Documentation for risk adjustment quick reference guide

Priority Health™

The information presented in this document complies with accepted coding practices and guidelines as defined in the ICD-10-CM coding book. It is the responsibility of the health care provider to produce accurate and complete documentation and clinical rationale, which describes the encounter with the patient and the medical services rendered, to properly support the use of the most appropriate ICD-10-CM codes according to the official coding guidelines.

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What is risk adjustment?

Risk adjustment is a methodology used to account for known health data elements to level-set comparisons of wellness among members. The risk adjustment process occurs annually and requires capturing each member's full burden of illness.

Risk adjustment drives both Centers for Medicare and Medicaid Services (CMS) Medicare capitation payment and the Patient Protection and Affordable Care Act (PPACA) product premium retention. For Medicare, diagnoses map to Hierarchical Condition Categories (HCCs) and are generally cumulative, resulting in higher capitation payments from CMS. For PPACA, diagnoses map to HCCs, but are not tied to predictable dollar amounts; rather they are used in a points system by which all plans in the state are evaluated at the end of every year. We are engaged in developing strategies that account for the unique timelines and fiscal impacts of each risk adjustment methodology.

Medicaid members are also risk adjusted and the health plan's risk score is determined by a historical cohort of members. This is then applied to a future population of enrollees within the same risk score levels. As with all risk adjustment models, data completeness and quality are the biggest implementation challenges. Provider education around clinical documentation is key.

Benefits of risk adjustment

We utilize risk adjustment strategies to cover the cost of care and keep premiums low for our members, while ensuring we meet CMS expectations for risk adjusted plans.

CMS has established aggressive goals and expectations for Medicare Advantage health plans to "improve patient care through the identification of certain risk actors, personalized health advice, and referral to additional preventative services and life style interventions."

The single most critical factor for meeting CMS' expectations is to have a complete and accurate annual assessment of each member's health status as the basis for driving optimal care and treatment.

We've identified the following risk adjustment strategies to provide the care our members need at the right cost, while meeting these expectations:

- Maintain a complete and accurate health record for our members
- Identify and engage members who may not be properly managing their chronic conditions
- Guide population health strategies
- Share our savings with providers in the form of gain/risk-sharing arrangements
- Increase Comprehensive Primary Care Plus (CPC+) program reimbursement for participating providers
- Increase Provider Incentive Program (PIP) incentive reimbursement for participating providers on specific measures

Documentation guidelines

The key to a successful relationship is dependent on our providers supplying timely and accurate documentation so we can receive proper reimbursement for risk adjusted products. This gives us the ability to provide improved benefits to our members.

Members with chronic medical conditions require additional services beyond preventive care. Correct documentation is crucial in order to obtain appropriate reimbursement to cover these additional services. This also gives us the ability to provide improved benefits to our members.

Problems assessed during a patient encounter must have supportive documentation in the Progress Note. Progress Notes found in electronic medical records typically contain the following components (order may vary by institutions):

Assessment = Problems addressed during the encounter (decision-making complexity, including concerns with outcomes, morbidity or mortality, can either be included in this section or incorporated in other sections of the note)

CC = Chief Complaint - concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter

HPI = History of Present Illness - chronological description of the development of the patient's present illness (may include one or all of the following depending on the complexity: location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms). Brief and Extended HPI’s are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems:

- Brief consists of 1 to 3 elements
- Extended consists of 4 or more elements

PE = Physical Exam

PFSH = Past, Family, and/or Social History

Plan = Orders (medications, diagnostics, patient education, DMEs, etc.)

ROS = Review of Systems - signs and/or symptoms the patient may be experiencing per body system

REMEMBER, IF IT IS NOT DOCUMENTED – IT DIDN'T HAPPEN.

The overarching goal for risk adjustment is to code all documented diagnoses to the highest level of specificity. Every diagnosis reported as an active, chronic condition must be documented with an assessment and plan of care, reflecting the **MEAT** or **TAMPER** concept. Properly utilizing **MEAT** ensures coders pick the correct evaluation and management level for each date of service (DOS).

