Risk Adjustment Coding, Quality-HEDIS, and Documentation

Provider Education Training

2019

Objectives

- ✓ Discuss the Risk Adjustment methodology
- ✓ Understand how complete and accurate documentation and coding supports good patient care
- ✓ Define Associated Quality and HEDIS measures
- ✓ Outline Tips for accurate and complete documentation
- ✓ Review Case Studies

Frequently Used Terms

Budget Neutrality – Normalization of risk scores to fit into pre-defined total budget for premium costs to cover care of all members assigned to all payers. Applies to Medicaid and Marketplace.

Experience Period – Dates of service span used to calculate risk score (usually 12 months). Risk score is typically calculated 3 months or more after experience period ends to allow for some claims run-out.

HEDIS – Set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance

Payment Period – Period of time during which rates are effective. (In Medicare, known as payment year).

Risk Gap – any suspected or known condition that has not been reported within the relevant experience period.

RADV Audit – Risk Adjustment Data Validation Audit. This is an audit activity where CMS asks HPs to submit medical records to support risk adjustment submissions. This will be yearly for Marketplace for all plans, yearly for Medicaid for a small sample of plans, and varies by state for Medicaid.

RAPS - Risk Adjustment Payment System is the encounter submission process of claims to CMS.

Risk Model – Method by which risk score is calculated. Most risk models are based on grouping categories of similar diagnosis codes into categories, and assigning coefficients to each category.

Acronyms

ACG- *Adjusted Clinical Groups*

AWV- *Annual Wellness Visit*

CDPS- *Chronic Illness & Disability Payment System*

CMS- *Centers for Medicare and Medicaid Services*

CPT- *Common Procedure Terminology*

DME- *Durable Medical Equipment*

Dx- *Diagnosis*

DxCG- *Diagnostic Cost Group*

EPSDT- *Early and Periodic Screening, Diagnostic, and Treatment*

FFS- *Fee for service*

HCPCS- *Healthcare Common Procedure Coding System*

HCC- *Hierarchical Condition Category*

HEDIS- *Healthcare Effectiveness Data and Information Set*

HHS HCC- *Health and Human Services Hierarchical Condition Category*

ICD-10-CM- *International Statistical Classification of Diseases and related Health Problems, Clinical Modification*

IHA- *In Home Assessment*

PAF- *Patient Assessment Forms*

RAF- *Risk Adjustment Factor*

What is Risk Adjustment?

Risk Adjustment is the mechanism by which government programs adjust the revenue to health plans based on the health status of the covered population(s).

Benefits of Risk Adjustment

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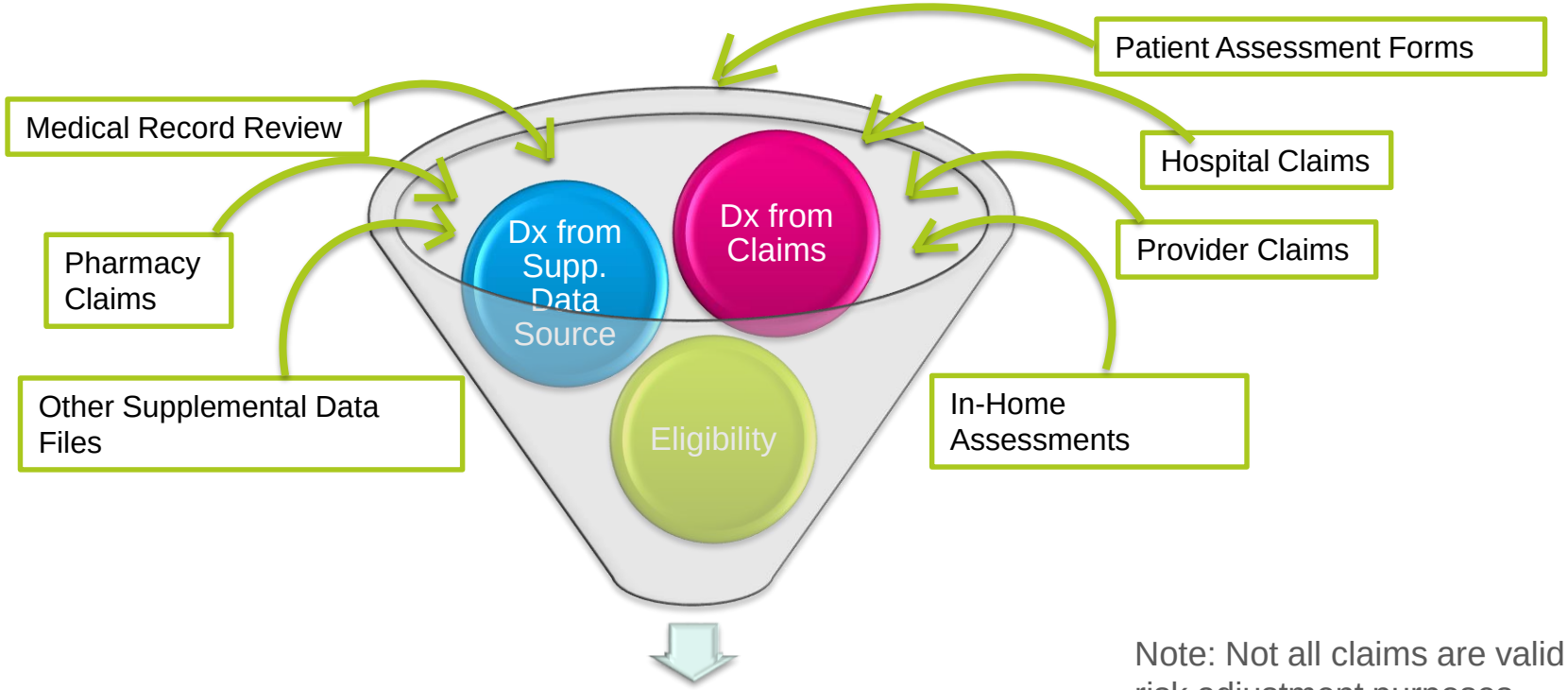
- Sufficient funding
- Minimize incentives
- Optimizing Quality and Efficiency
- Disease management
- Identifying Special needs

Risk Score Calculation

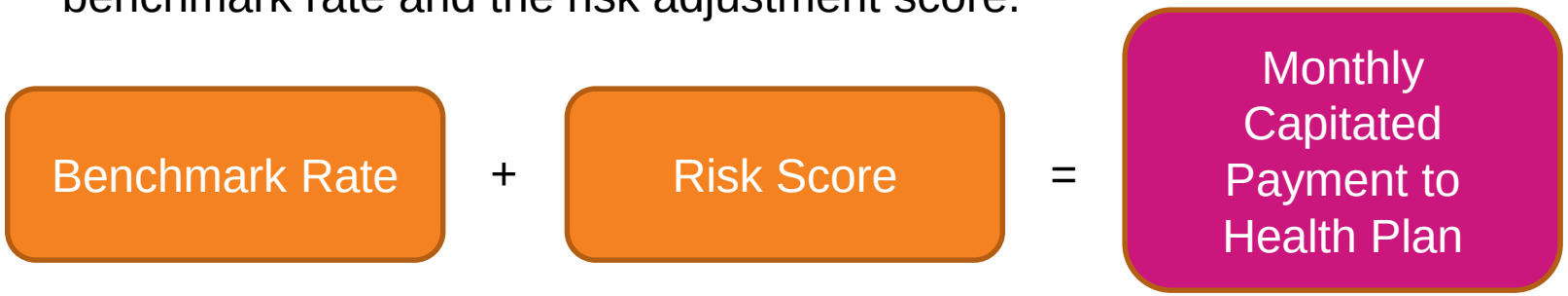


Note: Not all claims are valid for risk adjustment purposes.

