Risk Adjustment Factor (RAF)

Documentation & Coding Opportunities

May 4th 2016

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Disclaimer

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Objectives

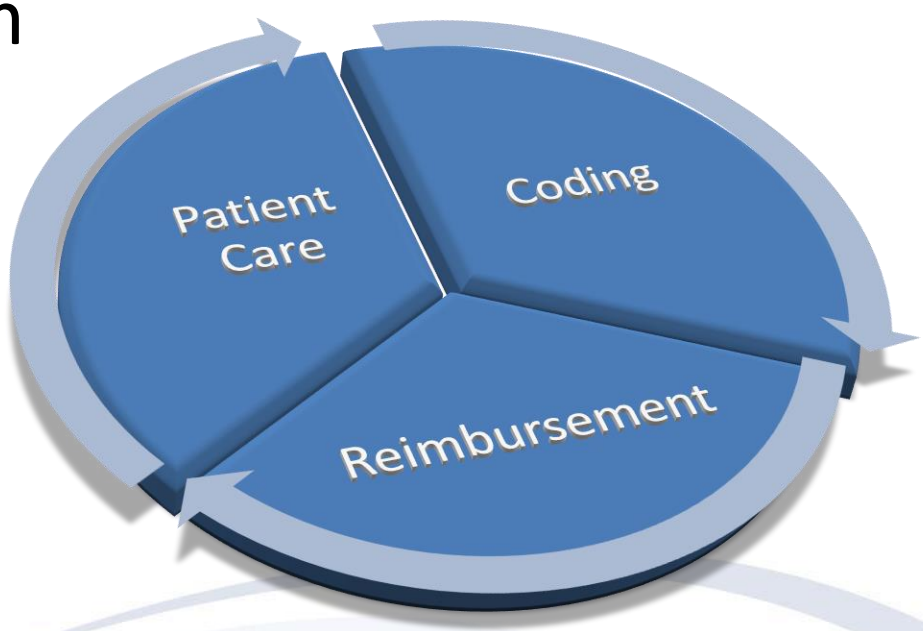
- Review education opportunities identified on Medicare Advantage (MA) encounters.
  - HCC's not reported
  - Coding opportunities
  - Provider queries

- Provide documentation and coding guidelines.

Who & Why?

We're your support TEAM!

- Coder Quality Analysts
- RAF Education Team



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HCC not reported

Definition: HCC not coded nor billed: dx documented and substantiated in the medical record. HCC needs to be submitted to CMS.

Example 1

Provider documented under A/P recurrent major depression (F33.9, HCC 58) this code was not billed.

CC: Follow-up multiple problems

HPI: Patient is here for follow-up of multiple medical problems. He has a history of benign essential hypertension, major recurrent depression, and diabetes mellitus type 2 controlled with diet. He has a hobby of taking care of an African gray bird. This is his neighbors bird, but he enjoys it. He had cataract surgery January 16. After that he noticed a group of blisters on his RIGHT lateral lower leg. It was itchy but is now scabbed over. He does have some numbness and tingling in his leg, but that is chronic. He plans on having the other cataract removed January 26. He had carotid endarterectomy 6 months ago and has done well.

Assessment and plan

, Carotid artery disease–he had carotid endarterectomy less than 6 months ago. He is on aspirin daily.
Resolving RIGHT lower leg shingles–she was informed of this diagnosis.
Diabetes mellitus type 2 controlled with diet–he will have lab work checked.
Recurrent major depression–continue citalopram
Benign essential hypertension–blood pressure is well controlled–continue current medication
High-dose pneumonia vaccine was given today

Follow-up in 6 months or before if needed

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. I25 10	B. B02 9	C. E119	D. Z23
E.	F.	G.	H.
I.	J.	K.	L.

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Example 2

Provider documented under A/P Congested Heart Failure (I50.9, HCC 85) this code was not billed.

Unchanged is acceptable substantiation for **chronic** diagnosis.

