CMS Risk Adjustment
Medicare Advantage
Where Clinical Documentation, Coding and Care Payment Meet

Donna Malone, CPC, CRC
Director: Ambulatory CDI – Risk Adjustment
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Donna Malone:

Donna.Malone@enjoincdi.com  or  dmmalone563@gmail.com

This presentation is designed for ease of reference regarding principles of Risk Adjustment and CMS guidelines for complete documentation and correct coding

Authoritative references from which this material is drawn are the ICD-9/ICD-10-CM Code Sets and Official Guidelines for Coding and Reporting, the CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide and the AHA Coding Clinic

All conditions affecting care, management, or treatment of the patient should be documented as precisely as possible and coded to the highest level of specificity according to the ICD-9/ICD-10 Official Guidelines for Coding and Reporting

The final arbiter of clinical impression selection is the judgment of the clinician
Agenda

- Risk Adjustment Basics and Beyond
- Overview of CMS Documentation Requirements and Coding Guidelines
- Common Documentation Challenges
- Common Errors and Missed Diagnosis Codes
- Grey Areas of Coding
- Encounter Review
- Strategic Initiatives
CMS RISK ADJUSTMENT
Terminology

Demographics: Characteristics of a beneficiary such as age, sex, Medicaid status, and disability.

Dual Eligible: An MA eligible individual who is also entitled to Medical Assistance under a State Plan under Title XIX (Medicaid).

EDI: Electronic Data Interchange Agreement - An agreement MA organizations have with CMS to follow provisions for submitting risk adjustment data through one of CMS’ accepted types of electronic connections.

EDPS: Encounter Data Processing System.

FERAS: Submitters send risk adjustment data to the Front-End Risk Adjustment System (FERAS) where front-end edits are performed.

HCC: The Hierarchical Condition Category is a diagnosis grouping with a single relative factor assigned to it for each model segment.

MA: Medicare Advantage.

MAP: Medicare Advantage Plan.

MARx UI: The Medicare Advantage Prescription Drug System (MARx) User Interface (UI) maintains Medicare beneficiary eligibility and payment data, and calculates the risk payment.

MCO: Managed Care Organization.
Terminology

- **MMR**: Monthly Member Report

- **Model Run**: The risk adjustment model is run to calculate risk scores for all beneficiaries with available data. This occurs three times each payment year: once for initial risk score, once for the mid-year update, and once for final reconciliation.

- **MRA**: Submitters send risk adjustment data to the Front-End Risk Adjustment System (FERAS) where front-end edits are performed.

- **PMPM**: Per Member Per Month

- **RADV**: Risk Adjustment Data Validation

- **RAF**: Risk Adjustment Factor

- **RAPS**: Risk Adjustment Processing System through which risk adjustment data are processed. After the data submitted by Medicare Advantage (MA) organizations passes the checks in the Front-End Risk Adjustment System (FERAS), the data is sent to the CMS data center for RAPS processing. RAPS performs complete editing of all detail records which are then stored in the RAPS database.

- **Risk Score**: Statistical weights used to determine final MAP Premiums

- **RxHCC**: Prescription Drug Hierarchal Condition Category
Risk Adjustment: *The Purpose*

- Risk adjustment predicts or explains the future healthcare expenditures of individuals based on diagnoses and demographics.
- Predicts the variations in resources that are required to care for different patients and to reimburse providers appropriately based on those variations.

*OREC = Original Reason for Entitlement Code*
Characteristics of the CMS-HCC Model

• **Prospective**
  o Diagnoses from the current (base) year used to predict payments for the following year

• **Demographic factors**
  o Sex and Age
  o Original Reason Entitled to Medicare
  o Medicaid Status
  o New Enrollee
  o ESRD Status (Different but similar HCC Model)

• **Disease groups**
  o Clinically related diagnoses with similar costs

• **Site neutral (Place of Service)**

• **Additive**

• **Hierarchical**
<table>
<thead>
<tr>
<th>Variable</th>
<th>Community, NonDual, Aged</th>
<th>Community, NonDual, Disabled</th>
<th>Community, Full Benefit (FB) Dual, Aged</th>
<th>Community, Full Benefit (FB) Dual, Disabled</th>
<th>Community, Partial Benefit (PB) Dual, Aged</th>
<th>Community, Partial Benefit (PB) Dual, Disabled</th>
<th>Institutional</th>
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<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0-34 Years</td>
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<td>1.031</td>
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<tr>
<td>35-44 Years</td>
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<td>0.303</td>
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<td></td>
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<td>0.999</td>
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<tr>
<td>45-54 Years</td>
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<td>1.007</td>
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<tr>
<td>55-59 Years</td>
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<td>65-69 Years</td>
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<td></td>
<td></td>
<td>1.200</td>
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<tr>
<td>70-74 Years</td>
<td>0.374</td>
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<td>0.511</td>
<td></td>
<td></td>
<td></td>
<td>1.092</td>
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<tr>
<td>75-79 Years</td>
<td>0.448</td>
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<td>0.611</td>
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<td></td>
<td>0.995</td>
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<tr>
<td>80-84 Years</td>
<td>0.537</td>
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<td>0.739</td>
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<td></td>
<td></td>
<td>0.860</td>
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<td>85-89 Years</td>
<td>0.664</td>
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<td>0.917</td>
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<td></td>
<td></td>
<td>0.749</td>
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<tr>
<td>90-94 Years</td>
<td>0.797</td>
<td>--</td>
<td>1.037</td>
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<td></td>
<td>0.626</td>
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<tr>
<td>95 Years or Over</td>
<td>0.816</td>
<td>--</td>
<td>1.094</td>
<td></td>
<td></td>
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<td>0.456</td>
</tr>
</tbody>
</table>
Risk Adjustment:
Hierarchical Condition Category (HCC)

- There are approximately 8,800 ICD-10-CM diagnoses that map to 79 Hierarchical Condition Categories (HCC).
- A coefficient or “weight” is assigned to each category of chronic complex diagnoses as well as severe acute diagnoses.
- The RAF score is calculated for each member by adding Hierarchical Condition Categories (HCCs) and demographic values.

