Diagnosis Coding
& CMS Risk Adjustment

Bernard J. Katz, M.D., M.B.A.
Family Medicine and Geriatrics
Medical Director, Community Physician Network
and Entertainment Industry Medical Group
What is ICD-10?

• The International Classification of Disease (ICD) is a standard diagnostic tool created by the World Health Organization (WHO), for monitoring the incidence and prevalence of diseases and related conditions.

• The ICD has diverse clinical applications, and is used not just by doctors but also by paramedic staff, insurance companies, researchers and policy makers. ICD is used to classify diseases and store diagnostic information for clinical, quality and epidemiological purposes and also for reimbursement of insurance claims.

• https://doctors.practo.com/icd-10-codes-important-doctors/
Structure of ICD-10 Codes

ANATOMY OF AN ICD-10 CODE

Category | Location | Extension
--- | --- | ---
S53.521A | Etiology | Laterality

ICD-10 code for torus fracture of lower right end of right radius, initial encounter for closed fracture
Why ICD-10 Codes are Important

- The ICD-10 code system offers accurate and up-to-date procedure codes to improve health care cost and ensure fair reimbursement policies. The current codes specifically help healthcare providers to identify patients in need of immediate disease management and to tailor effective disease management programs.
- ICD-10-CM has been adopted internationally to facilitate implementation of quality health care as well as its comparison on a global scale.
- Compared to the previous version (i.e. ICD-9-CM) ICD-10-CM is more specific and captures public health diseases, particularly diseases related to external injury, e.g. terrorism.
Why ICD-10 Codes are Important

• ICD-10 codes hold particular significance in research since code-analysis is an essential component of research and development. Code system and logic allows for fewer coding errors that ultimately benefits in the research and development analyses.

• The upgrade version of the ICD code system enhances health policy decision making by providing better data for organizational monitoring and performance.

• The ICD-10 code system is more easily configurable and retrievable into electronic format offering better format than ICD-9, other codes such as SNOMED CT and CPT codes.

• ICD-10 codes have specifically been developed for reimbursement purposes to offer a rational foundation for payment procedures.
Why ICD-10 Codes are Important

• Alphanumeric formats of the ICD-10 code system provide a better alternative than ICD-9-CM codes offering a more flexible and upgradable version e.g. diabetes mellitus – E10-E14

• Lastly, the ICD-10 coding system helps to:
  • Reduce medication error
  • Improve treatment options and disease outcomes
  • Lower treatment and claim cost
  • Improve health policy and operational and strategic planning
  • Improve payment systems through claims processing
  • Decrease claim submissions

https://doctors.practo.com/icd-10-codes-important-doctors/
Importance of Accurate Diagnosis Coding for Quality Clinical Care

• Leads to **better care**, important clinical issues are noted for care management and not forgotten (e.g. chronic kidney disease)

• **Problem List** in CareConnect populated by ICD-10s

• Drives multiple **reporting** that impacts care assessment (e.g. hospital quality reporting, clinical research, ambulatory quality metrics)

• Used for “**risk adjustment**” by health plans and others to indicate acuity of UCLA’s population

• Incorporated in various **reimbursement** methodologies
  • Risk adjustment payments to UCLA
  • Fee-for-service payments in certain CPTs
Easiest Place to Identify ICD-10 Codes

The PROBLEM LIST
UCLA Patients With Incomplete Problem Lists: Chronic Kidney Disease Example

% Seen by Nephrology 2+ Times in 18 Months Without CKD on Problem List

*CKD defined by most recent ambulatory GFR in 2 years or evidence of hemodialysis
Objectives/Agenda

- Provide an overview of Medicare Risk Adjustment
- Review CareConnect tools
- Review best practice documentation guidelines
- Review current UCLA Health initiatives
Disconnect with Risk Adjustment Between Providers & Health Plans

My patients are sicker

These numbers can’t be right

Now, which diagnosis risk adjusts?

I know I already documented it

Why can’t those doctors document correctly?

Diabetes and COPD don’t cure themselves, why aren’t they documenting it?

They want more $$ but their patients sure don’t appear sicker

That patient has diabetes and CHF, I wonder if there are any underlying conditions?
What is RAF?

In this case, it is **not** the Royal Air Force
Risk Adjustment Factor

• CMS calculates a score, called Risk Adjustment Factor, that is a measure of the “health” of the patient.

