



## Aetna Better Health® of New Jersey

### Top 10 Tips

#### Risk Adjustment Coding and Medical Documentation

#### **1 Document every page**

Include patient's name and date of service on each page of the medical record.

#### **2 Capture each diagnosis**

Five+ diagnosis codes for every visit represents "best practice" documentation.

#### **3 Be specific**

Document all diagnosis codes to the highest level of specificity.

#### **4 Add assessment and treatment plans**

Include assessment and treatment plans for each diagnosis (i.e. Assessment: Improved – Treatment Plan – Discontinue Medication).

#### **5 Ask about past conditions**

Reaffirm and document prior chronic conditions reflected in past visit notes during every visit.

#### **6 Be thorough**

For each condition noted, documentation must support that the physician Monitored, Evaluated, Assessed/Addressed, Treated (MEAT).

#### **7 Close gaps in care**

Include notes on any areas in need of assessment, evaluation or screening.

#### **8 Sign on the dotted line**

Ensure physician signature, credentials, and date are included to authenticate medical record.

#### **9 Use all tools available**

Utilize and provide Clinical Documentation Improvement (CDI) alerts from your EMR system.

#### **10 When in doubt, document**

The more information – the better – to ensure proper documentation of the medical record.

Proper coding and documentation: it's a win-win for physicians and health plans, ensuring:

- Appropriate reimbursement
- Accurate claims data
- Increased specificity to identify patients for disease and care management programs
- More comprehensive descriptions of patients' health and conditions



Aetna Better Health  
of New Jersey proudly  
serves NJ FamilyCare  
members statewide.

.....

Contact us today at

**1-855-232-3596**

**AetnaBetterHealth.com**  
**/NewJersey**