HCC Coding for Providers

Appropriate Documentation for the Medicare Patient

November 14, 2017
Welcome & Introductions - Troy Tyner, DO, President, PHA President; KPP Board Chair, Internal Medicine Inc.

- HCC coding and effect on Physician Practice
- Expectations of all providers
- Impact of HCC coding on primary care and specialty practices

The What - Michael Vincent Smith, MD, FACC, FACS, FCCP; Regional VP, Medical Director Anthem
- Risk Adjustment by CMS
- HCC Coding for providers
- Types of HCC Coding used by Specialty Providers

The How - Troy Tyner & Mark Couch, M.D./President of PriMed Physicians
- Where to chart HCC coding/common errors
- How to Use your EHR
- Lessons Learned/Panel Discussion
Speaker Introductions
Hierarchical Condition Categories (HCC) is CMS’s methodology for determining Risk adjustment factors for Medicare Advantage programs and payments.

Codes allow claims to be risk adjusted

based on demographic and disease complexity.
If it is Not Documented; It wasn’t Done

- Good documentation captures the great works done by the provider and captures the true condition of the patients we serve.
- HCC allows us to risk stratify our patient population resulting in CMS paying more for those high risk patients.
- This is why coding the chronic disease state of the patient is so important.
HCC Coding: Effects on the practice

- Providers that treat or monitor chronic care patients can have revenue gains or losses if not coded correctly.
- Lack of coding on chronic conditions can result in revenue leakage.
Example of Revenue Leakage in a 2 year Scenario

- A 76-year old female presents with Type 2 diabetes with acute complication.
- Also, the patient has congestive heart failure that is being monitored by the provider.
- Patient is dual eligible for Medicare and Medicaid, for a per member per month (PMPM) payment of $800.
First Year: New Patient

$800 \times 1.792 \times 12 \text{ months} = \$17,203.20

<table>
<thead>
<tr>
<th>Description</th>
<th>HCC</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>76-year old female</td>
<td>Demographic</td>
<td>0.437</td>
</tr>
<tr>
<td>Dual eligibility</td>
<td>Demographic</td>
<td>0.437</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus (DM) with acute complication</td>
<td>17</td>
<td>0.368</td>
</tr>
<tr>
<td>Congestive heart failure (CHF)</td>
<td>85</td>
<td>0.368</td>
</tr>
<tr>
<td>Disease interaction, diabetes mellitus type 2 (DMII) + CHF</td>
<td>Disease interaction</td>
<td>0.182</td>
</tr>
<tr>
<td>Total risk adjustment factor</td>
<td></td>
<td>1.792</td>
</tr>
<tr>
<td>PMPM payment</td>
<td>$800</td>
<td></td>
</tr>
<tr>
<td><strong>Annual payment</strong></td>
<td><strong>$17,203.20</strong></td>
<td></td>
</tr>
</tbody>
</table>
Second year: Follow-up

- It is important to prevent revenue leakage due to lack of coding HCC conditions of our patients
- This includes the specialist practices
- Code HCC every year or annual payment suffers a loss
Keys to Success for all Providers

- Success created by all providers commit to using proper coding

- KPP providers must chart chronic conditions yearly

- Impacts Primary Care and Specialty Practices
HCC Coding- Primary Care and Specialties

★ At times the specialist is the only provider the patient will see

★ Doesn’t matter if you are Primary Care, Surgeon, OB, or Cardiac- HCC coding applies to our patient population
HCC and Payer Contracting:

- Payer contract bases PMPM on HCC coding
- Not coding HCC coding can create a false sense of the patient’s true status
- HCC coding effect CMS risk scores and Payers contracts
- KPP Medicare payer contract with UHC ACO contract - Impacts RAF score; thus impacting the shared savings incentives
What do I need to know about HCC coding


- **The What of HCC Coding** - Michael Vincent Smith, MD, FACC, FACS, FCCP; Regional VP, Medical Director Anthem & Tiffany Maurer, MSN RN

- **The How** - Troy Tyner, D.O. & Mark Couch, M.D./President of PriMed Physicians
Risk Adjustment 101
Risk Adjustment - Background
Methodology

- Risk adjusted payment methodology was mandated by the Balanced Budget Act (BBA) of 1997 and implemented under a phased-in approach.
- By using the risk adjustment method (CMS-HCC Model), CMS is able to determine a risk score – or Risk Adjustment Factor (RAF) - for each member. Risk score is calculated based on member demographic and health factors.
- Member risk score impacts payment by CMS to the MA health plan.
- CMS payment to MA health plan, impacts resources health plan can devote to managing its membership and provider partnerships.
- In theory, the CMS-HCC model helps ensure accuracy of health plan payment based, in part, on predicted health-care expenditures.

The monthly payment adjustment is predicated on each member’s risk score

The CMS–HCC model determines the risk score and how the payment are calculated

The average risk score is 1 - adjusted for each member. The member’s risk score is re-set each year and follows the member for one year

Prospective CMS attempts to estimate next year’s health care expenditures from identified health status factors in the current year

Accurate risk scores rely on the accurate and complete diagnosis coding and medical record documentation collected from providers - CMS expects the member's medical record to validate the reported diagnoses
Benefits of Risk Adjustment

**Risk Adjustment** impacts Member Risk Score which impacts Plan payment

**Payment** impacts resources Plan can devote to managing services and membership

**Improved Patient Care**
- ✓ Identify actual disease burden of member and patient population
  - ✓ Helps move from episodic acute care to management of chronic conditions
- ✓ Greater ability to identify, stratify and assess patient population
  - ✓ Disease and medical management
  - ✓ Comprehensive care planning
  - ✓ Targeted interventions
- ✓ Complete and accurate coding allows for a more meaningful exchange between payors, members, and providers

**Improved Patient Benefits**
- ✓ Funding quality programs
- ✓ Reducing co-pays and out-of-pocket costs
Risk Adjustment Factor (RAF)

- Demographic factor includes age, gender, disability status, original reason for Medicare eligibility and Medicaid status.
- Health factor includes all conditions and disease interactions that are risk adjustable conditions that map to a hierarchical condition category (HCC).

Higher RAF scores represent members with a greater than average burden of illness.

Lower RAF scores represent a healthier population.

RAF scores may be inaccurate due to:
- Inadequate chart documentation
- Inaccurate ICD-10-CM coding
- Patient was not seen in the calendar year
Hierarchical Condition Categories

Medical Record Documentation Coding Specificity

- CMS utilizes HCC grouping logic
- HCCs are groups of related diagnosis codes (*disease groups*)
- Not all diagnosis codes map to an HCC (mostly chronic conditions)
- Only those diagnosis codes that map to an HCC are used in RAF calculation
- HCC and demographic factor have an associated coefficient weighted on the anticipated expenditures of the characteristic or diagnosis
- HCCs in the current model are subject to revision, regrouping, or deletion
**Sample of Coefficients for HCCs**

**Based on Community and Institutional Beneficiaries**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description Label</th>
<th>Community, NonDual, Aged</th>
<th>Community, NonDual, Disabled</th>
<th>Community, FBDual, Aged</th>
<th>Community, FBDual, Disabled</th>
<th>Community, PBDual, Aged</th>
<th>Community, PBDual, Disabled</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC38</td>
<td>Major Depressive, Bipolar, and Paranoid Disorders</td>
<td>0.395</td>
<td>0.209</td>
<td>0.444</td>
<td>0.178</td>
<td>0.413</td>
<td>0.163</td>
<td>0.271</td>
</tr>
<tr>
<td>HCC13</td>
<td>Diabetes with Chronic Complications</td>
<td>0.318</td>
<td>0.371</td>
<td>0.345</td>
<td>0.431</td>
<td>0.354</td>
<td>0.423</td>
<td>0.441</td>
</tr>
<tr>
<td>HCC19</td>
<td>Diabetes without Complication</td>
<td>0.104</td>
<td>0.128</td>
<td>0.097</td>
<td>0.160</td>
<td>0.098</td>
<td>0.136</td>
<td>0.160</td>
</tr>
</tbody>
</table>

- **Risk Adjustment** is an additive model used to predict future health costs
  - Coefficients are added across HCCs
  - More complex conditions within a HCC trump a less complex condition
  - These coefficients are added to a base RAF to get the total RAF (with a disease interaction factor if applicable)
## Why it Matters

Engagement across the delivery system drives shared impacts for improved revenue accuracy and health outcomes.

<table>
<thead>
<tr>
<th>Member</th>
<th>Demographics</th>
<th>HCCs</th>
<th>Interactions</th>
<th>RAF*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Example 1 - All Conditions Coded</strong></td>
<td>Female, 73 FB Dual, aged</td>
<td>HCC17 / Diabetes- Chronic Complications</td>
<td>Congestive Heart Failure Diabetes Group</td>
<td>2.614</td>
</tr>
<tr>
<td><strong>Example 2 - Some Conditions Coded</strong></td>
<td>Female, 73 FB Dual, aged</td>
<td>HCC19 / Diabetes w/o Complications</td>
<td></td>
<td>1.018</td>
</tr>
<tr>
<td><strong>Example 3 - No Conditions Coded</strong></td>
<td>Female, 73 FB Dual, aged</td>
<td>HCC22 / Morbid Obesity</td>
<td></td>
<td>0.511</td>
</tr>
</tbody>
</table>

*Additional normalization and coding intensity factors applied to RAF resulting in final risk score.*
For Risk Adjustment Purposes:

CMS requires all conditions be documented and reported at least once during each calendar year

– All health conditions reported to the MA health plan must be documented in and supported by the medical record

Providers should document:

– To greatest degree of certainty and specificity
– All known conditions from specialists, labs, diagnostic imaging, discharge summaries
– Any known condition that affects patient care and is part of the patient evaluation

If a condition isn’t documented in the medical record, it isn’t incorporated into RAF calculation for that calendar year.
**Key CMS Guidelines**

“The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians.”

Unacceptable data sources

- Diagnostic radiology
- Labs
- SNFs
- Respite Care
- Hospice
- Home Health Care
- Superbill
- Documentation from a RN, RD, MA visit

“All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.”

