Risk Adjustment Toolkit

For clinics using the Optum In-Office Assessment program

This packet provides convenient access to risk adjustment information, including educational materials you can share with your staff. We appreciate your attention to this important topic, which helps predict patient healthcare needs and costs.

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Risk Adjustment Documentation and Coding – Introduction, Diabetes Management, and Neoplasm	PowerPoint presentation
Risk Adjustment Documentation and Coding – Obesity and Major Depressive Disorder	PowerPoint presentation
Risk Adjustment Documentation and Coding – Circulatory Disorders	PowerPoint presentation

If you have questions, please contact the Population Health Team at PopulationHealth@PacificSource.com.

Risk Adjustment 101
For Providers

PacificSource

Discussion topics

- Why is risk adjustment important for providers?
- What is risk adjustment?
- Risk adjustable populations
- Risk adjustment model
- Risk adjustment success – tips and tricks

Why is risk adjustment important for providers?

- Ensures that health conditions, health status, and demographics are accurately documented to reflect patient complexity
- Helps to ensure that Medicare and Affordable Care Act beneficiary health conditions are being addressed at least annually
- Helps to ensure that the health plans managing these beneficiaries are adequately compensated, which can result in:
  - More affordable health plans
  - Additional value-added health plan benefits (such as wellness and fitness programs, and “Meals as Medicine” programs)
  - Higher payments to providers with value-based payment arrangements

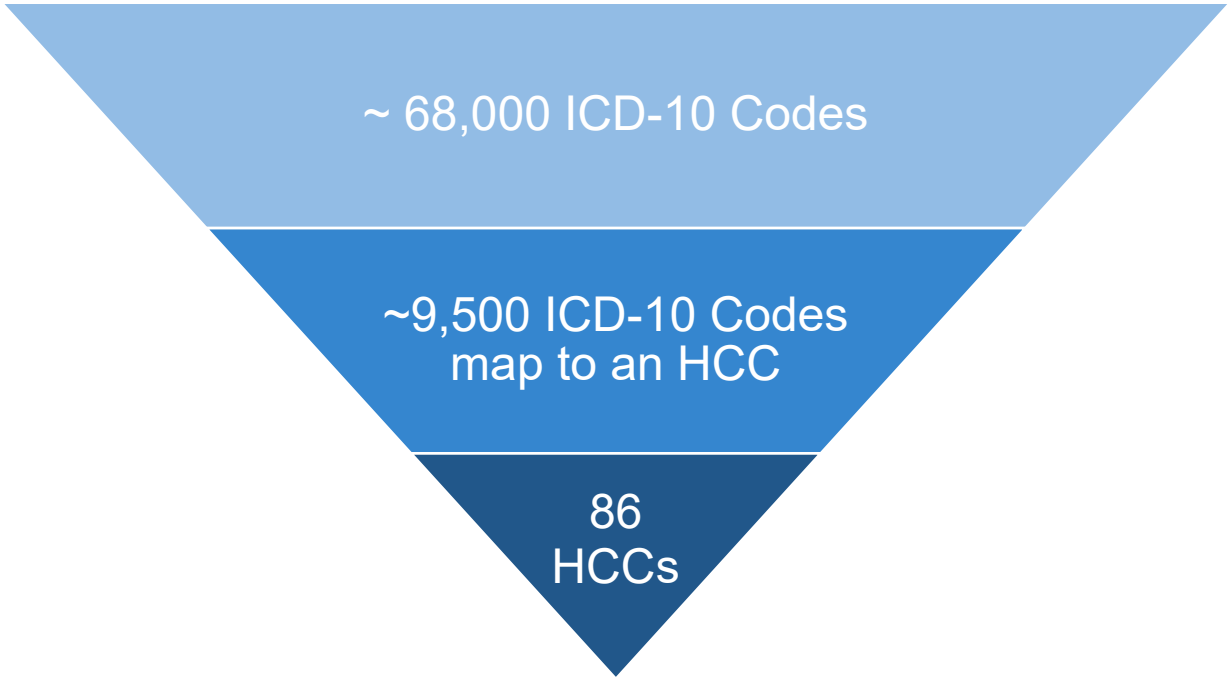
Definition of risk adjustment

- Risk adjustment is a statistical process that considers the underlying **health status** and **health spending** of the enrollees in an insurance plan when looking at their **healthcare** outcomes or **healthcare** costs.
- **Risk adjustment data** is pulled from diagnosis data reported from claims and medical record documentation from physician offices, as well as hospital inpatient and outpatient settings.
- In plain English: Risk adjustment is a way to predict patient healthcare needs and costs by using the patient's diagnoses.

Risk Adjustable Populations

Hierarchical condition category (HCC)

- HCCs are a grouping of clinically related diagnoses with similar cost implications.
- Only those diagnoses that map to an HCC are used to calculate risk scores.
- Every year, a new model is released with new diagnosis codes to HCC mappings.



Calculating the risk score

Every patient is assigned a risk score.

Example: A 74-year-old female diagnosed with Type 2 diabetes mellitus with hyperglycemia (E1165) and chronic obstructive pulmonary disease, unspecified (J449).

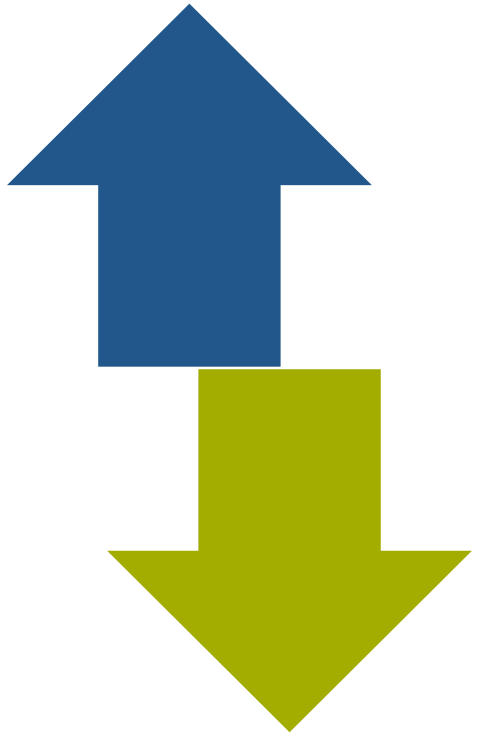
*Factors related to age, sex, disabled status, original entitlement reason, and Medicaid status are what make up demographics for a Medicare Advantage member.

