Risk Adjustment

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Disclaimer

The speaker has no financial relationship to any products or services referenced in this program. The program is intended to be informational only. The speaker is not an authoritative source by law. Attendees are advised to reference payer specific provider manuals, on-line or otherwise, for verification prior to making changes to their coding, documentation and/or billing practices.

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - What we know
    - Brief review
  - Clinical documentation guidance
  - Case discussion

  - Unless otherwise noted, Risk Adjustment Documentation & Coding is used as a reference.
    - I am not selling or promoting this book even though I happen to think it is wonderful

Sheri Poe Bernard, *Risk Adjustment Documentation & Coding*, American Medical Association, 2018

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Patient Risk Scoring

- Individual risk scores
  - Each enrollee risk score is based on individual's demographic and health status information.
  - A risk score is calculated as the sum of these demographic and health factors weighted by their estimated marginal contributions to total risk.

For example:		
Average	$1,000	
Female	$ 500	0.5 risk factor
Condition A	$ 700	0.7 risk factor
	$1,200	1.2 risk score

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What is Risk Adjustment (RA)?

- The process by which CMS reimburses Medicare Advantage (MA) plans based on the health status of their members;
- Implemented to pay MA plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (e.g., age & gender) as well as health status;
- Risk-adjustment data is pulled from diagnosis data reported from claims data and medical record documentation from physician offices, hospital inpatient and outpatient settings;
- *Hierarchical Condition Category* (HCC) Model

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HCC Example

19	Diabetes without Complication			0.118
19		E089	Diabetes mellitus due to underlying condition without complications	
19		E099	Drug or chemical induced diabetes mellitus without complications	
19		E109	Type 1 diabetes mellitus without complications	
19		E119	Type 2 diabetes mellitus without complications	
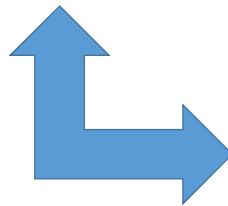
18	Diabetes with Chronic Complications			0.368
18		E0821	Diabetes mellitus due to underlying condition with diabetic nephropathy	
18		E0822	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease	
18		E0829	Diabetes mellitus due to underlying condition with other diabetic kidney complication	
18		E08311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema	

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What We Know

- Risk Adjustment (RA) is a statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

  https://www.healthcare.gov/glossary/risk-adjustment/

- Risk adjustment is an actuarial tool used to calibrate payments to health plans or other stakeholders based on the relative health of the at-risk populations.
  - A well-designed risk-adjustment system is one that properly aligns incentives, limits gaming, and protects risk-bearing entities (e.g., insurers, health plans).

5/8/2019   https://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf   7
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Why is RA Important?

- Gauges the risk a healthcare plan member will incur in medical expenses above or below an average, over a defined time period.
- Assists financial forecasting of future medical needs.
- Concept was introduced to minimize the incentive to choose enrollees based on their health status and encourage competition among health plans based on quality, efficiency, and premium stabilization.

5/8/2019   https://www.aapc.com/blog/31687-understand-risk-adjustment-basics/   www.soerriescodingandbilling.com   8

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IMPORTANT!!!

- There is more than one risk-adjustment model.
  - Medicare Advantage (MA)
  - Affordable Care Act (ACA)
  - Medicaid
  - Commercial Payors
- Each model may contain different HCCs.
- You MUST look at each model!
- We are looking at CMS model.

Commercial Payors and ACA

Medicaid

CMS (Medicare Advantage)
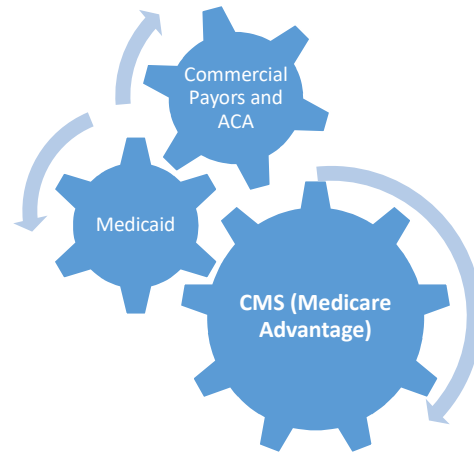
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Risk factors (RAFs) are added for each chronic disease for a given patient to determine the final RAF score.

The higher the RAF, the more resources are projected to manage the patient's health.
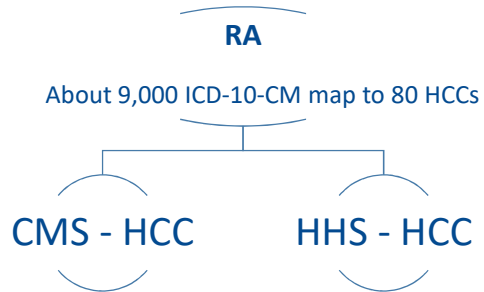
The more resources used, the higher the RA payment.

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Who Does This Affect

- Risk adjustment coding is based on correct coding principles.
- This affects *all* diagnostic coding scenarios.
- Not all conditions risk adjust although co-morbidities may risk adjust.

RA

About 9,000 ICD-10-CM map to 80 HCCs

CMS - HCC   **HHS - HCC**

With proper documentation and coding, all risk-adjusting codes will be appropriately abstracted from the medical chart.

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Morbidity

The diseased state of a patient

Severity

Conditions the patient has

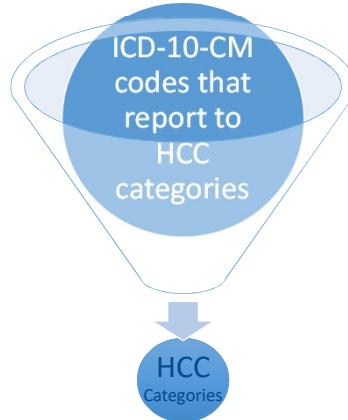## Co-morbidity

How conditions interact with other conditions

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Patient Risk Scoring

In order to accurately reflect a patient's risk profile, more than the standard ICD codes, commonly seen in current billing practices, are required.

ICD-10-CM codes that report to HCC categories

HCC Categories

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Two Patients, Same Diagnosis, Different Care

- How would the resources required to care for Patient A and Patient B differ, even though they have the same presenting problem?
- **Capturing the difference is called *risk adjustment*.**
  - If the comorbidities are not documented and coded for Patient B, the true cost of the encounter is not captured.
  - Comorbidities bring extra risk, requiring extra utilization of resources. The risk results in an adjustment of payment.
  - Erroneously reporting a more complex diagnosis can lead to overpayment.

Patient A is newly diagnosed with influenza and pneumonia.
- Patient age is 35
- Patient has no chronic diseases

Patient B is newly diagnosed with influenza and pneumonia.
- Patient age is 72
- Patient comorbidities:
  - Diabetes, type 2
  - Chronic bronchitis
  - Emphysema

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"Trumping"

- When two related conditions are diagnosed in the same year; only one is counted in the RAF score.
  - Coders will abstract all conditions; CMS may drop some from the RAF

HCC	If Disease Group is Listed in this Column...	...Then Drop the Disease Group(s) in this Column
	HCC Label	
8	Metastatic Cancer and Acute Leukemia	9, 10, 11, 12
9	Lung and Other Severe Cancers	10, 11, 12

Table VI-4 Disease Hierarchies for the 2017 CMS – HCC Model
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Comorbidities (Synergistic Disease)

- In some cases, the interaction of two diseases is worse than the sum of each disease separately.

