



Risk Adjustment Documentation, Coding & Quality Toolkit

Understanding key documentation and coding guidelines

ICD-9-CM





How to use this toolkit

This toolkit is a companion piece to the provider training and coding classes Optum provides each year. Some of the tools in this book are available as stand-alone pieces that can be ordered for your staff.

Please ask your Optum Healthcare Advocate for more information on how to order additional copies of these materials.

Table of Contents

A Comprehensive Diagnostic Patient Profile	3
Chart Mechanics for Risk Adjustment Data Validation	4
Potential Gaps in Data Submission	5
Chronic Conditions Need a Yearly Evaluation	6
Senior Patient Superbill	7-8
Model Progress Note	9
Documentation & Coding of Chronic Kidney Disease (CKD)	11-12
Diabetes Mellitus and Associated Manifestations	13
Hypertension Coding Tool	14
Documentation & Coding for Cardiovascular Disease	15
Stroke and Late Effects of Prior Stroke	16
Peripheral Arterial Disease (PAD) Documentation & Coding	17
Correctly Reporting Cancer Diagnoses	18
Overweight, Obesity and Morbid Obesity	19
Protein-Calorie Malnutrition	20
Major Depressive Disorder Algorithm	22
Cognitive-Function Screening	23
The Importance of Screening for Depression	24
Patient Health Questionnaire (PHQ-9) and Scoring the PHQ-9	25-26
The Medicare Annual Wellness Visit (AWV)	28
Preventive Medicine Assessment with Personalized Health Plan & Screening Schedule	29-30
ICD-9-CM vs. ICD-10-CM: Understanding Key Differences	31-32
ICD-10 Preparedness	33

Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year 2016, the bolding of ICD-9-CM & ICD-10-CM codes has been revised to reflect:

Black = Risk adjusts in the 2014 CMS-HCC model

Note: The 2016 Payment Year model is based on 100% of the 2014 CMS-HCC model mappings.

A Comprehensive Diagnostic Patient Profile

The Importance of Specific Documentation and Coding

Specific documentation and coding clearly depict the level of disease severity, comorbidities, underlying disease and other factors that contribute to the level of complexity for the patient encounter.

Per the ICD-9-CM Official Guidelines for Coding and Reporting:¹

“Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.”

Payment from Centers for Medicare & Medicaid Services (CMS) is based on the overall health status of the Medicare Advantage member. Diagnosis codes are some of the criteria used for determining severity of illness, risk and resource utilization. Diagnostic coding influences the “level of risk” in determining CPT® code assignment.

Moderate risk is equivalent to either:

- a) One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment
- b) Two or more chronic stable illnesses

High risk relates to either:

- a) One or more chronic illnesses with severe exacerbation, progression or side effects of treatment
- b) Acute or chronic illnesses or injuries that pose a threat to life or body function

Status codes can also indicate and contribute to the complexity level of the encounter. Consider these V codes:

Renal Dialysis Status or Noncompliance	V45.11 or V45.12
Tracheostomy Status	V44.0
Respirator Dependence	V46.11
Lower Limb Amputee	V49.7X
Artificial Openings for Feeding or Elimination	V44.X and V44.5X
Organ Transplant Status	V42.X to V42.8X
Asymptomatic HIV Status	V08

The presence of one or more of these conditions should be taken into account by the provider in the decision making process and could affect patient care, treatment and management. Other diagnosis codes that are not often reported, although the patient is being treated for the conditions, are:

Protein-Calorie Malnutrition	263.X
Major Depressive Disorder	296.2X and 296.3X
Alcohol Dependence & Drug Dependence	303.XX and 304.XX
History of Heart Attack	412

Specific documentation is reflective of the “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 and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal.

CPT is a registered trademark of the American Medical Association.

¹“ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification.” Centers for Disease Control and Prevention. Web. 27 Jan. 2012. <cdc.gov/nchs/icd/icd9cm.htm>

Chart Mechanics for Risk Adjustment Data Validation

DATA VALIDATION

Proper chart documentation helps ensure risk adjustment payment integrity and accuracy. Risk adjustment data validation is the process of verifying that diagnosis codes submitted for payment by the Medicare Advantage (MA) organization are supported by medical record documentation for an enrollee.¹

In order to help meet the Centers for Medicare & Medicaid Services' (CMS) documentation and validation requirements on risk adjustment data submission, refer to the recommended documentation tips below. This is not an all-inclusive listing of CMS requirements and is only a reminder of certain chart mechanics and documentation guidelines.

Chart Mechanics and Documentation Considerations¹

- **Identify patient (name) and date (of service) (and one additional patient identifier [e.g. date of birth]) on each page of the record²**
- Reported diagnoses must be supported with medical record documentation
- Acceptable documentation should be clear, concise, consistent, complete and legible
- Document and report co-existing diagnoses — any that require or affect the care and treatment of the patient that day³
- Use only standard abbreviations (acronyms and symbols)
 - » It is NOT appropriate to code a condition that is represented only by an up or down arrow in combination with a chemical symbol or lab abbreviation such as "↑chol" for "hypercholesterolemia"
- CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented

Authentication by the Provider¹

All dates of service must be signed (with credentials) and dated by the physician (provider) or an appropriate extender (non-physician practitioner) e.g., nurse practitioner. Stamps of the provider's signature are not acceptable per CMS.

The credentials for the provider of services must be somewhere on the medical record:

- next to the provider's signature, or
- pre-printed with the provider's name on the group practice's stationery

The physician (provider) must authenticate at the end of each note for which services were provided with:

- handwritten signatures, or
- electronic signature

Types of Acceptable Physician (Provider) Signatures and Credentials¹

- Hand-written signature or initials, including credentials (e.g., Mary C. Smith, MD; or MCS, MD)
- Electronic signature, including credentials
 - » Requires authentication by the responsible provider (for example, but not limited to, "Approved by," "Signed by," "Electronically signed by," "Authenticated by")
 - » Must be password protected and used exclusively by the individual physician (provider)

Signature Logs

Medicare documentation requirements state each patient encounter should include the date and legible identity of the provider.

- Type or print the provider's name in the first column.
- Type or print the provider's credential.
- The physician (provider) should sign his/her legal signature (full name, including credential).
- Under Actual Chart Signature, the provider should indicate all possible ways that he/she would sign the medical record (initials, first initial/last name, etc.).
- The date of implementation of the Signature Log must be on the Signature Log.

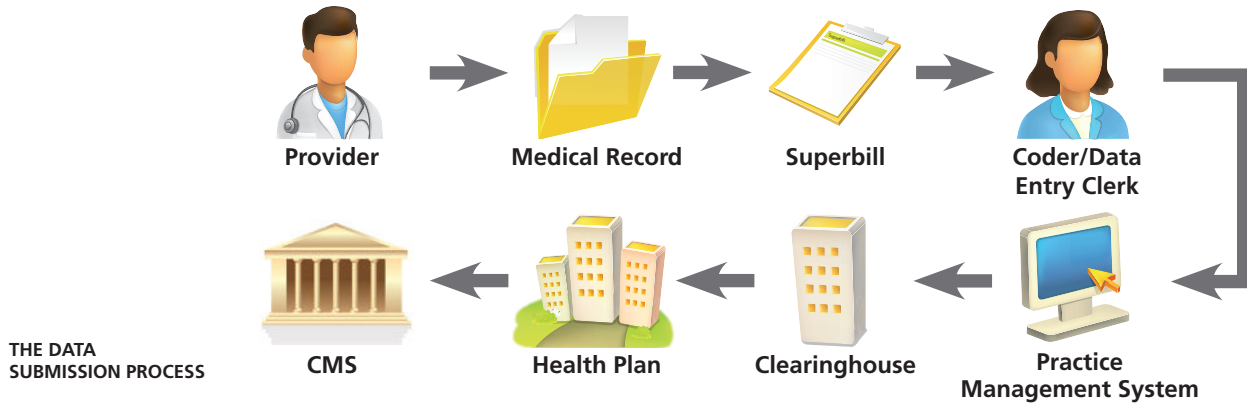
Example: Date of Implementation: _____

Provider Name	Credential	Legal Signature	Actual Chart Signature
John Smith	MD		

Your Optum Healthcare Advocate can supply signature logs (to be completed by the provider/practice) upon request.

1. CMS-Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.
 2. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 13 Dec 2012. <jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.
 3. World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2011 1-107. Web. 15 Nov 2011.<cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm>

Potential Gaps in Data Submission



The data path of the patient visit from provider all the way to Centers for Medicare & Medicaid Services (CMS) for Risk Adjustment reporting can be challenging. Providers and their staff must remember to:

1	<p>See Each Patient at Least Once Each Year The health status of a Medicare Advantage patient needs to be redetermined each year. Diagnoses from a prior year do not “carry over” for CMS.</p>
2	<p>Evaluate and Document All Chronic Conditions All conditions that constitute the “composite health picture” of the senior patient should be evaluated and documented clearly and legibly in the progress note of the medical record. This is not limited to what brought the patient to the doctor today. What other conditions is the patient dealing with every day?</p>
3	<p>Code All Diagnoses The coder must be careful to capture all diagnoses that have been properly documented. Does the coder have access to the latest ICD-9-CM codes? Does the coder code to the highest level of specificity to accurately report the level of disease severity?</p>
4	<p>Use an Accurate, Up-to-date Superbill (or Favorites List in EMR) If a superbill is used, does it contain a wide variety of ICD-9-CM codes to allow the specificity of the disease to be coded accurately? Is it up to date? Are providers trained to write in additional diagnoses if they apply or do they use the closest match on the superbill instead? Is the superbill evaluated each year to ensure it meets the needs of the practice?</p>
5	<p>Make Sure the Data is Captured The provider must be aware of the limitations of their practice management system. How many diagnosis codes does the system allow? Is there potential for any codes to be dropped? Is the provider correctly sequencing the diagnoses?</p>
6	<p>The Claim or Encounter Format or Form Must Contain All the Data When the data is extracted for claims or encounter reporting, are all diagnosis codes extracted to be sent to the health plan? Does the claim process limit the number of diagnoses that can be submitted? Is the practice in the habit of only sending one or two diagnosis codes to support the CPT code on the claim?</p>
7	<p>Verify that Clearinghouse or Submission Vendor Can Send and Receive All Recorded Codes How many codes can the vendor support for data submission? Are valid codes being dropped because the provider has not updated the number of codes that can be submitted? Many claims systems and practice management systems are being enhanced to capture more data due to HIPAA data requirements. Has the vendor’s submission been expanded to accept additional data as well?</p>
8	<p>Verify that Health Plans Can Send and Receive All Recorded Codes Not all health plans have expanded their systems to accept large numbers of diagnosis codes. How many codes can your payer accept? What happens to any codes submitted beyond the accepted number? Is there an alternative submission method (ASM) available?</p>

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Chronic Conditions Need a Yearly Evaluation

Correct coding requires that the immediate problem of the patient be evaluated, documented and coded. In addition, all conditions that affect the composite picture of the patient's health status need to be recorded at least once per year.

Conditions to Consider	ICD-9-CM Code(s) and Descriptors	HCC
Does the patient have HIV status?	<ul style="list-style-type: none"> • V08 Asymptomatic HIV Infection Status 	1
Is the patient insulin dependent?	<ul style="list-style-type: none"> • V58.67 Long-Term (Current) Use of Insulin 	19
Is the patient protein-calorie malnourished?	<ul style="list-style-type: none"> • 263.X Other and Unspecified Protein-Calorie Malnutrition 	21
Is the patient alcohol dependent?	<ul style="list-style-type: none"> • 303.XX Alcohol Dependence Syndrome 	52
Is the patient drug dependent?	<ul style="list-style-type: none"> • 304.XX Drug Dependence 	52
Does the patient have major depressive disorder (MDD)?	<ul style="list-style-type: none"> • 296.2X MDD, Single Episode • 296.3X MDD, Recurrent Episode 	55
Does the patient have a tracheostomy <u>or</u> is the patient dependent on a respirator?	<ul style="list-style-type: none"> • V44.0 Tracheostomy Status • V46.1X Respirator Dependence 	77
Is patient on long-term oxygen therapy? Are you also reporting the diagnosis (e.g., hypoxemia)?	<ul style="list-style-type: none"> • V46.2 Long-term Oxygen Therapy • 799.02 Hypoxemia 	79
Has the patient had an old, healed myocardial infarction?	<ul style="list-style-type: none"> • 412 Old Myocardial Infarction 	83
Is the patient on renal dialysis?	<ul style="list-style-type: none"> • V45.11 Renal Dialysis Status 	130
Is the patient noncompliant with renal dialysis?	<ul style="list-style-type: none"> • V45.12 Noncompliance with Renal Dialysis 	130
Does the patient have a major organ transplant (e.g., heart, lung, liver, bone marrow, peripheral stem cells, pancreas, intestines)?	<ul style="list-style-type: none"> • V42.X Organ/Tissue Transplants listed • V42.8X Other Specified Transplant except V42.89-.9 	174
Does the patient have an artificial opening (e.g., tracheostomy, gastrostomy, ileostomy, colostomy, cystostomy)?	<ul style="list-style-type: none"> • V44.X Artificial Opening Status except V44.7 • V44.5X Artificial Opening Status: Cystostomy 	176
Is the patient a lower limb amputee?	<ul style="list-style-type: none"> • V49.7X Lower Limb Amputation Status 	177

ICD-9-CM Medicare Diagnosis Codes (Senior Patient, PCP)

