

HCC CODING

A Documentation Strategy
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Agenda

- Terminology
- History of Medicare Risk Adjustment
- Coding Strategy
- Documentation Strategy



Terminology

- HCC-Hierarchical Condition Categories- *usually* chronic conditions used to create a risk adjustment methodology
- Rx HCC- Some HCC codes adjust risk due to prescription burden of disease
- CMS-Centers for Medicare & Medicaid Services
- Medicare Advantage (Managed Medicare)-A method of helping CMS budget for the cost of caring for populations of patients
- RAF-Risk Adjustment Factor-assessing the acuity of illness based upon reported ICD-9 codes & demographics, which ultimately is reflected in reimbursement-*HCC codes are payment multipliers*. (Average RAF is 1.0-Each .01 increase in RAF results in 1% higher reimbursement to the Medicare Advantage company from CMS)



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History of Risk Adjustment

- In 1997, beneficiaries could choose between traditional and managed Medicare
- Managed Medicare companies are given a fixed dollar amount per enrollee from CMS
- Enrollees may enjoy additional benefits with the managed Medicare companies
- Physicians may enjoy better revenue than with traditional Medicare
- Since 2007, the managed Medicare companies receive payments based upon the HCC diagnoses assigned to each enrollee, plus a demographic factor-this is the Risk Adjustment Factor
- There are over 3000 diagnosis codes in about 90 categories, and each carries a value



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A Long Term Strategy

- Payments are based upon acuity of diagnosis.
- Sicker patients will require more health care resources. The managed care plans depend upon accurate diagnoses that will ensure the appropriate dollars are available to care for each enrollee.
- Diagnoses must be reestablished each year to ensure that next year's payments will cover costs. For example, an amputation must be reported at least once per year to ensure that services related to this condition will be covered.
- Documentation must support the diagnoses that are reported AND A PLAN FOR EACH DIAGNOSIS. Physicians get familiar with patients over time and neglect documentation of chronic stable conditions.



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Coding Strategy

- ICD-9 Codes paint the picture and drive risk scores
- Risk scores drive the reimbursement from CMS to Managed Medicare Plans
- All diagnoses must occur as a result of face to face encounter
- Services rendered by physician, NP or PA



Coding Strategy

- Code all documented conditions that co-exist at the time of the encounter that require
 - Patient care
 - Treatment
 - Management
- Do not code conditions that were previously treated and no longer exist



Combinations in Coding

- A combination code is a single code used to classify
 - Two diagnoses
 - A diagnosis with an associated secondary process
 - A diagnosis with an associated complication
- Identified by referring to sub-term entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List
- Assign only the combination code when that code fully identifies the diagnostic condition involved. Secondary codes may be necessary



Signs & Symptoms

- Acceptable to code when a definitive diagnosis has not been established (usually do not risk adjust)
- Not acceptable when they are integral to the disease process
- Associated signs and symptoms that are not integral to a disease process should be coded
- Most found in 780.0-799.9
- “Rule out” or “Possible” are not valid diagnoses



Hypertension Coding HCC Categories 80, 131

- Fourth digit indicates malignant (40X.0) or benign (40X.1), and unless documented with these terms must code 40X.9 (Unspecified)
 - **Benign** HTN is essential hypertension, usually chronic, asymptomatic and without target organ damage
 - **Malignant** HTN is an accelerated hypertensive disorder, with diastolic BP usually >140 and accompanied by encephalopathy, nephropathy, retinopathy, heart failure or myocardial ischemia
 - Controlled or Uncontrolled? Indicates clinical response to treatment, but does not differentiate between benign and malignant type
- Elevated blood Pressure does not code to hypertension-use 796.2



How is HTN related to Heart and Kidney Disease?