*Medicare Managed Care Manual; Chapter 7 – Risk Adjustment*
Risk Adjustment - Coding Tools
Needed documentation: MEAT

**Monitored**
- Disease progression/regression
- Ordering labs/x-rays
- Diagnostic tests (echo, EKG)
- Review of logs (blood sugar, B/P)

**Assessed**
- Stable, improving, worsening etc.
- Exacerbation of condition
- Discussion/ counseling
- Relevant record review

**Evaluated**
- Reviewing lab/test results
- Review of diagnostic tests
- Relevant physical examination
- Medication/ treatment effectiveness

**Treated**
- Referral to specialists
- Adjusting, refilling, prescribing medication
- Surgical procedures
Needed Documentation: SOAP/Diagnosis, Status, Plan

- **S** – Subjective
- **O** – Objective
- **A** – Assessment
- **P** – Plan

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Status</th>
<th>Plan</th>
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</table>

CMS expects the member’s medical record to validate the reported diagnoses
Risk Adjustment - Best Practices
Documentation Recommendations

Documentation should include:

- Patient’s name and date of service (DOS) on each page
- All of the patient’s conditions, including those co-existing
- Details to code each condition to the highest degree of specificity
- Treatment and/or management for each known condition
- Provider’s signature, credentials and date (no stamps)

Characteristics of acceptable documentation:

- Clear
- Concise
- Consistent
- Complete
- Legible
- Standard acronyms
  - No up or down arrows
Document All Co-Existing Conditions

• Per CMS Participant Guide:
  - Physicians should document and code all conditions that co-exist at the time of the encounter/visit that require or affect patient care treatment or management.

• Co-existing conditions include:
  - Chronic, ongoing conditions
  - Status conditions
Establishing the Diagnosis

Condition(s) must be explicitly stated in the medical record by the provider who is legally accountable for establishing the patient’s diagnosis

• Coder cannot infer or assume a diagnosis based on:
  - Medication
  - Abnormal lab values
  - Radiology report findings
  - Up or down arrows or other symbols
  - Frequency
  - Patient’s statement
Specificity

- Use specific documentation that:
  - Clearly identifies condition
  - Identifies severity level
  - Indicates complexity of condition
  - Diagnosis must also be stated in text

Assessment:
ICD-10 E11.9, continue current meds

Assessment:
Diabetes Mellitus (DM), continue current meds

- If diagnosis is not definitive, code signs and symptoms (for outpatient services)

  Probable
  Suspected
  Questionable
  Rule Out
  Working

  Signs and/or Symptoms typically do not risk adjust

- Use unspecified codes only if unable to assign a more specific diagnosis code
Coding Personal History of -

Use a personal “History” code as secondary if the patient no longer has the condition

Examples:
• History of cancer (no evidence of current disease/treatment)
• History of stroke (no evidence of residual deficits)

Code the condition as current if it impacts patient care treatment and/or management

Examples:
• If a patient is given medication for current cancer treatment, code as current
• If a patient is experiencing hemiparesis related to a stroke, code as Residual Deficits of Stroke
Status codes indicate a patient is either a carrier of a disease or has the sequela or residual of a past disease or condition (ICD-10 Guidelines)

- Must also be reported annually
- Examples of status codes that impact Risk Score include:

- Organ transplant status
- Asymptomatic HIV status
- Renal dialysis
- Ventilator dependence
- Artificial openings (stoma)
- Lower extremity amputation
- Long term (current) insulin use
- Body mass index
Connecting the Dots – Linking Diagnoses

When documenting conditions that have a causal relationship, use linking verbiage to connect the two conditions such as:

- With
- Due to
- Secondary to
- In
- Associated with
Common HCCs

• Vascular Disease
• Diabetes With Chronic Conditions
• Behavioral Health
• Congestive Heart Failure
• COPD
• Specified Heart Arrhythmias
• Diabetes Without Complications
• Morbid Obesity
• Angina Pectoris
Details: Cerebral Infarction

Acute Stroke
I63.9

- Document only during acute event in hospital setting; has to be confirmed with diagnostics

Residual Deficits of Stroke
I69.3-

- Sequelae of cerebral infarction
  - Cognitive deficits
  - Speech and language deficits
  - Monoplegia of limbs
  - Hemiplegia and hemiparesis
  - Other paralytic syndrome

History of Stroke
Z86.73

- Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
Details: Obesity

Morbid Obesity (HCC 22)

E66.01 – Morbid (severe) obesity due to excess calories
E66.2 – Morbid (severe) obesity w/ alveolar hypoventilation

Z68.41 – BMI 40.0-44.9, adult
Z68.42 – BMI 45.0-49.9, adult
Z68.43 – BMI 50.0-59.9, adult
Z68.44 – BMI 60.0-69.9, adult
Z68.45 – BMI 70 or greater, adult

Morbid obesity should be accompanied by notation of a conversation/behavioral therapy related to health status:
- Discuss nutrition, exercise, behavior change
- Document Body Mass Index (BMI)

Other Obesity
E66.8

Morbid (severe) obesity
E66.01/E66.2
Details: Depression (F32. and F33.)

Major Depressive Disorder risk adjusts
- Single episode, specified
- Recurrent

PHQ-9 is a tool for assessment

F32.9 MDD, single episode, unspecified does not risk adjust

Note: Dash (-) indicates additional characters are required for valid code
**Take the Opportunity: Annual Visits**

A routine physical exam will help aid in appropriately diagnosing, monitoring, assessing, evaluating, and/or treating conditions that may not otherwise be captured, closing gaps in care, and creating a comprehensive care plan to manage possible chronic conditions.

Visits must be completed by a CMS–approved provider for the diagnosis codes to be used for risk adjustment

- MD, DO
- NP
- PA
- **Not** a RN

<table>
<thead>
<tr>
<th>Visit Types</th>
<th>Initial Preventative Physical Exam (IPPE)</th>
<th>Annual Wellness Visit (AWV)</th>
<th>Annual Routine Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0402</strong></td>
<td>Must be completed by a CMS-approved provider</td>
<td>Must be completed by a CMS-approved provider</td>
<td>Must be completed by a CMS-approved provider</td>
</tr>
<tr>
<td><strong>G0438 &amp; G0439</strong></td>
<td>50 in-network copayment</td>
<td>50 in-network copayment</td>
<td>50 in-network copayment</td>
</tr>
<tr>
<td><strong>G0438 Initial AWV:</strong></td>
<td><strong>Face to face visit; includes a personalized prevention plan of services.</strong> Services limited to beneficiary during the Second year the patient is eligible for Medicare Part B. Only one first AWV per beneficiary per lifetime.</td>
<td><strong>G0439 – Subsequent AWV:</strong> Face to face visit; includes a personalized prevention plan of services. Covered the year following the Initial AWV. This benefit is once per calendar year.</td>
<td><strong>Face to face comprehensive, multi-system exam based on the patient’s age, gender, and identified risk factors.</strong> The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does include a comprehensive system review and comprehensive or interval past, family, and social history, as well as a comprehensive assessment/history of pertinent risk factors. Includes clinical laboratory tests. This benefit is once per calendar year.</td>
</tr>
<tr>
<td><strong>G0439</strong></td>
<td>50 in-network copayment</td>
<td>50 in-network copayment</td>
<td>50 in-network copayment</td>
</tr>
</tbody>
</table>

*The IPPE and AWV are not a routine physical exam.*
Risk Adjustment Audits and Resources
**Risk Adjustment Data Validation (RADV)**

- Purpose to ensure the integrity and accuracy of HCC data previously reported by the MA health plan and for which the MA health plan received payment.
- MA health plan must submit medical records for each member HCC included in the audit.
- Submitted medical record must support and validate the member HCC.
- Provider cooperation with medical record requests is a requirement and is critical to our success in responding to a RADV Audit notice.

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**CMS* Conducts 2 Types of RADV Audits**

*RADV Audits may also be conducted by Secretary of HHS*

<table>
<thead>
<tr>
<th>National</th>
<th>Contract Specific (Targeted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Random selection of MA health plans and contracts.</td>
<td>• Specific MA health plans and contracts.</td>
</tr>
<tr>
<td>• Random selection of members.</td>
<td>• Member selection for each audited MA contract based on sampling of 3 risk categories:</td>
</tr>
<tr>
<td>• Discrepant findings reported to MA health plan.</td>
<td>highest, medium and lowest risk scores.</td>
</tr>
<tr>
<td>• MA health plan required to report all discrepant HCC findings to CMS</td>
<td>• Discrepant findings could result in negative financial impact (payment error calculation</td>
</tr>
<tr>
<td>as an overpayment deletion.</td>
<td>and payment recovery).</td>
</tr>
<tr>
<td>• Audit results will be released as an overall national error rate and</td>
<td>• Dispute and appeals process.</td>
</tr>
<tr>
<td>will not be reported as a MAO-specific error rate.</td>
<td></td>
</tr>
</tbody>
</table>


Value-based payments are becoming the “coin of the realm”

Target percentage of Medicare FFS payments linked to quality and alternative payment models

- **2016**
  - 85%
  - 30%

- **2018**
  - 90%
  - 50%

Source: Centers for Medicare & Medicaid Services
Value Based Care reprioritizes Medical and Network Management as core business functionalities for Leading Edge Health Management.

BY THE NUMBERS

75% of health plan managers say they would likely outsource the development and management of new value-based payment models because of inadequate technology or staffing.

8 out of 10 of the largest U.S. health payers currently outsource major portions of their operations.

