Risk Adjustment
Documentation and Coding

Complete Coding Matters to the Health of Your Practice and Patients

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Senior Consulting Manager of Risk Adjustment
Disclaimer

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

At the completion of this provider workshop, you will know what risk adjustment is and the impact it will have for your practice, and;

• How to apply new coding methods
• Understand Hierarchical Condition Categories (HCCs) applications
• Have knowledge of the future payment methods
• Recognize the need for, and know how to prepare for the new payment methodology starting **NOW**
• Become familiar with correct documentation guidelines
• Have a better grasp of the impact that inaccurate coding will have on your practice, as driven by audit results
New Language

Merit-based Incentive Payment System (MIPS)

v.

Alternative Payment Models (APMs)
MIPS (Merit-based Incentive Payment System)

- Physician Quality Reporting System (PQRS)
- Medicare EHR Incentive Program for Eligible Professionals (Eps) (Meaningful Use)
- Value-based Payment Modifier (VM)
MIPS (Merit-based Incentive Payment System)

- Beginning in 2019, CMS will apply a positive, negative, or neutral payment adjustment to each MIPS EP based on a composite performance score across performance categories:

2017 MIPS Performance

- Quality (50%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
APMs (Alternative Payment Models)

• MACRA establishes incentive payments for EPs participating in certain types of APMs.

• MACRA requires quality measures used in APMs to be comparable to the quality measures used in MIPS; therefore applicability of candidate measures to support a variety of future APMs is an important element of this MDP (measure development plan).
Reporting
Performance:
The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can join and provide care during the year through that model.

Send in performance data:
To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment by significantly participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback:
Medicare gives you feedback about your performance after you send your data.

Payment:
You may earn a positive MIPS payment adjustment for 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you may earn a 5% incentive payment in 2019.
Not participating in the Quality Payment Program:
If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment.

Test:
If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), you can avoid a downward payment adjustment.

Partial:
If you submit 90 days of 2017 data to Medicare, you may earn a neutral or positive payment adjustment and may even earn the max adjustment.

Full:
If you submit a full year of 2017 data to Medicare, you may earn a positive payment adjustment.
Quality Payment Program (QPP)

• Technical Assistance Resource Guide can be found at:
Considerations for Documentation
Monitored
• Signs
• Symptoms
• Disease progression or regression

Evaluated
• Test results
• Medication effectiveness
• Response to treatment

Assessed
• Ordering tests
• Discussion
• Review records
• Counseling

Treated
• Medications
• Therapies
• Other modalities
For Well-done MEAT, Providers must:

• Accurately and sufficiently document all chronic disease processes and manifestations that are both active and/or have a relevant history.

• Document all conditions evaluated during every face-to-face visit.

• Each progress/subjective, objective, assessment, and plan (SOAP) note must include key indicators: history of present illness (HPI), physical exam, and the overall medical decision-making process.

• Document every diagnosis reported as an active chronic condition with an assessment and plan of care.

• Cannot simply list every diagnosis in the medical record.
  • This does not support a reported HCC code and is unacceptable. It will not be upheld in the event of a risk adjustment data validation (RADV) audit.
Success With MEAT

- Capture HCCs at least once every 12 months.
- Ensure the medical record contains a legible signature with credential.
- Confirm the diagnosis codes billed correspond with the documentation.
- Document according to the M.E.A.T. principles.
- Annually document status V (Z) codes and chronic conditions.
- Use a verbiage that links a manifestation to its originating condition, or document a causal relationship.
- Add any diagnosed HCCs or RxHCCs to both the chronic problem list and the acute assessment.
- Evaluate each of the HCCs/RxHCCs on a semiannual basis for updates.
- Review all incoming correspondence, such as consultations, discharge summaries, radiology/pathology/laboratory, that may change the status of a chronic condition.
- Submit more than the standard four ICD-9-CM codes.
Diabetes Manifestations example

