Make Your Chart a Work of Art

A Primer in Clinical Documentation Improvement

October 28, 2026

Indian Health Service
California Area
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Objectives

- Understand the role and impact of accurate clinical documentation.
- Identify key components of high-quality medical documentation.
- Understand basic coding guidelines by disease.
- Avoid common documentation errors
- Apply best practices for improving documentation quality

So Why Is Clinical Documentation Important?

The ‘Creep’

Accountable care

Innovation

Transitional Care Management

Medicare Advantage

ANNUAL WELLNESS VISITS

Higher clinical complexity → more HCC's → higher RAF → higher benchmark/payment.

↑RAF + TCM + ↓ER/HOSPITAL UTILIZATION + Advanced care planning = SHARED SAVINGS

Clinical Example:



History of the Present Illness

84-year-old woman reports shortness of breath on minimal activity. Recent BNP 1065. Her HGBA1C is 8.2. Activity limited due to dyspnea. Sleeps in the recliner with head elevated. Since starting diuretic, she's lost 10 pounds and feels better. She denies chest pain but reports increasing palpitations.

Physical Exam

Pulse: 80, irregularly irregular, BP 132/70. BMI 41. JVP is normal; Carotids: no bruit. Heart S1, S2, IRR IRR, no murmur. Lungs: clear. Extremities: no edema; ulcer L great toe.

ECG: Atrial fibrillation, rate 96 BPM; Nonspecific ST and T-wave abnormalities.

"Providers know the patient is complex, but the note doesn't show it."

Partial Reporting		Accurate/Complete	
84 YR old female		84 YR old female	
Dual Eligible		Dual Eligible	
Type II, circulatory compl	**0.346**	Type II, with ulcer	**0.853**
CHF, unspecified	No RAF	CHF chronic diastolic	**0.355**
		DM + CHF interaction	0.205
Obesity unspecified	No RAF	Morbid Obesity BMI>40	**0.41**
Palpitations	No RAF	Atrial Fibrillation, chronic	**0.369**
		CHF + arrythmia interaction	0.2
Demo Score	Demo 0.739	Demo Score	Demo 0.739
RAF	**0.346**	**RAF**	**1.723**
Total	**1,085**	**Total**	**3.381**
Annual pymt	**$9,765**	**Annual pymt**	**$30,429**

