



home state health™

Risk Adjustment Coding, HEDIS, and Documentation

Provider Education Training

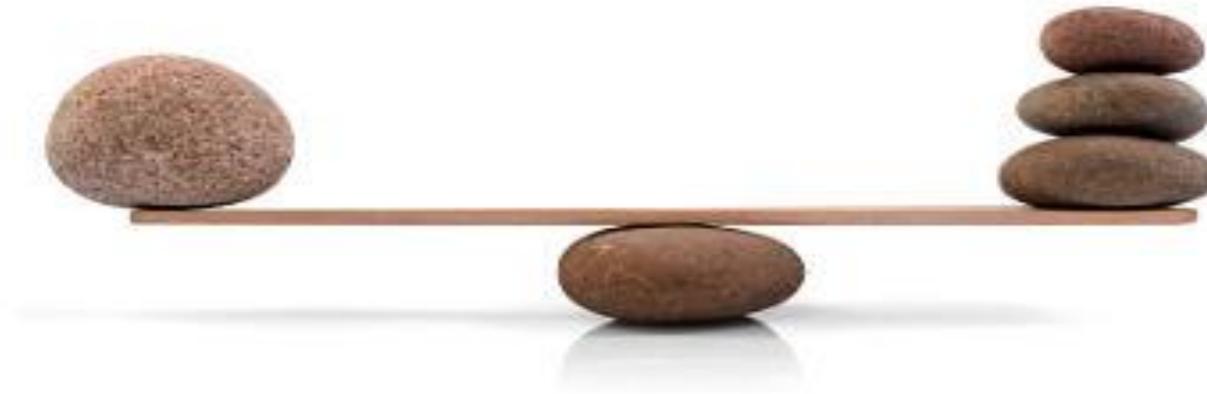
2018

Objectives for Today

- ✓ Discuss the Risk Adjustment methodology
- ✓ Understand how complete and accurate documentation and coding supports good patient care
- ✓ Tying in Quality and HEDIS measures
- ✓ Tips for accurate and complete documentation and coding of common conditions
- ✓ Review Case Studies