- Elevated BP increases pressure in the blood vessels, causing thickening over time.
- As the heart pumps against this pressure, it must work harder. This increased work causes the heart muscle to thicken, eventually leading to congestive heart failure if not treated.
- The thicker heart muscle needs more oxygen, and insufficient oxygen can lead to ischemia (angina)
- Thickening of the blood vessels may worsen atherosclerosis. This is most damaging to the smallest blood vessels, such as in the heart and kidney, leading to damage of these end organs



Systolic & Diastolic Heart Failure

- Systolic HF- a pumping problem caused by the ventricle losing its ability to contract normally because the heart muscle has become weak
- Diastolic HF is the result of a filling problem, caused by the ventricle losing its ability to relax normally because the heart muscle has become stiff. The heart can't fill with enough blood resulting in too little blood being pumped back out into the body
- Most patients have a combination of both; usually classified as whichever is worst



HTN & Heart Disease

- Documentation must state a causal ('due to' or 'secondary to'), or implied (using the adjective 'Hypertensive') relationship between HTN and Heart Disease –it is not assumed
 - Hypertensive CHF 402.91 & 428.0
 - Hypertensive HF 402.91 & 428.0
 - HTN due to CHF 402.91 & 428.0
 - HF due to HTN 402.91 & 428.9
- Dual code requirement of 402.XX and Heart Disease code.
- More than one code from category 428 may be assigned



| HYPERTENSIVE HEART DISEASE (HCVD) | | |
|-----------------------------------|--------------------|--------|
| RX ONLY | BENIGN W/O HF | 402.10 |
| RX ONLY | UNSPEC HTN W/O HF | 402.90 |
| RX ONLY | MALIGNANT W/O HF | 402.00 |
| HCC | **BENIGN W/CHF | 402.11 |
| HCC | **UNSPEC HTN W/CHF | 402.91 |
| HCC | **MALIGNANT W/CHF | 402.01 |

| HTN LINKED HEART DISEASE w/CHF REQUIRES <u>TWO</u> CODES-ONE EACH FROM HTN HEART DZ AND <u>CHF</u> | | |
|---|---------------------------|--------|
| HCC | CHF UNSPECIFIED | 428.0 |
| HCC | LEFT HEART FAILURE | 428.1 |
| HCC | SYSTOLIC-UNSPEC | 428.20 |
| HCC | SYSTOLIC-ACUTE | 428.21 |
| HCC | SYSTOLIC-CHRONIC | 428.22 |
| HCC | DIASTOLIC-UNSPEC | 428.30 |
| HCC | DIASTOLIC-ACUTE | 428.31 |
| HCC | DIASTOLIC-CHRONIC | 428.32 |
| HCC | COMBINED-UNSPEC | 428.40 |
| HCC | COMBINED-ACUTE | 428.41 |
| HCC | COMBINED-CHRONIC | 428.42 |
| HCC | HEART FAILURE UNSPECIFIED | 428.9 |

Chronic Kidney Disease (CKD)

Four digits-the fourth indicates stage of disease.

Stage 1&2 need additional evidence of kidney damage, such as urine protein that persists for 3 months or more, ultrasound or biopsy

Documentation must include stage, or is coded as *585.9 CKD unspecified*



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Dialysis

- Hemodialysis is the process of filtering the patients blood through a machine. Performed either as outpatient or inpatient
- Peritoneal dialysis uses the patient's abdominal lining to remove toxins. Usually performed in the patient's home.



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Staging CKD

| Stage | Severity | GFR Value | ICD-9 codes |
|-----------|---|---|-------------|
| Stage 1 | Some kidney damage with minimal or slight change in GFR | GFR >90 ml/min With kidney damage | 585.1 |
| Stage 2 | Mild Kidney damage | GFR 60-89 ml/min With kidney damage | 585.2 |
| Stage 3 | Moderate Kidney damage | GFR 30-59 ml/min | 585.3 |
| Stage 4 | Severe Kidney damage | GFR 15-29 ml/min | 585.4 |
| Stage 5 | Kidney Failure | GFR < 15 ml/min | 585.5 |
| | ESRD | Requiring chronic dialysis or transplantation | 585.6 |
| CKD Unsp. | CKD NOS, Chronic Renal Failure or Chronic Renal Insufficiency | Chronic Kidney Disease Unspecified | 585.9 |