BLOOD DISEASE		791.0	Proteinuria	556.9	Ulcerative colitis, unsp.
285.21	Anemia in chronic kidney disease	250.5x	DM (prim) w/ ophthal. manifest.	GENITOURINARY DISEASE	
280.9	Anemia, iron deficiency NOS	249.5x	DM (sec) w/ ophthal. manifest.	592.0	Calculus of kidney
285.9	Anemia NOS	366.41	Diabetic cataract	592.1	Calculus of ureter
281.0	Anemia, pernicious	362.01	Diabetic retinopathy NOS		Chronic Kidney Disease:
280.0	Anemia, secondary to blood loss	365.44	Glaucoma		<i>Note: For CKD below, code first</i>
CARDIOVASCULAR / CARDIOLOGY		362.02	Prolif diabetic retinopathy		<i>hypertensive chronic kidney disease</i>
410.90	Acute MI NOS	250.6x	DM (prim) w/ neurological manifest.		<i>if applicable (403.00-403.91,</i>
413.0	Angina decubitus	249.6x	DM (sec) w/ neurological manifest.		<i>404.00-404.93)</i>
413.9	Angina pectoris NOS	353.5	Amyotrophy	585.1*	CKD, Stage I
411.1	Angina, unstable	355.9	Causalgia / Mononeuropathy NOS	585.2*	CKD, Stage II
427.31	Atrial fibrillation	536.3	Gastroparesis	585.3*	CKD, Stage III
427.9	Cardiac dysrhythmia NOS	713.5	Neurogenic / neuropathic arthrop.	585.4*	CKD, Stage IV
425.4	Cardiomyopathies, primary NOS	Peripheral neuropathy due to DM		585.5*	CKD, Stage V
428.0	Congestive heart failure, unsp.	337.1	Autonomic	585.6*	CKD, ESRD
414.00	Coronary atherosclerosis, unsp.	357.2	Polyneuropathy in DM / LOPS	585.9*	CKD, unsp.
414.9	Heart disease, ischemic, chronic	250.7x	DM (prim) w/ periph. circ. manifest.		<i>*For all CKD codes: Use additional</i>
428.9	Heart failure, unsp.	249.7x	DM (sec) w/ periph. circ. manifest.		<i>code to identify kidney transplant</i>
429.0	Myocarditis, unsp.	440.2x*	Atherosclerosis, Ntv Art Extremities		<i>(V42.0) or renal dialysis status</i>
414.2	Occlusion, coronary artery, complete		<i>*Add 5th digits: 0 = Unsp.,</i>		<i>(V45.11) or noncompliance w/</i>
412	Old MI (history of)		<i>1 = w/ intermittent claudication,</i>		<i>dialysis (V45.12), if appl.</i>
427.81	Sick sinus syndrome		<i>2 = w/ rest pain, 3 = w/ ulceration,</i>	595.0	Cystitis, acute
427.0	Tachycardia, atrial parox.		<i>4 = w/ gangrene, 9 = other.</i>	599.70	Hematuria, unsp.
427.1	Tachycardia, ventricular parox.		<i>For 5th digits 3 & 4, code also</i>	788.91	Incontinence, functional urinary
			<i>assoc. ulcer (707.1x-707.9)</i>	996.64	Infection due to indw urethral cath
CEREBROVASCULAR			Gangrene	584.9	Kidney failure acute, unsp.
433.10	Carotid stenosis w/o mention of cerebral infarction	785.4		593.9	Renal Insufficiency/Disease (Acute)
		443.81	Peripheral angiopathy (PVD) in DM	597.80	Urethritis, unsp.
437.0	Cerebral atherosclerosis	250.8x	DM (prim) w/ other spec. manifest.	599.0	Urinary tract infection, site unsp.
437.1	Ischemic cerebrovascular disease, other	249.8x	DM (sec) w/ other spec. manifest.	GU DISORDERS / FEMALE	
435.9	TIA	731.8	Bone changes (also, append the appropriate code from category 730, osteomyelitis, periostitis, and other infections involving bone.)	795.04	Abn. Pap smear w/ HGSL
	Late effects of stroke:			795.03	Abn. Pap smear w/ LGSIL
438.11	Aphasia			611.72	Breast lump / mass
438.12	Dysphasia			112.1	Candidiasis, vulva & vagina
438.20	Hemiplegia / Hemiparesis, unsp. side	707.1x*	Ulcer, L-limbs, exc. pressure ulcer when not due to atherosclerosis	616.0	Cervicitis
			<i>*Add 5th digits: 0 = unsp., 1 = thigh,</i>	246.39	Hypogonadism, female
438.40	Monoplegia, LL, unsp. side		<i>2 = calf, 3 = ankle, 4 = heel/midfoot,</i>	257.2	Hypogonadism, male
438.30	Monoplegia, UL, unsp. side		<i>5 = other part of foot, 9 = other part of lower limb.</i>	627.2	Menopausal, symptomatic
438.89	Weakness / other			620.2	Ovarian cyst NOS
	<i>Also assign 728.87 for muscle weakness due to CVA</i>	250.9x	DM (prim) w/ unsp. complications	616.10	Vaginitis NOS
		249.9x	DM (sec) w/ unsp. complications	GU DISORDERS / MALE	
DERMATOLOGY		272.0	Hypercholesterolemia	600.01*	BPH w/ obstruction
706.1	Acne NOS	272.2	Hyperlipidemia, mixed		<i>*Use additional code to identify symptoms</i>
702.0	Actinic keratosis	252.00	Hyperparathyroidism, unsp.	600.00	BPH w/o obstruction
701.9	Atrophoderma (skin tag)	253.1	Hyperpituitarism	604.90	Epididymitis / orchitis NOS
691.8	Dermatitis, atopic & eczema	276.7	Hyperpotassemia	607.84	Impotence, organic
692.9	Dermatitis NOS	242.90	Hyperthyroidism w/o crisis	601.9	Prostatitis, unsp.
054.9	Herpes simplex w/o comp.	272.1	Hypertriglyceridemia	HYPERTENSIVE DISEASE	
053.9	Herpes zoster w/o comp.	257.2	Hypogonadism, testicular NOS		<i>Note: For heart failure, identify type of failure;</i>
696.1	Psoriasis NOS	276.1	Hyponatremia	401.1	<i>for CKD, identify stage of the disease</i>
702.11	Seborrheic keratosis, inflamed	276.8	Hypopotassemia	401.0	Hypertension, essential, benign
702.19	Seborrheic keratosis NOS	244.0	Hypothyroidism, postsurgical	401.9	Hypertension, essential, malignant
110.1	Tinea, of nail	244.9	Hypothyroidism, unsp.	401.9	Hypertension, unsp.
ENDOCRINOLOGY		278.01	Obesity, morbid (code also BMI)	403.90	Hypertensive CKD w/ CKD
259.2	Carcinoid syndrome	278.00	Obesity, unsp. (code also BMI)		stage I-IV or unsp.
255.0	Cushing's syndrome (use additional E identify cause if drug induced)	255.3	Overproduction of ACTH	403.91	Hypertensive CKD w/ CKD
		242.8	Overproduction of TSH		stage V or ESRD
276.51	Dehydration	263.9	Protein-calorie malnutrition, unsp.	404.91*	Hypertensive heart & CKD w/ heart failure & CKD stage I-IV unsp.
	Diabetes Mellitus:	GASTROENTEROLOGY		404.93*	Hypertensive heart & CKD w/ heart failure & CKD stage V or ESRD
	<i>Note: Category 250 is considered "Primary" DM; category 249 is considered "Secondary" DM. The following 5th digits are required for all DM codes where x=:</i>	789.06	Abdominal pain, epigastric	404.90	Hypertensive heart & CKD w/o heart failure w/ CKD stage I-IV, unsp.
	Primary DM (250 category only)	789.07	Abdominal pain, generalized	404.92	Hypertensive heart & CKD w/o heart failure, w/ CKD stage V or ESRD
	0 = Type II or unsp. type, not stated as uncontrolled	789.04	Abdominal pain, left lower		
	1 = Type I (juvenile type), not stated as uncontrolled	789.02	Abdominal pain, left upper	402.91*	Hypertensive heart disease w/ heart failure, unsp.
	2 = Type II or unsp. type, uncontrolled	789.03	Abdominal pain, right lower	402.90	Hypertensive heart disease w/o heart failure, unsp.
	3 = Type I (juvenile type), uncontrolled	789.01	Abdominal pain, right upper		<i>*Use additional code(s) for 402.xx & 404.xx to identify the type of heart failure, 428.xx</i>
	Secondary DM (249 category only)	574.20	Cholelithiasis w/o obstruction	INFECTIOUS DISEASE	
	0 = (Secondary), Not stated as uncontrolled or unsp.	571.2	Cirrhosis, alcoholic liver	682.6	Cellulitis / abscess, leg
	1 = (Secondary), Uncontrolled	571.5	Cirrhosis, non-alcoholic liver	682.9	Cellulitis / abscess NOS
250.0x	DM (prim) w/o mention of compl.	564.00	Constipation, unsp.	042	HIV (code all manifestations)
249.0x	DM (sec) w/o mention of compl.	555.9	Crohn's disease NOS	V08	HIV, asymptomatic
	<i>Note: Add 5th digits as noted above</i>	562.11	Diverticulitis, colon w/o hem.	795.5	PPD positive
250.4x	DM (prim) w/ renal manifest.	562.10	Diverticulosis, colon w/o hem.	079.99	Viral infection NOS
249.4x	DM (sec) w/ renal manifest.	536.8	Dyspepsia	MUSCULOSKELETAL	
585.x	CKD or chronic renal failure	560.32	Fecal impaction	714.0	Arthritis, rheumatoid
583.81	Nephritis / nephropathy	558.9	Gastroenteritis, noninfectious	726.60	Bursitis knee NOS
403.91	Nephropathy w/ HTN & CKD, Stage V or ESRD	530.81	Gastroesophageal reflux (GERD)	726.10	Bursitis shoulder NOS
		569.3	Hemorrhage, rectum / anus		
		455.6	Hemorrhoids NOS		
		571.40	Hepatitis chronic, unsp.		
		571.1	Hepatitis, alcoholic acute		
		070.9	Hepatitis, viral NOS		
		564.1	Irritable bowel syndrome (IBS)		
581.81	Nephrotic syndrome	578.1	Melena		

