2015 Diagnosing, Documenting and Coding Chronic Conditions for Risk Adjustment

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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.
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.
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)
  - Changes to the 2014 CMS-HCC Model
  - 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
  - Diabetes, CKD, HTN, HF & Depression in ICD-10-CM
- 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**.

<table>
<thead>
<tr>
<th></th>
<th>2013 Model</th>
<th>2014 Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>DXs</td>
<td>2,900+</td>
<td>3,000+</td>
</tr>
<tr>
<td>HCCs</td>
<td>70</td>
<td>79</td>
</tr>
<tr>
<td>RAF Score</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

2014 PY CMS HCC Model: A Blended Model
Changes in the 2014 CMS-HCC Model (V22 Version)

• 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
      – Primary and Secondary Hyperparathyroidism; Glucocorticoid Deficiency, Pituitary Disorders
    • Morbid obesity (BMI > 40 and Obesity Hypoventilation Syndrome)
  – Fibrosis of the lung and other chronic lung disorders
  – Exudative “wet” macular degeneration
  – Coagulation Defects, Other Hematological Disorders
    • Thalassemia, Thrombocytopenia, Hypercoagulable States
Changes in the 2014 CMS-HCC Model: Morbid Obesity¹,²

- **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

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Changes in the 2014 CMS-HCC Model: Kidney Disease¹

- 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)

Changes to the 2014 CMS-HCC Model

• Changes to existing HCCs: (continued)

  – Consolidation of the diabetes HCCs in the current model as follows:
    • diabetes with acute complications
    • diabetes with chronic complications
    • diabetes without complications

  – Dementia HCCs are not included in the 2014 model due to concerns about the specificity of coding

  – Lower severity pressure ulcer HCCs were removed

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>RAF</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>76-year-old female</td>
<td>0.426</td>
<td>0.426</td>
</tr>
<tr>
<td>Medicaid eligible (Aged)</td>
<td>0.202</td>
<td>0.202</td>
</tr>
<tr>
<td>Diabetes without complications (HCC19)</td>
<td>X</td>
<td>0.162</td>
</tr>
<tr>
<td>Diabetes w/ complications (HCC 18)</td>
<td>0.371</td>
<td>X</td>
</tr>
<tr>
<td>Vascular Disease (HCC 108)</td>
<td>X</td>
<td>0.284</td>
</tr>
<tr>
<td>Vascular disease with complications (HCC107)</td>
<td>0.594</td>
<td>X</td>
</tr>
<tr>
<td>CHF (HCC 85)</td>
<td>0.346</td>
<td>X</td>
</tr>
<tr>
<td><strong>Total RAF</strong></td>
<td>2.089</td>
<td>1.074</td>
</tr>
</tbody>
</table>
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?

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


- 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)
- **The model is dependent on accurate documentation and coding by PCPs**
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

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!

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.”

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

Specific Documentation and Coding Guidelines are Mandated by 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

Diagnosing, Documenting and Coding: Diabetes Mellitus & Manifestations
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”: $> 100 \text{ mg/dl} \text{ but } \leq 126 \text{ mg/dl}$
2. ‘Impaired’ glucose tolerance test “IGT”: $> 140 \text{ mg/dl} \text{ but } \leq 199 \text{ mg/dl}$ 2hr after 75 gm glucose load
3. HgA1C 5.7% to 6.4%***
4. Random Fingerstick or blood draw: (Random blood glucose $\leq 199$ 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 $\geq 6.5%$***
2. Fasting (8 hours): $> 126 \text{ mg/dl}$
3. 2-hour plasma glucose $\geq 200\text{mg/dl}$ after standard glucose load during an OGTT
4. Random blood glucose $\geq 200 \text{ mg/dl}$ 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.
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 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?
  – **250.4X** Diabetes with **renal** manifestations
  – **250.5X** Diabetes with **ophthalmic** manifestations
  – **250.6X** Diabetes with **neurological** manifestations
  – **250.7X** Diabetes with **peripheral circulatory** disorders
  – **250.8X** Diabetes with **other specified** manifestations
  – **250.9X** 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).*
Diagnosing, Documenting and Coding:
Chronic Kidney Disease
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.

• 40% of patients starting dialysis already have evidence of coronary heart disease (CHD) and only 15% are considered to have normal left ventricular structure and function by echocardiographic criteria.

• How about Early Stage CKD?

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


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 m² and greater.
  ■ Stage I and Stage II require evidence of kidney damage – often a urine test for microalbuminuria.