<table>
<thead>
<tr>
<th>HCC Category</th>
<th>Description Label</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC01</td>
<td>HIV/AIDS</td>
<td>0.312</td>
</tr>
<tr>
<td>HCC02</td>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock</td>
<td>0.455</td>
</tr>
<tr>
<td>HCC06</td>
<td>Opportunistic Infections</td>
<td>0.435</td>
</tr>
<tr>
<td>HCC08</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.625</td>
</tr>
<tr>
<td>HCC09</td>
<td>Lung and Other Severe Cancers</td>
<td>0.970</td>
</tr>
<tr>
<td>HCC10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.677</td>
</tr>
<tr>
<td>HCC11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.301</td>
</tr>
<tr>
<td>HCC12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.146</td>
</tr>
<tr>
<td>HCC17</td>
<td>Diabetes with Acute Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC18</td>
<td>Diabetes with Chronic Complications</td>
<td>0.318</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complication</td>
<td>0.104</td>
</tr>
<tr>
<td>HCC21</td>
<td>Protein-Calorie Malnutrition</td>
<td>0.545</td>
</tr>
<tr>
<td>HCC22</td>
<td>Morbid Obesity</td>
<td>0.273</td>
</tr>
<tr>
<td>HCC23</td>
<td>Other Significant Endocrine and Metabolic Disorders</td>
<td>0.228</td>
</tr>
<tr>
<td>HCC27</td>
<td>End-Stage Liver Disease</td>
<td>0.962</td>
</tr>
<tr>
<td>HCC28</td>
<td>Cirrhosis of Liver</td>
<td>0.390</td>
</tr>
</tbody>
</table>

Note: Coefficients shown are based on CMS HCC Model V22 – community, non-dual, aged.
Risk Adjustment:
Payments Based on Highest Degree of Severity

CMS accounts for varying severities within a disease grouping with payments based on the most severe form.

<table>
<thead>
<tr>
<th>HCC Category</th>
<th>Description Label</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC08</td>
<td>Metastatic Cancer and Acute Leukemia</td>
<td>2.625</td>
</tr>
<tr>
<td>HCC09</td>
<td>Lung and Other Severe Cancers</td>
<td>0.970</td>
</tr>
<tr>
<td>HCC10</td>
<td>Lymphoma and Other Cancers</td>
<td>0.677</td>
</tr>
<tr>
<td>HCC11</td>
<td>Colorectal, Bladder, and Other Cancers</td>
<td>0.301</td>
</tr>
<tr>
<td>HCC12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
<td>0.146</td>
</tr>
</tbody>
</table>

Example: Visit 1 2016:

January 2016 Sally Smith is diagnosed with:
LUQ Breast Cancer = HCC 12

Visit 2 2016:

June 2016 Sally Smith is diagnosed with:
LUQ breast cancer = HCC 12 (0.146)
with metastasis to ribs = HCC 8 (2.625)
Risk Adjustment: *Disease Interactions*

- CMS recognizes the increased burden and cost of managing members with multiple complex conditions, not accounted for in the mere adding of the disease coefficients.
- Disease interactions provide additional coefficients or “weight” to help with offsetting additional cost burden caring for these members based on Medicare eligibility.

**Example:**
Disease interactions for Community based, Non-Dual, Aged

<table>
<thead>
<tr>
<th>Disease Interactions - Description Labels</th>
<th>Community, NonDual, Aged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immune Disorders*Cancer Group</td>
<td>0.893</td>
</tr>
<tr>
<td>Congestive Heart Failure*Diabetes Group</td>
<td>0.154</td>
</tr>
<tr>
<td>Congestive Heart Failure*Chronic Obstructive Pulmonary Disease Group</td>
<td>0.190</td>
</tr>
<tr>
<td>Congestive Heart Failure*Renal Group</td>
<td>0.270</td>
</tr>
<tr>
<td>Cardiorespiratory Failure Group*Chronic Obstructive Pulmonary Disease Group</td>
<td>0.336</td>
</tr>
<tr>
<td>Congestive Heart Failure*Specified Heart Arrhythmias</td>
<td>0.105</td>
</tr>
</tbody>
</table>

*CMS applies these coefficients annually based on diagnosis data captured within the collection year*

Note: Coefficients shown are based on CMS HCC Model V22 – community, non-dual, aged
Robert Smith’s clinical picture Type II Diabetic with CKD stage 5, Chronic Diastolic CHF, & COPD

Demographics
- 84 yr old Female - Full Benefit (FB) dual aged 0.739
- COPD ICD-10-CM Code J44.9 (HCC 111) 0.422
- Type II Diabetes w/ Diabetic CKD ICD-10-CM Code E11.22 (HCC 18) 0.346
- CKD Stage 5 ICD-10-CM Code N18.5 (HCC 136) 0.244
- Chronic Diastolic CHF ICD-10-CM Code I150.32 (HCC 85) 0.355
- Disease Interaction (Diabetes and CHF) 0.205
- Disease Interaction (CHF and Renal Failure) 0.271
- Disease Interaction (CHF and COPD) 0.240

Total Raw RAF: (Demographics and HCC) 2.582

Risk Score
- Provider Impact – based on specificity and comprehensive documentation

Interaction coefficients added by CMS

All conditions precisely documented

Payment
- PMPM Payment $2,066
- Annual Payment $24,787
REVIEW OF CMS REQUIREMENTS & DOCUMENTATION AND CODING GUIDELINES
Medical Record Requirements: CMS HCC Code Capture

- Patient’s name, record number or identifier and date of service (DOS) must appear on all pages of the medical record.
- Encounter must be based on a *face-to-face visit*.
- Documentation must show that the condition(s) was monitored, evaluated, assessed, or treated or.
- Encounter must be legible by all not just the author.
- ICD-10 codes can be assigned to each condition substantiated by documentation in that specific date of service.
- Provider’s signature, credentials, and date signed must appear on each encounter.
- The encounter documentation must support all diagnoses coded for the date of service and must be able to stand-alone.
- Documentation must be completed by an acceptable provider type MD, DO, NP, PA or other acceptable provider types.
## Acceptable Provider Specialties