RISK/PAYMENT FACTOR	HCC	RAF
66-year-old male	(community, nondual, aged)	0.300
Congestive heart failure (CHF)	85	0.323
Prostate cancer	12	0.146
Diabetes mellitus (DM), complicated	18	0.318
Peripheral vascular disease	108	0.298
Below-knee amputation	189	0.588
Morbid obesity	22	0.273
Interaction CHF & DM	NA	0.154
Total RAF		2.400

If we assume a CMS capitated rate for McNally's locality of $800 per month, the MAO would receive a payment of $9,600 per year for an enrollee without risk diagnoses. Multiply the capitated rate ($9,600) by 2.400 (McNally's RAF) to determine the CMS payment to the MAO to cover McNally's care. The total is $23,040 annually. RxHCCs would be calculated separately and added to payment, if the patient subscribed to Part D.

A patient with McNally's comorbidities would be at higher risk for resource-intensive care, including hospitalization. The MAO would pay for such care.

Sheri Poe Bernard, *Risk Adjustment Documentation & Coding,* American Medical Association, 2018

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How Will This Affect Coding?

Records must be:

- Specific
- Accurate
- Clinically valid
- Unambiguous

Coding must be:

- According to guidelines
- Accurate
- To highest specificity
- Complete

5/8/2019   https://pixabay.com/en/medical-record-health-patient-form-781422/   www.soerriescodingandbilling.com   17

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Risk Adjustment Data Validation (RADV) Medical Record Checklist and Guidance

This checklist list has been provided to Medicare Advantage contracts involved in RADV audits. This list may help to determine a medical record's suitability for RADV. Any items checked "no" may indicate that the medical record will not support a CMS-HCC.

Yes   No

☐   ☐   Is the record for the correct enrollee?

☐   ☐   Is the record from the correct calendar year for the payment year being audited (i.e., for audits of 2013 payments, validating records should be from calendar year 2012)

☐   ☐   Is the date of service present for the face to face visit?

☐   ☐   Is the record legible?

☐   ☐   Is the record from a valid provider type? (Hospital inpatient, hospital outpatient/ physician)

☐   ☐   Are there valid credentials and/or is there a valid physician specialty documented on the record?

☐   ☐   Does the record contain a signature from an acceptable type of physician specialist?

☐   ☐   If the outpatient/physician record does not contain a valid credential and/or signature, is there a completed CMS-Generated Attestation for this date of service?

☐   ☐   Is there a diagnosis on the record?

☐   ☐   Does the diagnosis support an HCC?

☐   ☐   Does the diagnosis support the requested HCC?

5/8/2019   www.soerriescodingandbilling.com   https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/radvchecklist.pdf   18

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Clinical Documentation Guidance

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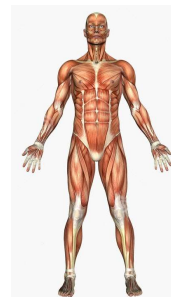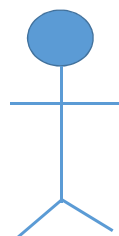## Accuracy is of THE Utmost Importance!

- Documentation should clearly indicate what was done.
- Include details outlining what took place during the encounter.
- Details, details, details!

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Documentation Guidelines

- No different than what is currently expected;
  - Reason for the encounter relevant history, physical exam findings, and prior diagnostic test results.
  - Assessment, clinical impression, or diagnosis.
  - Plan of care.
- Rationale for ordering diagnostic/ancillary services should be easily inferred (if not documented).
- Past and present diagnoses should be accessible to treating/consulting physician.
- Identify appropriate health risks.
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented.

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"MEAT" It

Monitored	Evaluated	Assessed	Treated
• Signs • Symptoms • Disease progression or regression	• Test results • Medication effectiveness • Response to treatment	• Ordering tests • Discussion • Review records • counseling	• Medications • Therapies • Other modalities

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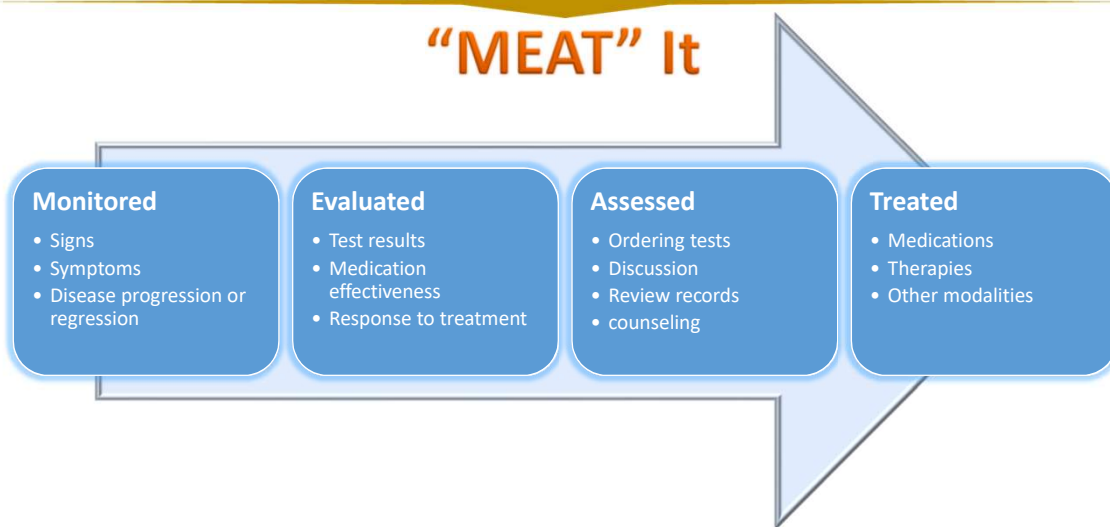
Examples Supported by MEAT

TABLE 3.1 Examples of Support As Described by MEAT

MEAT ELEMENT	PROBLEM	SUPPORT
Measured, monitored	Morbid obesity	George is still unwilling to consider bariatric surgery, even though it would help his knees considerably.
	Diabetes mellitus.	A1C today is 6.7
Evaluated	CHF	+3 LE edema
	Pneumonia	Film shows R lung is clearing
Assessed, addressed	HTN	Blood pressure is controlled. Continue low sodium diet.
	Moderate reactive asthma	Breathing improved with weather change
Treated	Assessment: Hypothyroidism	New Rx for levothyroxine 125 mcg daily
	New diagnosis of Stage 3 CKD	Referred to nephrology clinic

Abbreviations: CHF indicates congestive heart failure; CKD = chronic kidney disease; HTN = hypertension; LE = lower extremity; and Rx = prescription.