■ 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

2. OptumInsight, Coders’ Desk Reference For Diagnoses. 2013. Alexandria, VA: OptumInsight,
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
### Chronic Kidney Disease: Staging

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

- 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](http://www.aafp.org/afp/2005/1101/p1723.html)
## Clinical Quality Improvement - Chronic Kidney Disease

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All Stages</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stages 4/5</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-39</td>
<td>8.50%</td>
<td>5.90%</td>
<td>2.20%</td>
<td>0.30%</td>
<td>0.10%</td>
</tr>
<tr>
<td>40-59</td>
<td>12.60%</td>
<td>5.80%</td>
<td>4.40%</td>
<td>2.10%</td>
<td>0.20%</td>
</tr>
<tr>
<td>&gt;60</td>
<td>39.40%</td>
<td>5.00%</td>
<td>12.80%</td>
<td>20.30%</td>
<td>1.30%</td>
</tr>
</tbody>
</table>

### Diagnosed Diabetes

<table>
<thead>
<tr>
<th>Diagnosed Diabetes</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>40.20%</td>
<td>15.40%</td>
</tr>
<tr>
<td></td>
<td>19.50%</td>
<td>4.90%</td>
</tr>
<tr>
<td></td>
<td>11.40%</td>
<td>5.10%</td>
</tr>
<tr>
<td></td>
<td>8.20%</td>
<td>5.20%</td>
</tr>
<tr>
<td></td>
<td>1.00%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

### Cardiovascular Disease

<table>
<thead>
<tr>
<th>Cardiovascular Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28.20%</td>
<td>15.40%</td>
</tr>
<tr>
<td></td>
<td>4.50%</td>
<td>5.60%</td>
</tr>
<tr>
<td></td>
<td>10.80%</td>
<td>5.10%</td>
</tr>
<tr>
<td></td>
<td>10.50%</td>
<td>5.20%</td>
</tr>
<tr>
<td></td>
<td>2.40%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

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

Blood Calcium and Associated Parathyroid Hormone

• High levels of calcium and high PTH levels are related to primary hyperparathyroidism.

• Upper left shows elevated PTH levels with normal calcium.

• Levels related to CKD.

• High calcium and no elevation in PTH could indicate malignancy.
Secondary Hyperparathyroidism

- Secondary hyperparathyroidism occur in patients with kidney failure or severe vitamin D deficiency and are characterized by enlargement of all four parathyroid glands (hyperplasia)
- In secondary hyperparathyroidism, the vast majority of cases demonstrate only chief cell hyperplasia
- Decreased eGFR causes phosphate retention and aging kidneys convert less Vitamin D from $25(\text{OH})_2\text{D}$ to the active form $1,25(\text{OH})_2\text{D}$
- Patients with secondary disease are almost always normocalcemic
- KDIGO Guidelines suggest:
  - Recommend measuring serum levels of calcium, phosphate, PTH, and alkaline phosphatase activity at least once in adults with GFR $< 45$ ml/min/1.73 m2 (GFR categories G3b-G5) in order to determine baseline values
  - In people with GFR $\geq 45$ ml/min/1.73 m2 (GFR categories G3b-G5) the optimal PTH level is not known. Suggest that people with levels of intact PTH above the upper normal limit of the assay are first evaluated for hyperphosphatemia, hypocalcemia, and vitamin D deficiency
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

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
  4th digit “1” indicates Benign Hypertension
  5th 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 27. 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 28, urine alb/creatinine 41

Assessment
Hypertension
Chronic kidney disease stage 4  403.90 and 585.4
Low back pain due to osteoarthritis  715.98

Plan
Continue current medications
RTC 3 months or prn
Diagnosing, Documenting and Coding: 
Neuropathy
Neuropathy – Foot Screen

Complications

– Neuropathy:

• Monofilament testing:

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

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.

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)
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


## 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**

<table>
<thead>
<tr>
<th>ABI</th>
<th>Interpretation</th>
<th>Action</th>
<th>Type of Ulcer/ Other Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 1.4</td>
<td>Hardening of the Arterial Wall</td>
<td>Refer</td>
<td></td>
</tr>
<tr>
<td>0.9-1.4</td>
<td>Normal</td>
<td>Educate Reduce Risk Factors</td>
<td>Venous</td>
</tr>
<tr>
<td>0.8-0.9</td>
<td>Mild PAD</td>
<td>Manage Risk Factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise Regimen</td>
<td></td>
</tr>
<tr>
<td>0.5-0.8</td>
<td>Moderate PAD</td>
<td>Refer</td>
<td>Mixed Ulcer Claudication at ABI of 0.6</td>
</tr>
<tr>
<td>&lt;0.5</td>
<td>Severe PAD</td>
<td></td>
<td>Arterial Ulcer Rest Pain at ABI of 0.25</td>
</tr>
</tbody>
</table>
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
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
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 4\textsuperscript{th} digit is properly assigned on the **250.xx**
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 without mention of complications

