

Risk Adjustment Coding, HEDIS, and Documentation

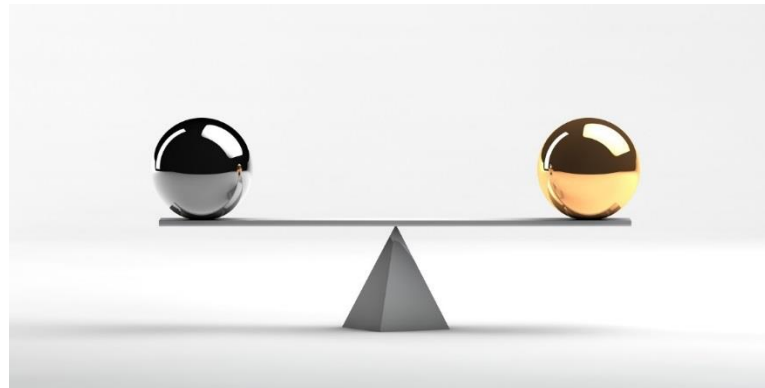
Provider Education Training

2018

What is Risk Adjustment?



Risk Adjustment is the process by government programs adjust revenue to health plans based on the health status of the covered population.



Benefits of Risk Adjustment

Sufficient
funding

Minimize
incentives

Quality and
efficiency

Disease
management

Special needs

Risk Score calculation



- Risk scores are calculated using demographics and all valid diagnoses found on paid claims for the experience year
- Not all claims are valid for risk adjustment purposes

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



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 Overview Example



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.

Physician's Role



- Risk adjusted payment relies on *accurate diagnosis coding* on claims and complete medical record documentation.
- *Specificity of diagnosis* coding is substantiated by the medical record.
 - Utilization of the most specific diagnosis codes helps to articulate the *severity of the conditions* being addressed at each visit
- Accurate documentation and coding helps:
 - Ensure health plans are reimbursed appropriately to provide funds to care for their sicker members
 - Identify new problems early
 - Coordinate care collaboratively
 - Could justify a higher Evaluation & Management (E&M) level.

Physician's Role



CMS Mandate

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

Outpatient Coding

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

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

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

Annual Wellness Visit & EPSDT



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.
<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</i> findings.”• 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>

Where can you find Diagnosis codes?

Anywhere in the medical record!

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



Why is this a problem??

- ✓ Was it coded correctly?
- ✓ Is the condition still active?
- ✓ When did the condition last occur?

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

MEAT



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- Medical record documentation must have MEAT documented for each diagnosis
- Monitoring Evaluation Assessment Treatment

Monitor	<ul style="list-style-type: none">• Symptoms• Disease progression/regression• Ordering of tests• Referencing labs/other tests
Evaluate	<ul style="list-style-type: none">• Test results• Medication effectiveness• Response to treatment• Physical exam findings
Assess/Address	<ul style="list-style-type: none">• Discussion, review records• Counseling• Acknowledging• Documenting status/level of condition
Treat	<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



MEAT (cont'd)

- Diagnoses exist everywhere in a medical record

Documentation examples

CHF	Stable. Will continue same dose of Lasix and ACE inhibitor
Type 2 DM	BS log and A1c results reviewed with the patient
GERD	No complaints. Symptoms controlled on current meds
Hyperlipidemia	Lipid profile ordered
Ulcerative colitis	Managed by Dr Smith
Peripheral neuropathy	Decreased sensation of BLE by monofilament test
Tobacco abuse	Advised on risks; smoking cessation counseling
Decubitus ulcer	Wound measurement
DJD, hip	Pain controlled
AAA	Abdominal US ordered

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.

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

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

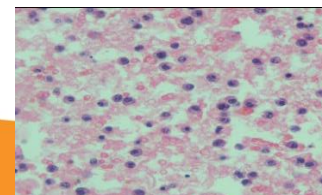
Cervical C53.0-C53.9, C79.82

• “History of”

Personal Z85.– (code range)

Mastectomy Z90.13

Cervix, absence Q51.5, Z90.710, Z90.712



HEDIS: CANCER



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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, 59856, 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> <i>*Note: When type of diabetes is not documented, default to category E11 (type 2).</i></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 Type 2 DM with ketoacidosis.</i>

HEDIS: Diabetes



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

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	—

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"> ○ Due to hypertension ○ Implied (hypertensive) ○ 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



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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.

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.

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 (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”...	<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 (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	<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: 99201,99202,99203,99204,99205,99211,99212,99213,99214,99215,99241,99242,99243,99244,99245,99341,99342,99343,99344,99345,99347,99348,99349,99350,99381,99382,99383,99384,99385,99386,99387,99391,99392,99393,99394,99395,99396,99397,99401,99402,99403,99404,99411,99412,99420,99429,99455,99456

HCPCS: G0402, G0438, G0439, G0463, 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

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.

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
- Lung cancer specified as metastatic from colon
- Remember to document status codes when documented
- 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, 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



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

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.

Questions