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

Sufficient funding

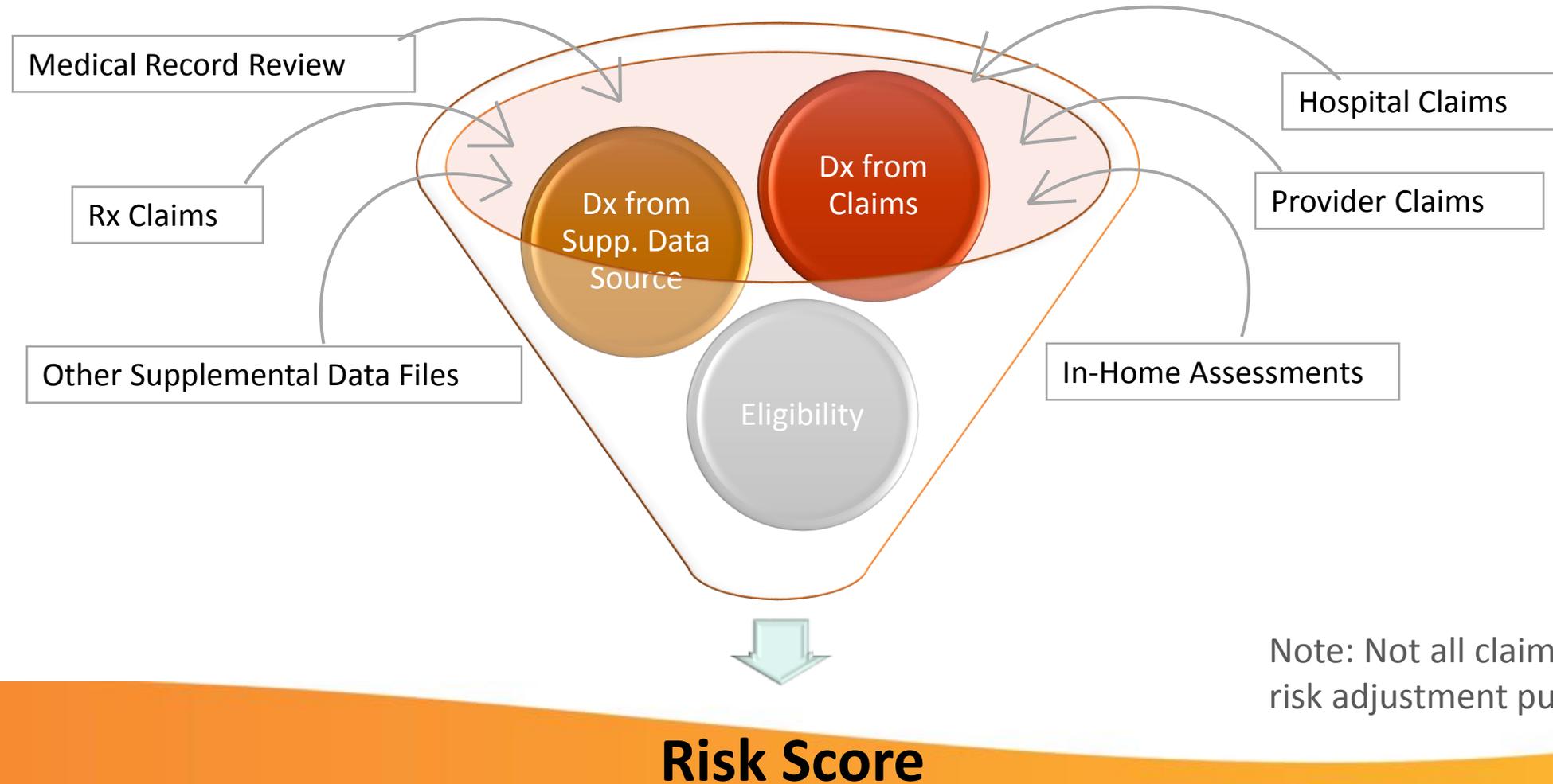
Minimize
incentives

Optimizing
Quality and
Efficiency

Disease
management

Identifying
Special needs

Risk Score calculation



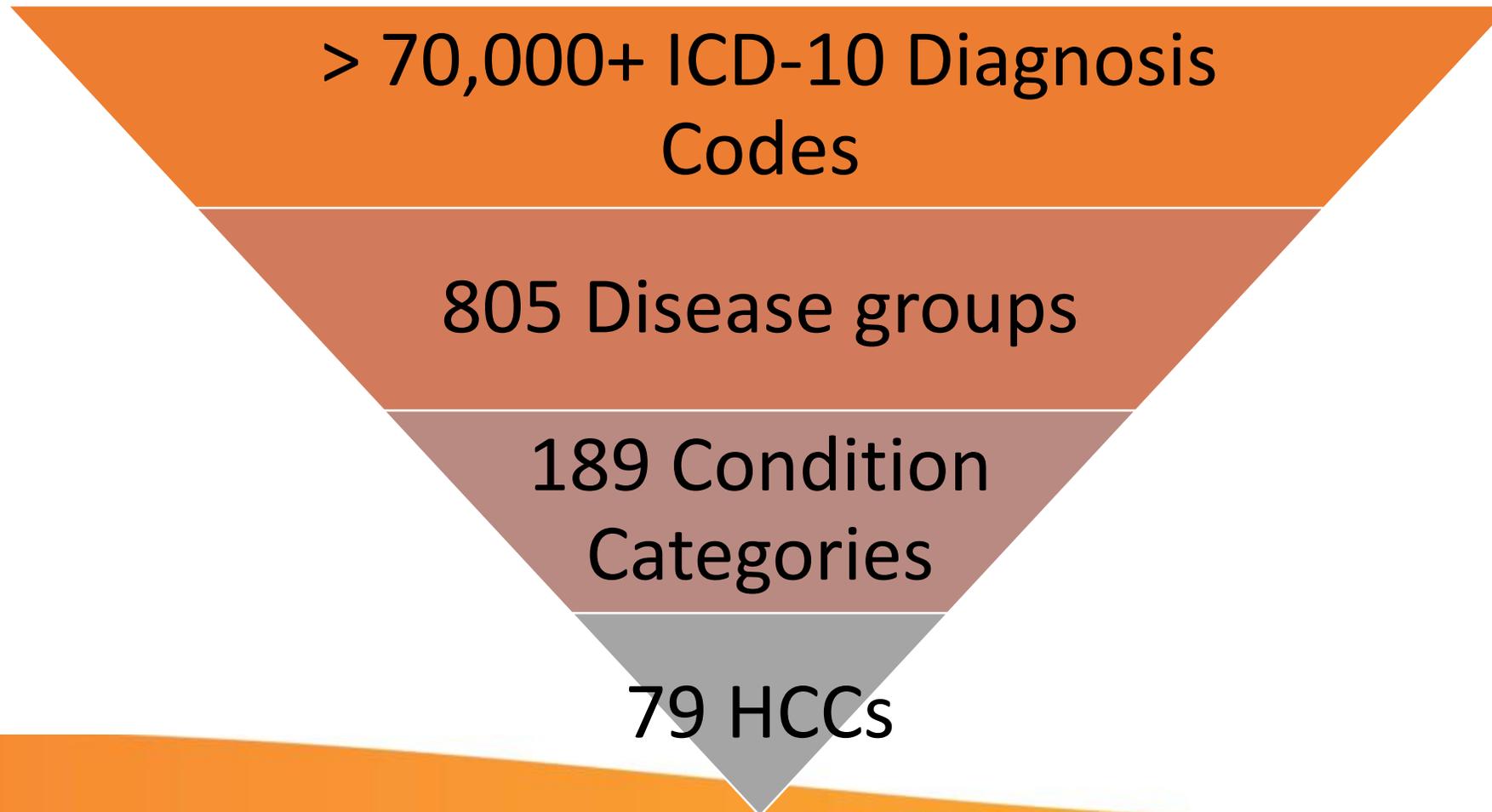
Risk Adjustment Models

Medicaid 1997	Medicare 2004	Marketplace 2014
<ul style="list-style-type: none">• ACG, DxCG, CDPS+Rx, MRx, etc (States decide)• Aggregated and Budget Neutral• Concurrent or Prospective Payments	<ul style="list-style-type: none">• CMS-HCC (Part C) and Rx-HCC (Part D)• Individualized and Additive• Prospective Payments	<ul style="list-style-type: none">• 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
 - HCCs (Hierarchical Condition Categories) *Medicare*
 - HHS-HCC (Health & Human Service's Hierarchical Condition Categories) *Marketplace*
 - CDPS+Rx (Chronic Illness and Disability Payment System) *Medicaid*
- HCCs allow for payment for only the most severe or complicated illness within a category
- Each HCC has an associated risk weight

2017 PY Medicare Advantage Risk Adjustment Model



Acuity and Specificity

Because ICD-10-CM codes are used in risk adjustment, the documentation of acuity and specificity can be significant. These are some examples of the increased specificity needs that are important to include in the documentation for risk adjustment:

<i>Disease</i>	Specificity	HCC
<i>Hepatitis</i>	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
<i>Bronchitis</i>	Bronchitis not specified as acute or chronic	No HCC
	Chronic bronchitis	HCC 111
<i>Renal failure</i>	Renal failure	No HCC
	Acute renal failure	HCC 135
<i>Obesity</i>	Obesity	No HCC
	Morbid obesity	HCC 22
<i>CKD</i>	Unspecified, Stage 1, 2, 3	No HCC
	Stage 4	HCC 137
	Stage 5	HCC 136
	Dependence on renal dialysis	HCC 134

