



# Getting Credit for Your Work in a Value-Based Care World

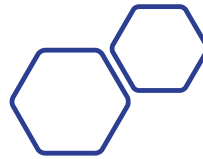
Medicare Model • Oct 2022

### **Disclaimer:**

- The information presented herein is for information purposes only.
- It is designed to provide accurate and trustworthy information on the subject matter.
- Every reasonable effort has been made to ensure its accuracy.
- Nevertheless, the ultimate responsibility for correct use of the coding system and publication lies with the user.
- The ICD-10-CM code books and the Official Guidelines for Coding and Reporting are certified references for accurate and complete coding.



## Today's topics



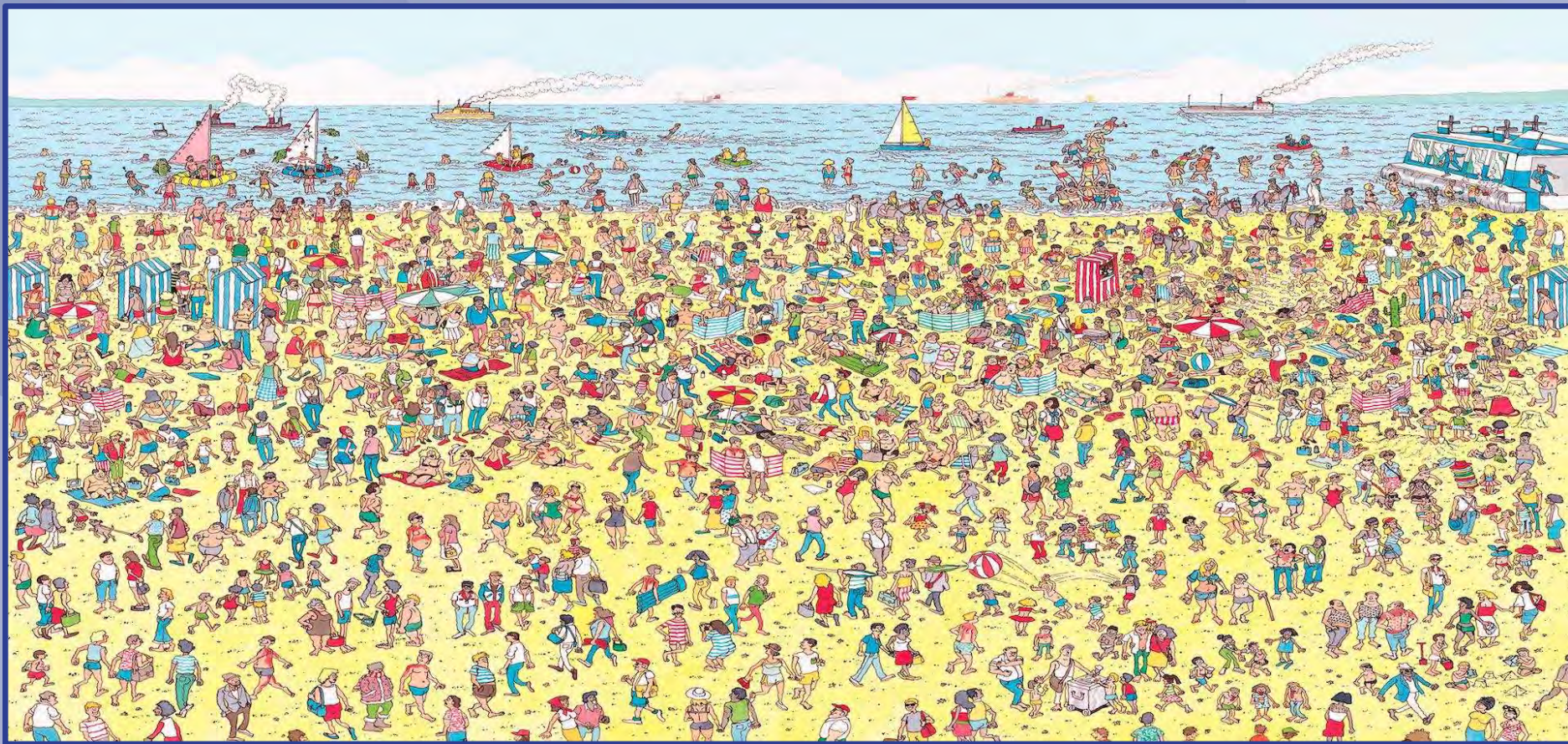
Risk Adjustment: What is it and Why Does it Matter?

