PATH TO PROMINENCE

Risk Adjustment
Clinical Documentation Specificity

M.E.A.T. Clinical Documentation “Best Practice”

Prominence Health Plan

UHS

Progress Note Documentation "Best Practice"

Tips for SUCCESS in Risk Adjustment Data Validation.

"Best Practice" Clinical Documentation Specificity

- Why high-level details in your Clinical Documentation are best:
  - Specifically, your Clinical Documentation supports the ICD-10 Codes submitted on your claims to report the patients care received and requires pertinent facts, findings and observations about the patient's health and history to be documented in your Progress Note.
  - **Documentation** of patient diagnoses that is clear, concise and uses high-level details to describe each diagnosis is critical for Risk Adjustment success and **facilitates**:
    - Quality patient care with better outcomes.
    - Accuracy of ICD-10 diagnosis code assignment to the highest specificity for submission on claims.
    - Accurate Risk Score Assignment, Accuracy of the patient's complete disease burden, "Portrait of Health to CMS".
    - Appropriate payment for all stakeholders (FFS, RA, MSSP ACO, CPC+ etc.)
    - If it wasn't documented, it didn't happen.
    - Risk Score representation "general rule."
      - The lower the risk score the healthier the patient.
      - The higher the risk score the sicker the patient.

Specific to Risk Adjustment Data Validation (RADV) audits

- It is one **Stand-alone Progress Note**, not the medical record in its entirety, that is used in an audit.
- **One DOS** and a single Progress Note that must validate the ICD-10 HCC diagnosis code(s) submitted on your claim for RADV.

Success in Risk Adjustment: Documentation and Coding

Suggested **"Best Practice"** standards

- Develop an internal "Best Practice" for documentation standards that works for your facility as a "standard" rule.
  - M.E.A.T.
- Be aware of code specificity.
  - Recognize unspecified codes, general code rule dx codes ending in 9 = "Unspecified"
    - When you see a diagnosis code ending in "9" consider further specifying if possible.

E11.**9** Diabetes Mellitus Type 2 Unspecified

I73.**9** Peripheral Vascular disease Unspecified

N18.**9** CKD Unspecified

- "History of" –
  - We will look at the CMS definition and what it means in Risk Adjustment vs. the way you were previously educated.
- Repeat, each Progress Note (PN) must **"Stand-alone"** for each DOS.
  - Documentation in PN must Support ICD-10 HCC diagnosis codes submitted on your claim / Risk Adjustment Data Validation (RADV) audit.
- * Be aware of your internal Informatics, Templates, Note Forms -
  - Progress Note "output" can be much different than your Progress Note "input" **Know your "output"**.
  - EHR driven documentation can = contradictions in your Progress Note for RADV.
- Attention to your Active Medical Problems List for accuracy.
  - Dx accuracy allows for ease year over year, use it to your advantage (system-driven descriptors/codes).
  - Active Chronic Conditions to the level of highest specificity in the code and narrative.
    - Narrative in the AMPL is the typically the narrative that appears in the Final Assessment, use it to drive your documentation.

Risk Adjustment Data Validation (RADV)

Best Practice overview: Clinical Documentation for Diagnosis Coding to the Highest Specificity

Why high-level details in clinical documentation are best?

High-level details in your documentation provide the specificity needed to code appropriately and report your patient's true/accurate picture of health to CMS.

The details in your documentation allow for diagnosis coding to the highest level of documented specificity to accurately capture your patient's health status.

Lacking details in your clinical documentation causes unspecified "default" codes to be used.

E11.9 Diabetes Mellitus Type II Uncomplicated/Unspecified

What are high-level details in documentation?

Pertinent facts, findings and observations about your patient's current health status as well as past medical history, in addition to your medical decision-making and treatment plan should be included in your clinical documentation.

Left, Right, Bilateral, Upper, Lower, Type, Due to, Associated with,

Patient has ulcer (?)

Patient has diabetes (?)

Patient has weakness (?)

Patient has AFIB (?)

What do high-level details in documentation represent?

Dx code assignment to the highest known specificity.
=
Accuracy of Disease Burden.
=
Accuracy of Risk Score Assignment.
=
Accuracy of Funding.

Documentation draws a self portrait of your patient's health status submitted to CMS in ICD-10 Dx codes on your claim.

What is a risk score?