Impression:
Added new problem of LEG PAIN, BILATERAL (ICD-729.5) (ICD10-M79.606) - hips to feet
Assessed CHF, MILD as unchanged
Assessed CAD as unchanged
Assessed ESSENTIAL HYPERTENSION as unchanged
Assessed DIABETES MELLITUS NON INSULIN as unchanged

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)			ICD Ind. 0
A. M79 606	B. I10	C. E119	D.
E.	F.	G.	H.
I.	J.	K.	L.

Example 2 cont.

Provider documented under A/P Legionnaire's disease (A48.1, HCC 114)

Unchanged is not acceptable substantiation for **acute** diagnosis.

Assessed CHRONIC KIDNEY DISEASE STAGE III (MODERATE) as unchanged - we have to avoid nsaids due to this - check renal fnx now
Assessed CONSTIPATION, INTERMITTENT as unchanged - controlled right now
Assessed PREDIABETES as unchanged - check this again now - it was to a mild degree
Assessed LEGIONNAIRES' DISEASE as unchanged
Assessed HYPOTHYROIDISM as unchanged - check level now

Example 3

Provider documented under A/P purpura senile (D69.2, HCC 48) this code was not billed.

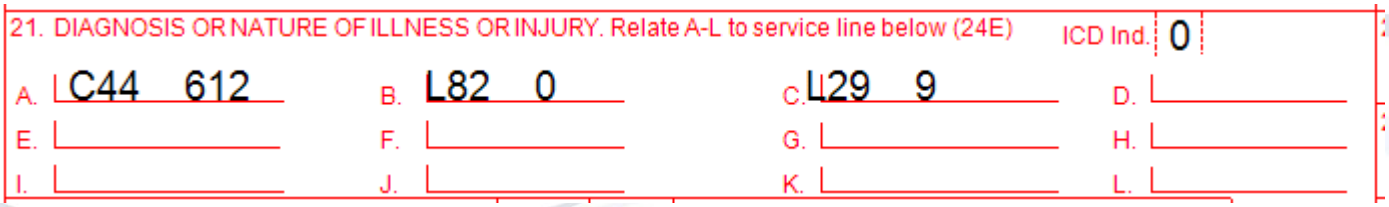
PLAN
Patient is to return to the office in 12 month(s).

Hx Basal cell carcinoma - UV protection, no recurrence noted (left nlf)

Inflamed seborrheic keratosis with itch - Discussed diagnosis, treatment, risks, benefits, expectations. Site(s) treated with cryotherapy with short pulses. Wound care instructions reviewed. RTC if sites recur, new lesions develop and regular screening. Total # sites: 4 (left and right cheek, right knee)

Seborrheic keratosis - Discussed diagnosis, benign in appearance, monitor sites for changes. If interest from patient, discussed options for treatment. (legs)

Purpura (senile) - discussed diagnosis, etiologies. rec limit or avoid trauma to areas. may consider vitamin c by mouth (arms)



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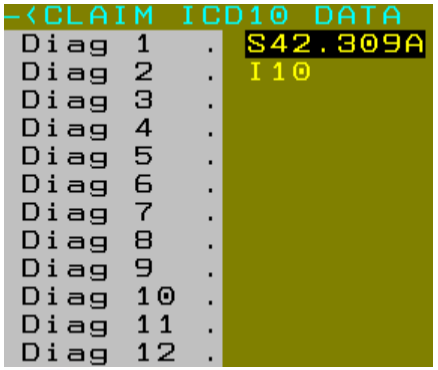
Example 4

Provider documented in discharge summary rheumatoid arthritis (M06.9, HCC 40) this code was not billed. Seven DX's listed on the D/C: 1 questionable and prostate ca w/o meat.