Sheri Poe Bernard, *Risk Adjustment Documentation & Coding*, American Medical Association, 2018

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Clinical Concept	✔
Type	
Temporal factors	
Caused by/contributing factors	
Symptoms/findings/manifestations	
Localization/laterality	
Anatomy	
Associated with	
Severity	
Episode	
Remissions status	
History of	
Morphology	
Complicated by	
External cause	
Activity	
Place of occurrence	
Loss of consciousness	
Substance	
Number of gestations	
Outcome of delivery	
BMI	

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The Problem with Problem Lists

Problem List	Must be comprehensive and show evaluation and treatment of each condition addressed during a given date of service.
Problem List	Do diagnoses drop off once condition is resolved?
Check Up	Does it document the HCC that was submitted for payment?

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"History Of"…

- Different meanings for providers and coding
  - Providers – represents the patient's medical status including past and present.
  - Coding - Past history means the condition has resolved, NOT a current, chronic, or controlled on-going problem
- Are these "history of" of current conditions?
  - Personal history includes diabetes mellitus, coronary artery disease, dyslipidemia, CVA, hypertension, back pain
  - Medical history: Hypertension, COPD, Atrial Fibrillation, s/p A/V node ablation, sinus bradycardia, CHF, BIV/ICD Medtronic DTBB1D4, 6/11/15.
- Coders must review documentation to determine what is history vs. ongoing medical conditions.

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"History of" Tips

- "History of" means the patient no longer has the condition
- Frequent documentation errors regarding "History of"
  - Coding a past condition as active
  - Coding "history of" when the condition is still active
- Exception: It is appropriate to document/code "history of" when documenting some status conditions (amputation)
- Instead of documenting "history of" (H/O)
  - Compensated CHF
  - Stable on nitro
  - COPD controlled with Advair

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"History of" and Mapping

Condition	Mapping	HCC
History of diabetic foot ulcer	Z86.31 Personal history of diabetic foot ulcer	No HCC
Diabetic foot ulcer, exposed fat layer, R midfoot	E11.621 Type 2 DM with foot ulcer L97.412 Non-pressure chronic ulcer of rt. heel/midfoot with fat layer exposed	HCC 18 HCC 161
History of prostate cancer	Z85.46 Personal history of malignant neoplasm of prostate	No HCC
Prostate cancer, stable on leuprolide	C61 Malignant neoplasm of prostate	HCC 12
History of pulmonary embolism	Z86.711 Personal history of pulmonary embolism	No HCC
Pulmonary embolism responding favorably to anticoagulation therapy	I26.99 Other pulmonary embolism without acute cor pulmonale	HCC 107

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Medication Lists

Include a list that has been historically prescribed to the patient

Must be updated and maintained regularly

Cannot infer a diagnosis based on list

May provide inventory of diagnoses to anticipate in documentation

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Test Results

- Physician must make the diagnosis, based on test values.
  - Even when it seems obvious.
- Coders cannot abstract diagnoses based on lab values.
  - Must query provider.
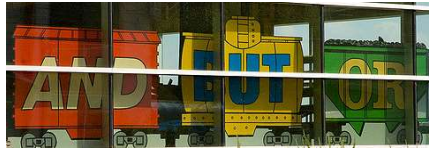
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Cause and Effect Relationship

Caused by

Due to

Resulting in

In

With

Associated With

You know you want to sing it … "Conjunction junction … What's your function?"

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Causal Relationships

- An underlying condition directly responsible for a second condition.
- Relationship should be stated in order to coding to be linked.
- Etiology for ICD-10-CM.
  - A disease that originates or causes a problem; the underlying condition
    - Heart failure due to hypertension [underlying condition].
- Manifestation for ICD-10-CM.
  - A complication from an underlying disease.
    - Thyrotoxicosis [manifestation] due to follicular carcinoma of thyroid.

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The Importance of Details

- Providers should "**THINK IN INK**" instead of defaulting to general terms for diagnosis.
- Use free-text, when available, to enhance documentation.

Positive for cough → Positive for chronic, dry cough that is worse at night

- "THINK IN INK" will support RA and show the work involved in patient care.
- Utilize HPI and SOAP note format to maximize narrative opportunities.

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Status Conditions

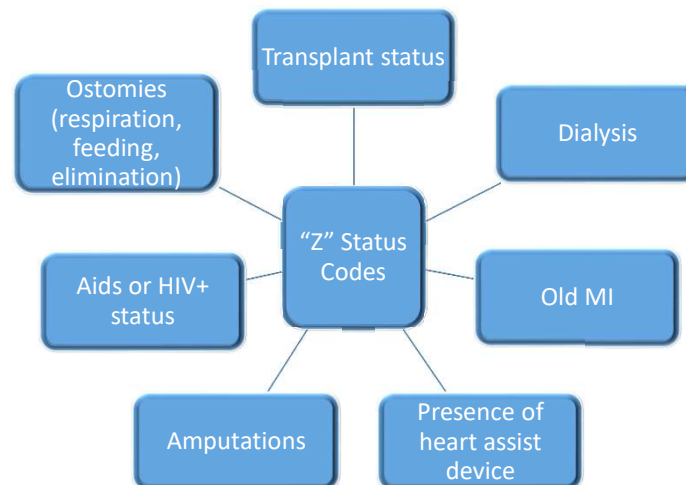Many status "Z" codes risk-adjust and are routinely overlooked.

- Transplant status
- Ostomies (respiration, feeding, elimination)
- Dialysis
- "Z" Status Codes
- Aids or HIV+ status
- Old MI
- Amputations
- Presence of heart assist device

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Documentation Tips for Providers

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Clinical Coding Example

Non-Specific Documentation
Assessment/Plan:
1. Hypercholesterolemia
2. Old MI
3. CAD
4. DM
5. PAD

Specific Documentation
Assessment/Plan:
1. Pure hypercholesterolemia. Stable on ezetimibe.
2. Old MI, apical-lateral transmural, stable and asymptomatic.
3. Coronary artery disease of native vessels, with angina pectoris; ezetimibe and atorvastatin. Schedule another stress test in six months.
4. Diabetes mellitus, type 2, well controlled with insulin.
5. Bilateral atherosclerosis of lower extremities and bilateral intermittent claudication. Patient is not a candidate for bypass.

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Arthritis

- Joint disorders that are chronic, systemic autoimmune implications.
- Rheumatoid arthritis (RA) diagnosis based on a combination of symptoms, not a single test.
  - Adult and juvenile forms
- Psoriatic arthritis
  - Joint pain
  - Erythematous plaques
  - Nail changes
- "Arthritis" equates to osteoarthritis, unspecified.
  - Does not capture type or severity of RA or PA.
    - RA and PA can cause complications to organ systems.
    - Long term steroids for RA can cause cataracts.

