Documenting and Coding Chronic Conditions for Medicare Advantage Risk Adjustment 1 Hour Part 1

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David's Professional Profile

- David Brigner currently performs as Sr Provider Training & Development Consultant as it relates to HCC documentation and Coding in coordination with Optum

- David has 30+ years of instructional proficiency coupled with developing managing and directing instructional curricula and product implementation within both collegiate and private education platforms for various institutions, health plans and medical management environments.

- David completed his undergraduate studies at both Baylor University and The University of Oklahoma, and earn a Master's of Liberal Arts degree in business leadership, business management and communication.

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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.

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.

Course Disclaimer

This course generally describes accepted coding practices and guidelines as defined in the ICD-9-CM and ICD-10-CM coding books, as well as certain accepted practices for HEDIS®, as administered by NCQA, and certain accepted practices for Stars, as administered by CMS. The physician or other healthcare provider must produce ***accurate and complete*** *documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support use of the most appropriate ICD-9-CM and ICD-10-CM code(s) under the guidelines and satisfy HEDIS and Stars measures.* ***If the documentation in the medical record does not support a given code, that code cannot be used.***

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- *CPT is a registered trademark of the American Medical Association.*

Bolding Legend

- Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year **2016**, the bolding of ICD-9-CM codes is being revised. Currently, our tools reflect:
  - **Black = Risk adjusts in both the 2013 CMS-HCC model and the 2014 CMS-HCC model**
- For 2016 dates of service, only those codes bolded in **black** will risk adjust.
  - The 2016 Payment Year model is based on 100% of the 2014 (V22) CMS-HCC model mappings.

http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

Agenda

- Introduction to ICD-10-CM
  - Documentation requirements, advantages, comparing code sets
  - ICD-10-CM relevance to documentation and coding
  - ICD-10-CM code book usage (Index and Tabular)

Agenda:

- Intro to Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Risk Adjustment
  - Methodology, The Risk Adjustment Factor (RAF), Hierarchical Condition Category (CMS-HCC) model
- Introduction to ICD-10-CM
  - Documentation requirements, advantages, comparing code sets
  - ICD-10-CM code book usage (Index and Tabular)
- Reporting MA RA Chronic Conditions per ICD-9 / ICD-10 Coding Guidelines
  - Documenting and Coding:
    - Chronic Kidney Disease (CKD) & Hypertension
    - Hypertensive Heart Disease with Heart Failure
    - Diabetes Mellitus & Associated Manifestations
  - Documentation Considerations & EMR

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Introduction to Medicare Advantage Risk Adjustment

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
  - Patients with multiple chronic conditions may require additional oversight and care

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

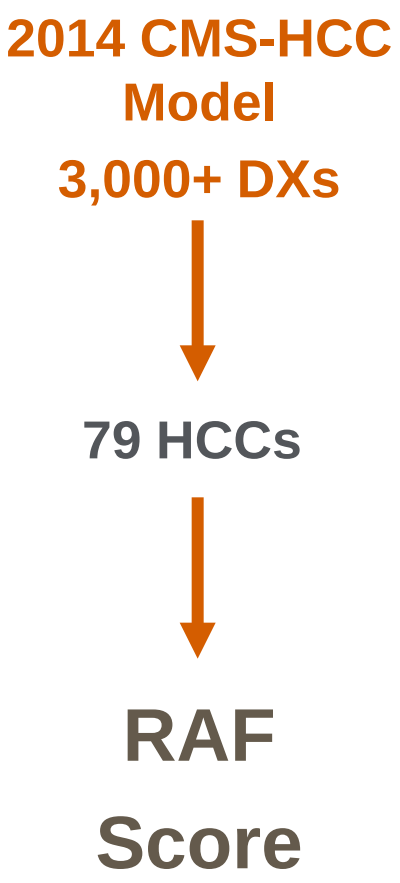
2016 PY Model: 100% 2014 CMS-HCC Model

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**.



Interpreting the 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)

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 resource needs for next year.
  - Health status is redetermined each year.

Bolding Legend

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http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf

It’s a Benefit Provided to the Beneficiary

As part of their Medicare Advantage health plan benefit, members have access to a comprehensive physical exam, that promotes the early detection, documentation and treatment of acute and chronic conditions.

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

CMS-Centers for Medicare & Medicaid Services, “2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide.” Leading Through Change, Inc. 2008 1-49.

Correctly Reporting Chronic Conditions

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!

United States. Centers for Disease Control and Prevention. *ICD-9-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2011. Web. http://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf

United States. Centers for Disease Control and Prevention. *ICD-10-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2015. Web. http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf

Correctly Reporting 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**."

United States. Centers for Disease Control and Prevention. *ICD-9-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2011. Web. http://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf

United States. Centers for Disease Control and Prevention. *ICD-10-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2015. Web. http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf

Clinical Specificity in Documentation

- Clinical specificity involves having a diagnosis fully documented in the source medical record instead of routinely defaulting to a general term or an unspecified diagnosis.

  - Remember, the practice of specific documentation and coding of the diagnoses can have an impact on E/M and procedural reimbursement due to "Medical Necessity."

  - The following examples involve situations in which a physician uses the most common code for all forms of a disease or condition.

    - Chronic Kidney Disease: **585.9** (N18.9)
    - Hypertension: 401.9 (I10)
    - Congestive Heart Failure: **428.0** (I50.9)
    - Diabetes: **250.00** (E11.9)

CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

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Intro to ICD-10-CM for Medicare Advantage Risk Adjustment

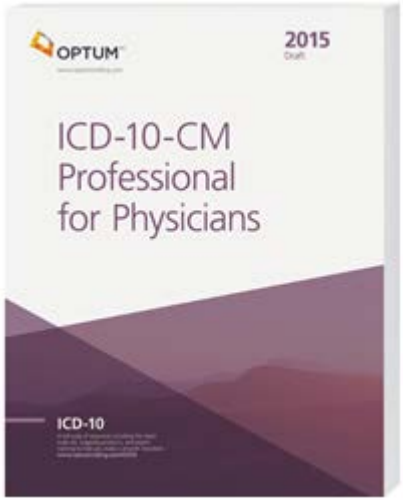
Helpful Sites

- CDC ICD-10 website:
  - Official flat files including guidelines and code sets
    - http://www.cdc.gov/nchs/icd/icd10cm.htm
- CMS ICD-10 website:
  - Fact sheets, FAQs, checklists and other resources
    - www.cms.gov/icd10
- CMS ICD-10, The Provider Perspective:
  - YouTube video of the CMS PAHCO National Webinar, "*ICD-10, The Provider Perspective*" (a little over 1-hr).
    - http://www.youtube.com/watch?v=LBXqy386Lfg4
- CMS ICD-10-CM/PCS Myths and Facts:
  - Responses to myths regarding implementation
    - https://www.cms.gov/Medicare/Coding/ICD10/downloads/icd-10mythsandfacts.pdf

There's an App for That!

Check your smart electronics downloadable application store for free ICD-10 apps.

Advantages of ICD-10-CM Implementation



Purpose and Benefits of ICD-10-CM Transition

Granularity Creates an Accurate Picture of Complexity

- **Greater specificity and enhanced clinical information (Granularity)**
  - Improves ability to measure research, statistics and other means of health care services
    - This "granularity" is good for government researchers tracking disease in the United States, because such statistics can help drive health care reform, research, and other payment systems.
  - Increases sensitivity when refining grouping and reimbursement methodologies
    - Supports important payer decisions regarding the most effective course and appropriation of treatment
  - Enhances ability to conduct public health surveillance
    - Aids in improvement of social programs and appropriation of necessary funding by congress for such programs.

*Optum, *Detailed Instruction for Appropriate ICD-10-CM Coding; An educational guide to the structure, conventions, and guidelines of ICD-10-CM coding*. West Valley City, UT: Optum, 2013. p. 11-12. Print.

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Comparing the Code Sets

Comparison: Diagnosis Code Sets

ICD-9-CM vs. ICD-10-CM Code Sets

Current Code Set	Purpose	New Code Set
ICD-9-CM Volumes 1 & 2	Used for inpatient & outpatient diagnosis coding	ICD-10-CM
ICD-9-CM Volume 3	Used for inpatient procedures	ICD-10-PCS

ICD-9-CM vs. ICD-10-CM: Some Basic Differences

ICD-9-CM

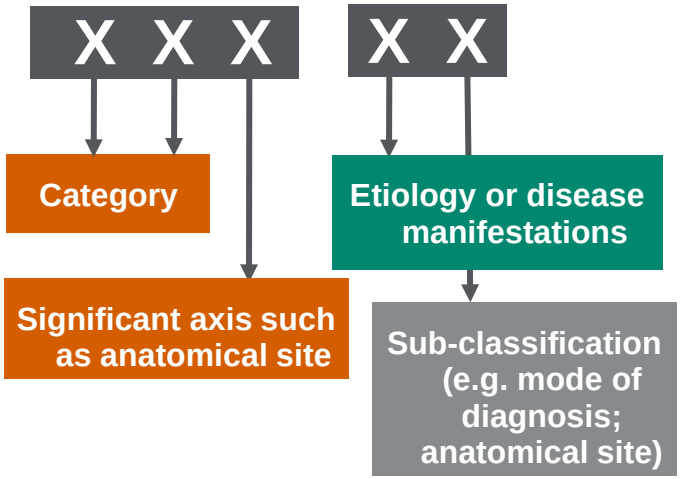
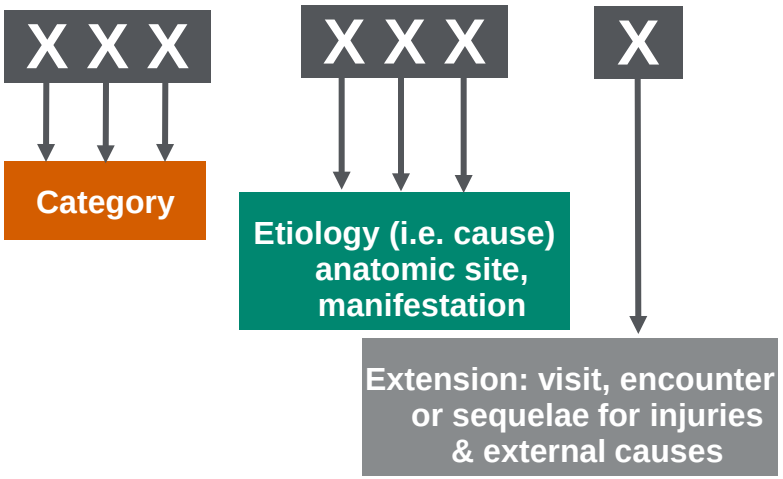
- **Outdated:** 1988-1989
- **17 chapters**
- **14,000+ codes**
- **2 supplementary chpts.**
  (V & E codes)
- **Numeric categories**
- **No placeholders**
  No room for future expansion

ICD-10-CM

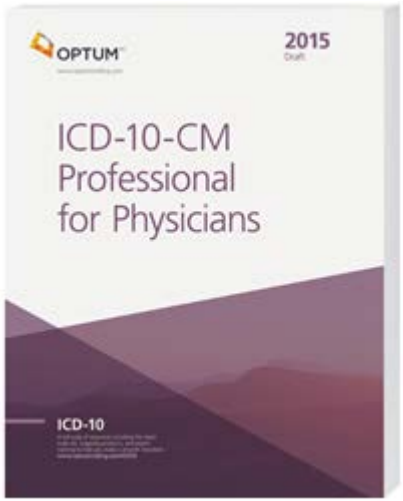
- **Updated: Oct 1, 2015**
- **21 chapters**
- **69,000+ codes**
- **No supplementary chpts.**
  (Incorporated within ICD-10-CM Tabular)
- **Alphanumeric categories**
- **"X" placeholders**
  To allow for future expansion of certain codes

*AAPC. *Introduction to ICD-10-CM for Providers, Vol. 2*. Salt Lake City, UT: AAPC, 2010. p. 8. Print.

