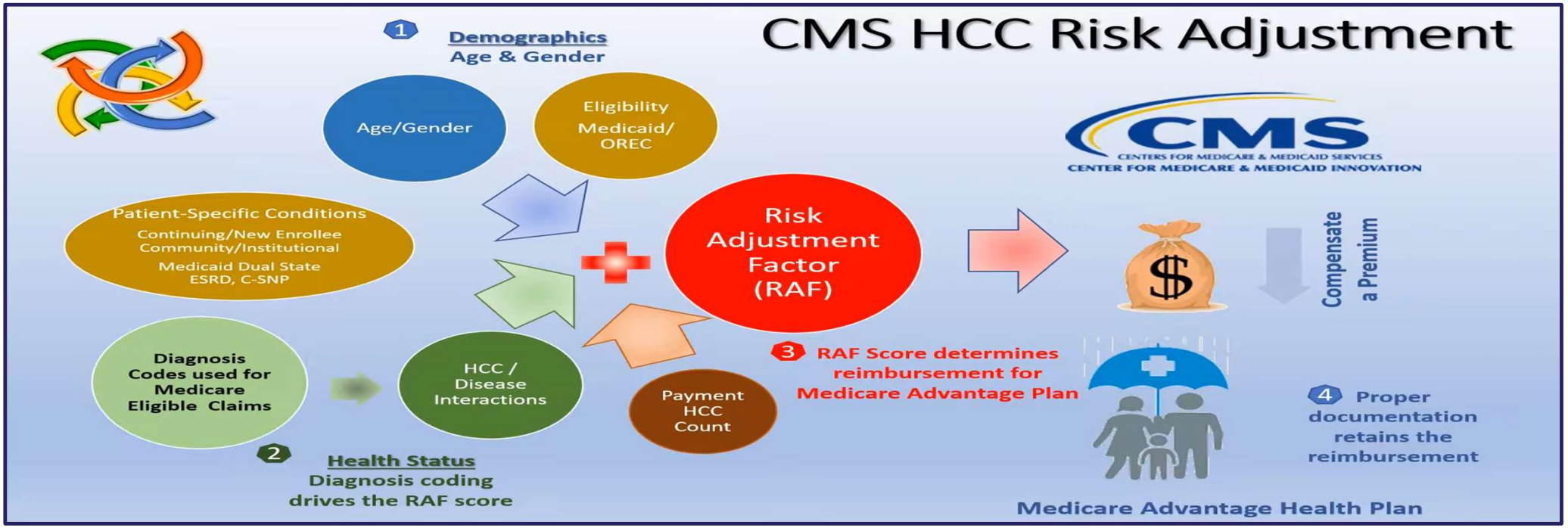
Risk Adjustment Essentials: Leveraging Annual Wellness Visits to Close Chronic Care Gaps

What is Risk Adjustment Methodology?

- A **methodology** used to **calculate** payments to healthcare providers **based on patient's health status**, expected use of **healthcare services**, and **associated care costs**
- Active conditions must be addressed and documented annually during (*face-to-face or qualifying telemedicine*) patient encounter



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CMS-HCC Risk Adjustment Calculator http://hcc.medicareinformatics.com

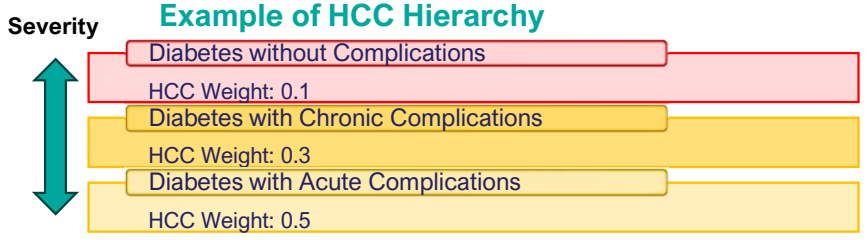
The Impact of Hierarchical Condition Categories (HCC) Codes to Risk Adjustment Factor (RAF)?

