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- Optum Approved Trainer
- AHIMA
  - AHIMA-Approved ICD-10-CM Trainer
- AAPC
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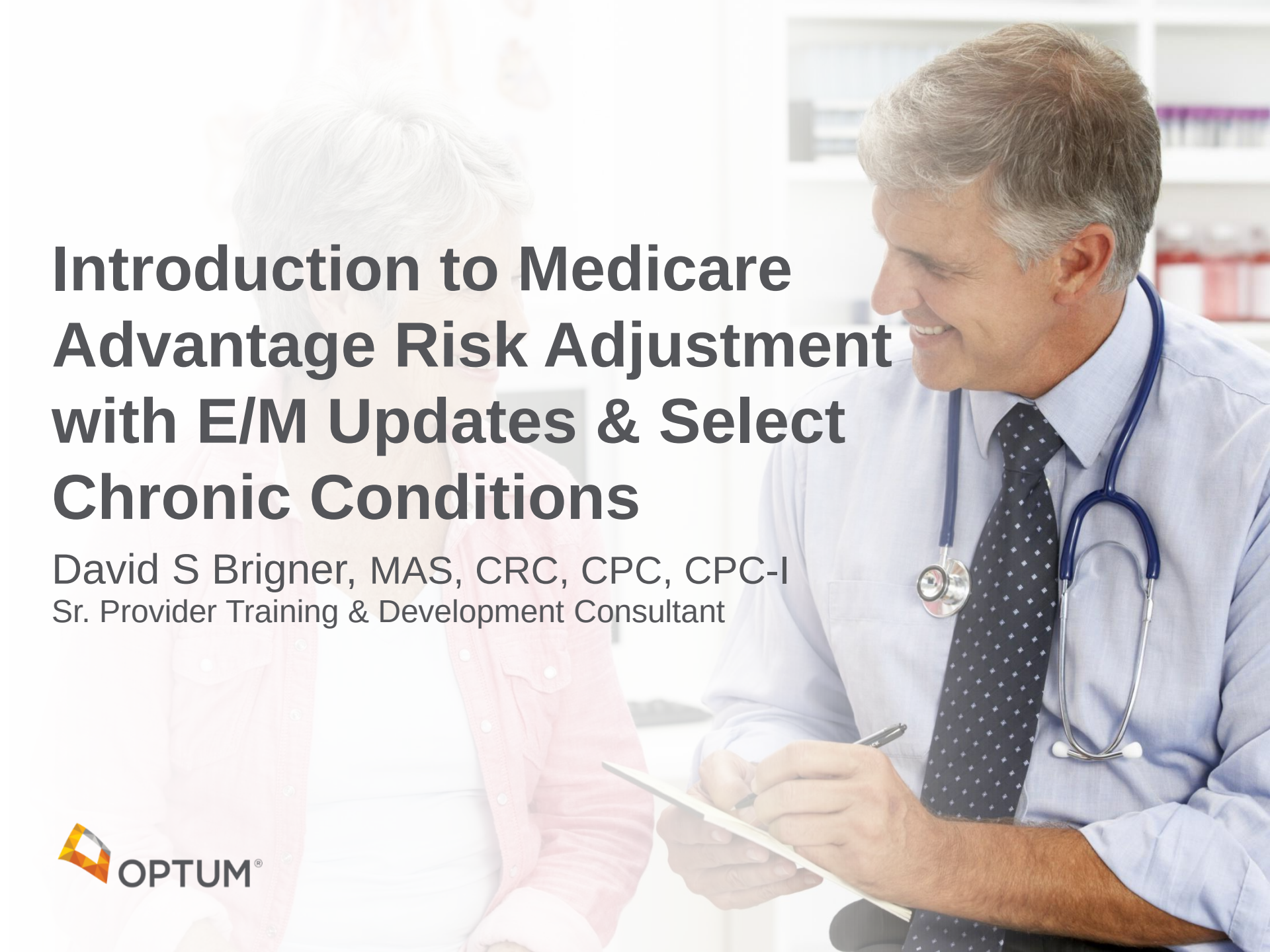
Introduction to Medicare Advantage Risk Adjustment with E/M Updates & Select Chronic Conditions

David S Brigner, MAS, CRC, CPC, CPC-I
Sr. Provider Training & Development Consultant



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David Brigner Professional Profile

- Senior Provider Training & Development Consultant relating to Risk Adjustment Documentation and Coding in coordination with Optum.
- Over 30 years of instructional acumen and design coupled with product implementation within both collegiate and private educational platforms for various institutions, health plans and medical management environments.
- Completed undergraduate studies at Baylor University and The University of Oklahoma, earning a Masters of Liberal Arts & Science Degree in Business Leadership, Management and Communication.

David S. Brigner, MAS, CRC, CPC, CPC-I
AAPC/AHIMA-Approved ICD-10-CM Trainer
Sr. Training & Development Consultant
Optum RQNS Network Program Manager

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Course Disclaimer

This course generally describes accepted coding practices and guidelines as defined in the ICD-10-CM code set. It is the responsibility of the physician or other healthcare provider to produce accurate and complete documentation and clinical rationale, which describe the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-10-CM code(s) according to the guidelines. If the documentation in the medical record does not support a given code, that code cannot be used.

Chart reviews and recommendations in this presentation are presented as examples only and are not intended to replace the professional judgment and expertise of the individual performing the coding. The ultimate decision regarding the specification of diagnosis resides with the clinical judgment of the physician and the reporting of the documented conditions must be in compliance with all applicable coding standards & guidelines.

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Bolding Legend

The bolding has been revised to reflect ICD-10-CM codes that map to the CMS-HCC risk adjustment model for Payment Year 2021.

Tools:

- Fully reportable codes that risk adjust are bolded in **Black**.
- Categories and subcategories where all the codes in the category or subcategory map to risk are bolded in **Black**.

Presentations:

- Fully reportable codes that risk adjust are bolded in **Black**.
- Categories and subcategories where all the codes in the category or subcategory map to risk are bolded in **Black**.
- Codes in images of the ICD-10-CM code book that risk adjust are boxed in Teal.
- Codes marked with a ✦ directly after them represent new additions to the FY 2021 ICD-10-CM code classification.

MA Payment Guide for Out of Network Payments. CMS.gov. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf. Published April 15, 2015. Accessed November 9, 2020.

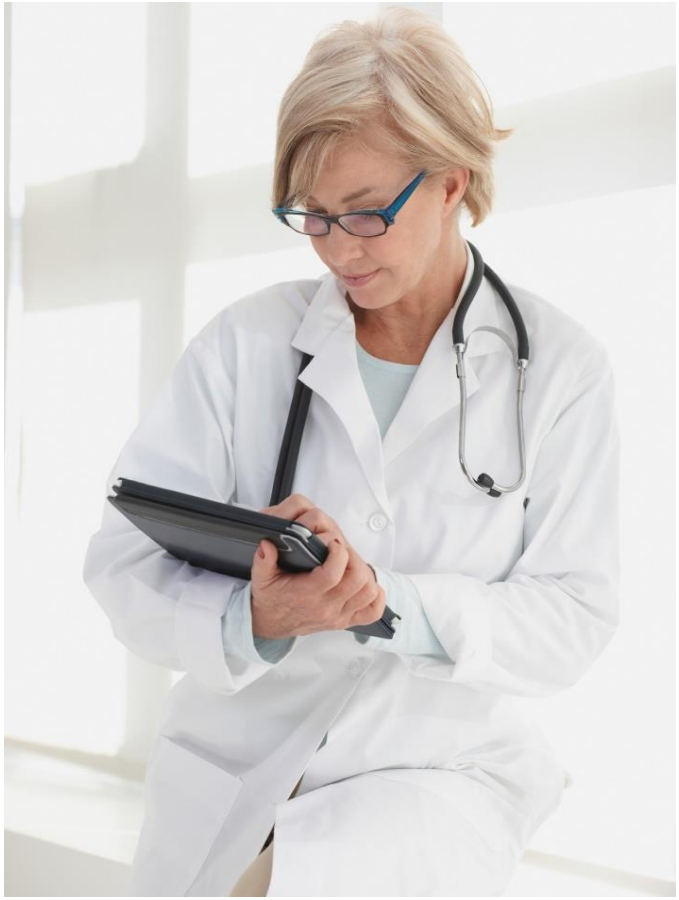
Medicare risk adjustment model diagnosis codes (2017 & 2021). CMS.gov. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors. Accessed November 9, 2020.

Announcement of Calendar Year (CY) 2021 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies. CMS.gov. https://www.cms.gov/files/document/2021-announcement.pdf. Published April 6, 2020. Accessed November 9, 2020.

Agenda

At the end of this session participants will have a better understanding of:

- Medicare Advantage risk adjustment model and process
- Evaluation and management (E/M) overview and how Medical Decision Making (MDM) correlates to condition diagnoses that may close risk adjustment gaps.
- Improving coding accuracy and completeness for chronic conditions
  - Vascular disease
  - Major depressive disorder
  - Chronic obstructive pulmonary disease
- Documentation considerations and chart mechanics



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Medicare Advantage

Part C Risk Adjustment

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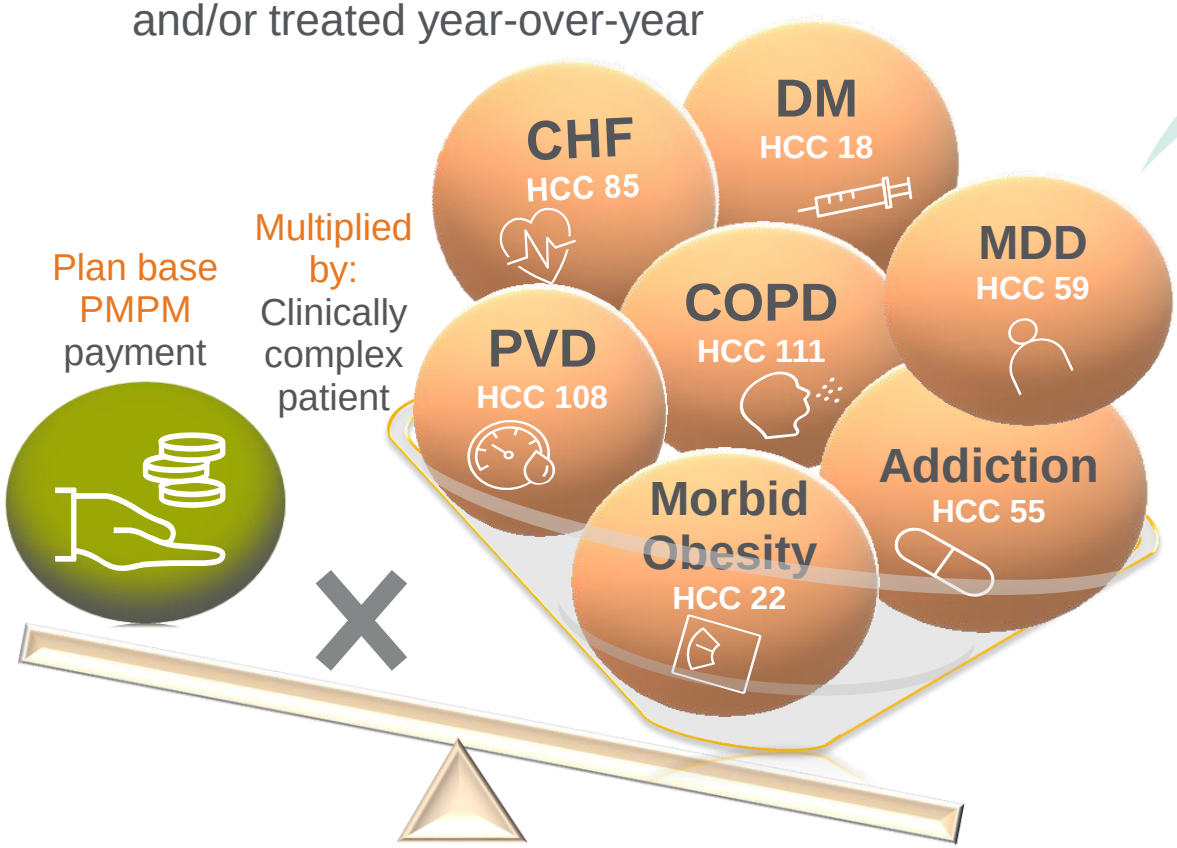
Medicare Advantage: Why Coding Matters

Funding for the Medicare Advantage plans (Medicare Part C)

- Determined based on specificity of high risk diagnoses
- Conditions must be monitored, re-evaluated or re-assessed and/or treated year-over-year



✓ Validation: Based on documented treatment of complex needs with appropriate DX codes

Equates to: more equitable funding to the MAO to support high risk medical resource utilization

Not: addressing complex needs with appropriate DX codes

Equates to: Reduced funding

Medicare Advantage Organizations (MAOs) are funded by CMS to provide services to Medicare beneficiaries based on severity of the member's illness.

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CMS-HCC Risk Adjustment Comparison

Example 1: *A* 76-year-old female (Community, Non-dual eligible) with the *following medical history of conditions:*

Health status	Risk weight
76-year-old (aged) Medicare nondual eligibility	0.450
Diabetes with vascular complications	0.306
Vascular disease (diabetic peripheral angiopathy)	0.291
Congestive heart failure (CHF)	0.329
Disease interaction (CHF + DM)	0.129
Total Risk Score	1.505

If the average Medicare FFS risk score is **1.0**, this patient is expected to be **66% more costly**.

Example 2: *A* 76-year-old *female* (Community, Non-dual eligible) *with no medical history of conditions:*

Health status	Risk weight
76-year-old (aged) Medicare nondual dual eligibility	0.450
Total Risk Score	0.450

If the average Medicare FFS risk score is **1.0**, this patient is expected to be **55% less costly**.

2021 Midyear Final Mappings. CMS.gov Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2021.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending. Published October 23, 2020.

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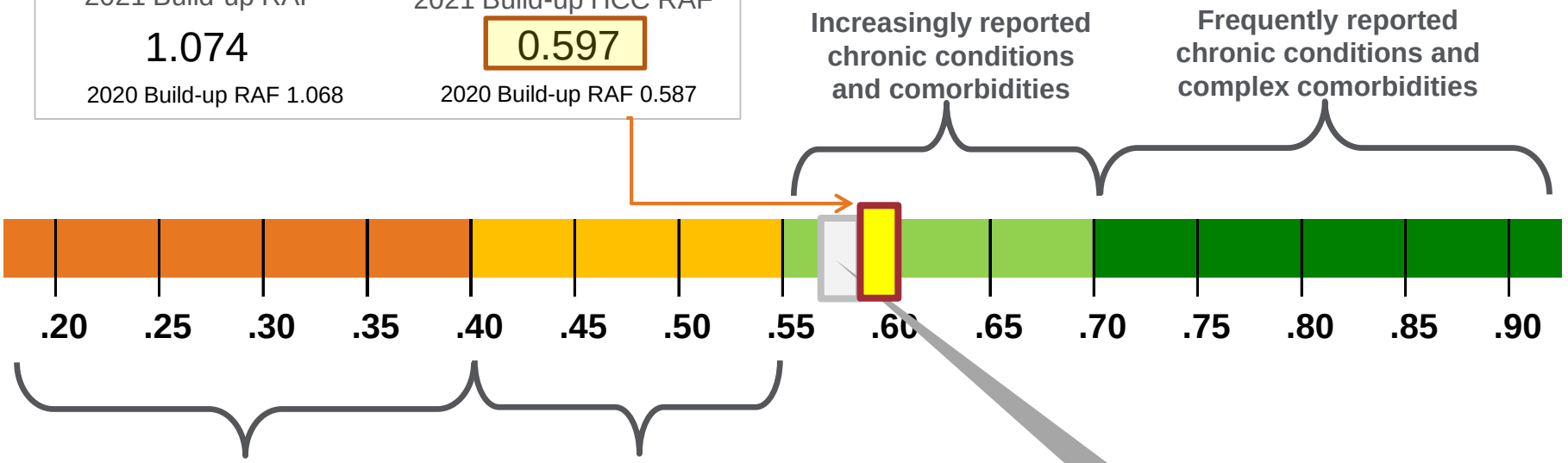
NEQCA MEDICAL GROUPS

2021 Build-up RAF

All contracted health plans combined data

Data Refreshed: 3/14/2021

2021 Build-up RAF	2021 Build-up HCC RAF
1.074	0.597
2020 Build-up RAF 1.068	2020 Build-up RAF 0.587



This is content is presented only for tracking performance against prior years to help ensure complete and accurate coding and identify opportunities for members to receive annual exams, and to provide opportunity to assess or address chronic conditions yearly.