- CONTINUED ON NEXT PAGE -

726.5	Bursitis, hip			intract. migraine, w/o mention of status migrainosus	486	Pneumonia, unsp.
723.4	Cervical radiculitis				477.0	Rhinitis, allergic pollen
717.7	Chondromalacia patella		332.0	Parkinson's disease NOS	472.0	Rhinitis, chronic
924.20	Contusion, foot		356.9	Peripheral neuropathy, unsp.	465.9	URI, acute NOS
923.20	Contusion, hand		345.90	Seizures, epilepsies, w/o mention of intractable epilepsy NOS	SIGNS & SYMPTOMS	
920	Contusion, head / neck / scalp				369.4	Blindness, legal
924.11	Contusion, knee		ONCOLOGY		578.1	Blood in stool
924.10	Contusion, lower leg		198.5	Malig neo bone, secondary	786.50	Chest pain, unsp.
923.00	Contusion, shoulder		174.1	Malig neo breast, central	786.2	Cough
733.6	Costochondritis		174.9	Malig neo breast, unsp.	787.91	Diarrhea NOS
722.4	DDD cervical		162.9	Malig neo bronchus / lung, unsp.	780.4	Dizziness and giddiness
722.52	DDD lumbar / lumbosacral		153.6	Malig neo colon ascending	787.20	Dysphagia, unsp.
722.10	Displacement, lumbar disc		153.2	Malig neo colon descending	782.3	Edema
812.20	FX arm upper NOS closed		153.1	Malig neo colon transverse	796.2	Elevated BP w/o hypertension
816.00	FX finger(s), unsp., closed		199.0	Malig neo disseminated	785.6	Enlargement lymph nodes
826.0	FX toe(s), closed		185	Malig neo prostate	780.60	Fever NOS
733.13	FX vertebrae, pathologic		199.1	Malig neo unsp. site (prim/sec)	785.4	Gangrene
814.00	FX wrist NOS, closed				784.0	Headache
274.00	Gouty arthropathy, unsp.		366.9	Cataract, unsp.	786.01	Hyperventilation
719.40	Joint pain, unsp.		372.00	Conjunctivitis, acute, unsp.	780.51	Insomnia w/ sleep apnea
724.2	Low back pain (lumbago)		372.14	Conjunctivitis, allergic	780.52	Insomnia, unsp.
724.4	Lumbosacral neuritis		930.9	FB eye external NOS	780.79	Malaise and fatigue, other
729.1	Myalgia / myositis, unsp.		366.10	Senile cataract	787.01	Nausea with vomiting
715.97	Osteoarthritis, ankle & foot				785.1	Palpitations
715.94	Osteoarthritis, hand		380.4	Cerumen impacted	786.09	Respiratory distress
715.96	Osteoarthritis, lower leg		381.81	Eustachian tube dysfunction	780.39	Seizures NOS
715.90	Osteoarthritis, site unsp		380.10	Otitis externa, infective	782.0	Skin sensation disturbance
715.91	Osteoarthritis, shoulder		381.01	Otitis media, serous, acute	780.2	Syncope and collapse
733.00*	Osteoporosis, unsp.		381.10	Otitis media, serous, chronic	788.30	Urinary incontinence, unsp.
	<i>*Use additional code to identify major osseous defect, if applicable 731.3</i>		382.00	Otitis media, suppurative, acute	783.21	Weight loss, abnormal
729.5	Pain in limb		461.0	Sinusitis acute, maxillary	786.07	Wheezing
728.71	Plantar fasciitis (traumatic)		473.9	Sinusitis chronic NOS	VASCULAR DISEASES	
725	Polymyalgia rheumatica				453.40	Acute DVT, lower ext NOS
843.9	Sprain / strain hip or thigh		303.90	Alcoholism, chronic, unsp.	453.82	Acute DVT, upper ext, deep
845.00	Sprain / strain ankle		300.00	Anxiety state, unsp.	453.81	Acute emb /thromb, superficial, upper ext
845.10	Sprain / strain foot		290.0-	Dementia (see entries under Neurology)	453.83	Acute emb /thromb, upper ext, unsp.
842.10	Sprain / strain hand		294.21		453.72	Chronic DVT, upper ext, deep
844.9	Sprain / strain knee or leg		311	Depressive disorder NOS	453.79	Chronic emb/thromb., other spec.
847.2	Sprain / strain lumbar		304.90	Drug dependence NOS	453.71	Chronic superficial, upper ext
847.0	Sprain / strain neck		300.4	Dysthymic disorder	453.50	Chronic DVT, lower ext, deep
840.9	Sprain / strain shoulder or arm		296.20	Major depression, single, unsp.	453.73	Chronic emb/thromb, upper ext, unsp.
842.00	Sprain / strain wrist		296.30	Major depression, recurrent, unsp.		<i>Code V58.61 Long-term (current) use of anticoagulants, if applicable</i>
726.32	Tennis elbow		310.89	Mild memory disturbance not amounting to dementia	453.6	Emb/thromb superficial, lower ext.
726.90	Tendinitis NOS		296.90	Mood disorder, episodic, unsp.	451.11	Phlebitis, femoral vein
727.00	Tenosynovitis NOS				451.19	Phlebitis, lower ext., deep
NEUROLOGY					443.9	PVD / PAD, unsp.
331.0*	Alzheimer's disease		415.0	Cor pulmonale, acute	459.81	Venous insufficiency, chronic NOS
	<i>*Use additional code, where applicable to identify w/ behavioral disturbance (294.11), or w/o behavioral disturbance (294.10)</i>		415.19	Pulm embolism / infarct, other	V-CODES	
			416.2	Pulmonary embolism, chronic	V49.70	Amputation, lower limb, unsp.
			416.9	Pulm heart disease chronic, unsp.	V85.41	Body Mass Index 40.0-44.9, adult
					V85.42	Body Mass Index 45.0-49.9, adult
					V85.43	Body Mass Index 50.0-59.9, adult
					V85.44	Body Mass Index 60.0-69.9, adult
					V85.45	Body Mass Index 70 and over, adult
354.0	Carpal tunnel syndrome		493.90	Asthma, unsp.	V66.7	Encounter for palliative care (code first underlying disease)
	Dementia		493.92	Asthma, unsp., w/ acute exacerbation	V67.9	Follow-up exam, unsp.
294.10	In conditions classified elsewhere w/o behavioral disturbance (Code first any underlying physical condition)		466.0	Bronchitis, acute	V04.81	Influenza virus vaccine (i.e. H1N1)
			491.9	Bronchitis, chronic, unsp.	V58.67	Long-term (current) use of insulin
			491.0	Bronchitis, simple chronic (Smokers' cough)	V15.81	Noncompliance with medical treatment
			496	COPD	V67.00	Post-op exam, unsp.
294.11	In conditions classified elsewhere w/ behavioral disturbance (Code first any underlying physical condition). Use additional code for "Wandering" (V40.31), if applicable.		488.12	Influenza: due to 2009 H1N1 (Swine)	V72.84	Pre-op exam, unsp.
			488.02	due to identified avian influ. virus	V45.11	Renal dialysis, status
290.0	Senile, uncomplicated		488.81	due to identified novel influ. A virus w/ pneumonia (Use additional code to identify the type of pneumonia (480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)	V45.12	Renal dialysis, noncompliance
294.21*	Unspecified w/ behavioral disturbance (Code first any underlying physical condition). Use additional code for "Wandering" (V40.31), if applicable.				V76.51	Screen, mal. neo., colon
					V76.0	Screen, mal. neo., lung
294.20	Unspecified w/o behavioral disturbance		488.83	due to identified novel influ. A virus w/ other manifestations	V76.12	Screen, mal. neo., mammogram, NEC
345.91	Epilepsy, unsp. w/ intractability			due to identified novel influ. A virus w/ other respiratory manifestations	V76.49	Screen, mal. neo., other sites
345.90	Epilepsy, unsp. w/o intractability		488.82	not otherwise specified (NOS)	V76.44	Screen, mal. neo., prostate
337.00	Idiopathic peripheral autonomic neuropathy, unsp.		487.1	with pneumonia (Use additional code to identify the type of pneumonia 480.0-480.9, 481, 482.0-482.9, 483.0-483.8, 485)	V76.47	Screen, mal. neo., vagina
	Migraine:		487.0		V77.2	Screen, malnutrition
339.00	Cluster headache syndr., unsp.				V44.3	Status - colostomy
346.90	Migraine, unsp. w/o mention of				V58.32	Suture removal
					V04.81	Vaccine, influenza virus

Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year 2016, the bolding of ICD-9-CM & ICD-10-CM codes has been revised to reflect:

Black = Risk adjusts in the 2014 CMS-HCC model

Note: The 2016 Payment Year model is based on 100% of the 2014 CMS-HCC model mappings.

The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "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, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 6, 2015, CMS announced the CMS-HCC Risk Adjustment model for payment year 2016 driven by 2015 dates of service. For more information see: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf>, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>, and <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>

Model Progress Note

Documentation Guidance

Patient Name, Date of Service (DOS) and an additional patient identifier (e.g., Date of Birth [DOB]) is required on every page.^{1,2}

Chief Complaint (CC): "Follow-up" alone is not a valid CC. The documentation must describe why the patient is presenting for follow-up.³

History: History of Present Illness (HPI) driven by the CC and Review of Systems (ROS) driven by the HPI.³

Exam: Exam driven by the patient history, describing in detail any pertinent positive findings and any chronic findings that affect the care and treatment of the patient.^{3,4}

Medical Decision Making:

Assessment that documents the diagnosis, its status and any causal relationships (e.g., diabetic, due to diabetes). Assessment that documents not only conditions being treated, but any chronic conditions that affect the care and treatment of the patient.^{3,4}

Plan that specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.³

Authentication:

Paper Record: Authentication by the provider author of the progress note which includes a legible name and credential, a hand-written signature and the date signed.

EMR: Authentication by the provider author of the progress note, password-protected to that provider only, at the end of the note (i.e., Authenticated by, Approved by), including typed name and credential and the date authenticated.¹

Sample Progress Note

Patient: Name **DOS:** 01/02/2015 **DOB:** 08/01/48

Reason for visit: Follow-up for diabetes

Medications List: glyburide 10mg PO q.d.; pregabalin 50mg PO t.i.d.

S: States she is able to get around, including bathroom and kitchen with aid of her walker. Denies any pain or shortness of breath. No change in bowel or bladder habits. She states she takes her glyburide regularly. She tries to follow her diet but does not check her fingerstick blood sugars.

O: Patient alert, oriented to person, place and time. No acute distress.
Vital Signs: T 98.2; BP 163/92; HR 63; Wt 203 lbs; Ht 68"; BMI 31.57
Cardiac: RRR no rubs, gallops or murmurs noted.
Lungs: Clear to auscultation.

Abd: Soft non-tender to palpation with colostomy intact, skin dry and intact surrounding pink-red stoma, liquid brown feces.

Feet: Peripheral pulses barely palpable, unchanged from prior exam. Left great toe amputation with healing incision. Monofilament testing shows increased loss of sensation bilaterally with absent ankle reflexes.

- A:**
1. Worsening diabetic polyneuropathy (**250.60** and **357.2**)
 2. Progressing PAD due to diabetes (**250.70** and **443.81**)
 3. Functioning colostomy (**V44.3**)
 4. Status post left great toe amputation, healing (**V49.71**)

- P:**
1. Continue current diabetic diet; continue current dosage of glyburide; refer for diabetic eye exam and education; lab testing for fasting CMP and A1C; increase pregabalin 100mg PO t.i.d. for worsening neuropathy.
 2. Refer to vascular surgeon for surgical evaluation.
 3. Continue monitoring of functional colostomy.
 4. Instructed and demonstrated proper wound care.

RTC 1 month.

Authenticated by: Joseph A. Williams MD, 01/02/15

1. Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.
 2. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 30 Nov 2012. <jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.
 3. Centers for Medicaid & Medicare Services. "1995 Documentation Guidelines for Evaluation & Management Services." (1999). Medicare Learning Network. Web.
 4. World Health Organization. "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." *National Center for Health Statistics 2011 1-107*. Web. 22 Oct. 2012. <cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm>.



Documentation & Coding of Chronic Kidney Disease (CKD)

The National Kidney Foundation Kidney Disease Outcomes Quality Initiative™ (NKF KDOQI) guidelines for chronic kidney disease (CKD) promote classification of all individuals with CKD into one of five stages. In order to be considered CKD Stage I or Stage II, the guidelines specify that there must be evidence of kidney damage as defined in the table below (e.g. abnormal untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick). For these patients, the Glomerular Filtration Rate (GFR) would determine whether they were Stage I (slightly increased or normal GFR) or Stage II (mild reduction of GFR).¹ Because different stages of CKD require different interventions, it is clinically important to specify the exact stage of CKD that a patient may have.

In addition, the guidelines also specify that documented evidence of kidney damage is not required if the GFR falls below 60 ml/min/1.73 m².

Diagnosing CKD

The diagnosis of CKD cannot be coded from diagnostic reports (e.g., lab reports) alone. The review of the diagnostic reports should be documented in the progress note, a clinical rationale regarding pertinent findings noted and the stage of the CKD clearly stated.^{2,3}

Note: The diagnosis of CKD requires at least two abnormal markers of damage or two abnormal GFRs persisting ≥ 3 months.⁴

Staging Chronic Kidney Disease^{2,3}

Note: All stages need to be chronic, not a one time event.

Stage	Severity	GFR Value	ICD-9 Codes
Stage I	Normal or Slightly ↑ GFR	GFR ≥ 90 ml/min/1.73 m ² with kidney damage*	585.1
Stage II	Mild	GFR 60-89 ml/min/1.73 m ² with kidney damage*	585.2
Stage III	Moderate	GFR 30-59 ml/min/1.73 m ²	585.3
Stage IV	Severe	GFR 15-29 ml/min/1.73 m ²	585.4
Stage V	Kidney Failure	GFR < 15 ml/min/1.73 m ²	585.5
	ESRD	Requiring chronic dialysis or transplantation	585.6
CKD Unsp.	CRD, CRF NOS or CRI	Chronic Kidney Disease, unspecified	585.9

- Assign **V45.11** for "dialysis status" or **V45.12** for "noncompliance with renal dialysis" with regard to all **585.6** and some **585.5**; assign **V42.0** for "kidney transplant status."³
- CKD is defined as either kidney damage or GFR < 60 ml/min/1.73 m² for ≥ 3 months.

**Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests (e.g., untimed spot urine albumin/creatinine ratio or microalbumin-sensitive dipstick) or imaging studies. Thus, patients can have chronic kidney disease with a normal estimated GFR.*

ICD-9-CM instructs the coder to use an additional code to identify kidney transplant status, if applicable (V42.0). A kidney transplant may not fully restore kidney function; therefore, patients who have undergone a kidney transplant may still have some form of CKD. Code V42.0, Kidney replaced by transplant, may be assigned in addition to the appropriate CKD code, based on the patient's post-transplant stage.

If a patient is on renal dialysis or if an arterial-venous shunt is present, code also **V45.11**. If a patient is noncompliant with dialysis, code also **V45.12**.

Patients that have had a kidney transplant where documentation indicates the presence of failure or rejection, assign code 996.81, Complication of kidney transplant, followed by a code to identify the nature of the complication.

1. National Kidney Foundation, "KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification." American Journal of Kidney Disease 39: 2002 supplement 1.
 2. OptumInsight, Coders' Desk Reference For Diagnoses. 2013. Alexandria, VA: OptumInsight, 2012.
 3. Optum ICD-9-CM for Physicians Professional 2015. Vols. 1&2. Salt Lake City: 2014.
 4. "Frequently Asked Questions About GFR Estimates." National Kidney Foundation, 2013. Web. <kidney.org/professionals/kls/pdf/12-10-4004_KBB_FAQs_ AboutGFR-1.pdf>.

Documentation & Coding of Chronic Kidney Disease (CKD)

CKD Documentation Tips

- **CKD:** The diagnosis of CKD cannot be coded from diagnostic reports alone. Documentation in the progress note should clearly state: review of reports, pertinent findings and the stage of CKD, including the GFR.
- **CKD and Diabetes:** There is no presumed linkage between diabetes and CKD. It must be implied (i.e. diabetic nephropathy) or a causal relationship stated (i.e. chronic kidney disease due to diabetes).
- **CKD and Hypertension:** ICD-9-CM assumes a relationship when a patient has both chronic renal disease and hypertension (cause-and-effect link). Both conditions, chronic kidney disease (staged) and hypertension, must be documented.
- **CKD, Hypertension and Heart Disease:** There is no presumed linkage between hypertension and heart disease. It must be implied (hypertensive) or a causal relationship stated (due to hypertension).
- **Kidney Failure:** It is important to specify the type of kidney failure — acute or chronic — and the cause of the kidney failure, if known. If kidney failure is chronic, document the stage of the CKD.
- **Acute Renal Failure:** If patient has temporary dialysis, document it and code **V45.11**.

Coding Examples

Examples of progress notes reflecting the cause and effect linkage when kidney disease is documented as due to diabetes, when CKD is present with hypertension and the accurate reporting of ICD-9 codes:

Coding Example #1

The patient has Stage 3 chronic kidney disease secondary to type 2 diabetes.

250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
585.3	Chronic kidney disease, Stage III (moderate)

Coding Example #2

The patient has type 2 diabetes with diabetic nephropathy.

250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
583.81	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere

In this case, the clinician did not document the presence of chronic kidney disease in the progress note, so it would be incorrect to use code 585.X.

Coding Example #3

The patient has nephropathy due to diabetes with hypertension, and CKD Stage 4.

250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
585.4	Chronic kidney disease, Stage IV (severe)

THE FOLLOWING FIFTH-DIGIT SUBCLASSIFICATIONS ARE FOR USE WITH ALL SUBCATEGORY 250.X DM CODES:

- 0 Type II or Unspecified Type, Not Stated as Uncontrolled*** **2 Type II or Unspecified Type, Uncontrolled**
- 1 Type I [Juvenile Type], Not Stated as Uncontrolled*** **3 Type I [Juvenile Type], Uncontrolled**

*When a provider documents "poorly controlled," the Index instructs "code to Diabetes, by type, with 5th digit for not stated as uncontrolled."

