INNOVATIVE Health Alliance of New York, LLC

St Peter's Health Partners
A Member of Trinity Health

Clinical Condition Documentation and Coding Guidebook

CCD Guidebook Table of Contents

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Medicare Risk Adjustment

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Population Health Quality, Performance & Risk Adjustment

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Medicare Risk Adjustment (MRA) is a methodology used by the Centers for Medicare and Medicaid Services (CMS) to pay Medicare Advantage Organizations (MAOs) more accurately for the projected healthcare expenditures of their members by adjusting reimbursement based on demographic information as well as the health status of those members. Using the CMS Hierarchical Condition Category (CMS-HCC) risk adjustment model, reimbursement to MAOs is higher for members with greater disease burden and lower for healthier members to more aptly align with projected costs of care.

The International Classification of Disease, Tenth Edition, Clinical Modification (ICD-10-CM) and Risk Adjustment

The CMS-HCC model uses certain ICD-10-CM diagnosis codes reported by providers to calculate risk adjusted reimbursement. Assigned codes not only reflect the member's diagnoses as evaluated and documented but also determine, along with demographic factors, their health status and risk of morbidity and mortality. For risk adjustment purposes, CMS will only accept ICD-10-CM diagnosis codes reported by approved provider specialty types and based on encounters in approved settings; such settings include face-to-face encounters in some inpatient and outpatient facilities. The CMS face-to-face requirement is met if the encounter occurs in-person or via telehealth (for example, real-time, simultaneous interactive audio and video telecommunications system).[1] Refer to the appendix for a complete listing of providers and facilities approved for submitting risk adjustment data.

ICD-10-CM: Impact on Documentation and Coding

ICD-10-CM classification brought about increased specificity in the coding system with a more logical structure and clinical accuracy. ICD-10-CM introduced to its code set the concepts of laterality and anatomical site and location. Documenting the episode of care such as initial, active care, subsequent episodes of care, and sequelae from injuries or disease is also an ICD-10-CM documentation and coding concept. The assignment of a diagnosis code is based on the provider's clinical expertise and diagnostic statement.

When a conclusive diagnosis has not been established by the end of the visit, it is appropriate to report codes for sign(s) and/or symptom(s) as a substitute for a definitive diagnosis. If the clinical information is insufficient, unknown, or unavailable when assigning a specific code for a disorder, it is acceptable to report the proper unspecified code. It is inappropriate to select a more specific code that is not supported by the medical record documentation.

Documentation Best Practices

To ensure that accurate and complete diagnosis data is being reported, it is important that provider documentation is thorough and specific. Coders can only assign a diagnosis code based on the information documented within the medical record. To code to the highest level of specificity, in compliance with ICD-10-CM guidelines, the documentation must be all of the following:

- Clear
- Concise
- Correct
- Complete
- Comprehensive

The ICD-10-CM guidelines state, *Code all documented conditions which coexist at the time of the visit that require or affect patient care or treatment.*[2] When documenting, providers should take the following into consideration:

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- Each encounter in the medical record should contain:
  - o Date of service on each page;
  - o Patient's complete name plus a second identifier, such as date of birth or medical record number;
  - o Provider's name, signature, credentials, and date signed;
  - o Handwriting that is legible (to someone else); and
  - o Only industry standard abbreviations.
- Each medical condition addressed during the encounter should include a statement indicating the impact to patient care, treatment, and/or management.
- At a minimum, include a brief statement that updates the status of each diagnosis.
- Medications may suggest the presence of a condition, but a diagnosis cannot be assumed based on medications.
  - o Make sure that for every medication prescribed, a diagnosis is listed and addressed in the medical record while specifying for which condition the medication is being prescribed.
- Document at least once a year: o Chronic conditions (such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus) that require ongoing treatment and monitoring
  - o Active status conditions (such as amputations and ostomies)
  - o Historic conditions that may no longer exist, yet have the potential for reoccurrence requiring continued monitoring
  - o All conditions that impact patient care, treatment, and/or management
- Be specific, for example:
  - o Include the recurrence and severity of major depression
  - o Include whether bronchitis is acute or chronic
  - o Specify the cardiac arrhythmia such as atrial fibrillation or atrial flutter
  - o When clinical criteria are present to support it, document *malnutrition* instead of *loss of weight*
  - o Use words to describe the status of conditions. For example,
    - ▪ Hypertensive heart disease is stable
- Use linking language to establish a causal relationship between two conditions. For example:
  - o Diabetic neuropathy, neuropathy *due to* diabetes mellitus (DM), or neuropathy caused by DM
- Use descriptive words and phrases to add specificity, such as acute, chronic, in remission, exacerbation, stable, or compensated
- Only use the words *history of* to describe conditions that no longer exist. Be mindful of the timing, especially of acute conditions, for example: o Document *history of myocardial infarction (MI)* instead of *MI* after 4 weeks post onset
  - o Document *history of malignant neoplasm* after all treatment is complete
  - o Document *history of transient ischemic attack (TIA)* or *history of cerebral infarction* and whether

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the patient has any residual deficits instead of *CVA* after the patient leaves the hospital and is seen in follow-up

• Do not use the words *history of* to describe active, chronic conditions. For example:
  o Document *chronic, stable COPD* instead of *history of COPD*
  o Document c*ontrolled type 2 diabetes mellitus* instead of *history of type 2 diabetes mellitus*

• Avoid entering conflicting information in the medical record. For example:
  o Documenting a final diagnosis of *hemiplegia* in the assessment with a physical exam finding of *5/5 strength in all four extremities*

Provider Signature Requirements in the Medical Record

All provider documentation, including progress notes, must be signed by the provider rendering the services. The provider must sign all progress notes with their name and credentials as part of their signature. Best practice is to also include the provider's printed name and credentials on any pre-printed note or stationery. Stamped signatures are not acceptable, effective April 28, 2008.