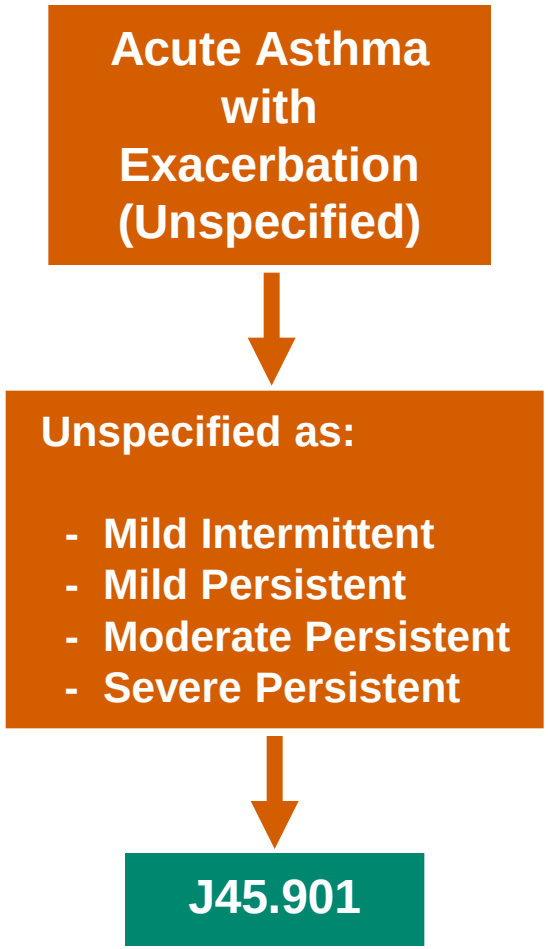
Comparison of ICD-9-CM vs. ICD-10-CM

Feature	ICD-9-CM	ICD-10-CM
Code Set	ICD-9-CM (Vol. I & II)	ICD-10-CM (Clinical Modification)
Structure	• Minimum of 3 digits; maximum of 5 digits with a decimal point after the 3rd digit.	• Minimum of 3 characters; maximum of 7 characters with a decimal point after the 3rd character.
	• Numeric, except for supplementary codes - V & E codes	• Alphanumeric – with all codes using an alphabetic lead character (A-Z, except U). *V & E codes have been eliminated and incorporated into the main code set.*
	• Structure of injuries designated by wound type	• Structure of injuries designated by body part (location)
	• No laterality (left vs. right)	• Laterality (left vs. right)
Format		

ICD-10-CM Relevance to Documentation and Coding



ICD-10-CM Coding - Expected Pitfalls

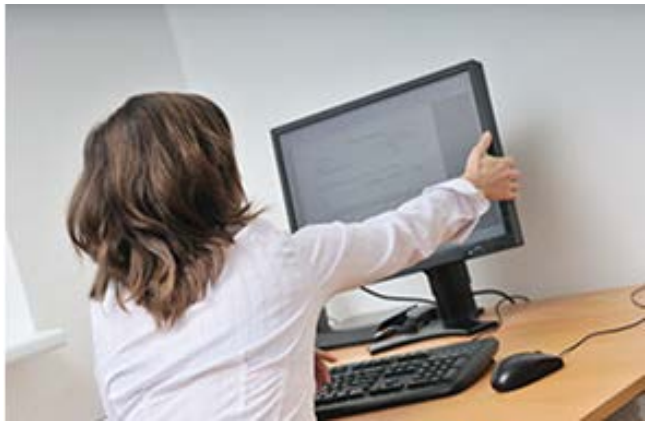


- It is expected that ICD-10-CM codes will be defaulted to “unspecified” code assignment, and the clinical detail of ICD-10-CM will be ignored.
  - There are several reasons for this:
    - Changing old habits is difficult
    - Standard assumptions that assigning unspecified codes carry little risk
    - There is vague understanding with regard to Medicare “Risk” and resource allocation by documenting and assigning codes to a higher level of specificity
    - Standard assumptions support no economic benefit to detailed documentation and coding

*AAPC. *Introduction to ICD-10-CM for Providers, Vol. 2*. Salt Lake City, UT: AAPC, 2010. p. 8-9. Print.

ICD-10-CM Coding - Expected Pitfalls

- Overutilization of “unspecified” codes does not wholly explain a Medicare Advantage member’s legitimate increases in condition severity.
- **From a clinical coding and compliance standpoint:**
  - Assignment of “unspecified” codes when greater specificity is warranted is inaccurate - and plays right into Medicare’s viewpoint of the need for documentation and coding adjustment to promote changes in coding patterns that accurately reflect patient severity. [1, 2]



1 ICD-10 Basics”, Medicare Learning Network, 22 Aug 2013, Web. 15 Jan 2015. cms.gov/Outreach-and-Education/Outreach/NPC/NPC-Video-Presentations-Items/2013-08-22-ICD-10-Basics.html?DLPage=2&DLSort=0&DLSortDir=descendingf

2 CMS-Centers for Medicare & Medicaid Services, “2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide.” Leading Through Change, Inc. 2008 1-49

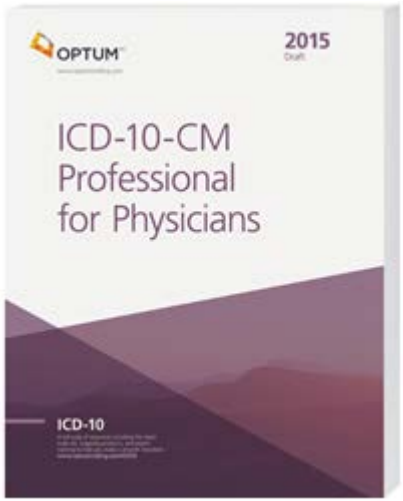
Specific Documentation: Laterality & Anatomic Site

Term	Coding Component	Codes
Chalazion	**Documentation must specify laterality and anatomic site:** *Right upper eyelid* *Right lower eyelid* *Right eye, unspecified eyelid* *Left upper eyelid* *Left lower eyelid* *Left eye, unspecified eyelid* *Unspecified eye, unspecified*	H00.11 Chalazion, right upper eyelid H00.12 Chalazion, right lower eyelid H00.13 Chalazion right eye, unspecified eyelid H00.14 Chalazion, left upper eyelid H00.15 Chalazion, left lower eyelid H00.16 Chalazion left eye, unspecified eyelid H00.17 Chalazion unspecified eye, unspecified

- Unfortunately, many will be tempted to assign the "*unspecified*" type codes, which may hinder the necessary specificity or "granularity" for placing Medicare Advantage members into the appropriate risk category for expected resource utilization.

*Optum, *Detailed Instruction for Appropriate ICD-10-CM Coding; An educational guide to the structure, conventions, and guidelines of ICD-10-CM coding*. West Valley City, UT: Optum, 2014. p. 8. Print.

ICD-10-CM Relevance to Documentation and Coding



Analyze Documentation

- With all of the attention around the increased specificity of ICD-10-CM code set, coders may be concerned that documentation will lack sufficient detail.

- What to do?
  - Determine which conditions the providers at specific facilities or practice most often treat
  - Evaluate the documentation to see what additional information providers will need to document with the added specificity.
  - Identify the information that providers can document now in comparison with details needed for the current ICD-10-CM draft

  … the additional information may not help now with ICD-9-CM; however, it will help prepare for such documentation details when ICD-10-CM is fully implemented.

Avoid the "*unspecified*" type codes!

*Prepare for ICD-10 documentation challenges. *Just Coding*. HCPro, Inc., 28 Nov 2013. Web. 15 Jan 2015. http://justcoding.com/298719/prepare-for-icd10-documentation-challenges

Encourage Documentation Specificity

Some things that weren't important in ICD-9-CM will be needed in **ICD-10-CM**.

- **Example:**
  - *A patient presents with **acute pancreatitis** and is also a chronically **dependent alcoholic**.*

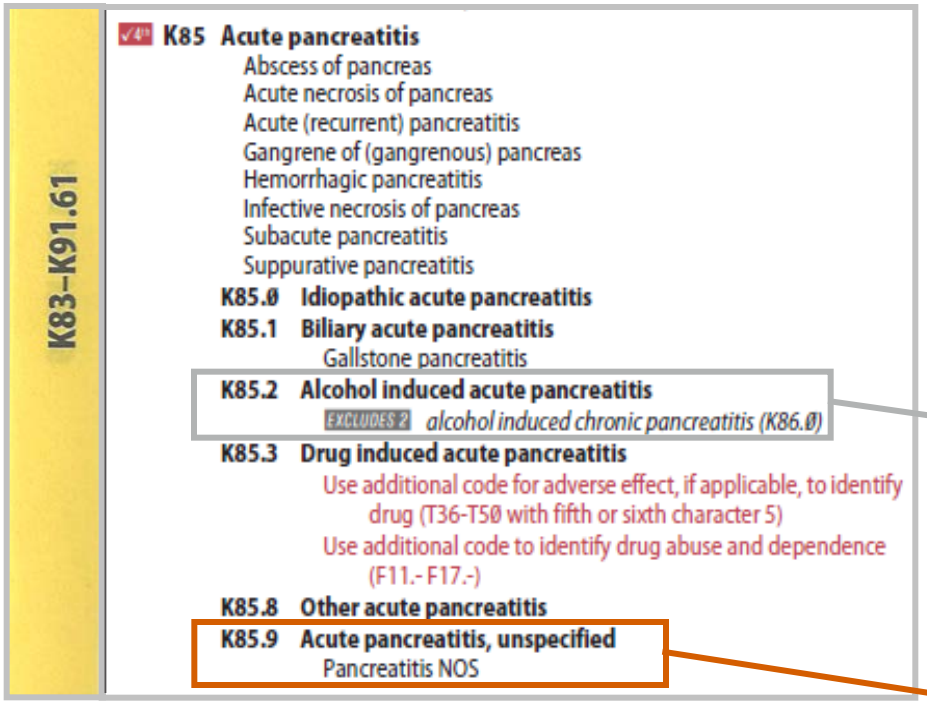
- **ICD-9-CM**: Assign acute pancreatitis (**577.0**) and a code for other and unspecified chronic alcohol dependence (**303.91**) with no need to identify that the two conditions are interrelated.

