

ICD-10 and Risk Adjustment

HCC coding, documentation and
audit preparation

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To get the most out of this webinar:

- Log into the webinar 5-10 minutes before the session begins
- Dial in to the conference line and mute your phone
- Be sure your laptop is muted as well!
- Print out the workshop handout for today
 - > Feel free to work ahead in the workbook before the webinar!
 - > You'll see this icon during the webinar when we are using the workbook



An aerial photograph of a coastline, showing a mix of blue water, brownish land, and white sandy areas. The right side of the image is heavily obscured by a dense, red, scribbled pattern. The text 'Documenting for Risk Adjustment' is overlaid in the upper left quadrant in a large, bold, black font.

Documenting for Risk Adjustment

Documentation: unclear example 1

CC: “Annual comprehensive visit”

HPI: Patient is 38yr old female here for annual physical. She has a history of CHF, diabetes and neuropathy.

O: HT:5.6 WT:130 BMI: XX

Physical exam shows no signs of distress...

Assessment: Annual exam, diabetes & neuropathy, *CHF*

Plan: Continue current medications; follow up in 3 months.

What would you add to make this documentation more clear?

Documentation: unclear example 2

Betty Borderline, a 36-year-old female, referred to psychiatrist by gynecologist for potential treatment of major depression.

Medical history includes:

- hyperlipidemia
- allergic rhinitis
- psoriasis
- doesn't smoke
- occasional alcoholic drinks
- no history of illicit drugs
- family history is significant for type 2 diabetes mellitus and coronary artery disease

Reports difficulty sleeping and concentrating; she has been feeling sad for more than 2 years, often feels hopeless.

The patient is on a trial of Prozac; recommend she begin seeing a psychologist as adjunctive therapy.

Based on assessment and past medical history, Diagnoses are:

- Axis I: Depression
- Axis II: None
- **Axis III: Hyperlipidemia, Allergic Rhinitis, Psoriasis**
- Axis: IV: None
- Axis: V 60

Treatment Plan/ Recommendations include:

- Cognitive Therapy & Relaxation Techniques; Rx for Seroquel XR 150 mg PO QD, continue other medications as prescribed.
- Return 2 weeks or earlier if needed.

What would you add to make this documentation more clear?

Coding for Risk Adjustment



Coding from chief complaint: example 1

CC: Ms. Jones is a 70-year-old female who comes in today for her follow up of her diabetes and COPD.

She has a history of DVT and peripheral vascular disease.

She has had no issues or complaints since her last visit to the office.

What would you code?

Coding from chief complaint: example 2

HPI: Mr. Smith is a 68-year-old male with a history of prostate cancer and rheumatoid arthritis.

He is here today for a follow-up on his hormonal treatment of androgen deprivation therapy and to evaluate the effectiveness of his current dosage on Humira.

What would you code?

Check-in: read the chart notes below and determine the correct coding

HISTORY OF PRESENT ILLNESS: The patient's CHF has been stable on the current regimen. Diabetes type II with polyneuropathy, A1c improved with increased doses of NPH insulin, nerve pain has improved on current medication. Chronic renal insufficiency is stable. He comes in today with complaints of having SOB, and increased wheezing and coughing. He has had no symptoms of CAD. He had follow-up with Dr. X and she also thought he was doing quite well.

PFSH: Quit smoking in 1998

Active Problems: COPD, DM II, CHF, Hyperlipidemia, Hypertension, CAD, GERD, CKD III

MEDICATIONS (*Reviewed and reconciled with patient today 08/06/20xx*)

Bumex - 2 mg daily

Lisinopril - 40 mg daily for high blood pressure

NPH insulin - 65 units in the morning and 25 units in the evening for diabetes

Toprol-XL - 200 mg daily for CHF

Protonix - 40 mg daily acid reflux

Amitriptyline – 150mg daily for nerve pain

ASSESSMENTS

COPD – exacerbated symptoms will refill his Albuterol and start patient on Spiriva.

Congestive heart failure - stable on current regimen. Continue.

Diabetes type II with polyneuropathy - A1c improved with increased doses of NPH insulin. Doing self-blood glucose monitoring, continue current regimen. Recheck A1c on return.

PLAN: Continue all current medications, follow-up in 3 months, by phone sooner if needed.

Check-in: list your codes

Self-check

Is my office prepared for an Initial Validation Audit?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do we have policies in place for responding to medical record audit requests?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do we regularly review our internal billing data for patterns that may point to billing irregularities?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do our clinicians and our coders understand best documentation and coding practices?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have we recently undergone an internal audit of documentation to claims?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have we considered asking an outside entity audit our documentation and claims?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Have we made corrections to procedures or training practices based on internal audit findings?

Documentation and Coding Best Practices: Self-Evaluation

How well do we...	We're doing great!	Clinicians need more training.	Coders need more training.	EMR or billing software needs updating.
Use 'history of' consistently and accurately?				
Ensure cause and effect are noted when appropriate?				
Update the current problem list at each visit?				
Update the current medication list at each visit?				
Ensure all conditions for refills are documented and coded? (Does my EMR link diagnoses to each medication filled in the chart note?)				
Code all co-existing conditions documented with MEAT/TAMPER in the visit?				
Bill more than 4 diagnoses per CPT in order to capture a complete picture of health status at each visit?				
Ensure signatures include credentials and date?				
Ensure dates of service are present for each face-to-face visit?				
Ensure the record is legible?				
Ensure all diagnoses with MEAT/TAMPER in the record are also on the claim?				
Ensure all diagnoses on the claim have MEAT/TAMPER in the record?				



1. Document thoroughly
2. Code to the highest specificity
3. Evaluate patients with chronic/complex conditions annually
4. Code all conditions that are supported in documentation
5. Ensure that codes make it to the claim
6. Review medication lists with patient as often as possible
7. Utilize PMH and active condition lists appropriately
8. Don't copy and paste
9. Review your documentation and verify it supports the codes
10. Don't forget to sign the note!



Thank you for participating