**Supported by MEAT**
- DM I or II controlled/uncontrolled
- Impaired fasting glucose
- Abnormal glucose result
- Abnormal glucose tolerance test
- Peripheral neuropathy “due to”, “associated with”, “secondary to” or “complicated by” DM I or II controlled/uncontrolled

**MEAT not supported**
- DM
- Probably uncontrolled
- Suboptimal
- Poorly controlled
- History of
- Borderline
- Prediabetic
- Most likely
- DM Peripheral neuropathy
Clinical Concepts

- Type
- Temporal factors
- Caused by/Contributing factors
- Symptoms/Findings/Manifestations
- Localization/Laterality
- Anatomy
- Associated with
- Severity
- Episode
- Remission status

- History of
- Morphology
- Complicated by
- External Cause
- Activity
- Place of Occurrence
- Loss of Consciousness
- Substance
- Number of Gestations
- Outcome of Delivery
- BMI
<table>
<thead>
<tr>
<th>Clinical Concept</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td></td>
</tr>
<tr>
<td>Temporal factors</td>
<td></td>
</tr>
<tr>
<td>Caused by/contributing factors</td>
<td></td>
</tr>
<tr>
<td>Symptoms/findings/manifestations</td>
<td></td>
</tr>
<tr>
<td>Localization/laterality</td>
<td></td>
</tr>
<tr>
<td>Anatomy</td>
<td></td>
</tr>
<tr>
<td>Associated with</td>
<td></td>
</tr>
<tr>
<td>Severity</td>
<td></td>
</tr>
<tr>
<td>Episode</td>
<td></td>
</tr>
<tr>
<td>Remissions status</td>
<td></td>
</tr>
<tr>
<td>History of</td>
<td></td>
</tr>
<tr>
<td>Morphology</td>
<td></td>
</tr>
<tr>
<td>Complicated by</td>
<td></td>
</tr>
<tr>
<td>External cause</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td></td>
</tr>
<tr>
<td>Place of occurrence</td>
<td></td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>Substance</td>
<td></td>
</tr>
<tr>
<td>Number of gestations</td>
<td></td>
</tr>
<tr>
<td>Outcome of delivery</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
</tr>
</tbody>
</table>
What is Risk Adjustment (RA)?
What is Risk Adjustment (RA)?

• The process by which CMS reimburses Medicare Advantage plans based on the health status of their members;

• Implemented to pay MA plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (e.g., age & gender) as well as health status;

• Risk-adjustment data is pulled from diagnosis data reported from claims data and medical record documentation from physician offices, hospital inpatient and outpatient settings;

• *Hierarchical Condition Category (HCC) Model*
Patient Risk Scoring

- There are approximately 87 risk score categories which map to over 3,000 different ICD-9 codes.
- In order to accurately reflect a patient’s risk profile, it requires more than the standard ICD-9-CM codes commonly seen in current billing practices.

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

  - Calculated relative to average expenditures:
  - For example:
    - Average = $1,000
    - Female, 57 = $500 = .5 risk factor
    - Condition A = $700 = .7 risk factor
    - Risk Score = 0.5 + 0.7 = 1.2
## HCC Example

<table>
<thead>
<tr>
<th>18</th>
<th>Diabetes with Chronic Complications</th>
<th>0.368</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>E0821 Diabetes mellitus due to underlying condition with diabetic nephropathy</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>E0822 Diabetes mellitus due to underlying condition with diabetic chronic kidney disease</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>E0829 Diabetes mellitus due to underlying condition with other diabetic kidney complication</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>E0831 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>19</th>
<th>Diabetes without Complication</th>
<th>0.118</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>E089 Diabetes mellitus due to underlying condition without complications</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>E099 Drug or chemical induced diabetes mellitus without complications</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>E109 Type 1 diabetes mellitus without complications</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>E119 Type 2 diabetes mellitus without complications</td>
<td></td>
</tr>
</tbody>
</table>
## Helpful Tips for Chronic Conditions