Overview Example: Marketplace

**Table 3.2:
Plan Liability Risk Scores for Silver Metal Level Plan -- Illustrative Examples
(2017 Risk Adjustment)**

Enrollee	Predicted relative plan liability expenditures	Induced demand factor	Plan liability risk score
Enrollee 1			
Age 56 and male	0.429	—	—
Diabetes with complications	0.925	—	—
Congestive heart failure	3.095	—	—
Total	4.449	1.00	4.449
Enrollee 2			
Age 11 and female	0.085	—	—
Asthma	0.231	—	—
Total	0.316	1.12	0.354
Enrollee 3			
Age 0 and male	0.608	—	—
Term and severity level 1	0.772	—	—
Total	1.380	1.00	1.380

NOTE: Plan liability risk score equals the total predicted relative plan liability expenditures based on the relevant HHS-HCC risk adjustment model for the enrollee's age group and plan's metal level, multiplied by the induced demand utilization factor due to cost sharing reductions.

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

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
 - Increasing 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 appropriately allocate revenue to health plans for the high risk members enrolled.

- ❑ 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:
 - ✓ Support what is coded and billed (ICD-10-CM, CPT, and HCPCS).
 - ✓ “Stand alone” making sure a single service date has proficient data to support the medical decision making.
 - ✓ Be complete and contain legible signature & credentials.
 - ✓ Show medical necessity.



“Document for others as you would want them to document for you.”

Where can you find Diagnosis codes?

Anywhere in the medical record!

•

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/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: A&P lists **I10** only *with no* description. Cannot list ICD-10 Dx code alone. Must document hypertension somewhere in the medical record.

Commonly overlooked diagnoses

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

Past Medical History

- Some conditions do not go away; however, coding from past medical history without current support for the condition is not acceptable.
- Some EMR software “auto-populates” all conditions previously coded for that patient



Beware of “copy and paste” without updates/edits

- ✓ Why is this condition a problem?
- ✓ Was it coded correctly?
- ✓ Is the condition still active?
- ✓ When did the condition last occur?

MEAT

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)

MEAT	Support	Disease Example	Documentation Examples
<u>M</u> onitor	<ul style="list-style-type: none"> • 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
<u>E</u> valuate	<ul style="list-style-type: none"> • Test results • Medication effectiveness • Response to treatment • Physical exam findings 	Type 2 DM	BS log and A1c results reviewed with the patient
		Decubitus ulcer	Relay wound measurement in exam
<u>A</u> ssess/ <u>A</u> ddress	<ul style="list-style-type: none"> • Discussion, review records • Counseling • Acknowledging • Documenting status/level of condition 	Peripheral neuropathy	Decreased sensation of BLE by monofilament test
		Ulcerative colitis	Managed by Dr. Smith
<u>T</u> reat	<ul style="list-style-type: none"> • 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

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
H/O CHF-meds Lasix	Compensated CHF-stable on Lasix
Breast cancer-status post R mastectomy	H/O breast cancer-status post R mastectomy
H/O Asthma, meds Symbicort	Asthma-stable on Symbicort
CVA 2007-currently stable	H/O CVA 2007-no residual deficits

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

Quality & Risk Adjustment

Annual Wellness Visits

Perfect opportunity to capture:

Quality

- EPSDT (*Early and Periodic Screening, Diagnostic and Treatment*)
- BMI
- Medication Review
- Vaccinations
- Lead Screening

Risk Adjustment (Chronic Conditions)

- Address historical conditions
- Status conditions
- Clean up Problems 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 visit, 18 or older	99385	Preventive visit, 18 or older	99395	Z00.00 General adult medical exam without abnormal findings Z00.01 General adult medical exam with abnormal findings

Preventive Diagnosis Clarity

Annual Wellness Exam Diagnosis Code Tips	
<p>Z00.01 (adult) or Z00.121 (child) “Routine health exam with abnormal findings” may include, but not limited to</p>	<p>Z00.00 (adult) or Z00.129 (child) “Routine health exam without abnormal findings” can be billed with chronic conditions even if they are stable.</p>
<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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 <i>normal findings</i>.”• Verify the condition, any medications, DME, injections/infusions, managed by specialist.• Rule out any suspected conditions or address them. <p><i>Source: American Academy of Pediatrics</i></p>