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| <u>HTN & CKD **REQUIRES TWO CODES-ONE FROM HTN DZ AND CKD</u> | | |
|---|---------------------------|--------|
| RX ONLY | BENIGN W/CKD (STAGE I-IV) | 403.10 |
| HCC | BENIGN W/CKD V-ESRD | 403.11 |
| RX ONLY | UNSPEC W/CKD (STAGE I-IV) | 403.90 |
| HCC | UNSPEC W/CKD V-ESRD | 403.91 |
| RX ONLY | BEN W/O HF W/CKD ST I-IV | 404.10 |
| HCC | BEN W/O HF W/CKD ESRD | 404.12 |
| RX ONLY | UNSPEC W/O HF W/CKD I-IV | 404.90 |
| RX ONLY | MALIGNANT W/CKD (ST I-IV) | 403.00 |
| HCC | MAL W/O CHF W/CKD ESRD | 404.02 |
| HCC | MALIGNANT W/CKD V-ESRD | 403.01 |

| <u>CHRONIC KIDNEY DISEASE (CKD)</u> | | |
|-------------------------------------|--------------------------|--------|
| HCC | CHRONIC STAGE 1 GFR>90 | 585.1 |
| HCC | MILD STAGE 2 GRF 60-89 | 585.2 |
| HCC | MOD STAGE 3 GFR 30-59 | 585.3 |
| HCC | SEVERE STAGE 4 GFR 15-29 | 585.4 |
| HCC | 5 GFR <15 | 585.5 |
| HCC | ESRD W/DIALYSIS | 585.6 |
| HCC | CKD UNSPEC, CRF | 585.9 |
| HCC | RENAL DIALYSIS STATUS | V45.11 |



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ESRD Coding

- Dual code requirement for patient on dialysis
585.6 ESRD
V45.11 Renal Dialysis status
- ESRD on Hemodialysis *due to* Diabetes
250.40
585.6
V45.11



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CKD and HTN (403.XX)

- Relationship may be assumed between these conditions if both are reported
- Dual code required when 403 series is used, indicating the related CKD (585.x)
 - Hypertensive* CKD Stage 4 - 403.90 & 585.4
 - HTN & ESRD on dialysis (CKD Stage 6)-403.91 & 585.6 & V45.11

*Even though coders may assume this relationship, coach providers to use the adjective form of the diagnosis



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Hypertensive Heart & Kidney (404.XX)

- Both hypertensive kidney disease and hypertensive heart disease must be stated, although the relationship between hypertension and the CKD is assumed
- Any hypertensive heart disease is acceptable, not just HF
- 5th digits are assigned
 - 0 without HF and with CKD Stage 1-4 or unsp
 - 1 with HF and with CKD Stage 1-4 or unsp
 - 2 without HF and with CKD Stage 5 or ESRD
 - 3 with HF and with CKD Stage 5 or ESRD



| HTN HEART DISEASE W/CHF & CKD **REQUIRES THREE CODES- ONE FROM HTN HEART DZ, CKD AND CHF Use add'l code | | |
|---|-----------------------------|--------|
| HCC | **MAL W/HF W/CKD STAGE I-IV | 404.01 |
| HCC | **MAL W/CHF W/CKD ESRD | 404.03 |
| HCC | **BEN W/ HF W/CKD ST I-IV | 404.11 |
| HCC | **BEN W/ HF W/CKD ESRD | 404.13 |
| HCC | **UNSPEC I-IV | 404.91 |
| HCC | **UNSPEC W/HF W/CKD ESRD | 404.93 |

| CHRONIC KIDNEY DISEASE (CKD) | | |
|------------------------------|-----------------------------|--------|
| HCC | CHRONIC STAGE 1 GFR>90 | 585.1 |
| HCC | MILD STAGE 2 GRF 60-89 | 585.2 |
| HCC | MOD STAGE 3 GFR 30-59 | 585.3 |
| HCC | SEVERE STAGE 4 GFR 15-29 | 585.4 |
| HCC | NO DIALYSIS STATE 5 GFR <15 | 585.5 |
| HCC | ESRD W/DIALYSIS | 585.6 |
| HCC | CKD UNSPEC, CRF | 585.9 |
| HCC | RENAL DIALYSIS STATUS | V45.11 |

