E&M Documentation for Diagnosis Reporting

UPMC Health Plan

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Title of course: E&M Documentation for Diagnosis Reporting

CME Information

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Target audience: Physicians, physician extenders, office staff, and coders/billers

Course director(s): UPMC Health Plan: Stephen Perkins, MD, Chief Medical Officer; Marlana Tice, Program Director; Brenda Stevenson, Lead Physician Educator; Shawn Shuman, Senior Director, Clinical and Business Development; Darlene Koritsky, MSN, MBA, RN, CMCN, Clinical Program Director

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OBJECTIVES

By the end of this program, participants will have reviewed:

- Diagnosis reporting importance for severity of illness.
- Risk adjustment and risk adjustment data validation (RADV) audits.
- Provider documentation requirements and guidelines for E&M and ICD-10-CM diagnosis reporting.
    - Connecting the new 2021 E&M documentation guidelines to ICD-10-CM reporting.
- Specific diagnoses that are problematic to RADV audits in terms of provider documentation and ICD-10-CM code assignment.

E&M Documentation for Diagnosis Reporting

1. Importance of diagnosis documentation and reporting
   - Risk adjustment (RA) overview
   - Severity of illness
   - RADV audit
2. Provider diagnosis documentation requirements
   - E&M guidelines
   - ICD-10-CM guidelines
3. Provider documentation problematic to RADV audits
   - Uncertain terminology
   - Active vs. “history of”
   - Specific conditions

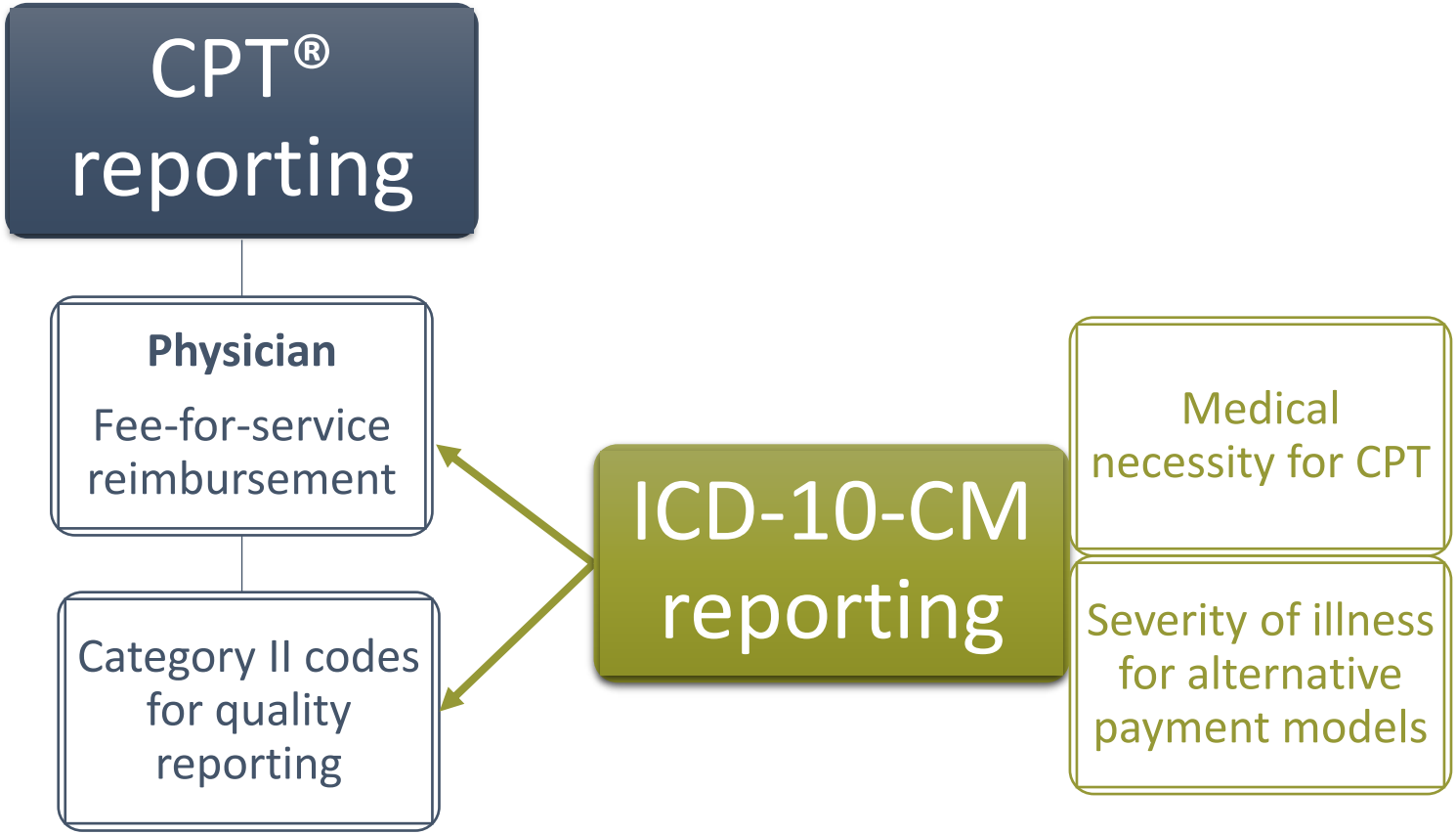
AGENDA

4. Documentation in practice
   - Review of actual provider documentation
5. Resources for diagnosis documentation and coding education
   - UPMC HP Provider OnLine coding tools
   - UPMC HP RA Physician Educator team
6. References
7. Live Q&A session

UPMC HEALTH PLAN

1 Importance of diagnosis documentation and reporting

Importance of diagnosis documentation and reporting



Risk adjustment: Overview

Risk adjustment is …

- A payment methodology implemented for Medicare Advantage plans by the Centers for Medicare and Medicaid Services (CMS) that is now being used across all facets of health care.
- Based on payment for serious or chronic conditions from reported ICD-10-CM diagnosis codes.
- A model that aims to make comprehensive insurance available to all individuals, regardless of risk.