• Used to determine the cost of medical expenses for the patient.

• Based on modifiable and non-modifiable factors:
  • Age, Gender, whether qualifies for Medicaid
  • HCC (Hierarchical Condition Categories) Diagnoses billed in face-to-face visits
The ICD-10s reset each year in January for risk adjustment

- Therefore: Every patient must have applicable Dx codes recorded each year. This is best done at the time of the yearly exam, but any applicable Dx from any encounter will be used.

ICD-10 codes for HCC are accepted from physician encounters (e.g. E&M codes), hospital inpatient discharge, and ambulatory surgery

- This means, all face-to-face encounters are used but excludes laboratory and radiology diagnoses

Each previously unreported ICD-10 diagnosis can be valued as much as ~ $4,700 per beneficiary per year

- This payment method uses Dx from clinicians to provide additional funds for pay for the care needed for the more ill patients, but only if the applicable Dx are used as visit Dx at least once yearly.

The RAF Score, as a sum of the HCC, quantifies the illness burden and expected costs of the population

- “High Score” = high expected costs due to illness
- “Low” Score”= lower expected cost, or, incomplete coding
Currently, UCLA looks as if our population is only 5% “riskier” than a healthy population. Our health plans project that we should be around 20% above healthy/1.0
The Centers for Medicare & Medicaid Services (CMS) uses ICD-10 diagnoses to assess risk burden of UCLA patients.

CMS adjusts payments to UCLA based upon risk to ensure we have enough resources to take care of our high risk patients.
8,000 ICD-10s Map to Risk Adjusted Hierarchical Condition Categories (HCC)

- HCCs are groupings of similar diagnoses that consume similar resources

- Each HCC is assigned a “weight” that impacts the patient’s risk score
  - Some HCCs are hierarchical, where more “severe” aspects of the disease are weighted more (diabetes with complications weight more than diabetes without complications)
  - Some HCCs are additive with disease interactions (weight is greater for a patient with CHF with CKD than a patient with just CHF).

- HCCs must be recaptured each calendar year or are not counted by CMS
Examples of Disease Interaction Diagnoses

• Cancer and Immune Disorders
• Congestive Heart Failure and COPD
• Congestive Heart Failure and Renal Disease
• COPD and Cardiorespiratory Failure
• Sepsis and Cardiorespiratory Failure
• Artificial Openings and Pressure Ulcers
Current HCC Diagnosis Coding May Not Capture Acuity for All Patients Seen

There is opportunity for physicians to improve HCC Diagnosis Coding efforts to better capture acuity for all patients seen.

60% of patients seen

Source: CareConnect Professional Billing
System Revenue Opportunities Through Appropriate Coding: 1 Patient Example

### 76 Year Old Medi-Medi Female with Diabetes, Vascular Disease, & CHF...

<table>
<thead>
<tr>
<th></th>
<th>All conditions coded appropriately</th>
<th>Some conditions coded (poor specificity)</th>
<th>Conditions not coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>76 year old female</td>
<td>.468</td>
<td>.468</td>
<td>.468</td>
</tr>
<tr>
<td>Medicaid eligible</td>
<td>.177</td>
<td>.177</td>
<td>.177</td>
</tr>
<tr>
<td>Diabetes w/vascular complications (HCC 15)</td>
<td>.302</td>
<td>.105</td>
<td>No diabetes coded</td>
</tr>
<tr>
<td>Vascular disease w/complications (HCC 104)</td>
<td>.515</td>
<td>.288</td>
<td>No vascular disease coded</td>
</tr>
<tr>
<td>CHF (HCC 80)</td>
<td>.331</td>
<td>CHF not coded</td>
<td>CHF not coded</td>
</tr>
<tr>
<td>Disease Interaction (DM + CHF)</td>
<td>.204</td>
<td>No Disease Interaction</td>
<td>No Disease Interaction</td>
</tr>
<tr>
<td><strong>Total HCC RAF</strong></td>
<td>1.997</td>
<td><strong>Total HCC RAF</strong></td>
<td><strong>Total HCC RAF</strong></td>
</tr>
<tr>
<td><strong>Annual Payment</strong></td>
<td>$21,179</td>
<td><strong>Annual Payment</strong></td>
<td><strong>Annual Payment</strong></td>
</tr>
</tbody>
</table>

- **Patient demographics captured by health plan**
- **Conditions requiring capture by the physician every year**
- **Financial impact to UCLA**