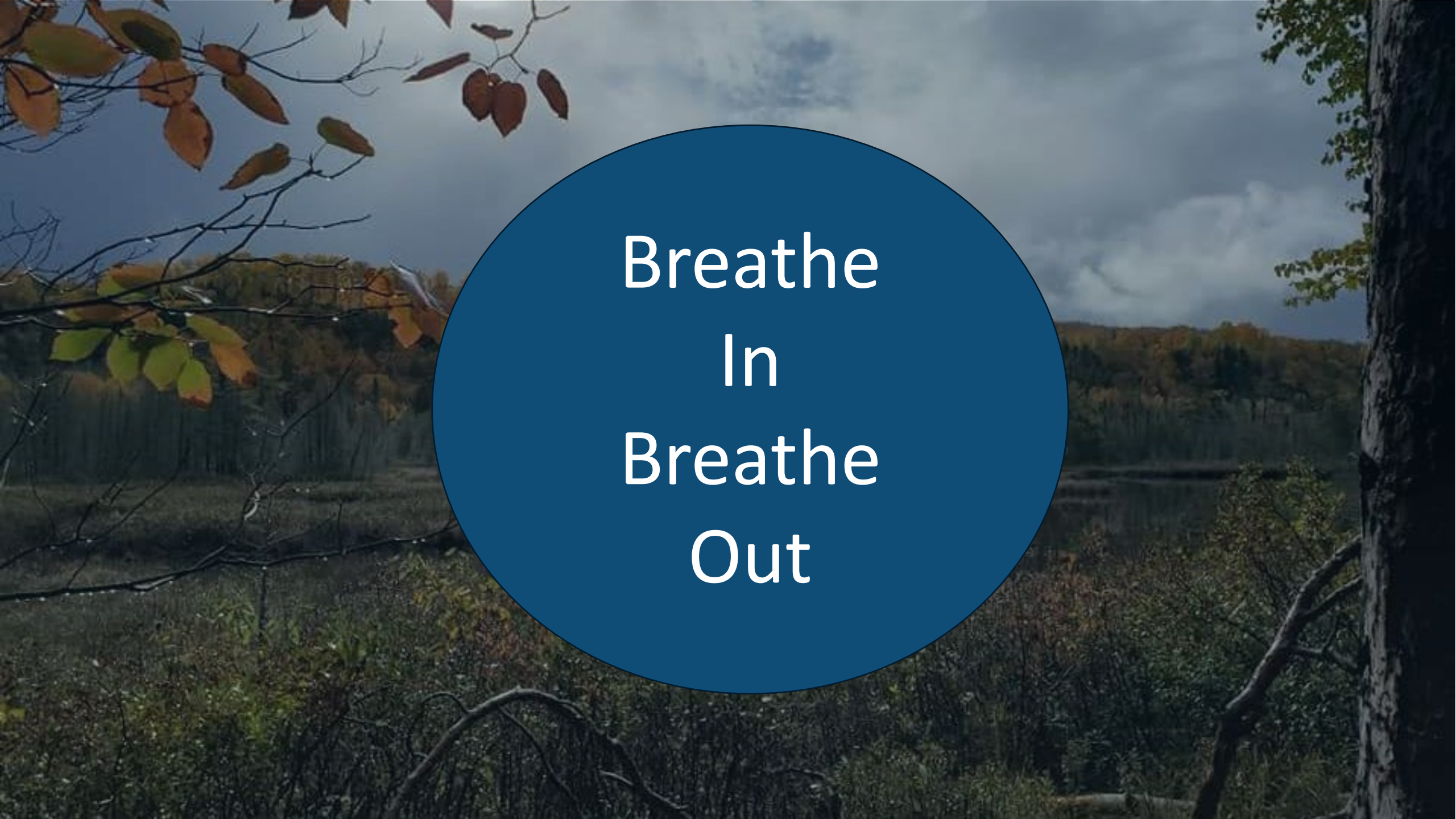
HCCs Present*

1. Atrial fibrillation
2. PVD with ulcer
3. Morbid obesity
   - Qualifies at BMI 35 w/ DM
4. Type 2 DM
   - Complicated by cardiomyopathy
5. Diastolic HF

*supported by documentation

PMPY Payment

$9,765 → $30,429

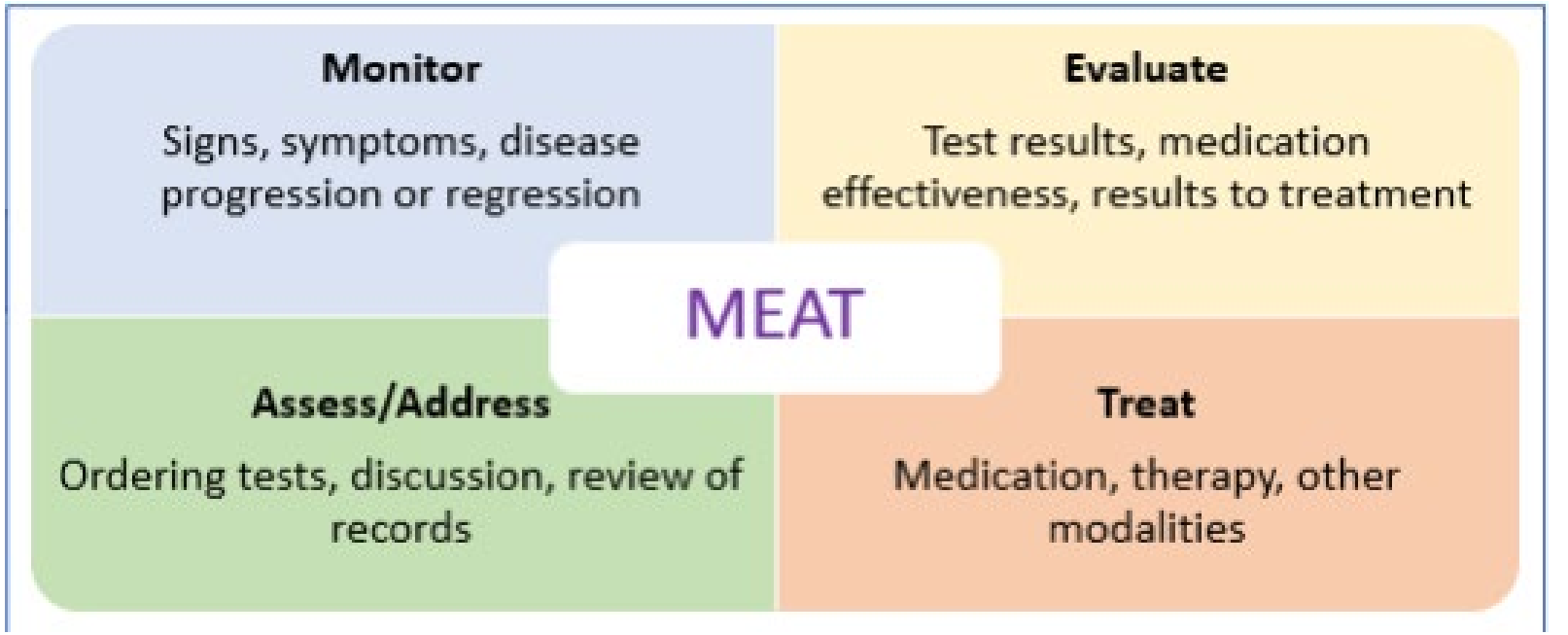

Breathe
In
Breathe
Out

Visit Planning

Optimizing your documentation

- If you requested records and/or any results, normalize that your back office staff are following up to ensure that you have what your need for the visit.
  - While rooming patients should be asked if they have been to urgent care, the ER or in the hospital recently
    - Then you staff gets the ROI signed and requests those records ASAP
    - Patients should be educated that you not only want to see them within a few days of these events, but that they are to bring in that paperwork
  - Medication reconciliation every visit – while waiting to be roomed
  - Incorporate prevention in every visit, episodic and well (all vaccines due/all cancer screening due, it takes 2-5 minutes)

MEAT "We like it well done, not rare!"



Providers know the patient is complex. The note doesn't show it. Retrospective review keeps finding conditions that were there along. Coding team are chasing post-visit clarification constantly.

Documentation in Action

Every Problem, Every Visit

Diagnosis: “Type 2 diabetes mellitus…”

Stable/Unstable: “Stable: HgbA1C 6.7”

Medications: “Metformin XL 750 mg daily, tolerating well, no issues or concerns with SE’s, etc…”

Who is managing this diagnosis: “***Under the regular and close supervision of*** endocrinology Dr. Jou – next visit December 12, 2026” – will send todays notes.”