Electronic signatures are an acceptable form of medical record authentication so long as the system requires the provider to authenticate the signature at the end of each note. Examples of acceptable signatures include: Electronically signed, Authenticated by, Signed by, Validated by, Approved by, or Sealed by. The signed EMR record must be dated within 180 calendar days of the encounter and closed to all changes.[3]

1 The CMS face-to-face requirement is met if the encounter occurs (i) in-person between a patient and acceptable provider type or (ii) via telehealth (i.e., real-time, simultaneous interactive audio and video telecommunications system). April 10, 2020, CMS HPMS Memo; April 29, 2020, CMS Stakeholder Call; Jan. 15, 2021 CMS HPMS Memo
2 ICD-10-CM Official Guidelines for Coding and Reporting, Section IV.4.J Retrieved May 2021 from: **cdc.gov/nchs/icd/index.htm**
3 Contract-Level 15 Risk Adjustment Data Validation Medical Record Reviewer Guidance. In effect as of 01/10/2020, Version 2.0. Retrieved May 2021: **cms.gov/files/document/medical-record-reviewer-guidance-january-2020.pdf**

HCC Documentation

Documentation, coding and submission of each patient's diagnoses or Hierarchical Condition Category (HCCs) is required **at least once per calendar year**, restarting every January 1.

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Validating HCC coding:

- document the status of each condition being **treated**
  - acute or chronic (not "history of…")
- document the plan of action (**MEAT**)
  - **MEAT Quick Guide**
- code each diagnosis **consistent with and supported by** documentation
  - include site, laterality, stage, severity, and complications or manifestations

Tips to close the gaps to capture all HCCs:

- identify and outreach sickest patients or those with the most active chronic conditions
- ensure annual face-to-face encounters are completed for each patient
- pre-visit planning (ex. chart preparation, review problem list and highlight all HCCs)

Opportunities	Solutions	Examples
Definitive diagnosis is not clarified (ex. rule out, probable, consistent with, versus, suspect)	Document symptoms or await test results	"Chest pain consistent with angina" becomes **"unstable angina"**
Relationship is not established between diagnosis and common corresponding complication	Causal relationship is assumed unless documented otherwise; most instances can be linked without risk of assumption (ex. with, due to, caused by)	"Type 2 diabetes" and "peripheral vascular disease" becomes **"peripheral vascular disease due to type 2 diabetes"**
Diagnosis is unspecified	When descriptors are known (ex. laterality, severity, clinical status) specific documentation provides clarity	"Depression, unspecified" becomes **"major depressive disorder, mild, in partial remission"**
Diagnosis in history status is not linked to corresponding residual or sequelae	If causal relationship exists, link without risk of assumption	"History of stroke (CVA)" and "left hemiparesis" becomes **"left hemiparesis due to CVA"**
Symptoms are listed in place of a definitive diagnosis	Consider if criteria is met for a diagnosis	"Abnormal weight loss, underweight, loss of appetite" becomes **"protein-calorie malnutrition"**
Cancer status is not accurate	Active, history of, in remission must have distinct supporting documentation	*Active: monitored, undergoing/awaiting/refuses treatment, watchful waiting *History of: resolved, no evidence or residuals *In remission (partial or full): reduced signs and symptoms

MEAT

One of the most critical and basic requirements in coding a medical record is proper documentation of a condition to capture the most accurate diagnosis. Per ICD-10-CM guideline IV.J, in the outpatient setting, "code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or

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management. Do not code conditions that were previously treated and no longer exist". To establish the presence of a diagnosis during an encounter and ensure proper documentation, providers should validate each diagnosis using one or more of the MEAT components.

M

Monitor - Signs and symptoms, disease progression, ongoing surveillance of chronic condition.

Example:

"HTN stable, continue current dose of lisinopril"

"AFIB controlled on warfarin, followed by cardiology"

E

Evaluate - Current state of chronic condition, physical exam findings, test results, medication effectiveness, response to treatment.

Example:

"Recurrent major depressive disorder, now moderate. Persistent feelings of sadness despite increase in Zoloft"

"Diabetic peripheral neuropathy – decreased sensation of BLE by monofilament test"

A

Assess - Discussion of chronic condition, review of records, counseling, ordering further testing.

Example:

"Ultrasound reviewed, AAA remains stable"

"Stage II pressure ulcer on right buttock increased in size"

T

Treat - Care of chronic condition, prescribing medication, referral to specialist, therapeutic services.

Example:

"Blood sugars remain elevated, refer to endocrinology for DM II treatment"

"Morbid obesity with BMI of 45 – advised patient monitor calorie intake"

All HCC diagnoses must be documented and coded at least once per year.

