Optum

Medicare Advantage

Documenting to satisfy reporting requirements

With the implementation of ICD-10-CM came the need for greater detail in clinical documentation. Specific documentation aids in effectively identifying, categorizing and communicating severity of conditions to better track quality of care, validate medical necessity, and predict future health care expenditures. The ICD-10-CM Official Guidelines for Coding and Reporting reiterate the importance of good documentation, "The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved." The guidelines also set the expectation for correct coding, stating that, "Each healthcare encounter should be coded to the level of certainty known for that encounter."

This tool outlines the required elements of the language of documentation for some of the more common chronic conditions, which will lead to coding that is both accurate and complete. This type of documentation will minimize coder query and can also help expedite claims processing, resulting in more timely payment. When possible, we included practical examples of documentation that satisfy reporting requirements. Documenting in this way will also result in better communication of the conditions being treated or considered when treating, better portrayal of medical necessity for appropriate reimbursement, improved communication between clinicians, better continuity of care and improved patient outcomes.

The importance of documentation

- Documentation should be clear, concise and legible.
- CMS requires submission of risk adjusting diagnosis codes:
  - From a face-to-face or synchronous audiovisual telehealth visit with physician or other approved provider.
  - Within the reporting period each calendar year.
- Document conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment and/or management.
- Diagnoses cannot be coded from diagnostic reports alone. The review and pertinent findings of the diagnostic reports should be documented in the progress note.

Documentation examples

- Spirometry completed 4/10/22, confirms COPD, continue Ipratropium as prescribed
- Diabetes type 2 with hypoglycemia, CKD 4 stable eGFR 20
- Rheumatoid arthritis, stable on Enbrel
- Hypertensive heart disease, stable, seeing cardio tomorrow
- Patient's BMI has increased since last visit from 42 to 43, patient is morbidly obese, right foot amputation 3 years ago, which contributes to his obese state due to limited mobility

Language of documentation

- All diagnosis codes reported must be supported by documentation in the medical record. It is recommended to identify evidence of monitoring, evaluating, assessing/addressing, and/or treating (M.E.A.T.).
- Utilize adjectives to specify conditions documented & coded such as: severity, site, stage, laterality, episode, type, complications, comorbidities, insulin status or amputation status.

Monitor (or)

- Signs and symptoms
- Disease progression and/or status

Evaluate (or)

- Response to treatment(s)
- Test results

Assess/Address (or)

- Counsel and/or discussion
- Records review
- Refer to specialist

Treat

- Stop or start medications
- Diagnostic and/or therapeutic plan
- Patient education and/or follow-up schedule

Diabetes

When documenting diabetes, specify:

- **Type of diabetes:** Type 1, type 2, secondary – drug or chemical induced (document first poisoning or adverse effect specific to drug), due to underlying condition (document first the underlying condition), postprocedural or due to genetic defects
- **Control status:** "Controlled;" if "inadequately controlled," "out of control" or "poorly controlled" (diabetes, by type, with hyperglycemia); if "uncontrolled," specify as hyperglycemic or hypoglycemic
- **Complications or any other body systems affected:** There is a presumed causal relationship regarding "diabetes with" many complications, unless documentation clearly states the conditions are unrelated. "Diabetes with chronic kidney disease" – document also the stage of CKD; "diabetes with an ulcer" – document also the ulcer by type, laterality, site and depth; "diabetes with glaucoma" – document also the type, stage and affected eye; other diabetic complication – specify the complication including stated or implied relationship (for example, "diabetic CAD")
- **Treatment:** Insulin use and/or oral antidiabetic or hypoglycemic drugs, and non-insulin injectables.

Chronic kidney disease (CKD)

When documenting CKD, specify:

- **Underlying cause:** Diabetes or hypertension. If CKD is unrelated to diabetes or hypertension, document the cause, if known.
- **Stage of CKD:** Stage 1, stage 2 (mild), stage 3 (moderate - 3a, 3b, unspecified), stage 4 (severe), stage 5 or end-stage renal disease (ESRD). Avoid documenting a range of severity, such as "moderate to severe." The diagnosis of CKD cannot be coded from diagnostic reports alone. Clearly state review of reports and pertinent findings including the GFR.
- **Presence of:** A/V fistula or shunt for dialysis; complication due to renal dialysis access device, implant or graft (such as embolism, hemorrhage, infection, occlusion, pain, stenosis or thrombosis)
- **Dialysis dependence:** Hemodialysis or peritoneal dialysis
- **Associated diagnoses/conditions:** "Diabetes with," "hypertension with" or "secondary hyperparathyroidism due to CKD" and state the stage of CKD
- **Transplant status:** Kidney transplant status (for those patients who still have some form of CKD, document the current stage of the CKD post-transplant)