Risk Adjustment Score Methodology

High Level Overview of Process

Step 1: CMS assigns a benchmark payment rate (baseline demographics).
Step 2: Members are assigned a risk adjustment score based on various diseases and conditions.
Step 3: Benchmark rate is adjusted based on the risk factors and expected cost to care for the member.
Step 4: Risk adjustment factor scores are used to establish payment for the following year. Health plan receives monthly payment based on the benchmark rate and the risk adjustment score.



Risk Adjustment Models

Medicaid 1997	Medicare 2004	Marketplace 2014
• ACG, DxCG, CDPS+Rx, etc (States decide) • Aggregated and Budget Neutral • Concurrent or Prospective Payments	• CMS-HCC (Part C) and Rx-HCC (Part D) • Individualized and Additive • Prospective Payments	• HHS-HCC (Federal), Various State Models as approved by HHS • Aggregated and Budget Neutral • Concurrent Payments

Risk Adjustment Models

- Disease groups contain major diseases and are broadly organized into body systems
  - HCC (Hierarchical Condition Categories) *Medicare*
  - HHS-HCC (Health & Human Service's Hierarchical Condition Categories) *Marketplace*
  - CDPS+Rx (Chronic Illness and Disability Payment System) *Medicaid*
- Each HCC has an associated risk weight; each Category within the CDPS+Rx Model has an associated risk weight
- HCC's are additive across different HCC's but not within the same HCC
- HCC's exhibit a trumping structure which is based on the severity of the documented disease. Credit is only provided for the most severe HCC within like HCC categories (Disease Hierarchies)
  - If a provider documented 5 different conditions all mapping to a different category from 8 to 12, the provider would only receive credit for the most severe and highest weighted HCC within that Disease Hierarchy, which in the above hierarchy is HCC 8

HCC Trumping Structure

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Table VI-3. Disease Hierarchies for the 2019 CMS-HCC without Count Variables Model

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the Disease Group(s) listed in this column
	Hierarchical Condition Category (HCC) Label	
8	Metastatic Cancer and Acute Leukemia	9, 10, 11, 12
9	Lung and Other Severe Cancers	10, 11, 12
10	Lymphoma and Other Cancers	11, 12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18, 19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28, 29, 80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
54	Substance Use with Psychotic Complications	55, 56
55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications	56
57	Schizophrenia	58, 59, 60
58	Reactive and Unspecified Psychosis	59, 60
59	Major Depressive, Bipolar, and Paranoid Disorders	60
70	Quadriplegia	71, 72, 103, 104, 169
71	Paraplegia	72, 104, 169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83, 84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87, 88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Intracranial Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107, 108, 161, 189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111, 112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135, 136, 137, 138
135	Acute Renal Failure	136, 137, 138
136	Chronic Kidney Disease, Stage 5	137, 138
137	Chronic Kidney Disease, Severe (Stage 4)	138
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158, 161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	161
166	Severe Head Injury	80, 167

An example of the HCC Hierarchy and Trumping Structure is shown:

- Column 1 indicates the HCC Category
- Column 2 provides the HCC Category Description
- Column 3 indicates which other HCC Categories are trumped by that HCC
  - Ex: HCC 8 trumps HCC 9, 10, 11, 12

Overview Example: Marketplace

Marketplace is a concurrent system and utilizes the HHS-HCC model. Marketplace has three age bands that are considered for risk adjustment: Adult, Child, Infant. There are five “metal levels” of insurance that can be purchased creating 15 possible risk scores for an HCC. The below table is an example that identifies the age and benefit level giving different scores for the HCC 161 Asthma:

Model	Platinum Level	Gold Level	Silver Level	Bronze Level	Catastrophic Level
Adult	0.951	0.833	0.723	0.648	0.646
Child	0.435	0.348	0.231	0.149	0.147
Infant	2.155	1.873	1.549	1.32	1.316

https://www.aapc.com/blog/40867-risk-adjustment-calculations-in-the-commercial-line-of-business/

Overview Example: Medicare

Medicare uses the HCC method to calculate the risk score. This means there is a flat fixed rate for every member, and the score increases depending on the individual RAF score. Medicare's rules are standard and apply to all plans who contract with Medicare. Medicare is a prospective system, meaning the payment is made based on a predetermined, fixed amount. Below is an example of how to document accurately in order to obtain and support a higher RAF score:

Example 1			Example 2		
67 year-old male with type 2 diabetes with no complications, hypertension, and body mass index (BMI) of 37.2			67 year-old male with type 2 diabetes with diabetic polyneuropathy, hypertension, morbid obesity with (BMI) of 37.2, and status post-left below knee amputation		
ICD-10-CM	**Description**	**RAF**	**ICD-10-CM**	**Description**	**RAF**
E11.9	DM II no complications	0	E11.42	DMII with diabetic polyneuropathy	0.0368
I10	Hypertension	0	I10	Hypertension	0
Z68.37	BMI 37.2	0	E66.01 + Z68.37	Morbid obesity with BMI 37.2	0.365
			Z89.512	Status post-left BKA	0.779
Total		**0**	**Total**		**1.1808**

Overview Example: Medicaid

Medicaid uses the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system. This method maps diagnoses to categories corresponding to major body systems or chronic diseases. There are various levels within categories, but only the most severe diagnosis mapping to the highest level within each category will count towards the risk score.

Levels are: very low, low, medium, high, and very high within each category.

Below is an example of how to document accurately in order to obtain and support a higher RAF score:

Example 1			Example 2		
50 year-old female with type 2 diabetes and bipolar disorder			50 year-old female with type 2 diabetes with diabetic polyneuropathy, hypertension, and bipolar disorder in remission		
ICD-10-CM	**Description**	**RAF**	**ICD-10-CM**	**Description**	**RAF**
E11.9	DM II no complications	0.232	E11.42	DM II with diabetic polyneuropathy	0.232
F31.9	Bipolar Disorder	0.618	F31.7	Bipolar disorder, in remission	0.915
Age		0.322	Age		0.322
Gender		0.130	Gender		0.130
Total		**1.302**	**Total**		**1.599**

Acuity and Specificity

Because ICD-10-CM codes are used in risk adjustment, the documentation of acuity and specificity can be significant.

Here are some examples of the increased specificity needs that are important to include in the documentation for risk adjustment:

Disease	Specificity	HCC
Hepatitis	Hepatitis, acute hepatitis, unspecified viral hepatitis, alcoholic hepatitis	No HCC
	Acute hepatitis with hepatic failure	**HCC 27**
	Alcoholic cirrhosis	**HCC 28**
	Alcoholic hepatic failure without coma	**HCC 28**
	Alcoholic hepatic failure with coma	**HCC 27**
Bronchitis	Bronchitis not specified as acute or chronic	No HCC
	Chronic bronchitis	**HCC 111**
Renal failure	Renal failure	No HCC
	Acute renal failure	**HCC 135**
Obesity	Obesity	No HCC
	Morbid obesity	**HCC 22**
CKD	Unspecified, Stage 1, 2	No HCC
	Stage 3	**HCC 138**
	Stage 4	**HCC 137**
	Stage 5	**HCC 136**
	Dependence on renal dialysis	**HCC 134**

Quality vs. Quantity

- Value-based compensation
- Shifting from FFS model to pay-for-performance methods
- Payers will reward value and care coordination-rather than volume
- Increase accountability for quality and total cost of care

- Already taking place in some states
- Category II codes required on claims for HEDIS

Physician's Role

Risk adjustment is an important process that allows the State and Federal government to gauge the acuity of a member population and consequently allocate resources to the members health plan accordingly. This process ensures that members with the highest risk of incurring medical expenses have the resources available to facilitate high quality care and meet their healthcare needs.