- **ICD-10-CM**: Specificity is needed in this statement to describe that the two conditions (pancreatitis and alcohol dependence) are interrelated.
  - This example could prompt a query to the provider because there is a more specific combination code that can be assigned to identify the conditions being related — code **K85.2** (Alcohol induced acute pancreatitis).

See example next slide

*"Take the fear out of switch to ICD-10-CM." *Just Coding*. HCPro, Inc., 15 Nov 2011. Web. 15 Jan 2015. http://www.justcoding.com/273342/take-the-fear-out-of-switch-to-icd10cm

Encourage Documentation Specificity



Example: *A patient presents with acute pancreatitis and is also a chronically dependent alcoholic.*

Note here that in ICD-10-CM, there are two possible ways this described pancreatitis can be coded.

a. K85.2 - providing that additional documentation identifies that the two conditions are interrelated

b. K85.9 - providing that no additional documentation supports that the two conditions are interrelated

Encourage Specific Documentation!

*"Take the fear out of switch to ICD-10-CM." *Just Coding*. HCPro, Inc., 15 Nov 2011. Web. 15 Jan 2015. http://www.justcoding.com/273342/take-the-fear-out-of-switch-to-icd10cm

Documentation Specificity Challenges

- Physicians may not be accustomed to being asked for correlation of some conditions as exemplified here because in the past it wasn't relevant to appropriate code assignment.

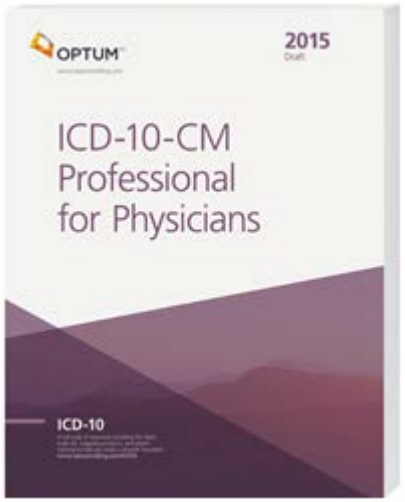
ICD-10-CM Index
Urosepsis - code to condition **Urticaria** L50.9 - with angioneurotic edema T78.3 - - hereditary D84.1 - allergic L50.0

  - For Comparison:
    - ICD-9-CM: Coders were able to report certain conditions that were not specifically clear.
      - Example: When providers document the diagnosis "urosepsis," it is not clear as to whether they mean a "UTI" or "sepsis" of a urinary source.
        - In a situation such as this, coders can simply look up "urosepsis" in the index and cross walk to the tabular code (599.0) for urosepsis, unspecified.
    - ICD-10-CM: "urosepsis" will no longer have an unspecified default code in ICD-10-CM, which will prompt coders to go back to the providers for clarification of specific condition.

Know that the specificity is necessary in order to code many conditions in ICD-10-CM.

*"Unraveling Sepsis Coding in ICD-9-CM and ICD-10-CM." *Code-Write*. AHIMA, Oct 2012. Web. 15 Jan 2015. <https://newsletters.ahima.org/newsletters/Code_Write/2012/October/sepsis.html>

ICD-10-CM Code Book Usage: The Index & Tabular



ICD-10-CM Index

The Alphabetic Index (Volume 2) is organized in the same manner as ICD-9-CM.

- **Punctuations are the same & codes are listed by:**

Condition
(Anomalies, disorder, complications, disease, injury, fracture, etc.)

Main Term
(describing the disease and/or condition. Nonessential modifiers are found after the main term in parentheses)

Subterm
(Specific subclassification such as acute or chronic; indented 2 character spaced to the right under the main term)

Specific Subterm
(More specific subclassification such as CKD stage; indented 4 character spaced to the right under the main term)

Carry Over Line
(Use to complete a sentence or phrase; indented 2 character spaced to the right under the line above it)

Disease, diseased — *continued*
Katayama B65.2
Kedani (scrub typhus) A75.3
Keshan E59
kidney (functional) (pelvis) N28.9
chronic N18.9
hypertensive — *see* Hypertension, kidney
stage 1 N18.1
stage 2 (mild) N18.2
stage 3 (moderate) N18.3
stage 4 (severe) N18.4
stage 5 N18.5
complicating pregnancy — *see* Pregnancy, complicated by, renal disease
cystic (congenital) Q61.9
fibrocystic (congenital) Q61.8
hypertensive — *see* Hypertension, kidney
in (due to)
schistosomiasis (bilharziasis) B65.9 [N29]
multicystic Q61.4
polycystic Q61.3
adult type Q61.2
childhood type NEC Q61.19
collecting duct dilatation Q61.11

**Optum ICD-10-CM: The Complete Official Draft Set 2015*. Salt Lake City: 2014.

ICD-10-CM Index: New Features

- General Rules when Indexing Codes:

  – Codes ending with a hyphen (-)

  In the Index, a (-) at the end of some entries indicates that additional characters are required, for example:

  – Timing (e.g. Loss of consciousness ≤ 30 min, 31-59 min, 1 hr to 5hrs 59 min, etc.)

  Hematoma, cerebrum, S06.36-

  – Trimester (e.g. 1st, 2nd, 3rd, Unsp.)

  Gestational edema, O12.0-

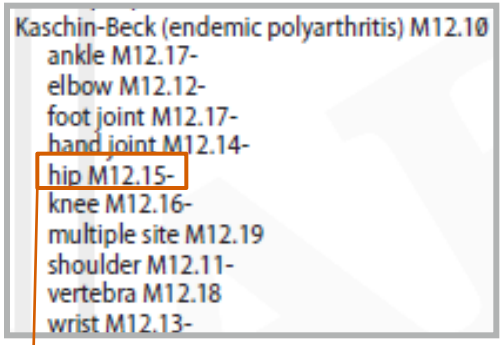
  – Laterality (lt., rt., bilat., unsp.)

  Code descriptions with hyphens that represent laterality represent the following:

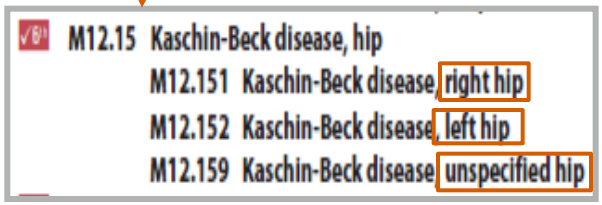
  - The right side is always character 1,
  - the left side is character 2,
  - bilateral is character 3,
  - unspecified is either a character 0 or 9.

Note: Even if a (-) is not included at an index entry, always refer to the Tabular List to verify that no extension is required.

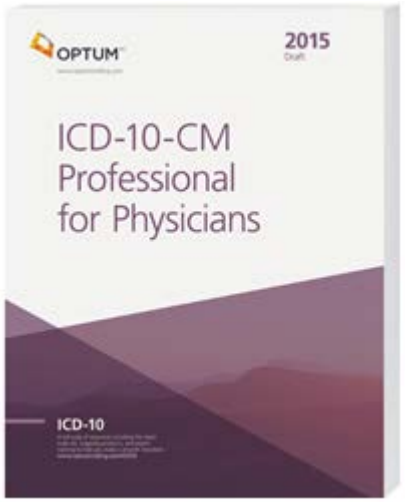
Index



Tabular

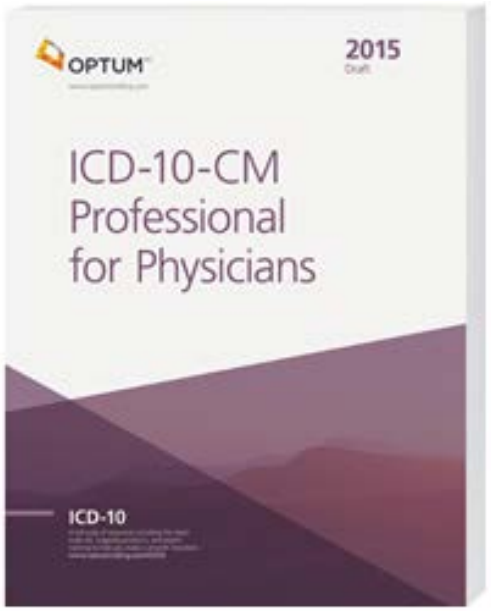


ICD-10-CM Code Book Usage: The Index and Tabular



ICD-10-CM: Locating Codes

- Use both the Index and Tabular Listing
- Codes may be 3, 4, 5, 6 or even 7 characters
- Always code to the highest level of specificity
- Codes for disease, symptoms, conditions, problems, complaints, injuries, ill-defined conditions or other reasons for the encounter are **A00.0–T88.9** and **Z00–Z99.8**



ICD-10-CM: Locating Codes

- Assign codes for Signs & Symptoms if a definitive diagnosis has not been established
- Do not assign codes for conditions that are an integral part of a disease process in most situations.
- Consider multiple coding for a single condition
- Code acute conditions
- Code all chronic conditions that are problem pertinent for each episode of care
- Consider combination codes
- Consider late effect codes

ICD-10-CM: Chapters & Locating Codes

- Consider impending or threatened conditions
- Consider laterality with the selection of new ICD-10-CM codes
- Consider appropriate coding of two or more comparative or contrasting conditions
- Code complications of surgery and other medical care
- Do not code uncertain diagnoses (e.g. possible, probable, suspected, rule out or any working diagnosis)
- Code previous conditions (e.g. history of)
- Code abnormal findings

Note: Always check special instructions (e.g. includes and excludes notes) at the beginning of each corresponding chapter when selecting codes from the Tabular Listing.