> **MEAT** is an acronym used to describe four factors that help providers establish the presence of a diagnosis during an encounter in proper documentation.
>
> **M**anaged or monitoring
> **E**valuated
> **A**ssessed
> **T**reated

Diagnoses can be reported from any portion of the medical record provided they are accurately documented as current. A simple list of diagnoses is not acceptable or valid per official CMS coding guidelines, nor does a simple list meet the definition of assessment and plan.

A current problem list is important so other providers can know the medical condition of the patient. Providers should be cautious of copying and pasting problem lists from previous encounters, to ensure all conditions are current. Problem lists also serve as a reminder to address each chronic condition at least once a year.

The **TAMPER** approach involves reviewing the chart for admissible evidence and knitting it together to tell the comprehensive and accurate story for ongoing and future care of a patient. Diagnoses and **TAMPER** can be found within the DOS.

TAMPER is an acronym that means:

Treatment	Surgery, therapy, procedure, counseling, education, DME ordered/given, lab(s) ordered
Assessment	Acknowledging/giving status/level of condition
Monitoring/Medicate	Ordering/referencing labs/other tests/prescribing medication
Plan	Plan for management or follow-up of condition
Evaluate	Examining (as in physical exam)
Referral	Referral to specialists for treatment or consultation of a confirmed condition

***TAMPER** does not rely on billing regulations, but comes from an HCC coding perspective that refers to the CMS guidance for valid risk adjustment coding.*

Purpose of practitioner signature

We require the individual who ordered and/or provided services be clearly identified in the medical records.

Acceptable digitized/electronic signatures:

- The responsibility for and authorship of the digitized or electronic signature should be clearly defined in the record.
- A digitized signature is an electronic image of an individual's handwritten signature. It is typically generated by encrypted software that allows for sole usage by the practitioner.
- An electronic or digitized signature requires a minimum of a date stamp (preferably includes both date and time notation) along with a printed statement such as, "Electronically signed by," or "Verified/reviewed by," followed by the practitioner's name and preferably a professional designation. An example would be: Electronically signed by: John Doe, MD 3/01/2018.

Unacceptable signatures:

- Signature stamps
- Missing signature on dictated and/or transcribed documentation
- "Signed but not read" indicators
- Illegible lines or marks

Rules for reporting diagnosis codes

It’s important to code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.

Members receiving a prescription for more than one year must also have an active, associated diagnosis to support the medication.

History codes (Z codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment (ICD-10-CM Guidelines IV). We accept and encourage up to 12 diagnosis codes on our professional outpatient claims.

Accurate diagnosis coding gives us a snapshot of medical conditions affecting our member population and appropriately deploys case management resources. Chronic conditions need to be reassessed each year for risk adjustment purposes.

Hierarchical Condition Categories (HCCs)

There are over 250 HCCs, although not all are applicable to the Medicare product or the Individual Patient Protection and Affordable Care Act product. Some HCCs are applicable for both products.

Risk adjustment and Hierarchical Condition Category (HCC) coding is a payment model mandated by CMS. This model identifies individuals with serious or chronic illness and assigns a risk factor score to the person based upon a combination of the individual's health conditions and demographic details.

The risk adjustment models are accumulative, meaning that a patient can have more than one HCC assigned to them.
There is a hierarchy of categories and some categories override other categories.

For each member, the HCC must be captured each year. It's important for the medical record to document all diagnoses from the patient encounter.

Specificity in documentation allows the most current and accurate ICD-10 codes to be assigned. This paints a more accurate picture of the patient's current health status. Where applicable, the documentation should specify the orientation of the presenting illness (i.e. right arm, left hip), as over a third of ICD-10 codes contain laterality.

We focus on capturing the full burden of illness each year for our Medicare and PPACA members.

Unspecified codes

Unspecified HCCs should be used in rare circumstances where a more specific code is not available. Most unspecified codes do not quantify an HCC, but there are some unspecified codes which do suffice as HCC appropriate. Here are examples of unspecified codes which do suffice as HCC appropriate:

B18.9 – chronic viral hepatitis, unspecified

F20.9 – schizophrenia, unspecified

F33.40 – major depressive disorder, recurrent, in remission, unspecified

G82.20 – paraplegia, unspecified

I20.9 – angina pectoris, unspecified

Reminder: Unspecified codes should be used rarely and in extenuating circumstances.

