2013 Diagnosing, Documenting and Coding Chronic Conditions for Risk Adjustment 1.5hr

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Introduction

- **Optum** collaborates with health care professionals and health plans towards improved health outcomes.
- **Optum** provides tools and support to assist providers in the early detection, ongoing assessment and accurate reporting of chronic conditions for Medicare and Medicaid patients.
- **Optum** applies technology and health intelligence solutions that help providers accurately document and code health care services while improving the overall quality of patient care.

Sir William Osler

The search for static security - in the law and elsewhere - is misguided. The fact is security can only be achieved through constant change, adapting old ideas that have outlived their usefulness to current facts.

-- Sir William Osler

Clinical Disclaimer

The information presented herein is for informational purposes only. It is not intended, nor is it to be used, to define a standard of care or otherwise substitute for informed medical evaluation, diagnosis and treatment which can only be performed by a qualified medical professional. Optum does not warrant or represent that the information contained herein is accurate or free from defects.

Coding Disclaimer

The information presented in this course complies with accepted coding practices and guidelines as defined in the ICD-9-CM and ICD-10-CM coding books. It is the responsibility of the physician or other healthcare provider to produce ***accurate and complete*** *documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-9-CM and ICD-10-CM code(s) according to the guidelines.* ***If the clinical information in the medical record does not support a given code, that code cannot be used.***

Agenda

- Health Insurance and Risk Adjustment Payment Methodology
  - Risk Adjustment methodology
  - Risk Adjustment Factor (RAF)
  - Hierarchical Condition Categories (HCCs)
    - Changes to the 2014 CMS-HCC Model
      - Obesity
      - CKD
  - Coding example talking points
  - How Risk Adjustment impacts you
- CMS Directive & the Conditions that Impact the Severity of Disease
- Illness Burden as defined by ICD-9-CM under HIPAA
- Diagnosing, Documenting and Coding:
  - Diabetes Mellitus & Manifestations
    - Chronic Kidney Disease (CKD) (including HTN)
    - Peripheral Neuropathy
    - Peripheral Vascular (Arterial) Disease (PVD/PAD)
  - Heart Failure (HF) (including HTN)
  - Depression
- Documentation Considerations & EMR

Risk Adjustment Methodology

Methodology implemented by CMS

- Mandated by the Balanced Budget Act of 1997
  - Model collects information this year to establish cost of patient care for next year
- CMS chose a "risk model" based on measuring chronic conditions
  - The more chronic conditions a patient has the more care they may require

Risk Adjustment Factor

- Each patient is assigned a Risk Adjustment Factor (RAF).
  - RAF is a numeric value assigned by CMS to identify the health status of a patient.
  - RAF score is made up of the following criteria for each patient:

1. A demographic RAF based on age & sex
2. Additional risk factors are added for Medicaid status & if patient was eligible for Medicare due to a disability
3. A RAF for the total of all chronic conditions and some disease interactions

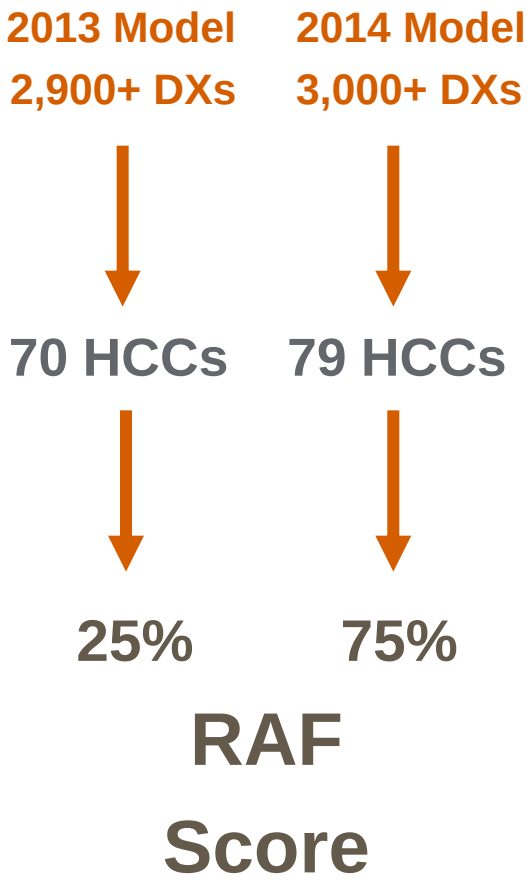
2014 PY CMS HCC Model: A Blended Model

Diagnosis Group (DX Group)

- Clinically homogeneous groups of codes in the HCC model
- Each code falls into one and only one Diagnosis Group and codes are grouped into Condition Categories (CCs).

HCC (Hierarchical Condition Category)

- Per CMS, the diagnosis codes are recorded per year, meaning each condition must be documented and coded each year.
- Diagnoses that demonstrate similar resource usage are categorized together.
- CMS designed the equation so that the average Medicare FFS patient has the score of **1.00**.



Bolding Legend

- Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year 2014, the bolding of ICD-9-CM codes has been revised to reflect:
  - **Red = Risk adjusts in only the 2013 CMS-HCC model**
  - **Black = Risk adjusts in both the 2013 CMS-HCC model and the 2014 CMS-HCC model**
  - **Orange = Risk adjusts in only the 2014 CMS-HCC model**
- Note: The 2014 Payment Year model is a blend of the 2013 CMS-HCC model (25%) and the 2014 CMS-HCC model (75%).

Changes in the 2014 CMS-HCC Model

- 79 HCCs (previously 70 HCCs)
  - new HCCs added to the model and several existing HCCs split

- HCCs added to the model:
  - Two new HCCs related to metabolic disorders were added:
    - Other significant endocrine and metabolic disorders
    - Morbid obesity

- Some broken out into separate HCCs:
    - Kidney disease

Changes in the 2014 CMS-HCC Model: Morbid Obesity[1,2]

- Overweight & Obesity (Subcategory 278.0x)
  - 278.00 Obesity, unspecified (≥30)
  - **278.01** Morbid obesity
  - 278.02 Overweight (≥25)
  - **278.03** Obesity hypoventilation syndrome

- Body Mass Index (BMI) (for persons over 20 years old)
  - **V85.41** BMI 40.0-44.9, adult
  - **V85.42** BMI 45.0-49.9, adult
  - **V85.43** BMI 50.0-59.9, adult
  - **V85.44** BMI 60.0-69.9, adult
  - **V85.45** BMI 70 and over, adult

1 "CMS and the National Center for Health Statistics (NCHS)." ICD-9-CM Official Guidelines for Coding and Reporting. N.p., 01 oct 2012. Web. <http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf>.

2 Obesity and overweight." Media centre. World Health Organization, n.d. Web. 12 Dec 2012. <http://www.who.int/mediacentre/factsheets/fs311/en/>.

Changes in the 2014 CMS-HCC Model: Kidney Disease[1]

- Renal failure is broken out into “Acute Renal Failure” and different severity levels of chronic kidney disease (CKD)
  - HCC Titles:
    - Acute Renal Failure (**584.x**)
    - CKD, Stage 5 (**403.x1, 404.x2, 404.x3, 585.5, 585.6**)
    - CKD, Severe, Stage 4 (**585.4**)

- Changes to several other HCCs to address MA coding intensity:
  - Removed the lower-severity kidney disease HCCs including:
    - Chronic Kidney Disease (CKD) stage 3 (**585.3**)
    - CKD stages 1-2, or unspecified (**585.1, 585.2, 585.9**)
    - Unspecified renal failure (**586**)
    - Nephritis (**583.9**)

1 United States. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Announcement 2014*. 2013. Web. <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf>.

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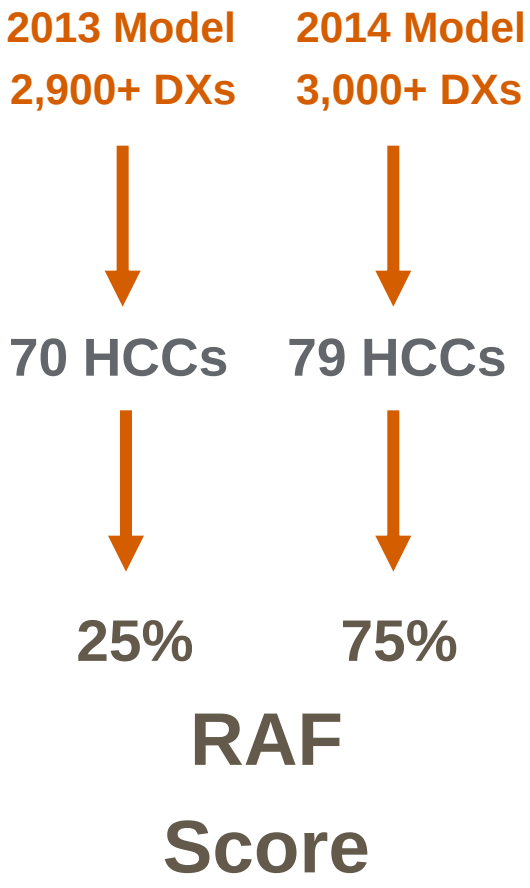


Interpreting Risk Adjustment Factor (RAF)

- RAF score identifies patient health status
  - Low RAF score may indicate a healthier population
  - High RAF score may indicate members with increased health risks

  OR

  - Low RAF score may falsely indicate a healthier population due to:
    - inadequate chart documentation (or)
    - incomplete and/or inaccurate ICD-9-CM coding
    - patients who were not seen
  - High RAF score may be inflated due to:
    - reported diagnoses not documented
    - overcoding (e.g., copying and pasting Problem List into Assessment/Plan)

Risk Adjustment Overview Example

Example:

- 76-year-old female
- Medicaid eligible
- Diabetes
- Vascular disease
- CHF

76-year-old female	0.426
Medicaid eligible (Aged)	0.202
Diabetes w/ vascular complications (HCC 15)	0.371
Vascular disease w/ complications (HCC 104)	0.594
CHF (HCC 80)	0.346
Disease Interaction (DM + CHF)	0.150
Total RAF	**2.089**

Determining a RAF Score

- **The Risk Adjustment model is additive.**
  - Takes in all qualifying diagnoses submitted to CMS in a given year for a particular patient.
  - Adds up risk factors to achieve a total health status "score" for patient.
- **The Risk Adjustment model is predictive.**
  - Codes reported this year, determine resources needs for next year.
  - Health status is re-determined each year.

How Strong is the Correlation?

