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RA and E/M Orientation: Documentation & Coding

16:9 format

June 22, 2022

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Introduction

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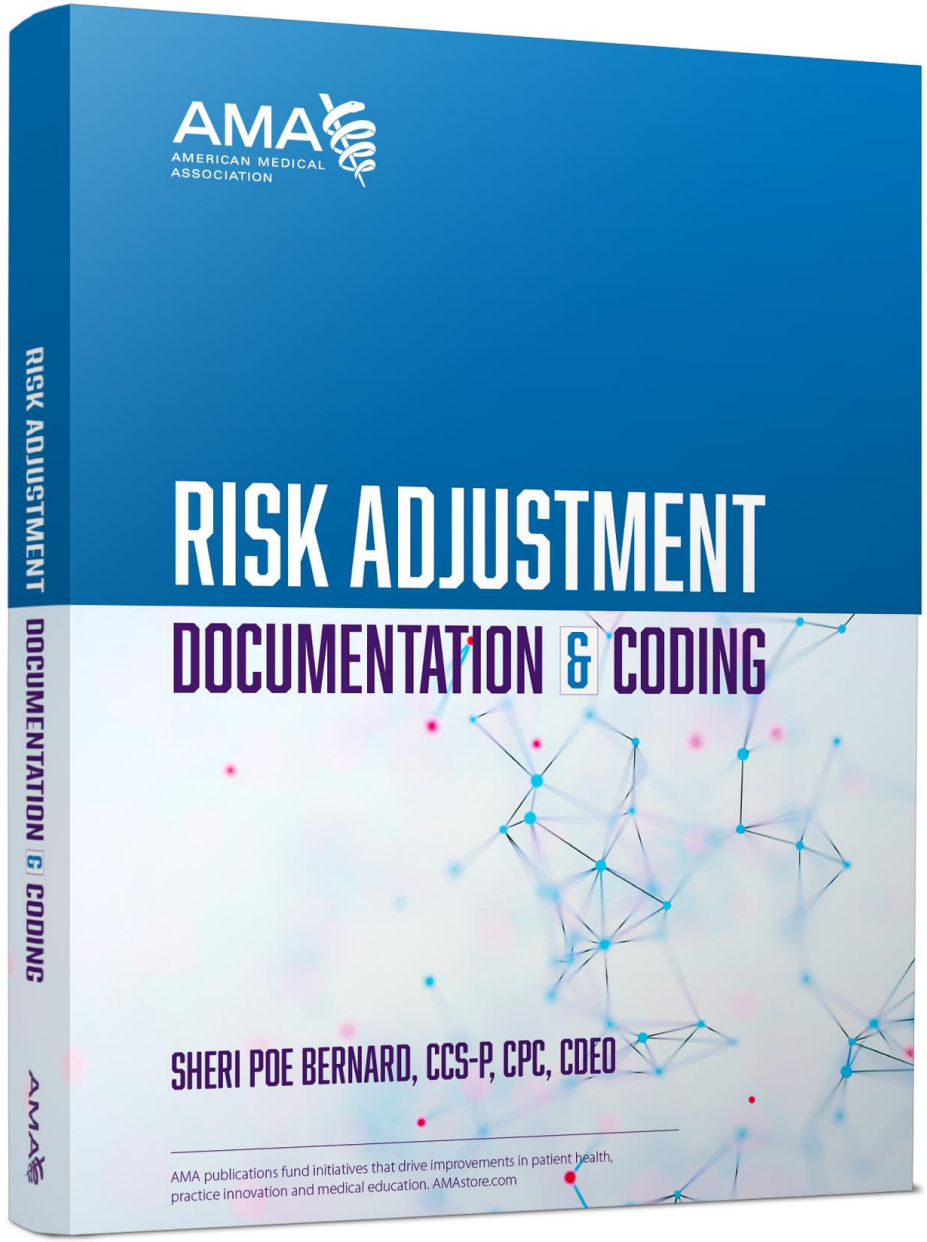
GRANITE GRC CONSULTING
Governance. Risk. Compliance.

PRESTIGE CEUs



Today's RA and E/M objectives

Learn basics.

What drives decisions on the encounter and how it is conveyed? A look at compliance requirements will explain what's needed.

- RA: How was the diagnosis addressed?
- E/M: What level of care was provided?

Note necessities.

How much is enough for documentation?

We will go over what is required for compliance, for reimbursement, and for medicolegal protection.

- RA: How can we maintain or improve patient health?
- E/M: MDM, treatment plan, risks, etc.

Be compliant.

There are plenty of guidelines from CPT, ICD-10-CM, and from CMS to consider as you document and code each patient encounter.

- RA: Are we specific and complete?
- E/M: What's essential to leveling?

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Learn basics.

The complexities of documenting medical decision making

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Medical documentation and coding goals

- Creation of a medical record/history
- Creation of a statement of work performed
- Creation of a care plan
- Creation of a legal record
- Continuity of care
- Time savings

Codes aren't enough: AMA E/M DGs

The general principles listed below may be modified to account for variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each encounter should include: reason for encounter and relevant history, physical examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis, should be documented.
7. The CPT/ICD codes reported should be supported by documentation in the medical record.

Codes aren't enough: CMS Guidelines

"A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

With the advent of electronic health records, providers are doing a lot of the coding, too.