Patient Demographic factors
+
ICD-10 diagnoses that map to an HCC category submitted on a claim
+
Any HCC Interaction categories
=
Patient Risk Score

DM = HCC
CHF = HCC
= HCC Interaction (DM & CHF)

Healthier = LOWER
Sicker = HIGHER

"Accuracy"

Recall: Stand-alone Progress Note (RADV) M.E.A.T.

One DOS, One Progress Note
One Claim

ICD-10 HCC Diagnoses submitted on your claim must have supporting Clinical Documentation in your Progress Note.

RADV = Targeted diagnoses submitted on your claim, for one DOS and must be supported in your Progress Note documentation per CMS to pass a RADV audit.

Clinical Documentation Best Practice as Defined by CMS

Coding Chronic Conditions & M.E.A.T.

Best Practices are to ensure each diagnosis coded is clearly documented as being:

Monitored - signs, symptoms, disease progression, disease regression

Evaluated - test results, medication effectiveness, response to treatment

Addressed - ordering tests, discussion, review records, counseling

and/*or*

Treated - medications, therapies, other modalities

**High-level clinical details in your documentation, specifically the patient's diagnosis and the status to the highest level of specificity for accurate ICD-10 HCC Code assignment and submission.

Success in Risk Adjustment:
How to identify a code needing more specificity.

- Code Specificity
  - Recognize unspecified codes, general code rule for Dx codes ending in 9 = “Unspecified.”
  - “Specific to diabetes”
    - E11.**9** Diabetes Mellitus Type 2 without complication / unspecified
    - E11.X9 Diabetes Mellitus Type II with Other Complication, “__SPECIFY__” the complication.
      - What is the complication?
        - Neurological (diabetic peripheral neuropathy) E11.42
        - Ophthalmic (diabetic retinopathy) E11.3X
        - Circulatory (diabetic peripheral vascular disease) E11.51
        - Kidney (diabetic kidney disease stage 3a) E11.22

Neurological
Ophthalmic
Circulatory
Kidney

  - Other Unspecified Diagnoses ending in “9”
    - I73.**9** Peripheral Vascular disease Unspecified
    - N18.**9** CKD Unspecified
    - J44.**9** COPD Unspecified
    - E66.**9** Obesity Unspecified
    - F32.**9** Depression, Single Episode, Unspecified
    - F33.**9** Depression, Recurrent, Unspecified

AHA ICD-10 Official guidelines
b. “Unspecified” codes
Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code.
For categories where an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

Success in Risk Adjustment: Documentation and Coding **best practice** standards

- "History of" –
  - The CMS definition and what it means in Risk Adjustment (resolved, gone, no longer present, true PAST medical history).

- This is perhaps one of the largest obstacles to overcome!
  - Use of the term "History of" is how many were taught to document.

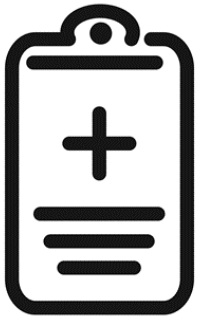
- Try to document in terms of active vs. using the term "history-of."
  - Active, long-term, on-going, continuous, continued, current, chronic

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Use of "history of". In ICD-10-CM, **"history of" means the patient no longer has the condition** and the diagnosis often indexes to a Z code, not in the HCC models. A physician can make errors in one of two ways with respect to these codes. One error is to code a past condition as active. The opposite error is code as "history of" a condition when that condition is still active. Both of these errors can impact Risk Adjustment.

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2012183293-yv-participant-guide-publish_052909.pdf

Best Practice Standards AMPL

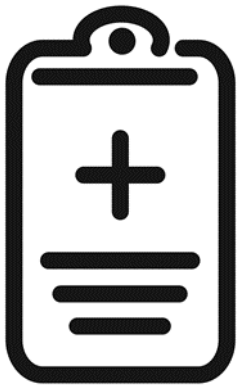


- Active Medical Problems List (AMPL)
  - Accuracy allows for ease year over year, use it to your advantage (System-driven Descriptors).
  - Active Chronic Conditions to the highest level of specificity.
    - Narrative in the AMPL is the typically the narrative that appears in the Final Assessment of your Progress Note.
- Use the Active Medical Problems List to your advantage. (True accurate picture of your patient's health status.)
  - Highest known level of specificity (Accuracy of disease burden to the highest level of specificity)
  - Choose the code and narrative to the highest level of specificity according to your patient's true picture of health.
    - Instead of an abbreviated version, see some of the narratives that would typically be available.
      - Instead of Diabetic Neuropathy, choose Diabetes Mellitus type II with Diabetic Peripheral Neuropathy.
      - Instead of Kidney Disease, choose Chronic Kidney disease Stage 3a.
      - Instead of Depression, choose Major Depressive Disorder, recurrent, moderate.
      - Instead of Joint Pain, choose Inflammatory Arthritis of multiple joints.
      - Instead of Pre-Diabetes, choose Diabetes Mellitus Type II.
      - Instead of Overweight, choose Obesity or Morbid Obesity.
- Current and active diagnoses relevant to the current care of your patient.
- Be as specific as possible.

