Individual & Family Plans

Medical record documentation tips

For health care providers

October 2025

Risk adjustment is a premium stabilization program that was established under the Patient Protection and Affordable Care Act (PPACA) to eliminate premium differences based solely on favorable or unfavorable risk selection.

A critical part of risk adjustment is the accurate submission of physician data on medical claims.

Compliant clinical documentation and coding helps to reflect more accurately the cost of caring for patients, as well as determine how resources are allocated for care of Cigna Healthcare® customers. Below are some tips to help with clinical documentation.[1]

Medical record documentation should:

- Include your patient's name, date of birth, and date of service on each page.
- Document all health conditions, including those that exist at the time of the visit, such as chronic and status conditions. *(See "Overlooked status" on the next page.)*
- Document patient care treatment and/or management for each condition. If the provider sees a patient to follow up on a resolved condition, document the resolved status of the condition.
- Provide details to support ICD-10-CM[2] diagnosis coding, and code each condition to the highest degree of specificity (laterality, severity, degree, and stage).
- Authenticate documentation with the provider's signature, including credentials and date of signature. A signature attestation will be required if handwritten signatures are illegible, credentials are missing, or the date of signature cannot be determined from available documentation.
- Include verbal descriptions and numeric diagnosis codes that are consistent with one another.
- Be sure information is clear, consistent, complete, and legible. An illegible diagnosis cannot be coded.

Document all health conditions annually during face-to-face visits for a more complete and accurate picture of a patient's overall health status.

1 Centers for Medicare & Medicaid Services. "2021 Benefit Year Protocols PPACA HHS Risk Adjustment Data Validation." Center for Consumer Information and Insurance Oversight. 11 November 2022. Retrieved from https://REGTAP.CMS.gov.

2 International Classification of Diseases, 10th Revision, Clinical Modification.

Diagnosis

- Medical record documentation dictates code assignment(s) (i.e., what documented is coded).
- A diagnosis can only be coded if it is stated by the provider in the current visit documentation. Each note must stand alone.
- A diagnosis must be stated and cannot be inferred from medications, a radiology report, a patient statement, lab values, or non-standard medical abbreviations or symbols.

Specificity

- Documentation supporting the diagnosis should include the highest level of specificity.
- Documentation that doesn't show the appropriate level of detail may lead to an unspecified diagnosis code assignment.
- Contradictory or indecisive diagnosis documentation can negate code abstraction or severity of the condition. (See examples below.)

Examples of documenting detail

Acute and/or chronic	Episode of care
Anatomical location	Late effects (sequela)
Associated conditions	Laterality
Cause and effect	Manifestations
Comorbidities	Remission status
Complications	Severity
Contributing factors	Timing

Linking verbiage for manifestations

When documenting conditions that have a causal relationship, use linking verbiage to connect the two conditions such as "secondary to," "due to," or "associated with."

Example: Type 2 diabetes mellitus associated with hyperlipidemia.

Overlooked status

- Frequently overlooked but important status conditions include (but are not limited to) the status of an amputation, organ transplant, dialysis, artificial opening, and human immunodeficiency virus (HIV).
- Include status conditions in claims submissions.

Status of condition

- Using the term "history of" indicates the condition no longer exists.
- Listing historic conditions as current or vice versa (current conditions as historic) under the past medical history may lead to many diagnosis codes being missed or improperly coded.
- Document chronic, ongoing conditions as often as they are considered in the patient's treatment or management.

Instead of documenting[3]	Document with details
History of congestive heart failure (CHF)	Compensated CHF, stable on medications
History of chronic obstructive pulmonary disease (COPD)	COPD controlled with inhaler
Stroke	Patient with history of stroke one year ago
History of diabetes	Patient with diabetes since 2010 on medication

Questions?

Visit the Cigna Healthcare Individual & Family Plans web page at CignaforHCP.com/IFP.

Email the Individual & Family Plan Risk Adjustment Coding Quality and Audit Review team at CignaHealthcareHCPEducation@CignaHealthcare.com.

3 For example only; not an all-inclusive list.

