Compliant Risk Adjustment Documentation and Coding

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Introduction

- Sheri Poe Bernard
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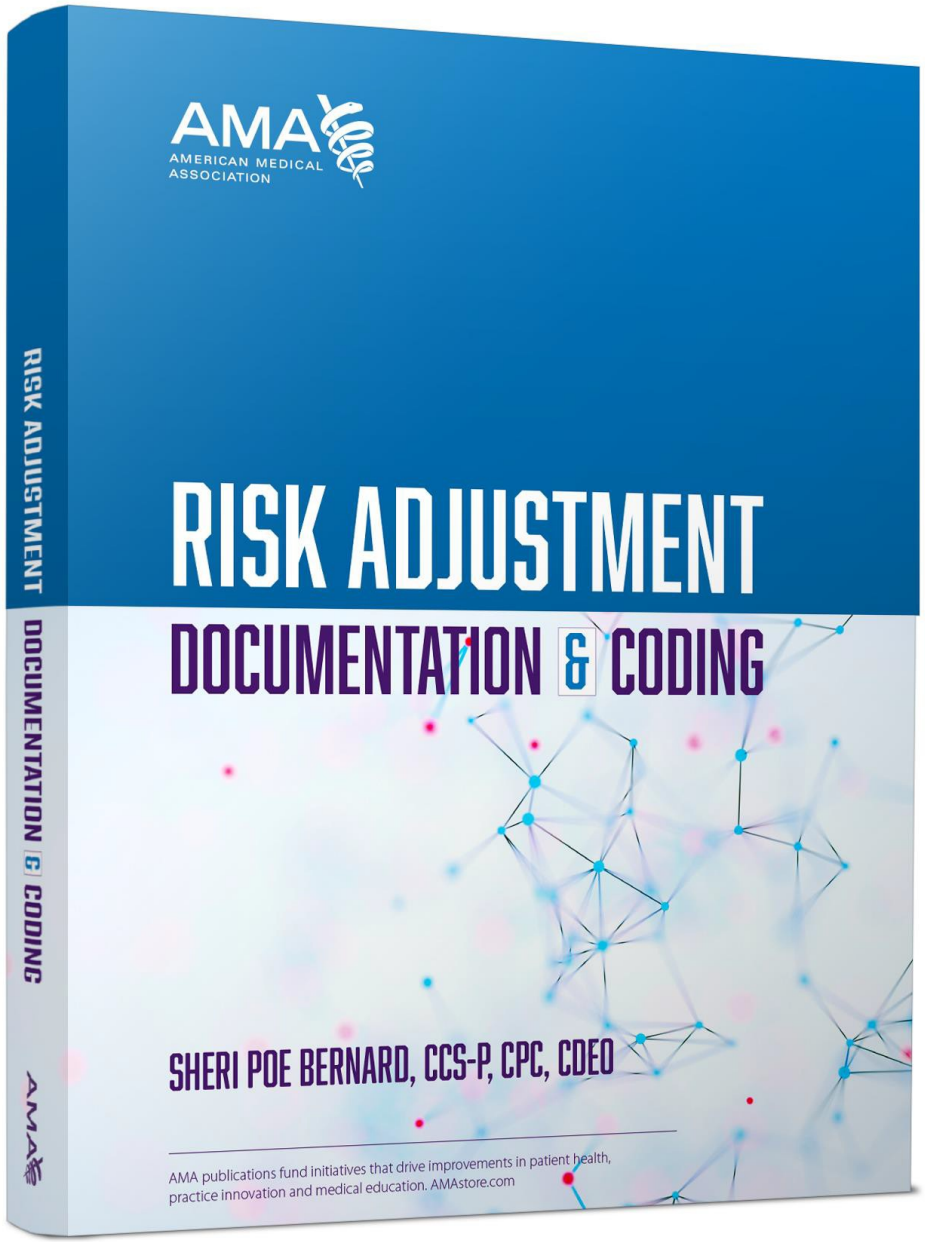

Today’s risk adjustment objectives

Understand it.

Improve the quality of your care and reimbursement by improving your diagnostic documentation and coding skills.

Document it.

Capturing the code description from the EMR pull-down list is not equivalent to documentation of the diagnosis. How much is enough?

Code it.