Capturing the Complete Health Profile: From Two Different Perspectives

Documentation Deep Dive



Where is **Waldo** the appropriate code?

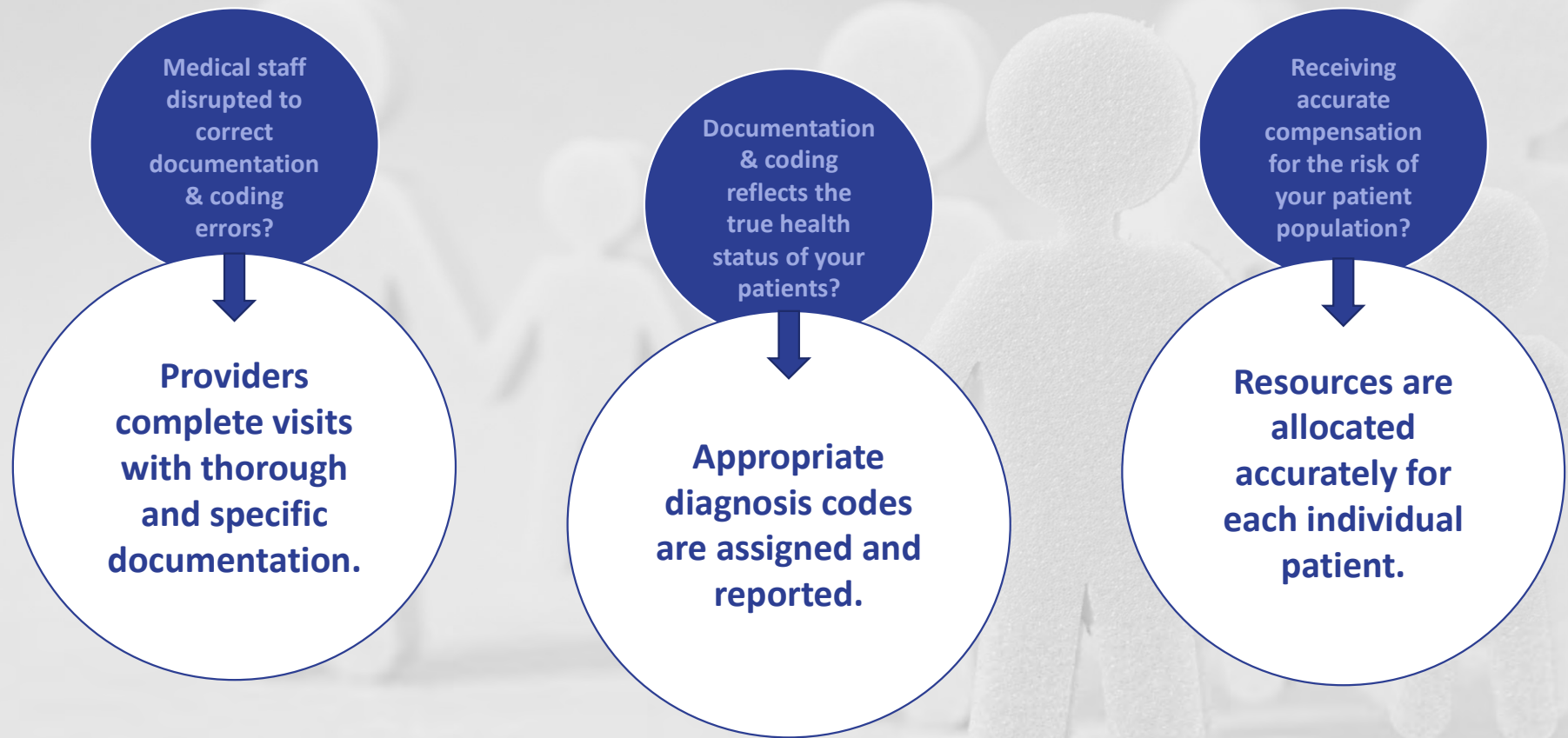


Where is **Waldo** the appropriate code?