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Polling Question #1

If a patient presents with an acute complaint, it is important to include all problem pertinent diagnoses in the assessment & plan because:

Which is correct?

A. additional risk weight can be added to the total RAF for the patient based on number of conditions the patient's conditions

B. additional CMS-HCC risk adjusted conditions can be captured.

C. Both A and B apply

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Evaluation and Management (E/M)

A Brief Overview

The E/M Process

First things to consider

Where did the service occur?

- *Place of service:* Office? Emergency department?

What type of service was it?

- Consultation? Admission? Office visit?

What is the patient status?

- New or Established? Outpatient or Inpatient?

Evaluation and Management Services. CMS-1715-F Federal Register/Vol. 84, No. 22. https://www.cms.gov/MedicarE/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F. Published November 15, 2019. Accessed November 9, 2020.

Ama-assn.org. 2020. Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. [online] Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed 19 October 2020.

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E/M Key Components

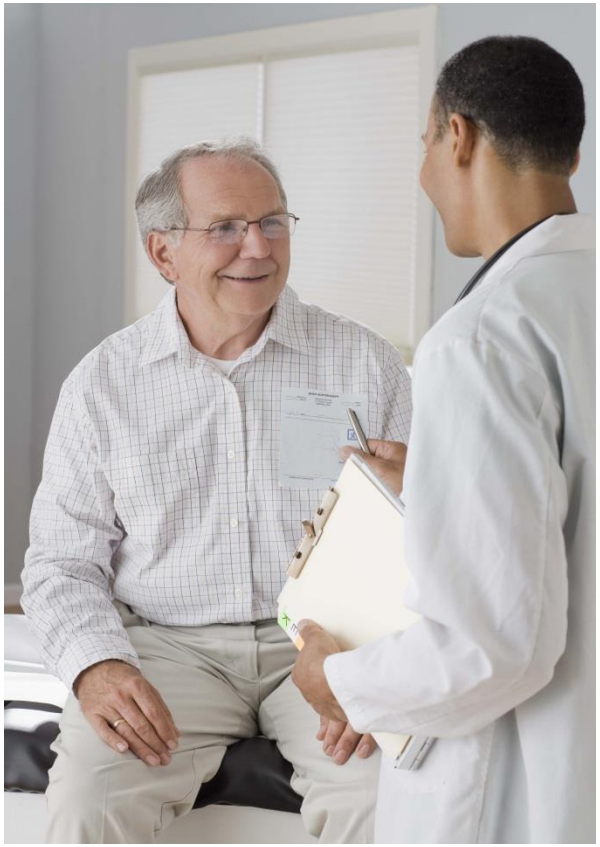
Every “face to face” Evaluation and Management encounter code has one required key component:

Medical Decision Making (MDM)

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

History and/or Exam - is not a required element in selection of E/M services.

- Office or other outpatient services include a medically appropriate history and/or physical examination, when performed.
- The nature and extent of the history and/or physical examination is determined by the provider reporting the service.



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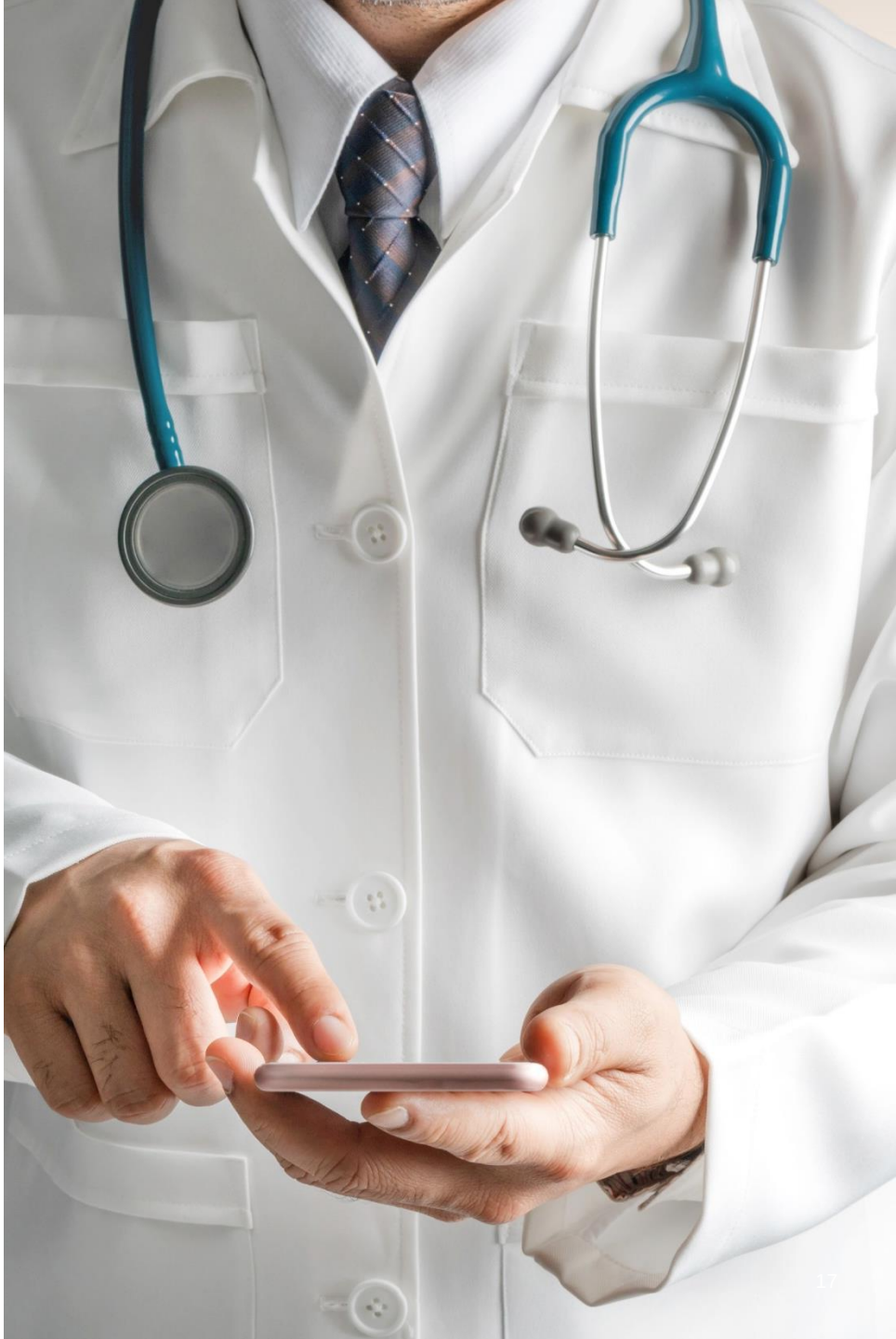
Evaluation and Management Documentation

Elements of Documentation that Validate an E/M Encounter



Evaluation and Management Service

With E/M
Start Counting!

The Evaluation and Management process is a calculation based on key elements documented in the chart.

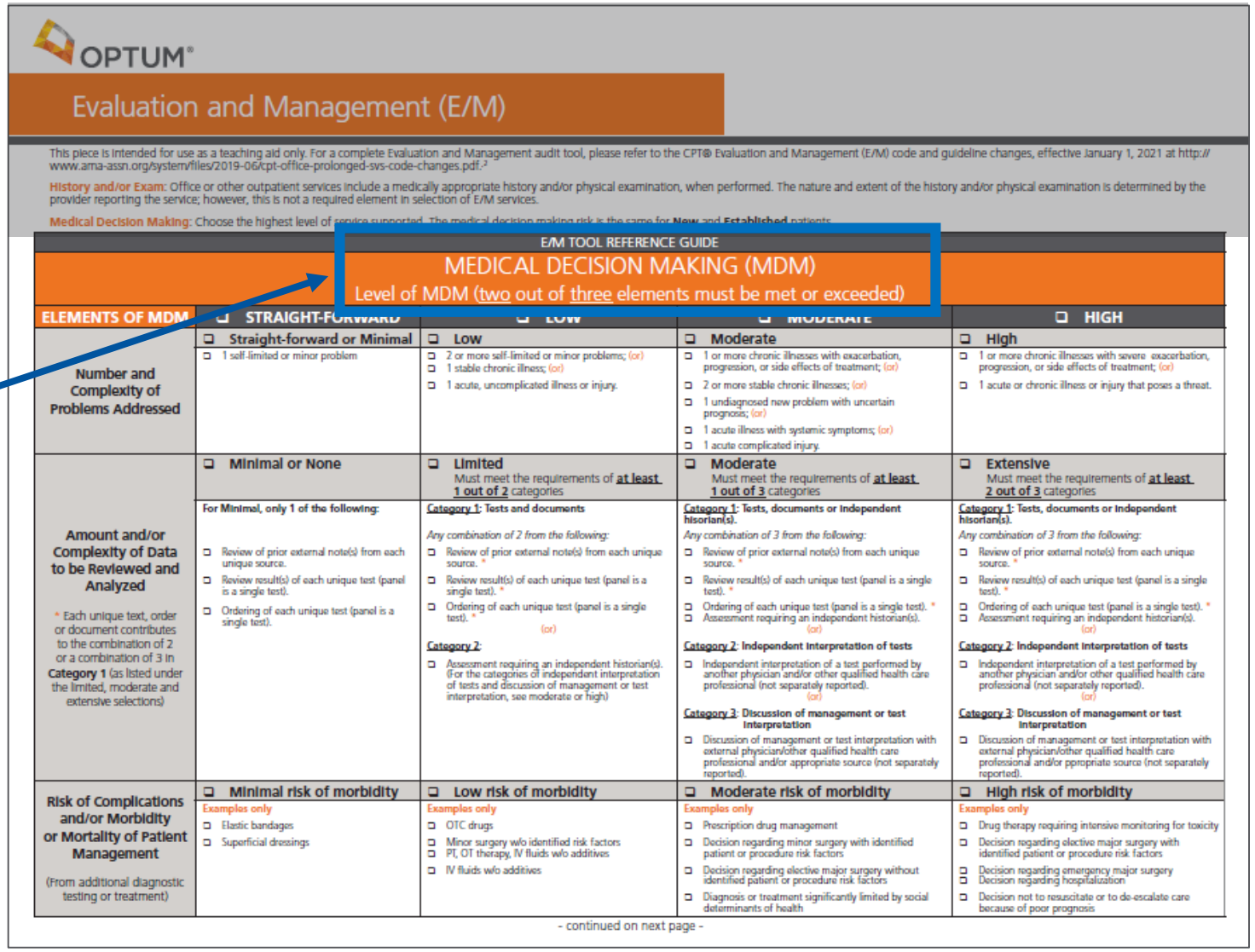
This will become more evident as we explore the components of the Medical Decision Making (MDM) service.

E/M Coding Tool

- Tool purpose
- History and/or Exam recommendation.
- MDM tool instruction

MDM reference guide

- To qualify for a given level of service two of the three key elements must be met or exceeded in documentation



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Evaluation and Management (E/M)

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Medical Decision Making: Choose the highest level of service supported. The medical decision making risk is the same for **New** and **Established** patients.

E/M TOOL REFERENCE GUIDE

MEDICAL DECISION MAKING (MDM)

Level of MDM (two out of three elements must be met or exceeded)

ELEMENTS OF MDM	❑ STRAIGHT-FORWARD	❑ LOW	❑ MODERATE	❑ HIGH
Number and Complexity of Problems Addressed	❑ Straight-forward or Minimal ❑ 1 self-limited or minor problem	❑ Low ❑ 2 or more self-limited or minor problems; (or) ❑ 1 stable chronic illness; (or) ❑ 1 acute, uncomplicated illness or injury.	❑ Moderate ❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or) ❑ 2 or more stable chronic illnesses; (or) ❑ 1 undiagnosed new problem with uncertain prognosis; (or) ❑ 1 acute illness with systemic symptoms; (or) ❑ 1 acute complicated injury.	❑ High ❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or) ❑ 1 acute or chronic illness or injury that poses a threat.
Amount and/or Complexity of Data to be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or a combination of 3 in **Category 1** (as listed under the limited, moderate and extensive selections)	❑ Minimal or None **For Minimal, only 1 of the following:** ❑ Review of prior external note(s) from each unique source. ❑ Review result(s) of each unique test (panel is a single test). ❑ Ordering of each unique test (panel is a single test).	❑ Limited Must meet the requirements of at least 1 out of 2 categories **Category 1: Tests and documents** *Any combination of 2 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * (or) **Category 2:** ❑ Assessment requiring an independent historian(s). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	❑ Moderate Must meet the requirements of at least 1 out of 3 categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or appropriate source (not separately reported).	❑ Extensive Must meet the requirements of at least 2 out of 3 categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or ppropriate source (not separately reported).
Risk of Complications and/or Morbidity or Mortality of Patient Management (From additional diagnostic testing or treatment)	❑ Minimal risk of morbidity Examples only ❑ Elastic bandages ❑ Superficial dressings	❑ Low risk of morbidity Examples only ❑ OTC drugs ❑ Minor surgery w/o identified risk factors ❑ PT, OT therapy, IV fluids w/o additives ❑ IV fluids w/o additives	❑ Moderate risk of morbidity Examples only ❑ Prescription drug management ❑ Decision regarding minor surgery with identified patient or procedure risk factors ❑ Decision regarding elective major surgery without identified patient or procedure risk factors ❑ Diagnosis or treatment significantly limited by social determinants of health	❑ High risk of morbidity Examples only ❑ Drug therapy requiring intensive monitoring for toxicity ❑ Decision regarding elective major surgery with identified patient or procedure risk factors ❑ Decision regarding emergency major surgery ❑ Decision regarding hospitalization ❑ Decision not to resuscitate or to de-escalate care because of poor prognosis