DIAGNOSES:
1. Right proximal humerus fracture, status post open reduction and internal fixation.
2. Hypertension.
3. Unsteady gait and ataxia with recurrent falls, negative orthostatics with history of peripheral neuropathy causing falls and apparently outpatient extensive workup by neurology including lumbar puncture to exclude normal pressure hydrocephalus.
4. Ectopic atrial rhythm. Echo ejection fraction of 70%.
5. Recent diagnosis of prostate cancer.
6. Question of mild cognitive impairment.
7. Rheumatoid arthritis with left knee effusion status post aspiration synovial fluid preliminary result not consistent with infection.

CONSULTATION:
Dr. Klopf, cardiology, Dr. Kelly of orthopedic service.

PROCEDURES:
1. Open reduction and internal fixation of right humerus.
2. Echo ejection fraction of 70%.
3. Chest x-ray upon admission, negative for acute.
4. X-ray of the right shoulder, acute right humeral fracture.



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Coding Opportunity

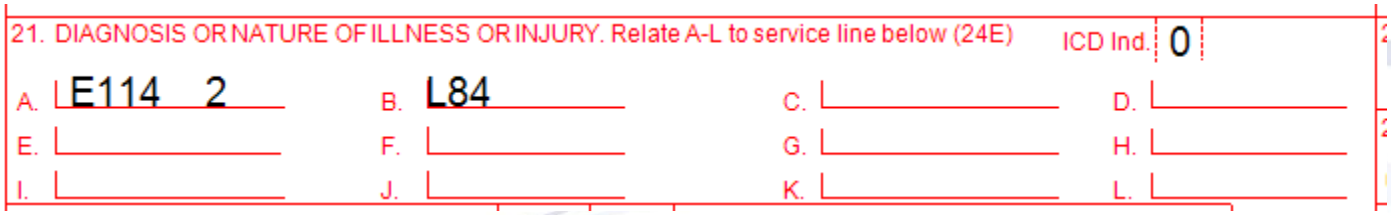
Definition: wrong ICD-10 code reported on CMS-1500. Coding guidelines may not have been followed.

Example 5

A/P Uncontrolled Diabetes with PVD (E11.51, HCC 18) was documented, diabetes uncontrolled requires an additional code (E11.65, HCC 18) both codes need to be included on the claim. On this scenario Diabetes with Polyneuropathy was billed.

ASSESSMENT:
1. Type 2 uncontrolled diabetes mellitus with peripheral vascular disease.
2. Pedal callusing.

PLAN:
Discussed diagnosis and treatment at length. Instructions for daily diabetic foot care. Diabetic foot exam. Instructions to utilize Bag Balm daily. He is at low risk for diabetic foot complications, recommend biannual followup.



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Example 6

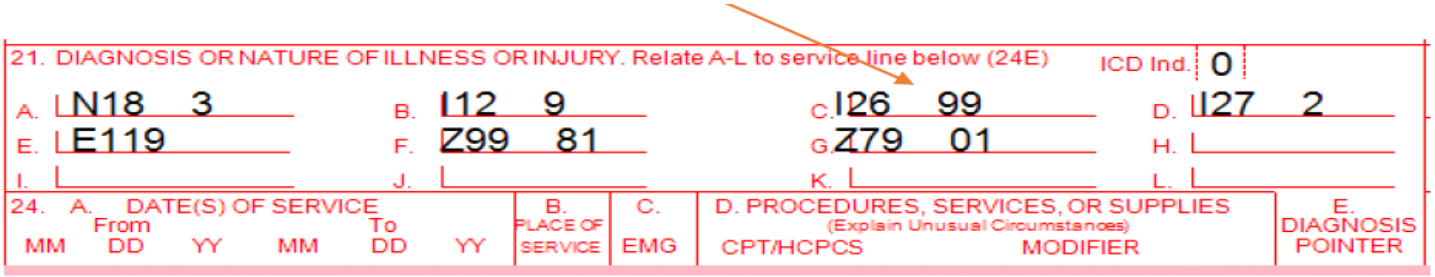
A/P pulmonary embolism (I26.99, HCC 107). Acute diagnosis requires inpatient treatment

