PATH TO PROMINENCE

Risk Adjustment
Clinical Documentation Specificity

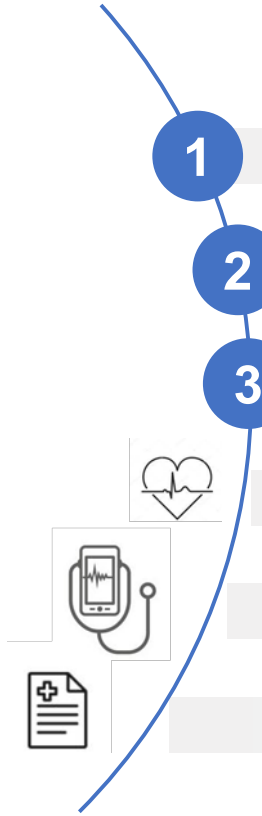
Session 2

Prominence Health Plan

UHS

Michelle DuFresne
CDIP, RHIT, CRC, CNA, PCT

Session 2 Agenda



1. Cancer – Active vs. Remission (Breast, Prostate)
2. Leukemia / Lymphoma
3. M.E.A.T. / Stand-Alone Progress Note

Diagnosis

Diagnosis Specificity Needed to assign the appropriate dx code

Clinical Documentation Required to support ICD-10 codes submitted on your claim

Disclaimer

- Information shared today is for educational purposes only, using 2021 data for accuracy at time of delivery.
- This guidance is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references.
- Specific documentation is reflective of the “clinical thought process” of the provider when treating patients.
- All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment plan in the Progress Note.
- The information shared today also serves to enhance your implementation of high-quality clinical documentation for ICD-10 coding accuracy to the highest level of specificity.

https://www.cms.gov/Medicare/Health- Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2018.pdf,
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors- Items/Risk2018.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

The Goal for Today's Content

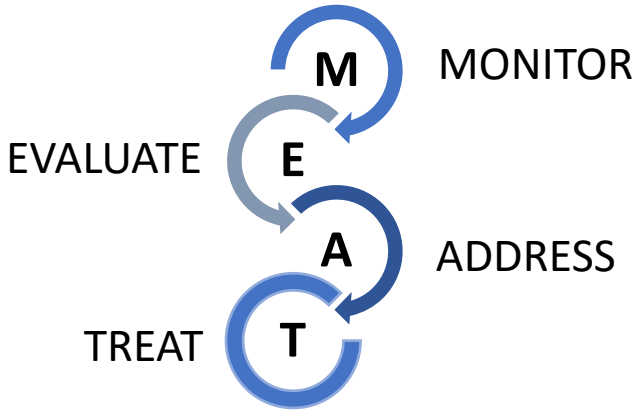
- Obtain a High-level understanding of Risk Adjustment specific to Neoplasms.
  - ✓ Utilizing CMS-HCC (Medicare) Risk Adjustment Model
- Information being shared today is in accordance with:
  - ✓ ICD10 Coding Guidelines
  - ✓ CMS Risk Adjustment Data Validation Guidelines
  - ✓ AHA Documentation Guidelines and Coding Clinics
  - ✓ Industry Best Practice suggestions for RA success
- Learn one thing you didn't know or that wasn't clear about Risk Adjustment, Clinical Documentation and/or ICD-10 HCC Coding.
- Take away one tip to ease the documentation burden in your day to day.

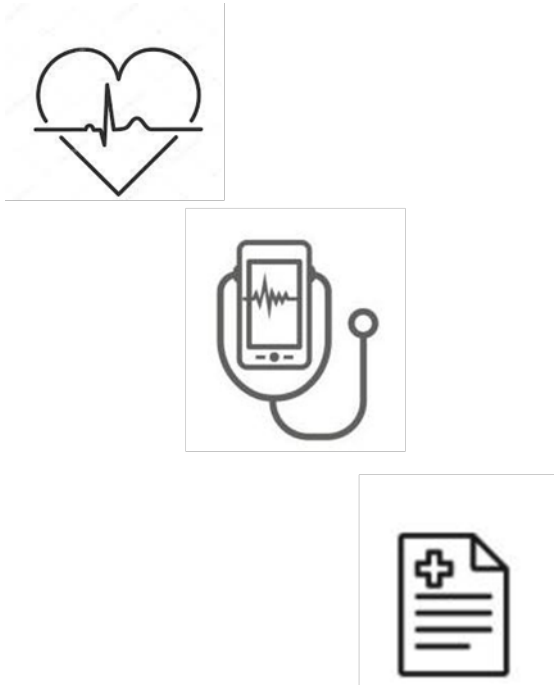
"Best Practice" Clinical Documentation Specificity

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.

