INTRO TO HCC CODING

Presented by Dana Brown, MBA, RHIA, CHC, CRC
Associate Director, Risk Adjustment Coding

Presenter's Bio

Dana Brown, MBA, RHIA, CHC, CCDS, CRC – Associate Director Risk Adjustment and Compliance Services at MRA.

Dana has been in HIM since 1983 holding various positions. In 1994 Dana founded RMC, which was acquired by Medical Record Associates (MRA) in 2022**.** Dana was instrumental in the creation of the Risk Adjustment Division at Reimbursement Management Consultants (RMC) in 2006. RMC was one of the few companies at that time performing HCC coding reviews.

Prior to founding RMC, Dana performed DRG Validation, Admission, and Utilization Reviews for the Oregon PRO/QIO. She has extensive management, education and coding experience spanning her 30+years in HIM. Ms. Brown's expertise in Compliance, Inpatient Coding, DRG's/MSDRG's, OIG & RAC Targets, Clinical Documentation Improvement, as well as Risk Adjustment/HCC coding round out her areas of focus at RMC. Ms. Brown's vision for MRA is to continue to support our clients with exceptional services, delivered by exceptional staff.

Disclaimer

Every reasonable effort has been taken to ensure that the educational information provided in this presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation. A thorough individual review of the information is recommended and to establish individual facility guidelines. MRA does not guarantee the contents of this material and denies any implied guarantee of appropriateness of this material for any specific purpose. MRA is not liable or responsible for any loss or damage caused by the information presented in this material including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this presentation. Furthermore, MRA does not guarantee that the content of this material will restrict disputes or differences of opinions with third party payers (Medicare or otherwise) as to the specific dollar amount that is to be paid to the service provider. Copying, distributing, recreating or any other unauthorized use of the content in these slides without the express written consent of Medical Record Associates is strictly prohibited.

Agenda

- What is Risk Adjustment
- Medicare Advantage & ACA
- How does HCC coding work?
- Documentation & Coding Guidelines
- Focus on Correct Coding
- Clinical Documentation Improvement Tips

What Is Risk Adjustment?

- Program goal is to keep patients healthy – CMS/HHS pays more to health plans to treat the sick
- Patients elect to join a Medicare Advantage (MA) or ACA program through a specific health plan
- The Health Plan will receive funds annually to take care of patients for an entire calendar year (monthly payments)
- Payments to Health Plan based on the “illness burden” (chronic conditions/diagnoses), not quantity of services. Greater disease burden = greater revenue
- Health Plan in turn pays are providers for care

Risk Adjustment is Taking off!

- No longer just Medicare Advantage Program, commercial plans now participate through ACA
- Common payors with Medicare Advantage Risk Adjustment programs: Blue Cross, Providence, Moda, Kaiser, United Healthcare…
- Some health plans in turn, share this increased revenue with its providers and IPA associations
- EDUCATION for Providers is Key!

Risk Adjustment Models

CMS-Medicare Advantage	HHS- ACA/Commercial
Developed by CMS for risk adjustment of the Medicare Advantage Program (Medicare Part C)	Developed by the Department of Health Human Services (HHS)
CMS also developed a CMS RxHCC model for risk adjustment of Medicare Part D population	Designed for commercial payer population
Based on age population (over 65)	Includes all ages

Medicare/ ACA Advantage Facts

MA Facts:

- 22 million people on Medicare Advantage (MA) plan
- Nationally 34% of all Medicare beneficiaries are on an MA Plan
- 44% of Oregon Medicare beneficiaries are enrolled in a Medicare Advantage Plan

ACA FACTS:

- 13.7 million people enrolled in ACA insurance plans
- 11.4 million enrolled in Marketplace plans

Medicaid facts:

- Dependent on State eligibility guidelines

The Future of Risk Adjustment!

- The Risk Adjustment “enrollments” have increased 10-fold in 10 years
- The model plan for the ACA
- Health Plans are getting smarter
- There is ALWAYS FRAUD!

Compliance is key – **CODE IT RIGHT**!

Risk Adjustment Model – HCC's

- Payments made to Health Plan based on Hierarchical Condition Codes or HCC's.
- Patients are assigned HCC's based on their ICD-10 diagnosis codes submitted on claims throughout the year (all claims – providers, hospitals, etc).
- There are 86 HCC's in the MA model.
- There are 127 HCC's in the ACA model.