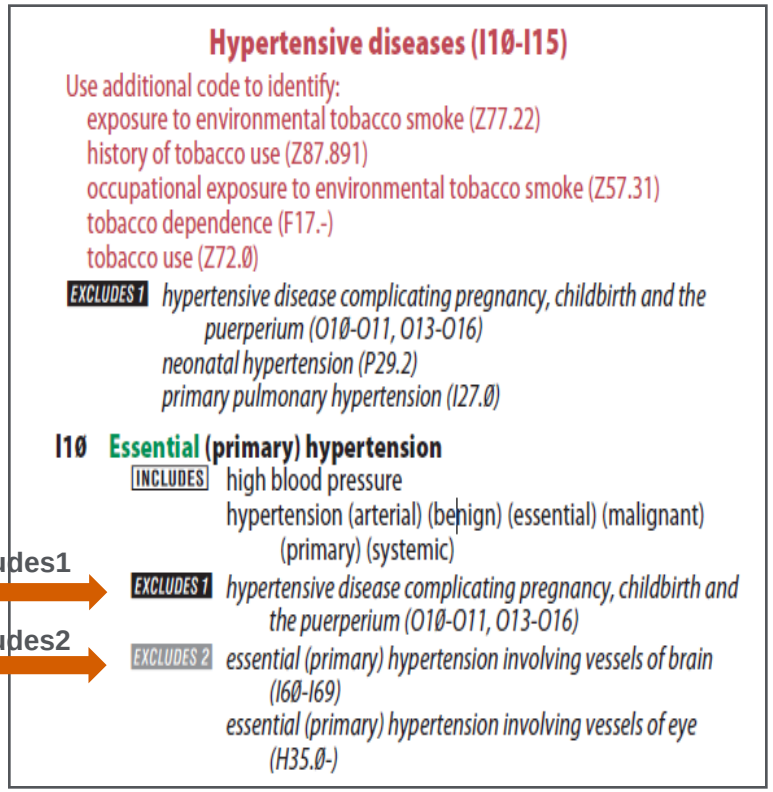
ICD-9-CM vs. ICD-10-CM: Coding Convention Changes

- Use of the Index and Tabular are unchanged
  - Except for Excludes Notes

- Exclude Notes have been subdivided into:
  - **Excludes 1** Not Coded Here
    - Two conditions cannot occur together
  - **Excludes 2** Not Included Here
    - It is acceptable to use both the listed code and excluded code together
    - It is not mandatory to use both

ICD-10-CM: Category Excludes Notes

- There are two types of "Excludes" notes, although each indicates that codes excluded from each other are independent of each other:
  - ***Excludes 1***
    - A type 1 excludes note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note:
      - An ***Excludes 1*** is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
      - Condition listed with ***Excludes 1*** are mutually exclusive.
  - ***Excludes 2***
    - A type 2 excludes note represents "*Not included here*."
      - An ***Excludes 2*** note indicates that the condition excluded is not part of the condition represented by the code; however, a patient may have both conditions at the same time.
      - When an ***Excludes 2*** note appears, it is acceptable to assign both the code in reference and the excluded code(s) together.



Optum ICD-10-CM: The Complete Official Draft Set 2015. Salt Lake City: 2014.

Additional Conventions

- Additional characters required (Tabular List).

✓4th – This symbol indicates that the code requires a fourth character.

✓5th – This symbol indicates that the code requires a fifth character.

✓6th – This symbol indicates that the code requires a sixth character.

✓7th – This symbol indicates that the code requires a seventh character following the placeholder ‘x.’

✓x7th

- Codes less than six characters that require a seventh character must contain placeholder ‘x’ to fill the missing characters.
- The seventh character must always be a valid seventh character for that code.
- Coders should also note that an ICD-10-CM code can start with an **X** (i.e., codes X00–X99 from Chapter 20).

**Optum ICD-10-CM: The Complete Official Draft Set 2015*. Salt Lake City: 2014.

ICD-10-CM Index: New Features

- General rules when indexing codes:

  'x' Placeholders

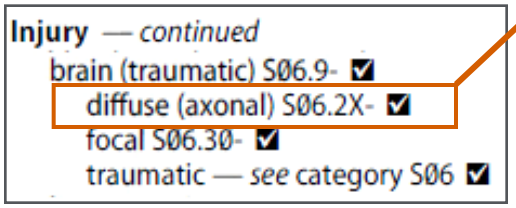
- In those cases, such as poisonings or injuries, coders will need to add a placeholder so the seventh character ends up in the correct position. The placeholder is reported as an 'x'.

  Example: S06.2x0D

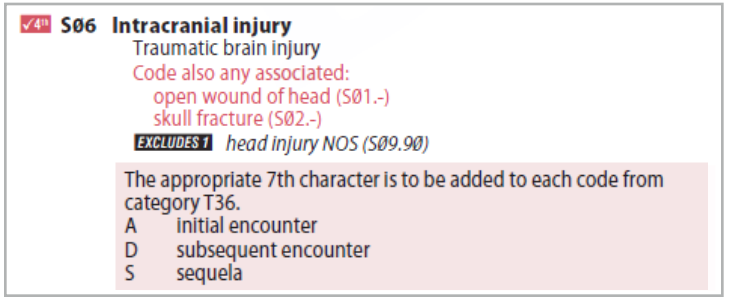
  "Diffuse traumatic brain injury w/o loss of consciousness, subsequent visit"

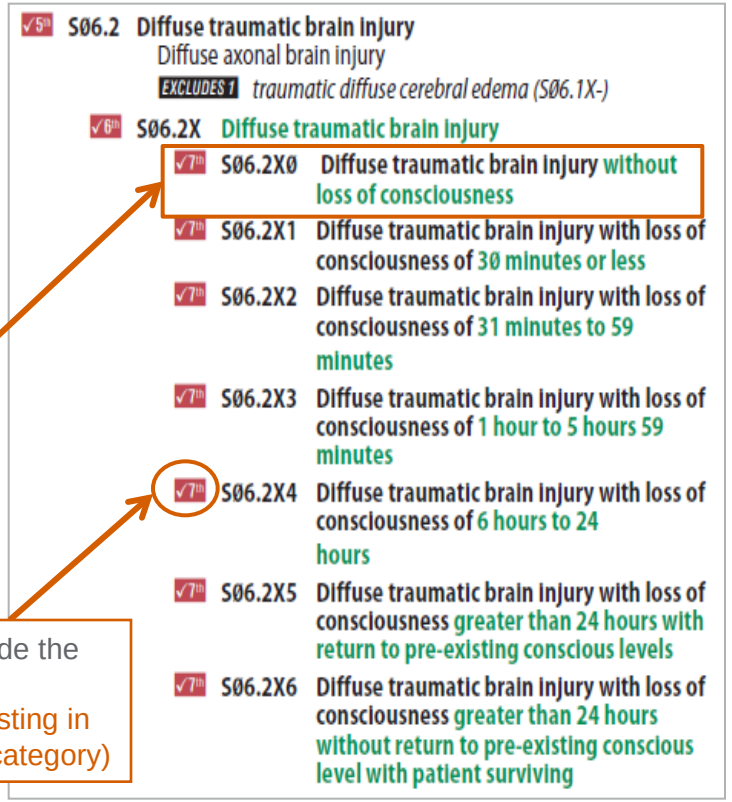
Note: If the character isn't in the correct position, the code isn't valid.

Index



Tabular





Note: the "*seven*" characters do not include the decimal point. 7th means another alpha character is needed at the end (refer to listing in pink just under the complimentary code category)

**Optum ICD-10-CM: The Complete Official Draft Set 2015*. Salt Lake City: 2014.

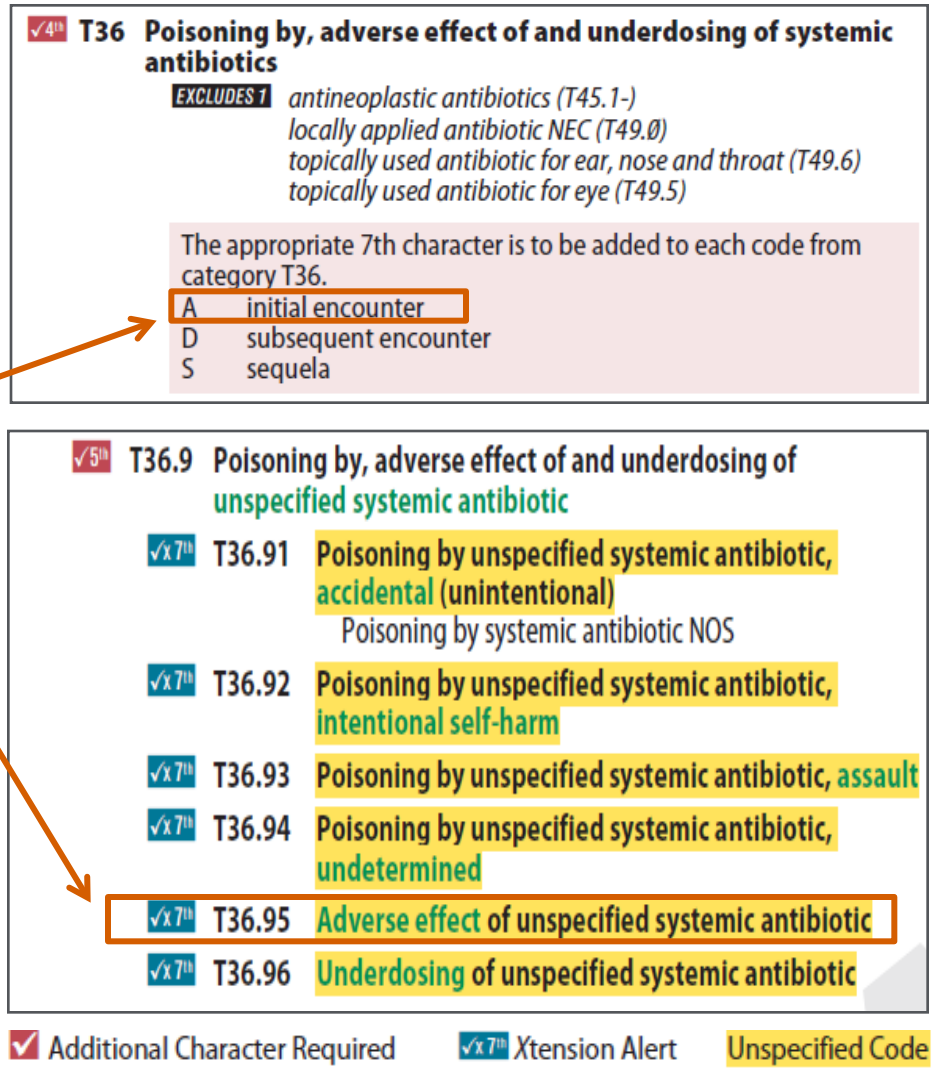
7th Character Examples with "x" Placeholders

✓x7th – Example 1

"Adverse effect of unspecified systemic antibiotic, initial encounter"

Code: T36.95xA

Note: The Index entries for these conditions only end with the first 4th or 5th characters. Always crosswalk to the Tabular Listing for additional conventions.



