PATH TO PROMINENCE

Risk Adjustment
Clinical Documentation Specificity

Session 1 Agenda

1. CMS Documentation Best Practice & Common Errors in RA
2. Diabetes Mellitus Uncomplicated
3. Diabetes Mellitus WITH Complication / Manifestation

- Diagnosis
- Diagnosis Specificity Needed to assign the appropriate dx code
- Clinical Documentation Required to support ICD-10 codes submitted on your claim

Disclaimer

Information shared today is for educational purposes only, using 2021 data for accuracy at time of delivery

This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references

Specific documentation is reflective of the “clinical thought process” of the provider when treating patients

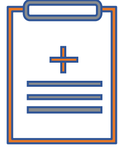
All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment plan in the Progress Note

The information shared today also serves to enhance your implementation of high-quality clinical documentation for ICD-10 coding accuracy to the highest level of specificity

https://www.cms.gov/Medicare/Health- Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf,
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors- Items/Risk2018.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

The Goal for Today’s Content

- Obtain a High-level understanding of Risk Adjustment specific to todays diagnoses being covered
  - Utilizing CMS-HCC (Medicare) Risk Adjustment Model
- Obtain High-level documentation and coding guidance to withstand today's documentation and coding rigors to apply as “Best-Practice” for your efforts
  - Information being shared today is In accordance with:
    - ICD10 Coding Guidelines
    - CMS Risk Adjustment Data Validation Guidelines
    - AHA Documentation Guidelines and Coding Clinics
    - Industry Best Practice suggestions for RA success
- Take away a better understanding of the detailed Clinical Documentation needed for ICD-10 HCC coding to the highest specificity on prevalent disease categories
- Learn one thing you didn’t know or that wasn’t clear about Risk Adjustment, Clinical Documentation and/or ICD-10 HCC Coding



Progress Note Documentation "Best Practice"

Tips for SUCCESS in Risk Adjustment Data Validation

“Best Practice” Clinical Documentation Specificity

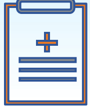
- Why high-level details in your Clinical Documentation are best:
  - Specifically, your Clinical Documentation supports the ICD-10 Codes submitted on your claims to report the patients care received and requires pertinent facts, findings and observations about the patient's health and history to be documented in your Progress Note
  - **Documentation** of patient diagnoses that is clear, concise and uses details to describe each diagnosis with high level details is critical for Risk Adjustment success and **facilitates**:
    - Quality patient care with better outcomes
    - Accuracy of ICD-10 diagnosis code assignment to the highest specificity for submission on claims
    - Accurate Risk Score Assignment, Accuracy of the patient's complete disease burden, “Portrait of Health to CMS”
    - Appropriate payment for all stakeholders (FFS, RA, MSSP ACO, CPC+ etc.)
    - If it wasn’t documented, it didn’t happen
    - Risk Score representation “general rule”
      - The lower the risk score the healthier the patient
      - The higher the risk score the sicker the patient

Specific to Risk Adjustment Data Validation (RADV) audits

- It is one **Stand Alone Progress Note**, not the medical record in its entirety that is used in an audit
- **One DOS** and a single Progress Note that must validate the ICD-10 HCC diagnosis code(s) submitted on your claim for RADV

Success in Risk Adjustment: Documentation and coding

Suggested **“Best Practice”** standards



- Develop an internal “Best Practice” for documentation standards that works for your facility as a “standard” rule
  - M.E.A.T
- Be aware of code specificity
  - Recognize unspecified codes, general code rule dx codes ending in 9 = “Unspecified”
    - When you see a diagnosis code ending in “9” consider further specifying if possible