Source: BlackBook Market Research survey

The Changing TERRAIN
Medical Management and Network Management drive the Core Competencies of Value Based Care Population Health Management

The 3 Core Competencies (Antelopes) of Successful Value-Based Population Health Management

1. Comprehensively identifying and documenting burden of illness (Medical, Behavioral, Functional, Social, Environmental and Economic)

2. Utilize evidence-based quality and performance guidelines to drive prevention, early detection, wellness and superior management of chronic illness (closing gaps in care)

3. Allocate resources to reduce avoidable episodes of treatment and lower the unit cost of unavoidable episodes of treatment
Converting disparate health data into valuable information is the alchemy of Population Health Management

- Exponential growth and profitability are linked to committed and continuous improvement and process automation in the collection, storage, analysis, reporting and utilization of the wealth of data obtainable on the attributed membership

**Conversion Impact:**
- 50% to 65% = 371% improvement
- 50% to 75% = 759% improvement
- 50% to 85% = 1419% improvement
- 50% to 95% = 2476% improvement
Mentorship

Collaboration

https://www.linkedin.com/pulse/what-sets-great-mentors-apart-farrah-farhang
2016-2017 Risk Adjustment Documentation, Coding and Quality Toolbook

Understanding key documentation and coding guidelines
Potential gaps in data submission
**Progress note (example)**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Status</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Encounter, Every Condition, Every Note</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DOCUMENTATION GUIDANCE**

Patient name, date of service (DOS) and an additional patient identifier (e.g., date of birth [DOB]) is required on every page.¹²

**Chief complaint (CC):** “Follow-up” alone is not a valid CC. The documentation must describe why the patient is presenting for follow-up.³

**History:** History of present illness (HPI) driven by the CC and review of systems (ROS) driven by the HPI.³

**Exam:** Exam driven by the patient history, describing in detail any pertinent positive findings and any chronic findings that affect the care and treatment of the patient.³⁴

<table>
<thead>
<tr>
<th><strong>Patient:</strong> Name</th>
<th><strong>DOS:</strong> 10/03/2016</th>
<th><strong>DOB:</strong> 12/05/48</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for visit:</strong> Follow-up for complicated diabetes following toe amputation. CC: Patient notes progressive loss of sensation in her feet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medications list:</strong> Glyburide 10mg PO q.d.; Pregabalin 50mg PO t.i.d.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S:</strong> States she is able to get around, including bathroom and kitchen with aid of her walker. She tries to follow her diet but does not check her fingerstick blood sugars. She has not been taking her blood pressure medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>O:</strong> Patient alert, oriented to person, place and time. No acute distress.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vital signs:</strong> T 98.2; BP 154/95; HR 63; Wt 208 lbs; Ht 64”; BMI 35.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac:</strong> RRR no rubs, gallops or murmurs noted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lungs:</strong> Clear to auscultation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Abd:</strong> Soft, nontender to palpation with colostomy intact, skin dry and intact surrounding pink-red stoma, liquid brown feces.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feet:</strong> Peripheral pulses barely palpable, unchanged from prior exam. Left great toe amputation with healing incision. Diminished vibratory sensation at right great toe DIP (5 seconds) and no sensation at left great toe.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Progress note (example)

Diagnosis-----Status------Plan Every Encounter, Every Condition, Every Note

Medical decision-making:
Assessment that documents the diagnosis, its status and any causal relationships (e.g., diabetic, due to diabetes). Assessment that documents not only conditions being treated, but any chronic conditions that affect the care and treatment of the patient.4

Plan that specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.3

A: 1. Dysmetabolic syndrome (E88.81)
   a. Morbid obesity (E66.01, Z68.35)
   b. Hypertension (I10)
   c. Type 2 diabetes
2. Diabetes with the following complications
   a. Worsening diabetic neuropathy (E11.40)
   b. Worsening diabetic peripheral vascular disease (E11.51)
3. Great toe amputation: Healing (Z89.412)
4. Functioning colostomy (Z93.3)
5. Medical noncompliance (Z91.14, Z91.19)

P: 1. Dysmetabolic syndrome
   a. Obesity: Patient to return to clinic in 2 weeks to discuss exercise and diet alternative. Will determine if patient is amenable to intensive behavioral therapy for obesity management.
   b. High blood pressure: discussed need for lifestyle changes, weight loss, and resume ACE-inhibitor.
   c. Type 2 diabetes: see below
Diagnosis------Status------Plan  
Every Encounter, Every Condition, Every Note

**Authentication:**

*Paper record:* Authentication by the provider author of the progress note which includes a legible name and credential, a hand-written signature and the date signed. *EMR:* Authentication by the provider author of the progress note, password-protected to that provider only, at the end of the note (for example, authenticated by, approved by), including typed name and credential and the date authenticated. 1

2. Diabetes with chronic complications:
   a. Patient advised on dietary changes.
   b. Continue current dose of glyburide for now.
   c. Diabetic peripheral neuropathy: Increase Pregabalin to 100 mg by mouth three times daily.
   d. CMP and HbA1c ordered for prior to next visit.
   e. Diabetic eye examination and education class referrals ordered.

3. Great toe amputation: Continue to monitor. Patient instructed to return to clinic for any signs of infection.

4. Functioning colostomy: Continue current management.

RTC 2 weeks for blood pressure monitoring and further counseling.

**Authenticated by:** Joseph A. Williams MD, 10/03/16
Documentation and coding of chronic kidney disease (CKD)

The National Kidney Foundation Kidney Disease Outcomes Quality Initiative™ (NKF KDOQI) guidelines for chronic kidney disease (CKD) promote classification of all individuals with CKD into one of five stages. In order to be considered CKD stage I or stage II, the guidelines specify that there must be evidence of kidney damage as defined in the table below (for example, abnormal, untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick). For these patients, the glomerular filtration rate (GFR) would determine whether they were stage I (slightly increased or normal GFR) or stage II (mild reduction of GFR).1 Because different stages of CKD require different interventions, it is clinically important to specify the exact stage of CKD.

In addition, the guidelines also specify that documented evidence of kidney damage is not required if the GFR falls below 60 ml/min/1.73 m².

Diagnosing CKD

The diagnosis of CKD cannot be coded from diagnostic reports (for example, lab reports) alone. The review of the diagnostic reports should be documented in the progress note, a clinical rationale regarding pertinent findings noted and the stage of the CKD clearly stated.3

Note: The diagnosis of CKD requires at least two abnormal markers of damage or two abnormal GFRs persisting ≥ 3 months.3
## Staging chronic kidney disease

**Note:** All stages need to be chronic, not a one-time event.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Severity</th>
<th>GFR value</th>
<th>ICD-10-CM codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>Normal or slightly ↑ GFR</td>
<td>GFR ≥ 90 ml/min/1.73 m² with kidney damage*</td>
<td>N18.1</td>
</tr>
<tr>
<td>Stage II</td>
<td>Mild</td>
<td>GFR 60-89 ml/min/1.73 m² with kidney damage*</td>
<td>N18.2</td>
</tr>
<tr>
<td>Stage III</td>
<td>Moderate</td>
<td>GFR 30-59 ml/min/1.73 m²</td>
<td>N18.3</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Severe</td>
<td>GFR 15-29 ml/min/1.73 m²</td>
<td>N18.4</td>
</tr>
<tr>
<td>Stage V</td>
<td>Kidney failure</td>
<td>GFR &lt; 15 ml/min/1.73 m²</td>
<td>N18.5</td>
</tr>
<tr>
<td></td>
<td>ESRD</td>
<td>Requiring chronic dialysis or transplantation</td>
<td>N18.6</td>
</tr>
<tr>
<td>CKD Unsp.</td>
<td>CRD, CRF NOS or CRI</td>
<td>Chronic kidney disease, unspecified</td>
<td>N18.9</td>
</tr>
</tbody>
</table>

- Assign **Z99.2** for dependence on renal dialysis or **Z91.15** for patient’s noncompliance with renal dialysis with regard to all **N18.6** and some **N18.5**; assign Z94.0 for kidney transplant status.
- CKD is defined as either kidney damage or GFR < 60 ml/min/1.73 m² for ≥ 3 months.

*Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests (for example, untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick) or imaging studies. Thus, patients can have chronic kidney disease with a normal estimated GFR.*
Documentation and coding of chronic kidney disease (CKD)

ICD-10-CM instructs the coder to use an additional code to identify kidney transplant status, if applicable (Z94.0). A kidney transplant may not fully restore kidney function; therefore, patients who have undergone a kidney transplant may still have some form of CKD. Code Z94.0, kidney transplant status, may be assigned in addition to the appropriate CKD code, based on the patient’s post-transplant stage.

If a patient is on renal dialysis or if vascular access for dialysis is present, code also Z99.2. If a patient is noncompliant with dialysis, code also Z91.15.

Patients that have had a kidney transplant where documentation indicates the presence of failure or rejection, assign a code from subcategory T86.1-, complications of kidney transplant to identify the specific nature of the complication.

**CKD documentation tips**

- **CKD**: The diagnosis of CKD cannot be coded from diagnostic reports alone. Documentation in the progress note should clearly state: review of reports, pertinent findings and the stage of CKD, including the GFR, if known.

- **CKD and diabetes**: ICD-10-CM presumes a relationship between diabetes and CKD. Document the stage of CKD; the GFR value alone cannot imply the stage.

- **CKD and hypertension**: ICD-10-CM presumes a relationship when a patient has both chronic renal disease and hypertension. Hypertension and the stage of chronic kidney disease must be documented. If hypertension is not the cause of the CKD, the provider should indicate the cause in their documentation.

- **CKD, hypertension and heart disease**: ICD-10-CM presumes a relationship between hypertension and heart disease. Documenting all three conditions will imply that they are all related.

- **Kidney failure**: It is important to specify the type of kidney failure — acute or chronic — and the cause of the kidney failure, if known. If kidney failure is chronic, document the stage of the CKD.

- **Acute renal failure**: If patient has temporary dialysis, document appropriately and code Z99.2 (dialysis status).
**Documentation and coding of chronic kidney disease (CKD)**

**Coding example #1**
The patient has type 2 diabetes with stage 3 chronic kidney disease.

<table>
<thead>
<tr>
<th>E11.22</th>
<th>Type 2 diabetes mellitus with diabetic chronic kidney disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>N18.3</td>
<td>Chronic kidney disease, stage 3 (moderate)</td>
</tr>
</tbody>
</table>

**Coding example #2**
The patient has type 2 diabetes with diabetic nephropathy.

| E11.21 | Type 2 diabetes mellitus with diabetic nephropathy         |

In this case, the clinician did not document the presence of chronic kidney disease in the progress note, so it would be incorrect to use a code from category N18.-.

