Risk Adjustment & Clinical Documentation
March 2017
Agenda

- Value Based Payment
- Why proper ICD-10-CM coding, risk adjustment, and quality incentive programs matter
- Strategies for clinical documentation improvement
- Strategies for improving coding
- Risk Adjustment
- Diabetes in Risk Adjustment
Payment Transformation

- Value Based Payment: shifts from FFS to payments determined by outcomes, reduced costs, & improved patient experience
- VBP now 2% - 5%, but expected to grow to 7% - 10% of payments
- PQRS is a VBP (pay for performance)
Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 30% All Medicare FFS
- 85%

2018
- 50% All Medicare FFS
- 90%
Value Based Payment (VBP)

- Medicare budget is zero-sum. How does CMS pay for VBP?
- Data collected through P4P programs is usually available to public
- With HMSA, hospitals and providers see PQRS & HEDIS scores factoring into payments, along with other quality measures
What’s Coming Next

- Risk Shifting
  - May be called “bundled payments” or “global payments” or “case rate,” “IPU”
  - Integrated practice units: a team of clinicians & non-clinicians that provide a full range of services to people with the same or similar chronic disease.
  - Team focus more efficient & effective and has common goal
    - West German migraine headache center reduced costs by 20% & improved symptoms in patients by 54% using IPU
  - Sort of like capitation, but with quality built in
High Value Healthcare

- Outcomes of data, utilization, and costs of care
- Collaboration and communication among members of the care team
- Patients are healthier and satisfied with the care received
- High value accountable care depends on coordination of services
How To Survive The Transition

- Keys to Success
  1. Vigilance to qualify for every bonus payment available
  2. Reduced practice costs (optimize margins)
  3. Maximized patient volume (Medicare & Medicaid included)
  4. Data integrity – Including the medical record
  5. Operational integration through EHRs
Provider Perspective

- Providers:
  - Just want to take care of patients
  - Exhausted by administrative burdens
  - Don’t get “paid” for diagnostic codes
  - Are Clinicians, Not Coders
What’s Clear

- Anytime someone is paid based on outcomes, diagnostic coding matters.
- Anytime someone is paid for cost saving, diagnostic coding matters.
- Anytime someone is looking at practice or provider specific data to evaluate case mix and workload, diagnostic coding matters.
What May Not Be So Clear

The impact of complete and correct coding extends far beyond one encounter’s medical necessity.
Diabetes in Hawaii

- CDC: ~ 30 million people have diabetes
- Hawaii: 154,365 (13.1%) have diabetes
  - 46,000 have diabetes but don’t know it
  - 442,000 have pre-diabetes

Diabetes costs an estimated $1.5 billion in Hawaii each year.
The serious complications include heart disease, stroke, amputation, end-stage kidney disease, blindness – and death.

1. About Prediabetes & Type 2 Diabetes

Prediabetes is a serious condition affecting 1 out of 3 American adults — that's 86 million people!
Example: Diabetic Foot Ulcer

- More days hospitalized
- More days requiring home health care
- More ED visits
- More outpatient/physician office visits

Conclusion: Diabetic foot ulcers impose a substantial burden on both public and private payers in addition to the costs associated with diabetes itself.
## Diagnosis Codes Spur Public Health Drives

<table>
<thead>
<tr>
<th>Reporting Area</th>
<th>Hep A 2016</th>
<th>Hep A 2015</th>
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<tbody>
<tr>
<td>Pacific</td>
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<td>Washington</td>
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<td>26</td>
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</tbody>
</table>
Diagnostic Codes Identify Trends

https://www.ccwdata.org/web/guest/home
Coding Matters

- Coding impacts provider and payer compliance, reimbursement, & performance measures
  - On a micro level, coding impacts every patient
  - On a macro level, coding impacts national policy, funding, & medical research
Coding The Medical Record
Where Good Coding Begins

- “The importance of consistent, complete documentation in the medical record cannot be over emphasized. Without such documentation accurate coding cannot be achieved.”
  - Introduction to ICD-10-CM Official Guidelines for Coding and Reporting 2017
Restrictions for Coders