Payment models are moving from fee-for-service toward value-based compensation.

- To efficiently transition to value-based compensation, providers need a good understanding of risk adjustment.

Risk adjustment: Overview

Health plans

"Government plans" offered by carriers:
Medicare Advantage, managed Medicaid, and Affordable Care Act (ACA) plans

↓

Funded by CMS/HHS via risk adjustment methodology

↓

Demographics and health status determine a patient's risk score → **ICD-10-CM Codes = HCC**
Hierarchical **C**ondition **C**ategory

↓

Risk scores for a plan population determine capitated payments → Health plans manage the care of their members enrolled in these plans with this funding.

Risk adjustment: Overview

Severity of illness

- In the Medicare Advantage model, in addition to "Medical HCCs," **RxHCCs** are a part of the model used by CMS to support Medicare Part D (prescription drug program).
  - Medical HCCs typically carry a higher risk.

- Not all ICD-10-CM diagnosis codes map to an HCC.

- HCC conditions are categorized **hierarchically.**
- The highest severity reported in the calendar year for that category is used to calculate the patient's risk score.

Example

Diabetes Hierarchy

HCC	HCC Description	Severity	
17	Diabetes with **Acute** Complications	Highest	
18	Diabetes with **Chronic** Complications	High	E11.22 Type 2 DM w/CKD
19	Diabetes with **No** Complications	Lower	E11.9 Type 2 DM, uncomplicated

Risk adjustment/HCC: Overview

Diagnoses

- **Hypertension**
  - RxHCC
- **COPD**
  - Medical HCC | Rx
- **Type 2 DM with CKD**
  - Medical HCC | Rx
- **CKD—unspecified stage**
  - No HCC
- **A-Flutter**
  - Medical HCC | Rx

Same demographics

- Sex
- Age
- Not Dual-eligible
- Full benefits
- On Medicare
- Live at home

Higher  **Lower**

Even though conditions do not resolve, CMS "wipes the slate clean" each year. That means health plans must report conditions each year.

Diagnoses

- **Hypertension**
  - RxHCC
- **Hyperlipidemia**
  - RxHCC
- **History of prostate cancer**
  - No HCC

Risk adjustment: Overview

Provider

- In performance-based payment models (such as the merit-based incentive payment program [MIPS]), providers' payments are closely tied to their patients' health outcomes.
- Improved performance of quality measures is achieved through risk adjusting the acuity in patients through accurate diagnosis reporting. RA allows for more accurate comparisons of providers and their patients' health outcomes by accounting for the differences in their patients' health acuity.
- Providers participating in a shared savings program may see HCC capture as a revenue component relating to a medical expense ratio (MER).
  - Generally, revenue minus expenses = shared savings
- Addressing risk-adjusted conditions improves direct patient care management and targets prevention and intervention for patients.
- The goal is for the provider to report an accurate clinical picture of the patient.

RADV audits

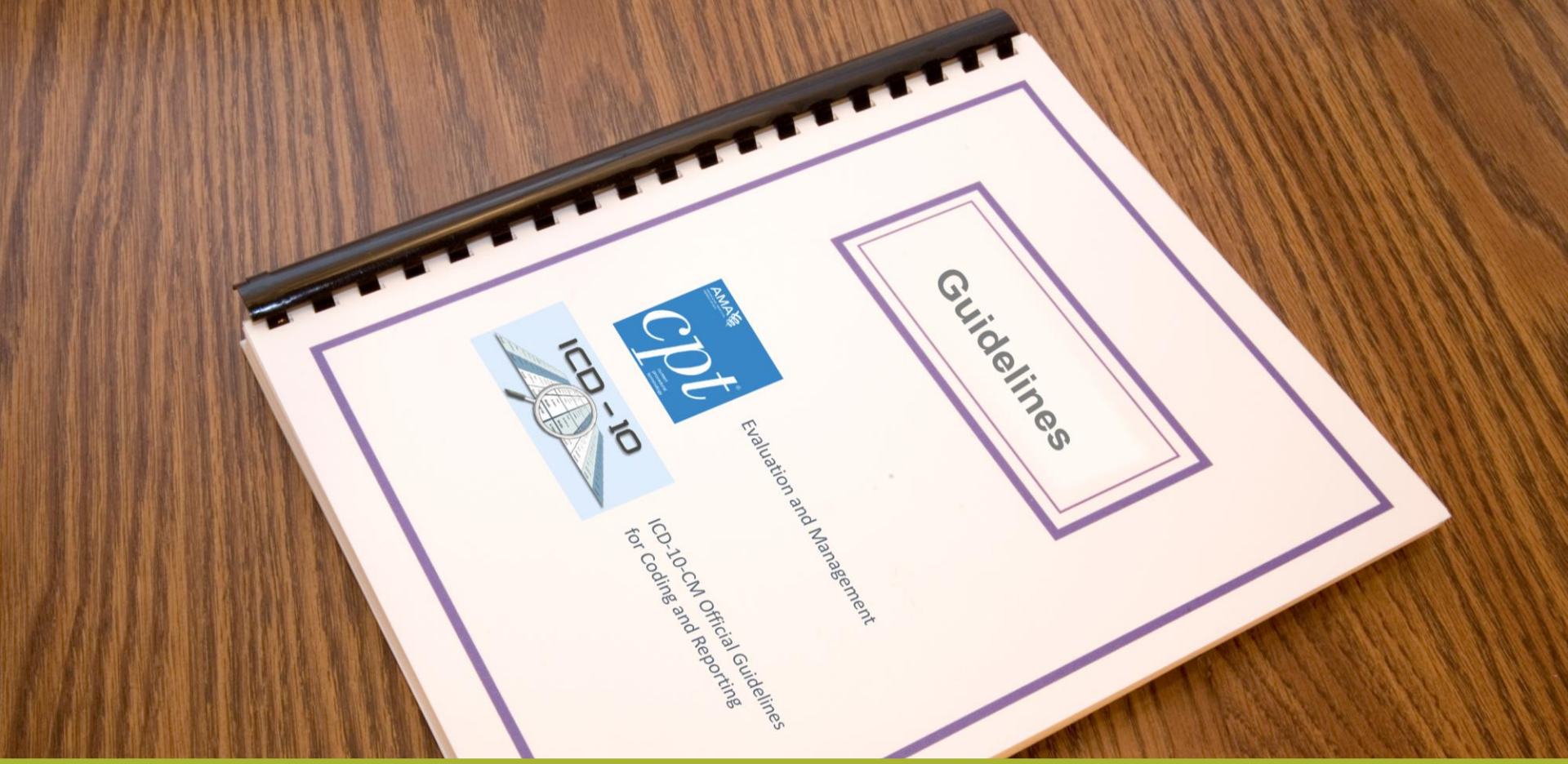
- Risk adjustment data validation (RADV) is the process by which CMS/HHS verifies that diagnosis codes submitted for payment by a Medicare Advantage or ACA plan are supported by provider medical record documentation for the enrollee.
- The Office of the Inspector General (OIG) also performs RADV audits.
  - These governing bodies are looking to see if the provider documents the reported diagnosis as managed, evaluated, assessed, and/or treated during the encounter in the medical record.

