2020
Reporting Accurate Diagnosis Quick Reference Guide

Iowa Total Care strives to provide quality healthcare to our membership. We created the Reporting Accurate Diagnosis Quick Reference Guide to help you correctly report the conditions affecting our members with each visit. Please always follow the Official ICD-10-CM Guidelines, State and/or CMS billing guidance and ensure the billing codes are covered prior to submission.

For more information, visit www.CMS.gov

1-833-404-1061
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IowaTotalCare.com

Reporting Accurate Diagnosis

Why is it important?

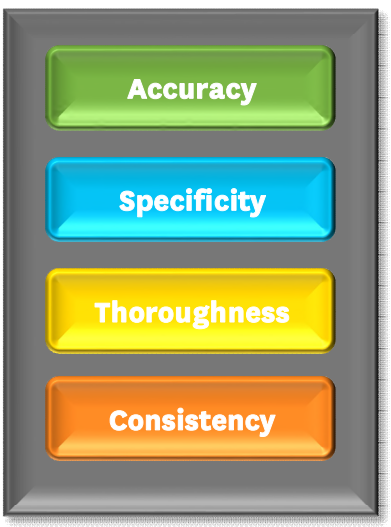
Conditions that go undocumented usually also go untreated. Comprehensive documentation and coding provide a complete and thorough insight into a patient's health profile for all those participating in their care. Coded data translates into:

- **Identification of members who may need disease management intervention.**
- **Accurate and complete claims for appropriate reimbursement.**
- **Tailored care management programs based on the specific conditions affecting our members.**
- **Better coordination of care between member, provider, and health plan**
- **More meaningful data exchanges between health insurance plans and providers, which helps members by:**
  - **Identifying new problems early**
  - **Reinforcing self-care and prevention strategies**
  - **Coordinating care collaboratively**
  - **Avoiding potential drug/disease interaction**

Provider Role

Providers are the largest source of medical data for accurate, comprehensive coding. It is important for providers to document each existing medical condition and ensure patient charts are thorough. Providers should take every face-to-face encounter as an opportunity to assess the patient's health and comprehensively document chronic conditions, co-existing conditions, active status conditions, and pertinent past conditions.

Specificity of diagnosis coding is substantiated by the medical record and contributes to the level of complexity for the patient encounter and is vital to a healthy patient. To ensure accurate, comprehensive condition coding:



- **Accurately assess member's health status to include chronic and complex conditions**
- **Document confirmed conditions, assessments, and medical notes appropriately in the member's medical record.**
- **Order and/or complete preventive measures to close HEDIS gaps**
- **Ensure each progress note /visit note stand alone to give a comprehensive picture of the member.**
  - **Each note must contain a legible provider signature with credentials clearly documented. E-signature is also acceptable.**
- **Ensure diagnoses are coded using applicable ICD-10 code to address medical conditions.**
  - **Code to the highest-specificity when applicable (using correct CPT/HCPS codes to support visit).**

Secure Provider Portal

Manage patient administrative tasks quickly and easily

- Go to the Iowa Total Care website (iowatotalcare.com) to register for our Secure Portal. Functions on the portal include:
  - Verification of member eligibility
  - Claims submissions
  - Entering pre-authorization
  - Viewing patient care gaps

HIPAA

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/member representative.

Glossary of Terms

ICD-10 – The 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

CPT - Current Procedural Terminology is a medical code set that is used to report medical, surgical and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

HCPCS -The Healthcare Common Procedure Coding System (HCPCS, often pronounced by its acronym as "hick picks") is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

Chronic Disease- A disease that persists for a long time. A chronic disease is one lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics.

Clearinghouse - Company that functions as an intermediary forwarding claims information from healthcare providers to insurance payers. Clearinghouses check the claim for errors and verify it is compatible with the payer software securely (protects patient health information, or protected health information).

Problem List - Used within health records, a list of illnesses, injuries, and other factors that affect the health of an individual patient, usually identifying the time of occurrence or identification and resolution. They are an important communication vehicle used throughout the entire healthcare continuum.