- Medical records must be documented in words, not codes.
- A code is not valid documentation of a diagnosis
Restrictions for Coders

- Codes, without narrative diagnostic descriptions, are “invisible” for coding
  - Documenting hypertension by writing “I10” does not provide qualitative information necessary to submit the code I10 on a claim form. WORDS matter!
  - If you document, “diabetes E10.9” (Type 1) the coder must code E11.9 (Type 2), because you documented “diabetes” without further specifying it, & the guidelines tell us unspecified diabetes is Type 2. Again, WORDS!
- These are rules coders live by & CMS demands
Restrictions for Coders

- Cloned lists of problems, medications, surgical histories cannot be a source for coding
  - If “Huntington’s disease” is listed as a past medical history or on a problem list, it cannot be coded, even though it is an incurable disease. It must be addressed in the CURRENT encounter, even to simply say the patient’s “Huntington’s symptoms are stable.”
- Med lists cannot be used for coding. There must be a diagnosis.
- Information from previous encounters cannot contribute to coding the current one
  - Each date of service or hospitalization stands on its own
Restrictions for Coders

- Coders are NOT clinicians.
  - Adjustment of the patient’s sliding scale for insulin is good clinical care, but without a documented diagnoses of “diabetes,” all the coder can abstract is long-term use of insulin
  - If a patient is documented as drinking a case of beer a day, without further note, this drinking would not be coded with a diagnosis of alcohol use, abuse, or dependence
  - A patient with a creatinine of 29 cannot be reported with a diagnosis of CKD
- PS – without the WORDS, the clinician can’t code it
Restrictions for Code Selection

- The code must match your documentation, based on your exact word choice as presented in the ICD-10-CM Index.
  - Choose your words carefully & document completely, or the ICD will finish your work for you:
    - “Sinusitis” is indexed to a code for **chronic** sinusitis
    - “Bronchiolitis” is indexed to **acute** bronchiolitis
    - “Lymphoma” is indexed to **non-Hodgkin** lymphoma
    - “Nevus” is indexed to **melanocytic** nevus
Clinical Documentation Improvement for Specificity
Key Considerations

- CMS gave everyone using ICD-10-CM AMNESTY for the first year
  - Nonspecific or erroneous coding was not rejected, so long as the code reported was valid.
    - Enough characters
    - Right code family to show medical necessity
    - OK if nonspecific (ie, NOS laterality on hip replacement)
Key Considerations

CMS Announced:

- “As of **October 1, 2016**, providers will be required to code to accurately reflect the clinical documentation in as much specificity as possible, as per the coding guidelines

- You should code each health encounter to the level of certainty known for that encounter

- Avoid **unspecified ICD-10 codes** whenever documentation supports a more detailed code
What Will Prevent CMS Troubles

- Specificity!
  - The old 80-20 rule:
    - 80 percent of problems are caused by 20 percent of the work performed
- Let’s look at 10 top errors in documentation & coding
  - ...and find some easy solutions
“History Of”

- Provider Definition
  - An account of a patient's family & personal background and past & present health

- ICD-10-CM Definition
  - A patient’s past medical condition that is no longer receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.
“History Of”

- **Solution**
  - Avoid using “history of” unless documenting a resolved condition
  - Use the phrase “continued care for” instead, as appropriate

- **Advantage**
  - Current conditions will be coded, ensuring medical necessity is captured for reporting
  - Past conditions appropriately will not be coded
Causal Relationships

- Issue
  - For most diseases with causal relationships, the causal relationship must be linked in documentation
    - “Records submitted .... should include language from an acceptable physician specialist which establishes a causal link between the disease & the complication”*
  - Comorbidity Exceptions
    - Diabetes (with), hypertension (with), and pregnancy (complication of)
Causal Relationships

- **Solution**
  - Follow many diagnoses with the words “due to”
    - Hip fracture **due to** secondary bone cancer **due to** primary breast cancer
    - Pneumonia **due to** RSV
    - Document no relationship for DM, HTN, Pregnancy, as needed