MA Disease Groups – HCC's

- 9,700+ ICD-10 codes in the CMS HCC model are divided into disease groups or "Hierarchical conditions"
  - **Examples of conditions:**

    -Infections -Neoplasms

    -Diabetes -Blood Diseases

    -Substance abuse -Lung Diseases

    -Artificial openings/Ostomies
  - Model is not all inclusive, so many diseases are not included

CMS HCC (MA) V24 Model!

V24 model includes:

9700 ICD-10-CM Codes that map to one or more of the 86 HCC Groups

The Top 10 Most Common HCC's are: (Ref #7)

1. Diabetes without Complication (HCC 19)
2. Breast, Prostate, and Other Cancers and Tumors (HCC 12)
3. Diabetes with Chronic Complications (HCC 18)
4. Seizure Disorders and Convulsions (HCC 79)
5. Specified Heart Arrhythmias (HCC 96)
6. Congestive Heart Failure (HCC 85)
7. Other Significant Endocrine and Metabolic Disorders (HCC 23)
8. Chronic Obstructive Pulmonary Disease (HCC 111)
9. Major Depressive, Bipolar, and Paranoid Disorders (HCC 59)
10. Morbid Obesity (HCC 22)

Risk Adjustment – Acute Conditions

- Most acute conditions are not included in model:
  - Appendicitis
  - Wrist Fracture
- BUT! Some major acute conditions are:
  - Hip fracture
  - CVA (Stroke)
  - MI (Heart attack)

MA Frequently Overlooked Conditions

- CHF
- Angina
- Atrial Fibrillation
- COPD
- Compression Fractures
- Seizure Disorder
- Hx of Alcoholism (not etoh "abuse")
- **ACA +** ASTHMA!

- Psychoses
- Rheumatoid Arthritis
- Polymyalgia Rheumatica (PMR)
- History of Amputation
- Transplant Status
- Dialysis Status

MA-HCC Examples

- HCC 1 – HIV, AIDS
- HCC 8 - 12, 46 & 48 - Malignant Neoplasms
- HCC 17 - 18 Diabetes with chronic complications
- HCC 19 - Diabetes without complications
- HCC 39 – Osteonecrosis
- HCC 54-55 – Alcohol Abuse, opioid abuse, dependence, etc
- HCC 85 – CHF, and pulmonary or cardiac conditions

Etc…

ICD-10 Codes Mapped to HCC

- When a provider submits a diagnosis code such as:
  - E11.9 Type 2 diabetes mellitus without complications

This code is mapped to **HCC 19** Diabetes

1699	E1169	Type 2 diabetes mellitus with other specified complication	18	Yes
1700	E118	Type 2 diabetes mellitus with unspecified complications	18	Yes
1701	E119	Type 2 diabetes mellitus without complications	19	Yes
1702	E1300	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)	17	Yes
	E1301	Other specified diabetes mellitus with hyperosmolarity	17	Yes

SAMPLE MAPPING (Ref #6)