**Coding example #3**
The patient has nephropathy due to diabetes with hypertension, and CKD stage 4.

<table>
<thead>
<tr>
<th>E11.21</th>
<th>Type 2 diabetes mellitus with diabetic nephropathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I12.9</td>
<td>Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td>
</tr>
<tr>
<td>N18.4</td>
<td>Chronic kidney disease, stage 4 (severe)</td>
</tr>
</tbody>
</table>
Correctly reporting cancer diagnoses

Current cancer vs. history of cancer

Correct reporting of a diagnosis of cancer requires the determination and documentation of whether the patient's cancer has been eradicated or is currently being treated. ICD-10-CM greatly increases the specificity of the neoplasm code classifications. Many neoplasm conditions have either been given unique classifications or have been further specified by type, anatomic site and laterality.

Neoplasms are listed in the ICD-10-CM Neoplasm Table by type and anatomical site. For each site there are six possible code categories situated within columns according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; for example, malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri.

If neoplasms are documented by the histological term, that term should be referenced in the ICD-10-CM Alphabetic Index for each variety, rather than going immediately to the Neoplasm Table. For example, if documentation indicates “adenoma,” refer to the term in the Alphabetic Index and review the entries and cross-referenced tabular instructional notes.

Current cancer
Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery, but is still receiving active treatment for the disease.

Cancers of unknown primary or secondary site
There are codes available for malignant (primary) neoplasm, unspecified C80.1, and malignant (secondary) neoplasm, unspecified C79.9. Use when appropriate.

Example
Malignant neoplasm of kidney NOS C64.-

Primary site with unknown secondary site

Example
Metastatic carcinoma from lung C34.9 (Primary site - Lung) 
Unknown secondary site C79.9 (Metastatic cancer NOS)

Secondary site with active primary site
A patient is admitted with metastatic bone cancer. The female patient had a mastectomy two months ago and is currently having radiation treatments for breast cancer. The neoplasm was located in the upper outer quadrant.

Example
Neoplasm, bone, secondary C79.51 
Neoplasm, breast, upper outer quadrant, C50.41-

Carcinoma in situ
Documentation describing patients with tumor cells that are undergoing significant malignant changes but are still confined to the point of origin without invasion of the surrounding normal tissue is to be coded as Ca in situ.

Example 
Carcinoma in situ of cervix uteri D05.-
Correctly reporting cancer diagnoses

**Current malignancy versus personal history of malignancy**

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. These Z codes require additional digits to identify the site of the historical event of the cancer, and the active cancer code is not reported.

**Example**

Personal history of malignant neoplasm, kidney Z85.5:

**Aftercare following surgery for neoplasm**

Visits to determine the effectivenss of cancer surgery that fall within the global postoperative period should be reported as “Aftercare following surgery for neoplasm,” code Z48.3. The aftercare Z code should be used with the current neoplasm code.

**Example**

Aftercare following surgery for malignant neoplasm Z48.3

**Follow-up for patients with history of cancer**

Follow-up exams to determine if there is any evidence of recurrent or metastatic cancers that result in no evidence of malignancy and no ongoing treatment should be reported as encounter for follow-up examination after completed treatment for malignant neoplasm with code Z08. This includes surveillance only following completed treatment.

**Example**

Follow-up examination, following radiotherapy Z08

**Cancer drugs prescribed for reason other than malignancy**

Patients with no history of cancer who take cancer drugs prophylactically should not be reported with an active cancer diagnosis or a personal history of malignant neoplasm. Instead, code the reason for the prescription.

**Example**

Family history of malignant neoplasm, breast Z80.3

* Use of selective estrogen receptor modulators (SERMS) Z79.810
Diabetes mellitus and associated manifestations

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

The word “with” in the phrase “diabetes with” now “presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related” (for example, “diabetic” or “due to diabetes”).

Diabetes documented as “inadequately controlled,” “out of control” or “poorly controlled” codes to diabetes, by type, with hyperglycemia (E10.65 for type 1, E11.65 for type 2). Diabetes documented as “uncontrolled” codes to diabetes, by type with either hyperglycemia or hypoglycemia. Providers must specify in their documentation and code selection.

Use additional code to identify control using insulin (Z79.4), oral antidiabetic drugs (Z79.84) or oral hypoglycemic drugs (Z79.84) for categories E08, E09, E11 and E13.
Diabetes mellitus and associated manifestations

**Type 1**

- **E10.2-** Type 1 diabetes mellitus with **kidney** complications
  - E10.21 Type 1 diabetes mellitus with diabetic nephropathy
  - **E10.22** Type 1 diabetes mellitus with diabetic chronic kidney disease
    - Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)
      - N18.1 Chronic kidney disease, stage 1
      - N18.2 Chronic kidney disease, stage 2 (mild)
      - N18.3 Chronic kidney disease, stage 3 (moderate)
      - N18.4 Chronic kidney disease, stage 4 (severe)
      - N18.5 Chronic kidney disease, stage 5
      - N18.6 End stage renal disease
    - Use additional code to identify dialysis status (Z99.2)
      - N18.9 Chronic kidney disease, unspecified
  - **E10.29** Type 1 diabetes mellitus with other diabetic kidney complications

- **E10.3-** Type 1 diabetes mellitus with **ophthalmic** complications
  - For E10.32-, E10.33-, E10.34-, E10.35- and E10.37-, add 7th character: 1 = right eye, 2 = left eye, 3 = bilateral, 9 = unspecified eye
    - **E10.311** Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
    - E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
    - E10.321- Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
    - E10.329- Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
    - E10.331- Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
    - E10.339- Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
    - E10.341- Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
    - E10.349- Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
Hypertension coding

The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

### Essential (primary) hypertension

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I10</td>
<td>Essential (primary) hypertension</td>
</tr>
</tbody>
</table>

Additional coding information for essential (primary) hypertension:
- I10 includes high blood pressure
- R03.0 is for elevated blood-pressure reading, without the diagnosis of hypertension

### Hypertensive heart disease

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I11.9</td>
<td>Hypertensive heart disease without heart failure</td>
</tr>
</tbody>
</table>

Additional coding information for hypertensive heart disease:
- Includes any condition in I50.- or I51.4-I51.9 due to hypertension

Assign a code from category I11 when a patient has hypertension with heart failure or hypertension with myocarditis, myocardial degeneration, cardiomegaly, Takotsubo syndrome, or other ill-defined or unspecified heart disease.

The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.

If coding hypertensive heart disease with heart failure (I11.0), use an additional code to identify the type of heart failure (I50.1-I50.9)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I50.1</td>
<td>Left ventricular heart failure</td>
</tr>
<tr>
<td>I50.20</td>
<td>Unspecified systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.21</td>
<td>Acute systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.22</td>
<td>Chronic systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.23</td>
<td>Acute on chronic systolic congestive heart failure</td>
</tr>
<tr>
<td>I50.30</td>
<td>Unspecified diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.31</td>
<td>Acute diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.32</td>
<td>Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.33</td>
<td>Acute on chronic diastolic congestive heart failure</td>
</tr>
<tr>
<td>I50.34</td>
<td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.41</td>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.42</td>
<td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.43</td>
<td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.44</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>
Hypertension coding

Hypertensive chronic kidney disease (CKD)

I12.0 Hypertensive CKD with stage 5 CKD or end stage renal disease
I12.9 Hypertensive CKD with stage 1 through stage 4 CKD, or unspecified CKD

Additional coding information for hypertensive CKD
Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and CKD are present.
If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

<table>
<thead>
<tr>
<th>I12.0, I12.9</th>
<th>N18.4</th>
<th>N18.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>N18.1</td>
<td>CKD, Stage 1</td>
<td>CKD, Stage 4 (severe)</td>
</tr>
<tr>
<td>N18.2</td>
<td>CKD, Stage 2 (mild)</td>
<td>CKD, Stage 5 (requiring chronic dialysis use N18.6)</td>
</tr>
<tr>
<td>N18.3</td>
<td>CKD, Stage 3 (moderate)</td>
<td>N18.6</td>
</tr>
</tbody>
</table>

*Use an additional code to specify: "Dialysis status" (Z99.2) "Noncompliance w/dialysis" (Z91.15) "Kidney transplant status" (Z94.0)

Hypertensive heart and CKD

I13.0 Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified CKD
I13.10 Hypertensive heart and CKD without heart failure, with stage 1 through stage 4 CKD, or unspecified CKD
I13.11 Hypertensive heart and CKD without heart failure, with stage 5 CKD, or end stage renal disease
I13.2 Hypertensive heart and CKD with heart failure and with stage 5 CKD, or end stage renal disease

Additional coding information for hypertensive heart and CKD
Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. The ‘Includes’ note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease then, per the guidelines, a single code from I13 should be used instead.

For patients with both acute renal failure and chronic kidney disease an additional code for acute renal failure is required.
# Hypertension coding

<table>
<thead>
<tr>
<th>I50.1</th>
<th>Left ventricular heart failure</th>
<th>I50.30</th>
<th>Unspecified diastolic (congestive) heart failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I50.20</td>
<td>Unspecified systolic (congestive) heart failure</td>
<td>I50.31</td>
<td>Acute diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.21</td>
<td>Acute systolic (congestive) heart failure</td>
<td>I50.32</td>
<td>Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.22</td>
<td>Chronic systolic (congestive) heart failure</td>
<td>I50.33</td>
<td>Acute on chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.23</td>
<td>Acute on chronic systolic (congestive) heart failure</td>
<td>I50.40</td>
<td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.41</td>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I50.42</td>
<td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I50.43</td>
<td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I50.9</td>
<td>Heart failure, unspecified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| N18.1 | CKD, Stage 1 |
| N18.2 | CKD, Stage 2 (mild) |
| N18.3 | CKD, Stage 3 (moderate) |
| N18.4 | CKD, Stage 4 (severe) |
| N18.5 | CKD, Stage 5 (requiring chronic dialysis use N18.6) |
| N18.6 | ESRD |

*Use an additional code to specify: “Dialysis status” (299.2) “Noncompliance w/dialysis” (291.15) “Kidney transplant status” (Z94.0)
Chronic obstructive pulmonary disease (COPD)

Although chronic obstructive pulmonary disease (COPD) is a preventable and treatable disease state, it is the only disease among the top 10 causes of death that is increasing in frequency. COPD is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. Cigarette smoking is the most significant determinant of the development and progression of COPD.1,2

COPD is an umbrella term, the predominant diseases that fall under this umbrella term are: emphysema, chronic bronchitis and chronic asthma.