Interpreting the risk score

Higher risk scores =
patients with greater-than-average disease burden

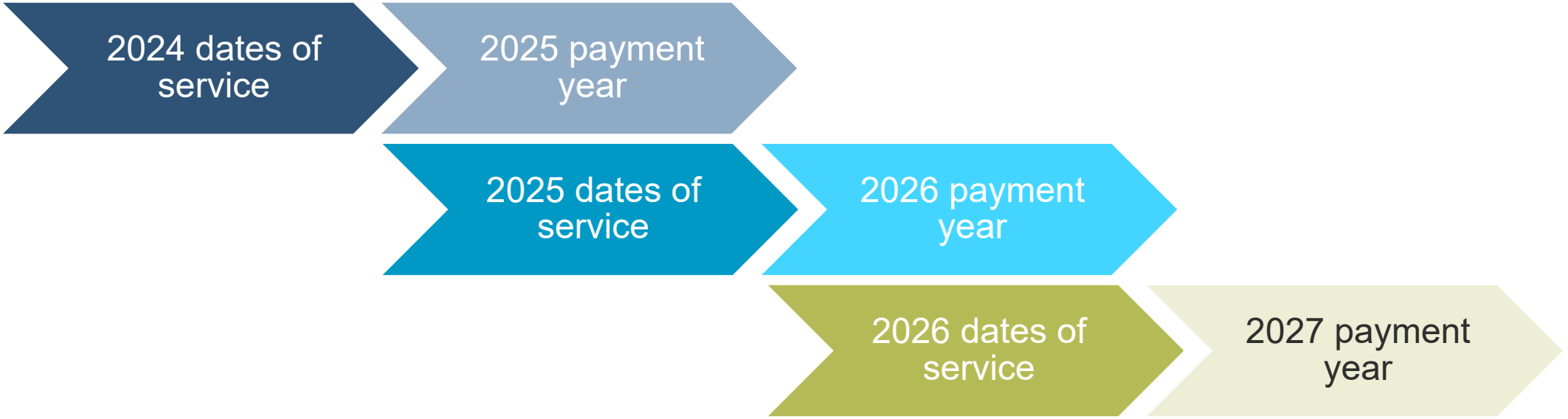
Lower risk scores =
healthier patients, but may also incorrectly indicate overall health due to:

- Inadequate or incomplete chart documentation
- Inaccurate or incomplete diagnosis coding



Risk model overview | MA model

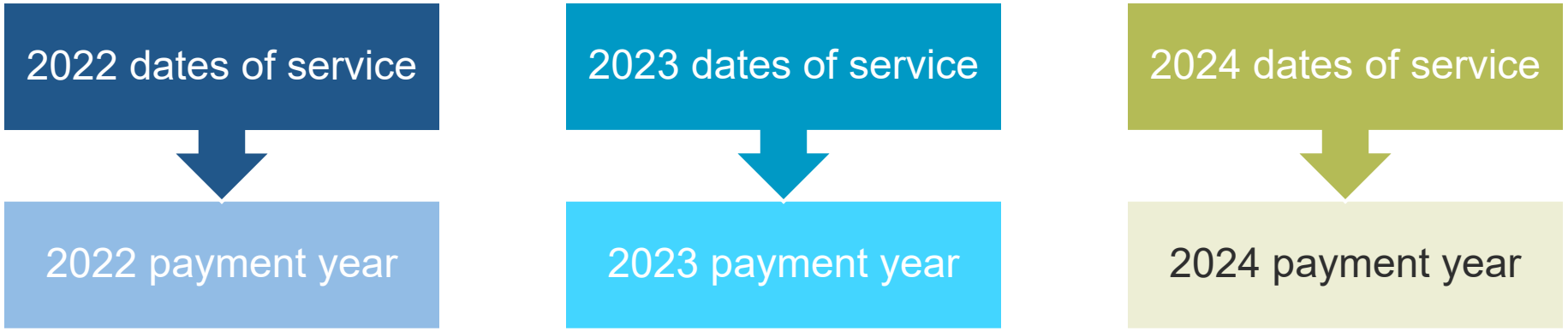
Prospective model



CMS/OHA requires chronic conditions to be reported annually for payment. (Patient risk scores are reset each year.)

Risk model overview | commercial model

Concurrent model



- ***CMS requires chronic conditions to be reported annually for payment. (Patient risk scores are reset each year.)***
- Individual and small-group members on ACA plans

Risk adjustment terms/definitions

Payment year – The enrollment year. Example: PY2021 CMS is paying for health plan members enrolled in 2021.

Base year – The dates of service used for a payment year. Example: PY2024 has a base year of 2023.

Stayers – 12 months of enrollment in base year, all 12 with PacificSource.

New members – 12 months of enrollment in base year, not all with PacificSource.

New enrollees – Does not have 12 months of Medicare Advantage (MA) enrollment in the base year, only has a demographic component of their risk score.

ESRD – End stage renal disease. A different model is used to calculate these patients' risk scores than the rest of the MA population.

Hospice – Hospice patients receive a risk score of zero. Hospice is not funded through risk adjustment, thus risk scores are zeroed out.

Risk adjustment success – tips and tricks

- Risk adjustment scores reset every year. Providers must document and code active diagnoses annually, even chronic conditions.
- The annual wellness visit is a good opportunity to capture all appropriate diagnoses.
- Preventive screenings, such as screening of risk factors for depression, functional status, and fall risk can aid in identifying additional diagnoses that contribute to a patient's risk.
- Document and code to the highest level of specificity to give an accurate picture of each patient's health status.
- Telehealth visits must include both audio and video to be risk adjustable.
- Use MEAT principles: a diagnosis should be (M)onitored, (E)valuated, (A)ssessed, or (T)reated (see the next slide).

Reference: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html

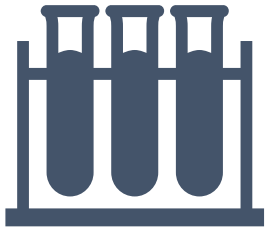
Understanding MEAT

Monitor

Signs/symptoms

Disease progression/regression

Review of previous labs or other tests



Evaluate

Test results

Medication effectiveness

Response to treatment

Physical exam findings

Assess/address

Discussion, review records

Counseling

Ordering of new labs /tests

Treat

Medications Reconciliation

Surgical/other therapeutic interventions

Referral to specialist for treatment/consultation

Questions

Risk Adjustment and the Optum IOA Tool 2024 FAQ

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Does a clinic have to use the Optum IOA tool to be successful with risk adjustment?

Optum is a great way to begin risk adjustment work and start to understand the importance of hierarchical condition category (HCC) recapture and coding to specificity. However, a clinic can choose not to use the Optum IOA tool and make full use of any internal EHR tools like Best Practice Advisory (BPAs) or software that pushes information from PacificSource into their Electronic Medical Record (EMR).