HTN LINKED HEART DISEASE w/CHF REQUIRES TWO CODES-ONE EACH FROM HTN HEART DZ AND CHF

| | | |
|-----|---------------------------|--------|
| HCC | CHF UNSPECIFIED | 428.0 |
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| HCC | COMBINED-UNSPEC | 428.40 |
| HCC | COMBINED-ACUTE | 428.41 |
| HCC | COMBINED-CHRONIC | 428.42 |
| HCC | HEART FAILURE UNSPECIFIED | 428.9 |

Diabetes

- Diabetes is derived from a Greek word 'siphon', referring to passing through of water from the body, as diabetics tend to urinate excessively when sugar is not controlled
- Mellitus is derived from the Latin language and it refers to 'honey-sweet', as in the high levels of sugar noted in blood and urine
- Insipidus is derived from the French language and refers to lacking of taste, or bland nature, probably due to nearly colorless urine noted in this condition



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Diabetes Coding

HCC Categories 15, 16, 18, 19, 119

- Documentation of complications or manifestations must be stated ('due to' or 'secondary to'), or implied (*Diabetic*) and are reported with 4th digit
- Type I or II indicates type-Juvenile onset or Adult onset. (*Type is not dictated by use of insulin*)
- If documentation indicates that the patient uses insulin *routinely*, append V58.67
- Sequence the 250 codes before the codes for the associated conditions
- Secondary diabetes coded to 249.XX



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5TH Digit in Diabetes Coding

- 0 indicates Type 2 or unspecified, *not stated as controlled or uncontrolled*
- 1 indicates Type 1, *not stated as controlled or uncontrolled*
- 2 indicates type 2 or unspecified, *uncontrolled*
- 3 indicates type 1, *uncontrolled*

Age is not a determining factor for type, though many develop Type 1 before reaching puberty, thus the term 'Juvenile' diabetes.



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Diabetes 249.XX

Secondary Diabetes-Diabetes whose underlying cause is not genetics or environmental conditions

Accounts for 1-5% of total diabetes cases

Presence of another underlying condition is major differentiating factor.

Coders must know:

- Manifestation
- Control
- Underlying etiology



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Causes of Secondary Diabetes

- Chronic pancreatitis
 - Hemochromatosis
 - Pancreatic disease due to cancer, trauma or other endocrine diseases
 - Carcinoid tumors of lung, intestine or stomach
 - Adrenal and pituitary tumors
 - Celiac disease and other autoimmune diseases
 - Removal of pancreas
 - Orchiectomy-removal of testes for cancer
- Drugs and chemical agents:
- Diuretics and beta blockers
 - Hormones
 - Steroids
 - Antipsychotics, lithium and antidepressants
 - HIV drugs
 - Seizure drugs
 - Immunosuppressive drugs



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Diabetes 250.XX

- Type 1 thought to be genetic, where the pancreas does not produce enough insulin. This usually manifests at an early age, and usually requires insulin to manage, but not always
- Type 2 diabetes is caused by insulin resistance- insulin is produced, but the body does not respond properly. This usually (but not always) manifests in adulthood, may be managed with diet and exercise, but may require oral meds or insulin. It may have a genetic component too.



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4th Digit in Diabetes Coding

| 4 TH DIGIT | MANIFESTATION |
|-----------------------|----------------------------|
| 0 | NO COMPLICATION |
| 1 | KETOACIDOSIS |
| 2 | HYPEROSMOLALITY |
| 3 | COMA |
| 4 | RENAL MANIFESTATIONS |
| 5 | OPHTHALMOLOGICAL |
| 6 | NEUROLOGICAL |
| 7 | PERIPHERAL CIRCULATORY |
| 8 | OTHER SPECIFIED |
| 9 | UNSPECIFIED MANIFESTATIONS |

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Linking Words

- Linking words create relationship between diseases and manifestations
- Assures coders of a cause and effect between disease and manifestation, as we cannot assume (except in hypertensive renal disease)
- Appropriate terms:
 - ✓ Due to
 - ✓ Secondary to
 - ✓ Use of associative suffix 'ic' or 'ive' (diabet^{*ic*} ulcer or hypertens^{*ive*} heart disease)



