Risk Adjustment Documentation & Coding Improvement Reference Information

In today's quality and patient-centered health care environment, the importance of accurate, specific and thorough medical record documentation and coding has become vital to physicians, other health care professionals and payers to assist in the optimization of clinical outcomes. The information below gives documentation and coding examples for the most common chronic conditions and also provides tips to assist in the accurate and specific capture of each patient's health status in accordance with ICD-10-CM Coding and Reporting guidelines.[1]

Remember, if a Condition Has Been:

Monitored (signs, symptoms, improvement/worsening of condition);
Evaluated (test results, medication effectiveness, response to treatment);
Assessed (ordering tests, review records, counseling) and/or;
Treated (medications, therapies, other treatments/procedures);

the condition should be coded and reported on the claim.

Please note: It is not enough to document a condition(s) in a problem list or simply state the condition in the history or physical exam. Condition(s) should be listed on the assessment/plan and reported on the claim to accurately capture and code. The accurate and thorough reporting of all conditions to the patient's disease severity level allows the patient to be identified for disease or care management programs that assist with improving health status.

Reasons to Focus on Documentation and Coding Improvement:

- Identify and clarify documentation that is conflicting, incomplete or missing in the medical record to facilitate the accurate capture of each patient's level of disease severity.
- Support and meet clinical quality initiatives and diagnosis driven program requirements.
- Take a proactive approach to improving documentation and coding to be prepared for diagnosis-driven payment models.
- Leverage and enhance electronic health record (EHR) technology to assist physicians with thorough documentation and specific coding. Create teams of physicians, nurses, coders and billing staff to champion improved documentation and accurate coding.
- Ensure you are able to fully report all diagnoses that were monitored, evaluated, assessed and/or treated during the encounter on a claim. Horizon BCBSNJ is able to accept up to 12 diagnosis per claim.
- Assist in the patient's continuity of care. The health care team involved in care management relies on thorough and accurate documentation to make ongoing medical and treatment decisions.

[1] Horizon BCBSNJ prepared this summary to assist providers with the Centers for Medicare & Medicaid Services coding requirements. Horizon BCBSNJ believes the determination of the appropriate diagnosis codes is made by the clinician.

Examples: Documentation and Coding

The following are examples of assessments/plans for some of the most commonly reported chronic conditions. The scenarios include documentation requirements supporting the condition(s) and ICD-10-CM code(s) as well as tips assisting in accurately and thoroughly recording the condition.

Diabetes with Hyperglycemia	
Assessment/Plan	Diabetes not controlled. Patient unable to keep blood sugar (BS) low enough. Will adjust insulin and see patient for follow up in two weeks. Asked patient to keep log of daily BS during this time.
ICD-10-CM Codes	• **E11.65** – Type 2 Diabetes Mellitus with Hyperglycemia. • **Z79.4** – Long-term (current) use of insulin.
Documentation/ Coding Tips	• **E11** (Type 2 Diabetes Mellitus) – if type of diabetes is not documented or documentation states patient uses insulin. • Hyperglycemia – not controlled/uncontrolled diabetes; patient with elevated BS or elevated A1c should be coded Type 2 Diabetes with Hyperglycemia. • **Z79.4** – code to indicate patient uses insulin. **Z79.4** is not utilized unless insulin use is presumed. To code conditions as being diabetic complications/manifestations, the medical record documentation must present a specific causal relationship between the two conditions. **Examples of such a causal relationship include:** *with, in related to, related with, diabetic, due to,* etc. Exceptions to the casual relationship rule in ICD-10-CM are any conditions listed under the sub term with. The following is an excerpt from the ICD-10-CM codebook index.[2] *Note this list is not all-inclusive. Please refer to the codebook for the complete list.* • Diabetes, diabetic (mellitus) (sugar) – **E11.9** with – Amyotrophy – **E11.44** – Arthropathy – **NEC E11.618** – Autonomic (poly) neuropathy – **E11.43** – Cataract – **E11.36** – Charcot's joints – **E11.610**

[2] ICD-10-CM Complete Code Set 2017, AAPC.