Two rules about electronic health records

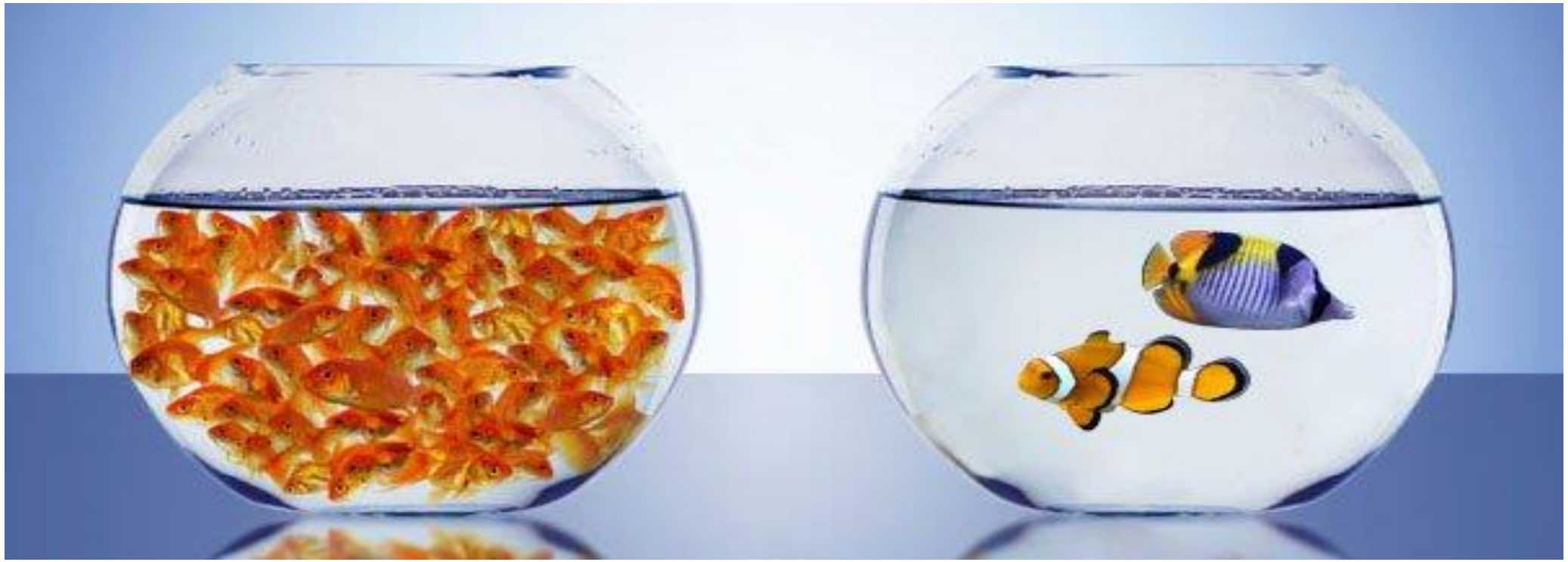
RULE #1: An EHR your best friend. It will save you time.

RULE #2: An EHR is your worst nightmare. It will cost you time.

Adopt good EHR habits to ensure best care and best compliance

- **Think in Ink.**
- **Tell the Story.**
- **Pull elements of PMH and Problem List into HPI as appropriate to the visit.**
- **Value qualitative information rather than quantitative**
- **Eschew Note Bloat!**

Qualitative vs. quantitative



COUGH **While prone? Productive? Dry? With chest pain? Mucopurulent? Chronic? Episodic after eating? Disruptive? Due to allergies? Due to asthma?**

CHEST PAIN **Intermittent? With exercise? Constant? When prone? Debilitating? Cardiac? Muscular? Respiratory? When anxious? Location? Intensity?**

DGs: Support codes with documentation

“Support”

- **For CPT, detail the service, time, and MDM of the visit**
  - **“Think in ink” to let auditors know how you drew your conclusions**
- **For ICD, detail the status of the diagnosis**
  - **Requires at least one element of TAMPER: treatment, assessment, monitor/medicate, plan, evaluate, referral**
  - **Also called MEAT: Monitor, evaluate, address, treat**

- **TAMPER/MEAT**
- **Diabetes:** meds, patient comfort level, complications, duration, BG or A1C, effect of DM on current infection or injury.
- **Autism:** duration, meds, symptoms, disability, ADLs

Codes aren't enough: Use your words

HPI: Patient complains of frequent urination and thirst, has been having difficulty managing DM on metformin alone. We discussed adding Lantus injection in the morning to supplement his oral medications, as well as dietary changes. He thinks his daughter may be willing to give his shots. BG measured 221. Note: Blood drawn. CBC revealed WBC WNL; no infection present.

