Using ICD-10-CM Guidelines to Document and Code to the Highest Level of Specificity

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Areas of Focus for Risk Adjustment Coding

- **Coding and documenting to the highest level of specificity**
- **Follow instructional guidelines to ensure all codes are captured**
- **Communicate with physicians and providers when documentation does not support the verbiage found within the index and individual code descriptions**

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Documenting Active Monitoring and Treatment Annually

- **MEAT**
  - Monitor—signs, symptoms, disease progression, disease regression
  - Evaluate—test results, medication effectiveness, response to treatment
  - Assess/Address—ordering tests, discussion, review records, counseling
  - Treat—medications, therapies, other modalities

Remember we <u>cannot</u> look to the patient's past history to support risk adjusted codes for the new calendar year

Each year the documentation must support the condition is being actively monitored/treated by the physician or provider reporting the codes

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"With" Guideline

- **Know the guidelines to code to the highest level of specification**
- **Communicate with**

15. "With"

The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index **(either under a main term or subterm)**, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions in order to code them as related.

The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

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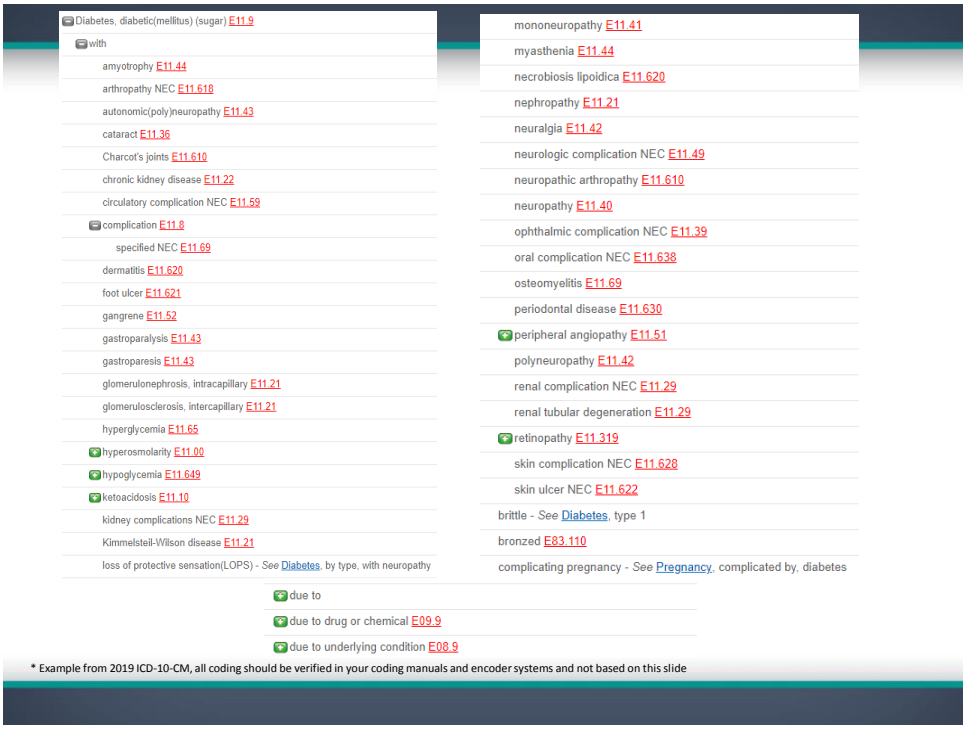

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Diabetes with Complications

- **Uncontrolled diabetes is no longer a part of the code descriptions for ICD-10-CM**
  - Documentation must specifically state hyperglycemia or hypoglycemia
- **Type 1, Type 2, or secondary diabetes should be specified within the note**
- **How a complication is affecting care of the patients diabetes**
  - Example: Wound care is treating the patient for their non-pressure skin ulcer but medication patient is on is affecting their insulin regimen
- **Complication of skin ulcer**
  - Anatomic location (including laterality if applicable)
  - Pressure vs. non-pressure ulcer
    - Pressure ulcer requires specification of stage
  - Layer exposed
    - Limited to breakdown of skin
    - Fat layer exposed
    - Necrosis of muscle
    - Necrosis of bone
- **Specify stage of renal failure for patient's with diabetes and chronic kidney disease**
- **Specify long term (current) use of insulin**
- **Diabetes without complication is not to be coded on the same DOS as a diabetic complication**
  - E11.9 for Type 2 diabetes mellitus without complications is not to be coded on the same date as E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease (or any other diabetic complication combination code)