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Buddy Codes in Diabetes

Required when 4th digit is 1-8

LINKING
WORDS

Peripheral neuropathy **due to** DM

250.60 Diabetes with neurological manifestations

357.2 Polyneuropathy in DM

Diabetic Peripheral vascular disease

250.70 Diabetes with peripheral circulatory disorders

443.9 PVD, unspecified

LINKING
WORD



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Why Documentation Matters

- “c/o visual disturbance. PMH + Retinopathy and DM2”
 - 250.00 and 362.10 (retinopathy w/o mention of diabetes)
 - Risk Score: .162 (.162 + 0)
- “Proliferated retinopathy due to DM2”
 - 250.50 and 362.02
 - Risk Score: .511 (.259 + .252)



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Ulcers and Wounds

- These terms are not synonymous, although wounds can develop into ulcers
 - Wounds are due to trauma or surgery-*not risk adjusted*
 - Ulcers are caused by skin breakdown from pressure or other chronic conditions (non-pressure)-*risk adjusted*
- Code ulcers to 707 series
- Code wounds to 870-879 series



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Ulcers

HCC Categories 148, 149

Types:

- Non-pressure, or chronic
- Decubitus, or pressure, stages 1-5

Documentation is critical, as decubitus ulcers carry a higher risk adjustment

Buddy codes required for both types

Stage 1 pressure ulcer of sacrum= 707.03 & 707.21

Diabetic calf ulcer= 250.80 & 707.12



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Cardiac Disease Coding HCC Categories 82, 83, 92

- 412 **Old MI** (myocardial infarction)-means > 8 weeks, currently presenting no symptoms.
Documentation may say 'Old MI', 'h/o MI', or 's/p MI'
- 410 Code series used for myocardial infarction <8 weeks in duration
- 411 Code series indicate other acute or subacute forms of ischemic heart disease
- 413 Code series used for various types of angina



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Vascular Diseases HCC Categories 104, 105

- 440 Atherosclerosis-a condition where there is reduced elasticity of the vessels and narrowing of vessel lumen
- 443 Peripheral Vascular Disease-a condition where the vessels in the arms or legs are compromised causing blood flow issues
- 451-453 Phlebitis and Thrombophlebitis-conditions where vessels are irritated (*'-itis'*) by disease or infection, or clogged (*thrombo-*) **and** irritated by blood clots



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Atherosclerosis 440

- Aortic atherosclerosis 440.0 May be noted from X-rays taken for other reasons-a Chest X-ray may show aortic atherosclerosis. Documentation must detail the finding of *aortic* atherosclerosis, (not just atherosclerosis) and the treatment plan for this condition
- Gangrene is coded to 440.24
- Ulceration without gangrene coded to 440.23



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Cerebrovascular Accident (CVA) HCC Categories 75, 95, 96

- Use 434.91 for the initial episode of care for an **acute cerebrovascular event** – may be documented as CVA or stroke- (usually within 24 hrs)
- Use V12.54 for a history of CVA/TIA with NO residual effects
- Once discharged, late effects are coded to 438 series



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Late Effects

- The residual effect after the acute phase (24 hrs for CVA) of an illness or injury has passed
- No time limit on when a late effect code can be used
- Requires documentation that the residual effect was caused by the illness or injury
- Code first the condition, followed by the late effect
- 'Weakness' is not appropriate documentation of hemiplegia or hemiparesis due to CVA



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Respiratory Diseases HCC Categories 108, 111, 112

- COPD (Chronic obstructive pulmonary disease) is a lung condition whereby the lungs lose elasticity and it is difficult to breathe, often associated with smoking
- Chronic bronchitis is inflammation of the airways that causes increased mucus to be produced. Bronchitis is considered chronic if there is cough and excess mucus production most days for three months in a year, two years in a row.
- Emphysema is a condition where the fine lacy architecture of the lung is disrupted, with less surface area available to exchange oxygen