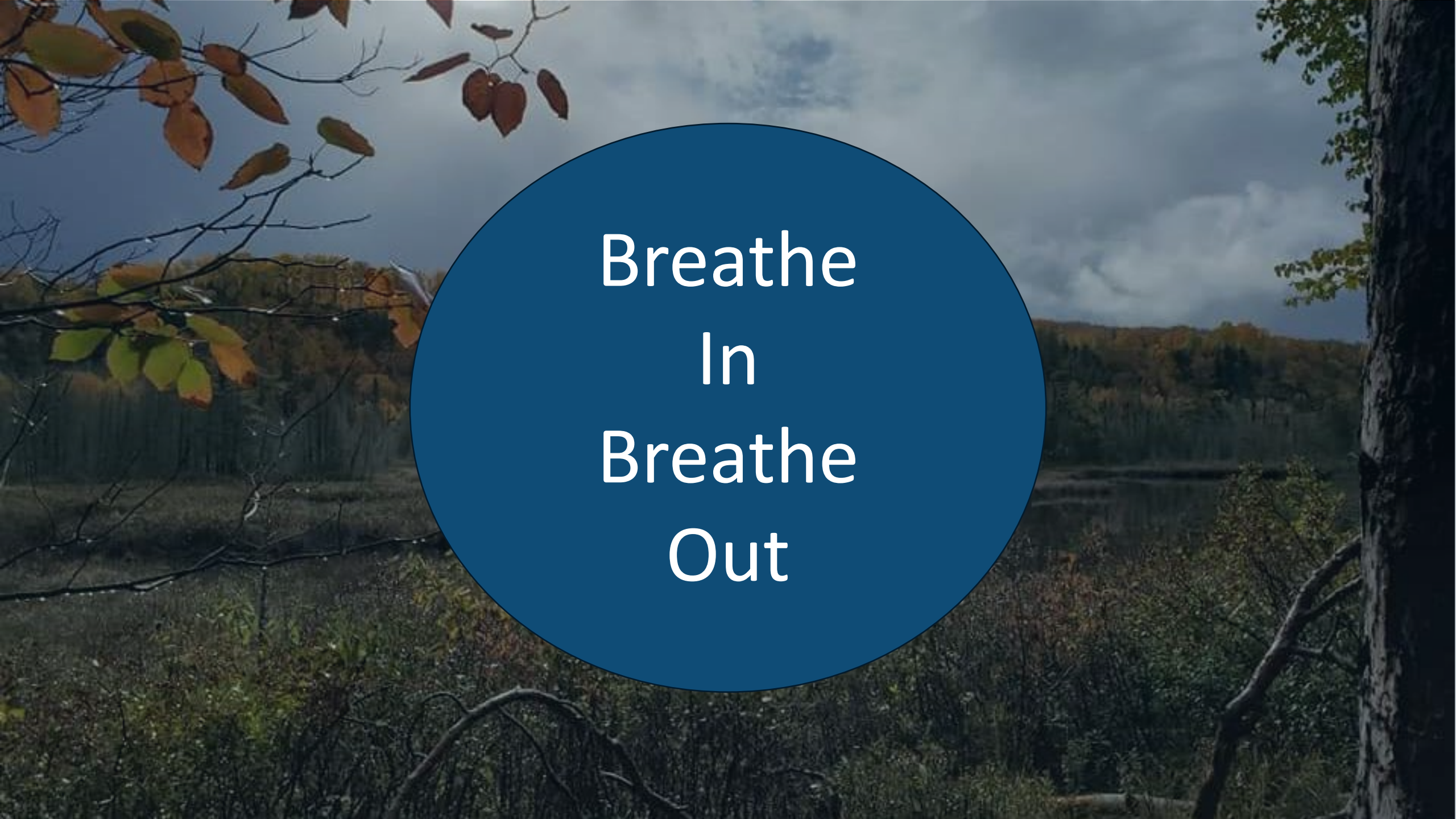
Plan: “Will continue to monitor, patient educated on s/sx’s to report, next appt with endocrinology as above, referral to CDE, podiatry, dental and ophthalmology; next fasting labs due 1 week prior to next visit: cbc, cmp, UACR, HGBA1C, lipids, B12. next visit 6 months. “