- CMS and other payers use these codes to predict future healthcare costs for the members.
- HCCs group serious or chronic conditions (Diabetes Mellitus with complications, CHF, Cancer)
- Each HCC has a weight that contributes to the member's overall risk adjustment factor score (RAF) score
- "Hierarchical: means more severe conditions override less severe ones to avoid double-counting
- Accurate, specific documentation and coding are essential to capture the full picture of a member's health and ensure appropriate reimbursement

Listing of CMS - HCC

CMS-HCC	If the Disease Group is listed in this column…	…Then drop the CMS-HCC listed in this column
	CMS-HCC Hierarchical Condition Category Label	
17	Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	18, 19, 20, 21, 22, 23
18	Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid	19, 20, 21, 22, 23
19	Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers	20, 21, 22, 23
20	Lung and Other Severe Cancers	21, 22, 23
21	Lymphoma and Other Cancers	22, 23
22	Bladder, Colorectal, and Other Cancers	23
35	Pancreas Transplant Status	36, 37, 38
36	Diabetes with Severe Acute Complications	37, 38
37	Diabetes with Chronic Complications	38
62	Liver Transplant Status/Complications	63, 64, 65, 68
63	Chronic Liver Failure/End-Stage Liver Disorders	64, 65, 68, 202
64	Cirrhosis of Liver	65, 68
77	Intestine Transplant Status/Complications	78, 80, 81

Example of HCC Hierarchy



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Best Practice for Accurate Coding & Documentation

To ensure proper risk adjustment and reimbursement, providers should follow these key guidelines:

1. **Document all chronic and active conditions annually**—or during any visit where they impact care.
2. **Link each diagnosis to treatment plans or clinical decisions** to show medical necessity.
3. **Code to the highest level of specificity** following **ICD-10-CM guidelines**.
4. **Avoid vague or unsupported diagnoses** (e.g., “history of” without current relevance).
5. **Ensure documentation reflects the patient’s current health status**, not just past conditions.

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Provider Documentation is a Major Contributor to HCC Capture:

BASIC	D.S.P.
STANDARD	M.E.A.T.
BEST PRACTICE	T.A.M.P.E.R.

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Basic: D.S.P.

D	S	P
Diagnosis	**Status**	**Plan**
Clearly stated by the provider (e.g., “Patient has congestive heart failure”).	Describes the current state of the patient’s condition: stable, uncontrolled, worsening, or improving, or remission (e.g., “Patient is stable”).	Addressed through treatment, monitoring, medication, referrals, or follow-up (e.g., “Patient will follow up with Cardiology”).

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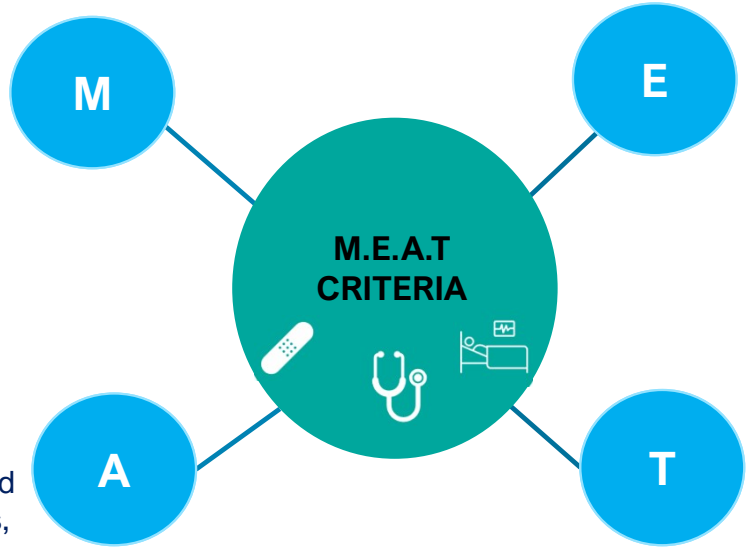
Standard: M.E.A.T Criteria

A problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service which includes consideration of further testing or treatment.

Monitoring
Monitoring signs, symptoms, disease progression, disease regression



Evaluating
Evaluating test results, medication effectiveness, response to treatment

Assessing/Addressing
Assessing or Addressing ordered tests, discussion, review records, counseling

Treating
Treating medications, therapies, other modalities

What Does not qualify:
Pulling in problem list without additional assessment or care coordination documented

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Best Practice: T.A.M.P.E.R.

Capturing the full story of every patient

Treat

The condition is being treated (medications, therapy, surgery, etc.).

Assess

The provider is evaluating the condition through history, exam, or data review

Monitor

The condition is being followed over time with labs, symptoms, or vitals.

Plan

The provider documents a plan of care (follow-up, medication changes, etc.).