ICD-10-CM has rules that do not mirror what you learned in medical school or on the job. This discussion may improve your coding.

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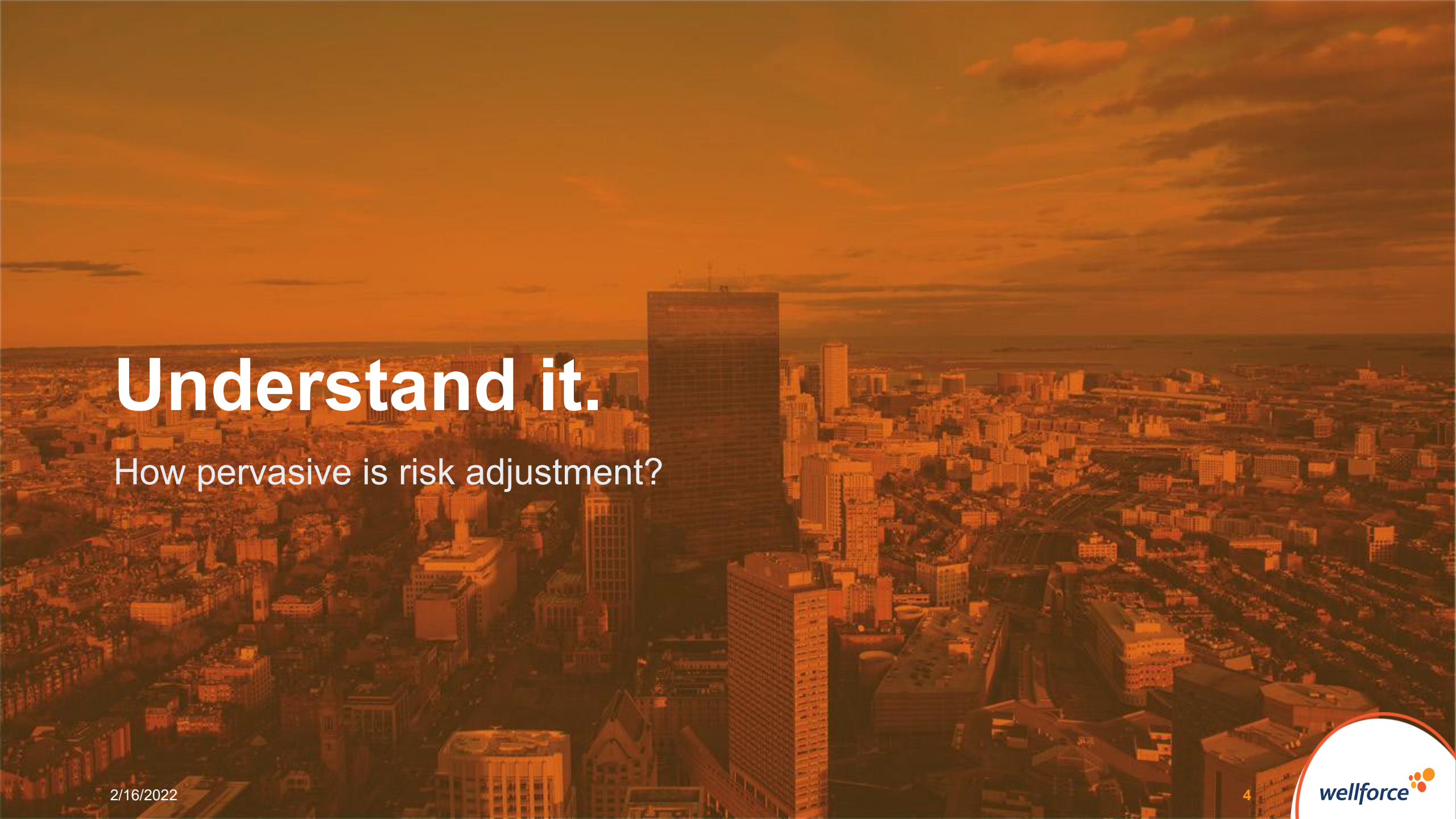

Understand it.

How pervasive is risk adjustment?

Goals of risk adjustment programs

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

How to succeed with risk adjustment

- There's two actions providers must do for risk adjustment to be successful in their practice:
  1. **Tell the patient's story**, and tell it completely
  2. **Abstract the diagnoses** from the written record, and abstract the diagnoses correctly

These two steps are the focus of today's webinar.