Does the clinical documentation in your Progress Note meet the CMS M.E.A.T. criteria to support the diagnosis codes assigned on your claim for submission?





Cancer
Active vs. Remission
(Breast, Prostate)

Tips for SUCCESS in Risk Adjustment Data Validation.

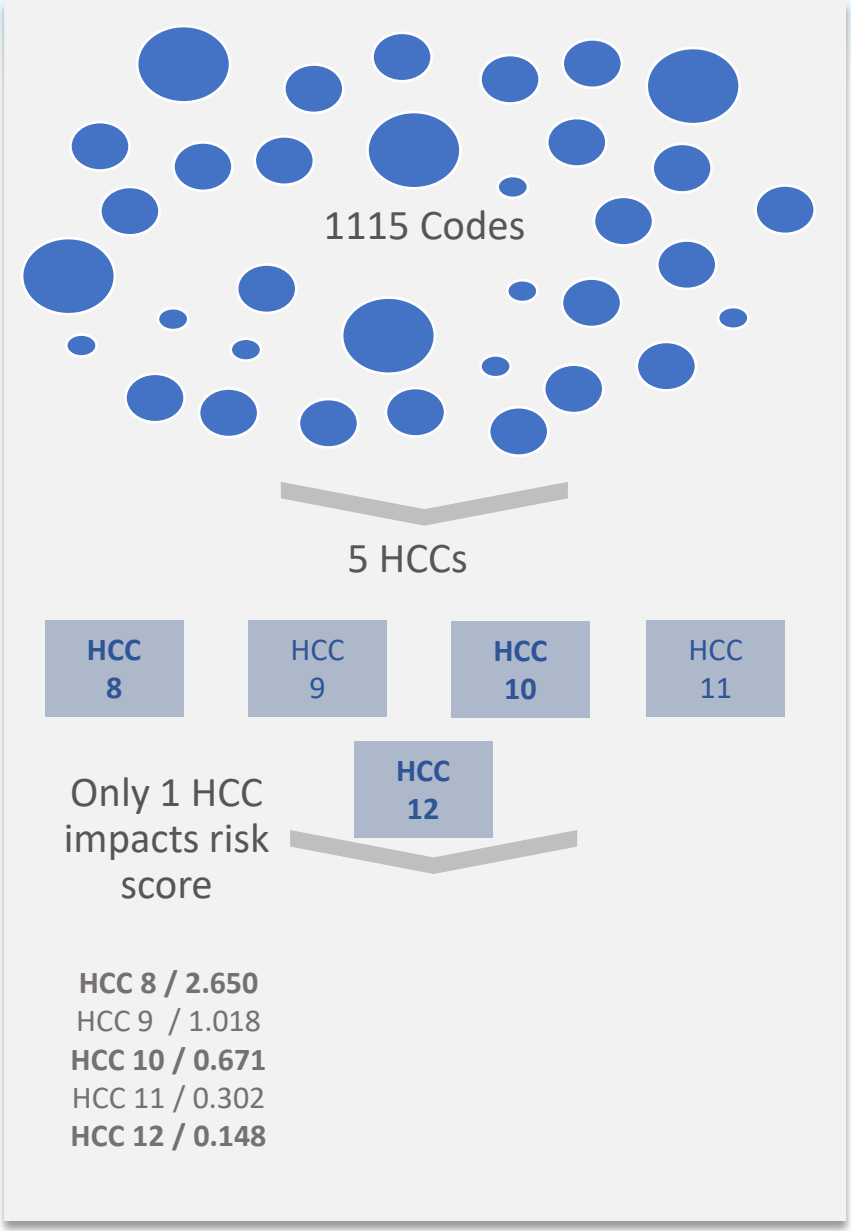
Neoplasms– CMS HCC Model

~1115 ICD10 Codes for Neoplasms are categorized into 5 HCCs.