- continued on next page -

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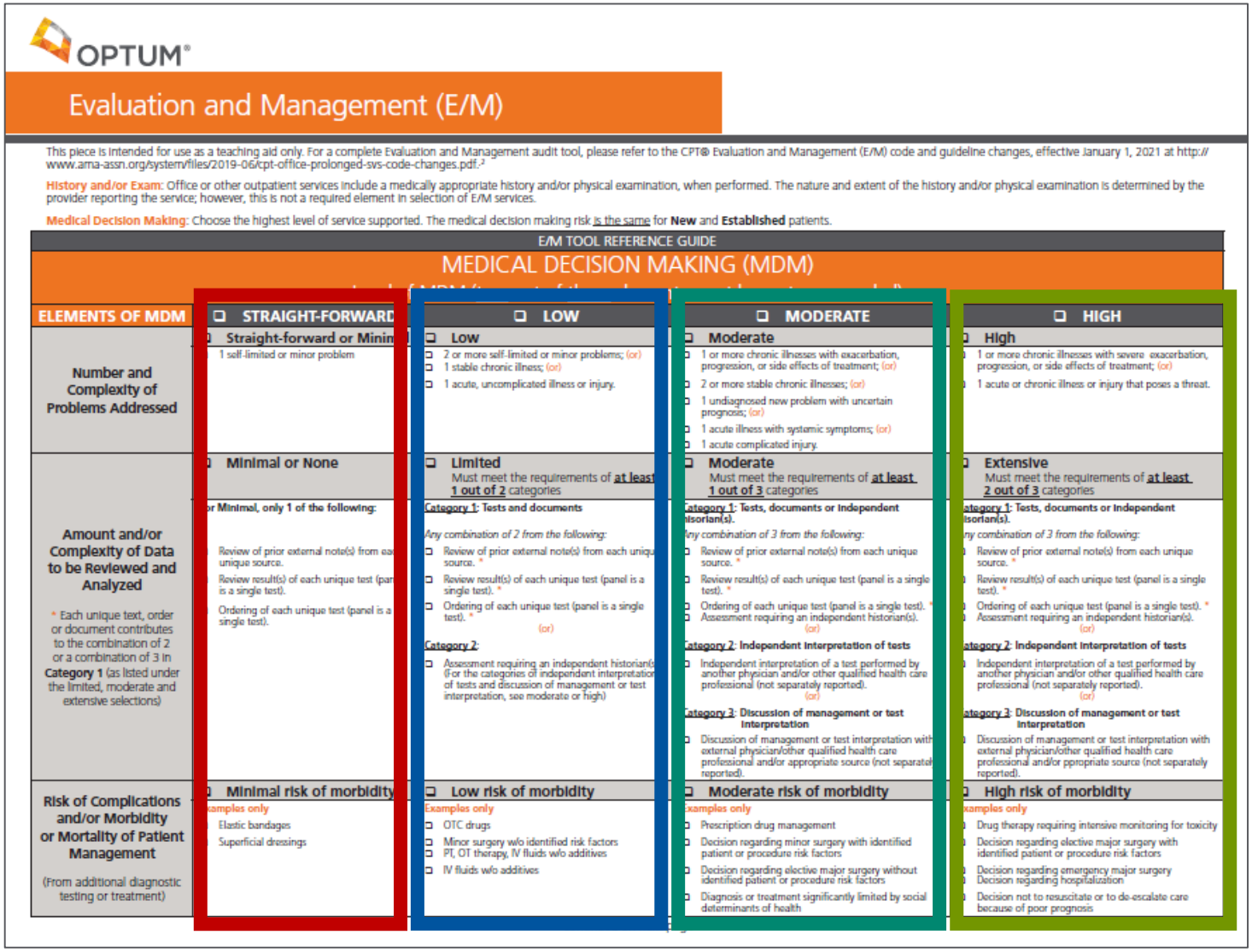
E/M Coding Tool

Level of MDM

- Straightforward
- Low
- Moderate
- High



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E/M Coding Tool

Elements of MDM

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E/M Coding Tool

E/M Tool Key

- Choose the highest level supported.
  - Outpatient provider visits New & Established
  - Prolonged services
  - Time

Use the following tables to select appropriate CPT codes based on the results obtained from the Medical Decision Making table.
Medical Decision Making: Appropriately document the services provided then select the service code that best matches that documentation. The medical decision making risk is the same for **New** and **Established** patients.

E/M OFFICE OR OTHER OUTPATIENT VISIT CODES

CPT	History and/or Exam	MDM	Time *(in minutes)*
NEW PATIENT			
99201	Deleted		Less than 15
99202	As medically appropriate	Straightforward	15-29
99203	As medically appropriate	Low level	30-44
99204	As medically appropriate	Moderate level	45-59
99205	As medically appropriate	High level	60-74
*99417	Prolonged services - for services 75 minutes or longer (in 15 minute increments)		75+
ESTABLISHED PATIENT			
99211	Minimal problems		Less than 10
99212	As medically appropriate	Straightforward	10-19
99213	As medically appropriate	Low level	20-29
99214	As medically appropriate	Moderate level	30-39
99215	As medically appropriate	High level	40-54
*99417	Prolonged services - for services 55 minutes or longer (in 15 minute increments)		55+

*CPT ® code 99417 (G2212 for Medicare Billing) – Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure, which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service. Code 99417 may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. A prolonged service unit of less than 15 minutes should not be reported.

Prolonged services - new patient		Prolonged services - established patient	
Total duration of new patient office or other outpatient services (use with 99205)	**Code(s)**	**Total duration of established patient office or other outpatient services (use with 99215)**	**Code(s)**
Less than 75 minutes	Not reported	Less than 55 minutes	Not reported
75-89 minutes	99205 x 1 and 99417 (Medicare G2212) x 1	55-69 minutes	99215 x 1 and 99417 (Medicare G2212) x 1
90-104 minutes	99205 x 1 and 99417 (Medicare G2212) x 2	70-84 minutes	99215 x 1 and 99417 (Medicare G2212) x 2
105 or more minutes	99205 x 1 and 99417 (Medicare G2212) x 3 (or	85 or more minutes	99215 x 1 and 99417 (Medicare G2212) x 3

Time is determined based on total time spent on the day of the encounter, which can include cumulative time from mulitple providers under the same tax ID number.

Activities that a provider can count toward total time include:

- Prepare for the patient visit (for example, review test results).
- Obtain and/or review separately-obtained patient history.
- Perform a medically necessary examination and/or evaluation.
- Counsel and educate the patient, a family member or a caregiver.
- Orders for tests, medicine or additional services
- Refer or communicate with other health care professionals.
- Enter clinical information in the patient's medical record *(not counted if entered another day)*.
- Interpret and share test results with the patient, a family member or a caregiver.
- Coordinate patient care (not reported separately).

Current Procedural Terminology CPT 2021. Professional ed. Chicago, IL: American Medical Association, 2020. Print. CPT is a registered trademark of the American Medical Association.
1. Ama-assn.org. 2020. CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed October 19, 2020.

CMS. Medicare Physician Fee Schedule (PFS) final rule. https://www.cms.gov/files/document/12120-pfs-final-rule.pdf. Published December 1, 2020. Accessed January 4, 2021.

E/M Coding Scenario

A 65 y/o female with HTN presents for follow-up. Current medications include atenolol 50 and HTCZ 25 mg daily. Complains of fatigue for the last few weeks, stating she is tired and sleepy by the end of the day with trouble staying awake while watching TV. Fatigue is 7 on a scale of 10 compared to normal. Seeing psych for mild depression per specialist note review.

ROS: No shortness of breath, GU, cardio, or other complaints.

Lab: Hgb 12.4; potassium 3.2

Working Sample Progress Note

Assessment
- Hypertension (I10) controlled on current meds
- Hypokalemia (E87.6) stable, due to diuretic
- Fatigue (R53.83) secondary to atenolol
- COPD (**J44.9**) secondary to atenolol
- MDD mild, (**F32.0**) stable on meds, seeing psych.
- Adverse effect of Atenolol (T44.7X5A)
- Adverse effect of hydrochlorothiazide (T50.2X5A)

Plan
- Continue atenolol and HCTZ as before
- Start potassium chloride tabs 8 mg TID with meals
- Explained cause of fatigue is a common side effect of meds, which should improve with intake of potassium
- RTC and check potassium in 2 weeks

OPTUM®

MDM:

Number and Complexity of Problems Addressed

❑ Straightforward or Minimal	❑ Low	❑ Moderate	❑ High
❑ 1 self-limited or minor problem.	❑ 2 or more self-limited or minor problems; (or) ❑ 1 stable chronic illness; (or) ❑ 1 acute, uncomplicated illness or injury.	❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or) ❑ 2 or more stable chronic illnesses; (or) ❑ 1 undiagnosed new problem with uncertain prognosis; (or) ❑ 1 acute illness with systemic symptoms; (or) ❑ 1 acute complicated injury.	❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or) ❑ 1 acute or chronic illness or injury that poses a threat.

Moderate bullet point key definitions:

- *Chronic illness with exacerbation, progression, or side effects of treatment*: A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.
- *Undiagnosed new problem with uncertain prognosis:* A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.
- *Acute illness with systemic symptoms:* An illness that causes systemic symptoms and has a high risk of morbidity without treatment. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.
- *Acute, complicated injury:* An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

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MDM:
Tool Reference Guide

Identify key complexities and/or problems addressed

A 65 y/o female with HTN presents for follow-up. Current medications include atenolol 50 and HTCZ 25 mg daily. Complains of fatigue for the last few weeks, stating she is tired and sleepy by the end of the day with trouble staying awake while watching TV. Fatigue is 7 on a scale of 10 compared to normal. Seeing psych for mild depression per specialist note review.

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Plan
- Continue atenolol and HCTZ as before
- Start potassium chloride tabs 8 mg TID with meals
- Explained cause of fatigue is a common side effect of meds, which should improve with intake of potassium
- RTC and check potassium in 2 weeks

MDM elements are the same for New and Established patients

Two or more stable chronic conditions = 3

One or more chronic conditions with side effects of treatment = 1

Level of complexity is **Moderate**

☐ Low	X ☐ Moderate	☐ High
☐ 2 or more self-limited or minor problems; (or)	☐ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or)	☐ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or)
☐ 1 stable chronic illness; (or)	☐ 2 or more stable chronic illnesses; (or)	☐ 1 acute or chronic illness or injury that poses a threat.
☐ 1 acute, uncomplicated illness or injury.	☐ 1 undiagnosed new problem with uncertain prognosis; (or)	
	☐ 1 acute illness with systemic symptoms; (or)	
	☐ 1 acute complicated injury.	

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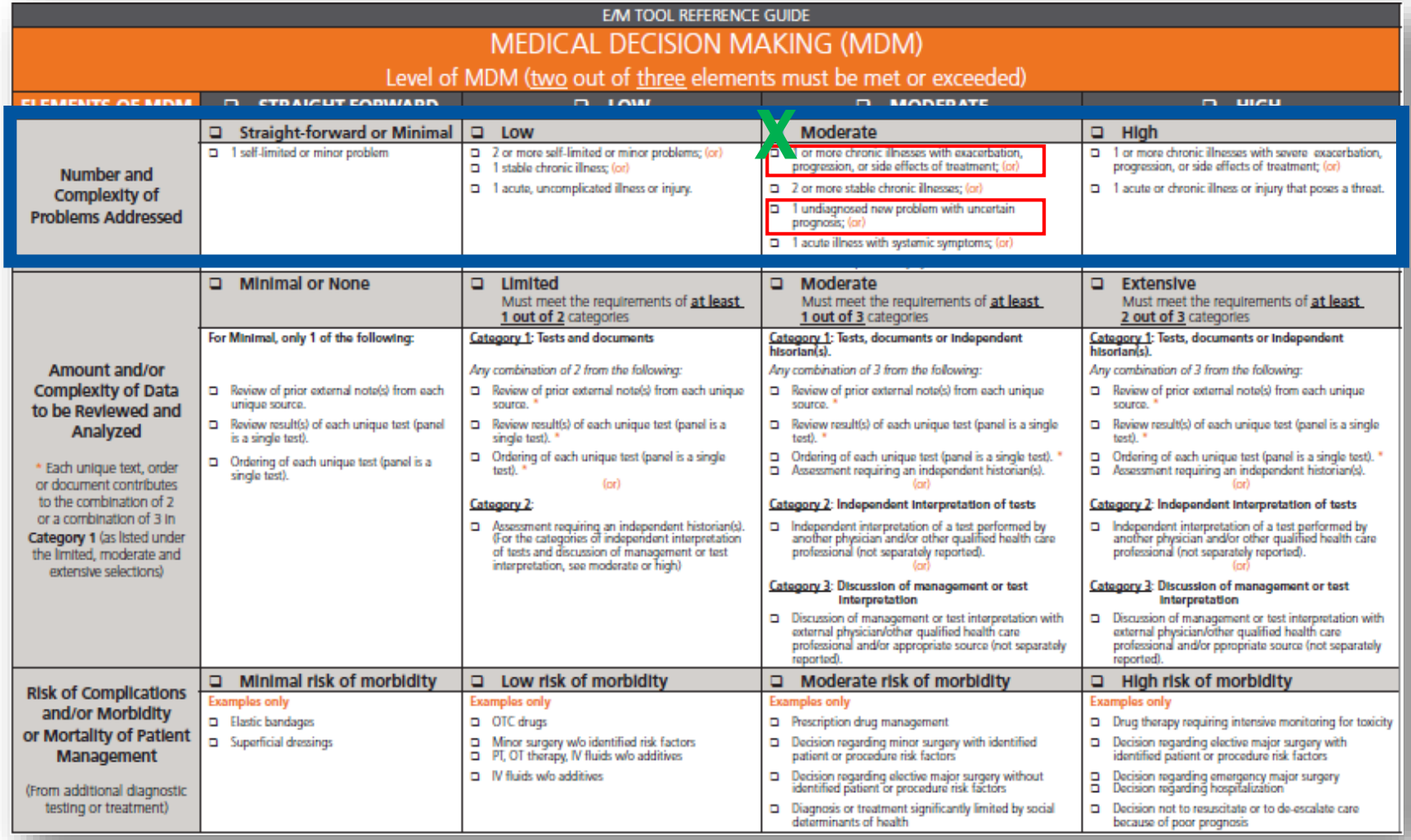

E/M TOOL REFERENCE GUIDE

MEDICAL DECISION MAKING (MDM)

Level of MDM (two out of three elements must be met or exceeded)