Complexities of a very simple visit

- 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
- 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 in more than a year. 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			

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

Document it.

Best practices for compliant medical documentation

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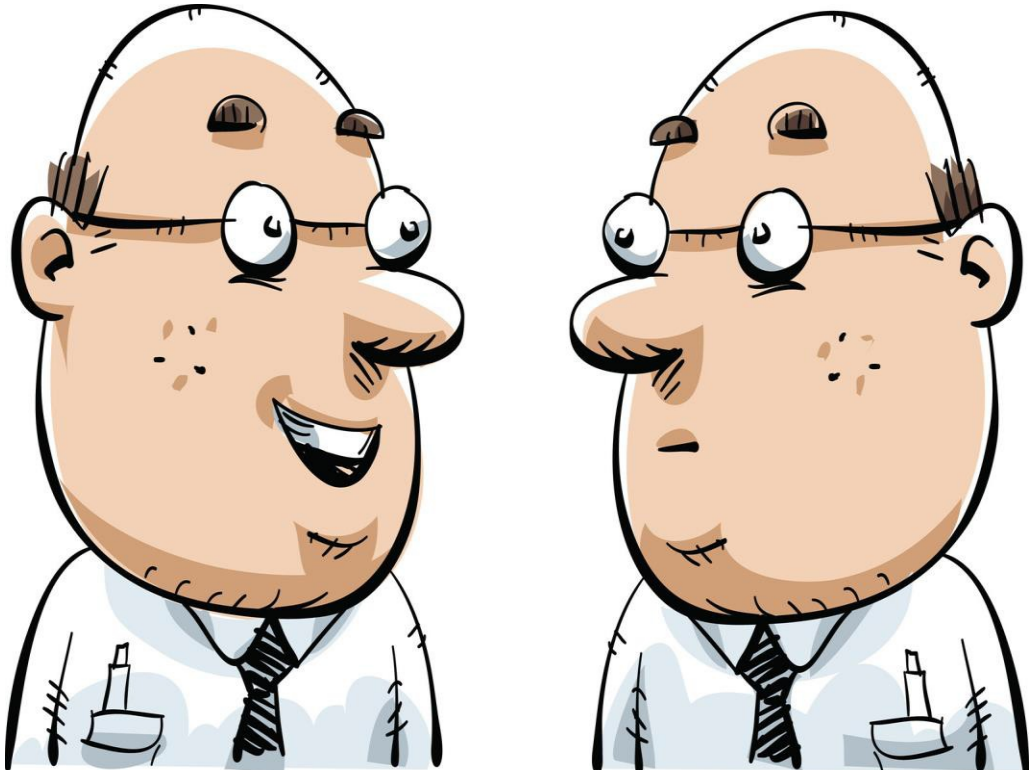
Separate documentation from coding

- 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 documentation from coding

Start by using WORDS, not LAB VALUES or CODES.

- CMS says clinicians must declare diagnoses, in words, in the written record, at each visit. Every DOS stands alone.
- Noting “eGFR drop from 33 to 28” is NOT documentation of CKD stage 4.
- Noting “N18.4” or “N18.4 CKD” is NOT documentation of CKD, stage 4.

- **“CKD has progressed to stage 4, based on the latest GFR of 28.”**

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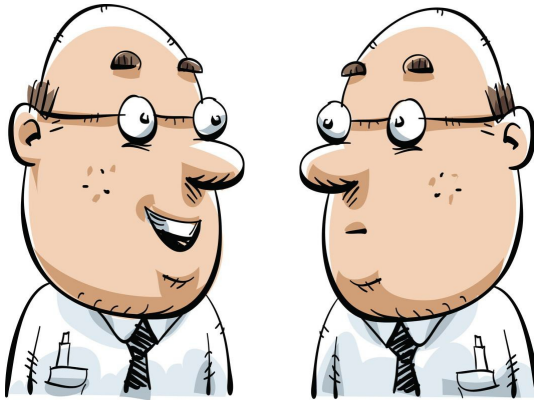
Separate documentation from coding

Codes themselves 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!"

Be holistic in your encounter care

Chronic conditions impact all care, regardless of who is managing them.