Active vs. History

Scenario: My patient had a CVA

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- Unless you are treating the acute event in the ER or inpatient setting, use **Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (Z86.73)** even if you are seeing them in follow up immediately after the hospitalization
    - Even if they're anticoagulated for stroke prevention? **Yes**
- What if they're having residual effects?
    - Document and code the effects as a late/residual effect of CVA, for example **Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (I69.951)**
    - Document residual effects as long as they're present, there is no time limit

Scenario: My patient had an MI

- For the first 28 days after the acute event, code the active MI with site and type when known. After 4 weeks, use **Old myocardial infarction (I25.2)**
    - Even if they're getting aftercare, such as cardiac rehab? **Yes**

Scenario: My patient was just released after having [major medical issue] and I'm seeing them for a hospital follow-up

- If the issue was surgically resolved, use personal history of [major medical issue]
    - Even if there is still active wound care/suture removal? **Yes**
- If they are still having active treatment and the condition has not completely resolved, such as antibiotics for pneumonia, use active condition code. If the condition is resolved, use personal history code
    - If they had a DVT/PE that is resolved but still treated with anticoagulants, can I code the active condition? **No**

Scenario: My patient has a solid tumor cancer

- If they are currently receiving active treatment, such as radiation, chemotherapy, or *will* undergo active treatment, code active cancer
- If the cancer is no longer being actively treated, use personal history of [cancer type] code
    - Even if they're getting surveillance testing, such as PSAs or mammograms? **Yes**
    - Even if the oncologist uses phrases such as "no evidence of reoccurrence" or "no active disease" and still codes active cancer? **Yes**
- Do not code active cancer if:
    - Biopsy results are pending
    - Cancer is suspected but not confirmed

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Diabetes Mellitus

Diabetes should be documented with:

TYPE
Type 1, type 2, drug induced, other specified type

COMPLICATION
See chart attached for common complications

SEVERITY and LATERALITY of complication (when applicable)
Ulcers – specify severity and location
CKD- specify stage
Retinopathy – specify

- Laterality
- Severity (mild/moderate/severe)
- Proliferative/nonproliferative
- With/without macular edema

You should document and code as many diabetic codes as are relevant to the patient's situation.

Complications can easily be attributed to diabetes with linking words such as:

- Diabetic ("diabetic neuropathy")
- Due to ("neuropathy due to diabetes")
- Secondary ("neuropathy secondary to diabetes")
- With ("diabetes with neuropathy")

"Uncontrolled diabetes" is a common clinical term that does not correspond to a complication code. Please indicate hyper- or hypoglycemia. Diabetes with hyperglycemia can also be indicated with:

- poorly controlled
- inadequately controlled
- out of control

Method of control, such as insulin, non-insulin injectables, or oral hypoglycemics, should also be documented and coded.

Does your documentation have MEAT? (Monitor, Evaluate, Assess, Treat)

All HCC diagnoses must be documented and coded at least once per year.

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Common Diabetic Complications

(Type 2 diabetes codes used for reference)

Bolded complications are presumed to be linked to diabetes- when both are present, use combination code. If diabetes contributed in any way to the complication, use a combination code.

Diabetes with:	DX Code (Type 2):	Notes:
Amyotrophy	E11.44	
Arthropathy, Other	E11.618	
Autonomic (poly)neuropathy	E11.43	
Cataract	E11.36	
Circulatory Complications, Other	E11.59	Specify and code complication
CKD	E11.22	Specify and code CKD stage
Dermatitis	E11.620	
Foot Ulcer	E11.621	Specify and code stage, laterality
Gastroparesis	E11.43	
Hyperglycemia	E11.65	
Hypoglycemia, w/o Coma	E11.649	Specify and code level of hypoglycemia
Hypoglycemia, with Coma	E11.641	
Kidney Complication, Other	E11.29	Specify and code complication
Mononeuropathy	E11.41	
Nephropathy	E11.21	
Neurological Complication, Other	E11.49	Specify and code complication
Neuropathic Arthropathy (Charcôt's joints)	E11.610	
Neuropathy	E11.40	
Ophthalmic Complication, Other	E11.39	Specify and code complication
Oral Complications, Other	E11.638	Specify and code complication
Periodontal Disease	E11.630	
Peripheral Angiopathy (w/o gangrene)	E11.51	
Peripheral Angiopathy (with gangrene)	E11.52	
Polyneuropathy	E11.42	
Retinopathy	E11.3XX	
Skin Complications, Other	E11.628	Specify and code complication
Skin Ulcer, Other	E11.622	Specify and code complication
Specified Complication	E11.69	Specify and code complication