ELEMENTS OF MDM	☐ STRAIGHT FORWARD	☐ LOW	☐ MODERATE	☐ HIGH
Number and Complexity of Problems Addressed	☐ **Straight-forward or Minimal** ☐ 1 self-limited or minor problem	☐ **Low** ☐ 2 or more self-limited or minor problems; (or) ☐ 1 stable chronic illness; (or) ☐ 1 acute, uncomplicated illness or injury.	X ☐ **Moderate** ☐ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or) ☐ 2 or more stable chronic illnesses; (or) ☐ 1 undiagnosed new problem with uncertain prognosis; (or) ☐ 1 acute illness with systemic symptoms; (or)	☐ **High** ☐ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or) ☐ 1 acute or chronic illness or injury that poses a threat.
Amount and/or Complexity of Data to be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or a combination of 3 in **Category 1** (as listed under the limited, moderate and extensive selections)	☐ **Minimal or None** **For Minimal, only 1 of the following:** ☐ Review of prior external note(s) from each unique source. ☐ Review result(s) of each unique test (panel is a single test). ☐ Ordering of each unique test (panel is a single test).	☐ **Limited** Must meet the requirements of **at least 1 out of 2** categories **Category 1: Tests and documents** *Any combination of 2 from the following:* ☐ Review of prior external note(s) from each unique source. * ☐ Review result(s) of each unique test (panel is a single test). * ☐ Ordering of each unique test (panel is a single test). * (or) **Category 2:** ☐ Assessment requiring an independent historian(s). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	☐ **Moderate** Must meet the requirements of **at least 1 out of 3** categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ☐ Review of prior external note(s) from each unique source. * ☐ Review result(s) of each unique test (panel is a single test). * ☐ Ordering of each unique test (panel is a single test). * ☐ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ☐ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ☐ Discussion of management or test interpretation with external physician/other qualified health care professional and/or appropriate source (not separately reported).	☐ **Extensive** Must meet the requirements of **at least 2 out of 3** categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ☐ Review of prior external note(s) from each unique source. * ☐ Review result(s) of each unique test (panel is a single test). * ☐ Ordering of each unique test (panel is a single test). * ☐ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ☐ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ☐ Discussion of management or test interpretation with external physician/other qualified health care professional and/or ppropriate source (not separately reported).
Risk of Complications and/or Morbidity or Mortality of Patient Management (From additional diagnostic testing or treatment)	☐ **Minimal risk of morbidity** Examples only ☐ Elastic bandages ☐ Superficial dressings	☐ **Low risk of morbidity** Examples only ☐ OTC drugs ☐ Minor surgery w/o identified risk factors ☐ PT, OT therapy, IV fluids w/o additives ☐ IV fluids w/o additives	☐ **Moderate risk of morbidity** Examples only ☐ Prescription drug management ☐ Decision regarding minor surgery with identified patient or procedure risk factors ☐ Decision regarding elective major surgery without identified patient or procedure risk factors ☐ Diagnosis or treatment significantly limited by social determinants of health	☐ **High risk of morbidity** Examples only ☐ Drug therapy requiring intensive monitoring for toxicity ☐ Decision regarding elective major surgery with identified patient or procedure risk factors ☐ Decision regarding emergency major surgery ☐ Decision regarding hospitalization ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis

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MDM:

Amount and/or Complexity of Data to be Reviewed & Analyzed

❑ **Minimal or None**	❑ **Limited** *(Must meet the requirements of at least **1** of the **2** categories)*	❑ **Moderate** (*Must meet the requirements of at least **1** out of **3** categories)*	❑ **Extensive** *(Must meet the requirements of at least **2** out of **3** categories)*
(For minimal, only 1 from the following) ❑ Review of prior external note(s) from each unique source. ❑ Review of the result(s) of each unique test *(panel is a single test)*. ❑ Ordering of each unique test *(panel is a single test)*.	**Category 1:** Tests and documents. *(Any combination of 2 from the following)* ❑ Review of prior external note(s) from each unique source.* ❑ Review of the result(s) of each unique test *(panel is a single test)*.* ❑ Ordering of each unique test *(panel is a single test)*.* (or) **Category 2** ❑ Assessment requiring an independent historian(s). *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high).*	**Category 1:** Tests, documents, or independent historian(s). *(Any combination of 3 from the following)* ❑ Review of prior external note(s) from each unique source.* ❑ Review of the result(s) of each unique test *(panel is a single test)*.* ❑ Ordering of each unique test *(panel is a single test)*.* ❑ Assessment requiring an independent historian(s). (or) **Category 2:** Independent interpretation of tests. ❑ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported). (or) **Category 3:** Discussion of management or test interpretation. ❑ Discussion of management or test interpretation with external physician/other qualified health care professional or appropriate source (not separately reported).	**Category 1:** *Tests, documents, or independent historian(s).* *(Any combination of 3 from the following)* ❑ Review of prior external note(s) from each unique source.* ❑ Review of the result(s) of each unique test *(panel is a single test)*.* ❑ Ordering of each unique test *(panel is a single test)*.* ❑ Assessment requiring an independent historian(s). (or) **Category 2:** Independent interpretation of tests. ❑ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported). (or) **Category 3:** Discussion of management or test interpretation. ❑ Discussion of management or test interpretation with external physician/other qualified health care professional or appropriate source (not separately reported).

* Each unique test, order, or document contributes to the combination of 2 or a combination of 3 in Category 1.

MDM:
Tool Reference Guide

Identify amount and/or complexity of data to be reviewed & analyzed

A 65 y/o female with HTN presents for follow-up. Current medications include atenolol 50 and HTCZ 25 mg daily. Complains of fatigue for the last few weeks, stating she is tired and sleepy by the end of the day with trouble staying awake while watching TV. Fatigue is 7 on a scale of 10 compared to normal. Seeing psych for mild depression per specialist note review.

ROS: No shortness of breath, GU, cardio, or other complaints.

Lab: Hgb 12.4; potassium 3.2

Assessment
- Hypertension (I10) controlled on current meds
- Hypokalemia (E87.6) stable, due to diuretic
- Fatigue (R53.83) secondary to atenolol
- COPD (**J44.9**) s
- MDD mild, (**F32.**
- Adverse effect o
- Adverse effect o

Plan
- Continue atenol
- Start potassium
- Explained cause meds, which sh
- RTC and check

Review of prior external note(s) from each unique source = 1

Ordering of each unique test = 1

Level of complexity is **Limited**

☒ **Limited** *(Must meet the requirements of at least 1 of the 2 categories)*	☐ **Moderate** *(Must meet the requirements of at least 1 out of 3 categories)*	☐ **Extensive** *(Must meet the requirements of at least 2 out of 3 categories)*
Category 1: Tests and documents. *(Any combination of 2 from the following)*	**Category 1:** Tests, documents, or independent historian(s). *(Any combination of 3 from the following)*	**Category 1:** *Tests, documents, or independent historian(s). (Any combination of 3 from the following)*
☑ Review of prior external note(s) from each unique source.*	☐ Review of prior external note(s) from each unique source.*	☐ Review of prior external note(s) from each unique source.*
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☑ Ordering of each unique test *(panel is a single test).**	☐ Ordering of each unique test *(panel is a single test).**	☐ Ordering of each unique test *(panel is a single test).**
	☐ Assessment requiring an independent historian(s).	☐ Assessment requiring an independent historian(s).

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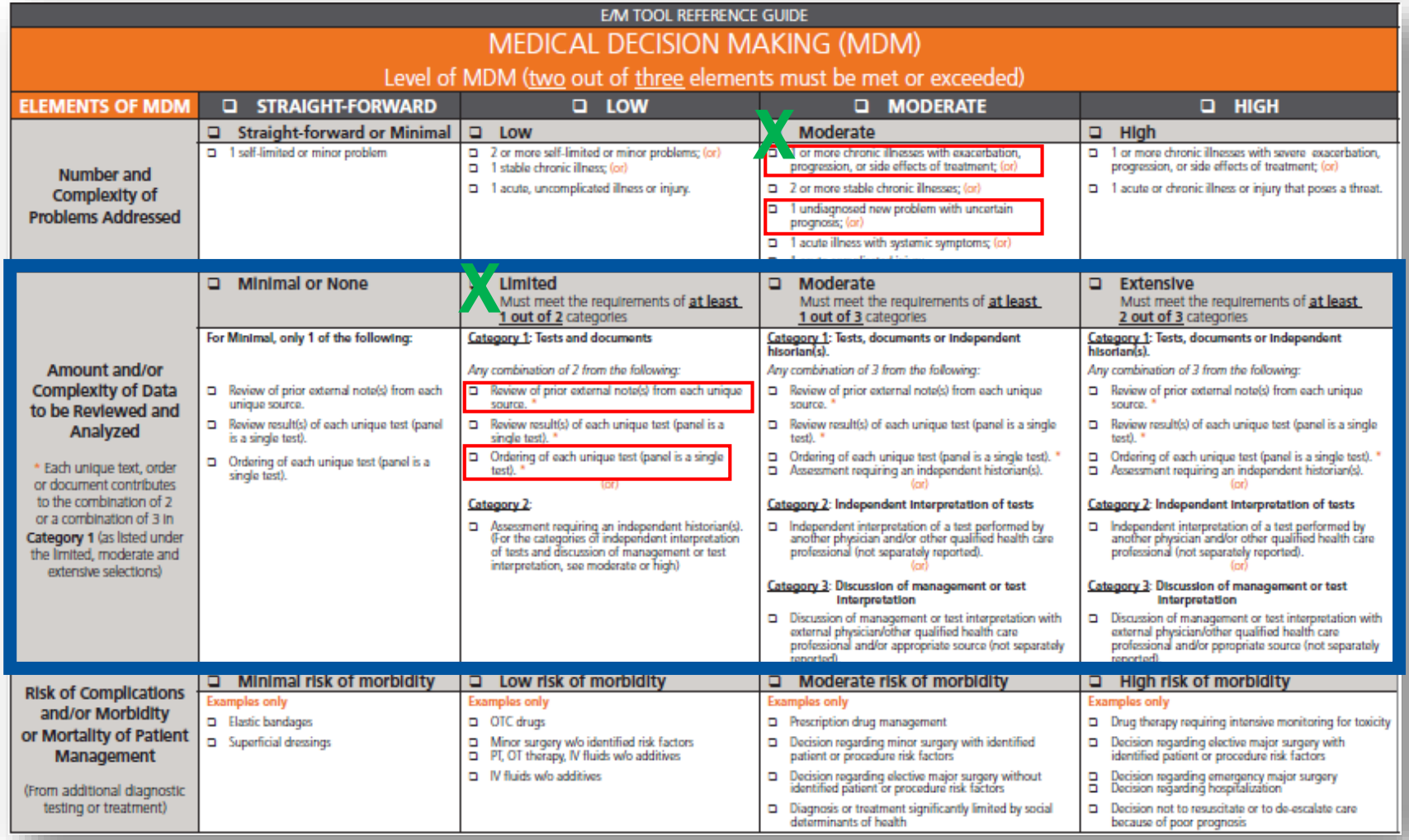
MDM:
Tool Reference Guide



E/M TOOL REFERENCE GUIDE

MEDICAL DECISION MAKING (MDM)

Level of MDM (two out of three elements must be met or exceeded)

ELEMENTS OF MDM	❑ STRAIGHT-FORWARD	❑ LOW	❑ MODERATE	❑ HIGH
Number and Complexity of Problems Addressed	❑ Straight-forward or Minimal ❑ 1 self-limited or minor problem	❑ Low ❑ 2 or more self-limited or minor problems; (or) ❑ 1 stable chronic illness; (or) ❑ 1 acute, uncomplicated illness or injury.	X ❑ Moderate ❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; (or) ❑ 2 or more stable chronic illnesses; (or) ❑ 1 undiagnosed new problem with uncertain prognosis; (or) ❑ 1 acute illness with systemic symptoms; (or)	❑ High ❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; (or) ❑ 1 acute or chronic illness or injury that poses a threat.
Amount and/or Complexity of Data to be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or a combination of 3 in **Category 1** (as listed under the limited, moderate and extensive selections)	❑ Minimal or None **For Minimal, only 1 of the following:** ❑ Review of prior external note(s) from each unique source. ❑ Review result(s) of each unique test (panel is a single test). ❑ Ordering of each unique test (panel is a single test).	X ❑ Limited Must meet the requirements of **at least 1 out of 2** categories **Category 1: Tests and documents** *Any combination of 2 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * (or) **Category 2:** ❑ Assessment requiring an independent historian(s). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	❑ Moderate Must meet the requirements of **at least 1 out of 3** categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or appropriate source (not separately reported)	❑ Extensive Must meet the requirements of **at least 2 out of 3** categories **Category 1: Tests, documents or Independent historian(s).** *Any combination of 3 from the following:* ❑ Review of prior external note(s) from each unique source. * ❑ Review result(s) of each unique test (panel is a single test). * ❑ Ordering of each unique test (panel is a single test). * ❑ Assessment requiring an independent historian(s). (or) **Category 2: Independent interpretation of tests** ❑ Independent interpretation of a test performed by another physician and/or other qualified health care professional (not separately reported). (or) **Category 3: Discussion of management or test interpretation** ❑ Discussion of management or test interpretation with external physician/other qualified health care professional and/or ppropriate source (not separately reported)
Risk of Complications and/or Morbidity or Mortality of Patient Management (From additional diagnostic testing or treatment)	❑ Minimal risk of morbidity Examples only ❑ Elastic bandages ❑ Superficial dressings	❑ Low risk of morbidity Examples only ❑ OTC drugs ❑ Minor surgery w/o identified risk factors ❑ PT, OT therapy, IV fluids w/o additives ❑ IV fluids w/o additives	❑ Moderate risk of morbidity Examples only ❑ Prescription drug management ❑ Decision regarding minor surgery with identified patient or procedure risk factors ❑ Decision regarding elective major surgery without identified patient or procedure risk factors ❑ Diagnosis or treatment significantly limited by social determinants of health	❑ High risk of morbidity Examples only ❑ Drug therapy requiring intensive monitoring for toxicity ❑ Decision regarding elective major surgery with identified patient or procedure risk factors ❑ Decision regarding emergency major surgery ❑ Decision regarding hospitalization ❑ Decision not to resuscitate or to de-escalate care because of poor prognosis

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MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

From additional diagnostic testing or treatment

❑ Minimal risk of morbidity	❑ Low risk of morbidity	❑ Moderate risk of morbidity	❑ High risk of morbidity
Examples only: ❑ Elastic bandages ❑ Superficial dressings	Examples only: ❑ OTC drugs ❑ Minor surgery without identified risk factors ❑ PT, OT therapy ❑ IV fluids w/o additives	Examples only: ❑ Prescription drug management. ❑ Decision regarding minor surgery with identified patient or procedure risk factors. ❑ Decision regarding elective major surgery without identified patient or procedure risk factors. ❑ Diagnosis or treatment significantly limited by social determinants of health.	Examples only: ❑ Drug therapy requiring intensive monitoring for toxicity. ❑ Decision regarding elective major surgery with identified patient or procedure risk factors. ❑ Decision regarding emergency major surgery. ❑ Decision regarding hospitalization. ❑ Decision not to resuscitate or to de-escalate care because of poor prognosis.

- *Social determinants of health*: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
- *Drug therapy requiring intensive monitoring for toxicity*: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy.

OPTUM®

MDM:
Tool Reference Guide

Identify risk of complications and/or morbidity or mortality of patient mgmt.

A 65 y/o female with HTN presents for follow-up. Current medications include atenolol 50 and HTCZ 25 mg daily. Complains of fatigue for the last few weeks, stating she is tired and sleepy by the end of the day with trouble staying awake while watching TV. Fatigue is 7 on a scale of 10 compared to normal. Seeing psych for mild depression per specialist note review.

ROS: No shortness of breath, GU, cardio, or other complaints.

Lab: Hgb 12.4; potassium 3.2

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- Hypertension (I10) controlled on current meds
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- Adverse effect of Atenolol (T44.7X5A)
- Adverse effect of hydrochlorothiazide (T50.2X5A)

Plan
- Continue atenolol and HCTZ as before
- Start potassium chloride tabs 8 mg TID with meals
- Explained cause of fatigue is a common side effect o meds, which should improve with intake of potassium
- RTC and check potassium in 2 weeks

Prescription drug management = 1

Level of complexity is **Moderate**

☐ Low risk of morbidity	X Moderate risk of morbidity	☐ High risk of morbidity
Examples only: ☐ OTC drugs ☐ Minor surgery without identified risk factors ☐ PT, OT therapy, IV fluids w/o additives ☐ IV fluids w/o additives	Examples only: ☑ Prescription drug management. ☐ Decision regarding minor surgery with identified patient or procedure risk factors. ☐ Decision regarding elective major surgery without identified patient or procedure risk factors. ☐ Diagnosis or treatment significantly limited by social determinants of health.	Examples only: ☐ Drug therapy requiring intensive monitoring for toxicity. ☐ Decision regarding elective major surgery with identified patient or procedure risk factors. ☐ Decision regarding emergency major surgery. ☐ Decision regarding hospitalization. ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis.