- ❑ Physician data (coding information submitted on physician claims) is critical for accurate risk adjustment.
- ❑ Physician claims data is the largest source of medical data for the risk adjustment models which help to determine how resources are allotted for care of the population.
- ❑ Specificity of diagnosis coding is substantiated by the medical record. Accurate coding helps to best reflect the cost of caring for members/patients:
  - ✓ It demonstrates the level of complexity for the patient encounters.
  - ✓ It is vital to a healthy revenue cycle, and more important, to a healthy patient.

- ❑ Each progress note must *(review the notes below for further description)*:
  - ✓ Support what is coded and billed (ICD-10-CM, CPT, and HCPCS).
  - ✓ "Stand alone" ensuring all information necessary to support medical necessity for services rendered on a given date of service are documented within each progress note for that date of service alone.
  - ✓ Ensure all work for which the provider is given credit towards their medical decision making is clearly documented within the progress note.
  - ✓ Be complete and contain legible signature, credentials, and date.

"Document for others as you would want them to document for you."

Medical Record Documentation Tips

- A condition only exists when it is **documented**
  - Diagnoses do not carry over from visit to visit or year to year
- A condition can be coded and reported as many times as patient receives care and treatment for the condition
  - Do not code for conditions that were previously treated and no longer exist
- Conditions can be coded when documentation states condition is being monitored and treated by a specialist
  - "Patient on Coumadin for atrial fibrillation; followed by Dr. Hill"
- Co-existing conditions can be coded when documentation states that the condition affects the care, treatment, or management of the patient.
  - "***Autistic*** patient comes in for ***chronic constipation***"
- Document and code status conditions at least once a year
  - Examples: Transplant status, amputation status, dialysis status, chemotherapy status, artificial opening status/maintenance
- Do not code unconfirmed diagnoses
  - Examples: Probable, possible, suspected, working diagnosis
- **Do not** use arrows or symbols alone to indicate diagnosis
  - ↑ cholesterol ≠ hypertension
- Be sure diagnosis code(s) billed are consistent with medical record documentation
  - Example: Assessment & Plan documentation lists **I10** only *with no* description.
  - **Cannot list ICD-10 Diagnosis code alone.** Must document hypertension somewhere in the medical record.

Commonly overlooked diagnoses

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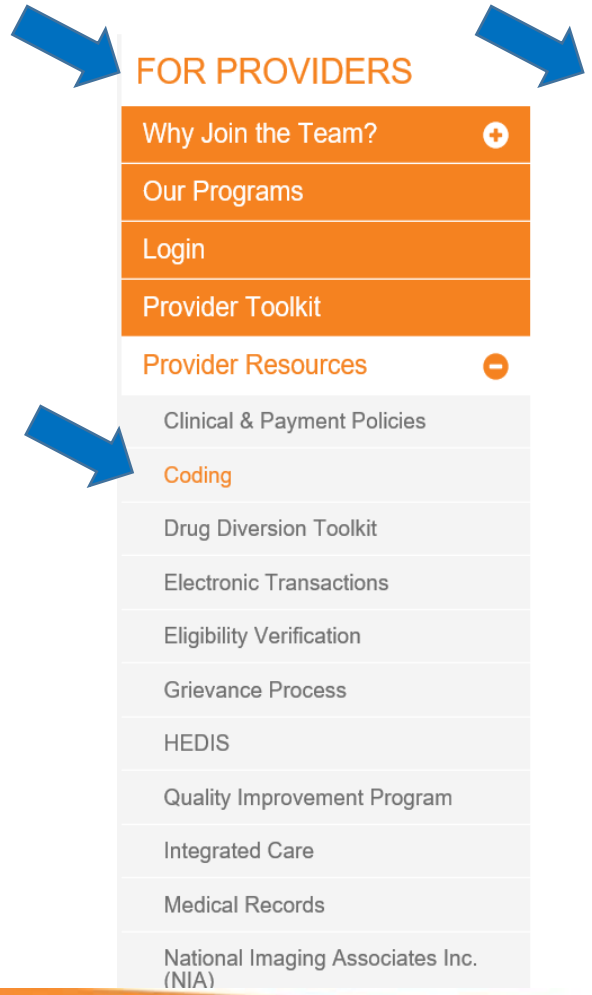
Description	ICD-10 code(s)
Major organ transplant	Z94.- Transplanted organ and tissue status
Artificial opening	Z93.- Artificial opening status
Amputation	Z89.4- - Acquired absence of foot and/or toe(s) Z89.5- - Acquired absence of leg below knee
Obesity	E66.- Overweight and obesity Z68.4- BMI 40 or greater
Renal dialysis	Z99.2 Dependence on renal dialysis
Paraplegia Quadriplegia	G82.2- Paraplegia G82.5- Quadriplegia
HIV status	B20 HIV disease, symptomatic
Myocardial Infarction	I25.2 Old or healed myocardial infarction

Diagnosis Coding Tips



Coding

Risk Adjustment Coding Awareness

The Coding Awareness is a series of issues to help educate providers, coders and billers on how to document and report chronic conditions. Guidance contains definitions, diagnostic criteria, treatment options, and pertinent coding tips designated for each diagnosis.

- RA Issue 1: What is Risk Adjustment (PDF)
- RA Issue 2: MEAT (PDF)
- RA Issue 3: Bipolar Disorder (PDF)
- RA Issue 4: Depression (PDF)
- RA Issue 5: ADHD (PDF)
- RA Issue 6: Behavioral Disorder (PDF)
- RA Issue 7: Autistic Disorder (PDF)
- RA Issue 8: Asthma (PDF)
- RA Issue 9: Diabetes (PDF)
- RA Issue 10: Cancer (PDF)
- RA Issue 11: Supplemental Oxygen (PDF)
- RA Issue 12: Cancer Part II (PDF)
- RA Issue 13: Colon Cancer (PDF)
- RA Issue 14: COPD (PDF)
- RA Issue 15: Smoking and Substance Abuse (PDF)

Documentation and Billing Examples

Diagnosis Coding Tips

Example of a Risk Adjustment Coding Tip for Providers on HSH website

Chronic Condition Coding Awareness: Asthma

Asthma

Asthma, sometimes called bronchial asthma or reactive airway disease[2], is a chronic lung disease that makes it harder to move air in and out of the lungs[1]. It can be serious, life threatening, and start at any age. With asthma, swollen airways become extra sensitive to things that one is exposed to in the environment every day—asthma "triggers." When a trigger is breathed in, the airways create extra mucus and swell even more, making it harder to breathe[2].

Symptoms of Asthma

Asthma symptoms include coughing (especially at night), wheezing, shortness of breath, and chest tightness, pain, or pressure[2]. Understanding the experiences or exposures that make the asthma flare-up is a key step to better managing the disease.