The 5 HCCs are arranged hierarchically 8, 9, 10, 11, 12.

Only the **highest HCC** in each hierarchy impacts risk score 1x per year when completely and accurately documented, coded, and submitted.

A disease interaction coefficient is also added for patients who have a qualifying Neoplasm and Immune Disorder (ex. Neutropenia, Pancytopenia, Mast Cell Disorder).



Neoplasm HCCs (CMS HCC Model)

Within each hierarchy, only the highest severity/lowest HCC number impacts the patient's risk score, even if multiple conditions are present.

Metastatic Cancer and Acute Leukemia (CMS-HCC 8) 2.650

Includes all sites of Secondary Malignant Neoplasms

Lymphoma and Other Cancers (CMS-HCC 10) 0.671

Includes Malignant Neoplasms of Bone, Peripheral Nerves, Brain

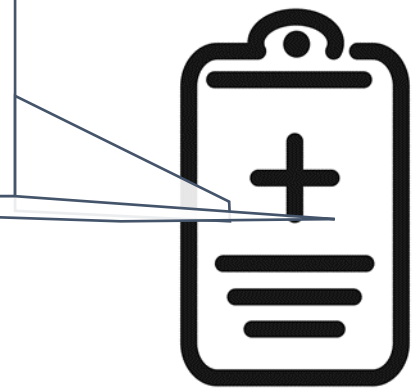
Breast, Prostate, and Other Cancers and Tumors (CMS-HCC 12) 0.148

Includes Malignant Melanomas, Malignant Neoplasms of the Eye, Benign Brain Neoplasms

Documenting Neoplasms

- Documentation should always include:
  - **Status** of condition
    - Active
    - History of
  - **Specificity** of condition
    - Benign
    - In-Situ
    - Malignant
    - Uncertain Histologic Behavior
    - Secondary
    - Adenoma
  - Current **Treatment Plan**
    - Managed by Oncologist
    - Continue Tamoxifen

"Malignant neoplasm of the left female breast, s/p mastectomy 4/2017, continues Herceptin for to prevent recurrence, managed by Oncology."



- Document and code *all* Neoplasms as appropriate when addressed at the encounter (even if currently managed by specialist).
  - Pulling in documented diagnoses and complications from specialist notes into your current documentation and the patients Active Medical Problems List is a suggested "Best Practice" to ensure conditions are being properly managed.
  - Documentation *solely* in a problems list, past medical history list, or medication list however is not sufficient to show M.E.A.T. for code submission on a claim (Monitor, Evaluate, Address, Treat).

Neoplasm Coding and Documentation

Model Inclusion

Most benign neoplasms are not included in the risk adjustment model.

Active Cancer vs. Historical Cancer

ICD 10 Guidelines indicate

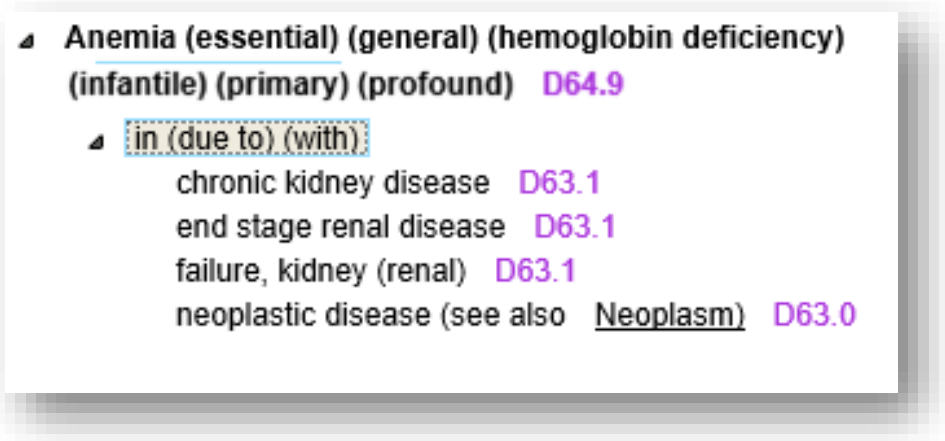
- *"When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed."*
- *"When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."*
- Adjuvant therapies to cure or prevent recurrence are considered active treatment (ex. Herceptin, Tamoxifen).