What are some best practice ideas for risk adjustment work?

- Implementing pre-visit planning and post-visit review to identify HCC gaps
- Scheduling patients who do not have upcoming appointments
- Designating a provider champion who understands the value of HCC recapture
- Facilitating leadership buy-in and provider accountability
- Facilitating contract alignment and considering financial incentives for providers
- Tracking Best Practice Advisory (BPA) use (if available in your EMR) and providing feedback
- Offering HCC coder staff training and coder feedback to providers prior to billing

Can clinics amend notes and resubmit claims for recent visits to capture HCC diagnoses? If so, what is the process?

The Centers for Medicare and Medicaid Services (CMS) allows amendments to a chart note within a reasonable amount of time after the original date of service. **Industry standard to amend a chart is 30 days after the visit date.** Claims may be resubmitted to count additional HCCs after the original submission. Defer to your billing office to submit a corrected claim.

When a suggested HCC diagnosis is reviewed and is not applicable to the patient (either the condition resolved or the diagnosis was incorrect), what is the process for communicating this back to PacificSource to have that gap removed from the list?

Clinics can email this information to RiskAdjustmentAnalytics@PacificSource.com in one of the following ways:

A. Send the Member ID, HCC, or diagnosis code along with an explanation

B. Send the HCC gap list Excel file back to us with the addition of a column that explains why the diagnosis is resolved or incorrect

Send the information in either format to RiskAdjustmentAnalytics@PacificSource.com.

Optum: We are working with Optum to remove HCCs that providers submit to us as not applicable or resolved. In the meantime, your providers can assess—**but not diagnose**—those conditions to get CGAP credit for the program to help meet the 75% closure rate.

PacificSource's software seems to only allow a certain number of ICD codes, and ghost claims have to be submitted for additional diagnosis. Is there a way to change the number of codes your software accepts?

Your Electronic Medical Record (EMR) or your claims clearinghouse may be limiting the amount of codes. Please contact PopulationHealth@PacificSource.com for more help.

Continued >

Are the Hierarchical Condition Category (HCC) gaps in the Optum IOA tool the same as the HCC Medicare gap list sent to clinics?

The gaps are essentially the same, although there are slightly different calculations used to determine which gaps are listed. You can use either or both tools to capture HCCs. Optum provides a way to organize and document the work and capture additional revenue.

PacificSource includes diagnoses that are captured, submitted, and accepted by the Centers for Medicare and Medicaid Services (CMS). Optum casts a wider net to include captured and submitted diagnoses from CMS where PacificSource was not the payor.

Optum payments and quality gap information for 2024

- Optum payments are made weekly via ACH within 45 days of submission
- **Medicare**
  - Administrative fee (timely filing within 60 days of the visit)—$50 ($25 late, $15 submissions with dates of service prior to deployment)
  - HCC recapture threshold of 75% met—$50
  - Quality gaps closure rate of 75% met—$50
- **ACA Commercial**
  - HCC recapture threshold of 75% met—$75

Questions?

Contact the Population Health team at:
PopulationHealth@PacificSource.com

Medicare quality gaps for 2024

- Breast cancer screening
- Colorectal cancer screening
- Controlling high blood pressure—any reading
- Glycemic status assessment for patients with diabetes (≤9.0%)—Any reading (revised—formerly A1C control)
- Eye exam for patients for diabetes
- Care of older adults—functional status assessment, pain assessment, medication review
- Osteoporosis screening in older women
- Statin therapy for patients with cardiovascular disease
- Statin use in persons with diabetes

Commercial (ACA) quality gaps for 2024

- Breast cancer screening
- Colorectal cancer screening
- Cervical cancer screening
- Controlling high blood pressure – any reading
- Glycemic status assessment for patients with diabetes (≤8.0%)—Any reading (revised—formerly A1C control)
- Eye exam for patients for diabetes
- Statin therapy for patients with diabetes

2024 Common Hierarchical Condition Categories (HCC) ICD-10 Codes

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Clear, supportive documentation is critical for accurate coding in risk adjustment to give the entire healthcare team a complete picture of the patient's health status.

1. Document and code all conditions that coexist at the time of the encounter and require or affect patient care, treatment, or management.
2. The encounter note must be complete, legible, and include the provider signature and credentials.
3. Code to the highest level of specificity and certainty documented in the encounter.

Endocrine, Nutritional, and Metabolic Disease (E00-E89)		
Diabetes mellitus (DM)	Type 1	Type 2
Use additional code *to identify Insulin use.*		Z79.4
Diabetes mellitus without complications	E10.9	E11.9
Complete documentation must include type, control and complications affecting body system(s) if applicable.		
Diabetes mellitus with hyperglycemia	E10.65	E11.65
When documentation specifies diabetes mellitus as "poorly controlled", "inadequately controlled," or "out of control", diabetes mellitus with hyperglycemia should be coded. Uncontrolled diabetes indicates that the patient's blood sugar is not at an acceptable level, because it is either too high or too low; therefore, there is no default code for "uncontrolled".		
Diabetes mellitus with diabetic nephropathy	E10.21	E11.21
When both diabetic nephropathy and chronic kidney disease (CKD) are documented, code only diabetic CKD, as it is more specific.		
Diabetes mellitus with diabetic chronic kidney disease	E10.22	E11.22
Use additional code *to identify CKD stage.*	N18.1-N18.6	N18.1-N18.6
Diabetes mellitus with unspecified diabetic retinopathy	E10.31-	E11.31-
Diabetes mellitus with diabetic cataract	E10.36	E11.36
Diabetes mellitus with diabetic neuropathy	E10.40	E11.40
Diabetes mellitus with diabetic polyneuropathy	E10.42	E11.42
Diabetes mellitus with diabetic peripheral angiopathy without gangrene	E10.51	E11.51
Diabetes mellitus with foot ulcer	E10.621	E11.621
Use additional code *to identify site of ulcer.*	L97.4-, L97.5-	L97.4-, L97.5-
Assign as many codes from categories E08-E13 as needed to identify all the diabetic complications documented.		
Morbid (severe) obesity due to excess calories	E66.01	
Use additional code *to identify BMI, if known.*	Z68.-	
Document and evaluate for morbid obesity in patients with BMI ≥ 40. BMI codes are never intended to be used as stand-alone codes; providers must document a clinically significant weight-related condition to capture **Z68** codes.		
Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)		
Dementia, unspecified without behavioral disturbance		F03.90
Dementia, unspecified with behavioral disturbance		F03.91-
Bipolar disorder, unspecified		F31.9
Major depressive disorder, single episode, moderate		F32.1
Major depressive disorder, single episode, severe, without psychotic features		F32.2
Major depressive disorder, single episode, severe, with psychotic features		F32.3
Major depressive disorder, recurrent, moderate		F33.1
Major depressive disorder, recurrent, severe, without psychotic features		F33.2
Major depressive disorder, recurrent, severe, with psychotic features		F33.3
Complete documentation requires the following: 1. Episode (single or recurrent), 2. Degree/severity (mild, moderate, severe with psychotic symptoms, severe without psychotic features), 3. Status (partial or full remission).		
Disease of the Nervous System (G00-G99)		
Alzheimer's disease	G30.-	
Must be confirmed by the providers' documentation to capture. Alzheimer's codes must be paired with an additional code from category **F02** as a manifestation of Alzheimer's. The physician does not have to mention dementia to code it.		
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909	
Do not assign **R56.9** when a patient has had a seizure disorder or recurrent seizures. When a seizure disorder or recurrent seizures are documented, use appropriate code from Category **G40**.		
Disease of the Circulatory System (I00-I99)		
Essential (primary) hypertension		I10
The classification presumes a causal relationship between hypertension, heart, and kidney involvement, unless the documentation clearly states the conditions are unrelated.		
Hypertensive heart disease with heart failure		I11.0
Use additional code to identify type of heart failure.		I50.-
Hypertensive heart disease without heart failure		I11.9
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease		I12.0
Use additional code to identify stage of CKD.		N18.5-N18.6