Treatment of Asthma

Treatment for asthma may include inhalers, oral medications, and drugs delivered in a nebulizer or breathing machine[2]. Making a plan to avoid or limit the environmental exposure to asthma triggers can eliminate asthma symptoms and help control the disease[1]. The use of action plans can assist with treating asthma and identify symptoms to watch for and to quickly get the breathing under control. There are 3 basic zones of green (stable for time- no coughing), yellow (coughs, wheezing, chest tightness), and red (danger and should seek medical care immediately) that are followed and should be kept up-to-date[2]. Providers can utilize the template from Asthma and Allergy Foundation of America to assist with controlling asthma[5].

Asthma Coding Guidance

TIPS:	ICD-10 Mapping & Education	
➢ **ICD-10-CM**	J45.20 – J45.998 (Asthma)[3]	
	J45.2- Mild Intermittent Asthma	Be sure to check for 6th digit of:
	J45.3- Mild Persistent Asthma	0 = uncomplicated
	J45.4- Moderate Persistent Asthma	1 = acute exacerbation
	J45.5- Severe Persistent Asthma	2 = status asthmaticus
	J45.901 Unspecified asthma with (acute) exacerbation	
	J45.902 Unspecified asthma with status asthmaticus	
	J45.909 Unspecified asthma, uncomplicated	
	J45.990 Exercise induced bronchospasm	
	J45.991 Cough variant asthma	
	J45.998 Other asthma	
➢ **Documentation should specify**	○ Frequency (intermittent, persistent) ○ Severity (mild, moderate, severe) ○ Exacerbation or decompensation ○ Environmental factors	
➢ **Use additional code…**	… to identify: ○ Exposure to environmental tobacco smoke *(Z77.22)* ○ Exposure to tobacco smoke in the perinatal period *(P96.81)* ○ History of tobacco dependence *(Z87.891)* ○ Occupational exposure to environmental tobacco smoke *(Z57.31)*	

➢ **Avoid terms such as "history of"…**	… if patient is still being monitored for the condition. ○ Incorrect wording: *Patient has history of asthma.* ○ Correct wording: *Patient has asthma with no recent onset to exacerbation. Current medication includes albuterol inhaler.*
➢ **Additional Coding Tips**	○ Bronchitis *(J40)*: too general, identify acute or chronic. ○ COPD with asthmatic conditions: code both the COPD & Asthma. ○ Smoker's cough *(J41.0)*: do not use bronchitis code.
➢ **Documentation Tips**	The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention… ○ Medications reviewed and are current. ○ If patient is seeing a specialist. ○ Whether there has been any or no recent onset to exacerbation.
➢ **HEDIS Tips**	Members age 5-64 years with persistent asthma who were dispensed one asthma control medication *and* they continued medication during the treatment period within the past year[4].

1. American Lung Association (http://www.lung.org/lung-health-and-diseases/lung-disease-lookup/asthma/learn-about-asthma/#reviewed) August 9, 2018
2. WebMD: Asthma Health Center (http://www.webmd.com/asthma/default.htm)
3. 2019 ICD-10-CM Expert for Physicians: The Complete Official Code Set. Optum360. 2018 Optum360, LLC
4. 2019 HEDIS Technical Specifications
5. Asthma and Allergy Foundation of America Asthma Action Plan (http://www.aafa.org/media/asthma-action-plan-aafa.pdf)

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➢ **Secure Portal Registration:** If you haven't already do so, please go to www.HomeStateHealth.com to register for our Secure Portal. Functions on the portal include: Verification of eligibility, submission of claims, entering authorizations, viewing patient care gaps, etc. Use of the portal is FREE for all services!

➢ **Electronic Funds Transfer / Electronic Remittance Advice**

- Home State Health Plan partners with PaySpan Health for EFT/ERA services.
- Please register with PaySpan Health at www.payspanhealth.com

MEAT

Providers must accurately document the patient's diagnoses for each visit (encounter). Utilizing the MEAT acronym is a great tool to use when documenting current and chronic conditions. Any condition that is supported by monitoring, evaluating, assessing or treating can be coded. The following slide has more definitive examples.

Monitoring

Evaluation

Assessment

Treatment

- Medical record documentation must have MEAT documented for each diagnosis
- A simple list of diagnoses is not acceptable.

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patients receive treatment and care for the condition(s).

The Mandate

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management.

Outpatient Coding

https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf Section IV. I. & J.

MEAT (cont'd)

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MEAT	Support	Disease Example	Documentation Examples
Monitor	• Symptoms • Disease progression/regression • Ordering of tests • Referencing labs/other tests	CHF	Stable. Will continue same dose of Lasix and ACE inhibitor
		DJD, hip	Pain controlled
		Hyperlipidemia	Lipid profile ordered
Evaluate	• Test results • Medication effectiveness • Response to treatment • Physical exam findings	Type 2 DM	Blood Sugar log and A1c results reviewed with the patient
		Decubitus ulcer	Relay wound measurement in exam
Assess/ Address	• Discussion, review records • Counseling • Acknowledging • Documenting status/level of condition	Peripheral neuropathy	Decreased sensation of bilateral leg extremities by monofilament test
		Ulcerative colitis	Managed by Dr. Smith
Treat	• Prescribing/continuation of medications • Surgical/other therapeutic interventions • Referral to specialist for treatment/consultation • Plan for management of condition	Tobacco abuse	Advised on risks; smoking cessation counseling
		GERD	No complaints. Symptoms controlled on current meds

Specificity

- Documentation should be as specific as possible.
- Specific documentation and coding guidelines are mandated by HIPAA.

If you mean…..	Don't say…..
Chronic obstructive asthma with acute exacerbation	COPD
Hypertensive heart disease with heart failure	Heart failure/Hypertension
Lung cancer with metastasis to liver	Lung cancer Liver cancer
Alcohol Dependence	Alcohol abuse
Dominant side hemiplegia due to CVA	History of CVA/ Hemiplegia

Past Medical History

- Medical history is the information about the patient's health before the presenting complaint
- Includes experiences with illnesses, operations, injuries and treatments
- Some conditions do not go away; however, coding from past medical history without current support for the condition is not acceptable
- Beware that some EMR software "auto-populates" all conditions previously coded for that patient
- Do not "copy and paste" without updating/editing the conditions
  - Why is this condition a problem?
  - Was it coded correctly?
  - Is the condition still active?
  - When did the condition last occur?
  - Who is treating the condition?

Current vs. History of

- Be sure to use proper tense when documenting conditions.
- Frequent documentation errors:
  - Coding a past condition as active
  - Coding a history of when condition is still active

Incorrect Documentation	Correct Documentation
History of CHF-meds Lasix	Compensated CHF-stable on Lasix
Breast cancer-status post R mastectomy	History of breast cancer-status post R mastectomy
History of Asthma, meds Symbicort	Asthma-stable on Symbicort
CVA 2007-currently stable	History of CVA 2007-no residual deficits

Risk Adjustment & Quality

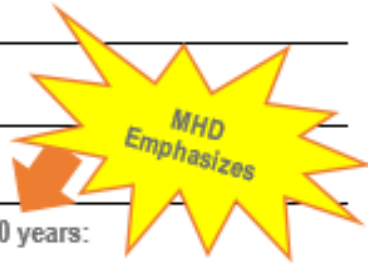
Annual Wellness Visit (AWV) and Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

Perfect opportunity to capture:

- **Quality**
  - AWV (*Annual Wellness Visit*)
  - EPSDT *(Early and Periodic Screening, Diagnostic and Treatment)*
  - BMI
  - Medication Review
  - Vaccinations
  - Lead Screening
  - Preventive Screenings *(Breast, Colon, etc.)*
- **Risk Adjustment** (Chronic Conditions)
  - Address historical conditions
  - Status conditions
  - Clean up Problem List