Evaluate

Labs, tests, or diagnostics related to the condition are being interpreted.

Refer

The provider refers the patient to a specialist or additional services.

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From Notes to Numbers:

How Documentation Shapes RAF Scores

No Conditions Coded Low Level of Specificity		Some Conditions Coded Moderate Level of Specificity		All Conditions Coded High Level of Specificity	
75 y/o male	**0.502**	75 y/o male	**0.502**	75 y/o male	**0.502**
No DM coded	**X**	Diabetes w/o complications (E11.9 – HCC 38)	**0.166**	Diabetes w/ CKD3A (E11.22– HCC 37)	**0.166**
No CKD coded	**X**	CKD unspecified (N18.9 –No HCC)	**x**	CKD3A (N18.31 – HCC 329)	**0.127**
No CHF coded	**X**	CHF not coded	**x**	Chronic diastolic (congestive) heart failure (I50.32 – HCC 226)	**0.360**
No COPD coded	**X**	COPD (J44.9 – HCC 280)	**0.319**	COPD (J44.9, HCC 280)	**0.319**
No disease interaction	**X**	No disease interaction	**X**	1. Disease interaction (DM +CHF) 2. Disease interaction (CHF + COPD) 3. Disease interaction (CHF + CKD)	**0.112** **0.078** **0.176**
No HCC counts	**X**	3 or more HCC counts	**X**	5 HCC payment counts	**0.050**
Total RAF	**0.465**	Total RAF	**0.987**	Total RAF	**1.89**
	X $800		X $800		X $800
Total Funding PMPM	**$401.60**		**$789.60**		**$1,512**

Assuming an average bid rate of $800 PMPM

High-Risk Diagnosis Groups for Audit

Office of Inspector General (OIG)

Figure: Errors in High-Risk Groups as of November 2023

High-Risk Group	Total	Errors	Error %
Acute stroke	945	908	96%
Acute heart attack	791	751	95%
Embolism	754	593	79%
Lung cancer	391	345	88%
Breast cancer	390	373	96%
Colon cancer	390	368	94%
Prostate cancer	360	322	89%
Potentially mis-keyed diagnosis codes	522	421	81%
Totals	**4,543**	**4,081**	**90%**

The table on the right represents, identified high risks diagnosis from OIG resulting in Risk Adjustment Validation (RADV) audits.

TOOLKIT

To Help Decrease Improper Payments in Medicare Advantage Through the Identification of High-Risk Diagnosis Codes

December 2023|A-07-23-01213

Toolkit To Help Decrease Improper Payments in Medicare Advantage

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Top 10 High-Impact Condition Categories

January – November 2025

Chronic Condition Opportunities (Persistent & Suspected)	Quantity
Diabetes	653
Heart Disease	341
Lung Disease	200
Kidney Disease	148
Psychiatric Disease	131
Neoplasm	118
Metabolic Disease	107
Musculoskeletal Disease	91
Vascular Disease	83
Blood Disease	63
Grand Total	**1935**

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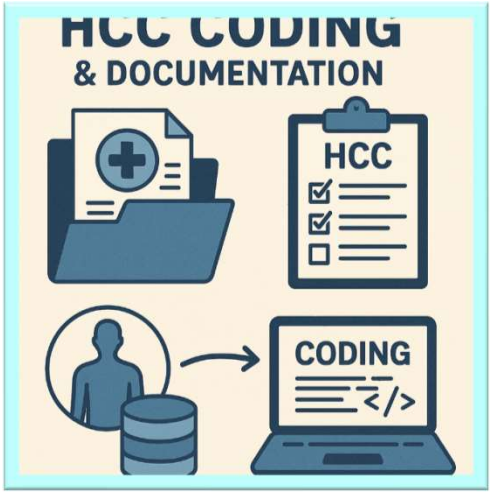
HCC Documentation & Coding Essentials