Amputation and status conditions

Certain health status codes are very important to assess, document and code at least annually using the highest level of specificity:

- Transplants
- Ventilators
- Asymptomatic HIV

“Status of” conditions:

- Tracheostomy status
- Dialysis
- Artificial openings/Ostomies
- Prosthetics/ Amputations

Status conditions must reflect active conditions that require treatment or influence medical decision making. Be sure to document the issues at least once a year while the patient has the status. If a patient has an artificial opening closed, that date should be on the problem list.

Asthma

Common signs and symptoms of asthma include coughing, wheezing, chest tightness and shortness of breath. While asthma affects people of all ages, symptoms most often manifest during childhood. When documenting asthma, there are three criteria to follow to ensure accurate coding is captured:

- Cause
- Severity (Mild, Moderate, Severe)
- Temporal Factors (Acute, Chronic, Intermittent, Persistent, Status Asthmaticus, Acute Exacerbation)

General coding guidelines in ICD-10-CM instruct that codes describing symptoms and signs are acceptable for reporting when the provider has not established a related, definitive (confirmed) diagnosis. If applicable, physician documentation should include if the condition is due to use or exposure to tobacco.

Cancer

A cancer diagnosis indicates the patient has active disease. Patients with active cancer may or may not be receiving treatment. Treatment may include, but is not limited to surgery, chemotherapy or radiation.

If adjuvant endocrine therapy or adjuvant chemotherapy is being administered, the cancer is considered active and should be coded accordingly; examples of adjuvant therapy includes Casodex, Tamoxifen, Lupron and 5-FU. However, if the documentation states the adjuvant therapy is prophylactic or preventative, it needs to be coded as history of cancer.

Patients in remission should have a diagnosis reflecting their condition (e.g. C91.91 Lymphoid leukemia, unspecified, in remission). Remission diagnoses are disease-specific.

Once the treatment is complete and the cancer has been eradicated (the cancer is neither active nor in remission) and should be coded as “history of” from category Z85-.

Refer to the ICD guidelines for specifics and questions regarding coding conditions.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) refers to chronic bronchitis, emphysema and alpha-1 antitrypsin deficiency, a genetic form of emphysema. COPD is characterized by the obstruction of airflow and interference with normal breathing. Chronic bronchitis and emphysema frequently coexist. Coding and sequencing for COPD are dependent on the physician documentation in the medical record and application of the official coding guidelines for care.

It is important to document the status of the member's pulmonary disease annually. Documenting the stability or successful self-management of the disease, is just as important as documenting the exacerbations. Chronic respiratory failure is common for patients with chronic respiratory diseases such as COPD, emphysema, pulmonary fibrosis, etc. If a patient is on continuous oxygen, a provider should consider the diagnosis of chronic respiratory failure.

J44.0	Chronic obstructive pulmonary disease with acute lower respitory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified

Chronic DVTs, PE and coagulation defects

Patients with a history of chronic deep vein thrombosis, chronic pulmonary embolism or coagulation defects may be treated with anticoagulants which are managed in a "Coumadin Clinic". It is important to document and assess the current status of these chronic conditions in the progress note from each visit.

Confirming that the correct diagnosis is available in the problem list may act as a helpful reminder. Additionally, documenting the date and diagnosis/findings of the last diagnostic test (e.g. duplex scan) within the problem list prevents providers from repeatedly searching for results.

Below are some examples of diagnoses. Remember that this list is not all inclusive and is only to be used for exemplary purposes.

I27.82	Chronic pulmonary embolism
I82.501	Chronic embolism and thrombosis of unspecified deep veins of right lower extremity
I82.502	Chronic embolism and thrombosis of unspecified deep veins of left lower extremity
D68.9	Coagulation defect, unspecified
D68.59	Other primary thrombophilia
D68.69	Other thrombophilia

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record.

Diabetes mellitus

Diabetes mellitus (DM) is a condition that results when the body is unable to produce enough insulin or properly use the insulin that it does produce.

