Documentation Tips for Risk Adjustment

Volume One

Major Depression

According to ICD-10-CM guidelines, any time "depression" is documented, a Major Depressive Disorder (MDD) diagnosis is assigned.

"Depression" and "depressive disorder" no longer fall under the same code set as "major depression." If a provider documents "depression" or "depressive disorder," the code is F32.A, regardless of severity. The code for "major depression" with severity is F32. If a provider documents the depression as "recurrent," the code is F33, depending on severity. Severity should always be documented as best practice.

If a patient has been on antidepressant medications for many years and multiple attempts to wean them have failed, they have recurrent depression rather than a single episode of depression. The severity of depression will vary among patients and should be specified in the documentation as mild, moderate, severe or in remission.

To assign a diagnosis code that accurately reflects a patient's severity of illness, providers must specify the recurrence and the severity of depression in their documentation.

Morbid (Severe) Obesity

Many providers use the terms "overweight," "obesity," "obese," or stratify obesity as class I, II, or III, despite the record including documented criteria for morbid (severe) obesity. This diagnosis gives the false perception that the patient is at a lower risk.

When documented, the ICD-10-CM code for morbid (severe) obesity should be assigned along with the ICD-10-CM code that **represents the patient's BMI**.

The NIH criteria for morbid obesity are:

1. 100 lbs. over the ideal body weight
2. BMI ≥ regardless of comorbid conditions
3. BMI ≥ with one or more comorbid conditions that may be linked to obesity (for example, DM, HTN, GERD, OSA, DJD of lower extremity joints or DDD of the lumbar spine)

When one of the criteria above is present, providers should document the diagnosis of "morbid (severe) obesity" instead of "obesity" or "overweight" to reflect the patient's true severity of illness.

Angina

The Centers for Medicare & Medicaid Services risk model uses the presence or absence of angina to predict the risk of morbidity and mortality in patients with atherosclerotic heart disease.

Patients who have **ASHD with angina**, for example, develop chest pain with exertion, or use sublingual or long-acting nitrates, are at a higher risk for acute cardiac events than patients who have **ASHD without angina**.

To represent a patient's accurate severity of illness, providers should specify in their documentation the presence of angina, in addition to and independent of the diagnosis of ASHD.

Diabetes with Complications

Patients with complications resulting from long-standing diabetes mellitus are regarded by CMS as being at a higher risk for morbidity and mortality than patients with uncomplicated diabetes. Chronic complications of diabetes include diabetic neuropathy, retinopathy, nephropathy, chronic kidney disease and peripheral vascular disease.

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Diabetes with Complications (continued)

ICD-10-CM Official Coding Guidelines allow coders to assume a cause-and-effect relationship between diabetes and some complications, but not others.

According to ICD-10-CM, hypoglycemia and hyperglycemia are also considered complications of diabetes. They should be documented when present. Documentation of "uncontrolled diabetes" no longer allows for the assignment of ICD-10-CM code E11.65 ("Type 2 diabetes with hyperglycemia"). Rather this code requires specific language in the documentation such as "poorly controlled," "inadequately controlled," or "out of control."

If multiple complications of diabetes are addressed during a patient visit, they should all be documented in the medical record and coded as such.

To capture the accurate severity of illness, providers should link the diagnosis of diabetes mellitus in their documentation to any conditions that are thought to be complications of diabetes and assign the appropriate ICD-10-CM combination codes.

Renal Disease

Patients with chronic kidney disease should have their disease stage based on their glomerular filtration rate, and the CKD stage documented in the medical record.

Patients with GFR lower than 45, for example, CKD stage 3b, 4, 5 or end-stage renal disease, are at risk for secondary hyperparathyroidism and should be screened with an intact parathyroid hormone.

If PTH is elevated and the diagnosis of secondary hyperparathyroidism of renal origin is confirmed, the provider should document the diagnosis and any further plans for workup or management. Examples include monitoring calcium, phosphorous and vitamin D levels or referring the patient to a nephrologist.

Malignant Neoplasm

ICD-10-CM Official Coding Guidelines dictate that malignant neoplasms are considered active only in the calendar year during the initial diagnostic workup or active treatment, unless the patient chooses not to receive treatment. In those cases, the malignancy remains active.

Providers should pay attention to cases in which prolonged adjuvant therapy (for example, tamoxifen or anastrozole for breast cancer and leuprolide or bicalutamide for prostate cancer) takes place. Malignances can be documented and coded as active for several years in those cases, as long as treatment is ongoing.

When all treatments have been completed and the patient is under monitoring or surveillance only, providers should document the malignancy as "history of."

The only exceptions to this rule are leukemia and multiple myeloma, which should be documented and coded as "in remission" once treatment is completed and the patient is under surveillance only.

ICD-10-CM diagnoses codes are ICD-10-CM Official Guidelines for Coding and Reporting are subject to change. It's the responsibility of the provider to ensure that current ICD-10-CM diagnosis codes and the current ICD-10-CM Official Coding Guidelines for Coding and Reporting are reviewed prior to the submission of claims.

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