<table>
<thead>
<tr>
<th>Sample Language</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Plan of Care</strong></td>
</tr>
<tr>
<td>Stable</td>
<td>Monitor</td>
</tr>
<tr>
<td>Improved</td>
<td>D/C meds</td>
</tr>
<tr>
<td>Tolerating Meds</td>
<td>Continue current meds</td>
</tr>
<tr>
<td>Deteriorating</td>
<td>Refer</td>
</tr>
</tbody>
</table>
# Common Status Conditions

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
</tr>
<tr>
<td>Dialysis</td>
</tr>
<tr>
<td>Old MI</td>
</tr>
<tr>
<td>Paraplegia and Quadriplegia</td>
</tr>
<tr>
<td>Amputations</td>
</tr>
<tr>
<td>Aids or HIV+ status</td>
</tr>
<tr>
<td>Chronic or debilitating neurological conditions</td>
</tr>
<tr>
<td>• MS, ALS, Huntington's Disease, Myasthenia, Epilepsy</td>
</tr>
<tr>
<td>Ostomies (respiration, feeding, elimination)</td>
</tr>
<tr>
<td>Ventilators</td>
</tr>
<tr>
<td>Common Risk-Adjusted Categories</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>Angina</td>
</tr>
<tr>
<td>Cancer tumors (breast, prostate, colorectal, other)</td>
</tr>
<tr>
<td>COPD</td>
</tr>
<tr>
<td>CHF</td>
</tr>
<tr>
<td>Diabetes, with any reported manifestations</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
</tr>
<tr>
<td>Ischemic or unspecified stroke</td>
</tr>
<tr>
<td>Rheumatoid arthritis &amp; inflammatory connective tissue disease</td>
</tr>
<tr>
<td>Specified heart arrhythmias</td>
</tr>
<tr>
<td>Vascular disease</td>
</tr>
</tbody>
</table>
How Does This Affect Reimbursement?
Effects on Providers

Why will providers be affected?

Each patient’s entire risk profile must be reflected in the medical record and completely coded in claims and encounter data.

How will providers be affected?

- Opportunities to Improve Care Practice
- Financial Health of Your Practice
Provider Preparation Steps

Review
Impact and opportunities to improve clinical documentation and complete code capture

Standardize processes
For complete medical record documentation and coding to minimize disruption to practice flow

Utilize tools and resources
To identify and remediate incomplete coding

Develop internal checkpoints
For the most common documentation and coding errors prior to claim or encounter submission
Provider Practice Implications

**Step 1:** Document each patient’s demographic information and clinical information in the medical record. Make sure you use the best practices for documentation accuracy.

**Step 2:** HHS and CMS use claims data and patient demographic information to calculate a patient’s risk score. Complete medical record documentation and submission of all appropriate diagnosis codes, using the highest level of specificity, comes as a result of employing best practices for documentation, coding and billing.

**Step 3:** HHS and CMS reviews and validate risk scores through data validation audits

*If coding is accurate and complete,* provider practices are minimally disrupted, allowing greater focus on patient care and other practice aspects.

*If coding is inaccurate or incomplete,* there is a higher likelihood of requests for medical records due to HHS requirements for documentation to support accurate risk score submission by insurers. More medical record requests, by HHS or a Plan, means higher practice disruption and cost. Inaccuracies in coding, once known, do require correction.
• Personal history includes diabetes mellitus, coronary artery disease, dyslipidemia, CVA, hypertension, back pain

• Medical history: Hypertension, COPD, Atrial Fibrillation, s/p A/V node ablation, sinus bradycardia, CHF, BIV/ICD Medtronic DTBB1D4, 6/11/15

• *Past history means the condition has resolved, NOT a current, chronic, or controlled on-going problem*
“History of” Tips

• “History of” means the patient no longer has the condition
• Frequent documentation errors regarding “History of”
  • Coding a past condition as active
  • Coding “history of” when the condition is still active
• Exception: It is appropriate to document/code “history of” when documenting some status conditions (amputation)