Risk Adjustment Model	Payment Years	R^2
Adjusted Avg. per Capita Cost (AAPCC) (Demographics)	Pre-2000	0.0077
PIP-DCG (Demographics, Inpatient)	2000-2003	0.0550
CMS-HCC (Demographics, Inpatient, Ambulatory)	2004-2008	0.0997
Version 12 CMS-HCC (2005 Recalibration)	2009-Current	0.1091
Version 21 CMS-HCC (2007 Recalibration, 2009 clinical revision)	Proposed	0.1246

From: Pope GC, *et al.* (2011). Evaluation of the CMS-HCC Risk Adjustment Model. https://www.cms.gov/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf

- CMS-HCC can be easily be modified year-to-year, based on demographic changes
- **It is *prospective* and predictive of Medicare expenditures for the following year (Pope et al., Risk adjustment of Medicare capitation payments using the CMS-HCC model, 2004)**
- **CMS-HCC outperforms other predictive models for in-hospital and 6-month mortality for patients with CHF, CVA, DM, and AMI** Li, P, *et al. (2010)* Comparison of the performance of the CMS Hierarchical Condition Category (CMS-HCC) Risk Adjuster with the Charlson and Elixhauser Comorbidity Measures in Predicting Mortality. *BMC Health Serv Res 10:245.*
- ***The model is dependent on accurate documentation and coding by PCPs***

It’s a Benefit Provided to the Beneficiary

As part of their Medicare Advantage health plan benefit, members have access to a **comprehensive physical exam**, that promotes early detection, documentation and treatment of acute and chronic conditions.

How Does Risk Adjustment Impact You?

- All chronic conditions must be assessed for all Medicare Advantage patients
  - *Providers obtain an overall health status for each patient*
  - *Results in all conditions being monitored by the providers*
    - Improves quality of patient care
    - Complex conditions are monitored and may reduce the need for emergency care

CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

CMS – the Directive

The Mandate from CMS

Any Condition that is taken into account or affects patient care, treatment or management should be documented and ultimately coded.

The listing of all pertinent diagnosis codes is important!

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), (2011, October). ICD-9-CM official guidelines for coding and reporting. Retrieved October 20, 2011, from Department of Health and Human Services (DHHS) Web site: http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

Chronic Conditions

– ***Outpatient Coding***: 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).

- "Code all documented conditions that coexist at the time of the encounter/visit, and **require or affect patient care, treatment, or management**."

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), (2011, October). ICD-9-CM official guidelines for coding and reporting. Retrieved October 20, 2011, from Department of Health and Human Services (DHHS) Web site: http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

Health Status Conditions

Many Conditions may have an Additive Effect on Risk Adjustment

- Renal Dialysis
- Tracheostomy Status
- Protein Calorie Malnutrition
- Artificial Openings for Feeding or Elimination
- Lower Limb Amputee
- Major Organ Transplant
- Active Treatment for Cancer
- HIV Status
- Major Depression
- Old Myocardial Infarction (Code 412)

Illness Burden is Defined by ICD-9-CM under HIPAA

Specific Documentation

and

Coding Guidelines

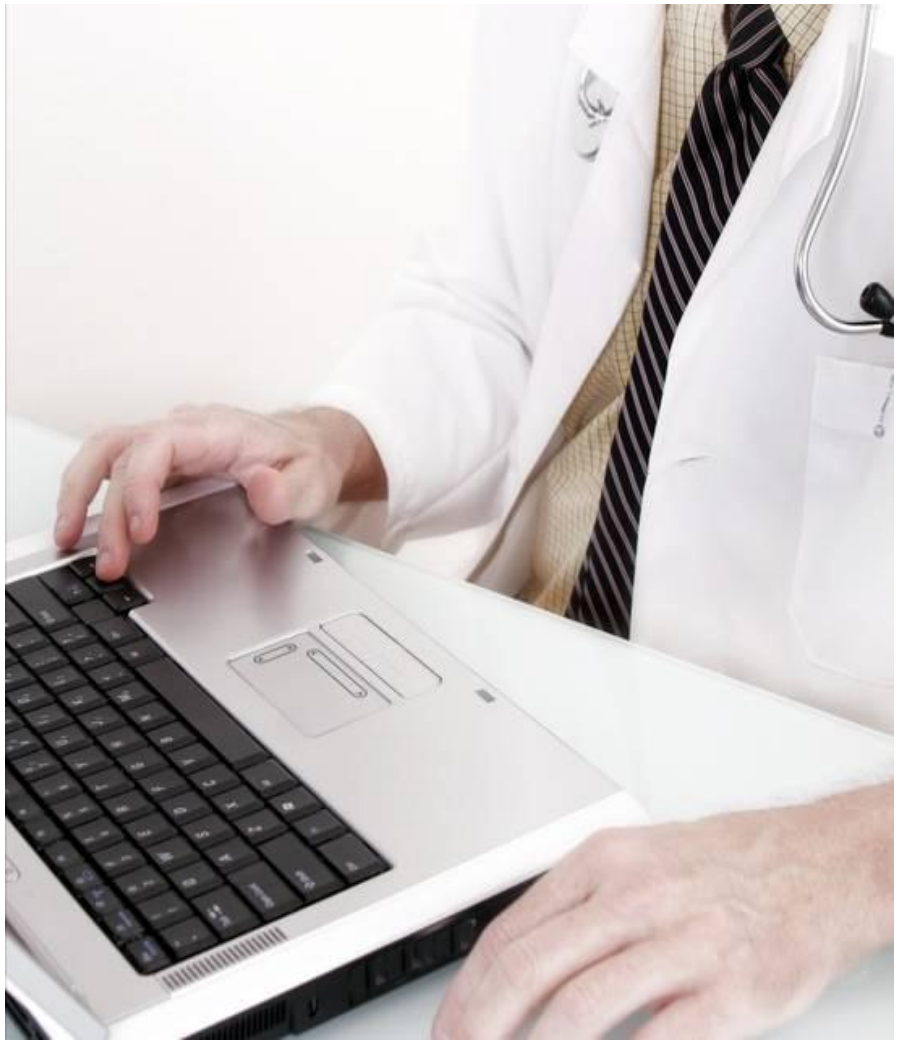
are Mandated by HIPAA

Centers for Medicare and Medicaid Services, (2009, April). Transaction and code sets standards: Overview. Retrieved July 20, 2009, from CMS Web site: http://www.cms.hhs.gov/TransactionCodeSetsStands/

Centers for Medicare and Medicaid Services, (2010, December). CMS-Evaluation & management services guide. *CMS* , *ICN: 006764. R*etrieved October 3, 2011, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

Illness Burden is Defined by ICD-9-CM under HIPAA

Specific Documentation & Coding Clearly Identifies the Severity Level of Disease



Illness Burden is Defined by ICD-9-CM under HIPAA

Specific Documentation and Coding Clearly Paints the Picture of the Level of Complexity for the Patient Encounter

Centers for Medicare and Medicaid Services, (2010, December). CMS-Evaluation & management services guide. *CMS , ICN: 006764.* Retrieved October 3, 2011, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

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Diagnosing, Documenting and Coding:

Diabetes Mellitus & Manifestations

Diabetes Mellitus – Screening for Diabetes

Testing for diabetes

From the American Diabetic Association (ADA) guidelines

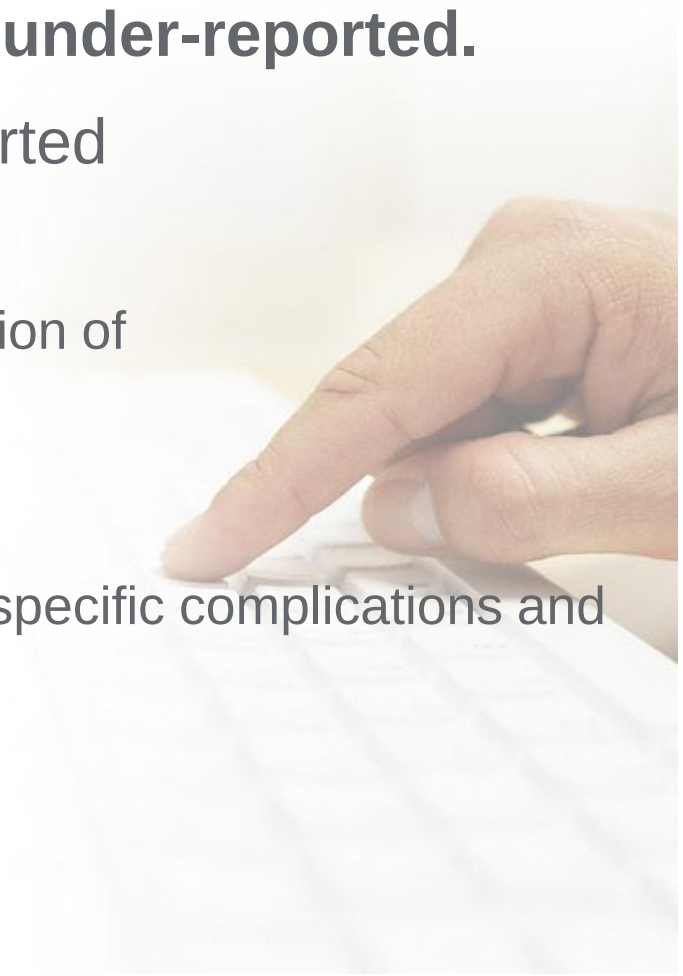
- **Patients are AT-RISK for diabetes* if one or more of the following tests are abnormal:**
  1. 'Impaired' fasting (8 hours) "IFG": ≥ 100 mg/dl but ≤ 126 mg/dl
  2. 'Impaired' glucose tolerance test "IGT": ≥ 140 mg/dl but ≤ 199 mg/dl 2hr after 75 gm glucose load
  3. HgA1C 5.7% to 6.4%***
  4. Random Fingerstick or blood draw: (Random blood glucose ≤ 199 is not sufficient for dx of pre-diabetes according to ADA)
- **Provider (s) can OFFICALLY DIAGNOSE diabetes** when one or more of the following tests are positive:**
  1. HgA1C ≥ 6.5%***
  2. Fasting (8 hours): ≥ 126 mg/dl
  3. 2-hour plasma glucose ≥ 200mg/dl after standard glucose load during an OGTT
  4. Random blood glucose ≥ 200 mg/dl with classic symptoms of hyperglycemia or hyperglycemic crisis

- **** For all three tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at higher ends of the range.***
- *****In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing.***
- ****** Performed in a laboratory using a method that is National Glycohemoglobin Standardization Program certified and standardized to the DCCT assay. Use of A1C for diagnosis is not recommended for certain populations.***

Underlying Disease – Diabetes Mellitus

Complications of diabetes are under-reported.

250.00 is over-reported



- Diabetes Mellitus, code **250.00** without mention of complication is appropriate at times.

- However, if complications exist, code to the specific complications and manifestations.