**Emphysema** pathologically denotes permanent enlargement of the air spaces distal to the terminal bronchiole, causing destruction of their walls, without obvious fibrosis. The tiny air sacs (alveoli) stretch out and air gets trapped (pink puffier).

**Chronic bronchitis** is an inflammation of the mucous membrane of the bronchial tubes. The airways become narrowed and tightened, over time these changes limit airflow in and out of the lungs (blue bloater).

**Chronic asthma** is paroxysmal dyspnea accompanied by wheezing caused by a spasm of the bronchial tubes or by swelling of their mucus membrane.

Screening spirometry should be obtained in all persons with a history of:3

- Exposure to cigarette (see codes below) and/or environmental or occupational pollutants
- Personal history of chronic cough, chronic bronchitis or chronic asthma (287.09)
- Family history of chronic respiratory illness (282.5, 283.6)

**Coding for COPD**

J44.x is the category for Other chronic obstructive pulmonary disease. This category includes:

- Asthma with chronic obstructive pulmonary disease
- Chronic asthmatic (obstructive) bronchitis
- Chronic bronchitis with airways obstruction
- Chronic bronchitis with emphysema
- Chronic emphysematous bronchitis
- Chronic obstructive asthma
- Chronic obstructive bronchitis
- Chronic obstructive tracheobronchitis

There is an instructional note to code also the type of asthma, if applicable (J45.-) and a note to use an additional code to identify:

- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)
Chronic obstructive pulmonary disease (COPD)

This category specifically excludes (Excludes 1):
- Bronchiectasis (J47.-)
- Chronic bronchitis NOS (J42)
- Chronic simple and mucopurulent bronchitis (J41.-)
- Chronic tracheitis (J42)
- Chronic tracheobronchitis (J42)
- Emphysema without chronic bronchitis (J43.-)

You would not report these conditions with a code from category J44.-

The category also excludes (Excludes 2):
- Lung diseases due to external agents (J60 - J70.-)

You could report these conditions with a code from category J44.-

The codes for COPD are:

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

There is an instructional note to use additional code to identify the infection.

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

Conditions included in this subcategory are:
- Decompensated COPD
- Decompensated COPD with (acute) exacerbation

This subcategory excludes (Excludes 2):
- Chronic obstructive pulmonary disease (COPD) with acute bronchitis (J44.0)

This condition can also be reported if the provider documents this condition in addition to COPD with (acute) exacerbation.

J44.9 Chronic obstructive pulmonary disease, unspecified

Conditions included in this subcategory are:
- Chronic obstructive airway disease NOS
- Chronic obstructive lung disease NOS
Chronic obstructive pulmonary disease (COPD)

Coding for asthma
Category J45.- is used to report asthma.
This category includes:
- Allergic (predominantly) asthma
- Allergic bronchitis NOS
- Allergic rhinitis with asthma
- Atopic asthma
- Extrinsic allergic asthma
- Hay fever with asthma
- Idiosyncratic asthma
- Intrinsic nonallergic asthma
- Nonallergic asthma

There is an instructional note to use an additional code to identify:
- Exposure to environmental tobacco smoke (Z77.22)
- History of tobacco dependence (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.-)
- Tobacco use (Z72.0)

This category specifically excludes (Excludes 1):
- Detergent asthma (J69.8)
- Eosinophilic asthma (J82)
- Lung diseases due to external agents (J60 - J70.-)
- Miner's asthma (J60)
- Wheezing NOS (R06.2)
- Wood asthma (J67.8)

You would not report these conditions with a code from category J45.-

This category also excludes (Excludes 2):
- Asthma with chronic obstructive pulmonary disease (J44.9)
- Chronic asthmatic (obstructive) bronchitis (J44.9)
- Chronic obstructive asthma (J44.9)

These conditions can also be reported if the provider documents the condition in addition to the type of asthma (for example, mild, moderate, severe; intermittent or persistent, etc.).
Chronic obstructive pulmonary disease (COPD)

The subcategories for asthma are:

J45.2 - Mild intermittent asthma
J45.3 - Mild persistent asthma
J45.4 - Moderate persistent asthma
J45.5 - Severe persistent asthma

Codes in the subcategories above are differentiated by 5th characters 0, 1, and 2 for: uncomplicated or not otherwise specified; with (acute) exacerbation; and with status asthmaticus, respectively.

J45.9 - Other and unspecified asthma

Codes in this subcategory are differentiated by:

Unspecified asthma:

- With (acute) exacerbation (J45.901)
- With status asthmaticus (J45.902)
- Uncomplicated (asthma NOS) (J45.909)

This subcategory includes:

- Asthmatic bronchitis
- Childhood asthma
- Late onset asthma

Other asthma:

- Exercise induced bronchospasm (J45.990)
- Cough variant asthma (J45.991)
- Other asthma (J45.998)

Coding examples:

COPD with acute bronchitis

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

Chronic bronchitis with decompensated COPD

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

Emphysema with chronic obstructive bronchitis

J44.9 Chronic obstructive pulmonary disease, unspecified
Documentation and coding for cardiovascular disease

Based on recommendations by the U.S. Preventive Services Task Force (USPSTF), the Centers for Medicare & Medicaid Services (CMS) will cover preventive services and counseling for cardiovascular disease prevention and risk reduction under HCPCS code G0446.1

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

CMS covers claims for one face-to-face cardiovascular disease (CVD) risk reduction visit annually for Medicare Advantage beneficiaries who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care provider in a primary care setting. It also gives the provider an excellent opportunity to document and recapture all chronic cardiovascular conditions and document the preventive services that demonstrate the health care quality measures are being met for these important chronic conditions. This documentation can help bridge gaps in communication between patients being seen by a number of health care practitioners and specialists in multiple settings, including primary care, to reduce serious breakdowns in the continuity of care, inappropriate treatment and potential harm to the patient.2

Clinical suggestions
Prior to this visit, ensure that the patient has had a phlebotomy for fasting lipid profile and glucose and review the patient’s most recent screening EKG.
# Documentation and coding for cardiovascular disease

**Reason for visit:** Cardiovascular disease risk reduction visit

**Medications:** Document all current cardiovascular medications (antiplatelet agents, antiarrhythmics, antihypertensives, thromboembolic prophylaxis, etc.) and their indications.

**Document all pertinent cardiovascular risk factors, such as:**

- Myocardial infarction (MI) ([I21.2, Acute myocardial infarction or I25.2, Old myocardial infarction] if outside of 4 weeks from the date of infarction) with date of event and type of MI (i.e., anterolateral, etc.), if known
- New for ICD-10-CM is guidance to use additional codes, if applicable, to indicate:
  - History of tobacco dependence ([Z87.891](#))
  - Exposure to ([Z77.22 Contact with and [suspected] exposure to environmental tobacco smoke [acute] [chronic]])
  - Occupational exposure ([Z57.31 Occupational exposure to environmental tobacco smoke])
  - Dependence ([F17.- Nicotine dependence]), or use ([Z72.0 Tobacco use])
- Body mass index (BMI) ([Z68.-])
- Angina ([I20.-, Angina pectoris])
- Coronary artery bypass graft (CABG) and/or coronary artery endovascular procedures (e.g., PTCA) ([Z95.1, Presence of aortocoronary bypass graft; Z95.5 Presence of coronary angioplasty implant and graft])
- Arrhythmia/Dysrhythmia (specify type) with appropriate code from categories I47-I49
- Hypertension ([I10 Essential [primary] hypertension; I11.1 - Hypertensive heart disease; I12.- Hypertensive chronic kidney disease; I13.- Hypertensive heart and chronic kidney disease])
- Diabetes (categories E08-E13)
- Peripheral vascular disease ([I73.9 Peripheral vascular disease, unspecified])
- Hypercholesterolemia ([E78.0, Pure hypercholesterolemia])
- Exercise tolerance, shortness of breath on exertion
- Family history of CVD ([Z82.49 Family history of ischemic heart disease and other diseases of the circulatory system])
Documentation and coding for cardiovascular disease

Physical examination:
- Document blood pressure, heart rate, height, weight and BMI during clinic visit
- Head and neck: JVD, carotid bruits
- Chest
- Heart
- Abdomen
- Lower extremity: peripheral edema, pedal pulses

Labs: Review lipid profile, diabetes screening and bring date of test(s) and pertinent findings into body of progress note.

EKG: Report results from screening EKG. Perform every 1–2 years depending on physician’s practice guidelines.

Assessment:
- Document all pertinent diagnoses (any condition being treated and any condition that affects care and treatment)¹
- Document all pertinent risk factors for cardiovascular disease²

Plan:
1. **Required**: Document discussion of diet and exercise and lifestyle modifying recommendations given to patient [Z71.3, Dietary surveillance and counseling] [use additional code to identify BMI]; Z71.89 other specified counseling] (use additional code[s] for any associated underlying medical condition)
2. **Required**: Document recommendation to implement or not implement a regimen of aspirin (based on patient’s other risk factors)
3. Document other recommendations that deal with patient’s cardiovascular status
4. Document follow-up visits, referrals, other recommendations that are relevant to cardiovascular disease risk prevention


Peripheral arterial disease (PAD) documentation and coding

Language of documentation

“Peripheral arterial disease,” “peripheral vascular disease” and “intermittent claudication” are coded as 173.9. It is important to note that this code excludes atherosclerosis of the extremities (I70.2–I70.7). When atherosclerosis (arteriosclerosis) is diagnosed by the clinician, the progress note should state “arteriosclerosis of” and the site including laterality, “arteriosclerotic” or “arteriosclerosis with” followed by the symptom or complication (for example, arteriosclerosis of the legs with intermittent claudication bilaterally). Arteriosclerosis and atherosclerosis may be used interchangeably for documentation and coding purposes. Documentation of arteriosclerosis that lacks specificity is coded as I70.90.