• Code 443.9 PVD

  ▪ With this example, there is nothing indicating that the PVD was due to the diabetes.
  ▪ The coding must be more generic in this case.
## DM and Diabetic Manifestations

| **Past Medical History** | **Vital Signs** | **Exam** | **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? |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DM Type II Controlled, w/ Periph Circ. Disease &amp; Renal Disease Nephritis &amp; Nephropathy HTN, Hyperlipidemia, Status CABG, Allergic Rhinitis, Cardiovascular Disease, Angiopathy, Nephralgia</td>
<td>T: 98.2; BP 163/92; HR 63; WT 203 lbs; Ht 68; BMI 31.57; RBS 128</td>
<td>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</td>
</tr>
<tr>
<td><strong>Family History</strong></td>
<td><strong>Assessment</strong></td>
<td><strong>Plan</strong></td>
</tr>
<tr>
<td>Father: Diseased with DM, complications at 94 yrs of age.</td>
<td>1. Sudden Redness and flushing of skin – 782.62 (primary)</td>
<td>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)</td>
</tr>
<tr>
<td>Mother: Diseased with cardiovascular complications. 90 yrs of age</td>
<td>2. Diabetic PVD, Type II, controlled – <strong>250.70</strong></td>
<td>3. Administer Influenza VI vaccine - (G0008)</td>
</tr>
<tr>
<td>Siblings: 4 brothers, 1 sister.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status: Married, lives with spouse of 40 years. Three children; 1 daughter; 2 sons.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug abuse: No history of smoking, alcohol or drug abuse. Caffeine: I cup coffee per day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation: Retired, Disabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise: Occasionally</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies: Phenergan, Demerol: both cause outbreak of rash</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
    - Diabetic retinopathy
    - Diabetic 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 [583.81]
  – 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

¹AHA Coding Clinic Sept-Oct 1984
³AHA Coding Clinic Nov-Dec 1984 & AHA Coding Clinic 2nd Qtr 1993
Diagnosing, Documenting and Coding: Heart Failure
Stages and Treatment Therapies for HF

**At Risk for Heart Failure**

**STAGE A**
At high risk for HF but without structural heart disease or symptoms of HF.
- e.g., Patients with:
  - Hypertension
  - Atherosclerotic disease
  - Diabetes
  - Obesity
  - Metabolic syndrome
  - or Patients
  - Using cardiotoxins
  - With FHx CM

**THERAPY**
- **GOALS**
  - Treat hypertension
  - Encourage smoking cessation
  - Treat lipid disorders
  - Encourage regular exercise
  - Discourage alcohol intake, illicit drug use
  - Control metabolic syndrome
- **DRUGS**
  - ACEI or ARB in appropriate patients (see text)

**STAGE B**
Structural heart disease but without signs or symptoms of HF.
- e.g., Patients with:
  - Previous MI
  - LV remodeling including LVH and low EF
  - Asymptomatic valvular disease

**THERAPY**
- **GOALS**
  - All measures under Stage A
  - Dietary salt restriction
- **DRUGS**
  - ACEI or ARB in appropriate patients (see text)
  - Beta-blockers in appropriate patients (see text)
- **DEVICES IN SELECTED PATIENTS**
  - Implantable defibrillators

**STAGE C**
Structural heart disease with prior or current symptoms of HF.
- e.g., Patients with:
  - Known structural heart disease
  - Shortness of breath and fatigue, reduced exercise tolerance

**THERAPY**
- **GOALS**
  - All measures under Stages A and B
  - Dietary salt restriction
  - **DRUGS FOR ROUTINE USE**
    - Diuretics for fluid retention
    - ACEI
    - Beta-blockers
  - **DRUGS IN SELECTED PATIENTS**
    - Aldosterone antagonist
    - ARBs
    - Digitalis
    - Hydralazine/nitrates
- **DEVICES IN SELECTED PATIENTS**
  - Biventricular pacing
  - Implantable defibrillators

**Heart Failure**

**STAGE D**
Refractory HF requiring specialized interventions.
- e.g., Patients who have marked symptoms at rest despite maximal medical therapy (e.g., those who are recurrently hospitalized or cannot be safely discharged from the hospital without specialized interventions)

**THERAPY**
- **GOALS**
  - Appropriate measures under Stages A, B, C
  - Decision re: appropriate level of care
  - **OPTIONS**
    - Compassionate end-of-life care/hospice
    - Extraordinary measures
      - Heart transplant
      - Chronic inotropes
      - Permanent mechanical support
      - Experimental surgery or drugs
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
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
    - 4th digit of 9 indicates unspecified hypertension
    - 5th 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
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 \textit{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

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
Documenting and 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).
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.”
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


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


This is presented as an example only and neither represents nor is it represented as appropriate documentation.
Diabetes, CKD, HTN, HF & Depression in ICD-10-CM
ICD-10-CM: Diabetes *(E08-E13)*

**Diabetes Mellitus (ICD-10-CM)**

- The DM codes are combination codes that include:
  - The type of diabetes
  - The body system affected
  - The complications affecting that body system.