Documented Condition	Code as:
Breast Cancer	C50.919* Malignant neoplasm of unspecified site of unspecified female breast
Secondary Malignant Neoplasm of Breast	C79.81*
Ductal Carcinoma In Situ (DCIS)	D05.90 Unspecified type of carcinoma in situ of
Benign Neoplasm of Breast	D24.9
Neoplasm of uncertain behavior of left breast	D48.60
Neoplasm of unspecified behavior of breast	D49.3
History of Breast Cancer	Z85.3 Personal history of malignant neoplasm of breast

Neoplasm Coding and Documentation

For Complications of a Neoplasm "Document"

- Management for the complication of a neoplasm with treatment only for the complication, sequence the complication first, followed by the code for neoplasm.
- Anemia is the exception, sequence the Neoplasm first, followed by anemia in neoplastic disease.



For Primary vs. Secondary "Document"

- Multiple tumors in the same organ should each be specified as separate primary malignancies or secondary when present.
- Sequencing of the diagnosis code is dependent upon which malignancy is being treated in the encounter (primary or secondary).

Documentation of Polyps

- Polyps documented as adenomatous are classified as benign neoplasms.
- Documentation of hyperplastic alone does not classify to neoplasm.

Common Errors When Documenting Neoplasms

Conflicting Documentation in the Progress Note	Omitting Documented Conditions from Claim Submission	Lack of Supporting Documentation for Conditions	Lack of Specificity in Documentation
• Cancer is documented as both Historical and Active in the encounter.	• Active adjuvant cancer treatment is documented; however, the condition is omitted from the Assessment and not coded on the claim for the encounter.	• Condition is simply listed in the assessment without documentation of M.E.A.T. • Condition is only in a problems or past medical history list but included on a claim for submission.	• Specific Histology of a tumor is not documented. • Lacking laterality, location, stage and/or status.

Common Neoplasm Coding and Documentation Opportunities

- Incorrect ‘History Of’ Documentation
  - Per ICD10 Guidelines:

    Personal history codes explain a patient’s past medical condition that no longer exists, resolved and gone, not receiving any treatment, medication, etc.

    Current conditions should not be documented as history of even when the signs and symptoms are controlled, not currently present, stable, still receiving treatment, medication, etc.
- Progress Note Documentation
  - Slashes are interpreted as either/or, avoid using slashes when documenting multiple conditions.
  - Dx documented as rule out, suspect, working, possible, code to signs and symptoms not an actual diagnosis (out-patient is much different from in-patient).
  - Avoid abbreviations, if used, spell the entire condition out at least once.

Common Documentation and Coding Error, Neoplasm

Neoplasm Status

- **Situation** Documentation indicates history of breast cancer, status post mastectomy, and completed adjuvant therapy without recurrence of disease, coded as active cancer.
- **Recommendation** Code as Personal History of malignant neoplasm of breast Z85.3
  - ICD 10 Guidelines indicate :
    - "When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed."
    - "When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."
- **Adjuvant therapies to cure or prevent recurrence are considered active treatment (ex. Herceptin, Tamoxifen).**

Current vs. “History of”

- **Current** (Still exists in the body)
  - Active treatment

    Even After Care – determining the effectiveness of surgery within the global postop period Z48.3 + Current neoplasm code.
  - Active treatment for the purpose of Cure or Palliation and/or when the record clearly shows
    a) Unresponsive to treatment
    b) The treatment plan is watchful waiting or observation only
    c) The patient refused further treatment
  - Adjuvant Therapy for cure or palliation

    Any treatment given after the primary therapy to increase the chance of long-term disease-free survival (chemotherapy, radiation therapy, hormone therapy, targeted therapy or biological therapy).