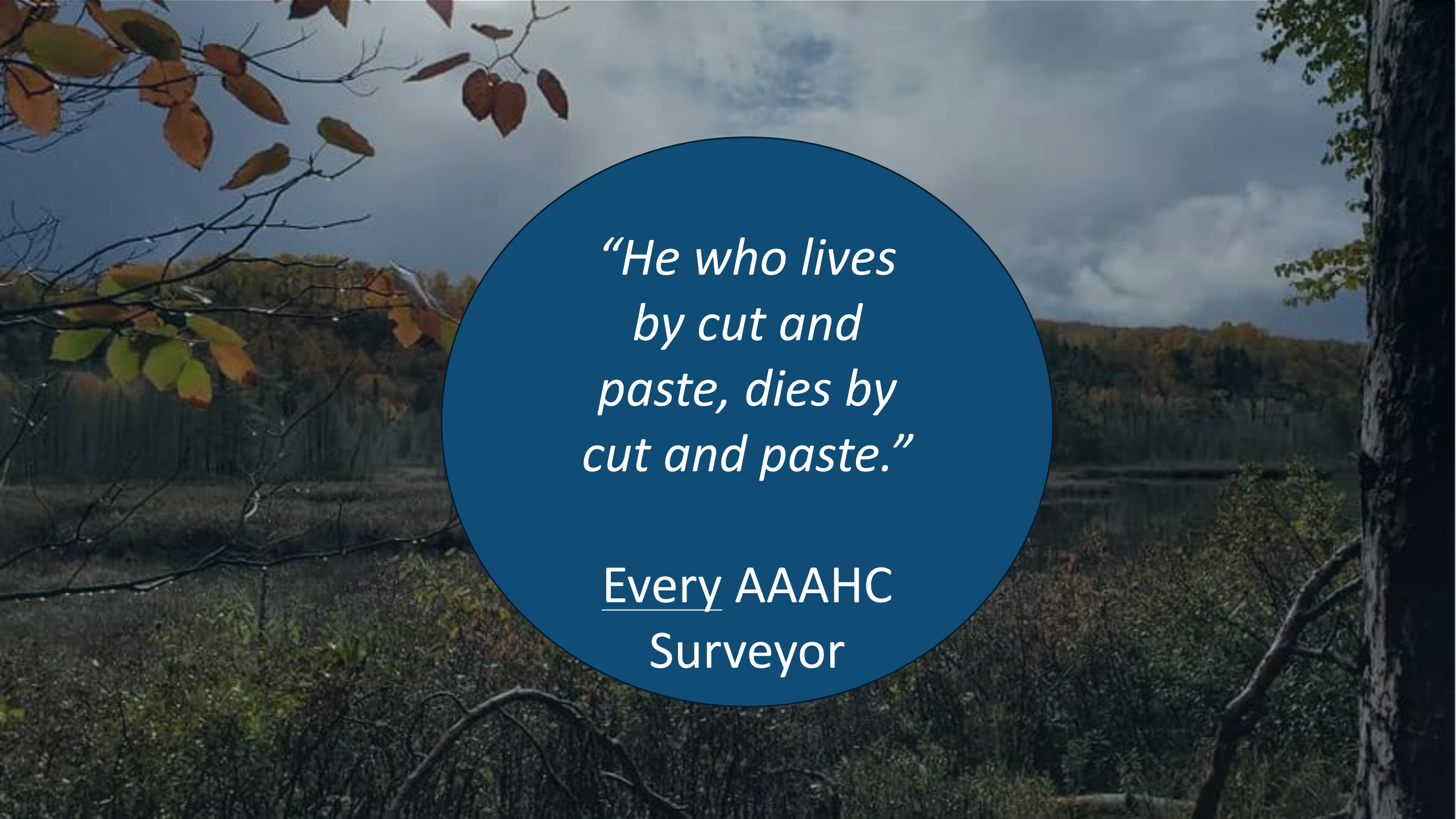
PCP Clinical Documentation Example



Assessment and Plan

1. Diastolic HF with preserved EF, *compensated. Stable*. *Under close and regular supervision of cardiology.* Meds: Lasix, Metoprolol. VSS. Last EF dated 12/1/2025 60%. Last BNP dated 12/1/2025 1065. Continue to monitor daily weights – notify of increased weight > 5lbs, worsening DOE or peripheral edema, keep all specialty appointments. F/u appointment in 1 month. Will continue to monitor.
2. Atrial Fibrillation. Stable. Under close and regular supervision of cardiology. Meds: Metoprolol, new anticoagulant. HAS-BLED low risk. Last ECG 12/1/2025 Afib with nonspecific ST and T wave abnormalities. Patient education provided regarding anticoagulant safety, when to notify PCP/cardiology/ go to ER – handout given. F/u appointment in 1 month. Will continue to monitor.
3. DM with Peripheral Circulatory Disorder, unstable. Under close and regular supervision of endocrinology, new left great toe ulcer – stage III +rest pain, no drainage present; has already been referred to wound care, ABI and TBI ordered and pending results. Meds: none. Patient and family education on s/sx's of infection to report. Keep all specialty appts. F/u appointment in 1 month. Will continue to monitor.
4. Morbid Obesity with BMI >40 with hypertension and DM. Unstable. Meds: none at this time. Under close and regular supervision of endocrinology. Will continue to monitor.
5. Fall risk. Stable. Meds: none at this time. Referral to physical therapy and PHN/CHR for home safety fall risk prevention. Will continue to monitor.
6. Advanced care planning discussion. Stable. POLST completed, patient wishes to be DNR, has discussed with her family. POLST completed/signed/copy in chart. Copy of note and POLST forwarded to cardiology/endocrinology. Patient education where to place in home. Emotional support provided. Will continue to monitor.


Breathe
In
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Out


“He who lives by cut and paste, dies by cut and paste.”
Every AAAHC Surveyor

Program Review

AAAHC Chart Review Standards - Diabetes

Diabetes Medical Records Audit **Reviewer Name:_ ANNA KNIGHT**
Date:10/16/2025

INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Physical Examination												
Documentation of allergies, vital signs, height, weight, and BMI; skin, **growth/pubertal development in children and adolescents**, review of systems, EENT, pain, onset, location and intensity of pain; **LMP** as indicated at Initial visit, follow-up visit, annual visit as indicated	✓	✓	✓									
Documentation of mental/behavioral screening, include depression, anxiety, disordered eating, bullying at initial visit, annual visit or as needed	✓		✓									
Documentation of Last Dilated or Retinal eye exam	✓		✓									
Documentation of oral health status, include oral exam or referral to a Dentist at Initial visit or annual visit as indicated	✓		✓									
Documentation of Comprehensive foot exam- include evaluation of sensation and vascular status, assessment of nails, skins, ulcers	✓	✓	✓									