Assign as many codes in the table below as needed to identify all of the associated conditions the patient has. When the provider assesses the condition, additional documentation is needed to completely classify the condition: type 1 vs. type 2 and manifestations associated with the condition, if any.

There are five diabetes mellitus categories in ICD-10-CM:	
E08	Diabetes mellitus due to an underlying condition
E09	Drug or chemical-induced diabetes mellitus
E10	Type 1 diabetes mellitus
E11	Type 2 diabetes mellitus
E13	Other specified diabetes mellitus

An additional code should be assigned from category Z79- to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned.

Diabetes with chronic kidney disease

With ICD-10 there is a presumed linkage between diabetes and chronic kidney disease. However, the best practice is to document any cause-and-effect relationships for diabetes with chronic kidney disease and neuropathy.

Establish a link between diabetes and kidney condition by documenting the following:

- Diabetes with chronic kidney disease, stage I
- Diabetic chronic kidney disease, stage III
- Chronic kidney disease, stage I due to diabetes
- Chronic kidney disease, stage II secondary to diabetes

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record. The ICD tabular instructs coders to also use an additional code to identify the stage of the chronic kidney disease.

Refer to the ICD guidelines for specifics and questions regarding coding conditions.

Diabetes with ophthalmic manifestations

Diabetic eye disease refers to a group of eye problems that people with diabetes may face as a complication of diabetes. All can cause severe vision loss or blindness. Documentation should be specific if there is a cause and effect relationship where the patient's eye disease is due to diabetes.

Diabetic eye disease may include:

- Retinopathy: damage to the blood vessels in the retina.
- Cataract: clouding of the eye's lens. Cataracts develop at an earlier age in people with diabetes.
- Glaucoma: increase in fluid pressure inside the eye that leads to optic nerve damage and loss of vision. A person with diabetes is nearly twice as likely to get glaucoma than other adults.

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record.

Diabetes with peripheral vascular disease

Peripheral vascular disease (PVD) includes several conditions that affect the blood vessels. PVD occurs when peripheral blood vessels, those located away from the heart, become blocked or damaged in some way. Peripheral artery disease, or PAD, is one type of PVD. It affects arteries in the arms and legs.

Links can be made between diabetes and peripheral vascular disease by documenting the following:

- Diabetes with peripheral vascular disease
- Diabetic peripheral vascular disease
- Gangrene caused by diabetes
- Peripheral vascular disease secondary to diabetes

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record.

Diabetes with neuropathy

Document the cause and effect relationship if the patient's neuropathy is secondary to diabetes to capture and code as a diabetic condition.

Neurological conditions may affect a patient's memory and ability to perform daily activities. It is important to document treatment of these conditions once a year.

Establish a link between diabetes and neuropathy by documenting the following:

- Diabetes with neuropathy
- Diabetic polyneuropathy
- Neuropathy caused by diabetes
- Polyneuropathy associated with diabetes

For example, when documentation supports a link between uncontrolled diabetes type 2 and neuropathy on insulin the code assignment would be:

E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
Z79.4	Long-term (current) use of insulin

Documenting the cause and effect relationship, captures and codes a more complete picture of the patient's overall health. All complications of diabetes should be coded.

Refer to the ICD guidelines for specifics and questions regarding coding conditions.

Hypertension

The ICD-10-CM 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.

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

Hypertension	I10
Hypertension and heart failure	I11 + I50
Hypertension and chronic kidney disease	I12 + N18
Hypertension and heart failure and CKD	I13 + I50 + N18
Hypertension and CKD and diabetes mellitus	I12 + N18 + E08-E13
Hypertension and heart failure and CKD and diabetes mellitus	I13 + I50 + N18 + E08-E13

Kidney disease—chronic

By definition, chronic kidney disease (CKD) is kidney damage for three months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Hypertension, diabetes, and heart failure are all conditions that presume a causal relationship with kidney disease. It is imperative these conditions are linked and coded correctly.