- **Advantage**
  - Reduces denials or queries from CMS
  - Medicolegal and patient care/outcomes
  - Ensures coders won’t link what they shouldn’t
Specificity

- **Issue**
  - Not enough information on the condition
  - Record qualitative information on patient conditions

- **Examples**
  - Acute DVT vs chronic DVT
  - Leg ulcer due to diabetes, venous stasis, pressure
  - Stage 1-4 leg ulcer
  - Crohn’s disease causing rectal bleeding/obstruction/ fistula/abscess
Specificity

Solution
- Add qualitative words to diagnosis, showing your assessment, as appropriate
  - Chronic/Acute; Stable/Improved/Worsening
  - Resolved; In Remission; Active
  - Specific site; Laterality; Complication

Advantage
- Reflect appropriate MDM that may affect E/M leveling
- Reduce denials or queries from CMS
- Medicolegal patient care/outcomes
Include Health Status

- **Issue**
  - Health factors often complicate a patient’s care and should be documented at least annually

- **Examples**
  - HIV positive
  - Active stoma
  - Dialysis
  - Amputation
  - Paralysis/hemiparalysis
  - Transplant recipient
  - Intellectual disability
  - Weight issue
  - (obese/underweight)
  - History of myocardial infarction
Include Health Status

- **Solution**
  - Review problem list to prompt attention to patient’s health status & update with a brief note in each visit
    - PE/HPI as appropriate

- **Advantage**
  - Reduce denials or queries from CMS
  - Reflect appropriate MDM that may affect E/M leveling
  - Medicolegal and patient care/outcomes
  - Impact on risk adjustment scores
Address Behavioral Health Issues

- **Issues**
  - Missing information in substance abuse
  - No mention of etiology in dementia, or manifestations including wandering or behavioral disturbance

- **Examples**
  - For substances, must state use, abuse, dependence, & if remission. Must link substance to any complication
  - Specify “history of” or “in remission”; single episode or recurrent
  - Specify current episode as mild, moderate, severe, with psychosis
  - Document intellectual disability
Address Behavioral Health Issues

- **Solution**
  - Document granularity in description of chronic behavioral health disease
  - Identify acute or situational conditions identified during medical encounter if they affect care or health

- **Advantage**
  - Primarily medicolegal and patient care or outcomes
  - Risk adjustment accuracy
Be Clear With Neoplasms

- **Issue**
  - Fuzzy neoplasm documentation leads to errors

- **Examples**
  - Secondary cancers not specifically identified as metastases
  - Primary site of neoplasm not clearly identified
  - “History of” cancer reported with active cases
  - Active cancer reported in cases in which surgery, chemotherapy and radiation therapies have been completed
  - Confusing or contradictory documentation
Be Clear With Neoplasms

Solution
- Document to the highest specificity primary malignant, secondary malignant, benign, and in situ neoplasms
- Remember that “uncertain behavior” is reserved for neoplasms that have undergone microscopic examination. “Unspecified” means the exam results are not back, or were not sent.

Advantage
- Primarily medicolegal & patient care/outcomes. Imagine if someone were taking over care for the cancer patient: Your details become exceedingly important if the new provider is to understand the patient’s history & provide continuity of care.
Keep Up With Change

- **Issue**
  - Code changes must lead to documentation adjustments
  - CMS rule changes must be implemented
- **Examples**
  - 2017 codes: E10.37X1 Type 1 diabetes mellitus with diabetic macular edema, resolved following treatment, right eye
  - Proposed expansion of eligible telehealth services to include dialysis, advanced care planning, & critical care consults*
  - Proposed diabetes prevention program expansion in 2018*
  - CMS published an EHR Toolkit last summer for guidance on compliance. Have you looked at what they recommend? Soon it will be what they require.
- *CMS 2017 MPFS Proposed Rule
Keep Up With Change

Solution

- Designate someone in your office to monitor CMS, read newsletters & evaluate annual CPT, ICD & HCPCS code changes
  - This person ensures changes are implemented & providers are informed of upcoming changes