*Table highlights the financial impact to UCLA of proper coding versus partial coding or no coding.*
To Health Plans, UCLA Appears to Have Fewer Patients with Complex Conditions

<table>
<thead>
<tr>
<th>HCC</th>
<th>UCLA Prevalence</th>
<th>Medicare National Prevalence</th>
<th>SCAN Prevalence</th>
<th>Total # of Additional UCLA Members Expected in Medicare and SCAN Population</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>018 Diabetes Chronic Complications</td>
<td>11.80%</td>
<td>13.80%</td>
<td>34.40%</td>
<td>2,482</td>
<td>$5,099,100</td>
</tr>
<tr>
<td>019 Diabetes Without Complication</td>
<td>6.70%</td>
<td>9.30%</td>
<td>6.10%</td>
<td>939</td>
<td>$1,807,094</td>
</tr>
<tr>
<td>022 Morbid Obesity</td>
<td>3.30%</td>
<td>4.50%</td>
<td>10.60%</td>
<td>1,031</td>
<td>$1,818,879</td>
</tr>
<tr>
<td>085 Congestive Heart Failure</td>
<td>9.80%</td>
<td>10.10%</td>
<td>15.20%</td>
<td>489</td>
<td>$846,836</td>
</tr>
<tr>
<td>088 Angina Pectoris</td>
<td>2.70%</td>
<td>2.30%</td>
<td>9.20%</td>
<td>360</td>
<td>$325,891</td>
</tr>
<tr>
<td>108 Vascular Disease</td>
<td>11.80%</td>
<td>11.70%</td>
<td>47.90%</td>
<td>2,729</td>
<td>$1,833,117</td>
</tr>
</tbody>
</table>
For these conditions alone, the financial impact is more than $18,000,000

<table>
<thead>
<tr>
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<th>UCLA Prevalence</th>
<th>Medicare National Prevalence</th>
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<th>Total # of Additional UCLA Members Expected in Medicare and SCAN Population</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>111 COPD</td>
<td>7.10%</td>
<td>11.00%</td>
<td>20.70%</td>
<td>2,491</td>
<td>$5,278,306</td>
</tr>
<tr>
<td>048 Coagulation, Hematological</td>
<td>5.40%</td>
<td>3.80%</td>
<td>19.30%</td>
<td>482</td>
<td>$688,262</td>
</tr>
<tr>
<td>137 CKD, Severe (Stage 4)</td>
<td>0.70%</td>
<td>0.70%</td>
<td>1.90%</td>
<td>79</td>
<td>$121,456</td>
</tr>
<tr>
<td>055 Drug/Alcohol Dependence</td>
<td>2.90%</td>
<td>1.90%</td>
<td>10.50%</td>
<td>201</td>
<td>$496,212</td>
</tr>
<tr>
<td>058 Major Depression, Bipolar, Paranoid</td>
<td>9.30%</td>
<td>6.30%</td>
<td>25.80%</td>
<td>174</td>
<td>$444,826</td>
</tr>
</tbody>
</table>
How Can We Ensure Appropriate Risk Adjustment Coding?

- Recapture Previously Captured HCC Codes – *Reassess from the Problem List*
- Optimize Specificity in Coding
- Appropriately Identify & Capture New Risk Adjustable ICD-10s
Default the Problem List with HCC at top if there is not a Specialty Default Set

<table>
<thead>
<tr>
<th>HCC Conditions</th>
<th>Change Dx</th>
<th>Resolve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senile purpura (HCC/RAF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CKD (chronic kidney disease) stage 5, GFR less than 15 ml/min (HCC/RAF)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gout</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypothyroidism, boarderline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertensive chronic kidney disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(1) Click the Wrench on Problem List
(2) Choose the HCC Conditions Button
### Selecting Diagnoses under Database Lookup: Preference List Shows HCC ICD-10s