**Risk adjustment is a clinical initiative designed to accurately capture your patient's complete health profile and protect beneficiaries' benefits.**

# Pathway to Successful Risk Adjustment





# Complete Health Profile: Provider's Perspective



## Common Medicare Risk Adjustment Conditions

Diabetes	Chronic Lung Disorders	Major Depressive Disorder	Chronic Kidney Disease	Morbid Obesity
Malnutrition	Heart Disease	Late Effects of Stroke	Vascular Disease	Skin Ulcers
Amputation Status	Transplant Status	Artificial Openings	Drug & Alcohol Dependence	Paralysis
Rheumatoid Arthritis	Cancer	Fractures	Parkinson's Disease	Alzheimer's Disease



## Common Medicare Risk Adjustment Conditions

Diabetes	Chronic Lung Disorders	Major Depressive Disorder	Chronic Kidney Disease	Morbid Obesity
Malnutrition	Heart Disease	Late Effects of Stroke	Vascular Disease	Skin Ulcers
Amputation Status	Transplant Status	Artificial Openings	Drug & Alcohol Dependence	Paralysis
Rheumatoid Arthritis	Cancer	Fractures	Parkinson's Disease	Alzheimer's Disease

## Case Study - Provider's Perspective

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74-year-old female presents with...

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Review records & applicable lab results; reconcile medications; discuss lifestyle (diet, exercise)

## Case Study - Provider's Perspective

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74-year-old female presents with...

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Note BMI in diabetes plan; discuss lifestyle (diet, exercise)

## Case Study - Provider's Perspective

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74-year-old female presents with...

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Noted during exam; encourage continued tobacco cessation

## Case Study - Provider's Perspective

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74-year-old female presents with...

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Reviewed record & noted dependence - consider when reconciling meds; is patient seeing specialist?

## Case Study - Provider's Perspective

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74-year-old female presents with...

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Monitor PHQ-9 score, signs & symptoms; continue current medication (sertraline); is patient seeing specialist?

## Case Study - Provider's Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

## Risk Score Calculation

74-year-old female	0.386
Diabetes w/o complications	0.105

Total Risk Score

**0.491**

Reimbursement

**\$4,713**

Numbers are for illustrative purposes; actual values may vary.





# Complete Health Profile: Coding/Compliance Perspective



## Case Study – Coder’s Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Is the hyperlipidemia associated with the diabetes?

## Case Study – Coder’s Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Is the patient’s BMI over 35 with co-morbidities?

## Case Study – Coder’s Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression



Smoker’s cough = mild chronic bronchitis

## Case Study – Coder's Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Substance use disorder is a lifelong condition.  
Is this sedative dependence, in remission?

## Case Study – Coder’s Perspective

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### Conditions reported in Assessment & Plan:

- Type 2 diabetes
- Hyperlipidemia
- Obese
- Chronic cough
- History of tobacco dependence
- History of sedative dependence
- Depression

Patient is on meds for depression. Is this major depressive disorder, recurrent?

## Risk Score Calculation

74-year-old female 0.386  
Diabetes w/o complications  
0.105

Total Risk Score  
**0.491**

Reimbursement  
**\$4,713**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

74-year-old female	0.386
DM w/ hyperlipidemia	0.302

Total Risk Score  
**0.688**

Reimbursement  
**\$6,604**

Numbers are for illustrative purposes; actual values may vary.



## Risk Score Calculation

74-year-old female	0.386
DM w/ hyperlipidemia	0.302
Morbid obesity	0.250

Total Risk Score

**0.938**

Reimbursement

**9,004**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

74-year-old female	0.386
DM w/ hyperlipidemia	0.302
Morbid obesity	0.250
Smoker's cough	0.335

Total Risk Score

**1.273**

Reimbursement

**\$12,220**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

74-year-old female	0.386
DM w/ hyperlipidemia	0.302
Morbid obesity	0.250
Smoker's cough	0.335
Sedative dependence 0.329 (in remission)	

Total Risk Score

**1.602**

Reimbursement

**\$15,379**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

74-year-old female	0.386
DM w/ hyperlipidemia	0.302
Morbid obesity	0.250
Smoker's cough	0.335
Sedative dependence 0.329 (in remission)	
MDD, recurrent	0.309

Total Risk Score

**1.911**

Reimbursement

**\$18,345**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

Demographic + Diseases 1.911

Total Risk Score

**1.911**

Reimbursement

**\$18,345**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

Demographic + Diseases 1.911  
SUD w/ psych  
0.138

Total Risk Score  
**2.049**

Reimbursement  
**\$19,670**

Numbers are for illustrative purposes; actual values may vary.