<table>
<thead>
<tr>
<th>Code</th>
<th>Specialty</th>
<th>Code</th>
<th>Specialty</th>
<th>Code</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Practice</td>
<td>25</td>
<td>Physical Medicine And Rehabilitation</td>
<td>67</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>2</td>
<td>General Surgery</td>
<td>26</td>
<td>Psychiatry</td>
<td>68</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>3</td>
<td>Allergy/Immunology</td>
<td>27</td>
<td>Geriatric Psychiatry</td>
<td>72*</td>
<td>Pain Management</td>
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<tr>
<td>4</td>
<td>Otolaryngology</td>
<td>28</td>
<td>Colorectal Surgery</td>
<td>76*</td>
<td>Peripheral Vascular Disease</td>
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<tr>
<td>5</td>
<td>Anesthesiology</td>
<td>29</td>
<td>Pulmonary Disease</td>
<td>77</td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>6</td>
<td>Cardiology</td>
<td>33*</td>
<td>Thoracic Surgery</td>
<td>78</td>
<td>Cardiac Surgery</td>
</tr>
<tr>
<td>7</td>
<td>Dermatology</td>
<td>34</td>
<td>Urology</td>
<td>79</td>
<td>Addiction Medicine</td>
</tr>
<tr>
<td>8</td>
<td>Family Practice</td>
<td>35</td>
<td>Chiropractic</td>
<td>80</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>9</td>
<td>Interventional Pain Management (IPM)</td>
<td>36</td>
<td>Nuclear Medicine</td>
<td>81</td>
<td>Critical Care (Intensivists)</td>
</tr>
<tr>
<td>10</td>
<td>Gastroenterology</td>
<td>37</td>
<td>Pediatric Medicine</td>
<td>82</td>
<td>Hematology</td>
</tr>
<tr>
<td>11</td>
<td>Internal Medicine</td>
<td>38</td>
<td>Geriatric Medicine</td>
<td>83</td>
<td>Hematology/Oncology</td>
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<tr>
<td>12**</td>
<td>Osteopathic Manipulative Medicine</td>
<td>39</td>
<td>Nephrology</td>
<td>84</td>
<td>Preventive Medicine</td>
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<tr>
<td>13</td>
<td>Neurology</td>
<td>40</td>
<td>Hand Surgery</td>
<td>85</td>
<td>Maxillofacial Surgery</td>
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<tr>
<td>14</td>
<td>Neurosurgery</td>
<td>41</td>
<td>Optometry</td>
<td>86</td>
<td>Neuropsychiatry</td>
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<tr>
<td>15</td>
<td>Speech Language Pathologist</td>
<td>42</td>
<td>Certified Nurse Midwife</td>
<td>89*</td>
<td>Certified Clinical Nurse Specialist</td>
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<tr>
<td>16</td>
<td>Obstetrics/Gynecology</td>
<td>43</td>
<td>Certified Registered Nurse Anesthetist</td>
<td>90</td>
<td>Medical Oncology</td>
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<td>17</td>
<td>Hospice And Palliative Care</td>
<td>44</td>
<td>Infectious Disease</td>
<td>91</td>
<td>Surgical Oncology</td>
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<td>18</td>
<td>Ophthalmology</td>
<td>46*</td>
<td>Endocrinology</td>
<td>92</td>
<td>Radiation Oncology</td>
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<td>19</td>
<td>Oral Surgery</td>
<td>48*</td>
<td>Podiatry</td>
<td>93</td>
<td>Emergency Medicine</td>
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<td>50*</td>
<td>Nurse Practitioner</td>
<td>94</td>
<td>Interventional Radiology</td>
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<tr>
<td>21***</td>
<td>Cardiac Electrophysiology</td>
<td>62*</td>
<td>Psychiatrist</td>
<td>97*</td>
<td>Physician Assistant</td>
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<td>Pathology</td>
<td>64*</td>
<td>Audiologist</td>
<td>98</td>
<td>Gynecologist/Oncologist</td>
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<tr>
<td>23***</td>
<td>Sports Medicine</td>
<td>65</td>
<td>Physical Therapist</td>
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<td>Unknown Physician Specialty</td>
</tr>
<tr>
<td>24</td>
<td>Plastic And Reconstructive Surgery</td>
<td>66</td>
<td>Rheumatology</td>
<td><strong>CO</strong>*</td>
<td>Sleep Medicine</td>
</tr>
</tbody>
</table>
Illegible Signatures

CMS update March 16, 2010

• Illegible signatures:
  o An illegible signature is acceptable if placed above a legible typed or printed name
  o An illegible signature is acceptable if the letterhead, addressograph, or other information on the page indicates the identity of the individual who signed the entry
  o Can be verified by a signature log

• Signature stamps are not acceptable unless there is a proven disability for which the provider is only able to utilize the stamp
Unsigned Documentation

• All documentation should be signed at the time of the entry to avoid the need of an attestation

• When CMS conducts Targeted Risk Adjustment Data Validation Audits (RADV) it’s based on services provided four years prior to CMS notification to the Medicare Advantage plan

Example:
Medicare Advantage Plans notified in September 2015 for RADV for Payment Year (PY) 2012 which corresponds to 2011 DOS

• CMS does have an attestation provision built into the RADV process however if the provider of record is unavailable to sign the attestation CMS will find the encounter as discrepant given CMS is unable to verify the encounter was performed by a CMS acceptable provider
How likely will you be successful finding the provider if this is their view?
Stand-A-lone Encounter

- Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.

- Conditions documented on previous encounters may not be clinically relevant on the current encounter.

- The provider is responsible for diagnosing and documenting all relevant conditions. A patient’s historical problem list is not necessarily the same for every encounter.

- When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter or admission. **However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without provider confirmation.**
Review:

**General Documentation & Coding Guidelines**

- The documentation must support the code selected and substantiate that proper coding guidelines were followed.

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s) (J ICD-9)(I ICD 10).

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. History codes (ICD-9:V10-V19)(ICD-10:Z80-Z87) personal and family history codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. (K ICD 9)(J ICD 10).
Co-Existing and Related Conditions

- Co-existing conditions include chronic conditions such as:
  - Diabetes
  - Congestive Heart Failure
  - Atrial Fibrillation
  - Chronic Obstructive Pulmonary Disease

- Conditions are generally managed by long-term medications and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions.

- It is likely that these diagnoses would be part of a general overview of the patient’s health when treating co-existing conditions for all but the most minor of medical encounters.

- Additional Co-existing conditions also include chronic conditions such as:
  - Multiple Sclerosis
  - Hemiplegia
  - Rheumatoid Arthritis
  - Parkinson’s Disease

- Although these do not have an impact on every minor healthcare episode, it is likely that patients having these conditions would have their general health status evaluated within a data reporting period, and these diagnoses would be documented and reportable at that time.
Documentation Requirements for ICD-10-CM Code capture

- Under the official ICD-10-CM Coding Guidelines, a diagnosis can only be coded when it is explicitly spelled out in the medical record.
- All documentation used for coding must be specific.
- Super-bills, encounter forms and referrals are not acceptable forms of documentation. CMS does not recognize superbills as an extension of your documentation. These forms are simply a billing tool to capture services provided for a specific encounter.