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Example Diabetic Patient with Skin Ulcer

Assessment: 67 yo female type 2 diabetic currenting using insulin with a non-pressure ulcer of right calf with limited skin break down

E11.622

Type 2 diabetes mellitus with other skin ulcer

Use additional code to identify site of ulcer (L97.1-L97.9, L98.41-L98.49)

Parent Code Notes: E11

Excludes1: diabetes mellitus due to underlying condition (E08.-)
drug or chemical induced diabetes mellitus (E09.-)
gestational diabetes (O24.4-)
neonatal diabetes mellitus (P70.2)
postpancreatectomy diabetes mellitus (E13.-)
postprocedural diabetes mellitus (E13.-)
secondary diabetes mellitus NEC (E13.-)
type 1 diabetes mellitus (E10.-)
Includes: diabetes (mellitus) due to insulin secretory defect
diabetes NOS
insulin resistant diabetes (mellitus)

Use additional code to identify control using insulin (Z79.4)
oral antidiabetic drugs (Z79.84)
oral hypoglycemic drugs (Z79.84)

L97.211

Non-pressure chronic ulcer of right calf limited to breakdown of skin

Parent Code Notes: L97

Code first any associated underlying condition, such as:
any associated gangrene (I96)
atherosclerosis of the lower extremities (I70.23-, I70.24-, I70.33-, I70.34-, I70.43-, I70.44-, I70.53-, I70.54-, I70.63-, I70.64-, I70.73-, I70.74-)
chronic venous hypertension (I87.31-, I87.33-)
diabetic ulcers (E08.621, E08.622, E09.621, E09.622, E10.621, E10.622, E11.621, E11.622, E13.621, E13.622)
postphlebitic syndrome (I87.01-, I87.03-)
postthrombotic syndrome (I87.01-, I87.03-)
varicose ulcer (I83.0-, I83.2-)
Excludes2: pressure ulcer (pressure area) (L89.-)
skin infections (L00-L08)
specific infections classified to A00-B99
Includes: chronic ulcer of skin of lower limb NOS
non-healing ulcer of skin
non-infected sinus of skin
trophic ulcer NOS
tropical ulcer NOS
ulcer of skin of lower limb NOS

Z79.4

Long term (current) use of insulin

Parent Code Notes: Z79

Code also: any therapeutic drug level monitoring (Z51.81)
Excludes2: drug abuse and dependence (F11-F19)
drug use complicating pregnancy, childbirth, and the puerperium (O99.32-)
long term (current) use of oral antidiabetic drugs (Z79.84)
long term (current) use of oral hypoglycemic drugs (Z79.84)
Includes: long term (current) drug use for prophylactic purposes

ICD-10-CM Codes:
E11.622
Z79.4
L97.211

* Example from 2019 ICD-10-CM, all coding should be verified in your coding manuals and encoder systems and not based on this slide

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Hypertension Guidelines

a. Hypertension

The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term "with" in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For hypertension and conditions not specifically linked by relational terms such as "with," "associated with" or "due to" in the classification, provider documentation must link the conditions in order to code them as related.

1) Hypertension with Heart Disease

Hypertension with heart conditions classified to I50.- or **I51.4-I51.7, I51.89, I51.9**, are assigned to a code from category I11, Hypertensive heart disease. Use additional code**(s)** from category I50, Heart failure, to identify the type**(s)** of heart failure in those patients with heart failure.

The same heart conditions (I50.-, **I51.4-I51.7, I51.89, I51.9**) with hypertension are coded separately if the provider has

documented they are unrelated to the hypertension. Sequence according to the circumstances of the admission/encounter.

2) Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the **provider indicates the CKD is not related to the hypertension**.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

3) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, an additional code for acute renal failure is required.