Continued on reverse >

Disease of the Circulatory System (I00-I99) *cont.*	
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I12.9
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure with stage 1 through 4 chronic kidney disease or unspecified chronic kidney disease	I13.10
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure and with stage 5 chronic kidney disease or end stage renal disease	I13.11
Use additional code to identify stage of CKD.	N18.5-N18.6
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage kidney disease	I13.2
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.5, N18.6
Atherosclerotic heart disease of native coronary artery with unstable angina pectoris	I25.110
Paroxysmal atrial fibrillation	I48.0
Longstanding persistent atrial fibrillation	I48.11
Other persistent atrial fibrillation	I48.19
Chronic atrial fibrillation, unspecified	I48.20
Permanent atrial fibrillation	I48.21
Unspecified atrial fibrillation	I48.91
Unspecified atrial flutter	I48.92
Sick sinus syndrome	I49.5
End stage heart failure	I50.84
Use additional code to identify the type of heart failure as systolic, diastolic, or combined, if known.	I50.2-I50.43
Heart failure, unspecified	I50.9
Diseases of the Respiratory System (J00-J99)	
Unspecified chronic bronchitis	J42
Emphysema, unspecified	J43.9
Chronic obstructive pulmonary disease with (acute) lower respiratory infection	J44.0
Use additional code to identify the infection.	
Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1
If COPD with acute exacerbation and COPD with lower respiratory infection are present: document and code both.	
Chronic obstructive pulmonary disease, unspecified	J44.9
Severe persistent asthma	J45.5-
Respiratory failure	J96.-
Diseases of the Digestive System (K00-K95)	
Crohn's disease, unspecified	K50.9-
Ulcerative colitis, unspecified	K51.9-
Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)	
Rheumatoid arthritis, unspecified	M06.9
If known, document and code with or without rheumatoid factor, specific joint impacted along with laterality.	M05-M06.8A
Systemic lupus erythematosus, unspecified	M32.9
Diseases of the Genitourinary System (N00-N99)	
Chronic kidney disease, stage 3 unspecified	N18.30
Chronic kidney disease, stage 3a	N18.31
Chronic kidney disease, stage 3b	N18.32
Chronic kidney disease, stage 4 (severe)	N18.4
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Use additional code to identify dialysis status.	Z99.2
Factors Influencing Health Status (Z00-Z99)	
Tracheostomy status	Z93.0
Gastrostomy status	Z93.1
Ileostomy status	Z93.2
Colostomy status	Z93.3
Unspecified cystostomy status	Z93.50
Heart transplant status	Z94.1
Lung transplant status	Z94.2
Liver transplant status	Z94.4

What to know about the new CMS-HCC Version 28

The new CMS-HCC risk adjustment model, Version 28 is scheduled for 2024 and will include changes to the Medicare Advantage (MA) capitation rate and risk adjustment methodologies. These changes will significantly impact risk adjustment factor (RAF) scores.

Version 28 changes

- The names and numbers of HCC codes
- How HCCs are mapped[1]
- The coefficient of HCC values
- The removal of 2,294 diagnosis codes that map to an HCC for payment
- 29 new HCCs
- 268 new diagnosis codes that did not previously map to an HCC

The new HCCs are calibrated to capture more complete and accurate data about the health status of patients with chronic conditions. This will help health plans and medical practices better understand their patients' health needs to provide them with the care they need.

Coding is key for HCCs

To mitigate the potential financial impact of the new HCC model changes, medical practices and health plans should consider investing in staff training and education to ensure clinical documentation is clear and supportive and coding practices are up-to-date and compliant. Practices should also consider working with certified medical coders and auditors to perform internal reviews and identify areas for improvement.

As the CMS-HCC risk adjustment model continues to grow and change, it's important to stay on top of these changes. This will ensure your organization can continue to provide quality patient care and receive the necessary financial resources to do so.

Continued >

[1] For the proposed list of HCC-to-ICD-10-CM mappings, visit the CMS website and review file PY 2024 Proposed Clinical Revision Part C Model ICD-10 Mappings.

Contact
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Removal of 2,000+ codes

Over 2,000 codes were removed from the model to enhance predictive ability by better reflecting current disease patterns, treatment methods and costs, as well as coding practices. Some examples include malnutrition, peripheral vascular disease (PVD), and amputation status.

The table below from the CMS Rate Announcement provides additional information on the underlying diagnosis code counts for the V24 (2020) and the V28 (2024) model.

	V24 2020 CMS-HCC Model	V28 2024 CMS-HCC Model
FY22/23 ICD-10 codes—total	73,926*	73,926*
FY22/23 ICD-10 codes—mapped to payment HCCs	9,797 (13.3%)	7,770 (10.5%)
FY22/23 ICD-10 codes—mapped to nonpayment HCCs	64,129 (86.7%)	66,156 (89.5%)
Not in 2020 Model but added to 2024 Model	-	209
In 2020 Model but no longer mapped to payment in 2024 Model	-	2,236
• No longer mapped—ICD-10 clinical updates	-	2,161 (96.6%)
• No longer mapped—Principle-10 focused updates related to discretionary coding	-	75 (3.4%)
HCCs—total	204	266
HCCs—payment	86 (42.2%)	115 (43.2%)
HCCs—nonpayment	118 (57.8%)	151 (56.8%)

* The total number of ICD-10 diagnosis codes varies by fiscal year.