Annual Wellness Visit & EPSDT

AGE	CPT Code: New Patient	AGE	CPT Code: Established Patient	ICD-10-CM Diagnosis Codes
Preventive visit,<1 year	99381	Preventive visit, <1 year	99391	**Z00.110** Newborn under 8 days old **Z00.111** Newborns 8 to 28 days old or **Z00.121** Routine child health exam with abnormal findings **Z00.129** Routine child health exam without abnormal findings
Preventive visit, 1-4	99382	Preventive visit, 1-4	99392	Z00.121 Z00.129
Preventive visit, 5-11	99383	Preventive visit, 5-11	99393	Z00.121 Z00.129
Preventive visit, 12-17	99384	Preventive visit, 12-17	99394	Z00.121 Z00.129
Preventive vis-it, 18 or older	99385	Preventive vis- it, 18 or older	99395	**Age 18-20 years:** Z00.121 Z00.129 **Age 21 years and older:** **Z00.00** General adult medical exam without abnormal findings **Z00.01** General adult medical exam with abnormal findings



Annual Wellness Visits

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Checklist

- ❑ Review and address all present conditions.
- ❑ Verify all conditions, medications, DME, injections/infusions
- ❑ Rule out any suspected conditions or address them

General exam diagnosis code…..	Definition…..	Example…..
Z00.01 (adult) or Z00.121 (child includes 18-20 years)	"**with abnormal findings**". Use with any abnormality that is present at time of routine examination. Report supplemental diagnosis codes, such as chronic conditions that had to be addressed, in addition to the well exam.	"Patient has mild depressed bipolar I disorder, without psychotic features. Increased LAMICTAL to 100 mg daily.
Z00.00 (adult) or Z00.129 (child includes 18-20 years)	"**with normal findings**". Use for chronic conditions that are stable or improving. Report the chronic condition in addition to the well exam.	"GERD is stable, no longer on medication. Follow up for next well visit or earlier if needed."

Risk Adjustment/Abnormal Findings

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Annual Wellness Exam Diagnosis Code Tips	
Z00.01 *(adult) or* ***Z00.121*** *(child) "Routine health exam* ***with abnormal findings****" may include, but not limited to*	***Z00.00*** *(adult) or* ***Z00.129*** *(child) "Routine health exam* ***without abnormal findings****" can be billed with chronic conditions even if they are stable.*
• an acute injury • an acute illness • an incidental or trivial finding that is diagnosed in the patient's chart • an abnormal screen • an abnormal exam finding • a newly diagnosed chronic condition • a chronic condition that had to be addressed (excluding medication refill) due to an exacerbation • a chronic condition being uncontrolled • new issues arising related to the chronic condition	• If the stable or improving chronic condition had to be addressed for medication refill or routine follow-up, you may report the chronic condition in addition to the well child exam "with *normal* findings." • Verify the condition, any medications, DME, injections/infusions, managed by specialist. • Rule out any suspected conditions or address them. *Source: American Academy of Pediatrics*

Risk Adjustment & HEDIS

Common Reported Diseases

HEDIS and EPSDT

What is HEDIS (Healthcare Effectiveness Data and Information Set)?

It is a data and information set that captures performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA)

- ❑ Includes 90 measures across 6 domains of care

-Effectiveness of Care
-Access /Availability of Care
-Experience of Care
-Utilization and Risk Adjusted Utilization
-Health Plan Descriptive Information
-Measures Collected Using Electronic Clinical Data Systems

What is EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)?

It is a Medicaid (State) benefit that captures comprehensive and preventive health care services on members under age 21

- ❑ Includes 5 main elements of the program

-Assess and identify problems early, starting at birth
-Check children's health at periodic, age-appropriate comprehensive well-child visits
-Provide screenings that include: vision, dental, physical, developmental, mental, labs, etc.
-Identifies risks and performs diagnostic tests and assessments: lead screenings
-Assists with treatment of identified conditions

How does HEDIS And EPSDT correlate?

Many of the measures overlap, such as lead screening, immunizations, weight assessment, testing children with pharyngitis, depression screening, ADHD medication, etc.

Utilizing the EPSDT components and accurately documenting/coding diagnoses and procedures assists with capturing data for HEDIS measures.

RA- Malignant Neoplasm Coding Tips

TIPS:	ICD-10 Mapping & Education
➢ **Current "Active" Malignancy**	Documentation must show clear presence of current disease. Active includes that the malignancy was excised but patient is still undergoing treatment directed to that site. Primary malignancy codes should be used until treatment is complete. ○ Physician/patient chose not to treat ○ Evidence of current/ongoing treatment ○ *Chemotherapy* ○ *Radiation therapy* ○ *Suppressive therapy*
➢ **"History of" vs "In Remission"…**	… if documentation ***does not show clear*** evidence of active disease or treatment, malignancy is considered a ***"history of"*** for coding purposes *(Z85.--).* … Evidence includes: ○ *Definitive surgical treatment* ○ *Completion of treatment regimen* ○ *Follow-up/surveillance for recurrence* …some neoplasms can be "in remission", such as leukemia
➢ **Documentation Tips**	The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention… ○ Medications reviewed and are current. ○ If patient is seeing a specialist. ○ Whether there has been any or no recent onset of the disease/condition.

EXAMPLES

Current Cancer

Colon	C18.0-C18.9, C19-C20, C21.2, C21.8, C78.5
Breast	C50.011-C50.929, C79.81
Cervical	C53.0-C53.9, C79.82

"History of"

Personal	Z85.– *(code range)*
Mastectomy	Z90.13
Cervix, absence	Q51.5, Z90.710, Z90.712

"In Remission"

Leukemia	C95.01
Multiple Myeloma	C90.01

HEDIS: Cancer Screenings

Colorectal Screening

Measure evaluates the percentage of members ages 50-75 who had at least one of the following screenings.

Exempt from measure

- Total colectomy
- History of colon cancer

FOBT

CPT	HCPCS
82270, 82274	G0328

Flexible sigmoidoscopy

CPT	HCPCS
45330-45335, 45337-45342, 45345-45347, 45349-45350	G0104

CT Colonography

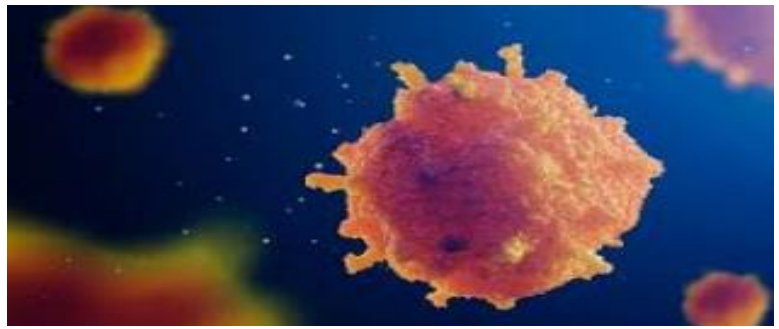
CPT
74261-74263

FIT-DNA

CPT	HCPCS
81528	G0464

Colonoscopy

CPT	HCPCS
44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398	G0105, G0121



Breast Screening

Measure evaluates the percentage of women age 50-74 who had a mammogram at least once in the past 27 months.