<table>
<thead>
<tr>
<th>Name</th>
<th>ICD-10 Codes</th>
<th>HCC Weight</th>
<th>HCC Category</th>
<th>Dx Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral neuropathy</td>
<td>G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy and sensorineural hearing impairment syndrom</td>
<td>Q87.89, G62.9, H90.5</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy caused by toxin (HCC/RAF)</td>
<td>G62.2</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to and not concurrent with chemotherapy (HCC/RAF)</td>
<td>G62.0, T45.1X5S</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to chemotherapy (HCC/RAF)</td>
<td>G62.0, T45.1X5A</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to disorder of metabolism (HCC/RAF)</td>
<td>E88.9, G63</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to hypervitaminosis B6 (HCC/RAF)</td>
<td>E53.8, G63</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to inflammation</td>
<td>M79.2, G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to ischemia</td>
<td>G62.89</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy due to metabolic disorder (HCC/RAF)</td>
<td>E88.9, G63</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
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<td>G62.2</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy during pregnancy</td>
<td>O99.350, G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy during pregnancy, antepartum, first trimester</td>
<td>O99.351, G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy during pregnancy, antepartum, second trimester</td>
<td>O99.352, G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy during pregnancy, antepartum, third trimester</td>
<td>O99.353, G62.9</td>
<td>0.472</td>
<td>75</td>
<td>Both Specific and General</td>
</tr>
<tr>
<td>Peripheral neuropathy during pregnancy, antepartum, unspecified trim</td>
<td>O99.350, G62.9</td>
<td>0.472</td>
<td>75</td>
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</tr>
<tr>
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</table>
New Best Practice Alert: Click to Add Previously Addressed Diagnoses to Visit Dx & Problem List

If documented during the visit, click “Add Visit Diagnosis” & “Add to Problem List”

CareConnect e-learning link: https://lms.ccnet.ucla.edu/elearning/HCC100
Best Practice Alert Key Components

Which HCCs
- All diagnoses submitted in the prior 3 years by a UCLA provider in any type of encounter which have not yet been “recaptured” this calendar year

What triggers BPA
- Fires if 5 HCCs were billed as a visit diagnosis in prior 3 years by a UCLA provider but not recaptured this calendar year

If you click “Do Not Add”
- BPA will continue to display in future encounters unless addressed by another physician. Choose “N/A to Patient” if not relevant to patient

BPA is “satisfied” when the diagnosis is coded somewhere within UCLA
Documentation Guidelines

• Code all documented conditions that coexist, and which affect patient care, treatment, or management

• Example #1
  • Patient with urinary tract infection also is diabetic. Does the presence of diabetes affect the treatment provided?
  • Code Diabetes

• Example #2
  • Patient with an ankle sprain also has atrial fibrillation
  • Does the presence of warfarin or direct oral anticoagulants affect treatment, possible limitation of NSAIDs? Code atrial fibrillation
Each diagnosis must be documented in the **Assessment**, and each diagnosis must show that the provider is **T**reating, **E**valuating, **A**ssessing/addressing, and **M**onitoring the condition.

A simple list of diagnoses is not acceptable or valid per official coding guidelines, nor does a simple list meet the definition of ASSESSMENT and PLAN.

Documentation must indicate how the physician is treating, managing, or addressing the chronic conditions.
T.E.A.M

- **Treating**—medications, therapies, other modalities
  - Continue furosemide for edema; Add tiotropium for COPD
- **Evaluating**—test results, medication effectiveness, response to treatment
  - Cardiac rate is controlled, Edema improved
- **Assessing/Addressing**—ordering tests, discussion, review records, counseling
  - Stable; Controlled; Worsening; Unchanged; Uncontrolled
- **Monitoring**—signs, symptoms, disease progression, disease regression
  - Weight stable, HgbA1c 6.7, comment on lipids, etc.
## Sample Language

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stable</td>
<td>• Monitor</td>
</tr>
<tr>
<td>• Improved</td>
<td>• D/C meds</td>
</tr>
<tr>
<td>• Controlled</td>
<td>• Continue current meds</td>
</tr>
<tr>
<td>• Tolerating Meds</td>
<td>• Obtain labs/studies</td>
</tr>
<tr>
<td>• Deteriorating</td>
<td>• Refuses/Declines Treatment</td>
</tr>
<tr>
<td>• Uncontrolled</td>
<td></td>
</tr>
</tbody>
</table>

