Risk Adjustment Documentation & Coding

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CHAPTER 3

Clinical Documentation and Coding for RA

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Documentation Guidelines

- Each patient encounter should include:
  - A reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
  - An assessment, clinical impression, or diagnosis.
  - A plan for care.
- **Would any of these documentation elements be excluded as a source for diagnostic code abstraction?**

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Documentation Guidelines *(continued)*

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
  - **What does “inferred” mean? Provide an example.**
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
  - **What problems can you see developing when past and present diagnoses are in the record for the encounter?**
- Appropriate health-risk factors should be identified.
  - **Provide examples of health-risk factors.**
- The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.

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Zeroing In On Diagnoses

- Because risk-adjusting diagnoses affect payment, the Centers for Medicare & Medicaid Services (CMS) wants to ensure diagnoses abstracted from the record are valid. Validating the diagnosis is called finding “support” for the diagnosis.
  - CMS does not define what constitutes “support.”
  - Did the physician make a note about this diagnosis during this encounter, or is it just listed in the past medical history or in an ongoing problem list?
- **MEAT: m**onitored/measured; **e**valuated; **a**ssessed/addressed; **t**reated
  - Many organizations use MEAT as a criteria for support.

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- **What skills do coders need to effectively determine MEAT in documentation?**

TABLE 3.1 Examples of Support As Described by MEAT

MEAT ELEMENT	PROBLEM	SUPPORT
Measured, monitored	Morbid obesity	George is still unwilling to consider bariatric surgery, even though it would help his knees considerably.
	Diabetes mellitus.	A1C today is 6.7
Evaluated	CHF	+3 LE edema
	Pneumonia	Film shows R lung is clearing
Assessed, addressed	HTN	Blood pressure is controlled. Continue low sodium diet.
	Moderate reactive asthma	Breathing improved with weather change
Treated	Assessment: Hypothyroidism	New Rx for levothyroxine 125 mcg daily
	New diagnosis of Stage 3 CKD	Referred to nephrology clinic

Abbreviations: CHF indicates congestive heart failure; CKD = chronic kidney disease; HTN = hypertension; LE = lower extremity; and Rx = prescription.

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Subjective, Objective, Assessment, and Plan (SOAP) Notes

- **SOAP notes often provide MEAT, as many formats link the assessment to a plan.**

TABLE 3.2. Sample Assessment/Plan

ASSESSMENT	PLAN
Hypertension	Propranolol ER 80 mg and continue home monitoring
Morbid obesity	Referral to bariatric clinic for initial interview for gastric bypass surgery
Hypercholesterolemia	Zetia, 10 mg daily, curb red meats and dairy
Major depressive disorder, recurrent, in partial remission	Continue fluoxetine and contact therapist

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CMS Advice On Problem Lists

- When reviewing medical records, pay special attention to the problem list on electronic medical records. Often, in certain systems, a diagnosis never drops off the list, even if the patient is no longer suffering from the condition. Conversely, the problem list may not document the HCC your organization submitted for payment.

- An acceptable problem list must be comprehensive and show evaluation and treatment for each condition that relates to an ICD-10-CM code on the date of service.

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Test Values

- Coders are not clinicians and cannot abstract diagnoses based on test values. The physician must make the diagnosis. If possible, the coder may query the physician regarding the importance of test values.

CLINICAL EXAMPLES

WHAT WAS DOCUMENTED	CLINICAL DIAGNOSIS INTENDED	CODER ABSTRACTION (ACCORDING TO GUIDELINES)
1. Diabetic, finger stick today BG 37	Diabetic hypoglycemia	E11.9, Type 2 diabetes mellitus without complications
2. Her mental frailty is stable, according to daughter	Alzheimer's disease	R41.81, Age-related cognitive decline
3. ⇧potassium	Hyperkalemia	No code

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Comorbidities In ICD-10-CM Guidelines

- 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). (Section IV[I])
- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. (Section IV[J])

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Comorbidities

- Comorbidities affect medical decision-making for almost all encounters.
- **How would a comorbidity of dementia affect the patient with a diagnosis of new onset type 2 diabetes?**
- **How would a comorbidity of COPD affect a patient with a new diagnosis of pneumonia?**

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History or History Of

- For physicians: The continuum of the patient's medical status, both past and present.
- For ICD-10-CM: A condition that no longer exists and no longer requires treatment.
- **How do these conflicting definitions cause problems for coders?**

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DOCUMENTATION	COMPLIANT CODING AND HCC
History of opioid dependence	F11.21, Opioid dependence, in remission (HCC 55, 0.383)
History of opioid abuse	F11.11, Opioid abuse, in remission Does not map for RA
Current methadone maintenance for opioid dependence	F11.20, Opioid dependence, uncomplicated (HCC 55; 0.383)
History of diabetic foot ulcer	Z86.31, Personal history of diabetic foot ulcer (no HCC)
Diabetic foot ulcer, exposed fat layer, R midfoot	E11.621, Type 2 diabetes mellitus with foot ulcer (HCC 18; 0.318) L97.412, Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed (HCC 161; 0.535)