Advantage

- Allows providers to focus on patient care
- Supports a compliant and effective practice
Address Weight Issues

- Issue
  - Obesity and morbid obesity not addressed in documentation, though BMIs indicate the conditions
  - Malnutrition & cachexia not addressed in documentation though BMI suggests patient has issues
- Examples
  - Patients with BMIs over 40 might be counseled on medical or surgical options & morbid obesity would be documented
  - Patients with chronic conditions like cancer or AIDS with cachexia have weight status that would be addressed & documented
Address Weight Issues

- **Solution**
  - Check BMIs with every encounter, and address unhealthy BMIs in office notes when they are identified

- **Advantage**
  - Closer monitoring of BMIs provides opportunities for intervention that can improve outcomes for the patient
Connect The Dots

- **Issue**
  - A diagnosis can be reported only when it is EXPLICITLY described in the progress note
  - Coders/auditors cannot infer a diagnosis or refer to a problem list

- **CMS:**
  - “Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment”
Connect The Dots

- Solution
  - Include qualitative elements with every diagnosis
  - Address chronic conditions with regularity and THINK in INK
  - Consider how chronic conditions affect today’s chief complaint
    - BKA a consideration for patient with DM or contralateral DVT
    - Intellectual disability affects the encounter & patient compliance

- Advantage
  - Providers who report diagnoses with a greater level of granularity fare better in PQRI & their patients may experience better outcomes
  - Properly documenting thought process may impact MDM and E/M
Focus on Documentation

- **Issue**
  - Details in diagnoses matter. As CMS stated:
    - “The important of consistent, complete documentation in the medical record cannot be over emphasized. Without such documentation accurate coding cannot be achieved.”
  - **Code to the highest level of specificity**

- **Examples**
  - Encounter forms are not acceptable documentation
  - Problem lists are not acceptable forms of documentation
  - Lists of meds & scripts in the medical record do not meet medical documentation requirements to show a condition has been addressed
  - Lists of lab results are not the equivalent of a diagnosis
Focus on Documentation

- **Solution**
  - Patient & financial outcomes may both benefit from changes in current work flow & content
  - Consider that your documentation should meet the needs of an audience other than yourself. Be thorough & address chronic conditions often
  - Determine if it makes economic sense for you to perform time-consuming coding, as well as whether it is the best protection for your practice
Risk Adjustment
Risk Adjustment

A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.
Risk Adjustment

Health Assessments

Provider Education

Data Validation

Chart Review

Patient Outreach
Medicare Advantage

- Offered by Private Insurance Companies
  - Plans equal to or better than traditional Medicare
  - Only those eligible for traditional Medicare may apply
  - Out-of-pocket caps on some plans
  - Offer drug, dental and vision benefits
- Roughly 31 percent of Americans (46% of Hawaiians) who were eligible for Medicare chose a Medicare Advantage plan for 2016 – 17.6 million Americans
- Seniors/disabled can select from numerous competitive plans

3/28/2017
Medicare Advantage Organization (MAO)

- CMS payment to MAO varies for each patient
  - Capitated: Base payment per enrolled member
  - Risk Adjusted: Additional payment per enrolled member based on chronic diagnoses from previous year’s claims
Medicare Advantage Disconnect

- Provider coding does not usually emphasize ICD accuracy or specificity, except to ensure medical necessity is met for CPT
- Each year, the diagnosis list is zeroed out by CMS
  - All patients are considered healthy until diagnoses are again reported, ensuring patients are being treated for the chronic conditions they have
- If providers don’t code correctly, or don’t code all diagnoses, the Medicare Advantage Organization has problems
  - Upcoding brings fines; downcoding brings losses
  - Lowered Star rating penalizes MAO
MEAT – Necessary for Risk Adjustment

Medical necessity: A diagnosis that shows evidence a service was warranted

Support: In risk adjustment, documentation that shows a diagnosis was considered by the physician Monitored, Measured Evaluated Assessed, Addressed Treated

