Risk Adjustment Documentation & Coding

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CHAPTER 4

Clinical Documentation Integrity and Coding

PART 1: TOPICS A–C

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Risk Adjustment Coding and Documentation by Topic

Chapter 4 provides disease-specific guidance:

- All CMS-HCCs and CMS-RxHCCs are covered.
- Values are from the Community, Non-Low Income, Age ≥ 65 column in the tables in Appendix A.
  - **Why would coders be interested in the relative values of different diseases in risk adjustment?**
- Specific ICD-10-CM codes for each HCC/RxHCC are found in Appendix B.
  - **This allows coders to check to see if specific diagnosis codes risk- adjust.**

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Risk Adjustment Coding and Documentation by Topic *(continued)*

- In this lecture we will focus primarily on coding, addressing documentation only when it affects coding decisions.

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Amputation: Anatomy and Pathophysiology (A&P)

- Most (82%) lower-limb amputations are due to vascular disease
  - Secondary to diabetes, atherosclerosis
- Loss of a lower limb affects mobility
  - **What are the dangers of reduced mobility due to lower-limb loss?**

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Amputation: Coding

- Amputation status is commonly found in physical examination notes or medical history.
- Do not report amputation status for congenital conditions.
- Codes map for traumatic amputation or amputation status.
  - Report the traumatic amputation code only until the wound is healed.
  - **The amputation of one pinky toe is equal to a below-knee amputation for purposes of risk adjustment. Why?**

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Arrest, Shock, Ventilator Status: A&P

- These HCCs report critical, life-threatening conditions:
  - Ventricular fibrillation: Ineffectual heartbeat
  - Respiratory failure: Oxygen exchange is impaired
  - Arrest: Lungs and/or heart cease operation
  - Shock: Generalized circulatory failure (usually with low blood pressure)

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Arrest, Shock, Ventilator Status: Coding

- Do not report ventilator status if the patient is receiving oxygen through a nasal cannula, CPAP, BiPAP, or tracheal mask.
- Do not report ventilator status when a patient is ventilated during surgery, when it is performed “for airway protection,” or if it only occurs within the 48 hours following major surgery.
- Tracheostomy status should always be coded when documented.
  - **What information is needed to correctly code for respiratory problems?**

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Arthritis and Inflammatory Disorders: A&P

- Systemic sclerosis (scleroderma)
  - Hardening of soft tissues affecting skin, esophagus, and other organs
- Chronic, systemic autoimmune disorders: psoriatic and rheumatoid arthritis, systemic lupus erythematosus
  - Inflammation damages joints; may damage organs
  - Rheumatoid arthritis has adult and juvenile varieties
- **What is a “sed rate”?**

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Arthritis and Inflammatory Disorders: Coding

- In rheumatoid arthritis:
  - Look for documentation of seronegative or seropositive.
  - Determine site and laterality.
  - Determine complications.
- **How is bilateral rheumatoid arthritis of the hand reported if there is no documentation of seronegative or seropositive, and no documentation of organ involvement or nodules?**

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Autism: A&P

- Autism spectrum disorder (ASD)
  - So named because the symptoms may be very mild or totally disruptive to activities of daily living.
  - Only 20% of people with autism are female.
  - Because the spectrum of comorbidities varies widely, code also any documented symptoms or comorbidities (eg, intellectual disability, speech or language delays, ADHD).
  - ASD is manageable, but it is a lifetime disorder.

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Autism: Coding

- Use the language in the medical record.
- Code all comorbidities *except* where there are exclusions (eg, categories R47-R49 has an **Excludes1** note for autism).
- Report regardless of the patient's age, as ASD follows the patient into adulthood.
  - **CMS expanded behavioral health care's list of acceptable providers to include which additional professionals?**

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Behavioral Disorders: A&P

- Most severe of these conditions is schizophrenia, affecting 3.5 million Americans. Schizophrenia requires medication throughout the patient's life to manage symptoms; suicide is a big risk.
- Major depression is a brain disorder, unlike situational depression, which is due to recent events in the patient's life.
- Psychiatric conditions affect the patient's ability to comply with any treatment plan, complicating care.
- Care may be provided by a behavioral health professional or the patient's primary care physician.

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Behavioral Disorders: Coding

- Identify whether the episode is recurrent or a single event, and look for any discussion of remission. Note any descriptors of mild, moderate, severe, or with psychotic elements.
- A “trait” is not a disorder (eg, “borderline personality traits” is not a diagnosis of borderline personality disorder).
- “Depressed” is not a diagnosis of depression. Depression screening tests with positive results are not a diagnosis of depression. The physician must document the diagnosis.
- Use the most specific documentation in the record. If the HPI states “recurrent depression,” and assessment states “depression,” report the recurrent depression.

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Blood Disorders: A&P

- Most blood disorders do not risk-adjust. Some that do:
  - Sickle cell disease, with malformed new cells
  - Bone marrow unable to produce certain cells, as in pure red cell aplasia or hemophilia
  - New cells malfunctioning, as in myelodysplastic syndrome
  - Too many new cells, as in polycythemia vera and thrombocythemia

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Blood Disorders: Coding

- Don’t confuse sickle cell trait (gene presence) with sickle cell disease:
  - *Trait* risk-adjusts to HCC 48 (0.625), while *disease* risk-adjusts to HCC 46 (1.388) – more than twice the value
  - **Turning to the tables on pages 351-353 in your book, can you see any other potential problems when coding blood disorders?**
- Look at code D57.01 in Appendix B. Determine the RxHCC and look that answer up in Appendix A.
  - **What do you see?**