<table>
<thead>
<tr>
<th>Incorrect Documentation</th>
<th>Correct Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O CHF, Meds Lasix</td>
<td>Compensated CHF, stable on Lasix</td>
</tr>
<tr>
<td>H/O angina, meds nitro</td>
<td>Angina, stable on nitro</td>
</tr>
<tr>
<td>H/O COPD, meds Advair</td>
<td>COPD controlled w/Advair</td>
</tr>
</tbody>
</table>
Documentation Tips

All chronic conditions must be assessed and reported annually
- CHF, Diabetes, COPD

Co-existing acute conditions
- Protein calorie malnutrition

Active status conditions
- Amputations, HIV, dialysis

Pertinent past conditions
- Old MI and other underlying medical problems

Medications that may indicate other conditions
### Documentation Tips

<table>
<thead>
<tr>
<th>Specific rather than general information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Major depression rather than depression</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Causality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetic neuropathy, not diabetes and neuropathy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest level of specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetes w/renal manifestations</td>
</tr>
<tr>
<td>• Include signs/symptoms</td>
</tr>
<tr>
<td>• Abnormal test results</td>
</tr>
<tr>
<td>• Other reason for visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support documentation of conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stable, controlled, poorly controlled, improving, worsening</td>
</tr>
</tbody>
</table>
## Opportunities for Clarification

<table>
<thead>
<tr>
<th>Do not document and report</th>
<th>When you know the patient has</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Depression”</td>
<td>Major Depression</td>
</tr>
<tr>
<td>“Bronchitis”</td>
<td>Chronic bronchitis</td>
</tr>
<tr>
<td>“Asthma”</td>
<td>Chronic obstructive asthma</td>
</tr>
<tr>
<td>“Vertebral fracture”</td>
<td>Pathological fracture of vertebrae</td>
</tr>
<tr>
<td>“CVA with weakness”</td>
<td>History of CVA with residual dominate side hemiplegia</td>
</tr>
<tr>
<td>“Patient is very obese”</td>
<td>Patient is morbidly obese</td>
</tr>
<tr>
<td>“Poorly controlled diabetes”</td>
<td>Uncontrolled diabetes</td>
</tr>
</tbody>
</table>
Patient: Sally Jones  DOB: 12/1/38  DOS: 10/11/12  Patient is a 72 year old female with UTI like symptoms. Patient c/o fatigue, low energy and poor appetite. Patient is status post MI 18 months ago. Patient appears frail and with mild malnutrition. Has lost 23 pounds in the last 4 months. Patient has been complaining of pain with urination, weakness, and has had dry, itchy skin for the past several months. U/A done today shows WBCs, leukocyte esterase, and microalbuminuria. Serum creatinine is 1.5.

PMH:  Type II diabetes, chronic kidney disease secondary to diabetes, history of BKA skin intact at stump, no erythema. History of MI. Previous UTI 4 months ago with a serum creatinine of 1.6. Lab results at that time revealed stage 2 CKD.

A/P:  Diabetes-Metformin 500 mg b.i.d.  Bactrim for UTI. Malnutrition-Ensure b.i.d. and nutrition consult.  RTC in 6 weeks.  Referral made to Dr. Smith (Nephrologist) for CKD.  Note Electronically Signed by John Anderson, MD 10/11/2012 0814
**Coding Example 1:** Typically submitted ICD-9-CM codes for the office visit

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Condition</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00</td>
<td>DM w/o complication type II</td>
<td>19 (HCC-C)</td>
</tr>
<tr>
<td>599.0</td>
<td>Urinary tract infection</td>
<td>Does not risk adjust</td>
</tr>
</tbody>
</table>