ICD-10-CM codes

Atherosclerosis of native arteries of the extremities (subcategory I70.2–) is further classified as:

<table>
<thead>
<tr>
<th>I70.20-</th>
<th>Unspecified atherosclerosis of native arteries of extremities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use a 6th character to identify laterality and/or location: (1) right leg, (2) left leg, (3) bilateral legs, (8) other extremity, (9) unspecified extremity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.21-</th>
<th>Atherosclerosis of native arteries of extremities with intermittent claudication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use a 6th character to identify laterality and/or location: (1) right leg, (2) left leg, (3) bilateral legs, (8) other extremity, (9) unspecified extremity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.22-</th>
<th>Atherosclerosis of native arteries of extremities with rest pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use a 6th character to identify laterality and/or location: (1) right leg, (2) left leg, (3) bilateral legs, (8) other extremity, (9) unspecified extremity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.23-</th>
<th>Atherosclerosis of native arteries of right leg with ulceration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use a 6th character to identify location of the right leg: (1) thigh, (2) calf, (3) ankle, (4) heel and midfoot, (5) other part of foot, (8) other part of lower right leg, (9) right leg with ulceration of unspecified site</td>
</tr>
</tbody>
</table>
ICD-10-CM codes

Atherosclerosis of native arteries of the extremities (subcategory I70.2-) is further classified as:

<table>
<thead>
<tr>
<th>I70.24-*</th>
<th>Atherosclerosis of native arteries of left leg with ulceration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>» Use a 6th character to identify location of the left leg: (1) thigh, (2) calf, (3) ankle, (4) heel and midfoot, (5) other part of foot, (8) other part of lower leg, (9) left leg with ulceration of unspecified site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.25</th>
<th>Atherosclerosis of native arteries of other extremities with ulceration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>» Use additional code to identify the severity of the ulcer (L98.49-)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.26-*</th>
<th>Atherosclerosis of native arteries of extremities with gangrene</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>» Use additional code to identify the severity of any ulcer (L97.-, L98.49-), if applicable</td>
</tr>
<tr>
<td></td>
<td>» Use a 6th character to identify laterality and/or location: (1) right leg, (2) left leg, (3) bilateral legs, (8) other extremity, (9) unspecified extremity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I70.29-</th>
<th>Other atherosclerosis of native arteries of extremities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>» Use a 6th character to identify laterality and/or location: (1) right leg, (2) left leg, (3) bilateral legs, (8) other extremity, (9) unspecified extremity</td>
</tr>
</tbody>
</table>

“Specificity is destiny”
Peripheral arterial disease (PAD) documentation and coding

“Specificity is destiny”

ICD-10-CM codes

Atherosclerosis of native arteries of the extremities (subcategory I70.2-) is further classified as:

When PAD or atherosclerosis is documented as a manifestation of diabetes, report the following combination code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.51</td>
<td>Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene</td>
</tr>
</tbody>
</table>

If a patient is documented as having diabetic PAD (or atherosclerosis) with gangrene, report the following combination code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.52</td>
<td>Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene</td>
</tr>
</tbody>
</table>

The progress note must provide the appropriate linkage between the diabetes and the manifestation. In a paper world, a provider must document the causal relationship (for example, "diabetic" or "due to diabetes"). In the EMR world, as providers make the clinical determination, they populate the correct combination code that reports the relationship.

Atherosclerotic disease is a progressive disease. Therefore, avoid documenting “history of peripheral vascular disease” and instead consider “known peripheral arterial disease.” In support of such documentation, providers can use a Z code for patients who have had peripheral arterial bypass (Z95.828 Presence of other vascular implants and grafts) in addition to the ICD-10-CM code for PAD, I73.9.

*Use additional code (L97.- below) to report the severity of the ulcer. These codes are for use with I70.23-, I70.24-, and I70.26-, if applicable, on the other side.
## Peripheral arterial disease (PAD) documentation and coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L97.1</td>
<td>Non-pressure chronic ulcer of thigh</td>
</tr>
<tr>
<td>L97.2</td>
<td>Non-pressure chronic ulcer of calf</td>
</tr>
<tr>
<td>L97.3</td>
<td>Non-pressure chronic ulcer of ankle</td>
</tr>
<tr>
<td>L97.4</td>
<td>Non-pressure chronic ulcer of heel and midfoot</td>
</tr>
<tr>
<td>L97.5</td>
<td>Non-pressure chronic ulcer of other part of foot</td>
</tr>
<tr>
<td>L97.8</td>
<td>Non-pressure chronic ulcer of other part of lower leg</td>
</tr>
<tr>
<td>L97.9</td>
<td>Non-pressure chronic ulcer of unspecified part of lower leg</td>
</tr>
</tbody>
</table>

- When documenting ulcers, be sure to document the type of ulcer, site of ulcer, laterality of ulcer and severity of ulcer.
  - All ulcer code descriptors include laterality: unspecified, right, left.
  - All ulcer code descriptors include severity: limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone, with unspecified severity.

- When documenting ulcers, it is important not to document them as wounds, “open wounds” or “lesions.”

- When documenting ulcers, it is important to code first any associated underlying condition, such as:
  - any associated gangrene (I96)
  - atherosclerosis of the lower extremities (I70.23, I70.24, I70.33, I70.34, I70.43, I70.44, I70.53, I70.54, I70.63, I70.64, I70.73, I70.74)
  - chronic venous hypertension (I87.31, I87.33)
  - postphlebitic syndrome (I87.01, I87.03)
  - postthrombotic syndrome (I87.01, I87.03)
  - varicose ulcer (I83.0, I83.2)
Depression is associated with higher rates of chronic disease, increased health care utilization, and impaired functioning.

Just over one-third (35.3%) of persons with severe depressive symptoms reported having seen a mental health professional in the past year.

Major depressive disorder algorithm

First determine if all of the following apply:

- Symptoms do not meet criteria for a mixed episode (for example, bipolar disorder)
- Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of concern
- Symptoms are not due to direct effect of a substance
- Symptoms are not more appropriately classified as bereavement (Z63.4) or acute grief reaction (F43.20) unless continuous for over two months or severe functional impairment, morbid preoccupation with worthlessness, psychotic symptoms or psychomotor retardation
- Symptoms have been present during the same two-week period and represent a change from previous functioning

If all the above is true, move to the next section.

Must have one or both of these symptoms:

- Depressed mood most of the day and nearly every day, self-reported or observed by others or
- Markedly diminished interest or pleasure in all, or almost all, activities on most days, nearly every day, self-reported or reported by others
Major depressive disorder algorithm

If either of the above is true, move to the next section.

Must have either one or both of the above symptoms plus three or four of these to make a total of five or more symptoms:

- Significant weight loss (not due to dieting) or gain (for example, 5% change in one month); or decrease or increase in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day, observable by others
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day:
  - May be delusional
  - Not merely self-reproach or guilt about being sick
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (self-reported or observed by others)
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
## Major depressive disorder algorithm

If you now have a minimum of five symptoms total, your patient meets the requirement for the diagnosis of major depressive disorder per DSM-5.\(^1\)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F32.0</td>
<td>Major depressive disorder, single episode, mild</td>
<td>F33.0</td>
<td>Major depressive disorder, recurrent, mild</td>
</tr>
<tr>
<td>F32.1</td>
<td>Major depressive disorder, single episode, moderate</td>
<td>F33.1</td>
<td>Major depressive disorder, recurrent, moderate</td>
</tr>
<tr>
<td>F32.2</td>
<td>Major depressive disorder, single episode, severe without psychotic features</td>
<td>F33.2</td>
<td>Major depressive disorder, recurrent, severe without psychotic features</td>
</tr>
<tr>
<td>F32.3</td>
<td>Major depressive disorder, single episode, severe with psychotic features</td>
<td>F33.3</td>
<td>Major depressive disorder, recurrent, severe, with psychotic symptoms</td>
</tr>
<tr>
<td>F32.4</td>
<td>Major depressive disorder, single episode, in partial remission</td>
<td>F33.40</td>
<td>Major depressive disorder, recurrent, in remission, unspecified</td>
</tr>
<tr>
<td>F32.5</td>
<td>Major depressive disorder, single episode, in full remission</td>
<td>F33.41</td>
<td>Major depressive disorder, recurrent, in partial remission</td>
</tr>
<tr>
<td>F32.81</td>
<td>Premenstrual dysphoric disorder</td>
<td>F33.42</td>
<td>Major depressive disorder, recurrent, in full remission</td>
</tr>
<tr>
<td>F32.89</td>
<td>Other specified depressive episodes</td>
<td>F33.8</td>
<td>Other recurrent depressive disorders</td>
</tr>
<tr>
<td>F32.9</td>
<td>Major depressive disorder, single episode, unspecified</td>
<td>F33.9</td>
<td>Major depressive disorder, recurrent, unspecified</td>
</tr>
</tbody>
</table>
The importance of screening for depression

- The evaluation and screening of risk factors for depression is mandatory for the “Welcome to Medicare” initial preventive physical exam (IPPE) and the initial Annual Wellness Visit (AWV) with the personalized prevention plan of service (PPPS). (HCPCS codes G0402 and G0438 respectively.)¹

- The annual screening and evaluation of depression in the Medicare Advantage enrollee is essential and also can be covered subsequently by billing for HCPCS code G0444.¹
The importance of screening for depression

Background

- One in six patients over the age of 65 years suffers from depression.¹
- Depression in older adults is estimated to occur in one-quarter of those with other chronic conditions including:
  - cancer
  - stroke
  - chronic lung disease
  - cardiovascular disease
  - arthritis and other chronic pain syndromes
- Stressful events, such as the loss of friends and loved ones, is also an expected consequence of elder living and can contribute to the development of mood disorders.

Annual screening for depression (ICD-10-CM code Z13.89) in the elderly in the primary care setting is important because 50-75 percent of older adults who commit suicide saw their medical doctor during the prior month for general care. Moreover, close to 40 percent were seen within a week prior to their death.¹

Older adults have the highest risk of suicide of all age groups.

Based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), CMS also covers annual screening for adults for depression in the primary care setting. Contractors shall reimburse for annual depression screening (HCPCS code G0444) in a primary care setting that has staff-assisted depression care supports in place in order to assure accurate diagnosis, effective treatment, and follow-up care.