If a provider chooses to use a superbill or encounter form for code capture, the codes MUST be supported in the documentation in the patient’s chart for that encounter.
CMS Ruling: Use of Problem Lists

- For CMS’ risk adjustment data validation purposes, an acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-9/ICD-10 code on the date of service.
- It must be signed and dated by the physician or physician extender (NP, PA).
Outpatient: Unconfirmed Diagnoses

- Probable, suspected, questionable, R/O, Versus, likely, most likely, etc. cannot be coded for professional claims (outpatient services)
  - Code the condition(s) to the highest degree of certainty for that encounter or visit such as signs, symptoms, abnormal test results, or other reason for the visit

Refer to Section IV-I: ICD-9 Official Guidelines for Coding and Reporting
Refer to Section IV-H: ICD-10 Official Guidelines for Coding and Reporting
DOCUMENTATION CHALLENGES
EDUCATING PROVIDERS
Commonly Missed Chronic Conditions

ALL chronic conditions—even if stable—should be assessed and captured at least every year as well as each time a chronic condition has an impact on the diagnosis or treatment of an acute or other chronic condition.

- Amputations
- Parkinson’s Disease
- Rheumatoid Arthritis
- Atherosclerosis of aorta
- Alcohol & Drug Dependency
  - (even in remission)
- Morbid Obesity (BMI >40)
- Ectasia
- Organ Transplants
- Multiple sclerosis
- CHF
- Chronic psychiatric diagnoses
- Ostomy
  - (Open? Closed?)
- COPD
- Aneurysm
Impact of Terminology on RA

Common terms or phrases that are not interchangeable

• Lesion =Wound=Ulcer
  o If Ulcer: Indicate Type
    • If Pressure Ulcer indicate location, laterality and stage
    • If Non-Pressure Ulcer indicate location, laterality, severity & underlying condition if applicable

• Elevated Blood Pressure = Hypertension (Essential)

• Diastolic dysfunction = Diastolic Heart Failure

• Weakness = Hemiparesis (except when sequela of a CVA)

• Renal Insufficiency Syndrome = Chronic Kidney Disease
  o If CKD, identify Stage I-V or ESRD

• Failure to thrive (common use) = Malnutrition
  o If Malnutrition: Type
    • If Protein-Calorie Malnutrition provide supportive evidence (labs, % weight loss, BMI < 18.5)

• Mass = Neoplasm
Language is Important: *Causal Relationship*

- Some conditions are the result of or manifestation of another condition
- Coders cannot interpret causal relationships between conditions if the “causal language” is not documented*
- Causal or “linking” language establishes the connection between the condition & a resulting manifestation or late effect:
  - Hypertensive Heart Disease: where the Heart Disease is a manifestation of hypertension *(This will be assumed as of October 1, 2016***)
    - Acceptable: Heart Disease *secondary to* HTN
  - Right hemiplegia *caused by* stroke: where the hemiplegia is a late effect of a stroke

*As in most rules... ICD-10-CM does incorporate exceptions
Example: Hypertension and Chronic Kidney Disease has an assumed relationship
Refer to Section I.C.Ch7.a.3-4: ICD-9-CM Official Guidelines for Coding and Reporting
Refer to Section I.C.Ch9.a.2-3: ICD-10-CM Official Guidelines for Coding and Reporting

** Refer to Section I.C.Ch9.a.1: (2017) ICD-10-CM Official Guidelines for Coding and Reporting
Language is Important: *History vs Active*

- **“History of” terminology is different for clinicians and coders:**
  - ICD-9 & 10 Coding Guidelines:
    - History of means: Condition has resolved and is now history
  - For providers:
    - History of means: it happened, maybe it’s in the past, or it may be ongoing

- **Phrases that can be used to reflect a current condition:**
  - In the HPI state:
    - Patient here for management of...
    - Patient here for follow-up of...
  - Assessment/Plan section
    - “Compensated CHF” vs “Hx of CHF”
    - “Leukemia in remission” vs “Hx of leukemia”
# History vs Active Conditions

<table>
<thead>
<tr>
<th>Medical Note States:</th>
<th>Coder and CMS Interpretation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF</td>
<td>CHF has resolved</td>
</tr>
<tr>
<td>CHF Compensated</td>
<td>CHF active and stable</td>
</tr>
<tr>
<td>History of Angina</td>
<td>Angina has resolved</td>
</tr>
<tr>
<td>Stable Angina Nitrostat® PRN</td>
<td>Angina is stable on active treatment</td>
</tr>
<tr>
<td>H/O Afib</td>
<td>Afib has resolved</td>
</tr>
<tr>
<td>Afib controlled on digoxin</td>
<td>Afib is stable on active treatment</td>
</tr>
<tr>
<td>Prostate Cancer s/p Chemotherapy</td>
<td>Prostate cancer is eradicated</td>
</tr>
<tr>
<td></td>
<td>Documentation does not indicate when patient completed chemotherapy (e.g. Jan ‘09, Dec ’15)</td>
</tr>
<tr>
<td>Prostate Cancer Lupron® Injections Q3mo</td>
<td>Prostate cancer is active with active treatment</td>
</tr>
</tbody>
</table>

If your patient has an **active condition** documentation must reflect the correct story. "History of" language should not be used.
## Non-Specific Documentation

Diagnoses that often default to “Unspecified” due to the use of non-specific language

<table>
<thead>
<tr>
<th>Example</th>
<th>Document specificity such as:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrhythmia</td>
<td><strong>Type:</strong> SSS, Tachy-brady syndrome, Afib, A-Flutter, Tachycardia, Bradycardia</td>
</tr>
<tr>
<td>CKD</td>
<td><strong>Stage:</strong> Stage I-V, ESRD</td>
</tr>
</tbody>
</table>
| Heart Failure            | **Type:** Systolic, Diastolic, Combined  
                          | **Severity:** Acute, Chronic, Acute on Chronic |
| Depression               | **Type:** Situational, Major Depression, Manic, Seasonal, Severe |
| Major Depression         | **Episode:** Single, Recurrent  
                          | **Severity:** Mild, Moderate, Severe, In Remission, Unspecified |
| Arthritis                | **Type:** Rheumatoid, Degenerative, Inflammatory, Psoriatic |
| Atherosclerosis          | **Location:** Coronary Artery, Extremities, Graft, Aorta |
Levels of Documentation:
Financial Comparison – Risk Adjustment Factor (RAF):