**Coding Example 2:** Opportunities for additional risk adjustment code reporting

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Condition</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.40</td>
<td>Diabetes w/ renal manif. Type II</td>
<td>18 (HCC-C)</td>
</tr>
<tr>
<td>585.2</td>
<td>Stage II CKD</td>
<td>125 (HCC-D)</td>
</tr>
<tr>
<td>263.1</td>
<td>Malnutrition of mild degree</td>
<td>21 (HCC-C)</td>
</tr>
<tr>
<td>599.0</td>
<td>Urinary tract infection</td>
<td>Does not risk adjust</td>
</tr>
<tr>
<td>412</td>
<td>Prior MI</td>
<td>89 (HCC-D)</td>
</tr>
<tr>
<td>V49.75</td>
<td>Amputation, below knee</td>
<td>189 (HCC-C)</td>
</tr>
</tbody>
</table>
Chronic diseases are responsible for 7 out of 10 deaths each year.

In 2014 chronic diseases accounted for 93% of all Medicare spending.

- Diabetes: $174 billion
- Lung disease: $154 billion
- Heart disease and stroke: $432 billion
- Alzheimer’s disease: $148 billion
Documentation

• “Clinical documentation was developed to track a patient's condition and communicate the author's actions and thoughts to other members of the care team. Over time, other stakeholders have placed additional requirements on the clinical documentation process for purposes other than direct care of the patient.” ¹

• For these reasons, the medical record must be:
  * Complete
  * Precise
  * Legible
  * Reliable
  * Consistent
  * Timely

¹Annals of Internal Medicine, 17 February, 2015, Vol 162, No. 4. (American College of Physicians)
Accuracy is of THE Utmost Importance!

• Documentation should clearly indicate what was done.
• Include details outlining what took place during the encounter.
• Details, details, details!
Best Practices for Documentation

The provider should:

• Be graphic by fully illustrating the visit
  • The more specificity, the better
• What are the thought processes that resulted in a final diagnosis?
• Make a case for the work performed
• Use key terms
• What were the results of treatment(s)?
• Document total time spent with patient
• Document time for counseling/coordinating care when applicable
Best Practices for Documentation

• Avoid words which are vague or have more than one meaning.
• Every entry must be signed and dated.
• All contact, including telephone calls and correspondence with the patient, should be documented in the record.
• Record all instructions given to the patient and/or caregiver
• Avoid recording conflicting information
A Closer Look

Diabetes
Arthritis
Heart Failure
Hypertensive diseases
Kidney disease

Asthma
Obesity
Atrial Fibrillation
Depression
## Arthritis

- **Type**
- **Temporal Factors**
- **Caused by/Contributing Factors**
- **Symptoms/Findings/Manifestations**
- **Localization/Laterality**
- **Anatomy**
- **Associated with**
- **Severity**

### Primary osteoarthritis of other joints

- **M19.0 Primary osteoarthritis of other joints**
  - **M19.01 Primary osteoarthritis, shoulder**
    - **M19.011 Primary osteoarthritis, right shoulder**
    - **M19.012 Primary osteoarthritis, left shoulder**
    - **M19.019 Primary osteoarthritis, unspecified shoulder**
  - **M19.02 Primary osteoarthritis, elbow**
    - **M19.021 Primary osteoarthritis, right elbow**
    - **M19.022 Primary osteoarthritis, left elbow**
    - **M19.029 Primary osteoarthritis, unspecified elbow**
  - **M19.03 Primary osteoarthritis, wrist**
    - **M19.031 Primary osteoarthritis, right wrist**
    - **M19.032 Primary osteoarthritis, left wrist**
    - **M19.039 Primary osteoarthritis, unspecified wrist**
  - **M19.04 Primary osteoarthritis, hand**
    - **Excludes2: primary osteoarthritis of first carpometacarpal joint (M18.0-, M18.1-)**
    - **M19.041 Primary osteoarthritis, right hand**
    - **M19.042 Primary osteoarthritis, left hand**
    - **M19.049 Primary osteoarthritis, unspecified hand**
  - **M19.07 Primary osteoarthritis ankle and foot**
    - **M19.071 Primary osteoarthritis, right ankle and foot**
    - **M19.072 Primary osteoarthritis, left ankle and foot**
    - **M19.079 Primary osteoarthritis, unspecified ankle and foot**
Asthma