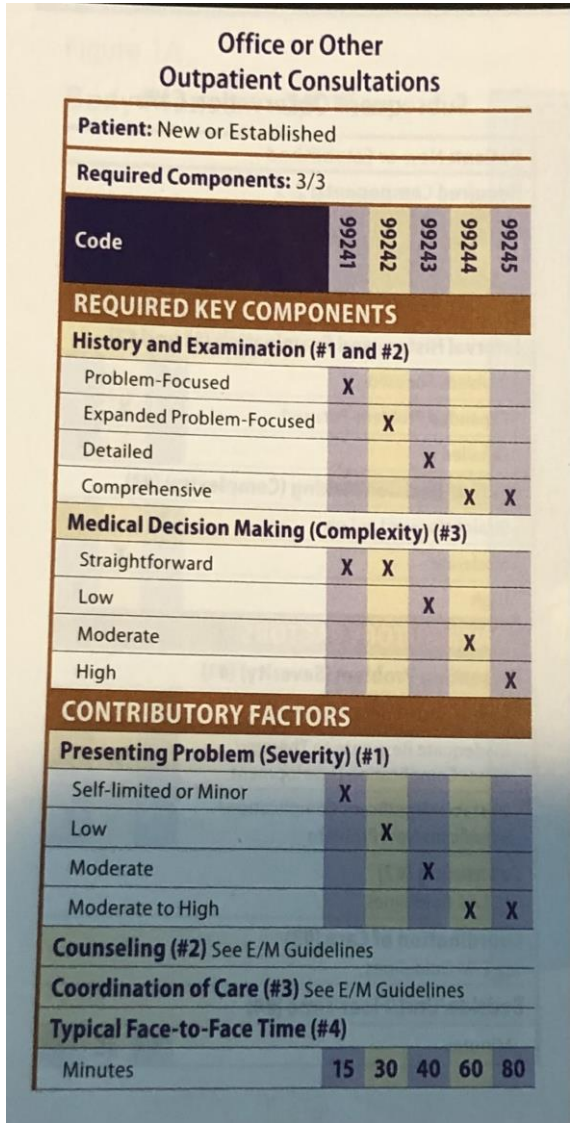
Assessment/Plan 99214, 83037, 36592

1. E11.65 Diabetes
2. Z79.84 Oral meds

Assessment/Plan

1. Uncontrolled diabetes, A1C today of 9.1.
2. Hyperglycemia, adding Lantus injection
3. Referred to dietician for nutritional counseling

Evaluation and management coding



Office or Other
Outpatient Consultations

Patient: New or Established

Required Components: 3/3

Code	99241	99242	99243	99244	99245
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X	X			
Low			X		
Moderate				X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Self-limited or Minor	X				
Low		X			
Moderate			X		
Moderate to High				X	X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Face-to-Face Time (#4)					
Minutes	15	30	40	60	80

HPI: Patient complains of frequent urination and thirst, has been having difficulty managing DM on metformin alone. We discussed adding Lantus injection in the morning to supplement his oral medications, as well as dietary changes. He thinks his daughter may be willing to give his shots. BG measured 221. Note: Blood drawn. CBC revealed WBC WNL; no infection present.

Assessment/Plan

1. Uncontrolled diabetes, A1C today of 9.1.
2. Hyperglycemia, adding Lantus injection
3. Referred to dietician for nutritional counseling

Process for evaluation and management coding

- Provides algorithm of reimbursement for evaluation and management services – “fee-for-service”

- Tied to PROVIDER reimbursement
- Includes a compliance framework used by CMS and private payers to ensure appropriateness of payment

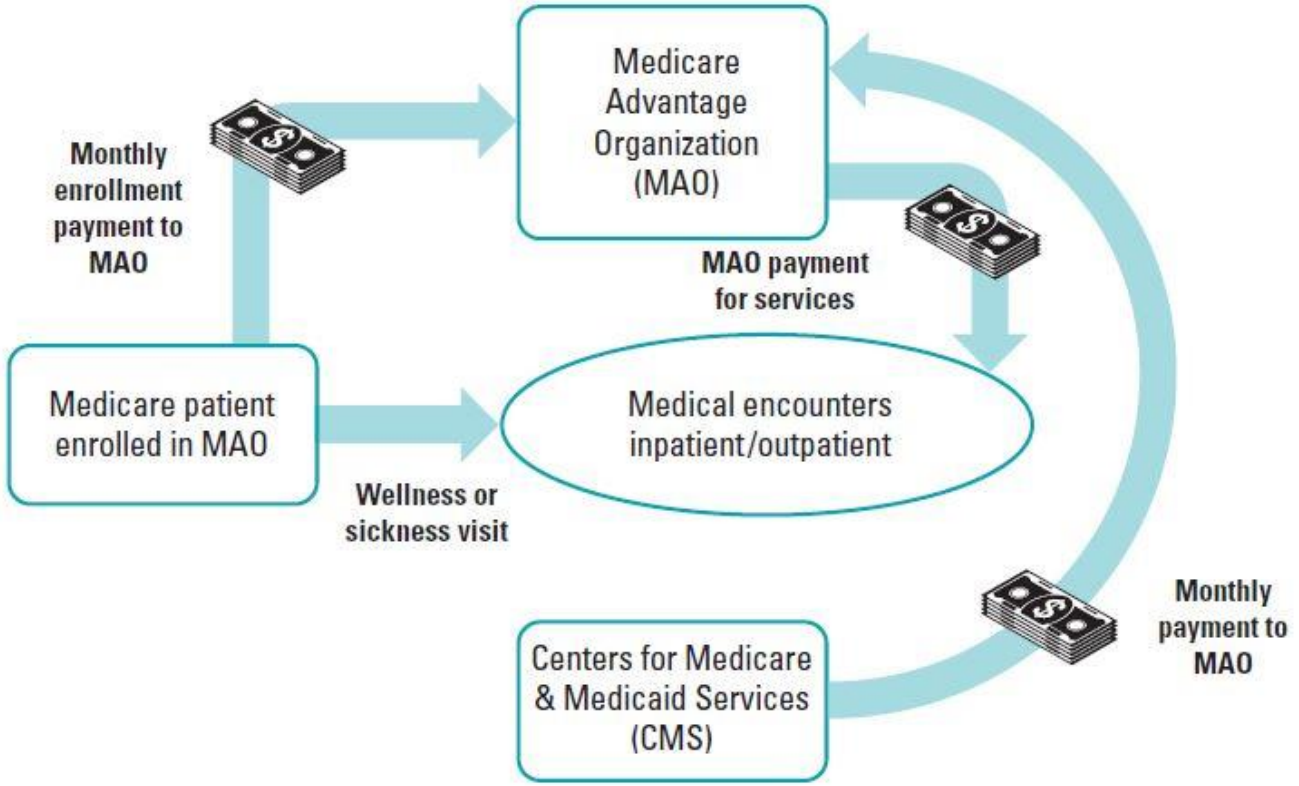
- E/M requires evidence of services be present in documentation.