History of Present Illness

Pt for follow up on his HBP and hx of PE still on Coumadin as well as CKD and hx of gout and diet controlled DM with last A1C at 6.1 Still O2 dependent with hx of secondary pulmonary HBP. Energy level ok and no CP or increasing SOB or swelling in legs or numbness in legs. Recent labs reviewed

Assessment/Plan

3. Pulmonary embolism
   Stay on current medications and continue on the coumadin



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)				ICD Ind. 0
A. N18 3	B. I12 9	C. I26 99	D. I27 2	
E. E119	F. Z99 81	G. Z79 01	H.	
I.	J.	K.	L.	

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER

- History of PE on Coumadin codes to: **Z86.711 and Z79.01** if the medication is used prophylactically
- Chronic PE on Coumadin codes to: I27.82 (HCC 107) and Z79.01 if the medication is used to manage the active condition. Provider must document the word “chronic”.

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Example 7

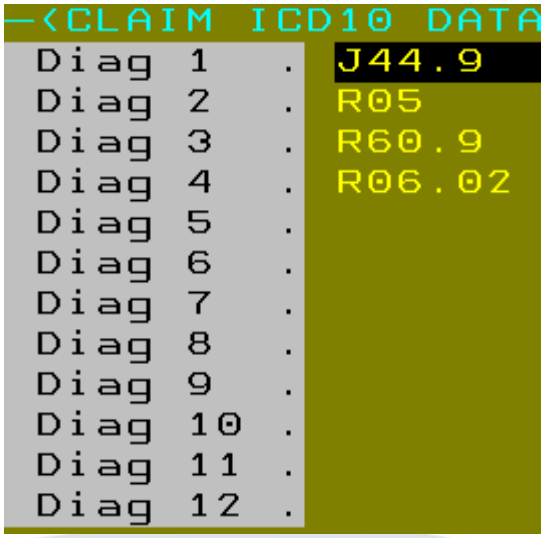
Higher specificity missed. A/P COPD exacerbation(J44.1, HCC 111). COPD unspecified J44.9 was billed.

ASSESSMENT AND PLAN:

1. Congestive heart failure.
2. Pulmonary edema.
3. Chronic obstructive pulmonary disease exacerbation.
4. Leg edema.
5. Shortness of breath.

PLAN:

Chest x-ray suggests pulmonary vascular congestion. His proBNP is elevated at 1652. I will check the Doppler of the lower extremity. I will check procalcitonin. Followup chest x-ray in the morning.



Provider Queries

Definition: Conflicting documentation found in the medical record.

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Example 8

Conflicting documentation: CKD 4 (N18.4 HCC 135) vs. CKD 3 (N18.3, no HCC)
Physician query warranted for diagnosis clarification.

ASSESSMENT AND PLAN:

2.type 2 diabetes Mellitus with CKD stage 4:stable. continue with endocrinologist Dr.Agarwaal.follows
with ophthalmology and podiatry once ayear
3.CKD stage 4: also has related Anemia. he has recieved procrit and has also recieved iron infusions.
continue to follow with nephrologist

Impression:

Added new problem of CHRONIC KIDNEY DISEASE STAGE III (MODERATE) (ICD-585.3) (ICD10-
N18.3)

Amendment

Electronically Signed by [redacted] on 01/13/2016 at 7:49 PM

append : carification of his ckd stage. based on gfr 32 in 12/15. his CKD is stage 3.

Electronically Signed by [redacted] on 01/22/2016 at 7:46 AM

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Example 9

Conflicting documentation: Pancreatitis (K86.1 HCC 34) Physician query warranted for status of active diagnosis.