- Providers cannot ignore comorbidities when assessing and treating the patient
- **Cardiology, vascular surgery, nephrology, endocrinology primary care** – regardless of specialty, regardless of the age of the patient or their insurance plan, the comorbidities affect treatment plan

Be holistic in your encounter care

- **Scientific method demands it.**
- **Risk adjustment depends on it.**
  - — You will think about the patient's comorbidities in your MDM and should document and document and code these thoughts as they represent why you do what you do.
- **Underdocumentation can lead to serious medicolegal risks and underserves your patient.**

Holistic patient care

A 67-year-old patient who has congestive heart failure, diabetes, CKD stage 3, hypertension, and COPD presents with +3 LE edema to his [*specialty*].

specialty insert your specialty here.

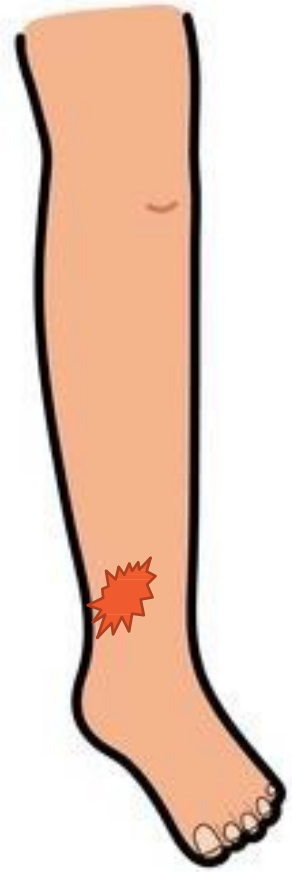
Is the edema nephrogenic, cardiogenic? Is the patient SOB? How is the patient's blood pressure?

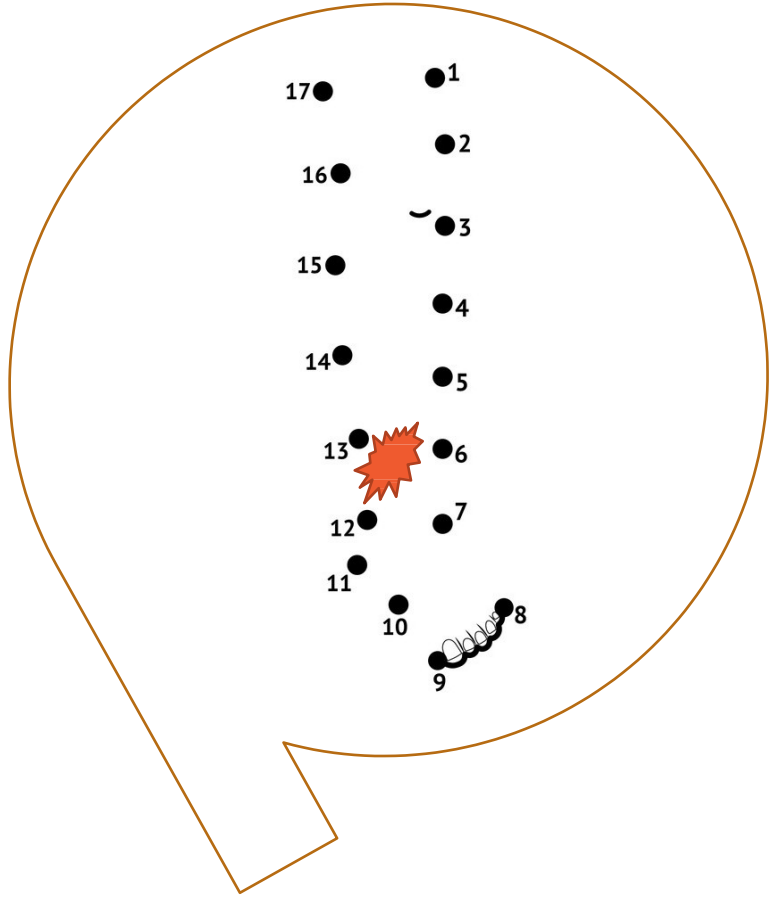
Be holistic in your encounter care

If assessment says	Code	HCC RAF	Cumulative
Heart failure (HF)	I50.9	**0.331, 0.124**	**0.331, 0.124**
HF w/ COPD	J44.9	0.335, 0.325	
HF w/ COPD synergies		0.155	0.821, 0.449
HF w/ CKD4	N18.4	0.289, 0.092	
HF w/ CKD synergies		0.156	1.266, 0.541
HF w/ DM	E11.22	0.302, 0.408	
HF w/DM synergies		0.121	1.689, 0.949
HTN	I1130	(included)	1.689, 0.949
Payment for HCC count of 5 diagnoses		0.042	
Payment demographics, male, 78		**0.472, 0.244**	**2.161, 1.193**

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.