**Example:** Type 2 Diabetes Mellitus with renal manifestations, stable and well controlled on meds.

**Example:** CHF, stable on meds; check BNP, BMP; monitor home weights.
Some Diagnoses are found Incidentally
Ex: Aortic Atherosclerosis
### Other Common HCC Chronic Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity, BMI ≥ 40, or BMI &gt; 35 with serious comorbidity</td>
<td></td>
</tr>
</tbody>
</table>
| Alcohol Disorders, Benzodiazepine or Opiate Use | • Moderate or severe; Active or in remission  
• Prior history of alcoholism (alcohol misuse) |
| Marijuana Dependence | • Marijuana dependence, in remission  
• Marijuana dependence, continuous  
• Marijuana dependence, episodic |
| Dementia | • Alzheimer’s  
• Old age Dementia  
• Parkinson's’ Dementia |
Remember - Patients who were 18 during the Summer of Love, 1968, ...
Are 70 years old now
Take Advantage of Time at the Annual Exam as a PCP or Annual Follow up as a Consultant

RAF for the Rest of Us

GO TO THE PROBLEM LIST
GO FOR THE BEST DIAGNOSES
GO WITH WHAT YOU KNOW

EXAMINE FOR DETAILS
ENTER INTO THE EHR
EVALUATE THE CHOICES

ASSESS THE DIAGNOSES
ADD SIMPLE NARRATIVE
ANSWER FOR THE T.E.A.M.

REMEMBER TO LINK
RECORD CAUSE AND EFFECT
REEVALUATE EACH YEAR

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But Don’t Always Wait until the Annual Exam – the patient may not always return annually

<table>
<thead>
<tr>
<th>HCC Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squamous cell carcinoma of oral cavity (HCC/RAF)</td>
</tr>
<tr>
<td>Alcohol use disorder, severe, dependence (HCC/RAF)</td>
</tr>
<tr>
<td>Moderate major depression (HCC/RAF)</td>
</tr>
<tr>
<td>Thrombocytopenia (HCC/RAF)</td>
</tr>
<tr>
<td>Chronic bronchitis (HCC/RAF)</td>
</tr>
<tr>
<td>Enter Staging Information</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphedema</td>
</tr>
<tr>
<td>Herpes</td>
</tr>
<tr>
<td>Routine adult health maintenance</td>
</tr>
</tbody>
</table>
General Tips

1. Check Imaging – is there calcification of the aorta?
2. Check Depression screen (PHQ-9) – is there any prior Depression with PHQ-9>4?
3. Check Labs – look at the eGFR and HgbA1c
4. Check the medications – anything that would indicate chronic medication use of a disease in remission
   • SSRI for depression; Gabapentin or Pregabalin for neuropathy
5. Does the patient have a BMI > 40 or BMI > 35 with comorbidity?
6. Does the patient have a malignancy that is either present or recently treated?
7. Does the patient have a sequelae of a stroke, ostomy status, etc.?
8. Does the patient have a history of prior alcoholism – Alcohol misuse in remission?
Joe Bruin’s Diagnoses

79 y.o. male with history of ulcerative colitis. Has been maintained on Prednisone 20 mg alternating with 30 mg daily for 6 months as intolerant of other agents. Has h/o hypertension and hyperlipidemia and osteoarthritis of the knee. His eGFR is 55. He has some claudication with ambulation and decreased pedal pulses.

HCC
- Ulcerative Colitis
- Immunosuppression due to chronic steroids
- Peripheral vascular disease

Not HCC
- Hypertension
- Hyperlipidemia
- Osteoarthritis
- CKD Stage 3
Sally Smith

76 year old female recently moved to Los Angeles and wishes to establish care. She has a history of COPD and Type 2 Diabetes Mellitus. She complains of a burning sensation in the feet, which has been gradually worsening over 18 months. She has tried several medications in the past without much success. She has been using THC/CBD oil daily for 6 months which she thinks may be helping.

Current medications include Metformin, Januvia, and aspirin. She also has been on Sertraline for 10 years due to a few episodes of major depression. She quit smoking in 2010, with a prior 50 pack year history. She used to drink heavily but quit in 1992.
Examination reveals:

- BP 130/76
- Weight 223 lbs., Height 5’2”, BMI 40.8
- Pulse 62, regular
- Decreased pedal pulses noted. Decreased sensation using monofilament. Mild edema with stasis dermatitis noted in the feet.
- Affect cheerful
1. COPD
2. Type 2 Diabetes Mellitus with neurological manifestations
3. Marijuana Use, continuous
4. Major Depression, in remission
5. Morbid Obesity
6. Alcohol use, in remission

Possible additional diagnoses:
7. Type 2 DM with vascular manifestations
8. Peripheral vascular disease
Paul Jones

82 y.o. male with h/o CAD, Hypertension, CKD-3, CHF, COPD. He has major depression with OCD. He has Type 2 Diabetes Mellitus. He also has burning feet from peripheral neuropathy and peripheral vascular disease. He is s/p Aortic Valve Replacement, has a chest x-ray indicating a tortuous and calcified aorta, and has hypothyroidism. He has mild Alzheimer’s.