- **Core Documentation Requirements**
  - Patient's name on every page
  - Date every entry and encounter
  - Use MEAT/TAMPER to support HCC diagnoses
  - Follow disease-specific coding guidelines
  - Include provider signature + credentials (authenticated for electronic signatures)
- **MEAT/TAMPER Quick Reference**
  - **M – Monitor:** signs, symptoms, labs, progression/regression
  - **E – Evaluate:** test results, medication effectiveness, response to treatment
  - **A – Assess:** clinical impressions, ordering tests, patient discussions
  - **T – Treat:** medications, therapies, procedures, referrals
- **HCC-Relevant Status Codes (Map to HCC)**
  - Z21 – Asymptomatic **HIV status**
  - Z89.43 –Z89.6 – Acquired absence of **foot, ankle, & leg above and below knee**
  - Z93 – Artificial **opening status**
  - Z94.0–Z94.4 – **Organ transplant status** (kidney, heart, lung, liver)
  - Z94.81–Z94.83 – **Bone marrow, intestine, pancreas transplant status**
  - Z95.811 – Presence of **heart assist device**
  - Z95.812 – Presence of fully **implantable artificial heart**
  - Z99.1- Dependence of **respirator**
- **Status Codes That Do Not Map (But Still Matter)**
  - Z79.4 – Long-term insulin use
  - Z79.84 / Z79.85 – Long-term diabetes medications
  - Z79.01 – Long-term anticoagulant use
  - Z87.891 – History of nicotine dependence
  - Z96.x – Orthopedic implants
  - Z99.2 – Dependence of renal dialysis
  - Z99.3 – Wheelchair dependence
  - Z99.81 – Oxygen dependence

- **Code All Active Conditions**
  - Code every condition requiring or affecting treatment, monitoring, or management
  - Include chronic conditions even if stable
  - Do not code ruled-out, historical, or unconfirmed conditions
- **Top Documentation Misses**
  - Missing linkage (e.g., diabetes with CKD)
  - Missing severity (HFpEF vs HFrEF)
  - "Stable" without assessment details
  - Chronic conditions not addressed annually
  - Missing ulcer or CKD stage
  - Contradictory documentation
  - Missing reason for refused/contraindicated screenings
  - Missing signature/authentication
- **Quality Measure Documentation Tips**
  - Document reason when screenings not completed
  - Capture fall risk, cognitive screening, depression screening, SDOH
  - Record vaccination status
  - Note care gaps addressed during the visit
- **Claim Submission Essentials**
  - Submit all active ICD-10-CM, CPT, and CPT II codes
  - Ensure diagnoses are supported by MEAT/TAMPER
  - Avoid unspecified codes when specificity exists



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Structure of ICD-10-CM Codes

The Importance of Specificity

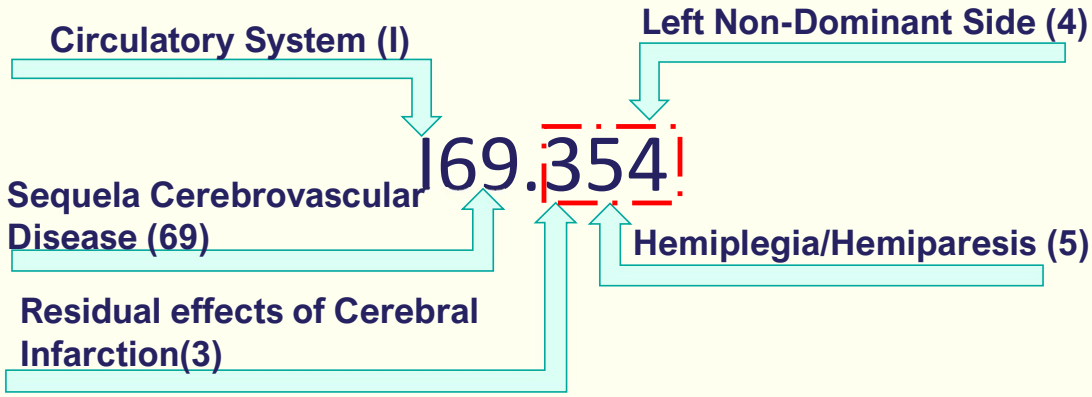
ICD-10-CM codes are **alphanumeric diagnoses codes** made up of **3-7 characters**, and each character has a specific meaning.

1. Character 1 – Letter
   - Always a **letter.**
   - Identifies the **chapter** or **body system** involved
   - (e.g., **E** for endocrine diseases like diabetes; **I** for circulatory system disease)
2. Character 2 – Number
   - Always a **number**
   - Defines the **category** of the condition.
3. Character 3-6 – Letter or Numbers

   These characters provide increasing levels of clinical detail:
   - **Etiology/cause**
   - **Anatomic site or body part**
   - **Severity**
   - (e.g., acute, chronic, unspecified)
   - **Other clinical descriptors**
4. Character 7 – Extension (when required)
   - Used for certain code categories (e.g., injuries, obstetrics).
   - Specifies **episode of care** (e.g., initial encounter, subsequent encounter, sequela).