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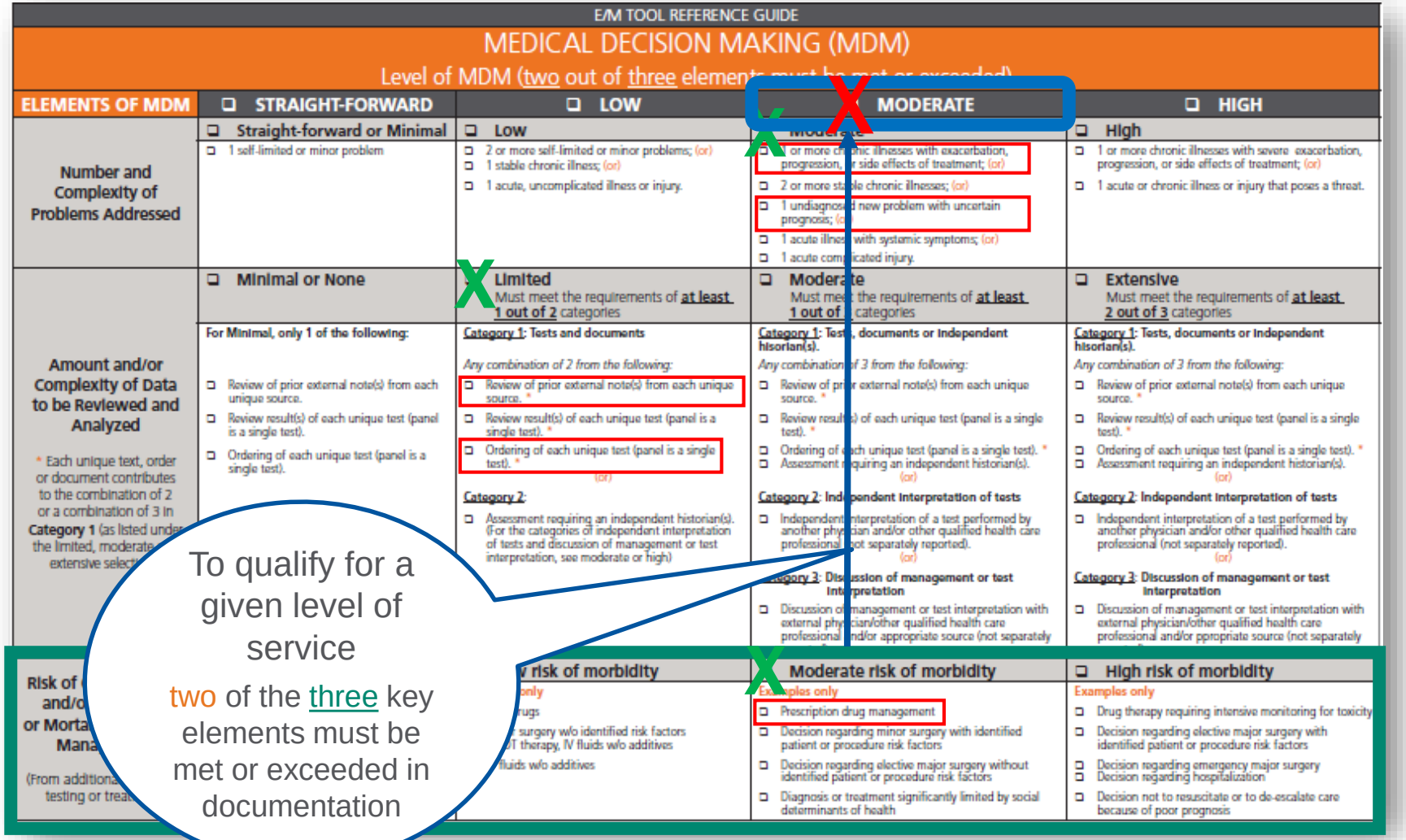
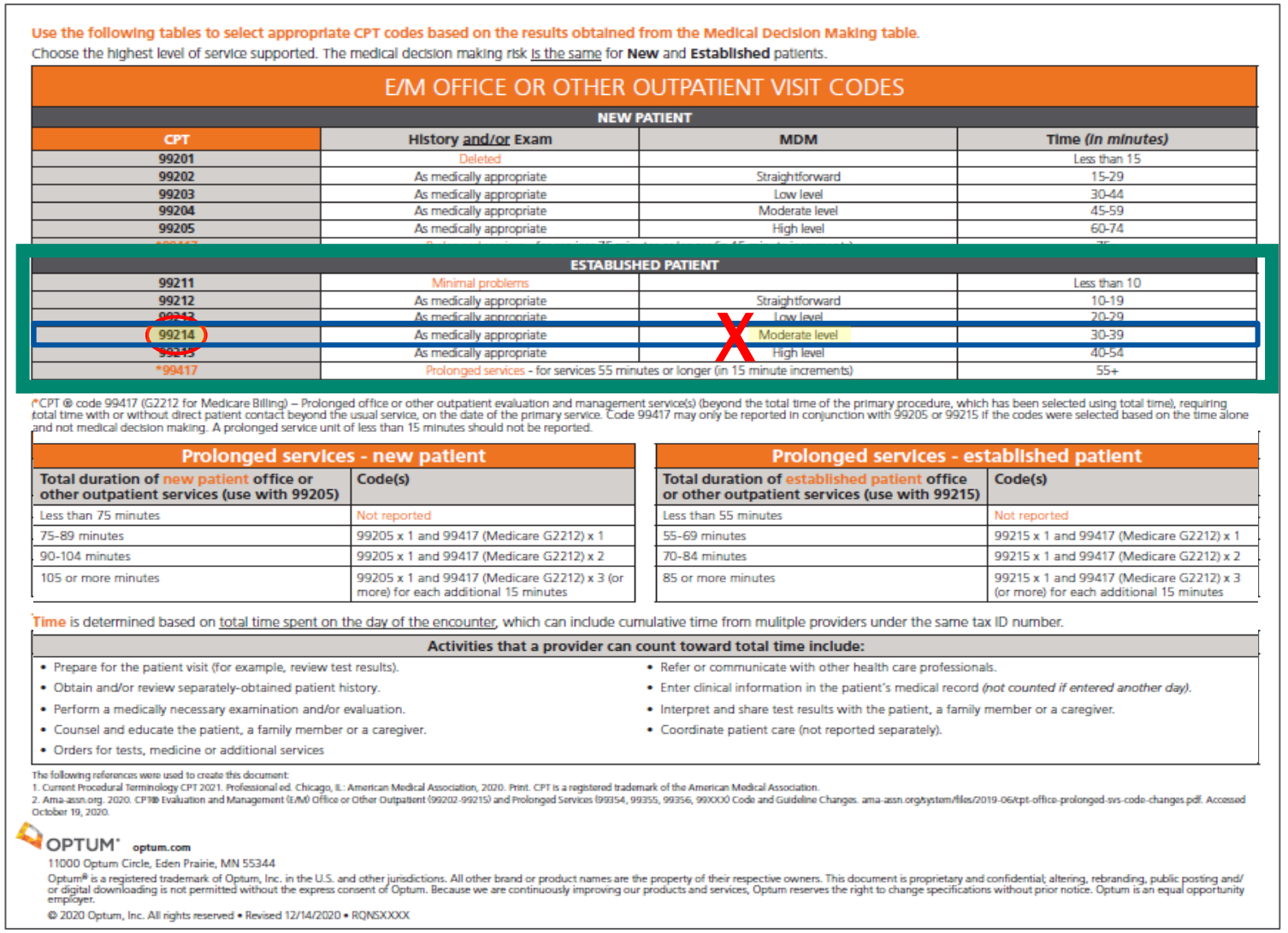
MDM:
Tool Reference Guide



E/M Coding Tool

E/M Tool Key

- Choose the highest level supported.
  - Outpatient provider visits
  - New and established patients



Use the following tables to select appropriate CPT codes based on the results obtained from the Medical Decision Making table.

Choose the highest level of service supported. The medical decision making risk is the same for **New** and **Established** patients.

E/M OFFICE OR OTHER OUTPATIENT VISIT CODES

CPT	History and/or Exam	MDM	Time (*In minutes*)
NEW PATIENT			
99201	Deleted		Less than 15
99202	As medically appropriate	Straightforward	15-29
99203	As medically appropriate	Low level	30-44
99204	As medically appropriate	Moderate level	45-59
99205	As medically appropriate	High level	60-74
ESTABLISHED PATIENT			
99211	Minimal problems		Less than 10
99212	As medically appropriate	Straightforward	10-19
[illegible]	As medically appropriate	Low level	20-29
99214	As medically appropriate	Moderate level	30-39
[illegible]	As medically appropriate	High level	40-54
*99417	Prolonged services - for services 55 minutes or longer (in 15 minute increments)		55+

*CPT ® code 99417 (G2212 for Medicare Billing) – Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure, which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service. Code 99417 may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. A prolonged service unit of less than 15 minutes should not be reported.

Prolonged services - new patient

Total duration of new patient office or other outpatient services (use with 99205)	Code(s)
Less than 75 minutes	Not reported
75-89 minutes	99205 x 1 and 99417 (Medicare G2212) x 1
90-104 minutes	99205 x 1 and 99417 (Medicare G2212) x 2
105 or more minutes	99205 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Prolonged services - established patient

Total duration of established patient office or other outpatient services (use with 99215)	Code(s)
Less than 55 minutes	Not reported
55-69 minutes	99215 x 1 and 99417 (Medicare G2212) x 1
70-84 minutes	99215 x 1 and 99417 (Medicare G2212) x 2
85 or more minutes	99215 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Time is determined based on total time spent on the day of the encounter, which can include cumulative time from mulitple providers under the same tax ID number.

Activities that a provider can count toward total time include:

- Prepare for the patient visit (for example, review test results).
- Obtain and/or review separately-obtained patient history.
- Perform a medically necessary examination and/or evaluation.
- Counsel and educate the patient, a family member or a caregiver.
- Orders for tests, medicine or additional services
- Refer or communicate with other health care professionals.
- Enter clinical information in the patient's medical record *(not counted if entered another day)*.
- Interpret and share test results with the patient, a family member or a caregiver.
- Coordinate patient care (not reported separately).

The following references were used to create this document:
1. Current Procedural Terminology CPT 2021. Professional ed. Chicago, IL: American Medical Association, 2020. Print. CPT is a registered trademark of the American Medical Association.
2. Ama-assn.org. 2020. CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed October 19, 2020.

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OPTUM®

E/M Services

Based on Time

E/M Time Factor

Reporting outpatient (office) time

Documentation must support:

- Total time spend on the day of the encounter
- Can include cumulative time from multiple providers (shared or split services) under the same tax ID number
- May be used to select a code level in office or other outpatient services whether counseling and/or coordination of care dominates the service.
  - As defined by the service descriptors require a face-to-face encounter with the physician or other qualified health care professional.
  - If time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

Prolonged time 99417

Prolonged time performed on the date of the encounter for office or other outpatient services (99205 or 99215).

- Determined based on total time spent on the day of the encounter, which includes the following:

  Both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter.

  Time in activities that require the physician or other qualified health care professional.

  - This does not include time in activities normally performed by clinical staff).
  - May include a shared or split visit in which a physician and other qualified healthcare professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.

Note: Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415 and 99416. Do not report 99417 for any time less than 15 minutes.

Time as a Component of E/M

New Pt Visit	Time (*minutes*)	Est. Pt Visit	Time (*minutes*)
99201	Deleted	99211	Less than 10
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54
* 99417	Prolonged Services - for services 55 minutes or longer (in 15 min increments)		55+

*CPT ® code 99417 (G2212 for Medicare Billing) – Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure, which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service. Code 99417 may only be reported in conjunction with 99205 or 99215 if the codes were selected based on the time alone and not medical decision making. A prolonged service unit of less than 15 minutes should not be reported.

Prolonged services - new patient	
Total duration of new patient office or other outpatient services (use with 99205)	**Code(s)**
Less than 75 minutes	Not reported
75-89 minutes	99205 x 1 and 99417 (Medicare G2212) x 1
90-104 minutes	99205 x 1 and 99417 (Medicare G2212) x 2
105 or more minutes	99205 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Prolonged services - established patient	
Total duration of established patient office or other outpatient services (use with 99215)	**Code(s)**
Less than 55 minutes	Not reported
55-69 minutes	99215 x 1 and 99417 (Medicare G2212) x 1
70-84 minutes	99215 x 1 and 99417 (Medicare G2212) x 2
85 or more minutes	99215 x 1 and 99417 (Medicare G2212) x 3 (or more) for each additional 15 minutes

Time is determined based on total time spent on the day of the encounter, which can include cumulative time from mulitple providers under the same tax ID number.

Activities that a provider can count toward total time include:

- Prepare for the patient visit (for example, review test results).
- Obtain and/or review separately-obtained patient history.
- Perform a medically necessary examination and/or evaluation.
- Counsel and educate the patient, a family member or a caregiver.
- Orders for tests, medicine or additional services
- Refer or communicate with other health care professionals.
- Enter clinical information in the patient's medical record *(not counted if entered another day)*.
- Interpret and share test results with the patient, a family member or a caregiver.
- Coordinate patient care (not reported separately).