ICD-10-CM codes	HCC category description	HCC	Disease hierarchy
B20, B97.35, Z21	HIV/AIDS	1	
A02.1, A20.7, A22.7, A26.7, A32.7, A39.2-A39.4, A40.-, A41.-, A42.7, A48.3, A54.86, B00.7, B37.7, P36.-, R57.1, R57.8, R65.1-, R65.2-, T81.12XA	Septicemia, sepsis and systemic inflammatory response syndrome/shock	2	
A07.2, A31.0, A31.2, B25.-, B37.1, B37.7, B37.81, B44.0-B44.7, B44.89, B44.9, B45.-, B46.-, B48.4, B48.8, B58.2, B58.3, B59	Opportunistic infections	6	
C77.0-C77.2, C77.4-C77.8, C78.-, C79.00-C79.72, C79.89, C79.9, C7B.-, C80.0, C91.0-, C92.00-C92.02, C92.40-C92.A2, C93.0-, C94.00-C94.22, C94.40-C94.42, C95.0-	Metastatic cancer and acute leukemia	8	9, 10, 11, 12
C15.-, C16.-, C17.-, C22. -, C23, C24.-, C25.-, C33, C34.-, C38.4, C45.-, C48.-, C90.00-C90.22, C92.10-C92.32, C92.9-, C92.Z-, C93.10-C93.92, C93.Z-, C94.30-C94.32, C94.80-C94.82	Lung and other severe cancers	9	10, 11, 12
C40.-, C41.-, C46.-, C47.-, C49.-, C56.-, C57.00-C57.4, C58, C70.-, C71.-, C72.-, C74.-, C75.1-C75.3, C77.3, C77.9, C79.2, C79.81, C79.82, C81.-, C82.-, C83.-, C84.-, C85.-, C86.-, C88.2-C88.9, C90.3-, C91.-, C95.10-C95.92, C96.-	Lymphoma and other cancers	10	11, 12
C01, C02.-, C03.-, C04.-, C05.-, C06.-, C07, C08.-, C09.-, C10.-, C11.-, C12, C13.-, C14.-, C18.-, C19, C20, C21.-, C26.-, C30.-, C31.-, C32.-, C37, C38.0-C38.3, C38.8, C39.-, C51.-, C52, C53.-, C57.7-C57.9, C64.-, C65.-, C66.-, C67.-, C68.-	Colorectal, bladder and other cancers	11	12
C43.-, C4A.-, C50.-, C54.-, C55, C60.-, C61, C62.-, C63.-, C69.-, C73, C75.0, C75.4-C75.9, C76.-, C7A.-, C80.1, C80.2, D03.-, D18.02, D32.-, D33.-, D35.2-D35.4, D42.-, D43.-, D44.3-D44.7, D49.6, E34.0, Q85.-	Breast, prostate, and other cancers and tumors	12	
E08.0-, E08.1-, E08.641, E09.0-, E09.1-, E09.641, E10.1-, E10.641, E11.0-, E11.1- , E11.641, E13.0-, E13.1-, E13.641	Diabetes with acute complications	17	18, 19
E08.21-E08.638, E08.649-E08.8, E09.21-E09.638, E09.649-E09.8, E10.21-E10.638, E10.649-E10.8, E11.21-E11.638, E11.649-E11.8, E13.21-E13.638, E13.649-E13.8	Diabetes with chronic complications	18	19
E08.9, E09.9, E10.9, E11.9, E13.9, Z79.4	Diabetes without complication	19	
E40, E41, E42, E43, E44.0, E44.1, E45, E46, E64.0, R64	Protein-calorie malnutrition	21	

Outranking/ Trumping – How It Works

HCC	If the HCC Label is listed in this column…	…Then drop the HCC(s) listed in this column
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
135	Acute Renal Failure	136,137
136	Chronic Kidney Disease (Stage 5)	137

How Payments are made with a Disease Hierarchy:

- In a "disease group" of HCC's such as HCC 8, 9, 10, 11, 12 (all neoplasm HCC's) – annually only the HCC with the lowest number (equates to highest reimbursement) will be paid.
- If a beneficiary triggers HCC 135 (Acute Renal Failure) and HCC 136 (Chronic Kidney Disease (Stage 5)), then HCC 136 will be dropped.

ACA vs. MA

- ACA has many more Dx/Codes than MA
- HCCs not in ACA
  - Obesity/BMI
  - Acute Kidney Injury
  - Alcohol/Substance Abuse
- Frequently found (not originally coded) in ACA review
  - Asthma

ACA Disease Groups/ HCC/ DX

- HIV (Z21)
- Low birth weight status (P05.01-P07.39)
- Postpartum care and examination (Z39.0-Z39.2)
- Organ or tissue replaced by transplant (Z94.0-Z94.840)
- Organ or tissue replaced by other means (Z95.811-Z99.120)
- Artificial opening status (Z93.0-Z93.9)
- Other dependence on machines (Z99.11-Z99.12)
- Lower limb amputation status (Z89.411-Z89.619)
- Fitting and adjustment of artificial leg (Z44.101-Z44.129)
- Attention to artificial openings (Z43.0-z43.9)
- Long term use of insulin (Z79.4)

LOTS MORE, NOT ALL INCLUSIVE

HCC Reimbursement Model
How it works!

- County rate
  - Between $800-$1200 (Marion Co. - $906.91)
- Demographic Rate
  - (age, sex, location, eligible for Medicare/not)
- HCC/RAF score
  - Each HCC has a specific RAF score

County rate x (demographic rate + RAF score) = Monthly Capitation Rate

HCC Reimbursement Model
How it works!