“Does the documentation have MEAT?”
MEAT in Your Documentation

- Monitor
  - Signs, symptoms, disease progression, disease regression

- Evaluate
  - Test results, medication effectiveness, response to treatment

- Assess/Address
  - Ordering tests, discussion, review records, counseling

- Treatment
  - Medications, therapies, other modalities
Specificity – Necessary for RA

- …in Both Documentation and Coding

<table>
<thead>
<tr>
<th>If Assessment Says:</th>
<th>It Does Not Risk Adjust</th>
<th>If Assessment Says:</th>
<th>It Risk Adjusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac dysrhythmia</td>
<td>I49.9 Cardiac dysrhythmia, NOS</td>
<td>Atrial fibrillation</td>
<td>I48.91 Afib, NOS</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>J40 Bronchitis, NOS</td>
<td>chronic obstructive bronchitis</td>
<td>J44.9 COPD, NOS</td>
</tr>
<tr>
<td>Obesity</td>
<td>E66.9 Obesity, NOS</td>
<td>Morbid obesity</td>
<td>E66.01 Morbid obesity</td>
</tr>
<tr>
<td>Hx of breast cancer</td>
<td>Z85.3 Personal hx of breast cancer</td>
<td>Breast cancer</td>
<td>C50.919 Malignant neoplasm of breast NOS</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>J18.9 Pneumonia, NOS</td>
<td>Pneumococcal pneumonia</td>
<td>J13 Pneumonia due to S. pneumoniae</td>
</tr>
</tbody>
</table>
STAR Ratings

- CMS ensures Medicare Advantage Plans Meet Standards
- STARS Evaluates:
  - Preventive services
    - Colonoscopy, mammogram, BMI, cholesterol tests of those with
    - Flu vaccine, BMI assessment, monitoring physical and mental health
  - Management of chronic diseases
    - Diabetics: foot and eye exams, A1Cs, kidney function, blood sugar control, medication adherence
    - Elder care: med review, functional assessment, pain, osteoporosis, fall reduction
  - Care coordination
  - Customer service and customer satisfaction
  - Responsiveness, complaints, appeals and disenrollments
Best Practices

- Accuracy
- Specificity
- Thoroughness
- Consistency

Best Practices in Medical Coding
Best Practices

- Engage Staff & Coders
- Accurate Risk Codes
- Engage Clinicians
- Adopt Technologies
Best Practices

- Standardize Processes
- Develop Internal Checkpoints
- Utilize Tools & Resources
- Review
Medicare Risk Adjustment Example

- **Patient:** Jane Smith  
  **DOB:** 01/19/40  
  **DOS:** 03/29/17  
  Patient is a 77 year old female with UTI like symptoms. Patient c/o fatigue, low energy and poor appetite. Patient is status post MI 18 months ago. Patient appears frail and with mild malnutrition. Has lost 23 pounds in the last 4 months. Patient has been complaining of pain with urination, weakness, and has had dry, itchy skin for the past several months. U/A done today shows WBCs, leukocyte esterase, and microalbuminuria. Serum creatinine is 1.5.

- **PMH:** Type II diabetes, chronic kidney disease secondary to diabetes, history of left BKA skin intact at stump, no erythema. History of MI. Previous UTI 4 months ago with a serum creatinine of 1.6. Lab results at that time revealed stage 2 CKD.

- **A/P:** Diabetes-Metformin 500 mg b.i.d. Bactrim for UTI. Malnutrition Ensure b.i.d. and nutrition consult. RTC in 6 weeks. Referral made to Dr. Jones (Nephrologist) for CKD. Note Electronically Signed by Mark White, MD 03/29/2017 0814
## Coding Example 1: Typically submitted codes for office visit

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Condition</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>E11.9</td>
<td>DM w/o complication, type II</td>
<td>19</td>
</tr>
<tr>
<td>N39.0</td>
<td>Urinary tract infection</td>
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<tr>
<td></td>
<td>Does not risk adjust</td>
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</table>