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Diabetic Complications	ICD-10-CM Code		Coding Guidelines & Documentation Best Practices
	Type 1	Type 2	
Kidney Complications			
Nephropathy, intercapillary glomerulosclerosis, intracapillary glomerulonephrosis, and/or Kimmelstiel-Wilson disease*	E10.21	E11021	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated
Chronic Kidney Disease*	E10.22	E11.22	ICD-10-CM Guideline: Use additional code to identify the stage of CKD, supported by documentation.
Renal Complication NEC+	E10.29	E11.29	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Renal Tubular Degeneration*	E10.29	E11.29	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated
Ophthalmic			
Retinopathy*	E10.31X-E10.35XX	E11.31X-E11.35XX	Use linking language such as "with, due to or associated with" in addition to the code for the complication
Cataract*	E10.36	E11.36	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Ophthalmologic complication NEC+	E10.39	E11.39	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Neurologic			
Neuropathy or Loss of Protective Sensation (LOPS)*	E10.40	E11.40	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Mononeuropathy*	E10.41	E11.41	
Polyneuropathy and/or neuralgia*	E10.42	E11.42	
Autonomic (poly)neuropathy and/or gastroparesis*	E10.43	E11.43	
Amyotrophy and/or Myasthenia*	E10.44	E11.44	
Neurologic Complication NEC+	E10.49	E11.49	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Circulatory			
Peripheral angiopathy (Peripheral Vascular Disease, or PVD)*	E10.51	E11.51	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Gangrene*	E10.52	E11.52	
Other Specified Complications			
Charcot's joints and/or neuropathic arthropathy*	E10.610	E11.610	ICD-10 CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Arthropathy NEC+	E10.618	E11.618	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Dermatitis (diabetic necrobiosis llopoidica)*	E10.620	E11.620	ICD-10 CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Foot Ulcer*	E10.621	E11.621	
Skin ulcer NEC+	E10.622	E11.622	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Skin Complication NEC+	E10.628	E11.628	
Periodontal Disease*	E10.630	E11.630	ICD-10-CM Guideline: Causal relationship presumed with diabetes unless documentation states unrelated.
Oral complication NEC+	E10.638	E11.638	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Hypoglycemia*	E10.64X	E11.64X	6th character required: E11.641 with coma, E11.649 without coma. 'Uncontrolled' is not an acceptable term. Use the term hypoglycemia for coding and billing purposes. Use additional code for hypoglycemia level, if applicable (E16.A1-E16.A3)
Hyperglycemia *	E10.65	E11.65	"Uncontrolled" is not an acceptable term. Use the term hyperglycemia for coding and billing purposes.
Other specified complications	E10.69	E11.69	Use linking language such as "with, due to or associated with" in addition to the code for the complication.
Diabetes Mellitus **without** Complications	E10.9	E11.9	Use when no other complications of diabetes exist.

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* Causal relationship with diabetes is presumed unless provider specifies condition is unrelated.
+ Not Elsewhere Classifiable.
Additional Types of Diabetes:
E08- Secondary Diabetes, E09- Secondary Diabetes due to drugs or chemicals, E13- Other specified

General Documentation Best Practices:

- ✓ Create a clear relationship between the condition and any manifestation. Use linking verbiage such as "with, due to or associated with."
- ✓ Do not use questionable language such as "possible, suspect or likely" for outpatient coding and reporting purposes.
- ✓ Document all conditions to the highest known specificity. Use ICD-10-CM codes that correspond to documentation.
- ✓ All conditions that affect the patient's care on the date of service should be documented and addressed in the medical record.
- ✓ All known chronic conditions should be addressed at least once per calendar year.
- ✓ Use M.E.A.T for documentation in order to ensure the condition is supported in the medical record.
  - Monitor – disease progression, signs, and symptoms
  - Evaluate – lab results, response to treatment, review, or refill medication.
  - Assess/Address – review medical records, counsel with patient.
  - Treat – prescribe medication, therapy, referrals.
- ✓ All records should be signed by the healthcare provider with their credentials. Date of service and patient identifiers should be included on every page of the encounter note.

Sources

Optum ICD-10-CM Expert for Physicians 2024: The complete official code set (October 1, 2023 – September 30, 2024)
Poe Bernard, S. (2020) Risk Adjustment Documentation and Coding, Second Edition

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Status Codes

Status codes, such as transplants, ostomies, and amputations are codes that influence a patient's health but are not an acute illness or injury**. It is important to document and code these at least once per calendar year**, since the HCC diagnoses are "wiped clean" every year on January 1st.

Transplants:

Dx Code	Description
Z94.0	Kidney transplant status
Z94.1	Heart transplant status
Z94.2	Lung transplant status
Z94.3	Heart and lungs transplant status
Z94.4	Liver transplant status
Z94.81	Bone marrow transplant status
Z94.82	Intestine transplant status
Z94.83	Pancreas transplant status
Z94.84	Stem cells transplant status
Z95.811	Presence of heart assist device
D84.821	Immunodeficiency due to drugs

Ostomies:

Dx Code	Description
Z93.0	Tracheostomy status
Z93.1	Gastrostomy status
Z93.2	Ileostomy status
Z93.3	Colostomy status
Z93.4	Other artificial openings of gastrointestinal tract status
Z93.50	Unspecified cystostomy status
Z93.51	Cutaneous-vesicostomy status
Z93.52	Appendico-vesicostomy status
Z93.59	Other cystostomy status
Z93.6	Other artificial openings of urinary tract status
Z93.8	Other artificial opening status

Amputations:

Please select code based on laterality - right sided codes shown below for example

Dx Code	Description
Z89.411	Acquired absence of right great toe
Z89.421	Acquired absence of other right toe(s)
Z89.431	Acquired absence of right foot
Z89.441	Acquired absence of right ankle
Z89.511	Acquired absence of right leg below knee
Z89.611	Acquired absence of right leg above knee
G54.6	Phantom limb syndrome with pain
G54.7	Phantom limb syndrome without pain

HIV/AIDS:

DX Code	Description
B20	Human immunodeficiency virus [HIV] disease
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status

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Malnutrition and Morbid Obesity

Morbid Obesity:

BMI should be measured on a yearly basis and during/after acute exacerbations of chronic illness.