CKD is classified into one of the five stages:
CKD, Stage I
CKD, Stage II (mild)
CKD, Stage III (moderate)
CKD, Stage IV (severe)
CKD, Stage V
ESRD, Renal dialysis status*

**End Stage Renal Disease treated with dialysis would be coded with N18.6 for the ESRD and Z99.2 for the dialysis status.*

***The diagnosis of CKD cannot be coded from diagnostic reports (e.g., lab reports) alone. The diagnosis of CKD requires at least two abnormal markers of damage or two abnormal GFRs persisting more than three months.*

Malnutrition—at risk for

Protein-calorie malnutrition and cachexia are important diagnoses that are often overlooked in Medicare patients who have other significant chronic underlying diseases. Physicians often describe patients as frail or with significant weight loss but then do not document a clear diagnosis of malnutrition in the progress note.

Symptoms include:
Involuntary weight loss >10% in the previous few months
BMI <18.5
Poor nutrition or loss of appetite or seriously curtailed food intake
Daily GI symptoms such as anorexia, nausea, vomiting or diarrhea for at least two weeks
Marked reduction in physical capacity
Wasting appearance or muscle wasting

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record.

Mental health and major depressive disorders

Mood disorders that produce depression may exhibit as sadness, low self-esteem or guilt feelings; other manifestations may be withdrawal from friends and family, or interrupted sleep. We encourage providers to address mental health concerns because unmanaged mental health issues can exacerbate a patient's other health conditions.

It's encouraged to screen for depression on a routine basis, at least annually. Use of the PHQ-2, PHQ-4 and PHQ-9 tools will help assess depressive symptoms and risk for suicide. These tools and other resources can be found in the Priority Health Provider Manual.

Major depressive, bipolar and paranoid disorders require very specific documentation. It is important to clearly indicate severity of condition such as mild, moderate, severe, with or without mentions of psychotic symptoms, recurrent or single episode, or in full or partial remission.

Before PHQ-9 is administered, however, providers must analyze whether or not the positive assessment is due to an adjustment reaction (ex. recent significant loss). If positive PHQ-2 is due to an adjusted reaction a code from ICD-10 F43 (reaction to severe stress), should be used.

PHQ-9 SYMPTOMS & IMPAIRMENT	PHQ-9 SEVERITY	PROVISIONAL DIAGNOSIS	RECOMMENDED FOLLOW-UP
1 to 4 symptoms, functional impairment	<10	Mild or minimal depressive symptoms	Every other month
2 to 4 symptoms and positive response to questions 1 or 2, functional impairment	10-14	Moderate depressive symptoms	Monthly
5 symptoms and positive response to questions 1 or 2, functional impairment	15-19	Moderately severe major depression	Every 2-4 weeks
5 symptoms and positive response to questions 1 or 2, functional impairment	>or =20	Severe major depression	1-2 weeks until PHQ improves ≥ 5 points

Major depressive, bipolar and paranoid disorders require very specific documentation. It is important to clearly indicate severity of condition such as mild, moderate, severe, with or without mentions of psychotic symptoms, recurrent or single episode, or in full or partial remission. To code a recurrent status, an interval of at least two consecutive months between separate episodes in which criteria for major depressive episode are not met is required. If there is no documentation of whether the disorder is recurrent or a single episode, the default is to code a single episode unless the coder has the ability to query the physician for clarification.

As long as the symptom time frame criteria are met, a diagnosis of partial or full remission can be made even if the patient is currently taking antidepressants and/or participating in other treatments, such as psychotherapy.

Our behavioral health staff are available 24/7 for emergencies and assistance.

Call 616.464.8500 or 800.673.8043. Our business hours are Monday through Thursday, 8 a.m. to 5 p.m., and Friday, 9 a.m. to 5 p.m.

Morbid obesity

Obesity increases risk of diabetes, heart disease, stroke and arthritis, as well as other diseases and conditions.

The diagnosis of being overweight or obese must be documented and coded from the provider's chart notes because the Body Mass Index (BMI) code alone does not capture the abnormal weight condition. Therefore, unless the physician makes a comment on the significance of the BMI, it cannot be coded. If the linkage between the BMI and a clinical condition is not clearly documented, query the provider for clarification.