Details of Documenting Diabetes

Diabetes:

- Type of diabetes
- Controlled or uncontrolled
- Complicated or uncomplicated
- Identify the system(s) with the complications
  - **60% of diabetics have systemic complications***
- Name the manifestation in the system

* The State of Diabetes Complications in America, Amer. Assoc Clinical Endocrinologists, 4/2007

Diabetes *Controlled/Uncontrolled*

The documentation must indicate the status of the diabetes.

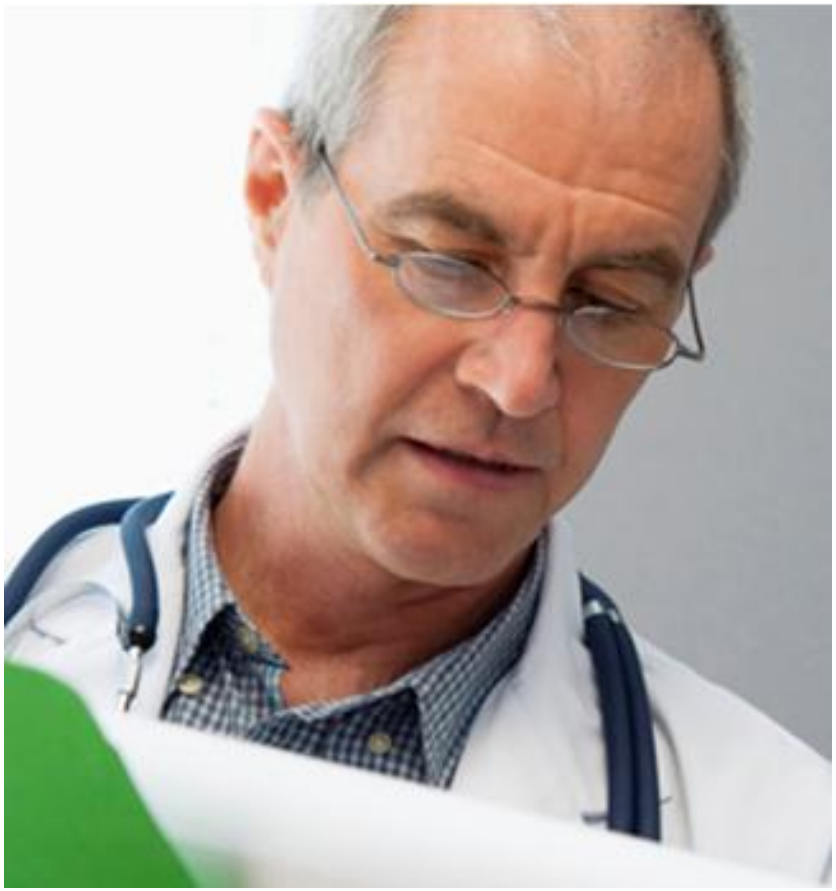
- **Poorly controlled** or **poor control** is vague terminology and does not necessarily indicate uncontrolled blood glucose levels.
- Out-of-control or uncontrolled DM is coded only when the physician specifically documents this status.

Example:

- **Type II DM, poorly controlled (250.00)**
- **Type II DM, uncontrolled (250.02)**

Underlying Disease – Diabetes Mellitus

- The documentation MUST make the connection.
- The coder must code to the specific complications and manifestations presented and documented in the chart.
- In order to code a disease or condition as a manifestation of DM, it must be stated that the disease or condition is diabetic or due to diabetes.



(The Coding Clinic, Third Quarter 1991, pages 7-8)

Underlying Disease – Diabetes Mellitus

- What System is being Affected?
  - **250.4**X Diabetes with **renal** manifestations
  - **250.5**X Diabetes with ophthalmic manifestations
  - **250.6**X Diabetes with **neurological** manifestations
  - **250.7**X Diabetes with **peripheral circulatory** disorders
  - **250.8**X Diabetes with other specified manifestations
  - **250.9**X Diabetes with unspecified complications

The X reports the type of diabetes and the control status.

Be sure to append V58.67 for long term (current) use of Insulin (except Type I).

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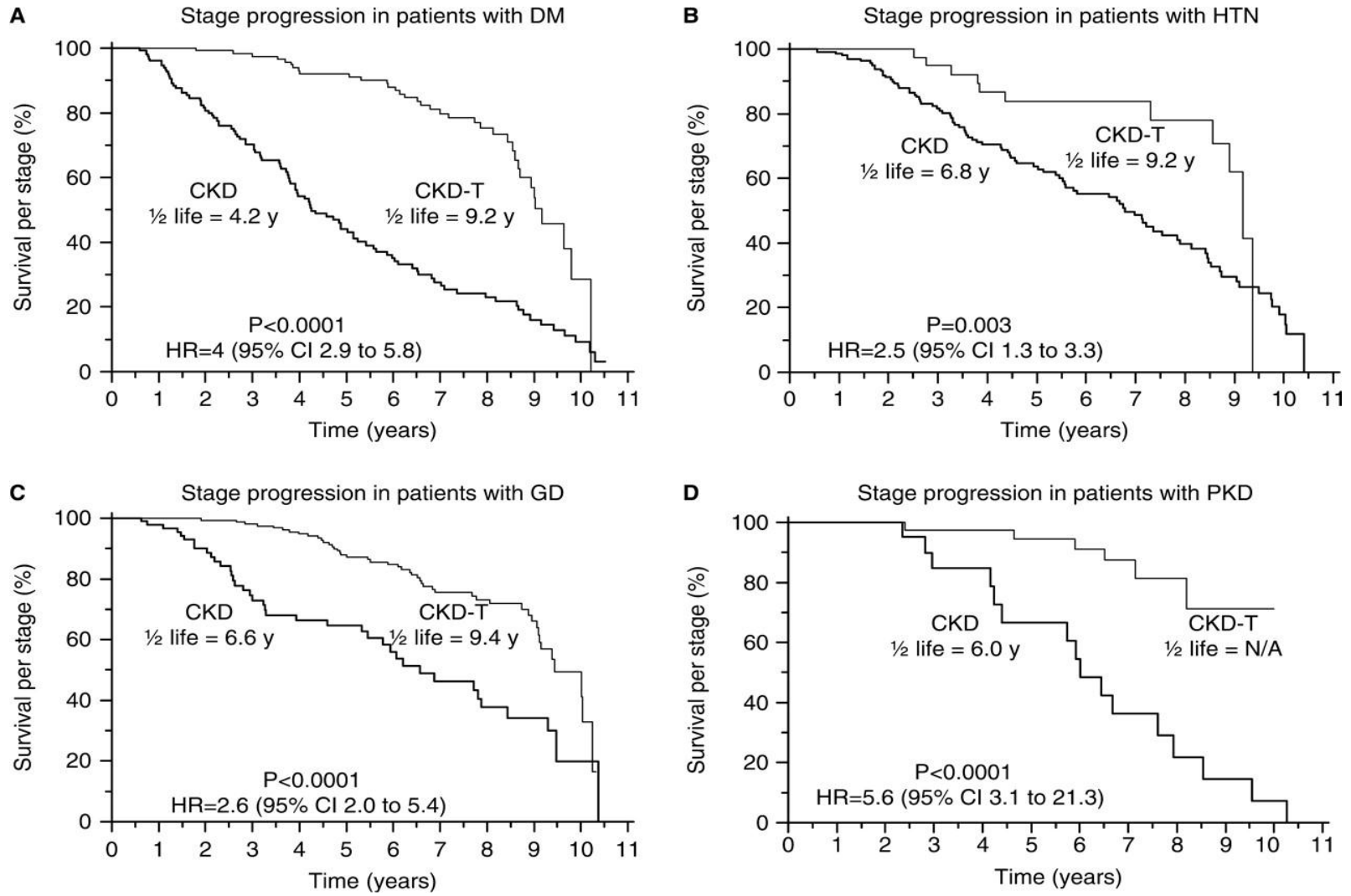
Diagnosing, Documenting and Coding:

Chronic Kidney Disease

What can I do to treat Early Stage CKD?



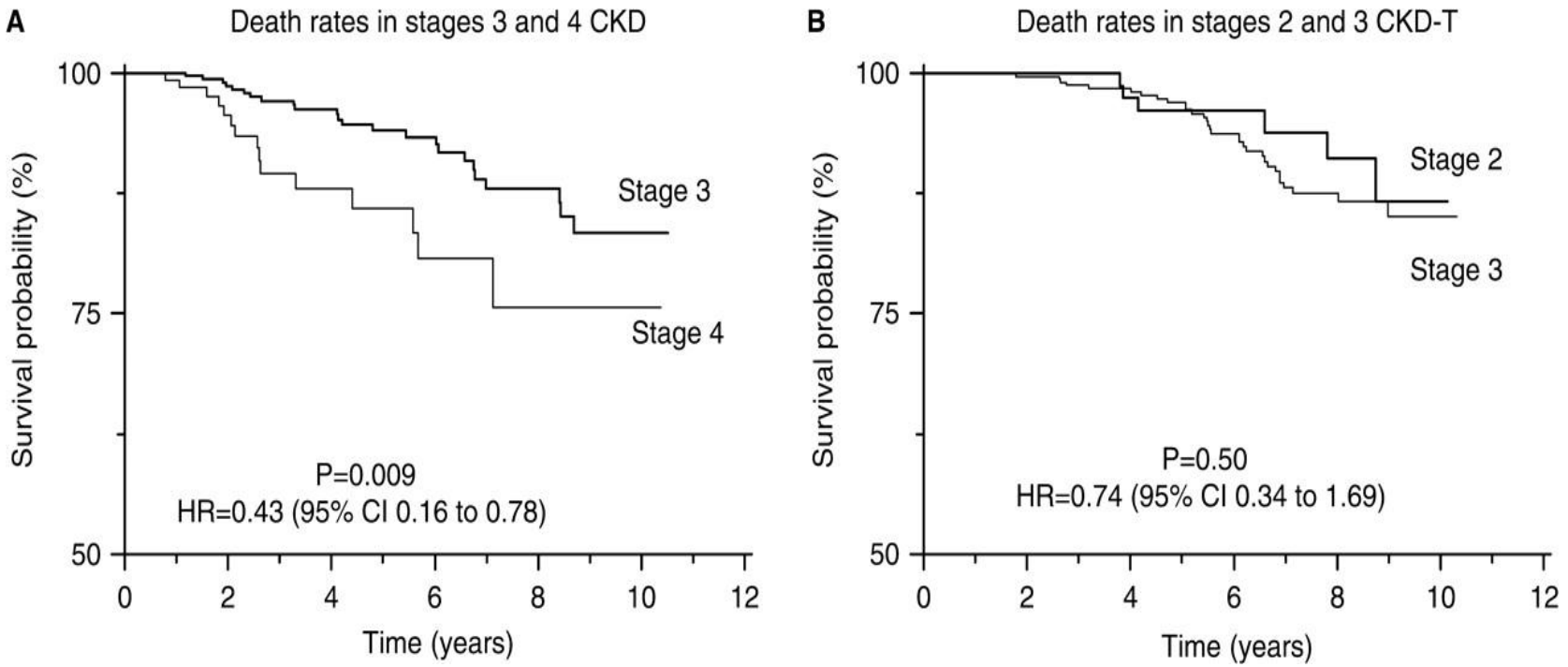
Kukla et al, CKD stage-to-stage progression in native and transplant kidney disease, *Nephrol Dial Transplant (2008) 23:* 693-700.