Process of risk adjustment

- Provides algorithm of reimbursement of services based on severity of illness rather than fee-for-service
- Tied to PAYER reimbursement for (providers in ACOs, eg, Medicaid, etc), and bonus payments to PROVIDERS with patients in traditional Medicare or in ACOs
- Includes a compliance framework used by CMS and private payers to ensure appropriateness of payment to protect Medicare Trust Fund and safeguard enrollee health
- RA requires evidence of TAMPER/MEAT be present in documentation to validate the diagnosis is authentic

Medicare risk adjustment

FIGURE 1.1 How Medicare RA Works



CMS' monthly payment to MAO is risk-adjusted based on the comorbidities of the enrollee rather than on the services provided. The base rate is capitated and risk-adjusted to reflect the chronic conditions of the patient.

Goals of risk adjustment programs

- No more pre-existing conditions in health care contracts, so more people have coverage and insurers are more protected against loss
- Acknowledgement of difficulty in managing or insuring patients with multiple chronic conditions, and reimbursing accordingly
- Improving outcomes of patients by addressing and managing these chronic conditions more regularly
- Federal capture of data on the overarching health of U.S. patient populations

Risk adjustment is a simple concept

- **Patient 1:** Physician encounter reveals symptoms, blood work and chest X ray consistent with pneumonia in 65-year-old woman who has mild hypertension and is overweight. Patient is prescribed antitussives and antibiotics.

- **Patient 2:** Physician encounter reveals symptoms, blood work and chest X ray consistent with pneumonia in 65-year-old woman who has mild hypertension, is overweight, and additionally has diabetes and COPD.

- **Which patient is going to consume more resources?**

What risk adjusts?

- Ten thousand individual diagnosis codes risk adjust.
- Easiest to consider what is **chronic** (eg, COPD, MS), and/or **resource-intensive** (eg, hip fracture, pneumococcus pneumonia) when talking about risk adjustment.

- Diagnoses are **additive**: the more risk-adjusting diagnoses, the more cumulative risk the patient carries and the higher payment is made to the MAO insuring the patient.

- More than 40% of Medicare enrollees subscribe to a Medicare Advantage plan. That number increases yearly. Bonuses from traditional Medicare look at RA codes, too.
- Twelve million patients are in ACA risk pools (RA pools). Medicaid plans risk adjust, too.

Common RA diagnoses

Diabetes	Heart disease
Most cancers	Hip fractures
COPD	Vascular disease
Stroke	Rheumatoid arthritis
Pneumonia	Behavioral disorders
Septicemia	Chronic kidney disease
Shock	Paralysis
Amputation status	Skin ulcers
Myocardial infarction	Dementia

Complexity of a simple, acute chief complaint

- Let's look at the case of Martha Wesley, an 83 YO, married patient with a history of COPD, Alzheimer's disease, and osteoporosis.
- Martha lives at home with her husband. She comes in today because she developed a nasty rash after clearing some weeds out of her rose garden. Her husband accompanies her.
- It's May. Martha's recent health has been stable. She has not been to the clinic since June of last year.

Documenting Martha's acute condition

Martha Wesley 5/1/21 BP 105/60 WT 82.3 BMI 15.7

Medical history: Hysterectomy 1996. Appendectomy 1976.

Problem list: Alzheimer's disease, COPD, osteoporosis with hip fracture, pneumonia

Chief complaint: Itchy, painful rash

HPI: 83-year-old Martha Wesley developed a rash after clearing her garden of weeds two days ago. Large poison ivy blisters are noted on both hands and forearms, as well as a small blister on her neck. Her forearms are treated with cortisone cream and wrapped in gauze, and the neck lesion is treated as well.

Assessment: L23.7 Allergic dermatitis due to plants, except food

Plan: RTC if symptoms worsen or persist more than three weeks.
Recommend OTC cortisone cream, gauze, and Benadryl.

Documenting Martha's story … better

Martha Wesley 5/1/21 BP 105/60 WT 82.3 **BMI 15.7**

Medical history: Hysterectomy 1996. Appendectomy 1976.

Problem list: **Alzheimer's disease**, **COPD**, **osteoporosis** **Chief complaint:** itchy, painful rash

83-year-old Martha Wesley developed a rash after clearing her garden of weeds two days ago. Large **poison ivy blisters** are noted on both hands and forearms, as well as a small blister on her neck. Martha has stable, mild Alzheimer's disease, and is accompanied by her husband, Rolly, who provides her history and will care for her rash at home. When I noted Martha's drop to **extremely underweight** status, he stated Martha had lost interest in meals and subsists on sweets. He attributes this to her dementia. Her BMI last year was 17.1 and has dropped below 16. CBC shows Hb is 9.2; she is **anemic** due to diet.
Martha's lungs are clear, and I prescribed refills for her emergency inhaler for COPD as well as Fosamax to treat her age-related osteoporosis. No falls. Her forearms were treated with cortisone cream and wrapped in gauze, and the neck lesion was treated and covered as well, as her husband stated Martha has been unable to restrain from scratching.