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Cerebral Palsy: A&P

- Cerebral palsy (CP)
  - A neurological disorder, either congenital or arising from birth injury
  - Affects 3.3 children per 1,000 live births
  - Milder cases may not be diagnosed until adulthood
  - “Post-impairment syndrome” is seen in adults
    - **What causes post-impairment syndrome? What are some examples? How is it coded?**

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Cerebral Palsy: Coding

- Forms of CP:
  - **Spastic:** Full-body weakness, more severe form
  - **Athetoid:** Uncontrolled writhing movements of hands, feet, arms or legs with hyperactivity of facial muscles or tongue
  - **Ataxic:** Balance and depth perfection causing wide and unsteady gait
  - **Quadriplegia:** All extremities affected
  - **Hemiplegia:** Extremities affected laterally (right or left)
  - **Diplegia:** Affecting both lower extremities or upper extremities (usually lower)
- **What do you think is the most commonly reported CP code?**

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Cerebrovascular Disease: A&P

- "Stroke," "CVA," and stroke-like events
  - **Ischemic:** Resulting from a disruption of blood supply to the brain due to a blood clot or long-term, progressive atherosclerosis. Causes infarction and death of brain tissue.
    - 90% of strokes are ischemic.
  - **Hemorrhagic:** Resulting from a break in a vessel in the brain, or an aneurysm bursting.
  - **Transient ischemic attack (TIA):** A clot moves on or dissolves before tissue death (necrosis). Symptoms resolve.
- **Which type of event would *not* risk-adjust, and why?**

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Cerebrovascular Disease: Coding [Sheri: you said ICD-10-CM codebook? Is it the codebook or the RA book?]

- Open the ICD-10-CM codebook to category I69.
  - Codes from category I69 report residual problems remaining after the patient's initial care for a stroke.
    - **What are some of the residual problems you see listed?**
  - Note the blocks identifying seventh characters to be used with these codes.
    - **What do the guidelines tell us about dominant/nondominant sides?**

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Chromosomal Abnormalities, Intellectual/Developmental Disorders: A&P and Coding

- Approximately 1% of the Medicare population has an intellectual disability.
- Intellectual disabilities always affect the patient encounter and care plan.
  - **Why is that true?**
- If the patient has an underlying condition causing the disability (eg, Down syndrome), report that condition, too.

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Coma, Brain Damage: A&P

- **Coma:** A prolonged and deep state of unconsciousness
- **Anoxic brain damage:** Brain damage due to asphyxia
- **Compression of brain:** Ischemia resulting from pressure on the tissue of the brain
- **Cerebral edema:** Swelling and ischemia of the brain following insult
- **Persistent vegetative state:** Permanent coma due to brain damage

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Coma, Brain Damage: Coding

- The Glasgow coma scale (R40.2-) is used in conjunction with injury or CVA codes as appropriate.
- Three codes reporting eye opening, verbal response, and best motor response are preferred, but a total coma score can be reported if that is all that is documented.
- Seventh characters identifying the circumstances of the assessment of the coma should be identical for all three coma scores reported.
- **When should a coder abstract a coma score for a patient in a medically-induced coma?**

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Complications: A&P

- Complications occur during or following a medical intervention, such as:
  - Mechanical complication
  - Displacement of a device
  - Inflammatory reaction to a device
- Complications must be so-called in documentation. Not all conditions occurring during or following medical interventions are complications.

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Complications: Coding

- Not all complications risk-adjust to HCC 176. For example, amputation stump complications risk-adjust to HCC 189, *Amputation status.*
- **How would you approach coding the following abbreviated operative note?**

  An obtunded patient with acquired hydrocephalus due to a benign tumor of the cerebral ventricle is taken to emergency surgery to repair a leaking shunt that is causing cerebrospinal fluid to leak into the ventricles instead of draining into the peritoneum. The cerebral pressure did not cause any permanent damage.

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Congestive Heart Failure: A&P

- Inability of heart to meet the demands of circulation
  - Early stages: Heart beats faster, works harder, increases muscle size
  - Symptomatic stages: Edema, cough, fatigue, weakness, difficulty sleeping in a reclined position
  - Chronic: Ongoing, body had adjusted (compensated)
  - Acute: Sudden onset causing medical emergency (decompensated)
- **What is ejection fraction and what does “HFrEF” indicate?**

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Congestive Heart Failure: Coding

- A causal relationship between heart failure and hypertension is assumed in ICD-10-CM. A common mistake is to report code I50.- with code I10.
- Systolic/diastolic dysfunction is not synonymous with heart failure.
- End-stage HF, biventricular HF, and right HF due to left HF each require a second code to identify the type of heart failure.
- **What codes are reported for:**
  1. **Acute HFrEF with stage D heart failure?**
  2. **Chronic HFpEF with hypertension?**

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Cystic Fibrosis: A&P

- Cystic fibrosis (CF)
  - A genetic disorder of the exocrine glands that affects 30,000 Americans
  - Exocrine glands generate secretions into epithelium or into ducts
    - Pancreatic secretions aiding in digestion
    - Sweat
    - Lining of lungs, intestines
  - May be diagnosed at birth; may be diagnosed years later
  - Pneumonia and nutritional deficiencies are the biggest threats to patients with cystic fibrosis

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Cystic Fibrosis: Coding

- Code also any endocrine pancreatic insufficiency with code K86.81.
  - Pancreatic enzymes taken orally help with digestion. Code K86.81 maps to an RxHCC in addition to the HCC and RxHCC for CF.
- Meconium ileus in CF is a neonatal diagnosis.
- **Code the following clinical scenario:**

  A 23-year-old CF patient hospitalized with MRSA pneumonia; also determined to have exocrine pancreatic insufficiency causing moderate protein-calorie malnutrition. Her BMI is 16.1.

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