Mortality/Morbidity Associated with CKD

- **All patients with chronic kidney disease should be considered in the "highest risk" group for cardiovascular disease, irrespective of levels of traditional CVD risk factors. Both "traditional" and "chronic kidney disease related (nontraditional)" CVD risk factors may contribute to this increased risk.**
- Similar to the general population, cardiovascular disease accounts for 40% to 50% of all deaths in the end-stage renal disease (ESRD) population, and CVD mortality rates in ESRD patients are approximately 15 times higher than the general population[1]
- 40% of patients starting dialysis already have evidence of coronary heart disease (CHD)[3] and only 15% are considered to have normal left ventricular structure and function by echocardiographic criteria[2].
- **How about Early Stage CKD?**

1. Foley RN, Parfrey PS, Sarnak MJ: Clinical epidemiology of cardiovascular disease in chronic renal disease. Am J Kidney Dis 32:112-119, 1998
2. Foley RN, Parfrey PS, Harnett JD: Clinical and echocardiographic disease in patients starting end-stage renal disease therapy. Kidney Int 47:186-192, 1995
3. US Renal Data System. USRDS 1998 Annual Data Report, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Bethesda, MD, 1998

What does early stage CKD mean to my patients?



The Death Rate in Stage 2 is the same as in Stage 3!

Strategy: Aggressively Document and Treat Stage 1 and Stage 2 Disease. (Avoid Progression from Stage 1 to Stage 2; Minimize Mortality associated with Stage 2)

Kukla et al, CKD stage-to-stage progression in native and transplant kidney disease, *Nephrol Dial Transplant (2008) 23:* 693-700.

Chronic Kidney Disease

- The Medicare Chronic Kidney Disease (CKD) Stage 5 population nearly doubled from 1997-2007.[1]
- Total costs for kidney disease now approach 24% of Medicare expenditures.[1]
- Chronic kidney disease is under-diagnosed and under-treated in the United States, resulting in lost opportunities for prevention.[2]

1. Clinical Practice Guidelines and Clinical Practice Recommendations for Diabetes and Chronic Kidney Disease. Am J Kidney Dis 49:S1-S180, 2007 (suppl 2) Diabetes Care January 2012 vol. 35 no. Supplement 1 S1-S2

2. CDC/Department of Health and Human Services, "Prevalence of Chronic Kidney Disease and Associated Risk Factors." Morbidity and Mortality Weekly Report 56(08) (2007): 161-165

Chronic Kidney Disease: GFR

- eGFR often reported when creatinine or metabolic panels are ordered.
  - Laboratories frequently report values for eGFR only when < 60 mL/min/1.73 m².
    - eGFR calculators can be used to determine values of 60 mL/min/1.73 m^2 and greater.
  - Stage I and Stage II require evidence of kidney damage – often a urine test for microalbuminuria.
- Clinical basis for diagnosis must be documented in the medical record by bringing the physician's interpretation into the progress note.

Chronic Kidney Disease: Documentation

- The diagnosis of CKD cannot be coded from diagnostic reports alone. Documentation in the progress note should clearly state: review of reports, pertinent findings (e.g. GFR) and the specific stage of CKD.[1,2]

- Chronic renal failure, chronic renal insufficiency and unspecified chronic kidney disease are coded as **585.9**, Chronic kidney disease, unspecified.[1]
  - Whenever your search defaults to a code with .9, consider that there might be a more specific code to accurately report the definitive diagnosis.
- It is important to specify the type of kidney failure — acute or chronic — and the cause of the kidney failure, if known.

1. World Health Organization: ICD-9-CM for Providers, Professional Ed. Volumes 1&2. 2013. Alexandria, VA: OptumInsight, 2012

2. OptumInsight, Coders' Desk Reference For Diagnoses. 2013. Alexandria, VA: OptumInsight, 2012.

Types of Renal Failure

- If the documentation is unclear, clarification and documentation must be obtained from the provider before assigning a code for renal failure.
  - Acute renal failure category, 584
  - Chronic kidney disease category, 585
  - Unspecified renal failure category, 586

Note: these are categories; therefore, the HCC bolding has not been applied.

Chronic Kidney Disease or Renal Insufficiency?

- Often times CKD is miscoded as "acute renal insufficiency" code 593.9 when the documentation supports CKD OR when the terms CKD and renal insufficiency are used interchangeably within the same record

- From an ICD-9-CM coding perspective, different codes are assigned for Chronic Kidney Disease and Renal Insufficiency

- Documentation of acute or chronic is crucial for accurate code assignment
  - Acute renal insufficiency OR renal insufficiency 593.9
  - Acute renal failure **584.9**
  - Chronic renal insufficiency **585.9**
  - Chronic renal failure **585.9**

Documenting & Coding Chronic Kidney Disease

Chronic Kidney Disease Reporting:

- **585.9** should not be used as the default code
- The staging of CKD should be reported based on documented clinical findings including GFR
- Knowing the stage is necessary to use the Hypertension / Chronic Kidney Disease combination codes for 2009
  - **The stage makes a difference in the codes**

Chronic Kidney Disease: Staging

Stage	Severity	GFR *(ml/min/1.73 m²)*	ICD-9-CM
Stage I	*Normal or slightly ↑ GFR*	GFR ≥ 90 With kidney damage *	585.1
Stage II	*Mild*	GFR 60-89 With kidney damage *	585.2
Stage III (a) and (b)	*Moderate*	GFR 30-59	585.3
Stage IV	*Severe*	GFR 15-29	585.4
Stage V	*Kidney Failure*	GFR < 15	585.5
	ESRD	Requiring chronic dialysis or transplantation	585.6
CKD Unsp.	*CRD, CRF NOS or CRI*	Chronic Kidney Disease, Unspecified	585.9

- Assign **V45.11** for "dialysis status" or **V45.12** for "noncompliance with renal dialysis" with regard to all **585.6** and some **585.5**; assign V42.0 for "kidney transplant status."
- CKD is defined as either kidney damage or **GFR < 60ml/min/1.73 m² for ≥ 3 months.**

* Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests *(e.g. untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick)* or imaging studies. **http://www.aafp.org/afp/2005/1101/p1723.html**

Clinical Quality Improvement - Chronic Kidney Disease

Optum National Rate 12.31%

Age Group	All Stages	Stage 1	Stage 2	Stage 3	Stages 4/5
20-39	8.50%	5.90%	2.20%	0.30%	0.10%
40-59	12.60%	5.80%	4.40%	2.10%	0.20%
>60	**39.40%**	5.00%	**12.80%**	**20.30%**	1.30%
Diagnosed Diabetes					
Yes	40.20%	**19.50%**	11.40%	8.20%	1.00%
No	15.40%	4.90%	5.10%	5.20%	0.30%
Cardiovascular Disease					
Yes	28.20%	4.50%	**10.80%**	**10.50%**	2.40%
No	15.40%	5.60%	5.10%	5.20%	0.30%

"...two recent online surveys suggest that primary care providers and internal medicine residents may be not familiar with KDOQI guidelines"

CDC/Department of Health and Human Services, "Prevalence of Chronic Kidney Disease and Associated Risk Factors." Morbidity and Mortality Weekly Report 56(08) (2007): 161-165
Agrawal V., Awareness and Knowledge of Clinical Practice Guidelines for CKD Among Internal Medicine Residents: A national Online Survey. *Am J Kidney Dis* 2008, 52 (6): 1061-1069

DM Coding Tool: Coding Diabetic CKD

250.4 ☐ **Diabetes w/ Renal Manifestations**
"Diabetic:"

- **581.81 Glomerulosclerosis, Intercapillary**
- **583.81 Nephritis and Nephropathy, not specified acute/chronic**
- **581.81 Nephrosis / Nephrotic Syndrome**

If Chronic Kidney Disease (CKD), use additional codes:

- **585.1 CKD (Stage I)** GFR ≥ 90 ml/min Filtration
- **585.2 CKD (Stage II)** GFR 60–89 ml/min Filtration
- **585.3 CKD (Stage III)** GFR 30–59 ml/min Filtration
- **585.4 CKD (Stage IV)** GFR 15–29 ml/min Filtration
- **585.5 CKD (Stage V)** GFR < 15 ml/min Filtration
- **585.6 CKD (ESRD)** requiring chronic dialysis / transplantation
- **585.9 CKD, Unspecified**
- **V45.11 Dialysis Status**
- **V45.12 Noncompliance with Renal Dialysis**

If hypertension is documented with diabetic CKD, use additional codes:

- 403.90 Nephropathy w/ HTN and CKD, Stage I – IV, or Unspecified *(code also, if applicable:)*
  - **585.1–585.4, 585.9 Chronic Kidney Disease** *(see above)*
  - **V45.11 Dialysis Status**
- **403.91 Nephropathy w/ HTN and CKD Stage V or ESRD**

  (code also, if applicable:)
  - **585.5 CKD (Stage V)** GFR < 15 ml/min Filtration
  - **585.6 CKD (ESRD)** requiring chronic dialysis / transplantation
  - **V45.11 Dialysis Status**

For abnormal lab, report:

- 791.0 Proteinuria, Albuminuria, Microalbuminuria

HTN & CKD

- ICD-9-CM assumes a relationship when a patient has both chronic renal disease and hypertension.[1]
  - Category 403 – Hypertensive Chronic Kidney Disease
    - Requires 585.X to be coded

> ***Caution:*** ***CMS does not automatically make this connection for you, the 403 code category must be reported.***

  - Category 404 – Hypertensive Heart and Chronic Kidney Disease
    - Requires 585.X to be coded
    - If reporting Heart Failure, Category 428 must be coded

1.The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), (2011, October). ICD-9-CM official guidelines for coding and reporting. Retrieved October 3, 2011, from Department of Health and Human Services (DHHS) Web site: http://www.cdc.gov/nchs/data/icd9/10cmguidelines2011_FINAL.pdf

Hypertensive Chronic Kidney Disease

- **The connection is presumed.**
  - Category 403 - Hypertensive Chronic Kidney Disease
    - **Example:** ***"Benign Hypertensive CKD, Stage 3"***

403.10 Hypertensive Chronic Kidney Disease

*4*th digit "*1*" indicates Benign Hypertension

*5*th digit "*0*" indicates with CKD Stage I-IV, or unspecified

Note: You must code stage of Chronic Kidney Disease per ICD-9

- **585.3** - Chronic Kidney Disease, Stage III

Case Study – Hypertension

76 y/o male previously lost to follow-up returns for refill of BP medications. Reports recurrent LBP for which he takes OTC Advil 2 to 3 times per week. Current meds are HCTZ 25mg qd and ASA 80mg qd. PMH positive for hypertension x 10 years and osteoarthritis.