- Type
- Temporal Factors
- Caused by/Contributing Factors
- Associated with
- Severity
## Classification of Asthma Severity

<table>
<thead>
<tr>
<th>Components of Severity</th>
<th>Classification</th>
<th>Persistent</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intermittent</strong></td>
<td></td>
<td>0-4 yrs 5-11 yrs 12 + yrs</td>
<td>0-4 yrs 5-11 yrs 12 + yrs</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td></td>
<td>≤ 2 days/week but not daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>0 ≤ 2x/month</td>
<td>1-2x/month 3-4x/month</td>
<td>&gt; 1x/month but not nightly</td>
</tr>
<tr>
<td>SABA use for symptom control</td>
<td>≤ 2 days/week</td>
<td>≤ 2 days/week but not daily</td>
<td>Daily</td>
</tr>
<tr>
<td>(not prevention of EIB)</td>
<td></td>
<td>&gt;2 days/ week but not daily, and not more than 1x on any day</td>
<td>Several time per day</td>
</tr>
<tr>
<td><strong>Interference with normal activity</strong></td>
<td></td>
<td>Minor limitation</td>
<td>Some limitation</td>
</tr>
<tr>
<td>Lung function</td>
<td></td>
<td>Normal FEV1, between exacerbations &gt; 80%</td>
<td>Normal FEV1, between exacerbations &gt; 80%</td>
</tr>
<tr>
<td>FEV1/FVC</td>
<td>N/A</td>
<td>&gt; 80%</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Exacerbations requiring oral systemic corticosteroids</strong></td>
<td>0-1/year</td>
<td>≥ 2 exacerbations in 6 months requiring oral steroids or ≥4 wheezing episodes/1 year lasting ≥ 1 day and risk factors for persistent asthma</td>
<td>≥ 2 exacerbations in 6 months requiring oral steroids or ≥4 wheezing episodes/1 year lasting ≥ 1 day and risk factors for persistent asthma</td>
</tr>
</tbody>
</table>

### Recommendations

- **Step 1**: Start short course of oral steroids
- **Step 2**: Start medium dose ICS and consider short course of oral steroids
- **Step 3**: Consider short course of oral steroids

### Consideration

- Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category.
- In 2-6 weeks, evaluate level of asthma control that is achieved.
- 0-4 years: If no clear benefit is observed in 4-6 weeks, stop treatment and consider alternate diagnosis or adjusting therapy. 5-11 and 12+ years: adjust therapy accordingly.
• Type
  • Type 1
  • Type 2

• Cause
  • Drug or chemical induced
  • Due to underlying condition
  • Gestational

• Complication/Manifestation
  • Kidney
  • Ophthalmic
  • Neurological
  • Skin
  • Oral
Hypertensive Diseases (I10-I15)

- **Type**
  - Essential (primary)
    - Hypertensive heart disease
    - Hypertensive chronic kidney disease
    - Hypertensive heart and chronic kidney disease
  - Secondary
    - Renovascular
    - Renal disorders
    - Endocrine disorders

- **Caused by/Contributing factors**
  - Chronic kidney disease
  - Heart failure

- **Associated complications**

- **Severity**

- **Symptoms/Findings/Manifestations**

- **Temporal factors**
Hypertensive diseases (I10-I19)

Use additional code to identify:
- exposure to environmental tobacco smoke (Z77.22)
- history of tobacco dependence (Z67.061)
- occupational exposure to environmental tobacco smoke (Z67.31)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

Excludes 1: neonatal hypertension (P28.2)
- primary pulmonary hypertension (I27.0)

Excludes 2: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O19)

I10 Essential (primary) hypertension

Includes:
- high blood pressure
- hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

Excludes 1: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O18)

Excludes 2: essential (primary) hypertension involving vessels of brain (I60-I69)
- essential (primary) hypertension involving vessels of eye (H35.0)