Resources

1. AACP Editorial Staff. (2023, May 2). *What is risk adjustment?* American Academy of Professional Coders. AAPC.com/resources/what-is-risk-adjustment
2. Centers for Medicare and Medicaid Services. (2023, March 31). *Fact Sheet: 2024 Medicare Advantage and Part D Rate Announcement.* Centers for Medicare and Medicaid Services. CMS.gov/newsroom/fact-sheets/fact-sheet-2024-medicare-advantage-and-part-d-rate-announcement
3. Goel, A. J., Curran, E. R., & O'Brien, K. (2023, April 5). *CMS Finalizes Risk Adjustment Model in 2024 Rate Announcement for Medicare Advantage and Part D.* Insights. MWE.com/insights/cms-finalizes-risk-adjustment-model-in-2024-rate-announcement-for-medicare-advantage-and-part-d/
4. Stearns, M., James, M., & Rykaczewski, K. (2023, February 27). *How CMS-HCC Version 28 will impact risk adjustment factor (RAF) scores.* Wolters Kluwer. WoltersKluwer.com/en/expert-insights/how-cms-hcc-version-28-will-impact-risk-adjustment-factor-raf-scores#:~:text=CMS%20made%20significant%20changes%20to,An%20expanded%20number%20of%20HCCs

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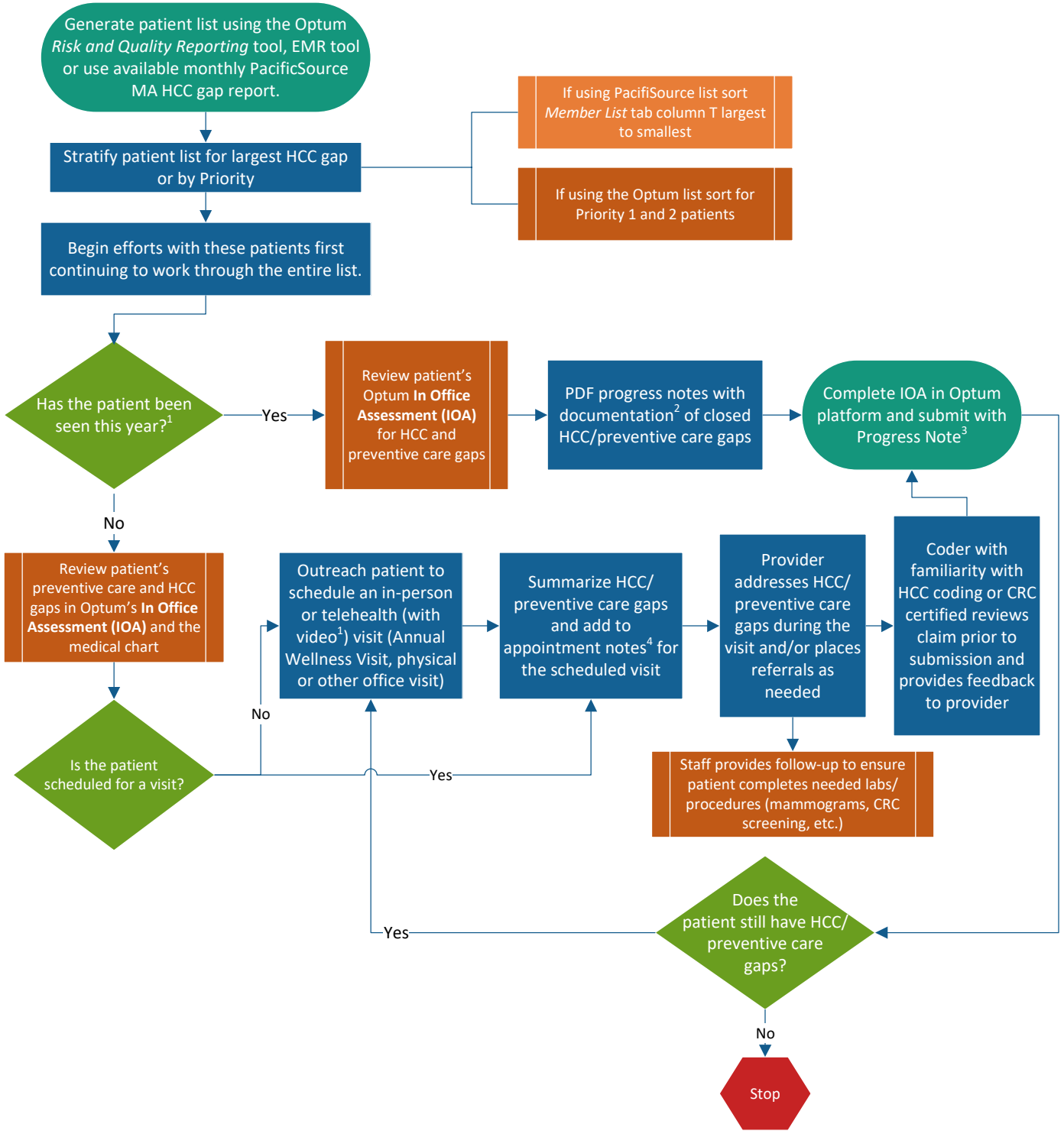
Risk Adjustment - Closing HCC Gaps – Sample Workflow Using the Optum Program - 2024

The Optum program allows our clinic partners to identify their Medicare Advantage (and ACA) covered patients with hierarchical condition category (HCC) and preventive care gaps that need to be addressed by the provider. Where possible, centralized management of the program for clinics is recommended to accurately track that each patient has been outreached and completed a visit with their provider. Clinic partners are encouraged to use existing Electronic Medical Record (EMR) Best Practice Advisories to close HCC and preventive care gaps and population based tools to more efficiently identify patients with and without a visit scheduled when available.



[1]Patient visits must be in-person or if the visit is conducted via telehealth include a video component to be risk-adjustable
[2]Complete Progress Note must be submitted including diagnosis, notes addressing gaps, DOS, type of visit, and electronic signature with credentials
[3]In-Office Assessments must be returned within 60 days for the full administrative fee - all returns must be submitted by 1/31/2025
[4]Different tools are available based on EMR capabilities to get this information in front of the provider for an upcoming visit – Use the tools that work best for your practice. EMR tools that place diagnoses in front of providers at the time of the visit can be very successful in recapturing HCC diagnosis and require less manual work.