Annual Wellness Visits

Checklist

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

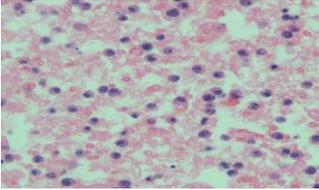
General exam diagnosis code.....	Definition.....	Example.....
Z00.01 (adult) or Z00.121 (child)	“with abnormal findings” . Use with any abnormality that is present at time of routine examination. Report supplemental diagnosis codes, such as chronic conditions that had to be addressed, in addition to 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)	“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.”

Common Reported Diseases

Risk Adjustment & HEDIS

Malignant Neoplasm Coding Tips

TIPS: ICD-10 Mapping & Education	
➤ Current Malignancy	<ul style="list-style-type: none"> ○ Documentation must show clear presence of current disease. <ul style="list-style-type: none"> ○ Physician/patient chose not to treat ○ Evidence of current/ongoing treatment <ul style="list-style-type: none"> ○ <i>Chemotherapy</i> ○ <i>Radiation therapy</i> ○ <i>Suppressive therapy</i>
➤ “History of”...	<p>... if documentation does not show clear evidence of active disease or treatment, malignancy is considered a “history of” for coding purposes (Z85.--).</p> <p>... Evidence includes:</p> <ul style="list-style-type: none"> ○ <i>Definitive surgical treatment</i> ○ <i>Completion of treatment regimen</i> ○ <i>Follow-up/surveillance for recurrence</i>
➤ Documentation Tips	<p>The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention...</p> <ul style="list-style-type: none"> ○ Medications reviewed and are current. ○ If patient is seeing a specialist. ○ Whether there has been any or no recent onset to exacerbation.

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
	

HEDIS: CANCER



Colorectal Screening

Measure evaluates the % of members ages 50-75 who had at least one appropriate screening.

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 % of women ages 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 % of women ages 21-64 who were screened from cervical cancer.

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

Absence of Cervix

CPT
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135

Diabetes Coding Tips



TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	E08 – E13 code series (Diabetes) O24 code series (Diabetes in Pregnancy)
➤ Documentation should specify	<ul style="list-style-type: none"> Type of DM (Type 1, Type 2, Other) Complication/manifestation affecting body system
➤ Secondary diabetes (E08- series)	<p><u>Code first</u> any <u>underlying conditions</u>, <u>code second</u> the type of <u>diabetes</u>:</p> <ul style="list-style-type: none"> Congenital rubella (P35.0) Cushing's Syndrome (E24.-) Cystic fibrosis (E84.-) Malignant neoplasm (C00-C96) Malnutrition (E40-E46) Diseases of the pancreas (K85.-, K86.-) <p>Example: <i>Secondary DM due to pancreatic malignancy (C25.9 + E08.9)</i></p>
➤ Cause and effect relationship...	<p>State any <u>relationship</u> between DM and another condition such as:</p> <ul style="list-style-type: none"> <u>Diabetic</u> coma Gastroparesis <u>secondary to</u> diabetes Neuropathy <u>due to</u> diabetes Foot ulcer <u>associated with</u> diabetes <p>Example: <i>Diabetic retinopathy with macular edema (E11.311)</i> *Note: When type of diabetes is not documented, default to category E11 (type 2).</p>
➤ Use additional code...	<p>... to identify:</p> <ul style="list-style-type: none"> Site of any <u>ulcers</u> (L97.1-L97.9, L89.41-L98.49) Stage of <u>chronic kidney disease</u> (N18.1-N18.6) Glaucoma (H40-H42)
➤ Controlling Diabetes	<p>... be sure to add:</p> <ul style="list-style-type: none"> Long-term insulin use (Z79.4) Oral antidiabetic drugs (Z79.84) or Oral hypoglycemic drugs (Z79.84)
➤ Avoid terms such as "history of"...	<p>... if patient is still being monitored for the condition.</p> <ul style="list-style-type: none"> <u>Incorrect</u> wording: <i>Patient has <u>history of</u> diabetes.</i> <u>Correct</u> wording: <i>Patient has <u>Type 2 DM with ketoacidosis</u>.</i>

HEDIS: Diabetes



Diabetes Care

Measure demonstrates the % of members ages 18-75 with diabetes (types 1 & 2) who were compliant.