<table>
<thead>
<tr>
<th>No conditions documented or patient not seen in CY</th>
<th>Conditions not documented to missing documentation</th>
<th>All condition precisely documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>84 year old female – Full benefit dual aged .739</td>
<td>84 year old female – Full benefit dual aged .739</td>
<td>84 year old female – Full benefit dual aged .739</td>
</tr>
<tr>
<td>No COPD documented --</td>
<td>COPD J44.9 (HCC 111) .422</td>
<td>COPD J44.9 (HCC 111) .422</td>
</tr>
<tr>
<td>No Diabetes documented --</td>
<td>Diabetes w/o Compl. E11.9 (HCC 19) .097</td>
<td>Diabetes w/ diabetic CKD E11.22 (HCC 18) .346</td>
</tr>
<tr>
<td>No CKD Stage 5 documented --</td>
<td>No CKD Stage 5 documented --</td>
<td>CKD Stage 5 N18.5 (HCC 136) .244</td>
</tr>
<tr>
<td>No Chronic Diastolic CHF documented --</td>
<td>No Chronic Diastolic CHF documented --</td>
<td>Chronic Diastolic CHF I50.32 (HCC 85) .355</td>
</tr>
<tr>
<td>No disease interaction --</td>
<td>No disease interaction --</td>
<td>Disease Interaction (DM + CHF) .205</td>
</tr>
<tr>
<td>No disease interaction --</td>
<td>No disease interaction --</td>
<td>Disease Interaction (CHF + RF) .271</td>
</tr>
<tr>
<td>No disease interaction --</td>
<td>No disease interaction --</td>
<td>Disease Interaction (CHF + COPD) .240</td>
</tr>
<tr>
<td>Total RAF score .739</td>
<td>Total RAF score 1.258</td>
<td>Total RAF score 2.582</td>
</tr>
<tr>
<td>PMPM Payment $566</td>
<td>PMPM Payment $963</td>
<td>PMPM Payment $1975</td>
</tr>
<tr>
<td>Annual Payment $6,788</td>
<td>Annual Payment $11,555</td>
<td>Annual Payment $23,716</td>
</tr>
</tbody>
</table>

Sue Smith DOB 1/10/1931 Clinical picture: Diabetic CKD Stage 5, Chronic Diastolic CHF & COPD

Values are for illustrative purposes only based on Full benefit dual-aged PY2017
Non-Recapture: *Financial Implications*

<table>
<thead>
<tr>
<th>Condition</th>
<th>HCC</th>
<th>HCC Coefficient &quot;weight&quot;</th>
<th>Revenue Impact PMPY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>85</td>
<td>0.323</td>
<td>$2,965</td>
</tr>
<tr>
<td>CKD Stage 4</td>
<td>137</td>
<td>0.237</td>
<td>$2,176</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>71</td>
<td>1.007</td>
<td>$9,244</td>
</tr>
<tr>
<td>COPD</td>
<td>111</td>
<td>0.328</td>
<td>$3,011</td>
</tr>
<tr>
<td>Ostomy Status</td>
<td>188</td>
<td>0.571</td>
<td>$5,242</td>
</tr>
<tr>
<td>Diabetes with Complications</td>
<td>18</td>
<td>0.318</td>
<td>$2,919</td>
</tr>
<tr>
<td>Amputation Status – (BKA)</td>
<td>189</td>
<td>0.588</td>
<td>$5,398</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>22</td>
<td>0.273</td>
<td>$2,506</td>
</tr>
</tbody>
</table>

Total plan membership = 100,000 of which 30% carry the diagnosis of CKD Stage 4 with 5% not recaptured. The financial HCC impact = $2,176 X 1,500 = $3,264,000

*Values are for illustrative purposes only based on non-dual aged PY2017 – Assumes 12 months of eligibility*
SPECIFICITY REQUIRED FOR ACCURATE CODE CAPTURE
Diabetes in ICD-10-CM: Accurate Code Capture

- There are fewer **two code conventions** with diabetic complications needed in ICD-10
  - Diabetic Ulcer will require a second code to identify:
    - Site, laterality and severity of the ulcer
  - Diabetic CKD will require a second code to identify:
    - The stage of CKD

- ICD-10 **allows for assumed causal relationships** with many of the chronic complications

- Reference:
  - AHA Coding Clinic: First Quarter, 2016, Page 11
  - Second Quarter, 2016, Page 36

---

**Diabetes, diabetic (mellitus) (sugar) E11.9**
- with
  - amyotrophy E11.44
  - arthropathy NEC E11.618
  - autonomic (poly)neuropathy E11.43
  - cataract E11.36
  - Charcot’s joints E11.610
  - chronic kidney disease E11.22
  - circulatory complication NEC E11.59
  - nephropathy E11.21
  - neuralgia E11.42
  - neurologic complication NEC E11.49
  - neuropathic arthropathy E11.610
  - neuropathy E11.40
  - retinopathy E11.319
  - skin ulcer NEC E11.622

*Not an inclusive list*
Major Depressive Disorder (MDD)

Required documentation:

- **Episode**: single or recurrent

- **Severity**: mild, moderate, severe, in remission, or unspecified
  - Treatment includes medication, therapy, monitoring for stability
  - Remission is further specified as partial or full remission

Without specification of episode and severity of MDD the complexity of the diagnosis is not represented and does not capture the complete diagnosis in ICD-10-CM

Note:

Documentation of Anxiety/Depression ≠ Anxiety with Depression
Depression NOS == Major Depression Disorder Unspecified
Coding: Hypertensive Heart with HF & CKD

Clinical Impression:
Hypertensive Heart Disease with Acute Systolic CHF and CKD Stage IV

I13._ Hypertensive Heart Disease & CKD
First 3 characters indicate category of the condition
I13.0 Hypertensive Heart Disease with Heart Failure & CKD Stage I-IV, or Unspecified
4th character indicates with Heart Failure & CKD stage range
Additional codes are required to describe the heart failure and CKD stage

I50._ Heart Failure
First 3 characters indicate category of the condition
I50.2_ Systolic Heart Failure
4th character indicates the type of Heart Failure
I50.21 Acute Systolic Heart Failure
5th character indicates further specification of severity

N18._ Chronic Kidney Disease
First 3 characters indicate category of condition
N18.4 CKD Stage IV

Final Codes I13.0 (HCC 85), I50.21 (HC 85) and N18.4 (HCC 137)
Cerebrovascular Accident (CVA)

- **Office visits are directed at follow up and to address any residual deficits**