Think in ink

Assessment/Plan

CAD: 2v**CABG** in 2010. Event monitor 3/10/2018 with baseline transmission showing SR. Echo 8/15/2018 with normal LV size and contractual function (EF 62%). **Moderate LVH**. Normal LV filling pressure and cardiac output. **RV enlargement with RVH** and mild RV contractile dysfunction**. PA systolic pressure estimated in the low 70s** with a borderline normal IVC. **Moderate TR**. Noted PAP and TR were improved with sildenafil 50 mg tid. Continue Metoprolol 100 mg BID, Lisinopril 10 mg BID, and ASA 81 mg once a day.

Lost risk adjustment value for this patient: $3,400 annually

Coding

I07.1 Rheumatic tricuspid insufficiency	No HCC
Z95.1 Presence of CABG	No HCC
I51.7 Cardiomegaly	No HCC

Inferred, but can't code:

I27.20 Pulmonary hypertension, unspecified
HCC 85, RxHCC 186

I11.9 Hypertensive heart disease without heart failure (I51.7 qualifies it though HTN is not expressly stated) ~~RxHCC 187~~

I25.810 Atherosclerosis of graft or I25.10 of native vessel? We don't even know if CAD was resolved or exists in other vessels…. RxHCC 188

Use your 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?

Use your problem list as a “to-do” list

Today’s chief complaint: 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”

- **Clearest way to illustrate the clinical picture**
  - —Patient with severe asthma, diabetes and CKD stage 4 has acidosis.
    - Acidosis due to severe asthma?
    - Acidosis due to diabetes (DKA)?
    - Acidosis due to uremia, distal/proximal renal tubular necrosis?

- Determined by symptoms, tests, and medical decision making that considers all three possibilities. Treat the whole patient to see the whole picture, and **document your thoughts and actions**

Do not equivocate unnecessarily

Avoid these phrases if you are coding the diagnosis

possible probable likely suspected
rule-out questionable indicative of
working diagnosis uncertain diagnosis concern for
still to be ruled out consistent with
suggestive of compatible with

These phrases are indicative that a final diagnosis has not been determined, and Guidelines tell us **we cannot code** outpatient conditions that haven't been confirmed.

Banish “history of” from your narrative

- **The Guidelines tell us NOT TO CODE “history of” because it 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

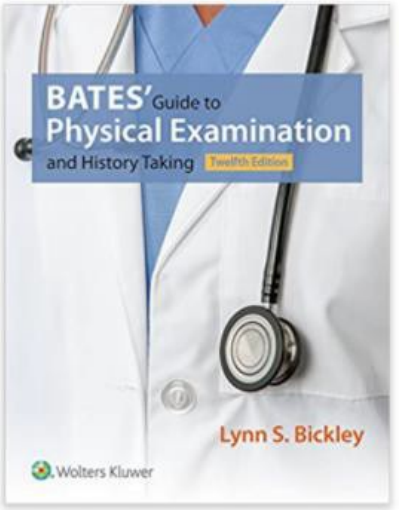
1. Diagnosis

2. Status

3. Plan

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

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



Documenting for DSP
Example

Patient has had controlled diastolic congestive heart failure with medication for 10 years. Patient now fails to take maintenance beta blocker resulting in **acute decompensated heart failure** that led to hospitalization. Patient has been having problems managing living alone because **his wife recently died**. He also has **trouble with his medication co-pays** because of his low income and as a result, he has been skipping doses. **We are helping him apply for Medicaid and have provided a 90-day supply of his medications in the interim**.