DOCUMENTATION	COMPLIANT CODING AND HCC
History of prostate cancer	Z85.46, Personal history of malignant neoplasm of prostate (no HCC)
Prostate cancer stable on leuprolide	C61, Malignant neoplasm of prostate (HCC 12; 0.146)
History of pulmonary embolism	Z86.711, Personal history of pulmonary embolism (no HCC)
Pulmonary embolism responding favorably to anticoagulation therapy	I26.99, Other pulmonary embolism without acute cor pulmonale (HCC 107; 0.400)

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Causal Relationship

- A medical scenario in which an underlying condition is directly responsible for a second condition (eg, pneumonia due to pseudomonas or heart failure due to hypertension).
  - Etiology: For ICD-10-CM, a disease that originates or cases a problem; the underlying condition (eg, follicular carcinoma of the thyroid [etiology] causing thyrotoxicosis)
  - Manifestation: For ICD-10-CM, a complication from an underlying disease (eg, thyrotoxicosis [manifestation] due to follicular carcinoma of the thyroid)
- In many cases, causal relationships must be so stated in documentation in order for the relationship to be linked in the coding.
- ICD-10-CM has exceptions.

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Causal Relationship: Guidelines

The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title, in the Alphabetic Index, or in an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. **These conditions should be coded as related even in the absence of provider documentation explicitly linking them,** unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (eg, sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).

Turn to “Diabetes” in your ICD-10-CM Alphabetic Index.

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Status Conditions

Status condition: Element within a patient's medical profile that is significant for current or future medical risk.

- **These status conditions risk-adjust and are often not coded when they should be:**
  - HIV-positive status
  - Stoma status
  - Lower-extremity amputation status
  - Major organ or stem-cell transplant status
  - Body mass index (BMI) of 40 or greater
  - Dialysis status
  - Presence of a heart assist device
- **How might these conditions affect care?**

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Codes In Documentation

CODING EXAMPLE

The physician treated the patient for an acute exacerbation of COPD. The coder must abstract the text. Codes cannot be abstracted from the simple documentation of a code number in the medical record.

DOCUMENTATION	WHAT CAN BE ABSTRACTED (ASSUMING THERE IS MEAT)	RATIONALE
J44.1	No code	No text to abstract
J44.1 COPD	J44.9 Chronic obstructive pulmonary disease, unspecified	COPD is documented. J44.1, which reports COPD with exacerbation, is rightly ignored.
J44.1 COPD w/exacerbation	J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	The text contains enough information to abstract with specificity.

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Coding Conventions

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NEC Vs NOS

- Not elsewhere classified (**NEC**) indicates that the classification does not have a code specific to the condition being reported, so a general code must be used.
- Not otherwise specified (**NOS**) indicates there is not enough information available to choose a more specific code, usually because the diagnostic process is still under way or because the documentation is insufficient.
- **In some instances, NEC codes risk-adjust, but NOS codes do not.**
- **In some instances, NEC and NOS classify to the same code.**

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Brackets

- When a code in the Alphabetic Index is followed by a second code in brackets, ICD-10-CM convention dictates that two codes are required to correctly report the etiology and manifestation (eg, Pick's disease G31.01 *[F02.80],* requiring a second code to report dementia in Pick's disease *[F02.80]).* The second code, F02.80 cannot be omitted, according to ICD-10-CM convention.

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Code First

- If the Tabular instructions state “Code First,” a second code is mandatory.
- If Tabular instructions state “Code Also,” a second code is optional.

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Code Lookup

- Per ICD-10-CM Guideline Section IV(A), the “most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.”
- **Can you think of any instances in which the search might start in the Tabular List?**

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Coding Instructions at the Tabular Code Level

- Go to category I85 in the ICD-10-CM code set.
- **What instruction might be missed if the coder does not perform a complete code lookup?**

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Documentation Nomenclature

EXAMPLE

Coders must use the language in the record. Physicians choose their nomenclature carefully. Different terms yield different results from the ICD-10-CM Alphabetic Index. It would be a mistake, eg, to assume that "mass" is a synonym for "tumor" in code lookup:

Mass, liver
R16.0 Hepatomegaly, not elsewhere classified

Lesion, liver
K76.9 Liver disease, unspecified

Lump, see Mass
R16.0 Hepatomegaly, not elsewhere classified

Tumor, liver (see also Neoplasm, unspecified behavior, by site)
D49.0 Neoplasm of unspecified behavior of digestive system

- Coders should never make assumptions regarding the language in the medical record.
- The language in the record should be the basis for code lookup in the Alphabetic Index.

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