BMI can be documented by a clinician other than a provider (such as an MA or LPN) but diagnosis, such as morbid obesity, must be made by a provider.

If a patient has a BMI ≥ 35 in addition to one or more co-morbid conditions that can be linked to obesity, such as high blood pressure or diabetes, the patient is considered to have morbid obesity. Patients with morbid obesity should be screened for complications that commonly occur with this illness.

Documentation of BMI alone cannot be used to code or assume morbid obesity; a provider must document the medical condition of "morbid obesity" or "severe obesity" in the patient's medical record for it be coded as such.

Diagnosis	Dx Code
Morbid (severe) obesity due to excess calories	**E66.01 + BMI code**
Morbid (severe) obesity with alveolar hypoventilation	**E66.2 + BMI code**
Drug-induced obesity	E66.1
Overweight	E66.3
Obesity, class 1	E66.811
Obesity, class 2	E66.812
Obesity, class 3	**E66.813**
40.0-44.9 Body mass index [BMI], adult	**Z68.41**
45.0-49.9 Body mass index [BMI], adult	**Z68.42**
50.0-59.9 Body mass index [BMI], adult	**Z68.43**
60.0-69.9 Body mass index [BMI], adult	**Z68.44**
70 or greater Body mass index [BMI], adult	**Z68.45**

Malnutrition:

Diagnosis	Dx Code	Diagnosis	Dx Code
Unspecified severe protein-calorie malnutrition	E43	Unspecified protein-calorie malnutrition	E46
Moderate protein-calorie malnutrition	E44.0	Sequelae of protein-calorie malnutrition	E64.0
Mild protein-calorie malnutrition	E44.1	Cachexia	R64

If you describe your patient as cachectic, consider including "cachexia" as a diagnosis in your assessment and plan.

Malnutrition codes cannot be coded from an RD consult, only when confirmed and diagnosed in a face-to-face encounter with a qualified provider.

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Cancer

Solid tumor cancer should be coded only when it is considered active. Cancer is considered active when:

- Current chemotherapy, radiation, or anti-neoplasm drug therapy (also adjuvant therapy such as Arimidex)
- Current pathology revealing cancer
- Newly diagnosed patient awaiting treatment
- Refusal of therapeutic treatment by patient or watchful waiting
- The cancerous organ has been removed or partially removed, and the patient is still receiving ongoing treatment

Clearly document the following information:

- Type of cancer
- Malignant primary and secondary metastases
    - Include laterality when applicable
- Status of cancer (active or historical)
    - Avoid using "history of" statement if the patient is currently receiving active treatment
    - Cancer that has been fully eradicated and is no longer getting active treatment can be assessed with a "Personal History of" code
- Current treatment

There are some benign neoplasms that risk adjust – those of meninges, brain, CNS, and endocrine glands.

Leukemias, lymphomas, and myelomas have HCC value even when in remission. Indicate:

- Not having achieved remission
- In remission
- In relapse

Other status codes that may be applicable: (document and code)

- Stem cell transplant status
- Ostomy status
- Immunodeficiency due to drugs

All HCC diagnoses must be documented and coded at least once per year

Does your documentation have MEAT? (Monitor, Evaluate, Assess, Treat)

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CVA and Other Neurological Disorders

Cerebral vascular accident (CVA), or stroke, documentation and coding includes

- **neurological deficits during the acute episode are symptoms (ex. facial weakness)**
- **history of CVA with(out) residuals becomes the status once discharged from acute episode**
    - residuals are sequelas and can occur at any time after initial onset

Residuals of CVA documentation and coding includes:

- **deficit (ex. hemiplegia, hemiparesis, monoplegia)**
- **mechanism of injury (hemorrhage or infarct)**
- **laterality**
    - right side is considered dominant for these residuals, unless otherwise documented

Neurologic deficits from other conditions include:

- quadriplegia
- paraplegia
- hemiplegia
- monoplegia

Neurodegenerative conditions include:

- Huntington's Disease
- Parkinson's Disease
- Alzheimer's Disease
- Dementia with Lewy Bodies
- Multiple Sclerosis
- Epilepsy (type, intractable/not intractable, with/without status)

Neuropathy should always be documented and coded with linkage to the underlying condition, if known.

Coding examples

Hemiplegia, right due to nontraumatic intracerebral hemorrhage	I69.151
Hemiparesis, left due to CVA	I69.354
Monoplegia, right upper limb	G83.21
Alzheimer's Dementia with Behavioral Issues	G30.9 and F02.81
Parkinson's Disease	G20
Epilepsy, not intractable, without status	G40.909
Polyneuropathy with Diabetes, Type 2	E11.42

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Peripheral Vascular Disease

Early diagnosis of peripheral vascular disease can be determined based on clinical findings. Signs and symptoms related to peripheral vascular disease that **should be documented if any are present** include:

- alopecia on legs
- claudication
- diminished pulses in legs
- ulceration and sores with poor healing on legs

For documentation and coding purposes, peripheral vascular disease (PVD) is synonymous with:

- peripheral artery disease (PAD)
- spasm of artery
- intermittent claudication

Atherosclerosis of the extremities **should be documented and coded** based on:

- cause
- site
- laterality
- status of artery (ex. native or bypass graft)
- complications or manifestations

Per coding guidelines, there is a causal relationship between diabetes and peripheral vascular disease unless they are documented as unrelated. **If diabetes contributes to PVD, then they should be linked.**

Other types of vascular disease include:

- pulmonary embolism
- deep vein thrombosis

Only the most complex level of PVD should be coded when more than one level is documented on an encounter.