Use additional code, if applicable, for associated long-term (current) use of insulin (V58.67) for Type II patients only.

Notation (A): All diabetic manifestations are dependent on chart documentation. Assign as many codes from category 250 as necessary to identify all the associated diabetic conditions. Multiple coding is required for this type of complication, with multiple codes for "Diabetes with Complications" as necessary, followed by a code(s) for the associated manifestation(s) indicating the complication(s).

Notation (B): Although arteriosclerosis occurs earlier and more extensively in diabetic patients, coronary artery disease, cardiomyopathy and cerebrovascular disease are not complications of diabetes and are not included in code 249.7x or 250.7x. These conditions are coded separately unless the physician documents a causal relationship. Brown, F. (2011). ICD-9-CM Coding Handbook 2012 with Answers, Chicago, IL/AHA Press.

250.0 **Diabetes Mellitus w/o Mention of Complication**
Refer to the gray section above for the fifth-digit subclassifications.
 Diabetes (mellitus), NOS
 Diabetes mellitus without mention of complication or manifestation classifiable to 250.1–250.9

250.1–250.3 "Acute Diabetes Codes"
(250.4–250.8) For Diabetes with Manifestations:
Refer to the gray section above for the fifth-digit subclassifications for the following 250.X DM codes. Also document causal relationship (i.e. "due to," or "Diabetic").

250.4 **Diabetes w/ Renal Manifestations**
"Diabetic:"

- 581.81 **Glomerulosclerosis, Intercapillary**
- 583.81 **Nephritis and Nephropathy, not specified acute/chronic**
- 581.81 **Nephrosis / Nephrotic Syndrome**

If Chronic Kidney Disease (CKD), use additional codes:

- 585.1 **CKD (Stage I)** GFR ≥ 90 ml/min Filtration
- 585.2 **CKD (Stage II)** GFR 60–89 ml/min Filtration
- 585.3 **CKD (Stage III)** GFR 30–59 ml/min Filtration
- 585.4 **CKD (Stage IV)** GFR 15–29 ml/min Filtration
- 585.5 **CKD (Stage V)** GFR < 15 ml/min Filtration
- 585.6 **CKD (ESRD)** requiring chronic dialysis / transplantation
- 585.9 **CKD, Unspecified**
- V45.11 Dialysis Status**
- V45.12 Noncompliance with Renal Dialysis**

If hypertension is documented with diabetic CKD, use additional codes:

- 403.90 **Nephropathy w/ HTN and CKD, Stage I – IV, or Unspecified (code also, if applicable):**
 - 585.1–585.4, 585.9 **Chronic Kidney Disease (see above)**
 - V45.11 Dialysis Status**
- 403.91 Nephropathy w/ HTN and CKD Stage V or ESRD (code also, if applicable):**
 - 585.5 **CKD (Stage V)** GFR < 15 ml/min Filtration
 - 585.6 **CKD (ESRD)** requiring chronic dialysis / transplantation
 - V45.11 Dialysis Status**

For abnormal lab, report:

- 791.0 **Proteinuria, Albuminuria, Microalbuminuria**

250.5 **Diabetes w/ Ophthalmic Manifestations**
"Diabetic:"

- 366.41 **Cataract**
- 365.44 **Glaucoma**
- 378.86 **Internuclear Ophthalmoplegia**
- 364.42 **Iritis**
- 362.07 **Macular / Retinal Edema**
Note: This code must be used with a code for diabetic retinopathy (362.01–362.06)
- 362.01 **Retinitis**
- 362.01 **Retinopathy, Background / NOS**
- 362.04 **Retinopathy, Nonproliferative, Mild**
- 362.05 **Retinopathy, Nonproliferative, Moderate**
- 362.03 **Retinopathy, Nonproliferative, NOS**
- 362.06 **Retinopathy, Nonproliferative, Severe**
- 362.02 **Retinopathy, Proliferative**

250.6 **Diabetes w/ Neurological Manifestations**
"Diabetic:"

- 353.5 **Amyotrophy**
- 355.71 **Causalgia of Lower Limb (burning pain)**
- 340 Dorsal Sclerosis**
- 355.9 **Mononeuropathy, NEC**
- 355.8 **Mononeuropathy, Unspecified, Lower Limb**
- 354.9 **Mononeuropathy, Unspecified, Upper Limb**
- 358.1 Myasthenic Syndromes in Diseases Classified Elsewhere**
- 336.3 Myelopathy in Diseases Classified Elsewhere**
- 713.5 **Neurogenic / Neuropathic Arthritis / Arthropathy (Charcot's)**
- 337.1 **Peripheral Autonomic Neuropathy (code also, if applicable):**
 - 536.3 **Gastroparalysis / Gastroparesis**
 - 596.54 **Neurogenic Bladder, NOS**
 - 564.81 **Neurogenic Bowel, NOS**
- 357.2 Polyneuropathy / Neuralgia / Neuritis / Neuropathy / Loss of Protective Sensation (LOPS) in Diabetes**

250.7 **Diabetes w/ Peripheral Circulatory Disorders**
"Diabetic:"

- 785.4 Gangrene**
- 443.81 Peripheral Angiopathy / Microangiopathy (PVD)**

If diabetic atherosclerosis is documented, code also:

- 440.20 Atherosclerosis, Extremities, NOS**
- 440.21 Atherosclerosis, Extremities, with Intermittent Claudication**
- 440.22 Atherosclerosis, Extremities, with Rest Pain**
Note: Includes any condition classifiable to 440.21
- 440.23 Atherosclerosis, Extremities, with Ulceration**
Note: Includes any condition classifiable to 440.21 and 440.22
- 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure**
- 440.24 Atherosclerosis, Extremities, with Gangrene**
Note: Includes any condition classifiable to 440.21, 440.22 and 440.23 with the following:
 - 785.4 Gangrene**
 - 707.1X* Any Associated Ulcer of Lower Limbs, Except Pressure**
- 440.29 Atherosclerosis, Extremities, Other**

250.8 **Diabetes w/ Other Specified Manifestations**
(i.e. Dermatitis, Complication NEC, Hypoglycemia, Hypoglycemic Shock)
"Diabetic:"

- 731.8 **Bone Changes**
Note: Use additional code to specify bone condition such as: Osteomyelitis, Periostitis and Other Infections Involving Bone (730.00–730.09)
- 259.8 **Glycogenosis, Secondary**
- 261 Lancereaux's**
- 272.7 Lipoidosis**
- 709.3 **Oppenheim-Urbach Disease/Syndrome**
- 707.1X* Ulcer of Lower Limbs, Except Pressure**
**X = 0 = unspecified 1 = thigh 2 = calf 3 = ankle
 4 = heel and midfoot 5 = other part of foot
 9 = other part of lower limb
 Assign 250.8X when Ulcers are not due to Atherosclerosis*
- 707.8 Ulcer of Skin, Chronic, Other Specified Sites**
- 707.9 Ulcer of Skin, Chronic, Unspecified Site**
- 272.2 **Xanthoma**

250.9 **Diabetes w/ Unspecified Complication**
Note: Known diabetic manifestations should be coded to the highest specificity using subcategories 250.4–250.8. See gray section above for fifth digits.

Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year 2016, the bolding of ICD-9-CM & ICD-10-CM codes has been revised to reflect:

Black = Risk adjusts in the 2014 CMS-HCC model

Note: The 2016 Payment Year model is based on 100% of the 2014 CMS-HCC model mappings.

Elevated BP	796.2	Elevated BP is not considered hypertension (HTN); Elevated BP w/o a diagnosis of HTN is correctly coded to 796.2.					
Per ICD-9: Words such as (crisis) (uncontrolled) and (systemic) do not change, define or validate code specificity, and may default to 401.9.	Malignant (Accelerated, Necrotizing) with progressive vascular damage and rapidly rising blood pressure, usually in excess of a diastolic reading of 130 mmHg. (AHA Coding Clinic 85:M-J:p19; 91:1Q:p16; 93:4Q:p37)	Benign Refers to a relatively mild degree of hypertension of prolonged or chronic duration. (AHA Coding Clinic 85:M-J:p19; 91:1Q:p16; 93:4Q:p37)	Unspecified Refers to unspecified "malignant" or "benign" form of hypertension of a prolonged or chronic nature. (AHA Coding Clinic 85:M-J:p19; 91:1Q:p16; 93:4Q:p37)				
Hypertension, Essential (NOS)	401.0	Malignant	401.1	Benign	401.9	Unspecified	
Hypertensive Heart Disease	402.00	Malignant, w/o HF	402.10	Benign, w/o HF	402.90	Unspecified w/o HF	
Special Coding Alert:	*402.01	Malignant, w/ HF	*402.11	Benign, w/ HF	*402.91	Unspecified w/ HF	
Per ICD-9: A cause & effect relationship between the heart condition and HTN must be established and documented when assigning these codes (i.e., Hypertensive CHF). If such linkage has not been established, then 401.X and 428.XX must be assigned instead. Note: review "includes" notes at category 402 in ICD-9-CM code book.	*Use an additional code to specify type of heart failure (HF) (428.0 - 428.43). The following represents a partial sample of selections:						
	428.0	Congestive HF (CHF), Unsp.	428.0	Congestive HF (CHF), Unsp.	428.0	Congestive HF (CHF), Unsp.	
	428.1	Left HF	428.1	Left HF	428.1	Left HF	
	†428.20	Systolic HF, Unsp.	†428.20	Systolic HF, Unsp.	†428.20	Systolic HF, Unsp.	
	†428.30	Diastolic HF, Unsp.	†428.30	Diastolic HF, Unsp.	†428.30	Diastolic HF, Unsp.	
	†428.40	Combined Systolic & Diastolic HF, Unsp.	†428.40	Combined Systolic & Diastolic HF, Unsp.	†428.40	Combined Systolic & Diastolic HF, Unsp.	
	428.9	Heart Failure, Unsp.	428.9	Heart Failure, Unsp.	428.9	Heart Failure, Unsp.	
	† More than one code from category 428 may be assigned if the patient has systolic, diastolic, or combined HF with CHF (428.0).						
Hypertensive CKD	403.00	Malignant, (CKD Stage I-IV / Unsp.)	403.10	Benign, (CKD Stage I-IV / Unsp.)	403.90	Unspecified, (CKD Stage I-IV / Unsp.)	
Special Coding Alert:	403.01	Malignant, (CKD Stage V / ESRD)	403.11	Benign, (CKD Stage V / ESRD)	403.91	Unspecified, (CKD Stage V / ESRD)	
Per ICD-9: An automatic relationship is assumed when a patient has both chronic kidney disease (CKD) and hypertension (HTN). Therefore, documentation of a cause & effect relationship between the CKD and HTN is not required. Note: review "includes" and "excludes" notes at category 403 in ICD-9-CM code book.	Use an additional code to identify the stage of CKD (585.1 – 585.9)						
	585.1	CKD, Stage I	585.1	CKD, Stage I	585.1	CKD, Stage I	
	585.2	CKD, Stage II	585.2	CKD, Stage II	585.2	CKD, Stage II	
	585.3	CKD, Stage III	585.3	CKD, Stage III	585.3	CKD, Stage III	
	585.4	CKD, Stage IV	585.4	CKD, Stage IV	585.4	CKD, Stage IV	
	*585.5	CKD, Stage V	*585.5	CKD, Stage V	*585.5	CKD, Stage V	
	*585.6	CKD, ESRD	*585.6	CKD, ESRD	*585.6	CKD, ESRD	
	585.9	CKD, Unsp.	585.9	CKD, Unsp.	585.9	CKD, Unsp.	
	*Use an additional code to specify: "Dialysis Status" (V45.11) <input type="checkbox"/> "Noncompliance w/ Dialysis" (V45.12) <input type="checkbox"/> "Kidney Transplant Status" (V42.0) <input type="checkbox"/>						
Hypertensive Heart & CKD	404.00	Malignant, w/o HF (CKD Stage I-IV / Unsp.)	404.10	Benign, w/o HF (CKD Stage I-IV / Unsp.)	404.90	Unspecified, w/o HF (CKD Stage I-IV / Unsp.)	
Special Coding Alert:	*404.01	Malignant, w/ HF (CKD Stage I-IV / Unsp.)	*404.11	Benign, w/ HF (CKD Stage I-IV / Unsp.)	*404.91	Unspecified, w/ HF (CKD Stage I-IV / Unsp.)	
Per ICD-9: A cause & effect relationship between the heart condition and HTN must be established and documented when assigning these codes (i.e., Hypertensive CHF). If such linkage has not been established, then 401.X and 428.XX must be assigned instead. Note: review "includes" notes at category 404 in ICD-9-CM code book.	404.02	Malignant, w/o HF (CKD Stage V / ESRD)	404.12	Benign, w/o HF (CKD Stage V / ESRD)	404.92	Unspecified, w/o HF (CKD Stage V / ESRD)	
	*404.03	Malignant, w/ HF (CKD Stage V / ESRD)	*404.13	Benign, w/ HF (CKD Stage V / ESRD)	*404.93	Unspecified, w/ HF (CKD Stage V / ESRD)	
	*Use an additional code to specify type of heart failure (HF) (428.0 - 428.43). The following represents a partial sample of selections:						
	428.0	Congestive HF (CHF), Unsp.	428.0	Congestive HF (CHF), Unsp.	428.0	Congestive HF (CHF), Unsp.	
	428.1	Left HF	428.1	Left HF	428.1	Left HF	
	†428.20	Systolic HF, Unsp.	†428.20	Systolic HF, Unsp.	†428.20	Systolic HF, Unsp.	
	†428.30	Diastolic HF, Unsp.	†428.30	Diastolic HF, Unsp.	†428.30	Diastolic HF, Unsp.	
	†428.40	Combined Systolic & Diastolic HF, Unsp.	†428.40	Combined Systolic & Diastolic HF, Unsp.	†428.40	Combined Systolic & Diastolic HF, Unsp.	
	428.9	Heart Failure, Unsp.	428.9	Heart Failure, Unsp.	428.9	Heart Failure, Unsp.	
	† More than one code from category 428 may be assigned if the patient has systolic, diastolic, or combined HF with CHF (428.0).						
	Use an additional code to identify the stage of CKD (585.1 – 585.9)						
	585.1	CKD, Stage I	585.1	CKD, Stage I	585.1	CKD, Stage I	
	585.2	CKD, Stage II	585.2	CKD, Stage II	585.2	CKD, Stage II	
	585.3	CKD, Stage III	585.3	CKD, Stage III	585.3	CKD, Stage III	
	585.4	CKD, Stage IV	585.4	CKD, Stage IV	585.4	CKD, Stage IV	
	*585.5	CKD, Stage V	*585.5	CKD, Stage V	*585.5	CKD, Stage V	
	*585.6	CKD, ESRD	*585.6	CKD, ESRD	*585.6	CKD, ESRD	
	585.9	CKD, Unsp.	585.9	CKD, Unsp.	585.9	CKD, Unsp.	
	*Use an additional code to specify: "Dialysis Status" (V45.11) <input type="checkbox"/> "Noncompliance w/ Dialysis" (V45.12) <input type="checkbox"/> "Kidney Transplant Status" (V42.0) <input type="checkbox"/>						