Assessment:

L23.7 *Allergic dermatitis due to plants, except food*
M81.0 *Osteoporosis without current pathological fracture*
J44.9 *Chronic obstructive pulmonary disease, unspecified*
G30.1 *Alzheimer's disease with late onset*
E44.1 *Mild protein-calorie malnutrition*
D53.9 *Nutritional anemia, unspecified*
F02.80 *Dementia NEC, no disturbance*
D53.9 *Nutritional anemia, unspecified*

Plan: RTC if poison ivy symptoms worsen or persist more than three weeks. Watch for new lesions. Recommend OTC cortisone cream, gauze, and Benadryl. Recommend Ensure and daily iron supplement. Refer husband to Alzheimer's support group.

Documenting Martha's story … IMPACT

Diagnosis	HCC	RAF	RxHCC	RxRAF
L23.7 *Poison ivy* D58.9 *Anemia*	-	-	-	-
E44.1 *Malnutrition*	21	0.435	-	-
M81.0 *Osteoporosis*	-	-	87	0.052
J44.9 *COPD*	111	0.335	226	
G30.1 *Alzheimer's*	52	0.346	111	0. 468
F02.80 *Dementia*	52	-	112	-
Demographics	82, F, home	0.528	82, F, home	0.615
Total 1st example	Total RAF 0.582		Total RxRAF 0.615	PAYMENT: **$6088.11**
Total 2nd example	Total RAF 1.644		Total RxRAF 1.135	PAYMENT: **$16,629.62**
	NOTE: Difference in value placed on patient care: $10,521 per year			

Example

- Patient with a history of **type 1 diabetes**, **CKD stage 3**, depression, **hypertension**, and **hypothyroid** is seen by his primary care provider due to increased swelling in his lower extremities, +3 **edema** and some **weeping** of the skin.
- The patient's blood pressure is **182/89**. The patient's GFR today is **18**. Blood glucose is **109**. The patient is experiencing significant **anxiety** associated with his **recurrent major depression**. Two **toes** were **amputated** two years ago after development of a **diabetic foot ulcer**. Patient states he is still sober.
- The provider does a comprehensive history and examination, with medical decision making of high complexity.
- The patient is referred to a behavioral therapist and nephrologist, and prescribed compression stockings, leg elevation, and exercise. His blood pressure medication is revised, with the elimination of lisinopril and the addition of two other antihypertensive medications. The patient, an **alcoholic**, has not had a drink in 7 years.

Example with poor documentation and coding

Poor notes	Poor codes	HCC/RxHCC	RAFs	
Diabetes	E11.9	19, 31	0.105,	0.270
CKD	N18.30	138, --	0.069,	--
Hypertension	I10	--, 187	--,	0.124
Depression	F32.A	--, 134	--,	0.132
Edema	R60.9	--, --	--,	--
Payment count	2	--	--	
Sex (F) and age (65)		0.520	0.520,	0.238
TALLY			0.694,	0.864

Proper documentation and coding

Proper notes	Proper codes	HCC/RxHCC	RAF
Type 1 diabetes with CKD	E10.22	18, 30	0.302, 0.408
CKD, stage 4	N18.4	137, 263	0.289, 0.092
Hypertension	I12.9	--, 187	--, 0.124
Hypertensive urgency	I16.1	--, 187	-- , --
Recurrent major depression, this episode, severe	F33.2	59, 132	0.309, 0.132
Anxiety depression	F41.8	--, --	--, --
Hypothyroidism	E03.9	--, 42	--, 0.010
Amputation of two toes, R foot	Z89.421	189, --	0.519, --
Alcoholism, in remission	F10.21	55, --	0.329, --
Edema	R60.9	--, --	--, --
Payment count	5	0.042	0.042
Sex (F) and age (65)		0.520	0.520, 0.238
TALLY			2.300, 1.004

Comparison of diagnosis-associated risk

Compare records	Total RAF, HCCs	Total RAF, RxHCCs	HCC multiplier $9,365.50	RxHCC multiplier $1,036.61	Annual payment
Poor notes/codes	0.694	0.864	$6,499.66	$895.63	$7,395.29
Proper notes/codes	2.300	1.004	$21,540.65	$1,040.76	$22,581,41

The difference between poor and proper documentation is $15,186.12 to the payer, and for MIPS, it is the difference between a patient with less than average RAFs and a patient with RAFs that are more than twice the average, indicating **triple the resource requirements**.

Average HCC payment based on 1.0 RAF; Average RxHCC payment based on 1.0 RAF

Risk adjustment is…

- A payment system also known as value-based care, affecting virtually all commercial contracts
- Designed to improve patient outcomes and positively reward preventive care
- Available in many flavors! (including DRGs, shared savings at ACOs, Obamacare, Medicaid, Medicare Advantage plans, pharmaceutical insurance, and Medicare MIPS bonus payments for efficiencies)
- **Easy for providers who focus on patient care and good medical record-keeping**

Value of risk adjustment

Payers happier with equity payments for sicker patients

Documentation safeguards medical and legal liabilities

Patient health benefits from preventive care

Providers earn more for more complex caseloads

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Documentation necessities.

What needs to be captured to ensure you get paid, insurance gets paid, and compliance risks are minimized?