Provider: A clinician, group of clinicians or facility, such as a hospital, offering healthcare services to members.

Pre-existing chronic condition: A medical condition or disease that an individual has been diagnosed with, prior to the current experience period.

Suspected chronic condition: The existence of a medical condition that is suspected based on other data points such as reported related conditions, lab data, pharmacy data, etc.

For additional information or questions related to reporting accurate diagnosis, please contact the Quality Improvement Department:

- **Provider Services Hours: Monday through Friday, 7:30 a.m. - 6:00 p.m. Central Time**
- **Provider Services Phone Number: 1-833-404-1061 (TTY: 711)**
- **Provider Website: www.iowatotalcare.com/providers/quality-improvement**

Table of Contents

Documentation Tips

Accurate Comprehensive Documentation and Claims Coding

The Medical Record

Due to its simplicity and popularity, many medical records take on the SOAP format: Subject, Objective, Assessment, and Plan. The SOAP format addresses patients' complaints in an organized and consistent manner. Over time, patients' chronic conditions may be overlooked, assumed or tacitly understood.

What does CMS say?

One of the documentation requirements, according to the May 9, 1992, HCFA (now CMS) bulletin for Associate Regional Medicare Administrators, Issue 9 and progress notes should stand-alone. This means that providers should code all documented conditions that coexist at the time of the encounter and affect the patient's care, treatment or management. This must be documented by the provider and cannot be inferred by coders. One way to document *conditions* is by using the acronym MEAT (Monitor-Evaluate-Assess/Address-Treat):

Monitor Evaluate Assess/Address Treat	
Monitor	Symptoms Disease progression/regression Ordering of tests Referencing labs/other tests
Evaluate	Test results Medication effectiveness Response to treatment Physical exam findings
Assess/Address	Discussion, review records Counseling Acknowledging Documenting status/level of condition
Treat	Prescribing/continuation of medications Surgical/other therapeutic interventions Referral to specialist for treatment/consultation Plan for management of condition

Quick Reference Guide

General Medical Record Tips

- Documentation should be legible and complete.
- Make sure to update the member's problem list with each visit.
- Ensure that each page of the medical records includes the member's name, date of birth and date of service.
- Provide a legible provider signature with credentials.
- Use only standard abbreviations when documenting in the medical record.

Past Medical History (PMH) Tips

- Defined as historical, resolved or no longer present.
- Do not code from the PMH list unless there is supported evidence through M.E.A.T.

Chronic Conditions

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the member receives treatment for the condition (even if documented as stable; should be restated).

Some common chronic conditions and/or missed chronic conditions:

- Morbid Obesity (BMI>40)
- COPD (Chronic Obstructive Pulmonary Disease)
- CHF (Congestive Heart Failure)
- Multiple Sclerosis
- Major Depression
- RA (Rheumatoid Arthritis)
- Chronic Kidney Disease
- Parkinson's Disease
- Alcohol/Drug Dependency
- Chronic Psychiatric Diagnoses

Documentation should specify the word "chronic", if appropriate. This can affect how the condition is coded and affect the coding value.

- Example:
  - Kidney Disease vs. Chronic Kidney Disease.
  - Diabetes, diabetic (mellitus) (sugar) E11.9 with chronic kidney disease E11.22

ICD-10-CM "With"

The words "with" or "in" should be interpreted to mean "associated with" or "due to". The classification presumes a causal relationship between the two conditions. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

The "with" guideline does not apply to "not elsewhere classified (NEC)" index entries that cover broad categories of conditions. Specific conditions must be linked by the terms "with", "due to", or "associated with".

- **Example: In order to link diabetes and a specific skin complication, the provider would need to document the condition as a diabetic skin complication. Do not assume a causal relationship when the diabetic complication is "NEC".**

"History of" Clarification

Documenting "History of" Indicates a condition no longer exists and should not be used for chronic conditions receiving active treatment.