Exempt from measure

- Women who have had bilateral mastectomy
- Diagnostic screenings

Mammography Screening:

CPT
77055-77057, 77061-77063, 77065-77067

HCPCS
G0202, G0204, G0206

Cervical Screening

Measure evaluates the percentage of women ages 21-64 who were screened for cervical cancer.

Exempt from measure

- Women who have had hysterectomy without a cervix

Cervical Cytology Codes (ages 21-64):

CPT	HCPCS
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

HPV code:

Ages 30-64 years old, Code from Cervical Cytology plus one

CPT	HCPCS
87620-87622, 87624, 87625	G0476

RA- Diabetes Coding Tips

home state health

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	E08 – E13 code series (Diabetes) O24 code series (Diabetes in Pregnancy)
➢ **Documentation should specify**	○ Type of DM (Type 1, Type 2, Other) ○ Complication/manifestation affecting body system
➢ **Secondary diabetes (E08- series)**	Code first any underlying conditions, code second the type of diabetes: ○ Congenital rubella *(P35.0)* o Cushing's Syndrome *(E24.-)* ○ Cystic fibrosis *(E84.-)* o Malignant neoplasm *(C00-C96)* ○ Malnutrition *(E40-E46)* o Diseases of the pancreas *(K85.-, K86.-)* Example: *Secondary DM due to pancreatic malignancy (C25.9 + E08.9)*
➢ **Cause and effect relationship…**	State any relationship between DM and another condition such as: ○ *Diabetic* coma o Gastroparesis *secondary to* diabetes ○ Neuropathy *due to* diabetes o Foot ulcer *associated* with diabetes Example: *Diabetic retinopathy with macular edema (E11.311)* **Note: When type of diabetes is not documented, default to category E11 (type 2).*
➢ **Use additional code…**	… to identify: ○ Site of any ulcers *(L97.1-L97.9, L89.41-L98.49)* ○ Stage of chronic kidney disease *(N18.1-N18.6)* ○ Glaucoma *(H40-H42)*
➢ **Controlling Diabetes**	… be sure to add: ○ Long-term insulin use *(Z79.4)* ○ Oral antidiabetic drugs *(Z79.84)* or Oral hypoglycemic drugs *(Z79.84)*
➢ **Avoid terms such as "history of"…**	… if patient is still being monitored for the condition. ○ Incorrect wording: *Patient has history of diabetes.* ○ Correct wording: *Patient has Type 2 DM with ketoacidosis.*

HEDIS: Diabetes

Comprehensive Diabetes Care (CDC)

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who were compliant with A1c testing, A1c control, Eye exam screenings, Blood Pressure control and Nephropathy.

Statin Therapy for Patients with Diabetes

Measure demonstrates the percentage of members ages 40-75 with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy and maintained statin adherence.

Type 1	Type 2	Other	Description
E10.1-	E11.1-	E13.1-	DM with ketoacidosis
E10.2-	E11.2-	E13.2-	DM w/kidney complications
E10.3-	E11.3-	E13.3-	DM w/ophthalmic complications
E10.4-	E11.4-	E13.4-	DM w/neurological complications
E10.5-	E11.5-	E13.5-	DM w/circulatory complications
E10.6-	E11.6-	E13.6-	DM w/other specified complications
E10.8-	E11.8-	E13.8-	DM w/other specified complications
E10.9-	E11.9-	E13.9-	DM w/o complications

Be sure to add Z79.4, long-term insulin use if appropriate

HEDIS: CDC - Nephropathy Screening

Nephropathy Screening

Measure demonstrates the percentage of members ages 18-75 with diabetes (types 1 & 2) who had a urine protein test performed at least once per year, treated for nephropathy (on ACE/ARB), has evidence of End Stage Renal Disease (ESRD), stage 4 CKD, a history of a kidney transplant or is being seen by a nephrologist.

Urine Protein Tests

CPT	CPT II
81000-81003, 81005, 82042-82044, 84156, 50300, 50320, 50340, 50360, 50365, 50370, 50380 (Kidney Transplant)	3060F-3062F, 3066F, 4010F

HCPCS
G0257, S9339, S2065

Staging Chronic Kidney Disease (CKD)

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

Stage	Severity	GFR* Value	ICD-10 Codes
Stage I	Normal	GFR > 90 ml/min/1.73 m^2 with kidney damage*	N18.1
Stage II	Mild	GFR 60-89 ml/min/1.73 m^2 with kidney damage*	N18.2
Stage III	Moderate	GFR 30-59 ml/min/1.73 $_m$2	N18.3
Stage IV	Severe	GFR 15-29 ml/min/1.73 $_m$2	N18.4
Stage V	Kidney Failure	GFR < 15 ml/min/1.73 $_m$2	N18.5
	ESRD	GFR < 15 ml/min/1.73 Requiring chronic dialysis or transplantation (End stage renal disease)	N18.6
CKD Unsp.	CRD, CRF NOS or CRI**	Chronic Kidney Disease, unspecified	N18.9

**GFR- Glomerular filtration rate*

***CRD- Chronic renal disease, CRF- Chronic renal failure, CRI- Chronic renal insufficiency, NOS- not otherwise specified*

RA- Hypertension Coding Tips

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	I10 - I16 (Hypertensive Diseases)
➢ **Hypertension (HTN) and Chronic Kidney Disease (CKD)**	○ Presumed cause and effect relationship when patient has both ***HTN*** and ***CKD***. ○ *Use additional code* to identify the stage of the chronic kidney disease ○ Code **HTN** -I12.0 **+ CKD-** N18.5, N18.6 (Stage 5, ESRD) ***or*** **HTN** -I12.9 **+ CKD** -N18.1-N18.4, N18.9 (Stage 1-4, CKD unspecified) ○ When ESRD (N18.6) is coded, assign: ○ Z99.2 for any "dialysis status" ○ Z91.15 for "noncompliance with renal dialysis"
➢ **HTN and Heart Disease**	○ No presumed linkage between **HTN** and **Heart disease**. ○ Causal relationship must be stated. Examples: ○ *Due to hypertension* ○ *Implied (hypertensive)* ○ If heart failure is recent, assign additional code from category I50 to identify the type of heart failure.
➢ **Other HTN Coding Tips**	○ Do not use symbols to express hypertension. ↑ blood pressure ≠ hypertension Use additional code to identify: ○ Exposure to environmental tobacco smoke *(Z77.22)* ○ Exposure to tobacco smoke in the perinatal period *(P96.81)* ○ History of tobacco dependence *(Z87.891)* ○ Occupational exposure to environmental tobacco smoke *(Z57.31)* ○ Tobacco dependence *(F17.-)* or Tobacco use *(Z72.0)*

HEDIS: Controlling High Blood Pressure

home state health

Controlling High Blood Pressure (CBP)

Measure demonstrates the percentage of members ages 18-85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

Statin therapy for Patients with Cardiovascular Disease (SPC)

Measure demonstrates the percentage of members ages 21-75 (males) and 40-75 (females) who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who received statin therapy and maintained statin adherence.

Specifications for Controlling High Blood Pressure

- Must be the most recent blood pressure reading taken during the measurement year.
- Blood pressure reading must occur on or after the date of the second diagnosis of hypertension.
- When there are multiple blood pressure readings on the same date of service, the lowest systolic and lowest diastolic should be used as the representative blood pressure.