I11 Hypertensive heart disease

Includes:
- any condition in I11.4-I151.9 due to hypertension

I11.0 Hypertensive heart disease with heart failure
- Hypertensive heart failure

Use additional code to identify type of heart failure (I50.-)

I11.5 Hypertensive heart disease without heart failure
- Hypertensive heart disease NOS

I12 Hypertensive chronic kidney disease

Includes:
- any condition in N18 and N29 - due to hypertension
- atherosclerosis of kidney
- arteriosclerotic nephritis (chronic) (interstitial)
- hypertensive nephropathy
- nephrosclerosis

Excludes 1: hypertension due to kidney disease (I15.0, I15.1)
- renovascular hypertension (I15.0)
- secondary hypertension (I15.-)

Excludes 2: acute kidney failure (N17.-)

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.8)

I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or

I13 Hypertensive heart and chronic kidney disease

Includes:
- any condition in I11.4-I151.9 - with any condition in I12.0
- cardiovascular disease
- cardiovascular renal disease

I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Use additional code to identify type of heart failure (I50.-)

Use additional code to identify stage of chronic kidney disease (N18.1-N18.4, N18.9)

I13.1 Hypertensive heart and chronic kidney disease without heart failure

I13.10 Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
- Hypertensive heart disease and hypertensive chronic kidney disease NOS

Use additional code to identify the stage of chronic kidney disease (N18.1-N18.4, N18.9)

I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

Use additional code to identify type of heart failure (I50.-)

Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)
Heart Failure I50

• Type/severity
  - Left sided: Fluid may back up in lungs causing shortness of breath
  - Right sided: Fluid may back up in abdomen, feet and legs, causing swelling
  - Systolic: Left ventricle doesn’t pump blood out to body as well as normal
  - Diastolic: Left ventricle cannot relax fully which limits ability to fill properly with blood
  - Congestive: Fluid that builds in lungs, liver, GI tract, arms and legs

• Temporal factors
  - Acute
  - Chronic
  - Acute on chronic
  - Combined systolic and diastolic
Heart Failure I50

- Associated conditions
- Cause/Contributing Factors/Complicated by
  - Code First in Tabular Index prior to codes
    - Complicating abortion or ectopic pregnancy
    - Due to hypertension
    - Due to hypertension with chronic kidney disease
    - Following surgery
    - Obstetric surgery and procedures
    - Rheumatic heart failure
Kidney Disease

• Type
  • Stage 1-6
  • End stage
• Temporal factors
  • Acute
  • Chronic

• Associated with/Caused by/Contributing factor
  • Underlying condition
  • Diabetic chronic kidney disease
  • Hypertensive chronic kidney disease
• History of
  • Transplant
Obesity

- Caused by/ Contributing Factors
- Associated with
- Severity

E66 Overweight and obesity

Use additional code to identify body mass index (BMI), if known (Z68-)

Excludes 1: adiposogenital dystrophy (E23.6)
- lipomatosis NOS (E88.2)
- lipomatosis dolorosa [Dercum] (E88.2)
- Prader-Willi syndrome (Q87.1)

Code first: obesity complicating pregnancy, childbirth and the puerperium, if applicable (O99.21-)

Z68 Body mass index [BMI]

Kilograms per meters squared

Note: BMI adult codes are for use for persons 21 years of age or older.
BMI pediatric codes are for use for persons 2-20 years of age. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC)
Atrial Fibrillation

- Type
- Temporal Factors
Depression

- Type
- Temporal Factors
- Caused by/Contributing Factors
- Manifestations
- Associated with
- Episode of Care
- Severity
Otitis Media

<table>
<thead>
<tr>
<th>Type</th>
<th>Temporal factors</th>
<th>Caused by/Contributing Factors</th>
<th>Symptoms/Findings/Manifestations</th>
<th>Localization/Laterality</th>
<th>Associated with</th>
<th>Severity</th>
<th>Episode</th>
</tr>
</thead>
</table>