Diabetes with Hyperglycemia *(continued)*	
Documentation/ Coding Tips	– Chronic kidney disease (CKD) – **E11.22** – Circulatory complication – **NEC E11.59** – Complication – **E11.8** ❍ Specified – **NEC E11.69** – Dermatitis – **E11.620** – Foot ulcer – **E11.621** – Gangrene – **E11.52** – Gastroparesis – **E11.43** – Glomerulonephrosis, intracapillary – **E11.21** – Gomerulosclerosis, intercapillary – **E11.21** – Hyperglycemia – **E11.65** – Hyperosmolarity – **E11.00** ❍ Coma – **E11.01** – Hypoglycemia – **E11.649** ❍ Coma – **E11.641** – Kidney complications – **NEC E11.29** – Kimmelsteil-Wilson disease – **E11.21**

Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation	
Assessment/Plan	Acute exacerbation of COPD with acute bronchitis due to patient smoking. Advised on smoking cessation. Increase prednisone, prescribed antibiotic and increased nebulizer treatments to every two to four hours. Follow up in five days or sooner if symptoms worsen.
ICD-10-CM Codes	• **J44.0** – COPD with acute lower respiratory infection • **J20.9** – Acute bronchitis, unspecified • **J44.1** – COPD with (acute) exacerbation • **F17.218** – Nicotine dependence, cigarettes, with other nicotine-induced disorders
Documentation/ Coding Tips	Four codes are required for the scenarios above: 1. COPD with acute exacerbation 2. Acute bronchitis • **J44.0** and **J20.9** – are necessary to correctly code acute bronchitis with COPD • **J44.0** – note: use additional code to identify the infection • **J20.9** – added to identify the infection, acute • **J44.1** – additional code to identify the COPD exacerbation 3. COPD with acute bronchitis 4. A cause and effect relationship must be documented to assign code **F17.218**. If cause and effect relationship is not documented, code **F17.210** (nicotine dependence, unspecified, uncomplicated) If causative organism is known and documented, code specified organism code under **J20**, acute bronchitis.

Asthma	
Assessment/Plan	Intermittent asthma with acute exacerbation due to exposure to secondhand smoke. Prescribed three-day course of prednisone and continue albuterol inhaler. Follow up in three days or sooner, if symptoms worsen.
ICD-10-CM Codes	• **J45.21** – Mild intermittent asthma with (acute) exacerbation • **Z77.22** – Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Documentation/ Coding Tips	Refer to the National Heart Lung & Blood Institute (NHLBI) for asthma severity guidelines: • Mild intermittent • Mild persistent • Moderate persistent • Severe persistent – Document and code for any use or exposure to tobacco. Should only be assigned if physician documentation states condition is due to exposure. (Do not assign as primary diagnosis). – Focus clinical documentation on the severity of asthma and relationship to other diseases when applicable.

Body Mass Index (BMI)	
Assessment/Plan	Morbid obesity recorded BMI is 40.2 – patient admits to overeating. Discussed dietary changes and reduced caloric intake at length. Will schedule consult appointment with our registered dietician. Type 2 Diabetes without complications: A1c within normal limits. Continue current medication.
ICD-10-CM Codes	• **E66.01** – Morbid (severe) obesity due to excess calories • **Z68.41** – BMI 40.0 - 44.9, adult • **E11.9** – Type 2 Diabetes mellitus without complications • **Z71.3** – Dietary counseling and surveillance
Documentation/ Coding Tips	• Any clinician can document BMI in the patient's medical record • Physicians and other health care professionals must document the condition and its medical significance (e.g., overweight/morbid obesity) • Two codes should be reported for conditions coded to **E66**, overweight and obesity, along with code for documented BMI

Atrial Fibrillation/Atrial Flutter	
Assessment/Plan	Patient has intermittent episodes of irregular heartbeat over the past year causing shortness of breath. Paroxysmal atrial fibrillation (PAF) recorded on Holter monitor. Patient is also being treated for hypertension. Patient admits to non-compliance with taking medicines. Stressed importance of compliance with patient. Follow up in one week. Patient had Myocardial Infarction (MI) six months ago.
ICD-10-CM Codes	• **I48.0** – PAF • **I10** – Essential (primary) hypertension • **T46.5X6D** – Underdosing of other antihypertensive drugs, subsequent encounter • **Z91.12** – Patient's intentional underdosing of medicine regimen • **I25.2** – History of MI
Documentation/ Coding Tips	Atrial Fibrillation (AF) is broken down into three categories: • Paroxysmal – Terminates within seven days • Persistent – Sustained > seven days and is subject to rhythm control to maintain normal sinus rhythm (NSR) via medication • Permanent (Chronic) – NSR cannot be sustained and physicians and other health care professionals or patient cease further attempts to maintain NSR • History AF – AF in the past but now NSR and the patient is not taking medicine to maintain NSR Atrial flutter (AFL) is broken down into two categories: • Type I (Typical) • Type II (Atypical) If sick sinus syndrome or another cardiac arrhythmia has been successfully treated by implantation of a pace-making device (which is not malfunctioning), the arrhythmia diagnosis should not be captured, as it is considered to be a historical condition, which has now been resolved. AF and AFL can specifically be captured when not specified as controlled, resolved or compensated, or when being controlled by medicine as long as that medicine is noted in the visit documentation by the physician or other health care professional. An assessment of the condition, e.g. stable EKG results or Physical Exam findings, may also serve as M.E.A.T. If non-compliance with medication is documented, it should be coded to category (**T36-T50**) for underdosing (taking less medicine than prescribed by a physician or other health care professional), along with a code from (**Z91.12-Z91.13**) for non-compliance or complications of care (**Y63.6-Y63.9**). For encounters occurring while the MI is equal to, or less than, four weeks old, including transfers to another acute setting or a post-acute setting, and the MI meets the definition for "other diagnoses" (see Section III, *Reporting Additional Diagnoses*, in the ICD-10-CM Codebook), codes from category **I21** may continue to be reported. For encounters after the four week time frame and if the patient is still receiving care related to the MI, the appropriate aftercare code should be assigned, rather than a code from category **I21**. For old or healed MI not requiring further care, code **I25.2** – Old MI, may be assigned.