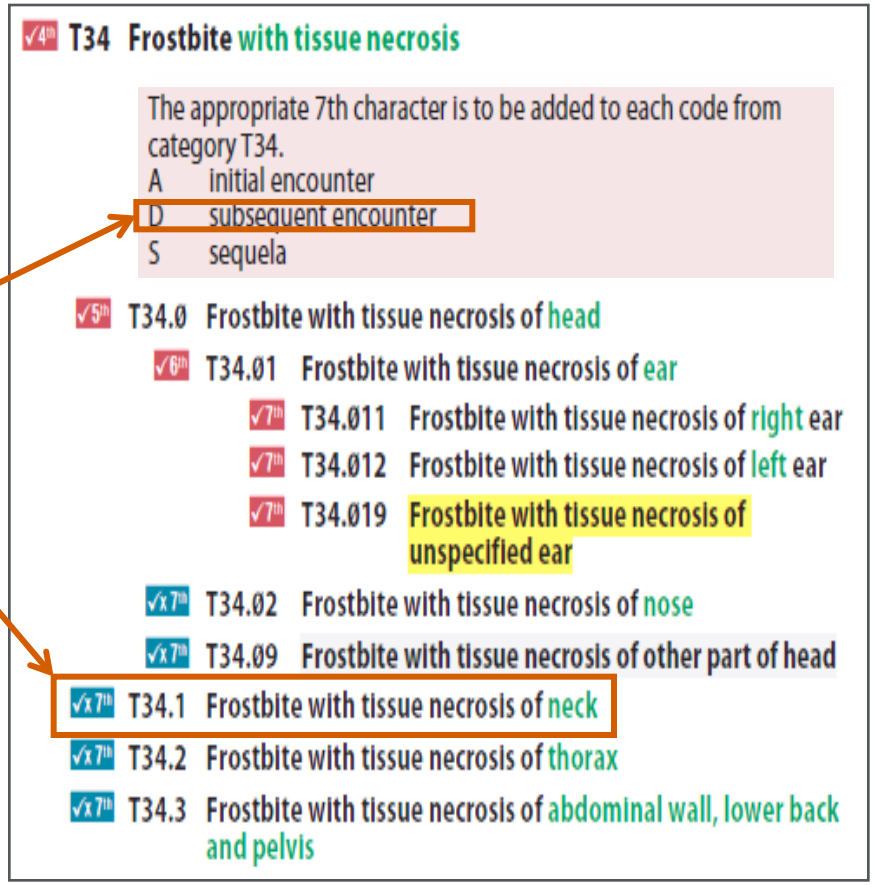
Optum ICD-10-CM: The Complete Official Draft Set 2015. Salt Lake City: 2014.

7th Character Examples with "x" Placeholders

✓x7th – Example 2

"Frostbite with tissue necrosis of the neck, subsequent encounter"

Code: T34.1xxD



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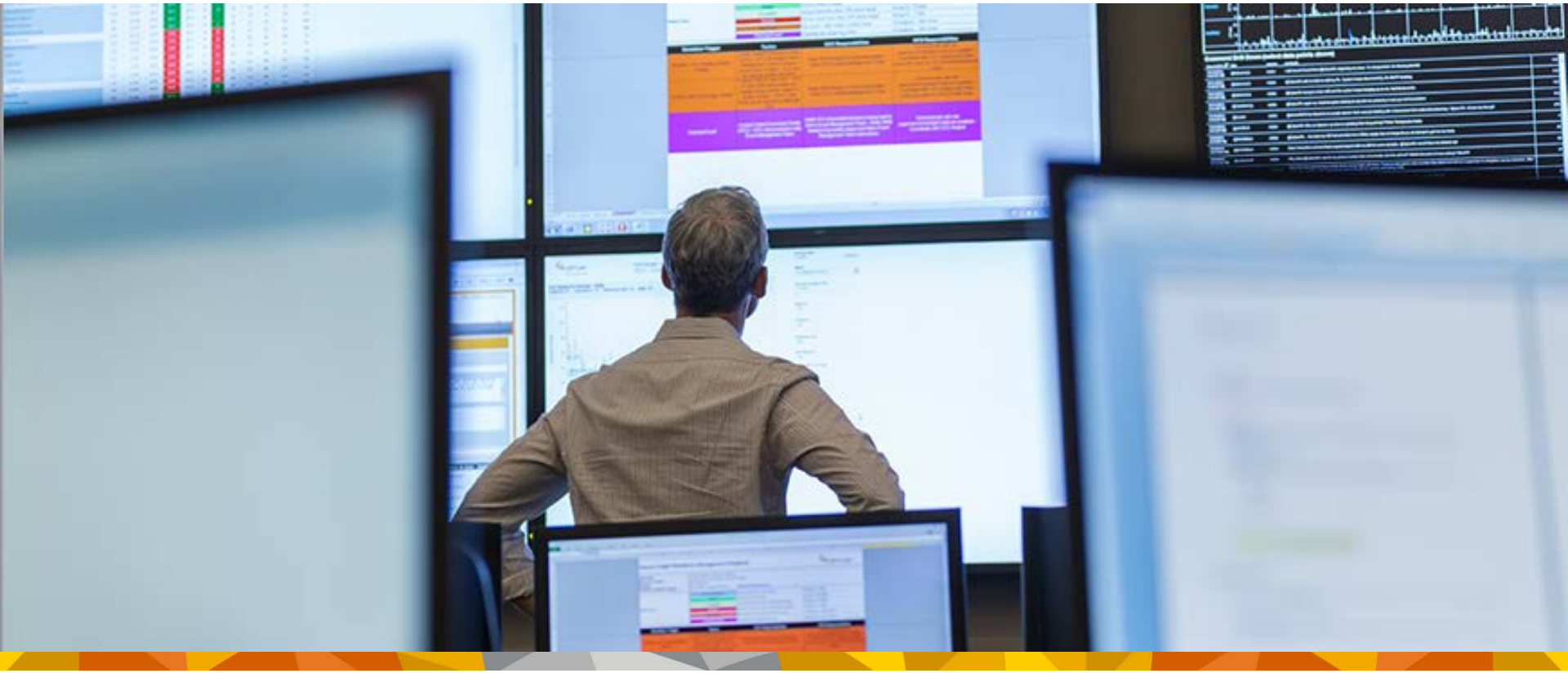

Chronic Conditions Documentation & Coding

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Documenting and Coding:

Chronic Kidney Disease (CKD) & Hypertension

Chronic Kidney Disease: GFR

Glomerular Filtration Rate	**Glomerular filtration rate (GFR) is the best estimate of kidney function***
Labs & GFR	**Some laboratories offer an estimated GFR (eGFR).** ***A manual calculation is necessary if the eGFR is >60 ml/min/1.73 m^2.***
Lab GFR Calculation	**Typically many lab reports print out the following:** ***"GFR: greater than 60 ml/min/1.73 m^2"***
Lab GFR Calculation Problems	**This does not give enough detail to stage CKD Stage I and CKD Stage II** ***Manual calculation of GFR may still be necessary.***

*"About Chronic Kidney Disease." *National Kidney Foundation*. 1 Jan. 2013. Web. 29 Jan. 2015. https://www.kidney.org/kidneydisease/aboutckd.

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Coding CKD in ICD-9-CM

- **585.9** Chronic kidney disease, unspecified

  Chronic renal disease

  Chronic renal failure NOS

  Chronic renal insufficiency

- **585.9** should not be used if the stage of CKD is documented.

- The staging of CKD should be reported based on documented clinical findings including Glomerular Filtration Rate (GFR).

- Knowing the GFR is necessary to use the Hypertension / Chronic Kidney Disease combination codes since 2009.

Note:

The stage makes a difference in the codes.

Chronic Kidney Disease: Staging in ICD-9-CM

Stage	Severity	GFR	ICD-9-CM
Stage I	*Normal or slightly ↑ GFR*	GFR ≥ 90 ml/min With kidney damage *	585.1
Stage II	*Mild*	GFR 60-89 ml/min With kidney damage *	585.2
Stage III	*Moderate*	GFR 30-59 ml/min	585.3
Stage IV	*Severe*	GFR 15-29 ml/min	585.4
Stage V	*Kidney Failure*	GFR < 15 ml/min	585.5
	ESRD	Requiring chronic dialysis or transplantation	585.6
CKD Unsp.	*CRD, CRF NOS or CRI*	Chronic Kidney Disease, Unspecified	585.9

- 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

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HTN and CKD in ICD-9-CM

- Chronic Kidney Disease (CKD) is a long-term inability of the kidneys to function adequately.
- ICD-9-CM assumes a relationship when a patient has both chronic renal disease and hypertension.
  - Category 403 – Hypertensive Chronic Kidney Disease
    - Requires 585.X to be coded
  - Category 404 – Hypertensive Heart and Chronic Kidney Disease
    - Requires 585.X to be coded
    - If reporting Heart Failure, Category 428 must be coded

United States. Centers for Disease Control and Prevention. *ICD-9-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2011. Web. http://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf

Hypertensive Chronic Kidney Disease in ICD-9-CM

The Connection is Presumed

"Benign hypertensive CKD, stage 4"

Or

"Benign hypertension and CKD, stage 4"

- Category 403 - Hypertensive Chronic Kidney Disease
  - 403.10 – Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified
    - 4th digit 1 indicates benign hypertension
    - 5th digit 0 indicates with Chronic Kidney Disease (Stage I-IV or unspecified)
- Must code stage of Chronic Kidney Disease per ICD-9-CM
  - **585.4** - Chronic kidney disease, Stage IV (severe)

Coding Chronic Kidney Disease in ICD-10-CM

- N18.9 Chronic kidney disease, unspecified
  - Chronic renal disease
  - Chronic renal failure NOS
  - Chronic renal insufficiency
  - Chronic uremia
- N18.9 should not be used if the stage of CKD is documented.
- Knowing the GFR is necessary to use the Hypertension / Chronic Kidney Disease combination codes since 2009.
  - The GFR ranges defining each “staged” subcategory are not listed in the ICD-10-CM. This does not necessarily mean that the GFR is not required in documentation as part of the clinical rationale for staging CKD Stage I-V and ESRD.

Note:

The stage makes a difference in the codes.

Chronic Kidney Disease: Staging in ICD-10-CM

Stage	Severity	GFR	ICD-10-CM
Stage I	*Normal or slightly ↑ GFR*	GFR ≥ 90 ml/min With kidney damage *	N18.1
Stage II	*Mild*	GFR 60-89 ml/min With kidney damage *	N18.2
Stage III	*Moderate*	GFR 30-59 ml/min	N18.3
Stage IV	*Severe*	GFR 15-29 ml/min	N18.4
Stage V	*Kidney Failure*	GFR < 15 ml/min	N18.5
	ESRD	Requiring chronic dialysis or transplantation	N18.6
CKD Unsp.	*CRD, CRF NOS or CRI*	Chronic Kidney Disease, Unspecified	N18.9

- Assign Z99.2, Dependence on renal dialysis, or Z91.15, Patient's noncompliance with renal dialysis, for all N18.6 and some N18.5; assign Z94.0, 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

OPTUM™

HTN and CKD in ICD-10-CM

- ICD-10-CM assumes a relationship when a patient has both chronic renal disease and hypertension.
  - Category I12 – Hypertensive Chronic Kidney Disease
    - Requires N18.- to be coded
  - Category I13 – Hypertensive Heart and Chronic Kidney Disease
    - Requires N18.- to be coded
    - If reporting Heart Failure, I50.- must be coded

United States. Centers for Disease Control and Prevention. *ICD-10-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2015. Web. http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf

Hypertensive Chronic Kidney Disease: ICD-10-CM

The Connection is Presumed

"Benign hypertensive CKD, stage 4"

Or

"Benign hypertension and CKD, stage 4"

- Category I12.- – Hypertensive chronic kidney disease
  - I12.9 – Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
    - 4th digit 9 indicates Chronic Kidney Disease stage 1-4 or unspecified
- Must also code stage of Chronic Kidney Disease per ICD-10-CM
  - N18.4 – Chronic kidney disease, stage 4 (severe)

Documenting and Coding:

Hypertensive Heart Disease with Heart Failure

Hypertensive Heart Disease in ICD-9-CM

- 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.