Risk Adjustment Documentation & Coding Part I

Introduction and Coding for Diabetes & Neoplasm

PacificSource

02/24

Agenda

- The concept of support
- MEAT – Monitor, Evaluate, Assess/Address, Treat
- Coding diabetes
- Coding neoplasm

The concept of support

- Code all documented conditions that *coexist at the time of the encounter/visit **and** require or affect patient care, treatment, or management.*
  (ICD-10 CM outpatient coding guidelines)
- Per CMS medical reviewer guidance: "*MA Organization is required to submit medical records to support all CMS-Hierarchical Condition Categories (HCCs) in the sampled beneficiaries' risk scores for the payment year.*"

The concept of support, continued

- Coding professionals should not assign codes based solely on diagnoses noted in the history, problem list, and/or a medication list. It is the provider's responsibility to document that the chronic condition *affected care and management* of the patient for that encounter.
  (AHA CC Q3 2021)
- **MEAT** was created by health plans to support coders in abstracting conditions that impact a patient's health status.

Understanding MEAT

Monitor

Signs / symptoms

Disease progression / regression

Review of previous labs or other tests

Evaluate

Test results

Medication effectiveness

Response to treatment

Physical exam findings

Assess/Address

Discussion, review records

Counseling

Ordering of new labs / tests

Treat

Medication reconciliation

Surgical/other therapeutic interventions

Referral to specialist for treatment/consultation

Diabetes Documentation & Coding

Diabetes documentation and coding

- Diabetes is a chronic condition that is often miscoded
- Complete documentation must include:
  - Type

    If not documented, the default per ICD-10 CM guidelines is type 2
  - Control

    No default code assignment for uncontrolled in ICD-10 CM Index
  - Complications affecting body system(s)

    Best practice is to always document causal relationships

Diabetes types

ICD-10 CDM Category	Description	Note
E08-	Diabetes mellitus due to underlying condition	Code first the underlying condition. Use additional code to identify insulin use.
E09.-	Drug or chemical-induced diabetes mellitus	Code first poisoning due to drug or toxic, if applicable. Use additional code for adverse effect, if applicable. Use additional code to identify insulin use.
E10.-	Type 1 diabetes mellitus	No additional code needed to identify insulin use.
E11.-	Type 2 diabetes mellitus	No additional code needed to identify insulin use.
E13.-	Other specified diabetes mellitus	No additional code needed to identify insulin use.

Diabetes control

Control	Documentation	ICD 10-CM
Uncontrolled – No default code. Assign E11.9, without complications, if no further specified.	Explicitly specified as hyperglycemia	E11.65
	Explicitly specified as hypoglycemia	E11.649
Poorly controlled	Alphabetic index directs to “with hyperglycemia”	E11.65
Inadequately controlled	Alphabetic index directs to “with hyperglycemia”	E11.65
Out of control	Alphabetic index directs to “with hyperglycemia”	E11.65

Diabetes complications

- Use as many codes from categories E08–E13 as necessary to capture all diabetic complications as they illustrate the need for different care management.
- The classification presumes a causal relationship between diabetes and any condition listed under the term “with” in the ICD-10 CM Alphabetic Index.
  - These conditions should be coded as related **unless** the provider clearly documented that they are unrelated.

Diabetes complications, continued

- For conditions not specifically linked by these relational terms in the classification, provider documentation must establish causal relationships.
  - Examples: diabetic, due to diabetes, secondary to diabetes.

Diabetes complications: examples

Body System	Complications with presumed link	ICD-10 CM	Note
Kidney	Chronic kidney disease (CKD)	E11.22	Use additional code for CKD stage. Use additional code for dialysis status, if applicable.
Eye(s)	Cataract	E11.36	
Nervous	Neuropathy	E11.40	
Skin	Foot ulcer	E11.621	Use additional code for ulcer site and severity (L97.4-, L97.5-).

Diabetes MEAT: examples

Monitor	• **Type 1 diabetes** Well controlled. A1C 6.1; patient is snacking less and following a healthy diet.
Evaluate	• **Type 2 diabetes with polyneuropathy** Controlled on Amaryl. Decreased sensation noted over both lower extremities.
Assess/Address	• **Type 2 diabetes with hyperglycemia** Uncontrolled. Recheck A1C today. Patient was counseled on the importance of diabetes control.
Treat	• **Type 2 diabetes** Continue current medication. Ophthalmology referral for due yearly eye exam.

Neoplasm Documentation & Coding

Neoplasm documentation and coding

- Neoplasm coding, especially malignant, significantly affects patient outcomes and healthcare priorities
- Clear and detailed documentation includes:
  - Anatomical location
    Laterality if applicable
  - Behavior
    Benign, malignant, in situ, uncertain, unspecified, metastasized
  - Status
    Active vs. historical, in remission, in relapse
  - Complications
    Neoplasm-related and treatment-related

Neoplasm coding best practices

- When terms like “mass,” “lump,” “tumor,” or “growth” are documented, start in the Alphabetic Index and look up the exact words from documentation. Never code these conditions using the Neoplasm Table.
- Know the difference between uncertain vs. unspecified neoplasm: An uncertain neoplasm has been examined microscopically, but its nature could not be ascertained. An unspecified neoplasm has an unknown etiology because no microscopy examination has been performed or documented.

Neoplasm coding best practices, continued

- Metastatic or secondary neoplasm: Documentation should clearly reflect the primary site and secondary site(s). Code accordingly.

Neoplasm status

Active	Historical
Newly diagnosed: Developing treatment plan, reviewing pathology finding	Cancer excised with no further treatment
Ongoing treatment: Chemotherapy, radiation therapy, surgical intervention	No evidence of malignancy (NED)
Refusal of therapeutic treatment	Under surveillance for recurrence
Watchful waiting: Risks outweigh benefits	Adjuvant therapy specified for *prophylactic* purposes

Neoplasm MEAT: examples

Monitor	• **History of prostate cancer** No reported new symptoms, continue monitoring PSA
Evaluate	• **Malignant neoplasm of upper-inner quadrant of right female breast** Biopsy done 10/20; results show stage 3 breast cancer
Assess/Address	• **Stage 4 malignant neoplasm of right main bronchus with liver metastasis** Patient counseled on treatment options but refused to proceed. Discussed palliative care options
Treat	• **Prostate Cancer** Receiving radiation therapy; referral to a new urologist

Questions

Risk Adjustment Documentation & Coding Part II

Coding for Obesity & Major Depressive Disorder

PacificSource

02/24

Agenda

- Coding obesity
- Coding major depressive disorder

Obesity Documentation & Coding

Obesity documentation and coding

- Weight-related diagnoses are often under-coded, although they are always considered clinically significant and reportable when documented in the medical record.
- To capture a weight-related condition, clinical documentation must:
  - Support the presence of the condition:

    Diagnosis documented in the history of present illness (HPI), physical exam (PE), and/or assessment and plan (A/P) sections.
  - Outline the provider's plan for management of the condition:

    Discussion of the patient's weight condition and a plan of care for it. Examples include referral to a dietitian, counseling on weight loss, nutritional counseling, lifestyle counseling, dietary changes, increased physical activity, and behavior modifications.