* Example from 2019 ICD-10-CM, all coding should be verified in your coding manuals and encoder systems and not based on this slide

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Congestive Heart Failure

- **Type of congestive heart failure:**
  - Systolic (I50.2-)
  - Diastolic (I50.3-)
  - Both systolic and diastolic (I50.4-)
  - Unspecified (I50.9)
- **Acute, chronic or acute on chronic**
  - This will determine 0-3 for the 5th digit
- **Is congestive heart failure due to hypertension?**
  - Hypertensive heart disease (I11.0)
    - Use additional code to identify type of heart failure (I50.-)
- **Is congestive heart due to hypertension *and* chronic kidney disease?**
  - Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0)
    - Use additional code to identify stage of chronic kidney disease (N18.1- N18.4, N18.9)
  - Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease (I13.2)
    - Use additional code to identify stage of chronic kidney disease (N18.5, N18.6)

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Example Congestive Heart Failure with Hypertensive Chronic Kidney Disease

Assessment: 70 yo male with hypertensive heart disease in stage 4 chronic renal failure presents with acute systolic congestive heart failure

I50.21

Acute systolic (congestive) heart failure

Parent Code Notes: I50.2

Code also: end stage heart failure, if applicable (I50.84)

Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)

Parent Code Notes: I50

Code first heart failure complicating abortion or ectopic or molar pregnancy (O00-O07, O08.8)
heart failure due to hypertension (I11.0)
heart failure due to hypertension with chronic kidney disease (I13.-)
heart failure following surgery (I97.13-)
obstetric surgery and procedures (O75.4)
rheumatic heart failure (I09.81)

Excludes1: neonatal cardiac failure (P29.0)

Excludes2: cardiac arrest (I46.-)

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

Use additional code to identify type of heart failure (I50.-)

Use additional code to identify stage of chronic kidney disease (N18.1-N18.4, N18.9)

Parent Code Notes: I13

Includes: any condition in I11.- with any condition in I12.-
cardiorenal disease
cardiovascular renal disease

N18.4

Chronic kidney disease, stage 4 (severe)

Parent Code Notes: N18

Code first any associated:
diabetic chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22)
hypertensive chronic kidney disease (I12.-, I13.-)

Use additional code to identify kidney transplant status, if applicable, (Z94.0)

ICD-10-CM Codes:
I13.0
N18.4
I50.21

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Peripheral Arterial/Vascular Disease (PAD)(PVD)

- **PAD and PVD unspecified** (I73.9)
- **Arteriosclerosis of extremity** (I70.2- through I70.8)**:**
  - Laterality
  - Complication – ulcers, gangrene, intermittent claudication, rest pain (and intermittent claudication)
    - Complication of skin ulcer
      - Anatomic location (including laterality if applicable)
      - Pressure vs. non-pressure ulcer
        - Pressure ulcer requires specification of stage
      - Layer exposed
        - Limited to breakdown of skin
        - Fat layer exposed
        - Necrosis of muscle
        - Necrosis of bone
  - Specify if disease is of a native artery or a graft
- **For diabetic complication report the combination code** (E11.51, E11.52)
  - E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
  - E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene

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Obesity and BMI

- **Any BMI 40 or greater will risk adjust**
- **Z code for BMI of 40 requires documentation of diet and exercise to substantiate it if no other weight related diagnosis is present (i.e.: morbid obesity due to excess calories)**
  - Documentation should support the obesity diagnosis and show if it is currently being monitored and treated by the physician provider documenting the face-to-face encounter
- **BMI between 35-39.9 should link a comorbidity in order to risk adjust**

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Status Codes - Z Codes

- **Z code "Status" to note any current status required ANNUALLY (otherwise, in the case of an amputation, it 'grew back' according to CMS)**
- **Examples of Z code "statuses" include: transplants, amputations, asymptomatic HIV, artificial openings (current ostomies-tracheostomies, colostomies, etc.), dialysis, ventilators**

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Active Conditions vs. History of

- **Cancer**
  - Active – (C code) provider must note current adjuvant therapy* (medication or regimen)
    - If adjuvant therapy is being used it is of high importance that the provider note if this is active treatment versus prophylaxis against a cancer's return (active treatment warrants a code for the presence of a malignant neoplasm: prophylaxis warrants a code for history of malignant neoplasm)
  - History of (Z code) – assumed if cancer was removed (i.e.: mastectomy, prostatectomy, etc.) and the treatment has been completed or noted "followed/monitored by [SCP]"
  - Remission – disease specific codes
    - Example: C95.91 Leukemia, unspecified, in remission

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Mental Health

- **"Mood changes" is a symptom, not a diagnosis. Instead, document Unspecified Mood Disorder (F39) which will risk adjust**
- **Major Depressive Disorder Unspecified (F32.9) only risk adjusts at the pharmacy (Rx) HCC level and NOT at the medical HCC level (all other F32x do). To clearly document the highest specificity, the following is required:**
  - Single vs recurrent
  - Remission status vs active
  - Severity (mild, moderate, severe)
  - Presence of psychotic features

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Thank you!

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