Documentation & Coding for Cardiovascular Disease

Background

Based on recommendations by the U.S. Preventive Services Task Force (USPSTF), the Centers for Medicare and Medicaid Services (CMS) will cover preventive services and counseling for cardiovascular disease prevention and risk reduction under a new HCPCS code:¹

→ **G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes**

face-to-face cardiovascular disease (CVD) risk reduction visit annually for Medicare beneficiaries who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care provider in a primary care setting. It also gives the provider an excellent opportunity to document and recapture all chronic cardiovascular conditions and document the preventive services that demonstrate the healthcare quality measures are being met for these important chronic conditions.²

Clinical Suggestions

Prior to this visit, ensure that the patient has had a phlebotomy for fasting lipid profile and glucose and review the patient's most recent screening EKG.

Patient Name, Date of Service and an additional patient identifier (e.g., Date of Birth) is required on every page.³

Reason for Visit: Cardiovascular Disease Risk Reduction Visit

Medications: Document all current cardiovascular medications (antiplatelet agents, antiarrhythmics, antihypertensives, thromboembolic prophylaxis, etc.) and their indications.

Document All Pertinent Cardiovascular Risk Factors, such as:

- Myocardial Infarction (MI) (410.xx, Acute myocardial infarction or **412**, Old myocardial infarction [if outside of 8 weeks from the date of infarction]) with date of event and type of MI (i.e. anterolateral, etc), if known
- Angina (**413.x**, Angina pectoris)
- Coronary artery bypass graft (CABG) and/or coronary artery endovascular procedures (e.g. PTCA) (V45.81, Aortocoronary bypass status; V45.82, Percutaneous transluminal coronary angioplasty status)
- Arrhythmia/Dysrhythmia (specify type) (427.xx, Cardiac dysrhythmias)
- Hypertension
- Diabetes
- Peripheral vascular disease
- Hypercholesterolemia (272.0, Pure hypercholesterolemia)
- Exercise tolerance, shortness of breath on exertion
- Family history of CVD (V17.49, Family history of other cardiovascular diseases)

Physical Examination:

- Document blood pressure, heart rate, height, weight and BMI during clinic visit
- Head and neck: JVD, carotid bruits
- Chest
- Heart
- Abdomen
- Lower extremity: peripheral edema, pedal pulses

Labs: Review lipid profile, diabetes screening and bring pertinent findings into body of progress note.

EKG: Report results from screening EKG. *Perform every 1-2 years depending on physician's practice guidelines.*

Assessment:

- Document all pertinent diagnoses (any condition being treated and any condition that affects care and treatment)⁴
- Document all pertinent risk factors for cardiovascular disease²

Plan:

1. *Required:* Document discussion of diet and exercise and lifestyle modifying recommendations given to patient (V65.3, Dietary surveillance and counseling [use additional code to identify BMI, if known]; V65.41, Exercise counseling)
2. *Required:* Document recommendation to implement or not implement a regimen of aspirin (based on patient's other risk factors)
3. Document other recommendations that deal with patient's cardiovascular status
4. Document follow-up visits, referrals, other recommendations that are relevant to cardiovascular disease risk prevention

1. "MLN Matters." Medicare Learning Network. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 23 2012. Web. 28 Dec 2012. <cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7636.pdf>.

2. Berry HD, et al. Lifetime Risks of Cardiovascular Disease. N Engl J Med 2012 366(4): 321-9.

3. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 30 Nov 2012. <jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.

4. World Health Organization, "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." National Center for Health Statistics 2011 1-107. Web. 28 Dec 2012.<cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm>.

Stroke and Late Effects of Prior Stroke

One of the most common coding errors seen in chart reviews is the assignment of a stroke code in the present tense when the coder is actually trying to code for the residual conditions *left behind by a prior stroke*. Acute stroke is only coded during the initial episode of care.

Cerebrovascular Accidents (CVA/Stroke)

In a CVA, there is a decreased supply of blood to the brain that can result in an area of infarction (necrotic cerebral tissue). CVA occurs because of thrombosis, embolism, occlusion (code categories 433 affecting precerebral arteries and 434 affecting cerebral arteries) or hemorrhage (category **430** to **432** to specify subarachnoid, intracerebral and other intracranial hemorrhage respectively).

There are codes for each type of CVA. The fourth and fifth digits of these codes indicate either "with" or "without" infarction.

Unless otherwise stated, CVA/stroke is considered an assumed ischemic infarction and is coded as **434.91**. The fifth digit of 1 indicates "infarction."

After the Initial Acute Care Episode of Stroke

After an initial stroke incident has occurred, generally one of two scenarios will exist. Either the patient will have deficits from the stroke (conditions left behind such as paralysis) or will make a recovery without any long-lasting effects.

- If the patient recovers without any lingering problems related to the stroke, the code would be V12.54, Personal history, transient ischemic attack (TIA), and cerebral infarction without residual deficits.
- If the patient has deficits present after the discharge from the initial acute care episode, all deficits are coded to "Late Effects of Cerebrovascular Disease" (category 438).

Prior to October 2004, CVA not otherwise specified was coded to category **436**. In the current 2013 ICD-9-CM there is an exclusionary note specifically stating not to use this code when documentation indicates "CVA, stroke, or cerebral infarction."

Caution: Code **436** "acute, but ill-defined, CVA" is now utilized for conditions such as apoplexy and cerebral seizure.

Post-Operative Cerebrovascular Hemorrhage or Infarction

A post-operative cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded as **997.02** – Complications affecting specified body systems: iatrogenic cerebrovascular infarction or hemorrhage. In addition, the specific type of postoperative infarction must be coded.

The Documentation is Significant

Example 1

Stroke initial incident

"Acute embolic CVA with infarction"

- **434.11** - Cerebral embolism with cerebral infarction

Example 2

Stroke initial incident; prior stroke with no deficits

"Acute embolic CVA, prior stroke with no deficits"

- 434.10 - Cerebral embolism without mention of cerebral infarction
- V12.54 - Personal history, transient ischemic attack (TIA), and cerebral infarction without residual deficits

Example 3

Stroke initial incident with deficits from prior stroke

"Acute embolic CVA with infarction; previous CVA with residual dysphagia"

- **434.11** - Cerebral embolism with cerebral infarction
- 438.82 - Other late effects of cerebrovascular disease, dysphagia
- 787.20 - Dysphagia, unspecified

Example 4

Follow-up for evaluation of a residual of stroke

"Office visit to evaluate dysphagia from a stroke one month ago"

- 438.82 - Other late effects of cerebrovascular disease, dysphagia
- 787.20 - Dysphagia, unspecified

Example 5

Postoperative stroke

"Acute embolic CVA with infarction postoperatively"

- **997.02** - Iatrogenic cerebrovascular infarction or hemorrhage
- **434.11** - Cerebral embolism with cerebral infarction

Example 6

History of TIA (or CVA)

- V12.54 - Personal history, transient ischemic attack (TIA), and cerebral infarction without residual deficits

Peripheral Arterial Disease (PAD) Documentation & Coding

Language of Documentation

“Peripheral arterial disease,” “peripheral vascular disease” and “intermittent claudication” are coded as **443.9**. It is important to note that this code excludes atherosclerosis of the arteries of the extremities. When atherosclerosis (arteriosclerosis) is diagnosed by the clinician, the progress note should state “arteriosclerosis of” and the site, “arteriosclerotic” or “arteriosclerosis with” followed by the symptom or complication (e.g., arteriosclerosis with ulceration). Arteriosclerosis and atherosclerosis may be used interchangeably for documentation and coding purposes. Documentation of arteriosclerosis that lacks specificity is coded as 440.9 and includes the following:

- Arteriosclerotic vascular disease NOS
- Generalized arteriosclerosis
- Endarteritis deformans
- Arteriosclerosis (obliterans) (senile)
- Arteriosclerosis with calcification
- Occlusive arteriosclerosis

ICD-9-CM Codes

Atherosclerosis of the native arteries of the extremities (Category 440) is further classified as:

<i>Use additional code, if applicable, to identify chronic total occlusion of artery of the extremities (440.4)</i>	
440.20	Atherosclerosis of native arteries of the extremities, unspecified
440.21	Atherosclerosis of native arteries of the extremities, with intermittent claudication
440.22	Atherosclerosis of native arteries of the extremities, with rest pain
440.23*	Atherosclerosis of native arteries of the extremities, with ulceration
440.24*	Atherosclerosis of native arteries of the extremities, with gangrene
440.29	Atherosclerosis of native arteries of the extremities, other

When PAD or atherosclerosis is documented as a manifestation of diabetes or secondary diabetes, report one of the following diabetes codes with the associated manifestation code:

250.70-250.73	Diabetes with peripheral circulatory disorders
249.70-249.71	Secondary diabetes with peripheral circulatory disorders

The progress note must provide the appropriate linkage between the diabetes and the manifestation. For example, if the documentation states “PAD due to diabetes,” the most appropriate code to describe the PAD is **443.81**. This becomes a two-code scenario:

250.70	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled
443.81	Peripheral angiopathy in diseases classified elsewhere

Atherosclerotic disease is a progressive disease. Therefore, avoid documenting “history of peripheral vascular disease” and instead consider “known peripheral arterial disease.” In support of such documentation, providers can use a V code for patients who have had peripheral arterial bypass (V43.4) in addition to the ICD-9-CM code for PAD.

*Use additional code to identify any associated ulceration:

707.1X Ulcer of lower limbs, except pressure ulcer		
X = 0 unspecified	X = 3 ankle	X = 9 other part of lower limb
X = 1 thigh	X = 4 heel and midfoot	707.8 Chronic ulcer of other specified site
X = 2 calf	X = 5 other part of foot	707.9 Chronic ulcer of unsp. site

When documenting ulcers, it is important **not to** document them as “wounds,” “open wounds” or “lesions.”

Correctly Reporting Cancer Diagnoses

Current Cancer vs. History of Cancer

To correctly report a diagnosis of cancer, determine whether the patient's cancer has been eradicated or is currently being treated. The neoplasm table in the ICD-9-CM code book establishes three categories of malignancy: primary, secondary and insitu. Malignant neoplasms should be coded as categorized; unknown sites (primary or secondary) must also be coded.

Current Cancer

Patients with cancer who are receiving active treatment for the condition should be reported with the malignant neoplasm code corresponding to the affected site. This applies even when a patient has had cancer surgery, but is still receiving active treatment for the disease.

Example

Malignant neoplasm of kidney NOS **189.0**

Primary Site with Unknown Secondary Site

Example

Metastatic carcinoma from lung **162.9** (Primary site - lung)

Unknown secondary site **199.1**

Secondary Site with Active Primary Site

A patient is admitted with metastatic bone cancer. The patient had a mastectomy two months ago and is currently having radiation treatments for breast cancer. The neoplasm was located in the upper outer quadrant.

Example

Neoplasm, bone, secondary **198.5**

Neoplasm, breast, upper-outer quadrant, **174.4**

Carcinoma in situ

Documentation describing patients with tumor cells that are undergoing significant malignant changes but are still confined to the point of origin without invasion of the surrounding normal tissue is to be coded as Ca in situ.

Example

Carcinoma in situ of cervix uteri **233.1**

History of Cancer

Patients with a history of cancer, with no evidence of current cancer, and not currently under treatment for cancer should be reported as "*Personal history of malignant neoplasm.*" These V codes require additional digits to identify the site of the cancer and should be reported only when there is no evidence of current cancer. If a patient's

presenting problem, signs, or symptoms may be related to the cancer history or if the cancer history (personal or family) impacts the plan of care, then report the appropriate V code and not the code for the active cancer.

Example

Personal history of malignant neoplasm, kidney **V10.52**

Aftercare Following Surgery for Neoplasm

Visits to determine the effectiveness of cancer surgery that fall within the global postoperative period should be reported as "*Aftercare following surgery for neoplasm,*" code **V58.42**. The aftercare V code should be used with either the current neoplasm code or code from category **V10**, Personal history of malignant neoplasm, whichever is applicable.

Example

Aftercare following surgery for malignant neoplasm **V58.42**

Follow-up for Patients with History of Cancer

Follow up exams to determine if there is any evidence of recurrent or metastatic cancers that result in no evidence of malignancy and no ongoing treatment should be reported as "*follow-up exam,*" using a V code from the **V67** category. This includes surveillance only following completed treatment.

Example

Follow-up examination, following radiotherapy **V67.1**

Cancer Drugs Prescribed for Reason Other Than Malignancy

Patients with no history of cancer who take cancer drugs should not be reported with an active cancer diagnosis or a personal history of malignant neoplasm. Instead, code the reason for the prescription.