I50.33 *Acute on chronic diastolic (congestive) heart failure*

T44.7X6A *Underdosing of beta-adrenoreceptor antagonists, initial encounter*

Z60.2 *Problems related to living alone*

Z63.4 *Disappearance and death of family member*

Z91.120 *Patient's intentional underdosing of medication regimen due to financial hardship*

Z59.6 *Low income*

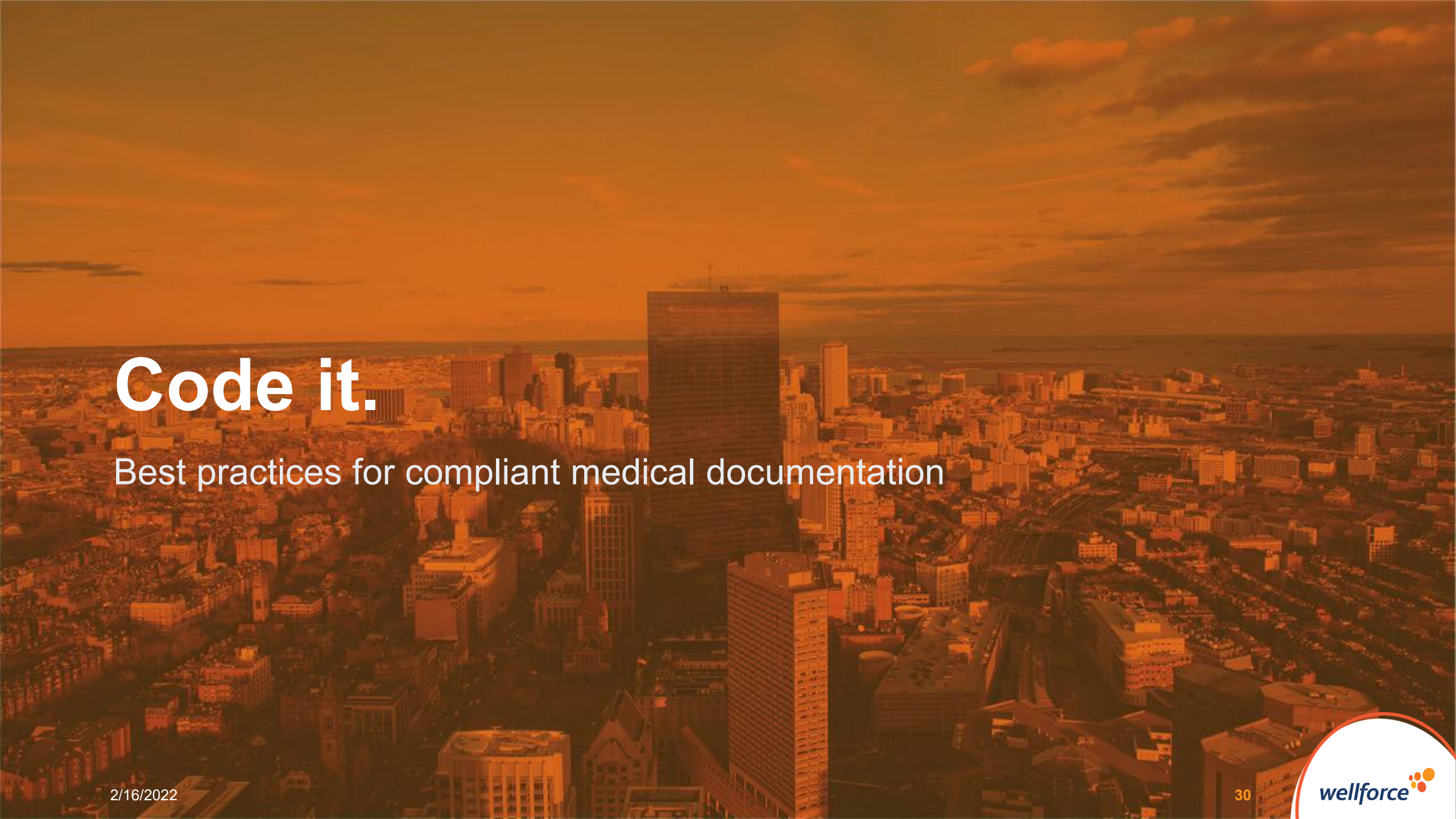
Value of complete documentation

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



Code it.

Best practices for compliant medical documentation

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Comorbidities and complications matter

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)"

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.