Levels of PVD, from highest to lowest, include:

- atherosclerosis of extremities with ulceration or gangrene
- vascular disease **with** complications (diabetes with PVD and gangrene, pulmonary embolism)
- vascular disease **without** complications (diabetes with PVD, deep vein thrombosis)

Coding examples

Diabetes type 2 with peripheral angiopathy and gangrene	E11.52
Pulmonary embolism and deep vein thrombosis	I74.4
Diabetes type 1 with peripheral vascular disease	E10.51

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Major Depressive Disorder (Mild, Moderate, or Severe) Documentation

Per CMS, the criteria for a major depressive episode includes five or more of the DSM (Diagnostic and Statistical Manual of Mental Disorders) symptoms present during the same two-week period. They represent a change from previous functioning, with at least one of the symptoms being either "depressed mood" or "loss of interest or pleasure." **Do not document as "depression (unspecified)."**

These daily symptoms include:

- depressed mood
- loss of interest or pleasure
- significant weight loss/gain or decreased/increased appetite
- insomnia or hypersomnia
- psychomotor agitation or retardation
- fatigue or loss of energy
- feelings of worthlessness or guilt
- diminished concentration
- recurrent thoughts of suicidal ideations or death

Documentation of major depressive disorder requires the following:

- **episode:** single or recurrent
- **severity**: mild, moderate, or severe with/without psychotic features
    - PHQ-9 results may be used to determine severity
- **clinical status of current episode** (when applicable): partial or full remission

Single episode:

- may last days, weeks, months, or longer
- chronic – duration of at least two years in an adult

Recurrent episode:

- interval of at least two consecutive months between separate episodes
    - criteria is not met for a major depressive episode during this interval

Severity:

- Screening tests, such as the Patient Health Questionnaire-9 (PHQ-9), do not diagnose depression but rather indicate severity of symptoms within a given period.

Clinical status

- patient may or may not be currently treated for depression (counseling and/or medication)
- defined as a level of depressive symptoms basically indistinguishable from that of someone who has never been depressed.
    - this low level of signs and symptoms traditionally used as a guide to measure remission

Sources:

NCA - Screening for Depression in Adults (CAG-00425N) - Decision Memo (cms.gov)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470645/

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Substance Use

Mental and behavioral disorders due to psychoactive substance use

Many substance abuse and dependence codes risk adjust, and proper documentation is important to make sure a code can be supported in the event of an audit. When documenting drug related disorders, please consider the following:

- Is it use, abuse or dependence?
- Code to the highest severity - Use < Abuse < Dependence
- Name the drug being used
- Any associated complications?
- Type of use, current remission, history of withdrawal or with current withdrawal
- Substance induced mood/psychotic symptoms - depression, hallucinations, anxiety, etc.
- Current presentation - intoxication, drunkenness, withdrawal

Drug	Code Prefix
Alcohol	F10.XX
Opioids	F11.XX
Cannabis	F12.XX
Sedative, hypnotic, or anxiolytic	F13.XX
Cocaine	F14.XX
Other stimulants	F15.XX
Hallucinogen	F16.XX
Inhalant	F18.XX
Other Psychoactive Substance	F19.XX

Does your documentation have MEAT? (Monitor, Evaluate, Assess, Treat)

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Psychiatric Disorders

Coding **major depressive disorders** accurately requires documentation of the following:

- If it is a **single** or **recurrent** episode (this is required)
- **Severity** (mild, moderate, severe with psychotic features, or severe without psychotic features) (severity can be specified from PHQ-9)
- If it is in **partial or full remission** (if applicable)

If the documentation does not meet the specificity as noted, it can only support the code for depression (F32.A) or major depression (F32.9) – these codes do not risk adjust and should not be used when a more specified code can be supported.

For example:

"Patient is mildly depressed" – F32.A **(no HCC)**

"Recurrent major depression, moderate per PHQ9" – F33.1 **(HCC)**

"Severe major depressive episode" – F32.2 **(HCC)**

When documenting **bipolar disorder**, the following should be indicated:

- **Current episode** (manic, depressed, mixed)
- **Severity** (mild, moderate, severe with psychotic features, or severe without psychotic features)
- If it is in full or partial remission (most recent episode should also be documented)

Dx Code	Diagnosis
F32.-	Single Episode, Major Depressive Disorder
F33.-	Recurrent Episode, Major Depressive Disorder
F20.-	Schizophrenia
F25.-	Schizoaffective Disorder
F31.-	Bipolar Disorder

Utilizing above chart:

First three characters indicate category of diagnosis, utilize characters after period to indicate severity and remission status.

A patient can be considered in remission if they have had depressive episodes in the past but have been free of depressive symptoms for several months.

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All HCC diagnoses must be documented and coded at least once per year.

Chronic Kidney Disease

A screening for chronic kidney disease (CKD) should be performed annually. Early detection reduces the risk of disease progression.