Category 402 – Hypertensive Heart Disease

Category 404 – Hypertensive Heart and Chronic Kidney Disease

"Hypertensive heart disease with congestive heart failure"

- **402.91** - **Unspecified 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

Failing to Make the Connection in ICD-9-CM

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 ***and*** congestive heart failure without the "linkage" in the chart, the proper coding would be:

    - 401.9 Hypertension, unspecified
    - **428.0** Congestive heart failure

Coding Guidelines for HF in ICD-9-CM

- **Hypertensive heart disease**
  - **402.01 Malignant** hypertensive heart disease with heart failure
  - **402.11 Benign** hypertensive heart disease with heart failure
  - **402.91 Unspecified** hypertensive heart disease with heart failure
- **Use additional code to specify type of heart failure, if known**

428.0 **Congestive heart failure, unspecified**
428.1 **Left heart failure**
428.2x **Systolic heart failure**
428.3x **Diastolic heart failure**
428.4x **Combined systolic and diastolic heart failure**
428.9 **Heart failure, unspecified**

- CHF is not an inherent component of systolic, diastolic, or combined systolic-diastolic heart failure.
- 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 Quarter, 2002, p. 52-53

428.2x - 428.4x: 5th digit reports Acute, Chronic, Acute on chronic or Unspecified

HF Documentation and Coding in ICD-9-CM

- **Other diagnostic statements regarding heart failure:**
  - *Fluid overload NOS (276.69)*
  - *Rheumatic heart failure, rheumatic left ventricular failure (**398.91**)*

- **Diagnostic statements that <u>do not</u> 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.*

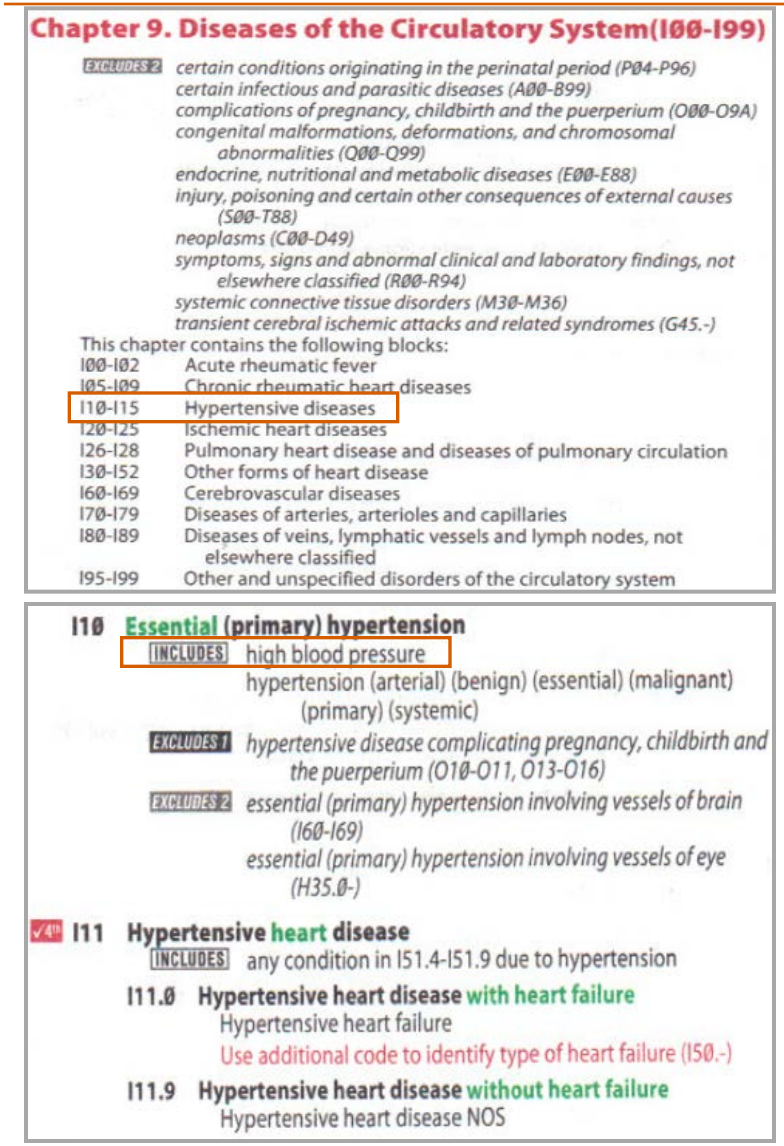
*Brown, Faye. *Faye Brown's ICD-9-CM Coding Handbook 2012*. 2010 Rev. ed. Chicago: AHA Press, 2011. Print.

Coding Guidelines for HF in ICD-9-CM

- **Hypertensive heart and chronic kidney disease (CKD)**
  - **404.01** Hypertensive heart and chronic kidney disease, **malignant**, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
  - **404.03** Hypertensive heart and chronic kidney disease, **malignant**, with heart failure and with chronic kidney disease stage V or end stage renal disease
  - **404.11** Hypertensive heart and chronic kidney disease, **benign**, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
  - **404.13** Hypertensive heart and chronic kidney disease, **benign**, with heart failure and chronic kidney disease stage V or end stage renal disease
  - **404.91** Hypertensive heart and chronic kidney disease, **unspecified**, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified
  - **404.93** Hypertensive heart and chronic kidney disease, **unspecified**, with heart failure and chronic kidney disease stage V or end stage renal disease
- **Use additional code to specify type of heart failure, if known**
- **Use additional code to identify the stage of CKD (585.1 - 585.6)**
- **Use additional code to report Renal Dialysis Status (V45.11), if applicable**

AHA Coding Clinic, 4th Quarter, 2002, p. 52-53

Coding HTN in ICD-10-CM



Chapter 9. Diseases of the Circulatory System(I00-I99)

EXCLUDES 2 *certain conditions originating in the perinatal period (P04-P96)*
certain infectious and parasitic diseases (A00-B99)
complications of pregnancy, childbirth and the puerperium (O00-O9A)
congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
endocrine, nutritional and metabolic diseases (E00-E88)
injury, poisoning and certain other consequences of external causes (S00-T88)
neoplasms (C00-D49)
symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94)
systemic connective tissue disorders (M30-M36)
transient cerebral ischemic attacks and related syndromes (G45.-)

This chapter contains the following blocks:

I00-I02	Acute rheumatic fever
I05-I09	Chronic rheumatic heart diseases
I10-I15	Hypertensive diseases
I20-I25	Ischemic heart diseases
I26-I28	Pulmonary heart disease and diseases of pulmonary circulation
I30-I52	Other forms of heart disease
I60-I69	Cerebrovascular diseases
I70-I79	Diseases of arteries, arterioles and capillaries
I80-I89	Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
I95-I99	Other and unspecified disorders of the circulatory system

I10 Essential (primary) hypertension
INCLUDES high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
EXCLUDES 1 *hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)*
EXCLUDES 2 *essential (primary) hypertension involving vessels of brain (I60-I69)*
essential (primary) hypertension involving vessels of eye (H35.0-)

I11 Hypertensive heart disease
INCLUDES any condition in I51.4-I51.9 due to hypertension
I11.0 Hypertensive heart disease with heart failure
Hypertensive heart failure
Use additional code to identify type of heart failure (I50.-)
I11.9 Hypertensive heart disease without heart failure
Hypertensive heart disease NOS

- 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 I10 and not coded separately.**

Note: Elevated blood pressure *reading* without a diagnosis of hypertension is coded as R03.0.

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Hypertensive Heart Disease in ICD-10-CM

- 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.

Category I11 – Hypertensive Heart Disease

Category I13 – Hypertensive Heart & Chronic Kidney Disease

"Hypertensive heart disease with congestive heart failure"

- I11.0 – Hypertensive heart disease with heart failure
  - 4th character of 0 indicates with heart failure
    - If there was no documentation of heart failure, the 4th character would be 9
- I50.9 – Heart failure, unspecified
  - 4th character of 9 indicates unspecified

Hypertensive Heart Disease with HF in ICD-10-CM

- **Code the hypertensive heart disease**
  - I11.0 Hypertensive heart disease with heart failure
- **Use additional code(s) to specify type of heart failure**
  - Subcategories include:
    - I50.1 Left ventricular failure
    - I50.20 Unspecified systolic (congestive) heart failure
    - I50.21 Acute systolic (congestive) heart failure
    - I50.22 Chronic systolic (congestive) heart failure
    - I50.23 Acute on chronic systolic (congestive) heart failure
    - I50.30 Unspecified diastolic (congestive) heart failure
    - I50.31 Acute diastolic (congestive) heart failure
    - I50.32 Chronic diastolic (congestive) heart failure
    - I50.33 Acute on chronic diastolic (congestive) heart failure
    - I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
    - I50.9 Heart failure, unspecified

Coding Guidelines for HF in ICD-10-CM

- Hypertensive heart and chronic kidney disease
  - I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
  - I13.10 Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
  - I13.11 Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
  - I13.2 Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

- If HF is present, code also the exact type(s) of HF (I50.-)
- Use additional code to identify the stage of CKD (N18.-) and Renal Dialysis Status (Z99.2), if applicable

Documenting and Coding:

Diabetes Mellitus (DM) & Associated Manifestations

Details of Documenting Diabetes

Diabetes:

- Type of diabetes
- Complicated or uncomplicated
- Identify the system(s) with the complications
  - **57.9% of diabetics have systemic complications***
- Name the manifestation in the system
- Controlled or uncontrolled