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Comorbidities and complications matter

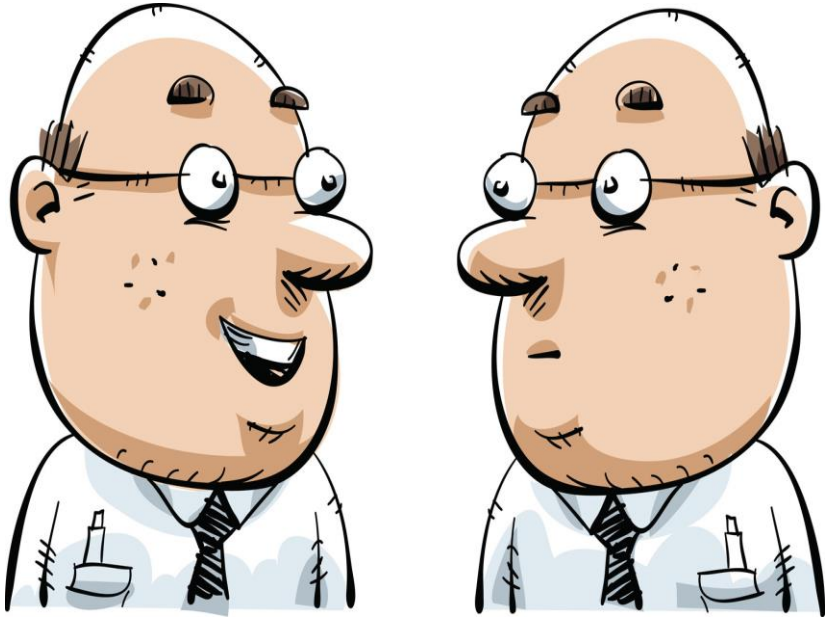
Ask yourself if the comorbidity or complication….

- Affects medical decision-making
- Affects treatment
- In any other way adds complexity to the encounter

A provider needn't be the primary manager of a condition to document and code it when it affects care planning or treatment.

Separate your tasks of documentation, coding

- Rules for documentation and coding written with the assumption that **two different people** were doing these two tasks.
- We are all charged with following rules developed for this assumption.
- Your best approach is to **separate these tasks** to ensure each is done correctly.



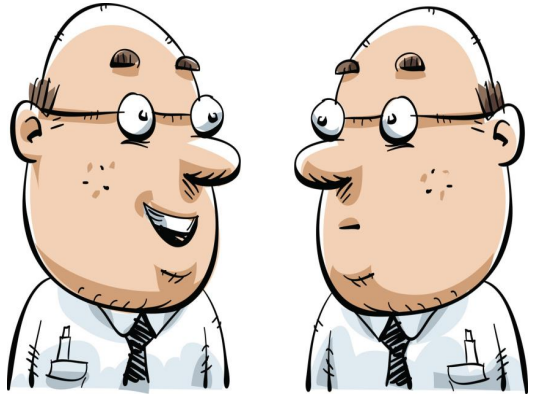
"I'll document. When I am done, you can code it!"

Separate your tasks of documentation, coding

Codes and descriptions do not provide qualitative information

- **E11.8** *Type 2 diabetes mellitus with unspecified complication*
  - If you can't say what it is, how do you know DM caused it?
- **I21.A9** *Other myocardial infarction type*
  - Is it post-revascularization? Maybe type 3, 4a, 4b, 4c, 5?
- **I70.269** *Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity*
  - Right or left? Surely you know.
- **N08** *Glomerular disorders in diseases classified elsewhere*
  - What's the etiology? Gout? Sepsis? Multiple myeloma?

    A second code will be required. Is the etiology documented?



"Our split personality may not be as quick, but it is much more accurate!"

Previous documentation doesn't count

All validation of diagnoses must be based on today's date of service

- Auditors can only look at other DOS for the basis of a query

Don't make assumptions regarding the patient's history

- A patient with a history of congenital malformation of the aorta may have had it repaired. It may also be a new diagnosis in an adult. Include these facts. Tell the story.

Underdocumentation can lead to serious medicolegal risks and underserves your patient.

Rules of coding

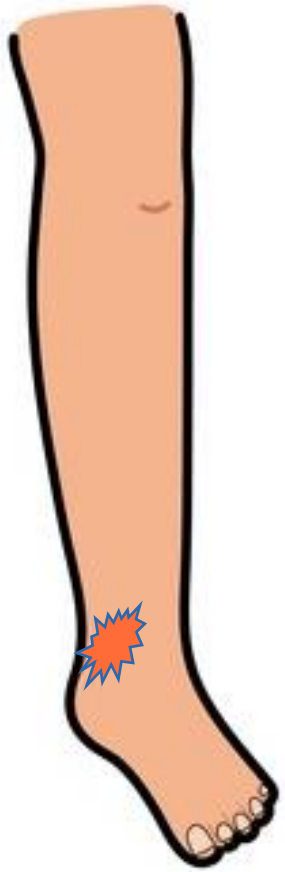
Auditors cannot:

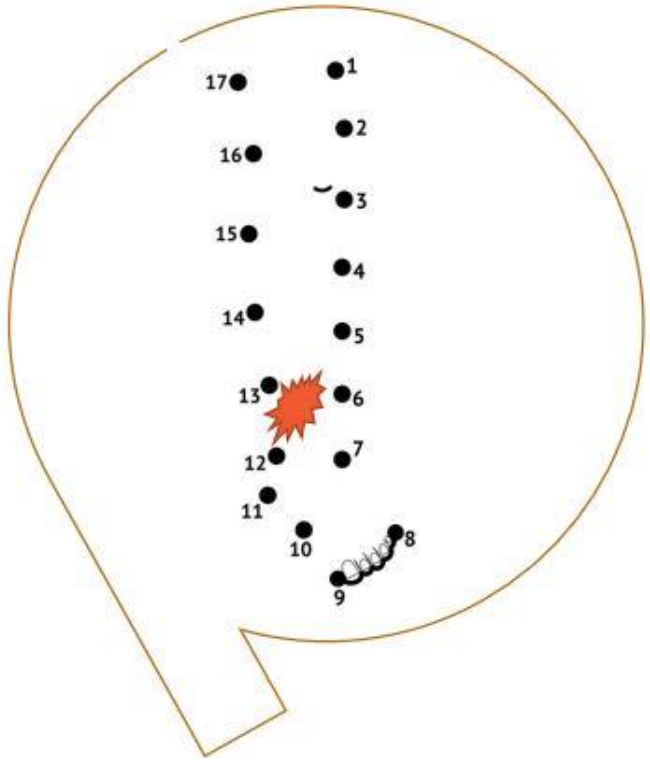
- Code from Past Medical History alone
- Code from Problem List alone
- Code “suspected” conditions
- Code from previous dates of service for today’s visit
- Code from lab values or other measurements
- Code from inferences

Think in ink

Connect the dots!

- Chief complaint REQUIRED
- The AMA understands the value of MDM in its E/M leveling, but it must be documented for risk, too.
- Historically, providers wrote their thoughts to draw conclusions in the medical record. Today, thought is largely undocumented due to EHRs and pull-down ICD menus.





Connect the dots

Soap Note

S: This is a 69-year-old male patient here today because of urinary frequency with burning and incontinence for the past few days. The patient reports that he as been drinking less water. He has protein in his urine. He is on **lisinopril**, **citalopram**, **gabapentin**, aspirin, and **synthroid**.

REVIEW OF SYSTEMS: The patient has no fever or chills, no abdominal pain, no nausea or vomiting.

0: Examination reveals that the patient is alert and in no acute distress. Blood pressure is **149/91**, pulse 64, respiratory rate of 16, weight is 180 pounds. Neck is supple. Heart is regular, with no murmur. Lungs are clear. No CVA tenderness noted. Urinalysis showed a specific gravity WNL, no nitrates and no leukocytes.

A: Urinary frequency and incontinence due to concentrated urine with albumin in urine.

P: Patient advised to drink more water, suspend daily baby aspirin. I refilled his prescriptions. The patient will return in 3 months.

Lost risk adjustment value for this patient: is at least $510 annually, possibly more

Connect the dots

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Coding

R35.0 Frequency of micturition	No risk
R30.9 Painful micturition, unspecified	No risk
R32 Unspecified urinary incontinence	No risk

Inferred, but can't code:

I10 Benign hypertension	RxHCC 187
F32.A Depression, NOS	RxHCC 134
E03.9 Hypothyroidism, NOS	RxHCC 42

We have no idea what diagnosis led to a prescription to gabapentin. PMH reveals post-herpetic trigeminal neuralgia. RxHCC 168

Connect the dots: Should we be thinking about vascular disease or kidney disease? Is HTN well controlled? Why was aspirin suspended?

Use the Problem List as a "to-do" list

But first, you may have to clean it up!

Patient had a kidney transplant 8 months ago. Why is dialysis status still in the problem list?

- Routinely move acute diagnoses from Problem List to Past Medical History when they are resolved.
- Use the same process to reconcile the Medication List.
  - Ensure each medication has an associated problem in the record (either in the assessment, PMH, or Problem List), and is linked to it
- How does the problem list dovetail with the presenting problem?

The Problem List

Today's chief compliant: Dizziness, syncope

Hyperlipidemia	Hypertension	Atrial fibrillation	Diabetes	LOPS
Exam				
• Order lipid panel • Refill prescription	• Measure blood pressure • Listen to carotids	• HR, EKG results, heart sounds examined	• Test blood sugar • Perform A1C	• Examine feet • Monofilament test
Discussion				
• Refill prescription • Discuss dietary restrictions	• Take history Adjust medications Discuss diet needs	• Frequency of Afib events? • Any symptoms at rest or when active?	• Symptoms, frequency of low sugars? • Discuss BG log, dietary needs, and glucose tablets	• Discuss home care, shoe choices and safety

Embrace the concept of "due to"

DUE TO: The clearest way to illustrate a clinical picture

CC: EPO resistant anemia	No HCC; No RxHCC
Due to CKD stage 4	HCC 137; RxHCC 263
Due to diabetes from underlying disease	HCC 18; RxHCC 30
Due to chronic pancreatitis	HCC 34; RxHCC 65
Due to alcoholism, in remission	HCC 55; No RxHCC

If only anemia is reported, the annual unreported risk totals $12,250

For best practices, follow "due to" until you run out of things to explain.

Speaking of "due to…"

…these codes capture organ damage caused by alcohol use, **but these codes do not capture the alcohol use**, which must be separately reported as use, abuse, dependence, or remission. Alcohol codes have risk adjustment the equivalent of complicated DM:

G31.2 *Degeneration of nervous system due to alcohol*
G62.1 *Alcoholic polyneuropathy*
G72.1 *Alcoholic myopathy*
K70.10 *Alcoholic hepatitis without ascites*
K70.11 *Alcoholic hepatitis with ascites*
K70.2 *Alcoholic fibrosis and sclerosis of liver*
K70.30 *Alcoholic cirrhosis without ascites*
K70.31 *Alcoholic cirrhosis with ascites*
K70.40 *Alcoholic hepatic failure without coma*
K70.41 *Alcoholic hepatic failure with coma*
K70.9 *Alcoholic liver disease, unspecified*

Report ETOH status as use with (identified) complication, abuse, or dependence.
Abuse and dependence is reported as in remission, as appropriate.