Exam:

- **BP 166/104, pulse 82**
- **Heart – RRR, no murmurs or gallops**
- **Lungs – clear**
- **Extremities – trace edema**
- **Back – full ROM, no tenderness**

Lab:

- **CBC and CMP normal except for BUN 30mg/dL, creatinine 1.8 and eGFR 47. Urine alb/creatinine ratio 45**

Assessment:

- **Hypertension, uncontrolled** 401.9
- **Low back pain – suspect due to osteoarthritis** 724.2
- **Microalbuminuria** 791.0

Plan:

- **Nephrology consultation**
- **Continue current medications**

Case Study – Hypertension (follow-up visit)

Patient returns after visit to his nephrologist two weeks ago, reports he was started on new medication for his blood pressure, and advised to use Tylenol instead of Advil for his LBP. No side effects noted from new medication. Nephrology consultation reviewed, and patient started on lisinopril 10 mg daily. Also had normal renal ultrasound.

Exam

- BP now 136/82, pulse 85
- Heart/Lungs – normal examination
- Back- FROM, minimal tenderness of LSS

Lab (3 months after first results)

- Creatinine 1.7, eGFR 50, urine alb/creatinine 41

Assessment

- Hypertension
- Chronic kidney disease stage 3 403.90 and **585.3**
- Low back pain due to osteoarthritis 715.98

Plan

- Continue current medications
- RTC 3 months or prn

OPTUM™

Diagnosing, Documenting and Coding:
Neuropathy

Guidelines for Comprehensive Foot Care

Key Components

History	Assess for prior ulcers, amputation, symptoms related to neuropathy or peripheral vascular disease, visual impairment, diabetic nephropathy and use of tobacco.
Inspection	Inspect feet for abnormalities, such as ulcers, erythema, skin temperature differences, as well as callus presence, nail changes and paronychia. Check shoes and socks for evidence of proper fit and bloody discharge.
Musculoskeletal	Check for deformities such as bunions, prominent metatarsal heads, toe deformities and Charcot foot.
Neurological	Perform tests to look for loss of protective sensation (LOPS), which should generally include testing with a 10gm monofilament and one other test (e.g. tuning fork, ankle reflexes, pinprick sensation).
Vascular	Assess dorsalis pedis and posterior tibial pulses in both feet. Patients with symptoms of PAD should have an ABI. Even in asymptomatic patients, perform or refer for ABI for diabetic patients > 50 years of age and consider in younger patients with other PAD risk factors, including presence of diabetes >10 years.

- [1] American Diabetes Association. Standards of Medical Care in Diabetes,(January2009). Diabetes Care, Volume 32, Supplement 1, 2009
- [2] http://www.ndep.nih.gov/media/Feet_HCGuide.pdf
- [3] Boulton, AJM et al. Comprehensive Foot Examination and Risk Assessment. Diabetes Care 2008;31:1679-1685

Neuropathy – Foot Screen

Complications

- Neuropathy:
  - *Monofilament testing:*

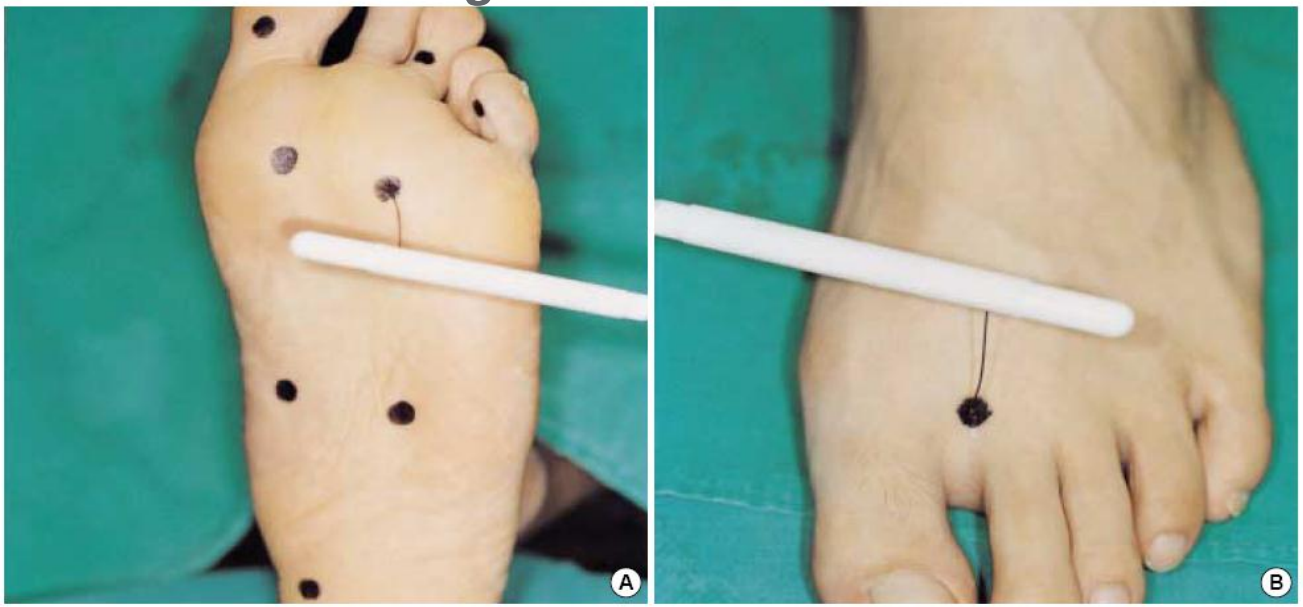


Fig. 1. The sites of Semmes-Weinstein monofilament test.

•*J Korean Med Sci 2003; 18: 103-7*

Diabetic Peripheral Neuropathy

- More than half of all lower-limb amputations in the United States occur in people with diabetes — 86,000 amputations per year.[1]
- Doctors estimate that nearly half of the amputations caused by neuropathy and poor circulation could have been prevented by careful foot care.[1]
- Screening for Diabetic Peripheral Neuropathy improves outcomes for your patients.

1 “Diabetic Neuropathies: The Nerve Damage of Diabetes”. National Diabetes Information Clearinghouse (NDIC). 08/16/10 <http://diabetes.niddk.nih.gov/dm/pubs/neuropathies/>

Diabetic Peripheral Neuropathy

Why Does it Matter?

- 20 million Americans currently have some type of neuropathy[1]
- 60 - 70% of diabetics have some type of nerve damage[2]
- Only 7% of all adults know they have the condition[3]

1 “Diabetic Neuropathies: The Nerve Damage of Diabetes”. National Diabetes Information Clearinghouse (NDIC). 08/16/10 http://diabetes.niddk.nih.gov/dm/pubs/neuropathies/

2 “About Peripheral Neuropathy: Facts”. The Neuropathy Association. 08/16/10 <http://www.neuropathy.org/site/PageServer?pagename=About_Facts>

3 “About Peripheral Neuropathy: Awareness and Attention”. The Neuropathy Association. 08/16/10 <http://www.neuropathy.org/site/PageServer?pagename=About_Awareness>

Why is it Important to Diagnose Peripheral Neuropathy?

Peripheral neuropathy may cause:

- Foot deformities, such as hammertoes and the collapse of the midfoot
- Muscle weakness and loss of reflexes
- Blisters and sores because numbness decreases awareness of pressure or injury
- Untreated infections which may lead to amputations

DM Coding Tool: Coding Diabetic Neuropathy

250.6 Diabetes w/ Neurological Manifestations

"Diabetic:"

- 353.5 Amyotrophy
- 355.71 Causalgia of Lower Limb (burning pain)
- **340 Dorsal Sclerosis**
- 355.9 Mononeuropathy, NEC
- 355.8 Mononeuropathy, Unspecified, Lower Limb
- 354.9 Mononeuropathy, Unspecified, Upper Limb
- **358.1 Myasthenic Syndromes in Diseases Classified Elsewhere**
- **336.3 Myelopathy in Diseases Classified Elsewhere**
- 713.5 Neurogenic / Neuropathic Arthritis / Arthropathy (Charcot's)
- **337.1 Peripheral Autonomic Neuropathy**

  (code also, if applicable:)

  - 536.3 Gastroparalysis / Gastroparesis
  - 596.54 Neurogenic Bladder, NOS
  - 564.81 Neurogenic Bowel, NOS
- **357.2 Polyneuropathy / Neuralgia / Neuritis / Neuropathy/ Loss of Protective Sensation (LOPS) in Diabetes**

Diabetic Manifestations: Linkage Validation

Assessment

Peripheral neuropathy is mild at this point normal monofilament still check at next visit.

Rash -782.1. is irritation from wires from coronary Artery Bypass Graft. needs to see cardiothoracic surgery as confirmed general surgery does not do that surgery repair. ear pain - resolved.

Foot Joint pain -719.4. to see podiatry, has small mass at base of left 2nd toe no trauma await eval.

Hypertension (high blood pressure) -401.9. is up to try lisinopril. Side effects reviewed and discussed. CAD- saw cardiology reviewed had normal stress test, did not address today. Patient has had follow-up for skin lesions-per patient just saw dermatologist but needs follow-up per last dermatologist note reminded pt.

Hematuria (blood in urine) -599.7.- normal on check and no visible blood. Did not address today.

Hypercholesterolemia with normal triglycerides (elevated blood cholesterol) -272.0. doing well reviewed labs.

Myalgia -729.1. call with probs. thyroid stimulating hormone will check again doing ok. Did not address today.

Diabetes Mellitus -250.00. doing well continue present management. call with probs.

Provider charted a diagnosis of DM (II); however, this diagnosis may not be documented to the highest level of specificity. Documentation requires appropriate linkage "due to" etc.