## Risk Score Calculation

Demographic + Diseases	1.911
SUD w/ psych 0.138	
5 payment HCC's	0.042

Total Risk Score



**2.091**

Reimbursement

**\$20,073**

Numbers are for illustrative purposes; actual values may vary.

# January 1st Miracle

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
26	27	28	29	30	31	1
2	3	<b>Dec 31<sup>st</sup></b> 		6	7	8
9						15
16				<b>Jan 1<sup>st</sup></b> 		22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

Analytically, all members are considered healthy as of Jan. 1<sup>st</sup> each year.



## Risk Score Calculation

74-year-old female

0.386

Total Risk Score

**0.386**

Reimbursement

**\$3,705**

Numbers are for illustrative purposes; actual values may vary.



# Documentation Deep Dive



# Documentation Deep Dive

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## Assessment & Plan

Diabetes w/o complication: A1C controlled at 6.8% most recently, on metformin. GFR 78. Continue to monitor.

Hyperlipidemia: LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling.

BMI 36.1. Encouraged weight loss. Declines nutritional referral.

# Documentation Deep Dive

## Assessment & Plan

Diabetes w/o complication: A1C controlled at 6.8% most recently, on metformin. GFR 78. Continue to monitor.

Hyperlipidemia: LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling. BMI 36.1. Encouraged weight loss. Declines nutritional referral.

## Assessment & Plan

Diabetes **associated with** hyperlipidemia: A1C controlled at 6.8% most recently, on metformin. GFR 78. LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling.

Morbid Obesity: BMI 36.1, **morbid obesity due to the presence of comorbid conditions.** Encouraged weight loss. Declines nutritional referral.

## Diabetes Associated With Dyslipidemia

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**Dyslipidemia is extremely common in type 2 diabetes mellitus,  
affecting around 70% patients**

[Management of diabetic dyslipidemia: An update - PMC \(nih.gov\)](#)

# Diabetes Associated With Dyslipidemia

The increased risk of coronary artery disease in subjects with diabetes mellitus can be partially explained by the lipoprotein abnormalities **associated with** diabetes mellitus. Hypertriglyceridemia and low levels of high-density lipoprotein are the most common lipid abnormalities.

In type 1 diabetes mellitus, these abnormalities can usually be reversed with glycemic control. In contrast, in type 2 diabetes mellitus, although lipid values improve, abnormalities commonly persist even after optimal glycemic control has been achieved.

## **Screening for dyslipidemia is recommended in subjects with diabetes mellitus.**

A goal of low-density lipoprotein cholesterol of less than 130 mg/dL and triglycerides lower than 200 mg/dL should be sought. Several secondary prevention trials, which included subjects with diabetes, have demonstrated the effectiveness of lowering low-density lipoprotein cholesterol in preventing death from coronary artery disease. The benefit of lowering triglycerides is less clear. Initial approaches to lowering the levels of lipids in subjects with diabetes mellitus should include glycemic control, diet, weight loss, and exercise. When goals are not met, the most common drugs used are hydroxymethylglutaryl coenzyme A reductase inhibitors or fibrates.

[Hyperlipidemia and Diabetes Mellitus - Mayo Clinic Proceedings](#)

# Documentation Deep Dive

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Documented causal relationship

## Assessment & Plan

Diabetes associated with hyperlipidemia: A1C controlled at 6.8% most recently, on metformin. GFR 78. LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling.

Morbid Obesity: BMI 36.1, morbid obesity due to the presence of comorbid conditions. Encouraged weight loss. Declines nutritional referral.

# Documentation Deep Dive

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## Assessment & Plan

Diabetes associated with hyperlipidemia: A1C controlled at 6.8% most recently, on metformin. GFR 78. LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling.

Morbid Obesity: BMI 36.1, morbid obesity due to the presence of comorbid conditions. Encouraged weight loss. Declines nutritional referral.

Documented to the utmost specificity



# Documentation Deep Dive

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## Assessment & Plan

Diabetes associated with hyperlipidemia: A1C controlled at 6.8% most recently, on metformin. GFR 78. LDL most recently 129 on atorvastatin, LFTs WNL. Continued dietary counseling.