- **History of**
  - ✓ After primary malignancy has been excised or eradicated
  - ✓ No further treatment directed to that site
  - ✓ No evidence of current cancer
  - ✓ Not currently under treatment
  - ✓ Follow-up exams – when monitoring for recurrence “Personal History of”

Breast Cancer
"Need to Know"

- Breast cancer **site(s)** – primary and secondary
- **Treatment plan** (document a clear and concise plan)
  Active vs. Surveillance
- When adjuvant therapy is used clearly state the purpose
  - Curative, Palliative, Preventive/Prophylactic
- Do not document a simple statement of 'Breast Cancer" to describe "History of"
- "History of" Breast Cancer
  - Includes medical surveillance following completed treatment

Breast Cancer - Documentation

Breast cancer **site**(s) primary and secondary

- Document whether the current breast cancer is primary / secondary / in situ.
  - Laterality (left / right)
  - The specific site (areola, nipple, upper outer quadrant, central portion etc.).
  - Any specific secondary sites.

Treatment plan

- Document a clear and concise plan of care.
- Clearly indicate
  - Active treatment of current breast cancer vs. Surveillance of historical breast cancer to monitor reoccurrence
- When adjuvant therapy is used, clearly state its purpose / goal.
  - curative, palliative, preventative

Breast Cancer

Adjuvant therapy (Treatment given after the primary treatment is completed)

- Destroy remaining cancer cells that are undetectable and/or Lower the risk that the cancer will come back (May include chemo, radiation, hormone, targeted, biological)
  - Drugs used for adjuvant therapy Tamoxifen, Arimidex, Faslodex, and Femara

Document the purpose of adjuvant treatment of breast cancer in each case.

- Curative – given to cure breast cancer
- Palliative – given to relieve the symptoms and reduce suffering caused by breast cancer without affecting a cure
- Prophylactic/Preventative – given to keep breast cancer from reoccurring in a person who has already been treated

Code breast cancer as “CURRENT” when

- The Progress Note clearly shows documentation of active breast cancer, receiving current treatment (which in some cases may be adjuvant treatment)
- When the documentation clearly shows breast cancer is still present but
  - is unresponsive to treatment
  - the current treatment plan is observation only, “watchful waiting”
  - the patient has refused further treatment

Documentation for Breast Cancer

- Documentation should include:
  Breast cancer site(s) – primary and secondary
  Treatment plan
- Do not document a simple statement of “Breast Cancer”.
- Provide Specificity
  - ✓ Primary, secondary, in situ
  - ✓ Laterality (right, left, bilateral)
  - ✓ Specific location (areola, nipple, upper outer quadrant, central
  - ✓ Any specific secondary sites
- Avoid vague documentation. Example: Breast cancer, stable
  - ✓ “Best Practice” documentation Example: Active breast cancer, left outer quadrant, undergoing chemotherapy, scheduled to see oncologist next week
- Use the Active Medical Problems List to your advantage. Choose the full details of the breast cancer in the EHR descriptor “Primary breast cancer of the left breast, outer quadrant”.
- If there is metastatic cancer specify **primary** and **secondary** site for coding accuracy, if documented and coded accurately metastatic cancer falls into a different HCC category.

Prostate Cancer

- Generally, a PSA level of 4.0 ng/mL or less is considered normal in most cases.
  - Some men with a PSA levels below 4.0 have prostate cancer while other men with higher PSA levels do not.
  - A continuous rise in PSA over time may be a sign of Prostate Cancer.

- Prostate Cancer treatment options:
  - ✓ Watchful waiting and active surveillance
  - ✓ Surgical removal of the Prostate (prostatectomy)
  - ✓ Cryosurgery (freezing cancer cells)
  - ✓ Chemotherapy
  - ✓ Hormonal Therapy (ADT androgen deprivation/suppression therapy)
  - ✓ External Radiation
  - ✓ Internal Radiation (radioactive seed implantation)

- In cases where clinical documentation is vague or unclear, the coder should query the provider for clarification.

Documentation for Prostate Cancer

Documentation and coding for Prostate Cancer presents a special challenge.

In most cases of Prostate Cancer, it is slow growing and can be observed/monitored for many years with no “active treatment”.

Your documentation should not be vague because it can lead to erroneous coding.