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Documenting & Coding

Vascular Disease

Peripheral vascular (arterial) disease (PVD/PAD)

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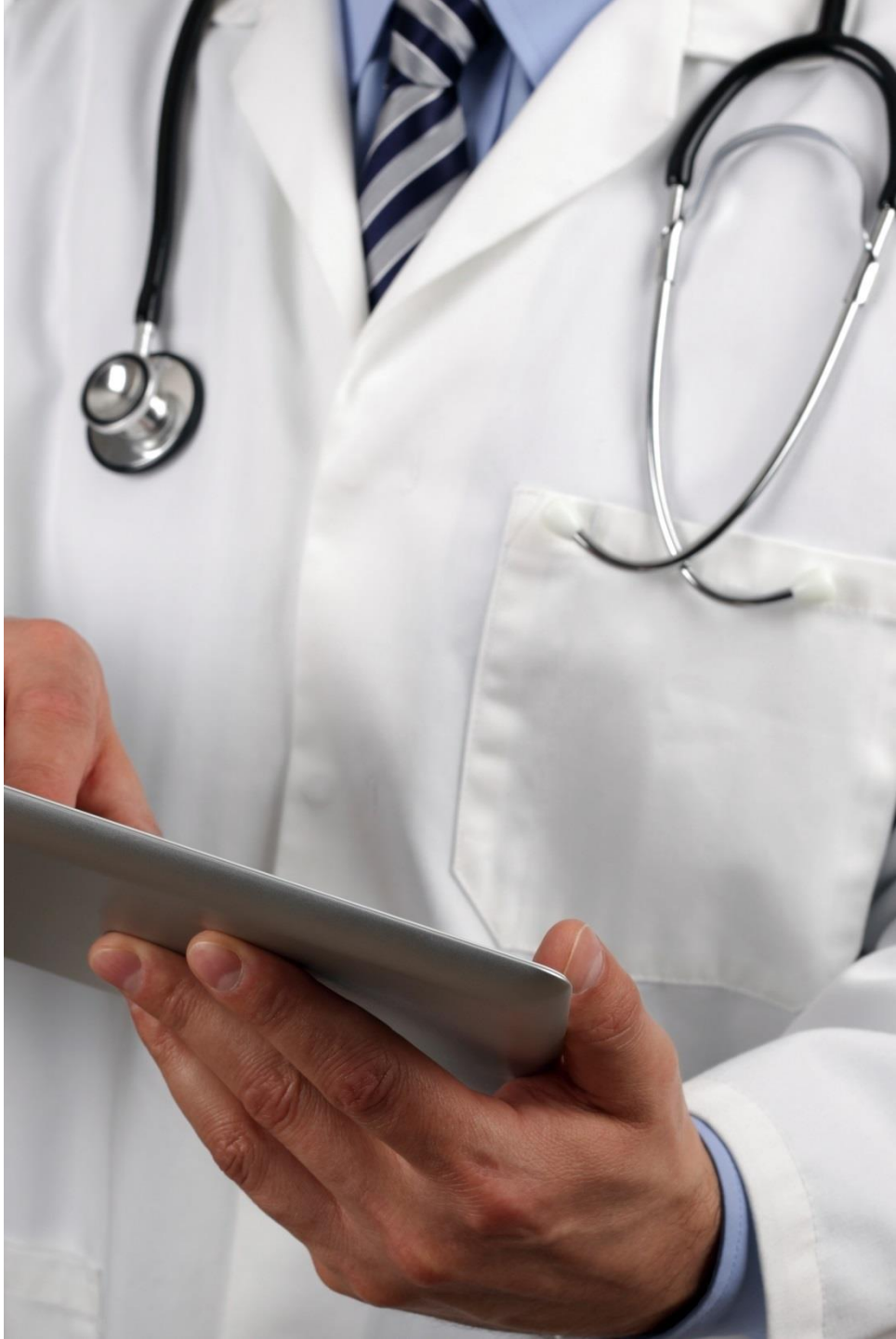

Documenting & Coding PAD / PVD

- **Vascular codes are often not coded specifically**

I73.9	Peripheral Vascular Disease, Unspecified
I70.90	Unspecified atherosclerosis
I70.91	Generalized atherosclerosis

- **Be Specific – Identify the Problem**

I70.0 – I70.9-	Specific documentation and coding PVD/PAD diagnoses can impact: ❖ Medicare Risk Adjustment ❖ E&M Level of Services ❖ Procedure Medical Necessity

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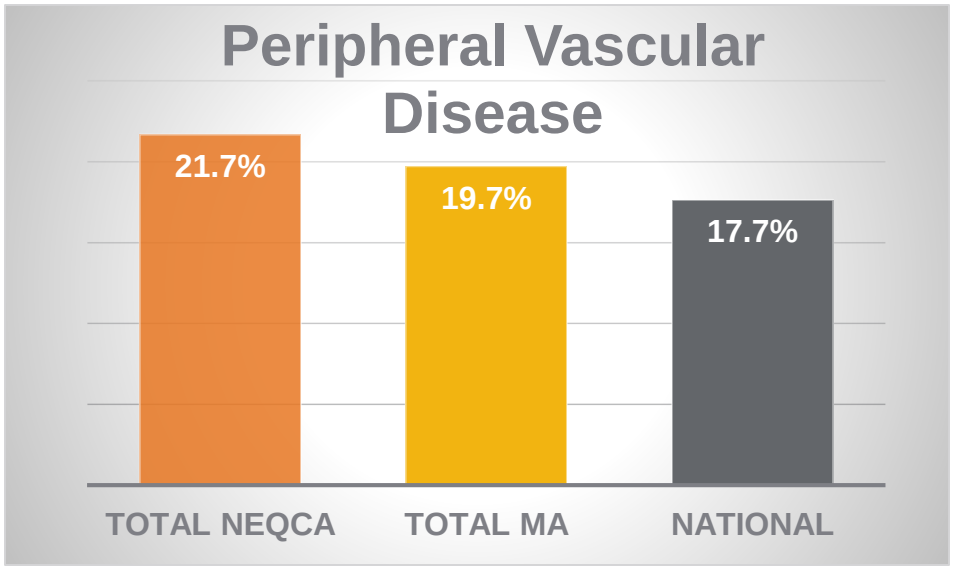


JANUARY 2021 BUILDUP (2020 DOS)

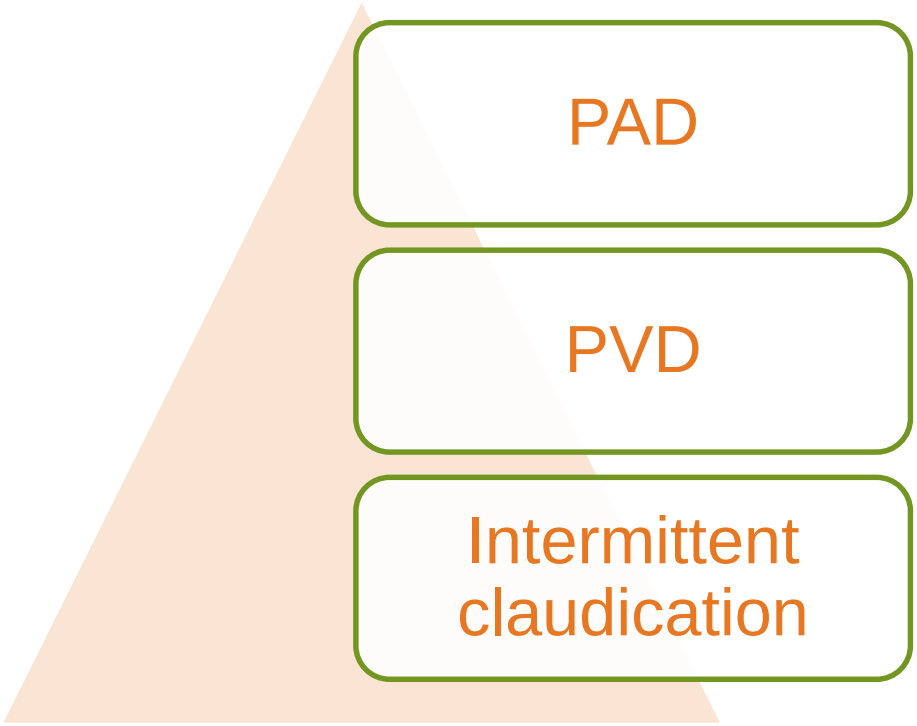
Members = 7,131

21.7% of these members have been reported to Peripheral Vascular Disease

- **12 providers have not reported PVD codes in 2020**
  (126 members assigned among them)

Documenting & Coding PAD / PVD

Atherosclerosis of native arteries of the extremities, subcategory **I70.2-**, is further classified as:



I73.9 PVD unspecified

- **I70.211** Atherosclerosis of native arteries of the extremities with intermittent claudication, right leg
- **I70.222** Atherosclerosis of native arteries of the extremities with rest pain, left leg
- **I70.232** Atherosclerosis of native arteries of the extremities right leg with ulceration of calf
- **I70.263** Atherosclerosis of native arteries of the extremities with gangrene, bilateral legs

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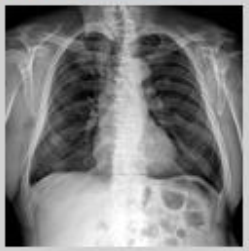
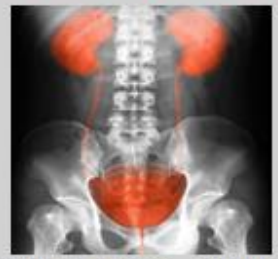
Vascular Disease: Take Away Tips

➢ Atherosclerosis/Calcification of Aorta	**I70.0**
➢ Atherosclerosis/Calcification of Renal Artery	**I70.1**
➢ Atherosclerosis/Calcification of Arteries, Lower Extremities	**I70.21-**
➢ PAD/PVD/Claudication Peripheral vascular disease, unspecified	**I73.9**
➢ Diabetic LE atherosclerosis (Type 2) Type 2 DM with diabetic peripheral angiopathy without gangrene	**E11.51** *and* I70.-

Code conditions above and document in your plan of care any clinical support from: Chest X-ray / KUB / Ultrasound / ABI … and Doppler Units

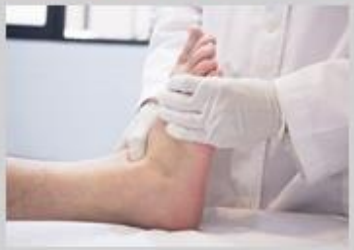


Chest X-ray



Kidney, Ureter, Bladder

Ultrasound



Manual or Doppler ABIs (i.e. Flowchec®)

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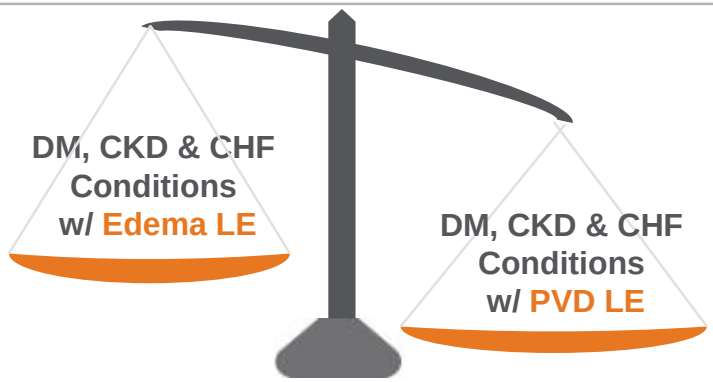
Improving Accuracy and Completeness

Diabetes with DM, CKD, CHF and PVD

Assessment/Plan: 72-year-old patient presents with recurrent ankle swelling bilaterally and follow-up of chronic conditions and medication refills.. DM2- Increased doses of Humalog recently (A1C at goal 7.1%). ESRD- on hemodialysis. Known chronic systolic CHF with EF 40% followed by cardiology. with h/o 3v CABG and aortic valve replacement 2011 (denies SOB). .

- **E11.9** Type 2 diabetes mellitus without complications
- **N18.6** End stage renal disease
- **I50.9** Heart failure, unspecified
- M25.476 Effusion, unspecified foot (ankle edema)



Greater specificity (suspects):

- Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene (**E11.51**)
  - Unspecified atherosclerosis of native arteries of extremities, bilateral legs (**I70.203**)
- Type 2 diabetes mellitus with diabetic chronic kidney disease (**E11.22**)
  - End stage renal disease (**N18.6**)
  - Dependence on renal dialysis (**Z99.2**)
- Chronic systolic heart failure (**I50.22**)
- Long term (current) use of insulin (**Z79.4**)

Accurate documentation can assist in correct health status reporting and assist the member in qualifying for additional quality programs

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Polling Question #2

A patient is diagnosed with diabetes (DM) on line item 3 and peripheral vascular disease (PVD) on line item 4 as illustrated:

Visit Diagnoses

Lipids abnormal E78.89
Essential hypertension I10
Type 2 diabetes mellitus without complication, without long-term current use of insulin (HCC) E11.9
Peripheral vascular disease I73.9

Which is of the following is correct?

A. ICD-10-CM assumes a causal relationship between the DM & PVD unless provider documents otherwise; therefore, creating a suspect logic that the DM condition is not coded accurately.

B. ICD-10-CM does not support a causal relationship between the DM & PVD; therefore, the two conditions are coded correctly without any suspected need for specificity.

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Documenting and Coding

Major Depressive Disorder

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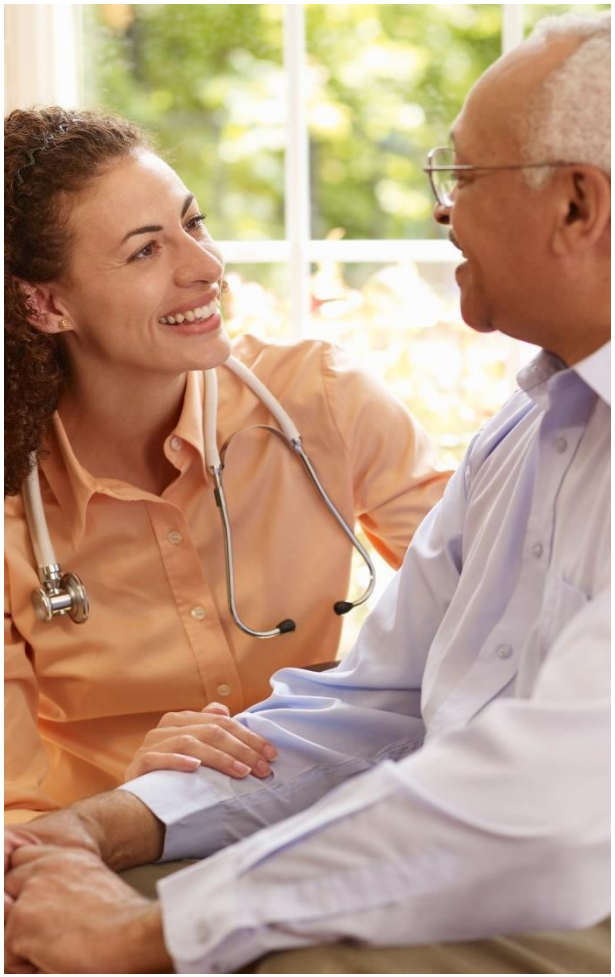
Coding Major Depression Disorders

- **Depression codes are often not coded specifically**

F32.9	MDD, single episode, unspecified
F41.8	Depression with anxiety
F43.21	Grief reaction; brief depressive reaction

  - These are often not coded correctly
  - These are appropriate at times.