- Ruby Mae lives in Silverton, OR. According to the CMS spread sheet, Marion county has a “county rate” of $906.91. She is 94 years old, still lives at home and is eligible for Medicare her demographic conversion factor is 0.85. She has uncomplicated diabetes (0.18), stable angina (0.14) and schizophrenia (0.61).
- 906.91 x 1.78
  - 1.78 (0.85 + 0.18 + 0.14 + 0.61)
- 1614.30 = Monthly capitation rate

Basic HCC Rules

- Each patient has an annual payment (county rate & demographic rate)
- HCC payments are additive
  - Each HCC has an individual payment which add together to equal a RAF (Risk Adjustment Factor) score
- Hierarchy trumping affects which HCC's are paid on a patient
  - 3 Diabetes levels (but only 1 Diabetes HCC will be paid – the highest)
- Paid prospectively
  - Disease captured in 2021 are paid in 2022

HCC Reimbursement Model
How it works – BIG CHANGES

Payment year 2021:

- 25% of the risk score using the 2017 CMS-HCC Model - Using diagnoses from RAPS and FFS
- 75% if the risk score calculated with the 2020 CMS-HCC model – using diagnoses from encounter data, RAPS inpatient records, and FFS

Payment year 2022:

- Based on the 2020 CMS-HCC Model
- As required by 21st Century Cures Act – adding variables that count conditions in the RA model and includes payment for mental health, substance use disorder and chronic kidney disease.
- Different from 2021 – where 75% risk score calculated using 2020 CMS-HCC Model and 25% risk score calculated using the older 2017 CMS-HCC model.

Two Risk Segments:

- Community Model – majority of Medicare beneficiaries
- Institutional Model - Beneficiaries living in nursing homes or assisted living facilities

ICD-10 Coding

Each diagnosis code must be documented, then reported **once annually** to be included in risk scoring.

But…only once!

Problems in ICD-10 Coding

Physician offices do not always code to highest level of specificity or include all eligible diagnosis codes on claim.

Average physician claim includes 1.6 diagnosis codes per claim. ***This is low!***

Problems in ICD-10 Coding

- Chronic conditions are often not coded if the patient is being seen for another complaint.
  - Chronic conditions are being managed by a specialist, so the PCP does not code them, these can be coded!
- Coding guidelines not followed – and codes not captured or captured when they should not be.
  - Diabetic Manifestations are frequently overlooked.
  - Can code both E11.22- Diabetic Chronic Kidney Disease 3(HCC 18) AND N18.3 Chronic Kidney disease, stage 3 (HCC 138)
- Historic conditions should not be coded
  - Old CVA, History of Cancer (no longer under treatment)

Documentation is Key!

- Accurate coding is dependent on clear and specific provider documentation in the patient's medical record.
- Code all documented conditions that exist at the time of the encounter, and require or affect patient care, treatment or management
    - ICD-10-CM Official Guidelines for Coding and Reporting (Ref #1)

Documentation Requirements

Compliant documentation requires:

- Signature
- Date
- Legibility
- Patient Name

Acceptable Physician Specialty Types..

(below is snippet of official list)

Acceptable Physician Specialty Types for
2022 Payment Year (2021 Dates of Service)
Risk Adjustment Data Submission

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
1	General Practice	29	Pulmonary Disease	81	Critical Care (Intensivists)
2	General Surgery	33*	Thoracic Surgery	82	Hematology
3	Allergy/Immunology	34	Urology	83	Hematology/Oncology
4	Otolaryngology	35	Chiropractic	84	Preventive Medicine
5	Anesthesiology	36	Nuclear Medicine	85	Maxillofacial Surgery
6	Cardiology	37	Pediatric Medicine	86	Neuropsychiatry
7	Dermatology	38	Geriatric Medicine	89*	Certified Clinical Nurse Specialist
8	Family Practice	39	Nephrology	90	Medical Oncology
9	Interventional Pain Management	40	Hand Surgery	91	Surgical Oncology

Caution in EMRs Friend or Foe?

- Cut/Copy and Paste
- Need to be wary
- Policies and Procedures

Focus on Correct Coding

Use the Guidelines!

- Coding must be in accordance with national coding guidelines
- Located in front of code book
- Google (cautiously!)
- Coding Clinic
  - Quarterly Published Guidance
  - Q/A
  - Official as per HIPAA

Coding Focus: Diabetes

Diabetes Mellitus and Associated Manifestations – A.K.A Diabetes With

According to the ICD-10-CM Official Guidelines for Coding and Reporting, the term "with" means "associated with" or "due to," when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions. The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. Assumed cause-and-effect relationships in the classification are not necessarily the same in ICD-9-CM and ICD-10-CM…… continued…..