A final impression of “Prostate Cancer – check PSA” is vague and ambiguous, it does not clearly indicate current active cancer over historical cancer.

Do not document a simple statement of “Prostate Cancer” for which there is

- No active treatment, and
- No evidence of disease or reoccurrence

“Best Practice” documentation Example: Active Prostate Cancer, radio seed implant post 2 months, check PSA.

Use the Active Medical Problems List to your advantage, choose the full details of the Prostate Cancer in the EHR descriptor “Primary Prostate Cancer, Primary prostatic adenocarcinoma”.

IF there is metastatic cancer specify the primary and secondary sites for coding and risk score accuracy.

Active vs. Historical

Model Inclusion

Most benign neoplasms are not included in the risk adjustment model.

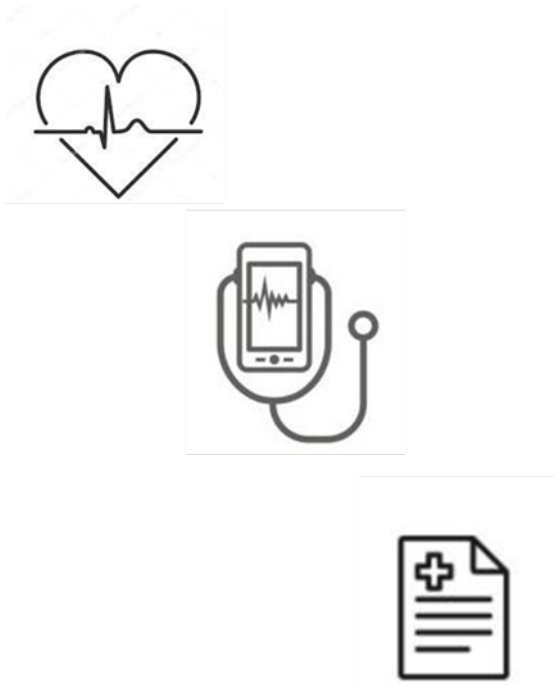
Active Cancer vs. Historical Cancer

ICD 10 Guidelines indicate

- *"When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed." (Active code)*

- *"When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy."*
  - *Prostatectomy, completed chemo and radiation, monitoring PSA – "History of"*

- Adjuvant therapies to cure or prevent recurrence are considered active treatment.



Leukemia / Lymphoma

Tips for SUCCESS in Risk Adjustment Data Validation.

Leukemia / Lymphoma

- The ICD-10 coding guidelines for leukemia /lymphoma are the only exclusion to the rule.
- Unless Cured, even when stated as “history of”, the code remains active.

Lymphoma

Divided onto 2 major groups

- Hodgkin Lymphoma
  - ✓ Cancer of the blood and bone marrow that affects lymphatic system.
  - ✓ Lymphoma cells grow and form masses, usually in the lymph nodes.
  - ✓ Presence of Reed-Sternberg cell Rare; accounting for .5% of all new cancers diagnosed.
  - ✓ 6 varieties of Hodgkin lymphoma.
- Non-Hodgkin Lymphoma (NHL)
  - ✓ Affects the lymphatic system; in some cases, NHL involves bone marrow and blood.
  - ✓ Different subtypes which may grow slowly or rapidly.
  - ✓ Starts with an abnormal change in a white cell in a lymph node (lymphocyte); the abnormal lymphocytes accumulate and form masses.
  - ✓ 61 types and subtypes of non-Hodgkin lymphoma (NHL).

Lymphoma

- Lymphomas are classified to ICD-10-CM diagnosis code categories C81–C88 and requires more specificity with documentation.
  - **Type** of lymphoma (Hodgkin, Non-Hodgkin, Follicular, Non-follicular, Mantle Cell)
  - **Histology:** Nodular, sclerosis, mixed, lymphocyte-rich etc.
  - **Location** (node or organ)
  - **Status** of disease, Active Treatment, In Remission, No clinical evidence
- Lymphoma patients in remission are still considered to have lymphoma unless stated as cured, always assign the appropriate C8X. diagnosis code.