Example

Family history of malignant neoplasm, breast **V16.3**

Use of selective estrogen receptor modulators (SERMS) **V07.51**

References:

AHA Coding Clinic, July-August, USA: American Hospital Association, 1985. Print.
 AHA Coding Clinic, 3rd Q. USA: American Hospital Association, 1995. Print.
 Faye Brown's ICD-9-CM Coding Handbook. USA: American Hospital Association, 2013. Print.

Overweight, Obesity and Morbid Obesity

Documentation of the Body Mass Index (BMI) is a reportable healthcare quality measure. For the general population, an increased BMI correlates well with excess body fat. Additionally, based on recommendations by the U.S. Preventive Services Task Force (USPSTF), CMS will cover preventive services and counseling for obesity, under a new HCPCS code, G0447 (Face-to-Face Behavioral Counseling for Obesity, 15 minutes).

Documentation Guidance

Patient Name, Date of Service (DOS) and an additional patient identifier (e.g., Date of Birth [DOB]) is required on every page.^{1,2}

CMS covers claims for multiple face-to-face visits for Medicare beneficiaries who are obese, as defined by a BMI equal to or greater than 30 kg/m²; who are competent and alert at the time that counseling is provided; and whose counseling is furnished by a qualified primary care physician or other primary care provider in a primary setting. Approved, scheduled visits are as follows:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 6.6 lbs (3 kg) weight loss requirement during the first 6 months.³

History

- Review any and all health changes that can be caused by the patient's increased weight
- Review activity level
- Dietary and nutritional assessment
- Family medical history of diabetes, cardiovascular disease, etc.

Exam

- Screening for obesity in adults, using the measurement of BMI and expressed as kg/m²
- Identify any physical findings consistent with comorbidities of obesity

All Intensive Behavioral Therapies Should be Consistent with the 5 "A"s

- **Assess:** Ask about/assess behavioral risks and factors affecting choice of behavior change goals/methods
- **Advise:** Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits
- **Agree:** Collaboratively select appropriate treatment goals and methods based on patient's interest in and willingness to change behavior
- **Assist:** Using behavior change techniques (self-help and counseling), aid the patient in achieving agreed-upon goals by acquiring skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive treatments when appropriate
- **Arrange:** Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust treatment plan as needed, including referral to more intensive or specialized treatment

Sample Note for Intensive Behavioral Therapy for Obesity (HCPCS code G0447)

Patient: Name **DOS:** 01/02/2015 **DOB:** 08/01/48

Reason for visit: Face-to-face visit for obesity counseling.

S:

O: Patient alert, oriented to person, place and time. No acute distress.

Vital Signs: T 98.2; BP 163/92; HR 63; Wt 203 lbs; Ht 64"; BMI 35.7

Cardiac: RRR no rubs, gallops or murmurs noted.

Lungs: Clear to auscultation.

Abd: Distended secondary to obesity, soft non-tender to palpation.

Feet: Peripheral pulses barely palpable, secondary to obesity.

Laboratory Values: Fasting Blood Sugar 120 mg/dl; Total Cholesterol 200 mg/dl with LDL of 170 mg/dl; Triglyceride 175 mg/dl

A: Patient with evidence of multiple complications secondary to obesity (278.00), including:

1. Dysmetabolic syndrome X (277.7) with hypertension (401.9), insulin resistance (277.7) and dyslipidemia (272.4)
2. Osteoarthritis of the hips and knees (715.95 & 715.96)
3. Pickwickian syndrome (**278.03**)
4. Sleep disorder (780.50), possible sleep apnea
5. Mild gastroesophageal reflux disease (530.81)

- P:**
1. Patient's changing health status was discussed in detail.
 2. At this time, she is amenable to begin an intensive weight loss program. She was commended on her desire to improve her health status and was given advice on diet and snacking. She understands to fill half her plate with fresh fruit and/or vegetables and also change to lean protein sources. She will snack on fresh fruit and nuts when hungry and increase her water intake to an additional liter per day. In addition, I assured her that there were several other options to support her weight loss goals.
 3. Exercise counseling: Patient's family has a gym membership and she plans to exercise or walk at least 30 minutes per day.
 4. Patient was advised on the risks of sleep apnea and was advised of a sleep referral clinic, which she refuses at this time.

Patient will return to clinic in 2 weeks to review her health maintenance and BMI by our nurse practitioner.

Authenticated by: Joseph A. Williams MD, 01/02/15

1. Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.

2. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 30 Nov 2012. <jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.

3 "MLN Matters." Medicare Learning Network. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Web. 8 Jan 2013. <cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7641.pdf>.

Protein-Calorie Malnutrition

In order to improve the reporting of malnutrition among the elderly, it is important for providers to document the condition in the medical record and for coders to be aware of malnutrition as a potential diagnosis (ICD-9-CM Code Categories 262 and 263).

The most severe malnutrition problems are associated with Protein-Calorie Malnutrition (PCM), also known as Protein-Energy Malnutrition (or Protein Calorie Undernutrition), which occurs in both chronic and acute forms.

Protein-calorie malnutrition is associated with many disease states, including:¹

- Cancer
- Alcohol Abuse and/or Dependence
- Liver Disease
- Chronic Kidney Disease (CKD)
- Pancreatitis
- Drug Abuse and / or Dependence
- Anemia
- End Stage Renal Disease (ESRD)

The Clinical Assessment of Nutritional Status (CANS) can provide a scoring system to determine whether or not a patient may have Protein-Calorie Malnutrition (PCM).

- Any combination, which provides a score of 2 or more, suggests that the patient may meet the diagnosis of Protein Calorie Malnutrition (PCM)
- Although PCM can be diagnosed when the BMI is ≤ 18.9 , it should be noted that the elderly are at increased risk of death when the BMI is ≤ 21 . Therefore, the PCP should ensure that the elderly have adequate caloric and protein intake so that the BMI is above 21.²

ICD-9 Codes	Code Description	Examples of Diagnostic Criteria
263.0	Malnutrition of Moderate Degree	"Second Degree" Characterized by superimposed biochemical changes in electrolytes, lipids, blood plasma ^{3,4}
263.1	Malnutrition of Mild degree	"First Degree" Characterized by tissue wasting in an adult, but few or no biochemical changes ⁴
263.8	Other Protein-Calorie Malnutrition	Not elsewhere specified ⁴
263.9	Unspecified Protein-Calorie Malnutrition	Dystrophy due to malnutrition Malnutrition (calorie) NOS ⁴
799.4	Cachexia	Wasting disease; general ill health and poor nutrition. ³ Code first underlying condition if known. ⁴

Parameters	Positive	Negative
	<i>Circle appropriate score and add for total on the last row and FOC</i>	
1. Unremitting, involuntary weight loss <input checked="" type="checkbox"/> Greater than 10% in the previous six months and especially in the last few weeks	1	0
2. Food intake is severely curtailed	1	0
3. Muscle wasting and fat loss <input checked="" type="checkbox"/> With presence of edema or ascites on exam	1	0
4. Persistent, daily gastrointestinal symptoms in the past 2 weeks <input checked="" type="checkbox"/> Including anorexia, nausea, vomiting, diarrhea	1	0
5. Marked reduction in physical activity	1	0
6. Presence of metabolic stress <input checked="" type="checkbox"/> Due to trauma, inflammation, infection	1	0
7. Albumin < 3.5	1	0
8. BMI ≤ 18.9	2	0
TOTAL SCORE:		

1. Hoffer, John L. "Clinical Nutrition: 1. Protein-energy Malnutrition in the Inpatient." Ed. Canadian Medical Association Journal. (2001). Print.
 2. Berrington de Gonzalez A and others (December 2010). Body-Mass Index and Mortality among 1.46 Million White Adults. N. Engl. J. Med. 363 (23): 2211-9. (2010)
 3. OptumInsight, Coders' Desk Reference For Diagnoses. 2013. Alexandria, VA: OptumInsight, 2012. Print., pp. 272.
 4. World Health Organization: ICD-9-CM for Providers, Professional Ed. Volumes 1&2. 2013. Alexandria, VA: OptumInsight, 2012



Major Depressive Disorder Algorithm¹

First determine if ALL of the following apply:

- Symptoms do not meet criteria for a mixed episode (e.g., bipolar disorder)
- Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of concern
- Symptoms are not due to direct effect of a substance
- Symptoms are not more appropriately classified as bereavement (V62.82) or acute grief reaction (309.0) unless continuous for over 2 months or severe functional impairment, morbid preoccupation with worthlessness, psychotic symptoms or psychomotor retardation
- Symptoms have been present during the same 2-week period and represent a change from previous functioning

If all the above is true move to the next box

Must have one or both of these symptoms:

- Depressed mood most of the day and nearly every day, self reported or observed by others
- OR**
- Markedly diminished interest or pleasure in all, or almost all, activities on most days, self reported or reported by others

If either of the above is true move to the next box

Must have either one or both of the above symptoms plus 3 or 4 of these to make a total of 5 or more symptoms:

- Significant weight loss (not due to dieting) or gain (e.g. 5% change in one month); or decrease or increase in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day, observable by others
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day:
 - May be delusional
 - Not merely self-reproach or guilt about being sick
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (self reported or observed by others)
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

If you now have a minimum of 5 symptoms total, your patient meets the requirement for the diagnosis of Major Depressive Disorder per DSM-IV.^{1,3}

ICD-9 Diagnosis:

- **296.2X** Major Depressive Disorder, Single Episode
- **296.3X** Major Depressive Disorder, Recurrent

Fifth Digits:

- 0** = Unspecified **1** = Mild **2** = Moderate
- 3** = Severe w/o psychotic behavior
- 4** = Severe w/ psychotic behavior
- 5** = In partial or unspecified remission
- 6** = In full remission

When reporting history of major depressive disorder, instead of coding V11.1, Personal history of affective disorders, "A code from the mental disorders chapter, with an in remission fifth-digit, should be used."³

Additional Resources:

The Patient Health Questionnaire 9 (PHQ-9) is a self-administered screening and diagnostic tool for mental health disorders used by health care professionals to improve the recognition rate of depression and anxiety and facilitating diagnosis and treatment.² Please contact your local OptumInsight Healthcare Advocate to order this useful patient assessment tool.

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Ed, Text Revision. Washington, DC, American Psychiatric Association, 2000.
 2. "Patient Health Questionnaire (PHQ) Screeners." Patient Health Questionnaire (PHQ) Screeners from Pfizer. Pfizer. Web. 01 Oct. 2012. <phqscreeners.com/overview.aspx?Screeners=02_PHQ-9>.
 3. The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). "ICD-9-CM Official Guidelines for Coding and Reporting." Department of Health and Human Services. DHHS, 2012, October. Web. 4 October 2012. <cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf>.

Cognitive-Function Screening

Dementia is a disease of advancing age, and one in eight older Americans has dementia due to Alzheimer's disease.¹ The lifetime risk of developing Alzheimer's is 17.2% in women and 9.1% in men.^{1,2} Alzheimer's dementia, which comprises 60-80% of all cases of dementia, is now the 6th leading cause of death.³

Risk factors for developing dementia include:

- Advanced age
- Female gender
- A family history of 1st-degree relatives with dementia
- Lower socioeconomic status
- Cardiovascular risk factors also are risk factors for dementia and are modifiable such as hypertension, hypercholesterolemia, type 2 diabetes, obesity, tobacco use and physical inactivity
- History of Mild Cognitive Impairment

Cognitive Testing

Detection of *any* Cognitive Impairment now is a requirement for reimbursement of the Initial Annual Wellness Visit (AWV) with Personalized Prevention Plan of Service (PPPS) (HCPCS code G0438) as well as the Subsequent AWV with PPPS (G0439).

Mild Cognitive Impairment

The diagnosis of Mild Cognitive Impairment (ICD-9-CM code 331.83) requires evidence of (1) a decline in memory and (2) a decline of at least one of the following cognitive abilities:

- Ability to generate coherent speech or understand spoken or written language
- Ability to recognize or identify objects, assuming intact sensory function
- Ability to execute motor activities, assuming intact motor abilities, sensory function and comprehension of required tasks
- Ability to think abstractly, make sound judgments and plan and carry out complex tasks⁴

Dementia

For dementia to be diagnosed, *in addition to meeting the criteria for mild cognitive impairment, the cognitive deficits must be severe enough to interfere with daily life.*^{2,4} Therefore, the primary care physician must screen the patient for abilities to perform activities of daily living, interview family members or caregivers and document these findings.

Documentation and Coding

Three factors to consider when documenting dementia include:

1. Type of dementia - there are many types listed under dementia in ICD-9-CM (Alzheimer's, dementia with Lewy bodies, frontal, senile, vascular, etc.)
2. Document any associated conditions (history of stroke, neurological conditions, associated epilepsy, etc.)
3. Document any associated behavioral disturbance (aggressive, combative or violent behavior or wandering [V40.31]).