Coding Focus: Diabetes

……..**However**, if the physician documentation specifies diabetes mellitus is not the underlying cause of the other condition, the condition should not be coded as a diabetic complication. When the coder is unable to determine whether a condition is related to diabetes mellitus, or the ICD-10-CM classification does not provide coding instruction, it is appropriate to query the physician for clarification so that the appropriate codes may be reported. (See ICD-10-CM Official Guidelines for Coding and Reporting, Section I.A.15.)

See Coding Clinic, First Quarter 2016, Page 11 for full details

Coding Focus: Diabetes

Diabetes Mellitus and Associated Manifestations

Example from the Alphabetic Index:

Diabetes, diabetic (mellitus) (sugar) E11.9

"With"

- amyotrophy E11.44
- arthropathy NEC E11.618
- autonomic (poly) neuropathy E11.43
- cataract E11.36
- Charcot's joints E11.610
- chronic kidney disease E11.22

Coding Focus: Diabetes

Diabetic Manifestations are frequently overlooked
EXAMPLE:

E11.21, Type 2 diabetes mellitus with diabetic nephropathy (HCC 18)
- **N18.5, Chronic Kidney disease (stage 5)** (HCC 136)
- Only CKD stages 3, 4, 5 and End stage renal disease are HCC valid (MA)

E11.621, Type 2 diabetes mellitus with foot ulcer (HCC 18)
- **L97.511, Non-pressure chronic ulcer of right foot limited to breakdown of skin (HCC 161)**

E11.51, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene (HCC 108)
- **I73.9, Peripheral angiopathy (PVD)** (HCC 108)

  Both same HCC but both should be coded

Coding Focus: NEOPLASMS

- Malignant neoplasms are to be coded when the patient is receiving any care or **MEAT**

- If the patient is refusing treatment, the provider may still be addressing the condition and the appropriate neoplasm code should be assigned.

Coding Focus: Metastatic NEOPLASMS

CAUTION:

- Be careful when coding metastatic neoplasms, as documentation may not be clear as to whether it is the primary or secondary site.
- Investigate whether it is metastatic “to” breast (secondary) or metastatic “from” breast (primary)
  - **Important because metastatic neoplasm (HCC 10) carries a higher HCC than the primary neoplasm (HCC 12)**

Coding Focus: History of Neoplasm

- Caution when assigning a code for history of malignant neoplasm.

- If patient is receiving treatment (ie. Chemo) for a neoplasm that has been excised – assign a neoplasm code, C00 – D49.

- If patient is no longer receiving treatment for neoplasm – assign a personal history of neoplasm code from category Z85 (no HCC)

Coding Focus: Breast Cancer

- **When to code breast cancer**
  - Patient is receiving active treatment
  - Breast cancer has reoccurred
  - Patient elects to not treat
  - Patient chooses palliative care

Coding Focus: Alcohol and Drug Abuse (ACA)

- Code what is documented, and document accurately!
  - "Dependent" is HCC
  - "non-dependent" is not HCC
  - "alcoholism" is HCC
- Without documentation, coder must default to "non-dependent" (no HCC)

*Frequently (but in error) **F10.20, Alcohol dependence, uncomplicated** (HCC 55) is coded – but "dependence" not stated.*

Coding Focus: History of Alcohol/Drug Dependence (ACA)

- If a patient has a history of addiction or dependence, and documentation supports diagnosis, code the dependence disorder to “in remission”

EXAMPLE:

- **F10.21, Alcohol dependence, in remission** / HCC 55
- **F12.21, Cannabis dependence, in remission** / HCC 55

Coding Focus: Myelodysplastic Syndrome (MA/ACA)

Myelodysplastic Syndrome (MDS), D46.9 is a blood and marrow disease that occurs when the bone marrow does not make enough healthy blood cells and the marrow cells are damaged.

Myelodysplasia of the spinal cord is a congenital anomaly and coded to Q06.1

These two conditions get confused. Review the documentation and confirm the diagnosis with MEAT from the provider. NEVER ASSUME!