- **Documentation to support coding**
  - Personal history of TIA or stroke without residual deficits
  - Late effects which include:
    - Cognitive deficits
    - Monoplegia of lower limb (Lt or Rt)\(^1\)
    - Monoplegia of upper limb (Lt or Rt)\(^1\)
    - Hemiplegia/paresis (Lt or Rt)\(^2\)
    - Other paralytic syndrome\(^2\)
    - Other late effects\(^2\) of cerebrovascular disease
    - Speech and language deficits\(^2\)

**Examples:**
Left hemiplegia **due to** stroke

**CVA sequelae:** aphasia, monoplegia right arm, difficulty swallowing, weakness\(^3\)

**Notes:**
1. Identify the dominant side for code specificity
2. Provide causal language linking stroke to the late effect
3. Weakness due to CVA should be coded as Hemiparesis/Hemiplegia due to CVA

*AHA Coding Clinic 2015, Volume 2, Quarter 1, Number 1*
Coding: Residual/Sequela Effects

• A late effect is the residual effect after the acute phase of an illness or injury has been terminated
• There is **no time limit** of when a late effect code can be used
• The late effect must be linked by the provider to the illness that caused the residual condition

**Example:**
Left-sided paralysis due to previous cerebrovascular accident (CVA)
I69.354:
Hemiplegia following cerebral infarction affecting left non-dominant side

ICD-9-CM Official Guidelines for Coding and Reporting: Section I.B.12
ICD-10-CM Official Guidelines for Coding and Reporting: Section I.B.10
The Body Mass Index (BMI) may be recorded by other clinicians (e.g. dieticians, CMA, RN)

The associated diagnosis such as overweight and obesity must be documented by the patient’s provider

The BMI should only be reported as a secondary diagnosis when they meet the definition of a reportable additional diagnosis

ICD-9-CM Official Guidelines for Coding and Reporting: Section I .B.16
ICD-10-CM Official Guidelines for Coding and Reporting :Section I .B.14
Fractures:

7th Character “A” Initial Encounter

- The assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time
- 7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition

Examples of Active Treatment:
- Surgical Treatment
- Emergency Department Encounter
- Evaluation and continuing treatment by the same or a different physician

ICD-10-CM Official Guidelines for Coding and Reporting

Pathologic Fractures: Section I.C.Ch 13.c
Traumatic Fractures: Section I.C.Ch19.c.1

AHA Coding Clinic
Volume 2, First Quarter, Number1, 2015, Page 3-
Fractures:

7th Character “D” Subsequent Encounter

- 7th character “D”, subsequent encounter is used encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

Examples of Routine Care:
- Cast change or removal
- X-Ray to check healing status of fracture
- Removal of internal or external fixation device
- Medication adjustment
- Other aftercare and follow up visits following treatment of the injury or condition
- Rehabilitation services, unless a sequela is being treated.

ICD-10-CM Official Guidelines for Coding and Reporting
- Pathologic Fractures: Section I.C.Ch 13.c
- Traumatic Fractures: Section I.C.Ch19.c.1
AHA Coding Clinic
Volume 2, First Quarter, Number1, 2015, Page 3-
When Clinical and Coding Worlds Collide

Provider – Clinical Parameters

Coder – Coding Guidelines

History of Cancer

Cancer
Oncology Coding Guidelines

• ICD-10 guidelines: when a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any primary existing malignancy, a code from category Z85, a personal history of malignant neoplasm, should be used to indicate the former site
  o Active treatment includes
    • Surgery
    • Chemotherapy
    • Radiation therapy
    • Adjuvant hormonal therapies

• If provider and patient opt for no treatment toward the malignancy or treatment in contraindicated, the provider must document as such in each encounter so the appropriate active cancer code can be assigned

Example:

• Low grade prostate cancer, patient opts for no treatment at this time. Will continue to monitor every 6 months for progression of disease. We will reassess treatment options at that time.
Documentation Examples: *Malignancy*

**Clinical impression:**

**Woman with primary left UOQ breast cancer receiving chemotherapy**

- Documentation identifies:
  - Gender
  - Precise anatomic location of the malignancy
  - Laterality
  - Current “active” treatment
- **Documentation supports “active” breast cancer diagnosis**

**Prostate cancer 6 years ago, completed all therapy**

- Documentation identifies:
  - Precise anatomic location of the previous malignancy
  - No active treatment identified
- **Documentation supports “history of” prostate cancer**

**Prostate cancer diagnosed 2 years ago, treatment declined by patient (Reevaluation q6 months for disease progression; documented each visit)**

- Documentation identifies:
  - Precise anatomic location of the previous malignancy
  - Treatment status: Reason for no treatment of the active cancer
- **Documentation supports “active” prostate cancer**
**Documentation Examples: Metastases**

- Document the metastatic site (also known as the secondary site) by anatomic location. Stating “Metastatic breast cancer” is incomplete. Where is the metastasis?

- Document the primary cancer as “active” or “history of...”. Additional descriptors (site, laterality) are not needed with “history of”

**Clinical Impression:**

**Here for treatment of thoracic spinal column metastasis with current primary RLL lung cancer**

- Documentation identifies:
  - Anatomic site of secondary cancer
  - Anatomic location and laterality of Primary cancer

- Documentation supports bone metastasis and “active” primary cancer

**Clinical Impression:**

**Pulmonary metastasis (RLL) associated with history of primary bladder cancer**

- Documentation identifies:
  - Anatomic location and laterality of secondary cancer
  - Status and Anatomic location of the primary cancer

- Documentation supports lung metastasis and history of primary cancer
GREY AREAS OF CODING
Arteriosclerosis Obliterans (ASO)

75 year old diabetic male presents for f/u of ASO to the podiatrist.

PE: Extremities: bilateral edema; Pedal Pulses diminished

Assessment:
  • A) ASO stable no intervention needed at this time
  • B) DM II controlled continue Metformin®

Codes submitted:
I70.209 Arteriosclerosis of extremities
E11.9 Diabetes Type II Uncomplicated
Morbid Obesity

The provider documents morbid obesity in the history and physical only without any additional documentation to support clinical significance of this condition, such as evaluation, treatment, or increased monitoring for this condition.

Can you code the morbid obesity?
SUBJECTIVE: The patient is now 6 years post limited chemoradiation for localized large cell lymphoma of the left pelvis. She is doing well. Her 97-year-old father recently died of cancer. She herself has no evidence of recurrence. She has no other complaints or problems at this time.

PHYSICAL EXAMINATION: An alert female in no acute distress. BLOOD PRESSURE is 130/78, the NECK is supple, the LUNGS are clear, the BREASTS are symmetric without masses, the ABDOMEN is soft, non-tender, and there is no supraclavicular, axillary or inguinal adenopathy.