INCORRECT DOCUMENTATION	CORRECT DOCUMENTATION
H/O CHF = CHF has resolved	Compensated CHF, stable on Lasix
H/O Angina = Angina has resolved	Angina is stable on active treatment
H/O COPD = COPD has resolved	COPD controlled w/meds
Prostate Cancer s/p Chemotherapy	Prostate Cancer is active with treatment or patient refused treatment

Errors regarding use of "History Of":

- **Coding a past condition as active**
- **Coding "History Of" when condition is still active**

General Visit and Documentation Tips

- **Document each patient encounter as if it is the only encounter.**
  - **Ensure that chronic conditions are reviewed at the visit, even if they are only presenting for an acute issue.**
  - **When refills are made outside of a visit, encourage patient to schedule a checkup so that the condition can be reviewed and managed at least once a year.**
- **Review and update the patient's active problem list at each visit. If a condition is no longer active, either remove it from the list or add "History of."**
  - **Document status codes such as amputations, ostomies etc. when factual.**
  - **Codes should be assigned for every condition documented in the chart note that has evidence of MEAT, not just the condition for which the patient came in.**

- All chronic and complex conditions need to be coded annually. Review and document conditions managed by a specialist. This counts as MEAT and can be coded on the claim.

- Specify the basis for ordering additional testing/treatment.
- Show patient's progress or lack of progress.

Documentation Examples	
CHF	Stable. Will continue same dose of Lasix and ACE inhibitor
AAA	Abdominal ultrasound ordered
Major Depression	Continued feelings of hopelessness despite increase in Zoloft. Will refer to psychiatrist for further management
Hypercholesterolemia and Chronic Hepatitis C	Prescribing Zetia for hypercholesterolemia as it won't adversely affect the liver as patient suffers from Chronic Hepatitis C
Type 2 DM	BS log and A1c results reviewed with patient
GERD	No complaints. Symptoms controlled on meds
Peripheral Neuropathy	Decreased sensation of BLE by monofilament test
Ulcerative Colitis	Currently managed by Dr. Smith
Morbid Obesity	Advised patient to monitor calorie intake and increase activity level
Decubitus Ulcer of Heel	Wound measurements

Coding Tips

General Claims Coding Tips

- Use codes to identify symptoms, conditions, diagnoses, complaints, issues and any other reasons for the visit.
- First, list the code for the diagnosis, condition, problem, or other reason for visit reflected in the medical record and which supports the treatment provided.
- Always code diagnoses using the highest number of available digits. For example, do not assign a 3-digit code if a 4-digit code is available for use.
- Code all documented conditions that coexist during the time of the visit and that affect the treatment of the member.
- Do not code conditions that were previously treated and no longer exist
- History codes (categories Z80-Z87) may be used as secondary codes when the historical condition has an impact on current care.
- Focus on what caused the patient to seek medical care, and this will help to identify any condition/ diagnosis that can be coded.

Do not code a diagnosis documented as "probable", "suspected", "questionable", "rule out" or "working diagnosis".

Common Codes for Chronic Conditions

Condition	ICD-10
Obesity	E66– overweight and obesity E66.01 – Morbid obesity Z68.4 – BMI 40 or greater
Major Organ Transplant	Z94 – Transplanted organ and tissue status
Artificial Opening	Z93 – Artificial opening status
Amputation	Z89.4 – Acquired absence of foot and/or toe(s) Z89.5 – Acquired absence of leg below knee
Diabetes There are two code conventions with diabetic complications needed in ICD-10-CM: Diabetic Ulcer will require a second code to identify – site, laterality and severity of the ulcer Diabetic CKD will require a second code to identify – the stage of CKD	E11.9 - Diabetes, diabetic (mellitus) (sugar) E11.22 - with chronic kidney disease
Cerebral Vascular Accident (CVA) /Stroke Acute stroke only in acute care setting (actively occurring)	Z86.73 – History of CVA/TIA without residual I69.30-I69.398 - Sequelae of CVA
Paraplegia/ Quadriplegia	G82.2 – Paraplegia G82.5 – Quadriplegia