NOS vs NEC

- **Be careful choosing codes that are "not otherwise specified" 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?
- **Other specified:** 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

The Index may disagree with you

- **Codes are chosen based on the words documented by you.**

  In an audit, if your documentation is insufficient, the Index will choose the diagnosis regardless of your code selection.

  - "Claudication" indexes to I73.9, PVD, compared to I70.211 Atherosclerosis of native arteries of extremities with intermittent claudication, right leg GET LOCATION
  - "Asymptomatic MI" indexes to a code for old MI (I25.2) GET CHRONICITY
  - "Aortic stenosis" is a valve defect; while "stenosis" is congenital vessel defect. GET CONTEXT
  - "HIV" is indexed to HIV disease (AIDS). GET SEVERITY
  - "Smoker" is indexed to nicotine dependence on nicotine. (F17.00). GET TIMING
  - "Uncontrolled diabetes" is indexed to Type 2 diabetes without complications, unless hyper- or hypoglycemia is documented too. GET CONTEXT

Today is the only day that matters

Only work performed and documented today can be coded for today's encounter

- State the condition that is the subject of "follow up" (never only F/U; never only Med Refill; never only "Post-Hospitalization Visit)
- Reconcile medications and document that they were reconciled
- Anything that looks computer-generated rather than original material from the provider may be discarded in an audit
- Clarity from previous encounters can help others write queries but can't help them code for today. Restate it today.

Read the book, or hire a coder

DM and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned. An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned**. If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.899, Other long term (current) drug therapy**. If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.899, Other long-term (current) drug therapy. **Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.**

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

Morbid obesity

Morbid obesity is often missed – by all specialties

1. A BMI code cannot be reported without a weight-related diagnosis documented and coded first
2. Document and code MO for any patient who has a BMI of 40 or higher.
3. Some people with BMIs of 35 or above may qualify as morbidly obese, if their weight is significantly affecting the patient's health. If such a causal relationship exists, it must be expressly noted in documentation, and the comorbidity must also be linked to the MO and separately coded
4. Vitals should be from the DOS during which MO is reported

Nephrology coding

Always document CKD stage, dialysis status, as appropriate

1. Always document CKD etiology.
   - ICD assumes a causal relationship between CKD and hypertension. For hypertension, report a code from **I12.0** *Hypertensive CKD with stage 5 or ESRD*, or **I12.9** *Hypertensive CKD with stage 1 through 4*.
   - Diabetes is also assumed by ICD to be the cause of CKD in a patient.
   - If CKD is attributable to a source other than hypertension or diabetes, document the cause in every encounter.
2. Document and report manifestations that arise: anemia due to CKD, secondary hyperparathyroidism, hypertension, fluid overload, hyperkalemia, etc, and link to the CKD
3. Complications of dialysis should be tied to the dialysis or appliances in documentation, and the episode of care (initial treatment, subsequent, sequela) must be noted.

Nephrology coding

Always document CKD stage, dialysis status, as appropriate

1. Document complication of transplant as a complication. For example, if the transplanted kidney develops CKD, note that the CKD is a complication of the transplant to establish cause. You must document complications as “complications” – No inferences allowed.
2. Cancer in a transplanted organ should be coded with three codes: First, **T86.19** *Other complication of kidney transplant;* **C80.2** *Malignant neoplasm associated with transplanted organ;* and an additional code for the specific malignancy (eg, **C64.2** *Malignant neoplasm of left kidney, except renal pelvis*)
3. Always report transplant status, dependence on dialysis, stoma status, or awaiting transplant status.

Endocrine coding: diabetes

Never report E--.8 (DM with unspecified complication**), Caution with E--.69** (DM with other specified complication)

1. **Persistent microalbuminuria** in a diabetic should be documented as such, and if linked to the DM would be reported as a complication (E--.21, diabetic nephropathy)
2. Report a **diabetic insufficiency fracture** as a pathological fracture. Specify the complication leading to it.
3. Examine, document, and **code for lower extremity amputation** every time.
4. Report **latent autoimmune diabetes of adults** with codes from E13.
5. Report **all complications of DM**, even those the endocrinologist does not manage (eg, retinopathy, nephropathy, peripheral atherosclerosis) and link in language to DM
6. When **DM resolves** (bariatric surgery) but complications of DM remain, report as a diabetic complication.
7. Ensure the diabetic foot ulcer classification you are using is documented, as grades differ between Wagner, University of Texas, and the ICD classification nomenclature.