Diabetes Medical Records Audit Reviewer Name:_ ANNA KNIGHT
Date:10/16/2025

INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
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Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Medical History												
Documentation of Diabetes history (family history, type, characteristics at onset e.g. age, symptoms; review of previous treatment regimens and responses; assess frequency/cause/severity of past hospitalizations)at Initial visit	✓											
Documentation of Personal history- comorbid conditions, celiac disease screen in children with type 1, HBP or abnormal lipids, presence of hemoglobinopathies or anemias, macrovascular and microvascular complications)at initial visit or as indicated.	✓											
Documentation of Interval history at Follow-up visit or Annual Visit. (changes in medical/family history since last visit)**.change in physical activity** and sleep pattern		✓	✓									
Behavioral Factors												
Documentation of tobacco, alcohol, and substance use screen at Initial visit, follow-up visit, or annual visit if indicated	✓		✓									
Medications and Vaccinations												

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									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Documentation and assessment of current medication regimen and adherence (e.g. medication-taking behavior, medication intolerance or side effects, complementary and alternative medication use)	✓	✓	✓									
Documentation of vaccination history and needs e.g. **influenza** as indicated												
Education and Referral												
Documentation of education on self-management, lifestyle changes, other as needed	✓		✓									
Referral to sub-specialty- e.g. podiatry; endocrinology; nutritionist; ophthalmologist at Initial visit, every follow-up visit, or annual visit as indicated	✓	✓	✓									
Social Life Assessment												
Documentation of Social network (e.g. existing social supports, identify surrogate decision maker, advanced care plan, identify social determinations of health) at Initial visit, follow-up, or annual visit	✓	✓	✓									
Laboratory Evaluation												

Diabetes Medical Records Audit Reviewer Name:_ ANNA KNIGHT
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									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Documentation of FBS, eAG, A1C testing: at Initial visit, follow up, annual visit (A1C results within the past 3 months or as ordered)	✓	✓	✓									
Documentation of kidney functions include: serum creatinine, BUN & estimated glomerular filtration rate (eGFR) at Initial or annual visit or as indicated by previous findings if indicated	✓	✓	✓									
Documentation of Thyroid-stimulating hormone in patients with type 1 diabetes was ordered at Initial or annual visit or as indicated by previous findings as indicated by previous findings if indicated	✓	✓	✓									
Documentation of Vitamin B12 test was ordered if patient is on Metformin(when indicated)at Initial or annual visit or as indicated by previous findings if indicated	✓	✓	✓									
Documentation of serum potassium levels was ordered in patients on *ACEs inhibitors, **ARBs, or ***diuretics at Initial or annual visit or as indicated by previous findings if indicated	✓	✓	✓									
Documentation of Lipid profile was ordered including total LDL, HDL cholesterol, and triglycerides at Initial or annual visit or as indicated by previous findings if indicated	✓	✓	✓									
Documentation for Liver function test was ordered (if not performed/available within the past year)at Initial or annual visit or as indicated by previous findings if indicated	✓	✓	✓									