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Arthritis

- RA and PA are only types of arthritis that risk-adjust.
- Include laterality and joint(s) affected.
- Document results of RA test.
- Patient requiring joint replacement.
  - History of pain (onset, duration, aggravating/relieving factors).
  - Limitations of activity/daily living.
  - Contraindications to nonsurgical solutions.
  - List of failed nonsurgical treatments (weight loss, braces, injections, medications, etc)
  - Physical exam identifying deformity, range of motion, gain, effusion, crepitus, etc.
  - Results of diagnostic tests and specific type of arthritis.
  - Comorbidities affecting mobility and care.
- Document any history of joint replacement.
- Do not rely on medication list for long-term (current) use.
- Document specific joint and laterality for joint pain, stiffness, or effusion.

Type of Arthritis	Code Category(ies)
Pyogenic: identify infective agent and whether a direct or indirect infection, and whether post-infective or reactive	M00-M02
Rheumatoid arthritis: note any rheumatoid factor, juvenile type, Felty's syndrome, specific organ or system involvement, bursitis, nodules, myopathy	M05-M06, M08
Gout: note etiology (renal, drug, lead, idiopathic, other secondary), chronic or acute, with or without tophus	M1A, M10
Other crystal arthropathies: specify type as hydroxyapatite deposition disease, familial chondrocalcinosis, or other	M11
Other: post-rheumatic and chronic, Kaschin-Beck, villonodular synovitis, palindromic rheumatism, intermittent hydrarthrosis, traumatic arthropathy, transient, allergic, monoarthritis NOS [not otherwise specified]	M12, M13
Arthritis in disease classified elsewhere: specify underlying disease	M14
Osteoarthritis: multiple sites, bilateral of single joint, primary, secondary, post-traumatic (also identify the type of trauma that led to the late effect arthritis)	M15-M19

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Documentation Improvement Examples

Nonspecific Documentation

Patient is 24 and has had rheumatoid arthritis for 11 years.

Improved Documentation

Patient who is 24 has had systemic juvenile arthritis for 11 years and is being seen today for bilateral arthropathies in his wrists and hands.

Nonspecific Documentation

Rheumatoid factor results are 31 U/ml with bilateral rheumatoid arthritis of the hands and shoulders.

Improved Documentation

Rheumatoid factor results are 31 U/ml with bilateral rheumatoid *with rheumatoid factor* arthritis of the hands and shoulders.

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Pulmonary Disorders (Chronic)

FIGURE 4-3.1 Chronic Forms of Bronchitis
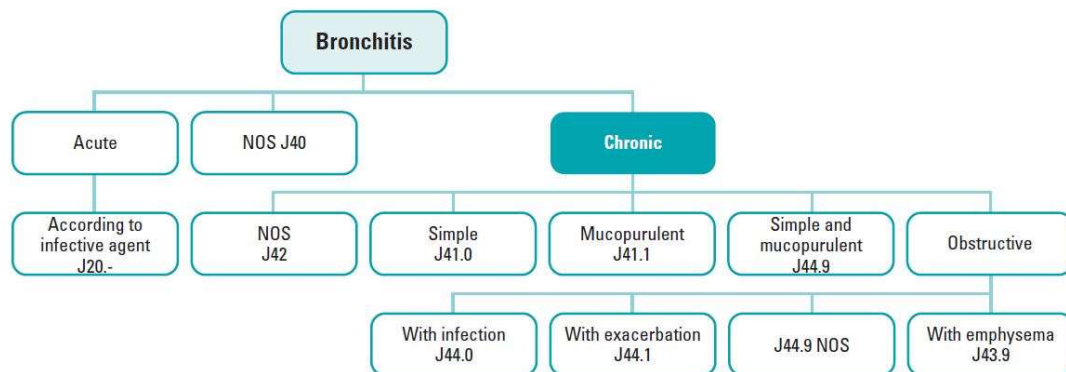
Bronchitis
- Acute
- NOS J40
- Chronic

Acute: According to infective agent J20.-

Chronic: NOS J42, Simple J41.0, Mucopurulent J41.1, Simple and mucopurulent J44.9, Obstructive

Mucopurulent: With infection J44.0, With exacerbation J44.1, J44.9 NOS, With emphysema J43.9

Sheri Poe Bernard, *Risk Adjustment Documentation & Coding*, American Medical Association, 2018

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Documentation Considerations

- Bronchitis without further documentation is coded to J40 Bronchitis, not specified as acute or chronic.
- Identify chronic bronchitis as obstructive and specify emphysema when present.
- Record pulmonary function test (PFTs) and chest x-rays to document airway limitations.
  - Coders cannot abstract from PFTs or lab values, document specifics.
- Document severity of COPD (mild, moderate, severe) and respiratory failure.
- Differentiate COPD with acute exacerbation and COPD with lower respiratory infection.
  - Include type of infection and infective agent.

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Documentation Considerations

- Asthma
  - Codes do not risk-adjust, but does RxHCC adjust (226).
  - Similar to COPD, but not necessarily progressive.
  - Usually in reaction to an intrinsic or extrinsic force.
  - Document
    - Uncomplicated
    - With exacerbation
    - With status asthmaticus
  - Document severity
    - Mild and intermittent
    - Mild and persistent
    - Moderate and persistent
    - Severe and persistent

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COPD and Asthma

- ARF is ambiguous and may be interpreted as acute respiratory failure, acute renal failure, or acute rheumatic fever.

Document
Specify bronchitis as acute or chronic and if chronic bronchitis if obstructive.
If exacerbation of COPD is with acute exacerbation and/or with lower acute respiratory infection (and infective agent when known).
Severity of COPD (mild, moderate, severe, end-stage).
Details of asthma.
Dependence on ventilator or tracheostomy.
Tobacco use, abuse, dependence, history of, or exposure to secondary smoke.
Tobacco counseling, treatment or intervention.
Dependence on supplemental oxygen.
Results of pulmonary function tests to show airway limitations.

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Documentation Improvement Examples

Nonspecific Documentation

Asthma exacerbation responding well to albuterol nebulizer.

Improved Documentation

Moderate persistent asthma exacerbation responding well to albuterol nebulizer.

Nonspecific Documentation

End stage COPD. Patient is on continuous home oxygen and currently has chronic hypercapnia. He is on maximum dose of steroids. We have referred him to hospice.

Improved Documentation

End stage COPD. Patient is on continuous home oxygen and currently has *acute on chronic respiratory failure* with hypercapnia. He is on maximum dose of steroids. We have referred him to hospice.

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Dementia

- Document mental health and decline.
- Age of onset of Alzheimer's disease.
- Document violent, combative, or aggressive behavior.
- Be as specific as possible.

Code(s)	Symptoms
G31.84	Mild cognitive impairment
I69.-	Cognitive deficit following stroke, specify deficit; note intracerebral/subarachnoid bleed vs infarct
R41.81	Age-related cognitive decline
R41.82	Altered mental status, unspecified
R41.841	Cognitive communication deficit
R41.844	Frontal lobe and executive function deficit
R90.82	White matter disease, diagnostic imaging, NOS
Z87.820	Personal history of traumatic brain injury

Link to any known etiology.