Documentation

Sample of a Generic Encounter Form / Progress Note

- RECALL RADV - M.E.A.T. (documentation criteria)
- 4 specific areas approved for code extraction
  - HPI, Physical Exam, Discussion Summary, Plan
- 1:1 Match / Mirror for Success “Best Practice”
  - **1 of 4 AND Mirror that same diagnosis in the Assessment



Generic Encounter Form

Patient:
DOB:
DOS:

Chief Complaint:_____

1) History of Present Illness:

Active Medical Problems List:

PMFSH:

Medications List:

ROS:

Vitals:

2) Physical Exam:

****Assessment:**

3) Discussion Summary / 4) Plan:

Signature:

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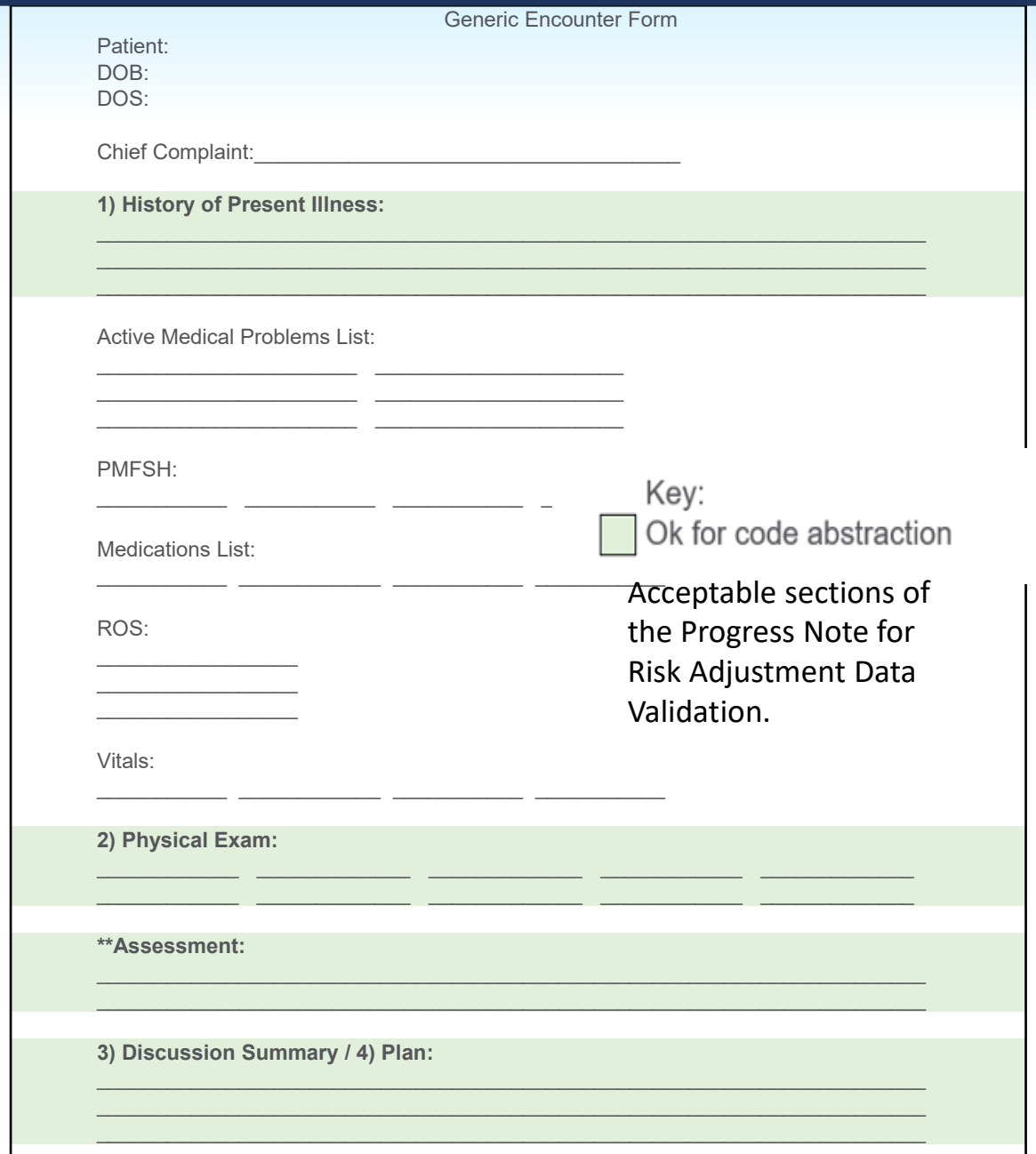
HPI establishes pertinent medical history and supports medical decision-making for the encounter.