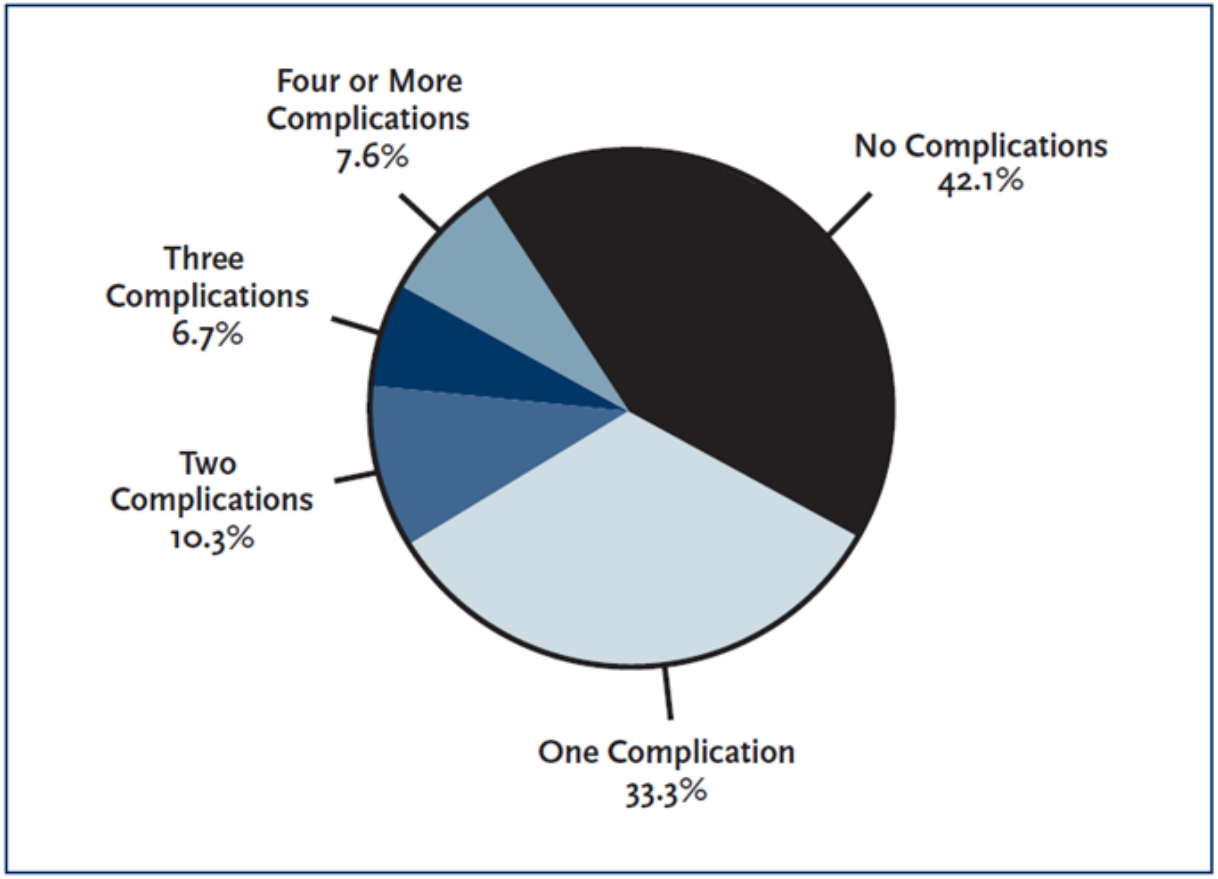
*The State of Diabetes Complications in America, Amer. Assoc. Clinical Endocrinologists, 4/2007

A Closer Look at Diabetic Complications

Diabetes:

57.9% of diabetics have systemic complications*

How do they break down?



*The State of Diabetes Complications in America, Amer. Assoc. Clinical Endocrinologists, 4/2007

Coding Diabetes Mellitus in ICD-9-CM

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.

ICD-9-CM: Underlying Disease – Diabetes Mellitus

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.
- As a provider makes the clinical determination of the causal relationship, it is best to document that relationship (e.g. diabetic, due to diabetes).

Note: The documentation makes the connection.

**Coding Clinic for ICD-9-CM*. Chicago, IL: American Hospital Association, Third Quarter (1991): 7-8. Print.

ICD-9-CM: 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.*

•**Note:** Specific complications and manifestations treated or considered when treating should also be documented and coded.

**Coding Clinic for ICD-9-CM*. Chicago, IL: American Hospital Association, Third Quarter (1991): 7-8. Print.

ICD-9-CM: 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 disorders, type II or unspecified type, not stated as uncontrolled
  - **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 4th digit is properly assigned on the **250.xx.**

ICD-9-CM: Underlying Disease – Diabetes Mellitus

- Be Specific

If the same scenario was documented as:

No cause and effect relationship established [1]

"PVD *and* Diabetes Mellitus"

- Code **250.00** Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled
- Code **443.9** Peripheral Vascular Disease, Unspecified
  - With this example, there is nothing indicating that the PVD was due to the diabetes.
  - The coding must be unspecified in this case.

1 According to the ICD-9-CM Index imperative, which takes precedence over all other coding literature reviews and advice, there is no automatic relationship here.

ICD-9-CM: Diabetes Documentation and Coding

- Evaluate every patient with diabetes, especially the senior patient, for manifestation(s) of the disease.

Diabetic Nephropathy, out of control	Diabetic CKD Stage III	Diabetic Retinopathy	Type I Diabetic Neuropathy, out of control
• **250.42** and **583.81**	• **250.40** and **585.3**	• **250.50** and **362.01**	• **250.63** and **357.2**
Diabetic Peripheral Autonomic Neuropathy	**Diabetic Neuralgia**	**Diabetic PVD**	**Diabetic Ulcer**
• **250.60** and **337.1**	• **250.60** and **357.2**	• **250.70** and **443.81**	• **250.80** and **707.9**

ICD-10-CM: Diabetes Documentation and Coding

- Evaluate every patient with diabetes, especially the senior patient, for manifestation(s) of the disease.

Diabetic Nephropathy, , out of control	Diabetic CKD Stage III	Diabetic Retinopathy	Type I Diabetic Neuropathy, out of control
• **E11.21** and **E11.65**	• **E11.22** and **N18.3**	• **E11.319**	• **E10.40** and **E10.65**
Diabetic Peripheral Autonomic Neuropathy	**Diabetic Neuralgia**	**Diabetic PVD**	**Diabetic Ulcer**
• **E11.43**	• **E11.42**	• **E11.52**	**E11.622** and **L98.499** *(Non-pressure chronic ulcer of skin of other sites with unspecified severity)*

Diabetes Mellitus (ICD-10-CM) E08-E13

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 few exceptions *(e.g., diabetic gastroparesis, diabetic ulcer, CKD due to diabetes)*
  - Diabetic manifestations are captured by the 4th, 5th, and 6th characters

Reporting Diabetic Codes

- **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)*

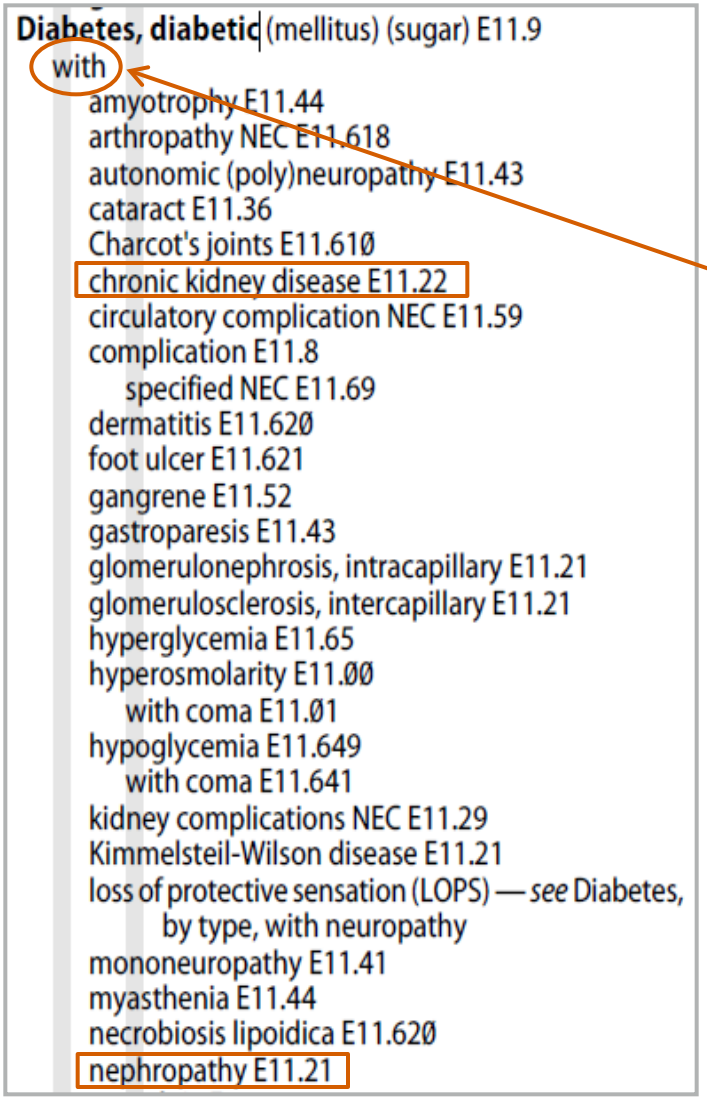
- **Diabetes Mellitus (ICD-10-CM)**
  - **Primary Diabetes Mellitus**
    - Type 1 diabetes is reported with codes in category **E10**
    - Type 2 diabetes is reported with codes in category **E11**
  - **Secondary Diabetes Mellitus**
    - due to underlying condition is reported with codes in category **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 (Subcategories)	
	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 (Subcategories)	
	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 **without** complications

Diabetes Mellitus – Index



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
chronic kidney disease 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
glomerulosclerosis, intercapillary E11.21
hyperglycemia E11.65
hyperosmolarity E11.00
with coma E11.01
hypoglycemia E11.649
with coma E11.641
kidney complications NEC E11.29
Kimmelsteil-Wilson disease E11.21
loss of protective sensation (LOPS) — *see* Diabetes, by type, with neuropathy
mononeuropathy E11.41
myasthenia E11.44
necrobiosis lipoidica E11.620
nephropathy E11.21

- 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**

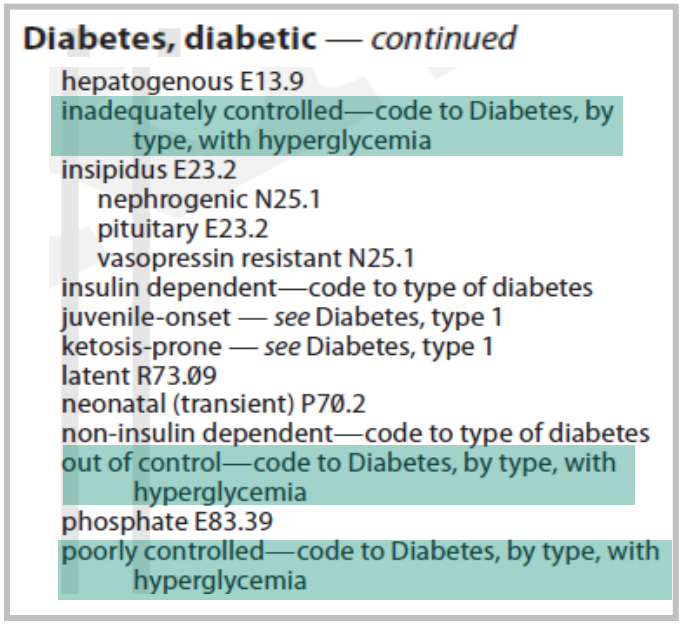
**Optum ICD-10-CM: The Complete Official Draft Set 2015*. Salt Lake City: 2014.

Documenting the Control Status in ICD-10-CM

ICD-10 offers codes when the clinical documentation indicates blood glucose levels as being:

- Inadequately controlled
- Out of controlled (uncontrolled)
- Poorly controlled

➢ The ICD-10 Index instructs to code such conditions to "Diabetes *(by type)* with hyperglycemia.