CMS

- **National finding:**
  40% error rate[1] for diagnoses reported on claims not documented by the provider as being addressed during the encounter.

OIG

- **Targeted reviews:[2]**
  Prior OIG reviews show diagnoses considered at high risk to be unsupported by the medical record.

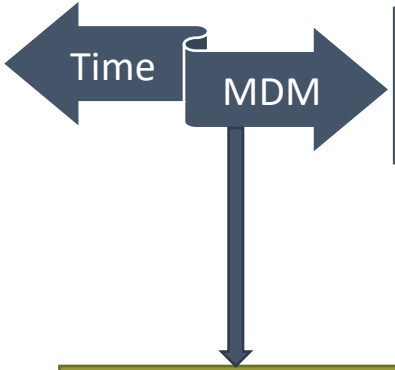


2 Provider diagnosis documentation requirements

Official coding and reporting guidelines

2021 Changes to E&M Documentation Guidelines

- Per CPT, the documentation of **time** or **medical decision making (MDM)** may be used to select a code level in office or other outpatient services.



- Amount/Complexity of problem(s)
- Amount/Complexity of data reviewed
- Treatment risk for complications

CMS states:
Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

- The volume of documentation should not be the primary influence upon which a specific level of service is billed.[3]

Diagnosis documentation

ICD-10-CM reporting guidelines

Official coding and reporting guidelines

2021 Changes to E&M Documentation Guidelines

Problem[4]
A disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter **addressed at the encounter,** with or without a diagnosis being established at the time of the encounter

Problem addressed[4]
A problem is addressed or managed when it is **evaluated or treated at the encounter** by the provider reporting the service.

Best practice documentation

Show elements of M.E.A.T.

Management, **E**valuation, **A**ssessment, and/or **T**reatment

- Assessment of the condition
- Review of prior records from other providers (outside of the practice)
- Review of test/lab/referral record data
- Social determinants of health screening
- Clear treatment plan with named medication
- Risks of the treatment plan

Official coding and reporting guidelines

Document for medical decision-making credit

Diagnoses:

- Established or new problem:
  - Explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
- Assessed using terminology of *"stable," "improving,"* or *"worsening"*:
  - A notation of "abnormal" or "worsening" without elaboration or a documented change in treatment is considered insufficient.
- Acute or chronic:
  - With or without exacerbation, progression, or side effects of treatment
  - With uncertain prognosis

Data considered:

- Results of each unique test
- Each unique test ordered
- Prior records from each external source (e.g., specialist's records)
- Assessment requiring an independent historian
- Independent interpretation of a test performed by another physician or health care professional and not separately reported
- Discussion of management or test interpretation with external physician or other qualified health care professional

Risks of treatment plan:

- Name(s) of the over-the-counter or prescription drugs for each diagnosis (not just the medication list)
  - Drug therapy requiring intensive toxicity monitoring
- Diagnosis for treatment affected by comorbidities or underlying conditions
- Diagnosis or treatment significantly limited by SDOH
- Risk of morbidity from diagnostic testing, treatment ordered, or surgical procedures

Official coding and reporting guidelines

2021 CPT Evaluation and Management

Problem addressed[4]
A problem is addressed or managed when it is evaluated or treated at the encounter by the provider reporting the service.

ICD-10-CM Official Guidelines for Coding and Reporting

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist.[5]

3 Provider documentation problematic to RADV audits

Problematic documentation: 'History of'[5]

Diagnoses of **acute/active conditions** typically report an HCC whereas reporting a "history of" a condition does not.