IMPRESSION: History of localized large cell lymphoma of the left pelvis.

PLAN: Continue observation and return back in 1 year. Repeat LDH and CBC at that time.

Code submitted : C83.36 Large Cell Lymphoma of the pelvis
Cancer: Active vs History

OFFICE CONSULTATION NEW PATIENT

HISTORY: This 70 year old patient referred by Dr. Monte but the patient was seen in the recent past by Dr. Smith who is a dermatologist. Patient is unsure how long this growth behind his ear has been present but it has been there for a while according to his wife. It was noted by Dr. Monte who referred the patient to Dr. Rodgers for management and he performed a biopsy which was reported to be malignant melanoma of the left ear so the patient was referred to me for further management.

Problem History:
DIABETES (ICD-E11.9)

Current Meds:
ACTOS TABS
LIPITOR TABS
INSULIN SYRINGE 29G X 1/211 1 ML MISC (INSULIN SYRINGE-NEEDLE U-100)

TREATMENT PLAN: We will obtain the biopsy report from the doctor's office. In the meantime he was advised wide and deep excision with reconstruction by local flap which will be done under local in ASU at the earliest convenient time.
At the same time it was explained about the possibility of metastases which could be spread by the blood or lymphatics. Once we obtain the final report from pathology further instructions will be given to the patient.

What Diagnosis code(s) would be coded?
Cancer: *Active vs History of*

A 78 year old male comes into the office for follow up of his prostate cancer. He is currently asymptomatic and is living an active life. He participates in a golf league twice a week and loves to travel with his wife of 30 years.

Assessment: Prostate cancer; Stable at this time

How would you code this?
Cancer: *Active vs History cont...*

Left blank intentionally by presenter
Dependence

Pt with history of Alcohol dependence seen today for his depression. Patient fully engaged in ADLs, and continues group therapy sessions. States depression is stable at this time.

Assessment:
Depression: continue Celexa®
Hx of Alcohol dependence
What is the correct code assignment?
Coding: Dependence vs Long Term Use

The physician documents continuous use of Vicodin for chronic degenerative joint disease of both hips. Chronic use of narcotics contract reviewed and signed by patient.

Codes submitted:
- M16.0 Bilateral DJD of Hip
- F11.20 Opioid Type Dependence (Vicodin®)

Is this the correct code assignment?
Coding: *Diabetes*

Follow up for multiple medical problems: Assume all relevant exam components have been completed

**Medications:** Glipizide 10mg p.o. b.i.d., Actos 15 mg q.d., Lisinopril 10 mg q.d., Lipitor 40 mg q.d., Synthroid 200 mcg q.d., and aspirin 325 mg q.d.

**Assessment:** A very pleasant 71 yr old female with multiple stable medical problems including a remote history Non-Q wave MI in 1998, HTN, hypothyroidism, type II DM, Hyperlipidemia, and CKD IV followed by nephrology

**Plan:** Today I have ordered a CBC, chem 7, fasting glucose, Hgb A1c, lipid profile, TSH, urine microalbumin and eGFR

**Codes submitted:**
I10 HTN, E03.9 Hypothyroidism, N18.4 CKD Stage IV
E11.9 DM T2 w/o complications, E78.5 Hyperlipidemia, I25.2 Old/Healed MI

Is this the correct code assignment for Diabetes?
Coding: Diabetes cont...

Left blank intentionally by presenter
Coding: **SSS - with Pacemaker**

Pt comes in for follow up CAD, HTN and SSS s/p pacemaker. BP 140/80  PE: Cardiac Heart regular rate and rhythm. The physician does an interrogation of the pacemaker. Pacemaker is working optimally.

Assessment:
HTN stable on Lisinopril® I10
CAD stable continue low fat diet I25.10
Sick Sinus Syndrome (SSS) Pacemaker fully functional. I49.5
Coding Fracture:
Initial – Subsequent - Sequela

69 year old female patient presents today for cast change for a previously treated left ulna shaft fracture. She is seeing Dr. Smith due to Dr. Rodgers being on vacation.

What 7th character would be reported?
Coding Fractures: Initial – Subsequent - Sequela

73 year old male patient who is status post open fracture of the right femur due to accidental gunshot wound 12 months ago, is admitted secondary to traumatic arthritis of hip due to femur fracture.

What 7th character would be reported?
Coding Fractures: 
*Initial – Subsequent - Sequela*

74 year old female patient who is seen in the ER for nondisplaced intertrochanteric fracture of the left femur due to fall out of bed

What 7th character would be reported?
Coding Fracture: *Rehabilitation*

Patient who is status post treatment of multiple fractures currently in the healing phase, is transferred the rehabilitation facility, where he is being covered by a new physician.

What 7\textsuperscript{th} character would be reported?
Encounter Review
Established Patient Encounter 10/20/2015

Chief Complaint(s): abnormal lab

History of Present Illness:
Labs showed TGC 164, H. The rest of labs WNL. Pt sent today FOBT to the labs. Asymptomatic.

Medical History
illnesses or other prior medical conditions – hypertension, hyperlipidemia.

Surgical History
RT BKA 2010

Family History

Social History
Smokeless Tobacco Use (No). tobacco use – non smoker. alcohol use – no alcohol use.
caffeine consumption – sodas none cans per day, coffee none cups per day, energy drinks none cans per day, drugs–none.
exercise – daily exercise.
pets – dogs 1.
sexual history – married.

Allergies: Aspir–Trin (aspirin) reaction: unspecified

Current Medications:
lisinopril 40 mg tablet Take 1 tablet by mouth once a day, as directed X 30 Days,
Disp. 30 NR
Plavix (clopidogrel) 75 mg tablet 1 tablet by mouth once a day, as directed X 30 Days,
Disp. 30 Rfi #6
simvastatin 20 mg tablet 1 tablet by mouth once a day, as directed X 30 Days, Disp.
30 Rfi #6

Review of Systems:
All systems are negative unless otherwise specified

Cardiovascular: normal, no problems indicated.
Pulmonary: normal, no problems indicated.

Vitals:
Height 62.99 inches Weight 235 pounds BMI 41.6 Temperature 98.2 °F (36.78°C),
Oral Pulse 77 bpm, Sitting Respiration 16 bpm Blood Pressure 135 / 75, Right arm sitting

All data fictitious for educational purposes
Missed Opportunities and RADV Risk

Left blank intentionally by presenter
Established Patient Encounter 05/10/2015
Patient: Christine Robbins DOB 5/25/1932

Chief Complaint(s): Follow up

Medical History
diabetes type II, hypertension, CVA 2012, RA, COPD, breast cancer 1999, Diabetic non-proliferative retinopathy

Surgical History
Right Breast Lumpectomy 1999
Colonoscopy 2010

Family History
all siblings currently healthy and alive.