### The importance of screening for depression

<table>
<thead>
<tr>
<th>Older adults have the highest risk of suicide of all age groups.</th>
<th>Older adults have the highest risk of suicide of all age groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practicing in the context of family and community. Appropriate places of service include a doctor's office, outpatient hospital, independent clinic or a state or local public health clinic. (Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospice are not considered primary care settings under this definition.)¹</td>
<td>At a minimum level, staff-assisted depression care supports consist of clinical staff (for example, nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient’s primary care physician.¹</td>
</tr>
</tbody>
</table>
The importance of screening for depression

Older adults have the highest risk of suicide of all age groups.

Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare.1

Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place.1

There are a number of evidence-based media tools that are effective in screening for depression. The Patient Health Questionnaire (PHQ-9) is one screening tool and is available from Optum.
Documenting to satisfy reporting requirements

Documenting to satisfy diagnostic reporting requirements

With the implementation of ICD-10-CM came the need for greater detail in the documentation. The ICD-10-CM Official Guidelines for Coding and Reporting reiterate the importance of good documentation, “The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.” The Guidelines also set the expectation for correct coding, “Each healthcare encounter should be coded to the level of certainty known for that encounter.”

This tool outlines the required elements of the language of documentation for some of the more common chronic conditions, which will lead to coding that is both accurate and complete. This type of documentation will minimize coder query and get the claim out the door more quickly, resulting in more timely payment. When possible, we included practical examples of documentation that satisfy reporting requirements. Documenting in this way will result in better communication of the conditions being treated or considered when treating, better portrayal of medical necessity for appropriate reimbursement, improved communication between clinicians, better continuity of care and improved patient outcomes.
### Documenting to satisfy reporting requirements

#### Diabetes

<table>
<thead>
<tr>
<th>When documenting diabetes, specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Type of diabetes:</strong> Type 1, type 2, secondary – drug or chemical induced (document first poisoning or adverse effect specific to drug), due to underlying condition (document first the underlying condition), postprocedural or due to genetic defects</td>
</tr>
<tr>
<td>• <strong>Control status:</strong> “Controlled,” if “inadequately controlled,” “out of control” or “poorly controlled” (diabetes, by type, with hyperglycemia); if “uncontrolled,” specify as hyperglycemic or hypoglycemic</td>
</tr>
<tr>
<td>• <strong>Complications or any other body systems affected:</strong> “Diabetic chronic kidney disease” – document also the stage of CKD; “diabetic ulcer” – document also the ulcer by type, laterality, site and depth; “diabetic glaucoma” – document also the type, stage and affected eye; other diabetic complication – specify the complication (for example, “diabetic CAD”)</td>
</tr>
<tr>
<td>• <strong>Treatment:</strong> Insulin use and/or oral antidiabetic or hypoglycemic drugs</td>
</tr>
</tbody>
</table>

#### Chronic kidney disease (CKD)

<table>
<thead>
<tr>
<th>When documenting CKD, specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Underlying cause:</strong> Diabetes or hypertension (for example, “diabetic” or “hypertensive”). If CKD is unrelated to diabetes or hypertension, document the cause, if known.</td>
</tr>
<tr>
<td>• <strong>Stage of CKD:</strong> Stage 1, stage 2 (mild), stage 3 (moderate), stage 4 (severe), stage 5 or end-stage renal disease (ESRD). Avoid documenting a range of severity, such as “moderate to severe.”</td>
</tr>
<tr>
<td>• <strong>Presence of:</strong> AV fistula or shunt for dialysis; complication due to renal dialysis access device, implant or graft (such as embolism, hemorrhage, infection, occlusion, pain, stenosis or thrombosis)</td>
</tr>
<tr>
<td>• <strong>Dialysis dependence:</strong> Hemodialysis or peritoneal dialysis</td>
</tr>
<tr>
<td>• <strong>Associated diagnoses/conditions:</strong> “Diabetes with,” “hypertension with” or “secondary hyperparathyroidism due to CKD” and state the stage of CKD</td>
</tr>
<tr>
<td>• <strong>Transplant status:</strong> Kidney transplant status (for those patients who still have some form of CKD, document the current stage of the CKD posttransplant)</td>
</tr>
</tbody>
</table>
### Hypertension

When documenting hypertension, specify:

- **Type:** “Essential hypertension,” “hypertension secondary to renal artery stenosis,” “renovascular hypertension”
- **Acuity of hypertension:** “Hypertensive urgency”
- **Systemic involvement:** “Hypertension with ventricular hypertrophy,” “hypertension with diastolic dysfunction,” “hypertension with heart failure” and state the type and severity of heart failure (systolic, diastolic, combination, acute, chronic, acute-on-chronic) or “hypertension with chronic kidney disease” and state the stage of CKD
- **Substance Use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

### Heart failure

When documenting heart failure, specify:

- **Underlying cause:** “Chronic diastolic failure due to hypertension,” “heart failure due to hypertension with chronic kidney disease,” “hypertension with chronic diastolic heart failure,” coronary artery disease (CAD), diabetes, cardiomyopathy, endocarditis, heart valve disorders, cardiac arrhythmias, congenital defects, thyroid disorders, alcohol and illicit drug use, HIV, AIDS, chemotherapy
- **Circumstance:** Postprocedural
- **Specific type(s), if known:** “Left ventricular failure,” “systolic heart failure,” “diastolic heart failure,” “combined systolic and diastolic heart failure,” “rheumatic heart failure”
- **Severity:** Acute, chronic, acute-on-chronic, cardiac arrest

If a provider documents “congestive heart failure,” it will be coded to heart failure, unspecified.
# Documenting to satisfy reporting requirements

## Arteriosclerosis (coronary artery disease [CAD] and peripheral arterial disease [PAD])

When documenting arteriosclerotic disease, specify:

- **Site (vessel):** Aorta, cerebral, carotid, coronary, extremities, mesenteric, pulmonary, renal, vertebral, etc.
- **Laterality:** Right, left, bilateral
- **Severity:**
  - CAD: With or without angina
  - ASPVD: Manifestations (intermittent claudication, rest pain, ulceration, gangrene); if ulceration, document the type, laterality, site and depth
- **Substance use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

## CAD®

When documenting atherosclerotic heart disease with angina pectoris, include the following:

- **Cause:** Assumed to be atherosclerosis; note if there is another cause
- **Stability:** “Stable angina pectoris,” “unstable angina pectoris”; if “angina equivalent,” document the associated symptoms
- **Vessel:** Note which artery (if known) is involved and whether the artery is native or autologous (for example, mammary, radial, etc.), chronic total occlusion of coronary artery
- **Graft involvement:** If appropriate, whether a bypass graft was involved in the angina pectoris diagnosis; also note the original location of the graft and whether it is autologous or biologic
- **Substance use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)
Documenting to satisfy reporting requirements

**PAD**
When documenting PAD, include the following:
- **Cause**: Diabetic, arteriosclerotic/atherosclerotic
- **Site of disease (vessel)**: If native, name of vessel; if bypass graft, autologous, nonautologous biological, nonbiological
- **Manifestations**: Intermittent claudication, rest pain, ulceration – specify type, laterality, site, severity, gangrene
- **Laterality**: Right, left, bilateral
- **Substance use/Exposure**: Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

**Stroke and sequelae of stroke**
When documenting stroke, specify:
- **Type**: Embolic, hemorrhagic, ischemic, occlusive, stenotic, thrombotic
- **Site (vessel)**: Cerebral (middle cerebral artery, anterior cerebral artery, posterior cerebral artery, cerebellar artery, other artery), precerebral (vertebral artery, basilar artery, carotid artery, other artery)
- **Laterality**: Right, left, bilateral
- **Circumstance**: In evolution, intraoperative (whether during cardiac surgery or during other surgery), postprocedural (following cardiac surgery or following other surgery)
- **Residuals of prior stroke (specify deficit)**: Cognitive deficit – specify exact type; speech and language deficit, monoplegia of upper or lower limb, hemiplegia and hemiparesis, other paralytic syndrome, other sequela (apraxia, dysphagia – specify type; facial weakness, ataxia, other – specify)
- **Score**: National Institutes of Health Stroke Scale score
- **Substance Use/Exposure**: Alcohol abuse or dependence; any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)
# Documenting to satisfy reporting requirements

## Chronic obstructive pulmonary disease (COPD)

When documenting COPD, specify:

- **Type:** For example, asthma with COPD – also document the asthma by severity, frequency and level of exacerbation; chronic asthmatic bronchitis, chronic obstructive bronchitis, chronic bronchitis with emphysema, and chronic obstructive tracheobronchitis
- **Severity:** Acute exacerbation, hypoxia, hypercapnia or chronic respiratory failure
- **Circumstance:** Sepsis, shock, respiratory failure, emphysema, obesity hypoventilation syndrome, severe obesity, ALS, restrictive diseases such as interstitial fibrosis and thoracic deformities
- **Infection:** Any lower acute lower respiratory infection and the infectious agent, if known
- **Cause:** Identify any additional lung disease due to external agent and specify agent (for example, organic dust, chemical, gases, fumes, vapors, ventilation system, etc.)
- **Substance use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

## Asthma

When documenting asthma, specify:

- **Severity:** Mild, moderate, or severe
- **Frequency:** Intermittent or persistent
- **Level of exacerbation:** Uncomplicated, acute exacerbation, or status asthmaticus
- **Key terms:** Allergic, allergic bronchitis, allergic rhinitis with asthma, atopic asthma, chronic obstructive asthma, extrinsic allergic asthma, intrinsic nonallergic asthma, idiosyncratic asthma, exercise induced bronchospasm, and cough-variant asthma
- **Cause:** Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational; establish a cause and effect relationship (for example, detergent asthma, miner's asthma, asthma due to dusts, etc.) – identify causative agent, if known
- **Substance use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)
### Documenting to satisfy reporting requirements

#### Arrhythmias

When documenting arrhythmias, include the following:

- **Location**: Atrial, ventricular, supraventricular, etc.
- **Rhythm name**: Flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.
- **Acuity**: Acute, paroxysmal, chronic, etc.
- **Cause**: Hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCl, etc.
- **Other**: Document any other abnormality of heartbeat (tachycardia, bradycardia – document if adverse effect of a drug and specify drug; palpitations)

#### Major depressive disorder (MDD)

When documenting MDD, specify:

- **Episode type**: Single or recurrent
- **Severity**: Mild, moderate, severe
- **Symptoms**: Presence or absence of psychotic symptoms or features
- **Remission status**: Full or partial

#### Obesity and body mass index (BMI)

When documenting obesity, specify:

- **Type**: Overweight, obese, morbidly (severely) obese, morbid obesity with alveolar hypoventilation (Pickwickian’s), obesity hypoventilation syndrome
- **Cause**: Due to excess calories, drug-induced obesity – specify drug
- **Weight and the BMI**: Documenting the BMI alone is not enough to satisfy the HEDIS requirement
- **Associated comorbid conditions**: For example, hypertension, diabetes
# Documenting to satisfy reporting requirements

## Protein-calorie malnutrition (PCM)

When documenting PCM, specify:

- **Severity:** Mild (first degree), moderate (second degree), severe (third degree); avoid documenting a range of severity, such as "moderate to severe," if documenting cachexia, document underlying cause, if known.
- **Associated conditions:** Alcohol abuse and/or dependence, alcoholic hepatitis, anemia, cancer, celiac disease, CHF, cirrhosis, cystic fibrosis, depression, ESRD, liver disease, obesity, pancreatitis.