A causal relationship, unless documented otherwise, is assumed between chronic kidney disease and diabetes and/or hypertension. These conditions must be documented and coded when both exist.

CKD stages must be documented by a provider and cannot be coded based on lab values alone.

Stages of CKD of all types

Stage	Qualitative Description	GFR (mL/min/1.73 m²)
1	Kidney damage – normal GFR	> 90*
2	Kidney damage – mild ↓ GFR	60-89*
3a	Moderate ↓ GFR	45-59
3b	Moderate ↓ GFR	30-44
4	Severe ↓ GFR	15-29
5	End-stage renal disease	<15

*A GFR >60 mL/min/1.73 m² in isolation is not CKD, unless other evidence of kidney damage is present

CKD, chronic kidney disease; *GFR*, glomerular filtration rate

Acute kidney injury (AKI), as well as the underlying condition, must be documented and coded.

Coding examples

CKD with diabetes type 1	N18.- and E10.22
CKD with diabetes type 2	N18.- and E11.22
Hypertension with CKD	I12.0- and N18.-
Hypertensive heart with CKD	I13.0- and N18.-
Kidney transplant status with ESRD	Z94.0 and N18.6
Renal dialysis with ESRD	Z99.2 and N18.6
AKI due to dehydration	N17.9 and E86.0

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Congestive Heart Failure and Other Cardiac Conditions

Congestive heart failure (CHF) is documented and coded based on:

- **type**: diastolic, systolic, combined diastolic and systolic, rheumatic, or left ventricular
- **acuity**: acute, chronic, acute on chronic diastolic/systolic/combined diastolic and systolic
- **cause**: ex. hypertension, kidney disease (also code documented underlying cause)
- **laterality**: left- or right-sided

A causal relationship is assumed between CHF, CKD, and hypertension. **When present together, these conditions must be documented and coded** (documented diabetes must also be coded with CKD).

Myocardial infarction (MI) is documented and coded based on:

- **Site**
- **Type: 1 (STEMI, NSTEMI), 2 (due to embolisms), 3 (causes death), 4A (due to angioplasty), 4 (due to stent thrombosis), 5 (due to bypass graft)**
- **Chronology of an acute MI**

Angina pectoris is documented and coded based on type:

- **Stable: Typical**
- **Unstable: Crescendo**
- **Variant: Prinzmetal's**

Cardiomyopathy is documented and coded based on:

- **Type:** dilated, (non)obstructive hypertrophic, alcoholic, drug-related, etc.
- **Location :** endocarditis, right ventricle, etc.
- **Cause :** ex. congenital, alcohol, gout ; also code when documented

Pulmonary hypertension is documented and coded based on:

- **Type:** 5 Groups
- **Underlying cause for secondary pulmonary hypertension:** ex. hyperthyroidism, sarcoidosis
    - also, code documented underlying cause

Coding examples

Congestive heart failure, diastolic and systolic	I50.4-
Hypertensive heart with CKD 4 and chronic diastolic CHF	I13.0 and N18.4 and I50.32
Myocardial infarction, type 2	I21.A
Coronary artery disease with other angina	I25.118
Alcoholic cardiomyopathy	I42.6 and F10.-
Secondary pulmonary hypertension due to hyperthyroidism	I27.29 and E05.-

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COPD and Other Respiratory Conditions

Chronic obstructive pulmonary disease, or COPD, should be documented and coded based on:

- **Type**
- **With(Out) Exacerbation**
- **Coexisting Conditions** (Ex. Asthma, Bronchitis, Pneumonia, Emphysema)
- **Complications:** ex. lower respiratory infection, asthma
    - **also document and code complication**
    - only code type of asthma, if documented

Asthma should be documented and coded based on:

- **Severity**: Mild, Moderate, Severe
- **Type**: Intermittent Or Persistent (Examples)
- **With(Out) Exacerbation**

Respiratory failure should be documented and coded based on:

- **Acuity**
- **With(out) hypoxia and/or hypercapnia**

Coding examples

Asthma, mild persistent	J45.30
Bronchitis, chronic	J42
COPD with acute bronchitis or pneumonia	J44.0 and J20.9
COPD with acute exacerbation	J44.9
COPD with asthma, mild persistent	J44.9 and J45.30
COPD with chronic bronchitis	J44.9
COPD with emphysema	J43.-
COPD with emphysema and bronchitis	J44.9
Smoker's cough (do not code with COPD)	J41.0
Acute respiratory failure with hypercapnia	J96.02
Chronic respiratory failure with hypoxia	J96.11

The most effective way to document is MEAT. This acronym can be broken down as follows:

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

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Infectious Disease

Infectious disease documentation and coding should include:

- **acuity**
- **supporting lab values (documentation only)**
- **site**
- **laterality**
- **underlying conditions**
- **manifestations**

Human immunodeficiency virus (HIV) documentation and coding should include:

- **coding only relates to confirmed documented cases**
- **once a HIV-related illness exists, every subsequent encounter is coded as B20**

Sepsis documentation and coding should include:

- **date of onset**
- **type**
- **infectious agent**
- **urosepsis (generic term) cannot ever be coded**

Methicillin-resistant Staphylococcus aureus (MRSA) documentation and coding should include:

- **type**
- **MRSA documented as causal agent**
- **carrier status (ex. "MRSA screen positive" or "MRSA nasal swab positive")**
- **resistance to penicillin (Z16.11) is never coded with MRSA**

Influenza documentation and coding should include:

- **infectious agent**
- **manifestations (ex. pneumonia)**
- **associated conditions (ex. pleural effusion)**

Coding examples

HIV with pneumocystis carinii pneumonia	B20 and B59
Severe sepsis with acute respiratory failure	A41.9, R65.20, and J96.00
Septic shock (also code acute organ dysfunction)	R65.21
Sepsis due to MRSA	A41.02
Pneumonia due to MRSA	J15.212
MRSA carrier status	Z22.322
Influenza with staphylococcus pneumonia	J11.08 and J15.3

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Rheumatologic Diseases

When documenting **Rheumatoid Arthritis**, please note if patient is seropositive or seronegative. Also, document affected joint(s) and laterality.