Program Review

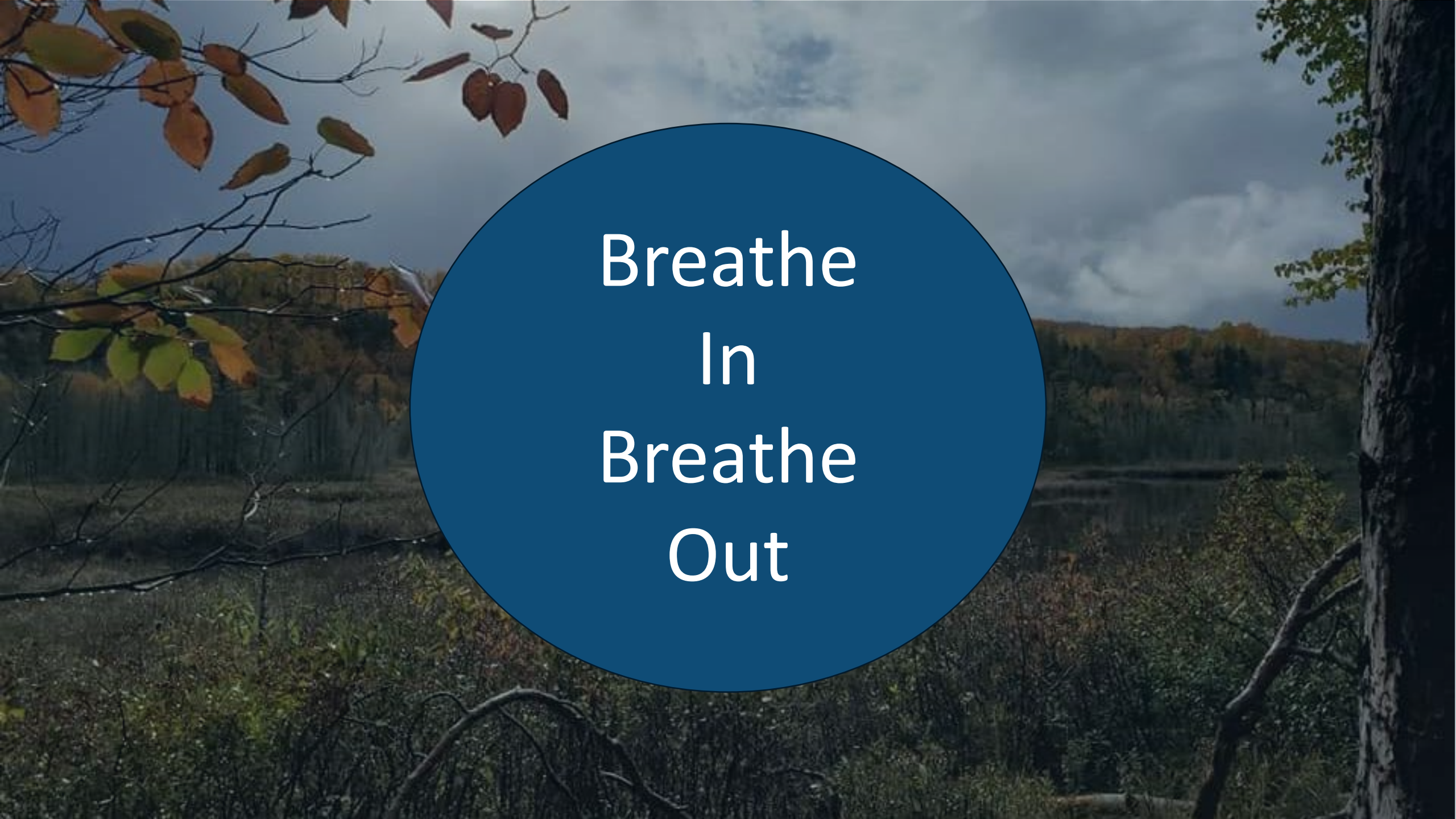
AAAHC Chart Review Standards - Obesity

Obesity Medical Records Audit	Reviewer Name:										Date:	
INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Documentation of blood pressure	✓	✓	✓									
Documentation of assessment for obesity symptoms or complications	✓	✓	✓									
Documentation that underlying disease has been ruled out (examples include hypertension, DM, Gall Bladder Disease, Gout, and Coronary Artery Disease, Thyroid disease)	✓											
Documentation of mental/behavioral screening, (include depression, anxiety, disordered eating, bullying, abuse, ADHD) at initial visit, annual visit or as needed	✓	✓	✓									
Documentation of Current Medications (including obesogenic medications)	✓	✓	✓									
Medical History												
Documentation of Family History (include obesity, Type 2 Diabetes, cardiovascular disease, hyperlipidemia, hypertention, and NAFLD)	✓											
Documentation of Medication History (including obesogenic medications)	✓											

Obesity Medical Records Audit	Reviewer Name:											Date:
INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Documentation of Personal history including ALL of the following: eating/nutrition, physical activity, recreational screen time, and sleep behaviors or routines	✓	✓	✓									
Behavioral Factors												
Documentation that member received education on nutrition/diet/weight management (healthy eating, portion control, meal frequency, physical activity) at Initial visit, follow-up visit, or annual visit as needed	✓	✓	✓									
Documentation of interval history, change in physical activity and sleep behaviors at Initial visit, follow-up visit, or annual visit if indicated	✓	✓	✓									
Documentation that one behavioral goal was set or renewed	✓	✓	✓									
Documentation that progress was assessed on previous behavioral goals (if applicable), including: (reassessment of relevant behaviors and an assessment or discussion of relevant barriers or facilitators)	✓	✓	✓									

Obesity Medical Records Audit	Reviewer Name:											Date:
INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Medications and Vaccinations												
Documentation of treatment or medication(s) therapy at Initial visit, follow-up visit, or annual visit as indicated	✓	✓	✓									
Documentation of evaluated response to treatment/medication therapy regimen and adherence (e.g. medication-taking behavior, medication intolerance or side effects. If no pharmacological treatment, documentation of response to lifestyle changes/alternate therapy. - Initial visit, follow-up visit, or annual visit	✓	✓	✓									
Education and Referral												
Documentation of plan for a return appointment, referral, or phone contact for continued obesity treatment was made	✓	✓	✓									
If patient is 12 years or older and is assessed as obese (BMI > or = to 95th percentile), documentation that weight loss pharmacotherapy was discussed as an adjunct to health behavior and lifestyle treatment	✓	✓	✓									

Obesity Medical Records Audit	Reviewer Name:											Date:
INDICATORS	ASSESSMENT TIMEFRAME			MEDICAL RECORDS					Numerator	Denominator	Percent	
									(A)	(B)	(C)	
Criteria	Initial Visit	Follow - Up Visit	Annual Visit	1	2	3	4	5	Total # of charts compliant with indicators	Total # of charts audited	Percent of charts meeting standards	Comments
Referral to sub-specialty at Initial visit, follow-up visit, or annual visit as indicated. (possibly includes nutrition, public health nursing, orthopedist, etc)	✓	✓	✓									
Documentation that provider followed up regarding multidisciplinary obesity treatment visits that were recommended, including verifying attendance and discussing outcomes												
Social Life Assessment												
Documentation that Social Determinants of Health were assessed (food security, economic security, or adverse childhood experience)	✓		✓									
Laboratory Evaluation												
Documentation of Lipid Panel	✓	✓	✓									
Documentation of Glucose												
Documentation of AST/ALT	✓	✓	✓									
Documentation of Hemoglobin A1c	✓	✓	✓									


Breathe
In
Breathe
Out

Alcohol and Drug Use and Abuse with Complications

Classify: continuous/episodic/in remission

Assess history of overdose:

- How many
  - Consider cognitive evaluation for hypoxic brain injury
  - Did resuscitation include compressions?