Condition	ICD-10
HIV status	B20 – HIV disease, symptomatic
Myocardial infarction (MI)	I25.2 – Old or healed myocardial infarction
Chronic Obstructive Pulmonary Disease (COPD)	J44.9
Congestive Heart Failure (CHF)	I50
Multiple Sclerosis	G35
Rheumatoid Arthritis	M06.9
Chronic Kidney Disease (CKD)	N18.9 – CKD unspecified N18.1 – CKD, stage 1 N18.2 – CKD, stage 2 (mild) N18.3 – CKD, stage 3 (moderate) N18.4 –CKD, stage 4 (severe) N18.6 – End stage renal disease (ESRD)
Renal Dialysis	Z99.2 – Dependence on renal dialysis
Parkinson's Disease	G20
Alcohol Dependency Drug Dependency • If both use and abuse are documented, assign abuse. • If both abuse and dependence are documented, assign dependence. • If use and dependence are documented, assign dependence. If all three are documented, assign dependence.	F19.2 F19.20 – Drug dependence NEC

Disease States

Asthma

What is Asthma?

Asthma, sometimes called bronchial asthma or reactive airway disease, is a chronic lung disease that makes it harder to move air in and out of the lungs. It can be serious and life threatening and can start at any age. With asthma, swollen airways become extra sensitive to things that one is exposed to in the environment every day—asthma "triggers." When a trigger is breathed in, the airways create extra mucus and swell even more, making it harder to breathe.

Asthma HEDIS® Measure (AMR)

This measure evaluates the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.

Asthma Coding Guidance

TIPS:	ICD-10 Mapping and Education
Refer to ICD-10-CM	J45 – J45.99 (Asthma)
Documentation should specify:	Frequency (intermittent, persistent) Exacerbation or decompensation Severity (mild, moderate, severe) Environmental factors
Use additional code to identify:	Exposure to environmental tobacco smoke (Z77.22) Exposure to tobacco smoke in the perinatal period (P96.81) History of tobacco dependence (Z87.891) Occupational exposure to environmental tobacco smoke (Z57.31)
Avoid terms such as "history of" if patient is still being monitored for the condition:	Incorrect wording: Patient has history of asthma. Correct wording: Patient has asthma with no recent onset to exacerbation. Current medication includes albuterol inhaler.
Additional Coding Tips	Bronchitis (J40): too general; identify acute or chronic. COPD with asthmatic conditions: code both the COPD and Asthma.
Documentation Tips	The following language supports actively monitoring any condition and must be documented by the provider. In the documentation, mention: Medications reviewed and that are current. If the patient is seeing a specialist. Whether or not there has been a recent onset or exacerbation.

Attention Deficit Hyperactivity Disorder

What is ADHD?

Attention deficit hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. The symptoms differ person-to-person, but both children and adults can have ADHD. There are three types of ADHD: inattentive, hyperactive, impulsive and combined. For a person to receive a diagnosis of ADHD, the symptoms of inattention and/or hyperactivity-impulsivity must be chronic or long-lasting, impair the person's functioning and cause the person to fall behind normal development for his or her age.

ADHD HEDIS® Measure (ADD)

The percentage of children ages 6-12 newly prescribed an ADHD medication that had at least three follow-up care visits within 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. The visit should be with a practitioner with prescribing authority. Two rates are reported: 30 days of starting the new medicine, and at least twice in the next 9 months.

ADHD Coding Guidance

TIPS:	ICD-10 Mapping & Education
Refer to ICD-10-CM	F90.0 – F90.9 (Attention deficit hyperactivity disorders)
Be precise	Avoid broad terms and unspecified codes such as "ADHD", F90.9 Be meticulous in picking up the details in documentation, it leads to precise coding and a better awareness about the disease and the population it affects.
Use specifying terms in the documentation, such as:	• Inattentive • Hyperactive • Combined
Progress Note	Codes within categories F90-F98 may be used regardless of the age of a patient. These disorders generally have onset within the childhood or adolescent years but may continue throughout life or not be diagnosed until adulthood.
Refill medication correctly	When documenting for medication refill, make sure to document the diagnosis, symptoms etc.