250.00 (DM, II, NOS). It may be possible that the peripheral neuropathy is a manifestation of the DM (II). If this is the case here, then documentation must reflect the linkage between the two conditions. In addition, coding of the DM must be to the highest level of specificity. For example:

250.60 (DM, II, with neurologic manifestations)

357.2 (Polyneuropathy in diabetes)

OPTUM™

Diagnosing, Documenting and Coding:

Peripheral Vascular (Arterial) Disease

Peripheral Arterial Disease Prevalence Rates

- **The German Epidemiological Trial on Ankle Brachial Index Study Group demonstrated that 21% of Patients aged 65 years and older had peripheral arterial disease**
- **THEREFORE, ACC/AHA *NOW* recommends lowering PAD screening to all patients aged 65 years (Dec 2011)**
  - "*This reflects the intent of both the original evidence-based document and this focused update to blunt the profound ongoing underdiagnosis and undertreatment of individuals with PAD until limb ischemia has become severe*"
- **Treatment is twofold:**
  - **Reduce the risk of cardiovascular death and stroke**
  - **Reduce the risk of limb loss**
- **New Recommendations: Smoking Cessation**
  - **Documentation of Tobacco Use/History at EVERY visit**
  - **Treatment: Counseling, Pharmacotherapy**
- **New Recommendations: Antiplatelet Therapy**

- **Diehm C, Allenberg JR, Pitrow, et al. Mortality and Vascular Morbidity in Older Adults with Asymptomatic Versus Symptomatic Peripheral Artery Disease. Circulation 120: 2053-2016. 2009.**
- **2011 ACC/AHA Focused Update of the Guideline for the Management of Patients with Peripheral Artery Disease (Updating the 2005 Guideline). Vascular Medicine 16(6): 452-476 (2011)**

Ulcers & ABIs: Is it Arterial or Venous

BY AGE

- Age less than 50 years old with diabetes and one other atherosclerosis risk factor:
  - Smoking
  - Dyslipidemia
  - hypertension, or
  - hyperhomocysteinemia
- Age 50-69 years AND history of smoking or diabetes
- Age older than 65 years

AT ANY AGE

- Leg symptoms with exertion
  - claudication
  - ischemic rest pain
- Abnormal lower extremity pulse examination
- Known atherosclerotic coronary, carotid, or renovascular disease

ABI	Interpretation	Action	Type of Ulcer/ Other Symptoms
> 1.4	Hardening of the Arterial Wall	Refer	Venous
0.9-1.4	Normal	Educate Reduce Risk Factors	
0.8-0.9	Mild PAD	Manage Risk Factors Exercise Regimen	
0.5-0.8	Moderate PAD	Refer	Mixed Ulcer Claudication at ABI of 0.6
<0.5	Severe PAD		Arterial Ulcer Rest Pain at ABI of 0.25

Documenting & Coding PAD / PVD

- ***Peripheral arterial disease, peripheral vascular disease, and claudication*** **are coded to 443.9**
  - **It is important to note that this code excludes atherosclerosis of the arteries of the extremities.**
- ***Atherosclerosis*** ***of native arteries of the extremities*****, Category 440, is further classified as such:**
  - **440.20** Atherosclerosis of extremities, unspecified
  - **440.21** Atherosclerosis of extremities w/ intermittent claudication
  - **440.22** Atherosclerosis of extremities w/ rest pain
  - **440.23** Atherosclerosis of extremities w/ ulceration
  - **440.24** Atherosclerosis of extremities w/ gangrene

PAD Documentation & Coding

- **Diagnostic statements that *do not* report illness severity specifically as they are coded to** 440.9**:**
  - **Arteriosclerotic (vascular) disease**
  - **Generalized arteriosclerosis**
  - **Arteriosclerotic endarteritis**
  - **Arteriosclerosis obliterans**
  - **Arteriosclerosis with calcification**

Rules of Coding PAD / PVD

When Assigning Atherosclerosis of Arteries of the Extremities (440 Category)

- **All patients documented as atherosclerosis with gangrene are coded to 440.24 ***
  - If gangrene is documented without mention of atherosclerosis, only code **785.4**
- **All patients documented as atherosclerosis without gangrene, but with ulceration are coded to 440.23 ***
  - If ulceration is documented without mention of atherosclerosis, only code **707.9**
- **Patients documented as atherosclerosis with neither gangrene nor ulceration, but with rest pain are coded to 440.22**
  - If rest pain is documented without mention of atherosclerosis, only code 729.5
- **Patients documented as atherosclerosis with intermittent claudication are coded to 440.21**
  - If claudication is documented without mention of atherosclerosis, only code **443.9**

* **Ulcers: Codes from subcategory 707.1x *(Ulcer of lower limb)* should be assigned in addition to 440.23 or 440.24**

Coding PAD / PVD: Ischemic Ulcers

- **Subcategory 707.1x Ulcer of lower limbs, except pressure ulcer**
  - **First: Code any underlying or causal condition**

    Example:

    - 440.23 – Atherosclerosis of Extremities w/ Ulceration
    - 250.8x – DM w/ Other Chronic Manifestations

  - **Second: Code associative ulcers to the highest level of specificity**

    Example:

    - 707.10 – Ulcer of lower limb, unspecified
    - 707.11 – Ulcer of thigh
    - 707.12 – Ulcer of calf
    - 707.13 – Ulcer of ankle
    - 707.14 – Ulcer of heel and mid-foot
    - 707.15 – Ulcer of other part of foot
    - 707.19 – Ulcer of other part of lower limb

- **Chronic ulcer of unspecified site – 707.9**
- **Varicose ulcer (lower extremity, any part) – 454.0**

Documenting & Coding PAD / PVD

Vascular diseases often occur as a manifestation of diabetes:

- ***Diabetes with Peripheral Circulatory Disorders*** **250.70-250.73**
  - If the PVD is due to diabetes mellitus, codes **250.7x** *and* **443.81** would be assigned.
    - The specificity of the PVD changes to **443.81**, Peripheral Angiopathy in diabetes mellitus.
    - Code **443.81** provides a more comprehensive picture of the patient's PAD/PVD condition in regard to DM as an underlying cause.
  - Provide the appropriate ***linkage*** for the diabetes with Peripheral Circulatory Manifestations (**250.7x**)

Underlying Disease – Diabetes Mellitus

- A patient with Type II controlled Diabetes that has treatment for a manifestation of the disease should have **both conditions coded**:
  - PVD **due to** Diabetes Mellitus
    - **250.70** Diabetes with peripheral circulatory disorder
    - **443.81** Peripheral angiopathy in diseases classified elsewhere

- The underlying disease is coded first, followed by the manifestation code.
- The linkage has been documented with "**due to**" and the 4th digit is properly assigned on the **250.xx**

DM Coding Tool: Peripheral Vascular (Arterial) Disease

250.7 Diabetes w/ Peripheral Circulatory Disorders

"Diabetic:"

- 785.4 Gangrene
- 443.81 Peripheral Angiopathy / Microangiopathy (PVD)

If diabetic atherosclerosis is documented, code also:

- 440.20 Atherosclerosis, Extremities, NOS
- 440.21 Atherosclerosis, Extremities, with Intermittent Claudication
- 440.22 Atherosclerosis, Extremities, with Rest Pain

  *Note: Includes any condition classifiable to **440.21***
- 440.23 Atherosclerosis, Extremities, with Ulceration

  *Note: Includes any condition classifiable to **440.21** and **440.22***
  - 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure
- 440.24 Atherosclerosis, Extremities, with Gangrene

  *Note: Includes any condition classifiable to **440.21**, **440.22** and **440.23** with the following:*
  - 785.4 Gangrene
  - 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure
- 440.29 Atherosclerosis, Extremities, Other

Underlying Disease – Diabetes Mellitus

- Be specific

  If the same scenario was documented as:

  1. Diabetes
  2. PVD
     - Code **250.00** Diabetes <u>without mention of complications</u>
     - Code **443.9** PVD

  - With this example, there is nothing indicating that the PVD was **<u>due to</u>** the diabetes.
    - The coding must be more generic in this case.

DM and Diabetic Manifestations

Past Medical History

DM Type II Controlled, w/ Periph Circ. Disease & Renal Disease

Nephritis & Nephropathy

HTN, Hyperlipidemia, Status CABG,

Allergic Rhinitis, Cardiovascular

Disease, Angiopathy, Nephralgia

Family History

Father: Diseased with DM. complications at 94 yrs of age.

Mother: Diseased with cardiovascular complications. 90 yrs of age

Siblings: 4 brothers, 1 sister.

Marital Status: Married, lives with spouse of 40 years. Three children; 1 daughter; 2 sons.

Social History

Drug abuse: No history of smoking, alcohol or drug abuse. Caffeine: I cup coffee per day.

Occupation: Retired, Disabled

Exercise: Occasionally

Allergies: Phenergan, Demerol: both cause outbreak of rash

Vital Signs

T: 98.2; BP 163/92; HR 63; WT 203 lbs; Ht 68; BMI 31.57; RBS 128

Exam

General Exam: HEENT: Eyes clear, EOMI, PERRLA. Neck-Thyroid: No palpable nodes, no JVD, no thyromegaly, bruits. Chest: Normal. Lungs: Clear, no rales, no ronchi. Heart: RRR, no murmurs, gallops, rubs, normal S1 S2. Abdomen: Soft and non tender, no BS, no organomegaly. Extremities: PVD, No edema, no cyanosis. Neurologic: No focal, motor, or sensory deficits. Reveals appropriate muscle bulk and strength with FROM in joints. Skin: Sudden flushing of skin, no evidence of rash or lesions

Assessment

1. Sudden Redness and flushing of skin – 782.62 (primary)
2. Diabetic PVD, Type II, controlled – **250.70**
3. Administer Influenza VI vaccine - (G0008)

Plan

1. Sudden Redness and flushing of skin: Continue Januvia tabs, 100 mg orally: disp 30 tabs; one tab once per day. Continue Actos tabs, 15 mg, orally, disp 90 tabs; one tab once per day.
2. DM with PVD, Type II, controlled: Continue Januvia tabs, 100 mg orally: disp 30 tabs; one tab once per day.

Labs: Glucose fingerstick RGS: 128, reported on 10-15-2009..

Administer Influenza vaccine on today's visit: 0.5 (G0008)

Note: In order to utilize the DM with Manifestations codes (i.e. *DM w/ Peripheral Circulatory Disorders*, 250.70), it is required to also list the specific manifestation, including the "renal disease" along with the PVD.

As listed in the assessment section and in the "Past Medical History" above, it appears that the peripheral circulatory manifestation of the DM is "*Peripheral Angiopathy (PVD)*," which should also be documented and coded as 443.81 along with the 250.70.

Query: Can the "Renal Disease" also be documented and coded using 250.40 with a "specified" renal manifestation providing there is a cause & effect relationship?

Case Study – Diabetes

- 67 y/o female with 15 year history of type 2 diabetes for routine check. Complains of recurrent tingling in both feet, primarily at night. Reports medications as Metformin 500mg po bid and Tylenol prn.
  - Exam
    - HEENT – retinal exam shows mild background changes
    - Heart – RRR, no murmurs or gallops
    - Lungs – clear to auscultation
    - Extremities – good DP and PT pulses
    - Neuro – Decreased pinprick sensation over feet bilaterally with reduced ankle reflexes bilaterally
  - Lab (drawn before visit)
    - A1c=8.1%, creatinine 0.8
  - Assessment
    - Type 2 diabetes, poorly controlled
    - Retinopathy
    - Peripheral neuropathy
  - Plan
    - Refer to ophthalmology for dilated retinal examination and to podiatrist for neuropathy
    - Increase Metformin to 1000mg am and 500mg pm
    - f/u visit in one month

With the current documentation, how would you code the diagnoses?
How might the documentation have been improved?