- **Be Specific – Identify the Problem**

F32.- **F33**.-	Major depressive disorder, single or recurrent episode ➢ Mild, moderate, severe, with or without psychotic features. ➢ In partial or full remission

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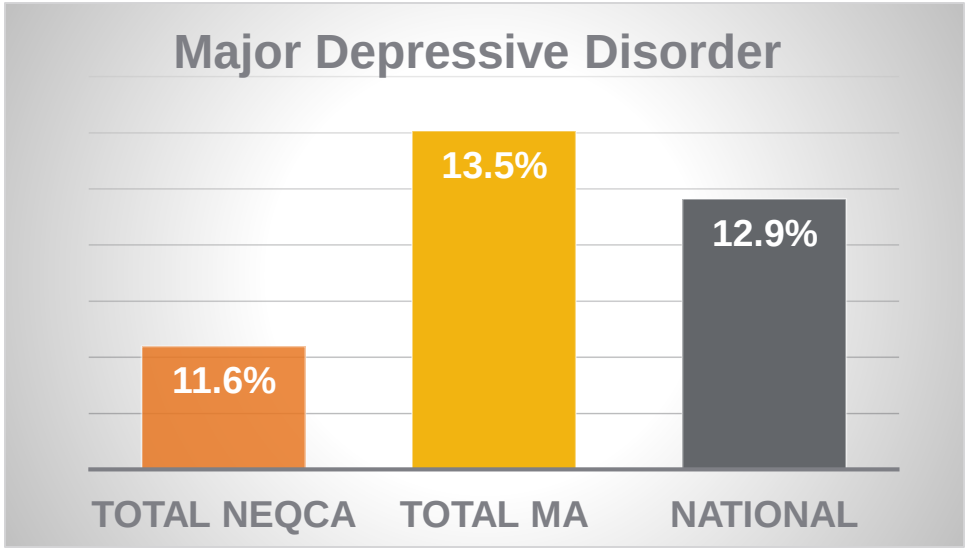

JANUARY 2021 BUILDUP (2020 DOS)

Members = 7,131

11.6% of these members have been reported to Major Depressive Disorder

- **16 providers have not reported MDD or Unspecified Mood Disorder codes in 2020** *(223 members assigned among them)*

Depression and Mood Disorder – Key Features

Major Depression Disorder

Single Episode

F32.-

Recurrent Episode

F33.-

4th and 5th characters define severity & clinical status

- **0** = Mild
- **1** = Moderate
- **2** = Severe without psychotic features
- **3** = Severe with psychotic features
- **4** = In partial, unspecified remission or full remission
- **5** = In full remission
- 8 = Other depressive episodes (Single F32.8- *does not RA*)
- 9 = Unspecified (Single F32.9 *does not RA*)

Mood Disorder

F39

(Used when not sufficient as hypomanic or mild depressive episodes)

Use only when clinically relevant

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Depression Screening

HCPCS/CPT Codes
G0444 - Annual depression screening, 15 minutes
ICD-10 Codes
Contact your local Medicare Administrative Contractor (MAC) for guidance
Who Is Covered
All Medicare beneficiaries are eligible for depression screening
Frequency
Annually for G0444. However, this service is included in the Initial AWV requirement. For subsequent AWV, this screening can be billed separately.
Medicare Beneficiary Pays
○ Copayment/coinsurance waived ○ Deductible waived

Improving Accuracy and Completeness

Major Depressive Disorder

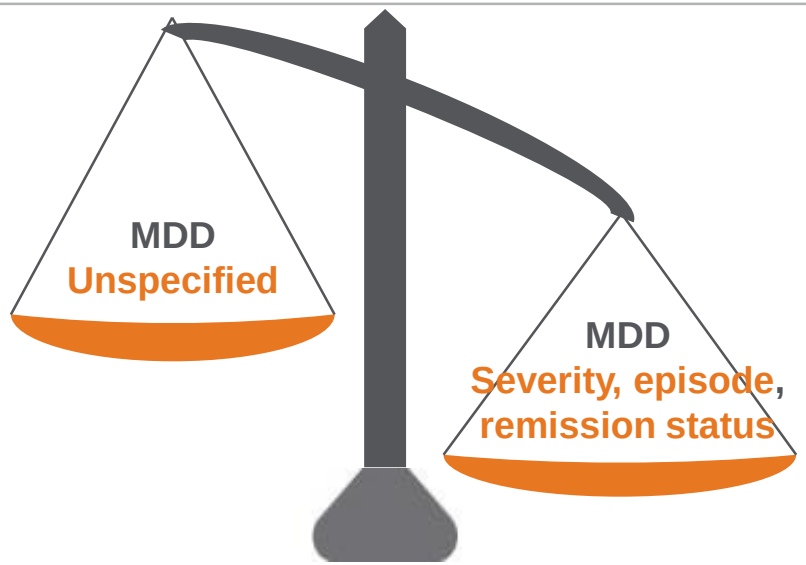
HPI: 79-year-old female with depression in partial remission.

Continues to have some symptoms. The current treatment plan includes: psychotherapy and meds (citalopram 20mg qd).

Assessment & Plan:

1. Depression F32.9
   Stable on med. Followed by psychiatry, Dr. John Doe
   - Continue current care

Note: FH, SH, Exam and other parts of this progress note have been selectively left out.



Greater specificity (suspects):

- Major Depressive Disorder, single episode, partial remission (**F32.4**)
- Major Depressive Disorder, recurrent episode, partial remission (**F33.41**)
  - Query provider to confirm

Accurate documentation can assist in correct health status reporting and assist the member in qualifying for additional quality programs

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Polling Question #3

A patient is diagnosed with a psychotic disorder manifesting hallucination with severe recurrent major depressive disorder.

This diagnosis may trigger a suspect condition for documentation and coding of this case.

Which is the suspected condition?

A. Suspected coding for psychotic disorder with hallucinations due to a known physiological condition.

B. Suspected coding for major depressive disorder, recurrent episode, severe with psychotic features.

C. Suspected coding for hallucinations.

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Documenting & Coding

Chronic Obstructive Pulmonary Disease (COPD)

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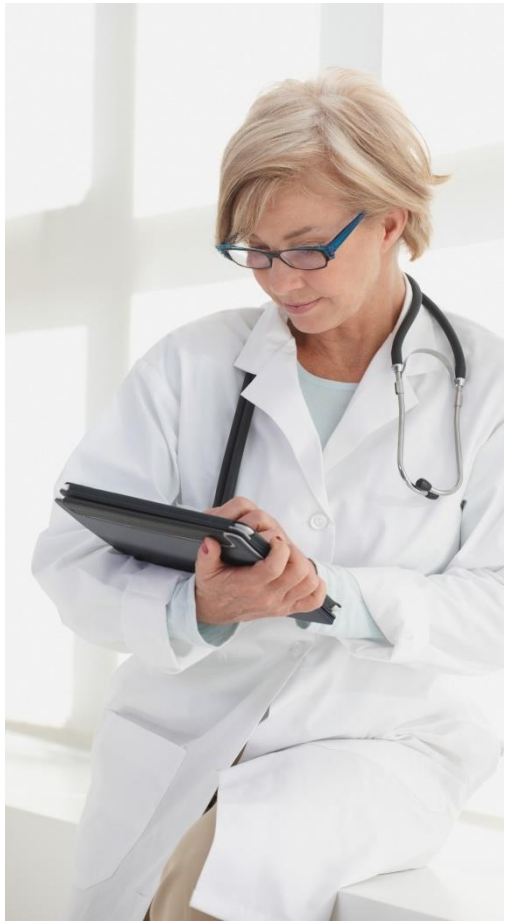
Documenting & Coding COPD

- **Chronic obstructive pulmonary disease is often under coded**

J44.9	Chronic obstructive pulmonary disease, Unspecified
R05	Chronic Cough
Z87.09	Personal history of other diseases of the respiratory system (history of chronic cough)



- **Be Specific – Identify the Problem**

J44.- and J45.-	Specific documentation and coding can impact: ❖ COPD w/ acute bronchitis ❖ COPD w/ acute exacerbation ❖ COPD w/ acute exacerbation triggered by an infection ❖ COPD w/ asthmatic conditions

Optum360. ICD-10-CM Professional for Physicians. 2021. Salt Lake City, UT: Optum360; 2020.
Optum360. Coders' Desk Reference for Diagnoses 2021. Salt Lake City, UT: Optum360; 2020.

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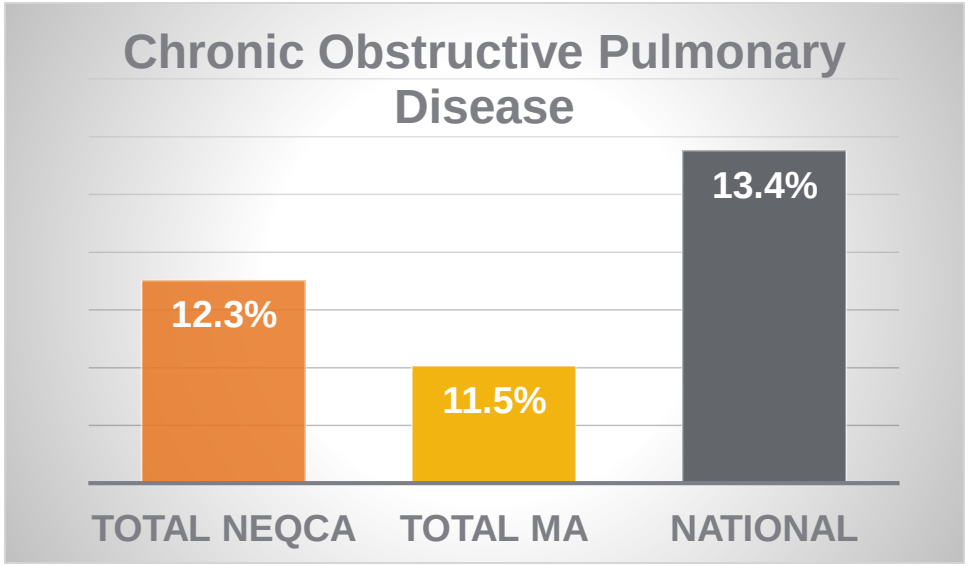


Members = 7,131

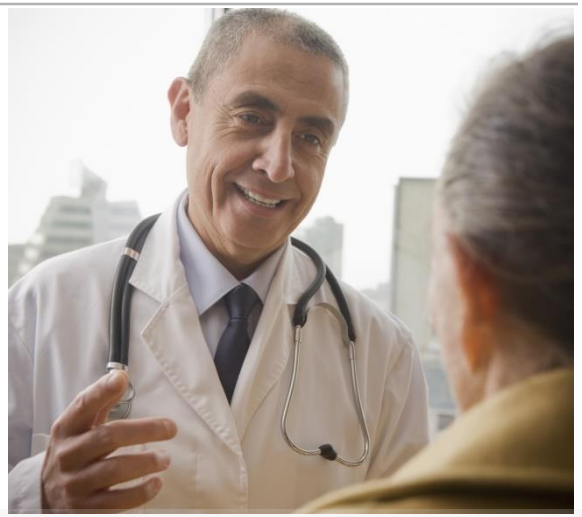
12.3% of these members have been reported to Major Depressive Disorder

- **14 providers have not reported COPD codes in 2020**
  (121 members assigned among them)

JANUARY 2021 BUILDUP (2020 DOS)

COPD Reporting

- Are there too many members being reported as Bronchitis, not specified as acute or chronic (J40)?



❑ **Report "smokers cough" to J41.0**

❑ Document and code COPD with asthmatic conditions using two codes for each condition:

- *Asthma is coded separately by severity and frequency (e.g. mild, moderate, severe; intermittent or persistent); acute exacerbation or status asthmaticus*

❑ **J44.1,** J45.21- **= Chronic obstructed asthma with mild intermittent (acute) exacerbation**
- *IMO search: COPD with asthma with exacerbation = **J44.1***
- *IMO search: asthma with mild acute exacerbation = J45.21*

❑ **J44.9,** J45.42 **= Chronic obstructed asthma with mild persistent status asthmaticus**
- *IMO search: chronic obstructed asthma with status asthmaticus = **J44.9***
- *IMO search: asthma with moderate persistent status asthmaticus = J45.42*

❑ **J44.9,** J45.20 **= Chronic obstructive asthma, mild intermittent (uncomplicated)**
- *IMO search: chronic obstructive asthma= **J44.9***
- *IMO search: mild intermittent asthma = J45.20*

❑ **J44.0 ,** J45.30, J20.9 **= Chronic obstructive asthma, mild persistent with acute lower respiratory infection *(acute bronchitis)***
- *IMO search: COPD with acute bronchitis= **J44.0***
- *IMO search: mild persistent asthma = J45.30*
- *IMO search: assign a code for the infection (A00–B99, U07.1) if known and for acute bronchitis (J20.9)*

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Diagnoses Suggested by Diagnostic Studies

A note that just states an abnormal finding "noted" on a diagnostic study, such as…

- " ***COPD***, *noted on CXR"*
- "***Secondary Pulmonary Hypertension***, *noted on Echocardiogram"*
- ***Atherosclerosis of the Aorta***, *noted on CXR"*

Diagnosis codes will NOT Validate

- **Abnormal test results – are not coded unless the provider has interpreted the tests and documents the significance of the abnormal test**
  - **The provider must document the "cognitive work" to support the diagnosis codes**

Consider

R93.8 Abnormal findings on diagnostic imaging of other specified body structures

R93.1 Abnormal findings on diagnostic imaging of heart and coronary circulation

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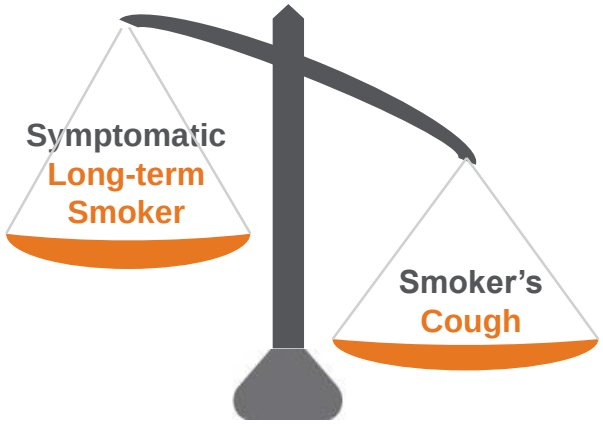
Improving Accuracy and Completeness

Smokers' Cough

Assessment/Plan: 68-year-old patient presents with a 4 month follow up of medications. PMH: hypertension- pt. to cont. to monitor BP off meds, goal 130/80 or less. Hyperlipidemia- simvastatin 80mg tab, daily. SH: Current smoker- 30 years, 1 pack per day, with occasional symptomatic coughing.

- I10 Essential (primary) hypertension
- E78.5 Hyperlipidemia, unspecified
- Z72.0 Tobacco use
- R05 Cough



Greater specificity (suspects):

- Essential (primary) hypertension (I10)
- Hyperlipidemia, unspecified (E78.5)
- Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders (F17.219)
- Simple chronic bronchitis (Smokers' cough) (**J41.0**)

Accurate documentation can assist in correct health status reporting and assist the member in qualifying for additional quality programs

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Post Presentation Quiz

Introduction to MA RA with E/M Updates & Select Chronic Conditions

To assist in our improvement efforts of knowledge retention, please take the post presentation review by clicking this link in the chat panel to begin:

https://forms.office.com/Pages/ResponsePage.aspx?id=yvoF2yrInUu5xQ9ktnVUIW9DasPLkCJHseZPVg3azBJURUVSQzI5TkxXMjEwTzJHTU5STFdNVU5GVSQlQCN0PWcu

You may take this post assessment at your leisure after the presentation has ended.