Morbid Obesity: BMI 36.1, morbid obesity due to the presence of comorbid conditions. Encouraged weight loss. Declines nutritional referral.

MEAT included for all conditions

# What is MEAT?



# What is MEAT?

MEAT	Support	Disease Example	Documentation Example
Monitor	<ul style="list-style-type: none"> <li>• Signs</li> <li>• Symptoms</li> <li>• Disease progression/regression</li> </ul>	Congestive Heart Failure	Stable, will continue same does of Lasix and ACE inhibitor
		Hyperlipidemia	Lipid profile ordered
Evaluate	<ul style="list-style-type: none"> <li>• Test results</li> <li>• Medication effectiveness</li> <li>• Response to treatment</li> <li>• Physical exam findings</li> </ul>	Type 2 Diabetes Mellitus	Blood sugar log and A1C reviewed with patient
		Decubitus Ulcer	Relay wound measurement in exam
Address/Assess	<ul style="list-style-type: none"> <li>• Tests ordered</li> <li>• Counseling</li> <li>• Record Review</li> <li>• Discussion</li> </ul>	Peripheral neuropathy	Decrease sensation of BLE by monofilament test
		Rheumatoid arthritis	Managed by rheumatologist, Dr. Jones
Treat	<ul style="list-style-type: none"> <li>• Medication</li> <li>• Therapy</li> <li>• Referral</li> <li>• Other modalities</li> </ul>	Alcohol dependence	Advised on health risks, referred to outpatient therapy
		Major Depressive Disorder	No complaints. Symptoms controlled with Wellbutrin.

## Key Documentation Requirements

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# Diagnosis

Clearly document a diagnosis for all conditions (based on your clinical impression)

# Status

I.e., Symptoms, Disease progression/regression, Referencing labs/tests, Response to treatment

# Plan

I.e., Tests ordered, Medication, Therapies, Referral, Follow-up



## HCC Documentation & Coding Reference Guide

If your patient has any of these problems, document the diagnosis, assessment, and plan (DSP), and report the corresponding code at least annually.

Includes documentation & coding tips for over twenty different condition categories!

Examples	ICD-10	CMS	RAF Value	Documentation and Coding Notes
<b>Chronic Lung Disease</b>				
Chronic respiratory failure	J96.10	84	0.282	<ul style="list-style-type: none"> <li>Smoker's cough = mild chronic bronchitis.</li> <li>For patients who are dependent on supplemental oxygen (SpO2 &lt; 87% on RA), consider chronic respiratory failure diagnosis.</li> </ul>
Smoker's cough	J41.0	111	0.335	
COPD, unspecified	J44.9	111	0.335	
Chronic obstructive pulmonary disease (COPD), other	J44.X	111	0.335	
Emphysema	J43.X	111	0.335	
Pulmonary fibrosis	J84.10	112	0.219	
<b>Neurologic Disease / Cerebrovascular Accident (CVA)</b>				
Sequelae and late effects of stroke (hemiplegia, hemiparesis)	I69.XXX	103	0.437	<ul style="list-style-type: none"> <li>For sequelae and late effects of stroke, document cause-and-effect relationship of CVA and specific related deficits.</li> <li>Acute CVA (ICD-10 I63.XXX) should only be documented during the initial episode of care. Post-discharge, document "history of CVA" with or without residual or late effects. History of CVA without residual effects (ICD-10 code Z86.73) has no RAF value. For patients with a history of CVA with residual effects, utilize the appropriate ICD-10 code(s) from codeset I69.XXX.</li> </ul>
Parkinson's disease	G20	78	0.606	
Multiple sclerosis	G35	77	0.423	
Paralysis	G83.9	104	0.331	
Seizure disorder	G40.909	79	0.220	
<b>Cardiac Disease</b>				
CHF	I50.9	85	0.331	<ul style="list-style-type: none"> <li>Consider: a patient's CHF may be controlled and remain stable with medications or surgical interventions (ACEI's, ARB's, diuretics, BBs, digoxin, ICD's, valve replacements, etc.).</li> <li>Consider: a patient's a-fibb may be controlled and remain in NSR with surgery, procedures, or medications (cardioversion, ablation, BBs, CCBs, antiarrhythmics).</li> </ul>
Atrial fibrillation	I48.91	96	0.268	
Coronary artery disease with angina	I25.119	88	0.135	
Angina	I20.9	88	0.135	
Unstable angina	I20.0	87	0.195	
Pulmonary hypertension	I27.20	85	0.331	
Cor pulmonale	I27.81	85	0.331	
Cardiomyopathy	I42.9	85	0.331	
Abdominal aortic aneurysm	I71.4	108	0.288	
Aortic atherosclerosis/calcifications	I70.0	108	0.288	
				<ul style="list-style-type: none"> <li>Often missed on radiologic reports. Must have CXR/US/CT scans verifying, document date of exam.</li> </ul>