Multiple Diabetic Manifestations

- **Diabetic Nephropathy 250.4x *[585.5]***
  - If CKD is documented as a manifestation of diabetes in addition to diabetic nephropathy, code also 585.x for the documented stage.[1]
- **Diabetic Retinopathy 250.5x *[362.01]***
  - Be sure to state whether "proliferative" or "nonproliferative", if known.
  - If diabetic macular/retinal edema is documented, report code **250.5x**, diabetes with ophthalmic manifestations, code **362.07**, diabetic macular/retinal edema, and code **362.01**, diabetic retinopathy, NOS.[2]
- **Diabetic Neuropathy 250.6x *[357.2]***
  - If gastroparesis is documented as a manifestation of diabetes, assign code **250.6x**, diabetes mellitus with neurological manifestations, code **337.1**, peripheral autonomic neuropathy in disorders classified elsewhere, and code 536.3, gastroparesis.[3]

[1]AHA Coding Clinic Sept-Oct 1984
[2]Ingenix 2010 ICD-9-CM Professional for Physicians. 6th ed. 2 vols. USA: Ingenix, 2009. Print.
[3]AHA Coding Clinic Nov-Dec 1984 & AHA Coding Clinic 2nd Qtr 1993

OPTUM™

Diagnosing, Documenting and Coding:
Heart Failure

HF Impact

- HF is the most common Medicare Diagnosis-Related Group (MDRG), and more Medicare dollars are spent for the diagnosis and treatment of HF than for any other diagnosis.

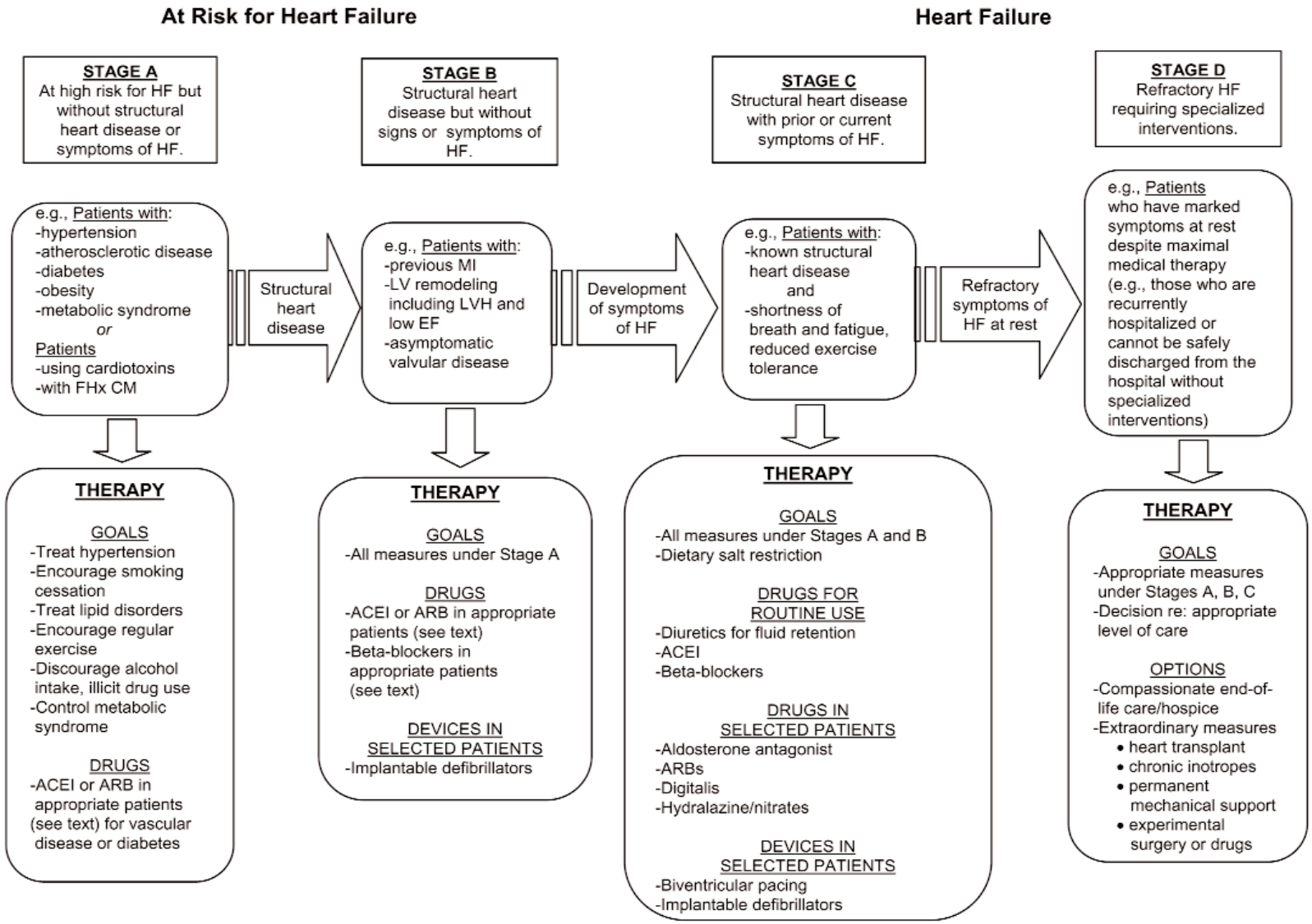
(ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult)

- In addition, 90% of admissions for HF as the primary diagnosis are due to congestion.

- Post discharge, the event rate for readmission or death within 60 days is as high as 35%.

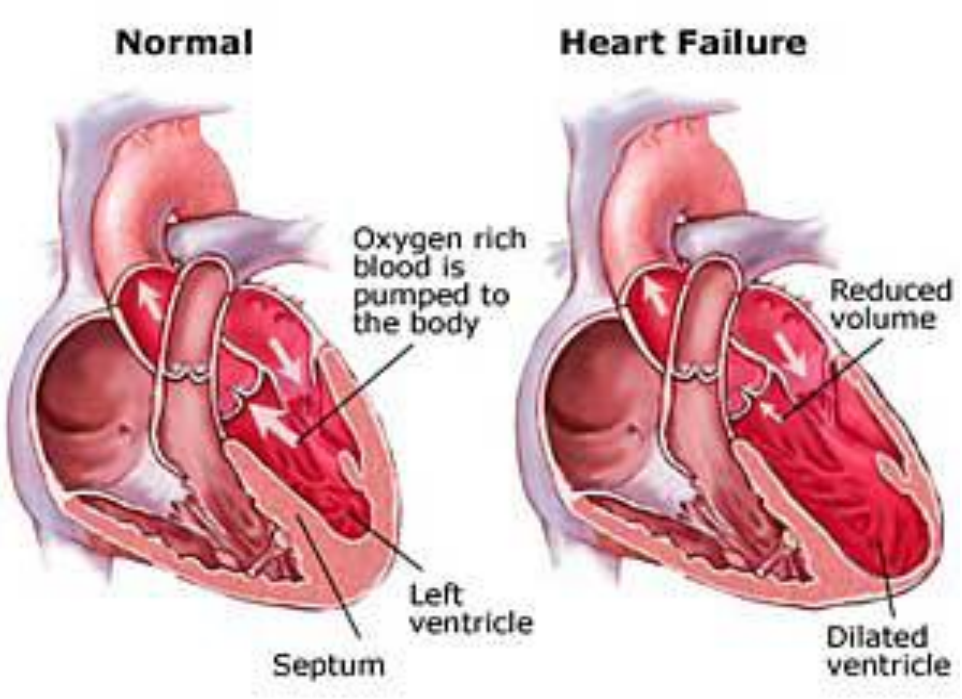
(O'Connell, JB. "Optimizing Outcomes for Patients with Congestive Heart Failure: Tools to Predict Outcomes and the Need for Advanced Therapies" presented at Innovations in Disease Management, Optum Health Care Solutions, October 14-16, 2008. Las Vegas, NV)

Stages and Treatment Therapies for HF



HF is a Progressive Disorder

- Left ventricular dysfunction begins with injury to the myocardium.
- Progressive process of change in the geometry and structure of the LV.
- Cardiac remodeling
  - Chamber dilation
  - Chamber hypertrophy
  - Spherical shape



Documentation: Make the Connection

- **There is no presumed relationship between heart disease and hypertension**
- **It is incumbent upon the provider to document the nature of the relationship between the two conditions.**
- **Document the connection; the connection is not presumed:**
  - **Hypertensive** heart disease with congestive heart failure
    - **402.91 - Hypertensive heart disease with heart failure**
      - **4**th digit of **9** indicates unspecified hypertension
      - **5**th digit of **1** indicates with heart failure
        - If there was no documentation of heart failure, the 5th digit would be 0
    - **428.0 – Congestive heart failure, unspecified**
      - 4th digit of **0** indicates congestive

Documentation: Make the Connection

Heart Failure and HTN Documentation

- When documentation mentions the conditions but without a stated causal relationship, each condition will be coded separately.

- If the physician had documented hypertension ***and*** congestive heart failure without the "linkage" in the chart, the proper coding would be:

    - 401.9 **Hypertension, unspecified**
    - **428.0 Congestive heart failure**

Heart Failure Documentation and Coding

- **Other diagnostic statements regarding heart failure:**
  - *Fluid overload NOS (276.6)*
  - *Rheumatic heart failure, rheumatic left ventricular failure (**398.91**)*
- **Diagnostic statements that do not provide full diagnostic specificity:**
  - *Heart failure (**428.9**)*
  - *Myocardial failure (**428.9**)*
  - *Cardiac failure (**428.9**)*
  - *Weak heart (**428.9**)*
  - *Acute and chronic heart failure (**428.9**)*
  - *Compensated heart failure (**428.0**)*
  - *Decompensated heart failure (**428.0**)*
  - *Congestive heart disease (**428.0**)*
  - *Right heart failure [secondary to left heart failure] (**428.0**)*

Acute pulmonary edema of cardiac origin is a manifestation of heart failure and is included in the heart failure code assignment.[1]

[1]Brown, Faye. *Faye Brown's ICD-9-CM Coding Handbook 2010*. 2010 Rev. ed. Chicago: AHA Press, 2009. Print.