Code(s)	Dementia Etiology
E--. with .49	Diabetes
E75.-	Cerebral lipidoses
F01.5-	Vascular dementia
F03.9-	Unspecified dementia
F03.9-	Senile dementia, not otherwise specified
F10.97, F10.27	Alcoholic dementia, state dependence, abuse
G10	Huntington's disease
G20	Parkinson's disease
G30.-	Alzheimer's disease, state early or late onset
G31.01	Pick's disease
G31.09	Frontotemporal dementia
G31.83	Lewy body disease
G35	Multiple sclerosis
G40.-	Epilepsy

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Clinical Coding Examples

Documentation: Pre-senile Alzheimer's disease, early onset. Will start patient on donepezil.

ICD-10-CM Code(s): G30.0 Alzheimer's disease with early onset

F02.90 Dementia without behavioral disturbance

Rationale: While patient is documented as being "pre-senile", ICD-10-CM requires two codes based on use of bracketed codes with G30.0 in Alphabetic Index.
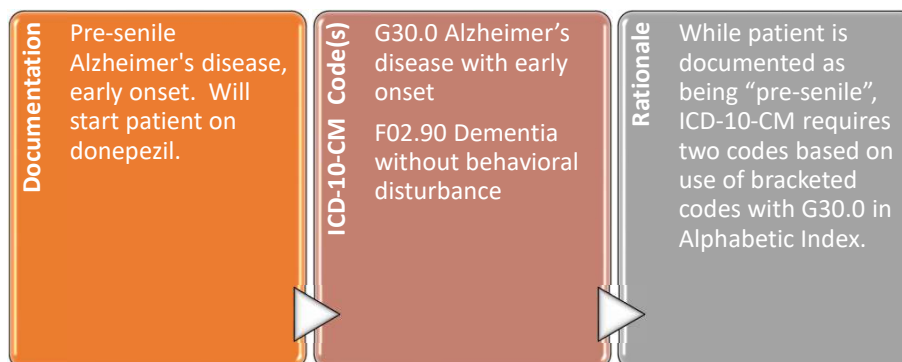
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Diabetes Mellitus

- Chronic, lifelong metabolic disorder affecting uptake and storage of protein, carbohydrates, and fat.
  - Two subgroups of diabetes
  - Without insulin production (Type 1)
    - Autoimmune response that destroys all insulin producing cells in pancreas.
    - Usually occurs in childhood/young adults.
  - With insulin production (Type 2)
    - Patient has hyperglycemia (excess glucose in bloodstream).
    - Found in elderly and overweight, can occur in juveniles.
- What about other types?
  - Type 1.5
  - Type 3?

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Documentation Considerations

- Hyperglycemia is no longer considered a symptom of diabetes.
  - Considered a complication and should be noted in the documentation.
  - Should be documented with language such as "blood glucose indicates hyperglycemia at 495".
- Assume causal relationship between most systemic disorders and diabetes.
  - If they coexist, ICD-10-CM considers them a complication of diabetes unless the provider documents otherwise.
- Prediabetes is coded as R73.03.
- Only document one type of diabetes.
- Coder cannot refer to other encounters for type – must be documented at each encounter.
- Document if controlled by diet and exercise.

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Diabetes Mellitus (DM)

DIABETES DO DOCUMENT	DIABETES DO NOT

Provide qualitative information
    "Good control", "A1C is 7.6 and goal is 6.5"
	Do not use outdated terms
	    IDDM, NIDDM, juvenile or adult onset, brittle diabetes

Address
    All complications
    Status of annual exams
        Eye, foot, lab values
	Do not document "BG of 495" – state the obvious
	    Coders can't code from lab values
	    "Patient's blood glucose indicates hyperglycemia at 495"

When a comorbidity is NOT due to diabetes	
Type (1, 2, secondary, other specified form)	
Document all referrals Dietetic counseling, foot care, etc.	
Any status resulting from diabetes (vision loss, amputations, dialysis status)	
Identify treatment method Diet and exercise, antidiabetic medications, insulin, or use of insulin pump	
Report hyperglycemia as appropriate No longer considered a sign/symptom – considered a complication of DM	

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Documentation Improvement Examples

Nonspecific Documentation

Patient has had diabetes since he was 10.

Improved Documentation
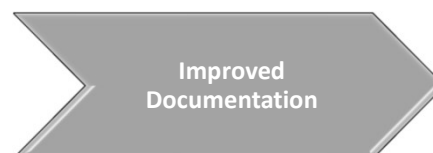
Patient has had *type 1* diabetes since he was 10.

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Heart Disease

- Document chest pain specifics (during respiration, intercostal, etc).
- Heart failure
    - Arteriosclerotic, left ventricular, systolic, diastolic, combined; right heart, high output, or end stage failure.
    - Indicate acute, chronic, or acute on chronic.
- Document if heart failure is not due to hypertension.
    - ICD-10-CM assumes a causal link between heart failure and hypertension.
- Myocardial Infarct timing
    - Old MI is one that is 28 days or older.
    - Subsequent is within 28 days of another MI and is identified by date.
    - STEMI or NSTEMI identified as left main, LAD, RC, LC, or inferior/anterior wall.
- Document history of prior bypass, pacemaker, valve replacements, heart transplant status or if patient is awaiting transplant.

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Heart Disease

- Coronary Artery Disease (CAD) – lipid-rich plaque or chronic total occlusion.
- Document valve associated with any heart murmur, if known.
- Specify insufficiency or stenosis in valve disease (and specific valve).
- Actively document long-term use of anticoagulants, NSAIDS, etc.
- Link cardiac arrest to underlying conditions.
- Document pertinent symptoms(non-exertional dyspnea fatigue, edema, weight gain).
- Document history of or current use of tobacco.

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Documentation Considerations

- "Congestive" is an unspecified type of heart failure
- Provider may document systolic or diastolic dysfunction *without* documentation of heart failure
  - Cannot assign I50.- category
- Controlled heart failure is referred to as "compensated" or "chronic".
- Uncontrolled heart failure is referred to as "decompensated" or "acute".

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Documentation Considerations

- Avoid "history of CHF" when it is a current condition.
- Relationship between CHF and hypertension is assumed unless provider documents HF is due to other cause.
  - Do not report I50.- with I10.
- Document symptoms related to CHF.
  - Only code symptoms when heart diagnosis is not present.
- Document tobacco use and history codes.
- Pulmonary hypertension is classified in CHF HCCs and should be documented when present.

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Documentation Considerations

- Spell out acronyms first time used in documentation and then use them subsequently.
  - CAD, MI, AMI, STEMI, NSTEMI
- Underlying mechanism.
- Location.
- Vessel Involvement.
- Immediate or prolonged consequences.
- Include status of long-term medications.
- Include nicotine dependence/exposure.
- Document history of coronary artery bypass surgery, cardiac devices, transplant status.

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Documentation Improvement Examples

Nonspecific Documentation

HPI: Patient is being seen today for history of atrial fibrillation. He continues digoxin therapy and is also taking dabigatran as prophylaxis. Current exam reveals regular rate and rhythm.