ASSESSMENT AND PLAN:
1.Hypothyroidsm:continue current dose of levothyroxine. tsh was stable in 10/15
2.b12 deficiency:continue current dose of b12 1000 microgram(s)daily. she is asking if she should cut down. how ever I advise t continue current dose as levels last year were low
3.Glaucoma and macular degeneration:continue to follow with ophthalmologist and retina specialat and continue with current eye drops. intolerant of diamox
4.recurrent pancreatitis: stable. no recurrence
5.underweight: she says she has always been slim. discussed balanced nutritious diet.
6.osteopenia: continue calcium/vit d and daily walks
7. mitral valve disorder: denies chest pain/shortness of breath/palpitations
8. HTN: she says its a white coat effect. looks like bp was elevated in prior visit wth Dr. Engel also. She is advised to keep a twice a day bp log for 2 weeks and send to our ffice for me to review. she says normally he bp is perfectly stable she would be reluctant to be put on meds

Does no recurrence means it has been resolved?

Example 10

Conflicting documentation: cardiomyopathy (I42.9, HCC 85) vs. ischemic cardiomyopathy (I25.5, no HCC). Physician query warranted for diagnosis clarification.

HPI: Pleasant 72-year-old female presenting today for follow-up

She has CAD s/p MI in 05/2011 in CA s/p Xience DES 3.00X23 mm stent to proximal LAD, ischemic cardiomyopathy EF 40-45%, no cardiac symptoms, following up regularly with the cardiologist, notes from Dr. Rossetti reviewed.

Impression:

Removed problem of -CHEST PAIN (ICD-786.50) (ICD10-R07.9)
Removed problem of -DYSPNEA ON EXERTION (ICD-786.09)
Changed problem from MYOCARDIAL INFARCTION (ICD-410.90) (ICD10-I21.3) to MYOCARDIAL INFARCTION, HX OF 2011 S/P PTCA STENT (ICD-412) (ICD10-I25.2)
Assessed CORONARY ARTERY DISEASE, S/P PTCA as unchanged
Assessed -CARDIOMYOPATHY 40-45% (NO ACE-I DUE TO BP) as unchanged

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72-year-old female presenting today for follow-up
#1. Coronary artery disease, status post percutaneous transluminal coronary
angioplasty stent 2011, history of myocardial infarction, cardiomyopathy
ejection fraction 40-45%
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Tips!

Tips

Provider	Coder
• Review PMH and chronic problem list, but addressed conditions in the body of the note.	• Code all chronic conditions with treatment
• Don't document "past history of" ANY disease that currently exists. The statement "history of" in ICD-10 means that the patient no longer has this condition.	• **Unchanged** is acceptable MEAT only for **chronic** conditions
• Link diabetes to manifestation e.g.	• A CVA is an acute event. Upon discharge, assessment in an outpatient setting should be reported (e.g. hemiparesis/ hemiplegia, aphasia, etc.)

Coder's Role

Codes may be assigned from the body of the note when **supported by the documentation (MEAT)** in the following areas:

- History of present illness (HPI)
- Physical examination (PE)
- Assessment
- Impression
- Plan

Codes will **not** be assigned from **list** such as:

- Active problems
- Current problem
- Problems

Codes will **not** be reported if diagnoses are documented as:

- Probable
- Suspected
- Questionable
- Rule out
- Working diagnosis

Or other similar terms indicating uncertainty as stated by ICD-10-CM guidelines.