Malignant Neoplasm of Breast	
Assessment/Plan	Estrogen positive Stage II ductal carcinoma lower inner quadrant of the left breast. Completed first round of chemotherapy. Follow up with patient after the next round of chemotherapy and repeat laboratory work.
ICD-10-CM Codes	• **C50.312** – Malignant neoplasm of lower-inner quadrant of left female breast • **Z17.0** – Estrogen receptor positive status [ER+]
Documentation/ Coding Tips	• Cancer codes are to be used for patients with documentation of active treatment for the condition. This applies even when the patient had surgery to remove the cancer but is still receiving treatment for the disease, such as antineoplastic medications, chemotherapy, radiotherapy, etc. As long as the patient continues to receive such treatment, the patient's cancer should be coded as a current, active disease condition (categories **C00-D49**). • A patient may be prescribed antineoplastic medicines for reasons other than active cancer (e.g. prophylaxis). In this case, do not code cancer.

Secondary Neoplasm of Bone	
Assessment/Plan	Metastatic bone cancer originating from breast cancer. Breast cancer was eradicated four years ago. Doing well with current pain management regimen. Follow up with patient after the next round of radiation.
ICD-10-CM Codes	• **C79.51** – Secondary malignant neoplasm of bone • **Z85.3** – Personal history of malignant neoplasm of breast
Documentation/ Coding Tips	• When a secondary cancer is coded and the primary cancer is still present, the primary cancer should be coded as well; if the primary cancer has been completely eradicated, it should not be coded. • Cancer (except those coded to categories [**C80-C95**] for which treatment is no longer received) would be coded with a **Z** code for History of malignant neoplasm. Likewise, any cancer stated to have been completely eradicated would be coded to a **Z** code.

End Stage Renal Disease (ESRD) with Dialysis Status	
Assessment/Plan	ESRD and hypertension. Glomerular Filtration Rate (GFR) 10-stable since last laboratory workup. Continue with dialysis three days a week. Hypertension is stable on current medications.
ICD-10-CM Codes	• **I12.0** – Hypertensive CKD with stage 5 CKD or ESRD • **N18.6** – ESRD • **Z99.2** – Dependence on renal dialysis
Documentation/ Coding Tips	• **CKD Stage 1** – (normal/slightly elevated GFR); **N18.1** (GFR > or = 90) with kidney damage • **CKD Stage 2** – (mild); **N18.2** (GFR 60-89) with kidney damage • **CKD Stage 3** – (moderate); **N18.3** (GFR 30-59) • **CKD Stage 4** – (severe); **N18.4** (GFR 15-29) • **CKD Stage 5** – N18.5 (If requires dialysis, code **N18.6**) (GFR <15) • **ESRD-N18.6** – requires dialysis or transplant • **CKD Unspecified** – **N18.9** – When both hypertension and CKD are present, code hypertensive CKD (**I12, I13**) first and assign the code from category **N18** to identify the stage of the CKD as a secondary code. ICD-10-CM presumes a cause-and-effect relationship and classifies CKD with hypertension as hypertensive CKD. – If patient has CKD Stage 5 and is on dialysis, code **N18.6** ESRD. – If patient is on dialysis and status is documented in the record, code **Z99.2** Dependence on renal dialysis. – The physician or other health care professional must document CKD stage; it cannot be coded based on laboratory values.