Comorbid conditions:

With anxiety
With sexual dysfunction
With sleep disorder
With mood disorder

Document use and advisory/assistance/referral

Acute Myocardial Infarction

- STEMI
- NSTEMI
- DATE IF KNOWN (still acute if within 28 days)

- Location
  - Anterior wall (left main, LAD, other)
  - Inferior wall (RCA, other)
  - STEMI (specific site/vessel)
  - Other sites

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Anemia

Document type (if known):

- Aplastic (drug induced, idiopathic, etc)
- Blood loss (acute, chronic, postoperative)
- Hemolytic (enzyme disorder, thalassemia, etc)
- Nutritional deficiency (iron, Vitamin B12, folate, protein, etc)

Document cause:

- Neoplastic
- CKD

Document: Medications with response, stable/unstable, under close and regular supervision of who/when

Document any:

- Alcohol or drug use/abuse/dependence or past history
- If medication relate: name of med/drug with purpose of use

Atrial Fibrillation/Atrial Flutter

Document:
- Paroxysmal
- Persistent
- Chronic

A Flutter:
- Typical
- atypical

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Cerebral Infarction & Occlusion

Document etiology:
- Embolus, thrombosis, occlusion or stenosis

Document laterality:
- left
- Right

Document:
- TPA administration

Artery affected:
- Pre-cerebral
- Vertebral, basilar
- Carotid
- Cerebral artery (middle, anterior, posterior, cerebellar)

If history of CVA:
- Document deficits (ie hemiparesis)
- Document laterality

Document any related deficits:
- Right or left hemiparesis, aphasia, seizure, etc

Document side dominance

Specify if intraperative or post-procedural complication

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Chronic Obstructive Pulmonary DZ

Document acuity:
- Acute, exacerbation/decompensated
- Chronic (AND obstructive)

Document:
- With acute lower respiratory tract infection (specify type)
- Oxygen dependence

Document if with respiratory failure (with severity):
- Acute respiratory failure
- Chronic respiratory failure
- Acute on chronic
- Include hypoxia and/or hypercapnia

ICD!) require that use of tobacco products or history of exposure to tobacco smoke be documented in patients with COPD

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Congestive Heart Failure

NIH S/SX'S OF CHF:

SYMPTOMS:
- DYSPNEA
- ORTHOPNEA
- PAROXYSMAL NOCTURNAL DYSPNEA
- LETHARGY/FATIGUE
- WHEEZE
- ANKLE SWELLING
- ANOREXIA

SIGNS:
- CACHEXIA & MUSCLE WASTING
- TACHYCARIDA
- WHEEZE
- THIRD HEART SOUND
- EDEMA
- HEPATOMEGALY
- ASCITES

Document acuity:
- Acute
- Chronic
- Acute on chronic

Type:
- Systolic (include EF – preserved)
- Diastolic
- Systolic and diastolic

Etiology:
- Dilated cardiomyopathy
- Hypertension
- Chronic kidney disease

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Major Depression

Classify:

- Mild
- Moderate
- Severe with out mention of psychotic behavior
- Severe, specified as with psychotic behavior

Major depression recurrent:

- In partial or unspecified remission
- In full remission

PHQ9 > 10

5 of 9 DSM IV criteria

SIGECAPS (sleep, interest, guild, energy, concentration, appetite, psychomotor changes and suicidal ideation plus a depressed mood)

If a patient is stable on medication – depression is still present it's just stable/in remission

Under close and regular supervision of:

Diabetes Mellitus

Type:
- Type I , II, or other specified
- Long term use of insulin for type II
- Secondary DM and any underlying condition, drug or chemical cause (i.e. steroid induced)

Document associated conditions:
- PVD with or without ulcer
- Nephropathy
- Neuropathy

Special:
- Insulin underdosing or overdosing r/t insulin pump malfunction
- With hypoglycemia with or without coma
- With hyperglycemia

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Drug Underdosing

Document:

- Intentional
- Unintentional
- Non-compliant

Reason:

- Financial hardship
- Age related dementia

Hypertension

Document:

- Primary essential
- Secondary to

Link hypertension to :

- Cardiac: hypertensive heart disease
- Kidney: document correlation with stage of CKD/ESRD

Document any tobacco use, abuse, dependence or exposure and advise/assist/refer

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

CKD

Acute kidney injury/acute renal failure:

- Acute tubular, cortical, medullary necrosis
- Post-procedural
- Post-traumatic

Chronic kidney disease:

- Specify stage with labs (eGFR/UACR/Cystatin C – especially with liver dz/amputations)

Document:

- Associated underlying condition
- Dialysis status
- Transplant status

Dialysis and noncompliance with dialysis should be documented by the provider when present.

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Pneumonia

Document type:
- Bacterial (specify specific organism)
- Viral
- Aspiration
- Fungal
- Ventilator associated

Document associated conditions:
- HIV
- Influenza
- Sepsis
- Etc.

Document any tobacco use:
assess/advise/assist/refer

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Pressure Ulcers vs Wounds

Provider must document diagnosis

- Type
- Site and stage (I – IV and unstageable)
- Location
- laterality

Document POA status

STABLE/UNSTABLE

MEDICATIONS with response, reconciliation, ensure no duplications

Labs results/pending/monitoring

Under regular supervision of who and next scheduled visit

Diagnostic results

Complications with devices/grafts/implants

Types of devices:

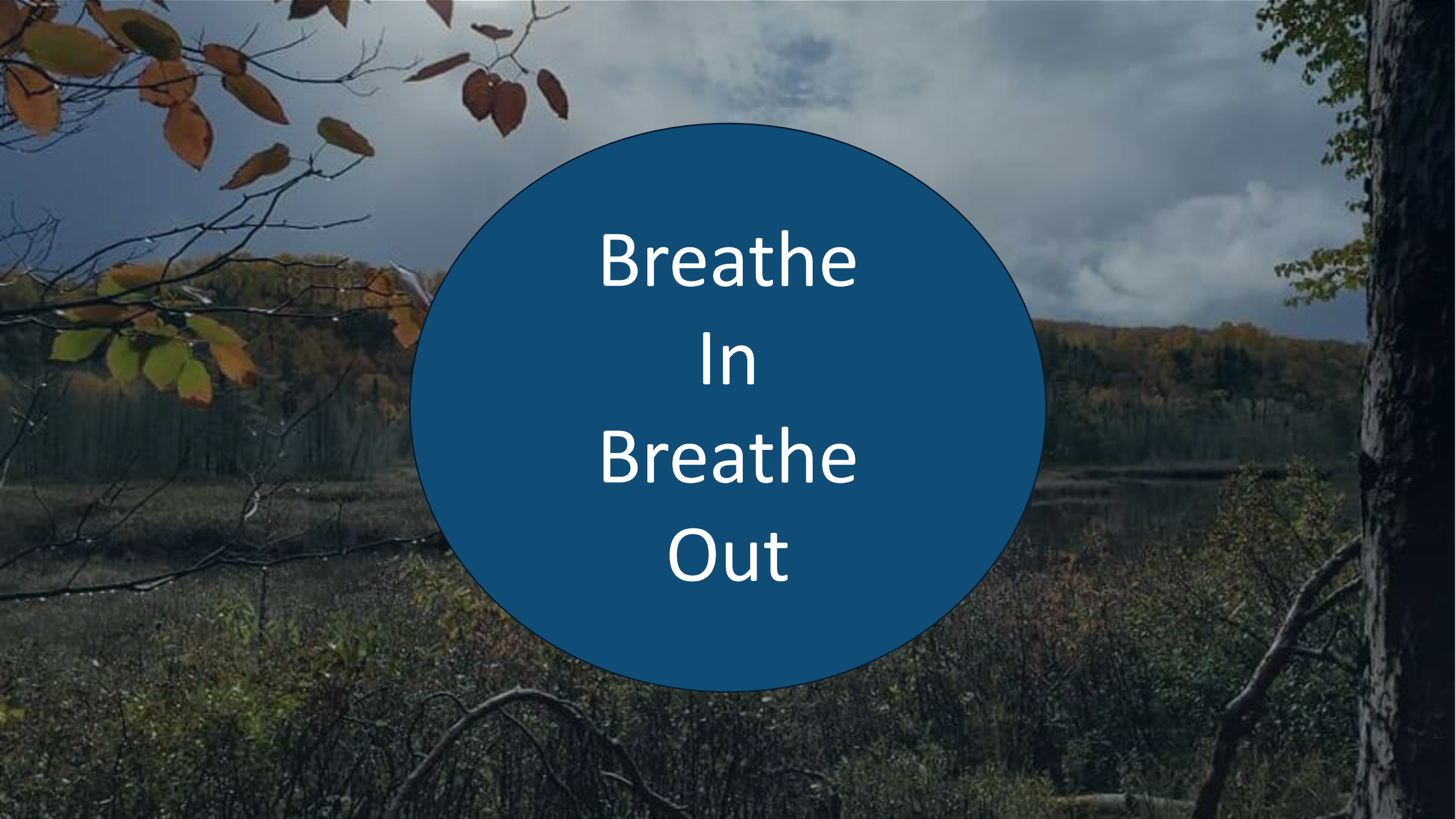
- Cardiac
- Vascular
- Nervous system
- Indwelling catheter
- Internal joint prosthesis
- Internal orthopedic devise
- Internal prosthetic
- Dialysis device

Types of complications:

- Occlusion
- Embolism
- Fibrosis
- Hemorrhage
- Pain
- Stenosis
- Thrombus
- Infection
- inflammation

Status Codes:

Any Artificial Opening	Any Transplant Status	Surgical Amputations	Traumatic Amputations
Gastrostomy	Heart	BKA	Partial
Colostomy	Kidney	AKA	Complete
Tracheostomy	Bone Marrow	Foot	Upper
Ileostomy	Liver	Toe	Lower
Cystostomy	Lung		
Supra-pubic Cath			
Nephrostomy			


Breathe
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References

Carlin CS, Feldman R, Jung J. The mechanics of risk adjustment and incentives for coding intensity in Medicare. Health Services Research. 2024;59(3):e14272. PMCID: PMC11063086. MedPAC

Centers for Medicare & Medicaid Services (CMS). ACO REACH and Kidney Care Choices Models: PY2025 Risk Adjustment. 2024–2025. CMS

Centers for Medicare & Medicaid Services (CMS). Advance Notice of Methodological Changes for Calendar Year 2024 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Fact Sheet). CMS Newsroom; 2023–2024.

Centers for Medicare & Medicaid Services (CMS). Risk Adjustment. CMS.gov. Accessed 2025. Becker's Payer Issues | Payer News

Curto VE, Politzer E, et al. Coding intensity variation in Medicare Advantage. Health Affairs Scholar. 2025;3(1). (Cited in MedPAC 2025 coding intensity review.) MedPAC

Emerson J. Medicare Advantage coding differences drove $33B in extra payments: Study. Becker’s Payer Issues. April 16, 2025. Summarizing a study published in Annals of Internal Medicine on differential coding and MA payments. Becker's Payer Issues | Payer News

Johnson A. Coding Intensity in Medicare Advantage and Part D. MedPAC public meeting presentation; June 2025. MedPAC

Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy. Chapter 11: The Medicare Advantage Program—Status Report. March 2025.

Nasution, D. (2025, December 7). *Understanding CMS HCC v28 in 5 minutes*. ParaDocs Health.

Thank you!

Questions?

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