<table>
<thead>
<tr>
<th>Non-HCC</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>Aortic Atherosclerosis</td>
</tr>
<tr>
<td>HTN</td>
<td>HTN Dz w/CHF</td>
</tr>
<tr>
<td>CKD-3</td>
<td>DM-2 w/kidney dz</td>
</tr>
<tr>
<td>Periph Neurop.</td>
<td>DM-2 w/neuropathy</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>DM-2 w/PVD</td>
</tr>
<tr>
<td>s/p AVR</td>
<td>Major Depression (OCD)</td>
</tr>
<tr>
<td>Hypothyroid</td>
<td>Peripheral Vascular Disease COPD</td>
</tr>
</tbody>
</table>
Billy Bear

67 y.o. male with prostate cancer who has opted for watchful waiting. He had an echo due to a mild murmur that showed 4.4 cm aneurysmal dilatation of the aortic root. His ejection fraction is 45%. He has HTN, NIDDM, and obstructive sleep apnea and uses CPAP. BMI=41. His eGFR is 28, HgbA1c is 7.1%. Medications: Losartan, Sertraline, Metoprolol, Atorvastatin, ASA. He has been on Sertraline x 3 years due to a prior h/o depression, now well controlled.

What are the HCC Diagnoses?

What are the non-HCC Diagnoses?
68 y.o. female with a history of breast cancer s/p lumpectomy and XRT 2 years ago. During adjuvant chemotherapy she had a CVA which left her with mild left hand weakness but otherwise neurologically intact. She had been moderately depressed since her diagnosis and her PHQ-9 was 15 but now, on Escitalopram 10 mg daily, it is 3. Her other medications include Anastrazole 1 mg daily, and Atorvastatin 20 mg daily which was started because aortic calcifications were noted in the abdominal aorta on CT done as part of her metastatic evaluation. Her physical examination is unremarkable.
Greta Grizzly

68 y.o. female with a history of breast cancer s/p lumpectomy and XRT 2 years ago. During adjuvant chemotherapy she had a CVA which left her with mild left hand weakness but otherwise neurologically intact. She had been moderately depressed since her diagnosis and her PHQ-9 was 15 but now, on Escitalopram 10 mg daily, it is 3. Her other medications include Anastrazole 1 mg daily, and Atorvastatin 20 mg daily which was started because aortic calcifications were noted in the abdominal aorta on CT done as part of her metastatic evaluation.

HCC Diagnoses:

Breast Cancer

Hemiparesis from CVA

Major Depression, Moderate in Remission

Aortic Atherosclerosis
# Common Diagnoses Either Underspecified or Underdiagnosed

<table>
<thead>
<tr>
<th>Condition</th>
<th>HCC (-)</th>
<th>HCC (+) additional payments for care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common Diagnoses That Are Underspecified</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>N189: Chronic Kidney Disease, unspecified</td>
<td>N184: Chronic kidney disease, stage 4 (severe)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N185: Chronic kidney disease, stage 5</td>
</tr>
<tr>
<td>Hypertension</td>
<td>I10: Essential (primary) hypertension</td>
<td>I110: Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td></td>
<td>I119: Hypertensive heart disease without heart failure</td>
<td>I509: Heart failure, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I5020: Unspecified systolic (congestive) heart failure</td>
</tr>
<tr>
<td>Depression</td>
<td>F328: Other depressive episodes</td>
<td>F320: Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td></td>
<td>F329: Major depressive disorder, single episode, unspecified</td>
<td>F330: Major depressive disorder, recurrent, mild</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F3340: Major depressive disorder, recurrent, in remission, unspecified</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>E663: Overweight</td>
<td>E6601: Morbid (severe) obesity due to excess calories</td>
</tr>
<tr>
<td></td>
<td>E669: Obesity, unspecified</td>
<td>E662: Morbid (moderate-severe) obesity with comorbidity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z6841: Body mass index (BMI) 40.0-44.9, adult</td>
</tr>
<tr>
<td><strong>Common Diagnoses That Are Underdiagnosed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>N/A</td>
<td>298 total ICD-10s. Following codes indicate specificity:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E1040: Type 1 diabetes mellitus with diabetic neuropathy, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E10311: Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
</tr>
</tbody>
</table>
# Diabetes Mellitus Type 2 (E11.xx): Specificity is Key