SIX ITEM COGNITIVE IMPAIRMENT TEST*			
1. What year is it?	<input type="text" value="0"/> CORRECT	<input type="text" value="3"/> INCORRECT	<input type="text"/> SCORE
2. What month is it?	<input type="text" value="0"/> CORRECT	<input type="text" value="3"/> INCORRECT	<input type="text"/> SCORE
3. Ask patient to remember the following address: John Brown - 42 Main Street - Bedford (Make sure patient can repeat address properly and inform him/her that you will ask him for it later.)		7. Repeat address phrase (address in # 3)	
4. What time is it (within one hour)?		<input type="text" value="0"/> CORRECT	<input type="text"/> TOTAL SCORE
		<input type="text" value="3"/> INCORRECT	<input type="text" value="2"/> 1 ERROR
		<input type="text"/> SCORE	<input type="text" value="4"/> 2 ERRORS
			<input type="text" value="6"/> 3 ERRORS
			<input type="text" value="8"/> 4 ERRORS
			<input type="text" value="10"/> ALL INCORRECT
SCORING: 0 - 7 Normal • 8 - 9 Mild Cognitive Impairment (consider referral) • 10 - 28 Significant Cognitive Impairment (refer)			

*The Kingshill Research Centre, Swindon, UK owns the copyright to The Kingshill Version 2000 of the 6CIT but allows free usage to health care professionals. patient.co.uk/doctor/six-item-cognitive-impairment-test-6cit

1. B.L. Plassman, Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study, *Neuroepidemiology* 2007;29:125-132.
 2. 2011 Alzheimer's Disease Facts and Figures. Alzheimer's Association. alz.org/downloads/Facts_Figures_2011.pdf
 3. Deaths: Preliminary Data for 2009. Centers for Disease Control. cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf.
 4. Brooke P, Bullock R: Validation of 6-Item Cognitive Impairment Test with a view to primary care usage. *Int J Gen Psychiatry* 14: 936-940. 1999

The Importance of Screening for Depression

- **The evaluation and screening of risk factors for depression is mandatory for the “Welcome to Medicare” initial preventive physical exam (IPPE) and the initial Annual Wellness Visit (AWV) with the personalized prevention plan of service (PPPS). (HCPCS codes G0402 and G0438 respectively)¹**
- **The annual screening and evaluation of depression in the Medicare Advantage enrollee is essential and also can be covered subsequently by billing for HCPCS code G0444¹**

Background

- One in six patients over the age of 65 years suffers from depression¹
- Depression in older adults is estimated to occur in one-quarter of those with other chronic conditions including:
 - cancer
 - stroke
 - chronic lung disease
 - cardiovascular disease
 - arthritis and other chronic pain syndromes

Stressful events, such as the loss of friends and loved ones, is also an expected consequence of elder living and can contribute to the development of mood disorders.

Annual screening for depression (ICD-9-CM code V79.0) in the elderly in the primary care setting is important because 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general care. Moreover, close to 40% were seen within a week prior to their death.¹

Older adults have the highest risk of suicide of all age groups.

Based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), CMS also covers annual screening for adults for depression in the primary care setting. Contractors shall reimburse for annual depression screening (HCPCS code G0444) in a primary care setting that has staff-assisted depression care supports in place in order to assure accurate diagnosis, effective treatment, and follow-up care.

A primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained

partnership with patients and practicing in the context of family and community. Appropriate places of service include a doctor's office, outpatient hospital, independent clinic or a state or local public health clinic. (Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospice *are not* considered primary care settings under this definition.)¹

At a minimum level, staff-assisted depression care supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care office who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment. More comprehensive care supports include a case manager working with the primary care physician; planned collaborative care between the primary care provider and mental health clinicians; patient education and support for patient self-management; plus attention to patient preferences regarding counseling, medications, and referral to mental health professionals with or without continuing involvement by the patient's primary care physician.¹

Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications, or chronic conditions resulting from depression, nor does it address therapeutic interventions such as pharmacotherapy, combination therapy (counseling and medications), or other interventions for depression. Self-help materials, telephone calls, and web-based counseling are not separately reimbursable by Medicare.¹

Screening for depression is non-covered when performed more than one time in a 12-month period. Eleven full months must elapse following the month in which the last annual depression screening took place.¹

There are a number of evidence-based media tools that are effective in screening for depression. The Patient Health Questionnaire (PHQ-9) is one screening tool and is provided on the next page.

Contact your Optum Healthcare Advocate for complimentary pads of this PHQ-9.

Additional guidelines for the documentation and management of depression, based on the PHQ-9, can be found at: depression-primarycare.org/images/pdf/phq_9_eng.pdf

1. Center for Medicare & Medicaid Services (CMS). Medicare Learning Network. CMS, June 2012. Web. 28 Dec. 2012. <cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-for-Depression-Booklet-ICN907799.pdf>.

Scoring the PHQ-9

For Healthcare Professional Use Only

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- If there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- If there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 • More than half the days = 2 • Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the PHQ-9 TOTAL box on the other side to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: Add up all checked boxes on PHQ-9

For every ✓

Not at all = 0;

Several days = 1;

More than half the days = 2;

Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

The PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute. Additional information can be found at: <ncbi.nlm.nih.gov/pubmed/11556941>



The Medicare Annual Wellness Visit (AWV)

The Patient Protection and Affordable Care Act (ACA) waives the deductible and coinsurance/copayment for the Annual Wellness Visit (AWV).¹

Annual Wellness Visit (AWV) with Personalized Prevention Plan Services (PPPS)

Codes	Diagnosis Code	Description
G0438	Any appropriate code is accepted	Annual wellness visit, includes a personalized prevention plan of service (PPPS), <i>first visit</i>
G0439		Annual wellness visit, includes a personalized prevention plan of service (PPPS), <i>subsequent visit</i>

What is Included in Initial AWV with PPPS (G0438)?

- Health risk assessment²
- Establishment of medical/family history
- Establishment of list of current providers and suppliers
- Measurement of: height, weight, BMI, blood pressure and other medically necessary routine measurements
- Detection of any cognitive impairment
- Review of potential risk factors for depression
- Review of functional ability and level of safety
- Establishment of a written screening schedule (see pages 30-31)
- Establishment of a list of risk factors and conditions for which interventions are recommended or are underway and a list of treatment options and their risks and benefits
- Furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs, or community-based lifestyle interventions to reduce identified risk factors and promote self-management and wellness (see pages 30-31)
- Voluntary advance planning upon agreement with patient*

What is Included in Subsequent AWV with PPPS (G0439)?

- Update of health risk assessment
- Update of medical/family history
- Update the list of current providers and suppliers
- Measurement of weight, blood pressure and other medically necessary routine measurements
- Detection of any cognitive impairment
- Update to the written screening schedule developed in the first AWV providing PPPS (see pages 30-31)
- Update to the list of risk factors and conditions for which interventions are recommended or are underway based on the list developed at the first AWV providing PPPS
- Furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs
- Voluntary advance planning upon agreement with patient*

AWV Coding Tips

- G0438 is for the first AWV only and is paid only once in a patient's lifetime
- G0438 or G0439 must not be billed within 12 months of a previous billing of a "Welcome to Medicare" exam (G0402) or G0438 or G0439 for the same patient. Such subsequent claims will be denied
- If a claim for a G0438 or G0439 is billed within the first 12 months after the effective date of the patient's Medicare Part B coverage, it will also be denied. A patient is eligible for only the "Welcome to Medicare" exam (G0402) in the first 12 months of eligibility³
- When a provider performs a separately identifiable medically necessary E/M service in addition to the AWV with PPPS, CPT codes 99201-99215 reported with modifier -25 may also be billed. When medically indicated, this additional E/M service would be subject to the applicable deductible, copayment or coinsurance for office visits.

Other Services Provided with the AWV

If you also bill other services with the AWV, and those services are normally subject to a copayment or coinsurance, that copayment or coinsurance will still apply even if the primary reason for the visit was a routine physical exam.

Other Preventive Services (Screenings)^{4,5}

Providers may also provide and bill separately for screenings and other preventive services. Medicare Advantage plans cover many Medicare-covered preventive services.

Please follow original Medicare coding rules when billing Medicare-covered preventive services, see:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html>.

**Voluntary advance planning refers to verbal or written information regarding an individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.*

CPT is a registered trademark of the American Medical Association.

1. Please note, payment policies regarding the AWVs vary by plan. Please check with your contracted plan for further information prior to billing.

2. For a Framework for Patient-Centered Health Risk Assessments, see: cdc.gov/policy/oph/hra/

3. For more information about the "Welcome to Medicare" exam, please ask your Healthcare Advocate for the Optum brochure "Understanding & Coding Medicare Preventive Services."

4. Slight exceptions may vary from plan to plan. Please check with your contracted plan for product variances. Certain eligibility and other limitations may apply.

5. For a complete list of services and procedures that are defined as preventive services under Medicare and which have waived coinsurance/deductible, see: cms.gov/mlnmattersarticles/downloads/SE1129.pdf and cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0752.pdf

PREVENTIVE MEDICINE ASSESSMENT WITH PERSONALIZED HEALTH PLAN AND SCREENING SCHEDULE

Make one copy for patient and file original in chart.

ALL FIELDS REQUIRED	DATE OF SERVICE:	
PATIENT NAME:		DOB:
MEMBER ID #:	PLAN NAME:	

	SCREENING/COUNSELING	PATIENT CRITERIA	DATE ORDERED/ PERFORMED	COMMENTS/ EXCEPTIONS (PHYSICIAN ONLY)
<input type="checkbox"/>	VACCINATION SCHEDULE	<p>Pneumococcal - Once after age 65 and if more than 5 years since last vaccination and / or uncertainty of vaccine status</p> <p>Influenza - Once per fall or winter season</p> <p>Hepatitis B Vaccine - Schedule course of vaccines if patient not previously vaccinated. *additional shots if medically necessary</p>	<p>____/____/____</p> <p>____/____/____</p> <p>____/____/____</p>	
<input type="checkbox"/>	BREAST CANCER SCREENING (MAMMOGRAPHY)	Annual screening mammography for all women >= 40 years	____/____/____	
<input type="checkbox"/>	COLORECTAL CANCER SCREENING	<p>For ALL patients 50 and Older:</p> <ul style="list-style-type: none"> Annual fecal occult blood test or Colonoscopy every 10 years or Flexible Sigmoidoscopy every 5 years Lower Endoscopy to be performed more frequently, if advised by GI 	<p>Type of screening:</p> <p>_____</p> <p>____/____/____</p>	
<input type="checkbox"/>	CERVICAL CANCER SCREENING	<p>Every 2 years for low risk or annually if: sexual activity began before age 16, more than 5 partners in a lifetime, history of STD, any abnormal PAP in the past 7 years, DES-exposure</p>	____/____/____	
<input type="checkbox"/>	PROSTATE CANCER SCREENING	<p>Once every 12 months for patients age ≥50 includes:</p> <ul style="list-style-type: none"> Digital rectal exam and/or Prostate specific antigen test 	<p>Type of screening:</p> <p>_____</p> <p>____/____/____</p>	
<input type="checkbox"/>	CARDIOVASCULAR DISEASE SCREENING BLOOD TESTS	<p>Asymptomatic patients: every 5 years</p> <p>High-Risk Patients to be screened more frequently:</p> <ul style="list-style-type: none"> Fasting lipid panel 	<p>____/____/____</p> <p>Results: LDL-C_____</p>	
<input type="checkbox"/>	DIABETES SCREENING TESTS Eligible Tests: Quantitative Urine Glucose, GTT, HbA1c	Annually or every 6 months if previous diagnosis of elevated FBS, elevated HbA1c, or impaired GTT, or glucosuria.	<p>Type of screening:</p> <p>_____</p> <p>____/____/____</p>	
<input type="checkbox"/>	OSTEOPOROSIS SCREENING	<p>Every 24 Months in Patients with at least one of the conditions below:</p> <ul style="list-style-type: none"> In women who have had a long-bone or vertebral fracture should undergo assessment for osteoporosis and treatment of osteoporosis within 6 months of the fracture. Women who are estrogen-deficient and at clinical risk for osteoporosis Patient with vertebral abnormalities identified by x-ray Patient receiving, or expected to receive, glucocorticoid therapy equivalent to an average of ≥5.0mg of prednisone per day, for more than 3 months Patient with known primary hyperparathyroidism 	<p>BMD Result:</p> <p>____/____/____</p> <p>Medication/ Supplement Regimen:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<input type="checkbox"/>	GLAUCOMA SCREENING Document name of physician who performed glaucoma screen: _____	<p>All patients 65 years and older without a previous history of glaucoma should be screened. (Glaucoma Screen Reporting Requires Tonometry Results.) High risk patients include:</p> <ul style="list-style-type: none"> Diabetes Family history of glaucoma African American ≥50 years of age Hispanic American ≥65 years of age 	<p>____/____/____</p> <p>Results: _____</p> <p>_____</p> <p>_____</p>	
<input type="checkbox"/>	ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSM	<p>One time only benefit within first six-months of enrollment IPPE for following risk factors:</p> <ul style="list-style-type: none"> Family history of AAA (Dx V17.49) Men age 65-75 smoked at least 100 cigarettes in their lifetime (DX V15.82) 	<p>____/____/____</p> <p>Results: _____</p> <p>_____</p> <p>_____</p>	