Autism Spectrum Disorder

What is Autistic Disorder?

Autism is a brain disorder that limits a person's ability to communicate and relate to other people. Also known as autism spectrum disorder (ASD), the term "spectrum" reflects the wide variation in challenges and strengths possessed by each person. Some people can navigate their world, some have exceptional abilities and some struggle to speak.

Symptoms of Autism

Signs of AD tend to appear between two and three years of age and can include repeated motions and/or words, avoiding eye contact or physical touch, delays in learning to talk and getting upset by minor changes. Additionally, some people with autism can experience physical symptoms such as constipation, sleep problems, poor coordination of muscles and seizures. These signs, however, can also occur in children without ASD and at any age. It is important that caregivers talk with healthcare provider to request a screening for autism.

Autistic Disorder Coding Guidance

TIPS:	ICD-10 Mapping & Education	
Refer to ICD-10-CM	F84.0 (Autistic disorder)	
Use additional code…	To identify any associated medical condition such as: • Constipation • Sleep problems • Poor coordination of muscles • Seizures	…and intellectual disabilities such as IQ: • Mild (IQ 50-69) F70 • Moderate (IQ 35-49) F71 • Severe (IQ 20-34) F72 • Profound (IQ under 20) F73 • Other intellectual disabilities F78 • Unspecified intellectual disabilities
Avoid terms such as "history of":	If patient is still being monitored for the condition. • Incorrect wording: Patient has autism. • Correct wording: Patient has autism continues medication.	
Documentation and Coding Tips	The following language supports actively monitoring [any] condition and must be documented by the provider. In the documentation, mention… • If the patient is receiving therapy. • Getting a refill on medication. • The status of the condition.	

Bipolar Disorder

Bipolar Disorder

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels and the ability to carry out day-to-day tasks. People who have bipolar disorder can have periods in which they feel overly happy and energized and other periods of feeling very sad, hopeless and sluggish. In between those periods, they usually feel "normal." One can think of the highs and the lows as two "poles" of mood, which is why it's called "bipolar" disorder.

Symptoms of Bipolar Disorder

People with bipolar disorder experience periods of unusually intense emotion, changes in sleep patterns and activity levels, and unusual behaviors. These distinct periods are called "mood episodes." A clinician would have to determine whether they may be the result of another cause (such as low thyroid or mood symptoms caused by drug or alcohol abuse).

Bipolar Coding Guidance

TIPS:	ICD-10 Mapping and Education
Refer to ICD-10-CM	F31.0 – F31.9 (Bipolar disorder)
Be precise	Avoid broad terms and unspecified codes such as "Bipolar disorder," F31.9, or "Bipolar II disorder," F31.81. Be meticulous in picking up the details in documentation. It leads to precise coding and a better awareness about the disease and the population it affects.
Use specifying terms in the documentation, such as…	Type I or II Current or in remission Manic or mixed Severity (mild, moderate, severe) Presence of psychotic features
Bipolar previously diagnosed? Consider the following…	Two similar conditions cannot occur together, e.g., reporting Depression when Bipolar has been addressed. Depression is considered inclusive of Bipolar disorder, per ICD-10-CM "Excludes 1" note.
Refill medication correctly	Don't forget to verify the condition and list the diagnosis in the Assessment and Plan.

Cancer

Cancer

Cancer starts when cells grow out of control and crowd normal cells. In all types of cancer, some of the body's cells begin to divide without stopping and spread into surrounding tissues. There are many types of cancer and the causes vary greatly.