- **Type**
- **Temporal factors**
- **Caused by/Contributing Factors**
- **Symptoms/Findings/Manifestations**
- **Localization/Laterality**
- **Associated with**
- **Severity**
- **Episode**

### Nonsuppurative otitis media

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H65</td>
<td>Use additional code to identify:</td>
</tr>
<tr>
<td></td>
<td>- exposure to environmental tobacco smoke (Z77.22)</td>
</tr>
<tr>
<td></td>
<td>- exposure to tobacco smoke in the perinatal period (P96.81)</td>
</tr>
<tr>
<td></td>
<td>- history of tobacco dependence (Z87.891)</td>
</tr>
<tr>
<td></td>
<td>- occupational exposure to environmental tobacco smoke (Z57.31)</td>
</tr>
<tr>
<td></td>
<td>- tobacco dependence (F17.-)</td>
</tr>
<tr>
<td></td>
<td>- tobacco use (Z72.0)</td>
</tr>
</tbody>
</table>

**Includes:** nonsuppurative otitis media with myringitis

### Suppurative and unspecified otitis media

<table>
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<td>- tobacco use (Z72.0)</td>
</tr>
</tbody>
</table>

**Includes:** suppurative and unspecified otitis media with myringitis
Otitis Media

- In underlying diseases
- Laterality
- Smoking exposure
- Acute/subacute
- Suppurative
- Non-suppurative
- Recurrent
- Chronic

- Serous
- Sanguinous
- Mucoid
- Allergic

- W/w-out rupture

- Serous
- Mucoid
- Allergic
- Nonsuppurative
Documentation Improvement

A Comparison of Three Notes
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Comments</th>
<th>Pre 2017-Changes Diagnosis Code(s)</th>
<th>Improved Assessment</th>
<th>Comments</th>
<th>Post 2017-Changes Diagnosis Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 diabetes controlled and stable on Lantis</td>
<td>• Type indicated&lt;br&gt;• Lantis could be used for Type 1 or 2 (since it is type I it is not coded)</td>
<td>E10.9 Type 1 diabetes mellitus without complications</td>
<td>Type 1 diabetes controlled and stable on Lantis</td>
<td>• Type indicated&lt;br&gt;• Lantis could be used for Type 1 or 2 (since it is type I it is not coded)</td>
<td>E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>Nonproliferative retinopathy</td>
<td>• Stage not indicated&lt;br&gt;• Laterality not indicated&lt;br&gt;• Not indicated if hypertension is associated with</td>
<td>H35.00 Unspecified background retinopathy</td>
<td>Nonproliferative retinopathy due to diabetes</td>
<td>• Relationship assumed due to index “in (due to diabetes)&lt;br&gt;• Severity not indicated&lt;br&gt;• Macular edema not indicated</td>
<td>E10.329 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>Hypertension</td>
<td>• Sufficient documentation for I10</td>
<td>I12.9 Hypertensive chronic kidney disease stage 1-4</td>
<td>Chronic hypertensive systolic congestive heart failure</td>
<td>• Relationship established with guideline change (CHF and hypertension)&lt;br&gt;• Documentation supports severity of CHF</td>
<td>I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1-4 CKD I50.22 Chronic systolic congestive heart failure</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>• Severity not indicated&lt;br&gt;• Specific type of CHF not indicated</td>
<td>I50.0 Heart failure, unspecified</td>
<td>Severe chronic kidney disease</td>
<td>• Relationship to hypertension assumed (per coding guidelines)</td>
<td>N18.4 Chronic kidney disease, stage 4</td>
</tr>
<tr>
<td>Severe chronic kidney disease</td>
<td>• Can assume relationship to hypertension (per coding guidelines)</td>
<td>N18.4 Chronic kidney disease, stage 4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

• Documentation must support medical necessity
  • Coding tells the patient’s story, the more detail, the better
• Provider’s should ask for feedback in Clinical Concepts vs. coding language
• Open lines of communication are important between coder and provider. This interaction is *crucial*
• Clear, concise and detailed documentation is the key
QUESTIONS

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