E11.**9** Diabetes Mellitus Type 2 Unspecified

I73.**9** Peripheral Vascular disease Unspecified

N18.**9** CKD Unspecified

- “History of” –
  - We will look at the CMS definition and what it means in Risk Adjustment vs. the way you were previously educated
- Repeat, each Progress Note (PN) must **“Stand Alone”** for each DOS
  - Documentation in PN must Support ICD-10 HCC diagnosis codes submitted on your claim / Risk Adjustment Data Validation (RADV) audit
- * Be aware of your internal Informatics, Templates, Note Forms -
  - Progress Note “out put” can be much different than your Progress Note “in-put” **Know your “out put”**
  - EHR driven documentation can = contradictions in your Progress Note for RADV
- Attention to your Active Medical Problems List for accuracy
  - Dx accuracy allows for ease year over year, use it to your advantage (system driven descriptors/codes)
  - Active Chronic Conditions to the level of highest specificity in the code and narrative
    - Narrative in the AMPL is the typically the narrative that appears in the Final Assessment, use it to drive your documentation

Risk Adjustment Data Validation (RADV)

Best Practice overview: Clinical Documentation for Diagnosis Coding to the highest specificity

Why high-level details in clinical documentation are best?	What are high-level details in documentation?	What do high-Level details in documentation represent?	What is a risk score?	Recall: Stand Alone Progress Note (RADV)
High level details in your documentation provide the specificity needed to code appropriately and report your patients true/accurate picture of health to CMS The details in your documentation allow for diagnosis coding to the highest level of documented specificity to accurately capture your patient's health status Lacking details in your clinical documentation causes unspecified "default" codes to be used E11.9 Diabetes Mellitus Type II Uncomplicated/Unspecified	Pertinent facts, findings and observations about your patient's current health status as well as past medical history in addition to your medical decision making and treatment plan should be included in your clinical documentation Left, Right, Bilateral, Upper, Lower, Type, Due to, Associated with, Patient has ulcer (?) Patient has diabetes (?) Patient has weakness (?) Patient has AFIB (?)	Dx code assignment to the highest known specificity = Accuracy of Disease Burden = Accuracy of Risk Score Assignment = Accuracy of Funding Documentation draws a Self portrait of your patient's health status submitted to CMS in ICD-10 Dx codes on your claim.	Patient Demographic factors + ICD-10 diagnoses that map to an HCC category submitted on a claim + Any HCC Interaction categories = Patient Risk Score DM = HCC CHF = HCC = HCC Interaction (DM & CHF) Healthier = LOWER Sicker = HIGHER "Accuracy"	One DOS One Progress Note One Claim ICD-10 HCC Diagnoses submitted on your claim must have supporting Clinical Documentation in your Progress Note for that same DOS RADV = Targeted diagnoses submitted on your claim, for one DOS and must be supported in your Progress Note documentation per CMS to pass a RADV audit M.E.A.T.

Clinical Documentation Best Practice as defined by CMS

Coding Chronic Conditions & MEAT

Best Practices are to ensure each diagnosis coded is clearly documented as being:

Monitored - signs, symptoms, disease progression, disease regression

Evaluated - test results, medication effectiveness, response to treatment

Addressed - ordering tests, discussion, review records, counseling

and/*or*

Treated - medications, therapies, other modalities

**High Level clinical details in your documentation, specifically the patient's diagnosis and the status to the highest level of specificity for accurate ICD-10 HCC Code assignment and submission

Success in Risk Adjustment:
How to identify a code needing more specificity

- Code Specificity
  - Recognize unspecified codes, general code rule for Dx codes ending in 9 = "Unspecified"
  - "Specific to diabetes"
    - E11.**9** Diabetes Mellitus Type 2 without complication / unspecified
    - E11.X9 Diabetes Mellitus Type II with Other Complication, "__SPECIFY__" the complication
      - What is the complication?
        - Neurological (diabetic peripheral neuropathy) E11.42
        - Ophthalmic (diabetic retinopathy) E11.3X
        - Circulatory (diabetic peripheral vascular disease) E11.51
        - Kidney (diabetic kidney disease stage 3a) E11.22
  - Other Unspecified Diagnoses ending in "9"
    - I73.**9** Peripheral Vascular disease Unspecified
    - N18.**9** CKD Unspecified
    - J44.**9** COPD Unspecified
    - E66.**9** Obesity Unspecified
    - F32.**9** Depression, Single Episode, Unspecified
    - F33.**9** Depression, Recurrent, Unspecified

Neurological
Ophthalmic
Circulatory
Kidney

AHA ICD-10 Official guidelines
b. "Unspecified" codes
Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code.
For categories where an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