Clinician interpretation

Past or active condition?

Example: "20-year history of smoking"

"Currently smoking for the past 20 years."

"Smoked for 20 years but stopped."

ICD-10-CM interpretation

"History of" = past condition that no longer exists.

Documentation Tips

Do not use "history of" in generalized terms for a chronic or incurable condition.

Problematic documentation: Acute/Active condition vs. 'History of'[6]

Myocardial infarction	CVA or stroke
• **ICD-10 code categories I21 and I22** *Typically, not happening in the office*	• **ICD-10 code category I63** *Typically, not happening in the office*

• **Acute codes are allowed to be reported within four weeks (or 28 days) of the acute onset.**
• **After four weeks (or 28 days), document as *"history of MI"* or *"old MI"* and report code I25.2 Old myocardial infarction.**
	• **Does the patient have residuals?**
	  • **Yes: Document *"history of CVA with the named residual"* and an A&P for the CVA after-care and residual.**
	  • **Report: CVA with residuals from code category I69.3**
	  • **No: Document *"history of CVA"* and an A&P for the CVA after-care.**
	  • **Report: code Z86.73 Personal history of [TIA] and cerebral infarction without residual deficits**

Documentation Tips

Problematic documentation: Acute/Active condition vs. 'History of'[7]

Active conditions

Deep vein thrombosis

- **ICD-10 code category I82.4 (Acute)**
  Typically, new thrombus initiating anticoagulant therapy
- **ICD-10 code category I82.5 (Chronic)**
  Typically, previously diagnosed and still exists

Pulmonary embolism

- **ICD-10 code category I26 (Acute)**
  Typically, new embolism initiating anticoagulant therapy
- **ICD-10 code category I27.8 (Chronic)**
  Typically, long-standing/reoccurring and continuation of established anticoagulation

Is the DVT/PE resolved?

Documentation Tips

No—to support reporting an active condition:

- Do not use "history of" DVT or PE terminology.
- **Acute**
  - Recent hospitalization for acute DVT/PE within 3-6 months, recommended anticoagulation therapy
- **Chronic**
  - Number and frequency of episodes
  - Anticoagulation given as treatment for "chronic" DVT/PE
  - Need for lifelong anticoagulation therapy
  - Greenfield (IVC) filter placement

Yes—the DVT/PE is resolved:

- Document "history of" DVT/PE.
  - If applicable, note prophylactic anticoagulation to prevent recurrence of DVT/PE.
- **Report code:**
  - **Z86.718 Personal history of venous embolism and thrombosis**
  - **Z86.711 Personal history of pulmonary embolism**

Problematic documentation: Active cancer vs. 'History of' cancer[8]

Clinically:
Many providers consider cancer "active/current" until five years have passed since treatment and want to use an "active/current" cancer diagnosis within that period.

- **This medical concept *does not* carry over to ICD-10-CM coding.**
  - ICD-10-CM coding guidelines do not capture this information and it would be inappropriate to code it as an "active/current" cancer because it does **not** meet the standards of the coding guidelines.

Providers consider monitoring a patient with a "history of" cancer as "active treatment" and want to use an "active/current" diagnosis.

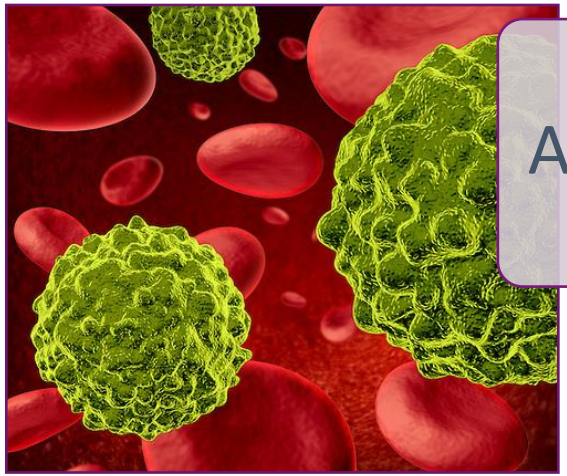
- In ICD-10-CM coding guidelines, "monitoring" and "active treatment" do **not** mean the same thing.

Problematic documentation: Active cancer vs. 'History of' cancer[8]

<u>One of the following must be documented</u> to report the cancer as active:

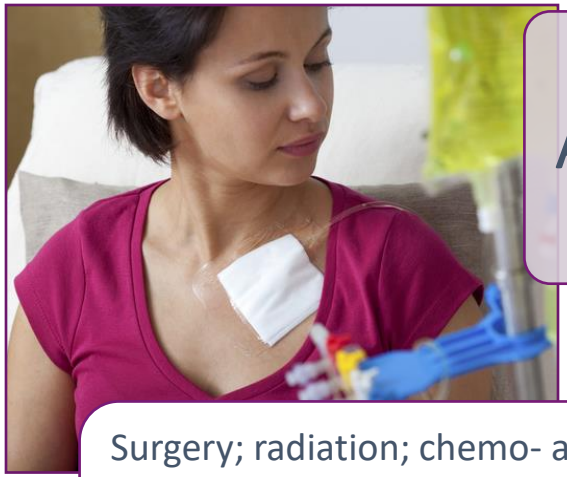
Active disease **<u>or</u>** active treatment

Disease status



Active

Current treatment[8,9]



Active

Surgery; radiation; chemo- and or immunotherapy (including biological adjuvants-monoclonal antibodies); and, in some instances, hormonal drug therapy

Problematic documentation: Active cancer vs. 'History of' cancer

- Prior to documenting or choosing a diagnosis code from the EHR:
  - Determine if the cancer is active/current or not.
  - Update problem lists or visit diagnosis lists to history of cancer when applicable.
  - Avoid mixing or using "history of" when the patient has "active/current" cancer.