Example Breakdown

- **I69.354 Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side**



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HCC Documentation & Coding Essentials Cont.

CONDITION	SUPPORTED (Validated)	NOT SUPPORTED (Not Validated)
COPD (HCC 110)	COPD with increased cough and wheezing. O_2 sat 92%. Started prednisone taper and adjusted inhaler regimen. Follow-up in 1 week.	COPD – patient states stable. No exam findings, no treatment changes, no MEAT.
CHF (HCC 96)	Chronic systolic CHF. Mild edema. Weight up 3 lbs. Increased diuretic dose. Reinforced low-sodium diet.	CHF – stable. No symptoms, no assessment of volume status, no medication review.
Diabetes with CKD (HCC 37)	Type 2 diabetes with stage 3 CKD. eGFR 48. Reviewed labs. Continue ACE inhibitor. Reinforced diet.	History of diabetes with CKD. No linkage, no labs, no treatment, CKD not addressed.

Avoiding unsupported diagnoses **prevents overcoding** and protects against **RADV audits findings.**

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Common HCC Conditions by Category & Annual Re-Documentation Requirements

Status Conditions		
HCC	**Condition Category**	**Examples**
HCC 8	**Metastatic Cancer & Acute Leukemia**	Metastatic carcinoma, acute leukemia
HCC 9	**Lung & Severe Cancers**	Lung, pancreatic, ovarian, liver cancers
HCC 10	**Lymphoma & Hematologic Cancers**	NHL, Hodgkin, chronic leukemia
HCC 134	**ESRD / Dialysis**	Z99.2
HCC 135	**Acute Renal Failure**	N17.x
Moderate-Severity Cancers & Organ Disease		
HCC	**Condition Category**	**Examples**
HCC 11	**Colorectal, Bladder, Kidney Cancers**	CRC, bladder, renal cancers
HCC 12	**Breast, Prostate, Thyroid Cancers**	Breast, prostate, thyroid
HCC 136	**CKD Stage 5**	N18.5
HCC 137	**CKD Stage 4**	N18.4
HCC 96	**Heart Failure**	I50.x
Common Chronic Conditions		
HCC	**Condition Category**	**Examples**
HCC 36	**Diabetes w/ Acute Complications**	DKA, HHS
HCC 37	**Diabetes w/ Chronic Complications**	CKD, neuropathy, retinopathy, PVD
HCC 38	**Diabetes w/o Complication**	E11.9
HCC 110	**COPD**	J44.x
HCC 111	**Pulmonary Fibrosis / ILD**	J84.x
HCC 112	**Severe Asthma**	J45.5x (not J45.40)
HCC 115	**Pulmonary Hypertension**	I27.x

These Z-codes count as active chronic conditions and must be assessed, monitored, or managed during the visit.

Behavioral Health & Neurologic		
HCC	**Condition Category**	**Examples**
HCC 57	**Major Depression, Severe**	F32.2, F33.2
HCC 58	**Bipolar Disorder**	F31.x
HCC 59	**Schizophrenia**	F20.x
HCC 71	**Parkinson's / Huntington's**	G20, G10
HCC 72	**Multiple Sclerosis**	G35
HCC 74	**Epilepsy**	G40.x
Metabolic, Nutrition & Other High-Value Conditions		
HCC	**Condition Category**	**Examples**
HCC 48	**Morbid Obesity**	E66.813
HCC 27	**Protein-Calorie Malnutrition**	E43, E44.x
HCC 47	**Rheumatoid Arthritis**	M05.x, M06.x
HCC 54	**Substance Use Disorders**	F11.x, F10.x
HCC 157	**Pressure Ulcers (Stage 3–4)**	L89.13x, L89.14x

Category	Examples	Documentation Requirement
Amputation Status (Z89.x)	**Absence of foot, absence of leg below knee**	Document annually
Organ Transplants (Z94.x)	**Heart, lung, bone marrow, pancreas**	Confirm transplant status
Artificial Openings (Z93.x)	**Ileostomy, colostomy**	Re-document each year
Ventilator/Respiratory Status	**Tracheostomy, ventilator dependence**	Confirm presence; MEAT not required

Disease Interactions (Increase RAF Score)