Success in Risk Adjustment: Documentation and coding **best practice** standards

- “History of” –
  - The CMS definition and what it means in Risk Adjustment (resolved, gone, no longer present, true PAST medical history)

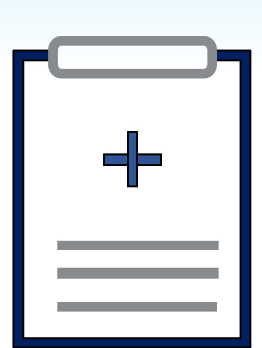
- This is perhaps one of the largest obstacles to overcome!
  - Use of the term “History of” is how many were taught to document

- Try to document in terms of active vs. using the term “history-of”
  - Active, long term, on-going, continuous, continued, current, chronic

Use of “history of.” In ICD-10-CM, **“history of” means the patient no longer has the condition** and the diagnosis often indexes to a Z code not in the HCC models. A physician can make errors in one of two ways with respect to these codes. One error is to code a past condition as active. The opposite error is code as “history of” a condition when that condition is still active. Both of these errors can impact Risk Adjustment.

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2012183293-yv-participant-guide-publish_052909.pdf

Best practice standards AMPL



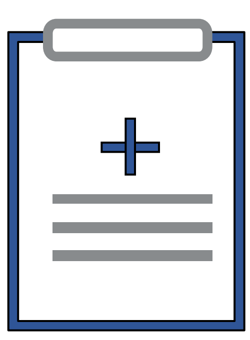
- Active Medical Problems List (AMPL)
  - Accuracy allows for ease year over year, use it to your advantage (System driven Descriptors)
  - Active Chronic Conditions to the highest level of specificity
    - Narrative in the AMPL is the typically the narrative that appears in the Final Assessment of your Progress Note

- Use the Active Medical Problems List to your advantage (True accurate picture of your patient's health status)
  - Highest known level of specificity (Accuracy of disease burden to the highest level of specificity)
  - Choose the code and narrative to the highest level of specificity according to your patient's true picture of health
    - Instead of an abbreviated version see some of the narratives that would typically be available
      - Instead of Diabetic Neuropathy choose Diabetes Mellitus type II with Diabetic Peripheral Neuropathy
      - Instead of Kidney Disease choose Chronic Kidney disease Stage 3a
      - Instead of Depression choose Major Depressive disorder, recurrent, moderate
      - Instead of joint pain choose Inflammatory arthritis of multiple joints
      - Instead of Pre-Diabetes choose Diabetes Mellitus Type II
      - Instead of Overweight choose Obesity or Morbid Obesity
- Current and active diagnoses relevant to the current care of your patient
- Be as Specific as Possible

Documentation

Sample of a generic Encounter Form / Progress Note

- RECALL RADV - M.E.A.T (documentation criteria)
- 4 specific areas approved for code extraction
  - HPI, Physical Exam, Discussion Summary, Plan
- 1:1 Match / Mirror for Success "Best Practice"
  - **1 of 4 AND Mirror that same diagnosis in the Assessment



Generic Encounter Form

Patient:
DOB:
DOS:

Chief Complaint:________________________________

1) History of Present Illness:

Active Medical Problems List:

PMFSH:

Medications List:

ROS:

Vitals:

2) Physical Exam:

****Assessment:**

3) Discussion Summary / 4) Plan:

Signature:

HPI establishes pertinent medical history and supports medical decision making for the encounter

Supporting documentation in the HPI is sufficient for diagnosis coding as long as there is a documented/written diagnosis

As long as there is a diagnosis documented in the **Physical Exam** it shows clinical evaluation and supports the diagnosis

Diagnoses should not simply be listed in the **Assessment/Plan** without further support of **M**onitoring, **E**valuating, **A**ddressing, and/or **T**reating in the acceptable sections of the Progress Note

1 of 4 AND Assessment
1:1 Mirror same diagnosis

Generic Encounter Form

Patient:
DOB:
DOS:

Chief Complaint:______________________________

1) History of Present Illness:

____
____
____

Active Medical Problems List:

______________ ______________
______________ ______________
______________ ______________

PMFSH:

________ ________ ________ ________ ________ ________

Medications List:

________ ________ ________ ________

ROS:

____
____
____

Vitals:

________ ________ ________ ________

2) Physical Exam:

________ ________ ________ ________ ________
________ ________ ________ ________ ________

****Assessment:**

____
____

3) Discussion Summary / 4) Plan:

____
____
____

M.E.A.T. - Document the full diagnosis to the highest possible specificity

Best Practice suggests for the Diagnosis and corresponding documentation to be in 1 of 4 sections of the Progress Note and that your diagnosis in those areas *"mirror"* the same diagnosis listed in the Assessment

Documentation in the other areas of the Progress Note, shown here support the level of service, medical decision making, and patient visit but are not acceptable areas for code extraction specific to RADV

Key:
☐ Ok for code abstraction

Acceptable sections of the Progress Note for Risk Adjustment Data Validation

Best Practice for Specificity

Best practice Documentation Standard

- For accurate reporting of ICD-10-CM Diagnosis codes, the clinical documentation should describe the patient's condition, using terminology that includes the **specific diagnoses** as well as symptoms, problems, or reasons for the encounter, an authenticated physician order for services, reason the service was ordered, and test results etc.

- The diagnosis should **again be spelled out in full as the final diagnostic statement in the Assessment**.

- The clinical documentation or source document/documentation (Progress Note) referred to by the coder should describe the patient’s condition using terminology that includes the **specific diagnoses**, as well as symptoms, problems, or reasons for the service.

ICD-10 2021 AHA Code Guidelines

C. Accurate reporting of ICD-10-CM diagnosis codes
For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes **specific diagnoses** as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these

Diagnosis, Status and Plan for that diagnosis and the same diagnosis should again be spelled out in the final Assessment = 1:1 Diagnosis match

http://bok.ahima.org/pdfView?oid=105782
https://www.encoderprofp.com/epro4payers/rcpDocHandler.do?_a=view&_dk=ICD10_CM_Guidelines

Best Practice for incorporating Dx from Specialists

When your patient is seeing a specialist(s)

Incorporate the specialist notes into your EMR / Patient record
Add all chronic Dx to your Active Medical Problems List
M.E.A.T. - Monitor, Evaluate, Address and/or Treat those chronic conditions during your visit

Patient has Diabetic CKD stage 3a, follows with Nephrology, currently stable, continue current treatment

Patient has Chronic AFIB, sees Cardiologist Dr. Smith, currently no palpitations, will continue to monitor

Patient has COPD, controlled on Spiriva, follow up scheduled with Pulmonologist

Patient has Chronic Depression, recurrent, currently stable on Prozac

Patient follows with Oncology for active prostate cancer, reviewed PSA results and discussed current treatment

Even when a condition is not presenting signs and symptoms it is appropriate to evaluate

Controlled by medication, presenting no current symptoms, the condition still exists unless completely resolved

* Diagnosis, Status and Plan for that diagnosis and the same diagnosis should again be spelled out in the final Assessment = 1:1 Diagnosis match

RECAP: Risk Adjustment Data Validation (RADV)

- Using the scenarios previously discussed on Diabetes Mellitus and your clinical documentation specificity for ICD-10 Code assignment please recall:
  - What is a RADV Audit ?
    - HCC ICD-10 Diagnosis codes submitted on your Claims for payment must be supported in your clinical documentation for that encounter per RADV guidelines
  - When a ICD-10 diagnosis code is assigned on your claim, your clinical documentation in the Progress Note for that same DOS must validate the ICD-10 HCC diagnoses using “M.E.A.T” (1:1 Mirror the diagnosis)
  - Document the actual Diagnosis, status of that diagnosis and the plan of care for that diagnosis as well as list the dame diagnosis in your Assessment and on your Claim

- Always Keep in mind that:
  - Each Progress Note must **“Stand Alone”** for each DOS and support each ICD-10 HCC Dx Code assigned on the claim
  - In the even of an audit
    - RADV: CMS, OIG, Internal/External Auditors