## Rheumatoid arthritis (RA)*

When documenting rheumatoid arthritis, specify:

- **Type:** Juvenile, seronegative, seropositive (presence of rheumatoid factor), other.
- **Joint(s) affected by RA:** Specific joint or multiple sites.
- **Laterality:** Right, left, bilateral.
- **Systemic involvement:** Rheumatoid: carditis, lung involvement, myopathy, polyneuropathy, splenoaderomegaly and leukopenia, vasculitis, visceral involvement.
Documenting to satisfy reporting requirements

**HEDIS and Five-Star Quality Considerations**

Here are some things to remember when documenting that help to satisfy the HEDIS/Stars requirements for documentation:

**Diabetes:**
- Document the date and value of the hemoglobin A1C in the progress note.
- Document the date of and the review of the retinal eye exam and any pertinent positive or negative findings. Document if the patient had a negative retinal eye exam the prior year.
- Document the date and the findings of the nephropathy test and if the nephropathy is evidenced, the order for the prescription to treat.
- Document if patient has steroid-induced diabetes as that is an exclusion under HEDIS/Stars for the Diabetes Care measure.

**Hypertension:**
- Document the initial diagnosis of hypertension.
- Document the blood pressure reading at each subsequent visit to demonstrate control.
- Document if patient has ESRD or has had a kidney transplant as those are exclusions under HEDIS/Stars for the Controlling Blood Pressure measure.

**COPD:**
- Document the order for spirometry for any new diagnosis of COPD or any newly exacerbated COPD.

**Obesity and BMI:**
- Document both the weight and the calculated BMI value.
- Document the patient’s refusal to weigh to explain why the HEDIS/Stars requirement was not met.

**Rheumatoid arthritis:**
- Document the diagnosis of rheumatoid arthritis.
- Document the prescription for a disease-modifying anti-rheumatic drug (DMARD).
- Document if the patient has HIV as that is an exclusion under HEDIS/Stars for the RA measure.

Lastly, document whenever a screening is not indicated, is contraindicated, and any patient refusal or noncompliance as this will explain to the auditor why the quality measure was not met.
“Autonomy, Mastery and a Sense of Purpose”

“Health care providers today are first and foremost in the information management business. The successful Emerging Health Care organizations will be the ones that collect, store, analyze, report and utilize health information in a manner that delivers the most value to health care consumers and payers”

-Michael Vincent Smith, MD, FACC, FACS, FCCP
How do I code HCC?

- The What of HCC Coding
- The Why of HCC Coding
- The How of HCC Coding - Troy Tyner, D.O. & Mark Couch, M.D. /President of PriMed Physicians
How do I code HCC?

Code according to your documentation.

- Accuracy
- Specificity
- Consistency
- Thoroughness

Best Practices in Medical Coding
How is the HCC code calculated:

**Demographic**
- Age
- Community or institution based
- Medicaid Disability

**Disease**
- HCC Category (based on disease reported by Provider per calendar year)
- Interaction between disease categories within the hierarchy

This is fixed and includes patient age and address

Based on active diagnoses reported at least once per calendar year (preferably every 6 months)
HCC Coding Facts:

- Coders will not be able to assign codes without the presence of accurate, consistent and comprehensive supporting documentation.

- Chronic conditions (such as alcohol dependence in remission, certain amputations, and artificial openings) are especially relevant because they serve as excellent predictors for future healthcare needs.

- Most documentation comes from outpatient office visits, and relatively little comes from inpatient encounters.
Clinical Documentation Matters!!!

- **Monitor**: (signs & symptoms, disease progression/regression)
- **Assess**: (tests ordered, record review, counseling, discussion)
- **Evaluate**: (test review, response to treatment)
- **Treat**: (medications, therapies, other modalities)

Documentation Requirements
How Does Your EMR Help?

- EPIC
- Athena
- Allscripts
What does the HCC score in the banner mean?

<table>
<thead>
<tr>
<th>Columns</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC Applies</td>
<td>Total number of HCCs that apply to the patient.</td>
</tr>
<tr>
<td>HCC Needs Refresh</td>
<td>Total number of HCCs that need a refresh in the current calendar year</td>
</tr>
<tr>
<td>HCC Potential Score</td>
<td>HCC potential score based on the patient’s age, gender and applicable HCCs</td>
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<tr>
<td>HCC Score</td>
<td>Total HCC score captured this calendar year based on age, gender, and HCCs documented in the current calendar year</td>
</tr>
<tr>
<td>HCC Score Gap</td>
<td>Displays the HCC score gap by subtracting the HCC captured score from the HCC potential score</td>
</tr>
</tbody>
</table>
Patient Risk

Existing clinical and claim data suggests the following as potential diagnoses for this patient. Determine whether these diagnoses are valid and document accordingly.

Potential Diagnoses

- **HCC 108: Vascular Disease**  
  RAF weight 0.299  
  ICD-10: I82.533: Chronic embolism and thrombosis of popliteal vein, bilateral
  Sources: Claim #639753, 03/17/2016

- **HCC 2: Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock**  
  RAF weight 0.535

- **HCC 18: Diabetes With Chronic Complications**  
  RAF weight 0.368

- **HCC 27: End-stage Liver Disease**  
  RAF weight 0.923

- **HCC 79: Seizure Disorders and Convulsions**  
  RAF weight 0.284

Risk Adjustment Factors

- **Risk score 2.436**
- **Demographics**  
  RAF weight 0.328
- **HCC 2: Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock**  
  RAF weight 0.535
- **HCC 18: Diabetes With Chronic Complications**  
  RAF weight 0.368
- **HCC 27: End-stage Liver Disease**  
  RAF weight 0.923
- **HCC 79: Seizure Disorders and Convulsions**  
  RAF weight 0.284
Problems

- Patient risk (1)
  Risk score 2.436 | Gap 0.299

- abnormal glucose level
- septicemia
- acquired hypothyroidism
- leukocytosis
- poisoning by opiate and/or related narcotic
- rectal hemorrhage
- seizure disorder
- hyperkalemia
- constipation
- backache
- urinary incontinence
- ESR raised
- nausea and vomiting
- candidiasis of skin and nails

Assessment & Plan

1 potential diagnosis has not been added to a claim this year.

- cirrhosis of liver
  - Provided cirrhosis: care instructions
  - Provided liver: disease diet: care instructions
  - Check afp (alpha-fetoprotein), serum
  - Check PT/PTT, plasma

- gastroparesis syndrome
  - Provided gastroparesis: care instructions

- esophageal varices
  - Provided esophageal varices: care instructions

- portal hypertensive gastropathy

- benign hypertensive heart disease
  - I11.9 Hypertensive heart disease without heart failure
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<th>Name</th>
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<tr>
<td>Abdominal pain, recurrent</td>
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<td>Abnormal weight loss</td>
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<td>BPH associated with nocturia</td>
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Most Commonly Missed Diagnosis Codes

- E66.01 - Morbid Obesity
- E11.65 - Diabetes with comorbid conditions
- I73.9 - Peripheal Vascular disease
- F32.0-F32.5 - Major depressive disorders, acute
- J44.9 - COPD
Most Commonly Missed Codes
Associated RAF Scores

- RAF 0.365 - E66.01-Morbid Obesity
- RAF 0.368 - E11.65-Diabetes with comorbid conditions
- RAF 0.141 - I73.9-Peripheral Vascular disease
- F32.0-F32.5-Major depressive disorders, acute
- RAF 0.346 - J44.9 COPD

Examples - 2 healthy 40 year old’s seen for acute illnesses only, such as strep, ear infection, etc.
- Their RAF scores are 0.205 and 0.197
Problem List Management

- It is the mandated documentation component of electronic health records supporting the longitudinal summarization of patient information in addition to facilitating the coordination of care by multidisciplinary medical teams.

- It should give a clear picture of the patient’s current condition and what condition is actively managed by specific providers.

The Problem List is a Shared Responsibility
**Maintenance Issues:**

- Deleting or altering “problems” someone else created raises issues.
- Not fully understanding another person’s intention and may remove or edit important information (redundancy gives them a count of how many times it happened instead of updating the problem???)
- Afraid to get rid of somebody else’s entry even if they appear as duplicates or triplicates.
- Thinking that the Problem List should only contain medical issues.
- Symptoms that are not up-coded to a diagnosis.
- “Laundry list” approach instead of a patient-centered, problem-oriented medical record approach.
Takeaways

- HCC Coding and RAF scoring is in our present and our future not just with the Medicare population.
- Documentation is the providers responsibility - coders and office managers can’t code what isn’t documented.
- Let your EHR be a tool.
- Ensure the 5 Commonly missed diagnosis codes area reviewed with all patients with chronic conditions.
- This isn’t just a primary care issue - specialists have a role and are impacted by this as well.
- You may have contract dollars at stake.