<table>
<thead>
<tr>
<th>Diabetic Eye Disease: E11.3x</th>
<th>Diabetic Neuropathy: E11.4x</th>
<th>Diabetic Vascular Disease: E11.5x</th>
<th>Diabetes with joint, skin, ulcers: E11.6</th>
<th>Diabetes with unspecified complications: E11.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinopathy</td>
<td>Peripheral Neuropathy</td>
<td>Peripheral Vascular Disease</td>
<td>Dermatitis</td>
<td>Need to specify the complication in the notes as it relates to Diabetes</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Gastroparesis</td>
<td>Coronary Artery Disease</td>
<td>Arthropathy (charcot joint)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cerebrovascular Disease</td>
<td>Foot and other ulcers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Carotid Disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Diabetes without complications: E11.9 should only be used if patient truly does not have any comorbidities. The HCC weight is only about 1/3 of the diabetes with complications HCC
Congestive Heart Failure (I50.xx)

- Chronic condition. May be “controlled” and asymptomatic
- Best to be as specific as possible

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diastolic</td>
<td>Chronic</td>
</tr>
<tr>
<td>Combined</td>
<td>Acute on Chronic</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
</tr>
</tbody>
</table>

- There are interactions with other disease states such as Hypertension, Chronic Kidney Disease and Diabetes Mellitus which are additive
  - CHF due to Hypertension
  - CHF due to Hypertension and CKD
Atherosclerosis and Peripheral Arterial Disease (I70 & I71): Quick Tips

Aortic Atherosclerosis
- Look at Chest X-ray or CT scans
- Tortuous Aorta
- Calcified Aorta or Calcified Vessels

Peripheral Arterial Disease
- Ankle Brachial Index (ABI)
- Absent Pulses – clinical diagnosis

AAA without rupture
- Any enlargement of aorta noted

Atherosclerosis of Native Artery with Ulceration
- Presence of ulcerations related to PAD is additive
Major Depressive Disorder (F32 & F33): Most Frequently Miscoded HCC

- **F32.9 does not risk-adjust.**
  - Depression
  - Major Depression (no other descriptors)
  - Major Depression, single episode
  - Melancholia
  - Depressed State
  - Postpartum Depression
  - Reactive Depression

**DO NOT USE** if alternative is more appropriate
Major Depressive Disorder (F32 & F33): Appropriate HCC In Most Cases

• HCC Weight = 0.33
• Severity, including remission, determines the code

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>REMISSION STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>.0 Mild</td>
<td>.4 Partial</td>
</tr>
<tr>
<td>.1 Moderate</td>
<td>.5 Full</td>
</tr>
<tr>
<td>.2 Severe, no psychosis</td>
<td>.8 Other</td>
</tr>
<tr>
<td>.3 Severe, with psychosis</td>
<td>.9 Unspecified</td>
</tr>
</tbody>
</table>

• F32.0 – Mild Major Depression
• F32.2 – Severe Major Depression, no psychotic features
• F33.1 – Recurrent Major Depression, moderate
• F33.45 – Recurrent Major Depression, in Remission
• F33.9 – Recurrent Major Depression, unspecified
Chronic Lung Disease (J41-44)

These conditions don’t resolve. They may be well controlled and patient may be asymptomatic, but they still have the underlying chronic lung disease.

*When you think bronchitis, what do you mean?*

- Simple Chronic Bronchitis (Smokers Cough)
- Unspecified Chronic Bronchitis
- Emphysema (need location, panlobar, unspecified)
- COPD
  - With pneumonia
  - With acute exacerbation
  - Chronic Obstructive Asthma
Chronic Lung Disease (J41-44)

These conditions don’t resolve. They may be well controlled and patient may be asymptomatic, but they still have the underlying chronic lung disease.