Obesity hypoventilation syndrome, also known as Pickwickian Syndrome, is a condition in which obese patients fail to breathe adequately and may result in low blood oxygen levels and high blood carbon dioxide levels. It is imperative to document and address this condition as the disease process puts strain on the heart and may eventually lead to heart failure.

Classification	BMI
Underweight (Z68.1)	<18.5
Normal weight (Z68.2-)	18.5 - 24.9
Overweight (E66.3)	25 - 29.9
Obesity (E66.9)	30 or greater*
Morbid obesity (E66.01)	40 or greater*
Super morbid obesity (Z68.43)	50+

*From a clinical perspective, a BMI of 35+ linked to a supported comorbidity of obesity by the clinician (comorbidities may include diabetes, hypertension, sleep apnea, COPD, cardiovascular disease: history of MI, CHF, venous stasis, atherosclerosis, osteoarthritis - weight bearing joints, and CVA) may be coded as morbid obesity ICD-10 E66.01. If there is no BMI documented and the member's appearance is listed as `massively overweight' morbid obesity may also be coded.

Myocardial infarction (heart attack)

Myocardial infarction (MI) is the death of myocardial tissue usually caused by a blocked coronary artery. Acute MI (AMI) is classified to ICD-10-CM subcategories I21.0-I21.4 and I22.0-I22.9.

Types of Myocardial Infarctions include ST Elevation Myocardial Infarction (STEMI) or Non ST Elevation Myocardial Infarction (NSTEMI).

Acute Myocardial Infarction (AMI) ICD-10-CM code is I21 and is used for only a four week period. Following the initial four week period, ICD-10-CM code I25.2 can be used. A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction is to be used when a patient who has suffered an AMI has a new AMI within the four week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Selection of an ICD-10-CM diagnosis code is based on the documentation in the medical record. Refer to the ICD guidelines for specifics and questions regarding coding conditions.

Peripheral artery disease

Peripheral artery disease (PAD), or peripheral vascular disease (PVD), is a disease of the blood vessels outside the heart and brain that is caused by a narrowing of vessels that carry blood to limbs and vital organs.

The most common symptom of peripheral artery disease is intermittent claudication, or pain, while walking or exercising that resolves after a period of rest. Commonly patients attribute this pain to being out of shape or a muscle strain.

Early detection of the disease is vital to reduce adverse cardiovascular outcomes and other complications.

Advanced PAD increases the chances of a stroke, heart attack, and lower extremity amputation. Documentation for this condition should include laterality, location, and if an ulceration is present. There is an assumed relationship between diabetes and peripheral artery disease. However, both conditions must be documented and valid to code.

Post-cerebrovascular accident

Acute cerebrovascular accident (CVA) is coded I63 and should only be used in a hospital setting.

ICD-10-CM diagnosis code I63 is used for the initial episode for an acute cerebrovascular accident. Because a cerebrovascular accident is an acute event, it should not be documented as an active diagnosis for prolonged periods of time.

ICD-10-CM code for "history of" or current CVA is not to be used. Following hospital discharge, use Z86.73 if there is no lasting sequelae or "Old CVA with late effects" (i.e. aphasia, slurred speech, gait problem, etc.).

- Categories I60 – I67 are used to indicate the area of the cerebrovascular disease.
- Category I69 is used to indicate sequelae of CVA, including conditions specified as such or as residuals which may occur at any time after the onset of the causal condition.
- Late effects may be present from the onset or may arise any time after the acute phase.
- There is no time limit on coding late effects of a CVA.
- Weakness vs. hemiparesis. Be specific with documentation.

Pressure ulcers

All codes related to pressure ulcers are found within category L89. This section includes combination codes to identify the site, laterality and stage of the pressure ulcer, as well as if the pressure ulcer spans more than one body part.

If multiple ulcers are present, assign as many codes from category L89 as needed to identify all the pressure ulcers the patients has.

Assignment of the code for unstageable pressure ulcer should be based on the clinical documentation when stages cannot be clinically determined. This should not be confused with the codes for unspecified stage that are to be used when there is no documentation present regarding the stage of the ulcer.