HbA1c Test: is completed at least once per year (includes rapid A1c).

CPT	HCPCS
83036, 83037	—

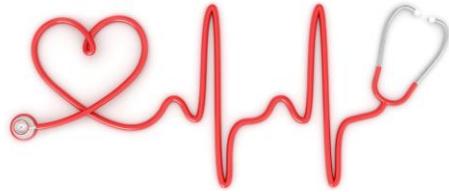
Type 1	Type 2	Other	Description
E10.1-	E11.1-	E13.1-	DM with ketoacidosis
E10.2-	E11.2-	E13.2-	DM w/kidney complications
E10.3-	E11.3-	E13.3-	DM w/ophthalmic complications
E10.4-	E11.4-	E13.4-	DM w/neurological complications
E10.5-	E11.5-	E13.5-	DM w/circulatory complications
E10.6-	E11.6-	E13.6-	DM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

Hypertension Coding Tips

TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	I10 - I16 (Hypertensive Diseases)
➤ HTN and CKD	<ul style="list-style-type: none"> ○ Presumed cause and effect relationship when patient has both HTN and CKD. ○ Use additional code to identify <u>the stage</u> 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 unspec) ○ When ESRD (N18.6) is coded, assign: <ul style="list-style-type: none"> ○ Z99.2 for any “dialysis status” ○ Z91.15 for “noncompliance with renal dialysis”
➤ HTN and Heart Disease	<ul style="list-style-type: none"> ○ No presumed linkage between HTN and Heart disease. ○ Causal relationship must be stated. Examples: <ul style="list-style-type: none"> ○ <i>Due to hypertension</i> ○ <i>Implied (hypertensive)</i> ○ If heart failure is resented, assign additional code from category I50 to identify the type of heart failure.
➤ Other HTN Coding Tips	<ul style="list-style-type: none"> ○ Do not use symbols to express hypertension. ↑ blood pressure ≠ hypertension Use additional code to identify: <ul style="list-style-type: none"> ○ 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: Nephropathy Screening



Nephropathy Screening

Urine protein test performed at least once per year. A member who is being treated for nephropathy (on ACE/ARB), has evidence of 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

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

Depression Coding Tips



TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	F32.0 – F33.9 (Major depressive disorder) ³
➤ Attempt for more specificity...	<p>Avoid broad terms and unspecified codes such as “Depression”, F32.9</p> <ul style="list-style-type: none"> ○ Be meticulous in picking up the details in documentation. ○ It leads to precise coding and a better awareness about the disease and the population it affects.
➤ In the documentation use terms that specify...	<ul style="list-style-type: none"> ○ Severity (mild, moderate, severe) ○ Episodes (single, recurrent, or in remission)
➤ Depression Screening Tool	<ul style="list-style-type: none"> ○ Mental Health America offers a convenient questionnaire making it easy to obtain specific diagnosis codes⁴. ○ 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 Coding Tips for Severity

DIAGNOSING TOOLS

Depression: The 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



New HEDIS measure:

Currently CMS and NCQA are exploring adding the use of measurement to assess the percentage of patients age 12 and older who were screened for depression and, if positive, received appropriate follow-up care within 30 days of the positive screen. This measure would be collected in 2018 for use on the display page in 2020.