Potential MEAT: Myelodysplastic Syndrome (MA/ACA)

- Patient receiving care from either a hematologist or oncologist.
- Observation of blood cell counts{ CBC)
- Transfusion and chelation therapy
- Erythropoiesis-stimulating agents(ESAs) and other growth factors
- Anti thymocyte globulin(ATG) therapy
- Drug therapy (Azacitidine and decitabine)
- Chemotherapy
- Allogenic stem cell transplantation
- Clinical trials

Coding Focus: Lymphoma (MA/ACA)

- Lymphoma patients who are in remission are still considered to have to lymphoma and should be assigned with the appropriate code from C81 – C88
  - However, if “history of” documented, assign history (Z) code

- AHA **Coding Clinic** for ICD-9-CM, 1992, second quarter, page 3

Coding Focus: Morbid Obesity & BMI (MA)

- A non-provider (RN, MA) may document the BMI, but to report the BMI (as a secondary diagnosis), a related diagnosis (overweight, obesity, morbid obesity) must be documented by the provider.

EXAMPLE:

- Vital signs: BMI: 42.1. Provider documentation states patient is "overweight".
  - **E66.3, Overweight** (No HCC) *BUT ALSO INCLUDE*
  - **Z68.41, Body mass index 40.0-44.9, adult (HCC 22)**

Coding Focus: Depression (MA)

- Depression, NOS is coded F32.9 – no HCC
- Depression & Anxiety is coded F41.8 – no HCC

Improve documentation!

- **F33.0 is Major depressive disorder, recurrent** (HCC 55).
  - Which is the code for recurrent episodes of depressive reaction, and likely the case for instances when “depression, NOS” is documented

Coding Focus: Chronic Kidney Disease (MA/ACA)

- CKD is often a complication of a other serious condition, i.e. Diabetes mellitus, hypertensive heart disease.

- In ICD-10 these complications should be captured with the combination code.

- Review the Index and Tabular carefully!

Coding Focus: Chronic Kidney Disease (MA/ACA)

- **ICD-10-CM Classifies CKD based on severity. The severity of the CKD is designated by stages 1-5**
  - N18.1 Chronic kidney disease, stage 1
  - N18.2 Chronic kidney disease, stage 2 (mild)
  - N18.3 Chronic kidney disease, stage 3 (moderate) (MA)
  - N18.4 Chronic kidney disease, stg 4 (severe) (MA/ACA)
  - N18.5 Chronic kidney disease, stage 5 (MA/ACA)
  - N18.6 End stage renal disease (MA/ACA)

Coding Focus: Dialysis Status (MA)

Review documentation for dialysis treatment, frequently these codes are not assigned

Z99.2, Dependence on renal dialysis (HCC 134)

Also the same code for a patient with a surgically created arteriovenous fistula for the purpose of dialysis – even if treatment hasn't started

Z91.15, Patient's noncompliance with renal dialysis (HCC 134)

Coding Focus: CVA

- Cerebrovascular accident (CVA) is decreased blood to the brain which causes an infarction.
- This condition is acute.
- CVA and Stroke are often used interchangeably
- Acute CVA codes rarely occur in the outpatient setting – unless the patient develops CVA while in clinic and is transferred to the Hospital for inpatient care.

Coding Focus: CVA

- Documentation to appropriately code ACTIVE stoke/CVA
  - **TYPE** of event (hemorrhage, embolism, etc.)
  - **LOCATION** (where in the brain or artery)
  - **ASSOCIATED "WITH INFARCTION"**
    - **"Without mention of infarction"** (No HCC)
- Documentation of history of stroke w/o neurological deficits – assign **Z86.73, personal history of TIA, and cerebral infarction without residual deficits** (No HCC)

Coding Focus: Sequela of CVA

- **I69, Sequelae of cerebrovascular disease** codes are used for neurological deficits caused by CVA, or diseases classifiable to I60-I67.
- Common sequelae of CVA is hemiplegia/hemiparesis or monoplegia. ICD-10 requires documentation of "dominance" of the affected side. If documentation does not indicate dominance, select code based on the following:
  - **Left side is affected – default is non-dominant**
  - **Right side is affected – default is dominant**
  - **Ambidextrous patients – default is dominant**

Coding Focus: Sequela of CVA

- Coding Clinic, Vol.2 No 1 1st Qtr. 2015:

  "Unilateral weakness that is clearly documented as being associated with a stroke, is considered synonymous with hemiparesis/hemiplegia."

  Example patient - History of left hemisphere stroke; patient has right-sided weakness (I69.351)

- The patient with history of CVA, and hemiparesis. Together, this makes them classifiable as late effects/sequelae CVA/Stroke that is appropriate to category I69.