Oncology Coding

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 primary existing malignancy, a code from category Z85, a personal history of malignant neoplasm, should be used to indicate the former site

Malignant Neoplasm Coding Guidance

TIPS:	ICD-10 Mapping and Education	
Refer to ICD-10-CM	C00 – D49 code series O9A.1- code series (Malignant neoplasm in Pregnancy)	
Specify Anatomical Site and Behavior	• Malignant Primary (original site) • Malignant Secondary (metastasized) • Carcinoma in situ	• Benign • Uncertain • Unspecified Behavior
Primary vs. Secondary	Exam is for Primary Malignant site(s) with known/unknown secondary site(s): 1st Dx: [Primary] Cancer 2nd Dx: [Known/Unknown] Cancer Exam is for Secondary Malignant site(s) with an active primary site(s): 1st Dx: [Secondary] Cancer 2nd Dx: [Primary] Cancer	
Admission for Treatment	1. Code First: • Encounter for radiation therapy (Z51.0) • Encounter For chemotherapy (Z51.11) • Encounter for immunotherapy (Z51.12) 2. Code Second: • Malignancy for which the therapy is being administered	

TIPS:	ICD-10 Mapping and Education
"Active" vs. "History of" vs. "In remission	Active: Malignancy is excised but patient is still undergoing treatment directed to that site. Primary malignancy codes should be used until treatment is complete. • Example: "Patient with ongoing chemotherapy after right mastectomy for breast cancer." History of: Malignancy has been previously excised or eradicated; there is no further treatment directed to that site and no evidence of any existing primary malignancy. • Example: "Breast cancer treated with mastectomy and adjunct chemotherapy 3 years ago." In remission: Don't confuse personal history with "In remission." Codes for leukemia, multiple myeloma and malignant plasma cell neoplasms indicate whether the condition has achieved remission. • Example: "Patient with leukemia documented as 'In remission' is admitted for autologous bone marrow transplantation."

Conduct Disorder

Conduct Disorder

Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. It is not uncommon for a child or teen to experience behavioral problems; however, the behavior is considered to be a conduct disorder when it is long-lasting and when it goes against accepted norms of behavior and disrupts the child's or family's everyday life.

Symptoms of Conduct Disorder

Symptoms of conduct disorder vary depending on the age of the child and whether the disorder is mild, moderate or severe. In general, the symptoms fall into four categories: (1) Aggressive, (2) Non-Aggressive or Destructive, (3) Deceitfulness, and (4) Violation of Rules.

Behavioral and Conduct Disorder Coding Guidance

TIPS:	ICD-10 Mapping & Education
ICD-10-CM	F91.0 – F91.9 (Conduct Disorders)
Do NOT code…	The following disorders if they exist: • Antisocial behavior (*Z72.81-*) • Antisocial personality disorder (*F60.2*)
DO code…	The following disorders if they exist at the same time as Conduct Disorder: • ADHD (F90.-) • Mood [affective] disorders (F30-F39) • Pervasive developmental disorders (F84.-) • Schizophrenia (F20.-)
Documentation and Coding Tips	The following language supports any condition and must be documented by the provider. It cannot be inferred by coders. In the documentation, mention: • If the patient is receiving therapy. • Getting a refill on medication. • The status of the condition.

Congestive Heart Failure

Congestive Heart Failure (CHF)

Congestive heart failure is a condition in which the heart is unable to pump blood to adequately meet the body's oxygen needs. The heart muscle is weakened and unable to keep up with the demands placed upon it.

Symptoms of CHF

The most frequently observed signs of CHF include shortness of breath, edema and weight gain. The heart's function is measured by a percentage known as an ejection fraction (EF). EF is the fraction of blood that is pumped out of the heart with each beat from the left side of the heart. A normal EF is above 50%.