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on documentation in the medical record.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

Social Determinants of Health (SDoH)

To improve the health of our patients and communities we serve, documentation of social needs and social determinants of health is needed. Societal and environmental conditions such as food, housing, transportation, education, social support, health behaviors, violence and employment should be addressed.

Incorporating a standardized approach to screening during encounters and documenting and coding social needs will enables hospitals and health plans to:

- Identify population health trends
- Tracking social needs that are impactful to patients will enhance the personalized care that addresses patients social and medical needs
- Data analytics to determine how to focus a social determinants strategy or program

ICD-10-CM codes from categories Z55-65 identify non-medical factors that may impact a patient's health status. Codes from these categories can be assigned based on documentation by all clinicians involved in a patients care. Another category to consider is Z91; Personal risk factors, not elsewhere classified which includes under-dosing due to financial hardship.

Substance use, abuse, dependence

Coding substance use, abuse and dependence correctly is necessary and dependent on accurate and complete documentation.

When documenting substance disorders, include the following information to ensure coding accuracy:

- Severity - mild, moderate, severe, etc
- Pattern of use - relapsed, in remission, continuous use, etc
- Psychotic symptoms /Substance-induced mood - depression, hallucinations, anxiety, etc
- Current presentation - intoxication, drunkenness, withdrawal
- Treatment plan - rehabilitation, maintenance therapy, substance support groups, etc

If both use and abuse (mild use) are documented	Assign only the code for abuse (mild use disorder)
If both abuse (mild use), and dependence (moderate and severe use) are documented.	Assign only the code for dependence (moderate or severe use disorder.)
If use, abuse (mild use), and dependence (moderate or severe use) are all documented.	Assign only the code for dependence (moderate or severe use disorder.)
If both use and dependence (moderate or severe use) are documented.	Assign only the code for dependence (moderate or severe use disorder.

Vascular disease

Vascular disease includes any condition that affects the circulatory system.

Vascular disease ranges from diseases of the arteries, veins and lymph vessels to blood disorders that affect circulation. The following are conditions that fall under the category of vascular disease:

- Peripheral artery disease
- Aneurysm
- Renal (kidney) artery disease
- Reynaud's phenomenon
- Varicose veins
- Blood clots
- Lymphadema
- Atherosclerosis of aorta

Selection of an ICD-10-CM diagnosis code is based on the documentation in the patient's medical record.

Virtual visits and telehealth

Criteria for virtual visits and telehealth:

- Meet all coding requirements including both audio and visual requirements
- Meet code time requirements
- Be included in contracted services
- Exclude use of codes specific to in-person or describe services that can only be performed in-person
- Be within scope of practice, licensure or credentialing

COVID-19

(Relates to COVID-19 criteria only and is subject to change. For the most current information about COVID-19 billing and telehealth visit *priorityhealth.com/covid-19/about/providers*

In response to COVID-19, the CMS issued guidance that allows plans to submit diagnoses for risk adjustment that are done via telehealth, as long as visits meet all criteria for risk adjustment eligibility. As a result we're temporarily allowing providers to bill routine practice codes for services provided through telehealth, as long as the guidelines for each code are followed.

Keep telehealth in mind when in-office visits aren't an option. Telehealth can be used as long as:

- A practice has the capability to host a telehealth visit with a video component
- The visit meets all other coding requirements and risk adjustment criteria for eligibility.

In accordance with CMS guidelines, previously established conditions that do not require interpretation of clinical data on the date of visit to support M.E.A.T for the condition are acceptable for telehealth. CMS guidance has been that interpretation of clinical data on the date of visit cannot be successfully accomplished via telehealth.

More information
See our telehealth policy for more information and learn more about billable codes on our virtual visits billing page. Behavioral health providers, see our ***behavioral health telehealth policy and outpatient billable codes.***

When to query the provider

A joint effort between the health care provider and the coding professional is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Providers should be queried whenever there is conflicting, ambiguous or incomplete information in the health record regarding any significant reportable condition or procedure.