Decision table[8,9]		
Disease status	**Treatment**	**Document and code**
Not eradicated	None	**Active cancer**
	Surgery, radiation, chemotherapy, or immunotherapy	
No residual disease	Surgery, radiation, chemotherapy, or immunotherapy	
	Hormonal drug therapy documented as part of an active treatment plan	
No residual disease	Hormonal drug therapy documented as preventive or prophylactic treatment	**"History of" cancer**
	Hormonal drug therapy lacking documentation as active or prophylactic	
	Completed active treatment (surgery, radiation, chemotherapy, or immunotherapy)	

Problematic documentation: Active cancer vs. 'History of' cancer

Primary care record

HPI: Patient present for follow-up of chronic conditions of DM, HTN, CAD, and prostate CA diagnosed in 2017. PT is followed by oncology.

ROS: Negative

Exam: No GU Exam

A&P:

Type 2 DM (E11.9)…….

~~Prostate CA **(C61)**~~: Follows with Oncology

HTN (I10) ……

CAD (I25.2)…….

Hyperlipidemia (E78.5)……..

Hx of Prostate CA (Z85.46)

Oncology record

HPI: Patient present for continued follow-up of Prostate CA diagnosed in 2017. Patient completed radiation therapy in June 2017…..

Last PSA results……

A&P:

Doing well, no residual disease

PSA stable at…….

Recheck PSA in 6 months

Problematic documentation: Uncertain terminology[10]

ICD-10-CM terminology making a diagnosis uncertain and therefore ineligible to report:

- Probable
- Suspected
- Questionable
- Rule out
- Compatible with
- Consistent with
- Likely
- Working diagnosis
- Other similar terms indicating uncertainty

Uncertain diagnosis (ICD-10-CM section IV.H.)

- **Is the condition confirmed?**
  - **<u>Yes</u>: Do not use these terms *anywhere* in the record when describing the condition.**
  - **<u>No</u>: It is OK to document a condition as uncertain (e.g., probable) while working to confirm the diagnosis. Only report the ICD-10-CM code for the symptoms, signs, abnormal test results, or other reason for the visit.**

Problematic documentation: Diabetes

ICD-10-CM classification

Code category	Type of diabetes mellitus (DM)
E08	DM due to underlying condition
E09	Drug- or chemical-induced DM
E10	**Type 1 DM**
E11	**Type 2 DM**
E13	Other specified DM (post-procedural)

With or without complications

With **acute** complications:
- Ketoacidosis/Hyperosmolarity with/without coma

With **chronic** complications
- Kidney (CKD, nephropathy)
- Ophthalmic (retinopathy)
- Neurological (neuropathy)
- Circulatory (angiopathy)
- Other (arthropathy, skin/ulcer, oral, hypo/hyperglycemia)

Without complications

Severity of illness

Problematic documentation: Diabetes[11]

The "with" guideline

ICD-10-CM presumes a causal relationship or diabetic complication when a provider documents diabetes and certain conditions, even without the provider explicitly linking the two.

Alphabetic Index
Diabetes, diabetic (mellitus) (sugar) E11.9
type 2 E11.9
with
amyotrophy E11.44
arthropathy NEC E11.618
autonomic (poly) neuropathy E11.43
cataract E11.36
Charcot's joints E11.610
chronic kidney disease E11.22
circulatory complication NEC E11.59
complication E11.8
specified NEC E11.69
dermatitis E11.620
foot ulcer E11.621

Common ICD-10-CM linked diabetic complications (caused by diabetes):

- CKD or nephropathy
- Angiopathy, PVD, or PAD
- Neuropathy or polyneuropathy
- Retinopathy or cataract
- Foot ulcer
- Dermatitis

Sample medical record

Problem list/visit diagnosis (same as A&P below)

CC:----------
HPI:------
ROS:-----
PFSH:----

Provider does not document that any of the conditions in the A&P are related or are caused by the diabetes.

Exam:----------

Assessment and plan:

1. ~~Type 2 DM, uncomplicated [E11.9]~~
2. H
3. C
4. CKD Stage 3 [N18.3]
5. Hyperlipidemia [E78.5]

Presumed link

Provider may have to search for a different description ***"Type 2 DM with CKD"*** to report ICD-10-CM code **E11.22**

Terms listed as **not elsewhere classified (NEC)** do not presume a causal relationship between diabetes and the term. The provider must specifically document a link between the two conditions to code the diabetic complication.

Problematic documentation: Diabetes

ICD-10-CM **does not presume a causal relationship** or diabetic complication for many documented conditions that a provider may diagnose as related.

- **The provider must document the conditions as being related to assign the diabetic complication code** (e.g., Type 2 DM with **other specified complication** E11.69).
- Common provider-diagnosed complications (caused by diabetes):
  - Hyperlipidemia
  - Hypertension
  - Coronary artery disease (CAD)
  - Skin ulcer other than foot
  - Obesity

Terminology creating a link between the conditions:

- Diabetic
- Associated with
- Due to
- With
- In

Diabetes with ICD-10-CM "non-presumed" complications

- The EHR description itself may create the documentation link, for example:
  - *DM type 2 with diabetic dyslipidemia*
  - *Dyslipidemia associated with type 2 diabetes mellitus*
  - *Diabetes mellitus in obesity*

Be sure to document an A&P for the associated diabetic condition.