Description	CPT II Category Codes
Diastolic 80-89	3079F
Diastolic Greater than equal to 90	3080F
Diastolic Less than 80	3078F
Systolic Greater than equal to 140	3077F
Systolic Less than 140	3074F, 3075F

RA- Depression Coding Tips

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	F32.0 – F33.9 (Major depressive disorder)
➢ **Attempt for more specificity…**	Avoid broad terms and unspecified codes such as “Depression”, F32.9 ○ Document depression in detail including severity and episode. ○ It leads to precise coding and a better awareness about the disease and the population it affects.
➢ **In the documentation use terms that specify…**	○ Severity (mild, moderate, severe) ○ Episodes (single, recurrent, or in remission)
➢ **Depression Screening Tool**	○ Mental Health America offers a convenient questionnaire making it easy to obtain specific diagnosis codes. ○ Note all disclaimers on the website. ○ Visit http://www.mentalhealthamerica.net/mental-health-screen/patient-health.
➢ **Refilling medication**	Don’t forget to verify the condition and list the diagnosis in the Assessment & Plan.

Depression Screening Tool: The Patient Health Questionnaire (PHQ-9) is a 9-question instrument given to patients in a primary care setting to screen for the presence and severity of depression. The results of the PHQ-9 may be used to assist providers in making a depression diagnosis, including corresponding severity. An acceptable site to find the questionnaire can be found here: http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

HEDIS: Depression

Antidepressant Medication Management

Measure evaluates the percentage of members ages 18 and older who were treated with antidepressant medication, had a diagnosis of *major depression* and remained on an antidepressant medication treatment.

- ✓ Effective Acute Phase Treatment- the percentage of members who remained on an antidepressant medication for at least 84 days.
- ✓ Effective Continuation Phase Treatment- the percentage of members who remained on an antidepressant medication for at least 180 days.

CPT Procedure Codes and ICD-10-DM Diagnosis Codes:

The following codes can assist with capturing the member population for the Antidepressant medication management HEDIS measure:

ED

CPT: 99281,99282,99283,99284,99285

AMM Stand Alone Visits

CPT: 98960-98962, 99078, 99201-99205, 99211-99220, 99241-99245, 99341-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463,H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

AMM Visits

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

Major Depression:

ICD-10: F32.0, F32.1, F32.3, F32.4, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9

Note: F32.9 not listed as Home State currently requires specificity.

**Make sure to check appropriate fee schedules for coverage.*

HEDIS: Depression

home state health

Additional HEDIS measures:

Depression Screening and Follow Up for Adolescents and Adults-
Percentage of members 12 years and older who were screened for clinical depression using a standardized tool and, if positive, received appropriate follow-up care.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults-
Percentage of members 12 years and older with a diagnosis of depression, who had an outpatient encounter with a PHQ-9 score present in the record in the same assessment period as the encounter.

Depression Remission or Response of Adolescents and Adults-
Percentage of members 12 years and older with a diagnosis of depression and an elevated PHQ-9 score who had evidence of response or remission within 4-8 months after the initial elevated PHQ-9 score.

Depression – DO NOT simply state "Depression" (F32.9)

SCORING AND DOCUMENTATION FOR DEPRESSION DO NOT simply state "Depression" (F32.9)			
PHQ-9 Score	Depression Severity (label the illness with these descriptions)	Proposed Treatment Actions for Depression	ICD-10-CM
0 - 4	**None-minimal**	None: if patient has no personal history of depression. Or In Remission: if patient is still receiving some type of treatment but their symptoms no longer meet criteria for Major Depression.	***Not previously*** diagnosed Depression = ***No ICD-10 Previously diagnosed*** Depression = (see ***"In Remission"*** codes below)
5 - 9	**Mild**	Watchful waiting; repeat PHQ-9 at follow-up	**F32.0 or F33.0**
10 - 14	**Moderate**	Treatment plan, consider counseling, follow-up and/or pharmacotherapy	**F32.1 or F33.1**
15 - 19	**Moderately Severe**	Active treatment with pharmacotherapy and/or psychotherapy	**F32.1, F33.1** [moderate] **F32.2, F33.2** [severe]
20 - 27	**Severe**	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management.	**F32.2, F33.2** [w/out psychotic features] **F32.3 or F33.3** [w/ psychotic features]
In Partial Remission	If member has been previously diagnosed with depression *(regardless of the severity),* make sure to document that the depression is "in partial remission".		**F32.4 or F33.41**
In Full Remission	If member has been previously diagnosed with depression *(regardless of the severity),* make sure to document that the depression is "in full remission".		**F32.5 or F33.42**

RA- Asthma Coding Tips

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	J45.20 – J45.998 (Asthma)
➢ **Documentation should specify**	○ Frequency (intermittent, persistent) ○ Severity (mild, moderate, severe) ○ Exacerbation or decompensation ○ Environmental factors
➢ **Use additional code…**	… to identify: ○ Exposure to environmental tobacco smoke *(Z77.22)* ○ Exposure to tobacco smoke in the perinatal period *(P96.81)* ○ History of tobacco dependence *(Z87.891)* ○ Occupational exposure to environmental tobacco smoke *(Z57.31)* ○ Tobacco dependence *(F17.-)* or Tobacco use *(Z72.0)*
➢ **Avoid terms such as "history of"…**	… if patient is still being monitored for the condition. ○ Incorrect wording: *Patient has history of asthma.* ○ Correct wording: *Patient has asthma with no recent onset to exacerbation. Current medication includes albuterol inhaler.*
➢ **Additional Coding Tips**	○ Bronchitis *(J40)*: too general, identify acute or chronic. ○ COPD with asthmatic conditions: code ***both*** the COPD & Asthma. ○ Smoker's cough *(J41.0)*: do not use bronchitis code.
➢ **Documentation Tips**	The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention… ○ Medications reviewed and are current. ○ If patient is seeing a specialist. ○ Whether there has been any or no recent onset to exacerbation.

HEDIS: Asthma

Asthma Medication Management

Measure evaluates the percentage of members age 5-64 who were identified as having *persistent* asthma and were dispensed appropriate medications which they remained on during the treatment period of the past year.

- ✓ Medication Compliance 50%- members who were covered by one asthma control medication at least 50% of the treatment period.
- ✓ Medication Compliance 75%- members who were covered by one asthma control medication at least 75% of the treatment period.

CPT Procedure Codes and ICD-10-DM Diagnosis Codes:

The following codes can assist with capturing the member population for the Asthma Medication management HEDIS measure:

ED

CPT: 99281,99282,99283,99284,99285

Acute Inpatient

CPT: 99221,99222,99223,99231,99232,99233, 99238,99239,99251,99252,99253,99254,99255,99291

Outpatient Visit

CPT: 99201,99202,99203,99204,99205,99211, 99212,99213,99214,99215,99241,99242,99243,99244, 99245,99341,99342,99343,99344,99345,99347,99348, 99349,99350,99381,99382,99383,99384,99385,99386, 99387,99391,99392,99393,99394,99395,99396,99397, 99401,99402,99429

HCPCS: T1015

Observation

CPT: 99217,99218,99219,99220

Asthma:

ICD-10: J45.20-J45.22, J45.30-J45.32, J45.40-J45.42, J45.50-J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

**Make sure to check appropriate fee schedules for coverage.*

RA- Body Mass Index (BMI) Coding Tips

TIPS:	ICD-10 Mapping & Education
➢ **ICD-10-CM**	Z68.1 – Z68.45 BMI value, Adult Z68.51 – Z68.54 BMI percentile, Pediatric
➢ **Documentation should specify**	○ ***Value*** for an Adult ○ Weight date and result ○ Note: Patients age 18-19 are considered pediatric. See notes below. ○ ***Percentile*** for Pediatric ○ Weight date and value ○ Height date and value ○ Counseling for Nutrition (diet) ○ Counseling for Physical Activity (sports participation/exercise)
➢ **BMI & Obesity**	○ The ***treating provider*** must document obesity, morbid obesity, or any other diagnosis-related code from a BMI measurement ○ Coders and billers **cannot** infer obesity from a BMI value or percentile. ○ If Obesity coded, consider if due to: ○ excess calories ○ endocrine related ○ morbid/severe
➢ **Additional Coding Tips**	○ BMI codes should never be a primary diagnosis code, per ICD-10-CM. ○ BMI may be documented and accepted from any clinician. ○ BMI can be coded during any visit.