Improved Documentation

HPI: Patient is being seen today for *paroxysmal* atrial fibrillation. He continues digoxin therapy and is also taking dabigatran as prophylaxis. Current exam reveals regular rate and rhythm..

Nonspecific Documentation

Patient will undergo insertion of pacemaker for atrioventricular and right bundle branch blocks.

Improved Documentation

The patient will undergo insertion of a leadless pacemaker for a third-degree atrioventricular block and a right bundle branch block.

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Documentation Improvement Examples

Nonspecific Documentation

Chief complaint: Patient being seen for follow-up on AMI for which he was hospitalized recently.

Improved Documentation

Chief complaint: Patient being seen for follow-up on ST-elevation myocardial infarction (STEMI) involving oblique marginal coronary artery, for which he was hospitalized two weeks ago. The STEMI occurred 4/15/2017.

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Documentation Improvement Examples

Nonspecific Documentation

Echocardiography in combination with the patient's symptoms lead to a diagnosis of biventricular heart failure.

Improved Documentation

Echocardiography in combination with the patient's symptoms lead to a diagnosis of **acute on chronic systolic** biventricular heart failure.

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Kidney Disease

- Renal insufficiency is a generic term that does not risk adjust.
- CKD will always be pertinent in a patient with diabetes, heart failure, or hypertension. Always document those conditions when addressing patient with kidney disease.
- Document underlying cause of CKD.
- Describe patient's condition.
- Document microalbuminuria when it exists.
- Link complication of dialysis (infection, hypotension, catheter break, etc.).
- Dialysis is not a stand along code -document etiology/manifestation of kidney disorder, presence of shunt for dialysis and any noncompliance.
- ARF should be spelled out to avoid confusion with other abbreviations.
- Note if patient is awaiting kidney transplant.

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Documentation Considerations

- Stages of CKD

Stage	ICD-10-CM	
Stage 1	N18.1	
Stage 2	N18.2	Equates to mild CKD
Stage 3	N18.3	Equates to moderate CKD
Stage 4	N18.4	Equates to severe CKD
Stage 5	N18.5	
End-Stage (ESRD)	N18.6	

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Kidney Disease

- Document hematuria as gross, benign essential microscopic, or asymptomatic.
- Identify stage in chronic kidney disease (1-5 or ESRD).
- Note the etiology of anemia in kidney patient.
- Identify the transplant complication (failure, rejection, infection).
- Indicate "non traumatic" to acute kidney injury to prevent misinterpretation.
- Specify type of glomerular disease or renal tubule-interstitial disease.

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Documentation Considerations

- Document microalbuminuria when it exists.
- Document underlying cause of CKD.
- Link complication of dialysis (infection, hypotension, catheter break, etc.).
- Dialysis is not a stand along code -document etiology/manifestation of kidney disorder, presence of shunt for dialysis and any noncompliance.
- ARF should be spelled out to avoid confusion with other abbreviations.
- Note if patient is awaiting kidney transplant.

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Dementia

- Progressive decline in cognition that affects short-term and long-term memory loss due to brain damage or disease and is not reversible.
- Dementia is inherent in:
  - Alzheimer's disease
    - Late form occurs after age 65.
    - Early onset can occur between ages of 30s - 60s.
  - Vascular dementia (atherosclerotic cerebral vessels)
  - Lewy body disease (associated with Parkinson's)
- Memory deficits and confusion or lapses in judgement.

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Dementia

- Caregivers usually accompany patient to provide history.
  - Patient may not be able to remember comorbidities, medications, care plans.
- Conditions may be *perceived* as inherent to dementia/ advanced dementia.
  - Classification may not capture the conditions in dementia.
    - Depression, sleep disorders, functional quadriplegia, cachexia, frailty)
      - Conditions may risk-adjust and should be documented.

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Documentation Considerations

- Most forms of dementia will need two codes:

```
                    Dementia

        Etiology              With/without
                              behavioral
                              disturbance
```
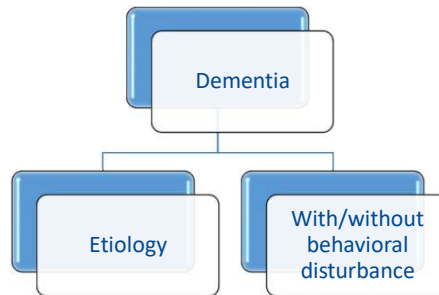
- Document when history is obtained from another person on patient's behalf.
- Documentation should include specifics on patient's mental capabilities, symptoms, diagnosis.

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Documentation Considerations

- Document dementia for all encounters since it affects the health of the patient and care planning.
- Dementia is inherent to Alzheimer's disease.
  - If provider documents Alzheimer's disease, Lewy body, or Pick's disease but not dementia, report:

G30.9 Alzheimer's disease	F02.80 Dementia in other diseases, classified elsewhere without behavioral disturbance.
G31.01 Pick's disease	
G31.83 Lewy body disease	

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Documentation Considerations

- Behavioral disturbances may be captured with one or two codes.
  - Violence, aggression, uncooperative (combative)
- Inclusion terms do not include wandering or Sundowner's. Report with separate code:

Wandering	Z91.83 Wandering in disease classified elsewhere
Sundowning	F05 Delirium due to known physiological condition

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Malnutrition

- Protein calorie malnutrition is insufficient nutrition due to lack of foods, inability/unwillingness to eat.
- All malnutrition risk-adjusts.
  - Mild
  - Moderate
  - Severe
- Aging population at risk for malnutrition.

Decreased sense of taste and smell - less desire for food.	Limited income.
Poor oral health – food is less enjoyable.	Decline in physical and mental health.

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Documentation Considerations

- Emaciation in adults
  - Reported with R64, Cachexia
  - Classified as E41 Nutritional marasmus in the Alphabetic Index.
    - Type of malnutrition in very young from severe protein-energy deficiency.
- Body mass index (BMI) can be documented by someone other than the provider once established by provider.
  - Any associated diagnosis must be documented by provider.
    - Obesity, pressure ulcer, etc.

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Documentation Considerations

- Cachexia – severe weight loss associated with chronic disease.
- Sarcopenia – muscle atrophy due to disease or age-related state.
  - Seen in end stage COPD, cancer, AIDS, dementia
- Kwashiorkor disease is usually found in children in impoverished countries.
  - Verify Kwashiorkor is actually documented in medical record (query provider).

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Documentation Considerations

- Documentation should be clear and concise.
- Use diagnosis description, not adjectives describing patient's appearance.

Instead of	Use (diagnosis)
Malnourished	Malnutrition
Cachectic	Cachexia

- If unsure, check main terms of Alphabetic Index for adjective form of the word to see if it can be used as a diagnosis.

Alphabetic Index	Adjective Form Present?	Use Adjective for DX?
Cachexia	Cachectic is not present	No
Malnutrition	Malnourished is not present	No
Nephritis, nephritic	Nephritic is present	Yes
Hernia, hernial	Hernial is present	Yes

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Obesity

- Obesity
  - Hyperalimentation; too much food intake.
  - Measured by weight compared to body mass index (BMI)
  - Contributing factors to heart disease, joint disease, sleep apnea, hypertension, diabetes, some cancers.