Problematic documentation: Diabetes[12]

As many codes from the diabetes code category should be assigned as needed to report all documented associated diabetic complications being managed, evaluated, assessed, or treated during the encounter.

Example: *"Uncontrolled Type 2 diabetes with hyperglycemia, polyneuropathy, and nephropathy"*
Codes Assigned:
E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
E11.21 Type 2 diabetes mellitus with diabetic nephropathy
E11.65 Type 2 diabetes mellitus with hyperglycemia

- Once a diabetic complication exists, do not report E11.9 (DM uncomplicated).
- Remove the E11.9 (DM uncomplicated) code from the active problem list once a diabetic complication develops.

Problematic documentation: Diabetes

ICD-10-CM classifies uncontrolled diabetes by:

- Type
- With hyperglycemia

E11.641 Type 2 diabetes mellitus **with hypoglycemia with coma**
E11.649 Type 2 diabetes mellitus **with hypoglycemia without coma**
E11.65 Type 2 diabetes mellitus **with hyperglycemia**

Documented statements of:

– *Uncontrolled*
– *Inadequately controlled*
– *Out of control*
– *Poorly controlled*

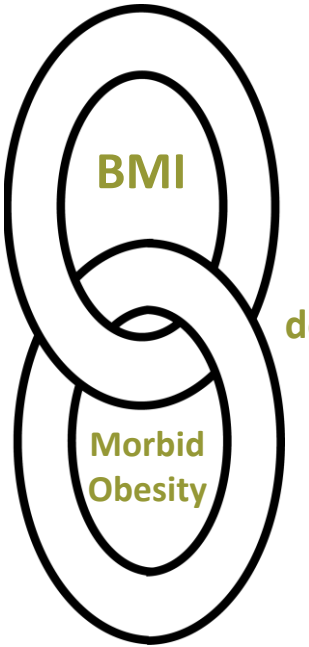
ICD-10-CM alphabetic index classifies to the type with hyperglycemia

Documentation Tips

- Documentation ***"not at goal"*** is not synonymous with uncontrolled.
  - *"Type 2 diabetes mellitus not at goal"* is reported as uncomplicated diabetes (E11.9).
- Best practice is to document uncontrolled diabetes with hyperglycemia and/or hypoglycemia.
- Documentation for the treatment of an uncontrolled condition should typically show a change in the treatment to support that the condition is being addressed during the encounter.

Problematic documentation: BMI/Morbid Obesity[13]

Documentation Tips



Provider documentation link

BMI value

- Not to be reported for routine capture
- Can be abstracted from ancillary staff notes
  - **Must be associated with a <u>provider-documented</u> condition**
    - **The associated condition must meet the criteria of a reportable diagnosis.**
  - **Only to be reported as a secondary diagnosis**
- Value of the BMI does not define the associated condition code (e.g., morbid obesity)

Associated Condition

- Must meet the criteria of a reportable diagnosis
  - Obesity and morbid obesity are coded based on the provider's documentation, not a BMI value.

Best practice example documentation

Morbid Obesity: *BMI remains at 38.9. Discussed lifestyle/dietary changes and possibility of bariatric surgery …*

Problematic documentation: CAD and angina[14]

A **causal relationship** can be assumed in a patient with both atherosclerosis (CAD) and angina pectoris, unless the documentation indicates the angina is due to something other than CAD.

I25.10 Atherosclerotic heart disease of native coronary artery **without** angina pectoris
I25.110 Atherosclerotic heart disease of native coronary artery **with unstable** angina pectoris
I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris **with documented spasm**
I25.118 Atherosclerotic heart disease of native coronary artery **with other forms** of angina pectoris
I25.119 Atherosclerotic heart disease of native coronary artery **with unspecified** angina pectoris

(ICD-10-CM has codes to report CAD in a bypass graft and/or transplanted heart.)

- Native artery is the default site if not otherwise specified.
- Stable angina is coded as "other form."
  - Do not miss opportunities to document and code CAD **with angina (even stable)**, as these codes risk-adjust.
- Support angina with documentation of:
  - *"Angina currently asymptomatic, will continue to monitor; use nitroglycerin as needed."*

Problematic documentation: Status conditions

- **Frequently missed reported status conditions: Ostomies, transplants, amputations**
- Often, PCPs will maintain they “do not treat the condition”; therefore, there is no documentation conveying the condition was addressed during the encounter.

Ostomies

- If a temporary ostomy, do not report the ICD-10-CM status code after it is reversed.
- Document an assessment of the stoma in the physical exam.

Transplants

- Although the condition is not actively being treated, the condition may affect the care provided.
  - For example, certain medications may not be indicated for a transplant patient, thus increasing the level of medical decision making of the provider.
- Document an assessment (e.g., “no problems”) and compliance with the transplant team managing the care.

Amputations

- Document an assessment of the stump in the physical exam.

4 Documentation in practice

Documentation in practice

History of present illness (HPI)/Review of systems (ROS):
She does have a history of a DVT in the lower extremities, as well as a history of paroxysmal atrial fibrillation. She had been on long-term anticoagulation therapy with Eliquis but did have a lower GI bleed in the recent past and this was discontinued. She does remain on aspirin therapy. History of coronary artery disease with a fairly recent non-ST elevation MI and congestive heart failure. Presently stable. Remainder 14-point review of systems is negative.

Exam/Objective:
LUNGS: Slightly decreased breath sounds bilaterally, otherwise clear. No rales, no wheezing.
HEART: Irregularly irregular with controlled ventricular response. Heart tones are somewhat distant. She is in atrial fibrillation.