When applicable, document and code **D84.821 – Immunodeficiency due to Drugs**

Lupus alone doesn't index to a diagnosis code- **type of Lupus** must be specified.

Diagnosis	**DX Code**
Drug Induced Systemic Lupus Erythematosus	M32.0
Systemic Lupus Erythematosus with Organ or System Involvement (specify)	M32.1-
Systemic Lupus Erythematosus Unspecified	M32.9
Discoid Lupus Erythematosus	L93.0
Lupus Anticoagulant Syndrome	D68.62

As of October 1, 2021, Sicca Syndrome codes have been updated to **Sjögren's Syndrome** as well as the addition of additional codes to identify complications.

Diagnosis	**DX Code**
Sjögren's Syndrome, Unspecified	M35.00
Sjögren's Syndrome with Keratoconjunctivitis.	M35.01
Sjögren's Syndrome with Lung Involvement	M35.02
Sjögren's Syndrome with Myelopathy	M35.03
Sjögren's Syndrome with Tubulo-Interstitial Nephropathy	M35.04
Sjögren's Syndrome with Inflammatory Arthritis	M35.05
Sjögren's Syndrome with Peripheral Nervous System Involvement	M35.06
Sjögren's Syndrome with Central Nervous System Involvement	M35.07
Sjögren's Syndrome with Gastrointestinal Involvement	M35.08
Sjögren's Syndrome with Other Organ Involvement	M35.09
Sjögren's Syndrome with Glomerular Disease	M35.0A
Sjögren's Syndrome with Vasculitis	M35.0B
Sjögren's Syndrome with Dental Involvement	M35.0C

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Ulcers

Ulcers are associated with HCC coding, while wounds are not. Please note that the two conditions are not synonymous. **Wounds are due to trauma or surgery**, while **ulcers are caused by skin breakdown from pressure or other chronic conditions.**

When known, it is important to **document and code the condition that is causing the ulcer, such as PVD or diabetes**.

Pressure/Decubitus Ulcers

Be sure to document:

Location/Laterality – What part of the body is affected
Stage –

- Stage I – Pre-ulcer skin changes limited to persistent focal erythema
- Stage II – Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
- Stage III – Pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue
- Stage IV – Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
- Unstageable – ulcer covered by eschar or that has been treated with skin or other graft

A provider must establish a pressure ulcer diagnosis; however, a nurse or other clinician can document a pressure ulcer stage. When pressure ulcers are associated with gangrene or gangrenous cellulitis, code I96 for gangrene should be reported first.

Diabetic Ulcers

Code diabetes first (diabetes with foot ulcer or diabetes with other skin ulcer), code ulcer second.

Be sure to document:

Location/Laterality- What part of the body is affected
Stage –

- Limited to breakdown of skin
- Fat layer exposed
- Necrosis of muscle
- Necrosis of bone
- Muscle involvement without evidence of necrosis
- Bone involvement without evidence of necrosis

Other Ulcers

Statis Ulcer (with Varicose Veins) - Indicate location/laterality and whether inflammation is present.

Arterial Ulcer (Atherosclerosis) – Indicate location/laterality

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Combination Codes

A combination code is a single code used to classify:

- Two diagnoses
- A diagnosis with an associated secondary process (manifestation)
- A diagnosis with an associated complication

1. Most **diabetic complication** codes capture conditions that are **presumed to be associated** with diabetes- if both conditions are present, it is best practice to link them and use a combination code. If diabetes contributed in any way to a complication, a combination code should be used to best capture patient's health burden. Some common diabetes combination codes include (but are not limited to):
   - Diabetes with CKD (also code CKD stage and dialysis status if applicable)
   - Diabetes with foot ulcer (also code ulcer location and severity)
   - Diabetes with polyneuropathy
   - Diabetes with PVD

2. **Arteriosclerosis of the extremities** often presents with complications that also have combination codes, such as:
   - Intermittent claudication
   - Ulceration (code to location)
   - Rest pain
   - Gangrene

3. **Drug or substance dependence** will often have combination codes to indicate complications. If the substance has contributed in any way to the complication, use a combination code such as associated:
   - Dependence
   - Mood or anxiety disorder
   - Psychosis

4. **Hypertension** is assumed to be linked to both CKD and congestive heart failure. When patient has one or both, utilize appropriate combination code.

5. **Coronary Artery Disease (CAD)** is presumed to be connected to angina when both are present. Indicate the following and select appropriate code:
   - Artery affected (native, bypass graft, transplanted heart)
   - Type of angina (unstable, with spasm)

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