Hypertension

When documenting hypertension, specify:

- **Type:** "Essential hypertension," "hypertension secondary to renal artery stenosis," "renovascular hypertension," "drug resistant," accelerated," etc.
- **Acuity of hypertension:** "Hypertensive urgency"
- **Systemic involvement:** "Hypertension with ventricular hypertrophy," "hypertension with diastolic dysfunction," "hypertension with heart failure" and state the type and severity of heart failure (systolic, diastolic, combination, acute, chronic, acute-on-chronic) or "hypertension with chronic kidney disease" and state the stage of CKD
- **Underlying cause:** For example: underlying renal conditions or hormonal disorders, sedentary lifestyle, excessive amounts of alcohol, stress, etc.
- **Tobacco Use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Heart failure

When documenting heart failure, specify:

- **Underlying cause:** "Chronic diastolic failure due to hypertension," "heart failure due to hypertension with chronic kidney disease," "hypertension with chronic diastolic heart failure," coronary artery disease (CAD), diabetes, cardiomyopathy, endocarditis, heart valve disorders, cardiac arrhythmias, congenital defects, thyroid disorders, alcohol and illicit drug use, HIV, AIDS, chemotherapy
- **Comorbidities:** *For example: renal insufficiency, diabetes, atrial fibrillation, chronic obstructive pulmonary disease, sleeping disorders, anemia, iron deficiency, etc.*
- **Circumstance:** Postprocedural
- **Specific type(s), if known:** "Left ventricular failure," "systolic heart failure," "diastolic heart failure," "combined systolic and diastolic heart failure," "rheumatic heart failure," "right heart failure," "biventricular heart failure," "high output heart failure," "end stage heart failure," or "other heart failure"
- **Severity:** Acute, chronic, acute-on-chronic

Please note, if a provider documents "congestive heart failure," it will be coded to heart failure, unspecified.

Arteriosclerosis (coronary artery disease [CAD] and peripheral arterial disease [PAD])

When documenting arteriosclerotic disease, specify:

- **Comorbidities:** Diabetes, alcoholism, dyslipidemia, hypertension, obesity, severe stress, etc.
- **Site (vessel):** Aorta, cerebral, carotid, coronary, extremities, mesenteric, pulmonary, renal, vertebral, etc.
- **Laterality:** Right, left, bilateral
- **Severity:**
  - CAD: With or without angina
  - ASPVD: Manifestations (intermittent claudication, rest pain, ulceration, gangrene); if ulceration, document the type, laterality, site and depth
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Coronary artery disease (CAD)/Atherosclerotic cardiovascular disease (ASCVD)

When documenting atherosclerotic heart disease with or without angina pectoris, include the following:

- **Cause:** Assumed to be atherosclerosis; document if there is another cause
- **Stability:** "Stable angina pectoris," "unstable angina pectoris"; if "angina equivalent," document the associated symptoms
- **Vessel:** Note which artery (if known) is involved and whether the artery is native or autologous (for example, coronary artery, left anterior descending, left circumflex artery), chronic total occlusion of coronary artery
- **Graft involvement:** If appropriate; and if a bypass graft was involved in the atherosclerotic heart disease diagnosis, also note the original location of the graft and whether it is autologous or biologic
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Peripheral arterial disease (PAD)

When documenting PAD, include the following:

- **Cause:** Diabetic, arteriosclerotic/atherosclerotic
- **Site of disease (vessel):** If native, name of vessel; if bypass graft, autologous, nonautologous biological, nonbiological
- **Manifestations:** Intermittent claudication, rest pain, ulceration – specify type, laterality, site, severity–gangrene
- **Laterality:** Right, left, bilateral
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Stroke and sequelae of stroke

When documenting stroke, specify:

- **Acute stroke**
  - Type: Embolic, hemorrhagic, ischemic, occlusive, stenotic, thrombotic
  - Site (vessel): Cerebral (middle cerebral artery, anterior cerebral artery, posterior cerebral artery, cerebellar artery, other artery), precerebral (vertebral artery, basilar artery, carotid artery, other artery)
  - Laterality: Right, left, bilateral
  - Score: National Institutes of Health Stroke Scale score
- **Residuals of prior stroke (specify deficit):** Cognitive deficit – specify exact type; speech and language deficit, monoplegia of upper or lower limb, hemiplegia and hemiparesis (affecting right/left dominant side, non-dominant side), other paralytic syndrome, other sequela (apraxia, dysphagia – specify type; facial weakness, ataxia, other – specify)
- **Substance Use/Exposure:** Alcohol abuse or dependence; any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)

Chronic obstructive pulmonary disease (COPD)

When documenting COPD, specify:

- **Type:** For example, asthma with COPD – also document the asthma by severity, frequency and level of exacerbation; chronic asthmatic bronchitis, chronic obstructive bronchitis, chronic bronchitis with emphysema, and chronic obstructive tracheobronchitis
- **Severity:** Stable, acute exacerbation with emphysema or an infection, or with chronic respiratory failure
- **Co-morbidities that can complicate COPD:** Such as but not limited to pulmonary artery disease, malnutrition, diabetes, cardiac disease, hypertension, heart failure, CAD and lung cancer
- **Infection:** Any lower acute lower respiratory infection and the infectious agent, if known
- **Cause:** Identify any additional lung disease due to external agent and specify agent (for example, organic dust, chemical, gases, fumes, vapors, ventilation system, etc.)
- **Tobacco use/Exposure:** Any related tobacco use, abuse, dependence, past history, or exposure (second hand, occupational, etc.)
- **Dependence on oxygen or mechanical ventilation**

Arrhythmias

When documenting arrhythmias, include the following:

- **Location:** Atrial, ventricular, supraventricular, etc.
- **Rhythm name:** Flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.
- **Acuity:** Acute, paroxysmal, chronic, etc.
- **Cause:** Hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCI, etc.
- **Other:** Document any other abnormality of heartbeat (tachycardia, bradycardia – document if adverse effect of a drug and specify drug; palpitations)

Major depressive disorder (MDD)

When documenting MDD, specify:

- **Episode type:** Single or recurrent
- **Severity:** Mild, moderate, severe
- **Symptoms:** Presence or absence of psychotic symptoms or features (An MDD diagnosis cannot be coded from the PHQ-9 score alone).
- **Remission status:** Full or partial

Obesity and body mass index (BMI)

When documenting obesity, specify:

- **Type:** Overweight, obese, morbidly (severely) obese, morbid obesity with alveolar hypoventilation (Pickwickian's), obesity hypoventilation syndrome
- **Cause:** Due to excess calories, drug-induced obesity – specify drug
- **Weight and the BMI:** BMI codes can be assigned from the dietitian's or other caregiver's documentation, but the provider must document the clinical condition (for example: overweight, obesity, morbid obesity)
- **Associated comorbid conditions:** For example, hypertension, diabetes, COPD

Protein-calorie malnutrition (PCM)

When documenting PCM, specify:

- **Severity:** Mild (first degree), moderate (second degree), severe (third degree); avoid documenting a range of severity, such as "moderate to severe;" if documenting cachexia, document underlying cause, if known
- **Associated conditions:** Alcohol abuse and/or dependence, alcoholic hepatitis, anemia, cancer, celiac disease, CHF, cirrhosis, cystic fibrosis, dementia, depression, ESRD, liver disease, obesity, pancreatitis

Rheumatoid arthritis (RA)

When documenting rheumatoid arthritis, specify:

- **Type:** Juvenile, seronegative, seropositive (presence of rheumatoid factor), other
- **Joint(s) affected by RA:** Specific joint or multiple sites
- **Laterality:** Right, left, bilateral
- **Systemic involvement:** Rheumatoid: carditis, lung involvement, myopathy, polyneuropathy, splenoadenomegaly and leukopenia, vasculitis, visceral involvement

The following references were used in the creation of this document at time of publication:

- Optum360. *ICD-10-CM: Professional for Physicians 2023*. Salt Lake City, UT: Optum360; 2022.
- Centers of Medicare and Medicaid Services. ICD-10 Coding and Clinical Documentation Resources.

How can we help you?

Our goal is to help health care professionals facilitate and support accurate, complete and specific documentation and coding, with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education, we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with the Centers for Medicare & Medicaid Services (CMS) risk adjustment requirements

Contact your Optum representative to find out how we can help you improve outcomes for your patients.

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