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COPD & Asthma

COPD (Chronic obstructive pulmonary disease) is a nonspecific 'umbrella term' for a host of conditions, and is used when type of COPD is not specified

491 Chronic bronchitis

492 Emphysema

493 Asthma

These codes distinguish between uncomplicated cases and those in acute exacerbation



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Documentation for Chronic Obstructive Bronchitis

- Code selection must be based upon terms as documented
- 491.20 'Chronic bronchitis **without** exacerbation of COPD'
- 491.21 'Chronic bronchitis **with** COPD exacerbation
 - "Acute exacerbation of COPD"
 - "Decompensated COPD"
- 491.22 "COPD with acute bronchitis"



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Coding for Emphysema

- 492.0 Emphysematous bleb-usually found on imaging studies
- 492.8 Other emphysema-lung or pulmonary, centriacinar, centrilobular, obstructive, panacinar, panlobular, unilateral, vesicular



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Coding for Asthma

4TH DIGIT DEFINES TYPE

- 493.0 Extrinsic, or allergic asthma, means that the cause is external to the body, such as from hay or other airborne allergens. This causes the majority of childhood asthma
- 493.1 Intrinsic asthma-cause not precisely known, usually has onset later in life
- 493.2 Chronic obstructive asthma-occurs in the presence of COPD
- 493.8 Other forms of asthma
 - 493.81-exercise induced bronchospasm
 - 493.82-Cough variant asthma
- 493.9-asthma unspecified



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Coding for Asthma

5th Digit defines current encounter

- 0 UNSPECIFIED
- 1 WITH STATUS ASTHMATICUS (a life-threatening form of asthma in which progressively worsening reactive airways are unresponsive to usual appropriate therapy that leads to pulmonary insufficiency)
- 2 WITH ACUTE EXACERBATION (a worsening or decompensation)



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Major Depression (296) HCC Category 55

Use of 296 category requires significant documentation that is not familiar to most primary care providers, but is a common condition that risk adjusts even in remission!

Providers many times use 311 series, which does not risk adjust. 311 is appropriate for situational depression or depressed mood due to bereavement



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Documentation for Major Depression

- Not directly due to a substance or bereavement
- Symptoms present for 2 weeks or more and cause clinically significant distress or impairment
- *At least one of the following:
 - Depressed mood most of the day, nearly every day
 - Diminished interest in activities
- *At least 4 of the following:
 - Weight/appetite loss or gain (>5% in a month)
 - Insomnia or hypersomnia
 - Agitation or retardation observed by others
 - Feelings of worthlessness or guilt
 - Diminished ability to think or concentrate
 - Recurrent thoughts of death, suicidal ideation or attempt

*PHQ-9 Score of 10, or some other standardized tool (Beck) may be used in lieu of above. This documentation must be noted with the provider's credentials and date of service in order to be considered



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Malnutrition (263) HCC Category 21

Supportive documentation:

- Albumin <3.4
- Unintentional weight loss >10% over 6 months
- Unintentional weight loss >5% over 3 months
- BMI <18.5
- Poor nutrition or loss of appetite
- Wasted appearance, or muscle wasting



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Neoplasms

HCC Category 10

- Current treatment codes to active cancer code, even if there is no evidence of disease. Documentation must state “*Breast cancer on Arimidex...*”
- If there is no evidence of disease and the patient is not being treated, the V code is reported.
- If documentation does not state that there is active disease or treatment, the V code is used
- Patients with cancer that is not being treated are coded to active cancer



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Metastasis of Cancer

- Metastatic cancer (spread of cancer to another organ system) is the highest risk adjusted diagnosis, and documentation is critical!
- If there is metastasis, documentation must state the primary cancer and the location of the metastasis (mets). “*Brain cancer with mets to lung*”. Code primary cancer first, then mets
- If the primary cancer has been removed and treatment is directed at the mets, code the mets first, followed by the V code for the primary cancer. Documentation must state “*history of breast cancer with mets to lung*”



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Codes that Providers Often Miss

- Artificial openings
- Amputations
- Aortic aneurysm
- Aortic atherosclerosis

If these are not documented yearly, the codes are not considered in the payment for the following year!