Not HCC codes
- Acute Bronchitis
- Asthma
- Pneumonia

HCC codes
- Simple Chronic Bronchitis
- Chronic Obstructive Asthma
- COPD with Acute Exacerbation
Malignancy

- General rule of thumb – able to code malignancy if it is:
  - Currently present
    - Currently undergoing treatment
    - Metastatic disease
    - Prostate cancer under observation
  - During the 1st five years following treatment
    - If not currently present now and previously treated more than 5 years ago, should code as “history of cancer” rather than coding the actual cancer diagnosis
  - Do not use “history of” if the cancer is currently present or if during the first 5 years following treatment
Chronic Kidney Disease – 4 & 5 are HCC but all may have disease interactions

<table>
<thead>
<tr>
<th>Stage</th>
<th>GFR Range</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>normal GFR (GFR &gt; 90 mL/min)</td>
<td>• may be noted on imaging or Proteinuria</td>
</tr>
<tr>
<td>Stage 2</td>
<td>GFR = 60-89 mL/min</td>
<td></td>
</tr>
</tbody>
</table>
| Stage 3 | • 3A – GFR = 45-59 mL/min  
• 3B – GFR = 31-44 mL/min |                                |
| Stage 4 | GFR = 15-30 mL/min |                                |
| Stage 5 | GFR < 30 mL/min |                                |
Sequelae of Chronic Conditions

Sequelae of Stroke
- Hemiparesis
- Hemiplegia
- Cerebellar Ataxia (use of walker after stroke)

Amputation of any digit or extremity except fingers (not thumb)
- Toe, Mid-foot, Leg
- Thumb, Hand, Arm

Ostomy status
- Colostomy, gastrostomy, J-tube status all have HCC diagnoses

Respirator dependent

Dialysis status
Common Skin Condition

• Senile Purpura – just because it is common doesn’t mean that it may not be a risk adjusting diagnosis
UCLA Coding Improvement Initiatives

Chart Review Process

- Identification of Potential HCC Diagnoses
- Billing Office Real-Time Chart Review
- BPA for Previously Coded HCC Conditions

Provider Expectation

- Update problem list if diagnosis is valid & assess
- Respond promptly* to queries from Billing Office & addend note if appropriate
- Code if still Relevant

* within 9 calendar days
Billing Office Initiatives

• CPC queries will be routed to a designated in-basket pool for the physicians. The query will prompt physicians to route any addenda back to the CPC for review.

• Charge sessions with outstanding queries will be pended by CPC for a period of 10 calendar days. If no addenda or response received from the billing physician within 10 calendar days, charges will be filed with original code.

PLEASE RESPOND PROMPTLY TO THE QUERIES – within 9 calendar days
One Approach – Review the Chart

This is the workflow I routinely use when seeing a patient:

1. Click on **Care Gaps** to see what is due and place orders if applicable for the visit
2. Look at the **chief complaint** for the visit.
3. Review **prior visit** with the patient to refresh on the care
4. Review the patient’s **meds** and **vital signs**
5. Review the patient’s **Problem List** to see if there are any chronic conditions and “assess” them to add them to the **Visit Diagnosis**.
6. Review **HCC BPA** if present and click if appropriate
Additional Suggested Actions 1/2

1. Look at old Chest X-ray or CT abdomen/pelvis to see if any **Aortic Atherosclerosis** is present

2. Look at patient’s **Creatinine**. Does the patient qualify for CKD 3, 4, or 5?

3. Review Problem List and if Depression is present then consider changing, if appropriate, to **Major Depression, Recurrent, (mild, moderate, severe, remission)**

4. If Diabetes Mellitus is listed, be sure that any complications are included or at least use “**Diabetes Mellitus with complications**”
1. If patient is on an anti-depressant medication, what diagnosis is listed? Is Major Depression appropriate?

2. If patient is on Gabapentin or Pregablin, does the patient have Peripheral Neuropathy?

3. If the patient is on DOAC, Warfarin, or Clopidogrel what condition is causing the patient to require anticoagulation or antiplatelet medication?

4. Is the patient being treated for CHF without it being on the problem list?

5. If malignancy, how recent? Is it still present? Monitored?
Take Aways

1. Recapture Diagnoses from Prior Years
   A. BPA
   B. Quality Link
   C. Problem List

2. Consider Sequelae of Chronic Conditions

3. Look at Imaging and Labs as well as Meds for Diagnoses

4. Code as specific as possible

5. Certain conditions are “Chronic” and won’t resolve even if they are “Under Control” or “In Remission”

6. Comment (at least briefly) on each diagnosis, just don’t list the diagnoses
I DON'T ALWAYS GET SUCKED INTO A JET ENGINE

BUT WHEN I DO, I USE ICD-10 CODE: V97.33XD