Description/Disease State	Definition	BMI	CDC Classification
Normal weight	Not obese	18.5 – 24.99	
Overweight	Not obese	BMI 25.0 – 25.9	
Obese	Low risk	30.0 – 34.9	Class 1
Obese	Moderate risk	35.0 – 39.9	Class 2
Morbid obesity	High risk	40.0 or more	Class 3

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Obesity

- Obese abdomen "apron of fat".
  - Indicates localized fat.
    - Can effect physical examination findings.
  - Do not use obesity codes.
    - Report with localized adiposity.
- BMI
  - Coder cannot determine weight diagnosis solely from BMI.
  - Cannot be reported without accompanying weight-related diagnosis.
  - Calculate at least annually.
  - Document when abnormal and the corresponding disease state.
- Identify cause of excess weight
  - Excess calories.
  - Adverse effect of medication.

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Documentation Considerations

- Document obesity in relation to other diagnoses at each encounter.

- Document treatment plan.

- Include postsurgical status for bariatric surgery.
  - Document sequelae in patient who remains obese after successful bariatric surgery.

- Pregnancy and obesity
  - It is provider's responsibility to document if the condition being treated is not affecting pregnancy.
  - Patient is at higher risk for gestational diabetes and complications.
    - Example – obesity in pregnant patient is a complication.
      - O99.21 Obesity complicating pregnancy, childbirth and puerperium AND
      - Separate code for morbid obesity.

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Documentation Improvement Examples

Nonspecific Documentation	Improved Documentation
The patient is being seen today for weight-loss counseling. The patient has a BMI of 36 and is morbidly obese, with comorbidities relating to obesity.	The patient is being seen today for weight-loss counseling. The patient has a BMI of 36 and is morbidly obese, with comorbidities relating to obesity, which are new-onset type 2 diabetes mellitus, hypertension, and obstructive sleep apnea. The patient's diabetes is stable and hypertension is regulated with lisinopril and a salt-restricted diet. He started using a sleep apnea machine 2 years ago.

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Ulcers

Skin ulcers are slow healing open wounds with ischemia as cause of most ulcers.

- Poor blood flow in extremities
  - Chronic skin ulcers, diabetic ulcers
- Infections or traumatic wounds
  - May be slow healing in diabetics
- Pressure points in bedridden or incapacitated patient
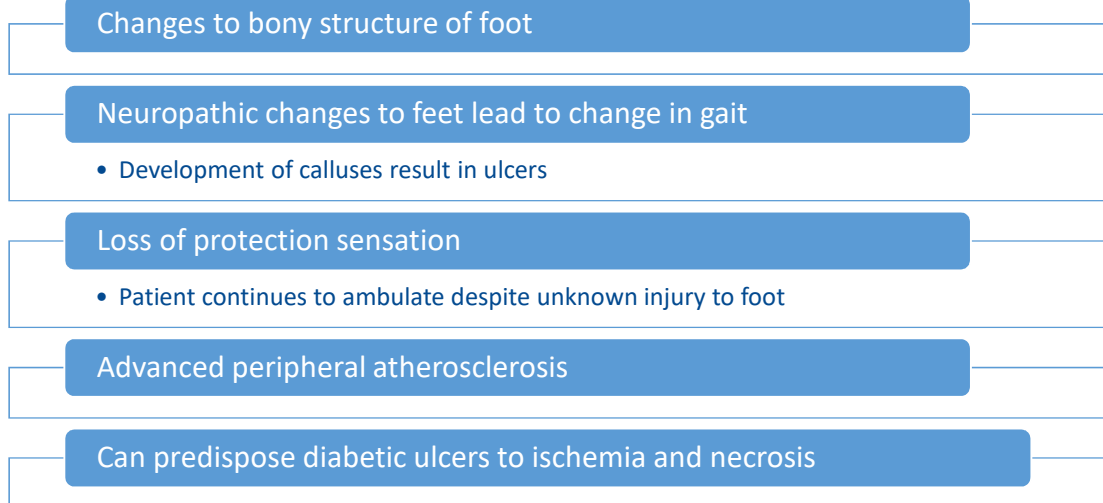 - Pressure or decubitus ulcers

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Diabetic Foot Ulcers

Changes to bony structure of foot

Neuropathic changes to feet lead to change in gait

- Development of calluses result in ulcers

Loss of protection sensation

- Patient continues to ambulate despite unknown injury to foot

Advanced peripheral atherosclerosis

Can predispose diabetic ulcers to ischemia and necrosis

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Diabetic Foot Ulcers

Chronic ulcers and pressure ulcers take longer to heal than regular wounds.

Could lead to deeper tissue ischemic, pressure, and diabetic foot ulcers

OR

Wider or multiple shallow ulcers in venous skin ulcers

Which could lead to amputation

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Diabetic Foot Ulcer Caution!

University of TX Classification (Select one stage and grade)	Wagner Classification	ICD-10-CM Classification
Grade 0: Epithelialized wound	**Grade 0** : Skin intact but bony deformities lead to "foot at risk"	
Grade 1: Superficial wound	**Grade 1:** Superficial ulcer	**Do not confuse diabetic foot ulcer classification grades or stages with pressure ulcer stages in ICD-10-CM. They do not correlate!**
Grade 2: Wound penetrates to tendon or capsule	**Grade 2:** Deeper, full thickness extension	
Grade 3: Wound penetrates to bone or joint	**Grade 3:** Deep abscess formation or osteomyelitis	
Stage A: No infection or ischemia	**Grade 4:** Partial Gangrene of forefoot	**Stage 1:** Limited to persistent focal edema
Stage B: Infection present	**Grade 5:** Extensive Gangrene	**Stage 2:** Abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
Stage C: Ischemia present		**Stage 3:** Full thickness skin loss involving damage or necrosis of subcutaneous tissue
Stage D: Infection and ischemia present	www.soerriescodingandbilling.com	**Stage 4:** Soft tissues through to underlying muscle, tendon, or bone 79

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Documentation Considerations - Severity

Pressure Ulcers
Stage 1 – 4
1 – limited to persistent focal edema
2 – abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
3 – full thickness skin loss involving damage or necrosis of subcutaneous tissue
4 – soft tissues through to underlying muscle, tendon, or bone
Deep tissue injury (code to unstageable)
Unstageable

Chronic Ulcers	
Limited to breakdown of skin	With muscle involvement without evidence of necrosis
With fay layer exposed	With bone involvement without evidence of necrosis
With necrosis of muscle	With other specified severity
With necrosis of bone	Without staging

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Documentation Considerations

Over 200 ulcer codes that can be documented by including:

- Etiology –
  - Venous stasis (link ulcer to varicose veins)
  - Atherosclerotic (ischemic)
    - Specify arteries (native, autologous/nonautologous, nonbiological bypass grafts)
    - Link ischemic ulcer and any gangrene to peripheral atherosclerosis
    - Other etiologies (skin ulcer with chronic infections)
    - Diabetic fool ulcer (identify type and etiology of secondary)
    - Pressure ulcer (include contributing comorbidity (functional quadriplegia, paraplegia, quadriplegia, MS, ALS, etc.)
  - Site and laterality

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Documentation Considerations

- Document pressure ulcers to the highest stage they reach, even after healing.
  - Do not "reverse state" ulcers (identifying a stage as it begins to heal).
  - As ulcer heals, it does not replace lost muscle, tissue, etc. and instead fills in with granulation tissue (scar).
    - Will not go from stage 4 to 3 to 2 to 1.
    - Example –once healed a stage 4 healed ulcer is coded as such, not as a stage 0 pressure ulcer.
- Code for any necrosis in non-pressure ulcers.