- CONTINUED ON NEXT PAGE -

	MEDICAL COUNSELING	RECOMMENDATION	CHECK ONE	DOCUMENT RECOMMENDATIONS GIVEN TO PATIENT
<input type="checkbox"/>	COUNSELING FOR TOBACCO CESSATION	<ul style="list-style-type: none"> For all tobacco users, including those who are asymptomatic. Also included are smoking cessation treatments prescribed by a physician. Two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed every 12 months 	<input type="checkbox"/> APPLICABLE <input type="checkbox"/> NOT APPLICABLE	
<input type="checkbox"/>	COUNSELING ON FALL PREVENTION	<ul style="list-style-type: none"> Discuss if any falls over past 12 months 	<input type="checkbox"/> YES	
<input type="checkbox"/>		<ul style="list-style-type: none"> Review high-risk medications (neuropsychiatric, opioid analgesic agents and cardiovascular medications) Review the medical necessity for any medications that fall into the American Geriatric Society's Beers Criteria* 	<input type="checkbox"/> YES	
<input type="checkbox"/>		<ul style="list-style-type: none"> Assess living environment for lighting, hazards, assistive devices 	<input type="checkbox"/> YES	
<input type="checkbox"/>	COUNSELING ON EXERCISE	<ul style="list-style-type: none"> Advise to start, increase, or maintain level of exercise in order to reach goal of 30 minutes of moderate activity <i>at least</i> 4 days per week 	<input type="checkbox"/> Discussed with patient	
<input type="checkbox"/>	COUNSELING ON NUTRITION	<ul style="list-style-type: none"> Assess and review protein, fat, simple sugar and fiber intake 	<input type="checkbox"/> Discussed with patient	
<input type="checkbox"/>		<ul style="list-style-type: none"> Recommend that half of plate is filled with fresh fruit, raw or steamed vegetable per meal 	<input type="checkbox"/> Discussed with patient	
<input type="checkbox"/>	COUNSELING/ SCREENING FOR HIV	<ul style="list-style-type: none"> Discuss risk of HIV in the elderly and consider HIV screening 	<input type="checkbox"/> Patient counseled on HIV <input type="checkbox"/> HIV screening test ordered	
<input type="checkbox"/>	COUNSELING ON URINARY INCONTINENCE	<ul style="list-style-type: none"> Review history of bowel and urinary incontinence and any recent changes in bowel habits and micturition Discuss bladder training, exercises, medication and surgery 	<input type="checkbox"/> APPLICABLE <input type="checkbox"/> NOT APPLICABLE	
<input type="checkbox"/>	DIABETES MANAGEMENT (for patients with known diabetes) Consider education for all pre-diabetics	<ul style="list-style-type: none"> Ophthalmology Referral 	____ / ____ / ____	
<input type="checkbox"/>		<ul style="list-style-type: none"> Nephropathy Screen 	eGFR: _____ Microalbuminuria: <input type="checkbox"/> Positive <input type="checkbox"/> Negative ____ / ____ / ____	
<input type="checkbox"/>		<ul style="list-style-type: none"> Foot Examination 	____ / ____ / ____	
<input type="checkbox"/>		<ul style="list-style-type: none"> HbA1c Performed 	Result: _____ ____ / ____ / ____	
<input type="checkbox"/>		<ul style="list-style-type: none"> Lipid Profile Performed 	Total Chol _____ HDL _____ LDL _____ Triglyc _____ ____ / ____ / ____	
<input type="checkbox"/>		<ul style="list-style-type: none"> Enroll in Diabetes Education Course 	____ / ____ / ____	

Provider Information			
Print Provider Name:		Group Name:	
Provider ID:		Tax ID Number:	
Provider Address:		City, State, Zip:	
Provider Signature:	_____ (check one) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other _____ Date: ____ / ____ / ____		

*americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines_recommendations/2012

ICD-9-CM vs. ICD-10-CM: Understanding Key Differences

ICD-10-CM Characteristics

ICD-10-CM characteristics affect: **which codes are assigned** (e.g., timeframes in obstetrics involving trimesters or when coding acute myocardial infarctions, which involves a duration of four weeks or less), **how many codes are reported** (e.g., combination codes vs. multiple codes), and **how we report them** (e.g., seventh characters, placeholders “x,” code sequence). Under the new guidelines, documentation makes the difference in the correct code choice.

ICD-10-CM Guidelines

The guideline content has been edited in accordance with the classification changes inherent in the ICD-10-CM system, including:

Combination codes (I.B.9.): This guideline affects the number of codes assigned. A combination code is a single code used to classify two diagnoses or a diagnosis with an associated secondary process (manifestation) or a diagnosis with an associated complication. Combination codes provide full identification of diagnostic conditions. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code as in the example below.

Example: Hypertensive chronic kidney disease stage 3	
ICD-9-CM	
403.90	Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified
585.3	Chronic kidney disease, Stage III (moderate)
ICD-10-CM	
I12.9	Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
N18.3	Chronic kidney disease, stage 3 (moderate)

Laterality and severity (I.B.12.-13.): This guideline includes anatomically paired organ or site designations and may include **right, left, or bilateral**. Separate right and left codes may be reported if no bilateral code is provided. You would only assign an unspecified code if the site is not specified in the record.

Example: Foot ulcer	
ICD-9-CM	
707.15	Ulcer of other part of foot (except pressure ulcer)
ICD-10-CM	
L97.5	Non-pressure chronic ulcer of other part of foot (requires a 5th digit) <ul style="list-style-type: none"> • L97.50 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot (requires a 6th digit) <ul style="list-style-type: none"> • L97.501 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot <i>limited to breakdown of skin</i> • L97.502 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot <i>with fat layer exposed</i> • L97.503 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot <i>with necrosis of muscle</i> • L97.504 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot <i>with necrosis of bone</i> • L97.509 Non-pressure chronic ulcer of <i>other part of unspecified</i> foot <i>with unspecified severity</i> • L97.51 Non-pressure chronic ulcer of <i>other part of right</i> foot (requires a 6th digit) <ul style="list-style-type: none"> • L97.511 Non-pressure chronic ulcer of <i>other part of right</i> foot <i>limited to breakdown of skin</i> • L97.512 Non-pressure chronic ulcer of <i>other part of right</i> foot <i>with fat layer exposed</i> • L97.513 Non-pressure chronic ulcer of <i>other part of right</i> foot <i>with necrosis of muscle</i> • L97.514 Non-pressure chronic ulcer of <i>other part of right</i> foot <i>with necrosis of bone</i> • L97.519 Non-pressure chronic ulcer of <i>other part of right</i> foot <i>with unspecified severity</i> • L97.52 Non-pressure chronic ulcer of <i>other part of left</i> foot (requires a 6th digit) <ul style="list-style-type: none"> • L97.521 Non-pressure chronic ulcer of <i>other part of left</i> foot <i>limited to breakdown of skin</i> • L97.522 Non-pressure chronic ulcer of <i>other part of left</i> foot <i>with fat layer exposed</i> • L97.523 Non-pressure chronic ulcer of <i>other part of left</i> foot <i>with necrosis of muscle</i> • L97.524 Non-pressure chronic ulcer of <i>other part of left</i> foot <i>with necrosis of bone</i> • L97.529 Non-pressure chronic ulcer of <i>other part of left</i> foot <i>with unspecified severity</i>
Note the increased documentation requirements: laterality (right, left) and severity (depth) of ulcer. One code in ICD-9-CM becomes 15 codes in ICD-10-CM. Documentation makes the difference in the correct code selection.	

ICD-9-CM vs. ICD-10-CM: Understanding Key Differences

Seventh-character extensions (I.A.5.): Seventh-character extensions are required, if applicable. They must always be in the seventh-character field. The placeholder “x” is required to expand codes greater than six characters. The seventh-character extensions are code specific to identify: **the episode of care** (initial, subsequent, aftercare, sequelae), **routine or delayed healing, complications, or type or severity of injury** (e.g., fracture type). (See also I.B.10., I.C.19., I.C.21.7)

Coding Diabetes in ICD-10-CM (I.C.4.a.): One of the biggest changes in the guidelines is in the area of diabetes mellitus, which will now include combination codes.

Separate code blocks/categories by cause or type:

- | | |
|---|---|
| • E08 Diabetes mellitus due to underlying condition | • E11 Type 2 diabetes mellitus |
| • E09 Drug or chemical induced diabetes mellitus | • E13 Other specified diabetes mellitus |
| • E10 Type 1 diabetes mellitus | |

Combination codes for diabetes mellitus include the **type**, the **body system affected**, and the **complications**.

Assign as many codes from the appropriate diabetes mellitus category as needed to identify all associated conditions.

Coding Example: Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy and macular edema

ICD-9-CM

250.50 Diabetes with ophthalmic manifestations	362.07 Diabetic macular edema
362.05 Moderate nonproliferative diabetic retinopathy	

ICD-10-CM

E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema

There is no distinction between *controlled* and *uncontrolled* disease in ICD-10-CM. Per the Alphabetic Index, the instruction regarding diabetes mellitus control at “Diabetes, diabetic” for “inadequately controlled,” “out of control,” or “poorly controlled” is “code to Diabetes, by type, with hyperglycemia.”

Other Key Differences in the Guidelines

Other differences can be found in the following areas:

- | | |
|--|---|
| • Anemia associated with malignancy (I.C.2.c.1) | • Acute myocardial infarction (I.C.9.e.) |
| • Substance abuse, use and dependence (I.C.5.b.) | • Adverse effects, poisoning, underdosing and toxic effects (I.C.19.e.) |

First Steps in Transition

ICD-10-CM provides tremendous opportunities for disease tracking, but also creates enormous challenges. To ease the transition, develop a solid foundation in understanding the coding conventions inherent in the ICD-10-CM text. The ICD-10-CM Official Guidelines for Coding and Reporting are updated regularly and are posted on the National Center for Health Statistics (NCHS) website at: cdc.gov/nchs/icd/icd10cm.htm.

A critical step in easing the transition from ICD-9-CM to ICD-10-CM is clinical documentation improvement. Understanding the specificity of the new code set will encourage providers to document to the greatest degree of certainty based on their clinical judgment and to document in adjectives (e.g., laterality, severity, episode of care, type of diabetes and complications).

Available Resources from Optum

Optum has training and tools available to help providers transition to ICD-10-CM. Our ICD-10-CM coding classes provide:

- Training on ICD-10-CM content, structure and key features of each chapter of the ICD-10-CM coding system
- Code translation examples that illustrate key contrasts and similarities between systems
- Knowledge assessments to help quantify understanding of the ICD-10-CM system

In addition, Optum offers additional ICD-10-CM coding resources. Please contact your Optum Healthcare Advocate regarding ICD-10-CM resources and discounts that may be available.

Sources:

- “ICD-9-CM - International Classification of Diseases, Ninth Revision, Clinical Modification.” Centers for Disease Control and Prevention. Web. 26 Nov. 2012. cdc.gov/nchs/icd/icd9cm.htm.
- “ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification.” Centers for Disease Control and Prevention. Web. 26 Nov. 2012. cdc.gov/nchs/icd/icd10cm.htm.

ICD-10 preparedness



Prepare now. Be ready.

The sooner you assess your strengths and limitations regarding ICD-10 compliance, the sooner you can allocate the resources to transition smoothly to this long-awaited new code set. The timeline is tight, but Optum can help you establish your individual implementation plan and successfully transition.

For more information visit: optum.com/icd-10-topic.html

To order ICD-10 training resources visit: optumcoding.com

The ICD-10 implementation will be the most far-reaching change in U.S. health care to date.

The health care industry is preparing for monumental changes as it transitions toward implementing the International Classification of Diseases, Tenth Revision, also known as ICD-10. These changes will impact every aspect of your organization's revenue or payment cycle. The federal government requires that the transition take effect October 1, 2015.

Upgrading to ICD-10 will:

- Provide better data for measuring health care service quality, safety and the efficacy of care
- Allow clinical IT systems to record far more specific and rich diagnostic information
- Boost efficiencies by helping to identify specific health conditions

Transitioning from the ICD-9 code set to ICD-10 provides detailed information on diagnoses (ICD-10-CM in every health care setting) and procedures (ICD-10-PCS for hospital claims for inpatient hospital), allows ample space for capturing new technology and devices, and provides a logical structure with clear, consistent definitions. This improves the amount and detail of data that can be sent electronically between health care organizations, resulting in improved quality of care and reduced costs.

Where you should be

Being prepared can significantly improve how your organization fares during this transition by minimizing the financial and productivity impacts in the first years of implementation. Organizations that will realize the benefits of ICD-10 more quickly are those that plan ahead, use innovative technology and meet the recommended deadlines dictated by CMS.

How can health care organizations prepare for this change

Become familiar with the new code sets and provide training to preview the structure and conventions of ICD-10. Educate staff regarding the challenges of translating clinical documentation into appropriate codes and understand the tools that can help. Assemble a team, develop an impact assessment and priorities, schedule training, and utilize technology and available mapping tools.

Business issues

ICD-10 presents an opportunity to provide more specific and meaningful diagnostic information. However, providers who are late complying with the regulation's deadline might face payment delays and claim denials.

Providers face multiple challenges including:

- Existing practice management billing system software may need to be replaced or updated
- Clinical and administrative staff will need training on new code sets and changes to technology
- Current practice work flow will need to be modified to accommodate new information technology
- Vendor, clearinghouse and health plan contracts and data requirements will need to be reviewed and amended or replaced
- Superbills and corresponding mapping strategies will need to be updated
- The quality and accuracy of clinical documentation practices must be improved to maintain compliant claims
- Billing forms must be revised or replaced

Critical questions every executive should be asking:

- Do I trust that vendors of my critical IT systems will be ready by the ICD-10 deadline?
- Does the switchover to ICD-10 mean that we will need to upgrade our older systems?
- Which aspects of the ICD-10 transition should I outsource?
- How do I budget for the added capital and personnel investments required?
- Do I need to make changes in my health plan contracts or coverage determinations?
- What do I need to do to improve the accuracy and quality of my clinical documentation?
- How will this affect my payment schedules and practice revenue?
- Will I be able to translate historical data and will I still be able to use that data with ICD-10? Will this affect quality reporting?

Why should you consider Optum as an ICD-10 partner?

Optum can help you use the transition to ICD-10 to your greatest advantage. We are able to provide a comprehensive solution suite for providers by offering consulting services, technology and data to help you begin identifying impacts and developing plans for an efficient, effective and compliant conversion.

Contact us to find out how Optum can help you

Contact your local Healthcare Advocate for more information on how Optum can help with the ICD-10 transition or visit: optum.com/icd-10-topic.html

To order ICD-10 training resources, visit: optumcoding.com



How can we help you?

Our goal is to help health care professionals facilitate and support accurate, complete and specific documentation and coding with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with Centers for Medicare & Medicaid Services (CMS) risk adjustment requirements

Call your Optum Healthcare Advocate to find out how we can help you improve outcomes for your patients.

Due to the updated, clinically revised CMS-HCC risk adjustment model for Payment Year 2016, the bolding of ICD-9-CM & ICD-10-CM codes has been revised to reflect:

Black = Risk adjusts in the 2014 CMS-HCC model

Note: The 2016 Payment Year model is based on 100% of the 2014 CMS-HCC model mappings.



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This guidance is to be used for easy reference; however, the ICD-9-CM and ICD-10-CM code books and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "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, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on April 6, 2015, CMS announced the CMS-HCC Risk Adjustment model for payment year 2016 driven by 2015 dates of service. For more information see: <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf>, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2016.pdf>, and <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>

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