Coding Focus: Hemiparesis vs Hemiplegia

- **Hemiplegia** is the *paralysis* of one side of the body
- **Hemiparesis** is the *weakness* of one side of the body

Documentation MUST state “hemiplegia” or “hemiparesis” to assign a code from category **G81.-** (HCC 103)

Coding Focus: Pulmonary Embolism

- Pulmonary embolism may be an acute event or chronic condition, not based on timeframe, but on provider documentation.
- **Coding for anticoagulant use**
- Patient may be treated with anticoagulant to treat chronic pulmonary embolism (HCC), or personal history of PE (No HCC). Review documentation!
- Be sure to assign **Z79.01, Long term (current) use of anticoagulants** if pertinent (No HCC)

Coding Focus: Peripheral Vascular / Artery Disease

- Peripheral **vascular** disease is a condition that results in reduced blood flow to the extremities.
- Peripheral **artery** disease is a more specific diagnosis for the same condition.
- PVD, PAD and intermittent claudication index to **I73.9, Peripheral vascular disease, unspecified** (HCC 108, MA only) with an EXCLUDES1 note referring to atherosclerosis of the extremities.

Coding Focus: Peripheral Vascular / Artery Disease

- PAD caused by atherosclerosis of the extremities must be reported with codes that describe:
  - Etiology
  - Site
  - Manifestation/complication

EXAMPLES:

- **I70.219 Atherosclerosis of native arteries of extremities, with intermittent claudication, unspecified extremity** (HCC 108)
- **I70.741 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of thigh** (HCC 106)
- **E11.51 Type 2 DM with diabetic peripheral angiopathy without gangrene** (HCC 18)

Coding Focus: Specified Heart Arrhythmias

Types of Heart Arrhythmia

- Paroxysmal supraventricular tachycardia (Paroxysmal atrial tachycardia (PAT))
- Paroxysmal supraventricular tachycardia (PSVT)
- Paroxysmal (atrial) tachycardia
- Atrial Fibrillation (ICD-10: paroxysmal, persistent or chronic)
- Atrial Flutter (ICD-10: Typical (Type 1) or Atypical (Type 2))
- Sick sinus Syndrome (Sinoatrial node dysfunction, Tachycardia-bradycardia syndrome; or Persistent/Severe sinus bradycardia)
- Atrioventricular block (Complete heart block or 3rd degree heart block)

Coding Focus:
Specified Heart Arrhythmias

Sick Sinus Syndrome and Pacemaker

- When SSS is controlled with a pacemaker – a code for the SSS CAN be assigned. See the Coding Clinic's below:

- ***AHA Coding Clinic for ICD-10-CM © 3rd Qtr, 2021, p. 32–33***
- ***AHA Coding Clinic for ICD-10-CM © 3rd Qtr, 2020, p. 33***

Coding Focus: Fractures

Fractures to the **hip and femur** can be captured as HCC.

ICD-10 specificity now requires more clinical concepts to be addressed in the documentation.

- **Site**
- **Laterality**
- **Type of fracture**
- **Displaced / Not Displaced**
- **Closed / Open (Gustilo classification)**
- **Encounter (Initial, subsequent…)**

Coding Focus: Compression Fractures

Compression fractures can be traumatic or pathologic/nontraumatic.

- Fracture terminology:
  - Spontaneous = pathologic
  - Chronic = current fracture
- Healing or healed compression fractures should be assigned a code from **Z87.31-, personal history of (healed) nontraumatic fracture**

Coding Focus: Osteoporosis

- Age-related osteoporosis is a systemic condition.
- When a patient with osteoporosis also has a pathological fracture, there must be documentation linking the conditions to each other.
- Never assume osteoporotic, or pathologic based upon age of the patient.

In summary

- Coding must represent patient profile of care and treatment rendered
- Documentation is KEY!
- Utilize and follow National Coding Guidelines

Proper documentation and accurate coding will result in appropriate and compliant reimbursement.

Questions?

I LOVE THEM!

Please email me at:

dbrown@mrahis.com

References

1. *ICD-10-CM Official Guidelines for Coding & Reporting 2021*
2. AHIMA's ICD-10-CM Coder Training
3. AHIMA's ICD-10-CM/PCS Documentation Tips
4. American Hospital Association's *Coding Clinic*
5. *Faye Brown for ICD-10-CM*
6. *https://provider.amerigroup.com/docs/gpp/ALL_CARE_CMSHCCRAModel.pdf?v=202111081831*
7. *https://www.rcxrules.com/blog/common-hcc-codes*