Diabetes, diabetic — *continued*

hepatogenous E13.9
inadequately controlled—code to Diabetes, by type, with hyperglycemia
insipidus E23.2
nephrogenic N25.1
pituitary E23.2
vasopressin resistant N25.1
insulin dependent—code to type of diabetes
juvenile-onset — *see* Diabetes, type 1
ketosis-prone — *see* Diabetes, type 1
latent R73.Ø9
neonatal (transient) P7Ø.2
non-insulin dependent—code to type of diabetes
out of control—code to Diabetes, by type, with hyperglycemia
phosphate E83.39
poorly controlled—code to Diabetes, by type, with hyperglycemia

Example:

Type 1 DM, uncontrolled (**E10.65**) *Type 1 DM with hyperglycemia*
Type 2 DM, poorly controlled (**E11.65**) *Type 2 DM with hyperglycemia*

ICD-10-CM: Diabetes Mellitus – Examples

– Some conditions cannot be captured by one code.

- Type 1 diabetic foot ulcer
  - Requires a code **E10.621**, Type 1 diabetes mellitus with foot ulcer, and a code from subcategory **L97.4** or **L97.5** to designate the exact location and severity of the foot ulcer

- Legal diabetic blindness, type 2
  - Requires a code **E11.39**, Type 2 diabetes mellitus with other diabetic ophthalmic complication, and a code from subcategory H54.8 legal blindness NOS (according to USA definition).

Multiple Diabetic Manifestations in ICD-10-CM

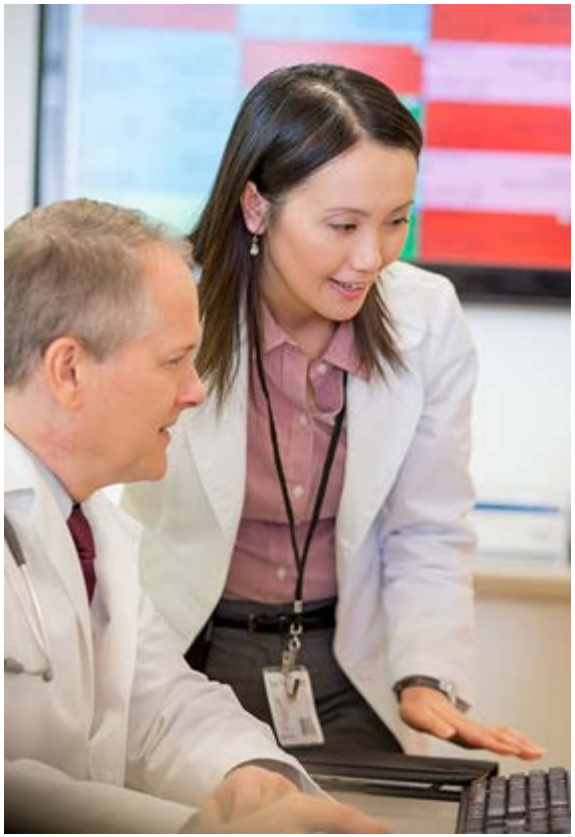
- **Diabetic Nephropathy E11.21**
  - If CKD is documented as a manifestation of diabetes in addition to diabetic nephropathy, code also N18.- for the documented stage.
- **Diabetic Retinopathy E11.319**
  - Be sure to state whether "proliferative" or "nonproliferative", severity (mild, moderate, severe) and with macular edema, if known.
- **Diabetic Neuropathy E11.40**
- If gastroparesis is documented as a peripheral autonomic neuropathy due to diabetes, assign code **E11.43,** Diabetes with peripheral autonomic neuropathy. Assign also code K31.84, Gastroparesis, if desired, to specify the actual neuropathic complication.[1]
  - Although "diabetes mellitus with diabetic gastroparesis" is listed as an inclusion term under the appropriate diabetes codes (E08.43, E09.43, E10.43, E11.43, and E13.43), the code titles are not specific for this condition. Therefore, it is appropriate to assign a secondary code to identify the manifestation as gastroparesis.[1]

*AHA Coding Clinic Q4 2013

OPTUM™

Documentation Considerations & EMR

MEAT Acronym for Effective Documentation



To determine whether a chronic medical condition can be coded, does the documentation:

- **M**onitor the condition
  - *Functioning colostomy*
    - **V44.3** (Z93.3)
- **E**valuate the condition
  - *ESRD, noncompliant with dialysis*
    - **585.6**, **V45.12** (N18.6, Z91.15)
- **A**ssess/Address the condition
  - *COPD stable on albuterol*
    - **496** (J44.9)
- **T**reat the condition
  - *Let's try OTC Advil for the LBP*
    - 724.2 (M54.5)

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 summaries[2]
- Documentation of all chronic conditions at least once per year[2]
- Documentation of any chronic condition that affects the care and treatment of the patient on that date of service[1]
- Conditions should be coded to the highest degree of specificity for that encounter/visit[1]

1 United States. Centers for Disease Control and Prevention. *ICD-9-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2011. Web. http://www.cdc.gov/nchs/data/icd/icd9cm_guidelines_2011.pdf

2 *CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.*

Documentation Requirements [1,2]

- In addition to documenting the diagnoses, it is best to document evidence of monitoring or evaluation or assessment or treatment.
- The medical record must thoroughly document all conditions evaluated.

  - Evaluative documentation would include:
    - **Status of diagnosis**
      - ***Condition worsening - document any treatment/referral***
      - ***Condition improving***
    - **Tests ordered - document which tests with identified risk factors**
    - **Tests reviewed - bring pertinent findings into progress note**

1 Centers for Medicare & Medicaid Services, (1995). 1995 documentation guidelines for evaluation & management services. Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

2 CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

Chart Mechanics & Documentation Considerations[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
  - Additional identifier recommended by the Joint Commission
- Reported diagnoses must be documented in the progress note
- 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 recommends 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

1 CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

2 The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 13 Dec 2012. <http://www.jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.

3 World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2011 1-107. Web. 15 Nov 2011. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

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 (e.g. MD, DPM, DO, PA-C, NP, etc.)
  - 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)

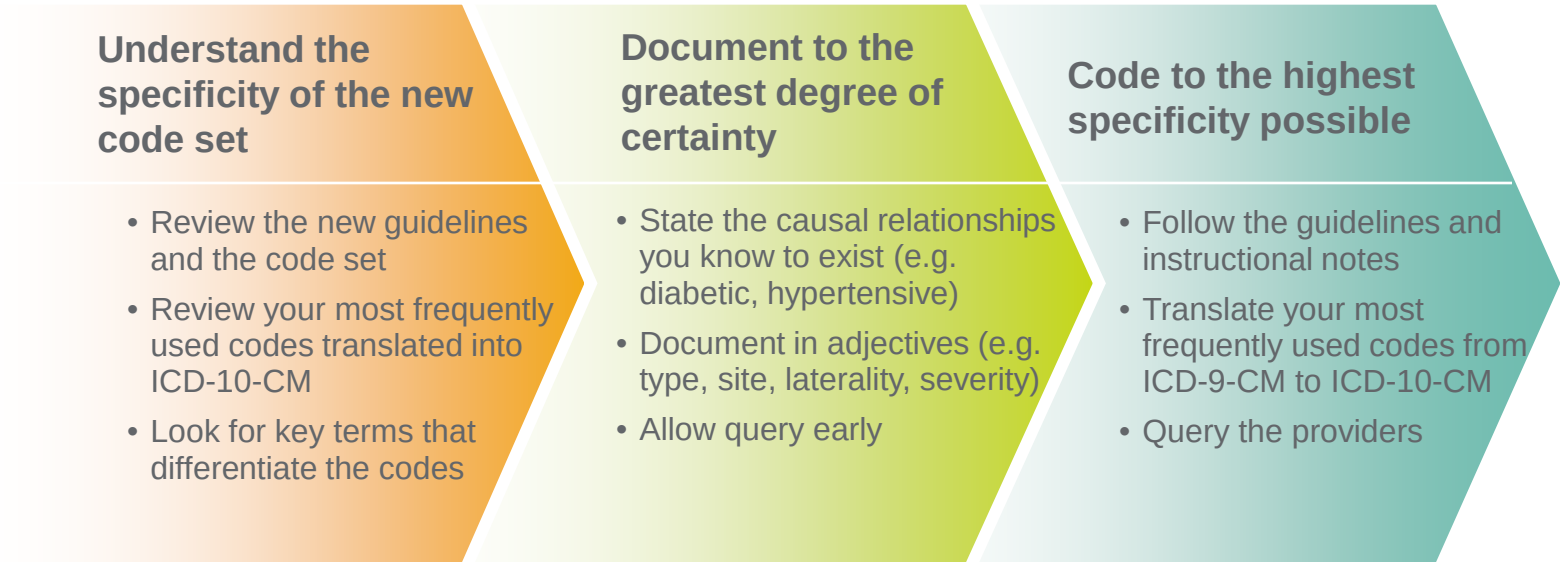
Disclaimer: This is not an all-inclusive listing of CMS requirements and is only a reminder of certain chart mechanics and documentation guidelines.

1 CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.
2 United States. Centers for Disease Control and Prevention. *ICD-9-CM Official Guidelines for Coding and Reporting*. Centers for Medicare and Medicaid Services and National Center for Health Statistics, 2011. Web. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Additional Steps in Making the Transition

A Three-Step Approach

- To ease the transition from ICD-9-CM to ICD-10-CM:



First Steps in Transition

- ICD-10-CM provides tremendous opportunities for disease tracking, but also creates enormous challenges.

- To ease the transition develop a solid foundation in understanding the coding conventions inherent in the ICD-10-CM text.

  – The ICD-10-CM Official Guidelines for Coding and Reporting are updated regularly and are posted on the National Center for Health Statistics (NCHS) website at: http://www.cdc.gov/nchs/data/icd/ICD10cmguidelines_2015%209_26_2014.pdf

- A critical step in easing the transition from ICD-9-CM to ICD-10-CM is clinical documentation improvement.

- Understanding the specificity of the new code set will encourage providers to:
  – document to the greatest degree of certainty based on their clinical judgment
  – document in adjectives (e.g., laterality, severity, episode of care, type of diabetes and complications)

Helpful Sites

Visit the **CMS ICD-10 website** for the latest news and resources to help you prepare.

- http://www.cms.gov/Medicare/Coding/ICD10)

- For practical transition tips:
  - Read recent ICD-10 email update messages:
    - http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html

    4
  - Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape
    - http://www.cms.gov/Medicare/Coding/ICD10
  - Utilize the CMS ICD-10 Implementation Guide
    - https://implementicd10.noblis.org
  - Start converting your highest volume ICD-9-CM codes to ICD-10-CM by utilizing the General Equivalency Mappings (GEMs) posted on the NCHS website http://www.cdc.gov/nchs/icd/icd10cm.htm

Available Resources from Optum

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

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- This guidance is to be used for easy reference; however, the ICD-9-CM and ICD-10-CM code books and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. 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. This tool supplies general information regarding HEDIS and Stars, but NCQA administers HEDIS and CMS administers the Stars measures and you should consult the NQCA and CMS websites for further information. Lastly, on April 6, 2015, CMS announced the CMS-HCC Risk Adjustment model for payment year 2016 driven by 2015 dates of service. For more information see: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf, http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf, and https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html
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Thank You for Your Participation!

We hope you have found this presentation informative and useful.

Any Questions?