HEDIS: Body Mass Index

Adult BMI Assessment

Measure evaluates the percentage of members ages 18-74 who had their BMI documented during the measurement year or the year prior to the measurement year.

- ✓ BMI Value- members 20 years and older
- ✓ BMI Percentile- members 19 years and younger

ICD-10-CM Codes:

Z68.1, Z68.20-Z68.39, Z68.41-Z68.45

Weight Assessment and Counseling for Nutrition and Physical Activity

Measure evaluates the percentage of members ages 3-17 who had an outpatient visit with a PCP or OBGYN provider and who had evidence of the following annually:

- ✓ BMI Percentile: **ICD-10-CM Codes** Z68.51-Z68.54
- ✓ Counseling for Nutrition: **CPT Codes** 97802-97804, **HCPCS Codes** G0270, F0271, G0447, S9449, S9452, S9470, **ICD-10-CM Code** Z71.3
- ✓ Counseling for Physical Activity: **HCPCS Codes** G0447, S9451, **ICD-10-CM Code** Z02.5

Case Studies

Case Study 1

home state health

Gender: M **DOB:**MM/DD/1943
BP: 133/71 **Weight:** 236 lbs **Height:** 5’5

S: He was recently hospitalized for stroke; returns for a follow up visit. Elevated cholesterol per labs.

Past Medical History: Abdominal Aortic aneurysm with repair, colostomy status post hx colon cancer with metastasis to Right Upper Lobe(RUL) lung, GERD, COPD,

O: HEENT: Normal. Heart-Regular rate and rhythm (RRR). Lungs-Clear to auscultation. Abdomen-colostomy, no masses or tenderness. Bilateral Leg Extremities-pulses decreased.

Assessment/Plan (A/P):

- CVA-stable
- Aortic aneurysm-stable
- Hypercholesterolemia-begin 10 mg Zetia daily as medication is safe for cirrhosis.
- Lung cancer-on chemo; continue f/u with oncology

Jane Doe MD

ICD-10 code	Description
Z86.73	History CVA
Z93.3	Colostomy
C78.01	Secondary malignant neoplasm of RUL lung
Z85.038	History colon cancer
E78.0	Hypercholesterolemia
K74.60	Cirrhosis

Documentation & Coding Notes

- CVA not during acute phase and no late effects—code as “history of”.
- Aneurysm has been *repaired* and therefore cannot be coded.
- Colostomy status documented in the past history section, therefore can code.
- Lung cancer specified as metastatic from colon where colon cancer is considered historical.
- Status of Chemotherapy (Z51.11) is not coded unless encounter is specifically for the chemotherapy treatment.
- Cirrhosis can be coded as documentation indicates condition affects management of patient

Case Study 2

Gender: F **DOB:** MM/DD/1945
BP:180/85 **Weight:**245 lbs **Height:** 5'5" **BMI:** 40.77

S: Patient returns for scheduled follow up of problems listed below. Depression seems to be worsening

PMH: Ulcer right ankle, left breast mastectomy 10/2015

Meds: Paxil, Aspirin

O: Hearing/Throat: Normal. Heart-RRR. Lungs-CTA. Abdomen-No ascites, tenderness, or masses. Bilateral leg extremities (BLE)- pulses decreased, no edema, no lesions, no ulcers, deformities.

Assessment/Plan (A/P):

- Ulcer right ankle: stable; continue same
- Recurrent Major Depressive Disorder: worsening; continue 50 mg Paxil daily; add Viibryd 20 mg daily
- Hypothyroidism
- Extremity atherosclerosis-weight control, exercise goals-walk daily
- Left breast cancer-stable

David Roberts MD

ICD-10 code	Description
F33.9	Recurrent major depression
I73.9	Peripheral vascular disease
Z85.3	History of breast cancer

Documentation & Coding Notes

- Conflicting information regarding ulcer: A/P states stable and Exam states no lesions/ulcers found on BLE.
- MDD could be further specified as mild, moderate, severe, etc.
- No "MEAT" documentation for hypothyroidism.
- Breast cancer not current as no evidence of active treatment and surgical treatment has been performed; therefore coded as "history of".

Case Study 3

Gender: M **DOB:** MM/DD/2001
BP:94/60 **Weight:** 110 lb 8 oz **Height:** 58”
BMI: 87%

S: History was provided by the patient, mother. Patient is a 14 y.o. male who presents for this well child visit. Sleep: trouble falling asleep, mind-racing-Dr. D---- is following.

Medical History: Developmental delay, Persuasive Development Disorder (PDD), below IQ per mother

Problem List: Mental retardation, Schizophrenic disorder (chronic)-sees psych at XYZ Center, Autism, Anxiety, Depression, Meatal stenosis

Current Issues: Include psychiatry issues-seeing Dr. D---- at XYZ Center for anxiety, trouble sleeping.

O: *(condensed)* General: active, alert, cooperative, no distress, social. HEART: RRR. GU: Male stage 3 NEURO: alert, oriented, normal speech.

Assessment/Plan:

- WCC (well child check) Meningococcal conjug vaccine IM
- Anxiety
- Depression

Needs to continue with psychiatrist. Concerns about pubic hair pulling, I told him it was ok to trim it if bothersome. Discussed healthy eating.

Author: Smith, John, MD Status: Signed Updated MM/DD/YYYY 12:26PM

ICD-10 code	Description
Z00.129	Routine child exam with normal findings
F20.9	Schizophrenia
F84.9	PDD with Autistic features
F79	Unspecified intellectual disabilities
Z68.53	BMI, 85-95% for age
Z23	Immunization

Documentation & Coding Notes

- Z00.129 general exam with normal findings. Chronic conditions were addressed with no changes.
- Clinical documentation stated *“seeing Dr. D---- at XYZ Center for anxiety, trouble sleeping”.* Anxiety could be replaced with schizophrenia, as anxiety and depression are symptoms of schizophrenia—both listed on the problem list.
- Autism (F84.9) with intellectual disability (F79) addressed. Two codes required to be billed per ICD-10-CM.
- There is no indication that the meatal stenosis has been resolved & the Exam did not address the issue; therefore should not be coded.

Resources

General:

- Official ICD-10-CM Guidelines for Coding and Reporting https://www.cdc.gov/nchs/icd/data/10cmguidelines-FY2019-final.pdf
- AMA Current Procedural Terminology (CPT) Coding 2019
- 2020 HEDIS Technical Specifications
- www.phqscreeners.com

Medicare:

- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide
- www.csscoperations.com
- www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats
- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-RiskAdj-FactSheet.pdf
- https://www.medpartners.com/risk-adjustment-cms-hcc-101/

Marketplace:

- https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf

Questions

Visit our website: www.homestatehealth.com/