- **Diabetic Manifestations**
  - Many diabetes with manifestations are combined into a single code.
    - There are a few exceptions where the manifestation must be coded separately *(e.g., diabetic gastroparesis, diabetic ulcer, CKD due to diabetes)*
    - Diabetic manifestations are captured by the 4th, 5th, and 6th characters
  - Most conditions may be reported using only one code
    - However, assignment of as many codes within a particular category as are necessary to describe all of the complications of the disease may be used

- **Underlying Conditions and additional codes**
  - Code first underlying conditions responsible for DM *(e.g., E08 category)*
  - Code in addition stage of chronic kidney disease for Diabetic CKD *(N18.1-N18.6)*
  - Code in addition the site of associative diabetic ulcers *(L97.1-L97.9, L98.41-L98.49)*
ICD-10-CM: Diabetes (*E08-E13*)

- **Diabetes Mellitus (ICD-10-CM)**
  - **Primary Diabetes Mellitus**
    - Type 1 diabetes is reported with codes in category *E10*
    - Type 2 diabetes is reported with codes in category *E11*
  - **Secondary Diabetes Mellitus**
    - due to underlying condition is reported with codes in category *E08*
    - due to drug or chemical induced is reported with codes in category *E09*
    - due to other specified diabetes mellitus is reported with codes in category *E13*
      such as:
      - Diabetes due to genetic defects
      - Diabetes due to pancreatectomy or other procedure
      - Secondary diabetes mellitus NEC

- **Patient Use of Insulin**
  - For *E08, E09, E11* and *E13*:
    - Use additional code to identify any long term (current) use of insulin *Z79.4*
ICD-10-CM: Diabetes Mellitus Type 1&2

### E10 Type 1 diabetes mellitus (Categories)

- E10.2_ Type 1 diabetes mellitus with kidney complications
- E10.3_ Type 1 diabetes mellitus with ophthalmic complications
- E10.4_ Type 1 diabetes mellitus with neurological complications
- E10.5_ Type 1 diabetes mellitus with circulatory complications
- E10.6_ Type 1 diabetes mellitus with other specified complications
- E10.8_ Type 1 diabetes mellitus with unspecified complications
- E10.9_ Type 1 diabetes mellitus without complications

### E11 Type 2 diabetes mellitus (Categories)

- E11.2_ Type 2 diabetes mellitus with kidney complications
- E11.3_ Type 2 diabetes mellitus with ophthalmic complications
- E11.4_ Type 2 diabetes mellitus with neurological complications
- E11.5_ Type 2 diabetes mellitus with circulatory complications
- E11.6_ Type 2 diabetes mellitus with other specified complications
- E11.8_ Type 2 diabetes mellitus with unspecified complications
- E11.9_ Type 2 diabetes mellitus with without complications
ICD-10-CM: Diabetes Mellitus – Index

- Diabetic cause and effect relationships using ICD-10-CM

  - The cause and effect relationship between diabetes and its manifestation can be indexed using the word “with.”

  - Example:
    - Diabetes (II) “with” diabetic CKD = E11.22

Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)

  - Example:
    - Diabetes (II) “with” diabetic nephropathy = E11.21
ICD-10-CM: Diabetes Mellitus – Control Status

• Diabetes Mellitus

  – Deletion of 5th digits ‘controlled’ and ‘uncontrolled’ within the specified DM categories.

    - The terms:
      • inadequately controlled
      • out of control (uncontrolled)
      • poorly controlled

• Now default code to “Diabetes (by type) with hyperglycemia.”
ICD-10-CM: HTN

• The terms "malignant" and "benign" have become nonessential modifiers and no longer affect code selection.

• Because of this change, the “Hypertension Table” is no longer needed.

• There are less subcategory HTN codes to choose from compared to ICD-9-CM

• There are no complicated “5th digit” details to contend with as with ICD-9.

• High Blood Pressure is included in I1Ø and not coded separately.