Assessment and plan:
Chronic atrial fibrillation with controlled ventricular response. On aspirin therapy because of a lower gastrointestinal bleed while on formal anticoagulation.
Plan: Continue same medications except we will restart her sertraline 50 mg at bedtime and increase her furosemide to alternating 20 mg with 40 mg every other day. Order complete laboratory profile and notify her of the results when available. Because of her deteriorating condition, I will make a home visit in three months or sooner.

- **Using "history of" terminology in generalized terms for conditions listed in the record.**
- **Without a clear A&P makes it hard to determine if the condition is active and addressed during the encounter.**

Documentation in practice

Visit diagnoses:

Type 2 Diabetes, uncontrolled	E11.65
Hypertension	I10

History of present illness (HPI): States that he had to go to the ER a couple months ago as his blood pressure was over 200 systolic. His wife does monitor his blood pressure and heart rate twice a day. Current readings have been ranging from 86/40 up to 160/70. No edema in his lower extremities. Wife states his blood sugars are stable and doing well. No hypoglycemia.

Exam: Nothing pertinent

Assessment and plan:

1. Type 2 diabetes, uncontrolled—Continue with Levemir and Ozempic. We will check HgA1c.
2. Hypertension—Change dosage of BP medication …

Uncontrolled/Unstable/Exacerbated condition should have a documented change in treatment.

Documentation in practice

Visit diagnoses:

- Type 2 diabetes with nephropathy E11.21

History of present illness (HPI):

61-year-old male past medical history of morbid obesity, diabetes mellitus poorly controlled. His diabetes is poorly controlled, with his last hemoglobin A1c above 10. Did review his diet. He reports that he is doing less snacking. Sugars are coming down. Fasting 180–200 range, lowest 180.

Review of systems (ROS): Nothing pertinent

Exam: Nothing pertinent

Assessment/Plan:

1. Type 2 diabetes with nephropathy [E11.21]: Hemoglobin A1c (11.2) not at goal. We did discuss diet. He is on a regimen that includes metformin 500 mg by mouth twice a day glipizide 10 mg twice a day Lantus 45 units twice a day Trilisate 1.5 MG every 7 days with not much improvement in his sugars. Increase metformin to 1000 mg twice a day as tolerated. Prior to next visit, check CMP, lipids, hemoglobin A1C.

- **Documentation supports "uncontrolled diabetes" (E11.65 Type 2 DM with hyperglycemia).**
- **A&P for diabetes is well documented, nephropathy not documented as addressed.**

Documentation in practice

HPI:
Primary hyperparathyroidism. Had been seen by Dr. _____, who told her she did not need surgery. Has had a parathyroid scan with no adenoma seen. In my opinion, she has hyperparathyroidism. We discussed that she likely has hyperparathyroidism, but she does not want surgery, so she does not further investigation. Discussed to monitor for signs/symptoms of hypercalcemia. She is not on Lasix.

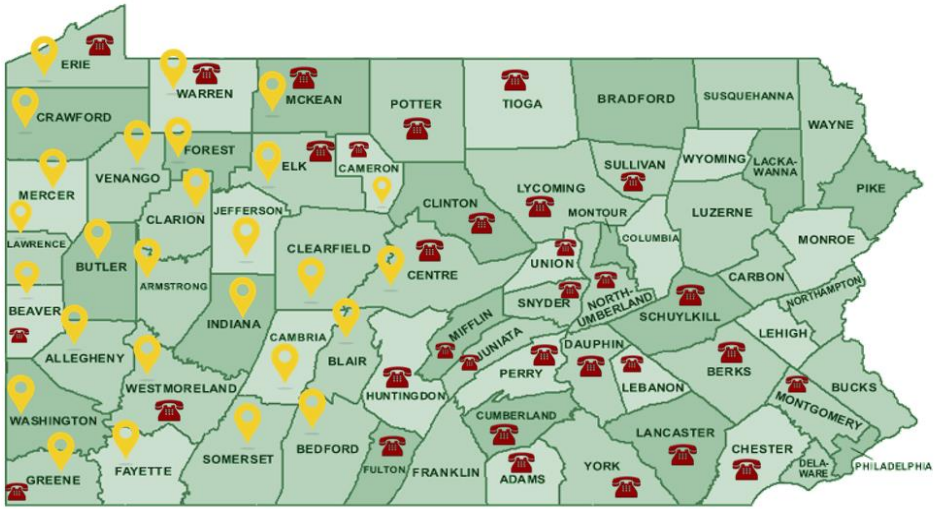
Exam: Nothing pertinent

Assessment/Plan:
Primary hyperparathyroidism. Her labs are compatible with primary hyperparathyroidism, despite the lack of adenoma seen on scan. Will await updated levels. At the visit, we discussed that she should seek endocrinology consultation for further evaluation. The patient reports she would decline surgery anyway and does not want to seek consultation at this time. Since her symptoms are improved, we will continue to monitor.

- **Uncertain terminology is used to make the diagnosis a non-reportable diagnosis.**

5 Resources

UPMC Health Plan Risk Adjustment/HCC Physician Educator team



- The regional team is a resource for provider documentation improvement and ICD-10-CM code assignment.
- Physician educators are assigned to sites based on higher enrollment of patients in Medicare Advantage and ACA plans.
- Face-to-face education encounters are the main goal, but encounters can occur telephonically or virtually.