### Why is risk adjustment important?

#### What is risk adjustment?

Risk adjustment is a process that predicts healthcare costs based on demographic information to a risk score. When providers use the data to identify what types of programs...

#### What are fundamental aspects of risk adjustment?



High-quality patient-provider relationship



Accurate medical charting and documentation

## Provider Documentation: Diabetes Documentation Tips & Best Practices

### Did you know that diabetes has multiple manifestations?

Establishing the cause of diabetes has caused confusion due to, because of, and documentation components.

- Type I or Type II
- Secondary to another condition
- With or without ketoacidosis
- With ketoacidosis

## Provider Documentation: Cancer Documentation Tips & Best Practices

### Did you know that cancer should be documented as "history of" if it has been excised or eradicated from its site, with no further treatment?

Documentation components necessary to capture the severity of cancer:

- Primary

## Provider Documentation: COPD & Asthma Documentation Tips & Best Practices

### Did you know that complete documentation of COPD and asthma can help identify patients for disease management programs?

Documentation components necessary to capture the severity of illness of your patients with COPD, asthma, and other...

## Provider Documentation: Major Depressive Disorder Documentation Tips & Best Practices

### Did you know that documenting the episode, activity, and severity of major depressive disorder is essential to complete and accurate coding?

- Documentation components necessary to capture the severity of illness in your patients with depression:
  - Episode: Single or Recurrent
    - Depression is considered recurrent at the second single episode.
    - Depression is recurrent if patient is currently on prescribed medication or receiving therapy services.
  - Activity: Current, Partial remission, Full remission
    - Consider "in remission" rather than "history of" if patient was previously diagnosed but is currently without symptoms.
  - Severity: Mild, Moderate, Severe with psychotic symptoms

### Patient Health Questionnaire-9 (PHQ-9)

PHQ-9 Score	Description
0 - 4	Not clinically significant
5 - 9	Mild depression
10 - 14	Moderate depression

## Coding and documentation examples

### Case study #1: Complete documentation

Gender: M DOB: MM/DD/1975

**Admission diagnosis:**  
Opioid overdose

**History of present illness**  
This a.m. patient was unresponsive; girlfriend reported patient took Oxycodone. EMS were called. Medics gave 2 of Narcan with improvement. Here in ER, patient does not know year, where he is, or what happened. Will get stat CT head, ABG, administer another dose of Narcan.

**Exam**  
General appearance: Alert, awake, conversant  
Head/eyes: PERRLA  
ENT: Moist mucosal membranes  
Neck: Full range of motion, non-tender, no JVD  
Cardiovascular: Normal capillary refill, normal heart sounds, regular rate and rhythm  
Lungs: Clear to auscultation  
Abdomen: Soft, clear to auscultation

Reason for encounter is clearly documented.

Provider clearly states substance

# Reference Materials for Providers & Support Staff

## Coding and Documentation Guide: Substance Use Disorders

Accurate coding and documentation are fundamental to the risk adjustment process representing each patient's complex health profile. Bright HealthCare's coding guides equip coders and medical staff with the information needed to support accurate coding and documentation.

### Documentation best practices

- Documentation must be provided. Coders cannot assume diagnoses exist based on orders.
- Documentation must be clear and require or affect...

### Case study #2: Missed opportunity

Gender: F DOB: MM/DD/1984

**Chief complaint:** Back pain

**History of present illness**  
The back pain is a chronic problem. Current episode started more than 1 year ago. The problem occurs daily, has been waxing and waning since onset. The pain is present in the lumbar spine; quality of pain is described as stabbing; pain radiates to the left thigh and right thigh with a severity of 4/10. The symptoms are aggravated by sitting and standing.



# Thank you!

Contact our team with questions:

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