Note: High blood pressure reading without a diagnosis of hypertension is coded as RØ3.Ø.
ICD-10-CM: HTN & CKD

Example:

Hypertensive chronic kidney disease stage 3

**ICD-9-CM**

403.90  Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified

585.3  Chronic kidney disease, Stage III (moderate)

**ICD-10-CM**

I12.9  Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

N18.3  Chronic kidney disease, stage 3 (moderate)
ICD-10-CM: HF

**Coding HF/CHF**: Identifying congestive heart failure as a common underlying condition:

- There are numerous coding options available based on the severity of the CHF condition.
- Coders require a confirmed diagnosis and clear communication of severity in the documentation to accurately code the CHF condition.
  - Not only can lack of severity specifics impact reimbursement, but it impacts resource allocation allowed by Medicare to care for the patient.  

ICD-10-CM: HF/CHF (Category I5Ø)

ICD-10-CM: HF

Example:

**Hypertensive** congestive heart failure

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>402.91</td>
<td>Hypertensive heart disease, unspecified, with heart failure</td>
</tr>
<tr>
<td>428.0</td>
<td>Congestive heart failure, unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I50.9</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>

- There is no assumed relationship between hypertension and heart disease or heart failure.
  - It must be stated (due to hypertension) or implied (hypertensive).
ICD-10-CM: Major Depressive Disorders

• Category F32, Major depressive disorder, single episode includes:
  – single episode of: agitated depression, depressive reaction, major depression, psychogenic depression, reactive depression, vital depression

• F32.0 Major depressive disorder, single episode, mild
• F32.1 Major depressive disorder, single episode, moderate
• F32.2 Major depressive disorder, single episode, severe without psychotic features
• F32.3 Major depressive disorder, single episode, severe with psychotic features
• F32.4 Major depressive disorder, single episode, in partial remission
• F32.5 Major depressive disorder, single episode, in full remission
• F32.8 Other depressive episodes
• F32.9 Major depressive disorder, single episode, unspecified
ICD-10-CM: Recurrent Depressive Disorders

- ICD-10-CM also includes codes for recurrent depressive disorders, as well as those in remission or partial remission. A recurrent depressive disorder is characterized by:
  - Repeated episodes of depression without any history of independent episodes of mood elevation and increased energy or mania
  - At least one previous episode lasting a minimum of two weeks and separated by the current episode of at least two months
  - No past hypompanic or manic episodes

ICD-10-CM: Recurrent Depressive Disorders

- Category F33, Major depressive disorder, recurrent includes:
  - recurrent episodes of: depressive reaction, endogenous depression, major depression, psychogenic depression, reactive depression, seasonal depressive disorder, vital depression

- F33.0 Major depressive disorder, recurrent, mild
- F33.1 Major depressive disorder, recurrent, moderate
- F33.2 Major depressive disorder, recurrent severe without psychotic features
- F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
- F33.4 Major depressive disorder, recurrent, in remission (requires 5th digit)
  - F33.40 Major depressive disorder, recurrent, in remission, unspecified
  - F33.41 Major depressive disorder, recurrent, in partial remission
  - F33.42 Major depressive disorder, recurrent, in full remission
- F33.8 Other recurrent depressive disorders
- F33.9 Major depressive disorder, recurrent, unspecified

ICD-10-CM: Major Depressive Disorder In Remission

- For a classification of “in remission,” the patient has had two or more depressive episodes in the past, but has been free from depressive symptoms for several months. This category can still be used if the patient is receiving treatment to reduce the risk of further episodes.

Examples:
- F33.0 Major depressive disorder, recurrent, mild
- F33.41 Major depressive disorder, recurrent, in partial remission

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 summaries²

• Documentation of **all chronic conditions** at least once per year²

• Documentation of **any chronic condition that affects the care and treatment** of the patient on that date of service¹

• Conditions should be **coded to the highest degree of specificity for that encounter/visit**¹


Documentation Requirements\textsuperscript{1,2}

- The listing of DX codes is not enough; there must be evaluation.
- The medical record must thoroughly document all conditions \textit{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

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

- Diabetic
- Hypertensive
- Due to
- Secondary to

Chart Mechanics & Documentation Considerations\textsuperscript{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


http://www.cdc.gov/nchs/lcd/lcd9cm_addenda_guidelines.htm
Authentication Requirements: Paper Record\textsuperscript{1,2}

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

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


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.

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**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/MedicareAdvtnSpecRateStats/Downloads/Advance2014.pdf, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtnSpecRateStats/Downloads/Announcement2014.pdf and www.cms.gov/Medicare/Health-Plans/MedicareAdvtnSpecRateStats/index.html.

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Thank You for Your Participation!

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