## Coding Example 2: Opportunities for additional risk adjustment code reporting

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Condition</th>
<th>HCC</th>
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<tbody>
<tr>
<td>E11.29</td>
<td>Diabetes with renal manifestations, type II</td>
<td>18</td>
</tr>
<tr>
<td>N18.2</td>
<td>Stage II CKD</td>
<td>125</td>
</tr>
<tr>
<td>E44.1</td>
<td>Malnutrition, mild degree</td>
<td>21</td>
</tr>
<tr>
<td>N39.0</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not risk adjust</td>
<td></td>
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<tr>
<td>I25.2</td>
<td>Prior MI</td>
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</tr>
<tr>
<td>Z89.512</td>
<td>Amputation, below knee</td>
<td>189</td>
</tr>
</tbody>
</table>
Diabetes Mellitus
Diabetes Mellitus

- **E11.9 - Type 2 diabetes mellitus without complications**
- Five major categories
  - **E08** – Diabetes due to underlying condition
  - **E09** – Drug or chemical induced diabetes
  - **E10** – Type 1 diabetes mellitus
  - **E11** – Type 2 diabetes mellitus
  - **E13** – Other specified diabetes mellitus
E10 & E11

- Ensure you take the proper steps:
  - Specify Type 1 or Type 2
  - Document the degree of control
  - Specify insulin use
  - Specify complications to a very specific degree
## Diabetes in Primary Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>E11.65</td>
<td>Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>E11.649</td>
<td>Type 2 diabetes mellitus with hypoglycemia without coma</td>
</tr>
<tr>
<td>E11.329</td>
<td>Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema</td>
</tr>
<tr>
<td>E11.22</td>
<td>Type 2 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>E11.42</td>
<td>Type 2 diabetes mellitus with diabetic polyneuropathy</td>
</tr>
<tr>
<td>Z79.4</td>
<td>Long term (current) insulin use</td>
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</table>
# Diabetes HCC Mapping

<table>
<thead>
<tr>
<th>Disease Coefficient</th>
<th>Description</th>
<th>Non Dual Aged</th>
<th>NonDual Disabled</th>
<th>Dual Aged</th>
<th>Dual Disabled</th>
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</thead>
<tbody>
<tr>
<td>HCC 17</td>
<td>DM w/Acute Complications</td>
<td>0.318</td>
<td>0.371</td>
<td>0.346</td>
<td>0.431</td>
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<tr>
<td>HCC 18</td>
<td>DM w/Chronic Complications</td>
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<td>0.371</td>
<td>0.346</td>
<td>0.431</td>
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<td>HCC 19</td>
<td>Diabetes w/o Complication</td>
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<td>0.128</td>
<td>0.097</td>
<td>0.160</td>
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CMS Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter:


2017 HCC ICD-10 Mappings:

- [https://www.cms.gov/Medicare/Health-Plans/MedicareAdvrtgSpecRateStats/Risk-Adjustors.html](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvrtgSpecRateStats/Risk-Adjustors.html)
Diabetes Coding Errors

- A cause and effect relationship between diabetes and diabetic manifestation codes is not sufficiently documented and/or coded.
- Patient status conditions are not evaluated and/or documented at least once a year.
- Poorly controlled DM vs uncontrolled
Documentation Coding Examples

- Chronic Conditions:
  Hepatitis B (followed by hepatologist)
  HTN (readings running high at home)
  DM (stable on current insulin dose)
  Breast cancer (mastectomy in 2012)

- A diabetic patient presents with a laceration on the bottom of his left foot. The wound requires a closure repair. What conditions should be reported?
Top 10 Coding Errors For Risk Adjustment

1) The record does not contain a legible signature with credential

2) The EHR was unauthenticated (not electronically signed)

3) The highest degree of specificity was not assigned the most precise ICD-10 code.

4) A discrepancy was found between the diagnosis codes billed vs the actual written description in the medical record.

5) Documentation does not indicate MEAT
Top 10 Coding Errors cont.

6) Status of cancer is unclear. Treatment is not documented
7) Chronic conditions are not documented as chronic
8) Lack of specificity
9) Chronic conditions or status codes aren’t documented in the medical record at least once per year
10) A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code
Living healthy and enjoying life to the fullest. That’s what we’re striving for.