Endocrine coding: other

Thyroid

- “Euthyroidism” is an ambiguous term that can mean a healthy thyroid, or adequate replacement of thyroid hormones in a patient with hypothyroidism. Specify which, and code appropriately.
- For post-thyroidectomy status, report organ removal status, hypothyroidism, and any other effects, for example, hypocalcemia or hyperprolactinemia.

Other

- Apply the “due to” rule to all endocrine disorders so that the cause is captured in documentation and coding.

Cardiology coding

Always note the date of an AMI whenever discussing it. (28 days)

1. **If NSTEMI evolves into STEMI** report only the STEMI. If thrombolytic therapy reduces a STEMI to NSTEMI, report the initial STEMI.
2. Report a code from **I11.-** *Hypertensive heart disease*, if a patient has HTN and HF. Do not use I11 codes with ischemic or electrical heart disorders, unless the patient also has HF.
3. Afib that becomes asymptomatic with medication is still being treated and is still documented and coded. **Afib and sick sinus syndrome treated with a pacemaker is still reported**, because it would be symptomatic if the device were removed. Afib that is resolved through ablation is not documented or coded, except as “history of”.
4. **Secondary hypercoagulable state is a rare complication** and not inherent to aFib.
5. Documentation must link diastolic or systolic dysfunction to heart failure for it to be reported as diastolic or systolic heart failure. **HFpEF or HFrEF is sufficient documentation of heart failure**. The type of heart failure must be reported in addition to end-stage heart failure.
6. ICD assumes vessels in CAD are native, unless otherwise documented.

Vascular coding

Acute vs chronic DVT is a big coding issue!

1. The index defaults to acute, but **acute DVT** is seldom treated in the office, and therefore is often the subject of audit.
2. **Intermittent claudication** can be vascular or neurological, so link to atherosclerosis as appropriate. Also, avoid **I73.9** to report intermittent claudication, instead selecting codes from I**70.21-** *Atherosclerosis of native arteries of extremities with intermittent claudication.*
3. **Peripheral angiopathy** will be linked by ICD to diabetes automatically, unless another cause is documented (**E11.51** *Type 2 DM with diabetic peripheral angiopathy*). Report a second code from **I70.2**- to identify the vessels and any complications.
4. **Aortic atherosclerosis** is often an incidental finding from radiology. Unless actions are taken to treat the finding, it should not be reported.
5. **PVD and PAD** can be confusing, so state and code specific arterial or venous disease.
6. **COVID-related microangiopathy** is reported with **M31.19**, a new code for 2022.

Value of 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

If you cannot commit to coding accurately, you may want to improve your productivity by hiring a certified medical coder.

Thank you!

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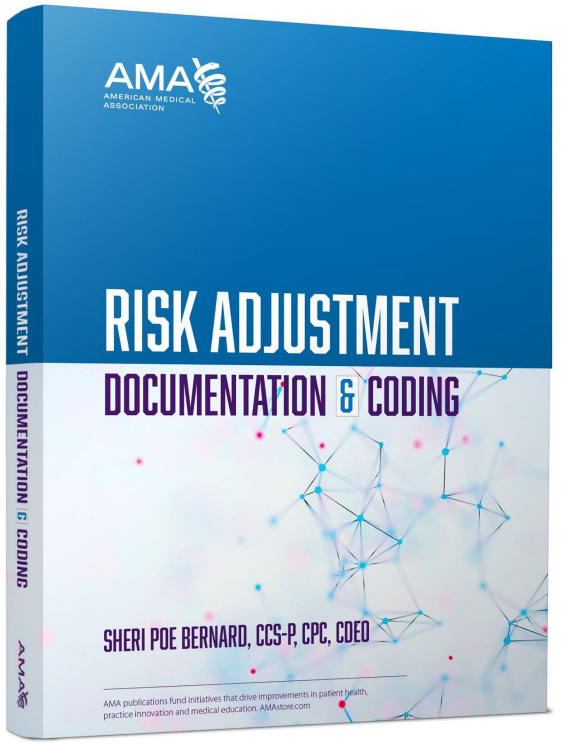

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