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A Documentation Strategy

All encounters must contain

- Patient Name & DOB on every page
- Date of Service
- Signature of provider + credentials
- Compliant signatures (authenticated electronic signatures or original signatures-typed or stamped signatures not acceptable)

Document to highest specificity (“Benign Hypertension” vs “HTN”)

All diagnoses must include an assessment and treatment plan- lists are not sufficient!



Documentation Tips

- Commonly used by providers to mean the condition is part of the patient's history, 'h/o' or 's/p' is indicative to coders of a **past** condition and cannot be coded as active disease.
- Remember to use linking terms like '*due to*' or '*secondary to*' to describe relationships between diseases and manifestations
- Documentation must indicate a treatment plan for each diagnosis, such as '*refer to cardiologist*', or '*observation for exacerbation or worsening*' and an assessment, such as '*stable*', '*worsening*', '*not responding to treatment*'



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Why Documentation Matters *or* ***Making*** Documentation Matter to Physicians!



CASE #1

- Dr. M:** Mrs. Green, you're here to follow up on your diabetes? How are you doing? Are you taking your meds?
- Pt:** I'm doing pretty good! I got a lot of chocolate for Valentine's Day-that's been yummy!
- Dr. M:** How are your feet doing? Are those sores healing? How is your angina?
- Pt:** I don't have much feeling left down past the ankles, so my feet don't really hurt. But, the odor is terrible and the bandages stay wet all the time-it's a real mess.
- Dr. M:** Your ulcers are a complication of your uncontrolled diabetes, and the culture showed an infection. It has reduced your circulation, so you don't heal like you should.
- Sounds like your angina is okay for now... I see we've rec'd a consult note from Dr. Corazon, and he says you have aortic stenosis-we'll have to watch that-could be a problem once you get up and around more.



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Documentation

Mrs. Billie Jo Green
DOB: 05 October 1949
Age: 60, Female
DOS: 25 February 2010

HPI:

- Diabetes, Type II, Uncontrolled with Complications: 250.62, 250.82, 250.72
- Foot Ulcers due to Peripheral Vascular Disease in Diabetes: 707.15, 443.9
- Neuropathy in Diabetes: 337.1
- Skin infection, Anaerobic: 041.84
- Angina: 413.9
- Aortic Stenosis (Consult: Rellax-10 January 2010): 424.1



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Documentation

Plan:

- Diabetes, Type II, not responding to treatment, worsening, will consult home health and adjust medications
- Foot Ulcers due to Peripheral Vascular Disease in Diabetes, will refer to rehab clinic for care of ulcers
- Neuropathy in Diabetes, stable, will continue Lyrica
- Skin infection, Anaerobic, not responding to treatment, will refer to surgeon for debridement
- Angina, stable, continue medications
- Aortic Stenosis, stable, followed by cardiologist



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Low Specificity Coding

| <u>ICD 9</u> | <u>Description</u> | <u>HCC</u> | <u>Rx HCC</u> | <u>Risk Score</u> |
|------------------------------------|-----------------------------|------------|---------------|-------------------|
| 250.02 | DM, Type II, Uncontrolled | 19 | 18 | 0.162 |
| 355.9 | Neuropathy, NOS | None | 86 | 0 |
| 707.15 | Foot Ulcers, NOS | 149 | 157 | 0.449 |
| 443.9 | Peripheral Vascular Disease | 105 | 106 | 0.316 |
| 424.1 | Aortic Stenosis | None | None | 0 |
| 413.9 | Angina, NOS | 83 | 92 | 0.244 |
| <i>Demographic Factor:</i> | | | | |
| 80 yrs old/Female/Assumed Aged in: | | | | 0.544 |