Obesity documentation and coding, continued

- All weight-related diagnoses are not treated equally under the risk adjustment model. For example, overweight and obese diagnoses do not affect risk adjustment payment. Morbid obesity, however, affects risk adjustment calculations and is weighted highly in risk and resource utilization.
- Complete documentation and accurate coding are critical for proper risk adjustment reimbursement. This includes:
  - **Severity**: Obese, overweight, morbid obesity
  - **Contributing factors**: Excess calories, drug-induced
  - **Comorbidities**: Coronary heart disease, atherosclerotic diseases (PVD/PAD), type 2 diabetes, sleep apnea/respiratory problems (e.g., COPD)
- Class 3 obesity is synonymous with morbid obesity, which is classified to code **E66.01**. For classes 1 and 2 obesity, query the provider to determine the type or etiology of the obesity if the documentation does not specify this information *(AHA CC 2022 Q2 p9).*

Body Mass Index (BMI)

- Use additional code for Body Mass Index (BMI)
  - BMI over 40 kg/m2 carry value in risk adjustment.
  - BMI codes were never intended to be used as stand-alone codes. The provider must document a clinically significant, weight-related condition (such as morbid obesity, obesity, overweight, underweight, malnutrition, cachexia, eating disorders, or abnormal weight gain/loss) to capture a code for BMI *(AHA CC 2018 Q4 p77).*

Body Mass Index (BMI), continued

- Use additional code for Body Mass Index (BMI)
  - BMI code assignment may be based on medical record documentation from clinicians who are not the patient's provider (healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record). However, the associated diagnosis must be documented by the treating provider *(ICD-10 Guidelines I.B.14).*
  - Coders cannot make the calculation to get an undocumented BMI.
  - Coders cannot imply a weight-related diagnosis based on BMI value.

Obesity MEAT: examples

Monitor	• **Morbid obesity due to excess calories** • During last visit, we asked patient to count calories/day, and today, they reported back more than 2,000 calories/day with snacking a lot between meals.
Evaluate	• **Obesity with Type 2 diabetes mellitus** • A1C elevated; increased abdominal fat noticed in physical exam; encouraged physical activity.
Assess/Address	• **Morbid obesity due to excess calories** • BMI 42. Counseled on importance of dietary changes to achieve target weight goal.
Treat	• **Morbid obesity due to excess calories** • Referral to dietitian.

Major Depressive Disorder Documentation & Coding

Major depressive disorder documentation and coding

- Depression is a common mental health disorder. Approximately 30% of patients report symptoms of depression to their primary care providers. However, fewer than 10% of these patients have major depression *(AHA CC 2021 Q4 p9).*
- *Effective October 1, 2021*, a code has been created to identify depression unspecified_**F32.A**.
  - Previously in ICD-10-CM, the default for depression not otherwise specified (NOS) was code **F32.9**, *Major depressive disorder, single episode, unspecified*. However, this code did not separately capture the actual occurrence of depression not further specified, and statistically inflated the incidence of major depressive disorder.

Major depressive disorder documentation and coding, continued

- Coders cannot code mental health disorders from problem lists or past medical history.
- Coders cannot assume diagnoses based on medications list or screening tools (PHQ-9). Providers must reiterate the condition with complete clinical documentation.

Major depressive disorder documentation

Complete clinical documentation is critical for accurate coding and must include the following:

- Episode
  - Single
  - Recurrent
- Severity/degree
  - Mild, moderate, severe with psychotic symptoms, severe without psychotic features
- Status
  - Current, partial remission, or full remission

Depression coding tips

- Bipolar disorder and recurrent major depressive disorder
  - Assign code **F31.9**, *Bipolar disorder, unspecified*. Bipolar disorder includes both depression and mania, and it is more important to capture the bipolar disorder. Therefore, a code for depression would not be reported separately *(AHA CC 2020 Q1 p23).*

Depression coding tips, continued

- Depression with anxiety
  - The classification does not assume a linkage between depression and anxiety. Unless there is a linkage in the documentation to indicate a single disorder, these conditions should be coded separately *(AHA CC 2021 Q1 p10).*
    - ✓ If the provider does indicate a relationship between the two conditions (anxiety and depression or mixed anxiety and depressive disorder, also known as MADD), it would be appropriate to assign code **F41.8**, *Other specified anxiety disorders*.

Major depressive disorder MEAT: examples

Monitor	• **Major depressive disorder, single episode, moderate** • Patient presents with feelings of sadness and hopelessness most of the days.
Evaluate	• **Major depressive disorder, recurrent, moderate** • Patient is very irritable and looks very tired during physical exam. Increase Paxil dosage.
Assess/Address	• **Major depressive disorder, recurrent, in partial remission** • Collaborate with therapist as needed. Reinforcement to keep taking medications consistently. Safety reviewed.
Treat	• **Major depressive disorder, recurrent, in partial remission** • Collaborate with therapist as needed. Reinforcement to keep taking medications consistently. Safety reviewed.

Questions

Risk Adjustment Documentation & Coding Part III

Coding for Circulatory Disorders

PacificSource

Agenda

- Coding atrial fibrillation
- Coding heart failure
- Coding cerebral infarction

Atrial Fibrillation Documentation & Coding

Atrial fibrillation definition and types

Definition

Cardiac dysrhythmia is a disturbance in heart rhythm, including rate, regularity, and sequence of atrial and/or ventricular contractions. Atrial fibrillation is the most common dysrhythmia. It occurs when the two upper chambers of the heart lose their normal rate and rhythm, and beat chaotically, increasing the risk of blood clots forming in the heart as well as thromboembolic stroke. Atrial fibrillation is typically treated by electrical or pharmacological cardioversion.

Types

- **I48.0,** *Paroxysmal atrial fibrillation* – Occurs when a rapid, erratic heart rate begins suddenly and then stops on its own. Episodes may last minutes, hours, or days.
- **I48.11,** *Longstanding persistent atrial fibrillation* – Does not resolve on its own and has lasted for more than a year. Repeat electrical cardioversion and antiarrhythmic drugs are required.
- **I48.19,** *Other persistent atrial fibrillation* – Does not terminate within seven days. It cannot get back to its regular rhythm on its own.
- **I48.20,** *Chronic atrial fibrillation, unspecified* – May refer to any persistent, longstanding persistent, or permanent atrial fibrillation. It is only coded based on the provider's documentation.
- **I48.21,** *Permanent atrial fibrillation* – Resistant to treatment and cannot be converted to a normal rate and rhythm, even with medication and attempts at electrical cardioversion, or where cardioversion is contraindicated.