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.	<i>Not previously</i> diagnosed Depression = <i>No ICD-10 Previously diagnosed</i> Depression = (see “ <i>In Remission</i> ” 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 (<i>regardless of the severity</i>), 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 (<i>regardless of the severity</i>), make sure to document that the depression is “in full remission”.		F32.5 or F33.42

HEDIS: Depression



Antidepressant Medication Mgmt

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

Rates

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.

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 requires specificity.

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

Asthma Coding Tips

TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	J45.20 – J45.998 (Asthma) ³
➤ Documentation should specify	<ul style="list-style-type: none"> ○ Frequency (intermittent, persistent) ○ Severity (mild, moderate, severe) ○ Exacerbation or decompensation ○ Environmental factors
➤ Use additional code...	<p>... to identify:</p> <ul style="list-style-type: none"> ○ Exposure to environmental tobacco smoke (<i>Z77.22</i>) ○ Exposure to tobacco smoke in the perinatal period (<i>P96.81</i>) ○ History of tobacco dependence (<i>Z87.891</i>) ○ Occupational exposure to environmental tobacco smoke (<i>Z57.31</i>) ○ Tobacco dependence (<i>F17.-</i>) or Tobacco use (<i>Z72.0</i>)
➤ Avoid terms such as “history of”...	<p>... if patient is still being monitored for the condition.</p> <ul style="list-style-type: none"> ○ <u>Incorrect</u> wording: <i>Patient has <u>history of</u> asthma.</i> ○ <u>Correct</u> wording: <i>Patient has asthma with no recent onset to exacerbation. Current medication includes albuterol inhaler.</i>
➤ Additional Coding Tips	<ul style="list-style-type: none"> ○ Bronchitis (<i>J40</i>): too general, identify acute or chronic. ○ COPD with asthmatic conditions: code both the COPD & Asthma. ○ Smoker’s cough (<i>J41.0</i>): do not use bronchitis code.
➤ Documentation Tips	<p>The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention...</p> <ul style="list-style-type: none"> ○ 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 Mgmt

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

RATES	APPROPRIATE MEDICATIONS
Medication Compliance 50%: Members who were covered by one asthma control medication at least 50% of the treatment period	Antiasthmatic combinations, Antibody inhibitor, Inhaled steroid combinations, Inhaled corticosteroids, Leukotriene modifiers, Mast cell stabilizers, Methylxanthines and Short-acting, inhaled beta-2 agonists
Medication Compliance 75%: Members who were covered by one asthma control medication at least 75% of the treatment period	

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.*

BMI Coding Tips

TIPS:	ICD-10 Mapping & Education
➤ ICD-10-CM	Z68.1 – Z68.45 BMI value, Adult ³ Z68.51 – Z68.54 BMI percentage, Pediatric ³
➤ Documentation should specify	<ul style="list-style-type: none"> ○ Value for an Adult <ul style="list-style-type: none"> ○ Weight date and result ○ Note: Patients age 18-19 are considered pediatric. See notes below. ○ Percentage for Pediatric <ul style="list-style-type: none"> ○ Weight date and value ○ Height date and value ○ Counseling for Nutrition (diet) ○ Counseling for Physical Activity (sports participation/exercise)
➤ BMI & Obesity	<ul style="list-style-type: none"> ○ The <u>treating provider</u> 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 percentage. ○ If Obesity coded, consider if due to: <ul style="list-style-type: none"> ○ excess calories ○ endocrine related ○ morbid/severe
➤ Additional Coding Tips	<ul style="list-style-type: none"> ○ 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.

BMI Coding Tips

BMI Assessment

Measure evaluates the % of members ages 18-74 who had their BMI documented in the past two years (recommended).

- 1) For patients 20 and over: Code the BMI value on the date of service.
- 2) For patients younger than 20, code the BMI percentile on the date of service.
- 3) Ranges and thresholds do NOT meet criteria; a distinct BMI value or percentile is required.