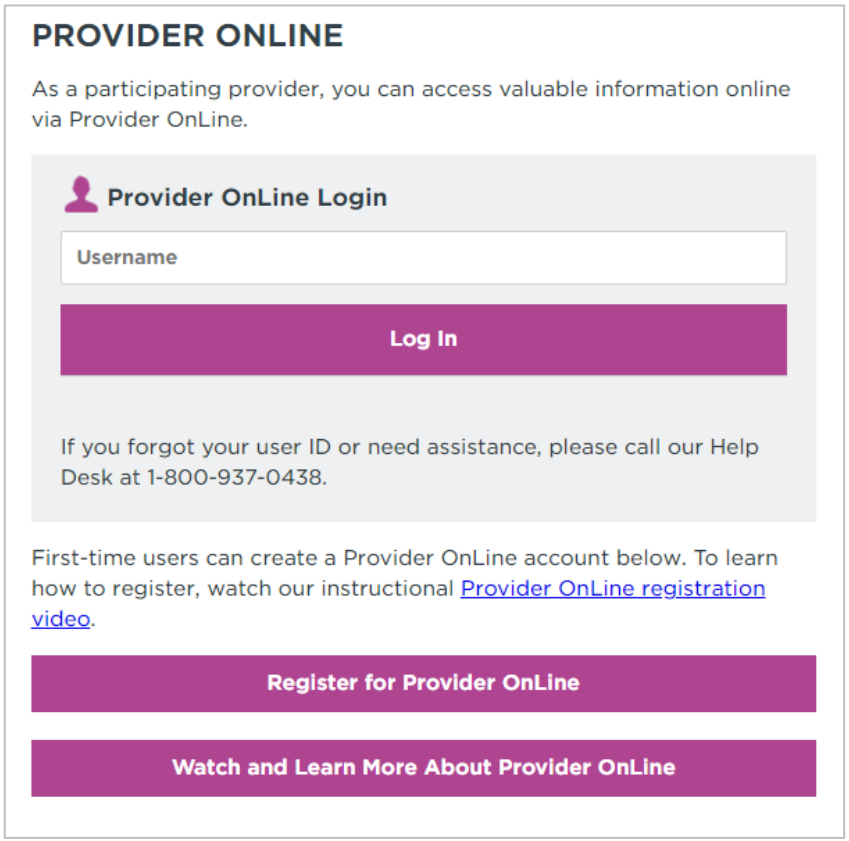
Face-to-face education coverage

Telephonic education coverage

Physician educators provide:

- Practice progress of HCC capture via monthly reporting.
- Time-friendly (20-30 minute) documentation and coding trainings for problematic diagnoses.
- ICD-10-CM coding tools or “cheat sheets.”
- Diagnosis/HCC chart reviews for educational purposes focused on:
  - Missed diagnoses/HCC opportunities.
  - Unsubstantiated diagnoses (not supported in the medical record documentation).
  - Provider documentation improvement.
  - Coding education/guidelines.

UPMC Health Plan: Provider OnLine



Numerous diagnosis-specific coding tools or "cheat sheets" are available to network providers and can be downloaded to assist with documentation and ICD-10-CM code reporting.

Visit our website

- Click the link above or go to upmchealthplan.com/providers.
- Log in to or register for Provider OnLine.
- You will land on the Provider OnLine homepage.
- In the left-hand navigation menu, click **Documents and Forms.**
- Scroll down to **HCC Risk Adjustment for Coding Tools.**

6 References

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[1]Shulte F. Medicare Advantage Audits Reveal Pervasive Overcharges. Aug. 29, 2016, Center for Public Integrity.

[2]Medicare Advantage Risk-Adjustment Data—Targeted Review of Documentation Supporting Specific Diagnosis Codes. Office of the Inspector General. oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000422.asp

[3]Medicare Claims Processing Manual. Chapter 12. Section 30.6.1.A. Centers for Medicare and Medicaid Services. cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

[4]CPT Evaluation and Management (E&M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99417) Code and Guideline Changes.

[5]2022 ICD-10-CM Official Guidelines for Coding and Reporting. Section IV.J. Centers for Medicare and Medicaid Services. cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

References

[6]*Acute Myocardial Infarction (AMI)* and I.C.9.d. *Sequelae of Cerebrovascular Disease.* 2022 ICD-10-CM Official Guidelines for Coding and Reporting. Sections I.C.9.e. 2021. cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

[7]History of recurrent deep vein thrombosis. American Hospital Association, Coding Clinic Advisor, 2nd Quarter 2020.

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[9] Primary Malignancy previously excised. 2022 ICD-10-CM Official Guidelines for Coding and Reporting. Section I.C.2.d. Centers for Medicare and Medicaid Services. 2021. cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

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Diabetes with arthropathy. American Hospital Association, Coding Clinic Advisor, 2nd Quarter 2018.
Diabetes and skin complications not elsewhere classified. American Hospital Association, Coding Clinic Advisor, 4th Quarter 2017.

[12] *Diabetes mellitus.* 2022 ICD-10-CM Official Guidelines for Coding and Reporting. Section I.C.4.a. Centers for Medicare and Medicaid Services. 2021. cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

[13] References pertaining to Obesity, Morbid Obesity, and BMI. American Hospital Association, Coding Clinic Advisor, 4th Quarter 2018.

[14] *Atherosclerotic Coronary Artery Disease and Angina.* 2022 ICD-10-CM Official Guidelines for Coding and Reporting. Section I.C.9.b. 2021. cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf

Live Q&A session

- Questions entered in the WebEx Q&A section will be addressed in the order they are received.

- Questions entered in the WebEx Q&A portion not addressed during the live webinar will receive a response via email.
- For any additional questions pertaining to the coding and documentation content from this webinar, please email riskadjustment@upmc.edu.

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Sept. 29, 2021 (Live—Virtual)

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UPMC HEALTH PLAN

Thank you for attending!