Atrial fibrillation coding tips

- **Chronic atrial fibrillation**

  The use of one of the more specific descriptive terms, when documented, is preferred over the use of the nonspecific term “chronic atrial fibrillation.”

  Example: Assign I48.19, *Persistent atrial fibrillation* for a documentation of chronic persistent atrial fibrillation. Chronic atrial fibrillation is a nonspecific term that could be referring to paroxysmal, persistent, long-standing persistent, or permanent atrial fibrillation. Since code I48.20 is nonspecific, code I48.19 is a more appropriate code assignment (*AHA CC 2019 Q2 p3*).

- **Chronic atrial fibrillation with rapid ventricular response**

  Assign code **I48.20,** *Chronic atrial fibrillation*, for chronic AF with RVR. The RVR is not coded separately. Chronic atrial fibrillation with rapid ventricular response (RVR) indicates problems with rate control, not paroxysmal atrial fibrillation (*AHA CC 2018 Q3 p6*).

- **History of atrial fibrillation on anticoagulant therapy**

  Query the provider for clarification of whether the patient has a history of atrial fibrillation that has resolved, or whether the atrial fibrillation is a chronic condition, currently maintained on long-term anticoagulation (*AHA CC 2013 Q4 p101*).

Heart Failure Documentation & Coding

Heart failure overview

Congestive heart failure (CHF) is the inability of the heart to pump blood efficiently, thus compromising circulation and causing *systemic complications* due to congestion and edema of fluids in the tissues.

Ejection fraction (EF) indicates the amount of blood that is pumped out from the ventricle to the body during systole (the phase in which the heart muscle contracts).

CHF includes two types: systolic and diastolic; patients may have components of both.

Systolic heart failure	Diastolic heart failure
Dilated, weak heart, and/or thin ventricular wall	Thickened myocardium/hypertrophic ventricle
Impaired ventricular pumping function	Impaired filling with blood
Ejection fraction (EF) less than 40% (“reduced” EF)	Ejection fraction (EF) preserved
Code **I50.2-**: • Heart failure with reduced ejection fraction (HFrEF) (mid-range or mildly) • Heart failure with low ejection fraction • Heart failure with reduced systolic function	Code **I50.3-**: • Heart failure with preserved ejection fraction (HFpEF) • Heart failure with a recovered EF • Heart failure with normal ejection fraction

Heart failure coding tips

- **Decompensated/exacerbated**
  - These terms indicate that there has been a flare-up (acute phase) of a chronic condition (*AHA CC 2008 Q3 p9*).
  - *Example*: Assign code **I50.23**, *Acute or chronic systolic heart failure*, for decompensated systolic heart failure.
- **Heart failure with dysfunction**
  - When the provider has linked either diastolic or systolic dysfunction with acute or chronic heart failure, it should be coded as “acute/chronic diastolic or systolic heart failure.”
  - If there is no provider documentation linking the two conditions, assign code **I50.9,** *Heart failure, unspecified* (AHA CC 2017 Q1 p46).

Heart failure coding tips, continued

- **Heart failure with hypertension**
  - Assign code **I11.0**, *Hypertensive heart disease with heart failure*, along with the appropriate code from category **I50.-**, *Heart failure*, for CHF in a patient with hypertension.
  - The classification presumes a causal relationship between hypertension and heart involvement, unless the provider documents that the conditions are unrelated (*ICD-10 CM C.9.a.1*).
- **End stage heart failure**
  - The American College of Cardiology and the American Heart Association classify heart failure in stages. End stage heart failure falls into stage D of this classification.
  - Use additional code to identify the type of heart failure as systolic, diastolic, or combined, if known (*AHA CC 2017 Q4 p15*).

Heart failure MEAT/supporting documentation

Monitor	• Signs and symptoms such as shortness of breath (SOB) or dyspnea, edema in extremities, fatigue, weakness
Evaluate	• Findings in the physical exam (PE), such as presence or absence of swelling in ankles, abnormal lung sounds, or heart sounds • Reviewing lab values (B-type natriuretic peptic (BNP)) and imaging (echocardiography, stress test, coronary angiogram)
Assess/Address	• Ordering labs and/or imaging • Discussing cardiac surgery • Counseling on heart-healthy diet and physical activity
Treat	• Medications reconciliation • Specialist referrals

Cerebral Infarction Documentation & Coding

Cerebral infarction overview

- Cerebral infarction can result from a blocked blood vessel due to a thrombus, embolus, or a constriction or narrowing of an artery in the head or neck (stenosis).
  - A **thrombus** is a mass of platelets, fibrin, and other blood components that form within the precerebral or cerebral vessels that supply blood to the brain.
  - An **embolism** is a clot or thrombus that travels from a remote site to another site; in this case, the embolus travels to the precerebral or cerebral arteries.
- Thrombi and emboli can obstruct the cerebral arteries, causing damage from the lack of blood supply reaching the brain.
- Cerebral infarction is classified based on:
  - **Type of occlusion**: thrombosis, embolism, or stenosis
  - **Site of the occlusion**, which requires identification of the specific precerebral or cerebral artery.
  - **Laterality:** does not apply to the basilar artery, because it is a single blood vessel that joins the vertebral arteries and is located at the base of the skull.

Cerebral infarction coding tips

- Acute stroke (Category **I63.-**), also known as cerebral infarction or CVA, should be coded only during the initial episode of care.
- Do not code diagnoses documented as probably, suspected, likely, questionable, possible, still to be ruled out, or other similar terms indicating uncertainty in emergency room (ER) and outpatient settings.
- When transient ischemic attack (TIA), also known as “mini stroke,” is diagnosed, use code **G45.9.**
- For post-discharge and follow-up visits, do not code for the cerebral infarction as active/current. Assign:
  - **Z86.73,** *Personal history of transient ischemic attack and cerebral infarction without residual deficits*, if the patient is seen in the outpatient setting and shows no residual deficits ***or*** if a diagnosis of a TIA was made and has been resolved.
  - Category **I69.-,** *sequela of cerebrovascular disease* if the patient has residual deficits from a stroke. Complete documentation includes:
    - Cause and effect relationship of CVA and deficits
    - Specific late effect, such as hemiparesis/hemiplegia, cognitive deficits, dysphagia, or ataxia
    - Laterality, if applicable, and whether the affected side is dominant or nondominant

Questions