- **CHF + Diabetes (higher risk, increased monitoring)**
- **CHF + COPD (adds complexity)**
- **CHF + CKD (significant chronic disease burden)**
- **CHF + Arrhythmias (cardiac instability)**
- **Cardiorespiratory Failure + COPD (higher severity)**

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Medicare Advantage Annual Wellness Visit:

Your Gateway to Better Care and Accurate Risk Adjustment

Promote Preventive Health

- Screenings for cancer, diabetes, depression
- Vaccination updates & fall risk checks
- Lifestyle counseling & patient engagement

Improve Documentation & Coding

- Capture chronic conditions accurately
- Support HCC coding for risk adjustment
- Enhance care coordination & quality incentives

Close Care Gaps & Build Relationships

- Identify food insecurity, housing instability
- Connect patients to resources
- Improve outcomes for vulnerable populations

Address Social Needs

- Strengthen provider-patient trust
- Meet HEDIS & CMS quality measures

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AWVs are more than a checkup—they drive quality, compliance, and better outcomes.

Note: Medicare Advantage Payers allow AWV to be completed starting January 1st regardless of last date of completion from previous calendar year.

2026 Annual Wellness Visit – Coding Summary Table

Codes	Description	When to Use	2026 Insights
G0438	Initial Annual Wellness Visit	First AWV in a patient's lifetime	No major 2026 changes
G0439	Subsequent Annual Wellness Visit	Every 12 months after G0438	No major 2026 changes
G0136	Social Determinants of Health (SDOH) Risk Assessment	When screening for housing, food, utilizes, transportation, safety, etc.	**CMS emphasizes integration with AWV workflow in 2026**
G0422	Alcohol misuse screening (annual)	Screening only	Can be paired with AWV
G0443	Alcohol misuse counseling (brief intervention)	When counseling is provided	Must follow screening
G0444	Annual depression screening	PHQ-2/9	Can be performed during AWV
G0446	Intensive behavioral therapy for cardiovascular disease	Counseling for CVD risk reduction	No 2026 changes
G0447	Obesity behavioral counseling	BMI ≥ 30	Covered as preventive service
99497	Advance Care Planning (first 30 min)	Optional add-on during AWV	Patient cost-sharing may apply unless ACP is part of AWV and voluntary
99498	ACP, each additional 30 min	Add-on to 99497	Same rules as above
G2211	Visit complexity add-on	When AWV is paired with a medically necessary E/M	**Expanded in 2026 to include home/residence E/M visits**
99406 / 99407	Tobacco cessation counseling	When counseling provided	No 2026 changes
99401–99404	Preventive counseling (individual)	Lifestyle, risk-factor counseling	Not AWV-specific but often paired
99408–99409	Alcohol/substance misuse structured assessment	When using validated tools	Not part of AWV but can occur same day

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Thank you for your time today.
For any questions, please feel free to reach out to:

For inquires/questions please email at:
riskadjustmenthelp@peakhealth.org

APPENDIX

Definitions of Terms

Terms	Description
Hierarchical Condition Categories (HCC)	HCCs are **groups of related medical conditions** used by Medicare to estimate how sick a patient is. If a patient has several conditions in the same group, **only the most serious one counts**. These groups help Medicare figure out how much care someone might need and how much it might cost. **Each HCC is assigned a relative factor** that is used to produce risk scores for Medicare beneficiaries, based on the data submitted in the data collection period.
Risk Adjustment Factor (RAF)	A **RAF score** is a number that shows how sick a person is, based on their health problems and age or gender. Medicare uses this score to **predict future healthcare costs** for each patient and to adjust payments to health plans accordingly
Medicare Advantage (MA) Plan	Also called **Part C**, a Medicare Advantage Plan is a type of Medicare coverage run by **private insurance companies**. It includes everything from hospital and doctor coverage (Parts A & B) and often adds extras like **dental, vision, and prescriptions**. Medicare pays these plans based on how sick their members are (using the RAF score), so they are **financially responsible** if care costs more than expected. CMS pays MA plan a **monthly premium** that estimated using RAF scores for their population.
Medicare Accountable Care Organization (ACO)	An ACO is a **team of healthcare providers** (doctors, hospitals, etc.) that work together to take care of Medicare patients. They try to **improve care and lower costs**. If they save money while keeping patients healthy, they get to keep part of the savings. If they spend more than expected, they may have to **pay money back to Medicare**.

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