ICD-10
ICD-10 BMI Value set Z68.1, Z68.20-Z68.39, Z68.41-Z68.45; ICD-10 BMI Percentile Value Set Z68.51-Z85.54

Weight Assessment and Counseling for Nutrition and Physical Activity

Measure evaluates the % of members ages 3-17 who has an outpatient visit with a PCP or OB/GYN and who had evidence of at least annually:

DESCRIPTION	CPT	ICD-10 DIAGNOSIS	HCPCS
BMI Percentile	—	Z68.51-Z68.54	—
Counseling for Nutrition	97802-97804	Z71.3	G0270, G0271, G0447, S9449, S9452, S9470
Counseling for Physical Activity	—	Z02.5	G0447, S9451

National Committee for Quality Assurance

NCQA has increased the percentile Targets for Adult BMI Assessment.

Measure Name	5 th Percentile	10 th Percentile	25 th Percentile	33.33 th Percentile	50 th Percentile	66.67 th Percentile	75 th Percentile	90 th Percentile	95 th Percentile
Adult BMI Assessment (ABA)	28.79	62.29	78.83	82	86.24	89.4	90.48	93.68	95

84.96
2017

Target
2018

Case Studies

Case Study 1

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.

PMH: Aortic aneurysm with repair, colostomy status post hx colon cancer with metastasis to RUL lung, GERD, COPD,

O: HEENT: NL. Heart-RRR. Lungs-CTA. Abdomen-colostomy, no masses or tenderness. BLE-pulses decreased.

AP:

- 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

Case Study 1

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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.
- Remember to document colostomy status codes when documented.
- 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 R ankle, L breast mastectomy 10/2015

Meds: Paxil, Aspirin

O: Hearing/Throat: NL. Heart-RRR. Lungs-CTA. Abdomen-No ascites, tenderness, or masses. BLE-pulses decreased, no edema, no lesions, no ulcers, deformities.

A/P:

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

David Roberts MD



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- Hypothyroidism
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- L breast cancer-stable

David Roberts MD



ICD-10 code	Description
F33.9	Recurrent major depression
Z68.41	BMI 40-44
I73.9	PVD
Z85.3	Hx breast cancer

Documentation & Coding Notes

- Conflicting information regarding ulcer: A/P states stable and PE states no lesions/ulcers found on BLE.
- MDD could be further specified as mild, moderate, severe, etc.
- Be sure to add BMI when documented as BMI is on some risk adjustment models and is also needed for HEDIS. Additionally if the patient is overweight the treating provider would need to document this. It cannot be inferred by the coder or biller.
- No MEAT for hypothyroidism.
- **Breast cancer not current** as no evidence of active treatment and surgical treatment has been performed.

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.

MH: Developmental delay, 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.

A/P:

- 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

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- 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



home state health™

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. No MEAT.

Resources

Know the “Rules of the Road”



All Things Coding:

- [Official ICD-10-CM Guidelines for Coding and Reporting](#)
- www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf
- [AHA Coding Clinic for ICD-10-CM](#)
- [Capstone Performance Systems](#)
- www.phqscreeners.com/

Medicare:

- [2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide](#)
- www.csscooperations.com
- www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats
- <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.regtap.info/uploads/library/ACA_HHS_OperatedRADVWhitePaper_062213_5CR_062213.pdf
- <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>

Module 6.3 of the 2008 Participant Guide states:

“The Coding Clinic for ICD-10-CM is the approved resource to update and clarify the use of ICD-10-CM.”

What are the ICD-10-CM Guidelines?

The **ICD-10-CM Official Guidelines for Coding and Reporting** are rules that supplement the conventions and instructions within the ICD-10-CM classification. Adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).

**ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)**

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2017 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

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.
- **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.
- **Risk Score - There are many “risk scores”, so it is very important to understand the context :**
 - **Risk Adjustment** – this risk score refers to the member or population score assigned based on one of several risk models (see above) which helps determine the payments health plans receive from government entities. Risk Adjustment scores are largely based on medical and/or pharmacy claims and is intended to represent the disease burden of the member for the purposes of adjusting premium to the health plan at either an individual or population level.

Questions



Visit our website: www.homestatehealth.com/