Queries are deemed appropriate when documentation in the patient's record fail to meet the following criteria:

Clarity — Diagnosis listed without statement of cause or suspected cause. Procedures not clearly documented to the suggestive documentation implied by CPT lay descriptions

Completeness — Entries to the patient record that do not correlate with clinical indicators or diagnostic tests

Consistency — Information documented that is conflicting, or not substantiated

Correctness — Instances when clinical reports suggest a need for more specific documentation

Legibility — Illegible handwritten notes where the data cannot be assessed for coding

Queries should not be used to question a provider's clinical judgment, and may only be used to clarify documentation when it fails to meet criteria.

The following use of information is encouraged to assist coding staff for a query process:

- ICD-10-CM Guidelines for Coding and Reporting
- American Hospital Association Coding Clinic
- CPT Assistant
- CMS Correct Coding Initiative (CCI)

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely-used set of performancemeasures in our national health care industry.

HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for profit organization committed to assessing, reporting and improving the quality of care provided by organized health care delivery systems.

HEDIS drives standardized care practices, national benchmarking, and evaluation of care provided in both medical and behavioral health in various domains:

- Preventive care
- Chronic condition management
- Medication management
- Appropriateness or overuse of care
- Access/availability
- Utilization
- Member experience using the Consumer Assessment of Healthcare Providers (CAHPS) survey

The Centers for Medicare and Medicaid Services (CMS) also leverages a select group of HEDIS and CAHPS measures to evaluate health plans offering Medicare products (Medicare Five Star program) and Medicaid products (Medicaid Bonus program). Performance in these select measures are directly tied to complying with federal government requirementsand reimbursement to the health plan.

Below are some of the common HEDIS measures:

Prevention

- Child and adolescent immunizations
- Well-child and adolescent well care visits*
- Cancer screenings (breast**, colorectal**, cervical)
- Depression screening
- Reducing opioid use
- Osteoporosis screening**
- Lead screening*

Chronic Conditions

- Diabetes Care: A1c screening/control; retinal eye exams, nephropathy monitoring, blood pressure control
- Statin therapy for patients with diabetes and with cardiovascular disease**
- Controlled blood pressure**
- Asthma and COPD medication management
- Rheumatoid arthritis medication management**

Member Experience

- Member access to primary, urgent, and specialty care
- Member utilization of ER and acute hospitalization
- Member experience with their doctor
- Member experience with quality of care
- Member experience with their health plan

*Medicaid Bonus program measure
**Medicare Five Star program measure

Acronyms and industry terms

BMI — Body Mass Index
CAHPS — Consumer Assessment of Healthcare Providers
CHF — Congestive Heart Failure
CKD — Chronic Kidney Disease
CMS — Centers for Medicare and Medicaid Services
COPD — Chronic Obstructive Pulmonary Disease
CPC+ — Comprehensive Primary Care Plus
CVA — Cerebrovascular accident (stroke)
DOS — Date of Service
DM — Diabetes Mellitus
DVT — Deep Vein Thrombosis
ESRD — End Stage Renal Disease
HEDIS — Healthcare Effectiveness Data and Information Set
HCC — Hierarchical Condition Categories
MI — Myocardial Infarction
NCQA - National committee for Quality Assurance
NSTEMI — Non-ST Elevation Myocardial Infarction
PAD — Peripheral Artery Disease
PE — Pulmonary Embolism
PIP — Partners in Performance
PPACA — Patient Protection and Accountable Care Act
PVD — Comprehensive Primary Care Plus
SDOH — Social Determinants of Health
STEMI — ST Elevation Myocardial Infarction

Care management

We support members with complex and/or serious health issues with an in-house team of more than 70 advanced practice nurses, doctors, pharmacists and certified case managers.

Our case managers help coordinate health care for members who:

- Are at risk for a high-cost, episodic, acute event
- Have a condition that could lead to an increased use of services
- Have suffered a catastrophic health episode

Referrals to care management services may be made by calling the care management triage line at 800.998.1037.

Priority Health contact information

Call the Provider Helpline

800.942.4765

Monday — Thursday 7:30 a.m. — 5 p.m. and

Friday 9 a.m. — 5 p.m.

Send us an email:

provider.services@priorityhealth.com

Contact us by mail:

1231 E. Beltline NE

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