Social History
caffeine consumption – sodas none cans per day, coffee 5–6 cups per day, drugs–none.
exercise – walking 3–4 times / wk.
pets – cats 4.
Allergies: No known drug allergies

Current Medications:
- hydrochlorothiazide 25 mg tablet  Take 1 tablet by mouth once a day, as directed
- lisinopril 5 mg tablet  Take 1 tablet by mouth once a day, as directed
- metformin 850 mg tablet  Take 1 tablet by mouth once a day, as directed
- metoprolol succinate 25 mg tablet extended release 24 hr Take 1 tablet by mouth once a day, as directed X 30 Days, Disp. 30 Rfl #5
- Spiriva inhaler twice daily
- Humira pen bi weekly

Review of Systems:
All systems are negative unless otherwise specified
Respiratory: Dyspnea on exertion
Cardiovascular: Complains of high blood pressure .
Endocrine: DM Type II.

Vitals:
Height 62.99 inches Weight  235 pounds BMI 41.6 Temperature  98.2 °F
(36.78°C), Oral Pulse  78 bpm, Sitting Respiration  16 bpm
Blood Pressure  115 / 70, Right arm sitting

Exam:
General appearance: well developed pleasant obese female. interactive during exam. overweight. well hydrated.
Respiratory: Lungs minimal crackles, mild wheezing
Cardiovascular: RRR Normal
Abdomen: soft, nontender, bowel sounds normal, no masses.
Back: normal exam of spine, ribs and pelvis.
Skin: healing heel ulcer left foot
Muskuloskeletal: rheumatoid changes
Neurologic: normal. alert and orientation x 3.
Psychiatric: normal. mood and affect appropriate for age.

Problems
Benign hypertension
DM II

Plan Note
- hydrochlorothiazide 25 mg tablet Take 1 tablet by mouth once a day, as directed
- lisinopril 5 mg tablet Take 1 tablet by mouth once a day, as directed
- metformin 850 mg tablet Take 1 tablet by mouth once a day, as directed
- metoprolol succinate 25 mg tablet extended release 24 hr Take 1 tablet by mouth once a day, as directed X 30 Days, Disp. 30 Rfl #5
- Glypizide 10 mg: 1 tab bid po.
- Retinopathy followed by Dr Yen

Disposition
Return to clinic in 3 months, fasting labs 1 week prior to apt
Next eye apt August 20,2015

Instructions
Continue current medications.; domestic violence education; Exercise; Increase fluids.; Loss weight; Low fat diet; Low Sodium diet; Medication indications, contraindications and side effects fully discussed; Encourage healthy diet and increase exercise.

Note electronically signed by: Doctor A, MD on 5/10/2015 at 05:09 PM

Codes submitted on claim:
401.1  Benign Hypertension
250.00 Diabetes Type II without mention of complications

All data fictitious for educational purposes
Missed Opportunities and RADV Risk

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STRATEGIC INITIATIVES
Better, Smarter, Healthier: Shift to Value

Collaboration
Coordination

Quality
Cost-effectiveness
Patient engagement

Physicians

Patient

Clinical Staff
Coder - CDI
Payers

Population
Risk
Outcome
Value
Patient Centered Care Takes a Village
Reporting

• Members without PCP visits
  o Members may have “specialist” of “Emergency room” visits however these are generally for very specific condition(s) and do not usually provide a comprehensive picture of the members over all health status

• Recapture of chronic conditions
  o This type of report will help ensure providers are aware of chronic conditions that still need to be addressed in the current year
  o Report should be run monthly

• Predictive Modeling: Suspect conditions based on Rx, DME and related conditions
  o Medications that do not appear to have an associated diagnosis
    Example: Member is on Coumadin with no condition submitted this year to warrant this medications

• Average age of membership
  o Average age of membership may provide understanding as to lower risk scores

• Check your claim infrastructure
  o Does the system allow for the submission of 12 diagnosis codes to be submitted?
  o Verify all codes are being received by the health plan
Provider Support

• Clean up problem lists
  o Active diagnoses versus conditions that have resolved
  o Resolved conditions should live in Past Medical History
  o RN, CMA’s and other clinical staff can help with these efforts

• Call campaigns to schedule all members listed on the “Members without PCP visits”

• Prepare the year by scheduling:
  o Comprehensive Health Assessment (CHA)
  o Annual Wellness Visits (AWV) for all members
  o Prepare visit to close gaps

• Know your membership
  o How many members are snowbirds?
  o Be sure to schedule these members in quarters 2 and 3

• Internal Chart Review
  o Providing feedback to providers on a real time basis
  o Understanding the impact of work flows within the EMR
  o Understanding the impact of paper workflows
Resources

- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide

- Risk Adjustment Processing Systems Guides
  http://www.csscoperations.com

- ICD-9-CM The Official Guidelines for Coding and Reporting
  http://www.cdc.gov/nchs/icd/icd9cm.htm

- ICD-10-CM The Official Guidelines for Coding and Reporting
  www.cdc.gov/nchs/icd/icd10cm.htm

- CMS News and Resources:

- ICD-10 CME modules developed by CMS and Medscape:
Resources

- CMS MLN Matters
- AHA Coding Clinic
- AAPC
  [https://www.aapc.com/](https://www.aapc.com/)
- AHIMA
Resources

• Quality Payment Program: Delivery system reform, Medicare Payment Reform and MACRA. The Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

• Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website:

• CMS Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) website:
  http://qhpcahps.cms.gov

• National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)1 Compliance AuditTM website:
Disclaimer

• This presentation is not to be copied or distributed without expressed written permission of the author. All inquiries can be sent to Donna Malone: Donna.Malone@enjoincdi.com or dmmalone563@gmail.com

• This presentation is designed for ease of reference regarding principles of Risk Adjustment and CMS guidelines for complete documentation and correct coding

• Authoritative references from which this material is drawn are the ICD-9/ICD-10-CM Code Sets and Official Guidelines for Coding and Reporting, the CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide and the AHA Coding Clinic

• All conditions affecting care, management, or treatment of the patient should be documented as precisely as possible and coded to the highest level of specificity according to the ICD-9/ICD-10 Official Guidelines for Coding and Reporting

• The final arbiter of clinical impression selection is the judgment of the clinician