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Ostomies

- Artificial openings that bypass normal bodily functions.
  - May be temporary for healing or a permanent diversion.
  - Actual end of the organ that creates an alternative elimination method.
    - Bowel or urinary
  - Ostomy can also be created for feeding in patient with weakness or blockage.
    - Located in esophagus or stomach

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Ostomies

- All ostomies risk-adjust regardless if temporary or permanent.

CODE	DESCRIPTION
Z93.1	Gastrostomy status
Z93.2	Ileostomy status
Z93.3	Colostomy status
Z93.4	Other artificial openings of gastrointestinal tract status
Z93.50	Unspecified cystostomy status
Z93.51	Cutaneous-vesicostomy status
Z93.52	Appendico-vesicostomy status
Z93.59	Other cystostomy status
Z93.6	Other artificial openings of urinary tract status
Z93.8	Other artificial opening status
Z93.9	Artificial opening status, unspecified

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Documentation Considerations

- Document at each visit:
  - Site of ostomy
  - Condition
  - Any complications
- If surgical encounter is to create an ostomy, indicate the reason for the ostomy.
  - Do not use "status" or "attention to".
- Avoid "stoma" and "ostomy" since they are non-specific
  - Use specific location (gastrostomy, cystostomy, ileostomy, colostomy, etc.) Do not report status code with ostomy complication.
  - Use "attention to"

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Amputation

- Lower limb amputations frequently missed in risk adjustment.
- 60% of lower limb amputations occur in patients with diabetes.
- Peripheral arterial disease (PAD) common complication of diabetes.
- Lower limb loss increases patient's risk for :
  - Obesity
  - Cardiovascular disease
  - Depression
  - Subsequent amputation of remaining intact limbs

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Documentation Considerations

- Amputation status commonly found in examination or medical history.
- Document any lower limb amputation including:
  - Level of amputation
  - Laterality
  - Impact on patient's current health (example – "coping well")
- Providers who are "not treating" the amputation must still consider it since it relates to overall health of patient.
  - Vascular disease
  - Neuropathy
  - Ambulation
  - Behavioral health

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Documentation Considerations

- Document underlying conditions (PAD, diabetes, etc.).
- Document foot ulcers on contralateral extremity, and if due to diabetes.
- Document current nicotine status; tobacco dependence or history of tobacco use, or nicotine dependence.
  - Per ICD-10-CM, "smoker" is coded as nicotine dependence
- Include any late effects of amputation.
- Do not report amputation status for congenital conditions.

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Documentation Considerations

- Do not report amputation status (189) for the encounter when the amputation occurs.
  - Report 173 for amputation initial/subsequent healing.
  - Only reported on subsequent encounters.

Location	Right	Left	Unspecified
Great toe	Z89.411	Z89.412	Z89.419
Other toe(s)	Z89.421	Z89.422	Z89.429
Foot	Z89.431	Z89.432	Z89.439
Ankle	Z89.441	Z89.442	Z89.449
Below knee	Z89.511	Z89.512	Z89.519
Above knee	Z89.611	Z89.612	Z89.619

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Variety of Documentation Examples

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Documentation Improvement Examples

Nonspecific Documentation
The anemia is caused by patient's peptic ulcer.

Improved Documentation
The patient's chronic blood-loss anemia is caused by patient's chronic gastric ulcer with hemorrhage. Will test for H. pylori and start her on proton pump inhibitors as well as two-week course of tetracycline.

Nonspecific Documentation
IBD. Will treat current flare-up with short course of prednisone.

Improved Documentation
Crohn's disease of large and small intestine, with acute flare-up causing limited rectal bleeding. Will start on short course of prednisone.

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Documentation Improvement Examples

Nonspecific Documentation
Compression fractures, T8 – T10.

Improved Documentation
Traumatic wedge compression fractures, T8 – T10.

Nonspecific Documentation
Fracture due to neoplastic disease.

Improved Documentation
X-ray reveled pathological fracture of left ulna, which we determine to be metastatic cancer from the breast to ulna. The patient underwent a right mastectomy six months ago and has completed chemotherapy.

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Documentation Improvement Examples

Nonspecific Documentation

70 year-old needs prosthesis evaluation.

Improved Documentation

70 year-old with right below-knee amputation (BKA) is here today to evaluate advancing from a wheelchair to a prosthesis now that his wound site has healed.

Nonspecific Documentation

Physical examination: Lower extremities: No change.

Improved Documentation

Physical examination: Lower extremities: Left ankle discoloration and diminished pedal pulses associated with atherosclerosis of native arteries of lower extremities. Right extremity: BKA status without evidence of pressure ulcers or skin irritation at the stump. Gait seems stable.

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Documentation Improvement Examples

Nonspecific Documentation

Patient's pancreatic cancer has advanced. I have suggested parenteral feeding, but she declines.

Improved Documentation

Patient's pancreatic cancer has metastasized to the peritoneum and liver. I have suggested parenteral feeding to address her severe malnutrition, but she declines.

Nonspecific Documentation

She has developed wasting syndrome.

Improved Documentation

She has developed wasting disease with a current BMI of 15.8. The main goal is to keep her hydrated and comfortable in her end-stage COPD. She is receiving morphine for her dyspnea.

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Documentation Improvement Examples

Nonspecific Documentation	Improved Documentation

Vitals:
Height: 6'1"
Weight: 322 lb.
BMIL 42.5
Temp: 98.65
BP: 138/90
Heart: 64 BPM
Resp: 20 BPM

Mickey is an obese man who is here today as a follow-up to his COPD and hypertension, and to discuss a weight-loss referral.

Vitals:
Height: 6'1"
Weight: 322 lb.
BMIL 42.5
Temp: 98.65
BP: 138/90
Heart: 64 BPM
Resp: 20 BPM

Mickey is a *morbidly* obese man who is here today as a follow-up to his COPD and his *controlled* hypertension, and to discuss a weight-loss referral.

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Summing it Up

- Risk adjustment isn't going away.
- Risk adjustment will change every year.
- Risk adjustment varies between MA, ACA and private payers.
- Don't forget about status conditions.
- "**Think in Ink**" is a new catchphrase for providers.
- "Conjunction Junction" to connect causal relationships.
- Begin working with providers on how to document to represent the severity of the conditions.

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QUESTIONS

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