Total Risk Score = 1.715



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High Specificity Coding

| ICD 9 | Description | HCC | Rx HCC | Risk Score |
|---|---|------|--------------|------------------|
| DM, Type II, poorly controlled with Peripheral Neuropathy: | | | | |
| 250.62 | DM, Type II, w/ Neuro, Uncontrolled | 16 | 17 | 0.408 |
| 337.1 | Peripheral Neuropathy in Diabetes | 71 | 79 | 0.327 |
| Bilateral foot ulcers – full thickness to sole of feet, with anaerobic infection and maggots: | | | | |
| 250.82 | DM, Type II, w/other, Uncontrolled | 16 | 17 | 0.408 |
| 707.15 | Diabetic Foot Ulcers | 149 | 157 | 0.449 |
| 041.84 | Anaerobic Infection | None | None | 0 |
| Peripheral Vascular Disease due to DM: | | | | |
| 250.72 | DM, Type II, w/ Peri Circ, Uncontrolled | 15 | 17 | 0.508 |
| 443.9 | Peripheral Vascular Disease | 105 | 106 | 0.316 |
| Aortic Stenosis with Angina: | | | | |
| 424.1 | Aortic Stenosis | None | None | 0 |
| 413.9 | Angina, NOS | 83 | 92 | 0.244 |
| <i>Demographic Factor:</i> | | | | |
| 80 yrs old/Female/Assumed Aged in: | | | | 0.544 |
| Total Risk Score = | | | 2.391 | |



Case #2

- Dr. M:** Hello-what can I do for you today?
- Pt:** I'm not doing very well-I only feel like eating mashed potatoes probably because I'm so tired all the time. My feet hurt all the time and I don't get much exercise. You told me to come back after I've been on the iron pills for a month, but they make me nauseous.
- Dr. M:** Your diabetes is probably out of control with a diet like that, and it only makes your neuropathy worse! Dr. Jone's notes say that the cancer has spread to your liver, which also affects your appetite and your energy level. We gave you the iron pills to help with anemia that is caused by your colon cancer. We may need to try something else if you're not able to tolerate.
- Pt:** I'm having some breathing trouble lately too-I can't even walk to the mail box without taking a puff on my inhaler, and that doesn't even help much.
- Dr. M:** Your last CXR showed your COPD but otherwise nothing new, so you're probably having a spell of asthma that's aggravating your lung disease. Your diabetic neuropathy may keep you from being active, in addition to everything else.



Documentation

Mrs. Jane Red
DOB: 05 October 1949
Age: 60, Female
DOS: 25 February 2010

Dx & Plan:

- Diabetes, Type II, with Complications: 250.60, worsening, advised re diet and compliance with meds
- Colon Cancer with METS: 197.7, not responding to treatment, followed by oncologist
- Anemia in Cancer: 285.22, not responding to treatment, consider IM iron treatment
- Polyneuropathy in Diabetes: 357.2, worsening, add Lyrica
- Asthma with COPD: 493.21, worsening, will add inhaler



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Low Specificity Coding

| <u>ICD 9 Documentation</u> | <u>HCC</u> | <u>Risk Score</u> |
|-----------------------------|------------|-------------------|
| 285.9 Anemia, Unspec | None | 0 |
| 153.9 Colon Cancer | 10 | 0.208 |
| 250.00 Diabetes, Unspec | 19 | 0.162 |
| 355.9 Neuropathy, NOS | | |
| 493.90 Asthma, Unspec | None | 0 |
| <i>Demographic Factor:</i> | | |
| 61 yrs old/Female/Disabled: | | 0.411 |

Total Risk Score = 0.781



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High Specificity Coding

| <u>ICD 9</u> | <u>Documentation</u> | <u>HCC</u> | <u>Risk Score</u> |
|-----------------------------|------------------------------------|------------|-------------------|
| 285.2 | Anemia in Cancer | None | 0 |
| 153.9 | Colon Cancer | 10 | 0.208 |
| 197.7 | Colon Cancer w/ Metastasis – Liver | 7 | 2.276 |
| 250.60 | Diabetes w/Neuro Manifestations | 16 | 0.408 |
| 357.2 | Diabetic Neuropathy | 71 | 0.327 |
| 493.21 | Asthma with COPD | 108 | 0.399 |
| <i>Demographic Factor:</i> | | | |
| 61 yrs old/Female/Disabled: | | | 0.411 |

Total Risk Score = 4.029



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Thank You!

Lynn Myers MD

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LAS611