Supporting documentation in the HPI is sufficient for diagnosis coding as long as there is a documented/written diagnosis.

As long as there is a diagnosis documented in the **Physical Exam** it shows clinical evaluation and supports the diagnosis.

Diagnoses should not simply be listed in the **Assessment/Plan** without further support of **M**onitoring, **E**valuating, **A**ddressing, and/or **T**reating in the acceptable sections of the Progress Note.

1 of 4 AND Assessment
1:1 Mirror same diagnosis



Generic Encounter Form

Patient:
DOB:
DOS:

Chief Complaint:_____

1) History of Present Illness:

_____
_____
_____

Active Medical Problems List:

_____ _____
_____ _____
_____ _____

PMFSH:

_____ _____ _____ _

Medications List:

_____ _____ _____ _____

ROS:

_____
_____
_____

Vitals:

_____ _____ _____ _____

2) Physical Exam:

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

****Assessment:**

_____
_____

3) Discussion Summary / 4) Plan:

_____
_____
_____

Key:
☐ Ok for code abstraction

Acceptable sections of the Progress Note for Risk Adjustment Data Validation.

M.E.A.T. - Document the full diagnosis to the highest possible specificity.

Best Practice suggests for the Diagnosis and corresponding documentation to be in 1 of 4 sections of the Progress Note and that your diagnosis in those areas *"mirror"* the same diagnosis listed in the Assessment.

Documentation in the other areas of the Progress Note, shown here support the level of service, medical decision-making, and patient visit but are not acceptable areas for code extraction specific to RADV.

Best Practice for Specificity

Best practice Documentation Standard

- For accurate reporting of ICD-10-CM Diagnosis codes, the clinical documentation should describe the patient's condition, using terminology that includes the **specific diagnoses** as well as symptoms, problems, or reasons for the encounter, an authenticated physician order for services, reason the service was ordered, and test results, etc.

- The diagnosis should **again be spelled out in full as the final diagnostic statement in the Assessment**.

- The clinical documentation or source document/documentation (Progress Note) referred to by the coder should describe the patient's condition using terminology that includes the **specific diagnoses**, as well as symptoms, problems, or reasons for the service.

ICD-10 2021 AHA Code Guidelines

C. Accurate reporting of ICD-10-CM diagnosis codes
For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes **specific diagnoses** as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

Diagnosis, Status and Plan for that diagnosis and the same diagnosis should again be spelled out in the final Assessment for a 1:1 Diagnosis match.

http://bok.ahima.org/pdfView?oid=105782
https://www.encoderprofp.com/epro4payers/rcpDocHandler.do?_a=view&_dk=ICD10_CM_Guidelines

Best Practice for incorporating Dx from Specialists

When your patient is seeing a specialist(s)

- Incorporate the specialist notes into your EMR / Patient record.
- Add all chronic Dx to your Active Medical Problems List.
- M.E.A.T. - Monitor, Evaluate, Address and/or Treat those chronic conditions during your visit.

Patient has Diabetic CKD stage 3a, follows with Nephrology, currently stable, continue current treatment.

Patient has Chronic AFIB, sees Cardiologist Dr. Smith, currently no palpitations, will continue to monitor.

Patient has COPD, controlled on Spiriva, follow up scheduled with Pulmonologist.

Patient has Chronic Depression, recurrent, currently stable on Prozac.

Patient follows with Oncology for active prostate cancer, reviewed PSA results and discussed current treatment.

Even when a condition is not presenting signs and symptoms it is appropriate to evaluate Controlled by medication, presenting no current symptoms, the condition still exists unless completely resolved.

* Diagnosis, Status and Plan for that diagnosis and the same diagnosis should again be spelled out in the final Assessment = 1:1 Diagnosis match.

“THANK YOU FOR ALL YOU DO”

“Small changes made now, to include high-level clinical details in your documentation, will make a huge difference in the future.”