Banish “history of” from your narrative

The Guidelines tell auditors and coders NOT to code “history of” because “history of” represents a resolved condition.

- Even if the meaning is contextually clear (“patient with a history of prostate cancer is being seen today for cardiac clearance for a total prostatectomy”), it can raise questions in an audit.

- Lose this habit and use the time you save typing to add more qualitative language to your encounter notes.

- Use alternative language to identify that it is a pre-existing condition (AMI 5 years ago; ongoing hypothyroidism, etc.)

Use the DSP method

Diagnosis

Status

Plan

Make sure all three elements are included, using E/M Documentation Guidelines to document:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

Remember status and social determinants

Status pertinent to risk adjustment

- Transplant status
- Amputation status
- Ostomy status
- Dialysis status
- Resolved macular edema in a diabetic

Social determinants pertinent to Medicaid

- Financial status
- Housing
- Transportation
- Family support
- Educational status

Value of complete documentation

Payers get payment for the complex work of chronic disease management

You comply with CMS and safeguard medicolegal liabilities

You create records that serve your patients in your absence

You create records that serve your own bottom line

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Be compliant.

How to succeed in coding begins with knowing what's at stake. Let's look at some of the most common errors we encounter.

June 22, 2022

Comorbidities matter, and not just for $$$

E/M Documentation Guideline

“Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.”

ICD-10-CM Guideline

“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)”

NOS vs NEC in diagnosis coding

Be careful choosing codes that are "not elsewhere classified" or "unspecified."

Unspecified: You DO NOT KNOW the diagnosis, or you FORGOT TO SPECIFY or document the diagnosis. This is abbreviated in the Index as NOS (not otherwise specified)

I73.9 *Peripheral vascular disease, unspecified* Etiology? Site?

Not elsewhere classified: You know exactly what the diagnosis is, but there is not a code unique to the condition. This is NEC (not elsewhere classified) in the Index

I70.218 *Atherosclerosis of native arteries of extremities with intermittent claudication, other extremity* Upper extremity

Documentation+Index+Tabular=correct code

Codes are chosen based on words documented. In an audit, if your documentation is insufficient, the Index will choose the diagnosis regardless of your code selection.

- "Asymptomatic MI" indexes to a code for old MI (I25.2).
- "Aortic stenosis" is a valve defect; while "stenosis of aorta" is congenital vessel defect.
- "HIV" is indexed to HIV disease (AIDS), not HIV positive status.
- "Smoker" is indexed to nicotine dependence on nicotine. (F17.00).
- "Uncontrolled diabetes" is indexed to Type 2 diabetes without complication, unless hyper- or hypoglycemia is documented too.

Read the ICD-10 book, especially Guidelines

Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Find the ICD-10-CM Guidelines in your book, or at:

https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

Behavioral health

Major depressive disorder targeted for clinical validation!

1. New for 2022, **F32.A** *Depression, unspecified* should be reported unless the patient is being medicated and under psychiatrist/psychologist care or has a past history of psychiatric hospitalization.

2. Do not report a substance abuse disorder if you are writing prescriptions for the substance.

3. Because substance dependence alters the brain, remission reporting is almost always appropriate for patients who have experienced dependence. Occasionally, “history of” is appropriate. If monitoring liver function, cognitive function, or when asking about meeting attendance and coping mechanisms, a code from F10-F19 is appropriate.

4. New codes in ICD-10-CM identify intentional, non-suicidal self-harm (eg, cutting, burning of skin, etc) and should be reported as appropriate.

Commit to Accurate Coding

Receive full payment for the complex disease management done

ICD-10-CM codes are used to allocate funding for disease prevention, SDOH

Claims ensure your payers are fairly reimbursed

Inaccurate coding can live forever in most EHRs, affecting patient lives

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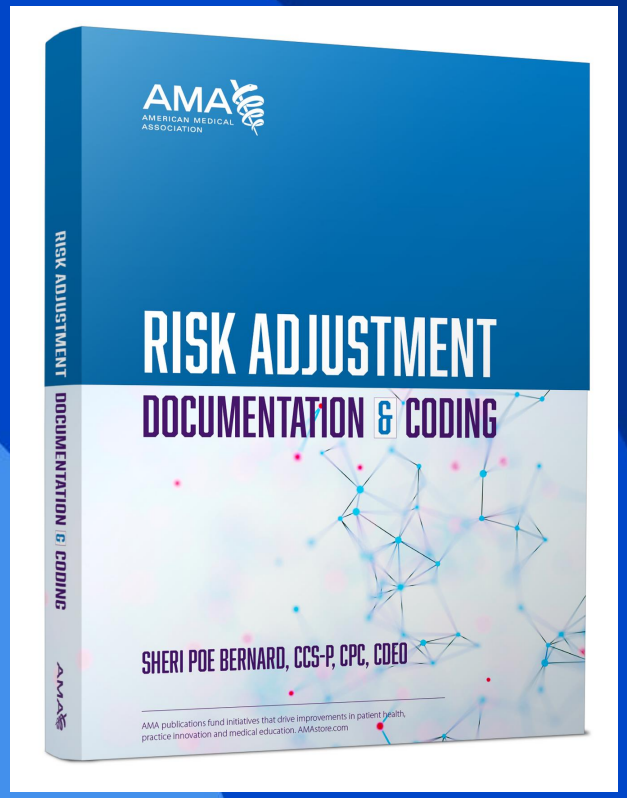

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Thank You!

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