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Progress Notes

Documentation, Chart Mechanics & Authentication Requirements

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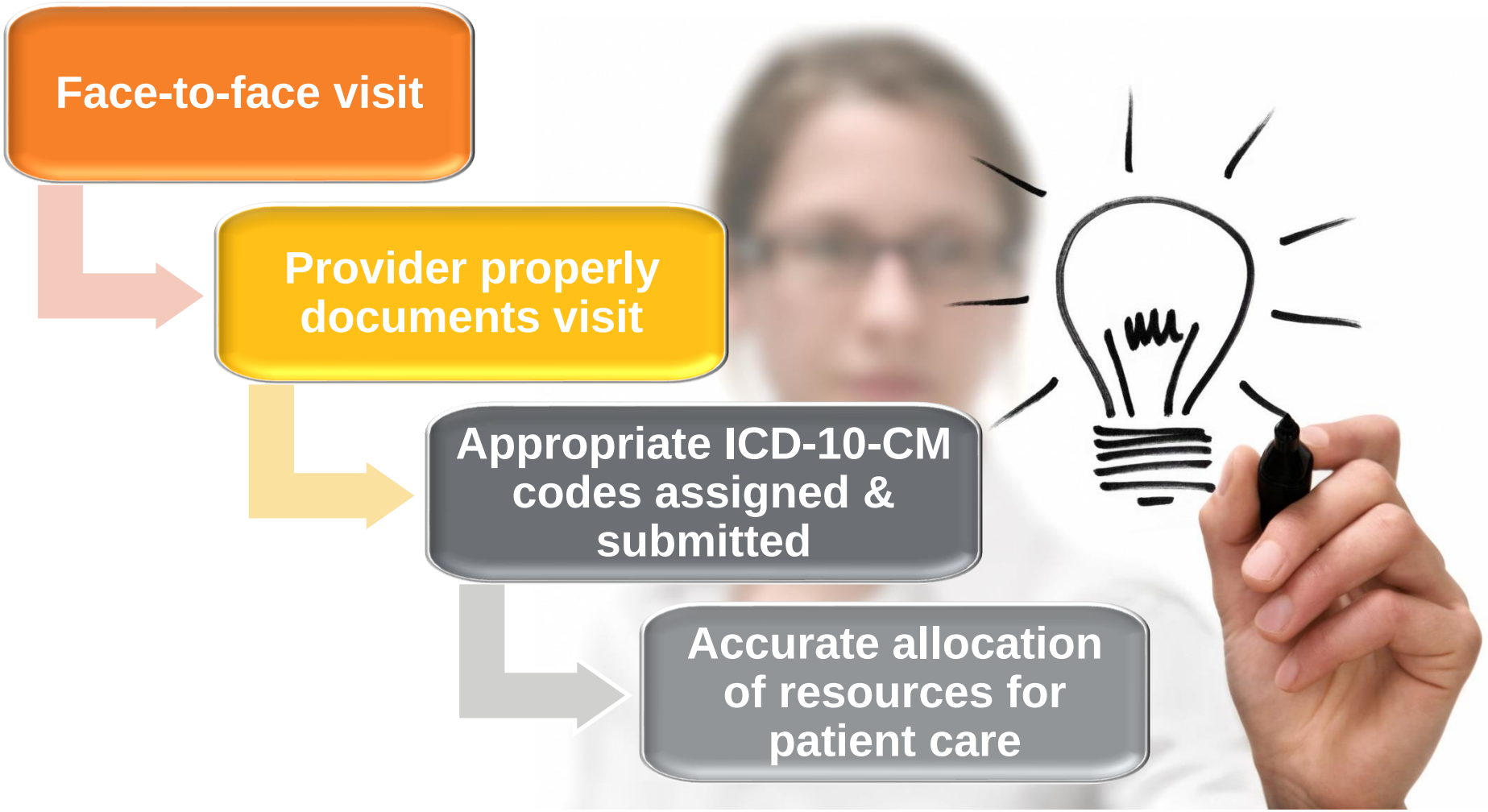
CMS Risk Adjustment Process Review



Good documentation = Accurate program funding

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Documentation: The Progress Note

Clinical conditions:

Document to the highest level of specificity for each diagnosis.

Document all known conditions from:

- *Consultant or specialist,*
- *Lab values,*
- *Radiology results,*
- *Discharge summaries*[2]

Document all chronic conditions at least once per year.[2]

Document any problem pertinent conditions that affects care, treatment and management of the patient on each date of service.[1]

1 ICD-10-CM Official Guidelines for Coding and Reporting FY 2021. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf. Published October 1, 2020. Accessed November 17, 2020.

2 Centers for Medicare & Medicaid Services. 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide. Palmetto GBA https://www.csscoperations.com/Internet/Cssc3.Nsf/files/participant-guide-publish_052909.pdf/$File/participant-guide-publish_052909.pdf. Published 2008. Accessed November 17, 2020.

Documentation Findings: Evaluative Language

In addition to documenting the condition(s), it is recommended to include evaluative documentation such as M.E.A.T.

M onitoring *(or)*

- Signs & symptoms, disease progression and/or status

E valuation *(or)*

- Response to treatment(s) and/or test results

A ssessment *(or)*

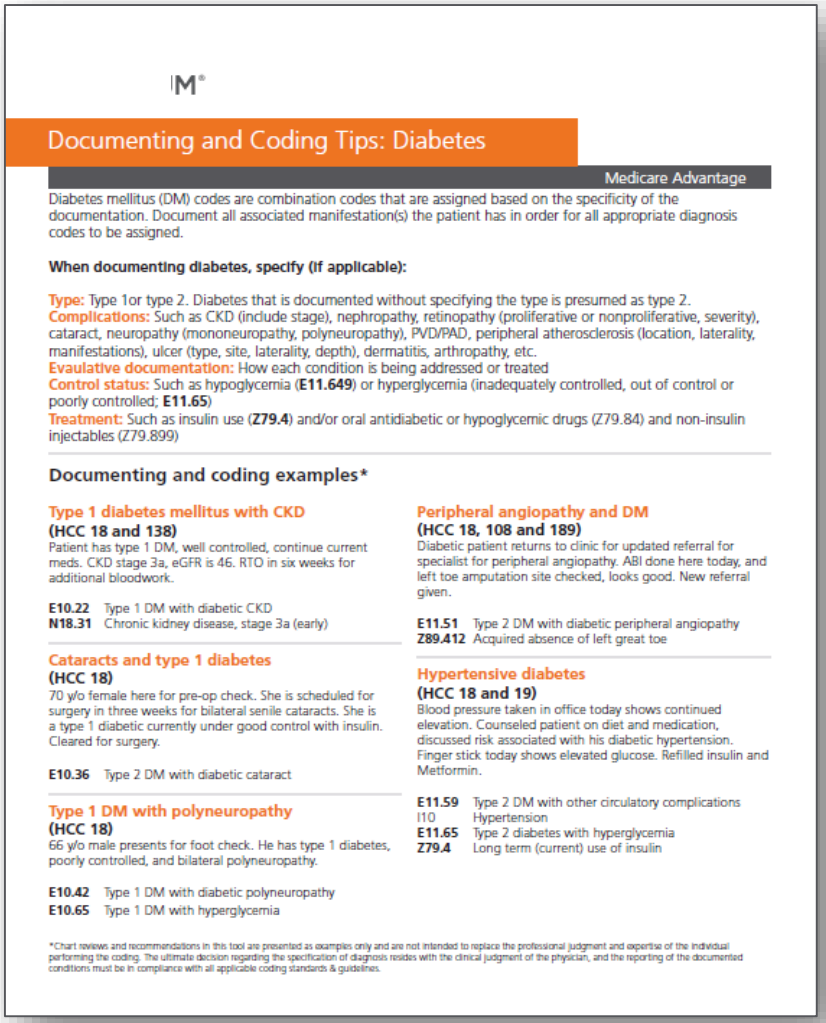
- Council and/or discussion, records review and/or referral to a specialist

T reatment

- Stop or start medications, diagnostic and/or therapeutic plan, patient education and/or follow up schedule

Ama-assn.org. 2020. Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes. [online] Available at: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf. Accessed November 23, 2020.

Coding Tools Available



IM®

Documenting and Coding Tips: Diabetes

Medicare Advantage

Diabetes mellitus (DM) codes are combination codes that are assigned based on the specificity of the documentation. Document all associated manifestation(s) the patient has in order for all appropriate diagnosis codes to be assigned.

When documenting diabetes, specify (if applicable):

Type: Type 1or type 2. Diabetes that is documented without specifying the type is presumed as type 2.
Complications: Such as CKD (include stage), nephropathy, retinopathy (proliferative or nonproliferative, severity), cataract, neuropathy (mononeuropathy, polyneuropathy), PVD/PAD, peripheral atherosclerosis (location, laterality, manifestations), ulcer (type, site, laterality, depth), dermatitis, arthropathy, etc.
Evaulative documentation: How each condition is being addressed or treated
Control status: Such as hypoglycemia (**E11.649**) or hyperglycemia (inadequately controlled, out of control or poorly controlled; **E11.65**)
Treatment: Such as insulin use (**Z79.4**) and/or oral antidiabetic or hypoglycemic drugs (Z79.84) and non-insulin injectables (Z79.899)

Documenting and coding examples*

Type 1 diabetes mellitus with CKD
(HCC 18 and 138)
Patient has type 1 DM, well controlled, continue current meds. CKD stage 3a, eGFR is 46. RTO in six weeks for additional bloodwork.

E10.22 Type 1 DM with diabetic CKD
N18.31 Chronic kidney disease, stage 3a (early)

Cataracts and type 1 diabetes
(HCC 18)
70 y/o female here for pre-op check. She is scheduled for surgery in three weeks for bilateral senile cataracts. She is a type 1 diabetic currently under good control with insulin. Cleared for surgery.

E10.36 Type 2 DM with diabetic cataract

Type 1 DM with polyneuropathy
(HCC 18)
66 y/o male presents for foot check. He has type 1 diabetes, poorly controlled, and bilateral polyneuropathy.

E10.42 Type 1 DM with diabetic polyneuropathy
E10.65 Type 1 DM with hyperglycemia

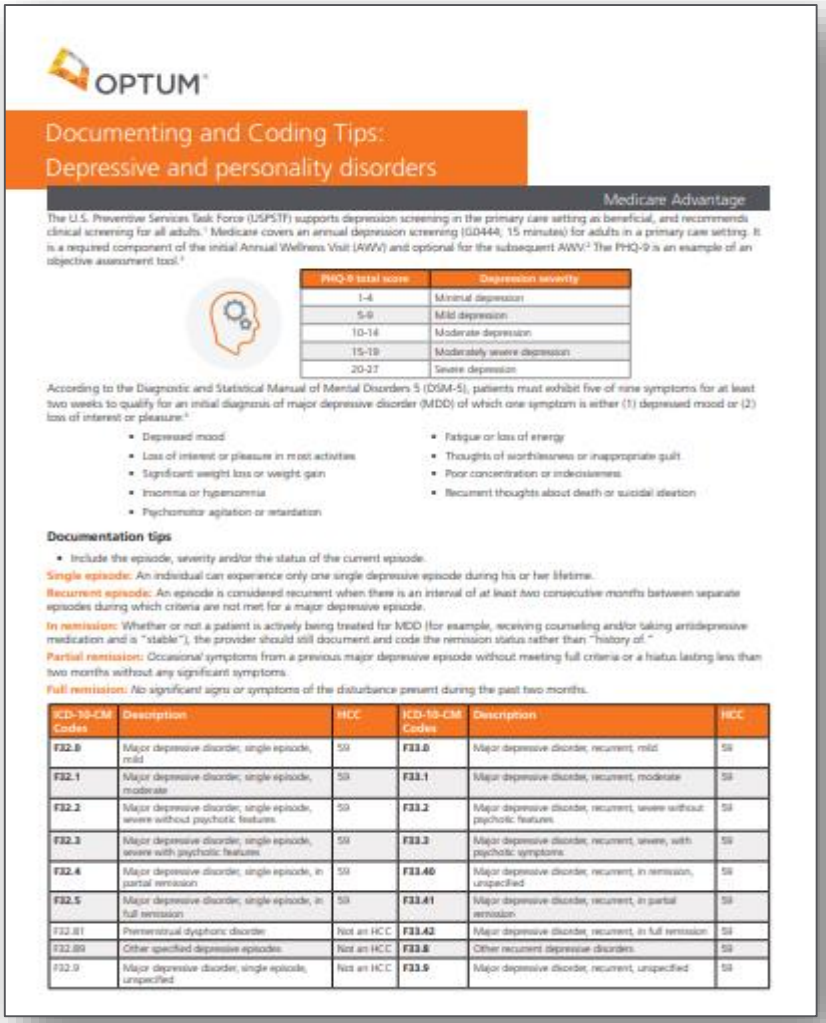
Peripheral angiopathy and DM
(HCC 18, 108 and 189)
Diabetic patient returns to clinic for updated referral for specialist for peripheral angiopathy. ABI done here today, and left toe amputation site checked, looks good. New referral given.

E11.51 Type 2 DM with diabetic peripheral angiopathy
Z89.412 Acquired absence of left great toe

Hypertensive diabetes
(HCC 18 and 19)
Blood pressure taken in office today shows continued elevation. Counseled patient on diet and medication, discussed risk associated with his diabetic hypertension. Finger stick today shows elevated glucose. Refilled insulin and Metformin.

E11.59 Type 2 DM with other circulatory complications
I10 Hypertension
E11.65 Type 2 diabetes with hyperglycemia
Z79.4 Long term (current) use of insulin

*Chart reviews and recommendations in this tool are presented as examples only and are not intended to replace the professional judgment and expertise of the individual performing the coding. The ultimate decision regarding the specification of diagnosis resides with the clinical judgment of the physician, and the reporting of the documented conditions must be in compliance with all applicable coding standards & guidelines.



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Documenting and Coding Tips: Depressive and personality disorders

Medicare Advantage

The U.S. Preventive Services Task Force (USPSTF) supports depression screening in the primary care setting as beneficial, and recommends clinical screening for all adults.[1] Medicare covers an annual depression screening (G0444, 15 minutes) for adults in a primary care setting. It is a required component of the initial Annual Wellness Visit (AWV) and optional for the subsequent AWV.[2] The PHQ-9 is an example of an objective assessment tool.[3]

PHQ-9 total score	Depression severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), patients must exhibit five of nine symptoms for at least two weeks to qualify for an initial diagnosis of major depressive disorder (MDD) of which one symptom is either (1) depressed mood or (2) loss of interest or pleasure:[4]

- Depressed mood
- Loss of interest or pleasure in most activities
- Significant weight loss or weight gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Thoughts of worthlessness or inappropriate guilt
- Poor concentration or indecisiveness
- Recurrent thoughts about death or suicidal ideation

Documentation tips

- Include the episode, severity and/or the status of the current episode.

Single episode: An individual can experience only one single depressive episode during his or her lifetime.
Recurrent episode: An episode is considered recurrent when there is an interval of at least two consecutive months between separate episodes during which criteria are not met for a major depressive episode.
In remission: Whether or not a patient is actively being treated for MDD (for example, receiving counseling and/or taking antidepressive medication and is "stable"), the provider should still document and code the remission status rather than "history of."
Partial remission: Occasional symptoms from a previous major depressive episode without meeting full criteria or a hiatus lasting less than two months without any significant symptoms.
Full remission: No significant signs or symptoms of the disturbance present during the past two months.

ICD-10-CM Codes	Description	HCC	ICD-10-CM Codes	Description	HCC
F32.0	Major depressive disorder, single episode, mild	59	F33.0	Major depressive disorder, recurrent, mild	59
F32.1	Major depressive disorder, single episode, moderate	59	F33.1	Major depressive disorder, recurrent, moderate	59
F32.2	Major depressive disorder, single episode, severe without psychotic features	59	F33.2	Major depressive disorder, recurrent, severe without psychotic features	59
F32.3	Major depressive disorder, single episode, severe with psychotic features	59	F33.3	Major depressive disorder, recurrent, severe, with psychotic symptoms	59
F32.4	Major depressive disorder, single episode, in partial remission	59	F33.40	Major depressive disorder, recurrent, in remission, unspecified	59
F32.5	Major depressive disorder, single episode, in full remission	59	F33.41	Major depressive disorder, recurrent, in partial remission	59
F32.81	Premenstrual dysphoric disorder	Not an HCC	F33.42	Major depressive disorder, recurrent, in full remission	59
F32.89	Other specified depressive episodes	Not an HCC	F33.8	Other recurrent depressive disorders	59
F32.9	Major depressive disorder, single episode, unspecified	Not an HCC	F33.9	Major depressive disorder, recurrent, unspecified	59

Please reach out to your local representative for coding & quality tools

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This guidance is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the “thought process” of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 6, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that 2020 dates of service for the 2021 payment year model are based on the Centers for Medicare & Medicaid Services Announcement. Website: https://www.cms.gov/files/document/2021-announcement.pdf.

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