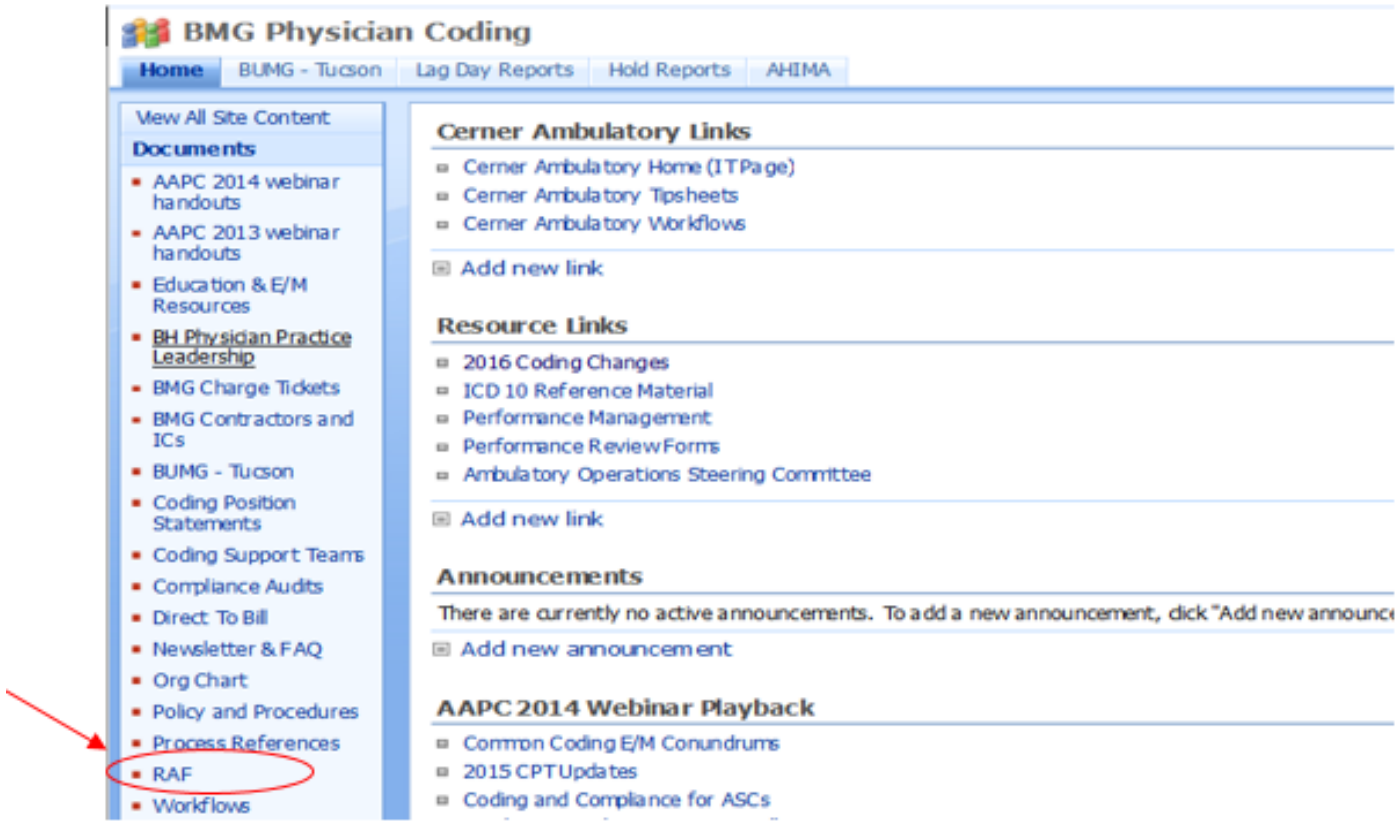
M.E.A.T

All codes reported on the encounter claim must have support

Monitor: B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits
Evaluate: stump well healed, ostomy site w/o infection appears clean & dry
Address: stable; controlled, worsening; unchanged, uncontrolled
Treatment: taking Fosamax for osteoporosis; taking tamoxifen for breast cancer “treatment”, DM controlled on insulin

SharePoint

For more information, learning tools and RAF news visit the SharePoint site.



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References

- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organization Participant Guide". Centers for Medicare & Medicaid Services.

  http://www.csscoperations.com/Internet/Cssc3.Nsf/files/participant-guide-publish_052909.pdf/$File/participant-guide-publish_052909.pdf

- ICD-10-CM Official Guidelines for Coding and Reporting

  http://www.cdc.gov/nchs/icd/icd10cm.htm

- HCC model mappings

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/IDC10Mappings.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

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Questions or Comments

Contact us!

RAF Team: RAFOps@bannerhealth.com

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