Coding for CHF

- Describe the type of CHF as systolic and/or diastolic
- Relate CHF to left or right side
- Note whether acute or chronic condition
- If known, link CHF to other associated conditions such as Hypertension or chronic kidney disease

ICD-10 Code	ICD-10 Description	Tips
I50.1	Left ventricular failure	
I50.2-	Systolic heart failure	Add 5th character 1 – Acute, 2 – Chronic, 3 – Acute or Chronic
I50.3-	Diastolic heart failure	
I50.4-	Combined heart failure	
I50.9	Heart failure, unspecified	
I11.0	Hypertensive heart disease with heart failure	Use additional code to identify type of heart failure
I13.0	Hypertensive heart and CKD with heart failure and stage 1-4 CKD, or unspecified CKD	Use additional code to identify type of heart failure Use additional code to identify stage of CKD (N18.1-N18.4, N18.9)
I13.2	Hypertensive heart and CKD with heart failure with stage 5 CKD, or end stage renal disease	Use additional code to identify type of heart failure

Depression

Depression

Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think and handle daily activities, such as sleeping, eating or working. To be diagnosed with depression, the symptoms must be present for at least two weeks. Doctors aren't sure what causes depression, but a prominent theory is altered brain structure and chemical function. Depression is not a sign of weakness or a negative personality. It is a major public health problem and a treatable medical condition.

Antidepressant Medication Management (AMM)

Measure evaluates percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.
Two rates are reported:

- Effective Acute Phase Treatment: percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Ongoing monitoring of medication adherence is critical to treatment.

Depression Coding Guidance

TIPS:	ICD-10 Mapping & Education
Refer to ICD-10-CM	F32.0 – F33.9 (Major depressive disorder)
Be precise	Avoid broad terms and unspecified codes such as "Depression," F32.9. Be meticulous in picking up the details in documentation. It leads to precise coding and a better awareness about the disease and the population it affects.
Use specifying terms in the documentation, such as…	Severity (mild, moderate, severe) Episodes (single, recurrent or in remission)
Use a depression screening tool	Mental Health America offers a convenient questionnaire that makes it easy to obtain specific diagnosis codes. Note all disclaimers on the website. Visit http://www.mentalhealthamerica.net/mental-health-screen/patient-health.
Refill medication correctly	Don't forget to verify the condition and list the diagnosis in the Assessment and Plan.

Diabetes

Diabetes

Diabetes is a disease that occurs when your blood glucose, or blood sugar, is too high, which can cause health problems over time. Diabetes causes more deaths a year than breast cancer and AIDS combined and nearly doubles the chance of having a heart attack. The main types of diabetes are type 1, type 2 and gestational.

Comprehensive Diabetes Care (CDC)

Measure evaluates percentage of members 18-75 of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1C (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%)
- Eye Exam (retinal) performed
- Medical Attention for Nephropathy
- BP control (<140/90 mmHg)

Diabetes Coding Tips

TIPS:	ICD-10 Mapping & Education
Refer to ICD-10-CM	E08 – E13 code series (Diabetes) O24 code series (Diabetes in Pregnancy)
Documentation should specify…	• Code first any underlying conditions. Code second the type of diabetes: • Congenital rubella (P35.0) or Cushing's Syndrome (E24.-) • Cystic fibrosis (E84.-) or Malignant neoplasm (C00-C96) • Malnutrition (E40-E46) or Diseases of the pancreas (K85.-, K86.-) ○ Example: Secondary DM due to pancreatic malignancy (C25.9 + E08.9)

TIPS:	ICD-10 Mapping & Education
Identify cause-and-effect relationships	State any relationship between DM and another condition such as: Diabetic coma or Gastroparesis secondary to diabetes Neuropathy due to diabetes or Foot ulcer associated with diabetes Example: Diabetic retinopathy with macular edema (E11.311) *Note: When type of diabetes is not documented, default to category E11 type 2
Use additional code to identify:	Site of any ulcers (L97.1-L97.9, L89.41-L98.49) Stage of chronic kidney disease (N18.1-N18.6) Glaucoma (H40-H42)
Controlling diabetes Be sure to add:	Long-term insulin use (Z79.4) Oral antidiabetic drugs (Z79.84) or Oral hypoglycemic drugs (Z79.84)
Avoid terms such as "history of" if patient is still being monitored for the condition.	Incorrect wording: Patient has history of diabetes.
	Correct wording: Patient has Type 2 DM with ketoacidosis.