HCC Category	HCC Category Description
10	Lymphoma, Leukemia, Other Cancers
Hodgkin Lymphoma	**Non-Hodgkin Lymphoma**
C81.X	C82.X, C83.X. C84.X, C85.X, C86.X, C88X
70 ICD-10 Codes	292 ICD-10 Codes

Lymphoma

Active Lymphoma – In an effort to code active lymphoma (not a history of), look for the following:

- Active Treatment – Is the patient is currently receiving treatment (e.g., watchful waiting, chemotherapy, radiation therapy, stem cell transplant, biological therapy, radioimmunotherapy), code as active lymphoma.

- Patient Choice – A patient who is diagnosed with cancer and has been counseled in regard to his/her diagnosis may choose not to have treatment, code as active cancer.

- Newly diagnosed – A patient who has been newly diagnosed may not have a treatment plan developed yet, this is coded as active lymphoma.

- 'In Remission' – **Patients who are in remission are still considered to have lymphoma** and should be **assign**ed the appropriate **code** from categories **C81–C88,** not a Z-code. (**Lymphoma** – Guidelines, Coding Clinic, Second Quarter 1992, Page: 3)

Leukemia Cancer of the blood and bone marrow

Document the Specific type: (example)

- Chronic lymphocytic leukemia (CLL) is the most common form
- Acute lymphoblastic
- Chronic lymphocytic of B-cell type
- Hairy cell
- Adult T-cell

Document Status:

- Acute vs. Chronic
- Not having achieved remission
- In-remission
- In-relapse

HCC Crosswalk Lymphoma, Leukemia, Stem Cell Transplants

C8190	Hodgkin lymphoma, unspecified, unspecified site	10
C8191	Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck	10
C8192	Hodgkin lymphoma, unspecified, intrathoracic lymph nodes	10
C8193	Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes	10
C8194	Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb	10
C8195	Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb	10
C8196	Hodgkin lymphoma, unspecified, intrapelvic lymph nodes	10
C8197	Hodgkin lymphoma, unspecified, spleen	10
C8198	Hodgkin lymphoma, unspecified, lymph nodes of multiple sites	10
C8199	Hodgkin lymphoma, unspecified, extranodal and solid organ sites	10
C9590	Leukemia, unspecified not having achieved remission	10
C9591	Leukemia, unspecified, in remission	10
C9592	Leukemia, unspecified, in relapse	10

*Be sure to document and code Stem Cell transplant for patients that receive this treatment.

Additive Risk Weight

DX Code	ICD 10 Dx Descriptor	HCC Category	Risk Weight
Z9484	Stem cells transplant status	186	0.823
C9591	Leukemia in Remission	10	0.671

CMS-HCC Risk Adjustment Coding Impact

Ensuring all diagnoses are documented to the highest level of specificity in your Progress Note and appropriately assigned and submitted on your claim is detrimental to Risk Adjustment success.

Report all chronic HCC conditions a minimum of 1x per year, “Best Practice” suggests at 2x per year or more.

Accuracy of Disease Burden and Risk Score is dependent upon the detailed clinical documentation specificity in your Progress Note for ICD-10 diagnosis code assignment and claim submission.

Active Medical Problems List Accuracy – Add all chronic conditions and status conditions to the patients Active Medical Problems to the highest level of specificity in the narrative and use that assigned narrative to your advantage to drive your clinical documentation in your Progress Note for accuracy.

Quick Debrief

High-level recap

- Incorporate diagnoses from specialists notes into your patient's Active Medical Problems List (AMPL) to the highest level of known specificity and use the descriptive narrative to your advantage.
- Use the AMPL to your advantage by using the descriptive narrative to drive your clinical documentation details in the Progress Note.
- Neoplasms - Attention to the term "Remission." (Commonly known as resolved and gone.)
    - Leukemia/Lymphoma – Use an Active Dx code unless stated as cured no longer existing, only if stated as cured assign a Z-Code for personal history of otherwise assign the appropriate code for an active condition even when stated "in-remission."
    - Cancer/Neoplasm – Unless documentation shows the status and treatment plan for "Active Cancer" assign a Z-Code meaning resolved and gone, no longer exists in the body, assign a personal history of code or seek clarification from the provider.

Thank you for your time today. We appreciate you!