Heart Failure Documentation and Coding

- **Report code to specify the type of heart failure, if known**
  - Categories include:

428.0 Congestive Heart Failure (CHF)

428.1 Left heart failure

428.2x Systolic HF

428.3x Diastolic heart failure

428.4x Combined Systolic / Diastolic HF

428.9 Heart failure, unspecified

- 5th digits represent:
  - 0 Unspecified
  - 1 Acute
  - 2 Chronic
  - 3 Acute on chronic
- All codes for heart failure include any associated pulmonary edema; no additional code is assigned.
- More than one code from category **428** may be assigned if the patient has systolic or diastolic failure with **CHF (428.0)**.

AHA Coding Clinic, 4th Qtr, 2002, p. 52-53

Coding Guidelines for HF

- **Hypertensive heart and chronic kidney disease (CKD)**
  - **404.01 Malignant** hypertensive heart disease w/ HF and CKD Stage 1–4
  - **404.03 Malignant** hypertensive heart disease w/ HF and CKD Stage 5 or ESRD
  - **404.11 Benign** hypertensive heart disease w/ HF and CKD Stage 1–4
  - **404.13 Benign** hypertensive heart disease w/ HF and CKD Stage 5 or ESRD
  - **404.91 Unspecified** hypertensive heart disease w/ HF and CKD Stage 1–4
  - **404.93 Unspecified** hypertensive heart disease w/ HF and CKD Stage 5 or ESRD
- **Use additional code to specify type of heart failure, if known**
- **Use additional code to identify the stage of CKD (585.1 - 585.6)**
- **If CKD is present, code the Stage of CKD and Renal Dialysis Status (V45.11), if applicable**

AHA Coding Clinic, 4th Qtr. 2002

OPTUM™

Documenting and Coding:

Major Depression

Documenting & Coding Major Depression

We often see it documented and coded as:

- Depression (311)
- Depressive reaction; depressive anxiety; reactive depression (300.4)
- Anxiety; anxiety reaction (300.00)
- Grief reaction*; brief depressive reaction (309.0)
- Major depressive episode (not codeable); *(see Steps 1 to 9, Morrison, pg 189-190)*

* When symptoms of bereavement last longer than two months, the patient **may have** a Major Depressive mood disorder (Morrison, pg. 541).

Morrison, J. (2001).; DSM-IV Made Easy: *The Clinician's Guide to Diagnosis*; New York, NY: Guilford Press

Coding Major Depression

- The **First Three digits** are **always** 296
- The **Fourth digit** indicates the description of the **current** episode:
  - **296.2_** Single Depressive Episode
  - **296.3_** Recurrent Depressive Episode
- The **Fifth digit** indicates the **severity** of the condition
  - **296.21** or **296.31** Mild
  - **296.22** or **296.32** Moderate
  - **296.23** or **296.33** Severe without psychotic features
  - **296.24** or **296.34** Severe with psychotic features

… or the **clinical status** of the current episode:

- **296.25** In Partial Remission
- **296.36** In Full Remission **(Check this; consider 296.26 or 296.36)**

- **When reporting history of major depressive disorder, instead of coding V11.1, Personal history of affective disorders, per ICD-9-CM Guidelines, "A code from the mental disorders chapter, with an in remission fifth-digit, should be used."**

Depression (311) vs. Major Depression (296.xx)

Oct 16, 2013

S: Patient is still complaining of right-sided lower lumbar discomfort. A few years ago, she was seen by Dr. _____ and had facet injections and has a lot of arthritis in the lumbar spine. She also has diabetes mellitus, type II, and is somewhat overdue for her usual lab work, as well as hypothyroidism and history of breast cancer status post mastectomy. She is quite depressed today, which has been a very long-standing problem for her. Otherwise, she has no new complaints or problems. Specifically, on review of systems, she has had no chest pains or shortness of breath, no major change in bowel habits. She has lost a bit of weight (6 pounds). She has had several falls including a huge laceration on the right side of her forehead and also a humerus fracture last December.

O: Blood pressure is normal. Lungs clear to P&A. Heart is regular. No CVA tenderness. She is a little bit tender in the right paralumbar area. Extremities: No edema. Abdomen soft and nontender

A: 1). History of diabetes mellitus, type II. 2). History of hypothyroidism. 3). History of breast CA. 4). History of peripheral neuropathy. 5). The patient is significantly depressed.

P: I have given her samples of Lexapro and also drawing blood work today. I will see her back in about 3-4 week.

This patient may classify as "Major Depression," which Risk Adjusts.

a). Of course the symptoms must meet specific criteria for major depression (see Tool Book, 2009).

b). The depressed mood must be evident most of the day, nearly every day for at least 2 weeks.

c). A change of more than 5% of body weight in a month, or decrease or increase in appetite nearly every day; or insomnia, hypersomnia, Psychomotor agitation, feelings of worthlessness, diminished ability to think or concentrate, recurrent thought of suicide or death

DSM IV Made Easy, (2008), p. 261.

OPTUM™

Documentation Considerations & EMR

Documentation: The Progress Note

Progress note should always include:

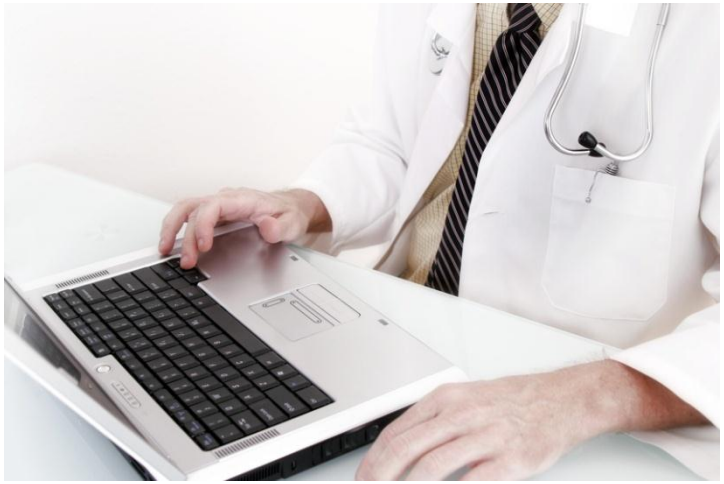
- Documentation to the greatest degree of certainty for each diagnosis
  - documentation of all complications/manifestations including the causal language (e.g. diabetic, hypertensive, due to)[1]
- Documentation of known conditions from a consultant or specialist, lab values, radiology results, discharge summaries[2]
- Documentation of all chronic conditions at least once per year[2]
- Documentation of any chronic condition that affects the care and treatment of the patient on that date of service[1]
- Conditions should be coded to the highest degree of specificity for that encounter/visit[1]

[1] "Centers for Disease Control and Prevention." *Classification of Diseases, Functioning and Disability* . 10012011. Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), Web. 21 Oct 2011.
http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

[2] *CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.*

Documentation Requirements[1,2]

- The listing of DX codes is not enough; there must be evaluation.
- The medical record must thoroughly document all conditions evaluated.
  - Evaluative documentation would include statements such as:
  - **Document status of DX**
    - **Condition worsening - document any treatment/referral**
    - **Condition improving**
  - **Tests ordered - document which tests**
  - **Tests reviewed - bring pertinent findings into progress note**



1 Centers for Medicare & Medicaid Services, (1995). 1995 documentation guidelines for evaluation & management services. Retrieved from http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf

2 CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

Documentation Requirements

- **Linkage (cause and effect) can be established in the chart with certain terms**

- **Diabetic**
- **Hypertensive**
- **Due to**
- **Secondary to**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), (2012, October). ICD-9-CM official guidelines for coding and reporting. Retrieved October 3, 2012, from Department of Health and Human Services (DHHS) Web site: http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf

Chart Mechanics & Documentation Considerations[1,2,3]

- Identify patient (name) and date (of service) and one additional patient identifier (e.g., date of birth) on each page of the record
- Reported diagnoses must be supported with medical record documentation
- Acceptable documentation should be clear, concise, consistent, complete and legible
- Document and report co-existing diagnoses — any that require or affect the care and treatment of the patient that day
- Use only standard abbreviations (acronyms and symbols)
  - It is NOT appropriate to code a condition that is represented only by an up or down arrow in combination with a chemical symbol or lab abbreviation such as ↑"chol" for "hypercholesterolemia"
- CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented
- The medical record must support all diagnoses coded for the date of service and must be able to stand alone for audit on those reported diagnosis codes

[1] CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

[2] The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 13 Dec 2012. <http://www.jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.

[3] World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2011 1-107. Web. 15 Nov 2011.http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Authentication Requirements: Paper Record[1,2]

- Medicare documentation requirements state each patient encounter should include the date and legible identity of the provider.
- All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate extender (non-physician practitioner) e.g., nurse practitioner
- Stamps of the provider's signature are not acceptable per CMS.
- The credentials for the provider of services must be somewhere on the medical record:
  - next to the provider's signature, or
  - pre-printed with the provider's name on the group practice's stationery
- The physician (provider) must authenticate at the end of each note for which services were provided with handwritten signature.
- The physician's signature and credentials must be on each chart entry as a condition of payment from CMS.

Disclaimer: This is not an all-inclusive listing of CMS requirements and is only a reminder of certain chart mechanics and documentation guidelines.

[1] CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

[2] World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2011 1-107. Web. 15 Nov 2011.http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Authentication Requirements: EMR[1,2]

- Medicare documentation requirements state each patient encounter should include the date and legible identity of the provider.
- The physician (provider) must authenticate at the end of each note for which services were provided with an electronic signature.
- Electronic signature, including credentials
  - Requires authentication by the responsible provider
    - for example, but not limited to, “Approved by,” “Signed by,” “Electronically signed by,” “Authenticated by”
  - Must be password protected and used exclusively by the individual physician (provider)

Disclaimer: This is not an all-inclusive listing of CMS requirements and is only a reminder of certain chart mechanics and documentation guidelines.

[1] CMS-Centers for Medicare & Medicaid Services, “2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide.” Leading Through Change, Inc. 2008 1-49.

[2] World Health Organization, “International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed.” National Center for Health Statistics 2011 1-107. Web. 15 Nov 2011.http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Optum can provide data, tools & training to assist you in areas such as:

1. Specific diagnostic coding to include chief complaint and all comorbidities
2. Status codes (V codes)
3. Documentation of underlying disease
4. Documentation of manifestations of disease
5. Specific coding regarding stages of disease (i.e. Chronic Kidney Disease codes)
6. Compliance to CMS documentation requirements

Coding Disclaimer

- This guidance is to be used for easy reference; however, the code book for the ICD-9-CM coding version used is the authoritative reference for correct coding guidelines. 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. On 4/1/2013, CMS announced that they "will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice" with some differences from the proposed model. For more data, see: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2014.pdf, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf and www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.
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Thank You for Your Participation!

We hope you have found this presentation informative and useful.
Any Questions?