ICD 10 Codes for Diabetes Eye Exam

Diagnosis	Type 1	Type 2
No retinopathy	E10.9	E11.9
PDR and ME	E10.351	E11.351
PDR and no ME	E10.359	E11.359
Mild NPDR and ME	E10.321	E11.321
Mild NPDR and no ME	E10.329	E11.329
Moderate NPDR and ME	E10.331	E11.331
Moderate NPDR and no ME	E10.339	E11.339
Severe NPDR and ME	E10.341	E11.341
Severe NPDR and no ME	E10.349	E11.349

Definition:

- ME – Macular Edema
- PDR- Proliferative Diabetic Neuropathy, neo vascularization and/or vitreous/pre-retinal hemorrhage
- NPDR – Non proliferative Diabetic Neuropathy
- Mild NPDR – Micro aneurysms only
- Moderate NPDR – More than moderate but less than severe
- Severe NPDR – No PDR and two or more of the following: severe intra retinal hemorrhages and micro aneurysms in each of four quadrant, definite venous bleeding in two or more quadrants and moderate intra retinal microvascular abnormalities in one or more quadrants.

Obesity

What is Obesity?

A person whose weight is higher than what is considered as a normal weight adjusted for height is described as being overweight or having obesity.

Adult BMI Assessment (ABA)

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

ABA Coding Guidance

TIPS:	ICD-10 Mapping & Education
Refer to ICD-10-CM	Z68.1 - Z68.45
Documentation should specify…	• Diagnoses of obesity and morbid obesity are always clinically significant and should always be reported. A diagnosis noted in the history of present illness (HPI), assessment, or discharge summary suffices without other support. • Always report BMI documented with other weight-related diagnoses when they are supported in the medical record. Do not report a diagnosis of overweight without additional support.

Documentation Tips

A diagnosis of "overweight" does not meet the definition of a reportable secondary diagnosis because it is not considered a significant health risk to the patient.

- If documentation further discusses the patient's overweight condition or a plan of care for it, report the condition.
  - For example, an overweight patient with prediabetes and a BMI of 29.7 is referred to a dietitian for counseling on weight loss to reduce her risk of developing diabetes. Report: E66.3 Overweight; R73.03 Pre-Diabetes & Z68.29 Body mass index (BMI) 29.0-29.9, adult.

- An associated, reportable diagnosis is required for reporting a BMI code.
  - Examples include underweight, malnutrition, failure to thrive, cachexia, anorexia nervosa, overweight, obese, morbidly obese, and abnormal weight gain or loss.

Prenatal and Postpartum Care

Prenatal and Postpartum Care (PPC)

Measure evaluates percentage of deliveries of live births on or between October 8 of the year prior and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- Timeliness of Prenatal Care: percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- Postpartum Care: percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

To Improve HEDIS Measures:

- Ensure that a Notification of Pregnancy form has been sent to the Health Plan.
- Encourage patient to attend all scheduled prenatal visits.
- Ensure that an antepartum flow sheet is completed at each visit.
- Ensure postpartum visit is completed 7-84 days after delivery and includes one of the following:
  - Pelvic exam; or
  - Evaluation of weight, BP, breast, and abdomen or notation of breastfeeding; or
  - Notation of postpartum care (pp check, pp care, postpartum care, 6-week check, preprinted form).

Pregnancy Coding Tips

TIPS:	ICD-10 Mapping & Education
Routine outpatient prenatal visits:	• For routine outpatient prenatal visits with no complications are present, a code from category Z34. • Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis.
Supervision of High-Risk Pregnancy:	• Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. • If no complications assign O80.
Postpartum visit code examples:	• CPT: 57170, 58300, 59430, 99501 • CPT-CAT-II: 0503F • HCPCS: G0101 ICD-10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2